COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

LEGAL AND CONSTITUTIONAL AFFAIRS LEGISLATION COMMITTEE

Legalising Cannabis Bill 2023

(Public)

FRIDAY, 10 MAY 2024

CANBERRA

BY AUTHORITY OF THE SENATE

[PROOF COPY]

LEGAL AND CONSTITUTIONAL AFFAIRS LEGISLATION COMMITTEE

Friday, 10 May 2024

Members in attendance: Senators Antic [by video link], Green [by video link], Roberts [by video link], Scarr [by video link] and Shoebridge

Terms of Reference for the Inquiry:

To inquire into and report on the Legalising Cannabis Bill 2023

WITNESSES

BROADLEY, Dr Karen, Executive Member and Researcher, Drug Advisory Council of Australia Ltd [by video link]

KRONBERG, Mrs Jan, National President, Drug Advisory Council of Australia Ltd [by audio link]

Committee met at 12:32

CHAIR (Senator Green): I declare open this public hearing of the Legal and Constitutional Affairs Legislation Committee for its inquiry into the Legalising Cannabis Bill 2023. Thanks to broadcasting for getting us set up. I acknowledge the traditional custodians of the land on which we meet and pay my respects to their elders past and present. I would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people who are participating in today's public hearing. The committee proceedings today will follow the program as circulated. These are public proceedings being broadcast live via the web. I remind witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to the committee.

The committee prefers evidence to be given in public, but, under the Senate's resolutions, witnesses may have the right to request to be heard in confidence. This is described as being in camera. If you are a witness today and intend to request to give evidence in camera, please bring this to the attention of the secretariat as soon as possible. If a witness objects to answering a question, the witness should state the grounds upon which the objection is taken, and the committee will determine whether to insist on an answer, having regard to the grounds which are claimed. If the committee determines to insist on an answer, witnesses may request that an answer be given in camera. Such a request may of course be made at any other time. A witness speaking for the first time should state their full name and the capacity in which they appear, and witnesses should speak clearly and into the microphones to assist broadcasting and Hansard to record proceedings. Mobile phones and other electronic devices should now be switched off and turned to silent mode.

I now welcome representatives from the Drug Advisory Council of Australia via videoconference and audio link today. Thank you for taking the time to speak with the committee. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you and is available from the secretariat. For the *Hansard* record, can I ask you to state the capacity in which you appear today.

Mrs Kronberg: Thank you very much. It's a great pleasure to be here with you today. We're also joined by my colleague Karen Broadley, and she'll be speaking later.

CHAIR: Mrs Kronberg, I will invite you to make a brief opening statement. Senators on the line do have questions for you, so, if you can keep that opening statement as brief as possible, we'll then go to questions.

Mrs Kronberg: Thank you very much. On behalf of the Drug Advisory Council of Australia Ltd, now a registered charity, and as their national president, we appreciate this opportunity. I empathise with the magnitude and the importance of your work. During my eight years as a member of the Legislative Council in the Victorian parliament, I served on the Joint Committee on Law Reform, and I chaired both the Joint Committee on Outer Suburban/Interface Services Development and the education committee. I draw upon much of this real-world learning today. My erudite colleague Dr Karen Broadley, with her PhD in child protection, will draw upon her 20-year career in the front line of child protection and youth justice.

For years, my electorate office, in suburban Ringwood, addressed problems associated with the nearby public housing estate—the home of single-parent families and people with serious mental health and drug addiction problems. Mothers and their little children lived under a hellish sea, terrified by the violence of drug dealers and users who continuously gained building access. So this proposed legislation causes great concern. We see an illusion of responsibility, darkly cloaked with a tone of businesslike reasonableness—namely the siren song of a tax yield; revenue through registration of strains of cannabis; regulation of growing, selling and manufacturing of cannabis; and the establishment of CANA. DACA says that legalising something harmful never removes the harm. It just changes legal consequences, usually for those who promote, produce or in other ways profit financially from a legalised substance. There was little to no regard for the negative impact on individuals or society. Frankly, this is the same as putting lipstick on a pig; it's still a pig. We also take exception to that hackneyed term 'recreational drugs'. Using any illicit drugs for recreation is a sign of a sick person and a sick society.

The son of one of our team members is a recovering cannabis addict who used from age 13 to 22. It took 15 months in rehabilitation for his shaky recovery. His family relationships and his family's finances are ruined. He collapsed after an hour under hot water. His distraught mother rescued all six foot four of him, writhing in pain as

the built up toxicity of cannabis had to be flushed out through his skin in a hot shower. Sliding down the walls was a toxic brown slime from his tortured body.

More emphasis must be put on the demand side. Demand reduction could be achieved through truthful and effective drug education and government sponsored anti-drug campaigns. There are far too many mixed messages, and, tragically, these are killing our kids.

CHAIR: Thank you very much, Mrs Kronberg. We'll go to questions.

Senator SCARR: Dr Broadley, is there anything in particular you would like to add to the opening statement from Mrs Kronberg? In particular, I'm interested in your views on the argument that's being made that one of the impacts of existing policies is that young people are left with criminal records and are criminalised by the system, and that this is perhaps an avenue to provide greater justice for that cohort of people.

Dr Broadley: I did prepare a little three-minute introduction that doesn't answer the question of criminalisation. I can deliver the three minutes within three minutes, or I can go straight to the question of criminalisation, whatever you'd prefer.

Senator SCARR: Maybe you could go straight to the question of criminalisation and then let's see how we're going. We do have limited time, so perhaps deal with the question first?

Dr Broadley: No worries, absolutely. To quickly go over my background, I worked for 20 years in child and family services, particularly in child protection and youth justice, and after that I studied as an academic. I've done quite a bit of research. Jan and I worked together to put the submission together. There's a lot of good and very recent research in that submission, as well as a lot of systemic reviews, which is really important.

Thinking about knowledge and different ways of knowing is interesting. I've got an 18-year-old daughter who's just started university and is taking an Indigenous subject called Indigenous Ways of Knowing. There are different ways of knowing. We can know because of the research, and we can also know from our, and other people's, experience and our collective experience. So I just want to draw a little bit on my experience of working as a child protection worker and a youth justice worker as a way of knowing.

I'll make two quick points. The first point is that, in all my time working in youth justice and working with young people who are involved in criminal behaviours and who were charged by the police and went through the court system, I never worked with a young person who just got found with any sort of drug on them. It was always the drug-related crime that drew the police's attention to them, and then, as a result of that, they got a cannabis charge or a heroin charge or whatever it may have been. But it was to do with a drug-related crime—thefts or burglaries or violence or whatever it was that they were doing. I am intrigued and puzzled by this sort of claim that there are these people who are going through the court system and potentially being put in prison just because of their drug use or, in this case, their cannabis use. The police don't have powers just to search warrant someone or search their pockets, car or house for a cannabis plant unless there is something that has brought the police's attention to them. So that does mystify me.

The second point I'd make—and this is somewhat confirmed in the research, but I wouldn't say what I'm going to say now is strongly research based—is that, in my experience, there are two types of drug users—two types of cannabis users. There are the children and young people with families that come to the attention of child protection services or youth justice services, and they often have what we call multiple and complex needs. That's talked about quite a bit in the research, where someone doesn't just have one problem; they have a multitude of problems. All of these problems—drug abuse, family violence, mental health issues, social isolation, disability, acquired brain injury, unemployment, long-term unemployment, intergenerational unemployment—are the cause and the consequence of each other, and they're linked together. In the child protection literature we talk about the 'toxic trio', which is family violence, drug and alcohol abuse and mental health issues coming together.

My comment about this group of people is that they do often become involved in the criminal system, and their criminal involvement is really connected to the fact that they need to do crime—they do crime for all sorts of reasons, but one of the reasons they do crime is to get money for their drugs. Prior to legalisation they get involved in the criminal system, and then after legalisation they get involved in the criminal system. They're a very different group of people to the middle-class people who work and have a full-time job and can afford to buy cannabis. They don't get involved in criminal system prior to legalisation, and they don't get involved in the criminal system after legalisation. That sort of links, I think, to the empirical research, which talks about the fact that we really do not know—and we say this in point 6 of our submission, at the end of the third paragraph:

In other words, we do not yet know the impact of cannabis legalization on over-all crime rates.

We don't know.

Senator SCARR: Dr Broadley, I'm sorry to interrupt. I've got a few other questions, and I know the chair will be keen to share time.

Dr Broadley: Sure.

Senator SCARR: Can you provide your opening statement to the secretariat in writing? Could you email it to them, so we have the benefit of seeing that? Is that something you could do?

Dr Broadley: Absolutely. I'm happy to do that.

Senator SCARR: Mrs Kronberg, I've got some questions for you in relation to the case study which you conveyed to us in the course of your opening statement. One of the issues that have been raised is whether or not there are adequate mental health services and rehabilitation services available to respond to the issues we've got in society at the moment, and then, if a policy such as this were introduced, what would be required in terms of additional mental health services and rehabilitation services to address the demand for such services. Do you have any views with respect to that?

Mrs Kronberg: I have strong views about this because of my lived experience. As a lecturer within the TAFE system, I had many drug affected students. As a parent I had to interface with my children at school and their school communities. And my eight years as a member of parliament gave me an exposure to all forms of the human condition—much of it suffering, directly and firsthand.

It was with a great degree of chagrin that we saw that, in the state budget handed down here in Victoria on Tuesday night, the government cut funding for 35 proposed mental health clinics. We were looking to have those clinics to absorb the patient load and provide people with mental health problems with adequate care, and now we don't even have those 35 centres because the funding has been cut.

I'd like to make another point too. I've had an interface with the leader of the conservatives in the Scottish parliament, Douglas Ross. He's the member for the Highlands and Islands in the legislature in Edinburgh. His view is that, as a possible worst-case scenario, where drugs are legalised we would then, under a human rights approach, be compelled to make sure that, for every drug-affected person, you've funded, provided and ensured access to a publicly funded bed for their recovery. We'd like to see that right-to-recovery approach enshrined in this country.

Senator SCARR: I'll ask you to take two other questions on notice, and that will be the conclusion of my questions. First, have you got any information, or access to the latest research, with respect to the use of cannabis products to manage pain relief, including any research in overseas jurisdictions? Lastly, have you got access to any research or evidence relating to the most up-to-date assessment of the impact of the policies contained in this bill in other jurisdictions where they've been tried? For example—and this is a question I've typically asked other witnesses—what is the impact in Portugal and Canada and in California, Oregon and other parts of the United States? Are those questions you could take on notice and provide any additional information you might have?

Mrs Kronberg: Yes, I'll be able to. I can table a document. It comes from the United States Association for the Study of Pain. It appeared in the *Journal of Pain*, volume 25, No. 4 in April 2024. The featured article is 'Cannabidiol (CBD) products for pain: ineffective, expensive and with potential harms'. This article goes to the heart of that. The Drug Advisory Council has extensive collaboration and contacts with what is happening in North America and also in Canada and, in particular, what's happening in Vancouver. I have personally visited ground zero in Vancouver. We have ongoing dialogue in terms of important information that comes to us from that.

CHAIR: Mrs Kronberg, I'm going to stop you there. We'll organise to get an electronic version of that document. I do need to share the call. I'm conscious that other senators might have questions before we run out of time with you. Senator Shoebridge, do you have questions for this witness?

Senator SHOEBRIDGE: Yes, a small number.

CHAIR: You have the call, and then, Senator Roberts, we'll come to you. We might go a little bit over time with this witness, and we'll get to the next one as soon as possible. Senator Shoebridge, you have the call.

Senator SHOEBRIDGE: Mrs Kronberg, is it your position that medicinal cannabis is ineffective? That's your position—that it doesn't work?

Mrs Kronberg: There's a lot of literature coming through in terms of medicinal cannabis. A lot of it is unproven and, for some people, the access to it is making people's position worse. There is evidence regarding the impact of medicinal cannabis dosage being administered to young children with epilepsy. There is some consternation about that.

Senator SHOEBRIDGE: You oppose medicinal cannabis being given to young children who have such severe epilepsy that they may otherwise die? Those are the circumstances in which young children get access to medicinal cannabis for epilepsy. Do you oppose the use of medicinal cannabis in those circumstances?

Mrs Kronberg: We question it.

Senator SHOEBRIDGE: And you oppose the use of medicinal cannabis for otherwise untreatable chronic pain as well?

Mrs Kronberg: The evidence I'm tabling underpins that argument. That's what I just referred to.

Senator SHOEBRIDGE: Is it your position that there's been some social harm caused by the 300,000-odd people who have had access to prescription cannabis under the medicinal cannabis scheme?

Mrs Kronberg: There's a lot of consternation and activity around allowing people who are prescribed medicinal cannabis so that they can continue to use equipment, operate in their workplace without consternation and also drive vehicles.

Senator SHOEBRIDGE: You have a lot of consternation, but do you have any evidence?

Mrs Kronberg: There's abundant evidence, yes.

Senator SHOEBRIDGE: Well, do you have any evidence at all that the hundreds of thousands of people getting access to medicinal cannabis in the last few years have caused any social harms? You said you have consternation; I'm asking if you have any evidence.

Mrs Kronberg: I'd like to go back to the very beginning of this argument and the fact that there is empirical evidence that in 1979 a gentleman by the name of Keith Stroup wanted to make marijuana sound, look and feel more benign—

Senator SHOEBRIDGE: Sorry. We have limited time, Mrs Kronberg—

Mrs Kronberg: He could see the phenomenon of medicinal cannabis—

Senator SHOEBRIDGE: and I was asking you about events that have happened in the 21st century, not in the 20th century. Could you answer my question?

Mrs Kronberg: That's a fundamental problem—

Senator SHOEBRIDGE: It is.

Mrs Kronberg: and I'm hoping, Senator Shoebridge, that in your capacity you are making deliberations in this committee so that, with an open mind and heart, you look to the origins of a rebranding of marijuana by attaching a prefix to it and calling it 'medicinal' for everybody doing their very best to justify it.

Senator SHOEBRIDGE: Okay. And that's your response to my request for evidence?

Mrs Kronberg: That's my response. That's history.

Senator SHOEBRIDGE: Alright. I don't have any more questions.

CHAIR: Senator Roberts, do you have some questions for the witness? We're having an issue with your microphone; I think you might be on mute. If we can't get your mic working, we may have to get you to put some questions on notice to this witness. We'll try sort out those technical difficulties.

Senator SCARR: Chair, with your indulgence, I might just ask one question. Is there any recent, up-to-date evidence or literature on the outcomes in Canada as a result of their policies? Could you send that through to us, Mrs Kronberg, that would be helpful.

Mrs Kronberg: The title of it is *Legislative review of the Cannabis Act: final report of the expert panel*, given that the Cannabis Act was enacted in Canada in 2018 and that it's gone through its legislated review process.

Senator SCARR: When was that report delivered?

Mrs Kronberg: It was in March this year. It's from Health Canada and was tabled in parliament. The expert panel conducted the legislative review of the Cannabis Act. The date I have is Friday 26 March 2024.

Senator SCARR: Okay. Thanks very much for bringing that to our attention.

CHAIR: Thank you to the witnesses. Senator Roberts may have some questions to give you on notice, and we'll give you a time by which to return them to our committee in written form—I think that might be the best way to deal with it. Thank you for giving evidence to the committee today; I appreciate it.

HEILPERN, Professor David, Private capacity [by video link]

[12:59]

CHAIR: I now welcome the representative from Harm Reduction Australia. Thanks for taking the time to meet with the committee. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you and is available from the secretariat. Do you have any comments to make on the capacity in which you appear?

Prof. Heilpern: I'm the dean of law at Southern Cross University. I'm the lead of Drive Change, which protects and lobbies for the rights of medicinal cannabis drivers. I'm also here de facto for Harm Reduction Australia.

