REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 1 – PREMIER AND FINANCE

IMPACT OF THE REGULATORY FRAMEWORK FOR CANNABIS IN NEW SOUTH WALES

UNCORRECTED

At Macquarie Room, Parliament House, Sydney, on Monday 19 August 2024

The Committee met at 9:00.

PRESENT

The Hon. Jeremy Buckingham (Chair)

The Hon. Robert Borsak (Deputy Chair)
Ms Cate Faehrmann
The Hon. Stephen Lawrence
The Hon. Cameron Murphy
The Hon. Natasha Maclaren-Jones
The Hon. John Ruddick

PRESENT VIA VIDEOCONFERENCE

The Hon. Dr Sarah Kaine

UNCORRECTED

The CHAIR: Welcome to the inquiry into the impact of the regulatory framework for cannabis in New South Wales by Portfolio Committee No. 1. This is the second hearing of the Committee's inquiry into the impact of the regulatory framework for cannabis. I begin by acknowledging the Gadigal people of the Eora nation, the traditional custodians of the lands on which we are meeting today. I pay my respects to Elders past and present, and celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of New South Wales. I also acknowledge and pay my respects to any Aboriginal and Torres Strait Islander people joining us today. My name is Jeremy Buckingham, and I am the Chair of this Committee.

I ask everyone in the room to please turn their mobile phones to silent. Parliamentary privilege applies to witnesses in relation to the evidence they give today. However, it does not apply to what witnesses say outside of the hearing. I urge witnesses to be careful about making comments to the media or to others after completing their evidence. In addition, the Legislative Council has adopted rules to provide procedural fairness for inquiry participants. I encourage Committee members and witnesses to be mindful of these procedures.

Mr NICHOLAS BROADBENT, Secretary, New South Wales Bar Association, affirmed and examined

The CHAIR: Welcome, Mr Broadbent. Thank you for making the time to give evidence. We appreciate that the Bar Association has made a submission, but do you have any remarks you'd like to make before we turn to questions?

NICHOLAS BROADBENT: Briefly, thank you. I would like to thank you for the opportunity to appear before the Committee on behalf of the New South Wales Bar Association, which is the professional association for practising barristers in New South Wales. I, too, would like to begin by acknowledging the Gadigal people of the Eora nation, the traditional custodians of the land on which we meet today, and I pay my respects to Elders past and present. I am the secretary of the New South Wales Bar Association and a public defender based in Dubbo. In my practice as a public defender, I cover an area bounded by Lightning Ridge in the north and Broken Hill to the west.

Drug abuse of one kind or another is a feature of many of the cases in which I appear, briefed as I am for the most part in serious indictable matters for legally aided individuals. Features in my cases include a cycle of incarceration, poverty, low education and intergenerational trauma. Many of my clients are Aboriginal people. Some live in the most remote and most socially and economically disadvantaged areas of our State. The tyranny of distance is real, and what has been described as postcode justice in this forum arises in different forms and for various reasons. There is an incontrovertible association between drug use and disadvantage. The New South Wales Bar Association has long advocated for decriminalisation of personal possession and use of currently prohibited drugs, and supports all recommendations of the Special Commission of Inquiry into the Drug 'Ice'. You have already heard extensive evidence of this, and we agree with the submissions made in that regard.

In the association's view, the current stance of our criminal law towards use and possession of drugs has failed to have any significant impact on the prevalence of illicit drug use in New South Wales. Criminalising use and possession carries significant and disproportionate financial, societal and personal consequences. It encourages stigmatisation of people who use drugs as the authors of their own misfortune. It fails to recognise the factors driving most problematic drug use, of which there are many. These are all things that I have seen in my own experience as a public defender. We have provided written submissions and I largely propose to rely upon those. At this point, that's all I wish to say.

The Hon. NATASHA MACLAREN-JONES: Thank you for your submission and for coming today. I have a couple of questions. You would like to propose that cannabis is treated differently to other illicit drugs. Could you outline the reason why but also specifically how that would be the case or what you would be recommending?

NICHOLAS BROADBENT: In relation to cannabis as a specific drug, we know very well that the incidence of cannabis use in the Australian adult population is quite high—far higher than other illicit drugs. In our submission, there is a problematic assumption that the way to solve a problem, as opposed to the extent that is posed by cannabis use, is to criminalise it. In our view, there is simply no evidence that criminal proceedings act as a genuine deterrent of individual cannabis use and, as the ice inquiry found, more generally in relation to drug use. This stance has failed to impact upon the prevalence of illicit drug use and, in our submission, that's particularly so in the context of cannabis.

There is very little causal evidence, in our submission, supporting any criminogenic effects of cannabis use. Only 6.4 per cent of people attributed offending to their cannabis use, and I can say, anecdotally, from my region, other drugs—and those drugs include alcohol—have a far larger criminogenic effect than that 6.4 per cent of cases that might be attributed cannabis. In respect of juvenile offenders, the evidence seems to suggest that cannabis use often postdates minor offending. So to the extent that it might be said to be somehow a gateway to further offending behaviour, that particular position, in our submission, is quite doubtful.

Finally, and picking up on what others have said, assuming that the data on cannabis use is a reflection of what might be described as hazardous use, in our submission, there has to be an assessment of what health and diversionary measures are in place for problematic use. Addressing harmful drug use must contemplate the broader social determinants of use and, in our submission, particularly on the question of cannabis, the legal system is an extremely poor vehicle to broker any kind of response to harmful use, and that's particularly so in the absence of any concomitant crime which might be otherwise punishable in its own right. That's broadly our position as to why we say that cannabis should sit in a different category, but I should also emphasise that the position of the association is one of decriminalisation generally and adoption of the ice inquiry.

The Hon. NATASHA MACLAREN-JONES: Would you say the current diversionary methods are adequate and are they being utilised effectively?

NICHOLAS BROADBENT: There are a number of diversionary measures in place, as I understand it. These particular diversionary measures—I think they are often referred to as de-penalisation. One of the difficulties that arises, and I can say this particularly from my region, is that the use of these particular measures appears to be somewhat haphazard. It disproportionately seems to act against Aboriginal people and that is because many of the criteria—if I can just deal with, for instance, the Cannabis Cautioning Scheme. Some of the criteria which apply for a person to be eligible for a caution include that the offender has no prior convictions for drug, violent or sexual offences, that the offender has to admit the offence, that they consent to a caution and sign a caution notice, and that they haven't been issued with two or more caution notices. We are aware of some recent research that demonstrates that a far higher proportion of Aboriginal people are deemed not eligible for that scheme, and the reason for that, according to that particular study, seems to be that, having regard to the criteria, they are just simply not eligible, and so that's a difficulty.

In circumstances where some discretion is to be afforded in the way that a particular scheme or caution scheme might be administered, that in and of itself relies on discretion—it relies on police discretion. Police discretion may vary depending on locations. It may vary depending on the individual who is being dealt with and also the individual who is exercising that discretion. We have seen, as I understand it, some quite significant disparities in the way that cautions are administered. That's one of the difficulties that arises. Finally, in respect of the administration of a fairly new scheme—the Early Drug Diversion Initiative—it's apparent that there were very few people who were actually diverted into that scheme in the first place. Another issue with these de-penalisation schemes is that if they're not in fact put into place, that's a very problematic thing.

The Hon. NATASHA MACLAREN-JONES: Putting aside the Bar Association's position on decriminalisation and looking at the criteria, do you think there is merit in a further review of how the criteria are used and whether or not there is the flexibility? You talked about regions and, obviously, concerns around Aboriginal people being able to, I suppose, qualify in it. Is there ability for that to be flexible, or is it just too hard to be even implemented?

NICHOLAS BROADBENT: As I recall it, a former police commissioner, in discussing this issue of a discretion, suggested that unless there are clear guidelines it can lead to real confusion. As I say, our principal position is one of decriminalisation. But if we're talking about de-penalisation, what that de-penalisation needs to focus on is bringing as many people as possible within the ambit of eligibility. As I see it, particularly in my region, one of the really significant barriers to these diversionary schemes, which can have very positive effects for individuals, is that by the time an individual may be eligible they're already on what we might describe as the criminal ladder. That's part of the problem.

There is also a very significant issue in relation to the fact that when, for instance, we look at the Cannabis Cautioning Scheme, it's necessary to admit the offence. There are difficulties, particularly with Aboriginal people, with trusting police. The admission of offending conduct is something that may indeed carry with it some real difficulties that arise from longstanding issues of trust, for instance. In our submission, any of these schemes really need to be focused on trying to improve the level of flexibility but, at the same time, providing that level of certainty as to how a discretion will be exercised. That's a very difficult balance, in my view.

The Hon. CAMERON MURPHY: Thank you, Mr Broadbent, for your submission and for coming along today to give evidence. How could criminalisation be relaxed while not removed? Do you think there are any mechanisms that could achieve that? I know your position is for decriminalisation but, if we weren't to recommend that at this Committee, what other steps could we take that could in effect relax it?

NICHOLAS BROADBENT: If we're dealing with the issue of cannabis, for instance, one of the previous questions was directed at this idea that perhaps cannabis falls into a slightly different category. We would embrace that as a proposition. Firstly, on the question of decriminalisation, if it is to be something that is a staged or in some way modified process, we need to look at the actual harm that's being caused by a particular drug. As I say, the issue of cannabis is that it carries with it quite low criminogenic effects, so there is scope to do it in that way. The other thing I need to emphasise is that when it comes to issues such as drug trafficking and manufacture, we certainly are not of the view that decriminalisation in that instance is appropriate. What we're dealing with here is the personal possession and use of a particular drug.

The Hon. CAMERON MURPHY: Are you familiar with the South Australian Expiation of Offences Act? Is that a mechanism that could provide a guide for use in New South Wales, where, for example, for people that are convicted of personal use/possession quantities only, in effect those convictions could be excluded under the Crimes (Sentencing Procedure) Act in terms of sentencing for other offences?

NICHOLAS BROADBENT: As I understand it, the South Australian model provides for expiation on payment of fines for, I believe, less than 100 grams of cannabis. There are other illicit drugs that are also eligible for that scheme. One of the important things about the expiation scheme in South Australia, as I understand it, is

that under the Expiation of Offences Act the expiation of an offence means that it is not something that can be subsequently used in further criminal proceedings—that is, the fact that a person has had an offence expiated cannot be used and doesn't constitute an admission of guilt.

The process of expiation, as I understand it, permits an individual to in effect deal with a matter in accordance with what might be described as a civil penalty without taking the matter any further, and without in fact being prosecuted at all. That's a positive thing. As I say, it is something which ensures or at least reduces the risk that the person enters onto that criminal ladder I discussed earlier. One thing we need to bear in mind is that the use of fines disproportionately discriminates against low-income individuals. There is no doubt there is a substantial correlation between drug use and poverty. One of the difficulties with, say, a fine-only approach is that the payment of fines is a condition of expiation. In South Australia, if you don't pay those fines, you proceed to be prosecuted. That in and of itself is an issue.

The Hon. CAMERON MURPHY: Other than that issue, you're saying it can provide benefits in terms of in effect removing what's a very small criminal offence—something that doesn't have a connection with other offending behaviour—from the criminal justice system so that people have an opportunity to get their life on track? That's really what you're saying, is that right?

NICHOLAS BROADBENT: Yes, I absolutely agree with that proposition. At the end of it, a criminal conviction is something that has substance. A person with a record is treated differently by a court to a person without a record. There is a substantial amount of stigmatisation that flows from that. The other thing I would say—and this is particularly so in our most marginalised communities—is that the more people who are convicted, the more that conviction and criminalisation is normalised. If everybody around you has criminal convictions or has spent time in custody, the process of being convicted and spending time in custody becomes something which is quite normalised. As a general proposition, I'd be very much in favour of reducing that.

The CHAIR: Mr Broadbent, you were talking about the Cannabis Cautioning Scheme being unavailable to a lot of First Nations people for a range of reasons. Which of those criteria, do you think, if we were considering reform of that scheme, would you prioritise? If you were going to increase accessibility to First Nations people, is it the admission of guilt or is it no prior offences?

NICHOLAS BROADBENT: As a general proposition, the fact of prior convictions for drug, violence or sexual offences is something which is quite problematic in the context of a cautioning scheme because if the discretion which is available under the Cannabis Cautioning Scheme has not been applied in the past and a person has been convicted, then potentially they are not able to access that. That is something that, in my view, needs to be a significant priority. The need to admit to an offence is problematic, I think, in the context particularly of young people. It needs to be made really clear, in my submission, that if a person is going to be admitting to some conduct or to an offence, that they have some certainty as to the outcome before they do that. One of the observations made was that the standard advice given to people is to say nothing, and that can be accepted. That often is the standard advice, but that might be against a person's interests because it leads to them being prosecuted.

The CHAIR: For our edification, when and where is that admission required to be made?

NICHOLAS BROADBENT: As I understand it, the admission needs to be made before the caution is administered. So if a person is not willing to admit the offending, then that is an issue for eligibility. That's where the difficulty lies. I think that's the position.

The CHAIR: And this happens on the spot, in a police station or—

NICHOLAS BROADBENT: I believe that to be so, yes.

The CHAIR: In your submission you argue forcibly for the decriminalisation of the personal use of all illicit drugs, but when it comes to cannabis you stop short of calling for a legalisation regime. Yet other jurisdictions like Canada, Germany and increasing parts of the US have moved that way. Why do you make that distinction between legalisation and decriminalisation?

NICHOLAS BROADBENT: The position that the Bar Association adopts is in accordance with the recommendations of the Special Commission of Inquiry into the Drug 'Ice'. That's the first proposition. We support that position. What any scheme of legalisation requires, I would suspect, is a truly whole-of-government proposition. It would require a very substantial health response. It would require a substantial amount of investment into programs to ensure that harm is minimalised. In our view, the appropriate first step is one of decriminalisation. In the context of what has been said by other speakers, I believe Mr Cowdery made reference to wearing two hats and expressed a particular view in relation to the merits of taxing, regulating and the like. That is a view which certainly has some academic and some real-world experience elsewhere. However, in the

absence of a very comprehensive whole-of-government scheme, really, the decriminalisation particularly of personal use and personal possession, in our submission, is entirely attainable and what should be aimed for here.

The CHAIR: You were making the point about the link between disadvantage and drug use, and you have said that the Cannabis Cautioning Scheme is unavailable to First Nations people. What's the consequence, in your experience, for a young person with a conviction for cannabis possession? In your experience, for someone who is convicted of that, what are some of the negative impacts that they may experience?

NICHOLAS BROADBENT: The first aspect is that the presence of a record, in and of itself, is something that is stigmatising. It may act as a deterrent to seek help, if help is required. One of the aspects, particularly in regional areas—and this doesn't only apply to young people; it applies across the board—is that there is a substantial risk of what is referred to as "secondary offending" that can flow from a person being convicted of a particular offence. If conditions are placed upon them—an example of that can be where the way that a person travels might somehow be restricted. In a remote and regional area where public transport, for instance, is not available or not particularly well resourced, then that's something that can give rise to, in effect, secondary offending.

Secondary offending is problematic because, particularly where it flies in the face of an order of the court, that is, in and of itself, quite a serious matter, and it is viewed as such. Very quickly, people's levels of criminality can escalate and increase. As I referred to earlier, one of the other issues I think, particularly for young people, is a change in expectations. There is a normalisation of criminality and punishment as being part of life. We have also made reference to the fact that criminalisation disrupts education, particularly if there is incarceration involved. It can disrupt working prospects. That's a very significant matter. If a person has a record, they may be prevented from doing particular jobs. Also, if we take it to the extreme and deal with issues of imprisonment, imprisonment in and of itself may increase the risk of reoffending.

People are placed in a position, particularly involving drugs of addiction, where they are effectively withdrawing from those drugs in police or court cells, which are ill-prepared to support any such withdrawal. People who may not have otherwise been exposed to serious offenders are placed in an environment where they are naturally exposed to that. Drugs may be readily available in custody, and the use of those drugs is often done in the context of high-risk situations, particularly associated with violence and also with high rates of transmission of bloodborne diseases and the like. Finally, people who are in the criminal justice system may have more difficulty with accessing appropriate alcohol and drug programs in custody. So that's another aspect. Indeed, on release, there can be difficulties with that as well.

The Hon. STEPHEN LAWRENCE: Mr Broadbent, I'm interested in your thoughts on a pretty specific matter. If we were to recommend a liberalisation of the criminal laws that apply to cannabis, perhaps as an interim phase prior to a full decriminalisation of cannabis, in that interim phase, do you see any reason why police should be able to search a person on a cannabis suspicion of possession of a small quantity of cannabis? To turn the question around, do you think there would be any problem, in a legal sense or a policy sense, of having a situation where cannabis possession remained a minor criminal offence but there was no power for police to search a person on account of a suspicion of possession?

NICHOLAS BROADBENT: Could I start by saying that search, as a general proposition, is problematic in the context of where drugs are criminalised. That is something which is likely to be exacerbated by measures such as the recent wanding legislation where, if a person is wanded and the wand responds, then they are liable to being searched. Your question, as I understand it, is about, in the context of a staged decriminalisation, whether the finding of a particular quantity of drugs—of cannabis, in this instance—is something that should be entirely decriminalised. Is that what your question is getting at?

The Hon. STEPHEN LAWRENCE: No, the question was more, in a potentially interim phase, where the application of the criminal law to cannabis is relaxed, might it be appropriate to remove from the Law Enforcement (Powers and Responsibilities) Act the power for police to search a person on account of a reasonable suspicion of possession of a small quantity. In effect, you would create an environment where it would still be a minor criminal offence to possess, but it couldn't be used as a basis to search.

NICHOLAS BROADBENT: In our submission, that would be an appropriate measure. As I say, one of the issues that arises, particularly with young people and young Aboriginal people, is the effect of proactive policing. There are powers of search that, inherently, particularly when we are dealing with things like wanding, cause significant problems. In our view, there is absolutely no difficulty with the proposal that you have put forward. It seems that, if we are going to be moving towards a model of decriminalisation, then at the very least the ability to search a person based on that suspicion should fall away quickly.

The Hon. STEPHEN LAWRENCE: Do you see any problem—conceptual, legal or policy—with a legal position where the default position or possession of cannabis is that a person is not convicted? For example, you could amend section 10 of the Crimes (Sentencing Procedure) Act so that a person can only be convicted if the court so orders. You could even condition it upon exceptional circumstances or something of that nature.

NICHOLAS BROADBENT: No, I do not. That seems to be something approaching a de jure depenalisation approach, as opposed to a de facto approach. One of the benefits of that, if we were to compare it to, say, the Cannabis Cautioning Scheme, is that you are placing the discretion in the hands of a decision-maker—the courts—who is applying the law every day and who is tasked with that specific job of making decisions about whether or not a conviction should follow. There is no difficulty with a statutory presumption against conviction. Statutory presumptions arise all the time in the criminal law. In our view, that would be an appropriate measure.

The CHAIR: Thank you for your evidence today, Mr Broadbent. That concludes our questions. We very much appreciate the Bar Association making a submission and for you taking the time today to give evidence. We very much appreciate it, and the work that you do generally. I don't think there were any questions taken on notice. Thank you, again.

(The witness withdrew.)

Ms SAMANTHA LEE, Supervising Solicitor, Redfern Legal Centre, affirmed and examined

The CHAIR: Good morning, Ms Lee. Thank you for taking the time to appear on behalf of the Redfern Legal Centre. We appreciate your submission and your attendance today. Do you have any beginning remarks you would like to make?

SAMANTHA LEE: Yes, thank you. I would first like to acknowledge the Gadigal people of the Eora nation and pay my respects to Elders past, present and emerging. The country still has a lot of truth-telling and healing to undertake, especially after the failure of the referendum. I would like to thank the Chair and Committee for inviting Redfern Legal Centre to give evidence. I specifically want to hone in on strip searches for minor drug possession.

I would like to commence by telling the story of Jess. Jess is 17 years old. She attended a music festival. She had saved up for some time to buy the ticket to enter this festival. While standing in line to enter the festival, she was tapped on the shoulder by a drug dog handler, who told her that the drug dog had indicated. Jess was then pulled out of the festival line to a tented area. She was told that the drug dog had indicated and she was asked if she had any drugs on her. She said she didn't. She said that a friend of hers had smoked some marijuana just before they had come in but she did not and she did not have any drugs on her.

They did not believe her—the police. They then asked her to take off all of her clothes and to stand naked with her hands against the wall. They asked her again if she had any cannabis on her and she said no. They then asked her to squat—a female officer was in the tent with her—and they asked her to cough and they asked her to pull apart her buttocks and lift up her breasts. She was crying at the time, still saying that she did not have any drugs on her. Nothing was found on her. They then searched her bag, and nothing was found in her bag. She was in tears. She was then told to get dressed and then told to leave the festival and told to put on her clothes. She was marched by two police officers out of the festival and her ticket was confiscated. This is on the basis of suspicion of minor drug possession—of having a minor amount of cannabis on her.

I'm mainly here today to ask you, as the Committee, to change the legislation when it comes to strip searches and make it very clear that suspicion of minor drug possession does not meet the legal threshold to conduct a strip search. The majority of strip searches are conducted on the basis of suspicion of minor drug possession. The after-effects of a strip search are lifelong and traumatic. The number of young people I've taken instructions from, both male and female, are in tears describing what has happened to them. I can only describe it as similar to taking instructions from someone who has been sexually assaulted.

This practice cannot continue. We cannot allow New South Wales police to continue to stripsearch someone on the basis of having minor drug possession—of having a minor amount of cannabis. The impact of drugs, particularly a minor amount of cannabis, is not as much as the impact of being stripsearched. The impact of being stripsearched is traumatic, long-lasting and really does impact on that young person, even more than a minor amount of drug itself. It's antiquated law, and here is your opportunity today to stop that practice.

The Hon. JOHN RUDDICK: Ms Lee, thank you very much for your opening statement, which I found very interesting. Talking more generally about cannabis use in New South Wales amongst First Nations peoples, would you say that cannabis use is increasing or decreasing over the last five to 10 years?

SAMANTHA LEE: I'm no expert in the amount of cannabis being used over a period of time, so it's probably best to ask someone else that question.

The Hon. JOHN RUDDICK: Do you think other, harder drugs are an increasing problem amongst Aboriginals or has it sort of stabilised?

SAMANTHA LEE: Again, I'm no expert in the amount of drugs being used and who is using the drugs. I think that should be directed to someone else.

The CHAIR: We've heard this morning that the Cannabis Cautioning Scheme is unavailable to people on the basis of the discretion of the officer, but also because of the various criteria that someone has to meet. Of those criteria—which we've heard is admission of guilt and so forth—which needs to be amended first to make it more available to people?

SAMANTHA LEE: I don't think there should be a limit on the number of cautions available to a police officer. Also, what we've found through some figures around policing and cannabis is that First Nations people are disproportionately over-policed when it comes to cannabis. Maybe there needs to be more rigour when it comes to the cautioning scheme itself.

The CHAIR: Do you think that some of the criteria, such as needing to admit guilt, need to be reviewed to make it more available as well? Or there's the situation that, if you have a prior conviction, you cannot avail yourself of the Cannabis Cautioning Scheme; you're removed from it. Do you think that is problematic? Is that something that we should—

SAMANTHA LEE: I do think it's problematic. I do think it needs to be reviewed. It does mean that very few people are able to make it through that cautioning scheme. What we're talking about is a small amount of drugs, minor possession, and we're talking about young people. If you don't look at the actual criteria for the cautioning scheme, you'll continue to narrow the amount of people who will go through that scheme and continue to see a disproportionate amount of First Nations people being allowed via that scheme.

