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committed to preventing tragedy that arises from illicit drug use

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Submission of Families and Friends for Drug Law Reform to
the Social Development Committee of the Queensland
Parliament charged with investigating and reporting on
Cannabis: suicide, schizophrenia and other ill-effects
research paper published by Drug Free Australia

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I. INTRODUCTION

1. Families and Friends for Drug Law Reform greatly appreciates the Committee's invitation conveyed in the letter of its chair, Ms Lindy Nelson-Carr MP dated 11 March to make a submission to the inquiry of the Social Development Committee "to investigate and report on the Cannabis: suicide, schizophrenia and other ill-effects research paper published by Drug Free Australia Ltd". Your letter informs me that the committee will consider:

- "The risks associated with cannabis use, particularly for young people; and
- "Strategies to reduce the level of cannabis use in Queensland." 21/04/10

2. Families and Friends for Drug Law Reform was formed in April 1995 around a group of people in the Australian Capital Territory who had a child, relative or friend who had died from a drug overdose. Its membership now extends across Australia. The grief that all shared turned to frustration and anger that those lives should not have been lost when all would be alive today if drug use and addiction had been treated as a social and medical problem and not a law and order one. The criminal law and how it was enforced contributed to the death of these young Australians.

3. Since then the group has been intent on reducing the tragedy from illicit drugs, reducing marginalisation and shame, raising awareness of the issues surrounding illicit drugs and encouraging the search for and adoption of better drug policies. The increasingly evident links between mental health and substance abuse has led it to make submissions that deal with mental health as well as substance abuse (e.g. FFDLR 2003 & FFDLR 2002).

4. Families and Friends for Drug Law Reform does not promote the view that currently illicit drugs should be freely available. Indeed it believes that they are too available now in spite of their illegality. Their distribution is in the hands of organised crime deriving wealth from them that can corrupt or influence all levels of society and government. Illicit drugs are an industry beyond the capacity of democratic governments to control. As this submission will go into, experience points to reliance on the criminal law to control their availability being ineffective and, in fact, counterproductive yet intensified reliance upon the processes of the criminal law is at the heart of what Drug Free Australia is calling the Committee to endorse.

5. At the outset Families and Friends for Drug Law Reform expresses its regret that the Committee is using Drug Free Australia's paper as the basis for its inquiry. This is for two reasons. In the first place, the paper does not reflect a comprehensive and accurate statement of the outcome of research on cannabis and, in the second place, the paper does not consider the substantial evidence that exists that the coercive measures recommended in the Drug Free Australia paper to combat use of cannabis will in fact bring about serious ill-effects that will magnify those of cannabis itself while at the same time do little if anything to reduce cannabis use.

6. Families and Friends for Drug Law Reform believes that the starting point of the Committee's inquiry should be formulation of the values that should guide the

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committee's deliberations in this important reference. We urge the committee to take to itself two principles:

- That the overriding objective should be to safeguard life and promote the physical and mental well-being and social functionality of all; and
- That in seeking to forward this objective they should be guided by the best available evidence of what promotes well-being .

7. In other words, Families and Friends for Drug Law Reform believes that the Committee should not make being drug free and overcoming addiction the overriding objective. Being drug free and overcoming addiction is what so many families dearly wish for their children or other family members but they do not wish this to be achieved at the expense of the life and well-being of their member. The choices are clear for them:

- if the choice is between being drug free and death, families will, when being drug free is not possible, choose life;
- if the choice is between regaining stability in life but still using drugs in place of continuing chaos, families will choose stability.

8. Judging what will save life and promote well-being is where being guided by the best available evidence comes in. Openness to truth is the moral principle that underlies the statement that drug policy should be based on the best available evidence. It is a principle to which all governments in this country, as reflected in their adherence to the current framework of the National Drug Strategy, have committed themselves. That framework commits governments to “promote evidence-informed practice”:

“Wherever possible, all supply-reduction, demand-reduction and harm-reduction strategies should reflect practices that are informed by evidence derived from rigorous research, critical evaluation, (including assessment of the cost effectiveness of interventions) [and] practitioner expertise” (Australian Government (2004) p. 11)

9. The Queensland Government reflects this principle in its own drug strategy which identifies “evidence-based approaches” as a principle upon which its drug strategy is based.(p. 7). What, therefore, families are entitled to expect of this Committee can be expressed succinctly. The Committee's work and recommendations should promote policy that safeguards the life and the physical and mental well-being and social functionality of family members by means of measures informed by the best available evidence. What is crucial is the integration of best available evidence with the value that guides its application. It alarms us that there appears to be a non-connect at this fundamental level in Drug Free Australia's paper. It is assembled an impressive body of evidence but it is all of a sort: the dangers of cannabis use.

Credible evidence to that effect should of course be considered but so should evidence about the impact on consumers and the community of the measures that Drug Free Australia recommends. Those measures are of a type – intensification of coercive measures with the object of eliminating supply of cannabis and forcing those caught using it to give up doing so. In short, Drug Free Australia's underpinning value is drug freeness and this outlook forms the blinkers that it uses to select evidence and

recommend measures. Drug Free Australia adopts what Professor Margaret Hamilton terms a “single-factor explanation of harmful drug use” (Hamilton 2007 p. 181). They argue for a cannabis prevention campaign that has been shown to fail and for which there is little or no evidence of success or strong rationale of promise (*ibid.*, p. 180).

“Drug-prevention programs can have unintended as well as (or instead of) intended consequences. For example, saturation policing in a specific area is often successful, at least in the short term, in removing visible, illicit drug trading and use from the area. However, it often merely displaces the activity to another locality, sometimes making the surveillance and opportunities for important harm reduction strategies more difficult. . . . Overall the net effect might be negative for all concerned.

“This shows why prevention interventions must be based on careful assessment, previous evaluation research about what is promising, and anticipation of possible unintended outcomes, as well as measuring intended outcomes. This requires quite specific consideration of aims and objectives through careful determination of targets” (Hamilton 2007 p. 167).

10. The absence of assessment and evaluation of all likely outcomes – intended and unintended – is the stand out characteristic of the Drug Free Australia’s paper. As such it is contrary to the Queensland Government’s own current drug strategy with its commitment to the principle of harm minimisation which underpins the national strategy:

“Australia’s harm minimisation approach focuses on both licit and illicit drugs and includes preventing anticipated harm and reducing actual harm. Harm minimisation is consistent with a comprehensive approach, involving a balance between supply reduction, demand reduction, and harm reduction strategies” (Queensland Government 2006 p. 7).

11. The Committee will do a great service if it insists that drug policy throughout Queensland reflects these principles because present drug policy does so only in part and families have suffered accordingly. In some respects it is muddled: lacking a clear focus on what it should achieve. In others it has the best of intentions: it seeks to safeguard life and promote well-being but is tragically misinformed on how those objectives can be achieved or government does not accord programs the resources needed to do so. In yet other respects it seeks to do what is wrong: it unashamedly seeks to sacrifice the life and well-being of Australians in pursuit of a supreme objective of making this state drug free. In Professor Hamilton’s words:

“cannabis is now well established in Australia. It is easy to grow and the steps between the raw plant product and consumption do not require sophisticated laboratories or refinement. It is therefore not sensible to direct significant prevention attention to the eradication of cannabis. Even those who think this might be desirable do not believe it is feasible” (Hamilton 2007 p. 171)

II. CANNABIS DEPENDENCE AND LIFETIME USAGE PATTERNS

12. For many years it was doubted that people would become dependent upon cannabis. It is now recognised that, as with other psychoactive drugs, dependency does occur in terms of widely used criteria of mental disorders. American writers report that

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“Two fairly large longitudinal studies offer estimations concerning those who have used one or more times in the previous year. Grant & Pickering (1998) found that 6% qualified for a diagnosis of cannabis dependence and 23% qualified for a diagnosis of abuse. Another study, focusing on self-report of problems attributed to cannabis by respondents found that 85% reported no problems, 15% reported one, 8% reported at least two and 4% reported at least three (National Institute on Drug Abuse, 1991). When current users (i.e. used at least once in the prior month) are considered, roughly 11-16% (1.6-2.3 million individuals) qualify for the diagnosis of cannabis dependence. In summary, the risk for the occurrence of three or more problems (a proxy indicator for dependence) among those who have used at least once in the past year appears to be roughly 4-6%, and 11-16% for those who have used at least once in the past month” (Roffman *et al.* 2006 p. 16). The same writers refer to the following rule of thumb for the risk of cannabis dependence put forward by Hall & Pacula:

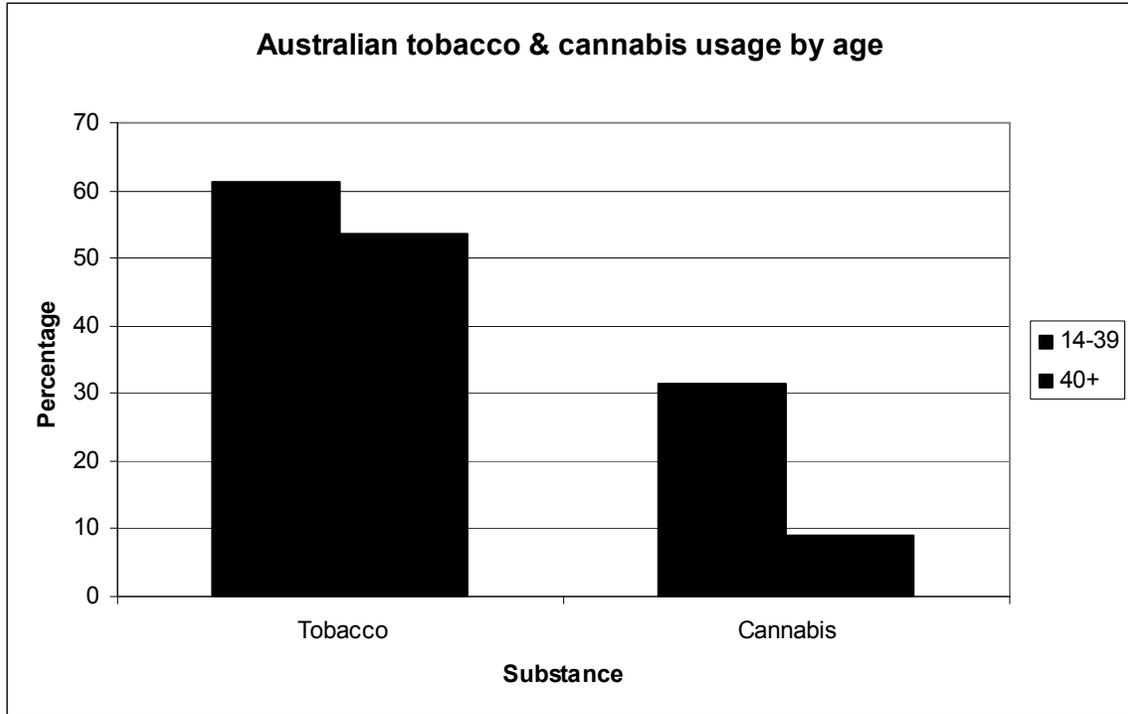
“1 in 10 for those who have ever used cannabis, between 1 and 5 and 1 and 3 of those who have used the drug more than a few times, and between 1 and 2 for daily users (Hall & Pacula, 2003)” (Roffman *et al.* 2006 p. 17).

13. Compared to other drugs cannabis is not highly addictive. Anthony and others have identified the following relative risk levels of dependence:

“tobacco (31.9%), heroin (23.1%), cocaine (16.7%), alcohol (15.4%), stimulants (11.2%) and cannabis (9.1%)” (Roffman *et al.* 2006 p. 17).

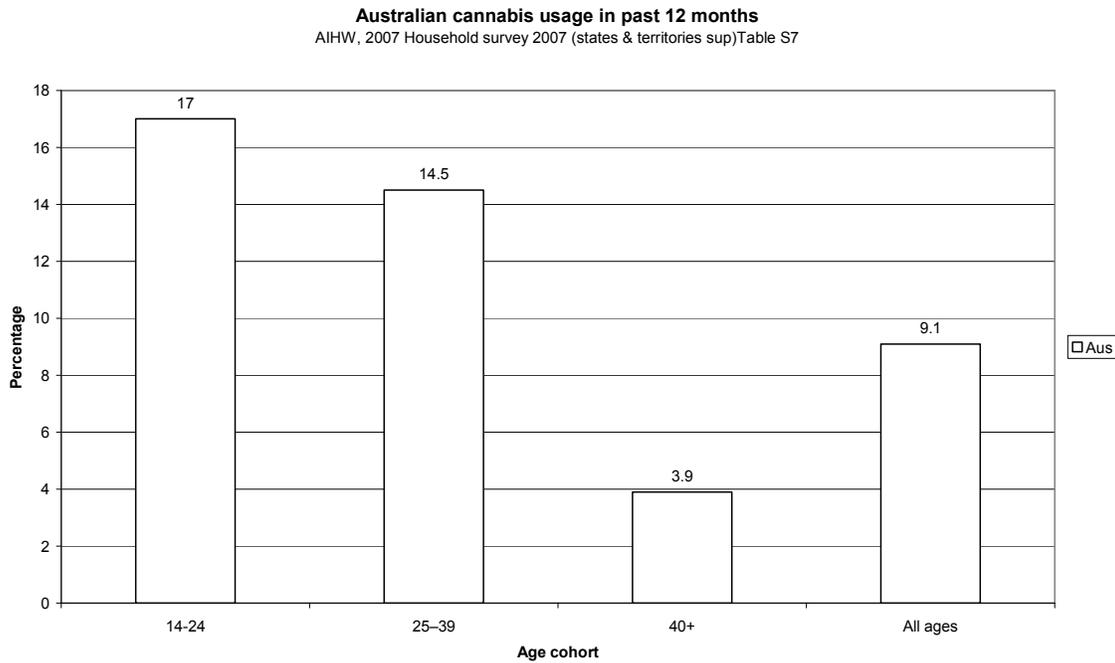
14. A characteristic of cannabis of particular relevance to the committee is the tendency of users of it to quit as they grow older. Indeed age is described as “the most striking socio demographic characteristic associated with the occurrence of first-time cannabis use” (p. 76). This age related correlation is illustrated by the Australian Household survey. One can make a rough comparison between the age profile of cannabis users and smokers of tobacco. This reveals that the highest usage of cannabis is in the 14-24 age cohort (17%). This declines sharply to 3.9% of those over 40. Fairly much the reverse happens with tobacco. The cohort over 40 is by far the biggest user 43.1%. This age related pattern of cannabis usage has been termed “maturing out”. The committee would be well advised to seek further, more accurate information of this phenomenon. There is little point in taking expensive and harmful measures against a large proportion of Queensland youth to prevent use of a drug that they will cease using as they mature. The message, we suggest, that the Committee should draw from this is development of further measures to discourage young people from taking up the drug, a trend which the Household Surveys shows is indeed happening.

Figure 1: Australian usage within past 12 months of cannabis and tobacco by age cohort



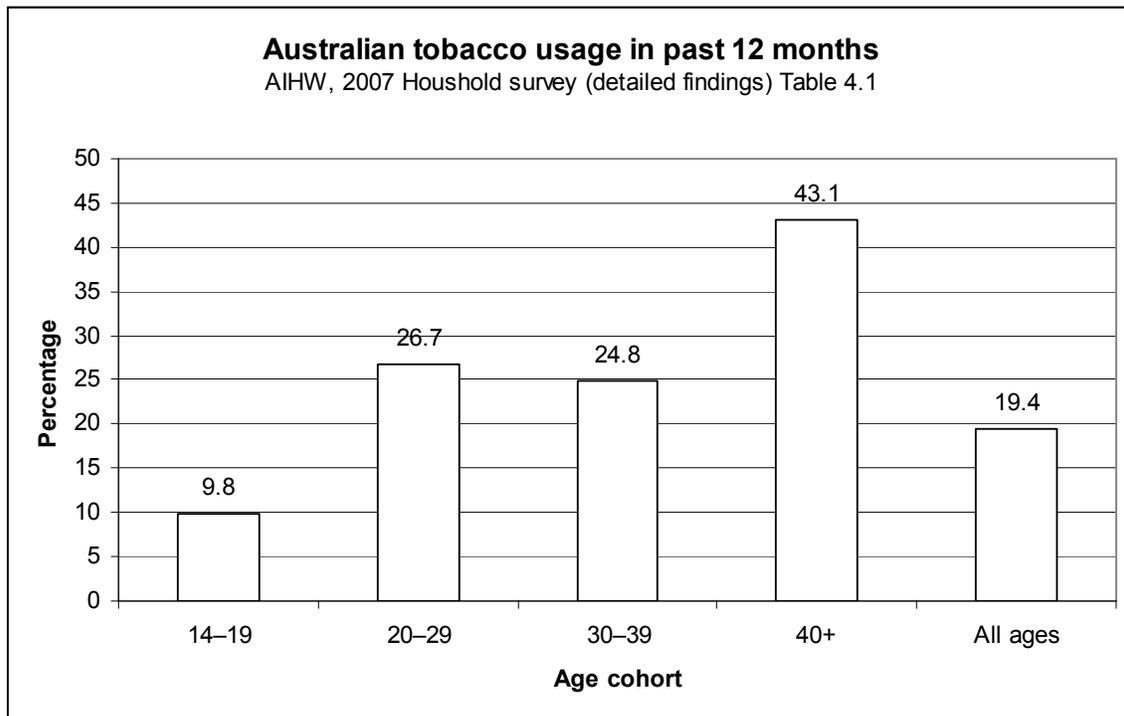
Source: AIHW, 2007 Household survey (detailed findings) Table 4.1 & AIHW, 2007 Household survey (states & territories) table: S7 p. 9

Figure 2: Australian cannabis usage by age cohort in past 12 months



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Figure 3: Australian tobacco usage by age cohort in past 12 months



III. CANNABIS MARKET IN QUEENSLAND

15. Drug Free Australia recommends an intensification of coercive measures to stamp out cannabis use. In particular, it calls for “blitzes every three months for a two year period”. The purpose of this should be to “target users and potential users; it should deal with plantation and hydroponically grown cannabis, trafficking, financing, and/or selling drugs to children.” What is more, further rolling series of campaigns after this should be financed from “the Proceeds of Crime funds” (rec. 4, p. 26). The current approach with all its costs has not been assessed for its cost effectiveness. This should be done, for the market indicators seem to show that law enforcement has not been reducing the supply of cannabis. Is this increased effort likely to be effective in reducing cannabis supply bearing in mind that, judging by the number of arrests, Queensland already puts in more law enforcement effort than any other state or territory to eliminate supply of this drug. Can the Queensland Government afford it when other possible solutions might be more effective?

IV. NEED FOR PERFORMANCE CRITERIA CONCERNING DRUG LAW ENFORCEMENT

16. There are a range of meaningful performance criteria for drug law enforcement to assess the effectiveness of existing law enforcement effort and the likely effectiveness of the intensified measures that Drug Free Australia proposes.

17. The purpose of invoking the criminal law to prohibit illicit drugs is clear. In the words of the Attorney-General in introducing the Law and Justice Legislation Amendment (*Serious Drug Offences and Other Measures*) Bill 2005 on 26 May this year

it is to “reduce the supply of illicit drugs”. Illicit drugs are a commodity traded in a market. Law enforcement is an influence on that market. Because of its black market status, there are, of course, difficulties in knowing as much about it as about legal commodities. Even so, important aspects of the illicit drug market that would reflect alterations in supply are either measured or measurable.

18. It is well recognised that law enforcement strategies, if effective to reduce supply, would reduce the “availability of the drug. These strategies also aim to disrupt the illicit drug market which can increase drug prices and decrease drug purity” (Spooner *et al.* 2004, 14). In a recent study on the role of police in preventing and minimising illicit drug use and its harms, the intended role of police in supply reduction is expressed to lead to:

- “↑ Drug prices
- “↓ Drug availability
- “↓ Drug purity
- “↓ Number of drug traffickers” (*ibid.* 25)

19. In addition, a number of indicators of demand reduction may in some circumstances reflect supply as much as demand and thus, with other data, may be taken as additional performance indicators of supply reduction strategies. A decrease in the number of recent users of illicit drugs could well be such an indicator. The study referred to on the role of police in preventing and minimising illicit drug use and its harms lists the following examples of indicators of successful demand reduction measures:

- “↑ Age of initiation of illicit drug use
- “↓ Number of new users
- “↓ Frequency of drug use among users
- “↓ Quantity of drug use per day among users
- “↑ Number of dependent users entering treatment (*ibid.*)

To this list may be added reductions in overdoses whether fatal or otherwise.

20. Apart from the number of drug traffickers, accurate information on all these matters is either currently being gathered or could be.

21. In recommending that market indicators be used in the assessment of the effectiveness of law enforcement supply reduction, we are reflecting work commissioned in 1992 by the National Police Research Unit into supply-reduction strategies. This was in response to a recommendation of the 1989 report, *Drugs, Crime and Society*, by the predecessor of this Committee, the Commonwealth Parliamentary Joint Committee on the National Crime Authority. The research, carried out by Dr Adam Sutton and Dr Steve James of the Criminology Department of the University of Melbourne, was undertaken with the co-operation of law enforcement agencies around the country and published in 1996 as an *Evaluation of Australian drug anti-trafficking law enforcement*. It criticised reliance on the traditional performance indicators adopted by drug enforcement agencies:

- “Our evaluation demonstrates that to date there has been little capacity in the law enforcement sector to reliably and validly relate its activities to changes in drug

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markets. In part, this is a function of the traditional performance indicators adopted by drug enforcement agencies: the number, volume, and type of illegal drug seizures, and the number and type of drug-related arrests and convictions. These measures are well recognised as basically flawed indicators of effectiveness. They reflect more upon levels of law enforcement *activity* than they do ratios of interdiction and reduction, and therefore cannot be used as indicators of the effectiveness of agencies in reducing the total supply of illegal drugs. Similarly, asset confiscation is subject to the same problems as an indicator, in that increased asset seizures are likely to be functions of such factors as the useability of the relevant enabling legislation and the resources that law enforcement devotes to pursuing confiscation” (Sutton & James 1996, 107).

A. Law enforcement indicators

22. To quote the recent study on the role of law enforcement in preventing and minimising illicit drug use and its harms:

“Supply-reduction strategies include higher-level strategies (for example, border control, dismantling clandestine laboratories) and lower-level strategies (for example, street-level crackdowns, policing local hot spots). Both aim to reduce supply, hence availability of the drug” (Spooner *et al.* 2004, 14).

23. Law enforcement resources such as the time of personnel devoted to these strategies would be a measure similar to the measure of effort used in fisheries management. To take the fisheries management analogy further and noting that fish like drugs are hidden commodities, law enforcement successes are similar to catch levels. Both effort and catch apply pressure to fish stocks. If a fisher makes a certain catch size in his favourite waters and then the next time makes a larger catch, he knows that the fish stock is increasing. If on the other hand he catches less then he knows that the fish stock is declining. Catch thus reflects the size of those stocks – the size of the drug illicit market in our terms. Whereas a combination of high effort but low catch levels spells bad news for fisheries management, the same would be good news in drug policy. “Catch” indicators of drug law enforcement would include:

- (a) number of middle and higher level suppliers arrested or otherwise put out of business;
- (b) proceedings against drug users including user-dealers;
- (c) levels of domestic drug crops like cannabis eradicated including the estimates of the harvest of immature crops;
- (d) clandestine local laboratories that manufacture synthetic drugs; and
- (e) quantity of drugs seized.

