Submission

to the

Inquiry into the use of Cannabis in Victoria

to the

Legal and Social Issues Committee

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1. Introduction

On 30 May 2019, the Legislative Council agreed to the following motion:

> *That this house, requires the Legal and Social Issues Committee to inquire into, consider and report, by no later than 2 March 2020, into the best means to —*
>
> *a) prevent young people and children from accessing and using cannabis in Victoria;*
> *b) protect public health and public safety in relation to the use of cannabis in Victoria;*
> *c) implement health education campaigns and programs to ensure children and young people are aware of the dangers of drug use, in particular, cannabis use;*
> *d) prevent criminal activity relating to the illegal cannabis trade in Victoria;*
> *e) assess the health, mental health, and social impacts of cannabis use on people who use cannabis, their families and carers;*
>
> *and further requires the Committee to assess models from international jurisdictions that have been successful in achieving these outcomes and consider how they may be adapted for Victoria.*[1]

The reporting date for this inquiry has been extended to 1 June 2021.

FamilyVoice Australia is a national Christian advocacy group – promoting family values for the benefit of all Australians. Our vision is to see strong families at the heart of a healthy society: where marriage is honoured, human life is respected, families flourish, Australia's Christian heritage is valued, and fundamental freedoms are valued and enjoyed.

Submissions are due **Monday, 31 August 2020**.

2. Drug trends and statistics

According to the National Drug Strategy Household Survey 2019:

> ***Illicit use of drugs***
>
> - *In 2019, around 3.4 million Australians reported using an illicit drug in the last 12 months.*
> - *In 2019, the most common illicit drug was cannabis, followed by ecstasy, misuse of pharmaceuticals, and then cocaine.*
> - *While overall use of methamphetamine has decreased, use of crystal methamphetamine (ice) continues to be a problem.*
> - *People who are using crystal methamphetamine (ice), are using it more frequently which increases the risks and harms.*
> - *While people aged 20-29 are still the most likely to use illicit substances, a greater proportion of older people are misusing pharmaceuticals and illicit substances than in previous years.*[2]

While the Australian Secondary Students' Alcohol and Drug Survey 2017 revealed that:

> ***Illicit substances***

> - *Cannabis was the most commonly used illicit substance with 16 per cent of students aged between 12 and 17 years ever using cannabis and 8 per cent using it in the month before the survey.*
> - *The proportion of students using cannabis increased with age.*
> - *Around 4 per cent of all students reported having used ecstasy/MDMA at some time in the past year and only 2 per cent indicated they had used ecstasy in the previous month.*
> - *The vast majority of secondary school students (98 per cent) had never used amphetamines.*
> - *Lifetime use of amphetamines increased with age from 1 per cent of 12-year-olds to 3 per cent of 17-year-olds.*
> - *Use of hallucinogens, such as LSD, was extremely low with 97 per cent of all students never having used them.*
> - *The use of opiates or narcotics such as heroin or morphine was very uncommon, with only 1 per cent of all students ever having used these substances.*
> - *A small proportion of students (2 per cent) reported ever using performance or image enhancing drugs, such as steroids, without a doctor's prescription.*
> - *Use of synthetic substances such as synthetic cannabis was very low, with 98 per cent of all students reporting no use in the past 12 months.*[3]

In terms of recent use of cannabis, the National Drug Strategy Household Survey 2019 found that in comparison to the 2016 survey there had been an increase from 10.4% to 11.6%.[4]

The WHO has reported that:

> *In high-income countries, such as the USA, cannabis use usually begins in the mid-to-late teens. Heaviest use occurs in the early twenties and declines throughout the late twenties into the early thirties. About 10% of people who use cannabis become daily users and another 20–30% use it weekly.*[5]

Globally, cannabis is the most commonly used psychoactive substance under international control:

> *In 2013, an estimated 181.8 million people aged 15-64 years used cannabis for nonmedical purposes globally (UNODC, 2015).*[6]

The highest age-standardised cannabis use rates are in Australasia and North America.[7]

Data also reveals that cannabis use is the primary reason individuals seek substance abuse treatment and that cannabis is the second reason for treatment entry behind alcohol.