The CHAIR: We heard this morning from the Bar Association that cannabis and possession of a small amount of cannabis can be the first step that young people and First Nations people take onto the rungs of the criminal justice ladder. Is that your experience?

SAMANTHA LEE: It is. My experience is the first stage is at the policing level. Those who are policed more are, obviously, given more offences and are given more CANs. The amount of money that you're looking at in terms of getting these young people through the justice system is ludicrous. At first, you have the policing costing, then you have the solicitors and youth workers, and then you have the judges and the legal system. All of this is for a small amount of cannabis. Then you have the impacts later on of them getting a criminal record that's impacting on their employment. In terms of an economic scale, it does not make sense. In terms of compassion to young people and the fact that young people make mistakes—like all of us did when we were young—it is a cruel system that does not allow for the honest perspective that young people make mistakes. It's not a big mistake, and it should not impact their lives in the way that it does.

The CHAIR: In your submission, you argue for a strict liability test for drug driving, effectively giving people a defence if they could prove they were not breaking the law, as well as a defence for medicinal cannabis users. Is that offence and that issue something that is emerging more and more for people defending First Nations people and others in the courts?

SAMANTHA LEE: I think there is a lot of injustice with roadside drug testing. It doesn't actually give you any indication how it's impacting on someone's driving level. It's not really equal to the alcohol testing system. It's catching a lot of people out and putting them towards the criminal justice system unnecessarily. I think it is a very unfair system. We've had a recent court case where it seems that the honest and reasonable mistake argument has now been taken out of the equation, which will make these matters before the court very difficult to win. You'll see more people ending up pleading guilty who may not even be affected by the drug that they took maybe seven or eight days ago.

The CHAIR: There is a lot of evidence emerging from the United States that the prohibition of cannabis and other drugs had a racial element. It was designed to police and prejudice particular racial minorities. Do you think our prohibition on cannabis has a discriminatory, racial basis? Effectively, are these laws racist, do you believe?

SAMANTHA LEE: I think the figures speak for themselves. In regards to the policing of cannabis, BOCSAR says that 80 per cent of those who are given a cannabis offence are First Nations. This is a really high proportion. You can only conclude from that that there is a racial aspect to the policing. We need to stop denying in Australia that all levels of government have some kind of racial bias. Policing is not averse to that. We certainly see from the figures that it is coming out on the ground.

Ms CATE FAEHRMANN: The drug summit is coming up. Hopefully, there'll be a few good sessions looking at different regulatory frameworks for drugs, whether it's decriminalising or legalising in different situations. In terms of decriminalisation, how would you like to see that? We have got what is deemed almost decrim-lite in some ways. Since the beginning of the year, data that my office has obtained suggests that the police aren't really using their discretion, if you like, to issue fines. It seems that most people are still being charged. If the Government was to go further, what type of decriminalisation model would the Redfern Legal Centre prefer to see?

SAMANTHA LEE: We actually haven't yet come up with the position of the preferred model. We're still taking a lot of information from more experts in the field—I guess, newer and unharmed—about which model to take on board. What we can say from our understanding at Redfern Legal Centre is that suspicion of minor drug possession, not just cannabis, is the most common way into a search. There was a question from Stephen Lawrence about if you can stop the searches for minor drug possession, then you would stop a whole range of offending or CANs being issued.

Police are, for good reason, I guess, quite skilled at starting a conversation around drugs and what's in the bag. If you put some tighter rigour around the easy way into a search, you will see a pullback in the number of people before the courts. It is so easy at the moment to search someone on the basis of minor drug possession. With the fine aspect, many cases are not getting before the courts and police are not needing to prove whether they've actually met the legal threshold of reasonable suspicion, because someone just pays the fine. There are real problems with a fine-based system because you then are not making police accountable for proving that they have met reasonable suspicion. The more you divert things to the fine system, the more you'll make reasonable suspicion less accountable.

Ms CATE FAEHRMANN: Interesting. From your experience over the last, say, five or 10 years working in this space—I suppose the data speaks for itself, but are less people ultimately going to prison because of a personal quantity of cannabis possession?

SAMANTHA LEE: I don't have those figures, so I can't answer that question.

Ms CATE FAEHRMANN: And people are still going to prison?

SAMANTHA LEE: Again, I don't have those figures. I don't know.

Ms CATE FAEHRMANN: From your experience, though? I don't necessarily need the stats now but from your experience, in terms of representing people.

SAMANTHA LEE: It depends on their criminal record. If they're on parole and they get called up for a minor drug possession, then yes, they could still go back to prison.

The Hon. ROBERT BORSAK: Ms Lee, did I hear you say earlier in your evidence that the current law is being motivated by racial prejudice?

SAMANTHA LEE: I said that all government institutions need to be aware of their racial position, and that certainly police—through the statistics around those who are policed for possession of cannabis, First Nations people are disproportionately over-represented in those figures from BOCSAR.

The Hon. ROBERT BORSAK: Why do you think that is the case? Because of naked racial prejudice or because First Nations people use more marijuana or drink more alcohol? What's the reason for that, as far as you're concerned? You are part of the Aboriginal—you're in the business of helping defend them and advocate for them, so perhaps you would see more of that than what happens outside of their community?

SAMANTHA LEE: Yes, sure, but it's not our figures; it's from the Bureau of Crime Statistics and Research that shows that First Nations people are over-represented when it comes to possession of cannabis.

The Hon. ROBERT BORSAK: I accept that because I've seen it myself, but why is racial prejudice being supported in those BOCSAR numbers?

SAMANTHA LEE: There are racial factors that come into play. There are people who are obviously over-policed more than others. There is poverty that comes into play. There are those who are more present on the streets. Certainly you cannot deny, based on figures coming out of those who have been searched, those who have been stripsearched, those who force is used against, First Nations people are over-represented in those figures. You cannot say that First Nations people are more likely to commit crime; I think what you could say is that First Nations people are more likely to be policed than anyone else.

The Hon. ROBERT BORSAK: You're saying that's because of their racial background?

SAMANTHA LEE: Of course, yes.

The Hon. ROBERT BORSAK: Where are the stats to prove that?

SAMANTHA LEE: BOCSAR.

The Hon. ROBERT BORSAK: The BOCSAR stats actually say that is evidence that they have been racially profiled? They don't, do they?

SAMANTHA LEE: The stats show that they are disproportionately over-represented in also very minor offences.

The Hon. ROBERT BORSAK: BOCSAR shows they are over-represented—there's no question of that—but not because of race.

SAMANTHA LEE: Maybe this inquiry can look at why they're over-represented.

The Hon. ROBERT BORSAK: Have you looked at what other forms of abuse, personal or otherwise, may be part of why the use of marijuana is perhaps overused in the Aboriginal community? In other words, is there a coincidence of overuse of alcohol, for example?

SAMANTHA LEE: I don't know if it is overused. It's overcharged. Whether that ends up in convictions is a different question.

The Hon. ROBERT BORSAK: I'm talking about other addictions. That's what I'm leading up to.

SAMANTHA LEE: I'm not an expert in addictions, only in my experience around policing.

The Hon. ROBERT BORSAK: That's not my question. You don't have to be an expert in other addictions. Do you see other addictions that happen besides the overuse of marijuana, for example? Do you see other drugs being overused with marijuana?

SAMANTHA LEE: In the general population?

The Hon. ROBERT BORSAK: No, I'm talking about in the population that you're representing.

SAMANTHA LEE: We don't just represent the First Nations population; we represent everyone across New South Wales, actually, who can come to our practice.

The Hon. ROBERT BORSAK: Let's talk about the First Nations population because that's what you're here giving evidence about.

SAMANTHA LEE: This isn't an alcohol inquiry; it's about cannabis. I don't know about the overuse around other drugs.

The Hon. ROBERT BORSAK: So you're just talking only about one thing. You don't know about the other parts of what may be happening in their community that may also influence addiction?

SAMANTHA LEE: No, I'm not an expert in addiction. I'm only here to give evidence about policing when it comes to cannabis regulation in New South Wales.

The Hon. ROBERT BORSAK: Your evidence is that, because they're over-represented in the BOCSAR statistics, that is supportive of the fact that there's racial profiling going on by the police.

SAMANTHA LEE: Yes. It's not a small over-representation—for example, First Nations people make up around 3 per cent of the population in New South Wales and make up around 80 per cent of searches in regard to cannabis, or they make up around 60 per cent of searches when it comes to strip searches. We're not talking about a minor increase; we are talking about a very significant, disproportionate amount of searches.

The CHAIR: Ms Lee, did you say 8 or 80?

SAMANTHA LEE: I thought it was 80, but I could stand to be corrected on that.

The Hon. ROBERT BORSAK: How does that support the contention that police are racially profiling Aboriginal people?

SAMANTHA LEE: It's based on my case work at Redfern Legal Centre and the instructions I take from my clients. It's also based on some research done by Tamar Hopkins in Victoria who has done some research around racial policing and profiling. It's not a concept I've taken out of the blue. It is a concept that has been quite well researched, particularly overseas and in America. Certainly here in Australia, there are papers that look at racial profiling and policing.

Ms CATE FAEHRMANN: Ms Lee, I wanted to see whether you're aware of the report by the Law Enforcement Conduct Commission in 2003, the *NSW Police Force Aboriginal Strategic Direction 2018-2023 Monitoring Report*, which found that in 2020 the LECC reported that 42 per cent of young people on a suspect targeting management plan were Aboriginal or Torres Strait Islander. They recommended that police reduce that over-representation. Police accepted that recommendation. You're aware of that in terms of a fair bit of research, including, I think, the police themselves accepting recommendations around over-representation of First Nations people?

SAMANTHA LEE: Certainly, yes. I'm also aware of the Mantus report where I did represent the young boy in that case, who was quite badly injured after a police chase out in regional New South Wales. I'm also aware of another LECC case where the nipples of a First Nations person were pinched by a police officer with other police officers in an ambulance. I'm aware of a lot of different research by the LECC and by BOCSAR, and by our own statistics from New South Wales police, that show that First Nations people are poorly treated by some aspects of New South Wales police and poorly over-represented in statistics when it comes to policing.

The Hon. STEPHEN LAWRENCE: Thank you for your evidence, Ms Lee. It's really helpful. I want to ask you about section 31 of LEPRA. Part of it provides that, when a police officer is considering undertaking a strip search, they need to have considered the seriousness and urgency of the circumstances and formed the view that they make it necessary to search. In your experience, does that part of the section get any use in terms of searching for possession of small quantities of drugs? Do you know of cases, or is it common for police to be considering a search but then form the view that, because it only pertains to a small quantity of, say, cannabis, that part of the section is not made out, and then decline to undertake the strip search? Is that common?

SAMANTHA LEE: What the figures suggest—because there were around 3,000 strip searches last year alone, that says to me that police are not turning their mind to the threshold of "serious and urgent". If the basis of the search is because of minor drug possession, my submission is that police are not turning their mind to and not meeting that legal threshold of "serious and urgent". The first step would be for them to first turn their mind to whether even a general search is necessary. Just because, for example, a drug dog indicates is not a reason to conduct a search. That's in the New South Wales police SOPs around drug dogs. It does not give police a reason to search; it only gives police a reason to question and then form reasonable suspicion whether a general search should be conducted. Even if a general search is conducted and nothing is found, that does not then give police the legal threshold to then conduct a strip search. A strip search has a very high legal threshold, and if you're going straight from a drug dog indication to a strip search, then that says to me that you have not turned your mind to the legal threshold of "serious and urgent".

The Hon. STEPHEN LAWRENCE: Are you aware of any internal police guidelines or documents that direct police as to how to consider this question of the seriousness and urgency of the circumstances—in particular, any guidelines or internal documents that say to police, for example, "You must consider what it is that is in your mind that the person might be in possession of"? And if it is a small quantity of cannabis, then you might form the view that "the seriousness and urgency of the circumstances" do not make it necessary.

SAMANTHA LEE: No. The current guidelines or standard operating procedures are called the Person Search Manual by New South Wales police. It does not set out a framework for what you have just said. What we really want is for LEPRA to make it clear that minor drug possession does not meet that legal threshold of "serious and urgent", and for the legislation to give that example and to provide better guidance to police about that threshold.

The Hon. STEPHEN LAWRENCE: Section 31, in that respect, would seem to be a legislative indication to police that they should be considering all the circumstances, including this potential offence that they have in mind. Would you agree that it's not an efficacious way to give that sort of direction or indication to the police by putting it in a subsection in a somewhat coded way where it talks about seriousness and urgency? To be efficacious, that sort of direction needs to be clearer.

SAMANTHA LEE: It does need to be clearer, yes. The police need to have a rigorous understanding of what "serious and urgent" means, otherwise we will see this many strip searches occurring—which has started around 5,500 in 2019. If there is just suspicion of minor drug possession, then that in itself tells me that they cannot conduct a strip search because it does not meet that high legal threshold of "serious and urgent". Once they form that suspicion, they cannot conduct a strip search.

The CHAIR: Are there any cases that have tested that? Have you or others taken cases that tested that threshold of "serious and urgent"?

SAMANTHA LEE: There are not many cases that have gone to hearing. Most stripsearch cases settle. There is a case called Attalla where a man was stripsearched, although it was in police custody. He was stripsearched on the basis of minor drug possession. The court found that police didn't even meet the threshold of "reasonable suspicion". He was awarded damages in the civil court of $110,000. There is only one other case, and I can't remember it off the top of my head. There are not many cases that come before the court.

The Hon. CAMERON MURPHY: Could you take that other case on notice?

SAMANTHA LEE: Sure.

The Hon. STEPHEN LAWRENCE: Your submission says that 91 per cent of all recorded reasons for conducting a strip search are about the possession of drugs.

SAMANTHA LEE: Yes, minor drugs.

The Hon. STEPHEN LAWRENCE: I appreciate that you won't be able to be specific, but how many of those cases do you think would fall into a category where searching for the possession of drugs is the ostensible reason for the search, but in fact the search is occurring as part of either a motivation in relation to some other

offence or searching for drugs as part of proactive policing because the person is on a target list—a sort of collateral reason for the search.

SAMANTHA LEE: It's hard to tell. What we do know through the statistics from the University of New South Wales and Vicki Sentas' report, is that only under around 10 per cent of strip searches end up in a conviction of supply, and even less end up in a conviction for the use of a weapon. That says to me that strip searches are being used unlawfully, but also proactively and as an aggressive way of policing. Strip searches are very traumatic. For me, taking instructions from young people, it feels like strip searches are being used as a means by police to say, "Well, don't do this again because this is what will happen." It's a very aggressive form of policing and it leaves a long and lasting impact. I would submit that the majority of strip searches done by police are unlawful, and they have not met the legal threshold to conduct them.

The Hon. STEPHEN LAWRENCE: If you assume that a lot of strip searches are being undertaken as part of proactive policing, for example, a person is on a target list not because police are concerned that they will be in possession of minor quantities of drugs, but police are concerned that they'll do other offending and they are using drug laws, in effect, as a part of proactive policing. Is that legitimate or not legitimate? Is that an important part of the police armoury of powers? Is that a legitimate way to interrupt offending, or is it not a legitimate thing to be using drug laws as a pretext for some other objective?

SAMANTHA LEE: It is unlawful, not legitimate and harmful. What we found through the Coroners Court inquest into deaths at music festivals is that stripsearching and drug dogs are having a harmful impact on young people's health and the possibility of them dying at a festival. What young people do is that they know police are going to be at these festivals and they preload—those who are taking drugs. Instead of taking one drug at a time, they may take four or three pills before going into the festival. They then go into the festival and it's hot, they don't drink water and if they do feel unwell, they won't ask for help because they're too scared that they're going to get into trouble. This whole atmosphere in context actually harms young people and causes an atmosphere where it may lead to death, mostly because they won't ask for help. What we want from New South Wales policing is where anyone can ask for help and not feel that they are going to get into trouble, but that they feel they're going to get some assistance—particularly if they're having a bad drug experience.

The CHAIR: Thank you very much for your evidence today. We very much appreciate you taking the time to appear. We also thank you for your submission and the work that you do in the community. The secretariat will be in contact regarding that matter you took on notice.

(The witness withdrew.)

(Short adjournment)

Dr ROBERT MAY, Chair of Addiction Psychiatry, Royal Australian and New Zealand College of Psychiatrists, New South Wales Branch, affirmed and examined

The CHAIR: Thank you for your attendance, Dr May, on behalf of the RANZCP. Would you like to make a short introductory statement?

ROBERT MAY: On behalf of the College of Psychiatrists and the New South Wales branch, we welcome the invitation to make a submission on this proposed legislation. From the perspective of psychiatrists who are concerned with mental illness and the subsection of addiction, this proposed bill is of interest to us—first, the potential effects of cannabis in the community and its effect on mental illness but as well the regulatory framework and the way in which some members of the community are targeted by the criminalisation of cannabis.

First and foremost, we would like to say that we are in support of decriminalisation of cannabis, from the point of view that criminalisation negatively affects people in our communities who are already disadvantaged, in terms of Aboriginal and Torres Strait Islanders, young people and people located in rural and remote communities. From our concern of increase in the incidence of mental illness, we have not found there to be any increased harms associated with psychosis or other mental disorders, as found in evidence from the United States as well as what we've observed in the ACT. In other matters related to the proposed bill, we do have concerns with some of the regulatory framework in relation to therapeutic prescribed cannabis, in that we have seen that there's been an increase or flooding amount of cannabis into patient populations with existing mental illness.

Ms CATE FAEHRMANN: In that last statement you're talking about medicinal cannabis that is readily available, via a phone call or whatever, to patients with existing mental illness. It seems very easy to obtain. Could you expand a little bit on that?

ROBERT MAY: There has been a rapid uptake in prescribed cannabis and, like you're mentioning, a lot of it is very easily accessible, sometimes without even having to see a doctor face to face. From our perspective of treating patients with underlying severe mental illness such as mood disorders or schizophreniform disorders, cannabis has been seen to exacerbate and cause relapse in people with those conditions.

Ms CATE FAEHRMANN: I want to tie that in with your submission where you talk about the ACT experience. It has legalised cannabis and when that happened, obviously, there was a significant reduction in cannabis offence notices being issued. A key part of any legal framework is education, information and, therefore, transparency, around use of the drug. You say that ACT Health did a public health campaign, and that ACT Health data showed "no increases in hospital presentations since the laws passed". Do you support a legal framework? Or are you just noting that what has happened in the ACT is reasonably beneficial? You're noting the increase in the use of medicinal cannabis by people with mental health issues. However, on the flip side, there is evidence, in terms of a legal framework, of increased public health information and warnings being issued by ACT Health. Are you saying there are not enough public health warnings in place under the existing medicinal cannabis framework?

ROBERT MAY: I would say that there could be more and that there isn't a good level of knowledge by people who are accessing medicinal cannabis, and that those who have found ways of acquiring it often are unaware of the harms.

Ms CATE FAEHRMANN: Your submission also states that research in the United States, where cannabis has been legalised, found:

> … there was no statistically significant difference in the rates of psychosis-related diagnoses or prescribed antipsychotics in states with medical or recreational cannabis policies compared with states with no such policy.

From your point of view, is that because where there is a legal framework people get access to that information and they are able to talk about the impacts of cannabis, and psychosis, much more openly and transparently? Otherwise, wouldn't there be more psychosis with people being able to access cannabis more? How come there isn't?

ROBERT MAY: I think we have to distinguish between the two different populations that are using cannabis. The first, and I think the one that we're talking about mainly here, is people who use cannabis recreationally. Having a framework to decriminalise cannabis, we believe, would be helpful. We see the criminalisation of cannabis as a harm in itself, because once someone is convicted then that has further consequences on their life. The second population we're discussing is people who are prescribed cannabis for a believed indication for a medical illness. It is true. In the submission that we have outlined, there hasn't been a statistical increases in psychosis or other mental health related conditions at a broad population level. However, from the point of view from the College of Psychiatrists, we are responsible for overseeing the health care of

people who are very vulnerable and a smaller subset of the population who are vulnerable to having exacerbation of underlying mental illness.

The CHAIR: That was your assessment when you talked about broad populations; you were talking about in the US, in jurisdictions that have moved to a broad legalisation, medicinal regime? There hadn't been a statistical uptick in presentations of psychosis or other disorders?

ROBERT MAY: No, there hasn't.

Ms CATE FAEHRMANN: Just to be clear as well, I think it's more than a medicinal regime. It's those states as well, isn't it, where cannabis has been legalised for recreation. So the importance, in terms of any regulatory framework—the fact is that allows for public health messages, information, for people to share and speak with their doctor, their GP, about cannabis use, because it's legal. Do you think that is significant? An important part of any regulation is the fact that information can then be widely shared.

ROBERT MAY: Yes. Education is extremely important in these situations. In terms of overall policy and harm minimisation, for people who are accessing any form of recreational substance, the more information available to them would better guide their decisions. The education that was received in the ACT we believe was helpful to their decision-making as a State and as individual users of cannabis.

The CHAIR: Your submission calls for stricter regulations on medicinal cannabis prescriptions?

ROBERT MAY: Yes.

The CHAIR: You've just alluded to the fact that some people may even be prescribed medicinal cannabis without seeing a doctor face to face. What changes do you suggest? What evidence shows that the current regulations may be inadequate?

ROBERT MAY: The evidence that we see, although I can't refer to any documents, is something that I see, and my colleagues see, day to day in clinical practice. There has also been SafeScript, if anyone is aware of that, but it's a new New South Wales real-time drug monitoring system. The amount of patients that we see who have been prescribed medicinal cannabis is very high. Often the prescribers aren't located near where they live. Often they are located in other States, such as Queensland. The access to these products is very easy. Because of that, it's very common. As I was alluding to before, there are patients who are very vulnerable to having prescribed cannabis. And without any further regulation they remain vulnerable to exacerbation of illness.

Some, I guess, practical improvements that could be made is that if patients are to be prescribed cannabis they have to attend to see their doctor face to face. If patients have a history of severe mental illness, such as requiring in-patient admissions to hospital, then they should be assessed by a psychiatrist prior to prescription. If patients have disclosed or shared that they have substance use disorders, then they should be referred to addiction treatment centres.

The CHAIR: You mention in your submission about cannabis use disorders and gaps in the current pathways for people who are suffering from that. Can you give some examples of some current gaps in that regime and what you think should be done to address it?

ROBERT MAY: Cannabis is the third most used substance in our population in Australia. Cannabis use disorder does develop in approximately 10 per cent of people who are regular users. Unfortunately, the knowledge of cannabis use disorder is quite low in the population. Often people who have the disorder might not even know they do, or where to go to seek treatment. There are limited available drug and alcohol centres that actually offer tailored interventions for cannabis use disorder. A lot of our treatments available target, I guess, drugs that are seen to be more problematic, such as crystal methamphetamine, alcohol or other substances. If there were more readily available outpatient counselling services for people who use cannabis, such as cannabis clinics, which were more prevalent in the last 10 to 15 years—I believe some of them have closed now—that would offer a new pathway forward for those who use cannabis, identify it as a problem and would like to seek treatment.

The CHAIR: Anecdotally, I've heard that quite a large number of the people who are using illicit cannabis are actually self-medicating for a range of ailments, such as pain but also for issues like PTSD, anxiety, depression, these types of things. Is that your belief as well, that a significant proportion of the illicit market of cannabis is actually a de facto medicinal market?

