NSW Parliament Portfolio Committee No. 1

Impact of the regulatory framework for cannabis in New South Wales

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Framework for Cannabis in NSW

PO Box 280, Rozelle NSW 2039 Australia
T +61 2 9352 3600 F +61 3 9642 5652
ranzcp@ranzcp.org www.ranzcp.org
ABN 68 000 439 047

Acknowledgement of Country

We acknowledge Aboriginal and Torres Strait Islander Peoples as the First Nations and the Traditional Owners and Custodians of the lands and waters now known as Australia. We recognise and value the traditional knowledge held by Aboriginal and Torres Strait Islander Peoples and honour and respect the Elders past and present, who weave their wisdom into all realms of life – spiritual, cultural, social, emotional, and physical.

Acknowledgement of Lived Experience

We recognise those with lived and living experience of a mental health condition, including community members and RANZCP members. We affirm their ongoing contribution to the improvement of mental healthcare for all people.

About the Royal Australian New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrist (RANZCP) is the principal organisation representing the medical specialty of psychiatry in Australia and New Zealand providing access to Fellowship of the College to medical practitioners. The RANZCP has approximately 8000 members bi-nationally. The NSW Branch represents over 2000 members, including over 1400 qualified psychiatrists.

The NSW Branch offers a substantial resource of distinguished experts – academics, researchers, clinicians, and leaders dedicated to developing expertise in understanding the risk factors of mental disorders, treating individuals and families, developing models of care and promoting public health measures that will reduce the personal suffering, loss of potential and huge economic costs caused by mental disorders in our community.

Recommendations from NSW Branch

1. Support the decriminalisation of cannabis use for adults in the general population and allow for greater emphasis of funding to address issues relating to demand (i.e., public health awareness and treatment services) rather than law enforcement (supply).

2. Initiate a public health campaign to warn residents of the potential harm from using cannabis (Replicate the approach taken by ACT in 2020).

3. Increase the regulatory requirements and safeguards around prescribing of ‘medical cannabis’ in NSW to ensure that patients with vulnerable mental health conditions are not being inappropriately prescribed cannabis.

4. Increase funding and support of research to better understand harms from cannabis use via smoking, ingestion or other modes of delivery, and including mental health and physical health harms.

5. Increase funding to improve pathways into interventions such as drug education, assessment, and treatment for those with cannabis use disorders / problems.

6. Fund harm reduction services for Aboriginal and Torres Strait Islander people and communities that are at least the same standard as interventions for non Aboriginal and Torres Strait Islander people and communities.

7. Increase incentives and opportunities for people to enter the professional drug and alcohol treatment workforce – in particular medical and allied health professionals.

Introduction

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is pleased to provide this submission on the impact of the regulatory framework for cannabis in NSW.

The complex interrelationship between cannabis use and other mental disorders is a core concern for psychiatrists. Mental health disorders are associated with increased rates of drug and alcohol problems, and in some cases precipitate illicit drug use or excessive alcohol consumption (1). The RANZCP recognises the impact that cannabis use can have on the general community as well as the additional risks and concerns it may represent for specific populations, particularly: Young people, Aboriginal and Torres Strait Islander communities, the LGBTIQA+ community, people living in regional, rural and remote communities, people from lower socio-economic communities and women who are pregnant (1-3). The impact of the regulatory framework on these communities will be addressed throughout this submission.

It is important to consider the impacts of cannabinoid use, misuse and dependence, but also the problematic issues (including but not limited to) stigma and marginalisation that are perpetuated by legal and criminal sanctions against users, rather than addressing substance use and related issues as a public health issue. The RANZCP also acknowledges that cannabis abuse, misuse and dependence, like other substance use disorders, occur in a complex psychosocial environment and are heavily influenced by social determinants of health or illness.

The RANZCP supports a harm minimisation approach that reduces the adverse health, social and economic consequences of using drugs including cannabis, for the user, their families and the wider community (4). In providing this submission, the RANZCP reaffirms its strong belief that harm minimisation should remain the official position on drug policy in Australia and changes to the regulatory framework should include harm minimisation interventions consistent with public health needs. These harm minimisation interventions should be made widely accessible, and harm reduction services should be extended to Aboriginal and Torres Strait Islander people and communities at least to the same standard as interventions for non-Aboriginal and Torres Strait Islander people and communities. (1).