24. As with market indicators, most if not all these “catch” indicators are either being gathered or could be. Families and Friends for Drug Law Reform is not aware that “effort” indicators such as financial and human resources deployed are quantified regularly on a standard basis but they should be. The important study that estimated the social costs of drug abuse in Australia in 1998-99 found that the cost of state policing was \$1,105.4m (Collins & Lapsley 2002 table 36, p. 67). The most recent annual reports,

which are for the year 2007-08, of the Queensland Police Service does not identify financial resources devoted to drug supply reduction but the Illicit Drugs Reporting System for 2008 reports that:

“As in 2007, law enforcement Key Informants in 2008 reported that cannabis manufacture and supply remained a key operational target in Queensland and that significant raids had occurred during this time in particular regions of the state. As with methamphetamine manufacture and distribution, Key Informants commented that there was a greater level of involvement of organised crime groups in cannabis production and supply throughout Queensland recently, particularly via the set up of rental properties as ‘hydro houses’, and large bush-grown cannabis crops in the far north” (IDRS Queensland Drug Trends 2008 p. 111)

B. Measures of law enforcement

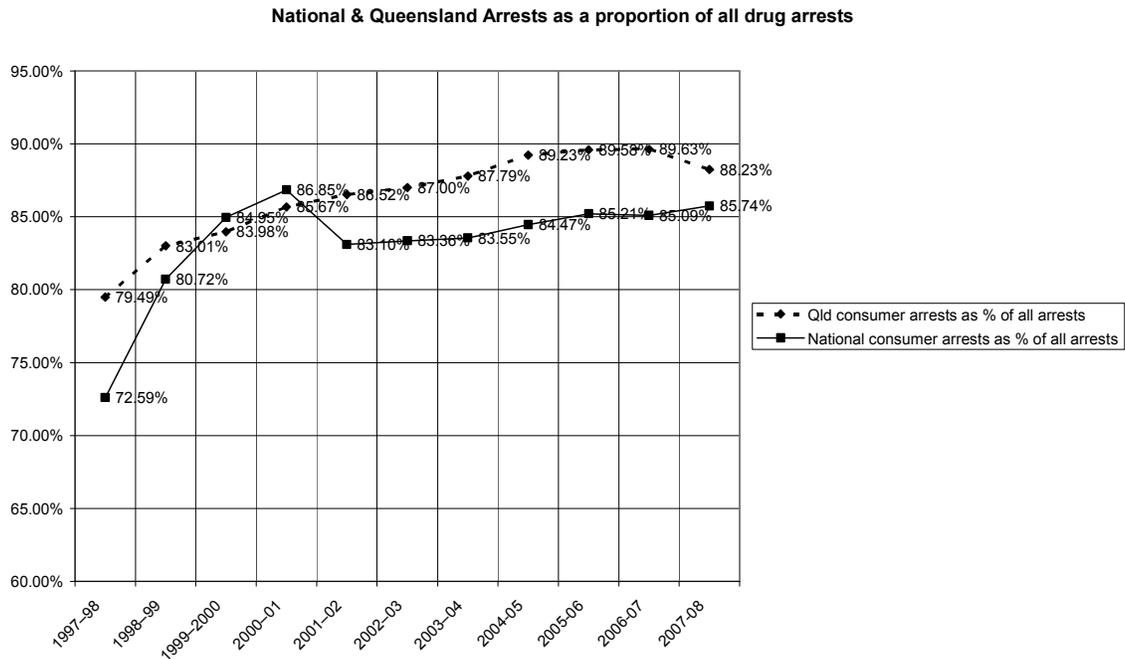
25. The following are examples of law enforcement “catch” indicators that are methodically collected namely, drug arrests, clandestine laboratories detected and the quantity of drugs seized.

1. Arrests

26. Statistics on arrests from law enforcement agencies across Australia are regularly collated by the Australian Crime Commission (e.g. IDDR 2003-04 tables, tables 17 ff p. 2 ff). The vast majority of these concern users who are caught for possession or for dealing in small quantities to finance their habit. The statistics thus reflect law enforcement activity at the retail level. If that level of activity remains constant the number of arrests is likely to reflect the level of use of the drug. Consistently with its status as the most used illicit drug, cannabis arrests outnumber all other drug arrests. As shown in the following graph consumer arrests constitute over 80% of all cannabis arrests including provider ones.

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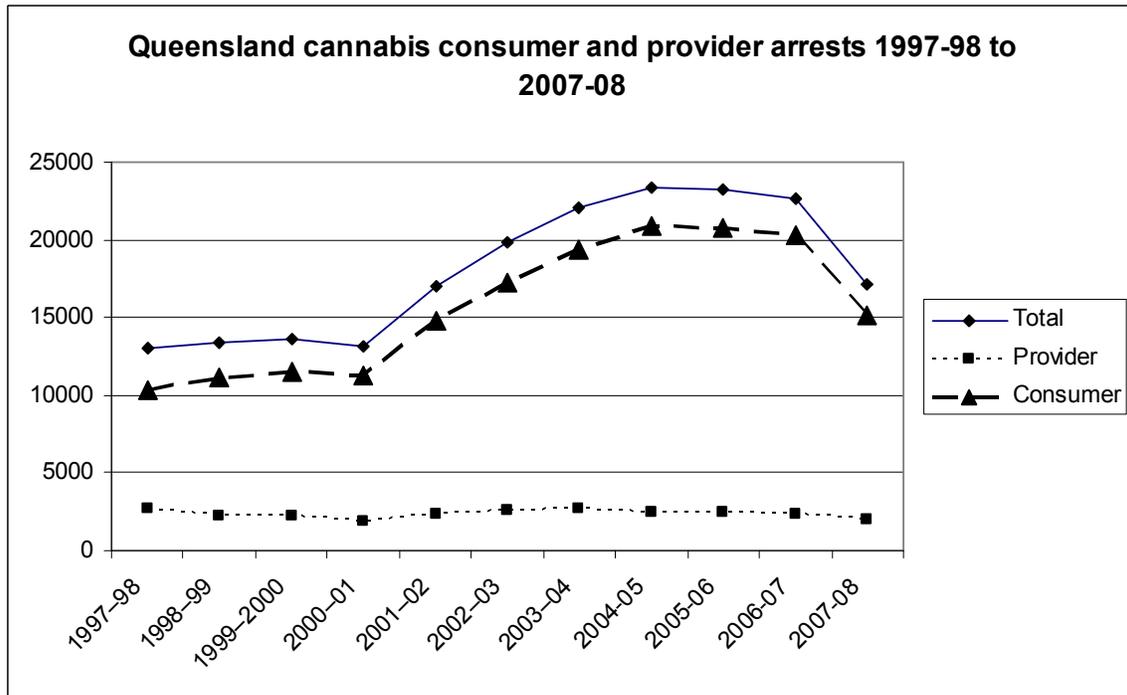
Figure 4: Nation and Queensland consumer arrests as a proportion of all drug arrests 1997-98 to 2007-08



SOURCE: Statistical tables of consumer and provider arrests in *Australian illicit drug reports* of the Australian Bureau of Criminal Intelligence & *The illicit drug data report* of the Australian Crime Commission.

27. The next chart tracks the relationship of cannabis consumer and provider arrests in Queensland. Note that from 2000/01 to 2007/08 there has been a growth in arrests, and like our fish stocks analogy, would indicate a growing market.

Figure 5: Cannabis arrests in Queensland 1997-98 to 2007-08

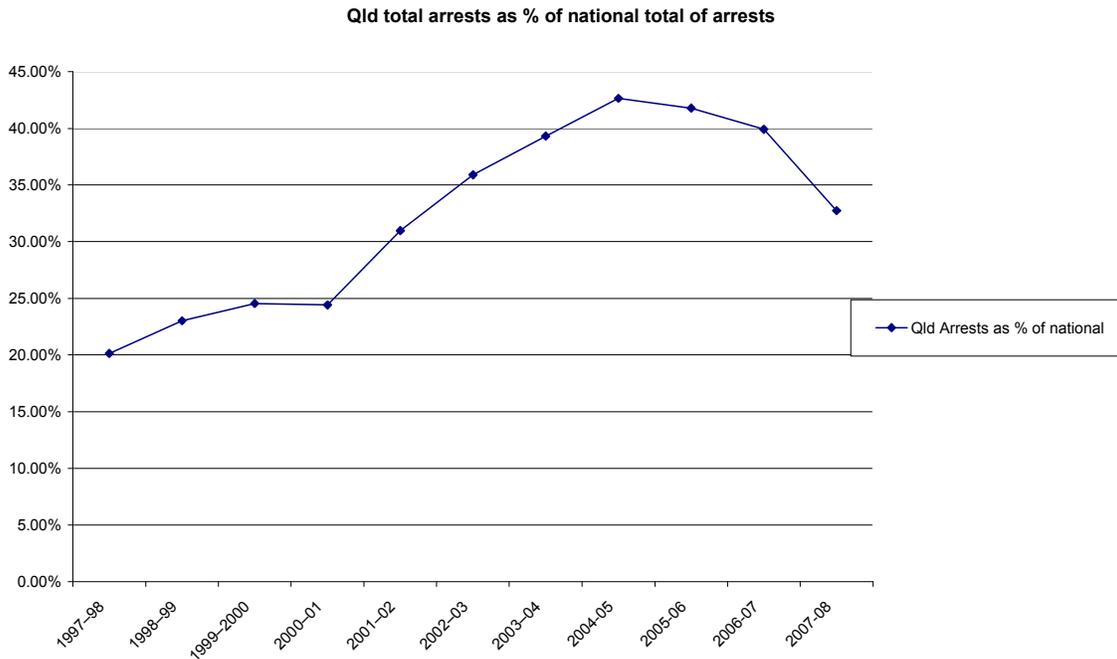


SOURCE: Statistical tables of consumer and provider arrests in *Australian illicit drug reports* of the Australian Bureau of Criminal Intelligence & *The illicit drug data report* of the Australian Crime Commission.

28. It is of considerable relevance to Drug Free Australia’s recommendation in favour of intensified police campaigns, that already Queensland arrests many, many more consumers than providers and, as the following chart shows, that the number of cannabis arrests represents a high proportion of the national total of cannabis arrests.

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Table 6: Total cannabis arrests in Queensland of consumers and providers as a percentage of total national such arrests



SOURCE: Statistical tables of consumer & provider arrests for cannabis in Australian illicit drug reports of the Australian Bureau of Criminal Intelligence & The Illicit drug *data report* of the Australian Crime Commission.

29. The high proportion of Queensland arrests compared to the total number of national arrests taken with the high proportion of Queensland cannabis seizures compared to national seizures (see chart 12 below), confirm intensive Queensland law enforcement effort against the drug. These facts, combined with stable or declining prices, and, if Drug Free Australia is to be believed, increasing potency, point to Queensland being a substantial producer if not the biggest producer in Australia of this predominantly locally grown drug. Indeed this has been asserted by the Queensland Justice Commission:

“The role of cannabis in the local economy was highlighted in Queensland. According to an address to the Queensland Parliament by a Queensland Justice Commission (CJC) illicit drugs committee member, ‘Queensland is the supply state for Australian users and the 70 tonnes of cannabis produced each year is conservatively worth \$360 million.’ The member, Mr Bob Aldred, added that such a large crop was vital to the Queensland economy and small country towns would decline if the illegal industry was stopped (*Canberra Times* 5 July 1994). The climate in Northern Queensland allows cultivators to grow at least two crops per year.

“QLDPol report that cannabis is prevalent and widely grown through the State in both rural and bush sites. The majority of crops are grown along the eastern coastline, in regions that receive regular rainfall and have dense vegetation to

camouflage. The [National Crime Authority] and [Criminal Justice Commission] also report that cannabis is in plentiful supply and consequently is relatively cheap. QLDPol in Cairns report that cannabis is extremely popular in Cairns and Far North Queensland and is almost socially acceptable among the general community” (Australian Bureau of Criminal Intelligence, *Australian illicit drug report 1995-96*, p. 29).

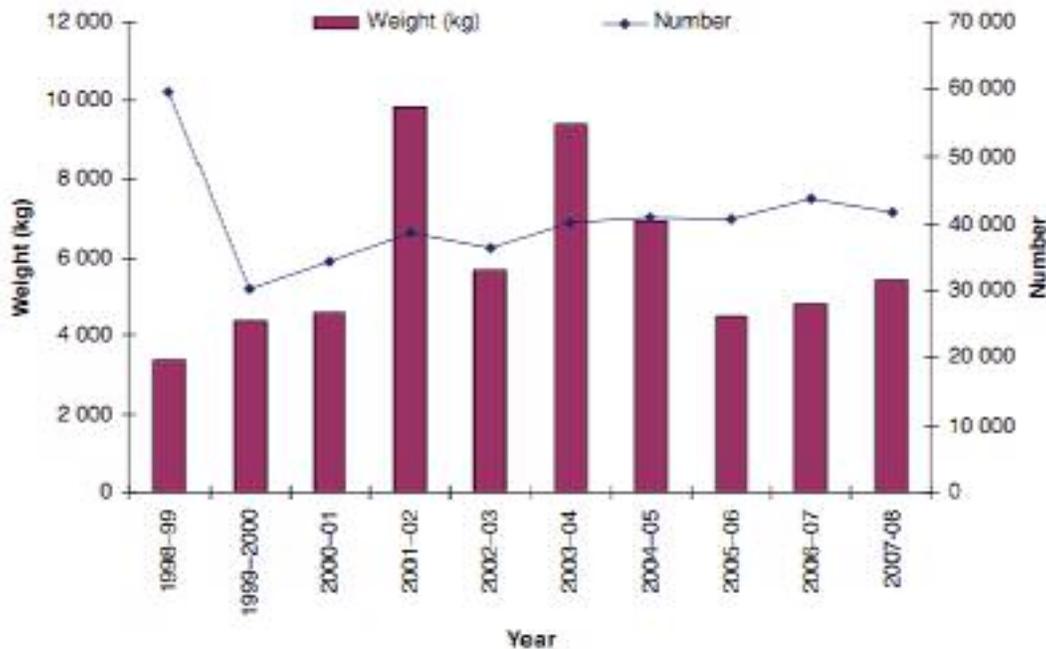
2. Drugs seized

30. The quantity of drugs seized by law enforcement agencies is the most cited example of law enforcement success against illicit drugs. Large seizures of imported drugs such as heroin and cocaine are made at the border just as the largest quantities of domestically produced illicit drugs such as cannabis are seized within Australia. For drugs produced in big quantities both overseas and domestically, the changing balance between domestic and border seizures can reveal changing patterns. This is particularly so for synthetic drugs – amphetamine type substances and drugs marketed as ecstasy.

31. Comparison between different catch indicators can also be revealing. The following graph of cannabis seizures shows large fluctuations in the quantities seized and a smaller reduction in the number of seizures. This differs markedly from the rise and decline over the same period in the number of cannabis arrests in Figure 5 at p. 11.

Figure 7: National cannabis seizures by weight and number, 1998-99 to 2007-08

FIGURE 19: NATIONAL CANNABIS SEIZURES, BY WEIGHT AND NUMBER, 1998-99 TO 2007-08



SOURCE: IDDR 2007-08 cannabis, figure 19, p. 43.

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V. WHAT DRUG MARKET INDICATORS AND MEASURES OF LAW ENFORCEMENT CAN SHOW

32. A comparison of drug market indicators with law enforcement measures can show the extent to which law enforcement achieves its goal of supply reduction. Potentially, drug markets can be influenced by a range of factors other than supply reduction brought about by law enforcement. Such factors may include:

- (a) changing tastes among drug users which may lead to reduced demand for some drugs and higher demand for others;
- (b) the take up of available drug treatment programmes. Dependent users on such programmes greatly reduce their illicit drug consumption;
- (c) deterrence of use by actual or threatened law enforcement action i.e. law enforcement working as a measure of demand rather than supply reduction;
- (d) publicity and educational campaigns about the undesirability of using the drug concerned;
- (e) reduced supply of drugs as a result of adverse circumstances unassociated with law enforcement action such as poor growing conditions or supply shortages of raw material and other resources (e.g. chemists to manufacture synthetic drugs and refine opium);
- (f) commercial decisions by importers to send product to a market other than Australia on financial grounds unrelated to Australian law enforcement.

33. Illicit drug suppliers and law enforcement have a common interest in maintaining the price of drugs at a level that is above the cost of production. The primary objective of most illicit drug suppliers is to maximise profits. Law enforcement is a factor that affects the drug traffickers' costs of supply. Circumventing the obstacles of law enforcement incurs costs, including the risks associated with getting caught. On account of the nature of drug markets, these costs can often be passed on to drug users in the form of higher prices. As a result, illicit drug suppliers are often able to sell drugs at a price well above the costs of production. Similarly, law enforcement aims to increase the cost of supply by seizing illicit drugs, creating barriers to supply and distribution and increasing the risks associated with supply. From a law enforcement supply reduction point of view, success would be indicated by evidence that the price of illicit drugs has risen to a level where consumption is insubstantial. There is, of course, uncertainty about how much law enforcement effort is necessary to increase prices to the level that would achieve the desired outcome. This issue is complicated by the fact that, as the level of enforcement effort increases, so too will the profit margin available to drug dealers.

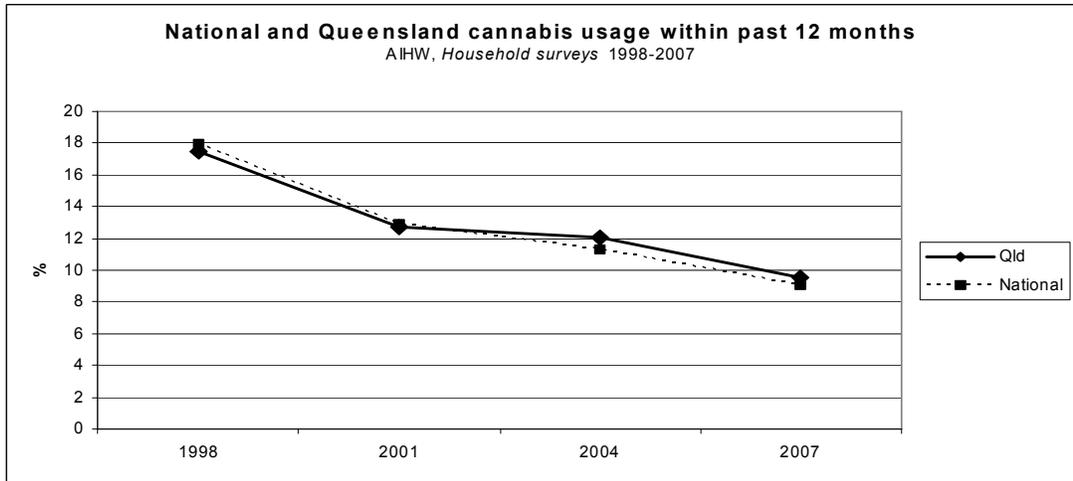
34. In the light of these considerations we will now examine indicators for what they reveal about the success of law enforcement in combating the supply of cannabis as opposed to other factors that may influence the market. In so far as they are capable of doing this, they serve as examples of performance criteria that we urge the committee to guide its consideration of the issue.

A. Drug market and drug law enforcement indicators

a) Number of recent drug users

35. Household surveys undertaken about every three years give an indication of the number of people who are currently using illicit drugs. The following chart reports the percentage of the population in Queensland and nationally that have used cannabis in the previous 12 months.

Figure 8: Cannabis usage in the past 12 months of the population 14 years and over between 1998 and 2007

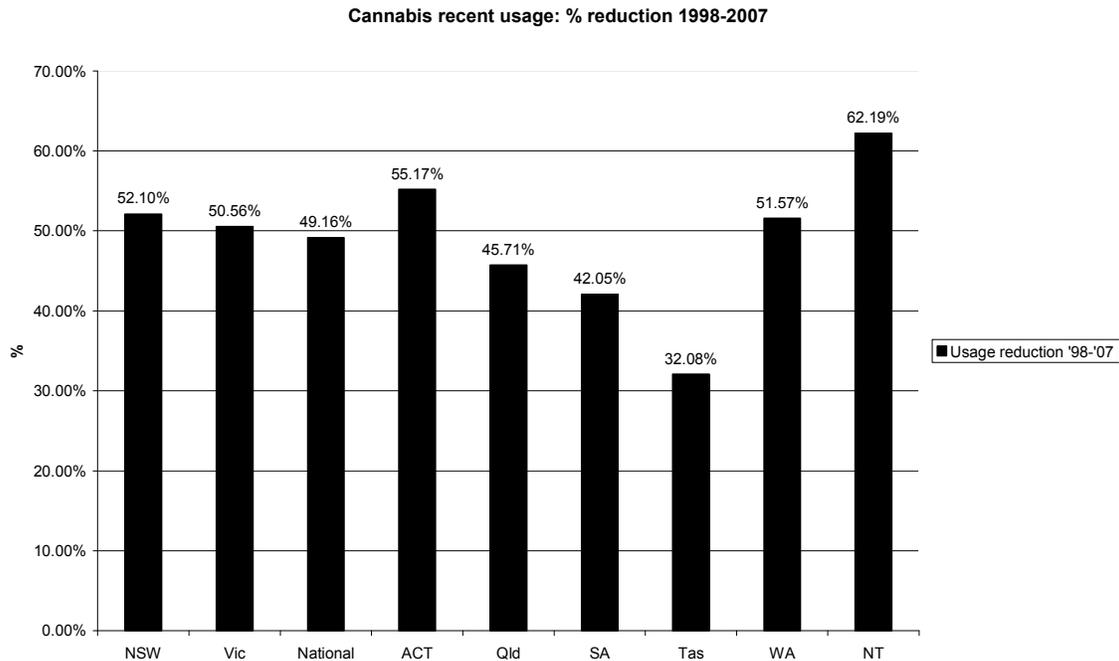


SOURCE: AIHW 2005 Table 2.1, p. 3.

36. The foregoing graph shows a distinct decline since 1998 in recent usage of cannabis. (defined as usage within the past 12 months). The next chart compares the level of decline in usage across different jurisdictions. Although the decline in Queensland is large (45%) most other jurisdictions recorded a somewhat higher decline.

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Figure 9: Decline between 1998 and 2007 in use of cannabis over the past 12 months by people over 14 years of age



SOURCE: AIHW 2005 Table 2.1, p. 3.

b) Age of initiation of drug use

37. The periodical household surveys also cover the age of first use of illicit drugs. It is most important to have drug strategies that effectively discourage the uptake of drugs by children in their early teens. In conjunction with other indicators, an increase in the mean age of first use may reflect the implementation of effective supply reduction strategies and a reduction may suggest ineffective strategies. Household surveys have revealed little change in age of first use. (See table 13 below at p. 26). For cannabis it was 15.6 years old in 1995 15.8 years old in 2007.