ROBERT MAY: I would have to start by saying that research of using cannabis for the treatment of mental health disorders is in a very preliminary stage. The opinion of the College of Psychiatrists is that cannabis is associated with mental illness in a more causative relationship than it is for treatment. We know that there is a very strong relationship between cannabis and depression, particularly in adolescence and young adulthood. Like I mentioned before, cannabis can certainly exacerbate underlying mood and psychotic disorders. We, as a college,

are hesitant to support cannabis as a use of treatment for mental disorders, particularly as currently there is no information in support of that. I do acknowledge that in other disorders such as chronic pain there has been evidence to suggest that as an emerging treatment it might be helpful. But to frame cannabis use as treating underlying mental illness, it would not be consistent with our views as a college.

The CHAIR: I wasn't asking you to comment on the efficacy of cannabis use, but do you have a view on why people are using it, why they are self-medicating, whether it's working or not? Is that your belief?

ROBERT MAY: I think that there would be a percentage of people who experience symptoms of one kind or another. It may be extreme emotions, anxiety or other forms of mental distress. Using cannabis in some way might blunt those feelings or those thoughts. However, similar to other substances—for example, alcohol—it will probably work in the short term but over the long term it's not an effective treatment. Although, as I guess what you are saying, underlying it are probably emotional issues that person may have that might make them more predisposed to using cannabis.

The CHAIR: You propose in your submission a public health campaign to discuss the potential harms of cannabis. Could you expand on that? What do you see the significant harms of cannabis being? How best would they be conveyed to the population?

ROBERT MAY: As I previously mentioned, cannabis is an addictive substance. Up to 10 per cent of people who use it regularly are at risk of developing dependence. Once someone is dependent, the risks of harm increase. There is associations between cannabis and depression, and cannabis and anxiety, as well as some concerns related around motivation and cognition for people who use cannabis chronically. In terms of a public health campaign to better educate people about these, particularly in a setting where they would have increased access, I would probably have to defer to my public health colleagues in what would be the best way of delivering that messaging to the populations who are most at risk.

The CHAIR: In your submission, you talk about attracting more professionals to the drug and alcohol treatment workforce. That is one of your suggested recommendations. What specifically would the college like to see to bring that to bear?

ROBERT MAY: Unfortunately, the workforce in addiction centres is burnt out and experiencing high volumes of vacancies. In order to attract more qualified staff, we'd have to have a difference in messaging in terms of why people would want to work in the drug and alcohol sector. But another ongoing issue within the health sector is remuneration for our services, which has not been increased—at least in line with inflation—for some time. So the workforce remains very burnt out and seems to be decreasing over time, and that is particularly in outpatient settings where people would seek treatment for cannabis use disorder.

The CHAIR: You talk about and advocate for harm reduction services for Aboriginal and Torres Strait Islander communities. What specific interventions do you propose, and how will they ensure these communities receive the same standard of care as non-Indigenous communities?

ROBERT MAY: The Aboriginal and Torres Strait Islander population is, unfortunately, at increased risk of harm. I think, at least from our submission, decriminalisation would be a great first step forward, particularly as the discretionary powers used by police are very unfavourable towards that population. For Aboriginal and Torres Strait Islander people to benefit the most from treatment, delivering it in a culturally competent way is essential and, as such, the employment of people from within the Aboriginal and Torres Strait Islander communities has been shown to be very helpful. The adoption of the peer workforce, particularly Aboriginal and Torres Strait Islander people co-located within addiction services, has been incredibly helpful. Allowing access to treatment locally—to regional, remote and rural areas—if the staffing was available, would be very helpful.

The Hon. STEPHEN LAWRENCE: Thank you for your submission and evidence, Doctor. You note in the submission that in jurisdictions that have legalised there has not been a reported increase in cannabis-related harms. I am wondering if that is because there has been no increase in the use of cannabis or if it is because the measures that accompany legalisation decreased some harms, which has offset an overall increase in use?

ROBERT MAY: Could you just repeat the first part of that question, sorry?

The Hon. STEPHEN LAWRENCE: Sure. The submission from the college reports that in jurisdictions that have legalised there has not been an increase in cannabis-related harms such as psychosis and the like. I am wondering if that is because, in those jurisdictions, there has been no increase in the use of cannabis, or is it because, notwithstanding an increase, some of the measures that accompany legalisation have offset the harm or reduced the harm?

ROBERT MAY: I don't know what the answer to that question is. I would assume that, with legalisation of cannabis, people would use more, if not stay the same. As for the effectiveness of a public health campaign

regarding the harms of cannabis, it would be difficult to quantify exactly which of those factors would be resulting in that outcome.

The Hon. STEPHEN LAWRENCE: In terms of mental health, what are the main negative effects of criminalisation and the lack of a legalised market for cannabis?

ROBERT MAY: People who use drugs as well as those with mental illness already belong to a highly stigmatised population, often struggling with socio-economic disadvantage. The criminalisation of using cannabis—although it has some harms, compared to other substances, not as much—further stigmatises this population, puts them at risk of remaining in socio-economic disadvantaged areas, limits their capacity to gain employment or rejoin the workforce and further entrenches their situation.

The Hon. STEPHEN LAWRENCE: In a market where cannabis is illicit, are people using more harmful cannabis than they might be in a legalised market?

ROBERT MAY: That's possible, but whenever there's an illegal market and people are buying any substance, obviously it's unregulated. We don't know what the percentage of THC or other cannabinoids are, and patients will tell you that whatever they buy could vary quite a lot from one day to the next. So there is an increased risk of harm with an unregulated supply.

The Hon. STEPHEN LAWRENCE: So there are types of cannabis that are available in the illicit market that would not be approved for sale in a regulated market. Is that what you are saying?

ROBERT MAY: Yes. We don't know what the percentages of the cannabinoids are within these products, so it's entirely possible that they wouldn't be appropriate to use, yes.

The Hon. STEPHEN LAWRENCE: I think one of the main concerns about decriminalisation and legalisation of cannabis is the belief in the community or segments of it that there is a link between psychotic illnesses like schizophrenia and the use of cannabis. Could you firstly explain what the link between psychotic illnesses and cannabis is, if any?

ROBERT MAY: There is a relationship with the incidence of schizophrenia and cannabis, which is related to age of onset of first cannabis dependence. For individuals who smoke cannabis daily at age 15 or below, there is an increased risk of schizophrenia, to the order of double. However, schizophrenia is a low-prevalence disorder affecting less than 1 per cent of the community, and the population who would be smoking cannabis aged 15 or below daily is extremely small already. So it is a very small increase to an already small number.

The Hon. STEPHEN LAWRENCE: Could you explain, in laypersons' terms, notwithstanding that link between cannabis use and psychotic illness, why it is that the college supports decriminalisation and/or legalisation?

ROBERT MAY: For the reasons that I've outlined already, it is an assessment of risks and harms. The college has come to its position, based upon the population of people who we represent, that criminalisation causes more harm to people living with mental illness than if it were decriminalised. As I mentioned, due to socio-economic factors, vulnerability, stigmatisation and marginalisation, decriminalisation would allow at least those people with cannabis to be less targeted by the current law enforcement.

The Hon. STEPHEN LAWRENCE: In terms of the vulnerable cohort—the people for whom, if they have daily use prior to that age of 15, there is an increased chance of development of psychosis—are they any more likely, do you think, to access cannabis under a regulated system involving decriminalisation and/or legalisation?

ROBERT MAY: I'm not sure if they would be at any increased risk or have any increased way of accessing cannabis. I would think that, for people of that population and their access to substances, the legal framework often isn't a barrier, particularly for independent use. So I would think that their substance use would probably be unchanged. However, at least there wouldn't be further consequences in the law or the legal system to a person who's already quite disadvantaged.

The Hon. STEPHEN LAWRENCE: How reliable is that research as a pointer towards cannabis being the cause of psychosis-related illness? For example, is it the case that it could be explained that people with that predisposition are more likely to use cannabis? Is the research clear that cannabis is causative, or is there some complexity there?

ROBERT MAY: It's a difficult relationship to characterise clearly. However, that's why that population is so defined. It is a causative phenomenon that has been shown in literature for that population. However, above the ages of 15, obviously cannabis use is more common and so is psychosis and schizophrenia. So the only causative relationship that has been able to be found is in that particular population of those 15 years and below.

The Hon. STEPHEN LAWRENCE: So it is causative—it's not explained by them being more likely to seek it out, on your understanding of the research?

ROBERT MAY: That would be another theory and also a confounder to the research body, but that's what the college and the literature support.

The Hon. STEPHEN LAWRENCE: What would be the objectives of the public health campaign that your submission speaks of in a legalised context? What would the objective be of a public health campaign? Would it be to reduce use overall, or to raise awareness of psychosis issues or issues like anxiety and depression as being possible products? What would be the objective of it?

ROBERT MAY: All of those things. I think, first and foremost, I know public health campaigns around any addictive substance would be to encourage people to use less, use more safely or not use at all, if possible. Followed by, if people did choose to use, how to use it in more safe circumstances, in terms of their mental or physical health. Also, if people did develop symptoms, knowing what symptoms are related to cannabis use and how to seek help would be helpful.

The Hon. STEPHEN LAWRENCE: Do you see any policy rationale under the existing law for treating the giving of cannabis to a friend not for financial benefit as supply rather than possession? I ask that question because under the Federal law, it's only drug dealing or trafficking if you're doing it for money. Whereas in New South Wales, under our State law you commit the offence of supply, which is the offence that applies to drug dealing, even if you give a small quantity of cannabis to a friend—for example, you might be smoking marijuana together and you give them a small quantity. What do you think about that as a policy issue? Have you got any thoughts on that?

ROBERT MAY: As I've alluded to, for people with substance use disorder—who are people that I see—legal or financial barriers are often not reasons why people would choose not to do the substance, given that it's an entrenched pattern of behaviour. I'm not really seeing the benefit of someone being charged with dealing in that situation, as it's likely that the person who receives the cannabis would've got it from some other place anyway.

The Hon. STEPHEN LAWRENCE: You said that cannabis is addictive. Sometimes there is dispute in the community about that proposition; some people think it is and some people think it isn't. People would think of something like methamphetamine or heroin as being more truly addictive. Are you able to explain on a medical level why it is that cannabis is considered to be addictive?

ROBERT MAY: Like any of the addictive substances that you've mentioned, daily use of a psychoactive substance, which can reformulate the pleasure/reward system in the brain, becomes addictive. Even, for example, nicotine is addictive. After people stop smoking cigarettes they can have a withdrawal syndrome. Cannabis is exactly the same in that respect. Daily smoking of THC, which is the active or psychoactive component, causes dependence. We can see in the DSM-5, for example, that they've got cannabis withdrawal as a discrete disorder. Those people who seek help sometimes require, say, in-patient detoxification where they're admitted for up to five days with a very recognisable psychiatric syndrome of cannabis withdrawal—agitation or insomnia, those sorts of things.

The Hon. STEPHEN LAWRENCE: Do you think medicinal cannabis is being used as a device to achieve a form of decriminalisation—a de facto legalisation? If you think so, are there any issue with that in terms of the role and purpose of the medical profession? Are we doing something that undermines the medical profession in some way, whereas maybe we should just engage with the real issue and decriminalise or legalise it? Have you got any thoughts on that?

ROBERT MAY: I do think that, at least from the perspective of psychiatrists, it does undermine our research and our work. Patients that we see will often say, "I'm taking this because it's my medicine or it's prescribed to me", when we are often much more concerned about the harms and have we prescribed it ourselves. Or, had we been in the process of the prescription with their regular doctor or doctor that they've had a text message with, we would've advocated strongly for the cannabis to not be prescribed. So I do have concerns with the way that medicinal cannabis has been granted access for patients in the community. My belief is that, for many patients who are prescribed medicinal cannabis, the harms are likely outweighing the gains.

The Hon. STEPHEN LAWRENCE: Lastly, there's a bit of a vexed issue that's canvassed in the submissions—I'm not sure if it's in the college's submission—about driving and cannabis. It's often said, for example, that there should be a medicinal cannabis use exemption to the drive illicit offence. It's also said that the drive illicit offence doesn't have a link in it between impairment and driving and, for instance, that there should be a drink driving type regime attached to that. Are you on top of those issues?

ROBERT MAY: I think that is quite a reasonable and commonsense approach. As with, say, alcohol, we've got an accepted range of what is appropriate to be allowed to drive with and what isn't. In the space of cannabis, medicinal or otherwise, we don't have a way of measuring what is safe and what is not safe when people are driving.

The Hon. STEPHEN LAWRENCE: That's what I wanted to ask you about. There are sort of two things to my mind. One is is there a test that can measure impairment? The second issue is, if there is such a test, are people able to reasonably adapt their behaviour to the test—i.e. work out how affected they're likely to be in the circumstances and then make a decision about driving? For example, we sort of know with alcohol that one or two drinks in the first hour and one drink every hour after that, or something like that, is the formulation. Are we able to, realistically, in a responsible way, move to some sort of different regime to govern driving after the use of cannabis in the context of those two issues, or are they insurmountable at the moment, do you think?

ROBERT MAY: I'm not aware of any research, currently, that has characterised that, or of any diagnostic test, or of something that's able to delineate what is safe and what is not safe. It's definitely being spoken about, but I can't say that I'm aware of any research that's currently being conducted.

The CHAIR: Dr May, you said in your previous answer—and I don't mean to verbal you—that the efficacy of cannabis, of its therapeutic benefit for some disorders like anxiety or depression, is contested, at the very least. What's your view, though, on cannabis as an alternative, and an alternative with less harms, when compared to other antidepressants and opiates that can be addictive as well?

Does the college have a view on whether or not the cannabis may well be less harmful in terms of ongoing psychological effects or addiction?

ROBERT MAY: Our standard treatments for high-prevalence psychiatric conditions such as anxiety and depression have been through numerous randomised control trials over the past 70 years, so we have a firm evidence base of what works in anxiety and depression with our current treatments compared to those that don't. The medications that are used for high-prevalence conditions such as anxiety and depression, and anti-depressant medications, are shown to be low risk in that they're actually not addictive. Sometimes it can be what we call discontinuation, but it's not a substance use disorder in that someone feels as though they need to take their medication otherwise they don't feel normal. Those drugs often have a delayed response, anyway, so it can take several weeks for people to experience a benefit from that. Usually when they do stop the medication, the side effects are mild or insignificant. I think you did mention opiates. Opiates we only really use in opiate agonist treatment for replacement for, say, heroin and other things.

The CHAIR: What if someone is taking opiates because they're in pain and that pain causes them to be depressed?

ROBERT MAY: I see what you're saying. That question would probably be better addressed to a pain physician. However, the current treatment of chronic pain is for deprescribing of opioid medications. It's more recognised now that medical treatment such as those using opiate medication or other substance dependence-forming medications is unhelpful and that the biomedical model of chronic pain has been challenged in the last five to 10 years. I see what you're saying with that question. Maybe cannabis would be less harmful than, say, opiate medication, which may be true. I know that there is some evidence in that area. However, the overarching perspective is that for chronic pain, medications are not particularly helpful and generally cause more harm.

The CHAIR: Thank you, Dr May, for your evidence today, to the college for the submission you made, and for your work you do in the community. Thank you very much for attending today. It is much appreciated.

(The witness withdrew.)

Dr THOMAS LU, General Practitioner, Royal Australian College of General Practitioners, sworn and examined

The CHAIR: Thank you, Dr Lu, for your attendance at today's hearing into the regulatory framework for cannabis in New South Wales. Do you have an opening address or some introductory comments you would like to make?

THOMAS LU: I do. I'm here today on behalf of the Royal Australian College of General Practitioners. I would like to thank the Committee for the opportunity to give evidence at this hearing. The RACGP is Australia's largest professional general practice organisation, representing over 40,000 members working in or towards a specialty career in general practice. The RACGP and ACT faculty actively supports and advocates for GPs working throughout the State. I'm a member of the RACGP's specific interest groups on addiction medicine, psychological medicine, neurodiversity and geriatrics. I'm also a member of the NSW and ACT faculty. I'm here to represent the views of the RACGP.

The RACGP is a strong advocate for evidence-based medicine and does not currently recommend nor encourage the use of medicinal cannabis. However, it does recognise that, as specialists, general practitioners may offer to prescribe medicinal cannabis products to a limited number of patients with specific conditions in consultation with those patients and their care teams in alignment with the most up-to-date evidence. This inquiry is an opportunity to illustrate the state of play for accessing cannabis-based products as well as the potential for legal decriminalisation posed by the current regulatory framework. I look forward to working with the Committee on this matter.

The CHAIR: Dr Lu, can you elaborate on the evidence base that informed your submission, particularly regarding the relative risks and benefits of cannabis use?

THOMAS LU: The submission is based on the most current, up-to-date literature, which I think many people have referred to. Currently the literature is not well defined on the role of medicinal cannabis, although it is most well researched for chronic pain. The research currently is limited by studies that are of low to moderate quality, and that's because of their low sample size, short follow-up periods and perhaps their study design as well. There are also inconsistencies regarding the studies in terms of the type and route of administration of cannabis as well. There is some other evidence within the literature currently which looks at the use of cannabis for some other indications, such as severe or persistent muscle spasms, post-traumatic stress disorder, seizure disorders and cachexia wasting, but these are currently being looked into.

The CHAIR: Is it the college's position that despite the fact that medicinal cannabis has been legalised over a large swathe of the world, including Germany, United States, United Kingdom and Australia, there's very little evidence that it has any therapeutic benefit for pain and other conditions, and that any evidence that there is is based on faulty or flawed research?

THOMAS LU: I wouldn't say that. I think the evidence base for medicinal cannabis medicine is not strong compared to some of the more traditional forms of therapies that we have, for example, the management of hypertension and hypercholesterolaemia. They are very well defined within the literature. I think certainly the current evidence base, in comparison to those other forms of more mainstream therapies, is not present. That is not to say that the current evidence isn't supportive of general practitioners who are specialists to discuss medicinal cannabis with their patients with very specific conditions based on their understanding of the most up-to-date evidence.

The CHAIR: Pain is not a very specific condition, and it is the number one reason that people are being prescribed medicinal cannabis in Australia. Do you think that's a mistake, that there is not an evidence base that it is actually having a positive impact on people's condition?

THOMAS LU: I wouldn't say, again, that there is not an evidence base. I would say the evidence base at the moment is of mild to moderate quality, and I think that is sufficient for some general practitioners in some specific patient cases to prescribe for patients with chronic pain—in the case of, for example, chronic low back pain. But I would also suggest that medicinal cannabis is not a panacea and that for many of these more complex conditions—for example, chronic low back pain that is quite debilitating—where other forms of therapy have not been effective, medicinal cannabis can play a role, but it is done within a multidisciplinary, holistic and integrated framework, which general practitioners are able to provide.

Ms CATE FAEHRMANN: One of the criticisms, in fact, sometimes of general practitioners is that they don't provide a holistic framework, though, and that they are in some ways quite quick to prescribe standard prescription drugs. I'm thinking just in terms of lower back pain that exercise is one of the things for lower back pain. Are you seeing any reduction in people seeking standard prescription drugs for chronic pain or standard

treatments for chronic pain because of the increase in medicinal cannabis prescriptions and medicinal cannabis use in the State? Have you noticed any difference there?

THOMAS LU: I guess first to the comment that there is a perception that general practitioners offer scripts for most things, I would disagree with that wholeheartedly, as part of the RACGP. We strongly advocate for multidisciplinary care, holistic and integrated care, that general practice practitioners are most suited to be providing. I think that's very evident from the college teachings and very evident from the training of the next generation of future general practitioners, especially within the curriculum. I acknowledge that perception, but I would strongly disagree with it, and I think most general practitioners would disagree with that perception of how general practice is undertaken. In terms of the question—I think your second question is: Has there been a reduction in other prescribed medications due to medicinal cannabis?

Ms CATE FAEHRMANN: Yes.

THOMAS LU: I think it's difficult to say because there isn't really currently—I'm not aware of holistic research on that matter. I think certainly for some patients, anecdotally, they might prefer medicinal cannabis and use it in replacement of another medication. For others, it is an addition. I think the data is just currently not there at the moment to be able to give a firm answer on it.

Ms CATE FAEHRMANN: Which points to potentially the need for more research in this space, doesn't it, particularly probably at a State and Federal level here—more research around what people are using it for, what they are potentially substituting medicinal cannabis for in terms of other more standard prescription drugs?

THOMAS LU: Yes, I think there is definitely a role for looking at that question in particular. I think there is some data, though, at the moment just on what medicinal cannabis is used for.

Ms CATE FAEHRMANN: I want to turn to your submission where you talk about our current roadside drug testing laws. Your submission makes the point—it calls the current regulation unreasoned because the distinction is made between medicinal cannabis and other potentially sedating medicines such as opioids. I think your submission is making the point that that's potentially discriminatory. Would you care to expand on that?

THOMAS LU: Yes. I guess there is some actually good evidence about medicinal cannabis and driving. There is a paper published within the *Australian Journal of General Practice* back in 2021 which summarises the state of play at the moment. Looking at crash risk and crash culpability estimates, medicinal cannabis at the moment has an increased crash risk of maybe 1.1 to 1.4 times compared to not being on anything. This is on a similar level in comparison to a blood alcohol level of 0.05. So there is an increased risk of crash, and that I think has been delineated within the Austroads guidelines about the current state of medicinal cannabis usage. But at the same time, other substances such as benzodiazepines or opioids can also increase crash risk, and those are things that are not currently tested by the roadside. So I think there is, yes, some inconsistency there, and I think that could be what the submission is referring to.

Ms CATE FAEHRMANN: Sorry, the research that you were referring to, what was that again?

THOMAS LU: Unfortunately I did not get to put this in the table, but this is a paper published by Arkell et al. with Iain McGregor.

Ms CATE FAEHRMANN: Yes, I know that one.

The CHAIR: Could we get a copy of that?

THOMAS LU: Of course, yes, definitely.

Ms CATE FAEHRMANN: Do you have the research in front of you there?

THOMAS LU: I do.

Ms CATE FAEHRMANN: You mentioned, for example, benzos. What was the increased crash risk for other pharmaceutical drugs?

THOMAS LU: For benzodiazepines, the increased risk estimate is 1.17 to 2.30.

Ms CATE FAEHRMANN: So higher than medicinal cannabis?

THOMAS LU: They are within the normal confidence interval. The confidence interval overlaps. I think it's really difficult to say whether benzodiazepines are more riskier than cannabis because I think the data isn't super clear and there is no head-to-head studies, so it is very hard to say. But I think there is increased risk of benzodiazepines and other opioids and other prescription drugs, particularly if they are taken not as per the guidance of the medical practitioner and if they are causing clinical symptoms, such as sedation and confusion, for the patient.

The CHAIR: So is it the college's view that we should be testing for opiates if they are comparable to cannabis in terms of its impairment? Is it the college's view that we should be testing at the roadside for opiate and benzodiazepine impairment? If not, why not?

THOMAS LU: I think that's a difficult question to answer. I'm not sure if the college has a view. I will take that question on notice and get back to you.

The CHAIR: Are you aware that there is currently an exemption, there is a medical defence, in the Roads Act for opiates? I would be interested in the college's view on the retention or not of that defence.

THOMAS LU: I'm not sure about that, and I can take it on notice and get back to you.

The CHAIR: If you could take that on notice, it would be appreciated.

The Hon. JOHN RUDDICK: Thanks for joining us, Dr Lu. I wasn't quite following you. When you say that there is an increased risk of a car accident with medical marijuana, and you said a figure of 1.4, are you saying there's like a 40 per cent increased risk of having a crash?

THOMAS LU: It's a range based on multiple different studies, and it's a range of 1.1, so maybe 10 per cent more likely, to 1.42, or 42 per cent more likely—so 1.1 to 1.4 times more likely.

The Hon. JOHN RUDDICK: Would I be correct in assuming that would be within the 12 hours of consuming the medical marijuana and they wouldn't be impaired after that period? Would that be accurate?