CHAIR: Thank you very much for joining us today. Do you have a brief opening statement you'd like to make before we go to questions?

Prof. Heilpern: I do. Prior to becoming dean of law at Southern Cross I was a magistrate in New South Wales for 22 years, largely on the North Coast of New South Wales, which is probably the drug capital of Australia. I support the bill as proposed.

I would like to paint a picture of the face of prohibition in New South Wales. Last year, there were 22,000 matters involving breaches of AVOs and 32,000 for possession of prohibited drugs. There were 225,000 random roadside tests—more random roadside tests in Australia than in the rest of the world put together. There were about 2,000 spot bail checks in New South Wales in domestic violence matters, yet there were 225,000 roadside random drug tests. There is a presumption against bail for a whole range of drug offences, including some cannabis offences, yet there's no presumption against bail for sexual assault. That is what prohibition looks like.

On the North Coast of New South Wales when I was there the drug squad had about 10 times the number of personnel than the child abuse squad did. That's what prohibition looks like. It bears no resemblance to community values. Community values would always put domestic violence, domestic assaults, breaches of AVOs and sexual assault of children above drug offences, but that is not the way our law enforcement service works. That's the face of prohibition.

Part of the problem of this discussion—I've read all of the submissions and was most interested by the evidence of the last witness—is, firstly, that the police choose their own priorities. If we lived in a country where the police really didn't care too much about drugs and left them alone unless they were in their face, we probably wouldn't be here today because there'd be no need for such a bill. But we don't. One example of the kind of dishonesty that is preached in this ground is in the Police Federation of Australia submission, which is submission No. 24, at page 2. This is a classic example of the kind of police peddling of drug misinformation:

> … in some regional areas, when police test for methamphetamine and cannabis they are finding a 60 per cent detection rate … That means one in every two drivers is driving under the influence of a drug …

That is completely untrue. It's untrue, because if you're driving under the influence, you get charged with that. This is about drug detection laws, but I'm raising it because it is typical of the misinformation and of the emphasis of the police on enforcement.

All of those who are opposed, in the material that I have read, make a classic and erroneous assumption. I have been working in this space—as an academic in drug law reform, a judicial officer or a lawyer—for most of my working life. The big error that is made—the last witness exemplifies it perfectly—is that there is an assumption that simply saying there will be an increased use if legalisation occurs means that it's true. But, in some ways, it's the wrong question. The right question is, 'Will there be an increase in problematic drug use, not just cannabis use, if cannabis is legalised?' The answer overwhelmingly is no. There is no increase in problematic drug use if you legalise cannabis. You can see that in Portugal.

There is only one document in Canada that counts and it's not the prohibitionist propaganda; it is the *Canadian cannabis survey 2023*, put out by the Canadian government. It shows that there has been an increase in use from 2018 to 2023—of under two per cent. There has also been a mass decrease in other problematic drug use. There is also a mass reduction in the kinds of problems that prohibition breeds, which I opened with. Even more interestingly, 'Fewer people'—this is by a rate of 10 per cent—'are driving after consuming cannabis.' So if you break down the assumption and ask this question, 'Does legalisation like is proposed in this bill lead to increased cannabis use that is problematic?' the answer is resoundingly no. That takes the wind out of all of the sails of all the police, the AMA and the last witness that you had, because if there is no increase in problematic use then all we're doing is reducing all the problems created by prohibition. So I would urge the committee to simply focus on that very simple question. Is there an increase in problematic use if cannabis is legalised? Unless there's evidence to that effect, all the other arguments truly go out the window.

That's my opening statement. Thank you so much for giving me the opportunity to speak today. I want to finish with one example. In the area where I live, which is around Byron Bay, Nimbin and Lismore, the cannabis street price is about four times dearer—I'm talking about the amount you'd need to 'have a good night out'—than ice. In other words, it is cheaper for young people to go and get ice for a whole big night out than it is for cannabis, certainly cheaper than alcohol, and of course ice is the preferred drug because it is easily 'hideable'. It's a very small pill. You can drive after 24 hours, unlike with cannabis. So if we really want to keep down the road we're going on then what we are doing is pushing young people into harder and harder drugs by raising the price of street cannabis for non-medicinal use. Thank you very much.

CHAIR: Thank you very much, Professor. I'll hand the call to Senator Scarr and then to Senator Shoebridge.

Senator SCARR: Thank you, Professor Heilpern, for attending today. I acknowledge your service to the community through your various roles and also your extensive experience in dealing with these issues, so thank you for making your time available. Later today, we're going to have a witness from South Australia Police. Have you had an opportunity to read their submission?

Prof. Heilpern: Yes, I have.

Senator SCARR: I want to put a few propositions from their submission to you and give you an opportunity to respond. Feel free to them take on notice if you would like to provide a more detailed response to their submission, because I'd be very interested in your views.

On the first page of their submission, they say this:

Traffic deaths in Colorado involving drivers who tested positive to cannabis more than doubled from 2013 to 2020.

I understand the point you're making with respect to people testing positive, and potential issues resulting from that in a driving context, but the submission that's being made by the South Australian police is this increase in correlation between people testing positive to cannabis and driving deaths between 2013 and 2020. ow do you respond to their reference to that argument? I think the implication is that, if you made cannabis more available, then this can have implications in terms of traffic accidents.

Prof. Heilpern: I can speak to that easily. Firstly, I want to go back to my point that I made in my opening, and that is that there's a heroic assumption—that is incorrect—that legalising cannabis will lead to a mass increase in use. We do know that there are at least one million scripts and in excess of 300,000 people in Australia now taking medicinal cannabis. Of course, the period you mentioned saw an explosion in medicinal cannabis in Colorado. We don't know how many of those people were driving with scripts or with medicinal cannabis in their system. What we do know, in Australia, is this: the one state that has a defence to driving with cannabis if you have a prescription is Tasmania. I'm not suggesting this is a causative relationship, but it is the only state where the death toll is going down. There is not a single death in NSW or Australia where a coroner has found it was due to medicinal cannabis, and there are precious few that show recreational cannabis. If you have an increase in the use of drugs in the community—generally from medicinal cannabis or the slight increase in recreational cannabis—then you are going to have more people driving with remnants or a detectable level of cannabis in their system. For NSW, that's five nanograms—5,000 millionths of a gram—in your saliva.

So you're right to call it a correlation, but there is no causative effect. In other words, there is absolutely no evidence to show that those with a detectable level—I'm not talking about people who have a bong and go driving, weaving all down the street. All of us want them off the road. But, when I'm talking about people with a detectable level of cannabis in their system, there may well be—in fact, one would expect there to be—an increase in that raw number because more people are using medicinal cannabis. Some—two per cent in Canada; perhaps 1.3 per cent in Portugal—are using more cannabis as opposed to prescription drugs, opioids and alcohol. We are going to see that increase, but that does not mean there's a cause with effect.

As I say, there is not a single coronial finding saying that medicinal cannabis caused a death on the road, and, if recreational cannabis is only, very minimally, going to increase—this is a figure that's trotted out all the time. Just by way of example, in New South Wales—I can't speak for South Australia—the majority of deaths on the roads are 18- to 25-year-olds, males in particular. Their rate of cannabis use is about nine per cent, and one would expect to detect that in those people, the cohort that are going to die, sadly, on our roads. Nine per cent have used cannabis at least once in the last 12 months. We should expect to see numbers of that type. This is a furphy.

Senator SCARR: That's very helpful evidence. I'll give you the chance to respond to another statement, which is provided in their submission on page 2, and this question really dovetails to the comment you made in your opening statement about the priorities of policing, in particular in relation to violent offenders or AVOs et cetera and where resources should be dedicated. South Australia Police's submission talks about an intersection between 'chronic cannabis use, withdrawal and violent aggression', and they say:

The Norwegian Institute for Alcohol and Drug Research, SIRUS, has shown a link between chronic cannabis use, withdrawal and violent aggression, reporting cannabis withdrawal is linked with 60% more relationship violence among people with a history of aggressive behaviour.

They extrapolate from that, and say:

Legalising cannabis is likely to have negative impacts and do harm in Indigenous communities,—

I note your experience in northern New South Wales—

in other vulnerable communities, and in remote communities.

I'd like to give you an opportunity to respond to that.

Prof. Heilpern: More than happy to. In the 22 years that I was sitting on the bench, I saw one or two cases of domestic violence involving cannabis use. I saw tens of thousands involving alcohol. If we could get communities off alcohol and onto cannabis, my view is that we would see an overall reduction. In terms of chronic cannabis use and aggression, there is, again, the same heroic assumption that legalising cannabis as Senator Shoebridge's bill would do would lead to an increase in use. There is just no evidence to support that, beyond what I've said of the two and the 1.3 per cent. But again, those people would be much more likely to be giving up other problematic drugs or prescription drug habits.

There's no doubt that drug abuse is problematic, whether it's cannabis or chocolate or heroin. We are all against drug abuse. I know that I certainly am, and I've been touched by it deeply in my family. I wouldn't be here if I didn't believe that legalisation was the path to less drug abuse than maintaining our current prohibitionist model.

I say this to the police in South Australia: if you support this bill, then you would see a reduction in domestic violence for two reasons. Firstly, because alcohol is the big evil in that space, and, secondly, the resources you could put into policing domestic violence, as opposed to policing possession of drugs, would well outweigh any danger or any risk. There are 32,000 possession matters brought by New South Wales police—I'm making an assumption they're all are cannabis, but they're not—so imagine if 15,000 or 18,000 matters were wiped from police diaries and times and court time and lawyer time and all the rest of it, and were instead dedicated to providing protection of women and victims of family violence.

Senator SCARR: Thank you.

CHAIR: Senator Shoebridge, you have the call.

Senator SHOEBRIDGE: Thanks for your evidence today, Dr Heilpern. Regarding the impacts on an individual—particularly in regional parts of the country—when somebody lost their licence as a result of a finding that they had the smallest detectable level of cannabis in their system, what were some of the impacts you saw in people's lives?

Prof. Heilpern: That was one of the reasons I left the bench—and I've made that very public. It is so sad to see someone who is simply following the directions of their doctor and taking a prescription, lose their licence for three or six or 12 months as a result. If a single parent suffering from chronic pain or chemotherapy is taking cannabis to ease the burdens of that, and they lose their licence, they can't drive their kids to school, they can't work and they can't pay their mortgage, I can't tell you how enormous that tragedy is to watch—I've seen people literally being dragged out of my courtroom in tears, screaming, 'Don't take my licence.'

In New South Wales, 10,000 people a year lose their licence to drug driving detection laws, and they are not driving under the influence, because if they were and their driving was adversely affected and there was any evidence of that, they'd be charged with a different offence altogether. So it is tragic and it leads to other much more serious crime and imprisonment. I say that because people run the gauntlet.

In the six to 12 months that she's off road, the woman I just described is likely to drive once or twice, get caught, and then drive while disqualified. The penalties then get more and more serious, and the suspension and disqualification periods longer and longer, so it's a downward spiral.

Senator SHOEBRIDGE: In your some two decades on the bench, in the northern part of New South Wales, where there was very aggressive policing of cannabis laws, were you aware of any coronial case that found a causal connection between cannabis consumption and either driving fatalities or other deliberate acts of violence?

Prof. Heilpern: The short answer is no, with one exception. As well as being the magistrate in country, you're also the coroner. Suicide is probably an exception to that. That's because there is, of course, a causation between mental health and seeking to self-medicate on cannabis. Therefore, I would say that there were suicides where there was cannabis use. In terms of violent crimes, there were none. In terms of traffic matters, there were none.

Senator SHOEBRIDGE: As you say, sitting as a magistrate in a regional part of New South Wales, you also had the role of coroner from time to time.

Prof. Heilpern: Indeed. I think you might have even visited my court at one stage in Lismore and seen the fact that DV matters were put to one side to deal with the floods of cannabis matters that were coming before the court at that time, particularly drug-driving matters. We were talking about dozens of drug-driving matters every week. All of that takes up court time and leaves domestic violence victims waiting in the wings.

Senator SHOEBRIDGE: Do you have any opinion in relation to the evidence we heard from a witness earlier today that police don't have any powers to search people for cannabis?

Prof. Heilpern: That's an absurd statement. It's demonstrably incorrect. Northern New South Wales is not only linked to aggressive ongoing targeted policing of cannabis users but we are also blessed with a myriad of music festivals. I'm sure that everybody here is aware of the police integrity commission inquiry into the searching of children and the aggressive dog-detection policing that goes on. Police have power. It's simply false to say that the police don't have power to search.

It's not only that. The same witness also said that, in her experience, she'd never known of a young person to only get caught for drug possession, drug use or cultivation, as opposed to being involved in some other criminal activity. As a children's court magistrate for 22 years, my experience is completely the opposite of that. Indeed, it is the involvement of the criminal justice system from being busted with a minor amount of cannabis that leads onto an integration to the criminal system. The other factor with that is, of course, if cannabis is legalised and people want to use cannabis, they can do so without having to go to an illicit dealer, an underground criminal element that leads to all sorts of other problems, including debt, harder drugs et cetera.

Senator SHOEBRIDGE: Once cannabis becomes legal, at least for adults, there would be no reason to visit a drug dealer and have access to obviously more harmful drugs, such as ice and the like, because you could obtain cannabis through a legal pathway. It's not a gateway drug. In fact, it shuts the gate to other drugs.

Prof. Heilpern: By far the largest illicit drug use in Australia in cannabis. If cannabis is legalised, it takes those purchasers or consumers of the drug outside the criminal milieu and places them in an entirely different milieu, which is a commercial one, and also a much safer one. They can be quality controlled. You can call for help when you need it. There are a whole range of reasons. We're also all aware of the number of drug related deaths. By these, I'm not talking about overdoses or motor vehicles. I'm talking about crime related to murders and deaths. I know they're called the cocaine wars, but in my view that's a misnomer. What underpins all of that criminal gang activity is cannabis. It is the drug of choice for a vast majority of illicit drug users.

Senator SHOEBRIDGE: Legalising cannabis and taking that multibillion dollar market out of the hands of organised crime is actually a substantial harm reduction measure, because those grossly unethical players of organised crime and outlaw motorcycle gangs will be seriously disempowered through the process of legalising cannabis—won't they?

Prof. Heilpern: Absolutely. The other factor with that is that the temptation for young people to get involved in the supply of cannabis is really huge. They've got to pay their rego. We all know how that works. Some of us even stole milk money, back in the days when they had milk money. The point is that the whole criminal milieu related to cannabis comes out of the equation. What's left is a criminal milieu related to very few drugs for a much smaller percentage of the population.

Senator SHOEBRIDGE: It's an active measure to disempower organised crime, and it's an active measure to keep young people away from those kinds of entry elements into criminal behaviour, isn't it?

Prof. Heilpern: It is laughable to me the amount that we spend on organised crime in this country, when one measure could so simply and swiftly pull the rug out from under the feet of a significant proportion of that activity, and it's free, and it doesn't involve any other legal things—search warrants, violence, imprisonment or anything else. It's just the stroke of a pen, the legislature doing what has worked in Portugal, Canada and many states in the United States. It's saying, 'We don't want to play this game anymore; it's a silly game; it doesn't help.'

Senator SHOEBRIDGE: Thanks, Professor. I note the time. And, just for the record, I never did steal the milk money!

Prof. Heilpern: Well, I've confessed!

CHAIR: Thank you, Senator Shoebridge. I have a couple of questions, Professor. You may have a view on this or not. I'm sympathetic to some of the arguments being made around harm reduction. What I'm concerned about are the mechanisms for legalisation or decriminalisation through Commonwealth legislation. I've got a different view than the sponsor of this bill about the constitutionality of this bill.