1. Drug market indicators

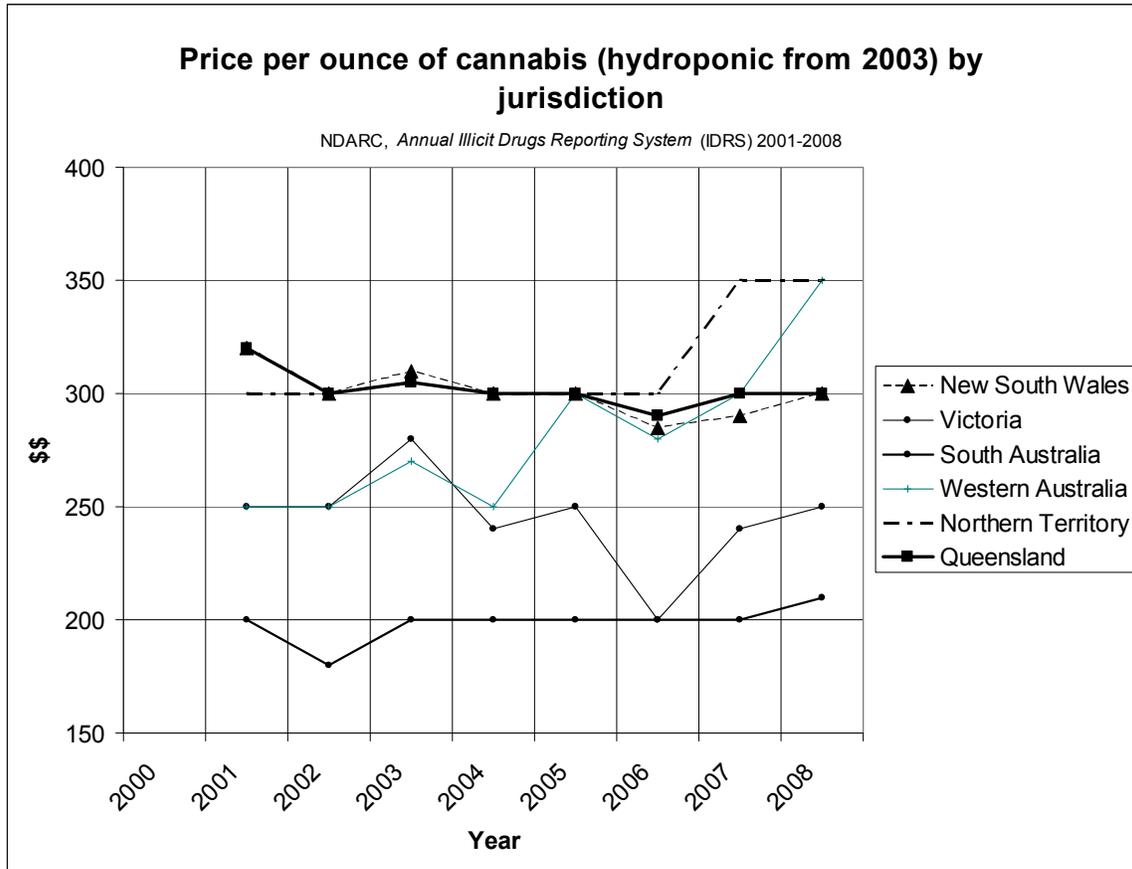
38. The following is a selection of information that bears upon the size of the illicit drug market, namely, drug prices, user reports of drug availability and the potency of drugs seized at street level.

a) Drug prices

39. The retail price is a useful indicator of the levels of supply and demand. Information is collected from drug users in the course of a regular annual survey in all jurisdictions as part of the Illicit Drug Reporting System (IDRS) and the Party Drugs Initiative (PDI) co-ordinated by the National Drug and Alcohol Research Centre of the University of New South Wales. The following graph shows median price changes over seven years for cannabis in Queensland and other jurisdictions. The graph reflects large

retail quantities. In those seven years the price of an ounce of cannabis in Queensland declined from \$320 to \$300. The general picture of stable or declining prices shows that law enforcement was having little if any effect in reducing its availability by forcing up the price.

Figure 10: Price of an ounce of cannabis by jurisdiction, 2001-2008



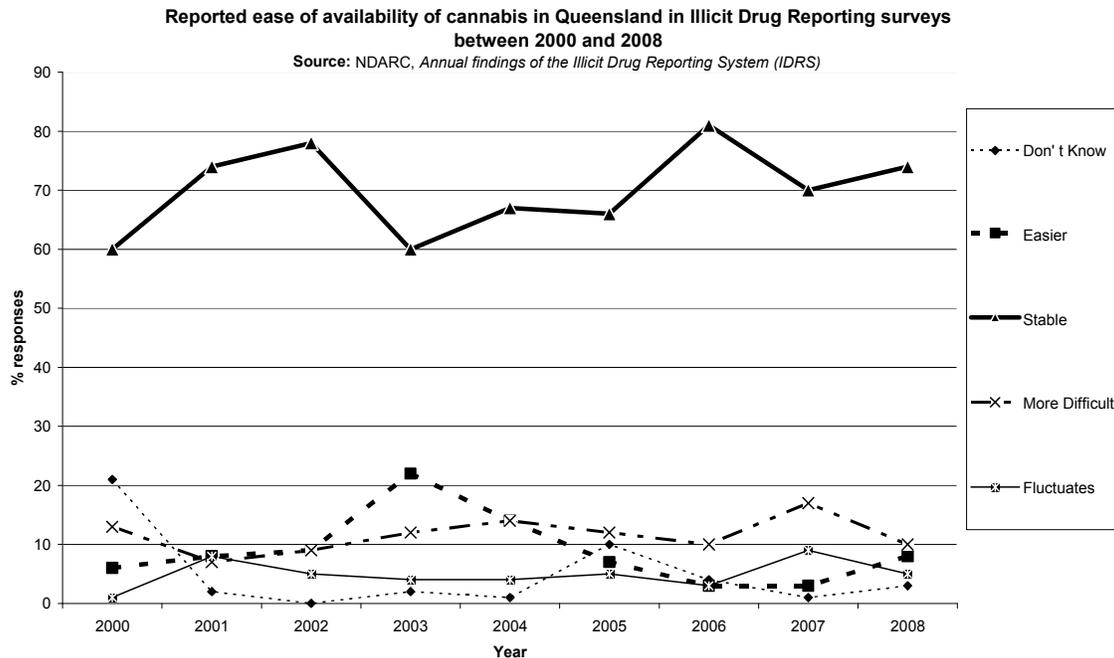
SOURCE: Annual Illicit Drugs Reporting System (IDRS) 2001-2008

b) User reports of drug availability

40. As part of the Illicit Drug Reporting System (IDRS) and the Ecstasy and related drugs reporting system (EDRS) drug users are regularly surveyed on how easy it is to obtain drugs and whether this has changed in the last six months. Other measures are changes in the length of time taken by users to procure drugs.

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Figure 11: Ease of availability of cannabis in Queensland reported in Illicit Drug Reporting surveys between 2000 and 2008



VI. INCREASED POTENCY OF CANNABIS

41. The potency of drugs at street level are a good indicator of supply. Drugs that are imported in concentrated form to reduce bulk will generally be adulterated with other substances to maximise profits. The greater the degree of adulteration, the greater it is likely that there is pressure on supply. While lower purity spells good news for supply reduction, it can have negative health consequences for users. This is the case not only with injected drugs like heroin but also when cheaper and more dangerous drugs are mixed with swallowed drugs like ecstasy as very frequently happens.

42. Drug Free Australia misleads the committee in claiming that highly potent cannabis is now the norm:

“High potency cannabis, or cannabis containing high THC concentrations, is currently cultivated in all states of Australia, largely through the use of hydroponics cultivation” (p. 10).

43. It warns that some publications dated as recently as 2006 such as the Australian National Council on Drugs (ANCD’s) position paper (2006), should be treated with caution as the evidence base has now substantially changed. But the authority that it cites for this is a much earlier 1993 report by the Australian Bureau of Criminal Intelligence to the effect that “a THC content in cannabis plants of up to 30%, a substantial increase from the early 60’s when the typical cannabis joint contained as little as 0.5%.” The ANCD’s paper concluded that there was no evidence of the availability on the market of

cannabis with a consistently higher potency. It is worth quoting the paper's conclusion and the reasons why it came to the conclusion it did:

“There has been controversial speculation in Australia and the United States that the THC content of cannabis has increased up to thirty-fold during the past two decades, and that this has contributed to reported increases in cannabis-related harm, particularly in young regular users. Although this is a tempting argument, it is as yet unsubstantiated by research. In fact, cannabis potency monitoring has shown only small increases in THC over the past few decades.

“Australia has no uniform program for the ongoing testing of cannabis THC content. Therefore, information is reliant on intermittent examination of cannabis seizures or small independent research studies. For example, while there was one isolated South Australian seizure of compressed heads with a THC content of 15 per cent, a small study of other seizures of leaf and head from around the country indicated a lower THC content of 0.6–13 per cent, with the majority being 0.6–2.5 per cent THC. A sample of 168 seizures in 1996 by Western Australian police found an average of 3.7 per cent THC content across all samples. This figure almost doubled (6.4%) in the 59 sub-samples of heads.

“One recent study examined two batches of cannabis samples, the first from a controlled experimental crop and the second from the black market in New South Wales, South Australia and Queensland. Results showed relatively low THC levels in the experimental crop of 0.19–5.05 per cent THC. However, variations in THC content in the black market samples were considerable, ranging from 0.5 per cent to 22 per cent THC in a sample of hybrid cannabis. Despite this, most samples contained below 5 per cent THC in the black market and 2 per cent THC in the experimental batches, respectively.

Outside Australia, the New Zealand Government has monitored cannabis seizures since the mid-1970s. Between 1976 and 1996, there were no substantial increases in average THC content, which has remained at 2–4 per cent” (Copeland (2006) p. 10).

44. The conclusion of this paper is effectively reaffirmed by the NCPIC - National Cannabis Prevention and Information Centre. Its fact sheet on potency states:

“It cannot be definitively determined whether the cannabis used here in Australia has become more potent over time because there is no data on this. The increase in health problems is more likely to be due to the increased popularity of using stronger parts of the plant. While cannabis users in the 1970s were most likely to smoke the leaves, cannabis users today prefer to smoke the more potent flowering tops, or buds of the plant. Furthermore, there is good evidence that the age at which people commence using cannabis has, until recently, been going down. Research shows, that young regular (daily or near daily) users are most at risk of many of the adverse effects of cannabis including mental health problems and dependence.

“In the USA, THC levels of cannabis have risen over the last 25 years. According to data recently released, cannabis potency has risen from about 4% to 9% since

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1983. In New Zealand, the potency of THC has not changed. In Europe, cannabis potency appears to have remained the same in most places, except the Netherlands, where an increase has occurred. Certain varieties of cannabis such as sinsemilla have also recorded increased potency in the UK”

So what's the story?

Long-term users of cannabis in Australia report that cannabis appears to be stronger than in the past. On the available evidence it would appear that the strength of cannabis has increased to some extent over the last 25 years, but is not 30 times stronger as is sometimes claimed.

It would appear that the main difference nowadays is the part of the plant people smoke and the age at which people commence regular use. It is more common for people today to smoke the flowering heads of the plant which are much more potent than the leaf product. In addition, people are more likely to smoke cannabis in a 'bong'. These changes in the patterns of use may result in users of today taking in higher levels of THC than in the past. Additionally, the younger people start and the more regularly they use, the more likely they are to be adversely affected by cannabis. Simply focusing on cannabis potency may obscure the fact that young regular users are most at risk of cannabis related harm. (NCIPC NDb).

45. The European Monitoring Centre on Drugs and Addiction has sponsored research on the potency of cannabis available in Europe. The result is a picture of considerable fluctuation:

“From time to time, a wave of media interest across Europe contends that cannabis in contemporary society is stronger and thus more harmful than it was in the 1960s and 1970s. Claims have been made that cannabis consumed today is 30% stronger than in the past. This belief, though strongly held, is something of an urban myth. As King in this section notes, the myth has been fuelled by media and politicians, and researchers have suggested that the figures come from misinterpretation of the data which, when calculated in accurate terms, actually translate to a 1 % increase” (EMCDDA (2008) pp. xxiii-xxiv).

46. It seems that while some higher potency cannabis is available on the market, this is far from being generally so. A couple of points may be made in relation to this:

In the first place higher potency is to be expected. The profit in supplying illegal, addictive substances encourages the development (in the case of cannabis through plant breeding) of high potency products just as prohibition in the United States encouraged the availability of concentrated alcohol in the form of spirits. Concentration makes it less risky to transport and smuggle, rather than bulkier fermented products. The tendency to high potency product is a marker of the failure of supply-side interdiction.

47. The other issue is whether the resulting product may, indeed, be less harmful than its lower potency predecessor. The EMCDDA has pointed out that:

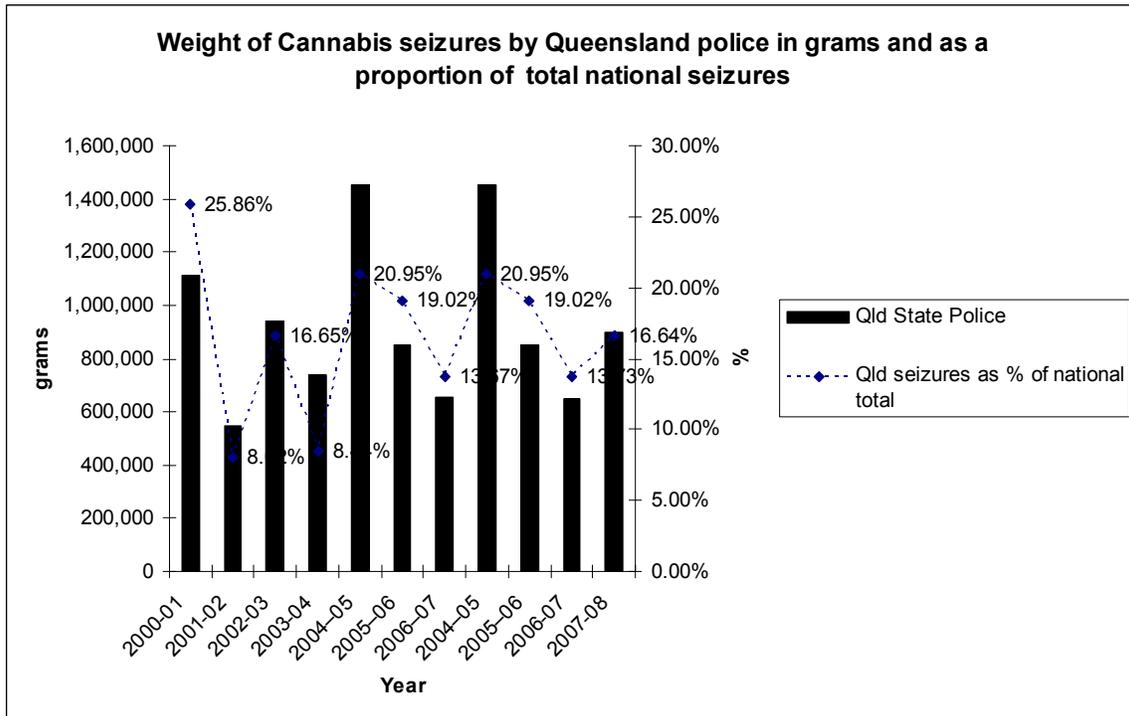
THC potency increase does not necessarily mean that there will be an increase in adverse health effects, as an increase in potency may lead to an adaptation by the

users to smoke less cannabis. In turn this would lead to less inhaled smoke in lungs and thus decreased risk of respiratory diseases” (EMCDDA (2008) p. xxiv).

1. Cannabis seizures

48. The Queensland police seize vast quantities of cannabis. According to the latest available *Illicit drug data report* of the Australian Crime Commission, Queensland Police seized over 897 kilograms in 2007-08. This was substantially less in absolute terms than the 1,114 kilograms that they seized in 2000-01. The proportion of national seizures that Queensland seizures represented in 2007-08 was 16.6% (down from 26%).

Figure 12: Weight of Cannabis seizures by Queensland police in grams and as a proportion of total national seizures 2000-01 to 2007-08



SOURCE: Statistical charts of seizures in *Australian illicit drug reports* of the Australian Bureau of Criminal Intelligence & *The Illicit drug data report* of the Australian Crime Commission.

49. In spite of the high level of seizures, prices for cannabis in Queensland have, of course remained stable and even declined. A large seizure in July 2008 of 15 tonnes does not seem to have had any effect on the market price:

“In July 2008, a joint operation between the Cultivated Drug Operations Team, State Operations Command and police from Southern Region successfully netted one of the largest cannabis crops ever uncovered in Queensland. An anonymous tip off via Crime Stoppers led police to a property near Inglewood in south west Queensland and resulted in 15 tonnes of cannabis with a market value of around

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\$500 million being seized” (Queensland Police Service, *Annual Report 2008–09*, p. 58).

A. Conclusions on the bearing of law enforcement on cannabis availability

50. The fairly reliable surveys of usage of this drug show it to be in decline since 1998 (figure 8, p. 15). This is occurring in the context of the following market indicators.

51. *Price:* According to the Illicit Drug Reporting System (IDRS) the price was overwhelmingly stable or declining (figure 10, p. 17): “Consistent with the result of the IDRS in previous years, cannabis remained cheapest in SA and the price of an ounce of cannabis has gradually declined from 1997 in VIC, NSW and SA. The price has remained relatively stable (ranging from \$200-\$300) in the other jurisdictions since data collection began in 2000. The majority of the national sample [of users who were surveyed] reported the price of hydroponic and bush cannabis as stable: 72% and 61% respectively. Substantial minorities in the NT (16%) and SA (15%) reported that the price of hydroponic cannabis had increased recently” (IDRS 2004, 85). Information from law enforcement sources reported by the ACC fairly much co-incide with that: “During the reporting period a slight rise in the price of a pound of cannabis head was recorded in South Australia, Western Australia, Tasmania and Northern Territory. The price of a pound of bush-grown cannabis increased from around \$2400 to \$3500 in the ACT after the January 2003 bushfires, however, it is unclear how long this increase in price continued” (IDDR 2003-04 cannabis, p. 5).

52. *User reports of drug availability:* “As in previous years, cannabis (hydroponic and bush) was described as ‘very easy’ or ‘easy’ to obtain by the vast majority of participants in all jurisdictions, and the majority of those [injecting drug users] who commented perceived the availability of hydroponic and bush cannabis to be stable over the six months preceding the interview. Substantial proportions in TAS reported that hydroponic and bush cannabis had become easier to obtain over the last six months (22% and 20% respectively)” (IDRS 2004, 88). The ACC reported that: “Cannabis remained widely available throughout Australia” (IDDR 2003-04 cannabis, p. 5).

53. *Conclusion regarding cannabis drawn from indicators:* In this environment of easy availability, law enforcement indicators show an increase of 85% in arrests between 2000-01 and 2004-05 (figure 5, p. 11) contrasting with a lower level of seizures between 2001-02 and 2003-04 (figure 12, p. 21) followed by a rise.

54. The indicators show that the use of cannabis, while still the most popular illicit drug in Australia, is declining. This cannot be because of law enforcement bringing about a reduction in supply. Other things being equal, a small level of seizures would be consistent with low availability but market indicators show this is not the case. The reduction in cannabis usage must be attributable to one or other of the other factors mentioned above at p. 14.

VII. CANNABIS AS A GATEWAY DRUG

55. The Drug Free Australia paper asserts that research supports a long standing claim that cannabis is a gateway to other illicit drugs: that cannabis has a tendency “to introduce the user to other illicit drugs” (p. 12). Such an assertion is based on “epidemiological research, concentrated in North America and Oceania, [which] has documented a

common sequence of drug use initiation that begins with tobacco and alcohol use, followed by cannabis and then other illicit drugs”. This is properly described as a “gateway pattern” (Degenhardt *et al.* 2010 p. 85). Drug Free Australia appears to adhere to the theory that there is more than a correlation and rather that cannabis actually causes other illicit drug use. It cites the dubious authority of the “2008 Marijuana Sourcebook” of the US Office of National Drug Control Policy which “clearly states” that recent research supports the gateway hypothesis, specifically that “its use creates greater risk of abuse or dependency on other drugs, such as heroin and cocaine” (p. 12). In contrast the United States Institute of Medicine has concluded that: “There is no conclusive evidence that the drug effects of marijuana are causally linked to the subsequent abuse of other illicit drugs” (US, Institute of Medicine (1999)). If cannabis use actually caused those who try it to use “harder” drugs like heroin we would expect a substantial proportion of the many who have tried cannabis to move on to heroin but only a tiny fraction have done so. Dillon dismisses the asserted gateway connection in the following terms:

“In fact, over a third of the Australian population have tried cannabis at one time, whereas only a very small percentage (2 per cent) have ever tried heroin. If the gateway theory is true there should be far more heroin users in this country.” (Dillon (2009) p. 117).

56. The Drug Free Australia’s recommendations in favour of intensified coercive action can be justified only if the gateway theory is correct. In the absence of evidence from further research, the simple fact of a correlation proves nothing about causation. If it did the consumption of water or milk could just as much be said to be gateway substances for illicit drugs. In fact there is persuasive evidence from research that far better explains the correlation between cannabis use and the use of other drugs. This includes the so-called “common factor theory”, the risk factor model and the self medication theory. Under the common factor theory, use of cannabis “is associated with a greater propensity to use other drugs . . . because both are controlled by an individual’s liability to experiment with drugs” (Barton 2008 p.205). In other words reviews show that that progression from cannabis to other drugs (or indeed from alcohol to tobacco to cannabis to other drugs) is more likely to be a combination of personality traits combined with the effects of socialisation into the illicit drug culture.

Morrall *et al* 2002 describe the impact of personality traits and socialisation in the following terms:

“proponents of the common-factor approach suggest that ordering in drug use initiation results from the order in which opportunities to use marijuana and hard drugs are presented to young people (Goode 1972; Jessor & Jessor 1980). Those with the highest propensities to use drugs are likely to use the first one offered to them, and that happens to be marijuana in most cases. Moreover, if a high drug use propensity is associated with greater frequencies of drug use, the common-factor theory can also account for the dose–response phenomenon: marijuana use frequency is associated with risk of hard drug initiation because both are controlled by drug use propensity” (Morrall *et al* 2002, p. 1,494).

57. If a common factor theory based upon propensity to use drugs is right, as evidence seems to show, Drug Free Australia is barking up the wrong tree by advocating coming

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down harder on cannabis as a means of reducing the uptake of illicit drugs generally. Morral and his colleagues came to the following conclusion: “Using a simulation model, we demonstrate that the primary evidence supporting the marijuana gateway effect can be explained completely by the order in which youths first have the opportunity to use marijuana and other drugs, and by assuming a non-specific liability to use drugs, without any assumption that use of marijuana contributes to the risk of initiating use of hard drugs. We argue that although marijuana gateway effects may truly exist, available evidence does not favour the marijuana gateway effect over the alternative hypothesis that marijuana and hard drug initiation are correlated because both are influenced by individuals’ heterogenous liabilities to try drugs” (Morral *et al* 2002, pp. 1,493-94)..

The common-factor model is appealing in part because it takes account of what is a substantial scientific literature demonstrating the existence of genetic, familial and environmental characteristics associated with a generalized risk of using both marijuana and hard drugs. For instance, several studies examining drug use among monozygotic and dizygotic twins in the USA demonstrate genetic and family environment contributions to the likelihood of any drug use (van den Bree *et al.* 1998) and any drug use initiation (Tsuang *et al.* 1998; Kendler *et al.* 1999, 2000). Similarly, community drug use or drug availability may contribute to individuals’ risk of using drugs (Lillie-Blanton, Anthony & Schuster 1993)” (Morral *et al* 2002, p. 1,494-95).

“marijuana policies would have little effect on hard drug use, except insofar as they affected either an individuals’ propensity to use any drugs (as might be the case with drug use prevention programs) or they resulted in hard drugs becoming less available or available later in youths’ lives” (Morral *et al* 2002, p. 1,503).