THOMAS LU: I think this particular paper, or this particular guidance documentation or evidence summary, doesn't delineate this. My understanding of the current research is that, yes, that's the case. But it also depends on many other factors as well, I would think—whether the patient is on long-term medicinal cannabis or on cannabis, how it affects them personally and also whether they are tolerant of their medications.

The Hon. JOHN RUDDICK: But as the Chair just said, there is a carve-out for—if somebody's driving and they've got an opioid in their system but they have it prescribed, it's not an offence. But I understand if people consume medical marijuana and they have a roadside test, it can show up for 30 days afterwards. I think common sense tells us that people aren't going to be impaired after 12 hours—maybe it's 24 hours—but surely a week or a month after consuming the medical cannabis, they're not driving impaired. However, if they do have a road test and it's showing it's in their system, it's an automatic default. Would the college be supportive of the law being changed so that there would also be a carve-out for medical marijuana?

THOMAS LU: I think the current systems of detection for THC are very complex.

The Hon. JOHN RUDDICK: Yes.

THOMAS LU: Firstly, my understanding is that it's a saliva test. I think within New South Wales you have to have two saliva tests and then a blood test. The testing currently is random. Within the saliva test itself, I think the current evidence is that THC is present within four to six hours of smoking or vaporising or using the oil. Cannabis is not excreted by saliva as a majority excretion, so usually it's got to be present within saliva through use. That actually excludes some forms of oral capsules or gummies. If you consume oral capsules or gummies and it doesn't mix in with your saliva, the current suggestion from the literature is that it's not going to be detected via saliva testing. So once saliva testing—

The Hon. JOHN RUDDICK: But it would be detected by a blood test if there was an accident.

THOMAS LU: Correct. Coming back to the question of what the college position is—whether there's a carve-out for cannabis—again, that's a really difficult question to answer. I'm not sure if the college is in a role to give a recommendation in that regard. We are medical practitioners.

The Hon. JOHN RUDDICK: Yes, but you do support, in your submission—you seem a little bit ambivalent about medical cannabis, but you do say, "Look, we accept that some of our members will be prescribing it." That means some of the customers, some of the patients of your members will be getting caught under this quite serious offence when they're completely not impaired, because it might have been three weeks earlier. I would think that innocent people are getting caught up here. It feels to me like there is a fairly serious hole in the law. The law has recognised it for opioids but not for medical marijuana.

THOMAS LU: Thanks for your comment. I think it's difficult to know, if a patient has had THC within their system, using the current evidence, whether that is contributing to any impairment—or any crash, for that matter—besides what I've already quoted.

The CHAIR: Dr Lu, how many people in Australia die from overdoses each year from opioids that were prescribed to them by a GP?

THOMAS LU: I'm actually not very familiar with that figure. As it wasn't within the terms of reference I didn't get to look it up, unfortunately.

The CHAIR: How many people die from an overdose from medicinal cannabis? On the former question, could you take that on notice?

THOMAS LU: Sure, I can take it on notice.

The CHAIR: That would be good. Are you aware of anyone who has ever died—if I told you it was higher than the road toll, that it's thousands a year, would you be surprised?

THOMAS LU: I would be, yes. I think with medicinal cannabis, the risk of overdose in itself is not high. I wouldn't know the particular figure.

The CHAIR: What if I said it was zero? Would you accept that's probably the case?

THOMAS LU: I probably would accept that—although in the context of very complex patients with poly-substance misuse or inter-use, cannabis can contribute. But I wouldn't be able to give you a definitive figure today.

The CHAIR: What's the number one reason people are prescribed opiates?

THOMAS LU: As the previous psychiatrist mentioned, we use it primarily in opioid treatment programs for people who are opioid dependent. There are people who do prescribe opioids for acute pain, and that is very evidence-based and very effective. There is also a significant role for opioids in cancer pain. I think that is very well delineated.

The CHAIR: But which of those would be the principal reason?

THOMAS LU: Probably acute pain, really. For people who present to hospital with a fracture or perhaps a kidney stone, opioids can be highly effective in mitigating their pain and suffering.

The Hon. STEPHEN LAWRENCE: Thanks, doctor, and thank you for the submission from the college. Does the college have a view or a sense about the adverse health outcomes for Australians occasioned by the criminal regulation of cannabis? I'm talking about the accumulation of any adverse health effect from the searching, the arresting, the incarceration et cetera.

THOMAS LU: The people who commit crimes in the context of substance use—for many of them their substance use is the key problem that is causing the criminal activity. There is currently a wide array of diversion programs which are aimed at tackling those things. For example, the Cannabis Cautioning Scheme—

The Hon. STEPHEN LAWRENCE: I was getting more at the adverse health effects as a consequence of the operation of the criminal justice system. You might have a patient who presents who has been the subject of a strip search. You might find there's some trauma issue from that. Or you might have a client who's been charged with cannabis possession and has to go to court and then suffers anxiety as a consequence of that—or they might lose employment, and then you might see adverse health effects because of that. I was getting more at the accumulation of adverse health effects on Australians as a consequence of the penal regulation of cannabis, the criminal regulation of it.

THOMAS LU: Again, I wouldn't have any specific data to pinpoint any of the things you've mentioned—although what you mentioned makes a lot of sense and, anecdotally, is something that we do see, that the penal effects can have an effect on people's health and mental health.

The Hon. CAMERON MURPHY: Would you be able to take that on notice and come back to us if you have a considered view.

THOMAS LU: Sure, we can take it on notice.

The Hon. STEPHEN LAWRENCE: That's great. Page 4 of the submission from the college states:

> … the potential impact of MC on driving safety is mitigated in the context of clinical consultation; patients being prescribed MC as part of their care can be advised against driving when feeling sedated, when changing dose …

Is that based on any research or is that more of a commonsense proposition, in the sense that if it's prescribed there's that avenue for advice to be given that might mitigate against the road safety effects?

THOMAS LU: I'm not aware of any firm research. However, I think that sort of advice is present in most clinical guidelines and education for general practitioners. It's common advice that general practitioners would give within the holistic, integrated appointment, being able to provide a lot of information for their patients. Once patients are aware of the risks associated with this, then they do take it on board generally.

The Hon. STEPHEN LAWRENCE: Does the college have a view on the decriminalisation of cannabis?

THOMAS LU: I'm not sure if the college has a view. I don't think the college, at the moment, has a view on the decriminalisation of cannabis.

The Hon. STEPHEN LAWRENCE: I might have gleaned that from the submission. There certainly doesn't seem to be a positive statement in favour of decriminalisation.

THOMAS LU: I'm not sure. I think certain members definitely are very supportive of decriminalisation. There is a lot of evidence base, particularly from Portugal, to support decriminalisation. What you can see in Portugal is that it's not legalisation, but it's certainly removing the penal punishment, as you said, and then pointing people who do need help to the right form of help. I think that would be something that we do support, although it has not been firmly discussed, really.

The Hon. STEPHEN LAWRENCE: Assuming that there is not a positive, clear policy position in favour of decriminalisation that the college has arrived at, it's certainly not the case that the college has a positive view in favour of criminalisation, is it? It's more that you just haven't reached a view to the contrary, but you are not endorsing the status quo. Would that be fair to say?

THOMAS LU: Yes, I would suggest that. Yes, correct.

The Hon. STEPHEN LAWRENCE: Is that the same in respect of legalisation, so the creation of a regulated cannabis market where one can purchase it legally et cetera?

THOMAS LU: I wouldn't think that the college, at the moment, has a view on that either, and probably purely because the evidence is really not out in that regard. Secondly, we probably haven't seen it as our role in having a view on this at the moment.

Ms CATE FAEHRMANN: I'm curious about whether the position of the RACGP has officially changed since it came out very strongly a couple of years ago in relation to the ice inquiry's recommendations, which are about removing the criminal sanctions for the personal use of drugs. The RACGP signed a joint statement with the AMA and the Royal Australian and New Zealand College of Psychiatrists, which called on the Government to stop delaying its response to the inquiry. I don't know whether the president is still Adjunct Professor Karen Price.

THOMAS LU: No, it's not.

Ms CATE FAEHRMANN: Has that changed?

THOMAS LU: Firstly, I wasn't aware of that declaration. Also, I'm mainly going off our submission, which didn't mention decriminalisation. I wouldn't think that there has been a change; I probably just wasn't aware of it.

Ms CATE FAEHRMANN: I think some of the statements here are basically about ensuring that personal addiction issues are treated as health and social issues and not in the criminal justice sector. I think I have heard statements in the past by your organisation to that effect. I want to clarify whether something has significantly shifted in the past two years that we should aware of.

THOMAS LU: No, I don't think so. I would agree with that statement. I just wasn't aware of that formal declaration.

The CHAIR: Dr Lu, are you aware that cannabis has, for medical and recreational purposes, has been legalised in California for eight years?

THOMAS LU: I'm well aware of that, yes. It's present in Canada and quite a few states in the US.

The CHAIR: Yes, including California, which is the largest state in the United States. The Medical Board of California supports a whole range of prescribing practices for a whole range of conditions in California. It has widespread support and is underpinned by a large body of research in terms of its efficacy.

THOMAS LU: Am I aware of that?

The CHAIR: Yes.

THOMAS LU: I wasn't aware of that fact particularly. I'm definitely aware it is very prevalent in Canada and the US.

The CHAIR: Could you respond to that? Why do you think the Medical Board of California has taken a much more positive view of cannabis than, say, the college has?

THOMAS LU: I would firstly like to say I think the college does recognise that, as specialist general practitioners, some of us are very happy to, and do offer to, prescribe medicinal cannabis products to a limited number of patients with specific conditions, in alignment with the most up-to-date literature. I don't think we have a very positive or even negative spin on this fact. I just think that the current evidence is mild to moderate. There are general practitioners who do prescribe medicinal cannabis. In terms of the question about California et cetera, I wouldn't be able to give you a good answer for that. It could be a lot of social, societal and cultural differences that are present and prevalent which contribute, but that's probably outside of my scope of expertise.

The CHAIR: What's the college's view on the current regime around telehealth when it comes to prescribing medicinal cannabis? Do you think it is as robust as it should be? If there were reforms there, what do you think they should be?

THOMAS LU: I'm not familiar with the college's current perspectives on telehealth. Again, I think it wasn't part of the statement of terms of reference.

The CHAIR: We heard from the college of psychiatrists that, in some instances, face-to-face interactions with a health professional is preferred. Is that something that you would concur with?

THOMAS LU: Absolutely. I think face-to-face visits are really important because as general practitioners we do need to examine the patient. I think some of that is lost over telehealth. Yes, I think face to face can definitely add a lot more to the consultation, especially for these complex patients, particularly in providing holistic and integrated care.

The Hon. STEPHEN LAWRENCE: Do you think that the current scheme for medical cannabis prescriptions is inequitable in the sense that it's allowing certain more advantaged people to legally obtain, possess and use cannabis, maybe for a mixture of reasons sometimes, whereas other less advantaged people are left with the illicit market and all of the consequences of that?

THOMAS LU: I think that's, again, a difficult question to answer. At the moment, the cannabis prescriptions are done through a SAS B or Special Access Scheme and also the Authorised Prescriber Scheme. Currently, the Authorised Prescriber Scheme, where practitioners can get approval from the TGA to prescribe directly, has quite blown out. The model of prescribing at the moment seems to be that patients can go to specific cannabis clinics and also general practitioners. There could be a cost associated with that. At the same time, that cost is probably less or comparable to other specialist services. Then comes the question of the medicine itself. Again, that is a question of comparison. Compared to, say, more mainstream medications, such as antihypertensives or anticholesterols, cannabis medications are more expensive. That is because the cannabis medications are not part of the PBS, where there is a subsidy for these medications.

However, compared to illicit cannabis from illicit sources, medicinal cannabis can be cheaper compared to illicit sources or more expensive because there is a wide array of different cannabis products within the market at varying price points. I think it is a game of comparison within this current model in the sense that, yes, medicinal cannabis is more expensive compared to PBS-subsidised medications and there can be a fee associated with seeing a medical practitioner, but the fee is probably less than seeing a non-GP specialist but is probably more than a bulk-billing doctor, obviously, would be. I think then the question of the inequality of access lies within this model. I think then more vulnerable community groups, who have less socioeconomic access, will definitely not be able to access medicinal cannabis as much as people who have more wealth, yes.

The Hon. STEPHEN LAWRENCE: Irrespective of the purpose that you are seeking medicinal cannabis, the more advantaged you are, the more likely you are to be able to access it and, in fact, access it. Would you agree with that?

THOMAS LU: I would agree with that, yes.

The Hon. STEPHEN LAWRENCE: If you are someone who wants to access medicinal cannabis wholly or in part for what is, in effect, a recreational purpose, you are more likely to be able to do that the more advantaged you are. Would you agree with that?

THOMAS LU: Yes, I would agree with that.

The CHAIR: Thank you, Dr Lu, for your attendance today and for giving evidence on behalf of the college. We very much appreciate you taking the time and the college making the submission. The secretariat will be in contact in due course to follow up on some matters that were taken on notice. Once again, thank you very much. We deeply appreciate it.

(The witness withdrew.)

Mr MICHAEL WHAITES, Assistant General Secretary, NSW Nurses and Midwives' Association, and Assistant Branch Secretary, Australian Nursing and Midwifery Federation, NSW Branch, affirmed and examined

The CHAIR: Thank you for your attendance this morning. We very much appreciate it. We also appreciate the submission made by the NSW Nurses and Midwives' Association. Do you have some remarks to make before we turn to questions?

MICHAEL WHAITES: Not at this stage. I'm happy to go straight to questions, thank you.

Ms CATE FAEHRMANN: Thank you, Mr Whaites, for appearing today and for your submission. Is it fair to say that, based on the evidence of your members, the current regulatory framework around cannabis, in terms of technically still criminalising people for personal use, is not very beneficial to society?

MICHAEL WHAITES: Yes. We agree with that direction. Our view is that, with all drug use, whether that's alcohol or other drugs, harm minimisation is the best approach. We are particularly concerned that, when you take drug use down a criminal path, it creates the potential for a cycle but it also creates a level of stigmatism for those people, which is not the way that you deal with any health issue. The best way you deal with any health issue is being able to work with people in a caring and nurturing way, not in a punitive way. We see drug addiction as a health issue, not a criminal issue.

Ms CATE FAEHRMANN: I think it is potentially important, isn't it, that at some stage in the future, if the New South Wales Government did decide to move to a decriminalisation model, more funding would need to go into health services and into ensuring that there were more staff, for example, for treatment places and more nurses in that way as well? I think we have seen in some areas—in Oregon in particular, with decriminalisation there—that there hasn't been the necessary investment into health services. Do you have anything to say about that?

MICHAEL WHAITES: The feedback from our members that work in drug and alcohol at the moment is that it is under-resourced and underfunded, particularly in areas where the use of illegal drugs and alcohol is high. Of course, we would welcome more investment in that, particularly making sure that we have safe spaces within our emergency departments for the treatment of people who are experiencing high levels of being affected by alcohol and other drugs. I think I would have to take on notice the question about the—certainly, there's a long and proud history of changes to the way we deal with matters, envisaging that the health system will be able to cope without the health system getting the subsequent resources. That's always mindful.

I'm only aware of one study that talked about the rate of use in the ACT following decriminalisation, and there were no significant increases. That is my understanding of that report. Would we expect to see higher levels of activity in our emergency departments as a result of the decriminalisation of cannabis? I don't know that there's any evidence for that. The issues that our members face most commonly in our emergency departments don't arise from cannabis use. It's usually polydrug use, methamphetamine and alcohol.

Ms CATE FAEHRMANN: I'll turn to a specific recommendation in your submission, if you care to expand upon why you've come recommending this. It is specifically in relation to closing the gap for Aboriginal and Torres Strait Islander peoples. Reforming the regulatory framework for cannabis, your submission suggests, could go some way to closing the gap. Would you care to expand on why that is?

MICHAEL WHAITES: Certainly. Our submission cites a report that says, when you look at the Aboriginal and/or Torres Strait Islander population, they are greatly over-represented in the people who are being—I'll put it in the reverse way. There's the option for the police to provide a caution. If you're an Aboriginal or Torres Strait Islander person, you're much less likely to receive a caution, even where the cautions can apply. The issue there means that for those Aboriginal and Torres Strait Islander people, it would appear on one examination that, simply because of the colour of their skin, they are entering the criminal pathway for cannabis use at a much greater rate than the rest of the population. That is one very clear, easy way to help close that gap. Drug use and overuse of drugs, whether that's alcohol or other drugs, needs to be seen as a health issue, not as a criminal issue. If we're serious about closing the gaps, it can't just be about treating the outcomes; we also have to look at the causative factors.

The Hon. JOHN RUDDICK: Thank you for your submission, Mr Whaites. The association quite enthusiastically supports decriminalisation, but I don't think you've said anything about legalisation. Do you see decriminalisation as a step towards legalisation?

MICHAEL WHAITES: I'd have to take that on notice. I don't know that we've considered that view and put that to our membership more broadly. I think decriminalisation is a logical next step.

The Hon. JOHN RUDDICK: The problem that I have with decriminalisation is that the drug market is a market, so there is supply and demand. If we decriminalise the demand side, then there may even be an increase in demand, so they have got to get it from somewhere. What we're doing by continuing to make it illegal is fostering organised crime. We haven't dealt with that problem at all. Do you see any merit in that argument?

MICHAEL WHAITES: I haven't seen the evidence of where cracking down harder and harder on drug use improves the situation. Again, the evidence that we referred to in our report coming out of the ACT doesn't indicate that there was a big increase in the use. I also note that within the ACT, the ability to have some plants and grow your own means that you're not coming into contact with the criminal elements at all; you're merely growing a plant and using that for your own recreational purposes. In that way, I think the logic should flow that less people are coming into contact with criminal elements who might look to trade you up. That's a poor use of terms. The more we can decriminalise it, the more likely it is that people won't come into contact with the criminal elements.

The Hon. JOHN RUDDICK: I enjoyed your couple of paragraphs on your argument about drug testing. You're saying that impairment should be the key when driving, not detection. That makes logical sense. As the Chair said, there are a lot of jurisdictions where cannabis is either decriminalised or legalised. What jurisdictions do you think are doing that well in terms of having an impairment test, not a detection test?

MICHAEL WHAITES: The only awareness I have is that there are processes that have been assessed as effective. I'd have to take it on notice as to which jurisdictions are deemed and what are the parameters around which they're assessing that. The point there is that with medicinal cannabis, if we have members who are taking medicinal cannabis under a prescription and under the care of their treating physician, the detection of that alone can then create problems for their registration where they may not be impaired at all, because of the amount of time that it remains detectable. We see the impairment as being an important issue not just for our members but for everyone.

The CHAIR: I assume that some of your members are medicinal cannabis patients themselves. How is the association dealing with, if at all, the issue of workplace drug testing and impairment in the workplace—that is, nurses and midwives who may be prescribed medicinal cannabis, taking it in accordance with their doctor's directions, but then may be subject to workplace drug testing that may turn up a positive result? Is that an issue that is appearing for your members?

MICHAEL WHAITES: Not that I'm aware of. Under the processes, the regulatory bodies would look at whether or not that was a prescribed medication. They'd have to be given evidence of impairment, as opposed to people who might take drugs not under prescription, and being detected and having conditions placed on their registration which requires routine testing. The pathways are quite different. If it has been prescribed, the board would take a different view.

The CHAIR: So there's essentially a defence. Because they have got it prescribed, one of your members can provide a prescription and, therefore, a defence and say, in the absence of them being impaired, "I've got a prescription. I shouldn't be subject to any penalty or deregistration," as if they had been taking recreational cannabis.

MICHAEL WHAITES: If I understand your question correctly, if a nurse is questioned about their ability to practise, the things that are looked at are whether or not they were impaired and the cause of that impairment. A nurse or a midwife always needs to take into consideration their ability to practise at any given moment. They might be impaired from fatigue. They might be impaired for a range of reasons. If we're questioning the use of cannabis, the decisions of the board would be different if there was a prescription for the use of that medication and whether or not the nurse was impaired whilst working or whether there was simply the detection of the medication in their stream. That's the key difference.

The CHAIR: I attended one of your conferences recently. One of the issues that was raised that was becoming an increasing difficulty, it appeared, for your members was how they were managing medicinal cannabis patients—in particular in a hospital setting—when they have got a mix of medications and medicinal cannabis patients self-medicating. Is that a growing concern and a growing issue for you and your members?

MICHAEL WHAITES: I can't speak to the frequency of that as an issue but, as you say, yes it becomes a problem—whether or not it's declared, whether or not the hospital has suitable policies and processes, whether the admitting doctor is willing to prescribe that. There's a range of issues that arise from that.

The CHAIR: One area that your submission doesn't touch on is the effectiveness of cannabis as a medicine. What are the association's views on the risks and benefits of medicinal cannabis?

MICHAEL WHAITES: We can only go by the peer-reviewed literature that's available. My understanding of the current status is that, whilst there are some benefits noted, the effectiveness is still questioned. The reports are mixed as to whether or not the outcomes are always replicable. It's still an area that, deservedly, needs further investigation as to the efficacy.

The CHAIR: We've heard some evidence and there's a suggestion that, in effect, the medicinal cannabis market is becoming a proxy for legalisation. Is that something that you could comment on? Essentially it's being accessed by some people whose principal reason for accessing the medicinal cannabis market may not be for health reasons but for reasons to do with recreation and relaxation. Is that something that you could comment on?

MICHAEL WHAITES: I'm not personally aware of that. It's not an issue that's been brought to us. I assume that if you are accessing medicinal cannabis it's because you've got a treating physician who has prescribed it under the regulations et cetera, so I couldn't comment.

The CHAIR: Currently in New South Wales there's a medical defence. We don't test for opiates. There is a defence in the Act. If you are involved in an accident and you have a blood test and it returns levels of opiates, there's a medical defence if you have a prescription for opiates. We know that opiates can be very impairing and the statistics show a causal link between opiate use and some pretty serious accidents. Do you think that we should be testing for opiates in roadside drug tests, or should we take away the medical defence for opiates?

MICHAEL WHAITES: We don't have a view on either of those things. We'd have to take them on notice. Again, our principal approach to alcohol and other drugs is to take a harm minimisation approach, that addiction in any form is a health issue and needs to be treated as such. I couldn't comment further than that.

The Hon. STEPHEN LAWRENCE: Mr Whaites, can you talk to the adverse health impacts of incarceration?

MICHAEL WHAITES: I'd be happy to provide a more detailed response on notice, but the effects of the stigmatisation of having been incarcerated, the effects on your potential employment, isolation from family and friends, the reports of exposure to other drugs within the jail system—these are all things that are well documented. We also know from our members that work within the jail system—providing healthcare services within the jails, whether that's through public or private—that the health care for patients who are incarcerated is not as good as it could be. There are long waiting lists to get to be reviewed. If you are transferred whilst you're on that list, you go to the bottom of the list at the next jail, so people's healthcare concerns can take quite some time to get addressed. Urgent things take priority. There's some concern from our members that health conditions can deteriorate in jail because you're not having the routine tests and checks in a timely manner. That's obviously not for the entirety of the population, but there are concerns for certain people depending on their transfers and time in jail.