You make some recommendations around the way that Commonwealth offences hinder state and territory authorities. I just wonder whether you could step that out a little bit further for me. I think there are probably two

tangents to that argument: there are states that make their own laws regarding criminalisation and decriminalisation, but then there are territories as well. I just wondered whether you could step through those recommendations you've made.

Prof. Heilpern: Sure. In the end, constitutionality, of course, is a question for the courts. There are plenty of bills that get passed into acts and are struck down by the High Court as being inconsistent with state laws. I guess what I'm saying by that is: that's no reason not to give something a go.

But, having said that, yes, the fact that we've got parallel Commonwealth, state and territory laws with respect to, for example, possession of prohibited drugs gets in the way of reform. We see that with the tenuous situation in the ACT where, effectively, the Commonwealth has said, 'We'll back off; we won't ask the Federal Police to enforce our laws, and we'll let sleeping dogs lie,' unlike, for example, with euthanasia in the Northern Territory, where they actually overrode it. There's no doubt that, as it currently stands, the Commonwealth could override the territory law if it saw fit to do so. So it does create a tension, and it's a tension that would be removed by this bill.

As for the issue with states, I am not a constitutional expert, but Patrick Keyzer is. If ever I have a constitutional question that I don't know the answer to, he is my go-to. I've read his opinion. He's the expert, and I agree with him that there is a power for the Commonwealth to exercise here. The extent of it is, in the end, going to be up to the courts. But, if the Commonwealth really believes in something like saving Tasmanian dams or legalising abortion or doing any of those sorts of things, then there's nothing wrong with the Commonwealth enacting its position and putting it to the courts.

CHAIR: Sure. It wouldn't prevent future Commonwealth governments from going the other way, though, if we open up or create a power, constitutionally. I'd hate to think about what would have happened with abortion laws if there had been a power that allowed former prime minister Abbott a chance to have a say on that. I have a view around the states having a bit more authority when it comes to the criminalisation of matters. I wanted to ask you about something. You made reference to three drugs in your previous answer to Senator Scarr. Those were cannabis, chocolate and heroin. You're not suggesting that those three substances are on the same level or should be managed or regulated in the same way?

Prof. Heilpern: It's probably not relevant to this inquiry in any event, because it's just an inquiry into the legalisation of cannabis. However, no. What I was talking about was that all of us are against drug abuse. I was being slightly facetious. Caffeine is a drug; so is heroin. And we're all against drug abuse. I'm against abuse of cannabis, and I think it is capable of being a drug that is abused. But, used in an educated manner and taken out of the criminal context, we're much less likely to see harm. That's really what we're all about.

CHAIR: I understand the point you were making. I think I might have been seeking to give you the opportunity to clarify those comments, if you can understand what I was doing there.

Prof. Heilpern: Sure.

CHAIR: I think that to hear those three substances referred to in conjunction is a little alarming to people and probably feeds into an argument against harm minimisation or harm reduction. This is my last question, and it goes to what you just mentioned. On substance abuse, you've made a recommendation around a public awareness campaign of education and public health messaging. Surely that wouldn't be enough to reduce substance abuse if we did decriminalise cannabis.

Prof. Heilpern: Again, the erroneous assumption that I see people make is that problematic drug use increases when you legalise, and I say it doesn't. I say the evidence is overwhelmingly that it doesn't. Any education program is an adjunct. And look—I think the more drug education we've got, whether it be for illegal, regulated, decriminalised or completely legalised drugs, the better. We all want to see less harmful use, and I think there is a whole range of very simple things that make things clearer, particularly with cannabis—for example, about eating cannabis. I'm sure we have all had the experience of seeing friends and people that we know who have eaten cannabis and gotten really, really affected, way more than they wanted to be. There are safety measures that can be put in place to ensure that any use is safer use. I can only repeat that, if you make the assumption that legalisation does not lead to a massive increase in problematic use, then any education program will be an adjunct.

CHAIR: This is my final question. As I understand it, the position of Harm Reduction Australia is that cannabis is a substance that people could potentially be addicted to or have an adverse response to but that that would need to be managed, and people would need to be supported if they were addicted to cannabis.

Prof. Heilpern: Absolutely. I would use alcohol as the example. We all know that there are people who are alcoholics, and not everyone who drinks is an alcoholic. These people deserve our support. There are people who

are going to be abusing cannabis and who will become addicted to it in one way or another. Again, if problematic use does not increase, then issues of addiction do not increase, either. All of the arguments against lose water if you make the assumption that problematic use does not increase with legalisation. I'm more than happy to take any questions on notice. The secretariat has my email.

CHAIR: Thank you very much for giving your evidence today, Professor.

VENDITTO, Mr John, Assistant Commissioner, South Australia Police [by video link]

[13:34]

CHAIR: I now invite representatives from South Australia Police who are joining us via videoconference today. Assistant Commissioner, thanks for taking the time to speak with the committee today. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you and is available from the secretariat. I remind senators and witnesses that the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy. It does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. Do you have any additional comments about the capacity in which you appear today?

Mr Venditto: I am in charge of the Crime Service.

CHAIR: Would you like to make a brief opening statement before we go to questions?

Mr Venditto: Sure. In addition to the written submission that we've made, South Australia Police is opposed to the Legalising Cannabis Bill 2023. The basis for opposing the bill is the prevention of a manifestation of drug related crime, as well as public safety and road safety. Having approached this issue with an open mind, I've referred to the parliamentary speech on 10 August 2023 and the reading of the bill. I find that speech, in part, trivialises this important issue and does not address the key issues that concern police in South Australia. The key policing issues are how the bill will address or safeguard effectively managing compliance and policing of the industry; managing obvious work health and safety conflicts; Aboriginal participation and effects to populations, particularly in remote areas; mental health as it relates to the police front line; road safety; and child protection. I want to emphasise that of critical importance is the potential impact that legalising cannabis may have on making domestic and family abuse worse.

The area of serious concern in the bill was found in child protection. The South Australian Controlled Substances Act punishes supplying cannabis to children as a major indictable offence which carries life imprisonment. The bill penalises it as a summary offence, with a maximum of six months imprisonment or a fine, and this effectively means that there is hardly any penalty at all. I find this to be an irresponsible position for the supporters of the bill to propose. I'm happy to listen to your questions.

CHAIR: We will go to questions now, but thank you for your submission and for that opening statement. Senator Scarr, do you have questions for the assistant commissioner?

Senator SCARR: Yes, I do. Assistant Commissioner, thank you for appearing today and for the very extensive submission that South Australia Police provided. I found it very useful, and, in fact, I was putting excerpts from the submission to previous witnesses who were giving testimony and getting their response to a number of matters. The first point that I wanted to get your views on is in relation to laws concerning driving under the influence. We just received evidence from someone who served as a magistrate for 22 years, I think, and he expressed his consternation that, at times, the law operated to require individuals who were on, say, medicinal cannabis for pain relief to be recorded with a driving conviction, leading to all sorts of personal consequences for them—losing jobs because they didn't have transport, making it harder to do the things that we all need to do in order to live in a modern society and pay the bills. There was a reference to the fact that in Tasmania there is a bit more flexibility in the law around the treatment of drivers who are taking medicinal cannabis. I'm interested in your views, or any thoughts the South Australia Police have, in relation to that issue. The distinction between someone who's gone to a doctor and is taking prescribed medicinal cannabis as opposed to getting access to cannabis otherwise is noted in your submission. I'm interested in your views on that issue.

Mr Venditto: That's a good question, because it affects a broad range of the population and it affects, importantly, noncriminals who are trying to do their best with their treatment. The situation in South Australia is that we don't test for impairment when testing for drugs like cannabis. It's either present or it's not. I understand that it might be around for a couple of days, but my rebuttal to that is, if you've had an operation and you're taking other traditional medicine, you have a warning not to drive for four or six weeks, and you normally comply with that. You should apply the same test for cannabis as the laws currently stand in South Australia. We don't test for impairment.

The other issue is that we can't see the impairment. Your traditional drink driver, who can't walk the line or who has bloodshot eyes or slurred speech, has an obvious impairment that we can work with. But with a person taking cannabis we can't see or test for the impairment, but that doesn't mean there isn't one. There might be some effect on the sensory system or reflexes et cetera. It's not the answer that you're looking for, but, as to the law as it

stands in this state, we don't test for impairment for cannabis. I think it's just for THC full stop, and there is no solution to what you're suggesting.

Senator SCARR: I guess that begs a question. There are people in our community who are suffering from chronic pain. They might be getting chemotherapy and they're using a particular product to manage the impacts of nausea et cetera. A lot of medication which we're given—and, as you were giving your answer, I was just thinking of some medications I might have taken over time—will have a generic warning, 'This may impact your ability to drive or to operate heavy machinery.' You get this overall warning or injunction about needing to take care with respect to this medicine and how it may impact you. If I'm pulled over and I'm taking one of those medicines, even though it might be having an impact on me which isn't terribly visible, I wouldn't trigger an offence, whereas if I was taking medicinal cannabis and it wasn't having a negative effect, noting it could have an effect, but it might not have an effect either, then I have committed a driving offence. Do you understand? When I look at that, I can see the discrepancy in how we're treating different drugs, both of which are being taken under a prescription from a medical practitioner.

Mr Venditto: Correct. But in the first one that's not cannabis, if you're affected—and I speak from personal experience—by medication after an operation and it makes you a little bit drowsy, that's obvious to an officer that you've committed an offence, that you're driving under the influence of the drug. But, to take your point, say you don't show any effects and you're fine, sure, technically you don't commit an offence if you're not impaired, whereas with the other one, if you can't see or test the impairment, just the mere presence of it means you're being penalised. But both of those drivers have got a choice: if, after an operation, I think I'm impaired and my reflexes aren't quick or whatever, I'm choosing to drive and so is the other one. Not to be mean, but they know the potential consequences beforehand. It's not a surprise that we test for THC. This might be a call or a question for other services that people who are taking medicinal cannabis for legitimate reasons might need to have, like driving assistants, like I have for my relatives. I've driven them because they're not in a position to drive or take a risk. This might be a question for a broader solution rather than the drink-driving one.

Senator SCARR: It could well be. Are you aware of any research that's being done in relation to impacts of medicinal cannabis on driving ability and the different range of responses? Is there any research you're aware of that is being done in that regard?

Mr Venditto: I'm personally not aware. Road safety is not my particular area of expertise. There might be another part of our service that would—

Senator SCARR: I was interested in your comments in relation to child safety and I've seen a number of studies, including out of Canada, which have said implementation of the policies there has led to a greater incidence of children ingesting cannabis related products and presenting to emergency wards of hospitals with respect to the impacts of that. Is that one of the issues that concerns you? What are the child welfare issues of particular concern from your perspective?

Mr Venditto: Firstly, I acknowledge that, if a home has legally got a jar of cookies, it's just another jar that that child can access in a relaxed, non-legally-threatening way. They're legitimately there. There's your ingestion. My concern is that, if a home brings home cannabis because it's legal, you're now socialising those young children into accepting that cannabis is good because Mum and Dad are smoking it or however they consume it. The fundamental issue for me is that this bill potentially puts a life-imprisonment offence, which is focusing on child protection, to zero—because six months and a fine means effectively zero. How do the proponents of that answer that question?

Senator SCARR: One of the proponents may well ask you a question. He lines it up with a comment. He's a very smart individual, so I'll leave that to him. The other issue I'm interested in—and, again, I come back to some comments made by a previous witness who has served on the bench as a magistrate for a number of years. I put to him the discussion in your submission around correlation between violence and cannabis use. His response was, "Well, I saw far more cases before me, when I was on the bench, in relation to alcohol induced violence than I did in relation to cannabis-use violence—far, far more cases in relation to alcohol-abuse violence." How do you respond to that response?

Mr Venditto: We don't often agree with magistrates, but I agree about the alcohol. I also put forward that it's not the comparison that we're really concerned about; it's the mixture, the volatility that it creates and the environment that the woman and family find themselves in when the male is abusing alcohol and cannabis and then there's not a thing—at the moment, if a male is abusing and consuming cannabis in a domestic situation and we attend, we can take him away even for that reason. When it's legalised, there's nothing we can do in terms of that. We've got to find another substantive offence. So one is the policing issue of it, and the second one is the combination of the two: the volatile situation that we don't want.

Senator SCARR: Alright. I'll leave it there, Chair. Thank you.

CHAIR: Thank you, Deputy Chair. Senator Shoebridge, you have the call.

Senator SHOEBRIDGE: Thanks, Chair. Thanks, Assistant Commissioner. Do I understand—it was a bit hard to follow, but I think some of your evidence on drug driving was that police couldn't tell if someone was impaired by cannabis when they pulled them over. You didn't have any basis for telling whether someone was or wasn't impaired from cannabis use, and that's one of the reasons that you supported the maintenance of the existing laws. Is that right?

Mr Venditto: You're talking about the traffic laws?

Senator SHOEBRIDGE: I'm talking about your evidence that you gave in answer to Senator Scarr.

Mr Venditto: What I'm saying is that, if a person takes cannabis and they're pulled over, we can't tell if they have a sensory impairment on reflexes. You're talking about medicinal cannabis, aren't you?

Senator SHOEBRIDGE: I'm asking you about your evidence. You said that police at that roadside setting can't tell if someone is or is not impaired from the consumption of cannabis. Is that right?

Mr Venditto: Yes.

Senator SHOEBRIDGE: But you can tell in a domestic setting. Can you tell me how those two things work? That was your second set of evidence to Senator Scarr—that you thought cannabis had a particularly bad effect in a domestic setting. How is it that you give evidence about being able to see cannabis impairment in a domestic setting but not in a driving setting? I couldn't understand what you were trying to say; it was quite hard to follow.

Mr Venditto: Sure. I'll explain it to you. In a traffic setting, the person is stationary, static and compliant, and they're doing their best not to show any sensory impairments. We can't see it, and we can't test for it. It might be reflexes, for instance, because, if a person consumes cannabis, the general person will say they want to relax or get high. We don't want relaxed drivers. We don't want high drivers. We don't want happy drivers. We just want—

Senator SHOEBRIDGE: I'm not asking about what you want or don't want. I'm asking about what you observe or don't observe as a police officer.

Mr Venditto: Then we go into a domestic situation, and we know that the victim, which is often a woman—not necessarily, but often—will say: 'When he's on the booze and the cannabis, he's violent. He's smashing things up; he's doing this and doing that.' That's what I'm talking about.

Senator SHOEBRIDGE: How much of the South Australian Police resource is directed to policing cannabis use?

Mr Venditto: Are you talking about the number of police officers?

Senator SHOEBRIDGE: You must have some metric. I assume you look at how much of a public resource you're dividing up for different matters. How many hundreds of millions or millions of dollars of public policing resources are directed to policing cannabis?

Mr Venditto: Every police officer polices cannabis, because they've got the authority to issue expiation notices. I'm not sure if you're aware, but for up to less than 100 grams they can issue expiation notices. For instance, nearly 4,000 were issued in 2022-23, so every police officer can police that. The next level up might be detectives doing a higher level of policing cannabis. Then we come to my service, which has the serious and organised crime branch. There's a particular area for drug investigation, which includes a specialist squad of detectives for cannabis. It scales right up, depending on severity.

Senator SHOEBRIDGE: How does that compare to the amount of policing directed towards domestic violence?

Mr Venditto: It's the same principle.

Senator SHOEBRIDGE: I'm not asking about principles; I'm asking about actual resource allocation.

Mr Venditto: It's the same. You've got the frontline family violence units, which are detectives, and then you've got my branches, which are the specialist domestic violence—

Senator SHOEBRIDGE: You're telling me you spend the same amount of resources policing cannabis as you spend policing domestic violence. Do you think the public supports that?

Mr Venditto: That's not what I said. What I said is that the same amount of people have responsibility for and can act in either domestic violence or cannabis.

