The Senate

Economics References Committee

Personal choice and community impacts

Interim report: sale and use of marijuana and associated products (term of reference c)

May 2016

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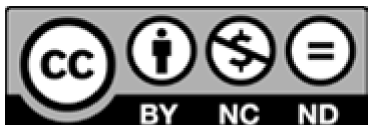

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Chapter 1
Introduction and overview

Referral and conduct of the inquiry

1.1 On 25 June 2015, the Senate referred an inquiry into personal choice and community impacts to the Senate Economics References Committee (committee) for inquiry and report by 13 June 2016.[1]

1.2 The committee's terms of reference require it to report on:

> The economic and social impact of legislation, policies or Commonwealth guidelines, with particular reference to:
>
> a. the sale and use of tobacco, tobacco products, nicotine products, and e-cigarettes, including any impact on the health, enjoyment and finances of users and non-users;
>
> b. the sale and service of alcohol, including any impact on crime and the health, enjoyment and finances of drinkers and non-drinkers;
>
> c. the sale and use of marijuana and associated products, including any impact on the health, enjoyment and finances of users and non-users;
>
> d. bicycle helmet laws, including any impact on the health, enjoyment and finances of cyclists and non-cyclists;
>
> e. the classification of publications, films and computer games; and
>
> f. any other measures introduced to restrict personal choice 'for the individual's own good'.

1.3 In accordance with usual process, the committee advertised the inquiry on its website and wrote to relevant persons and organisations inviting submissions to the inquiry.

1.4 To date, the committee has received 485 public submissions and two confidential submissions. The public submissions are available on the committee webpage.

1.5 The committee has held seven public hearings. At its first public hearing, on 11 September 2015 in Canberra, the committee heard evidence on decision making generally. The other public hearings focused on specific matters in relation to the inquiry terms of reference as follows:

- on 3 November 2015, in Parramatta, the committee heard evidence on proposed restrictions on the activities of fans of the Western Sydney Wanderers Football Club;

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1 *Journals of the Senate* No. 102, 25 June 2015, p. 2832.

- on 16 November 2015, in Melbourne, the committee heard evidence on mandatory bicycle helmet laws in accordance with inquiry term of reference (d);
- on 20 November 2015, in Sydney, the committee heard evidence relating to inquiry term of reference (b) concerning the sale and service of alcohol with focus on Sydney's lockout laws;
- on 9 March 2016, in Sydney, the committee heard evidence regarding inquiry term of reference (a) concerning tobacco, nicotine and e-cigarettes;
- on 11 March 2016, in Sydney, the committee heard evidence regarding the sale and service of marijuana in accordance with inquiry term of reference (c); and
- on 22 April, in Canberra, the committee heard evidence regarding the classification of publications, films and computer games under term of reference (e).

1.6 This report focuses on the evidence in relation to the term of reference (c) concerning the sale of marijuana and associated products.

1.7 The committee thanks all those who have participated in the inquiry so far.

Purpose of the interim report

1.8 The purpose of this interim report is to consider the evidence provided to the committee on the topic of the sale of marijuana and associated products. It considers the sale and use of marijuana for recreational purposes and personal enjoyment and explores the arguments for and against personal choice to use marijuana. In particular, it examines the key argument made by some advocates that the legislative response to marijuana is disproportionate to the risk it poses to individuals and the community, and that the lack of personal choice in using the drug causes negative consequences.

1.9 For the purposes of this report, the term 'marijuana' will be used to include references to other cannabis products.

What is marijuana?

1.10 Marijuana is a substance which derived from the *cannabis sativa* plant, which contain chemical compounds that produce psychological and physiological changes in the body. The main psychoactive element in the plant is delta-9-tetrahydrocannabinol (THC), which causes many of the health and psychological issues linked with using marijuana.[2]

1.11 The leaves, stems, flowers and seeds of the plant are used to make three types of substances that are usually either consumed via smoking or as an ingredient in food. The three forms of cannabis are:

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2 Australian Crime Commission, *Illicit Drug Data Report 2013-14*, https://crimecommission.gov.au/sites/default/files/IDDR-201314-Complete_0.pdf (accessed 13 January 2016) p. 58.

- marijuana, which is made up of a mix of dried leaves and flowers of the plant, and is the most common but weakest form of cannabis;
- hashish, which consists of dried cannabis resin, and tends to be more potent than marijuana due to a higher THC content; and
- hashish oil, which is the strongest form of cannabis but is rare in Australia.[3]

1.12 The Australian Drug Foundation described the substance's effects as follows:

> Cannabis users report a number of perceived benefits, including: the pleasure derived from an altered state (e.g. euphoria or relaxation); the social benefits of a shared experience; a way to cope with or escape problems experienced in everyday life; cognitive benefits and enhanced creativity; heightening of ordinary sensory experiences; and therapeutic value for a physical or mental health problem.
>
> …
>
> Adverse acute effects of cannabis include anxiety, panic, loss of attention and reduced motor coordination skills, while negative health effects include risk of cannabis dependence syndrome; in addition, long-term heavy smokers risk chronic bronchitis, respiratory cancers and cardiovascular disease. People who begin cannabis use in adolescence face higher risks of some psychosocial effects (including cannabis dependence), impaired educational attainment and an increased risk of mental health problems.[4]

1.13 The Department of Health (department) advised the committee that marijuana is the most widely used drug in Australia to date.[5] The 2013 National Drug Strategy Household Survey indicated that 35 per cent of Australians surveyed had used marijuana products at some point in their lives. 10.2 per cent Australians over the age of 14 years old had used it within the past 12 months. The study noted that 3.5 per cent of Australians had used marijuana within the past week prior to the survey.[6] The largest group of users were concentrated in the 20- to 29-year-old age group.[7]

1.14 In recent decades, marijuana use has decreased in the Australian population. However, certain groups remain of concern to health officials. Adults within the ages of 40- to 49-years-old are most likely to use marijuana on a daily basis. 'Heavy

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3 Australian Institute of Criminology, *Cannabis*, 14 May 2015, http://aic.gov.au/crime_types/drugs_alcohol/drug_types/cannabis.html (accessed 15 December 2015).