The Hon. STEPHEN LAWRENCE: There has been evidence in the inquiry so far that even the recreational or personal use of cannabis can ultimately lead to incarceration, whether by way of a prison sentence for an offence of possession or cultivation, or because it interacts with later interactions that you have with the system—for example, you might breach a good behaviour bond or a community service order that was originally imposed because of that, or the punishment for a later unrelated offence might be ramped up because you've got this history of being convicted of cannabis-related matters, which is why I ask that question. I'm interested in whether you've got any knowledge—you might be able to take it on notice—of research about the adverse health impacts of some of those other interactions with the criminal justice system: people who might be stopped and searched on account of possession of cannabis, perhaps numerous times, or people who are charged and taken to court and not ultimately jailed but who go through the criminal justice system, and whether there are adverse health effects as a consequence of those things as well.

MICHAEL WHAITES: Yes, I imagine we could have a look at and make comment on the psychological impact of that.

The CHAIR: Thank you very much, Mr Whaites. We very much appreciate you taking the time to make the submission and also to appear here to give evidence. I think there were one or two things taken on notice. The secretariat will be in contact with you in due course about those, so thank you very much for the work you and your members do.

(The witness withdrew.)

(Luncheon adjournment.)

Dr MICHALA KOWALSKI, Postdoctoral Research Fellow, National Drug and Alcohol Research Centre, affirmed and examined

Professor DON WEATHERBURN, Professor, National Drug and Alcohol Research Centre, affirmed and examined

The CHAIR: We very much appreciate you taking the time to appear and for the submissions you've made. Do either or both of you have an opening statement that you'd like to make?

DON WEATHERBURN: Yes, I have six descriptive comments. These are some specific problems with the current policy responses to cannabis, and I will just go quickly through them. As everybody here knows, the aim of the Cannabis Cautioning Scheme was to divert people away from court, hopefully to avoid them receiving a criminal conviction for an offence for which they are not likely to ever receive another offence. As it turns out though, the ratio of cannabis cautions to prosecutions for cannabis use and possession last year was less than half of what it was in 2013. In other words, there's been this steady decline in the relative use of cautions compared with prosecutions, so much so that in the past year there were some 4,300 individuals prosecuted for the use and possession of cannabis compared with the 2,600 who actually received a cannabis caution.

What is additionally worrying about that is that a disproportion of those who are actually eligible for a caution are not given one. Seventy-four per cent of Indigenous offenders are prosecuted for the use and possession of cannabis compared with 39 per cent of non-Indigenous persons who are picked up for the use and possession of cannabis. For the prosecution of cannabis users, things have changed dramatically since the scheme was introduced. More than 90 per cent of the population in Australia these days, over the age of 15, are not supportive of prosecution. We know that from the National Drug Strategy Household Survey. The preferences of most people are either no action, education and treatment, or a fine. Less than 8 per cent now support prosecution if that means community service, weekend detention or prison.

There is little evidence that prosecution acts as a deterrent. More than 40 per cent of the population over the age of 15 have tried cannabis. In the 2019 National Drug Strategy Household Survey, there was a question which asked respondents whether or not they would use cannabis if it was legal. We analysed that data and found that 4.2 per cent said that they would try cannabis if it was legal. There is, though, compelling evidence that criminal prosecution, if it results in a conviction, inevitably reduces a person's subsequent employment and earning prospects, which is something that people have to live with if they're doing things like break and enter, motor vehicle theft or armed robbery. For most cannabis users, people who are picked up for cannabis use will never appear in court again, but the conviction stigma attached to their criminal record will pursue them over a very long period. I just wanted to draw your attention to those facts, and I leave it now to my colleague.

MICHALA KOWALSKI: I thank the Committee and the Chair for the opportunity to provide evidence for the inquiry. The National Drug and Alcohol Research Centre at the University of New South Wales is Australia's leading research group in the alcohol and other drug sector. We produce evidence-based, multidisciplinary research that informs treatment, policy and our communities regarding alcohol- and other drug-related harms. Together with cannabis research experts from the Global Cannabis Cultivation Research Consortium, we have conducted policy reviews and the largest international survey of people who use and grow cannabis, in which we asked people about their growing practices, motivations for growing and their attitudes towards regulation.

In our policy review, which focused on the applicable penalties for possession, cultivation and distribution of cannabis, we found seven different approaches across 79 different jurisdictions to cannabis in law, ranging from full criminalisation to a legal model that retained civil and criminal penalties for proscribed activities. Our findings also indicate that there is no one approach to regulating cannabis, and that adopting one type of regulatory scheme for a specific use case, such as medicinal use, is not necessarily predictive of adopting a future regulatory scheme for other uses, such as industrial use or recreational use. Our paper on cannabis growers' attitudes towards regulation is forthcoming, but I can share the findings from our respondents from New South Wales with the Committee. That might be of particular interest given the proposed amendments.

We found that most growers agree that only adults should be able to grow cannabis for private use, and that, if it was to be legal to sell cannabis, that only licensed entities should be able to sell cannabis. We also found large levels of support in the community of New South Wales for setting a limit of up to six plants for private growers. One of the key messages coming from international colleagues working in public health in jurisdictions that have already legalised recreational cannabis is that there are some important health-based safeguards for regulators to consider. These are restricting the local and international cannabis industry's influence on regulation; banning promotional materials and advertising for cannabis; restricting access to cannabis for minors; setting limits on the percentage of psychoactive compounds in the cannabis; and restricting where cannabis can be

consumed. It is important to note that our colleagues recommend that the ideal time to put these safeguards in place is while designing the regulatory model, and that they are applicable no matter which profit model approach is adopted. I can share advanced copies of the research I was talking about with the Committee, and I'm happy to answer any questions.

The CHAIR: We would welcome that research. Is that confidential at this stage?

MICHALA KOWALSKI: It has not gone through peer review yet at this stage. It is also a subset of the findings because I drew out the findings from New South Wales to talk to the committee today because I thought it would probably be more applicable for the purposes of today to hear what the people growing cannabis in New South Wales thought rather than the people who grew it in Belgium. I've got that here. It's from 116 people, the responses. I'm happy to share that with the Committee, and I've spoken to my co-authors about that. You need to remember that this part hasn't been through peer review yet, for this piece of work.

Ms CATE FAEHRMANN: Do you have a time frame for that? In terms of the time frame for peer review and the time frame of this Committee, how long you are expecting? Is it going to be many months or can we expect something sooner?

MICHALA KOWALSKI: I can give you the results that we have now. As far as the publication going through review, publication is probably going to take quite a few months and in the publication we are not going to draw out the responses from New South Wales separately. My co-authors and I are happy to share the responses from New South Wales today.

The CHAIR: If you're happy to share them, that's fantastic.

Ms CATE FAEHRMANN: Thanks for appearing today. You have already provided very valuable evidence. Professor Weatherburn, do you have any thoughts, based on the data and statistics that you collect, around the reason behind the decline in cannabis cautions over the past decade?

DON WEATHERBURN: I would love to say I know the reason, but I don't. I'm as surprised as anybody else. In fact, it is something that I only realised in the past week or so when I was looking at it before coming to this Committee. I thought I would just have a closer look at what has been going on with cannabis cautions, and although the raw number of both cautions and prosecutions is going down, what's happening is that cautions are going down much more rapidly than prosecutions. That's why you're seeing a shift towards a higher proportion of prosecutions. Why that should be, I have no idea. There has certainly been no change in the prevalence of cannabis use, so that wouldn't explain it. I assume it has something to do with the way in which police have decided to exercise their discretion or what they've decided to focus on. But you would have to ask the police about that.

Ms CATE FAEHRMANN: I can see that the data you have goes until just beyond August 2023. Of course, the Early Drug Diversion Initiative was implemented at the end of January this year. Data that my office has obtained suggests that police certainly are using their discretion, and in fact the majority are still choosing to charge people caught with a personal quantity of drugs. This shows the potential issues with allowing the police discretion. Do you believe so?

DON WEATHERBURN: I think that's right. There are several examples; this is one. Another one is the Young Offenders Act where although the legislation specifies the criteria that police are allowed to take into account, there is always this residual discretion they enjoy which is ungoverned. As a consequence, it is easy to find large variations within local area commands and the way in which these laws are implemented and, in this particular case, large variations over time and the extent to which they choose to caution versus prosecute people. There is one point I should probably draw to your attention because I am sure police would raise it, although I don't think it's an explanation for the current trend, and that is it sometimes happens that when a case is being prosecuted for supply in the District Court, they will accept a plea to a possession offence. But that's a very small percentage of the cases. In those cases, of course, the person would be prosecuted rather than given a caution. But as I say, that percentage is very small. So what you're looking at is a genuine decline in a relative willingness to caution—as opposed to prosecute—someone for cannabis possession.

Ms CATE FAEHRMANN: It is extraordinary data. Have you broken down the data or is there any research into how the different local area commands apply this? I have requested data broken down by local area command. That hasn't come back to me yet. I assume it's available. Have you done the same?

DON WEATHERBURN: It is readily available information. In fact, it can be obtained be from the website of the Bureau of Crime Statistics and Research. But in that handout that I gave you, that single sheet, you will find a paper published by the Bureau of Crime Statistics and Research on cannabis cautioning. That paper by Sara Rahman and Adam—I've forgotten his second name—specifically looks at the question of whether or not the local area command makes a difference to the likelihood of getting a cannabis caution, and finds that there is

a significant effect. Do you know the paper I'm referring to? I handed out all my copies, of course. It will be one of the dot points there. The paper in question I'm looking at here is—where are we?

Ms CATE FAEHRMANN: While you are looking for that, I wonder whether you also look at regulatory frameworks across the country and the differences between when police discretion is and is not allowed. Do you have any comments about that?

DON WEATHERBURN: I don't. That's my colleague's work.

MICHALA KOWALSKI: We haven't compared the cautioning rates for New South Wales and other States. As far as other regulatory schemes, I'm happy to provide them on notice, because I don't want to get this wrong. I do have it, but I didn't bring it to the Committee today. My understanding is, with the exception of Queensland, and that's quite recent, every jurisdiction in Australia has discretion. Even the ACT's wording is "may". I think Queensland's latest amendments have changed it to make that where—I think Queensland's decriminalisation is not discretionary now, but I take that on notice. I don't want to mislead the Committee.

Ms CATE FAEHRMANN: If you could take that on notice, it would be interesting because it potentially indicates a cultural shift. I don't think it could be a lack of awareness of the fact that it exists. These are the questions: regarding police discretion in other States, whether the leadership and cultural attitude within the police force in other jurisdictions is different to ours? I think it would be interesting to consider whether the discretion is applied less often. I have spoken with local area commands in areas with extremely high rates of alcohol and illicit drug use—I won't name them—that weren't aware of the Early Drug Diversion Initiative. This was four months after it was introduced, and the superintendent and the officers weren't using it. Do either of you have any comment about what the police should be informed about and how that occurs? Are they aware of it or not? Again, I hope we will call the police to this inquiry to ask. We shouldn't have discretion if the police aren't using it. It's a failure.

DON WEATHERBURN: I don't see discretion in and of itself as being problematic. I think the problem arises when it is becoming clear that there are big variations across police commands in the way that discretion is being exercised. I would have thought a sensible thing to do would be to monitor that—and it's not a difficult thing to monitor—and, where evidence of big variations appears, to sit down and discuss why that might be and how to deal with the problem, bearing in mind that there are legitimate factors the police should consider and have to consider. It's what's left over—that variation that is left over after they've taken that into account.

Ms CATE FAEHRMANN: I just wanted to check—you said that the data was available. Have you analysed that? Do you have that information, broken down by local area command? If so, could you provide it to the Committee?

DON WEATHERBURN: I have it broken down by local government area at the moment. I haven't analysed it, but I could analyse it. It wouldn't be difficult to get it broken down by local area command, which would be more useful. That information can be readily obtained from the Bureau of Crime Statistics and Research. Just one point—I misled the Committee earlier about the name of the bulletin which contains this discussion. It's Crime and Justice Bulletin 258. The authors are Sara Rahman and—I'm afraid I've forgotten the other author's name. But that looks specifically at the police command contribution to the variation.

The CHAIR: Doctor, you were talking in your introductory remarks about, regardless of the models that you consider, that front-loading the regulatory reform is essential. You said there was essentially seven different models operating globally but that, regardless of which ones you go with, you should do the regulatory reform and the transition process well before it goes live. Is that what you were saying? Is that your evidence? And if so, why? How?

MICHALA KOWALSKI: What I was trying to say, or weave together, is there are certain things that—when we look to jurisdictions that have legalised recreational cannabis, such as the state of Washington in the US, the different states of Canada, so British Colombia—do they call them states there?

The CHAIR: Provinces.

MICHALA KOWALSKI: Provinces, thank you. British Colombia, as opposed to Quebec—there were different things that people were taking into consideration about how they wanted to regulate their cannabis. Canada, in some of the provinces like Quebec, they were paying specific attention to certain things they were seeing coming out of different jurisdictions. The idea here is that if you want to put in things to safeguard health, the time to do that is before you do your reform, and not afterwards. That's what I was trying to talk about when I was talking about front-loading your reforms—so, like, whichever type of model you go with. That wasn't necessarily referring to the different approaches from criminalisation to legal, even though that's applicable then. It was more about the conversation that if you have a government monopoly or if you have a co-op scheme, or a

club type of scheme, and that people think that this might be safeguarding public health—I think the argument here is that safeguarding public health is something you should do regardless of whatever it is you choose to do.

The CHAIR: What are the key things you think need to be done? You referred to making it adults only. What are some of the other things you can do, regardless of the model, to safeguard public health?

MICHALA KOWALSKI: One of the things that people talk to is about setting limits on the percentage of psychoactive compounds in cannabis. In places that don't have limits, such as Washington state in the US, they've found different products on the market with up to 70 per cent of active THC, and beyond that. That is a concern that some public health officials bring up, and people who work in mental health at District, because that can have an effect, so that is one of the things that people talk about wanting to put into effect. Bans on promotional material and advertising for cannabis—limiting the extent of the cannabis industries in regulation is something that is one of the first things that people bring up that are worth considering.

The CHAIR: What do you mean by that? Is it the size of an individual enterprise, or the size of the whole industry?

MICHALA KOWALSKI: No. We're talking about, if you were to have a regulatory body, restricting people from sitting on that regulatory body if they have ties to the local or international cannabis industry.

Ms CATE FAEHRMANN: Alcohol and gambling influence.

MICHALA KOWALSKI: Yes.

The CHAIR: In terms of the seven models, could you provide us more information on those? And which ones do you think are the best? Which one is the worst? If you had to pick a place in the world that you think is doing it better than other places, where would that be, in your opinion?

MICHALA KOWALSKI: Okay. So the models are not—first of all, this is kind of early work. It's not necessarily the way you are used to thinking about it. We were really looking at what penalties are applicable: Who applies what penalties for what, when it comes to cannabis? We were specifically looking at possession, cultivation—so growing and distribution. So it's when we look at that and see what type of penalties are applicable for those three behaviours, that's when we came up with this idea that there are seven different approaches that people take. One of them is full criminalisation, so criminal penalties are applicable for all three at every scale. That's something we saw in the state of Texas in the United States. That was very rare. I'm not going to speak about Texas, but it's probably not my preferred approach—speaking as myself, not as NDARC.

On the other side, on the other end of the spectrum, you have full legal models. So that would be what you've got in place in Canada. It's what you've got in place in a selection of states across the United States, such as California, Colorado, Washington State. In all those places, you have a legal framework for recreational cannabis. But they still have civil and criminal penalties that are applicable for different proscribed activities, such as large-scale, illicit cannabis grows. Some of the states also still ban large-scale possession. That can still get criminal penalties. If you're found with a large amount of cannabis in your home, you can face criminal penalties in some of these states—something that wouldn't be applicable for, say, hoarding alcohol, for example.

It's worth considering that cannabis is still regulated in a different way, even when it's legal. In between you kind of have this whole different mix of—possession only faces civil or no penalties, but there'll still be criminal penalties for growing or for distribution, and that is how we ended up with the seven. I am happy to provide that on notice. I don't have the full breakdown here. But it's really just about that kind of mix.

DON WEATHERBURN: The dilemma you pose, can I say, is that NDARC is not an advocacy body, so we're really here to present the facts as they are understood to be the case. Obviously, as in all policies, it's a balance of competing interests and that is really a political decision, rather than a scientific one.

MICHALA KOWALSKI: So the "better" would depend on your aims. So the question is better for what?

The CHAIR: Better if you were trying to reduce harm.

DON WEATHERBURN: They all offer the capacity to reduce harms, but you can only reduce some harms without having to put up with increases in others. For example, if you were to fully decriminalise cannabis use, you will see, probably, an increase in cannabis consumption, and that carries with it an increase in people driving on roads affected by cannabis. The benefit you get is that you've got far fewer people with a criminal conviction whose job prospects are limited. If you go the other direction and criminalise it completely, so there is no cannabis cautioning whatsoever, there will be a lot more people with convictions for cannabis use that interfere with their job and employment prospects. But there may be fewer people driving around on the roads with cannabis in their bloodstream. So there is no single solution which reduces all harms. It's a trade-off of harm reduction on one side versus the other.

MICHALA KOWALSKI: Also, if you legalise cannabis, there is certain benefits you would get that you would miss out on in both of those two models. That comes from taxation revenue, but also about having more control over the supply and being able to put in different types of incentives to safeguard around, like, the percentages, psychoactive compounds in the cannabis, the quality of it.

DON WEATHERBURN: Those are things you could do regardless of the model.

The Hon. STEPHEN LAWRENCE: Thank you, NDARC, for your submission. It is really helpful. My first question is maybe for you, Professor. What role do you think cannabis regulation is playing in the continuing over-representation of Aboriginal people in the criminal justice system?

DON WEATHERBURN: Insofar as the people being disproportionately prosecuted for cannabis possession are Aboriginal, it certainly makes a significant contribution. I think perhaps the more important concern is that States and Territories and the Federal Government have committed themselves to reducing rates of Aboriginal over-representation in prison. One of the reasons that Aboriginal people are over-represented in prison is that they tend to have longer criminal records, and one of the contributions to those criminal records is being picked up for offences such as use and possession of cannabis when they could otherwise have had a caution. So it also makes an indirect contribution to Aboriginal over-representation in prison.

The Hon. STEPHEN LAWRENCE: How much of the over-representation in prison—I am not expecting you to quantify it as a figure—is indirectly referable to cannabis, in terms of people being on good behaviour bonds which they subsequently breach, people having sentences for unrelated offences increased on account of a criminal record and factors like that?

DON WEATHERBURN: It's a good question, and I don't know the answer. There is no question that once you have—as you correctly point out—a supervised bond, for example, as a consequence of being picked up for a minor offence, and you breach that, that will go down as a further conviction for a justice procedure offence and, of course, if you come before a court with a justice procedure offence, that is, a failure to comply with a previous court order, the chances of you ending up in jail are consequently increased. These things act as what some people call snares. They snare you and make it more likely, should you commit a further offence, that you are going to end up in jail. They accumulate over time, if you get my drift.

The Hon. STEPHEN LAWRENCE: Yes. We have got evidence before us that 91 per cent of strip searches are for drug possession or suspicion of drug possession. I am interested in your thoughts on the extent to which drug laws or laws that pertain to the possession of small quantities of drugs are being used as an avenue for proactive policing when the aim of the proactive policing is indirectly for some other form of offending. For example, police are using traffic and minor drug laws as a way to monitor people that they might suspect are recidivist domestic violence offenders or for some other sort of offence that is maybe more serious.

DON WEATHERBURN: Certainly, starting a few years ago, police in New South Wales began to focus on what they would have called prolific or high-rate offenders—that is to say, people who have a criminal record, regardless of what's in that criminal record. Most of you will be familiar with the Suspect Target Management Plan. The object there was to find key people who are suspected of being prolific offenders under constant surveillance, and constantly looking for circumstances in which—for example, if they're on bail, they might be in breach, or if they are breaching a court order.

Police would have argued, in those circumstances, that they are doing nothing more than enforcing the law. To that extent, that is absolutely correct, but the consequence is that you are not dealing with a situation where police are, say, facing a huge problem of armed robbery or a huge problem of break and enter and going around looking for the culprits. They are basically drawing up a list of people in each local area command who they believe to be major offenders and looking for anything they do which might be a basis for refusing bail or prosecuting the person, and minor offences play just as important a role in that as major offences do. It is what used to be known as the Al Capone strategy—that is, you go looking for whatever you can get the person for rather than dealing with a particular problem, whether it be armed robbery or trafficking or whatever else. Does that make sense?

The CHAIR: Yes, it does make sense. How important is it to the police to keep those offences on the books? I will have to ask the police that, but they might not give me a straight answer. How important do you think it is to the police that they retain the criminality of cannabis so they can then pursue more serious offences?

DON WEATHERBURN: I wouldn't have thought that cannabis offences play a huge role in that. They may to some degree, but if I was a police officer and I was looking to implement something like the Suspect Target Management Plan, the first port of call would be an outstanding warrant or a bail breach. The reason I say outstanding warrant or bail breach is because, automatically, if you have got the person, you can have them locked up. It is a different story again if you pick somebody up for cannabis possession. Then there is not going to be any

automatic removal from the street, so I wouldn't have thought cannabis laws play a huge role in the Suspect Target Management Plan-type thing.

I should be honest here and say that the evidence is quite strongly in favour of targeted policing. The problem is that there has always got to be a balance struck between pushing crime down and unfairly intruding on people's liberty or becoming harsh and aggressive. But that's by the by. To answer your question, I don't think the cannabis laws are anywhere near as crucial as the laws pertaining to breach of bonds, breach of supervised orders, breach of bail and breach of apprehended violence orders. Those things, I would have thought, are far more important to them than cannabis possession.

The Hon. STEPHEN LAWRENCE: But it is commonly a condition of bail to be on good behaviour?

DON WEATHERBURN: Yes.

The Hon. STEPHEN LAWRENCE: For example, if a person is on bail for a more serious offence and they are surveilled, found to be visiting a drug dealer's house and searched as they leave, then that could be a trigger for a drug possession charge as well as a breach of bail, couldn't it?

DON WEATHERBURN: Breach of bail, as I understand it, is still not an offence; it is a basis for bail revocation. Yes, that's absolutely true. It could happen, although I think most of the people who get dealt with for breaching bail are dealt with for not complying with one of the conditions—that classically being domestic violence. If they don't stay away from the person, there is an immediate breach and the consequence is that they have bail refused. But I wouldn't doubt for a second that it's possible a breach of bail might involve a possession offence.

The Hon. STEPHEN LAWRENCE: Do you think the imperatives of proactive policing are a legitimate rationale to maintain a criminal offence?

DON WEATHERBURN: No. I would have thought there has to be some inherent justification for a criminal offence other than the fact that it helps police catch people for other kinds of offence. That would be an odd justification, from my standpoint.

The Hon. STEPHEN LAWRENCE: In terms of the Cannabis Cautioning Scheme, we have got evidence before us about the high rates of Aboriginal people not being eligible for that scheme or not receiving the benefit of discretion under that scheme. Do you think that evidence, as far as you are aware of it, might be a basis to amend the scheme to require police to disregard a prior history of cannabis matters?

DON WEATHERBURN: I think that would help. I think prior history is the big driver here of whether you are going to end up getting a caution or whether you are not. To some extent, that could be seen as somewhat unjust in the sense that whatever prior offences a person has done they have already served time for. In a sense, it is like double punishment to deny them a caution, if that's all they have got—a small quantity of cannabis. But I do think an enormous amount of attention is paid to prior record in circumstances that would make you scratch your head a bit. If a person has a prior record for a break, enter and steal, it is not at all clear to me why, if they are picked up for a small quantity of cannabis, you would be denied the cannabis caution because you have done a break, enter and steal. I'm much more in sympathy with the notion if you have been a drug trafficker and you are picked up in possession of a drug. That would make more sense to me. But I'm speculating here; I don't know.