Senator SHOEBRIDGE: But you told me there were 4,000 notices issued in relation to cannabis by your frontline officers. You then said there was an unspecified amount of additional senior policing resourcing to deal with cannabis. I'm asking you what the equivalent resourcing allocation and outcomes are for domestic violence in your police force.

Mr Venditto: The same amount of people have the same amount of authority, but, in domestic violence, we're dealing with some 20,000 domestic violence reports a year.

Senator SHOEBRIDGE: How many convictions are there?

Mr Venditto: A lot.

Senator SHOEBRIDGE: You issued 4,000 criminal notices in relation to cannabis. How many criminal proceedings did you commence in response to the 20,000 reports of domestic violence last year?

Mr Venditto: I couldn't tell you that. I asked for—

Senator SHOEBRIDGE: It's many less than the 4,000 that were for cannabis.

CHAIR: Senator Shoebridge, sorry—

Mr Venditto: No, no.

Senator SHOEBRIDGE: Well, tell me.

Mr Venditto: No.

CHAIR: Excuse me. I'm the chair. I'm just going to intervene for a moment. Senator Shoebridge, if you could let the witness answer the question you've asked or put to him and stop interrupting, we might be able to get to the end of this with some useful evidence for both you and other committee members. I'd just ask you to stop interrupting before the witness has a chance to answer your question.

Mr Venditto: Let's break this down into simple mathematics. Let's say there are 5,000 police officers; they're all authorised to act for policing cannabis, and they're all authorised to act under domestic violence. The statistics that you're after are that there were nearly 4,000 expiation notices and another 500-odd detections above expiation that expiation couldn't resolve. How many officers gave that—I don't know the answer, but they're all eligible.

If we move into domestic violence, they're all eligible to take action and respond to a domestic violence incident and there have been some 20,000 incidences. You're asking me, 'How many went to trial?' and you expect me to know, without notice. I don't know the answer to that. One answer I can give you is: not enough.

Senator SHOEBRIDGE: You commenced 4½ thousand proceedings of one form or another in relation to cannabis. I'm asking how many proceedings you commenced in relation to domestic violence.

Mr Venditto: Four thousand expiation notices are not proceedings. Either they're paid or a fraction of those will go not guilty and then go to trial—so they're expiated; they're not court proceedings. How many do we launch an investigation for? That's a question that I get back to you on, but that's not a question that you would seriously expect me to understand now, in the way you've asked it.

Senator SHOEBRIDGE: You don't think that the community would be far more comfortable with you directing your limited policing resources to the scourge of domestic violence than to some 4½ thousand tickets, policing instances and the like in relation to cannabis? What's the community telling you is a greater scourge in South Australia: cannabis or domestic violence?

Mr Venditto: They're not the only two things we do. There are a lot more scourges than that, and—

Senator SHOEBRIDGE: But they're the two I asked you about.

Mr Venditto: What's the question?

Senator SHOEBRIDGE: What's the community telling you is a greater scourge to which they want police resources in South Australia directed: domestic violence or cannabis? What are they telling you?

Mr Venditto: That's a rhetorical question.

Senator SHOEBRIDGE: You're not going to answer it?

Mr Venditto: What answer do you want? Both of them.

Senator SHOEBRIDGE: I want you to give me an honest answer.

Mr Venditto: The honest answer is that we police both those issues, as well as other issues. What's the community telling us? They're grateful when we police illegal drugs; they're grateful when we intervene in domestic violence; they're grateful when we intervene in child protection.

Senator SHOEBRIDGE: You gave some fairly forthright evidence about criminal offences in relation to the supply of cannabis to a minor. How many of those prosecutions did the South Australia Police commence last year, the year before or the year before that? How many prosecutions did they commence?

Mr Venditto: I gave the inquiry an opportunity to send me questions; they declined. Now you're asking me a question that I can't possibly respond to unless I check the statistics.

Senator SHOEBRIDGE: You came out of the gates quite aggressively on it, so I'm assuming you did some research before you did that. How many prosecutions were commenced, and do you know if anyone went to jail for it?

Mr Venditto: There's an offence in our statute where supplying a controlled substance to a juvenile gets life imprisonment.

Senator SHOEBRIDGE: Have you used it?

Mr Venditto: I don't know.

Senator SHOEBRIDGE: Surely you did that basic due diligence before you came out so aggressively on that point. Are you telling me you didn't determine whether or not South Australia Police had ever used it, let alone look at the sentencing on it? Is that seriously the evidence you're giving? You didn't even do that basic due diligence.

Mr Venditto: I'm comparing that section of our statute to your bill. One has life imprisonment, and one has zero. That's what I'm telling you.

Senator SHOEBRIDGE: You have responsibility, Assistant Commissioner, for policing under the existing laws, and you can't even tell us if you've used it. Is that the case?

Mr Venditto: No. What I'm telling you is that you're putting an absolutely ridiculous proposition to me—that I should know a statistic that you didn't request in a question on notice—and now you're trying to conjure up a response that says I don't know what I'm talking about. Life imprisonment to zero.

CHAIR: Assistant Commissioner.

Mr Venditto: Yes?

CHAIR: I apologise. I'm sure you're familiar with the parliamentary procedures in South Australia. To assist you, and to assist Senator Shoebridge to get the answer to his question, you are able to take questions on notice in this hearing if you don't have the answer with you and provide that answer after the hearing. We'll give you a date to provide that to us by. It's quite common for witnesses in our parliamentary proceedings to take a detailed question like that on notice. I'll provide you some assistance in giving you that opportunity if you don't have answers on hand. Senator Shoebridge, if you have other questions, I'll ask you to put them, and we can proceed on that basis.

Senator SHOEBRIDGE: Assistant Commissioner, I think your evidence was that you looked at this bill with an open mind. Was that your evidence?

Mr Venditto: Yes.

Senator SHOEBRIDGE: How many proponents for cannabis law reform did you speak to—with your open mind—before putting the submission in?

Mr Venditto: I read all of the submissions you've had so far from organisations and proponents, other than the individual nonsensical ones that you got. I opened a few of the individual ones but not all of them. I read all of the ones you've posted by witnesses who have already given evidence.

Senator SHOEBRIDGE: Did you speak to anybody who supported legalising recreational cannabis before you put your submission in?

Mr Venditto: To a person, do you mean?

Senator SHOEBRIDGE: You could have spoken to an AI bot. I don't know. Did you speak to any entity that gave you a response that supported legalising cannabis before you put your submission in?

Mr Venditto: No. I read the documents on your site.

Senator SHOEBRIDGE: On my site?

Mr Venditto: On the parliamentary site on this bill.

Senator SHOEBRIDGE: Assistant Commissioner, you didn't have an open mind at all, did you? You are personally, aggressively against legalising recreational cannabis, and your evidence about having an open mind wasn't genuine evidence, was it?

Mr Venditto: No, you're wrong there. I'm aggressively against people who completely dismiss child protection by putting a life imprisonment offence to zero.

Senator SHOEBRIDGE: Before you speak further to us on that, do you actually have some evidence rather than rhetoric about what happens in South Australia on the current offence?

Mr Venditto: The evidence is that in our statute we have an offence of life imprisonment for supplying children with drugs.

Senator SHOEBRIDGE: Assistant Commissioner, the chair has given you an opportunity to actually get some evidence, to take it on notice and find out if your police force has used that offence at any time and also to work out if your police force has ever sought life imprisonment and if anyone has gone to jail and what the jail term was. Are you going to take up the chair's option or are you just going to continue on your current path?

Mr Venditto: If you're asking for a question on notice, I accept.

Senator SHOEBRIDGE: Done.

Mr Venditto: That's not what you're asking.

Senator SHOEBRIDGE: Done. Alright, Chair, I think others may have more patience than me.

CHAIR: Assistant Commissioner, your response to this legislation refers to the, as you put it, difference in the sentence or the proposed sentence for providing cannabis to minors. Senator Shoebridge asked you about that. Could you explain to me and the committee why that behaviour would be criminalised under South Australian law? It sounds like I'm asking a silly question but I do want to step through it. Why is it so crucial that we have sanctions or criminalisation of selling a drug to a young person, and how do you see that play out in the community? What impacts does it have on young people?

Mr Venditto: As you'd be well aware, that's the law that was passed by our parliament that we have. The stance of tough on drugs, and there's an offence for life imprisonment for supplying a child. What that recognises is that they're the most vulnerable people in terms of drug use or getting them on an early path to drugs, which is what we're trying to prevent. It's reflected by the legislation and it's reflected by the penalty. What does it mean if we don't have an offence of that severity? People, including children, would be freely in usage of drugs, which is what we don't want. I don't think it's a silly question, but I'm just astonished that there's even a debate about it.

CHAIR: I think the reason I'm asking you for evidence around the impact in the community is that, out of all the witnesses we're speaking to, you probably have had experience—in policing—where children have been sold drugs—

Senator SHOEBRIDGE: Sorry, Chair. That wasn't his evidence—

CHAIR: and you probably have more evidence or understanding of who the people are who are selling drugs to children. In your experience, can that from time to time be organised crime?

Mr Venditto: It can be organised crime, but it can be also non-organised crime. Parallel to this offence of supplying with children is also one that, if you're supplying cannabis within a school zone, it's life imprisonment as well. That's the platform that we're coming from.

CHAIR: This bill seeks to decriminalise the use of cannabis by adults. Is your evidence that the bill doesn't treat the difference between the way possession or selling to children would be different from selling or possession by adults—that there isn't enough of a distinction made, primarily in the way that the penalties are applied?

Mr Venditto: Not just in children, there's also all of those key areas, as I said, as it affects policing. It doesn't safeguard or [inaudible] what the industry or the bill was going to do about them. So, yes, one of them is the penalty but also the notion that, if you grow a thousand plants today on your farm and in your property—we've got instances here of people with large commercial quantities getting 14, 12, 11 or six years. This bill says, 'As long as it's on private property, the worst that's going to happen to you is—here we go again—two years or a fine. That means nothing.' So we're going from big penalties, for growing a thousand cannabis plants, to zero.

Senator SHOEBRIDGE: That's because it's becoming legal.

CHAIR: The system or regime that's proposed under this bill would enable the selling of cannabis at cannabis cafes. In your submission, you deal with how that would be policed. What concerns do you have about that proposal? I understand that what's being proposed in the bill wouldn't reduce policing of cannabis to zero because there would still be policing required around whether these cafes were complying with the law or that they're not selling to children. Would you have the resources to deal with that type of policing?

Mr Venditto: You're reducing it to almost a regulatory offence. We wouldn't get involved in the checking of stores et cetera unless there was evidence or suspicion of high level criminality. It's not something that we're going to get involved in. It's a little bit like all the complaints about tobacco because they're undercutting prices. That's a matter for other agencies; we're not going to have the resources to concentrate on that.

CHAIR: On the impacts that you see in the illegal use of cannabis at the moment in the community—you referred to how you come across the use of cannabis in a case of domestic violence—it's a pretty blunt tool to compare the policing of domestic violence and drug offences alone. When your police force are dealing with domestic violence cases, there are a lot of factors involved in those matters not just drug use. Is that right?

Mr Venditto: That's right. The point I was making was that it exacerbates the violence, and the predisposition to violence, if they're mixing alcohol with cannabis. That's what our victims are telling us, 'When he's on the gear, this is what happens.'

CHAIR: I'm going to leave it there. For my part, I think it's pretty unfair to compare how important policing is to domestic violence given the public cases we've seen recently. I think the community understands how important that is. That goes without saying. Thank you for your evidence today. I think you have agreed to take some questions on notice. If you were able to do that, we'll give you a date to return those questions to us. Thank you for your evidence today.

Mr Venditto: Thank you. It's been an absolute pleasure.

CHAIR: Thanks very much, Assistant Commissioner. If the committee members don't mind, we will take a short suspension, and we'll return with Astrid Dispensary and Clinic.

CHEMAL, Ms Cadrie (Kady), Chief Operating Officer, Astrid Health

NGUYEN, Ms Lisa, Chief Executive Officer, Astrid Health

[14:14]

CHAIR: I now welcome representatives from Astrid dispensary and clinic who are joining us in the room today. Thank you very much for joining us and taking the time to speak to the committee. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you, and it is available from the secretariat. Would you like to make a brief opening statement before we go to questions?

Ms Chemal: Yes, thank you.

Ms Nguyen: Good afternoon, members of the committee. My name is Lisa Nguyen. I'm a pharmacist and the CEO of Astrid Health. It is an honour to be here today to talk to you about our stance on legalisation. As such, I would like to introduce you to our chief operating officer, Kady Chemal, who will expand on our position.

Ms Chemal: As a way of introduction, Astrid Health is a dispensary and clinic specialising in cannabinoid medicine. To date, we have helped over 20,000 patients in their medicinal cannabis treatment journey. Our aim today is to share insights from our practice that may inform the development of regulations for an adult-use cannabis market.

The establishment of the medicinal cannabis market has led, without a doubt, to advancements in research, product quality, patient education and stigma reduction. Since 2020, we've witnessed a significant migration of patients from the illicit market to the medical sector, intensifying the pressure on prescribing approval pathways. This influx has placed additional demands on healthcare professionals, shifting the focus of discussions from clinical consideration to non-medical terminologies such as strain, lineage and cultivation methods.

At Astrid, we see two types of patients. Of our patients, 55 per cent are medical patients, whereby they are accessing cannabis for cancer pain and endometriosis, for example. It's possible for these patients to not have tried cannabis before; hence, they have very little knowledge about it. We recognise that the remaining 45 per cent of all patients are cannabis experienced patients, which means that they moved from the black market to the legal market. This is not to say that these cannabis experienced patients are not accessing medicinal cannabis for valid medical reasons—for example, sleep and anxiety. However, they often come with a vast specialised cannabis experience and ask very niche questions, which means that our nurses and doctors need to upskill really fast on terminology to have meaningful conversations. Concurrently, products formulated and packaged with these patients in mind have flooded the medical market, featuring colourful packaging and strain names like gorilla glue or garlic mints. At Astrid, we uphold a policy of inclusivity, acknowledging that patients may possess varying levels of knowledge about and experience with cannabis. We recognise that education is key, regardless of a patient's background, and we place safety at the forefront of everything we do.

Educational empowerment has played a pivotal role in challenging the stereotypical stoner image often associated with cannabis use, as these patients are, or return to be, highly functional members of our society. Many of these patients transitioned from traditional smoking methods to utilising devices like dry-herb vaporisers, a shift that not only minimises exposure to harmful carcinogens but also offers a discrete consumption experience and allows for precise dosing. Feedback received from these patients underscores the superior quality and labelling of products available in the medical market compared to those found in the black market, highlighting the importance of stringent regulations and quality control measures.

Astrid's vision for legalisation advocates for the co-existence of medical and other-use markets, ensuring the medical patients continue to receive appropriate clinical care, whilst experienced cannabis consumers continue to access quality products from licensed retailers. In line with this, we propose the establishment of a national cannabis regulator that will standardise regulations, conduct routine product testing and ensure transparency and consistency in regulatory enforcement. This would also entail the licensing of cannabis suppliers and retailers upon completion of a pre-vetting process and training, for example. In conclusion, Astrid supports responsible cannabis legalisation, as it will relieve the pressure on the medical market and will focus on harm reduction and the wellbeing of individuals and society as a whole. Thank you.

CHAIR: Thank you very much. We'll just go to questions now. Senator Scarr, do you have questions for these witnesses? We'll go to you first, and then we'll go to Senator Shoebridge.