58. Further doubt has recently been thrown on the gateway theory by a study published this year comparing the extent that in different countries drug users progressed from one of the gateway drugs (cannabis, alcohol or tobacco) to other illicit drugs. If cannabis use did actually cause later use of illicit drugs one would expect “that initiation reflects a universally ordered sequence in which rates of drug use later in the sequence must necessarily be lower than those earlier in the sequence.” (Degenhardt *et al.* 2010, p. 95). In fact, the inter-country comparison found that: “a lack of exposure and/or access to substances earlier in the normative sequence did not correspond to reductions in overall levels of other illicit drug use.” What the comparison did suggest was that the overall prevalence of drugs in the countries concerned predicted the extent that use of “gateway drugs” preceded the use of illicit drugs other than cannabis and that “the risk for later development of dependence upon a drug may be more affected by the extent of prior use of any drug and the age-of-onset at which that use began ((Degenhardt *et al.* 2010 p. 95) “As expected by a model in which environmental factors such as access and/or attitudes toward use of a drug play some role in the order of substance initiation, gateway substance use was differentially associated with the subsequent onset of other illicit drug use in countries/cohorts based on background prevalence of gateway substance use (i.e. alcohol/tobacco more strongly associated with the subsequent onset of other illicit drug use in countries/cohorts with higher rates of alcohol/tobacco use and cannabis initiation more strongly associated with the subsequent onset of other illicit drug use in countries/cohorts with higher rates of cannabis use). Thus, while previous studies have

consistently documented that the use of an earlier substance in the gateway sequence predicts progression to use of later substances (Grau *et al.*, 2007; Kandel *et al.*, 1986; van Ours, 2003; Yamaguchi and Kandel, 1984), the present analyses conducted across diverse countries and cohorts showed that the strength of associations between substance use progression may be driven by background prevalence rather than being wholly explained by causal mechanisms” (Degenhardt *et al.* 2010, p. 95)

59. The influence of peers and other aspects of the social environment in which a teenager lives rather than any gateway effect of cannabis provide the strongest explanation for the correlation between cannabis use and those of other illicit drugs: “It is now believed that the environment that a young person is exposed to has a much stronger influence on what drug is used in the future, rather than there being a logical progression from one drug to another. That is, if it’s easier for a young person to get their hands on cannabis than alcohol, then it’s more likely they will smoke pot. This is known as the ‘common liability model.’ It states the likelihood that the movement of use from one drug to another is not necessarily determined by the previous use of a particular drug, but instead by the young person’s individual tendencies and environment circumstances” (Dillon pp. 117-18).

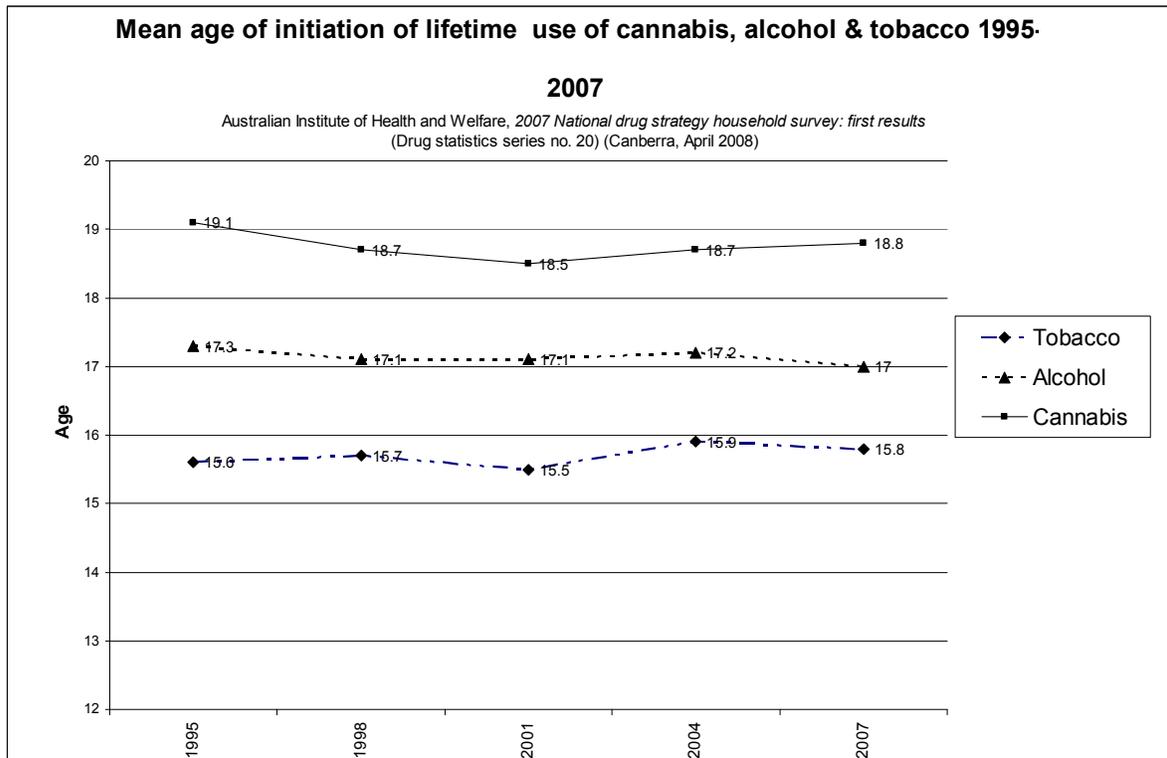
60. The common factor model which better explains the correlation between cannabis use and use of other drugs is not the only evidence based explanation for that association. A risk factor model and the self medication theory seek to explain the frequent overlap between ADHD and Conduct Disorder. The risk factor model proposes that the strong association between ADHD and drug use is mediated through Conduct Disorder (CD). “According to this model, ADHD increases the likelihood of developing CD, which in turn increases the risk of problematic drug use” (Flory & Lynam 2003). Under the self medication theory it is noted that: “nicotine acts as a psychomotor stimulant (Pomerleau *et al.* 1995), and individuals with ADHD are likely to use nicotine as a stimulant to manage their symptoms of inattention (Tercyak *et al.* 2002). Individuals with adult and/or childhood symptoms of ADHD are more likely to experience depressed mood, insomnia, irritability, restlessness, and difficulty concentrating when withdrawing from nicotine compared to individuals with no history of the disorder (Pomerleau *et al.* 2003) As nicotine provides temporary relief from chronic inattention, distractibility, and restlessness, smoking is very likely to be appealing to people with symptoms of ADHD, possibility as a pharmacological coping response or an attempt to self-medicate (Pomerleau *et al.* 1995).” (Barton & Hay 2008, p. 206).

61. Degenhardt and her colleagues point out in their comparative study of different national and cohort patterns of progressions from one drug to another, that rather than the drug of first use being predictive, “the risk for later development of dependence upon a drug may be more affected by the extent of prior use of any drug and the age-of-onset at which that use began” (Degenhardt *et al.* 2010 p. 95). A United States study found that: “more frequent cigarette smoking in adolescence was associated with higher risk for drug use disorders by young adulthood. Compared to adolescents who smoked infrequently, adolescent daily smokers were at significantly increased risk for future cannabis and hard drug use disorders and for multiple substance use disorders. Our findings suggest that the relationship between cigarette smoking and risk for illicit drug use problems may be dose-dependent” (Lewinsohn (1999) p.918).

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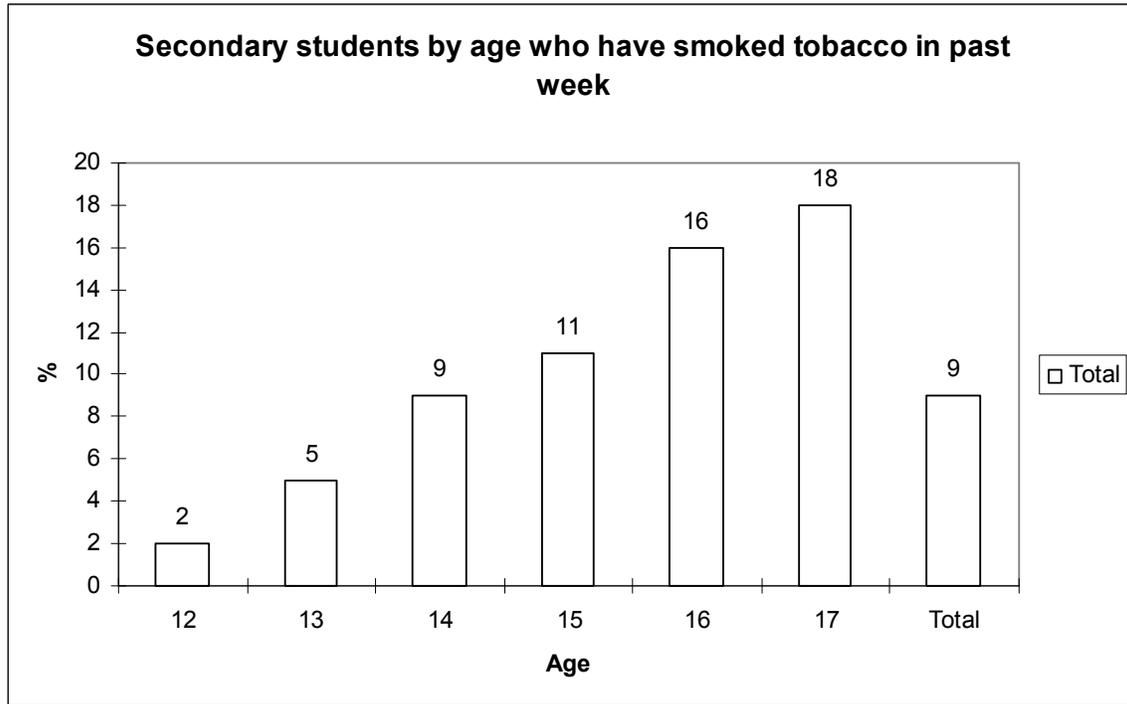
62. In other words, what the committee should be most concerned about is not so much the usage of cannabis but the age at which that or any other drug including alcohol and tobacco was first used and the extent of that use. Whereas the mean age of initiation of use of cannabis was found to be 18.8 in the 2007 Household survey, it was almost two years less for alcohol and three years less for tobacco.

Figure 13: Mean age of initiation across Australia of lifetime use of cannabis, alcohol & tobacco 1995-2007



SOURCE: Australian Institute of Health and Welfare, *2007 National drug strategy household survey: first results* Table 2.3: Secondary students across Australia who by age in 2005 have smoked tobacco in past week.

Table 14: Secondary students by age who have smoked tobacco in the past week 2005



SOURCE: Smoking behaviours of Australian secondary students in 2005, Table 2: Lifetime experience and current cigarette smoking by secondary school students according to age and gender, Australia, 2005 (%).

63. Australian-wide surveys of secondary school students give an indication of the frequency of use by teenagers of cannabis, alcohol and tobacco. While the 2005 survey shows a worrying level of weekly cannabis use by 12 to 15 year olds (13%), this represents more than a halving of the rate within the previous 10 years. Paul Dillon describes the waxing and waning of cannabis use by children in the following terms:

“Through the 1980s and 90, cannabis use across the community continued to increase, with particular concern focused on the increasing number of school-based young people who were experimenting with the drugs. . . . Since that time, cannabis use among school-based young people in Australia has halved. That said, it still continues to be the illicit drug most commonly used by school students” (Dillon (2009), p. 112 & 113).

“There is evidence that cannabis use in the 20-29 year age group “tends to be largely experimental and intermittent” (Dietze, 2007 p 43).

64. Equally worrying is the extent of teenage smoking of tobacco. A survey of adolescents in the United States tracked over several years found that:

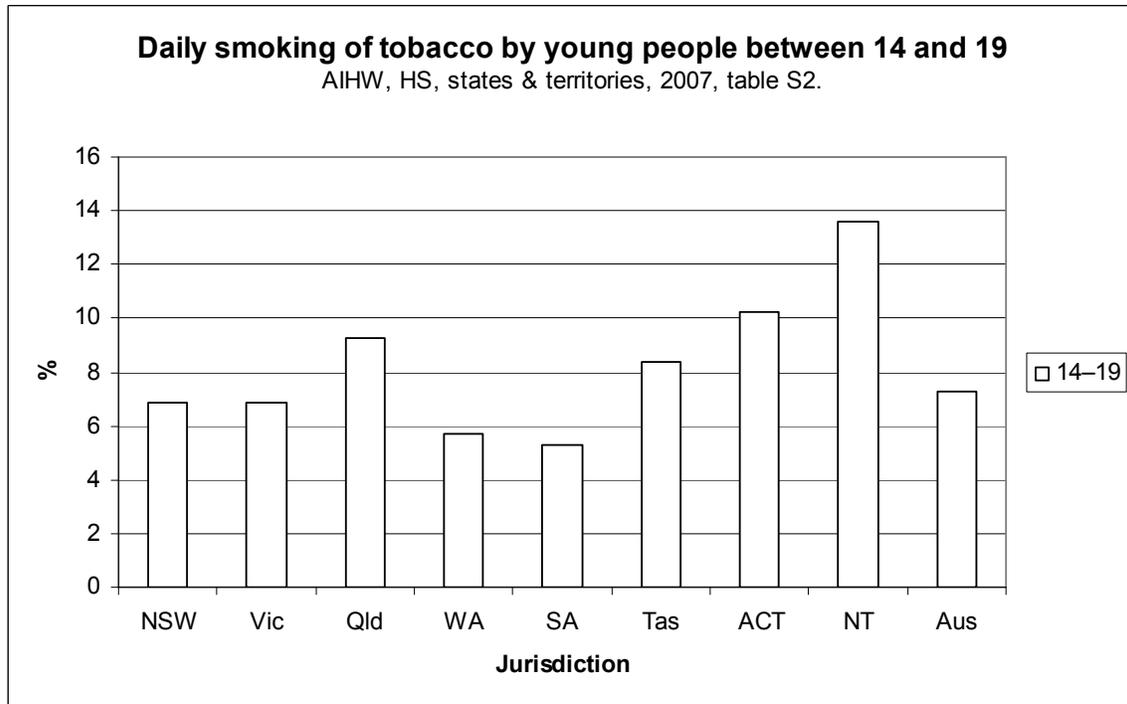
“early smoking onset age is a risk factor for future substance use disorders. Among adolescent daily smokers, an earlier age of smoking onset was

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significantly associated with an increased likelihood of future alcohol and hard drug use disorders; the same pattern of results was noted (but non-significant) for future cannabis use disorder” (Lewinsohn (1999) p. 919).

65. According to the National Cannabis Prevention and Information Centre, “early onset of tobacco use may act as a ‘gateway’ to future cannabis use” (NCPICa 2010). The 2007 Household Survey shows, that Queensland has the third highest daily smoking rate among teenagers:

Table 15: Daily smoking of tobacco by teenagers between 14 and 19 2007

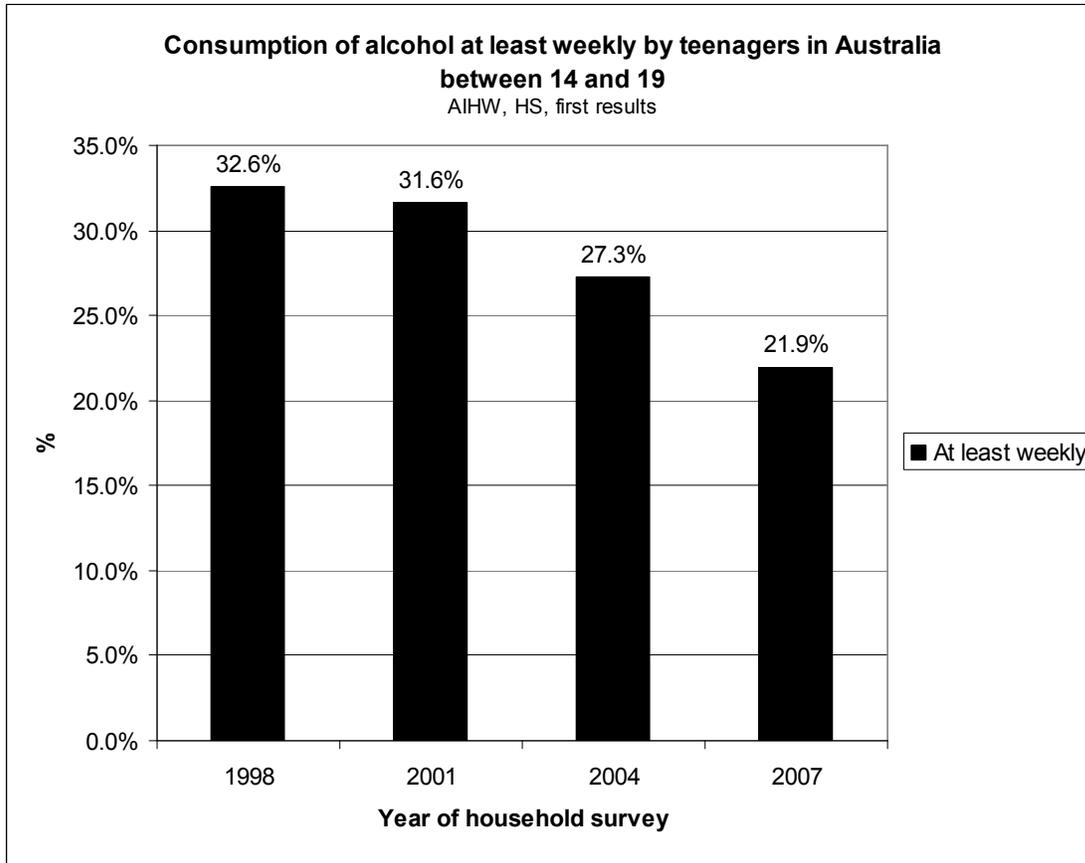


SOURCE: AIHW, HS, states & territories, 2007, table S2: Daily smoking: proportion of the population aged 14 years or older, by age and sex, states and territories, 2007 (per cent).

66. Of much greater frequency is alcohol consumption by secondary school students than use of cannabis or tobacco. Dillon observes: “Interestingly, research has shown that regular heavy alcohol use, particularly during the early teens, is possibly the strongest predictor of future illicit drug use. Of course, this does not fit into the messages that most parents want to give their children about drug use – alcohol is a legal drug, one which the vast majority of Australians use on a regular basis. However, excessive drinking by young people causes many problems and particular patterns of use are regarded as possible indicators of future illicit drug use” (Dillon p. 118).

67. The next two charts show, firstly, what the 2007 Household survey revealed of weekly drinking by teenagers between 14 and 19 and the second chart, risky consumption of alcohol in the past week across Australia by teenagers between 14 & 19:

Figure 16: Consumption from 1998 to 2005 of alcohol at least weekly by teenagers between 14 and 19



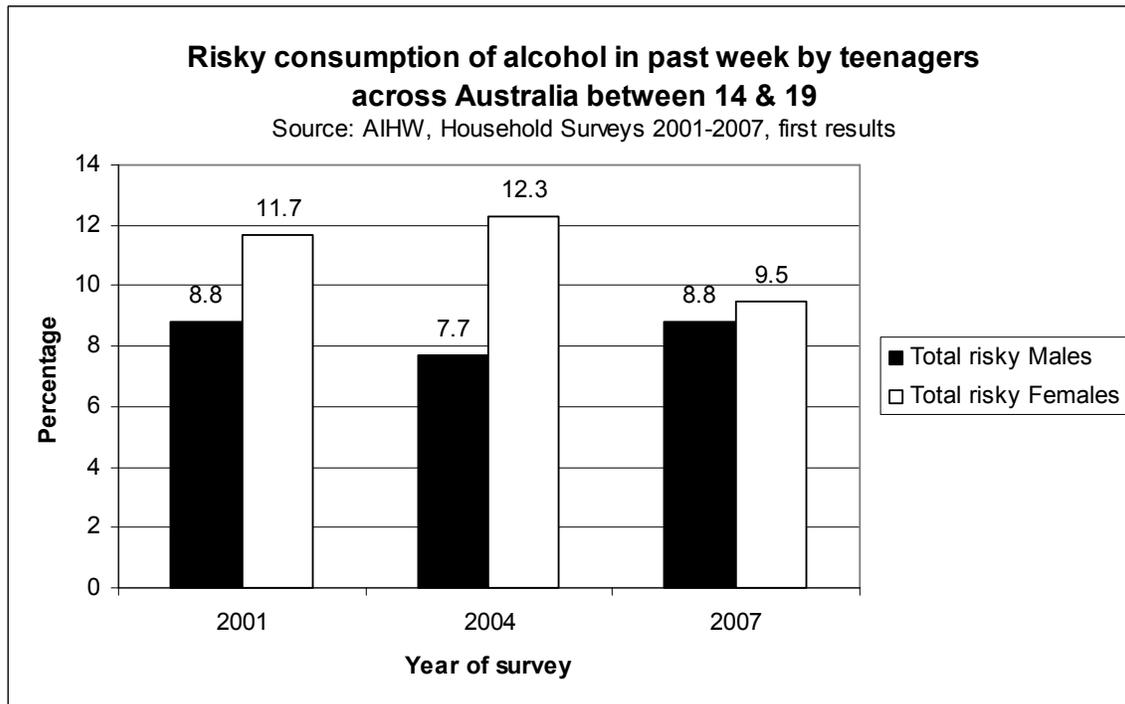
Source: Australian Institute of health and Welfare, Household surveys: first results 1998-2007.

68. Bonomo also comments on the worrying prevalence of dangerous levels of drinking among teenagers:

“More than 70 per cent of Australian children under 13 years of age report having consumed alcohol and this increases to 90 per cent by 15 years of age. Regular (weekly) alcohol consumption is reported by 25 to 30 per cent of teenagers (AIHW (2002a). Epidemiological surveys show that binge drinking is common among young people (AIHW 2002a). Approximately 40 per cent of young males and females drink alcohol at levels defined as putting them at risk for short-term harm (PDPC 2002). In general, males drink more heavily than females, however gender differences in alcohol consumption appear to be decreasing (Hibbert *et al.* 1990; Hill *et al.* 1993; AIHW 2002a)” (Bonomo (2007) p. 188).

Indeed, as the next chart shows, more females than males are engaging in risky drinking.

Figure 17: Risky consumption of alcohol in past week across Australia by teenagers between 14 & 19



SOURCE: AIHW, Household Surveys 2001-2007, first results

69. Dillon comments in similar terms of teenage drinkers who do so to excess: “There is much debate as to whether this group is growing – I don’t believe it is, although it is quite clear that heavy-drinking teenagers are consuming at much riskier levels and at a younger age” (Dillon (2009) p.7).

VIII. RISK FACTORS AND DRUG USE

70. The foregoing discussion discredits the “gateway theory”. A far more likely explanation of the correlation between use of cannabis and other illicit drugs lies in “a generalized risk of using both marijuana and hard drugs.” Mention has already been made of personal factors (propensity to experiment with drugs or personality traits, genetic) socialisation, (familial) and environmental characteristics. This section will look further into these individual and other risk factors, namely environmental and family ones. Given what is known about their influence it will be futile to intensify coercive action against cannabis rather than addressing on a broad front the range of potent risk factors for drug use causing serious problems. In succinct terms Bonomo describes why: Adolescent drug use and abuse cannot be explained in terms of a single or immediate cause. Individual factors and the social context such as school, family, and peers as well as the wider community-all play a role in how drug problems come about. Negative life experiences and stressful occurrences have also been observed to precipitate alcohol or other drug misuse. For this reason, a framework has been proposed that takes into account body risk factors and protective factors thought to influence the developing adolescent. This

framework helps us understand why some adolescents follow trajectories that lead to substance abuse, while many others, even when faced with the most severe psychosocial stressors and the most glaring adversities, remain resilient and do not develop drug and alcohol, or other, problems (Ratter 198.5). Resilience refers to the ability to be well adjusted and interpersonally effective in the face of an adverse environment (Spooner, Hall & Lynskey (2001)). Psychosocial risk-factors for a given individual often 'cluster'. That is, rather than a single risk factor, it is more common to observe within an individual a number of risk factors that impact on health-related behaviours. This explains why many health-risk behaviours (alcohol abuse, heavy tobacco use, other substance use, depression, suicide, delinquency) co-occur. Protective factors are described as countering risk factors and are processes that enable people to deal positively with life changes. They may be events, circumstances, or life experiences that can help to protect young people from harm. They reduce risk impact through direct effects on the risk, through alteration of exposure to risk, reduction of negative chain reactions, promotion of self-esteem and self-efficacy, and processes such as education that open up opportunities. A number of risk factors for substance use and abuse, both environmental and individual, have been identified in the research literature and are briefly outlined below (Bonomo (2007) pp.121).

