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:
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> - 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.

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

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

Senator Chris Ketter
Committee Chair