Senator SCARR: My apologies that I can't be there in person. I extend that apology to you, Senator Shoebridge, but thank you for holding the fort there for us. Ms Chemal, my first question follows from a line of questions I've asked a number of witnesses today. The issue has been raised, including by a former magistrate with over 20 years of experience on the bench, of drivers who are offending traffic laws because they're taking

medicinal cannabis that has been prescribed by medical experts. As I understand the evidence we've been given today, the law in most jurisdictions—Tasmania may be an outlier—doesn't discriminate between whether you've taken cannabis under a medical prescription and whether you've taken it otherwise. It's simply a binary test: do you have it in the system or not? If you have it in the system, you've committed an offence and you could lose your drivers license, with potentially very harsh consequences for you.

I'm interested in any research you're aware of or any thoughts you have in relation to the impact on driving of medicinal cannabis that has been prescribed by a medical practitioner and in whether or not there are any studies in that regard. Just to more forcibly introduce the question, I raised the point with a member of the South Australian police force that a lot of medications we receive have warnings that say, 'This may impact your ability to drive,' or 'Be careful if you're operating heavy machinery.' There are these generic warnings about the impact of a whole range of medicines, but the issue seems to be that, with respect to medicinal cannabis, if you've got it in your system, you've committed an offence. I'm very interested to hear your thoughts in relation to that issue.

Ms Chemal: Obviously, as you are aware, the fact that the THC molecule—now we're talking only about the THC molecule in cannabis, which is the molecule that has potential impairment consequences. The sole presence of this molecule in the blood doesn't equate to impairment. Unfortunately right now, in the way the laws are written, they do not differentiate between presence and impairment. To give you an example, in Canada, the way the college of physicians over there advise the patient is they say do not drive eight hours after oral intake and six hours after an inhalation because the likelihood of impairment happens right after the dose is taken.

This is from studies looking at the way the drug is eliminated from the body, but then there are studies that have been done in real driving conditions, where the scientists took 26 healthy volunteers, made them drive on a motorway at 100 kilometres per hour and then split them between groups. One group were given a placebo, which means a sugar pill; some were given a combination of CBD and THC—CBD being the non-impairing molecule from cannabis—and, as well, they gave another formulation with a high THC level. They noticed, in the case of the products where THC was present—in a one-to-one ratio with CBD or at a higher level—the impairment was there for about a maximum of four hours and then it was gone. The CBD molecule, which is non-intoxicating, had no impairment. It was the same, I suppose, as a placebo.

I think this result is in line with previous clinical trials where we say it is possible for the patient to be impaired for maybe up to four hours when they're inhaling cannabis and maybe up to eight hours when they are ingesting an oral formulation. It seems that this blanket warning from the college of physicians in Canada has worked. There was no conclusive evidence to say that, after legalisation, the number of traffic accidents increased in Canada, because this advice is good. It's based on science and then it's seen in these clinical trials, which are conducted in real-life conditions on motorways. I hope that answers your questions.

Ms Nguyen: At Astrid we have over 20,000 patients that we've helped so far, within Australia, over the three years that we've been operating. Any one of our patients that is on THC cannot legally drive. What that means for a patient is that it impacts their quality of life. We have lots of patients, who are mums, teachers and professional workers, who have to choose between quality of life and reducing pain and anxiety levels verses whether or not they can use the cannabis products. What our patients are asking us a lot is: why isn't cannabis treated just like any other opioid medication? It should be about deciding whether or not you are impaired, rather than just the presence of cannabis.

Senator SCARR: How do you, as a pharmacologist, compare the potential impact of, say, an opioid pain relief drug as opposed to the cannabis related drug, in terms of impairment? Do you have any particular views with respect to that?

Ms Chemal: There is limited data to say that THC may impair to the same level as maybe 10 milligrams of diazepam or maybe a low level of alcohol, not at the level of opioids per se. In saying that, because it has the potential for impairment, education and counselling are key. If legalisation is going to be successful, I feel public awareness campaigns are really important in this space. Education is key. In Canada we've seen groups of mum associations going into school and educating the young people about the dangers of driving under the influence et cetera. Education is key. It works, and it's based on science, as well. There is an easy solution in this case: amend the driving legislation.

Senator SCARR: You mentioned there are 20,000 people who Astrid has helped, through the provision of your services. What's a cross-section of the conditions those 20,000 have suffered from? From your perspective, where is the prescription of medical cannabis indicated?

Ms Chemal: When it comes to evidence—excuse the jargon, but we always classify the evidence. We say the gold standard for evidence is the randomised control trial, where the results are 100 per cent bulletproof—let's put

it that way. The evidence is in four key areas: chemotherapy-induced nausea and vomiting, spasticity, multiple sclerosis and epilepsy.

Senator SCARR: Can you just go through those? I'm very keen to hear that range. If you could just slow down a bit that would be helpful.

Ms Chemal: I'm sorry. So there's nerve pain—neuropathic pain; chemotherapy-induced nausea and vomiting; epilepsy—

Senator SCARR: Sorry, which sort of nausea induced—

Ms Chemal: Chemotherapy-induced nausea and vomiting.

Senator SCARR: Okay. The first one is neuropathic—

Ms Chemal: Neuropathic pain is nerve pain, and also epilepsy. In this category, we have a paediatric or child population. We have the golden standard of evidence in these four key areas, however—

Senator SCARR: I think you also mentioned multiple sclerosis.

Ms Chemal: Yes, spasticity caused by multiple sclerosis. In multiple sclerosis, your nerves are damaged, muscles are tense the whole time and you have spasms, and in this case medicinal cannabis can help with that. We have a registered medicine for that indication.

But what I'm trying to say is that, in these four therapeutic areas, we have the golden standard of evidence. However, when we look at the five-year prescription data in Australia, it's been prescribed in Australia for an astonishing number of 149 distinct indications. It is mind-blowing. It can cover a lot of the population of Australia with different conditions. The reason why it's prescribed for so many different indications is that medicinal cannabis has a lot of receptors around the human body, so it can act on a constellation of symptoms at the same time. It can help with anxiety, insomnia and pain in certain circumstance as well. I don't want to generalise, but usually it works on more than one symptom. It's not like your traditional medication like paracetamol, where it will work only as a pain reliever. With medicinal cannabis, we have to think a little bit broader than that.

Ms Nguyen: In Astrid's perspective, we've collated over time 20,000 patients, and we've seen a multitude of indications, like Cadrie's mentioned. We've seen that the majority of our patients are suffering from anxiety-related conditions, a lot of chronic pain conditions and insomnia as well. The reality is that all three of those conditions are overlapping. Most patients who have chronic pain also can't sleep or have anxiety as well. It is a medication that has helped lots of different indications, not just those ones, but those are the most common indications that we see in clinical practice.

Senator SCARR: My last question really goes to one of the nubs of the issues, from my perspective. If there's a pathway to prescribe medicinal cannabis where it's indicated under the supervision of medical practitioners and pharmacologists—you've indicated there are 20,000 people who you're assisting in that regard—then why do we need to look at broader law reform which would open the door, potentially, to more recreational drug use and the use of unregulated products, products that might be available on the black market through organised crime? Organised crime is involved in the tobacco industry, notwithstanding the fact that we have regulation of the tobacco industry. Why shouldn't we simply focus on, perhaps, making sure we undertake the relevant research to potentially expand the uses of medicinal cannabis where it's indicated and supported by research like the golden standard, which your Chief Operating Officer referred to, as opposed to opening the door to a broader legislative reform that could potentially lead to far more unregulated use?

Ms Nguyen: It's a really great question. To paint a picture of the reality of what's happening in the current cannabis market of Australia, we mentioned earlier that 55 per cent of our patients are medical patients. They are genuinely coming to Astrid because they've got cancer pains or they've got anxiety, and they've probably never used cannabis in their life ever. It's probably a third or fourth line of treatment because they've tried everything and nothing else worked. In that scenario, we have clinicians, nurses and pharmacists that can have really robust, clinical conversations with those patients to help them through their treatment journey.

The other 45 per cent of our patients are patients who are moving from the black market and are wanting to go to the legal market because we are a market that has quality standards of products. That's not to say that those patients who are coming from the black market are not using for medical purposes; they are. They've got pain and anxiety. They've probably gone to the black market because they were using it for some sort of condition that they couldn't access in the legal pathways. They've gone to the medical market in order to help them.

When my team of doctors, nurses and pharmacists are speaking to this 45 per cent, what's been happening at the moment is that it's creating a bottleneck in or strain on the medical system. What I mean by that is that, instead of having clinical conservations about dosing, titration and things like that, we're having conversations about the

girl scout cookie strain, where it's grown, what it tastes like, what the aroma is and what the lineage is. Those are non-medical conversations that are out of the clinical depth of our clinicians. That's not to take away from the importance of that, because I think the cannabis plant is ever changing. It's always changing, and it's a plant that has different variables all the time. These are the questions that we're getting on a daily basis. We're inundated and are having to upskill very quickly. We've now created two systems, or processes, to cater for both kinds of patients. One kind is very clinical, and one is talking about garlic mints, girl scout cookies and pink kush. They're talking about understanding the growing facility and that kind of thing.

What I'm trying to highlight here is that there is an importance to this because the third market that we're not really talking about here is the illicit market. We are trying to move people from the illicit market to a controlled adult use market where everything is controlled; there's a safety element here. There's a harm minimisation element here as well; it's regulated. We are educating even experienced cannabis users about the quality of products and how things are grown. That is also, in itself, very important.

Senator SCARR: When this inquiry was initiated, I saw that the *Los Angeles Times* in California had run a series of articles with respect to the role of organised crime in cannabis production in California. There are analogues with illegal tobacco in Australia. Because of the way the taxation system and regulation work in California, there's an opportunity for organised crime to simply produce at a lower cost, undercut the regulated market—the controlled market—and generate demand for their unregulated product through the price differential, thereby having an impact on those who are complying with all the regulation et cetera. Do you recognise there's still that risk—even if it's legalised and there is an attempt to regulate it—that there'll still be a black market. There'll still be potential for organised crime to leverage off a price differential that they can produce by simply not complying with regulation or paying taxes or duties?

Ms Nguyen: My opinion on this is that if we do create a national system for the adult use market, it will need to be very controlled. What that means is that if someone wants to access cannabis legally, they will have to go to a licensed facility and licensed suppliers. We've seen that in the medical market, where probably 45 per cent of our patients are from the black market. We're decreasing the size of the illicit market, and that means that we are reducing harm in society.

CHAIR: Senator Shoebridge, you have the call.

Senator SHOEBRIDGE: Thank you both for your attendance. You're the witnesses that probably have the greatest depth of experience in the current medicinal cannabis market. I think your evidence is really critical, so thanks so much for coming. Could I ask about those 45 per cent of patients who have, as I understand your evidence, come to you from the black market. Is that how you're identifying those patients?

Ms Nguyen: Yes. We call those patients 'cannabis experienced'. That means that oftentimes they're educating us at the same time. The data is so limited. I've been in the cannabis industry for seven years. I started, as an MSL, educating doctors, but I've learnt more from patients than I have from the data because they've had lots of years of experience. Just because they've come from the black market doesn't mean they haven't been using it for a medical purpose. They have been. There was just no other way to access.

Senator SHOEBRIDGE: So, many of them had been self-medicating for conditions in the black market?

Ms Nguyen: Correct.

Senator SHOEBRIDGE: You indicated some of the reasons they're approaching your services, one of which seemed to be assurance of quality, labelling and strength. Do you want to talk us through that? What do they see as the benefits of coming into your services?

Ms Chemal: They definitely notice the differences between the products available on the black market and the products available through the medical system. Cost wise, they say the medical system is almost on par with the black market right now. What is very interesting is that traditionally you would think that these patients would increase their THC dose and strength more and more, but it's actually not true. The products that they are prescribed right now actually have lower THC doses and strengths, even though higher THC doses are available on the market. Nobody is touching those. They are decreasing their doses because they have medical devices which are so efficient at extracting the cannabinoids that they don't need to use so much of the product. They have tiny doses of 0.1 grams compared to what's on the black market—one gram, two grams or something like that.

Smoking is out of the picture. We have patients with 20 years' experience in the black market. They say: 'How come I never knew about these devices? I can go and pick up my children now, and I don't smell of cannabis or anything like that.' They definitely see the advantage of a quality-controlled product. They are educated on how to decrease their doses. They are educated on how to manage potential side effects and interactions as well. Education is key.

Ms Nguyen: It's also consistency. If I've come from the black market, it's very rare that I'll get the same thing every time. There are probably different products from different people, and there's no supply chain in the black market. In the medical market, everything is controlled. Everything is GMP. Everything is the same label for the same product. If I get the pink kush strain this month, I can guarantee it's the exact same product next month.

Senator SHOEBRIDGE: From your evidence just then, that is leading to people having lower doses of cannabis because they know for certain what the strength will be, and they're not upsizing because of the unknown strength. Is that your experience?

Ms Nguyen: Correct; yes.

Senator SHOEBRIDGE: One of the benefits of labelling, consistent quality and a national regulator is that a significant portion of people transitioning from the illicit market to the legal market reduce their level of cannabis use, in your experience.

Ms Chemal: Yes.

Ms Nguyen: Yes.

Senator SHOEBRIDGE: I want to ask you then about what people are saying to you—maybe it's anecdotal, maybe otherwise—about the benefits, once they've experienced a well-regulated market. What are they telling you?

Ms Nguyen: Do you mean in terms of product quality or therapeutic outcome?

Senator SHOEBRIDGE: Therapeutic outcome and also their levels of assurance and comfort.

Ms Nguyen: I can talk about a lot of things with this, but a lot of patients who were coming from the illicit market couldn't tell their workplace or their family members. They were ashamed to tell their friends. There is a certainty and a validation aspect to going through an approved pathway, because you can tell your friends and colleagues, 'Actually, I'm on a legal cannabis product.'

Senator SHOEBRIDGE: Have you had anyone come to you with addiction issues from cannabis? Is that part of the pattern of the 20,000 that you see?

Ms Chemal: Not really; not here in the medical market, because there is constant education. There's an open-door policy, basically. If anything happens to them, they can call us. Transitioning this experience in an adult-use market, that indication is going to be key.

Ms Nguyen: I think it's education. Even if it is an adult-use market, we're still educators, if you're accessing.

Senator SHOEBRIDGE: We've had two witnesses today, one of which was the South Australian police commissioner, say that one of the reasons they oppose legalising cannabis was because they see cannabis leading to significant levels of violence. You've seen some 20,000 patients. Do you have any response to that evidence?

Ms Nguyen: My response is that cannabis has been shown to improve quality of life. If anything, it's been shown to reduce anxiety levels. The majority of our patients, as we've submitted in our evidence, are anxiety patients. That translates to how they behave in society, at home, with their friends and with colleagues. So, no.

Ms Chemal: I feel it's a very simplistic thing to just pinpoint cannabis and say it's a cause of violence. I feel what causes violence can be multifaceted. It can be socioeconomic status, culture or education level. It's way easier to point towards cannabis and control a drug in the legislation than to change socioeconomic status, education level and all the other factors that contribute to violence.

Senator SHOEBRIDGE: One of your recommendations for the bill is to put in place an advisory committee in addition to a national regulator. Can you talk us through why you recommend that?

Ms Nguyen: We have a lot of learnings from the medical market. One of the things we've noticed, and one of the challenges in the current market, is that there are a lot of regulators. There's a lot of regulatory arbitrage. We have the TGA; we've got the ODC; we've got Ahpra; we've got the state government. There is an inconsistency in messaging and, I guess, legislation. So what we'd like is one regulator for the medical market, which is the TGA, and one regulator for the adult-use market, which we can name something else. Within that, there'll be a committee that then talks to both regulators so that there is alignment.

Senator SHOEBRIDGE: That's partly from your current experience, where you're seeing some people who might use it for medical purposes but are also seeing combined medical and recreational use. You're seeing that crossover already, and that's why you recommend ensuring the two systems talk to each other. Is that right?