71. These factors have been identified as follows:

Risk factors for drug abuse

Individual

- genetic predisposition:
- behavioural under-control personality:
- lack of social bonding, alienation,
- high tolerance of deviance,
- resistance to authority
- knowledge about drugs
- coping skills
- commitment to education/academic problems
- early age of first use

Family

- ineffective parental/family management techniques
- negative communication patterns
- poor family relationships
- parental role-modelling

Local environment

- traumatic experiences e.g. child abuse, war, refugee camp

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- socioeconomic status support (e.g. peers, community)
- peer influences
- labelling

Macro-environment

- legislation
- law enforcement
- availability
- social ‘messages’ about use e.g. via the media

Source: Spooner, (1999) (p. 48)

72. The Committee would do well to heed the conclusions of a paper on Structural determinants of drug use published by the Australian National Council on Drugs that government should “Take a broader view of drug prevention: “a. Acknowledge that drug use is one of a range of problem behaviours and should not be seen in isolation. Work collaboratively with others concerned with problem behaviours, including crime, suicide and educational problems, to address the shared pathways to these outcomes.

“b. Understand how drug use is shaped by human developmental processes from birth. This requires consideration of:

- i. critical and sensitive periods in child development (hence the importance of early interventions);
- ii. developmental transitions (hence the importance of timing interventions to coincide with natural transitions);
- iii. the importance of family, community and other social networks in shaping human development.

“c. Acknowledge that drug use is not simply an individual behaviour, but is shaped by a range of macro-environmental factors, including the economic, social and physical environment.

“d. Consider the impact of all government policies and programs on the macroenvironmental influences on developmental health. This needs to be done at the national, State/Territory and local government levels, and in all areas (including taxation, employment, education, urban planning, transport, justice and so on), not just the health portfolio.

“e. Shift the focus from the negative to the positive. Work towards supporting young people to be happy, socially connected, and engaged in life, rather than focusing on negative outcomes such as drug use (Spooner, Hall & Lynskey (2001),p. xi).

73. It is vital to take a broad view of drug prevention, because single-minded attention to one aspect as Drug Free Australia does (overwhelmingly cannabis use) is likely to intensify risk factors for other social problems and even for drug abuse. Thus, the focus on deleterious effects of cannabis use on mental health can well lead to the adoption of

measures that will themselves cause or aggravate mental health problems. This is readily appreciated when one considers that commonality of risk factors associated with drug problems, mental health and crime. The Committee should probe the intimate link between the three of them before recommending the stronger coercive action proposed by Drug Free Australia against cannabis. In fact the evidence points not only to existing coercive measures against cannabis being ineffective in reducing availability (see pp. 14ff above) but worse than that: those coercive measures create and intensify risk factors for drug use, mental ill health and crime. They are, in short, worse than self-defeating. Families are known to have a big influence on the likelihood that a child will engage in antisocial behaviour including serious drug problems and crime. Supportive and caring parents, family harmony, security and stability, a supportive relationship between the child and another adult and strong family norms and morality are among the factors that are considered to provide protection against this outcome (National Crime Prevention (1999) p. 138). “The evidence is now quite overwhelming that juveniles with strong attachments to their family are less likely to engage in delinquency”(Braithwaite (1998) pp. 27-28). At the same time, such are the potency of personal and other environmental risk factors affecting many young people that they will get into trouble with drugs in spite of caring and supportive families. Indeed, Commonwealth Governments acknowledge this in published advice to parents on talking with their children about drugs:

“Some parents think that young people use drugs only if they are having problems at home or at school. But there are many other reasons:

- Availability and acceptability of the drug.
- Curiosity and experimentation.
- Wanting to be accepted.
- Rebellion.
- Depression.
- As a way to relax or cope with stress, boredom or pain.
- To experience a high or a rush.
- To feel OK, at least temporarily (self-medication)”

(Australian Government, Department of Health and Ageing (2007) p. 11)

74. At the same time, illicit drug use can degrade the wellbeing of a family and its capacity to be a protective influence against a child becoming a delinquent or enmeshed in other problems like depression, homelessness and attempted suicide. A family can be affected by illicit drug use in various ways and degrees of severity. At one extreme the impact can be so severe as to render the family dysfunctional. At the lower end of the continuum, the family may remain robust with capacity to provide support for a child who has developed a drug habit. For the purpose of discussion the families in which there is drug use are grouped into low, medium and high risk families.

A. The “low” risk family

75. Young people who get into trouble with drugs can come from families that display a low set of family risk factors for crime. The Commonwealth’s publication,

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Pathways to prevention lists factors personal to the child, school factors and community and cultural factors that are associated with antisocial behaviour including drug use causing problems and crime. Thus there is a higher risk of children ending up in crime if they are of low intelligence, lacking in empathy and low self-esteem (listed child risk factors), have failed at school and been rejected by their peers (schooling risk factors) and have suffered intense loss from the death of a family member (a life event risk factor). The risk will be intensified if the child starts abusing illicit drugs. There are many cases where the family of a child that becomes drug dependent and caught up in the criminal law is a family with a low set of family risk factors for crime. It is particularly troubling that dependent drug use leading to crime also occurs in families where the protective factors are high.

76. This is explained by the attitude of young people to drugs. Research carried out for the Commonwealth Government revealed that illicit drugs were potentially attractive to a wide range of young people of normal personality types (Blue Moon Research & Planning Pty Ltd (2000). The following account is drawn from pp. 1-30 of this report and in particular pp. 27-29). There were those who tended to be outward looking and those who tended to be inward looking. Outward looking ones tended to be more extrovert, positive and confident in their approach to life and were typically more independent and emotionally stable. Those who tended to look inwards were “generally more introvert and pessimistic in attitude. While many are serious and deep thinking they often appear to be less stable emotionally and more likely to follow the lead of others.” In both groups there were those who would be most unlikely ever to touch drugs. Among the outward lookers these were the “considered rejectors” who “believe that drugs are bad, and are a major problem in all circumstances. They are self-motivated people, with little or no need to add excitement to their lives. They are happy with their lives and feel in control of things.” They accounted for 16% of 15 to 24 year olds. Among the inward lookers 13% of 15 to 24 year olds “have little or no need to add excitement to their lives. They differ from the Considered Rejectors in that they are not particularly happy or secure in their lives, and they do not feel in control of things.” At the other end of the scale among the outward lookers were “thrill seekers” who were prepared to take risks. Comprising 20% of 15-24 year olds, they “. . . enjoyed the excitement of drugs, the ‘buzz’, the sense of risk, the excitement and the belief that drugs were ‘cool’. Their curiosity and pursuit of excitement could tempt them to trial ‘hard’ drugs, despite their awareness of the potential dangers.” Among the less confident inward lookers were “reality swappers” comprising 16% of 15-24 year olds. They “believed that the reality they experience while on drugs was better than the ‘straight’ world. They believed they lacked the self-respect, love and interests that their peers enjoyed. Moreover while they often acknowledged that their problems were increased because of the drugs they took, the only relief they knew was through drug-taking.” The heaviest drug users were likely to come from these two groups.

77. The 37% between the extremes of both the inward looking and outward looking personality types “showed a moderate level of use or potential use of illegal drugs”. In short, among the young population there is a large proportion with personality types with a moderate or high potential risk of using illicit drugs. Some of the personality qualities such as preparedness to experiment and take risks that predispose young people to use are qualities that are generally admired. The point that drug use can be a problem in any

family is also expressed in the Commonwealth *Talking with your kids about drugs* quoted above (p. 33) under the heading “Why do young people take drugs?”

78. What this means from the point of view of the present inquiry is that illicit drug usage will lead to the entanglement within the criminal law system of a significant number of young people from families displaying few if any of the risk factors commonly associated with serious drug problems, crime and the like. Illicit drug usage serves as a potent recruiter of young people to crime. This is particularly so where the young person has a serious mental disorder like schizophrenia, major affective disorders, bipolar disorders and other psychotic conditions (Mullen 2001 pp. 14 & 44). The “low risk” family of such a child will, like any other, be subject to high stress by the crime, drug use and, possibly, mental disorders of the child. Even so, it is likely still to retain the capacity to provide considerable support to help the reintegration of even adult children. In the event that someone from such a family is imprisoned it is in the interests of everyone that the family’s capacity is supported and enhanced.

B. The “medium” risk family

79. Research shows that the greater the accumulation of risk factors bearing on a young person and the fewer the protective factors, the greater the likelihood of the child becoming caught up in delinquent behaviour. Substance abuse, a mental disorder or the combination of these magnifies the risks considerably. An otherwise low risk family may be put under a lot of stress if one or both parents loses a job or if the father is absent for long periods. Circumstances may lead to low involvement in a child’s activities. There may be marital discord. Such factors are also risk factors for drug use (Mitchell *et al.* (2001) p. 6). Crime could result from the combination of these sort of family factors with others that are personal to the child, school factors and community and cultural factors.

80. Such a family with a member imprisoned will have a highly stressful event added to other severe stresses that by themselves call for support of that family. It will be so much the more in need of support as a result of the arrest and imprisonment.

C. The “high” risk family

81. Very often the family structure of the imprisoned is in tatters. The family of these young people, as the imprisoned typically are, may have disintegrated. They may have a partner and a child themselves. As likely as not drugs were a big destructive influence in their family of upbringing. Their partner as well as themselves could have a drug problem too. The worst imaginable does happen. The director of an ACT family and child protection service has painted some such scenarios at a forum arranged by Families and Friends for Drug Law Reform: “We see children who are 8 years old or even younger who really I can only describe as feral. They often have been exposed to multiple adults and the behaviours of those adults. Often they have been exposed to direct or indirect sexual experiences. They’re often very grossly inappropriate in the way they seek attention and affection and they often cause grave offence to people in the community. I can remember a child who came to live with us in one of the residential cottages and who was very unhappy about his separation from his mother, giving a very graphic account of what he would do to my mother if he ever bumped into her. And all of this places them at extraordinary risk in the community at large.

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“We see toddlers who are often looking after themselves for significant periods of time when their parents are either physically or mentally unavailable to them. They have inadequate food and sleep. Terrible accidents sometimes happen to them. They suffer burns, have falls from quite high places. And the chaos of the household often means that health needs are not met. We had a little girl who had had hearing difficulties diagnosed. Hearing aids had been provided to her but the hearing aids could never be found in the morning before going to school so she would go to school. She wouldn't hear anything. She wasn't learning anything”(FFDLR (2001).

82. These nightmare visions of an underworld can be recognised in the following list of family factors associated with drug abuse assembled by researchers in the United States.

Table 1: Family factors associated with drug abuse

<p>Family factors associated with drug abuse (Kumpfer, Olds & Alexander (1998) p. 15)</p> <p>Family history of behaviour problem, including:</p> <ul style="list-style-type: none">• parental or sibling role modelling of antisocial values and drug-taking behaviours• favourable attitudes about drug taking• parental criminality, psychopathology, antisocial personality disorder & substance abuse <p>Poor socialisation practices, including:</p> <ul style="list-style-type: none">• failure to promote positive moral development• neglect in teaching life, social, and academic skills to the child or in providing opportunities to learn these competencies• failure to transmit prosocial values and disapprove of youth's use of drugs <p>Ineffective supervision of the child, including:</p> <ul style="list-style-type: none">• failure to monitor the child's activities• neglect• latchkey conditions• sibling supervision• too few adults to care for the number of children <p>Ineffective discipline skills, including:</p> <ul style="list-style-type: none">• lax, inconsistent, or excessively harsh discipline• parental behavioural undercontrol or psychological over control of the child• expectations that are unrealistic for the developmental level of the child creating a failure syndrome• excessive, unrealistic demands or harsh physical punishment <p>Poor parent-child relationships, including:</p> <ul style="list-style-type: none">• lack of parental bonding and early insecure attachment• repeated loss of caregivers• negativity and rejection of the child by the parents, including:<ul style="list-style-type: none">- cold and unsupportive maternal behaviour- lack of involvement and time together, resulting in rejection of the parents by the child• maladaptive parent-child interactions <p>Excessive family conflict and marital discord with verbal, physical, or sexual abuse</p> <p>Family disorganisation, chaos, and stress</p> <ul style="list-style-type: none">• often because of poor family management skills, life skills, or poverty <p>Poor parental mental health, including depression and irritability</p> <ul style="list-style-type: none">• which cause negative views of the child's behaviours, parental hostility to child, and harsh discipline <p>Family isolation:</p> <ul style="list-style-type: none">• lack of supportive extended family networks

- family social insularity
 - lack of community support resources
- Differential family acculturation:**
- role reversal
 - loss of parental control over adolescents by parents who are less acculturated than their children

83. Drug abuse is a particularly potent element in the transmission and magnification of risk factors from one generation to another because of its close association with many other potent risk factors. It is easy to see how a downward spiral through several generations can occur. Imagine generation one being brought up in a low risk family. While the risks of drug abuse among the children may be low, the discussion of “low” risk families (pp. ff). showed how drugs are potentially attractive to a wide range of perfectly normal young people – from among those who have a normal risk taking personality or who have low self esteem. Some from this low risk environment have their life chances and those of their own children badly degraded. There may be capable grandparents to help out. A further generation on and there will no longer be this intergenerational support. To quote again the Director of an ACT family and child protection service: “[W]e’re now certainly seeing second generation families. Of course, there are children who are resilient, who will break out of the lifestyle of drug abuse but there are others who have not been able to escape that and it’s really quite difficult to imagine how they’re going to find their way out of that.”(FFDLR 2001).

84. In ways such as this drug abuse is bringing about a growing community of suffering embracing both indigenous and non-indigenous Australians.

D. Importance of support being provided in the context of the family

85. The snapshot of low, medium and high risk families illustrates, if crudely, the wide range of human situations that the Committee will need to take into account in its recommendations on support services for families. One set of measures is most unlikely to be helpful for all. The immediate situation of the drug user and their family should not be considered in isolation from their life up to that point and from the future. The reasons for this largely self evident proposition include the following:

- (1) We are dealing not just with individual human beings but with human beings dependent on each other. The family is likely to be the grouping where the interdependence is most concentrated or which, if strengthened, holds out the greatest promise of benefit to all.
- (2) The insights of early intervention highlight the importance of the family in its influence on the upbringing of young people. Many of the most potent risk and protective factors associated with mental health, substance abuse and other social problems as well as crime are closely associated with families. The influence of the family is of most significance at transitions between life phases (National Crime Prevention (1999) pp. 131-32), of which the exercise of the coercive powers of the State through arrest and detention is clearly one. The capacities of the family of upbringing and additional family relationships established in early adulthood by the person in custody have a strong bearing on the outcomes for the detained person.

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86. Risk-taking predisposition and latent propensity to use drugs is just one of a range of risk behaviours, rather than a causal effect of earlier gateway drugs

IX. SECTION TWO: CANNABIS HARMS

A. Adverse Health Consequences

Families and Friends for Drug Law Reform will seek to provide in a supplementary submission further comments on the adverse health effects of cannabis.

B. Pulmonary

C. Mental Health

D. Attention deficit hyperactivity disorder

87. Attention deficit hyperactivity disorder (ADHD) is the most commonly occurring childhood disorder. The Child and Adolescent component of the National Mental Health Strategy found that 11.2 per cent of Australian people have the condition (Barton & Hay pp. 196-97). According to the diagnostic criteria, DSM-IV the impairment which is more frequent in males should be present before 7 years of age. About a third of those diagnosed in childhood continue to meet the criteria in adulthood (ibid. p. 197). It is also thought that genetics plays a big part in ADHD, indeed at 85-90 per cent, a bigger role than in any other behavioural disorder.(p. 200). Thus, overwhelmingly if not exclusively its onset cannot be attributed to cannabis use by the young people suffering the disorder yet between 50 and 80 per cent of children with the disorder also have comorbid disorders (ibid., p. 201). “Childhood ADHD” has been “associated with an increased risk for the use of and problematic use of alcohol, and early, heavier use of tobacco and other drugs in adolescence” (ibid., pp. 203-04). In other words ADHD, a condition unrelated to cannabis or other drug use of the person concerned, renders those suffering from it vulnerable to developing drug problems.

- 1. Anxiety**
- 2. Depression**
- 3. Psychoses**
- 4. Schizophrenia**

88. Suspected links between cannabis use and the serious and disabling mental illness of schizophrenia are at the centre of concern of the Committee’s inquiry. The postulated links are several: that cannabis precipitates schizophrenia among those predisposed to it; that it aggravates symptoms of the condition, that it precipitates relapses and even that it actually causes schizophrenia among those not otherwise prone to it. Such concerns must be taken very seriously indeed. The focus should be on the identification of measures that makes these.

89. Families and Friends for Drug Law Reform does not presume expertise in this highly technical subject of linkage. Our understanding of the issue is assisted by the account of schizophrenia and its etiology in the article on that subject in Wikipedia which is very well referenced to the medical literature. The following is what Families and Friends for Drug Law Reform understands of the situation:

(a) typically schizophrenia occurs in young adulthood. This age coincides with high cannabis use (Wikipedia 16/4/10 quoting Castle *et al* (1991)).

(b) the prevalence in the population of the illness is small: around 0.4–0.6% of the population affected (Wikipedia 16/4/10 quoting (Bhugra D 2005 & Goldner et al. 2002). In other words it can be expected that for every 1,000 people, 5 will suffer from schizophrenia.

(c) If cannabis were a large contributor to schizophrenia, it would be expected that there would be a large increase in the illness in the countries where there is a high prevalence of cannabis use but this is not the case:

“A major epidemiological puzzle, given this evidence (linking cannabis use to schizophrenia), is that the treated incidence of schizophrenia, particularly early onset acute cases, has declined (or remained stable) during the 1970s and 1980s despite very substantial increases in cannabis use among young adults in Australia and North America (Hall & Degenhardt, 200b)” (Hall & Solowij 2006, p. 121).

(d) Not only have epidemiological studies failed to detect a correlation between the level of cannabis use and schizophrenia but there has also been a reduction in the treated incidence of the disease in countries where a lot of cannabis is used:

“Although there are complications in interpreting such trends, a large reduction in treated incidence has been observed in a number of countries which have a high prevalence of cannabis use and in which the reduction is unlikely to be a diagnostic artefact (Hall, 1998; Degenhardt et al., 2003)” (Hall & Solowij 2006, p. 121).

(e) The Drug Free Australia paper does not refer to a careful and thorough review by Theresa Moore, Stanley Zammit and others published in 2007 in *The Lancet*. This study analysed all available studies of sufficient rigour – five consisting of adult population cohorts and two of birth cohorts i.e. seven in all. This determined that the overall odds ratio of developing schizophrenia after having used cannabis was 1.41, a great deal less than the 600% greater risk of a schizophrenia diagnosis quoted in the Drug Free Australia paper. The increased risk of schizophrenia from use of cannabis must be put in perspective. If it can be expected that 5 in 1,000 will develop schizophrenia in the ordinary course of things, only a further 2 will do so if all that population used cannabis (Moore, *et al.* 2007). It must be admitted that on a population level, this is significant. On the basis that cannabis actually causes schizophrenia (which Moore and her colleagues admit remains an open question), they equated the increase in risk of a psychotic outcome of 1.4 times which their analysis of other studies suggested, as meaning that 14% of psychotic outcomes in young adults currently in the UK would not occur if cannabis were not consumed” (Moore, *et al.* 2007 p. 326). Families and Friends for Drug Law Reform believes that the current state of research is summarised by the Mental Health Council of Australia in its fact sheet on cannabis:

“Cannabis use precipitates schizophrenia in people who have a family history of that mental illness.

“There is a 2-3 times greater incidence of psychotic symptoms among those who used cannabis, however, the epidemiological data shows that cannabis cannot be considered a major causal factor” (Mental Health Council of Australia ND)

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(f) There are many other risk factors for schizophrenia which Wikipedia groups as genetic, pre-natal (such as the potent influence of prenatal exposure to infections) and social factors play a big role as well as substance abuse (Wikipedia 26/4/10). There is thus a danger that responding to one possible factor (substance abuse as Drug Free Australia recommends) could aggravate other risk factors. Zammit, in his analysis of Swedish conscripts acknowledged that “Previous research has found that psychiatric diagnosis at conscription, IQ score, personality variable concerned with interpersonal relationships, place of upbringing, paternal age, and cigarette smoking are all associated with schizophrenia” (Zammit *et al.* 2002)

(g) If cannabis aggravates symptoms of schizophrenia or even causes the illness, a Brisbane study has shown that the relationship with cannabis is a two-way street: the severity of psychotic symptoms is a “significant predictor of cannabis relapse”, in other words of cannabis use (Hides 2006, p. 140): “there was a high rate of cannabis relapse, with 60.9% of participants increasing their use of cannabis to a level that fitted with the definition of a cannabis relapse [at least 5 days per week]” (Hides 2006, p. 141). The authors who included Dr Hides at Griffiths University and Dr Kavanagh of the University of Queensland commented that:

“by indicating that the relationship between cannabis use and psychosis is bidirectional, these findings provide some support for the stress-vulnerability coping model of psychosis, and highlight the need for early intervention programmes to target both cannabis use and psychotic symptom severity in this population” (Hides 2006, p. 142).

(h) It is essential that a broad focus be adopted regarding the link between cannabis and schizophrenia and indeed of other mental disorders. The formulation of a response concerning schizophrenia, cannabis and other addictive substances needs to take into account all known risk factors and not be confined to Drug Free Australia’s single focus on cannabis. As Dr Paul Mullen, clinical director of the Victorian Institute of Forensic Mental Health and Professor of Forensic Psychiatry at Monash University has written:

“The evidence is mounting that the frequency with which those with mental disorder are resorting to the abuse of drugs and alcohol is increasing. In one of our own studies the rate of recorded problems with substance abuse among first admissions increased from 10% in 1975 to 35% in 1995” (Mullen 2001, 17).

In a more recent study of those treated for schizophrenia for each of five years between 1975 to 1995, known substance abuse problems among persons with schizophrenia increased from 8.3% in 1975 to 26.1% in 1995 (Wallace *et al.* 2004, 721). The authors of that study added that “had we examined a 2000 cohort, the rate would have been well over 30%” (*ibid.*, 725).

5. Brain Function

E. Mental health problems as a risk factor

“This was lent support in this study through the finding that the number of early onset mental disorders (prior to age 15 years) was an important moderator of risk for developing dependence. The finding that adolescents with externalising and internalising

disorders were at elevated risk of developing drug dependence is consistent with prospective cohort studies, which have found that early onset drug use and mental health problems are risk factors for later dependent drug use (Toumbourou *et al.*, 2007), and that comorbid mental health problems escalate risk of developing dependence once drug use begins” (Degenhardt *et al.* 2010 p. 95).

Suicide

90. Drug Free Australia would have us believe that the use of cannabis induces those who use it to commit suicide. For example, it cites several papers that show: “children over a 21-year period and concluded that cannabis use, particularly heavy or regular use, was associated with a later increase in depression and suicide” (p. 17).

91. Once more this raises the familiar question of correlation and causation. There may be a correlation between cannabis use and suicide but that is a long way from proving a link that cannabis induces people to suicide. There is also the second familiar issue of whether the correlation may be better explained by a set of factors common to both cannabis use and suicide or the even more challenging explanation that the coercive measures applied to combat cannabis use (and which Drug Free Australia seeks intensified) are themselves the causative correlates. Families and Friends for Drug Law Reform assert that there is much evidence in favour of the latter proposition.

92. Wherever the truth lies in relation to causation, the Drug Free Australia study is seriously defective in not examining other credible explanations such as these. Certainly, the Committee should not recommend intensified coercive measure unless it thoroughly examines and satisfies itself on these matters. To do otherwise may be potentially promotive of the very harm of suicide that the Committee aims to reduce.