1.1 Cannabis use disorder (Cannabis dependence)

Cannabis use disorder[1] manifests in isolation and disengagement from education, employment, relationships, and other social networks. Opportunities are lost and relationships breakdown. Trusts are broken and self-confidence is eroded. [9] These experiences lead to depression or anxiety which can increase the level of dependency and lead to more serious mental health conditions (5).

Dependence on cannabis (Cannabis Use Disorder) is less common than dependence on other addictive substances but up to 10% of users meet the criteria for lifetime cannabis dependence (6). The Diagnostic and Statistical Manual of Mental Disorders, DSM–5, defines cannabis use disorder as the presence of clinically significant impairment or distress in 12 months, manifested by at least 2 of the following:

- Cannabis is taken in larger amounts or used over a longer period than intended
- Persistent desire to cut down with unsuccessful attempts
- Excessive time spent acquiring cannabis, using cannabis, or recovering from its effects
- Cravings for cannabis use
- Recurrent use resulting in neglect of social obligations
- Continued use despite social or interpersonal problems
- Important social, occupational, or recreational activities foregone to be able to use cannabis
- Continued use despite physical harm
- Continued use despite physical or psychological problems associated with cannabis use
- Tolerance
- Withdrawal symptoms when not using cannabis (7).

1.2 Medicinal cannabis

The RANZCP's updated memorandum: Therapeutic use of medicinal cannabis products states that the evidence to assess the efficacy, effectiveness and safety of medicinal cannabis products is limited. The RANZCP statement highlights many of the known risks associated with cannabis use, such as the increased risk of psychosis and other mental illnesses and cognitive deficiencies and many of the unknown risks (8).

The combination of cannabinoids in medicinal cannabis is prescribed to treat specific symptoms. Some medicinal cannabis products don't contain THC or only have low levels of THC depending on the condition they are prescribed to treat. The non-inclusion of THC or low levels of THC reduces the risk of psychoses and other mental illnesses (9).

[1] DSM V references Cannabis Use Disorder with a range of severity. The term cannabis dependence is still used and refers to both physiological and psychological dependence components.

There is insufficient evidence to support medicinal cannabis as a treatment for anxiety and other mental disorders, and there is no substantial evidence to support its use outside of properly approved research trials (10). Yet despite the lack of evidence, Australia has followed the global trend towards using medicinal cannabis because it is considered to have a low risk of harm.[2]

Concerns about the over-prescribing of medicinal cannabis are becoming widespread. In February officials from the Department of Health and Aged Care, along with the Australian Health Practitioner Regulation Agency (AHPRA), the Therapeutic Goods Administration (TGA), the Medical Board of Australia and a string of other regulators held a rare joint meeting in February 2024 to discuss how to protect patients(11).

Associate Professor Stephen Parker, Director of Research at Metro North Mental Health is among the growing number of doctors alarmed at the dramatic increase in the prescribing of medicinal cannabis and Chair of the RANZCP Queensland branch, Professor Brett Emmerson, recently said in a May 2024 Australian Doctor News (AusDoc) special report on the overprescribing of medicinal cannabis that the problem over over-prescribing is happening “all along the Queensland coast (11)”.

1.3 Increased risk factors associated with recreational cannabis

The impact of recreational or illicit cannabis on the user may be vastly different, and potentially more harmful than the impact of medicinal cannabis. An association between cannabis use and psychosis has been demonstrated in a number of longitudinal studies (12). Cannabis use by adolescents also increases the risk of depression, and that risk extends into young adulthood, even after quitting cannabis by the end of adolescence. The risk of depression from cannabis use extending into young adulthood is more prevalent in young women (13).

If recreational cannabis contains high levels of THC – which it often does - the risk of psychosis, mood disorders, seizures and other factors is significantly increased. Cannabis products that contain THC have the potential for dependence and associated withdrawal in the same way that users of benzodiazepines and opioids can become dependent (9).

2. The current regulatory framework disproportionately impacts vulnerable people and communities

The current regulatory framework unnecessarily places people who are in possession of small amounts of cannabis in contact with the criminal justice system (14). Some of the consequences of having a criminal record for possession of minor amounts of cannabis for personal use include difficulty gaining employment, particularly in occupations requiring a police check or clearance, applying for a bank loan and secure housing, and complications applying for overseas travel to name just a few (1, 3, 15).