Ms Nguyen: Correct. Part of the reason we're here today is that it's causing a lot of strain on our nurses, our doctors and our pharmacists. The fact that we have to get a prescription and try to fit it into the prescription every single time—it's not possible. What I mean by that is, in the medical market, if you have a prescription for 25 per

cent THC, the plant changes and the label comes back at 26 per cent, we've got to call the doctor, ask them for a new prescription and issue the new prescription. That creates delays, frustration and administration that are unnecessary in this kind of market. Whereas, if there's a medical market and an adult-use market, it's much more streamlined.

Senator SHOEBRIDGE: So one of the benefits of creating a well-regulated, consistent recreational market would be that the skills and attention of your medically trained team can be fully directed towards all of those medical concerns and not distracted by some of those recreational discussions. Is that your evidence?

Ms Nguyen: Correct. We believe that they can coexist.

Senator SHOEBRIDGE: Can I ask you about cost and access, particularly with regard to GPs and prescriptions. That's one of the concerns that's often raised about the medicinal market. The price may have come down in the last few years, but one of the access issues is being able to see a GP—being able to afford a GP. I looked at your data; you've got coverage across the country. What are your patients telling you?

Ms Nguyen: The price for consultations has varied over time as the market has grown. It used to be over $200 for a consultation with a doctor, and now it's gone down to maybe $95 or something like that. A consultation with a nurse is a little bit more affordable as well. So the price has gone down. Similarly, with products—products were very expensive. It was around $600 to access medical cannabis products maybe six years ago. That's gone down significantly as well, to around $150 per product now. However, the number of products on the market has grown from, when I started in cannabis, three products. I was representing one of them. Now there are over 750 SKUs in the market, which means there have been price reductions in products and access.

Senator SHOEBRIDGE: Even with this very modest legal market, the medicinal market, you're now seeing some competitiveness in pricing between the black market and the legal market. That's your evidence, as I understand it.

Ms Nguyen: Correct. Yes.

Senator SHOEBRIDGE: Therefore do you think—and this may be unfair to ask of you—if you created a far deeper, well-regulated recreational market, that we would be likely to see that price competition continue and a further squeezing out of the black market?

Ms Nguyen: I think that it's quite on par with the black market. I don't think it would be squeezed anymore. The price is already on par, and it's about quality. If you could pay $100 for a black market product or $100 for a regulated product, you would choose the regulated product because of the quality, consistency and control. You can trust the person you're talking to every time you go to a dispensary. There is a relationship and there's authority there.

Senator SHOEBRIDGE: In your experience, that is an incredibly powerful motivator for people to move from the black market to the legal market?

Ms Nguyen: Yes.

Senator SHOEBRIDGE: And it's likely only to increase if there is well-regulated recreational cannabis. Is that your evidence?

Ms Nguyen: Yes.

Senator SHOEBRIDGE: Chair, I think you have some questions. Is that right?

CHAIR: Yes. Too many.

Senator SHOEBRIDGE: Okay. Could I ask you about a public health promotion campaign. That's also one of your recommendations. If parliament goes down this pathway and legislates, a public health campaign is essential. How much easier is it to do a public health campaign when you're talking about a known, regulated, certain product than to do a public health campaign talking about the unknowns in a black market?

Ms Chemal: I think you've nailed it—that's exactly right. As I've mentioned before, what the medical market has done is reduce the stigma. We've been in this medical market for a few years now, and major media outlets have picked up the stories about patients that are doing really well on medicinal cannabis et cetera. I feel that there's not an image problem anymore with cannabis. It's easier to talk, and we have the right terminology to conduct a really effective public health campaign. In comparison, talking about an unregulated, black-market product would be way more difficult, I would say.

Ms Nguyen: At the moment, one of the other challenges with the current market is that we're in a prescription medicine market, which means that you cannot advertise prescription medicine. How can you actually raise

awareness when you can't talk about it? If we were in a controlled-use, recreational market, we could do so in a way that can legitimise the use of cannabis.

Senator SHOEBRIDGE: Within well-understood public health parameters, so people know what they're taking and can monitor their dose and seek help if they need it.

Ms Nguyen: Yes.

Ms Chemal: Correct.

Senator SHOEBRIDGE: Yesterday I had the benefit of visiting Tasmanian Botanics, which is an incredibly professional outfit just north of Hobart. In terms of the attention to detail to ensure that the product is of a guaranteed standard, I've got to say that I found their testing and quality control quite impressive. There may well be other producers who have similar levels of quality control. When you're looking at product, do you see any difference between domestically produced products in the medicinal market and imported products, in terms of quality control?

Ms Nguyen: There is a difference. We don't import products, so I don't have as much experience in that. But part of what I do know is that the standard for Australian cultivation is extremely high—probably the highest in the world. What I mean by that is that it's GMP the whole way through.

Senator SHOEBRIDGE: Could you tell us what GMP is?

Ms Chemal: GMP stands for 'good manufacturing practice', which is a very stringent set of regulations for pharmaceuticals. When we talk pharmaceuticals, we talk only one molecule. When we talk cannabis, we talk hundreds of molecules, so to apply the same set of rules would be a little bit silly. It just doesn't fit. But, because those rules are in place, these suppliers have to abide by them, so they go to extreme measures to make sure—

Ms Nguyen: There are exceptional standards in Australia for growers and cultivators—

Ms Chemal: A hundred per cent, yes.

Ms Nguyen: versus importers, who can import a product in but it's not necessarily GMP, unless they put it through a GMP process when it gets to Australia.

Senator SHOEBRIDGE: And that's not necessarily required when it comes into Australia, is it? You can't test the process that happened before it came onshore?

Ms Nguyen: That's right.

Senator SHOEBRIDGE: So, in fact, we have a real opportunity here, don't we, for using that experience that Australia has for some of the best-quality product, and for creating a different but similarly high-quality recreational market, which will have far higher standards than an imported product?

Ms Nguyen: That's right, yes.

Senator SHOEBRIDGE: I think they're all my questions. Thanks, Chair.

CHAIR: Thank you, Senator Shoebridge. I just have a couple of questions—I will be really brief because I know we've got our next witnesses due to appear in a few minutes. My question is about your business. I know you've given us some information today, which we'll consider as a tabled document so it can be circulated to other committee members. But can you give us a bit of a background on your business?

Ms Nguyen: Sure. I started Astrid in 2020. In 2020, it was just an idea. In 2021, during the pandemic, I opened my first dispensary, or pharmacy, based in South Yarra, Melbourne. I started with just myself and a few pharmacists and I grew it in a year into about 15 staff members. In the second year, we opened our online dispensary. In the third year, which was last year, we launched Astrid Clinic, in collaboration with our Chief Medical Officer Dr Shu, and also launched our second dispensary, which is based in Byron Bay. Essentially, we are a team of doctors, pharmacists and nursing assistants who help patients with cannabis education and access all throughout Australia.

CHAIR: What would be the impact of the bill and the decriminalisation or regulation of cannabis on your business?

Ms Nguyen: I think our business is very interesting in that we are already seeing both markets within our business. We have 55 per cent medical patients, and our doctors are so passionate about seeing through the clinical governance required to help patients with their medical conditions. There'd be no disruption to the medical arm of the business, because, like I said before, I believe that both markets can co-exist. If there is an adult use market then there will be the ability to have licensed dispensaries. In the dispensary arm of our business, we upskill our pharmacists to learn about growing, cultivation, lineage and strains so that we can keep up with the conversations and have meaningful conversations with our patients, who are wanting to have those conversations.

So I don't think it will have much impact. What it will do is alleviate some of the administrative burden that's happening, from a prescription pharmacy clinic perspective. There's a lot of compliance in the medical market that we have to abide by, and that's causing a lot of frustration within our teams.

Ms Chemal: I foresee that some of the time, I suppose, it's going to be given back to the doctors and nurses to focus on the medical patients. You have to remember these medical patients are very complicated patients. They don't think of medicinal cannabis as a first line. They have failed God knows how many treatments. They have comorbidities, and there is polypharmacy. They're very complicated patients, and it takes a lot of time to go through their medical history and their pharmaceutical history. In that sense I see it as a positive because the doctors will have more time to have clinical conversations with these medical patients.

CHAIR: Do you expect to get more customers?

Ms Nguyen: From a medical perspective and an adult use perspective, I think that you're opening up more access. Yes, we can get more patients, medically and from an adult use perspective as well, but we are already seeing that currently. I think what it will do is eliminate some of the bottlenecks, which means that clinicians will have more time to see patients, which means that we can actually see more patients in the medical market. Similarly, from an adult use perspective, our dispensaries could have more time to learn more about cultivation, growing, lineage, strain types and that sort of thing, and then we'd have more time for education for the consumer market as well. So, yes, we could see more patients, but in a way where we can open up capacity to provide more education.

CHAIR: One of the recommendations that you made in your submission was to ensure that access to health and social services is improved to address any issues associated with cannabis use. What services are you referring to, and what do you mean by 'issues associated with cannabis use'? Could you to step that out for us. This bill doesn't have an allocation of funding for those sorts of services.

Ms Nguyen: I think that was a secondary or tertiary consideration that would have to be explored if this were to go ahead. What we mean by that is that we have lots of different types of patients. If someone is needing reimbursement for cannabis, whether it's recreational use or adult use, we would have to consider different funding mechanisms—things like Workplace Safety and TAC. What does that reimbursement look like in reality? For example, at the moment in the medical system there is some reimbursement through health insurance. What would that look like in an adult use market?

CHAIR: You referred to any issues associated with cannabis use. Are you talking about people who might have adverse effects or who might become addicted? Is that what you mean about 'access to health and social services'?

Ms Nguyen: No, we were more talking about reimbursement.

CHAIR: Understood. On notice, could you explain a bit more about what services you're referring to? That would be helpful. We'll have to leave it there. That's all the time we have today. Thank you for your evidence. If you've taken any questions on notice, we'll give you a date to return those to the committee.

Ms Nguyen: Thank you so much.

Ms Chemal: Thank you so much.

FARRELL, Dr Michael, Director, National Drug and Alcohol Research Centre, University of New South Wales

LALOR, Dr Erin, Chief Executive Officer, Alcohol and Drug Foundation

LENTON, Professor Simon, Director, National Drug Research Institute, Curtin University [by video link]

TAYLOR, Mr Robert, Manager, Policy and Engagement, Alcohol and Drug Foundation

[15:00]

CHAIR: I welcome witnesses from the National Drug and Alcohol Research Centre, the National Drug Research Institute and the Alcohol and Drug Foundation. Do any of you have any comments to make about the capacity in which you appear?

Prof. Lenton: I've been doing cannabis policy research for the last 30 years.

Dr Farrell: I've also been involved in a full range of policy and drugs research for the last 30 years.

CHAIR: Would any of you like to make a brief opening statement before we go to questions? We can start with you, Dr Farrell, if you like.

Dr Farrell: First of all, NDARC, the National Drug and Alcohol Research Centre, is a federally funded research centre that, as part of this process, was involved with the TGA in the development of the evidence and clinical guidance for the medicinal cannabis program. As a research centre we do not have a fixed position on the legalisation of cannabis. We are clear that our role is to look for, and present to government and interested bodies, an impartial a view as possible on the policy options. We favour a consideration in the context of balancing the harms arising from current illegal status, and the potential harms and benefits that might accrue from legalisation. We do our best to pull those together and make them available.

CHAIR: Professor Lenton, do you have a brief opening statement?

Prof. Lenton: Sure. Thanks for the opportunity. Like NDARC, NDRI receives funding from the Australian government Department of Health and Ageing through the drug program, and we also get financial support from Curtin University, and we receive money from research-granting bodies. Overall, we see the bill as well intended and consistent with the developing research evidence on the impact of cannabis legalisation schemes and expert advice regarding the potential public health benefits of middle-ground options, rather than fully commercial profit-driven models of cannabis legalisation.

We don't have a view about whether cannabis should be legalised, but we do have a view about what the shape of that model should look like if it were to be legalised, and we are very mindful of not repeating mistakes that have been made with alcohol and tobacco. We think there are a number of elements of this bill that fit with that view. Our major questions and concerns about the bill are about how it would operate with state and territory governments who in Australia have primary responsibility for matters related to possession, use and supply of drugs that are currently illicit and how the bill would interact with them and who'd be responsible for policing and on the ground, deciding whether a substance that someone had in their possession was consistent or inconsistent with the strain registration under this proposed bill. I'll leave it at that and wait for questions. Thank you.

CHAIR: Thank you very much. And Alcohol and Drug Foundation, Dr Lalor?

Dr Lalor: Thank you. The Alcohol and Drug Foundation is committed to evidence based policy that minimises harm via the three pillars of the National Drug Strategy. We know that currently cannabis is the most used illicit drug in Australia, with 41 per cent of Australians having used it in their lifetime and about 11 per cent having used it in the last 12 months. Most of them are accessing it by the illicit market where the product is more likely to be harmful, through either unknown potency or additives or where they increase the risk of contact with the criminal justice system, which can have long-term impacts on their quality of life. Regulatory approaches to any psychoactive substance sit along a continuum with prohibition at one end and an unregulated commercial market at the other. We know that harms are greatest at either end of that continuum. With prohibition, we're seeing harms from stigma and contact with the criminal justice system, whereas at the other end we see greater health harms in a commercially driven market.

What we are bringing to this conversation is the need to understand what regulatory approaches can be implemented that strike a balance between these two ends to minimise harms. As Simon has said, lessons from alcohol and tobacco control have demonstrated that creating safer environments through regulating availability, pricing and promotion can have profound impacts on public health outcomes and commercial determinants of health that are drivers of health outcomes and that are motivated by commercial rather than public health interests,

because for-profit entities will invariably seek growth and profit as key drivers without consideration of public health.

The example of the tobacco industry demonstrates how for-profit businesses can actively work against the public good, and it has taken decades of hard-fought regulation to contain the power of the tobacco industry in the developed world. We're seeing similar challenges in the alcohol and gambling spaces in Australia today. The ADF would therefore recommend that any regulatory model of cannabis be done with the role of commercial entities minimised, particularly at the point of retail sale. There has been a lot of discussion during the debate around this bill about the impact of legalisation on use. We've just completed an evidence review about the impacts of legalisation on use and harms which shows overall no increased use amongst adolescents in legalised jurisdictions. What's interesting is that the studies included in that review varied in their findings, similar to the diverse opinions that we've heard about this bill, but this diversity relates to the quality of the studies and also to the jurisdiction in which the data was gathered, which reflects the different impacts of regulatory frameworks on harm.

This brings us back to the need to be mindful of how the regulatory model will achieve a goal of harm minimisation. If the model of cannabis legalisation outlined in this bill was adopted, we would support certain specific regulatory factors being legislated rather than being devolved to the regulator. While allowing a regulatory body to make decisions allows it to be responsive to emerging trends and to use its expertise to ensure the public health effect of the legislation, legislation would serve as a more solid foundation. To this end, we would prefer legislation that contains a clear objective and that prioritises the minimisation of harm caused by cannabis in the community and potentially legislated restrictions on products, potencies and types more associated with harm. Thank you.

CHAIR: Thank you very much. We'll go to questions, and I'll hand the call to Senator Scarr, who is joining us online today.

Senator SCARR: Thank you Chair, and thank you to all the witnesses for all your work in this space and also for your submissions. One of the common themes in some of the jurisdictions that have gone down this path is the continued involvement of organised crime in relation to the marijuana/cannabis industry. In California, you've had a phenomenon of small, licensed growers who are complying with regulations being pushed out by organised crime. I just had a quick look at Royal Canada Mounted Police website, which says half of the national high-threat organised crime groups are involved in the illicit cannabis market in Canada. Obviously legalisation has not addressed the issue of organised crime, and various comments have been made about the for-profit industry, and we put organised crime in the for-profit industry, except it's unregulated and not complying with the law.