93. There is certainly a correlation between suicide and harmful drug use:

“There is substantial evidence that harmful drug use is associated with increased risk for suicide. Risk factors for suicide and engaging in harmful drug use are related” (Australian Government, Department of Health and Aged Care (nd)).

94. Darke & Ross have found:

First, mortality among heroin users is in the order of 13 times that of matched peers (Hulse *et al.* 1999). While there are many causes of this excess mortality, suicide makes a substantial contribution. Studies of heroin users reporting suicide as a cause of death range between 3% and 35% of cases, and the suicide rate among this group is estimated at 14 times that of the general population (Harris & Barraclough 1997). Not surprisingly, given the rates of completed suicide, attempted suicide also occurs at a rate well in excess of the general population, as does suicidal ideation. Suicide represents a major risk for heroin users, and a major problem for drug treatment agencies that deal with this population.” (Darke & Ross 2002 pp. 1,390-91

95. Interestingly Darke & Ross refer to a significant correlation between other drug use and suicide but do not mention cannabis:

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“Alcohol dependence, benzodiazepine dependence and mixed drug dependence have all been related independently to an increased risk of suicide” (Darke & Ross 2002 p. 1387).

96. The same study identifies a range of by now familiar risk factors associated with drug users who attempt suicide:

unemployment

homelessness

lower income

lower educational status

arrests and impending imprisonment

unstable social groupings

physical disability

social isolation and dysfunction

poorer social functioning.

poorer current social functioning

higher levels of hostility and interpersonal conflict

adverse events in childhood - ‘shattered childhood’ (which bear upon poor social functioning) – “the more adverse childhood events the greater risk of attempted suicide”

elevated rates of parental psychopathology

parental drug and alcohol problems

Childhood factors have been associated strongly with future suicide attempts among heroin users

parental factors appear to be crucial.

social isolation and dysfunction

absence of parents during childhood

parental drug and alcohol problems

Sexual and physical abuse during childhood have been related strongly to suicide

a history of psychiatric treatment in childhood

97. We have already seen (see pp) that similar risk factors are associated with mental disorders and drug use. In other words, they generally precede drug use. Citing Toumbourou and others, Professor Hamilton observes:

“The cumulative number of risk factors was also found to be associated with crime, depression, suicide behaviour, sexual risk taking, and risk of homelessness (Bond *et al.* 2000; Toumbourou 2002)”(Hamilton pp. 174).

98. This is confirmed by the risk factors identified by the Commission for Children and Young People and Child Guardian:

Table 2: Number and proportion of common factors among children and young people who have suicided in Queensland, 2004–2007

Emerging risk factors and circumstances	Number of cases n	Proportion of cases %
Arguments and relationship breakdowns	51	78%
Argument with a significant other	26	
Relationship breakdown with a significant other	24	
Behaviour and disciplinary problems	41	63%
Suspended or expelled from school	31	
Contact with police or youth justice	25	
Communicating suicidal intent	39	60%
Suicidal behaviour	38	58%
Previous suicide attempts	14	
Mental health issues	28	43%
Presented to medical practitioner with mental health issues	21	
Mood disorders	19	
Schizophrenia and psychosis	7	
Attention-deficit and disruptive disorders	7	
Contagion suicide	27	42%
Imitative (friend, acquaintance, community member)	14	
Familial (family member)	13	
Childhood abuse, chronic familial conflict and violence	26	40%
Known to the Department of Communities (Child Safety Services)	14	
Case file current with the Department of Communities (Child Safety Services) at death	7	

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Data source: Queensland, Commission for Children and Young People and Child Guardian 2009 p.10 using RYSQ Preliminary Findings Database (2004–2007)

99. The pathway from personal, family, school and wider environmental risk factors to drug use, mental illness, crime, imprisonment and suicide is well documented. One does not need to postulate the pharmacological effects of drug use as the causative factors of the unhappy developments. They are adequately and more credibly explained by the intensification of risk factors brought about by the very sort of measures that Drug Free Australia is advocating.

100. The similar risk factor for mental ill health are listed in a National Mental Health Strategy Publication, *Promotion, prevention and early intervention for mental health-a monograph* (Australian Government 2000, table 2 p. 16). The extent that substance disorders and other mental health disorder coincide is so marked that the Senate Select Committee on Mental Health declared:

“Over the last twenty years the number of people with mental illness who also have a substance abuse disorder has been increasing. Service providers now report dual diagnosis is the ‘expectation not the exception’ in treated populations. Tragically, many of those affected are young” (Senate, Select Committee on Mental Health 2006 §141, p. 365).

101. In using an illicit drug, a person becomes a criminal and an outcast in the eyes of the law. Figure 5, p. 11 shows that 1,000s of plain drug users are arrested in Queensland every year. Other links between illicit drugs and crime are very strong indeed for the following reasons:

- Users are moved to commit a crime when under the influence of illicit drugs;
- Dependent Users are moved to crime to raise the funds required to purchase further supplies of drugs;
- People young and not so young are attracted to the distribution of illicit drugs by the money to be made;
- Those burdened by risk factors brought about by illicit drug use within their family and social environment are more likely to engage in crime as a result;

102. Criminal processes and imprisonment intensify the risk factors which already burden the typical young person who is afflicted with a drug problem and a mental health condition. A National Anti-Crime Strategy publication, *Pathways to prevention*, prepared by Prof. Ross Homel of Griffiths University and colleagues lists a familiar set of child, family, school, life events and community and cultural risk factors and protective factors (National Crime Prevention 1999, tables 3.3 & 3.4 and pp.135 & 138). The working out of these factors is reflected in the discussion paper of the Commission for Children and Young People and Child Guardian:

“In 38% of suicides, children and young people had offence-related contact with police or the youth justice system. Offences committed by these children and young people included:

- physical and sexual assaults

- possession of drugs
- stealing and breaking and entering
- graffiti and wilful damage, and
- unlicensed and drink driving.

Several children and young people suicided just prior to a court date or following an arrest. In these cases there is evidence that they feared detention or were extremely apprehensive about the impact of involvement with the youth or criminal justice system. It is acknowledged that many youth who come into contact with police are not suicidal. The challenge therefore lies in identifying features that point specifically to increased suicide risk among some of these children and young people.

In 39% of cases, children and young people had both offence-related contact with police and had been suspended or expelled from school. This means that those most at risk may be difficult to engage due to their challenging behaviours” (Queensland, Commission for Children and Young People and Child Guardian 2009 p. 11).

1. Suicide and self harm in detention

103. There is no greater demonstration of the injury to mental health caused by the prison environment than the high level of suicide and other self harm by detainees. The extent that this happens and the degree of mental distress in prisons that it demonstrates is alarming.

“The rate of suicide in prisons is estimated to be between 2.5 and 15 times that of the general population. . . . It has been estimated that for every suicide there are 60 incidents of self-harming behaviour. It is evident that inmate self-harm has become endemic in many correctional institutions.” (McArthur *et al.* (1999) p. 1)

104. It is thus “inescapable that suicide is a longstanding, major issue for correctional authorities” (*ibid.*).

105. Prompted by a string of inquiries and inquests, correctional authorities have taken firm steps to reduce successful suicide attempts. Seclusion in cells without hanging points and under continuous or regular monitoring is effective in preventing this. However, the same measures may further harm the mental health of the person confined making it more likely that he or she will attempt suicide again.

106. According to a leading manual on the management of mental disorders, “individuals who have a depressive or bipolar illness are more likely to commit suicide than individuals with any other psychiatric or medical illness. The rate of death from suicide among individuals with a bipolar illness is high, with a mean of 19% (rates vary across studies) and the rates in Major Depressive Disorder may be similar” (WHOCC (2004) p. 22). Bipolar illness and depressive disorders fall into the category of affective disorders. On reception to the NSW corrections system, 33.9% of women and 21.1% of men had an affective disorder of some kind.

107. Under standard prison practices efforts through seclusion to prevent suicide take place at the expense of the mental health of those concerned. The words of Professor Mullen from *Forensicare* in Victoria go to the heart of the matter:

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“Placing potentially suicidal prisoners in isolation cells stripped of furniture, clear of hanging points and subject to the constant gaze of prison staff may be a cheap and, in the very short term, effective suicide prevention strategy, but should remain unacceptable to a mental health professional concerned with the state of mind and long term mental health of their patient” (Mullen (2001) p. 37).

108. The same point was a matter of concern to the Senate Select Committee on Mental Health which reported:

“The process of isolating such persons and placing them in seclusion appears effectively to prevent suicide and may prevent disruption to other inmates, but is hardly therapeutic for people who are mentally ill. A former visiting general practitioner to the [Brisbane Women’s Correctional Centre], Dr Schrader, made the following observations about the use of the isolation cells at the Centre:

The treatment is the opposite of therapeutic. The use of seclusion is inappropriate for those of risk of self-harm and suicide. Observation alone does little to help the woman overcome her distress and suicidal or self-harming feelings and is alienating in itself A key element in suicide prevention is the presence of human interaction.

“The committee heard similar evidence about the use of seclusion facilities for prisoners assessed to be “at risk” in other jurisdictions. Mr Strutt, a member of Justice Action, a prisoners’ activism organisation, referring to the use of isolation cells in NSW, stated that:

If you are a prison officer and you see a prisoner who seems to be seriously depressed your No. 1 priority is to make sure that that person does not kill themselves while you are on duty. So basically you put them in a strip cell. For all the talk about care and attention they are getting in prisons and hospitals, the way those institutions are structured means they are not getting the appropriate care and attention” (Senate (2006) §§13.110-111).

109. In fact, the practice of seclusion is the opposite of the “key element in suicide prevention”, namely human interaction, that Dr Schrader mentioned in her words that the Senate Committee quoted.

110. Positive human interaction and support are fundamental for suicide prevention (WHOCC (2004) p. 23). A set of measures should be implemented to improve suicide prevention practices:

“It would be preferable to focus on suicide prevention measures, including those identified by Liebling as follows:

- family support and visits;
- constructive activity within the prison system;
- support from other prisoners;
- support from prison visitors and other services;
- having hopes and plans for the future;

- being in a system with excellent inter-departmental communication; and
- staff who are professionally trained and valued by the system” (AHRC (2007) p. 82).

2. Post release suicide

111. There is a sharp rise in the suicide deaths of men in the first weeks after release from prison. A large Australian study now supports findings of similar American and British ones. The American study found that “the risk of suicide within the first 2 weeks after release was over four times greater than that observed during other periods. In the British study, over one-fifth of all suicides occurring within 1 year of release from prison took place within 4 weeks of release (Kariminia *et al.* (2007) p. 389).

112. The NSW survey of all 85,203 adults who had spent some time in full-time custody in prisons there between 1988 and 2002 found that the suicide rate in men in the 2 weeks after release was 3.87 times higher than the rate after 6 months when the rate approaches that observed in custody. Male prisoners admitted to the prison psychiatric hospital had a threefold higher risk than non-admitted men both in prison and after release (Kariminia *et al.* (2007)).

“Suicide peaked in men during the first 2 weeks after release at a rate of 507 per 100 000 person-years, declining to 118 per 100 000 person-years after 6 months (adjusted relative risk, 3.87; 95% CI, 2.26–6.65). In men, the association between time after release and suicide was not uniform among different age groups. The highest increased risk in the first 2 weeks after release was for those aged 45 years or older (adjusted relative risk, 13.38; 95% CI, 5.37–33.37). The excess risk was reduced during subsequent weeks but remained significant for those aged 35 years or older. No suicides occurred among women in the first 2 weeks after release.” (Kariminia *et al.* (2007) pp. 388-89)

113. The NSW study observed no rise in the first 2 weeks after release in the already high suicide rate among Aboriginal Australians.

114. The authors of that study commented that:

“Suicides in prison receive considerable attention from prison authorities. Programs, policies, and even architectural considerations are in place to minimise the risk of suicide during incarceration. In contrast, far less attention is paid to the post-release period, when the duty of care shifts from the custodial authorities to the community. Release from prison may not increase the overall risk of suicide compared with being in prison, but the first few weeks after release are a period of intensified risk.

“Our findings suggest that the initial adjustment period after release is a time of extreme vulnerability, particularly for men. It is possible that on return to the community, historical variables associated with suicide such as hopelessness, significant loss, social isolation, lack of support, and poor coping skills are especially significant for this group, as a considerable number of them are already predisposed to suicide because of mental illness and/or substance misuse” (Kariminia *et al.* (2007) pp. 389)

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115. One might add to the comments that responsibility of the Government for the well-being of those who are detained should not end upon release, particularly in the light of the Correction Coalition's understanding that:

- Physical measures like seclusion taken to prevent self harm within prisons may well harm the mental health of those subject to it thus making suicide more likely when those physical safeguards are not present;
- The detention, through the disruption it brings about of the life of those detained, itself undermines their capacity to function in the community;
- There is a need to compensate for the disruption of detention through the provision of support in the community after release in co-ordination with support within the prison. The Corrections Coalition is concerned at an apparent lack of whole of government planning for this.

116. Suicide attempts are a feature of institutionalisation. The high rates of return to prison of young offenders (see above at 62), the chronic relapsing feature of addiction and the fact that many drug dependent people take years to shake their habit all point to the continuing exposure of vulnerable people to a high risk of self harm and suicide under present policy settings. One can be confident that the measures proposed by Drug Free Australia would be added to these already high risks. No doubt many people would be better off if they had not or do not continue to use cannabis but additional efforts to cure that situation, which as shown earlier in this submission is tending to cure itself, should not make things worse. Doing as Drug Free Australia proposes would be equivalent to galloping into a mob of cattle already moving in the desired direction. Doing so would result only in a stampede.

X. CANNABIS TREATMENT

Need for stress-free treatments

117. Families and Friends for Drug Law Reform agrees with Drug Free Australia that clients in treatment require a sense of hope and that positive expectations are especially critical when facing a protracted period of withdrawal (Zweben & O'Connell, 1992). While joining with DFA in seeking measures to reduce cannabis use, particularly among early teenagers, Families and Friends for Drug Law Reform suspects that it will part from DFA in the terms of giving overriding importance to abstinence. Like As Professor Kavanagh of the Mental Health Centre at the Royal Brisbane Hospital has remarked of treatments and services for comorbidity : "An approach that . . . sees abstinence as the only positive goal will have limited applicability" (Kavanagh 2001, 65).

In a supplementary submission Families and Friends for Drug Law Reform will address promising interventions such as motivational enhancement theory.

Complexity

118. The endorsement by Drug Free Australia for the indigenous population of recommendation Number 70 of the report to the *Ampe Akelyernemane Meke Mekarle*

“Little Children are Sacred” Inquiry which “recommends that government develop and implement a multi-faceted approach to address the abuse of illicit substances in Aboriginal communities, in particular cannabis.” Is much closer to the approach that Families and Friends for Drug Law Reform believes should be implemented across the whole Australian population. Measures under recommendation no. 70 were to:

- a) Recognise the geographic context of substance abuse, which occurs in both urban and remote locations, and its implications; and
- b) Are population-based, youth-focused and integrate substance abuse, mental health and other health and welfare concerns into youth programs. (DFA paper p. 27)

XI. DRUG FREE AUSTRALIA’S RECOMMENDATIONS CONSIDERED

119. At this point Families and Friends for Drug Law Reform turns its attention specifically to some of Drug Free Australia’s recommendations.

A. Impact of coercive processes of the criminal law

120. Intensification of coercive measures is at the heart of Drug Free Australia’s recommendations. This is particularly evident in its recommendation 4 call for:

Federal, State and Territory police are resourced to implement NOAH (Narcotics, Opiates, Amphetamines, Hashish 1992) blitzes every three months for a two year period.

121. There is a huge literature on the harms imposed by drug law and policy. We include just two summaries of these harms. The first is from a recent systematic review of harm reduction:

“There is a set of harms arising from the illegal status of drugs. These harms are largely accrued by the drug user and include imprisonment and loss of liberty, a criminal record (which leads to difficulties with employment etc.), developing criminal experience, and associating with criminal networks. In addition corruption and the presence of black markets are harms borne by the community. The potential for blood borne virus transmission is also associated with the illegal status of drug use (hurried, inadequate injecting practices for fear of detection; and illegality of injecting equipment in some countries/states).”(Ritter & Cameron 2005, p. 47)

122. The second and similar account of the harms inflicted by drug law and policy was written over ten years ago. It shows that knowledge about the harms of drug laws and policy are far from new. The statement was in fact made by an officers’ committee inquiring into serious drug offences:

“... it has become increasingly apparent that significant elements in the harm which results from habitual use of illicit drugs are a consequence of criminal prohibitions and their effects on the lives of users. Quite apart from the risks of arrest and punishment, there are risks to health or life in consuming illicit drugs of unknown concentration and uncertain composition. The circumstances in which illicit drugs are consumed and the widespread practice of multiple drug use add to those risks. Medical intervention in emergencies resulting from adverse drug

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reactions may be delayed or denied because associates fear the criminal consequences of exposing their own involvement. The illicit consumer's expenditure of money, time and effort on securing supplies may lead to the neglect of other necessities. It will often impose substantial costs on the community, and the user, if the purchase of supplies is funded from property crime. Further social costs result from the stigmatisation of habitual users as criminals and their alienation from patterns of conformity in employment, social and family life.

"Risks are inherent, of course, in habitual use of most, if not all, recreational drugs. But criminal prohibitions amplify those risks. They amplify, for example, the risk of death from overdose." (SCAG 1998, pp. 6-7).

123. In full recognition of these dangers, the officers committee, in error in our view, went on to recommend what has evolved into the *Law and Justice Legislation Amendment (Serious Drug Offences and Other Measures) Act 2005* which, contrary to what one might expect from its title, makes mere possession by drug users a serious drug offence under Commonwealth law. The officers committee went on to say that the imposition of extra risks on drug users was intended:

"We may say that [the amplification of risks] is precisely what criminal prohibitions are meant to do. The greater the risks, the greater the deterrent effect, both on those who are habitual users and those who might otherwise be tempted by the lifestyle. Mark Moore, a leading American authority on drug law policy, refers to the 'effective cost' of heroin use – the effective cost of use is an amalgam of all those factors which make the life of the habitual user dangerous, arduous, frightening and expensive. To the extent to which criminal law prohibitions have as their object an increase in the effective cost of heroin use, they counter the requirements of humanity with the logic of pure deterrence." (*ibid* p. 7).

124. It should not be beyond this Committee's ability to propose a system that dissuades use of illicit drugs without resorting to the blunt and severe instrument of the criminal law. That, after all, has been successfully done to reduce tobacco consumption which, ironically, Drug Free Australia commends in generous terms:

"That the Federal and all States and Territory Governments resource and conduct a long-term cannabis QUIT campaign, to be organised and implemented along lines similar to the successful "QUIT Tobacco" campaign. Further, that the Cancer Council of Australia be encouraged to promote the message that cannabis has carcinogenic properties that cause the same adverse health consequences as tobacco (rec. 6).

125. There is no wonder that families feel themselves in a hopeless situation. The core of drug law and policy is to threaten and often to inflict harm on their drug using member with a view to that member ceasing to use. The moral compass applied to reach this point is not the protection of the life and well-being of the drug users but rather the overriding importance of enforcing abstinence. Only by a refusal to be open to the truth is it possible to hide the awfulness of this moral choice.

126. As we know from the consideration of the drug market indicators discussed above at pp. 6 ff. and the example of many addicted users who continue using (or commence using) in prison, law enforcement pressure has a very limited impact on reducing drug use. Parents are advised to stand back and wait till their children hit “rock bottom” – the accumulation of enough misery to bring them to their senses and give up drugs. In the case of heroin addiction, families are told to expect the death of their member: that a third of those addicted will die. In this sense Australian families are called on to reconcile themselves to the likely death of a family member brought about by law and policy responses. Parents experience grief before their child’s death. (Oreo & Ozgul 2007). That death is so likely does not necessarily follow from the heroin addiction. Death is avoidable and a good quality of life possible even though people remain addicted.

127. Whatever the harms of cannabis, they do not compare to the harms of heroin. There is a real danger, though, that application of the criminal processes will bring into being or intensify risk factors precipitating heroin use while at the same time destroying the young person’s life chances. Research on different strategies used to counter the availability of cannabis show how misguided attempts to combat cannabis can have this effect. The standard processes of the criminal law have been varied in some jurisdictions (most recently in Western Australia) for minor cannabis offences to provide for an expiation notice process similar to on-the-spot parking tickets. Under this system the drug remains prohibited but minor offences incur a civil rather than a criminal penalty.

128. A comparison was made between South Australia which has long had an expiation system and Western Australia before a similar system was introduced there. The study found that those prosecuted in Western Australia were more likely to report negative employment consequences than those who received an expiation notice in South Australia. The difference was marked. Of the Western Australia group 32% identified at least one negative employment consequence and 16% of these were sacked as a result of the offence. In South Australia only 1.7% reported such a negative consequence.

129. In personal relationships only 5% of the South Australian group reported negative consequences compared to 20% of the Western Australian group. Whereas 16% of the West Australian group reported negative consequences in their accommodation, none of the South Australian group did so.

130. In contrast to the marked negative impact of the application of the traditional criminal processes in Western Australia compared to South Australia, the Western Australian process did not serve as a stronger deterrent against actual cannabis usage. This aspect is mentioned further below (Lenton *et al.* 1998, x).

131. The study thus found that the different strategies used to combat cannabis usage had significantly different incidental impacts on cannabis users – impacts that heighten known risk factors for mental illness and drug use such as unemployment, poverty, homelessness, insecurity, divorce and family break-up.

B. Incarceration

132. There is no more cogent indicator of the negative impact on mental health of current strategies to combat illicit drug use than the high proportion of the population of Australian prisoners who have a mental illness or disorder associated with the use of

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illicit drugs. Imprisonment is also a potent aggravating experience for those with a mental illness or disorder.

133. Dr Richard Matthews, Chief Executive Officer of the NSW Corrective Health Service gave evidence on 16 August 2002 to a House Representative Standing Committee on Family and Community Affairs that 90.1% of women on reception in NSW have some form of mental illness or disorder as do 78.2% of men. On substance abuse he reported that compared to 2.8% in the general community, 74.5% of women on reception in NSW corrective institutions are dependent on or abuse alcohol or another drug. For men the figures are 7.1% and 63.3%. The drugs concerned are interesting. 20.5% of the men were dependent on or abused cannabis, 35.2 % on an opioid, 11.9% on a sedative, 30.8% on a stimulant and 22.4% on alcohol. The levels of dependency or abuse by women was much higher for all categories of drug (Butler & Allnutt 2003).

C. Drug Testing

134. Drug Free Australia asks the committee to endorse student drug testing in schools. It sees this measure as “prevention and as a deterrent”. It sees testing as “giving a clear message that drug use including cannabis, is not permitted” and as encouragement for families “to seek help for their children in need” (rec. 10). Drug Free Australia’s advocacy for school drug testing collides with the review of the practice undertaken by Professor Ann Roche, head of National Centre for Education and Training on Addiction for the Australian National Council on Drugs (NCETA): a review which considered Drug Free Australia’s arguments. (Drug Free Australia made a submission to it.) NCETA concluded in uncharacteristically strong terms that:

“Overall, the body of evidence examined indicates a strong case to be made against drug detection and screening strategies being utilised in the school setting” (Roche 2008, p. ix).