MICHALA KOWALSKI: Just on that, the rates—we talked about this before. In one of the first studies done for the cannabis cautioning—this is BOCSAR's work, not NDARC's—the initial evaluation found a difference in the rates of cautioning for people from Aboriginal and Torres Strait Islander backgrounds and people who are not, and they also found that when they followed up a couple of years ago. I think we made reference to both in our submission to the Committee, to say that it is a longstanding problem. The points of difference that BOCSAR identified were really structural: Percentage-wise, fewer Aboriginal and Torres Strait Islander people were eligible for the caution in the first place, and a lot of that difference had to do with the requirement to not have a prior criminal record for offending that was drug related. But, among people who were eligible that didn't have that, there was also a difference in having an existing prior criminal record. If that were to change, logically those numbers should change dramatically as well.

The Hon. STEPHEN LAWRENCE: It's a bit of an unusual thing, because normally the policy of the criminal law is to have regard to prior matters, whether that might help in some unusual sense or might count against someone. It's fairly unusual to have a scheme that requires disregard of prior history. I just wonder if the rationale for this offence is seen to be less, in terms of it being a health issue and so forth, maybe there is a rationale for excluding consideration of prior matters.

DON WEATHERBURN: You don't get tough penalties for parking because you've had 40 parking fines before; you get the fine. If you were to think about a small quantity of cannabis possession in the same light as an

infringement notice, you would be sanctioned, but the sanction wouldn't depend on how many times you've been sanctioned before for this offence. I guess it depends on how you want to look at the thing: Is cannabis possession more akin to an offence like burglary, where a criminal record is clearly relevant, or more akin to a minor offence deserving of an infringement notice or a caution, where if there was going to be a sanction, it wouldn't be one that would get worse every time.

The Hon. STEPHEN LAWRENCE: The other thing I wanted to ask was that a lot of the evidence we've received is premised on the dichotomy between criminalisation and decriminalisation, and you've probably heard that the Premier has ruled out the decriminalisation of illicit drugs, at least in this term of government. I'm interested in things in that criminalisation space where you could, perhaps, relax criminalisation. Some of the things that occurred to me was you could change the maximum penalty for possession from two years and move it down, you could change the definition of supply so that giving away drugs to friends is possession rather than supply or you could change the police powers laws so that you couldn't stop and stripsearch on account of a suspicion of minor possession. I was wondering if you had any other ideas about how you could relax criminalisation without removing it altogether.

DON WEATHERBURN: I don't.

MICHALA KOWALSKI: You've named quite a few of the options. In different jurisdictions around the world, small-scale supply—particularly supply that's referred to as gifting, without the exchange of money—is not treated as supply across the board. There are jurisdictions that do, but there are also jurisdictions that have simple penalties for that, or also just regard it as possession, which is what I think you're talking about. You could also do that with things like growing—production. There are jurisdictions that treat that as akin to distribution and there are also jurisdictions that treat that as akin to possession. That's one of the places that there can be movement as well. Another thing is to move towards a blend that's more towards a mix of civil and criminal penalties, or move towards civil penalties. You can absolutely reduce the severity of those penalties. There's big variation in how severe a penalty is for these things. Those are all things that you can play with.

The Hon. STEPHEN LAWRENCE: That's interesting. The other thing we have evidence on is the possibility of changing the Crimes (Sentencing Procedure) Act so that the default position is no convictions for cannabis possession, and one would only be convicted if the court was satisfied as to a certain threshold or test. Have you got any thoughts on that?

DON WEATHERBURN: They're all worth pursuing, but they all need to be evaluated. I think the last thing anyone wants is what's happening with methamphetamine, which is a huge increase of people entering hospital with overdose problems. But I don't see that as a huge risk at all. I certainly think those things that you've described are well worth exploring—principally because they reduce the current harm associated with prosecution and conviction. It's not a situation that anyone can be terribly happy with if someone who is otherwise leading a normal, lawful, community life is picked up for a small quantity of cannabis and has that stain on their history, affecting their job prospects and employment. I think that's the big harm that needs to be considered in looking at ways to reduce that, without, at the same time, exacerbating any drug-related harm that might be of concern to the public.

The Hon. STEPHEN LAWRENCE: Just on that, where the criminalisation regime was relaxed but not eliminated, do you think that they would lead to any significant increase in use, or do you think people's behaviour is not really driven by the minutiae of the criminal law in that respect?

DON WEATHERBURN: I don't think it would lead to a big increase. The reason I say that is that if you take people at their word, the National Drug Strategy Household Survey asked people would they try cannabis if it was legal—that is to say, without any criminal sanctions whatsoever—and only 4 per cent said that they would. They're the percentage who would actually try it. The percentage who would use it regularly would be smaller than that. So I think the market for cannabis, over the many years that it's been available, has reached almost saturation point. The bigger concern would be people driving under the influence of cannabis, and we already have effective laws for dealing with that problem.

The CHAIR: Thank you, both. Unfortunately our time for questions has ended. Again, apologies for the late start. That is all my fault, apparently. We've looked at the tape, and I got the time wrong. The secretariat will be in contact in due course for questions taken on notice. Thank you very much for your submission, for the time you've taken to give evidence and also for the work that you do in a really important area.

(The witnesses withdrew.)

Mr JAMES GASKELL, Chief Operating Officer, Australian Natural Therapeutics Group, affirmed and examined

Mr MATTHEW CANTELO, Chief Executive Officer, Australian Natural Therapeutics Group, affirmed and examined

The CHAIR: Good afternoon. Do either or both of you have some introductory remarks you would like to make before we turn to questions?

JAMES GASKELL: I will give just a very brief summary on our activity for clarification if any is needed. We were founded in 2015, pre-legalisation, as a New South Wales hemp business, endemic here in the State. Since then, since legalisation, we have expanded to three sites, two of which are in New South Wales, one in Armidale, which is our big cultivation manufacturing facility. Our activities are essentially pharmaceutical-grade production, cultivation, manufacture and distribution of medical cannabis in various forms, namely flower oil and inhalation formats. Our major markets are Australia by far, New Zealand and the European Union, specifically Germany. We have also conducted cannabis-related businesses in California as well. So we're reasonably well-versed in how the global markets work.

Our emphases, domestically, are on high-quality production. We are honest about the profit motive inside our business, but we also pay special attention to clinical research. Our products and cash are variously involved in 11 different clinical studies using cannabis materials and medicines, and a fairly big emphasis on healthcare professional, or HCP, education. We devote quite a lot of our resources in that direction to try to, if you like, foster greater understanding and destigmatisation of the medicine that we believe in.

The Hon. NATASHA MACLAREN-JONES: Thank you very much for coming today. In relation to your submission, first of all, could you elaborate on what steps the TGA has taken to address the anti-competitive practices that you refer to?

JAMES GASKELL: I think we described it as closed-loop activity.

The Hon. NATASHA MACLAREN-JONES: Yes.

JAMES GASKELL: It's essentially twofold. It's the investigation of prescribing practices and the medicines prescribed therein, if you like, and then there's a fairly large-scale inquiry into various entities around advertising practices. We as an industry are clearly obliged not to induce or encourage the use of cannabis, and there are arguments that that has been happening. Equally, within these closed-loop environments, the allegation, I think, is that there are certain products being preferred over others, shall we say. The alleged motivation for that might be seen as commercial rather than patient outcome.

The Hon. NATASHA MACLAREN-JONES: Do you think that the steps taken thus far have gone far enough or are being, potentially, too restrictive?

JAMES GASKELL: Too early to say, I think. It's a recent thing, this sort of crackdown, if you call it that. We're in the very early stages of the investigation, so it's impossible to say.

The Hon. NATASHA MACLAREN-JONES: The other is, you say the current framework doesn't have the balance between the public health and also economic benefits. Could you elaborate a little bit more about what benefits you see from a State perspective that we're missing out on—whether it's purely from a jobs perspective, or is there something further?

JAMES GASKELL: Jobs and research. The industry gets very hung up on the intrinsic imbalance between Australian-generated product, manufactured product, cultivated product—however you would characterise that—and then the imported product that comes from one jurisdiction in the main, which is Canada, which has had a history of commercial underperformance and therefore a surfeit of product and therefore the ability to send product elsewhere in the world very cheaply. There are two competing priorities in there. One is the establishment of a domestic industry and the other is, put bluntly, financial.

That's the intrinsic friction that we see. There is an argument that, on the one hand from an industry point of view, job creation, knowledge creation and so forth is being hampered by the free availability of imported product. Then, equally, on the previous point around closed-loop behaviours, it could be that the cheaper products or the products with higher gross margins are preferable to a particular type of transaction where the Australian-grown product might not be, and there is a question around the efficacy of the imported product versus the higher rigour that's applied to the Australian domestic product.

The Hon. NATASHA MACLAREN-JONES: Do you have any research or work that's done around the actual financial side of that, whether it's Australian manufactured versus import from overseas, and what benefit that has to a country?

JAMES GASKELL: Endemically in our business we can see the difference between imported product and domestic product in terms of costs reduced. That's, for us, fairly straightforward. We wouldn't call it research; it's more of a day-to-day experience. The relative benefit of that is purely financial, in as far as the company can measure it. Also, from an outcomes point of view, there's an argument to say that the medicines produced by an Australian business in Australia with an interface to the Australian healthcare professional community has a more specific target to aim for when it comes to the production of medicines.

The Hon. NATASHA MACLAREN-JONES: Finally, in relation to how businesses operate in New South Wales, what restrictions do you currently see that would prohibit other companies entering the market?

JAMES GASKELL: Again, a lot of it comes back to two things. One is the free availability of imported product. It is very unshackled by comparison to what we have done, so organic growth of the business. You can be up and running in terms of a NSW Health permit and a Department of Health, TGA-level, Federal permit very quickly—let's say 60 to 90 working days. A minor change or major change of business processing inside the TGA can take up to 190 working days so we're robbed of agility. We also have a larger cost impost because we're carrying infrastructure costs, we're carrying employees and we're carrying all sorts of obligations around our day to day that the more nimble import businesses don't have to deal with.

The Hon. JOHN RUDDICK: Gentlemen, thank you for your submission, which I enjoyed. You included this line:

> … Canada and many US states have adopted commercial models that have led to increased availability, reduced prices, and the introduction of new cannabis products. These models have shown both positive and negative public health outcomes …

My first question is what are the negative public health outcomes that we've seen from an increased level of cannabis consumption?

JAMES GASKELL: I think the reference there is what we don't know and what we need to know about cannabis is its potential interactions with other drugs. I should caveat, nearly everything we talk about in cannabis is anecdotal because we don't have a whole bunch of research that underpins many of the assumptions that people in general might make, and that's certainly not something that we ascribe to ANTG in terms of those assumptions. Drug interaction is a big thing that I think we are understanding now, in a market like Canada or a recreational market like the US, where it's essentially untrammelled, there's no filter through which the majority of cannabis products are pushed. There's definitely considerations around the quality of the product. By quality, I don't necessarily mean potency; I mean heavy metals content, pesticide use and drug interactions. At least three major things that are of concern to prescribing partners are things that go without any close scrutiny at all in those markets.

MATTHEW CANTELO: I might add too, just in those markets where it's now fully commercialised, that the proliferation of dispensaries on every street corner is not necessarily a good thing for society in general and/or cannabis and the stigma related around it. We don't believe in that model.

The Hon. JOHN RUDDICK: You've said:

> These models have shown both positive and negative public outcomes, highlighting the need for careful regulation.

In Parliament, we're grappling with what is politically possible, but if we put that question aside for the moment, what do you believe is the ideal level of regulation around cannabis? What jurisdiction in the world do you think is the one that we should be learning from the most?

JAMES GASKELL: I think our personal recent experience in terms of frameworks, we've lived through the German change, which became effective on 1 April this year. It contemplates three major things. One is home cultivation, which we don't feel particularly strongly about in terms of that being a threat to industry, and that's very much a personal prerogative and probably one that should be contemplated, with limits, which is probably a pragmatic thing to do. The second thing is consumption spaces, which is, again, probably pragmatically sensible, where people can, if they wish to, consume cannabis together. We don't see anything wrong with that. The third thing is the rescheduling of cannabis from a narcotic down to a regular medicine.

That piece of liberalisation, if you'd like to call it that, is really important for a number of reasons because, from our perspective, it maintains that quality, it maintains the oversight of a doctor, it maintains the existing supply chain, which is really important from an investment point of view—perhaps a little bit more selfishly, where we see there's been a liberalisation or a decriminalisation change. That doesn't mean a free-for-all in the Canadian or US model where there's retail opportunities at every street corner. What it does, it allows a more

widespread mechanism for the distribution of cannabis through a prescriber but straight to a pharmacist—no need for special access schemes or authorised prescribers, in our context. But it maintains the level of safety, scrutiny over interaction and supply chain efficacy and security that we think is very important.

The way that Germany has rolled that out has been pretty good. There's a bit of thinking to be done around retrospective and retroactive convictions for cannabis use. These things don't necessarily sit inside our purview but we can certainly see it being considered by distribution partners there. So a long story short, I think that's certainly the strongest precedent we've seen for any kind of "liberalisation" around the access to the medicine.

The CHAIR: Within Australia, the Office of Drug Control is handing out the permits and licences for production of medicinal cannabis. You've touched on the issue of the different regime for Australian cultivators when compared to people importing. What proportion of cannabis that's currently in the Australian medicinal cannabis market is imported and how much is home-grown?

MATTHEW CANTELO: It depends on the quarterly figures that you look at, but we're looking at probably 70/30 traditionally, and that gap could be starting to bridge more to 60/40, but it's roughly in that space.

The CHAIR: Is there any regulation or statute or guideline that you're aware of that the ODC has to limit the amount of import? Or is it just laissez faire, just the market operating, if people want to import it, they'll import it no matter what? Is there no regard for the domestic producers when they approve those licences and permits?

JAMES GASKELL: That's certainly what we've seen so far. There's certainly been no quantities or capping or anything like that discussed with us. It's very much been around compliance to the permitting process and the speed of the import. It doesn't seem to be looked at on a more macro level.

MATTHEW CANTELO: We're obliged, obviously, to report to the United Nations on quantities—starting material and finishing material—at any given period, and that's provided to the United Nations. At the moment, there's a fair bit of product that's opening balance, you might say, at the start of a quarter. That's certainly not sitting necessarily in our vaults; it could be the importers' vaults or our competitors' vaults—not sure—but there's a fairly substantial starting amount each quarter.

The CHAIR: Within Australia, you've got a facility in New South Wales and I understand you've got one in Queensland. Is there a different regulatory environment across States? Are some of the States or Territories better to do business in? If so, which ones and why?

JAMES GASKELL: Very slight variations in the State-level poisons handling regulations. Queensland is slightly more liberal maybe when it comes to its deference to the TGA, but negligible in terms of doing business. If there is a State where there has been some sort of positive noises made, it has probably been Victoria. But from a point of view of a direct comparison between the States, from our experience I think there's no difference between doing business in New South Wales and doing business in Queensland.

The CHAIR: Are any of the States or Territories really taking the lead on seizing the opportunity, if there is one, of growing a medicinal cannabis industry in their various jurisdictions, either by direct financial assistance or policy? Anything like that?

JAMES GASKELL: Policy, like I say, historically I think Victoria has been quite vocal about the educational side. From the point of view of access to infrastructure funding and job creation funding, New South Wales is pretty good. That has certainly been our experience in Armidale. Queensland have yet to show any hand on this. We haven't seen any cannabis-specific stimulus manifesting in any policy. But New South Wales, of any of those three which we've had a reasonable amount of exposure to now over the last nine years, has been specifically proactive about the regions and I think cannabis is seen as an opportunity within the regions.

The CHAIR: How big is your facility at Armidale? How many people are employed there? Can you tell us a little bit about it?

JAMES GASKELL: Sure. It's an 11-acre site. It's a four-bay greenhouse, so it's a controlled climate environment and cultivation environment. There's a genetic breeding area, there's a propagation area and there's about 10 multipurpose GMP manufacturing clean rooms that we do various activities in—everything from trimming, flower, through oil production, extractions for oils and so forth. It's a fairly large facility in the Australian context. Overseas in Canada or the US, for example, it would be seen as quite small. There are about 110 people employed there. About 95 of those, I think—but probably could come back to you on the actual numbers—are full time, and then there's a sort of rolling roster of casuals from the local community and from the University of New England.

The CHAIR: Fantastic. What are the prospects for Australian medicinal cannabis? How is it considered globally, if you consider the oversight of the TGA and the ODC and your GMP process? Is there a growth profile globally for Australian cannabis? Is there a big global opportunity there?

JAMES GASKELL: One hundred per cent. First of all, TGA GMP is globally renowned, so the Australian gold standard when it comes to pharmaceutical production is without parallel. But we see partners or friends in other jurisdictions—Colombia, for example—seeking out Australian TGA approval for their sites in those countries just to help them with their global reputation. Although it's easy to complain about, our regulatory environment is pretty good. We're not nimble but we get there. I think our reputation for quality, for purity and for innovation is pretty strong internationally.

I can tell you that one of the reasons our German partner has seen consistent market share from our Australian products over there is consistency, quality and the Australian sheen. They use the "grown in Australia" kangaroo on the German language packaging. It is seen as something of a differentiator, so we're pretty strong in the export markets. Equally, I think the interface that our industry is increasingly having with academia and the healthcare professional industry bodies is also something that's not common in the industry, so we're doing a good job. There are always sceptics, and we understand that. There's a lot of work to do when it comes to education, but we have really good engagement with the universities and those communities, and that's something else that I think helps us grow the potential that we've got.

The Hon. STEPHEN LAWRENCE: I have heard it said, and I don't repeat it in order to endorse it, that the legal cannabis industries overseas have been infiltrated by organised crime and are used as a way for organised crime to raise money. Is that something that you can speak to? I only raise it in the sense that it could be considered a regulatory risk, for example, if we were to proceed with legalisation, that it might somehow become an avenue for organised crime to fundraise.

MATTHEW CANTELO: We have not really heard of that ourselves. There's a company called JuicyFields in Europe which had a fair bit of attention and public scrutiny. I believe that has been quashed and the criminal gangs, I suppose, that were in charge of that are hopefully being brought to justice, but we have not seen or heard of that. The United States is a very large, complex place, so I wouldn't want to speculate, but it's very different in each state there, but we have not had any exposure to any organised crime, certainly not in Australia.

The Hon. STEPHEN LAWRENCE: I suppose a layperson might say, well, it has previously been illegal, so the people that are going to be most adept at growing it are going to be the people that were growing it under the old regime, so therefore you might expect to see that. Have you got any comment on that?

MATTHEW CANTELO: The fit and proper testing that the ODC does for any licence holder is pretty extensive. I don't think you would get any criminals getting past that.

The Hon. STEPHEN LAWRENCE: What's that? Could you explain that to us?

MATTHEW CANTELO: Basically you need to submit an application to the Federal police for a referral back to the ODC to say that you're clean, you haven't had any criminal charges for any reason over the past five years. Unless it's outside of five years, it will be captured in those reports.

The Hon. STEPHEN LAWRENCE: To the extent the market here might grow and have approval for different purposes to cultivate, you could certainly construct regulatory regimes that would ensure that you could keep any organised crime involvement out of the industry?

MATTHEW CANTELO: I believe so.

JAMES GASKELL: The cost of doing business, frankly, inside the cannabis supply chain is probably pretty preclusive for those guys who were enjoying the bigger margins back in the old days because it lends itself more now to efficient manufacturing practices and good management than it does to opportunism.

The Hon. STEPHEN LAWRENCE: Why is that? Because illegally it's so profitable that—

JAMES GASKELL: Throw some plants in the ground, grow them, dry them, sell them; where we have to do a multitude of steps, employ a multitude of different skill sets and then incur a whole bunch of different types of costs just for distributing finished product. Your margins just move downwards. I think as that contracts, it gets less attractive for unscrupulous elements because it's just not worth it.

The Hon. STEPHEN LAWRENCE: So there wouldn't necessarily be any greater motive for organised crime to be involved in that industry than in ordinary farming, for example?

JAMES GASKELL: Not that I can see. Opioids, poppy farms, no reason for them to be involved in that either.

The CHAIR: If there were regulatory changes in New South Wales that you would like to see to help grow your businesses, what would they look like?

JAMES GASKELL: I'd go back to probably the scrutiny around the imports. It's a State-level thing as well as a Federal-level thing.

The CHAIR: How is it a State-level thing?

JAMES GASKELL: In terms of the poison storage. There are always two levels of negotiation or two levels of approval that we need to go through. One is Federal, which gets the most airtime, but the second is always State.

The CHAIR: So there is a requirement under that Act in New South Wales to have like a bonded area or a designated area for the storage.

JAMES GASKELL: Yes.

The CHAIR: Who oversees that? Is that NSW Health?

JAMES GASKELL: Yes. That's not an accusation in terms of how they might be hampering or helping, but I think that certainly it could be examined. But that's probably from a strictures point of view the only thing we can see. The flip side of it is, as I said before, the willingness to engage on industry growth in New South Wales could always be expanded upon, but it's a good start.

The CHAIR: Thank you both for your evidence. We really appreciate the submission you've made and the great work you're doing in pioneering what's a very important industry, with a big future in this country. There is my little political spiel. Thank you very much for all the work you're doing; we really appreciate it.

(The witnesses withdrew.)

Mr EDWARD STRONG, Head of Government Relations, Montu Group Pty Ltd, sworn and examined

Mr MATTHEW McCRONE, Industry and Government Engagement Lead, Montu Group Pty Ltd, affirmed and examined

The CHAIR: I welcome our next witnesses. Gentlemen, thank you for your attendance today. Do either or both of you have some introductory remarks to make?

EDWARD STRONG: I have a brief opening remark. On behalf of Montu and the approximately 70,000 patients in New South Wales who've been seen by our clinic, we would like to thank the Chair, Deputy Chair and Committee members for the opportunity to lodge a submission and appear before you today. Matthew has spent 23 years working in senior positions for both the Australian and Victorian governments and is a senior pharmacist at the Therapeutic Goods Administration and was the chief medicines regulator in Victoria. It was in that role that Matthew led the taskforce that legalised medicinal cannabis in 2015 and also led the implementation of SafeScript. I grew up in the New South Wales village of Jugiong and Matthew is from Temora, so we both have a firsthand understanding of the challenges of regional access to health care.

Founded in 2019, Montu is now Australia's largest health tech business with a focus on medicinal cannabis therapies. There are several arms to our organisation. Our patient clinic, Alternaleaf, is an end-to-end online platform that allows patients to receive care from highly trained nurses and doctors. Our wholesale company, Leafio, provides pharmacies access to medicinal cannabis products. Our training platform, SAGED, provides medicinal cannabis education to clinicians. As you'll have seen, our submission explores four key areas: the use of medicinal cannabis in Australia, its increase in uptake and the barriers to expanded use; the impact of drug driving regulation on medicinal cannabis patients and the need to amend the Road Transport Act to protect these patients; the impact of workplace drug testing on medicinal cannabis patients and the opportunities to improve regulation; and the importance of telehealth for medicinal cannabis patients, particularly those in regional areas. I again thank the Committee for holding this inquiry. These are really significant issues for many of our patients and we welcome any questions you may have.

The Hon. NATASHA MACLAREN-JONES: I'm interested to find out a little bit more about access to medicinal cannabis for rural and regional patients. What are the limitations in accessing a doctor to prescribe, and is telehealth the only solution?