Under the current ‘de-facto’ decriminalisation legislation in NSW, conviction for minor possession of cannabis disproportionately impacts the priority populations that our National Drug Strategy purports to protect (4). The practice of net-widening – an increase in the number of sanctions for people who don’t

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[2] https://www.yourhealthinmind.org/treatments-medication/medicinal-cannabis

qualify for intervention programs – is known to occur because of the ease associated with processing minor drug offences after de-facto legislation has been implemented (16).

Aboriginal and Torres Strait Islander peoples are four times more likely to be pursued through the courts than non-Aboriginal and Torres Strait Islander people despite the existence of the 'Cannabis Cautioning Scheme' which exists for non-indictable 'personal use' quantities of cannabis possession (2). In NSW, some Police Local Area Commands (LACs) may not be as supportive of the Cannabis Cautioning Scheme as other LACs and prefer charging to cautioning (17). This has also proven to be the case in some US jurisdictions (3). We also know that the burden of illicit drug use including cannabis use is in areas with higher unemployment rates and large proportions of young people. These are the people in our communities who can least afford to be disadvantaged socially or economically (1).

The Illicit Drug Diversion Initiative in rural and regional Australia[3] and decriminalisation reforms in Portugal and other European countries demonstrate that successfully removing penalties in favour of diversion practices depends on cooperation between police, healthcare and social welfare systems (3).

Removing penalties for possession of small amounts of cannabis eliminates the risk that minority groups will be unfairly disadvantaged by discretionary policing. Global research shows that removing penalties is not associated with increased drug use nor is it associated with progression to other more addictive drugs like ecstasy or heroine (16).

Further endorsement for investigating alternative approaches to the regulatory framework will come from the policy makers in many other countries and jurisdictions who are both investigating and adopting alternatives to criminalisation (3).

3. The ACT experience since cannabis was legalised

In the year following the introduction of the new laws, ACT Policing figures showed the number of Simple Cannabis Offence Notices issued dropped by almost 90 per cent — down from 56 to five. ACT Health, conscious of the potential impacts of cannabis use launched a public health campaign to warn residents of potential harms such as reduced brain function and an increased risk of psychoses. As a result, ACT Health data showed no increases in hospital presentations since the laws passed, nor was there any increase in drug driving (18).

Regulations governing the personal use and possession of cannabis in the ACT introduced in January 2020, are comparable to the proposed amendments introduced in a private member's bill to the NSW parliament by Jeremy Buckingham MLC.

The ACT legislation allows for possession of up to 50 grams per person – the same as the proposed NSW legislation - and a maximum of four plants per household. In NSW an adult may possess cannabis leaf from six cannabis plants that have been removed from the medium in which the plants were grown.

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[3] Australian Institute of Health and Welfare: The effectiveness of the Illicit Drug Diversion Initiative in rural and remote Australia https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/effectiveness-illicit-drug-diversion-initiative/summary

4.1 Arrest rates after decriminalisation: International data

There is strong data from both the US and Europe that alternatives to criminalisation reduce the number of cannabis-related arrests.

Drug related arrests in US jurisdictions:

- Massachusetts, Connecticut, Rhode Island, and Vermont reduced by at least 50 percent and
- Maryland 25%

European studies show that alternatives to criminalisation also reduced the number of arrests:

- In Portugal arrests and imprisonments fell.
- Netherlands has relatively low levels of problematic drug use due to a combination of measures including depenalisation for cannabis offences.
- When Denmark reintroduced penalties for possession (after they'd removed them) there was an increase in the number of drug law offenders(3) .

As we have already referred to in this submission, alternatives to criminalisation for small amounts of cannabis for personal use are often undermined by the discretionary powers of police. We have cited examples of this occurring in NSW, and in the US, states that have formally decriminalised possession of small amounts of cannabis often have higher arrest rates than states that have not.

4.2 Psychosis related diagnoses after decriminalisation – International data

A large cohort 2023 study (n>63 million) looked at health-insurance (claims) data to see whether states in the USA with legalised cannabis saw more claims for psychosis than states without legalised cannabis. The authors found there was no statistically significant difference in the rates of psychosis-related diagnoses or prescribed antipsychotics in states with medical or recreational cannabis policies compared with states with no such policy (12).

In England and Wales there was also a reduction in admissions for cannabis psychosis following the implementation of the cannabis warning scheme in 2004 (3).

Contact

If you have any queries regarding this submission, please contact Richard Hensley, Policy and Advocacy Advisor NSW Branch via Richard.hensley@ranzcp.org or on (02) 9352 3609

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