135. Drug Free Australia’s “message” argument would seem to be thoroughly discredited by a survey referred to in the NCETA study undertaken by Father Peter Norden of Jesuit Social Services of Catholic secondary schools:

“In a national consultation of 1700 Catholic secondary schools in Australia (660 000 students), the Jesuit Social Services examined how schools responded to incidents of illicit drug use by students (Norden, 2005). The Keeping Them Connected report concluded that, rather than reducing drug use by students, random drug testing, which was implemented in a handful of schools, forced the problem underground, reflecting a breakdown in trust and communication and making it harder for schools to handle. The messages received by students in drug testing schools were: ‘don’t allow your continuing drug behaviour to be detected by school authorities; and if you or another student has problems in relation to illicit drug use, don’t approach school authorities for assistance’ (Norden, 2005). Thus, ‘the approach was seen to be effective in protecting the school’s reputation as being “tough on drugs”, but questionable with respect to the school’s duty of care for the student concerned” (Roche 2008, p. ix)

136. Two of the studies mentioned in the Drug Free Australia paper were assessed in scathing terms by the NCETA study:

“A post hoc survey was also conducted in nine United States schools, which used a variety of drug testing programs (DuPont *et al.*, 2002). Overall, survey results showed limited data pertaining to the effectiveness of drug testing programs. No schools conducted formal evaluations, yet reductions in the number of positive tests for a variety of substances were reported. Since the survey results included only those schools that described their programs as ‘successful’, it is not surprising that the authors concluded that drug testing programs were successful. No control schools were included in the survey to determine whether other components of the program (e.g. drug education, parental/community support) contributed to reduced drug use. For example, evidence from a survey of secondary school students in Victoria (Australia) and Washington (United States) showed significant associations between drug education with strong abstinence or harm minimisation messages (without drug testing programs) and reduced drug or alcohol use at school (Evans-Whipp, Bond, Toumbourou) & Catalano, 2007)” (Roche 2008, p. 77).

137. In other words, benefits are possible in reduction of drug use in school by strategies that do not involve the harmful unintended effects of drug testing which alienate students most at risk and thus intensify the likelihood of them getting into more serious drug and other problems:

“Highest prevalence of drug use occurs among high-risk and vulnerable groups of children, including the poorer academic performers and Indigenous students, indicating that punitive and inquisitorial methods of deterrence are ill-advised” (Roche 2008, p. 77).

138. Drug testing gets no support from the Commonwealth’s *National Schools Drug Education Strategy* adopted in May 1999. This Strategy listed as principles for drug education in schools:

“Objectives for drug education in schools should be linked with the overall goal of harm minimisation.” and

“Effective drug education should reflect an understanding of the characteristics of the individual, the social context, the drug and the interrelationship of these factors” (Australian Government (1999) p. 8).

D. Drug education and media campaigns

Drug Free Australia urges governments to engage in intense education and media campaigns on the harmful effects of cannabis: It calls for the Commonwealth Department of Health and Ageing in cooperation with State and territory governments to issue and “constantly reinforce” “clear messages about the harmful effects of cannabis on the young body” (rec. 8). It also recommends:

“That the Federal and all States and Territory Governments resource and conduct a long-term cannabis QUIT campaign, to be organised and implemented along lines similar to the successful “QUIT Tobacco” campaign. Further, that the Cancer Council of Australia be encouraged to promote the message that cannabis has carcinogenic properties that cause the same adverse health consequences as tobacco”(rec. 6).

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139. Good intentions are no guarantee that drug education and media campaigns will be successful. As always, the rule of thumb should be to do no harm. Unfortunately, ill-informed anti-drug strategies can cause harm. They can actually increase drug use. For example, a United States program, Project SMART (Self-Management And Resistance Training), implemented in the 7th grade “resulted in negative impacts on rates of marijuana incidence and prevalence, with [students who underwent the training] reporting significantly higher rates of use and greater rates of initiation at follow-up than their control counterparts” (Soole *et al.*, (2005) pp. 21-22)

140. Even the Drug Abuse Resistance Education program, DARE for short, that is widely used in the United States and has been the model for many similar programs around the world has been shown to be useless if not worse in reducing drug uptake.

“There were four evaluations of the DARE curriculum [which were delivered by police officers], one being an evaluation of the DARE Plus curriculum, which took the original curriculum and added multifaceted family and community components. Overall, the three evaluations of the standard DARE curriculum failed to find evidence of the effectiveness of the program. The program failed to significantly impact either marijuana or other illicit drug use, either in the short- or long-term. Follow-up rates of hard drug use were almost identical amongst treatment and comparison youths. There was also very little evidence to suggest favourable impacts of the program on marijuana use trajectories, with one study suggesting a significant negative impact of the program on marijuana use rates. The added family and community components of the DARE Plus program failed to improve the effectiveness of the program, finding no significant impact on marijuana use rates. These findings align with findings of previous reviews and meta-analyses of the DARE program” (Soole *et al.*, (2005) pp. 21-22).

141. According to evaluations, competence enhancement education programs tend to be the most effective in reducing uptake of drugs (Soole *et al.*, (2005), pp. 23-24 & 27).

“Competence enhancement programs emphasise the teaching of generic life skills such as communication skills, decision making, problem solving, coping skills and stress management, assertiveness, and other socially relevant skills such as those pertaining to dating and relationships. Programs adopting this approach may also include components highly similar to social influences programs such as refusal skills training, normative behaviour and identification of the social influence on drug use. However, many do not directly address drug use, instead addressing a variety of intermediate, interpersonal factors believed to be associated with drug use susceptibility.” (Soole *et al.*, (2005) p. 17)

142. In addition, some social influence programs including an Australian one, the Illawarra Program, “showed significant positive effects on rates of marijuana use that persisted for three years after the completion of the program” (Soole *et al.*, (2005) p. 22). In social influence programs “youths are educated about the influence of the media, peers, and adults on subsequent drug use.” (Soole *et al.*, (2005) p. 17)

143. The principles for drug education in schools contained in the Government’s own National School Drug Education Strategy (Australian Government 1999), seem consistent with these findings. For example, they state that:

- “Effective drug education should reflect an understanding of the characteristics of the individual, the social context, the drug and the interrelationship of these factors”;
- “Approaches to drug education should address the values, attitudes and behaviours of the community and the individual”; and
- “Drug education needs to be based on research, effective curriculum practice and identified student needs.” (Australian Government 1999 p.8)

Families and Friends for Drug Law Reform believes that this Committee would do well to reaffirm the principles of this education strategy.

144. There is little evaluation on the extent that media campaigns impact on the uptake of illegal drugs. As the Australian National Council on Drugs put it in its recent position paper on methamphetamine, media campaigns have to be well thought out and targeted if they are not to backfire:

“Media campaigns have been used successfully to reduce unhealthy behaviours (e.g. tobacco smoking), but their application in relation to illicit drug use is limited and unfortunately not well evaluated. Successful media campaigns are also expensive and require substantial planning and research. In particular, they require a segmented marketing strategy that identifies and successfully targets the ‘at-risk’ audience (e.g., use media channels that are accessed by drug users and a delivery that is appealing to this audience), research on the target audience to understand their attitudes, beliefs and values (including pre-testing or media campaigns), and most importantly, the campaign must receive adequate and sustained coverage. Media campaigns run the risk of unintended increases in drug use if they are not adequately research and focus tested.” (ANCD 2007).

145. Again it must be stressed that even the most successful school education drug programs and media campaigns cannot prevent people using illicit drugs. All they can realistically hope to do is to influence a moderate percentage of their audience who might otherwise have taken up drugs not to do so. This is illustrated by the successful Illawarra program where students who received the program reported significantly less cannabis use than comparison students at each of the follow-up periods. At 7th grade 6% of the students who received the program reported having tried cannabis compared to 13% in the group that did not receive the benefit of it. In 8th grade the proportions were 12% and 31%, at 9th grade 23% and 40% and in 10th grade 27% and 41%. (Soole *et al.* 2005 pp. 95-96.) Put in other words, even the best preventative programs will fall far short of ensuring that all young people do not use readily available illicit drugs. If young people and their families are not to be written off as non-persons, drug policy must reflect this reality. It is for this reason that the Commonwealth Government’s National School Education Strategy includes among its principles the statements that:

- “The emphasis of drug education should be on drug use likely to occur in the target group, and drug use which causes the most harm to the individual and society”; and
- “Objectives for drug education in schools should be linked with the overall goal of harm minimisation.” Australian Government 1999 p. 8).

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146. Families and Friends for Drug Law Reform has gained the impression that Drug Free Australia wishes to see media campaigns emphasising the dangers of illicit drug use so as to frighten people into not using them. Accordingly, we venture some observations on the effectiveness of scare campaigns and the influence of popular culture on drug use.

1. Scare campaigns

147. Given the waste of life that so often is associated with illicit drug use, Families and Friends for Drug Law Reform would support hard hitting media campaigns which are objective, carefully formulated and targeted. Like the Australian National Council on Drugs (ANCD 2007), we emphasise the danger that poorly formulated and targeted media campaigns will make the drug problem worse. The United States has a recurrent history of failed scare campaigns (Skager 2006, pp. 169-70 & 185). Reefer madness publicity of the Anslinger era has acquired a cult status which encourages children to use. Consideration of the personality profile of those at greatest risk of drug use will show why strategies emphasising the dangers of drug use are ineffective for many. For the “thrill seekers” mentioned on page 34, danger is a challenge. Painting drug use as boring would be a far more effective turn off for these people. The following explains the pitfalls of scare campaigns in a school context:

“Intuitive approaches have led in the past to the use of ‘scare tactics’ in drug education. ‘Scare tactics’ are based on the assumption that ‘if we could just show how risky it is - they wouldn’t do it’. Students, parents, and teachers are often convinced that confronting young people with the most severe harms will deter them from using drugs. However, programs that rely on ‘scare tactics’ have not shown a reduction in the incidence of harmful drug use. There may be a number of reasons why this is so. These include a tendency to believe in one’s own invulnerability - ‘this is not going to happen to me’ - and a poor fit between the young person’s observation or experience of drug use and the consequences shown in the ‘scare tactics’ program - ‘this is not what I have seen happening to others’. Many students have observed parents, peers, or community members using drugs such as cigarettes, alcohol, and cannabis without appearing to come to harm.

“A health-education program can work against its overt message by inadvertently reinforcing the behaviours it aims to work against. ‘Scare tactics’, for example, can inadvertently ‘glamorise’ risky behaviours. ‘Survivors’ or ex-addicts can gain a heroic status in the telling of their story. Thus ‘scare tactics’ may make certain behaviours more attractive or compelling, especially to those with something to prove, those with an adventurous streak, or to those who are driven to cause themselves harm” (Cahill 2007 p. 148).

148. Exaggerated scare campaigns pose another danger. This is that parents are more likely than children to believe the worst about illicit drugs. This is evident from taking telephone calls from parents who have just come across evidence of drug use by their child. Wishful thinking that all has been well with a child whose behaviour has changed is often switched to a panic infused by the most lurid media accounts about drugs. This can lead to parents plunging into a response that has the opposite effect of what they dearly want by, for example, pushing their child closer to a peer group which regards drug use as cool. Where there is drug use, the best outcomes occur when the channels of

communication are kept open. This requires reliable information and understanding which do not thrive in a climate of exaggeration and panic.

E. Law enforcement

149. Drug Free Australia recommends “That greater penalties be introduced to prosecute suppliers and traffickers of drugs to children” (rec. 7 p. 27).

To this one can make at least three observations:

As described below, very heavy penalties indeed already exist on both the Commonwealth and State statute books for drug offences aimed at children.

It is unlikely any increase in the severity of penalties involving children will be anything more than cosmetic. Heavy penalties have not prevented drugs getting into the hands of children.

Surveys show those who supply drugs are generally part of or at least associated with the peer group of drug user. The stereotype of the man in hat and overcoat hovering around the school yard enticing children into drugs is a myth. One’s dealer is generally a dependent user who regards dealing as a more honourable way of raising the funds for his own habit than ripping off friends and family or engaging in property crime.

150. For example, the Commonwealth Law and Justice Legislation Amendment (Serious Drug Offences and other Measures) Act 2005 no. 129, 2005 includes a separate division (no. 309) dealing with “Drug offences involving children”.

The offence of supplying any amount of drugs to children carries a penalty of imprisonment for 15 years or 3,000 penalty units (\$330,000) or both (s. 309.2).

Supplying marketable (i.e. large) quantities of controlled drugs to children carries a penalty of imprisonment for life or 7,500 penalty units (\$825,000), or both (s.309.3

Procuring children for trafficking controlled drugs has a penalty of imprisonment for 25 years or 5,000 penalty units (\$550,000), or both.

151. Matching Queensland drugs legislation, the Drugs Misuse Act 1986, adopts a somewhat different scheme. Under s.6, Offences involving children, or the intellectually impaired or involve smuggling drugs into prison or an educational institution are specified as constituting an aggravation for which stiff penalties are provided.

6 Supplying dangerous drugs under Drugs Misuse Act 1986

“A person who unlawfully supplies a dangerous drug to another, whether or not such other person is in Queensland, is guilty of a crime.

Maximum penalty--

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- (a) if the dangerous drug is a thing specified in the Drugs Misuse Regulation 1987, schedule 1 and the offence is one of aggravated supply--25 years imprisonment;
 - (b) if the dangerous drug is a thing specified in the Drugs Misuse Regulation 1987, schedule 1 and paragraph (a) does not apply—20 years imprisonment;
 - (c) if the dangerous drug is a thing specified in the Drugs Misuse Regulation 1987, schedule 2 and the offence is one of aggravated supply--20 years imprisonment;
 - (d) if the dangerous drug is a thing specified in the Drugs Misuse Regulation 1987, schedule 2 schedule 2 and paragraph (c) does not apply--15 years imprisonment.
152. It may not be out of place to repeat here the observations concerning the considerable federal/state implications of Law and Justice Legislation Amendment (Serious Drug Offences and other Measures) Act 2005 that Families and Friends for Drug Law Reform made in its submission in July 2005 to the Senate Legal and Constitutional Affairs Committee considering the then bill:
- “91. This Commonwealth Bill is a striking extension of Commonwealth legislative authority into the heartland of criminal law in this country. State law has traditionally occupied the field of criminal law apart from criminal law intimately associated with specific areas of Commonwealth responsibility such as communications, customs and aviation. Over the years, the criminal law on drugs has become a large and important part of State criminal law with Commonwealth criminal law on the subject being confined principally to its responsibilities for banking and overseas trade.
92. Founded as drug policy largely is on treaties and other international cooperation, the Commonwealth has long probably had the legislative capacity to regulate most if not all the field under the external affairs power. Why it should have decided to do so now is not explained. The 1998 United Nations Convention against Illicit Traffic in Narcotics Drugs and Psychotropic Substances which the Bill in cl. 300 purports to implement has long been in force and, indeed, was implemented so far as the Commonwealth then chose to implement it by the Crime (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990. The present Bill would supersede that act. It and complementary State and Territory law would have been regarded as a sufficient basis for Australia to meet its international obligations under the convention.
93. That the Government has used the occasion of implementation of Chapter 6 on serious drug offences of the Model Criminal Code to extend the Commonwealth’s legislative reach into State and Territory criminal law is all the more curious. The Model Criminal Code was conceived of as a model State and Territory law. The present Bill does not implement that concept. The Commonwealth, by legislating across Australia may be seen to have made the code exercise redundant so far as Chapter 6 on drug offences is concerned.
94. The explanatory memorandum comes across as somewhat disingenuous when it asserts that the Bill proposes nothing out of the ordinary: “Overlapping State

and Territory drug offences will also continue to operate alongside the offences in Part 9.1 of the Criminal Code. This approach is consistent with the approach taken in other areas of criminal law, such as terrorism, fraud, computer crime, money laundering and sexual servitude. It is intended that drug offences will continue to be investigated in accordance with the established division of responsibility between federal and State and Territory law enforcement agencies” (p. 2). The precedents are all confined, relatively new and linked to areas of particular Commonwealth responsibility”
(www.ffdlr.org.au/submissions/docs/SeriousDrugOffencesSenSub.pdf)

F. Compulsory treatment

153. Drug Free Australia calls for compulsory treatment to be made the norm “for young offenders” (p. 27). By default one assumes that consignment to prison is the recommended fate for drug consumers who can no longer be described as “young” where they will be forced to overcome their dependence (and suffer all the brutalisation that incarceration in prison brings). The employment of coercive measures forcing treatment on people for their own good engages the principle of liberty in a fundamental way. Such action is offensive to liberal principles even if it is for a person’s own good. In short, in our society, the presumption should be very much against invoking of coercion for the good of a person. The burden of proof should be very much on those supporting compulsory treatment to justify the measure.

154. Joel Feinberg, a foremost American writer in defence of liberal legal principles, has written on the *parens patriae* doctrine of English law under which the state is said to have a “sovereign power of guardianship” over minors and other legally incompetent persons, which confers upon it the right, or perhaps even the duty, to look after the interests of those incapable of protecting themselves:

“It is all too easy however to confuse the “nonblamable paternalism” of government protection of the helpless, those who either freely choose to receive the proffered help or else are no longer capable of freely choosing anything, from the presumptively blameable imposition of government “help” on unwilling persons who are still quite capable of deciding for themselves. The confusion is especially common in respect to so-called “mentally ill” persons. Many persons who are properly called “mentally ill” or “disturbed” are subject to upsetting emotions and distortion of affect, but are not so cognitively deranged as to be legally incompetent. Indeed many of them keep their intellectual capacities altogether unimpaired throughout their “illness,” and some do not wish to be confined and treated in mental hospitals. The forcible incarceration of such persons cannot be justified under the doctrine of *parens patriae*, for that legal principle in its forcible application extends only to those unfortunates who are rendered literally incapable of deciding whether to seek medical treatment themselves, and even in those cases, the doctrine grants power to the state only to “decide for a man as we assume he would decide for himself if he were of sound mind” (Feinberg (1986) p. 6).

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155. What at a minimum must be satisfied, if the compulsory treatment is to be justified? Based on the analysis of compulsory treatment published by the ANCD, the following are suggested:

1. Principle of beneficence

156. The biomedical ethical principle of ‘beneficence ... requires that an action produces benefits and that its benefits outweigh its burdens’. Thus, the answers to several questions must be known and weighted: Does compulsory treatment help the individual? Does it help the community? How does compulsion impact upon the individual’s motivation to engage in AOD treatment? What negative impacts does it have on the individual and/or community? The research base to inform answers to these questions, however, is young and incomplete” (Pritchard *et al.* (2007) p. x). In other words we need to know much more about the effects, intended and unintended of compulsory treatment before ever we think of implementing the practice.

157. Drug Free Australia does not state clearly the objectives it anticipates will flow from the compulsory treatment it calls for cannabis abuse but one might deduce them to be:

- Abstinence;
- Reduced recidivism (given the association between drug use and crime); and
- Improvements in physical and mental health.

158. Whatever the case, the objectives of any treatment and particularly compulsory treatment should be clearly laid down. They should be realistic. In this context, the experience of the compulsory treatment provided by the existing Queensland Drug Courts, should be considered. Assessments of it and other drug courts around the country do not hold out much optimism that compulsory cannabis treatment on top of intensified policing will make much of a difference. In an evaluation of the South East Queensland Drug Court undertaken by the Institute of Criminology only 44 of the 264 entered on its program actually graduated (16.67%) (Makkai, Toni and Keenan Veraar (2003) pp. 12 & 36).

159. The numbers are daunting. The 2007 Household Survey tells us that in Queensland 19.4% of the 14-24 year age group had used cannabis recently (i.e. within the previous 12 months). There are 3,322,000 in that age group in Queensland. In other words there is a potential “market” of “young people” for Drug Free Australia’s compulsory treatment of at least 644,468 cannabis users (AIHW (2007B)). Is it an effective use of the taxpayer’s resources to fund the intensive Drug Court-like treatment for this number or even for the 37,910 arrested in 2006-07 for consuming or providing cannabis?

160. There is just not strong evidence that compulsory treatment is effective. A study sponsored by the ANCD noted:

“Most evaluative work has examined diversion programs and produced results that are largely weak and inconclusive. In general, indicators have been chosen opportunistically, often because of limited funding, rather than being designed to answer specific policy-related questions. There is, however, some evidence to

- suggest that some people benefit from compulsory treatment. While the evidence is weak and cannot be said to strongly support the continuation of compulsory treatment programs, neither does it suggest that they are ineffective and should be discontinued. Strong evidence in either direction simply does not exist” (Pritchard *et al.* 2007 p. xix).
161. Klag and his colleagues at Griffiths University have concluded that:
“Regrettably, three decades of research into the effectiveness of compulsory treatment have yielded a mixed, inconsistent, and inconclusive pattern of results, calling into question the evidence-based claims made by numerous researchers that compulsory treatment is effective in the rehabilitation of substance users”(Klag S, O’Callaghan F, Creed P. (2005)).
162. Following the revelation of abuse, there was a strong move away from compulsory treatment in the mental health area. This should equally apply to the drug and alcohol sector not least because drug dependence is defined as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-IV for short) and the World Health Organization’s *The classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines (ICD-10)*.
163. Compulsory detention has received much attention in the United Kingdom in recent years thanks to a judgment of the European Court of Human Rights in the Bournemouth case whom, it was agreed, lacked capacity. The court held that detention of an autistic person in his own ‘best interests’ under the common law doctrine of ‘necessity’ was invalid because the action “was too arbitrary and lacked sufficient safeguards” and, for that reason was incompatible with Article 5 of the European Convention on Human Rights.
164. This prompted a Cochrane review of all relevant randomised controlled clinical trials of compulsory community treatment compared with standard care for people with severe mental illness. The conclusion was a sober warning:
165. The review found:
“little evidence to indicate that compulsory community treatment was effective in any of the main outcome indices: health service use, social functioning, mental state, quality of life or satisfaction with care. However, risk of victimisation may decrease with 'Outpatient Commitment' (OPC). In terms of numbers needed to treat, it would take 85 OPC orders to prevent one readmission, 27 to prevent one episode of homelessness and 238 to prevent one arrest” (Kisely 2005).
166. The authors of the review commented:
Based on current evidence, community treatment orders may not be an effective alternative to standard care. It appears that compulsory community treatment results in no significant difference in service use, social functioning or quality of life compared with standard care. There is currently no evidence of cost effectiveness. People receiving compulsory community treatment were, however, less likely to be victim of violent or non-violent crime. It is, nevertheless, difficult to conceive of another group in society that would be subject to measures that

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curtail the freedom of 85 people to avoid one admission to hospital or of 238 to avoid one arrest. We urgently require further, good quality randomised controlled studies to consolidate findings and establish whether it is the intensity of treatment in compulsory community treatment or its compulsory nature that affects outcome. Evaluation of a wide range of outcomes should be included if this type of legislation is introduced (Kisely 2005).

167. Apart from the large issue of principle hanging over compulsory treatment, there are a range of other practical considerations. These are:

168. As discussed above at pp. 3 ff. only 10% of cannabis users are dependent. Treatment will be wasted on 90%.

169. If Drug Free Australia would have the 90% who are not dependent consigned to prison, huge harm will be done to the lives of these young people. Introduced to a peer group that will, overwhelmingly be dependent on much more addictive and dangerous drugs than cannabis, they are likely to emerge from prison with a serious drug problem, suffer from a mental health problem brought about by the stresses of incarceration, unemployed and have their support network disrupted. A study on recidivism released earlier this year by the Bureau of Statistics identifies imprisonment as an extraordinarily potent risk factor for returning to prison:

“Younger prisoners were more likely than older prisoners to be reimprisoned following release. Within 10 years of being released, the reimprisonment rate for the teenager group (those aged 17–19 years when released) was 61%, compared with 23% for those aged 35 years and over” (ABS 2010 p. 2).

170. While those graduating from compulsory treatment involving drug testing may well be abstinent in the course of the treatment, given the fact that dependence is a chronic relapsing condition, there seems little likelihood that they will remain abstinent in the absence of motivation from within themselves to be so.