EDWARD STRONG: It is incredibly difficult for regional and rural patients to access health care in general, but particularly medicinal cannabis as a treatment pathway. Only about 5 per cent of GPs are able to prescribe medicinal cannabis. As such, most bricks-and-mortar GPs, particularly in regional areas, might not be able to prescribe through TGA's two pathways. That causes real challenges for those patients who are looking to access medicinal cannabis. Very often medicinal cannabis is a treatment of last resort. For many of those patients, telehealth is the only option available to them.

MATTHEW McCRONE: If I can just add to Mr Strong's statement, another significant barrier to being prescribed medicinal cannabis for patients in rural and regional areas is that they can't drive while they're being prescribed it. For them to drive to a doctor's appointment and then to the pharmacy would not be practical under current laws. Telehealth really does offer the solution for that reason.

The Hon. NATASHA MACLAREN-JONES: Are there barriers to GPs becoming prescribers, or is it just a choice that some are not taking up?

MATTHEW McCRONE: When I was running the medicinal cannabis taskforce in Victoria, the Victorian Law Reform Commission looked very thoroughly at what would be the best model moving forward. The model it recommended imagined a future where a person could go to their GP and the GP could prescribe medicinal cannabis, just as they'd prescribe their anti-hypertensives or whatever else. That hasn't been what the reality has come to be 10 years down the road.

The reasons for that are many. Stigma is one, whether it's that specialist colleges aren't really strongly endorsing the use of medicinal cannabis or whether it's a lack of training or education. GPs say that their patients come to ask them about medicinal cannabis and they don't know what to say. As much as the TGA access pathways do work, they are complicated. A normal GP wouldn't necessarily be engaging on a day-to-day basis with the TGA in the way that TGA access pathways for unapproved medicines work. It's complicated, and that makes it even more unlikely for GPs to take it up. But I think the major problem is still with stigma.

The Hon. NATASHA MACLAREN-JONES: My final question is in relation to your recommendation around the Work Health and Safety Act. What changes would you like to see?

EDWARD STRONG: It's incredibly challenging for a lot of patients when employers have drug-testing programs, randomised or otherwise, in the workforce. Some of you might be aware—I'm sure Mr McCrone can go into a little bit more detail—about the pharmacology of THC. THC takes a lot longer to break down than the impairment actually lasts. You have a number of people—patients of our clinic or others—in the workforce who are unimpaired but still with THC in their system. If they are subject to a drug-testing program, that's incredibly challenging for them. They have the potential to lose their job. We are in no way saying that impaired people should be at work, but the unimpaired—which lasts, as I mentioned, for a lot longer—should be able to return to the workforce.

MATTHEW McCRONE: The idea that safety-critical roles need a regulatory framework around them is without question. But what is being done to ensure that the employees who are in those safety-critical roles are being properly protected? This surrogate measure of presence of THC—it's scientifically questionable that it's an appropriate proxy for whether or not a person is able to do their job safely. Ed touched on the pharmacology. Blood alcohol concentration is something we all know and we've known for years. Roadside testing for alcohol has been around for 40 years. But alcohol's kind of unusual, in a way, to other substances, in that because it is so short-acting—because it takes such a short amount of time to go through the body—there's a linear correlation between the amount in the blood and the amount that you are impaired. That's not the case for many other substances, and it's particularly not the case for cannabinoids.

The physical properties of THC, particularly—it's attracted to fatty areas of the body. It goes to those fatty areas and it stays there for a very long time. That can be days; that can be weeks. When a patient is taking something chronically, there is a question as to whether there's any impairment at all, but if there is any impairment, it's gone within a few hours. The proxy measure of the level of THC in a person's blood is actually not an effective measure of whether or not they're impaired. That's all we're saying.

The Hon. NATASHA MACLAREN-JONES: Then what is the most effective measure of someone's impairment, whether they're operating heavy machinery or driving?

MATTHEW McCRONE: Yes, indeed, that's probably the area of policy that does need to be worked on. We recently appeared at the Victorian parliamentary inquiry into workplace drug testing. There was a lot of talk there about technology solutions, whether it's an app or whatever else. The DRUID app is one that's being used at the moment for the closed road trial that's happening in Victoria for driving. There's mixed views on that sort of technology, not least of all because it needs to have a baseline to an individual person, rather than there's a universal baseline and if you score less than 3 then you're impaired, or whatever it is. But there certainly needs to be more work in that area. To measure the concentration of a substance that has little or no bearing on whether you're impaired or not is just not fair. Further to that, the number of substances that do cause significantly more cognitive impairment that are not tested through workplace drug testing programs further demonstrates the inconsistency and the injustice of medicinal cannabis patients, particularly, not being treated fairly.

The Hon. NATASHA MACLAREN-JONES: Is there any international work that's being done? There is an app that is being looked at in Victoria, but is there anything else internationally that can be used as a safe measure so that you can say, in a workplace or for a person driving, you're not impaired?

MATTHEW McCRONE: In terms of driving, we have had a position paper developed on this with an academic who specialises in road safety. Again, I don't mean to be constantly plugging Victorian arrangements, but they're the ones I am most familiar with. There is a behavioural impairment testing program that Victoria Police has developed. Since 2000, everyone who goes through officer training is actually trained in this. Not to diminish it, but effectively there are two stages to it. There's a behavioural impairment screening that can happen right there, roadside. It only takes a few minutes. The vast majority of people would pass that initial behavioural impairment test. We would envisage that they're still tested.

For medicinal cannabis, if it's present, they then do the roadside test. On the rare occasion that they fail that, then there would be a more comprehensive test that would need to be done at a station or whatever. That program exists. Officers are already trained in that. It does not require technology; it does not require new resources. We see that as a fairly pragmatic solution—perhaps even to say that New South Wales could look at a medical exemption trial. As part of that trial, the NSW Police Force could look at the behavioural impairment testing as part of that trial, and it could be tested to evaluate it at the end of the trial.

Ms CATE FAEHRMANN: Of course, there's the situation of Tasmania. I'm not sure whether you mentioned that in your responses then. But they have been able to survive with no real increase in fatalities or accidents in terms of their situation, which has been different to the rest of the country, and they're often raised. Would you care to comment about how Tasmania deals with the issue of drug driving?

MATTHEW McCRONE: It is a general exemption. If a driver is pulled over and they are able to demonstrate to the officer that they have been legally prescribed medicinal cannabis, then that's the end of that.

Ms CATE FAEHRMANN: When they're pulled over, do you know the details of what they need to provide?

MATTHEW McCRONE: Therein lies the rub. Firstly, we would love to see data from Tasmania as to whether they have done any sort of analysis of increased incidents or otherwise since they've brought this in. But the quirk about Tasmania that's probably not really understood well is that, when we talk about "legally prescribed in Tasmania", that means it has to be prescribed by a medical practitioner who is resident and present in Tasmania at the time of prescribing. We've talked about why telehealth is a solution for many patients who can't otherwise access medicinal cannabis. Telehealth is actually not a solution for patients in Tasmania because they need to have it prescribed by a Tasmanian doctor in order for it to be legally prescribed and, therefore, be able to have the exemption for driving.

Ms CATE FAEHRMANN: I did want to turn to a slightly different issue that I have been contacted about by an alcohol and other drug stakeholder. Are you aware of the requirement in terms of prescribing unregistered schedule 8 cannabis medicines in New South Wales to not—basically, if somebody is a drug-dependent person, I understand they are unable to be prescribed that. As a result, there has been quite an increase, particularly in recent months, as I understand it, of people who are on opioid treatment programs who have essentially been told by various providers that they have been discharged, basically. This is happening at an increasing rate. Would you care to comment on that?

MATTHEW McCRONE: Poisons legislation is State based but more or less the same across all the jurisdictions. In broad terms, as long as a doctor checks SafeScript, that's all they need to do for most patients. The wording is different in different jurisdictions, but if they have reason to believe that a patient has substance use disorder or they are known to have substance use disorder, then they have to get a permit—again, the term is "permit", "approval", "licence" or whatever it is in the jurisdiction—before they can even commence prescribing any schedule 8 for that patient, including medicinal cannabis. That is quite a regulatory burden for a lot of medical practices. It's something that we're looking at in our clinic because it's particularly burdensome in a telehealth model. But what is happening with patients with substance use disorder, including opiate use disorder—because that permit is required legally before a medical practitioner can even commence treatment—is that a lot of medical practitioners see that as too hard.

Ms CATE FAEHRMANN: Would it be fair to say that this is also a result of people getting medicinal cannabis online, as well as telehealth? The increase in that type of prescribing is potentially more burdensome than having to go through those requirements, as opposed to a GP who knows their patient. Is that potentially one of the disadvantages?

MATTHEW McCRONE: Yes, it's a disadvantage. The Pharmaceutical Services Unit within the Ministry of Health here would have a policy around what needs to happen in order for a treatment permit to be issued for a patient with substance use disorder in order for them to have S8s. It might be, for instance, that they have to have a letter of endorsement from a specialist or that the GP that's seeking the permit has to provide all of their primary care—conditions like that. They're not overwhelming, but it's a higher—

Ms CATE FAEHRMANN: It probably cuts into the profit margin a little bit. These people are just being booted off, as I understand it. That is the feedback I'm getting.

MATTHEW McCRONE: I hear what you're saying.

Ms CATE FAEHRMANN: Is it just New South Wales specific?

MATTHEW McCRONE: No, every jurisdiction does have the requirement that if a person has substance abuse disorder, there needs to be this permission issued beforehand. We are honestly looking at how we can work through that but, least of all, the requirement that the medical practitioner who's receiving the permit is responsible for all of that patient's primary care is difficult.

The Hon. JOHN RUDDICK: Mr Strong, you mentioned in your opening statement that there is a problem around the Road Transport Act. We've heard from other witnesses who said that there is a problem with people getting medical marijuana and not being impaired, and driving and getting in serious trouble with the law. What do you think is the legislative fix?

EDWARD STRONG: Mr Ruddick, there is an existing component within the Act, at section 111 (3) through (6), I believe, that deals with the provision of morphine. It allows for a medical defence for those who have been prescribed morphine and then who have driven to appear before a magistrate and be able to prove that prescription. What you would need to do is allow for medicinal cannabis to sit alongside something like morphine,

or to be able to take a more robust approach and acknowledge that that should be for all prescription drugs where there is no actual impediment on your ability to drive at that point in time—so you're no longer under the influence of it—and attach that alongside those provisions of section 111 (3) to (5).

The Hon. JOHN RUDDICK: Where it says "morphine", just add in "morphine, and medicinal cannabis". I didn't know about this Tasmanian thing. I was interested to hear about it. Is that effectively what's happened in Tasmania?

EDWARD STRONG: I do believe that it is a defence in Tasmania but, as mentioned, there are a number of other restrictions around Tasmanian patients requiring treatment through a Tasmanian-registered doctor.

The Hon. JOHN RUDDICK: Mr McCrone, about the Tasmanian thing, you were saying that the prescription is an automatic defence. I'm all for liberalisation. Is impairment a factor in Tasmania or is it just that the prescription gets you off?

MATTHEW McCRONE: My understanding is that it's just the prescription. But it may be—and we could take this on notice, perhaps—that the requirements in order to get the permission through the Tasmanian Department of Health and Human Services are ones where the doctor actually has to make an assessment of the patient as to whether they're fit to drive or not. I don't know. But it could be that there is some sort of assessment done at that stage.

The CHAIR: Mr McCrone, we heard evidence earlier today from the college of GPs saying that there was little—I might be paraphrasing or verballing the doctor—or limited or poor-quality—words to that effect—evidence on the efficacy of medicinal cannabis. That was one of the principal reasons. It is relatively new, with not a lot of research, and that is why we don't have as many GPs prescribing it. What's your response to that? Is there evidence we can look to? Could you respond to that?

MATTHEW McCRONE: I say respectfully that medical colleges tend to be quite conservative in their positions on things, and that's for them. In terms of evidence, there is often talk of the hierarchy of evidence when it comes to clinical evidence of the efficacy and the safety of something. The best that there can be is a randomised controlled trial. There are many reasons why, whether they're logistical reasons, regulatory reasons or practical reasons, randomised controlled trials for medicinal cannabis are not as easily established as randomised controlled trials for standardised single-molecule pharmaceutical medicines. It may not be that randomised controlled trials really ever happen to the level that they might happen for research and development of a standardised single-molecule medicine. What can we do instead, is the question.

Certainly, there is move generally—not just about medicinal cannabis but generally in the world of evidence. In terms of drug development, a drug company spends billions of dollars developing a new drug. They will have phase 1 clinical trials, which is the first trial in humans; then phase 2 where it's the first trial in the target population; then phase 3 when it's actually the target dose; and then phase 4 is after it has been marketed out in the general world. Drug companies will only show a regulator the trials that tell a positive story about a medicine and that it's doing the things that they want it to do and that it's safe.

The move away from that is, "Well, let's actually look instead at real-world evidence. Let's look at the data that happens out in the real world, analyse that big data and then we can determine in an actually more robust way that something is both safe and efficacious." I think that the solution is to really look at real-world evidence for medicinal cannabis. Given the number of patients that we have at our clinic, we are looking at ways that the real-world evidence can actually be brought forward to properly demonstrate both safety and efficacy. It's two things. It's not just whether or not it does treat chronic pain but it's equally at the same time that it doesn't cause any harm.

The CHAIR: You talked at the beginning in your introductory remarks about the 70,000 prescriptions or patients in New South Wales that your organisation is aware of or has carriage of. You must have some sort of indication of what cooling effect the roadside drug testing laws have had on accessibility. Can you quantify it? How many people do you think would be availing themselves of this medicine if they weren't worried about losing their licence, especially in the regions, or they weren't getting that advice from their GPs? Are there potentially hundreds of thousands more people who could benefit from this legal medicine?

EDWARD STRONG: It's always difficult to speak to an exact number in that sense. What I can tell you is that I have personally—and I know many within our organisation have—spoken to patients who have said they might have tried medicinal cannabis once and found it to be particularly beneficial. They might have been on it for a longer period of time and they might have had their own experiences with it but they've had to stop or they have not been able to explore that pathway in treatment because of the roadside drug testing arrangements. I think it is particularly onerous on New South Wales to make sure that patients in New South Wales who could benefit from a treatment, who are potentially going through severe PTSD or are suffering from chronic pain, don't have

a treatment option removed from them because a blood test would show that they were, potentially, several days or weeks ago, impaired.

MATTHEW McCRONE: Chair, we periodically do patient surveys with patients who choose to volunteer to opt in. We have done patient surveys in the past about driving and the impact of the driving laws on their life generally but also on their decisions of when to take the medicinal cannabis and when not to. I'll see if we can get some data for you on that that's specific to our New South Wales patients.

The CHAIR: That would be very much appreciated, Mr McCrone.

The Hon. CAMERON MURPHY: I want to come back to this issue around Tasmania. When I had a look at section 6A of the Road Safety (Alcohol and Drugs) Act in Tasmania, it seems to be a complete defence as long as you're taking it in a way that's been prescribed under the Poisons Act.

MATTHEW McCRONE: Yes, in accordance with the Poisons Act.

The Hon. CAMERON MURPHY: It doesn't really engage at all with the issue of impairment. Is there a model somewhere else that you can point to that may provide a better way of dealing with the issue of impairment?

EDWARD STRONG: We might have to take that on notice and come back to you.

The Hon. CAMERON MURPHY: Yes, take it on notice and come back to the Committee on if you can see some other jurisdiction that has a model that deals with impairment, other than just a complete defence in the way that Tasmania does.

MATTHEW McCRONE: I will mention again the program that Victorian police officers have had training in for the behavioural impairment test. Generally, there are two separate offences. There is driving under the influence and then there is driving with a prescribed substance.

The Hon. CAMERON MURPHY: In terms of work health and safety, I wondered if you could expand on your submission on the same issue of impairment in the workplace. You were saying earlier that you would see some sort of division between—for want of better words—high risk and low risk in terms of safety and managing in that way. But how practically do you see it would operate? Would that mean an employee would need to disclose that they are using medicinal cannabis as a treatment before a testing regime is in place? Can you take me through the steps of how you think that might operate practically in a workplace?

EDWARD STRONG: I think it's important to first look at the really broad range of occupations where there is testing, and there are whole companies that are able to conduct testing. Within the New South Wales Act, I do believe it allows for any role where there is team-based work and any role where there is of course safety-based work but also where there are tasks that require motor skills. Very quickly, that starts to capture almost the entire gamut of modern working environments, from basic labour-based roles through to knowledge-based roles and beyond.

For the vast majority of those roles, there would be limited impact if you were impaired, but if you're not impaired but have it in your system, there would be no impact. There are, of course, a few roles—aviation is a terrific example and, likewise, working with heavy plant and machinery—where we understand the need for additional provisions and protections in place. If you are an office cleaner, for example—and we know of cases where there have been office cleaners who have had THC in their system but are no longer impaired who have had disciplinary action in relation to that.

The Hon. CAMERON MURPHY: So, in your view, you would need to distinguish between occupations, rather than dealing with the question of impairment?

EDWARD STRONG: I think you also have to come back to impairment. We in no way think that you should be impaired and working but, particularly for those occupations that are higher risk, you do need to be having a deeper look. For those occupations that are a lower risk, if you are not impaired, there should be no concern with your ability to do your work.

MATTHEW McCRONE: To take it further, it's aviation, it's police, it's commercial passenger vehicles and it's boats. Anyone who is in those industries, there's no question that—

The Hon. CAMERON MURPHY: Any industry could be dangerous, couldn't it, depending on what your particular role is or the type of work you're tasked to do? You could be a police accountant, where you may be no risk to anyone if you have THC in your system or if you're slightly impaired, versus a frontline officer about to effect an arrest. It's a completely different situation but same occupation, isn't it?

MATTHEW McCRONE: Agreed. But these are statutory. What we're referring to is where there are already statutory requirements for those industries. Beyond those ones where there are statutory requirements, we

would say that there needs to be a testing regime that is best practice. I can give you the details of this on notice. NCETA at the University of Adelaide developed, some years ago, what a best practice model of drug testing looks like.

The Hon. CAMERON MURPHY: If you could provide that, that'd be great.

MATTHEW McCRONE: Regardless of the best practice model, it still needs to focus on impairment rather than mere presence of a substance.

The Hon. STEPHEN LAWRENCE: It seems to me that there might be two parts to this driving question. One is the impairment question and whether technology exists to test that, and then the other one is the decision to drive after consumption, whether short term or medium term after consumption. I'm interested about whether you know anything about advice, technology or understanding around that second part. For example, with alcohol—and it's not 100 per cent reliable—we're told two drinks in the first hour and one every hour after that. Is there any equivalent formula in relation to cannabis that is emerging that might assist people?

MATTHEW McCRONE: No. Again, a medicinal cannabis patient is taking medicinal cannabis every day chronically. For a medicinal cannabis patient who is taking their medicines regularly and every day, there's probably no impairment at all. If there was what is called a cannabis-naive person who was to take the same amount of cannabis as the medicinal cannabis patient, they would be impaired. Equally, someone who doesn't drink a lot of alcohol, they have one drink and they're impaired, but someone who is a fairly regular drinker could have several drinks and not feel impaired.

The Hon. STEPHEN LAWRENCE: Is that a problem? I imagine that the existence of these rough formulas in respect of alcohol operates to keep a fair few impaired drivers off the road. Even though people might get it wrong on occasion or might miscount, by and large, there is a bit of an understanding about when you should or shouldn't drive.

MATTHEW McCRONE: Indeed.

The Hon. STEPHEN LAWRENCE: If there's not such an understanding with respect to cannabis, is that not an argument to maintain this driving prohibition because, if we don't, we're asking people to do the impossible in terms of make assessments about when they can drive?

MATTHEW McCRONE: Not that I'm saying that this should be the legislative answer but, equally, we know when we're too tired to drive for whatever reason. If the kid has been up sick all night and I haven't slept, I shouldn't get behind the wheel and drive for four hours tomorrow because I'm too tired. You make that decision personally. You are aware of your own capacity. I'm not saying that is the legal answer, but we are making these decisions every day ourselves.

The Hon. STEPHEN LAWRENCE: We are. But one is sort of a natural part of the human condition, i.e., getting tired, and the other is the introduction of an intoxicating substance.

The CHAIR: We do that with other prescription medications. The doctor says, "If you have this, don't drive for four hours, six hours, 12 hours or at all."

MATTHEW McCRONE: Methadone is a very clear example. I don't want to bring this up to cause further stigma to patients on pharmacotherapy, but it is actually stated in policy that doctors should advise their patients to not drive in the first two weeks that they're taking methadone. That's a broad yardstick. It's not definitive; it's not exact. It is to allow them to titrate their dose and to get used to that medicine being in their body.

The Hon. STEPHEN LAWRENCE: Is there any similar thing with cannabis—like, don't drive for eight hours or 10 hours?

MATTHEW McCRONE: I'm talking about policies that are issued by governments. The New South Wales Ministry of Health has a policy for pharmacotherapy and, equally, the Victorian Department of Health. They're certainly not issuing these policies for cannabis in the context of driving.

The Hon. STEPHEN LAWRENCE: They used to say 12 hours for cannabis, but they took that down, I think, off the website.

The CHAIR: Mr McCrone, is there any research you could point to that Swinburne or the Lambert Initiative have done in this area? Could you take that on notice and provide us with any research on a similar comparable scheme where doctors or a researcher may be saying don't drive after four or six hours or until the morning?

MATTHEW McCRONE: Yes. What Swinburne has done to date has actually been with a driving simulator. They are patients who have brought their own medicine and have self-declared about their level of

impairment before or after their medicine. What is yet to take place at Swinburne—and everyone is looking to this as being the answer for everything—is patients being enrolled and then actually getting in a real car and driving on a closed road. It seems the results of that trial will not be available until late 2026.

The CHAIR: We'll see about that. We're running a little bit over time.

The Hon. CAMERON MURPHY: If I can just ask also if you're aware, as part of that question that you're taking on notice, whether other jurisdictions have adopted that type of yardstick or have evidence of it. It's a problem everywhere in the world where people drive and have cannabis. Maybe you're aware of some other jurisdiction that has come to grips with it.

The CHAIR: If you could take that on notice, we'd appreciate that.

MATTHEW McCRONE: Yes.

The CHAIR: The time for questions has run a little bit over. I apologise to our next witnesses. Thank you, Mr McCrone and Mr Strong, for the submission from Montu, for taking the time to appear today and for the work you're doing in the community. We really do appreciate that. The secretariat will be in contact with you in due course about those matters which were taken on notice. Again, thank you and good afternoon.

(The witnesses withdrew.)

Ms ALICE SALOMON, Head of Media and Advocacy, Uniting NSW/ACT, affirmed and examined

Dr MARIANNE JAUNCEY, Medical Director, Uniting Medically Supervised Injecting Centre, Uniting NSW/ACT, affirmed and examined

The CHAIR: Good afternoon, Dr Jauncey and Ms Salomon. Do you have any introductory remarks that Uniting would like to make?

ALICE SALOMON: We appreciate the opportunity to contribute to this inquiry. Our submission includes Uniting's discussion paper, *Possession and Use of Drugs: Options for changing the law*, which explores why we support decriminalisation of personal use and possession of all drugs and how this could work in practice. Uniting leads the Fair Treatment campaign, along with 70 partners, advocating for the decriminalisation of personal use and possession of all drugs and an increased investment in treatment. In other words, our campaign supports the removal of criminal penalties for the possession of drugs for personal use and equitable and affordable access to treatment for everyone who seeks it.