> *The number of persons seeking treatment for cannabis-use disorders and associated conditions have increased since the 1990s in many developed and some developing countries. Cannabis is now the drug of primary concern in a significant proportion of treatment episodes in the UNODC regions of Africa, Oceania, the USA and EU (UNODC, 2015). The number of cannabis users seeking help has increased over the past two decades in Australia, Europe and the USA (EMCDDA, 2015a; Roxburgh et al., 2010; WHO, 2010).*[8]

Cannabis has been reported as a growing burden on emergency services in Australia.[9]

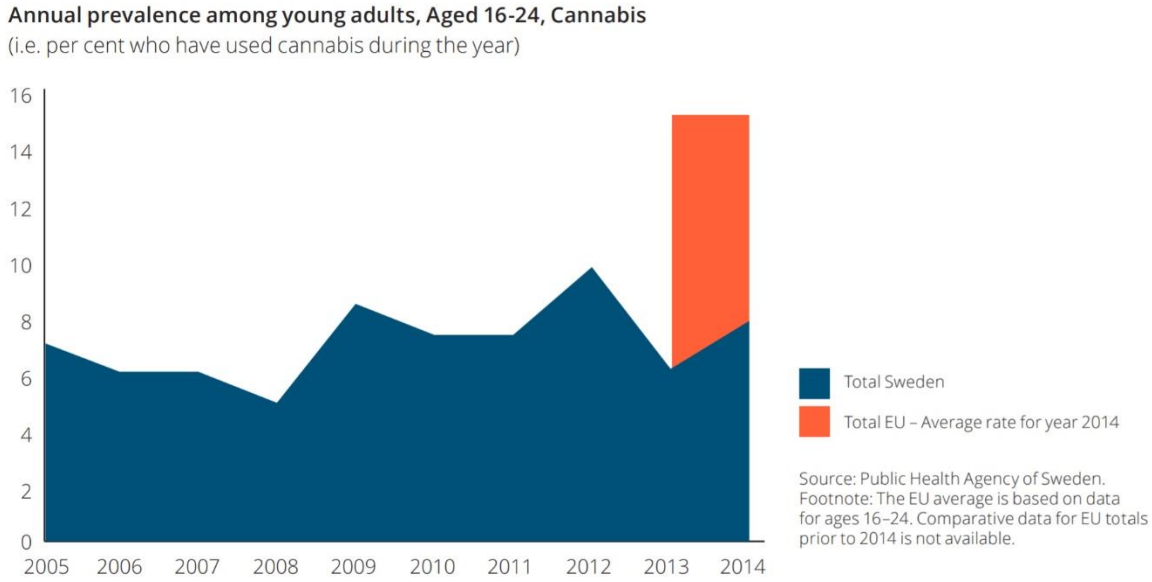
Recommendation 1

The Victorian Government should set annual cannabis use reduction targets with consequences if they are not met.

3. Prevent young people and children from accessing and using cannabis in Victoria

Victoria should look to Sweden as a model to reduce the use of cannabis. Sweden's approach to tackling the scourge of drugs has been described as targeting both the supply and demand of narcotics with a three-pronged approach of prevention, treatment and control.[10]

While cannabis is the most used illicit drug in Sweden, its use is low relative to the average of European nations, as seen in the diagram below.[11]



Sweden's prevention approach has been described as follows:

> *Preventive work against drugs has developed from small-scale projects and campaigns to structured local work using methods that are continuously evaluated and adjusted over time. This preventive work has resulted in a relatively stable and low level of drug use among young people.*
>
> *Preventive work is often based on cross-cutting measures in schools, clubs and associations, social services, health and medical services, psychiatric services, etc. The objective is to strengthen protective factors around children and adults. This work is supplemented by targeted interventions aimed at individuals and groups in risk zones. To limit drug use, the police and social services also collaborate to offer social support at an early stage.*[12]

Preventing young people using cannabis is a key priority in Sweden, hence there is a strong emphasis on school-based education:

> *School-based prevention interventions play an important role in municipalities, and they are often implemented to promote a healthy school environment. They cover both licit and illicit substances. Several interventions focus on the development of children's social and emotional capacities, and many schools also have interventions in place that involve parents. A number of community-based programmes at the municipal level focus on providing alternative leisure activities and ensuring safe recreational settings, primarily in cooperation with sports organisations, the temperance movement, police and other community-based organisations.*
>
> *The number of programmes for parents on alcohol and drugs has increased, as has the amount of research done on such programmes.*[13]

Recommendation 2

The Victorian Government should replicate Sweden's prevention approach to combating cannabis use by encouraging strong collaboration between police and social services and working with schools and clubs.

Sweden communicates a strong message that drugs are harmful by not having a soft approach to personal use.

> *In Sweden, using drugs, i.e. having drugs in your body, has been a criminal offence since 1988 and imprisonment was added to the scale of sanctions for personal use in 1993. The intentions of the legislator were to send a clear signal that drugs are not acceptable in society and to give the police authority grounds to carry out drug tests in the event of suspected drug use. Criminalisation of personal use has been added to protect people from the harmful effects of drugs, to enable early intervention to offer care and treatment, and as part of efforts to prevent young people from using drugs, as well as becoming involved in criminality.*[14]

Recommendation 3

Laws against possession and use of cannabis should remain so that mixed messages are not communicated, particularly to the young, about the harmful effects of cannabis use.