2. Financial implications

Drug Free Australia makes no attempt to cost the stringent measures against Queensland cannabis users that it proposes. The Government will, of course, need to do so. The cost of compulsory options against cannabis users would be significant for the Queensland government which must balance the range of options for use of its funds. In committing to more coercive and compulsory actions against cannabis users and sellers the government must of necessity decide which possible services it must curtail. That is of course unless the government adopts the unpopular option of raising taxation, or believes that substantial savings would come from such actions.

In contrast a motive of a tendency in Europe decriminalization has been to free up “resources that could be channeled into treatment and other harm-reduction programs” Greenwald, (Glen 2009, p. 9).

It has been noted that cannabis cultivation forms part of the Queensland economy and although it is untaxed and unregulated, income is derived by way of sales tax and GST from money used to fund growing activities or from goods purchased from the proceeds of that activity.

While the economic effect of the loss of that activity – presuming that in the unlikely event that Drug Free Australia’s proposal actually achieves that outcome - is beyond the capacity of Families and Friends for Drug Law Reform, it has been possible to estimate the possible maximum costs.

Two options are possible:

- 1 Incarcerate cannabis users while they undergo compulsory treatment
- 2 Adopt a drug court approach.

In the first case the pursuit and arrest of some 644, 468 cannabis users in Queensland could cost up to \$M7.7 per year and the total cost of incarceration of these 644,468 could be (at the rate of \$280 per day per imprisoned cannabis user) some \$M65,864 per year giving (with the cost of pursuit and arrest) a total cost of \$M65,872 for the year.

On the other hand if a drug court approach was adopted and the costs were similar to those of NSW (Lind 2002) and half of the arrestees opted for the drug court (and the other half incarcerated), the yearly cost would be \$M49,861.

XII. CANNABIS USE AND DRUG POLICIES THAT AVOID COERCIVE MEASURES

Families and Friends for Drug Law Reform accepts that Drug Free Australia has made out a case that cannabis has distinct dangers and thus that it is desirable for government to take effective measures to hasten the existing decline in its use. At the same time intensifying coercive measures as Drug Free Australia recommend will almost certainly cause more harm than cannabis itself. The review of drug market indicators discussed at pp. 14 ff has shown that existing substantive coercive measures have not brought about a reduction in cannabis use. In spite of protracted and intensive law enforcement effort indicated by large seizures and arrests, the price of cannabis has remained stable or even declined, it remains readily available and there is some, though limited, evidence that it has become more potent. This experience gives no hope that intensified police activity and other coercive measures that Drug Free Australia proposes will be any more successful in eliminating cannabis use.

Families and Friends for Drug Law Reform has sought to show that not only will the measures likely to be ineffective, but that they will also be very costly and, according to much evidence, will most likely intensify harm to the very people they are ostensibly intended to help and in the very domains of mental health and suicide that the Drug Free Australia paper singles out as of particular concern.

Acceptance of this does not mean that we should throw up our hands and do nothing to reduce the harm that may be caused by cannabis. Its use, particularly by teenagers, should be discouraged. At the same time, informed by the large body of evidence about risk and protective factors, the Committee should recommend measures to reduce risk factors of substance abuse and strengthen protective factors. Taking such steps will produce dividends not only in terms of reduced drug use but also in other domains like mental health, crime, child protection and suicide.

The Committee will necessarily be required to face up to a threshold objection – an objection that is one of perception rather than actuality. It is that advocacy of non-

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coercive measures is vulnerable to characterisation as being soft on drugs – a charge that, unfortunately, has so often seen good intentions of governments collapse because of political fear of an electoral backlash. There are Australian examples that give the lie to this purported political truism. The Liberal Carnell Government in the ACT and, for many years, the Liberal Kennet Government in Victoria increased their poll popularity while their leaders took forward positions on drugs. Labor in Victoria also benefited from a similar strategy in the 1999 election. The Kennet Government withdrew its support for medically supervised injecting room in the hope of the leaving the Bracks Labor Opposition (which had also supported the measure) politically exposed. Drug policy was thus at centre stage of the 1999 Victorian election and of the two by-elections that followed soon after. In spite of its perceived vulnerability on the issue, the Bracks government, of course, won.

A. Weaker law enforcement strategies and reduced cannabis use

171. What is the evidence that forward positions utilising non-coercive measures are consistent with reduction in drug consumption?

1. Expiation notice system in South Australia

172. In 1987 South Australia adopted an expiation notice system for minor cannabis offences. This was done to reduce the harmful consequences on young people of the enforcement of the criminal law on their employment and interpersonal relationships and indeed life chances and also to free up police resources to on other crime issues. A study compared South Australia's experience with that of Western Australia when that State followed a stringent law enforcement approach. Not only were the forecasts of less harm under the South Australian programme confirmed (see pp. 51 above) but there was no evidence of resulting increase in use to offset these benefits:

“There is no evidence to date that the [expiation] system in South Australia has increased levels of regular cannabis use, or rate of experimentation among young adults.” (Donnelly *et al.* (1998) p. 13)¹

2. Intercountry comparison of school student drug use

173. The level of illicit drug use in different countries bears no direct relationship to the repressiveness of measures against that use as one would expect if strong law enforcement had a significant impact on the uptake of drugs. The degree of repressiveness of anti-drug measures varies greatly between countries. In 1999 a survey was made of tenth graders in the United States and 30 European countries using methods designed to produce comparable results. (State University of New York, 2001), The United States is generally very repressive. Most European countries are less so. The survey found that usage rates varied widely:

1. Neil Donnelly, Wayne Hall & Paul Christie, *Effects of the cannabis expiation notice scheme on levels and patterns of cannabis use in South Australia: evidence from the national drug strategy household surveys 1985-1995*, National drug strategy monograph series no. 37 (Dept of Health & Aged Care, Canberra, May 1998) p. 13.

“ . . . 41% of 10th grade students in the United States had used marijuana or cannabis in their lifetimes. . . . [A]n average of 17% of 10th grade students in the 30 participating European countries had ever used marijuana or cannabis (19% in Northern Europe, 14% in Southern Europe and 16% in Eastern Europe). This proportion varies among European countries from 1% in Romania to 35% in the Czech Republic, France and the United Kingdom. All the participating European countries had a lower rate of lifetime cannabis use than did the United States.” (ibid).

16% of 10th grade students in the United States had used amphetamines compared to an average of 2% for amphetamines across the European countries surveyed. The highest European rates of amphetamine use was 8% in the United Kingdom and 7% in both Estonia and Poland. The only countries with a rate of drug injection over 1% were Russia (2%) and the United States (3%).”

3. Portuguese decriminalisation

174. In July 2001 Portugal decriminalized all drugs including cocaine and heroin thereby becoming the only state of the European Union to explicitly “decriminalize” drug usage. “Decriminalization” applies to the purchase, possession, and consumption of all drugs for personal use (defined as the average individual quantity sufficient for 10 days’ usage for one person).” “Thus, drug possession for personal use and drug usage itself are still legally prohibited, but violations of those prohibitions are deemed to be exclusively administrative violations and are removed completely from the criminal realm. Drug trafficking continues to be prosecuted as a criminal offense.” (Greenwald, 2009 p. 3).

175. A review carried out on behalf of the Cato Institute in Washington after seven years of operation of the legislation found:

Those data indicate that decriminalization has had no adverse effect on drug usage rates in Portugal, which, in numerous categories, are now among the lowest in the EU, particularly when compared with states with stringent criminalization regimes. Although post-decriminalization usage rates have remained roughly the same or even decreased slightly when compared with other EU states, drug-related pathologies—such as sexually transmitted diseases and deaths due to drug usage—have decreased dramatically. Drug policy experts attribute those positive trends to the enhanced ability of the Portuguese government to offer treatment programs to its citizens—enhancements made possible, for numerous reasons, by decriminalization. . .

“The data show that, judged by virtually every metric, the Portuguese decriminalization framework has been a resounding success. Within this success lie self-evident lessons that should guide drug policy debates around the world. (Greenwald, 2009 p. 3).

“Usage Rates. Since decriminalization, life-time prevalence rates (which measure how many people have consumed a particular drug or drugs over the course of their lifetime) in Portugal have decreased for various age groups. For students in the 7th–9th grades (13–15 years old), the rate decreased from 14.1 percent in 2001 to 10.6 percent in 2006. “For those in the 10th–12th grades (16–18 years old), the lifetime prevalence rate, which increased from 14.1 percent in 1995 to 27.6

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percent in 2001, the year of decriminalization, has decreased subsequent to decriminalization, to 21.6 percent in 2006. “For the same groups, prevalence rates for psychoactive substances have also decreased subsequent to decriminalization.

“In fact, for those two critical groups of youth (13–15 years and 16–18 years), prevalence rates have declined for virtually every substance since decriminalization (see Figures 4 and 5)” (Greenwald, 2009 pp. 11-12).

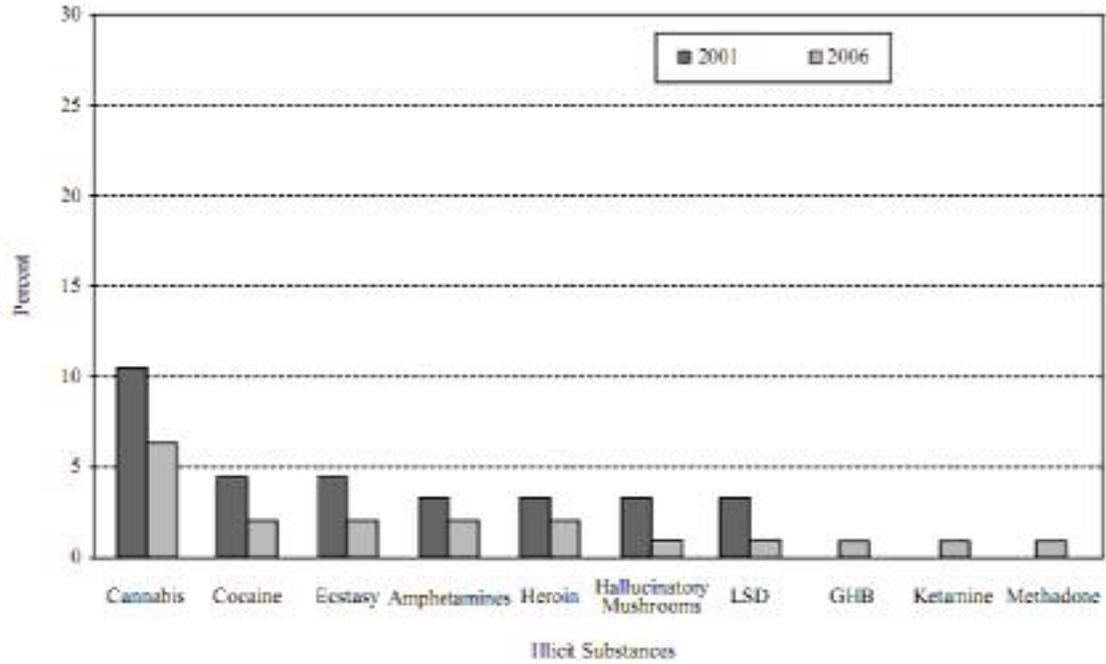
176. Provision for treatment is another striking feature of the Portuguese law which established “Commissions for Dissuasions of Drug Addiction,” described as bodies solely responsible for adjudicating administrative drug offenses and imposing sanctions, if any.

“While the Dissuasion Commissions are not authorized to mandate treatment, they can make suspension of sanctions conditioned on the offender’s seeking treatment. This is typically what is done, though in practice, there are very few ways to enforce the condition, since violations of a commission’s rulings are not, themselves, infractions of any law. 4

“In fact, Dissuasion Commissions are directed by Article 11(2) to “provisionally suspend proceedings”—meaning to impose no sanction—where an alleged offender with no prior offenses is found to be an addict but “agrees to undergo treatment.

“Where the offender is deemed to be a nonaddicted consumer of drugs and has no prior offenses, the commissions are mandated by Article 11(1) of the decriminalization law to “provisionally suspend proceedings,” whereby no sanction is imposed. Article 11(3) vests the commissions with discretion to “provisionally suspend proceedings” even for an addict who has a prior record, provided he or she agrees to undergo treatment. Alternatively, under Article 14, a commission, in the case of an addict with a prior record, can impose sanctions but then immediately suspend them contingent on ongoing treatment. In the event that treatment is completed and there is no subsequent offense, the proceeding will be deemed closed after a specified time period” (Greenwald, 2009 p. 3).

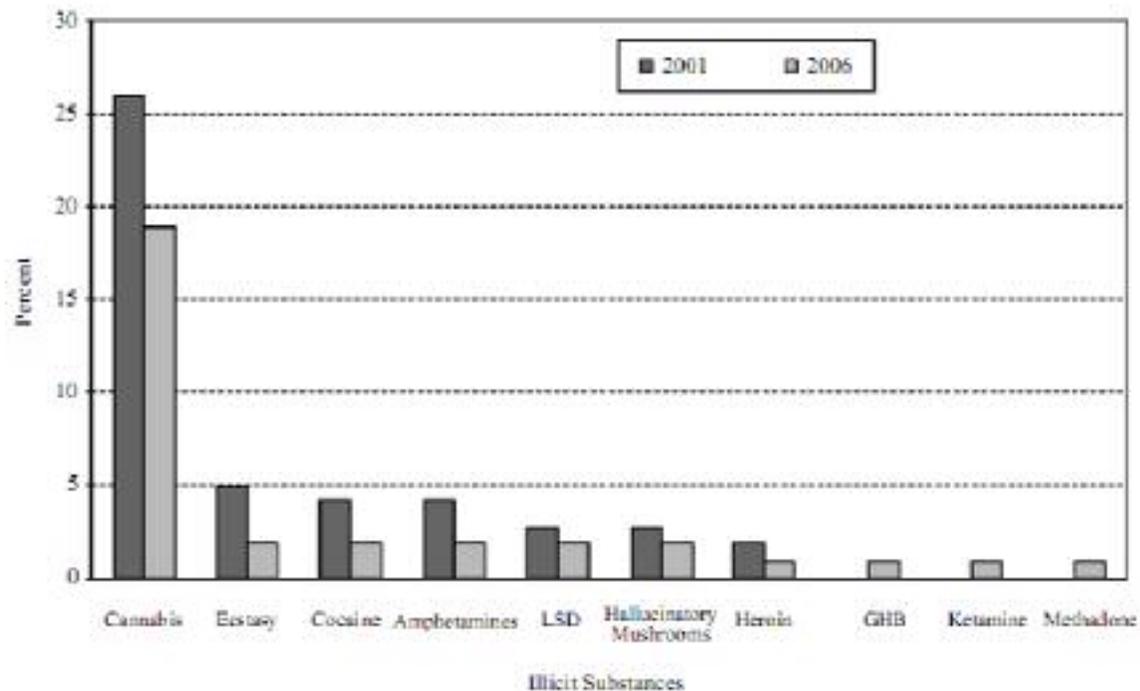
Figure 18: National Investigation in School Environment, 2001 and 2006, 3rd Cycle (7th, 8th, and 9th years), Portugal, Prevalence Over Entire Life



Source: Instituto da Droga e da Toxicodependência de Portugal, Draft 2007 Annual Report, slide 13 from Greenwald, 2009 p. 12.

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**Figure 19: National Investigation in School Environment, 2001 and 2006, Secondary (10th, 11th, and 12th years), Portugal
Prevalence Over Entire Life**



Source: Instituto da Droga e da Toxicodependência de Portugal, Draft 2007 Annual Report, slide 14 at Greenwald 2009, p.13.

177. In European terms, following decriminalisation, Portugal now has the lowest prevalence of lifetime cannabis usage:

“For the period 2001–2005, Portugal—for the 15–64 age group—has the absolute lowest lifetime prevalence rate for cannabis, the most used drug in the EU. Indeed, the majority of EU states have rates that are double and triple the rate for post decriminalization Portugal” (Greenwald, 2009 p. 22).

178. In some respects the work of the Dissuasions of Commissions in ordering treatment for addicted users is similar to the recommendation of Drug Free Australia “for young offenders be directed toward compulsory treatment rather than jail” (rec. 7). The role of police is to shepherd people towards treatment.

“Even in the decriminalization framework, police officers who observe drug use or possession are required to issue citations to the offender, but they are not permitted to make an arrest. The citation is sent to the commission, and the administrative process will then commence. The cited offender appears before the commission within 72 hours of the citation’s issuance. If the commission finds compelling evidence of drug trafficking, it will refer the case to criminal court.” (Greenwald, 2009 p. 4).

“Portuguese and European officials familiar with the Dissuasion Commission process emphasize that the overriding goal of that process is to avoid the stigma that arises from criminal proceedings. Each step of the process is structured so as to de-emphasize or even eliminate any notion of “guilt” from drug usage and instead to emphasize the health and treatment aspects of the process” (Greenwald, 2009 p. 6).

179. The Cato Institute report stresses that Portugal took the step not as an act of despair or surrender to the inevitability of a significant drug problem but as a way of getting on top of it:

“. . . There is a consensus that decriminalization, by destigmatizing drug use, will bring a higher proportion of users into treatment, thereby increasing the need for treatment”

Put another way, Portuguese decriminalization was never seen as a concession to the inevitability of drug abuse. To the contrary, it was, and is, seen as the most effective government policy for reducing addiction and its accompanying harms. (Greenwald, 2009 p. 11).

180. All too often the threat of criminal prosecution serves as a disincentive to those most in need of treatment and other help from accessing that help:

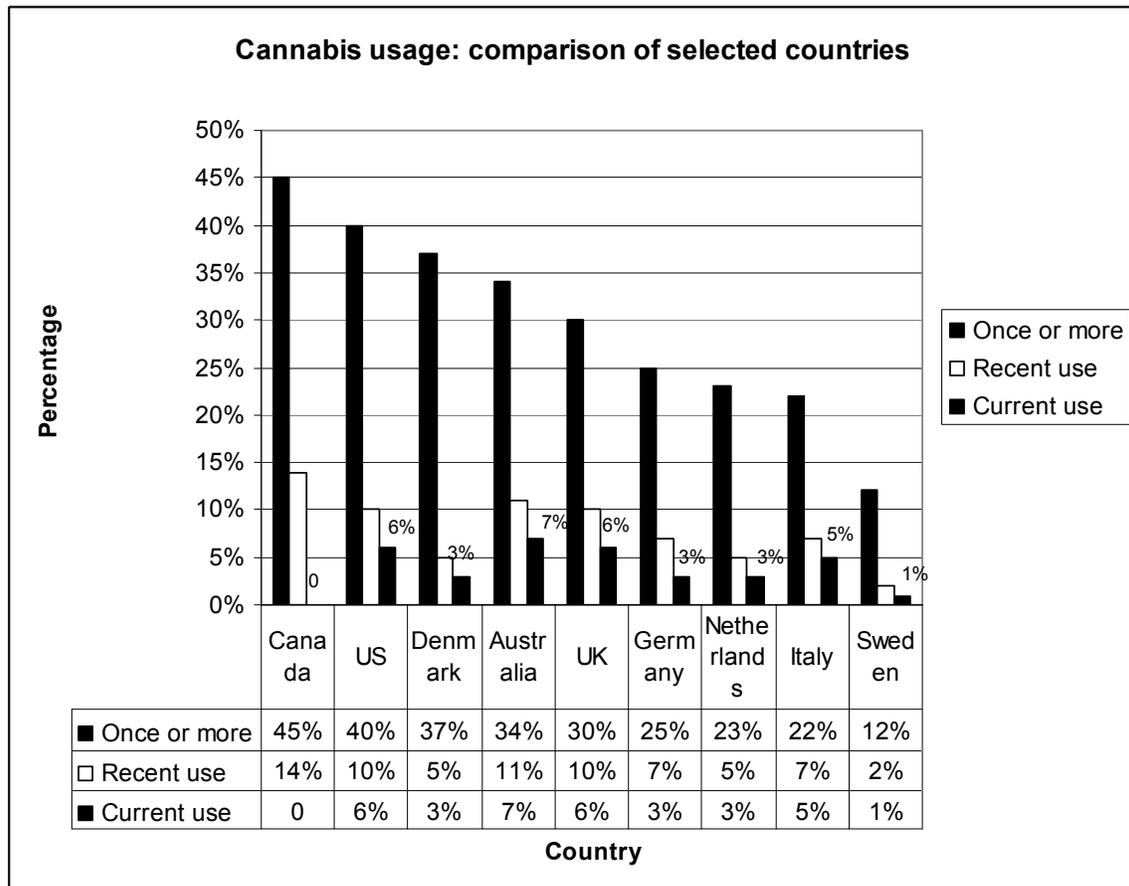
“One prime rationale for decriminalization was that it would break down that barrier, enabling effective treatment options to be offered to addicts once they no longer feared prosecution.”

4. Expediency principle of The Netherlands

181. No country exceeds the Netherland’s permissive reputation for cannabis with its so-called “coffee shops”. Cannabis is not decriminalized there as in Portugal. Instead, in accordance with an expediency principle under Dutch law, those who use the drug are not prosecuted for possession of small quantities for personal use. It is surprising in the light of this practice, that usage of cannabis (and indeed) of other drugs is substantially lower there than in Australia and the United States:

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Figure 20: Rates of cannabis usage in selected countries



Source: Netherlands Ministry of Foreign Affairs, FAQ drugs: A guide to Dutch policy (Amsterdam June 2008) at <http://www.minbuza.nl/dsresource?objectid=-buzabeheer:58788&type=pdf> visited 23/04/2010

182. Usage is lower in a few other European countries such as Sweden which, with its repressive drug policies, Drug Free Australia holds up as a model for Australia. It is not because of its very different demographics, culture and traditions (Olsson 2008 & van Solinge 1997 chaps. 2 & 3). Australian society is closer to that of the United States where repressive policies have singularly failed.

“Countries with more stringent policies towards illegal drug use did not have lower levels of such drug use than countries with more liberal policies. In the Netherlands, for example, which has more liberal policies than the US, 1.9% of people reported cocaine use and 19.8% reported cannabis use. (Degenhardt et al quoted in Greenwald, 2009 p. 25).

183. The experience of Switzerland with the far more addictive and dangerous drug than cannabis is also revealing. A recent study of the canton of Zurich has shown a large decline in the number of new heroin users:

“The incidence of regular heroin use in the canton of Zurich started with about 80 new users in 1975, increased to 850 in 1990, and declined to 150 in 2002, and was thus reduced by 82%.” (Nordt & Stohler (2006) p. 1,833)²

184. Since 1990 substitution treatments have been widely available there. Any physician who has received instruction may prescribe methadone or buprenorphine and clinics exist where heroin may be prescribed. Not only did the introduction of these measures to protect the life and well-being of heroin users not lead to an increase in drug use (the point being argued here) but those measures seem to have brought about a large decline in recruitment of new dependent heroin users.

185. None of these examples prove what the relationship is between the level of drug use and, on the one hand, a drug policy guided by harm minimisation objectives and, on the other, one with a strong prevention and law enforcement approach. What the examples do, is provide forceful evidence that a drug policy focusing on the protection of the life and well-being of drug users is compatible with the objective of reducing the level of drug use. The Cato Institute’s study of Portugal’s decriminalisation of drugs puts it this way:

“stringent criminalization laws do not produce lower drug usage, and . . . some data suggest the opposite may be true” (Greenwald, 2009 p. 25)

If the evidence points in that direction, the Committee should recommend action consistent with it including research to further clarify the point. The absence of proof of a link should not become a pretext for inaction if the evidence points towards an inconvenient truth. To insist on proof in that situation is not being open to truth.

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2. Carlos Nordt & Rudolf Stohler, “Incidence of heroin use in Zurich, Switzerland: a treatment case register analysis” in *The Lancet*, vol. 367, pp. 1,830-34 (3 June 2006) at p. 1,833.

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