How do you address that phenomenon? How do you come up with a model that addresses that phenomenon? It's hard to find a successful model that's been introduced anywhere that addresses that issue of the involvement of organised crime leveraging off the fact that they don't have to comply with the licensing conditions. They just don't care. They're using unregulated labour and they're not paying sales tax, and therefore they can sell the product at a lower price. They might have higher potency product, for which there might be a demand. Again, that gives them product distinction. How do you combat those issues, also noting that Australia has a major issue with illicit tobacco and there's some pretty high-profile instances of warfare breaking out between organised crime syndicates in relation to market share?

Do any of the panel have any thoughts? I'd like to give each of you an opportunity to give feedback on that issue. Dr Farrell?

Dr Farrell: You've picked a very important question that there's a lot of contention around, which is the role of legalisation in reducing organised crime. There's a view among many people that the current establishment of organised crime will not be totally shifted by the legalisation process, and that has clearly been the case in the United States, but there are, for instance, some countries where they've talked about different models like cannabis clubs and that sort of stuff. There are other ways to potentially attempt to address it, but I don't think there's any good evidence that it will address it. I think Simon, or possibly Erin, might have stronger views on that than me.

Senator SCARR: I'll got to the National Drug Research Institute. Professor Lenton?

Prof. Lenton: It's a very important point, and the evidence that exists currently is consistent with what Michael and you have said, which is that the legalisation examples that we have currently haven't eliminated the black market. There are arguments about the extent to which it's been reduced, but, as you say, particularly in the North American examples where there's been rampant commercialisation with large numbers of outlets, we've seen organised crime getting into that system. There are outlets in America that look just like legal outlets, and to

every person who walks by they look the same, but actually they're run by organised crime who, as you say, don't pay the taxes and don't manage potency issues and so on.

It's clearly the case that in a largely unregulated or poorly regulated commercially driven market, it seems as though the opportunities for organised crime to find their way in and subvert that market are much greater than they would be in a much more restricted legal market where there are a limited number of outlets, a limited number of growers, very tight regulation, cannabis social clubs and so on that are very tightly regulated.

The issue about the attractiveness of legally regulated cannabis compared to what would be available on the illicit market is an important balancing act and it goes to issues like the relative price, quality and public education about the difference between legally regulated and unregulated markets. Those are all things which would need to be very carefully thought through and addressed in any well-functioning middle ground legal model that isn't dominated by profit-driven commercial interests.

Senator SCARR: Just before I go to the Alcohol and Drug Foundation, are there any examples, Professor Lenton, that have introduced a system which has had the success that, if this policy were introduced, I'm sure the mover of the bill would aspire to?

Prof. Lenton: Yes.

Senator SCARR: Are there any examples where organised crime has actually been addressed successfully?

Prof. Lenton: I think the answer to that is: not yet. One of the issues that we need to be aware of is that, for many of the consequences of these kinds of changes, the impacts are going to emerge over a decade or more. The evidence is accruing, but it's not there yet. In my view, there's been a lot of focus on those fully commercial models in North America. The Canadians tried to have a more public health oriented model, but it was subverted by international tobacco, alcohol and soft drink companies who got in there and did their thing. But, with some of the other models like the cannabis social clubs and the model that's about to be implemented in Germany in July, it's too early to say. So my take on it is that the evidence isn't really in on whether those models, as Michael Farrell has suggested, will minimise the impact of the black market.

Senator SCARR: Okay. I'll go to the Alcohol and Drug Foundation.

Dr Lalor: I think Simon and Michael have summarised the evidence really well. The only thing I would add is that Simon's point that we haven't yet seen evidence of legalisation addressing the black market is really important. We can see, in Canada, over the years since the regulation of recreational cannabis, a shift over time of more and more people accessing their cannabis via a legal market and fewer people accessing it via a black market. The model by which cannabis is regulated is incredibly important. If there are commercial drivers there, it will incentivise commercial or black market entities to be operating as commercial entities, as we've seen in the US. So again—

Senator SCARR: Notwithstanding that comment you made in relation to trends in Canada, the Royal Canadian Mounted Police's website, which I just visited during the course of listening to evidence today, was updated on 7 May 2024, and it actually states:

Half of the national high-threat organized crime groups are involved in the illicit cannabis market.

That's a horrifying comment. If we're trying to find a system where it's working and where organised crime is not involved, it seems to me that Canada's not the place to look. Can you understand how I'd come to that conclusion?

Dr Lalor: My response to that would be that I'm not sure what the proportion of cannabis cartels—for want of a better term—would've been before cannabis was introduced in a regulated market. We're looking at a single point in time. It could've been much worse. I don't know whether they have data that talks about what this looked like five years ago. I don't know, Simon or Michael, if you have any insights on what it looked like in terms of a market. We know that more and more Canadians are accessing the legal market for their cannabis.

Senator SCARR: Okay. I'm happy for you to all take this on notice and come back to me with any further information. After reading some of the stories in the *LA Times* and on National Public Radio in the United States with respect to the experience in California, one of the quotes that grabbed me in one of the stories was with respect to a fellow called Mr Noel Manners, who was one of the pioneers in having a small, licensed growing farm to produce marijuana. He talks about waking up one morning and finding men with bandanas and an assault rifle setting up on his land in rural California, and he just left the industry. That was it; it was all over, red rover.

So is it right to say, in terms of coming up with the model, that this is a real issue? There's an issue with respect to for-profit commercial enterprise, which is complying with the law, regulations and licensing, and I understand the concerns witnesses have with respect to that. But, at the same time, there's the organised crime element that also has to be considered, those who potentially leverage off the fact that they don't care about complying with the

law and actually seeking a price differential, particularly linked to sale taxes et cetera. Do you have any comment?

Dr Farrell: My understanding is that, if we look at the American market, people like Jonathan Caulkins and Beau Kilmer have done work on this that shows that there's been very strong competition between the medicinal market and the recreational market and that the biggest threat to the very longstanding producers has been the bigger commercial market, not primarily the illegal people. It's simply the scale of the business now. It's a corporate business, and so these small independent operators have not fared well in it.

Senator SCARR: Yes. Professor, do you want to—

Prof. Lenton: Yes. Again, I'll just make the point that there are differences between provinces in Canada and between states in the US. It's interesting to look at the example of Quebec, which has much tighter regulation and much tighter potency controls and product controls, so it's much more of a limited legalisation and not so commercially driven. My understanding is that on a number of variables, including this one, the early signs are that that model is actually faring very well in comparison to other provinces in Canada who have a more liberal system. Thank you.

Senator SCARR: This is my final question, and I'm keen to get a response from each of you. At this point in time—and all of the senators on this committee would see it every day in our work, as I'm sure all of you do—there's a chronic shortage of mental health services in this country. Young people cannot access mental health services on a timely basis. The same no doubt applies to rehabilitation—rehab—services. I have read about the experience in Portugal. When they started out on their journey, there were promises: 'We're going to increase government services to assist people who have become addicted and who suffer from disorder impacts of addiction.' But, at the end of the day, those services simply didn't eventuate. They didn't keep up with the demand. So if we go down this path and we as members sitting in the parliament need to consider this bill, given the evidence in relation to what cannabis use disorder can do to people, especially young people, how important is it that any policy such as this be linked to there also being an expansion of appropriate mental health services and rehabilitation services so that downsides can be addressed for people taking cannabis and suffering, in some cases, disastrous mental health outcomes? I will give each of you an opportunity to respond to that, and I'll go in the same order. Dr Farrell?

Dr Farrell: Thank you very much. First of all, in relation to the claim in part of the legalisation process that the tax revenue would actually finance health interventions, the experience to date has been that the tax yield has not been of a magnitude that can adequately support the development of these services. That might be different in different settings, but in general there is always the risk with governments, once they have revenue, that they have a lot of demands on where it may be expended, and they do not like hypothecated taxation. So the funding model has not really been demonstrated.

In terms of the actual level of exposure to cannabis and the mental health consequences of it, the current burden is already, we estimate, that about eight per cent of schizophrenia or psychosis is accounted for by cannabis consumption. That's according to a publication from the United Kingdom. As to the notion that we're going to see any major shift in that, there is a big debate about whether the potency of the cannabis being consumed, particularly the THC content, has an influence on that. It is possible to have some mechanism, if we had a highly regulated model, to keep the THC levels lower. Whether that would make a difference would be the thing. We have done a review of the role of medicinal cannabis from the point of view of mental health, and we're repeating that review a few years later. At the moment, the evidence for the benefits is pretty low.

Senator SCARR: Okay. Professor Lenton?

Prof. Lenton: Thanks. Firstly, I'd make the point that there's an obvious case for expanding resources for mental health services in Australia, irrespective of what happens with this bill and what happens with drug use. That's an absolute given, no question about that. Secondly, as Michael Farrell has alluded to, we know that some of the worst aspects of what's happened in North America has been that the price has fallen through the floor for legal cannabis, potency has gone up and the proportion of cannabis that's high potency—above 70 per cent THC, as opposed to 12 to 13 per cent THC—has grown as commercial entities try to make a profit and compete with each other to get the biggest share of the profit. That's clearly not a model you'd want from a mental health perspective and a public health perspective.

What we also know, however, is there is promise—and the evidence isn't really in yet, in terms of impact—from some of the middle ground options, such as cannabis social clubs or community oriented trusts et cetera, where some of the opportunities and some of the focus is about people who access their cannabis through those services actually being able to talk to someone about their cannabis use in a nonthreatening environment. The

experience in Europe, where cannabis social clubs have been operating, is that part of what happens is that people who are smoking a lot actually get asked about their use and there's an opportunity for them to talk to someone and to be referred to treatment. That's not something that happens in a criminally dominated, illicit market. There's no opportunity for health oriented contact with people that are buying cannabis from those markets.

I understand the concern. I think it's independent of what happens with cannabis under this or any other bill. But I do think the most promise for maximising opportunities for contact between people who are having trouble with cannabis and a healthcare provider is in those middle ground options, rather than what we've seen in the commercially driven markets in North America.

Senator SCARR: Okay, thank you very much. Lastly, the Alcohol and Drug Foundation?

Mr Taylor: I'll just be repeating largely what's already been said. Like we're saying, harm is not necessarily associated with all cannabis use. It's really associated with risky use. What we're getting at with a lot of what's being said is that we're looking for the way to minimise harm, under whatever regulatory approach we choose—and we already do choose a regulatory approach in Australia, which is a kind of mixed approach between prohibition, medicinal and some kind of decriminalisation in different places, and we also already have harm outcomes.

What we're thinking about is, what are the ways we can minimise the harm associated with use? We know that there are certain evidence based factors that we can regulate. We've spoken about potency. Also, under a commercial model or if there was a retail model, it's looking at things like advertising, outlet density, where and when products are sold and to whom. All of those things can be regulated and all of those can affect the level of harm experienced in the community, as a result of cannabis use. So, it's not necessarily the case that a change in regulation of cannabis is necessarily going to lead to an increase in harm. But, as the others have said, greater investment in mental health and AOD treatment is always going to be welcomed.

Senator SCARR: But, having said that, if you were talking to a young person—15 years old, say, who'd never taken cannabis and it wasn't medically indicated—you would do your best, wouldn't you, to try to talk them out of it and say that the risks are just too high, in terms of potential development of mental health issues and other issues. I know it's never going to be a perfect world, but the reason I ask this question is because there almost seems to be a perception in some quarters that those of us who ascribe to that view are denying young people a good time et cetera. But the medical evidence is quite clear that if a young person approached you and said, 'Do you think it's a good idea if I take cannabis before I go out on Friday night with my friends?' You would tell them, 'For goodness sake, don't do it. The risks are too high.' Is that a fair comment?

Mr Taylor: I think there's a very strong parallel with alcohol, except that where alcohol is a legal and regulated substance, and we can have conversations about that. The stigma of criminalisation often gets in the way of having evidence based discussions with young people about risk. That would be one potential benefit.

CHAIR: Senator Shoebridge, you have the call.

Senator SHOEBRIDGE: Dr Farrell, regarding your evidence about revenue, are you aware of what Statistics Canada says that Canada, as a whole, obtained in revenue from cannabis taxes and licences in the 2022-2023 financial year?

Dr Farrell: Yes.

Senator SHOEBRIDGE: You said that the revenue—

Dr Farrell: I was referring to work by Jonathan Caulkins and Beau Kilmer and that group in the United States.

Senator SHOEBRIDGE: Statistics Canada—the official statistics authority for Canada—is a pretty good resource. Do you agree?

Dr Farrell: Sure.

Senator SHOEBRIDGE: They say that in 2022-23 the revenue to provincial governments and to the federal government in Canada from legalised cannabis sales is Can$1.9 billion, which is in excess of A$2 billion. Were you aware of that when you gave your evidence?

Dr Farrell: I wasn't referring to the Canadian data, no.

Senator SHOEBRIDGE: That's pretty compelling data for significant government revenue from legalising cannabis, isn't it? You can do a lot of public health work with A$2 billion.

Dr Farrell: Possibly, yes.

Senator SHOEBRIDGE: Possibly? You can certainly do a lot of good work with A$2 billion. And it's a significant amount of revenue, isn't it?

Dr Farrell: Yes.

Senator SHOEBRIDGE: That evidence from Statistics Canada goes against the position you put on revenue, doesn't it? It's pretty compelling evidence that if you properly regulate a recreational cannabis market you can get quite significant revenue.

Dr Farrell: The only caveat to that is that it's pretty early days for how the markets are evolving.

Senator SHOEBRIDGE: Do you disagree with Dr Lalor's evidence that over time a greater proportion of the market is moving into the legal market in Canada. In fact, there's pretty compelling evidence of that, isn't there?

Dr Farrell: Yes. I think the tension has been between the income from the medicinal market and the income from the recreational market and how they've been influencing the overall income. That's my understanding. I have given evidence to the best of my knowledge. I am not an economist and I'm not asking you to add too much weight to what I've said.

Senator SHOEBRIDGE: So we shouldn't give too much weight to that evidence you gave there. And we should, perhaps, rely on the hard data that comes out of Statistics Canada instead.

Dr Farrell: I think we should rely on multiple jurisdictions on how to see it rather than—

Senator SHOEBRIDGE: If you want to talk about different jurisdictions, we can go down that path. Washington State got some US$200 million in 2015 and Colorado State $88 million in 2014. There's significant public revenue from a regulated, taxed, recreational cannabis market, isn't there?

Dr Farrell: If you wish to put words into my mouth. I don't know if you might like to ask—

Senator SHOEBRIDGE: I'm asking—

Dr Farrell: Professor Lenton.

Senator SHOEBRIDGE: You gave the evidence saying that there were inadequate revenue streams to deal with public health issues. I'm testing—

Dr Farrell: I answered the question.

Senator SHOEBRIDGE: I'm testing where that evidence came from, I'm putting some data points to you and I'm asking if you stand by your evidence.

Dr Farrell: I'm standing by what I quoted, which was work in the United States from two leading cannabis policy analysists—Jonathan Caulkins and Beau Kilmer from the RAND Corporation—and I don't think they have an axe to grind in how they're trying to understand the trends. That's what I presented—

Senator SHOEBRIDGE: From the RAND?

Dr Farrell: If you want to present other evidence, fine.

Senator SHOEBRIDGE: So you're relying on that study? That's your evidence base—that study?

Dr Farrell: It's not a single study; it's an aggregate.

Senator SHOEBRIDGE: You gave evidence that legalising recreational cannabis doesn't—I think the question asked of you was 'address the illegal market' and 'address organised crime'. Do you accept that, when you legalise cannabis and there's a significant transfer from people accessing cannabis in the illegal market to accessing cannabis in the legal market, every time that happens there's a reduction of money going into the illegal market—

Dr Farrell: Sure.

Senator SHOEBRIDGE: and a disempowering of organised crime?