4. Health, mental health, and social impacts of cannabis use

There is a large body of research concerning the adverse impacts of cannabis use. Cannabis use places a user at increased risk of psychotic disorders. As the WHO has reported:

> *A 15-year follow-up study of schizophrenia among 50 465 Swedish male conscripts found that those conscripts who had tried cannabis by age the age of 18 years were 2.4 times more likely to be diagnosed with schizophrenia over the next 15 years than those who had not (Andréasson et al., 1987). After statistical adjustment for a personal history of psychiatric disorder by age 18 and a number of psychosocial confounders, those who had used cannabis 10 or more times by age 18 were 2.3 times more likely to be diagnosed with schizophrenia than those who had not used cannabis.*
>
> *Zammit et al. (2002) reported a 27-year follow-up of the above-mentioned Swedish cohort. They also found a dose–response relationship between frequency of cannabis use at the age of 18 years and the risk of schizophrenia during the whole follow-up period (although the strength of the relationship declined with age).*

> *This effect persisted after statistically controlling for confounding factors. The researchers estimated that 13% of cases of schizophrenia would have been averted if no one in the cohort had used cannabis.*[15]

FamilyVoice has previously detailed the case of Max Schwartzberg who testified before the New York City Council at hearings on medical marijuana in 2011. He first used marijuana at age 12 and became a long-term addict. He said (in part):

> *The biggest danger in smoking marijuana is that most of the destruction does not occur right away.*
>
> *It is a slow, progressive collapse of the person's life. It isn't until a person is truly addicted that they start to experience the cognitive, emotional, and psychological consequences.*
>
> *I was a healthy, bright, caring, and sensitive child. My first real hit of marijuana at age 12 sparked the slow death of everything.*
>
> *It is nearly impossible to get help for a problem that is not recognised as a problem. I had been to at least a dozen psychiatrists. There was only one who said that my mental and emotional collapse was due to my pot smoking.*
>
> *She went on maternity leave. I continued to smoke and soon became a shell of a person, paranoid and emaciated after an eating disorder that just popped up out of nowhere.*
>
> *A sound and sober mind would see that smoking pot made me very hungry. When I ate, I ate a lot, which killed my high. I liked being high, so I would throw up and start again.*
>
> *It wasn't until my life had come to this pitiful point that I started to believe that smoking marijuana helped me with my nausea.*
>
> *The funny thing about this is that the only time that smoking marijuana as medicine made any sense, was when I was high after smoking marijuana. What happens when your medicine is harming you more than it helps?*
>
> *Forty pounds lighter, using stronger pot, I ended up in the psychiatric ward for 13 days. I thought I was being chased by Osama Bin Laden. I had had a drug induced psychotic episode. I am still seeing doctors.*[16]

Other adverse effects include:

- impairments in memory and cognition[17]
- changes in brain tissue connectivity[18]
- reduced volumes in the amygdala, the cerebellum and frontal cortex[19]
- suboptimal decision-making capacity and increased impulsivity[20]
- reduced brain capacity to synthesize or release dopamine[21]
- lower educational attainment and lower grades[22]
- four-fold higher risk of mortality[23]

Cannabis use is not only problematic in and of itself, but can lead to the use of so-called "harder" drugs:

> *Epidemiological studies in Australia, New Zealand and the USA in the 1970s and 1980s found that regular cannabis users were more likely to use heroin and cocaine, and that the younger they were when they first used cannabis the more likely they were to use the other drugs (Kandel, 2002).* [24]

Being a gateway to other drugs, reducing cannabis consumption is therefore important to prevent the use of “harder” drugs.

5. Conclusion

Australia has one of the highest cannabis use rates in the world, while approximately one in six high school aged students have used the substance.

Given the large amount of research showing the adverse impact of cannabis use, including psychotic disorders, the Victorian Government needs to do more to address this problem. Being a gateway to other drugs, reducing cannabis consumption is also important to prevent the use of “harder” drugs.

It is critical that laws against possession and use of cannabis are not watered down which would send a mixed message, particularly to the young, about the harmful nature of cannabis.

The Victorian Government should replicate the approach taken by Sweden which seeks to minimise both supply and demand through a prevention, treatment and control approach.

6. Endnotes

[1] https://www.parliament.vic.gov.au/lsic-lc/inquiries/inquiry/974
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[10] Maria Larsson, Minister for Children and the Elderly, Speech at Folkets Hus, Stockholm 08 September 2008, https://web.archive.org/web/20140116183255/http://www.government.se/sb/d/8018/a/110658
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[16] Roslyn Phillips, FamilyVoice Australia, "The new drugs war", VoxBrief, August 2013
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[18] "Cannabis: The health and social effects of nonmedical cannabis use", World Health Organization, 2016, 4.1.2
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[24] "Cannabis: The health and social effects of nonmedical cannabis use", World Health Organization, 2016, p25