4 Australian Drug Foundation, *Submission 291*, pp 14-15.

5 Department of Health, *Submission 444*, p. 2.

6 Intergovernmental Committee on Drugs, *National Drug Strategy 2016-2025 – Draft: for public consultation*, October 2015, http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/73E3AD4C708D5726CA257ED000050625/$File/draftnds.pdf (accessed 15 December 2015).

7 Australian Crime Commission, *Illicit Drug Data Report 2013-14*, https://crimecommission.gov.au/sites/default/files/IDDR-201314-Complete_0.pdf (accessed 13 January 2016) p. 58.

patterns of use' are reported among users aged between 14 and 19 years.[8] Marijuana users who suffer a psychotic condition or illness may more acutely experience symptoms such as hallucinations, and can exacerbate symptoms.[9] The Australian Drug Foundation noted that certain groups are more likely to develop marijuana-related problems, such as:

- young people under the age of 17 years old, who can experience problems such as memory impairment, cognitive issues, decline in IQ, and mental health problems such as schizophrenia and depression; and
- people with a family history of psychosis (as cannabis may trigger a psychotic episode) or with a pre-existing psychiatric condition.[10]

1.15 Furthermore, marijuana accounts for the 'greatest proportion of illicit drug offences in Australia'.[11] The Australian Crime Commission (ACC) reported that a record number of arrests were reached in 2013–14, accounting for 66,684 arrests. This represents a 21.3 per cent increase in marijuana-related offences in the past decade, the majority of which were directed towards consumers (as opposed to marijuana suppliers).[12] The jurisdiction with the most marijuana-related offences in the past decade is Queensland, followed by New South Wales.[13] In combination with the rates of usage, the ACC argues that these statistics indicate that marijuana 'continues to account for the greatest proportion of illicit drug use, seizures and arrests' and is the 'dominant illicit drug in Australia'.[14]

Legislative framework

1.16 Marijuana is currently prohibited in Australia, with a combination of Commonwealth and state or territory law used to enforce the restrictions. Australia is bound to three international agreements which advocate the control and prohibition of illegal substances such as marijuana. These agreements are:

- the Single Convention on Narcotic Drugs (1961);
- the Convention on Psychotropic Substances (1971); and

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8 'Heavy patterns of use' is defined as 'use of more than 10 cones or joints per day': Roxburgh A, et al, 'The epidemiology of cannabis use and cannabis-related harm in Australia 1993-2007' *Addiction*, vol. 105, no. 6, pp 1071–9, 1074.

9 Australian Crime Commission, *Illicit Drug Data Report 2013-14*, https://crimecommission.gov.au/sites/default/files/IDDR-201314-Complete_0.pdf (accessed 13January 2016) p. 59.

10 *Submission 291*, p. 15.

11 Australian Crime Commission, *Illicit Drug Data Report 2013-14*, https://crimecommission.gov.au/sites/default/files/IDDR-201314-Complete_0.pdf (accessed 13 January 2016) p. 68.

12 Australian Crime Commission, *Illicit Drug Data Report 2013-14*, p. 68.

13 Australian Crime Commission, *Illicit Drug Data Report 2013-14*, p. 68.

14 Australian Crime Commission, *Illicit Drug Data Report 2013-14*, p. 69.

- the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).[15]

1.17 The department indicated that government policy at both the Commonwealth and state levels regarding illicit drugs is guided by the *National Drug Strategy 2010-2015* (NDS).[16] As 'a product of collaboration between Commonwealth, state and territory governments, and extensive community and sector consultations', the NDS aims to improve:

> health, social and economic outcomes for Australians by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in our society.[17]

1.18 Under Commonwealth law, the control and prohibition of cannabis and cannabis products is legislated using a number of legal instruments, including:

- the *Therapeutic Goods Act 1989*, which regulates the availability of cannabis and other materials as therapeutic substances (cannabis is listed as a Schedule 9 Prohibited Substance under the Poisons Schedule);[18]
- the *Narcotic Drugs Act 1967*, which regulates the manufacture of cannabis and other narcotic drugs;
- the *Customs Act 1901* and *Customs (Prohibited Imports) Regulations 1956* and *Customs (Prohibited Exports) Regulations 1958*, which controls the import and export of cannabis and other narcotic drugs in and out of Australia; and
- the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990* and Part 9.1 of the *Criminal Code Act 1995*, which contains offences relating to the cultivation, import and export, and possession of controlled plants and drugs, which includes cannabis.[19]

1.19 The production, sale, possession or use of any form of the cannabis plant for recreational purposes is uniformly prohibited in all Australian states. Enforcement of marijuana-related offences is a state responsibility. However, different penalties apply depending on the state or territory in which the offence took place. In South Australia, the Australian Capital Territory and the Northern Territory, minor marijuana offences have been decriminalised and attract only civil penalties. Most states and territories offer diversion programs or drug and alcohol treatment programs before criminal

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15 Senate Legal and Constitutional Affairs Legislation Committee, *Regulator of Medicinal Cannabis Bill 2014*, August 2015, p. 10.

16 Department of Health, *Submission 444*, p. 2.

17 Department of Health, *Submission 444*, p. 2; Australian Government, *National Drug Strategy*, 24 November 2015, http://www.nationaldrugstrategy.gov.au (accessed 22 December 2015).

18 Senate Legal and Constitutional Affairs Legislation Committee, *Regulator of Medicinal Cannabis Bill 2014*, August 2015, p. 14.