In addition to the campaign, Uniting's operation of the medically supervised injecting centre, or MSIC, in Kings Cross, led by my colleague Dr Marianne Jauncey over the last 23 years, has shown the positive result of a health-based approach to drug use. Through MSIC and our Fair Treatment campaign, Uniting has significant interest in reforming laws to ensure a health-based approach to drug use and dependency and better outcomes for people and communities. As outlined in our paper, most people use drugs and lead very ordinary lives; nothing needs to be done. It is the harm of criminalisation that is having the most impact.

For a small number of individuals who do go on to develop drug dependency, the current approach erects barriers to accessing help and support. Existing drug laws create unnecessary obstacles, hindering people from seeking treatment, amplifying stigma and exacerbating the isolation felt by those who might actually benefit from connection. When society responds to drug issues primarily with law enforcement rather than treatment and support, it is essentially punishing individuals instead of offering genuine solutions. It's important to recognise that drug dependency often arises from complex social circumstances, disadvantage and trauma. Therefore, responses to harmful drug use and dependency should address underlying causes and reframe from this target on individuals.

It's well established that treatment and harm reduction is effective. By shifting the focus of the system towards providing these services, lives can be saved, costs can be reduced and law enforcement resources reallocated. We'd invite the Committee members to engage with Uniting and the Fair Treatment campaign as we work towards the New South Wales parliamentary drug summit. We urge the inquiry to consider the benefits of a more health-focused, harm-reduction-based regulatory framework for cannabis and other drugs in New South Wales. We look forward to any questions you may have.

Ms CATE FAEHRMANN: Thanks for coming today. It is great to see you both here. My first question is to explore a bit more the importance of having treatment programs and other services in place for any decriminalisation model, should we get there in this State. We know that some criticism is starting to come out of decriminalisation—for example, in Oregon. But we've also—and I think you can speak to this—seen stakeholders say that's because there hasn't been the required investment into health programs. Why is it so important to make sure that's right? What does that look like?

ALICE SALOMON: Our campaign specifically asks for the two things—the decriminalisation and the investment in treatment and harm reductions—because of the relationship between those two things. We know that most people found in possession of small quantities of drugs don't need any interventions but, where people are seeking support and seeking treatment in that moment, those services need to be available. We can see that playing out internationally. The combination of these things has been quite important.

MARIANNE JAUNCEY: I think people often point to Portugal. I think sometimes the narrative around Portugal is "See what decrim did?" but it's actually very clear that what happened in Portugal was not merely the decriminalisation; it was, at the same time, the really significant investment in treatment and support services. That, I think, is not always appreciated. Decriminalising on its own without anything else is not in any way going to be the panacea that some people might think it's magically going to be.

Ms CATE FAEHRMANN: There's also the huge reduction in days—for example, when somebody in Portugal is caught in possession of illicit drugs and needs treatment, they can pretty much get into treatment within a couple of days compared to here. And, of course, Uniting ran a very successful Fair Treatment campaign. We still don't have a rehab centre in Dubbo, for example. In terms of waiting times, I don't know if it's any worse than it was when I was part of that campaign a few years ago, but I'm sure it hasn't gotten any better, if you wanted to talk about that.

MARIANNE JAUNCEY: In terms of the front line—in many ways, working in a metro area, I'm already doing better than a lot of my colleagues who work in rural, regional and remote areas. It is definitely a postcode lottery in New South Wales. I haven't got a sense that things have particularly changed in the last few years. There are places in New South Wales where you can be on a waiting list for something like methadone or buprenorphine—pharmacotherapy for opiate dependence, which are considered essential medicines in any civilised country—for up to a year. That is still very much an ongoing concern. Even if we're better than some other States, it is still difficult when somebody finally gets to that point of putting up their hand and asking for help—and we've maybe been working with them for some time and we already know there's a delay of up to a decade after they've run into problems before they put up their hand and ask for treatment. It just seems so cruel to have no room at the inn when they finally put up their hand for help.

Ms CATE FAEHRMANN: I wanted to ask about discretionary powers within the police. We got some very disturbing research earlier from NDARC by Professor Don Weatherburn about the decline in cannabis cautions compared to cannabis prosecutions over the last decade. My office recently obtained data from the new EDDI, the Early Drug Diversion Initiative. That's also very concerning, particularly in relation to ice. I know how involved you were with the ice inquiry. For example—and I'll just give you one stat and get your view on police discretion—just in the first three months, 1,247 people were charged with using or possessing ice while just 60 people were issued with a fine and diverted into the initiative. Meanwhile, cocaine is different: 258 people caught with cocaine were charged and 99 were issued with a fine. That seems to say that police discretion isn't working and it's also discriminatory in terms of how they deal with the different drugs. Would you care to comment on that?

ALICE SALOMON: From our position, and what's in our discussion paper, we think that the issue of police discretion does need to be looked at. We think that, even with the Cannabis Cautioning Scheme, you can see that the statistics bear out depending on whether you're a First Nations person or not. If you're not a First Nations person, you're 75 per cent more likely to get a cannabis caution. If you're a First Nations person, you are more likely to go through the criminal system. We think that part of considering decriminalisation is to also consider the ability of police to stop and search people for possession of a small amount of a drug that is no longer carrying a criminal consequence. We know that discretion is really important to the police that we speak to. The statistics you spoke to about the rollout of the early diversion program concerned us. When we were speaking to police, they seemed quite enthusiastic about it—about having another kind of tool in the toolkit about how you could respond to possession of small quantities of drugs—but we know that the issue of stigma is very strong around which drugs and which people.

MARIANNE JAUNCEY: Which is why I think having a faith-based organisation—and I say this as somebody who doesn't describe herself as somebody who is religious—active in this space is really helpful and really important, because we have to change this simplistic narrative that says, "Drugs are bad and people who use drugs are bad," because that plays out across society, including amongst police, who are ultimately just members of society. I think an organisation that is perhaps a bit more familiar and confident about talking about good/bad, right/wrong and moral/immoral is a good organisation to be encouraging the community as a whole to have a rethink about the way we talk about drugs and the people who use them.

Ms CATE FAEHRMANN: With the paper that you've submitted as a part of your submission, does Uniting or the campaign have an ideal decriminalisation model? I assume police discretion and potentially fines are not a part of that. Can you talk us through what research you have done in the area?

ALICE SALOMON: The paper is options to consider. Things to think about are questions about thresholds. At the moment we have a deemed supply—so whether we need to think about this reverse burden of proof that a person has to prove that the quantity of drugs were not a supply and instead put the responsibility on police to prove issues like supply. There are questions about what to do with the drugs: Is it confiscation? What needs to happen? What interventions are appropriate? We advocate a health and harm-reduction based intervention. Fines would be inconsistent with that type of approach.

MARIANNE JAUNCEY: The basis of it, which I like, is it is saying, "We've not got all of the answers." What it's saying is that you need to have some underlying values and principles and use the evidence. Those two things should be how you make your decisions rather than ideologies.

The Hon. JOHN RUDDICK: Thank you very much for what Uniting has done over the last few decades being out there on the front line with people who do need help. Your views are very welcomed. Uniting does support the decriminalisation of all drugs. Is that correct?

ALICE SALOMON: Yes.

The Hon. JOHN RUDDICK: I hear conflicting views about what's happened in Portugal, and I'm happy to learn. About 20 years ago, all drugs were decriminalised. Is that correct?

ALICE SALOMON: Yes.

The Hon. JOHN RUDDICK: But not legalised.

ALICE SALOMON: Yes.

The Hon. JOHN RUDDICK: There has been a number of changes of government in Portugal. Despite changes of government, they have largely stuck with that policy. Is that correct?

MARIANNE JAUNCEY: Yes.

The Hon. JOHN RUDDICK: Do you consider that to have been a successful case study?

MARIANNE JAUNCEY: Yes. I would say that even the fact that subsequent governments of different colours and flavours did not seek, and have not sought, to change the policy in and of itself is somewhat of an indication of the success. There was very high rates of harm and very high rates of use of drugs like heroin back in about 2001. The year that we opened was the year that they decriminalised drugs. Broadly speaking, there really isn't a lot of contention that it was anything other then a good thing. I think in more recent times, especially with what's happened in the States and elsewhere, there's been some reassessments. Across Europe there has been increasing rates of drug overdose, and there were concerns that some of the investment and treatment were being perhaps undermined and eroded. But the various architects of the policy have come out again to clarify they are absolutely not suggesting that the underlying policy of Portugal should change. I've been there and spoken with police. Interestingly, the police are very supportive of that policy, which I think is really crucial.

The Hon. JOHN RUDDICK: In Oregon, about two years ago, there was also a blanket decriminalisation but not legalisation. Is that right?

MARIANNE JAUNCEY: Yes.

The Hon. JOHN RUDDICK: I'm hearing bad reports coming out of Oregon. I'm hearing about a surge in crime and antisocial behaviour. What do you think is behind that in Oregon?

MARIANNE JAUNCEY: Very simplistically, I would say that there was an awful lot of problems going on already. To expect something that didn't have the corresponding investment in treatment to have any kind of magical powers in a relatively short space of time was unrealistic. I'm not surprised, to be honest, that they haven't magically turned things around. There are a mountain of problems going on across North America, and we know that. I think many of us are desperately concerned that we don't have a similar thing happen across Australia in terms of synthetic opioids and particularly potent opioids.

As a general thing, I think there was an unrealistic expectation—a bit like this simplistic thing of saying, "They decriminalised in Portugal, and everything was okay." That is not the case, and that is not what happened. I think the narrative got beyond them that somehow there was this expectation that they would decriminalise and make everything better. That is not what anybody should expect, and you are going to set yourself up to fail if that is the narrative that's being accepted.

The CHAIR: I think, Mr Ruddick, it's important to note that in Portugal, that regime was brought in by a socialist government and António Guterres. You'll like that. The system that didn't work so well was the capitalist system.

The Hon. JOHN RUDDICK: It hasn't been reversed, so that's good.

The CHAIR: Dr Jauncey, could you tell me about your experience of cannabis use in Kings Cross? You would deal with a lot of people that have got polydrug use. How often do you see people whose cannabis use is the most critical thing in terms of their health? What does cannabis use look like for some of your clients?

MARIANNE JAUNCEY: I suppose there is probably two things I'd say. The first is that cannabis use is quite common amongst our clients. The use of plant-based substances in our clients is almost invariably never the most significant concern in terms of their substance use and often polysubstance use. However, that is not always the case when people have started using synthetic cannabis. We've had a couple of clients that I can think of where they really ran into trouble because, in an attempt to use something that maybe wasn't going to be caught or wasn't technically illegal, they were using far more harmful substances than the plant-based products. That was a particular concern for them.

The other thing I'd say in terms of the picture in Kings Cross which often really surprises me is that, in talking with police colleagues when we have various meetings and they are reporting about drug-related crime

statistics, arrests and charges, I'm always looking at the figures thinking what is the breakdown between heroin, methamphetamine and cocaine. When I ask questions, I'm always reminded that the vast majority of those are always for cannabis. Even on the streets of Kings Cross, the police are spending more time on cannabis than the other substances, which strikes me as a little out of step.

The CHAIR: That's remarkable. Remind me—with the Medically Supervised Injecting Centre, is that available to people under the age of 18?

MARIANNE JAUNCEY: No.

The CHAIR: When you look at places like Oregon, they brought in the decriminalisation of all drugs, but also did move to a legalisation regime for cannabis. They had a referendum in their state. Why haven't you made a distinction between cannabis and other drugs?

ALICE SALOMON: For us, our motivation in supporting decriminalisation comes from our role as a faith-based organisation. We are concerned with the dignity of the human person, with people experiencing the most disadvantage and for the common good and solidarity. The issue of decriminalisation was brought to the synod. The Uniting Church is a little bit different to other churches—they vote on a whole lot of stuff, including the position that they take as a church. The question of decriminalisation and increased funding for treatment was brought to the synod, and the decision was made to support that for all substances. The question of legalisation actually hasn't been brought in front of the synod. Why we say all substances is because our position comes from an understanding that it is the criminalisation of people who use drugs, and the criminalisation of people who experience drug dependency, that is causing harm in and of itself. Our motivation then is to look at systems that reduce that kind of harm.

The Hon. STEPHEN LAWRENCE: Thanks for your submissions. They are really helpful. I have a few questions. You might be aware that Chris Minns, prior to the election, ruled out the decriminalisation of drugs. So that is now Government policy, at least for this term of government. I am interested in talking to you about some policy measures that would be short of decriminalisation but might involve a relaxation of the criminal regime, and to get your response on some of them. Have you got any thoughts on an administrative arrangement where, for example, the police and the police prosecutors and the DPP prosecutors are given directions not to prosecute minor drug matters as a matter of policy?

ALICE SALOMON: Firstly, we look forward to the upcoming New South Wales drug summit. We look forward to that being an opportunity to come with open hearts and open minds to evaluate the evidence, and to come with nothing ruled off the table. We think that's a real benefit of having this drug summit coming up by the end of the year. In terms of measures other than decriminalisation, I think we'd want to be looking at can we do an expansion of the current diversion scheme and what can we learn from what's happening overseas. We know that in the UK, in the States, and in Canada, there are measures where the police are playing quite a different role in the community around the issue of drug possession, and especially around the complexity of drug dependency—so really leaning into that being a health and welfare story, and not wanting to be in the business of policing homelessness, poverty, mental health and drug dependency.

In the ACT, they have passed laws to decriminalise personal use and possession of drugs. What I think is really interesting about that is the way the police worked very closely with CAHMA, which is the peak user group representative, to design how that was going to be rolled out, and the decisions that police made about how they would then go about policing the decriminalisation of drugs. And so I think there are opportunities where policy can be used. I would want to see what happened with this current diversion scheme that saw such a low uptake in the police actually doing that, and make sure that any system that came in was really seeking to address that. We know that part of the harm of the drug laws is the way that police are currently interacting with otherwise over-policed communities. We would want to make sure that it was really bringing in the best options.

The Hon. STEPHEN LAWRENCE: Under the Director of Public Prosecutions Act there is a power for the Attorney General to direct the DPP in relation to prosecutions, there is a power for the DPP to direct the police, and then the police commissioner, obviously, has broad powers. I'm interested, specifically, in what room you see for administrative policy to be used in a legal context—for example, drug possession and cultivation remains a criminal offence, but as a matter of administrative policy, directions are given not to enforce particular laws, maybe on condition or maybe absolutely.

MARIANNE JAUNCEY: You can either change the law and have du jour decriminalisation or you can have various measures of de facto, which is getting around it and being practical. If we can't have one, then I think, as a general rule, it would be something that we would be interested in working out, in practical terms, what can be done to reduce the impact. I don't know the details of what you're talking about, but as an in-principle response, yes, I would be approving of something that overall is going to reduce the impact of personal use or possession in

terms of criminal responses to people, where those criminal responses are just wildly out of step and do nothing to help them in any way, shape or form.

The Hon. STEPHEN LAWRENCE: We have taken evidence in support of the suggestion that the Law Enforcement (Powers and Responsibilities) Act should be amended to remove from the police the power to search people on suspicion of possession of small quantities of illicit drugs. What are your thoughts on that?

ALICE SALOMON: When we speak with police, they are looking for a broader range of responses that they can have when they find someone in possession of small quantities of drugs. When we speak with police in Portugal, they laugh at the idea that you need stop-and-search powers to find drug traffickers or high-end, organised crime powers. We know that, for instance, it is right at the point of contact with police, to the decision to charge, to appearances in front of a court, to bail decisions, to sentencing decisions where First Nations people are having a disproportionate negative outcome compared to other parts of our community. And so looking for opportunities to decrease police interactions that are not grounded in solid need and concern of harm to that person or to the community is worth exploring.

The Hon. STEPHEN LAWRENCE: What's your response to the idea or the reality that people are being stripsearched, including children, on suspicion of the possession of a small quantity of, for example, cannabis, but it could be some other drug? What's your response to that, on a human level?

MARIANNE JAUNCEY: I'm appalled.

ALICE SALOMON: I'm horrified.

MARIANNE JAUNCEY: On a human level, I am absolutely, utterly appalled.

The Hon. STEPHEN LAWRENCE: Do you see any legitimate policy reason why police should retain a power to search a person on account of suspicion of possession of a small quantity of illicit drugs?

MARIANNE JAUNCEY: No, I don't. The position of Uniting is that the personal possession and use of drugs—so small quantities for personal use—should not be a crime. And if it is not a crime, then why on earth should the police have the right to search you?

The Hon. STEPHEN LAWRENCE: Some people may respond that for so long as it is a criminal offence, there should be a power to search for it. I am interested in your response to that. Why is it that something might remain a criminal offence for an indeterminate period of time, but in that interim period there ought not be a power to search for possession of it? How would you justify what some people might say is a discrepancy in that respect?

ALICE SALOMON: Our approach to drug use and possession is one of harm reduction. When people are stopped and searched by police, when that is shown statistically to have very low success rates in identifying or finding possession of small amounts of drugs, when that is coupled with things like strip searches which are being conducted outside the boundaries of when strip searches should be utilised, I think we need to ask ourselves what harm is being caused in the way this is being policed. Given that it has a very low success rate in what its stated aims are, I think it is inconsistent that that be allowed to continue as a practice.

The Hon. STEPHEN LAWRENCE: Alice, I think you talked about this in your evidence—is there work to be done, short of decriminalisation, on the thresholds at which something is deemed to be supply, and also to the definition of supply? In New South Wales, a drug dealer who is dealing for commercial purposes and a person who gives a tenner to their friend are caught by the same criminal offence. It might be different penalties, but they're caught by the same criminal offence. Do you think there is work to be done in the harm-reduction space in terms of looking at those elements and thresholds, and relaxing the existing criminal regime through that?

ALICE SALOMON: Currently, it is the quantity of drug you are in possession of that says whether it is personal use or supply. We argue that that's an improper way to go about making that assessment. We know, for instance, personal use for our clients at MSIC will look very different to other people who are casual drug users. Some people might buy their month's supply. A casual user might buy a month's supply, a casual user might buy a supply in terms of a social supply where I'm buying for myself and a friend. When we're looking at non-personal use, then the responsibility sits with the police to show supply, and then other elements should be called in to demonstrate that this is supply beyond the reverse "guilty until you prove yourself innocent" that we have in the way that we deem supply right now.

MARIANNE JAUNCEY: I think that is really crucial, because I remember when I first came into this sector— and I'm no lawyer, but the underlying tenet of our law is innocent until proven guilty. Then you dig under the surface and you start talking to clients about their experiences, and you think, "Hang on, it's not innocent until proven guilty." Because if I am this much over, and it's the total weight—not the weight, the absolute weight. So if you've got a certain amount of white power and 90 per cent of that is salt or bicarb or something, it doesn't

matter. It's not the absolute quantity of the drug; it's the total weight of the substance. And nothing else needs to be done, so it literally is guilty until proven innocent. I was really shocked when I first understood that. I don't really have an explanation for it, because I'm not aware of that operating in other areas of the law. Again, it's this thing where the narrative around substances and the people that use them needs to change, because our mentality is it's all bad, and I think that is where we really need to shift our thinking.

The Hon. STEPHEN LAWRENCE: So right now the maximum penalty for mere possession of drugs is imprisonment for two years. Now, obviously, a criminal offence that carries a fine only is still a criminal offence. So within that rubric of continued criminalisation, what do you think is an appropriate maximum penalty for possessing a small quantity of drugs, not for supply? Should it be a fine? Should it be three months as a maximum? You obviously advocate decriminalisation, but in an interim period, where would you relax it—to have an interim process in that respect, with harm reduction principles?

ALICE SALOMON: If you are applying harm reduction and health-based responses—and to be clear, we don't think fines are health-based responses. What you want to do is increase people's opportunities to access support. So if you imagine many casual users of currently illicit substances who are otherwise living their ordinary lives can probably manage to go to court, go through that kind of process. But, in and of itself, that is a harmful and difficult thing for a person to go through. We put our young people at risk of future employment opportunities, future travel, those kinds of things. Then, for people who are experiencing drug dependency and other life challenges that are happening, and who are less able to defend themselves in those kinds of circumstances, we would be looking at what an expanded diversion system might look like—having more than two opportunities for somebody to be able to access information or access a treatment service or those kinds of options. And we would be looking at how we make sure that is embedded in policing practice—like what is happening in the ACT, where police are like, "I don't want to be chasing after people for a $100 fine".

The Hon. STEPHEN LAWRENCE: Just on that, we took some evidence earlier to the effect that there shouldn't be any regard in the cautioning or diversionary schemes to prior matters. The analogy was given to traffic matters, where, inside of the points system, you can continue to commit traffic offences, and your eligibility for a ticket doesn't depend on whether you've had one before. There might be some circumstances in terms of good behaviour bonds which the RTA or RMS imposes where they might have regard to whether you've had one before, in terms of the conditions and so forth, but, overall, the scheme doesn't have regard for how many prior matters you've had in that respect. So would you agree that either the Cannabis Cautioning Scheme or something of that nature, some future scheme, actually shouldn't have regard to prior matters? And you certainly shouldn't be ineligible on account of prior matters?

ALICE SALOMON: We think the question of eligibility is really important, and that there shouldn't be eligibility criteria to be able to access diversionary-type schemes or decriminalisation.

MARIANNE JAUNCEY: I think as a general rule most people who use drugs don't need treatment for their drug use. So the first few times that somebody is coming into, or is found, they don't need to be referred for treatment. I think there is a misunderstanding that somehow they have a problem and we need to fix them. That is actually not right. But I do think, again, as a general rule, for example, if you are picking up somebody who clearly has problematic dependent drug use, then I think there is some kind of overall narrative that says the more frequently you are picking up someone, the more likely it is that there is an underlying problematic or dependent drug use and the more appropriate it is to try to offer them assistance and support and treatment.

The Hon. STEPHEN LAWRENCE: Just lastly from me, would you support amending the sentencing law so the default position is that a person is not convicted for drug possession? And they can only be convicted, for example, if the threshold test is met and the court satisfied there is exceptional circumstances, or something of that nature?

ALICE SALOMON: We haven't explored that. I'm happy to come back to you.

The Hon. STEPHEN LAWRENCE: If you wouldn't mind, and if you wouldn't mind taking on notice any other measures you think might be good as a relaxation from criminalisation, short of full decriminalisation—respecting your ultimate position of course on decriminalisation.

Ms CATE FAEHRMANN: I'm keen to get a little bit more information on the record about the—you make specific mention again in your submission about section 29 of the Drug Misuse and Trafficking Act. In terms of deemed supply, you use the example of heroin. An amount greater than three grams of heroin is deemed supply. You want to reverse the onus of proof, which happens in other jurisdictions. Why have you put that into this submission? Why is that important, in terms of reducing harm? As in, what are some of the problems with that—which I think you've already outlined in your submission, but I do just want to get some more information on the record.

MARIANNE JAUNCEY: The people who are coming to the Medically Supervised Injecting Centre are not the kingpins of drug trafficking in Australia. I see them getting caught up for what is personal use. People running, doing the go between, and if they do that three times and they earn $10 each time, then they are caught up in all sorts of what is thought to be significant trafficking activity. Whereas, in reality, you know what is going on for that individual. There is just an absolute mismatch.

Ms CATE FAEHRMANN: And it's inflexible as well, right?

MARIANNE JAUNCEY: Yes. Even when the individuals understand within the court what is going on, because of the laws, and they've got to stay in their lane, this is what then is the inevitable outcome. Even when everybody acknowledges that it's nonsensical.

The CHAIR: Thank you very much for the evidence you've given today. It's of enormous value. Thank you for the submission you've provided to the inquiry, and for the work you do in the community. It is very much appreciated. We look forward to seeing you at the drugs summit soon. I think some questions were taken on notice. The secretariat will be in contact with you in due course regarding those.

(The witnesses withdrew.)

(The Committee adjourned at 15:50.)