Dr Farrell: I was asked the question by our other colleague about the impact of legalisation on the criminal market, and the answer I gave was that, to date, we have seen the persistence of the criminal market—and I rely particularly on an analysis from economists from the London School of Economics and Political Science. I don't think you can take the cannabis market alone. I think you've actually got to look at the illegal drugs markets, how they perform, how entrenched they are and the challenges we face in addressing them.

Senator SHOEBRIDGE: But surely you acknowledge the evidence out of multiple states in the United States and evidence out of the jurisdiction perhaps most similar to us on the globe, Canada, that legalising the recreational market has seen billions and billions of dollars taken from revenue in the black market—

Dr Farrell: I never said that it hadn't done that.

Senator SHOEBRIDGE: That's a benefit, isn't it?

Dr Farrell: Sure.

Senator SHOEBRIDGE: In fact, it's a very significant benefit. Taking billions of dollars away from organised crime is a public policy win, isn't it?

Dr Farrell: Possibly.

Senator SHOEBRIDGE: You say 'possibly'. Are there circumstances where taking billions of dollars away from organised crime is not a public policy win?

Dr Farrell: It depends on how the organised crime diversifies its response to that change.

Senator SHOEBRIDGE: If we take them out of the cannabis market and they cease to make billions and billions of dollars from the cannabis market, that's a good thing; isn't it? It's unambiguously a good thing.

Dr Farrell: We would hope so.

Senator SHOEBRIDGE: Well, it just is. I don't know why you're cavilling with me on this. It just is, isn't it? Taking billions of dollars—

Dr Farrell: Well, you're—

Senator SHOEBRIDGE: Let me finish the question.

CHAIR: Senator Shoebridge.

Senator SHOEBRIDGE: Taking billion dollars from organised crime is just a good thing, isn't it? Can't we agree on that?

Dr Farrell: You wish for me to put the things I say into categories where I'm happy to be more nuanced in what I say.

Senator SHOEBRIDGE: Okay. Perhaps I might ask Professor Lenton and then either Dr Lalor or Mr Taylor. The evidence from Canada—let's lean into that jurisdiction—shows that different models in different provinces produce different outcomes in terms of the proportion of the market moving into the legal market and the proportion remaining in the black market. Dr Lalor, you have a very useful graph in your submission, which shows those kinds of tensions between public policy outcomes, taxing levels, restrictions on use and the proportion of the market that's in or out of the black market. Can you talk us through those tensions and how best a parliament should pitch a legalising model to deal with those two tensions? I'll go to you first, Professor Lenton.

Prof. Lenton: The general idea is that there's a U-shaped curve between legal availability and harm. So, at high levels of legal availability—let's take alcohol and tobacco, which are highly legally available—we have high levels of harm due to high rates of use, commercialisation, low cost and so on. Then, as you go down to the other side of the curve, at low levels of legal availability—so think of what are sometimes called the harder illicit drugs—we have high levels of harm due to problems to do with the black market, lack of purity in known product, overdoses, contamination, organised crime involvement and so on. Then, at the bottom of the curve, somewhere in the middle, in that theoretical model which I and others have written on a lot, there's a potential for the lowest level of harm. The tension and the question, really, become: 'Where should we put different drugs in terms of that U-shaped curve?' and, yes, I would argue that there is greater net harm in a criminalised model than in one that is more towards the middle of that curve. I think that those options at the middle of that curve are the middle-ground options that we've talked about in many places—options where there is a limited number of suppliers, no promotion, restrictions on use, restrictions on the number of products, low THC limits and so on. As I said in my opening statement, there are a number of elements in your bill that tick a lot of those boxes, and I think that's to be noted.

Senator SHOEBRIDGE: Either Dr Lalor or Mr Taylor?

Mr Taylor: Obviously, Simon knows this back to front and has said it all very well. I'd just add to the other end of the scale, to talk about commercialisation a little bit and some of the particular risks associated with that. Alcohol is the key similar product we look to, in terms of being a harmful product in the community that can cause harm through its use—and we see that through commercialisation. There are really well established, evidence based factors that are associated with greater harm in alcohol regulation in the community. We know that greater advertising, lower prices, increased trading hours of outlet stores and higher retail density for takeaway stores are all associated with increased harm for alcohol in the community. Those are the kinds of things we'd looking at within any regulated model to try and minimise, whether that's minimising commercial interests through having an entirely socialised model, like Simon is describing, in a not-for-profit or social club model, or a model that otherwise tries to minimise commercial factors by keeping out large industry players or

whatever it is. It is important, we think, to try and establish those things very clearly from the outset, and, as my colleague mentioned in the beginning, potentially in the legislation, to try and avoid industry taking hold and then having to try and claw back through regulation, which, we know, can be quite difficult.

Senator SHOEBRIDGE: One of the things that your submission suggests, Mr Taylor, is adding a very clear goal of minimising harm to the objective of any regulator.

Mr Taylor: Yes.

Senator SHOEBRIDGE: I assume, Professor Lenton, you'd support that as well?

Prof. Lenton: Sure.

Senator SHOEBRIDGE: I would say this, because my office drafted the bill. The bill tried to deal with those tensions in different ways: by limiting the scope for for-profit corporations—not removing it entirely, but limiting it—but also by prohibiting the existing alcohol, tobacco and pharmaceutical industries from getting access to the market. I might ask you about that second measure first. First of all, do you think that is a good social policy goal? Secondly, do you think it can work?

Dr Lalor: Do you think what is, sorry?

Senator SHOEBRIDGE: Prohibiting the alcohol, tobacco and pharmaceutical industries—I think with the exception of solely medicinal cannabis players—from getting access to a recreational market. Do you see a use in that from a public policy point of view?

Dr Lalor: Yes, absolutely. As we've pointed out in our opening statement and in some of the comments that Robert and other colleagues here have made, any model that minimises the ability for commercial interests to be at play in this is the best model and most likely to deliver lower harms, particularly at the point of retail sale. The bill describes cannabis cafes but devolves a lot of the regulatory decisions around how they operate to the regulator.

When we look, as Rob said, to the alcohol space, we can see very large outlets frequently put into communities that are most disadvantaged. Being able to manage the risks of that as an outcome of any model of regulation of cannabis would be important.

Senator SHOEBRIDGE: Professor Lenton, jumping off that, would there be benefit in putting additional measures in place or additional statutory considerations—such as density of outlets, socioeconomic harm—when the regulator is considering issuing a licence for a dispensary? Is that one way? Or are there other methods of doing it?

Prof. Lenton: If this model was implemented, I think that would be imperative. We've seen in the emerging data in the US and Canada a theme that with commercialisation and number of outlets and so on—this higher density of outlets—just like with alcohol, we see greater levels of harm, and Robert made that point. We've already seen that in the cannabis emerging data. In terms of keeping out the profit-driven international experts—and alcohol, tobacco and pharmaceuticals are also in that group, and so are soft drink manufacturers—we've seen that in the US as well. So I think you'd need to be careful about that.

The other thing I would say is that the designers of the Canadian system had a very public health oriented goal. They thought they'd got it right and they got undermined by international players and very quickly it unravelled. I think the intention is absolutely good. I think it's incredibly imperative that we try and do it, but I also think it's not as easy as we'd like it to be. The only other thing I'd say, just on point of sale, is that we've also seen in the US that a lot of the penalties are actually applied to staff that work in those cafes and so on. University students working part-time lose their job, but the guy who owns the store, who makes the profit from it, can keep his licence going. There's a lot of nuance in terms of the way the regulations are applied for point of sale that we want to learn from. Thank you.

Senator SHOEBRIDGE: One of the ways the bill seeks to do that is to seek to direct the penalties towards licence holders rather than staff, but perhaps that could be strengthened in the bill to ensure that's where the regulatory attention is focused. When we're talking about what the ideal regulatory model is, some of the evidence we saw in our consultation process was to allow for a nimble, proactive regulator and to therefore not be too prescriptive in the model you set because the Canadian experience shows you can have quite substantial changes in the nature of the market, even in the short period we've seen in Canada. The bill tries to get that balance right by allowing a significant role for regulatory action, hopefully guided by a public interest regulator. As I understand particularly your evidence, Dr Lalor, but also yours, Professor Lenton, you think there should be more prescription early in the legislative model. Can you just take me through those elements where— I know you

mentioned the objectives, the types and quantities of cannabis for sale, but are there other areas where you think more prescription is needed at the outset?

Mr Taylor: Yes—

Senator SHOEBRIDGE: Or less, if you think?

Mr Taylor: I can give a couple of examples. The New South Wales liquor regulator has recently halved the community consultation for particular licence types. These are the kinds of processes that can take place when it's all sitting within regulation. Community consultation is a big thing. If an outlet is going to be in a community, I think having a well-established and generous community consultation period in legislation would be useful. It would be really useful to have in legislation cumulative impact assessments that look at the cumulative impact of new outlets within geographic areas and consider the needs of those communities and any particular needs of those particular communities.

Senator SHOEBRIDGE: Just stopping you there: cumulative impact statements is one of the ways to address the density concerns Professor Lenton raised. It might be a more elegant way of doing that, requiring a cumulative impact assessment.

Mr Taylor: Yes, and ideally under a cumulative impact assessment you will name those factors—our density, impact on particular groups and so on—within the legislation so that it's really clear and so that's not watered down at some potential, hypothetical point sometime down the track.

Senator SHOEBRIDGE: Professor Lenton, hearing that, I note that one of the issues when you're creating a legal market from an already very widespread illegal market is that there needs to be sufficient access to a legal market to actually replace, so far as possible, an illegal market. How would a regulator deal with those tensions—ensuring there's adequate supply—and also address some of those issues about cumulative impact and harm? Again, is that just that U-shaped curve where you see the best fit?

Prof. Lenton: First of all, I don't think we know, because we're sort of imagining. So let me just make a couple of comments with that as the precursor.

In my view, we should recognise that the undermining of the illegal market is something that is a longer-term gain and that the evidence so far suggests that it's incrementally being undermined in those jurisdictions that have some form of legal cannabis availability. So I think it's important that we temper our expectations about the models, capacity and timing on that. What is much more of a concern is actually the other end, the end that Robert talked about. What we want to make sure we do is to keep commercial drivers out of the system right from the start. It's actually much safer from a public health and regulatory viewpoint, in my view, to start with a very constrained model and then, as that is bedded down and settles in and we learn what the intended and unintended impacts are, think about expanding it: for example, a limited number of outlets; a limited number of suppliers; a limited number of products and, in fact, probably very low-potency products rather than the high-potency products, up to 80 per cent, that we've seen in the commercial markets—those kinds of elements. We know from alcohol and tobacco how hard it is to roll an industry back once it's been established. In my view, we should go cautiously first and then evaluate and carefully make decisions about expanding.

CHAIR: Senator Shoebridge, do you have many more questions? I'll probably have more than five minutes worth of questions.

Senator SHOEBRIDGE: I could probably put some other questions on notice, because I note the time: it's 3.52. I'm happy to hand over to you, Chair.

CHAIR: Thank you. They might touch on some of your issues as well. My questions are particularly for the Alcohol and Drug Foundation, but I'm happy for others to add to those answers. It was just some questions to clarify some terms, because I'm not really familiar with all of the things in your submission. One of the terms in your submission is 'commercial determinants of health'. I'm just wondering if you can tell us a bit about what that means.

Mr Taylor: Sure. Commercial determinants of health is an emerging field of study that's based on previously understood social determinants of health—so sociodemographic features that could influence someone's health outcomes or a community's health outcomes. Commercial determinants of health is looking at the way in which commercial factors—the operation of commercial entities and their actions in the community, in the environment and in the regulatory space—can affect public health and individual and community health.

CHAIR: Okay. You refer to this as being an emerging field of study, and we're learning more about it. We've seen internationally that, when cannabis has been legalised, there has been a commercialisation of cannabis. Do

you know about, and can you speak to, some of the impacts of commercialisation internationally, if there have been some?

Mr Taylor: Yes, I can. I'm sure others could too. To take the US states where we see particularly high commercialisation, we do tend to see higher harm outcomes in terms of health—physical health, road harms and so on—as a result of legalisation. The data is still emerging. The evidence probably isn't conclusive at this stage. Simon might be able to talk to it with more accuracy. But that's generally the correlation that we see: the higher the level of commercialisation, the higher the level of harm. We see that with alcohol as well. It's consistent.

Dr Lalor: I'll add to that. One of the drivers of commercial determinants of health is that the outcome that is being sought is a commercial outcome and not a health outcome. The system is incentivised to sell more product—and it is a harmful product. Simon talked about increased potency, lower cost and expanded products et cetera all trying to increase their share of the market. We see the same thing playing out in the alcohol and vaping spaces. They're all also examples of commercial determinants of health at play.

CHAIR: That's why you've all spoken to the regulation that would be required to support legalisation to manage that commercialisation.

Dr Lalor: And the preference for a model to minimise the role of commercial interests.

CHAIR: Yes, understood. Simon?

Prof. Lenton: I have two very quick additional comments. 'Commercial determinants of health' is a newly coined term, but the understandings behind it are well known. It's a newly described term, but we've always known about the impact of commercialisation on health.

The other thing we've seen is that, within the cannabis industry, there are examples of commercial cannabis players looking for ways to subvert the regulatory demands on them, just as the tobacco industry did—so, recognising that the top 80 per cent of people who smoke, the most dependent and heaviest smokers, is where their market share is. They target regular, heavy users because that's where the money is. Those are the same elements that we saw with tobacco companies.

CHAIR: Thanks for adding that. We already have medical cannabis in Australia. To some degree people have access to it. This might not be the case, but are we seeing any hallmarks of commercialisation in the medical cannabis industry here in Australia? What does that look like? I know we've been talking a lot about the international experience, but we have a version of it here. Can anyone talk to that?

Dr Farrell: I'm happy to talk to it briefly. You heard very clear evidence before us about some of those issues and the expansion of that market. The question may be about what the need is and how well the need is being met. There's a lot of critique that, in terms of the need, the model, as it currently exists, does not meet the breadth of the need. The recent previous witness's report of the diversification of the range of products is an example where you would see the regulatory system not seeming to work at the level we would like it to work, where we would have more clearly defined products available rather than 700 different types of products. I'm not clear about the economics and scale of the market, but clearly there is a profit driven element within components of it. Clearly, it is also important to say that it has filled an important gap.

In terms of talking to the future, how we find the balance between a regulated market and a medical market might be one of the benefits of the process of legalisation that would get a better definition. At the moment there's a clear view—but I can't give you firm evidence on it—that it is, effectively, operating as a recreational supply system for some parts of the population.

CHAIR: Does anyone else want to talk to that?

Prof. Lenton: My understanding, as a clinical psychologist in private practice, as well as from doing research in this space, is that, particularly early on, there were many examples of medical cannabis being available in a way that the scheme didn't intend it to be. There were a number of companies where the regulator had to either exercise its regulatory authority onto a movement from the market or at least cut down their practices. My understanding is that we've seen a rapid expansion; the data's there. I think you've already heard it from the Commonwealth Department of Health and Aged Care. My understanding is that they're putting a lot of effort into trying to tighten those regulations up.

It's not my area of expertise, but my take on it is that what it looks like from the outside is that there have been challenges in controlling the commercial elements, even within the medical market as it exists. But others are probably more qualified to comment on that from a regulatory perspective.

CHAIR: I'll ask other witnesses to take that on notice. I have a couple of other questions I might give to you on notice as well. Unfortunately, we've run out of time. The committee has agreed that the answers to questions

on notice should be returned by close of business on 23 May 2024. I think that gives us a decent amount of time. I thank all the witnesses who have given evidence to the committee today. I also thank Broadcasting and the secretariat. That concludes today's hearing.

Committee adjourned at 16:01