19 Senate Legal and Constitutional Affairs Legislation Committee, *Regulator of Medicinal Cannabis Bill 2014*, August 2015, pp 11-12.

sanctions are applied.[20] Table 1.1 provides a summary of cannabis possession laws in each state and territory.

1.20 As Table 1.1 demonstrates, there is a range of consequences for marijuana-related offences, depending on the state or territory a person is charged in. While there is an emphasis by states and territories on addressing drug dependence and channelling sanctions towards rehabilitation programs, significant differences remain between jurisdictions. While a person may attract criminal prosecution and serious penalties in one state, in another state the same person may face only drug counselling or information.

Table 1.1 – Treatment of minor cannabis offences in Australian Jurisdictions[21]

Jurisdiction	*Treatment of minor cannabis offences*
Australian Capital Territory	The ACT introduced a civil penalty system for the possession of 'small amounts' of cannabis in 1993. If someone is caught with up to two non-hydroponic cannabis plants, or up to 25 grams of marijuana (cannabis plant material), they receive a $100 fine with 60 days to expiate (pay the fine) instead of a criminal charge. Instead of paying the fine, the person may choose to attend a drug assessment and treatment program.
South Australia	In 1987, South Australia was the first state to decriminalise minor cannabis offences. The possession of up to 100 grams of marijuana, 20 grams of hash, one non-hydroponic plant or cannabis smoking equipment can result in a fine of $50 to $150 with 60 days to expiate.
Northern Territory	Since 1996, adults found in possession of up to 50 grams of marijuana, one gram of hash oil, 10 grams of hash or cannabis seed, or two non-hydroponic plants can be fined $200 with 28 days to expiate rather than face a criminal charge.
New South Wales	If someone is caught with up to 15 grams of cannabis, they may receive a 'caution' from the police, which includes information about the harms associated with cannabis use and a number to call for drug-related information or referral. Only two cautions are allowed to be given to the same person before criminal charges are laid.
Victoria	A police officer may give someone a caution and offer them the opportunity to attend a cannabis education program if they are caught with no more than 50 grams of cannabis. Like NSW, only

20 Senate Legal and Constitutional Affairs Legislation Committee, *Regulator of Medicinal Cannabis Bill 2014*, August 2015, p. 15.

21 Senate Legal and Constitutional Affairs Legislation Committee, *Regulator of Medicinal Cannabis Bill 2014*, August 2015, p. 16.

	two cautions are allowed to be given to the one person.
Tasmania	Someone found in the possession of 50 grams of cannabis can be given a caution up to three times in ten years. For the first caution, information and referral is provided. A brief intervention is given with the second caution. On the third and final caution, the offender must be assessed for drug dependence and attend either a brief intervention or treatment program.
Queensland	Police officers in Queensland offer someone the option of diversion, rather than prosecution, if they are found in possession of up to 50 grams of cannabis. The diversion includes a mandatory assessment and brief intervention program. Only one offer of diversion is allowed per person.
Western Australia	Individuals in possession of not more than 10 grams of harvested cannabis and/or a used smoking implement who have no prior cannabis offences are required to attend a Cannabis Intervention Session within 28 days or receive a cannabis conviction for the offence. All cannabis cultivation offences will attract a criminal conviction.

Recent legislative and social change

1.21 Since the introduction of laws restricting the sale and possession of marijuana in Australia in 1926, there have been significant changes in public opinion and legislative responses to marijuana use.[22] Changing community views are reflected in legislative reforms as indicated by the decriminalisation of 'minor' marijuana offences in South Australia in 1987, the Australian Capital Territory in 1993, and the Northern Territory in 1996. Notwithstanding this, no state or territory is yet to fully decriminalise marijuana possession and use for recreational purposes.

1.22 Further significant change has occurred in relation to marijuana used for medicinal purposes. The committee notes that there has been a prolonged public debate regarding marijuana use specifically for medicinal purposes. A number of federal, state and territory government parliamentary inquiries which have considered this issue.[23] There have also been several attempts in the past by legislatures at the

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22 Library Council of New South Wales, *History of drug laws – Australia*, 2015, http://www.legalanswers.sl.nsw.gov.au/guides/hot_topics/drugs/history_drug_laws_Australia.html (accessed 12 January 2016).

23 Senate Legal and Constitutional Affairs Legislation Committee, *Regulator of Medicinal Cannabis Bill 2014*, August 2015; Standing Committee on Health, Ageing, Community and Social Services, *Inquiry into the exposure draft of the Drug of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 and related discussion paper*, Legislative Assembly of the ACT, Report No. 6, August 2015; General Purpose Standing Committee No. 4, *The use of cannabis for medical purposes*, Parliament of NSW, Report No. 27/48, May 2013. Further examples can be found in other state and territory parliaments.

state, territory and federal levels to establish regulatory bodies or schemes for the medicinal or scientific use of cannabis.[24]

1.23 On 10 February 2016, the Minister for Health, the Hon Susan Ley, presented the Narcotic Drugs Amendment Bill 2016 to the House of Representatives. The bill was designed to facilitate the production of medicinal cannabis for medicinal trials, treatment for patients, and scientific research.[25] The legislation passed both Houses on 24 February 2016, and it received Royal Assent on 29 February 2016.

1.24 These changes to the *Narcotic Drugs Act 1967* are yet to be fully implemented, and the long-term policy implications of the new regime will require further analysis. However, as community support appears to be strong for medicinal marijuana, legislative change in this area has the potential to serve as a barometer on community attitudes in relation to the use of marijuana more broadly, including for recreational purposes.

1.25 The committee suggests that public opinion in relation to medicinal marijuana may serve to inform future attempts to deregulate the substance if further reforms are to be considered.

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24 Most recently, the Regulator of Medicinal Cannabis Bill 2014 was debated in the Senate as a potential pathway for regulation, culminating in a Senate committee inquiry which recommended that the bill be passed with some amendments to facilitate the scientific study of cannabis. See: Senate Legal and Constitutional Affairs Legislation Committee, *Regulator of Medicinal Cannabis Bill 2014*, August 2015, pp 71-73.

25 Department of Health, 'Narcotic Drug Amendment Bill 2016, Public Information Paper', 10 February 2016, https://www.health.gov.au/internet/ministers/publishing.nsf/Content/5E437BF8715C3EBACA257F540078A07A/$File/Public%20Information%20Paper.pdf.

Chapter 2

Support for deregulation and decriminalisation of marijuana

2.1 A number of submissions to the inquiry were strongly critical of the restriction of cannabis products in Australia, arguing that it was a denial of an individual's personal choice to use the substance. Those arguing this point were of the opinion that the legislation and regulations controlling marijuana were disproportionate to the risks posed by the substance to users and the community at large, and that relaxing restrictions on marijuana use would result in positive outcomes at an individual and societal level.

Personal choice to use marijuana

2.2 Laws prohibiting recreational marijuana use were identified as an infringement on personal liberty and the freedom to choose whether or not to consume the substance.[1] Many submitters noted the connections between personal choice and the principles of liberal democracy, ethics and morality. Mr Mark Hoffman argued that the state should not intervene in the personal choices of a citizen provided that the person involved was a 'responsible adult'.[2] Mr Hoffman emphasised the connection between individual choice and the libertarian principles of democracy, stating that 'an individual living in a modern, free democracy should have the choice to enjoy the use of Cannabis, and any other substance that they choose'.[3]

2.3 Mr Gabriel Buckley concurred with this viewpoint, arguing that the restriction of personal choice relating to marijuana was immoral. Mr Buckley argued, when compared with the evidence of success in jurisdictions internationally which have decriminalised marijuana, that:

> [T]here are no legitimate, moral, ethical, economic or social grounds on which the prohibition of cannabis can be predicated. And, as such, any laws that seek to prohibit the use of cannabis or the sale of cannabis between consenting adults are without basis. In any society that is attempting to be a fair and equitable society, laws without basis should simply be struck off the books.[4]

2.4 Some submitters argued that the individual's personal choice to consume marijuana should be permitted providing that harm was not caused to others. An example was provided to the committee of a working father using marijuana to relax at the end of a work week. It was argued that an individual in this situation causes no

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1 Mr Mark Hoffman, *Submission 136*, p. 1; Mr Gabriel Buckley, *Submission 79*, pp 1-2.

2 Mr Mark Hoffman, *Submission 136*.

3 Mr Mark Hoffman, *Submission 136*, p. 1.

4 Mr Gabriel Buckley, private capacity, *Committee Hansard*, 11 March 2016, p. 4.

harm to anyone else, and only affects the person consuming the substance. If the individual's actions affect no-one but themselves, it was claimed, it should not be a matter for the state to legislate upon.[5]

2.5 The use of marijuana was argued to be similar to other personal choices made by citizens which do not attract government regulation. Mr Mark Hoffman contended that the personal choice to consume marijuana was no different from the personal choice to belong to a particular religion, the clothes a person wears, or the food a person consumes.[6]

Disproportionality

2.6 Submitters and witnesses in favour of allowing marijuana to be used freely argued that the threat of any harms from marijuana use should not be met with a disproportionately harsh legislative response. Dr Samuel Douglas told the committee that the balance between the principles or harm reduction and retaining personal choice should be the goal in policy marking, but that this balance has been lost in relation to marijuana:

> I put it to the committee that, in the case of cannabis, as a society we have tried the approach of restricting individual choice. This approach has failed to protect the individual from harm. This failure is not only practical; it cuts to the core of why we make laws in the first place.[7]

2.7 The majority of those arguing in favour of relaxing the prohibitions on marijuana use suggested that it posed significantly less harm to users than other drugs. It was noted that marijuana had a historical basis, having been used by humans for thousands of years in various forms.[8] Mr Mark Hoffman argued that:

> Cannabis is a natural product and is proven to cause much less harm to both the user and community as a whole than Alcohol and Tobacco products which are currently legally available to adults in Australia … There are virtually no adverse impacts to the community which are caused by Cannabis users, other than the impacts which are a direct result of the illegal status of the substance.[9]

2.8 Other submitters agreed with Mr Hoffman that marijuana causes far less individual and social harm than tobacco and alcohol, and that it should not be subject to the same legal treatment as more harmful drugs such as heroin.[10] It was also

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5 Mr Gabriel Buckley, *Submission 79*.

6 Mr Mark Hoffman, *Submission 136*.

7 Dr Samuel Douglas, *Committee Hansard*, 11 March 2016, p. 2.

8 Mr Gabriel Buckley, *Committee Hansard*, 11 March 2016, p. 9.

9 Mr Mark Hoffman, *Submission 136*, p. 1.

10 Mr Seppy Pour, *Submission 255*, p. 5; Professor Wayne Hall, *Committee Hansard*, 11 March 2016, p. 4.

pointed out that there have been few deaths directly attributable to marijuana.[11] According to these arguments, the substance itself poses no danger to the individual or the community at large. Instead, the harm is caused by the disproportionate legislative response and the resulting illegal status of the substance which cause further harm.

2.9 Public health organisations presented counter-claims to these arguments, which will be explored in Chapter 3.

Effects of criminalisation

2.10 Submitters commented on the effects of the current regulatory system prohibiting recreational marijuana use, including a lack of control over marijuana production and use, the impact on the lives of users who are subject to law enforcement, and difficulties associated with furthering cannabinoid research.

Lack of control over marijuana production and use

2.11 Submitters argued that the criminalisation of marijuana results in consumers obtaining marijuana from black market sources with no assurances regarding ingredient quality or safety. For example, Drug Policy Australia contended that the current approach of criminalising illicit drugs and thus rejecting the normal drug control mechanisms applicable to legal drugs 'has the effect of ceding control of illegal drugs to the organised crime syndicates, and preventing governments properly controlling how they are produced, distributed, marketed, taxed and used'.[12]

2.12 Mr Mark Hoffman commented further on the issue of quality control for marijuana products in his submission:

> Production is in the hands of criminals and clandestine growers whose sole motivation is financial gain. They have little regard for the health and safety of the users of their products. There are no standards for production as there are for food and medical crops, and no guarantee that dangerous pesticides and fungicides have not been used which may adversely affect the health of users.[13]

2.13 Mr Gabriel Buckley concurred, arguing that unlike alcohol drinkers, cannabis consumers 'enjoy none of the consumer protections in place to ensure drinkers receive a product of known quality and potency'.[14]

Use of synthetic cannabinoids

2.14 Additionally, it was suggested that those seeking a legal alternative to marijuana may instead opt for synthetic cannabinoid products, which may be unsafe.

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11 Mr Gabriel Buckley, Professor Wayne Hall, Dr Samuel Douglas, *Committee Hansard*, 11 March 2016, pp 5-6.

12 Drug Policy Australia, *Submission 480*, p. 2.

13 Mr Mark Hoffman, *Submission 136*, p. 2.

14 Mr Gabriel Buckley, *Submission 79*, p. 3.

A number of witnesses expressed their concern with the proliferation of synthetic cannabinoid products and the safety risks they posed.[15] Mr Hoffman stated:

> With regard to the synthetic cannabinoids, I think the biggest danger is that there is absolutely no labelling as to what is contained within these products. The formulations of the different chemicals that are used can vary greatly, and there is absolutely no research because of the novel aspect of these chemicals. They are brand-new research chemicals for all intents and purposes. There is very little data as to the safety of them, and the user does not know what they are getting themselves into by using them.[16]

2.15 Dr Samuel Douglas argued that these products are used 'just to avoid the potential criminal sanction of using cannabis'.[17] Dr Douglas contended further that while marijuana use does not directly cause the death of users, there have been instances of deaths due to the use of synthetic cannabinoid products which were potentially preventable if marijuana were legal.[18]

Impact of law enforcement activities on recreational users

2.16 The impact of criminalising marijuana use on the lives of individuals who use the drug recreationally in the privacy of their own home was highlighted in evidence. Mr Mark Hoffman noted that, due to approximately 10.2 per cent of the Australian population having used the substance in the past 12 months, there is widespread civil disobedience occurring in relation to marijuana laws. As a result, this makes a significant proportion of the Australian population criminals in the view of their government.[19]

2.17 Several submitters noted that the criminalisation of marijuana use has harsh effects on the lives of those who are prosecuted for possession or use. By possessing or consuming marijuana, an individual may attract a penalty that can substantially affect their employment, ability to travel and other areas of their personal life.[20] If a person is charged with a cannabis offence, this can result in a criminal record, if not jail time and a pecuniary penalty. Mr Gabriel Buckley expanded on this point in his submission:

> A criminal record for drug crimes relegates the user to a second-class citizen in many aspects of life. Convicted cannabis users experience difficulty gaining and/or keeping some jobs, obtaining clearance-based qualifications such as the "Blue Card" and travelling internationally. The stigma associated with having a criminal record can—in itself—be a major

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15 Mr Gabriel Buckley, Professor Wayne Hall, Mr Mark Hoffman, Dr Samuel Douglas, *Committee Hansard*, 11 March 2016, pp 5-6.

16 Mr Mark Hoffman, *Committee Hansard*, 11 March 2016, p. 6.

17 Dr Samuel Douglas, *Committee Hansard*, 11 March 2016, p. 6.

18 Dr Samuel Douglas, *Committee Hansard*, 11 March 2016, p.6.

19 Mr Mark Hoffman, *Committee Hansard*, 11 March 2016, p. 1.

20 Mr Mark Hoffman, *Submission 136*, p. 2; Mr Tim Nixon, *Submission 210*; Mr Stephen Flood, *Submission 206*; Mr Andrew Toft, *Submission 236*; Mr Seppy Pour, *Submission 255*, p. 5.

> driver behind an individual's descent into poverty or further criminality. The war on drugs does not target criminals, it creates them.[21]

2.18 The inconsistency between the penalties associated with marijuana offences in different states and territories (as noted in Chapter 1) adds a further layer of complexity in how different individuals may be treated under the law for the same activities.

Stalling research and the uptake of cannabis-related therapies

2.19 Several submitters argued that the blanket prohibition on marijuana use has prevented it being used as a medical treatment, sometimes using their own personal experiences with chronic pain to illustrate the point.[22] One submitter noted in their evidence that the legal restrictions surrounding marijuana has significantly impacted on the ability of scientists to conduct medical research into the substance's possible therapeutic effects, stating:

> Australia has an opportunity to be a leader in the field of cannabinoid research, clinical trials, and an export of cannabis plant and processed cannabinoid based pharmaceuticals of the future. This has been addressed by the "medical cannabis bill" already discussed in the senate with the provision of medical research licences.[23]

2.20 This position was shared by public health organisations who support medicinal cannabis and associated research. The Public Health Association of Australia advocated the legalisation of the drug for the purposes of medicinal research and treatment. It argued that its position was supported by evidence from studies and clinical experience suggesting that the substance was beneficial in alleviating pain and countering side-effects from certain types of medicinal treatment.[24] The Australian Drug Foundation similarly supported the availability of medicinal cannabis for those suffering intense pain or severe disability due to medical conditions.[25]

2.21 It should be noted that the majority of submissions regarding marijuana were submitted prior to the legislative changes regarding medicinal marijuana that occurred in February 2016 (see Chapter 1). The arguments posed here therefore reflect the law prior to the reforms. However, future scrutiny of the effects of the new legislation will require consideration of the issues raised by submitters in relation to barriers that hinder research and innovation.

Options for decriminalising or regulating marijuana

2.22 Submitters calling for legislative change regarding marijuana discussed a range of issues, including whether marijuana should be legalised under a system

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21 Mr Gabriel Buckley, *Submission 79*, p. 4.

22 Mr Stephen Flood, *Submission 206*; Mr Andrew Toft, *Submission 236*.

23 Name withheld, *Submission 248*.

24 Public Health Association of Australia, *Submission 172*, p. 16.

25 Australian Drug Foundation, *Submission 291*, p. 16.

where its cultivation and supply is still regulated by government, or instead fully legalised and decriminalised with no (or extremely limited) regulation or restrictions.

Benefits of a regulated industry

2.23 Some submitters argued that it was critical to have a government-regulated industry when decriminalising marijuana. Mr Mark Hoffman suggested that production and sale of cannabis should be licenced and regulated, resulting in a safer product. He suggested a system of licencing for producers and retailers, with product standards applied similarly to the food industry.[26] Professor Wayne Hall agreed with this view, calling for a regulatory regime akin to the tobacco industry which would take into consideration the risks associated with the product. In this scenario, Professor Hall argued:

> We should tax the product to deter heavy use, we should put bans on advertising and the promotion of use, and we should have reasonable restrictions on availability so that it is not too accessible to people under age.[27]

2.24 Professor Hall also noted that further regulations on product packaging would be required, displaying THC content and health warnings.[28] These measures would ensure that users would maintain their independence in choosing to use marijuana while ensuring that accurate information and warnings regarding excessive use were in place.

2.25 Some submitters argued that creating a regulated industry would reduce harm to users and the community caused by other harmful substances. Mr Timothy Nixon emphasised that by promoting the safe production and sale of marijuana, it would reduce the market share of the tobacco and alcohol industries, which he argued were more harmful in terms of illness and death caused.[29]

Eliminating the role of organised crime

2.26 Mr Mark Hoffman noted that a consequence of decriminalisation would be that those choosing to use marijuana would be able to do so 'without fearing prosecution and the implications associated, and could purchase from safe premises without being exposed to violent criminals or without fear of being criminalised themselves'.[30] This would also reduce the negative impacts of criminalisation, such as the impact of a criminal record on users' lives, reduce the demand on the law enforcement and justice system, and reduce the ability of criminal organisations to proliferate in the drug industry.

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26 Mr Mark Hoffman, *Submission 136*, p. 3.

27 Professor Wayne Hall, *Committee Hansard*, 11 March 2016, p. 8.

28 Professor Wayne Hall, *Committee Hansard*, 11 March 2016, p. 8.

29 Mr Timothy Nixon, *Committee Hansard*, 11 March 2016, p. 8.

30 Mr Mark Hoffman, *Submission 136*, p. 3.

Potential for tax revenue from sales of marijuana products

2.27 Some submitters and witnesses argued that a regulated industry would also provide benefits to the community at large in the form of revenue generated by the application of the goods and services tax (GST) or other specific taxes to sales of marijuana.[31]

2.28 This argument is supported by modelling conducted by the Parliamentary Budget Office (PBO), which suggests that the application of the GST on legalised marijuana would lead to $259 million generated per annum.[32] The PBO included in its calculations that $104 million per annum would be saved due to reduced demand for law enforcement from the Australian Federal Police and the Australian Border Force in relation to policing marijuana offences.[33] The PBO, however, noted that these figures were of 'low reliability', and that the uncertainty of price and quantity of consumption (currently and in an environment where marijuana was legal) cast doubt on their analysis.[34] Additionally, the analysis was conduct on the basis of marijuana being fully legalised as opposed to decriminalised and regulated, and thus does not provide modelling on partial deregulation.

Arguments in favour of fully legalising marijuana

2.29 Unlike those who conceded a need for government regulation, some submitters to the inquiry called for the total decriminalisation of the drug barring some exceptions. Mr Gabriel Buckley argued that any restrictions on marijuana would be tantamount to a state overreach into the personal choices of those wishing to use the substance, with the exception of children.[35] Mr Buckley argued that creating a regulated industry for marijuana would still cause harm to the individual and in the community due to restrictions still remaining on cultivation, possession and use:

> The whole idea of setting up these schemes, labels and warnings—the idea that we somehow need to curtail grown adults from taking responsibility into their own hands and making decisions about which drugs they would like to consume smacks, to me, of the old puritan fear that somewhere someone out there might be having a good time.[36]

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31 Mr Mark Hoffman, *Submission 136*, p. 2.

32 This figure relates to the fiscal balance as opposed to the underlying cash balance which does not accommodate for the lag of accrual of GST revenue; Parliamentary Budget Office, *Legalising marijuana*, 17 December 2015, p. 5, http://www.aph.gov.au/~/media/05%20About%20Parliament/54%20Parliamentary%20Depts/548%20Parliamentary%20Budget%20Office/Publicly%20released%20costings/17122015%20%20PBO%20%20Legalising%20marijuana.PDF?la=en (accessed 11 March 2016).

33 Parliamentary Budget Office, *Legalising marijuana*, 17 December 2015, p. 5 (accessed 11 March 2016).

34 Parliamentary Budget Office, *Legalising marijuana*, 17 December 2015, p. 2 (accessed 11 March 2016).

35 Mr Gabriel Buckley, *Committee Hansard*, 11 March 2016, p. 9.

36 Mr Gabriel Buckley, *Committee Hansard*, 11 March 2016, p. 9.

International examples of marijuana decriminalisation and regulation

2.30 Many submitters pointed to overseas examples of marijuana deregulation as models that could potentially be adopted in an Australian context. The Public Health Association of Australia suggested that Australia could adopt a similar system to the Portuguese model, which focusses on regulation of the substance rather than criminalisation.[37] It also suggested that the ability to regulate marijuana would assist in reducing usage, incorporating a regulatory system similar to what is currently used for tobacco.[38]

2.31 Mr Seppy Pour noted the example of the State of Colorado in the United States of America, which has successfully regulated the substance. He highlighted that the state collected an additional US$53 million in tax revenue in the first year since legalising recreational marijuana, not including the savings made by the state in not investigating and prosecuting offenders for cannabis-related crimes.[39]

2.32 Other models suggested included the Spanish system of regulation, which allows 'clubs' to be established for the cultivation and distribution of marijuana amongst paying members.[40]

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37 Public Health Association of Australia, *Submission 172*, p. 16; Mr Timothy Nixon, *Committee Hansard*, 11 March 2016, p. 8.

38 Public Health Association of Australia, *Submission 172*, p. 16.

39 Mr Seppy Pour, *Submission 255*, p. 5.

40 Dr Samuel Douglas, *Committee Hansard*, 11 March 2016, p. 8; Gareth Platt and Marc Vargas, *Cannabis clubs of Spain: Inside the legal weed dens which are turning Barcelona into Amsterdam*, 15 May 2015, http://www.ibtimes.co.uk/cannabis-clubs-spain-inside-legal-weed-dens-which-are-turning-barcelona-into-amsterdam-1501531 (accessed 15 March 2016).

Chapter 3

Support for continued criminalisation of marijuana

3.1 Despite claims from some submitters and witnesses that marijuana use should be a personal choice, concerns about the substance's negative health and social impacts were highlighted in other evidence to the committee. Public health organisations argued that the health risks associated with marijuana use are substantial and impact not only the individual user but also the wider community.

3.2 This chapter examines the argument against relaxing the regulations on marijuana use for recreational purposes. The key points raised to support the current regulatory regime focussed on the health and social harms on the individual and the community, namely:

- medical concerns regarding the impact of marijuana on individual users, particularly over a prolonged period of time;
- social harm to the community and its cost to the health system; and the
- disproportionate impact of marijuana use on vulnerable groups.

Medical concerns

3.3 The Department of Health (department) advised the committee that the act of smoking marijuana was more harmful than the act of smoking a tobacco cigarette. Marijuana tends to be inhaled for a longer period of time, thus increasing the damage caused:

> Compared to tobacco cigarette smokers, people who smoke cannabis typically inhale more smoke (two-thirds larger puff volume), inhale the smoke deeper into the lungs (one-third greater depth of inhalation) and hold the smoke in the lungs for longer time periods (up to four times longer). This results in the lungs being exposed to greater amounts of carbon monoxide and other smoke irritants and a greater retention of tar in the respiratory tract.[1]

3.4 The department advised the committee that those who smoke cannabis often combine the drug with tobacco, which caused further damage to the respiratory system. Combining tobacco and marijuana can result in higher amounts of harmful chemicals entering the body, which can increase potential harm to the lungs, respiratory organs, and cardiovascular system.[2]

3.5 The department indicated that smoking cannabis using a bong was the most harmful method, as the cooled water increased the amount of smoke entering the lungs, which could then be inhaled more deeply. As a greater volume of smoke fills

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1 Department of Health, *Submission 444*, p. 3.

2 Department of Health, *Submission 444*, p. 3.

more of the lungs, a greater amount of surface area of lung tissue can be affected by tar and other carcinogens.[3]

3.6 The risks to the individual of prolonged use were highlighted by the department, as follows:

> Chronic cannabis use can be associated with a number of negative health and social effects, including diverse health risks associated with smoking, including respiratory diseases, cancer, decreased memory and learning abilities and decreased motivation in areas such as study, work or concentration. People with a family history of mental illness are more likely to also experience anxiety, depression and psychotic symptoms after using cannabis.[4]

3.7 The department also noted that the side effects of marijuana could affect a person's behaviour, thus causing harm to others. The department highlighted the point that marijuana can cause symptoms which trigger a separate and greater problem. For example, cannabis can result in symptoms such as drowsiness and disinhibition, which can lead to a significantly increased risk of incidents such as motor vehicle accidents.[5] Therefore, the argument posed by those supporting the legalisation of marijuana that it has never directly caused the death of a user may not reflect instances where marijuana usage has been a contributing factor to a user's death.

Social harm and cost of marijuana use

3.8 Submitters from public health bodies and government agencies argued that the social and medical harms associated with marijuana legitimised its control and outweighed any arguments for personal choice.

3.9 The department provided evidence to the committee which indicated that marijuana creates a significant social problem for the Australian community. It estimated that in 2013–14, 22 per cent of people seeking assistance for drug addiction did so because of marijuana addiction.[6]

3.10 The department pointed to evidence relating to specialist drug treatment which suggested that in 2013–14, 24 per cent of episodes were for primary cannabis use, amounting to 43,371 episodes per annum. The cost per episode was $16,100, or approximately $70 million per year in total.[7]

3.11 The department also pointed to research from 2007 regarding the significant legal, social and healthcare burden created by marijuana use, which found that:

> dependent cannabis users cost the health system $1.2 billion per annum and…the social costs attributable to crime for both dependent and

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3 Department of Health, *Submission 444*, pp 2-3.

4 Department of Health*, Submission 444*, p. 3.

5 Department of Health, *Submission 444*, pp 2-3.

6 Department of Health*, Submission 444*, p. 2.

7 Department of Health, *Submission 444*, p. 2. See also Victorian Alcohol & Drug Association, *Submission 153*, p. 3.

> non-dependent cannabis users was $1.9 billion, with 80 [per cent] of these costs being attributable to dependent users. This is greater than the costs associated with illicit opioid use.[8]

3.12 The Victorian Alcohol & Drug Association stated that marijuana use creates a significant amount of harm due to chronic use and dependency, which placed pressures on the health care system. It submitted that:

> Currently, cannabis features prominently on a number of measures of harm, including:
>
> - ambulance callouts, with 2212 callouts in Victoria during 2013/14; and
> - alcohol and other drug (AOD) treatment episodes, with cannabis being the principle drug of concern in just under one in four treatment episodes nationwide and secondary drug of concern in 44 [per cent] of all episodes.[9]

3.13 Furthermore, the department pointed to studies that suggested that there is a monetary community cost to cannabis use, which can outstrip other forms of narcotic substances. The department pointed to evidence suggesting that:

> in 2007 … the total annual social cost of cannabis use was in the vicinity of $3.1 billion. Social costs associated with dependent cannabis use accounted for $2.8 billion, or almost one quarter of the total social costs ($12 billion) associated with drug use in Australia.[10]

Disproportionate effects of marijuana on particular social groups

3.14 The committee was presented with evidence regarding the impact of marijuana use on vulnerable or isolated social groups. The department indicated that young people under 17 years are more likely to suffer long-term and serious health effects such as memory impairment and mental health problems. People with family histories of psychosis or who have a pre-existing psychiatric condition may also disproportionately suffer the negative effects of marijuana use.[11]

3.15 The rate and frequency of marijuana use in rural communities was also discussed during the inquiry. The National Rural Health Alliance (NRHA) noted that rural communities have higher rates of marijuana use compared to cities while users in these communities often consume marijuana more heavily than those living in high density areas. The NRHA indicated:

> A study of long term rural users of cannabis has found that 60 per cent use cannabis daily, with 94 per cent using it at least twice weekly. Over one

8 Department of Health, *Submission 444*, p. 3.

9 Victorian Drug & Alcohol Association, *Submission 153*, p. 3.

10 Department of Health, *Submission 444*, p. 3.

11 Department of Health, *Submission 444*, p. 3.

> third also combined regular cannabis use with consumption of alcohol at hazardous levels.[12]

3.16 The NRHA provided evidence from studies showing that in some remote indigenous communities, up to 90 per cent of the community's population were engaged in marijuana use. In such high-use communities, periods of limited supply and withdrawal coincided with outbreaks of violence. Incidents of theft to support marijuana consumption contributed to a cycle of poverty and malnourishment. These factors contributed to the 'breakdown of community and family life' in these communities.[13]

Committee view and recommendation

3.17 The committee notes the diversity of views on recreational marijuana use, from those in favour of continued prohibition to those who recommend complete deregulation.

3.18 The committee accepts that marijuana is not innocuous and that consumption, as with alcohol and tobacco, can have serious adverse consequences on certain individuals.

3.19 The committee notes that relaxation of laws in relation to marijuana would be more difficult to achieve at a Commonwealth level rather than by the States, given Australia's adoption of a number of international treaties.

3.20 The committee notes that despite personal consumption being virtually legal in practical terms as a consequence of state policies, production, distribution and sale remain a major focus of law enforcement.

3.21 The committee notes that this enforcement comes at a considerable cost to the community.

3.22 The committee notes that predictions of negative consequences of deregulation of marijuana should be relatively easy to assess, given the number of countries and states that have already legalised it.

Recommendation 1

3.23 The committee recommends that the Australian Government, in conjunction with the states and territories, undertake an objective assessment of prohibition, decriminalisation, limited deregulation and legalisation, including a full cost-benefit analysis, based on the outcomes of these options in other parts of the world.

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12 National Rural Health Alliance, *Submission 284*, p. 8.

13 National Rural Health Alliance, *Submission 284*, p. 8.

Senator Chris Ketter

Committee Chair

Dissenting Report

Senator Sean Edwards – Liberal Party of Australia

1.1 Senator Edwards rejects the proposition outlined in recommendation 1 and notes the evidence presented by the Department of Health, the National Rural Health Alliance and the Victorian Drug & Alcohol Association that cannabis use brings significant medical and social harm to users and the broader community. These findings provide compelling reasons as to why the decriminalisation of cannabis should not be pursued and why actively doing so would be a waste of state and Commonwealth time and resources.

1.2 Alongside these findings, the committee heard examples of where the cultivation and regulation of cannabis would be beneficial. In these instances the government has already acted appropriately.

1.3 In February 2016 the Turnbull Government introduced and passed legislation to enable the cultivation of cannabis for medicinal and scientific use through a licensing scheme to be established under the *Narcotic Drugs Act 1967*.

1.4 This legislation will open the way for Australian doctors and patients to access medicinal cannabis products safely, legally and reliably to manage some conditions and will satisfy the committee's reported findings.

Senator Sean Edwards

Liberal Party of Australia

Appendix 1

Answers to questions on notice

1. Answers to questions on notice from a public hearing held in Erskineville on 11 March 2016, received from the Department of Health on 8 April 2016.

2. Answers to questions on notice from a public hearing held in Erskineville on 11 March 2016, received from the Department of Health on 8 April 2016.

3. Answers to questions on notice from a public hearing held in Erskineville on 11 March 2016, received from the Department of Health on 21 April 2016.

Appendix 2

Public hearings and witnesses

ERSKINEVILLE, 11 MARCH 2016

BROOKE, Ms Fiona, Policy Adviser, National Rural Health Alliance

BUCKLEY, Mr Gabriel, National President, Liberal Democratic Party

DOUGLAS, Dr Samuel

GREGORY, Mr Gordon, Chief Executive Officer, National Rural Health Alliance

HALL, Professor Wayne Denis

HOFFMANN, Mr Mark Nicholas

NIXON, Mr Timothy

STUDDERT, Dr Lisa, First Assistant Secretary, Population, Health and Sport Division, Department of Health

TURNER, Mr Noel (Bill), Assistant Secretary, Office of Drug Control, Department of Health