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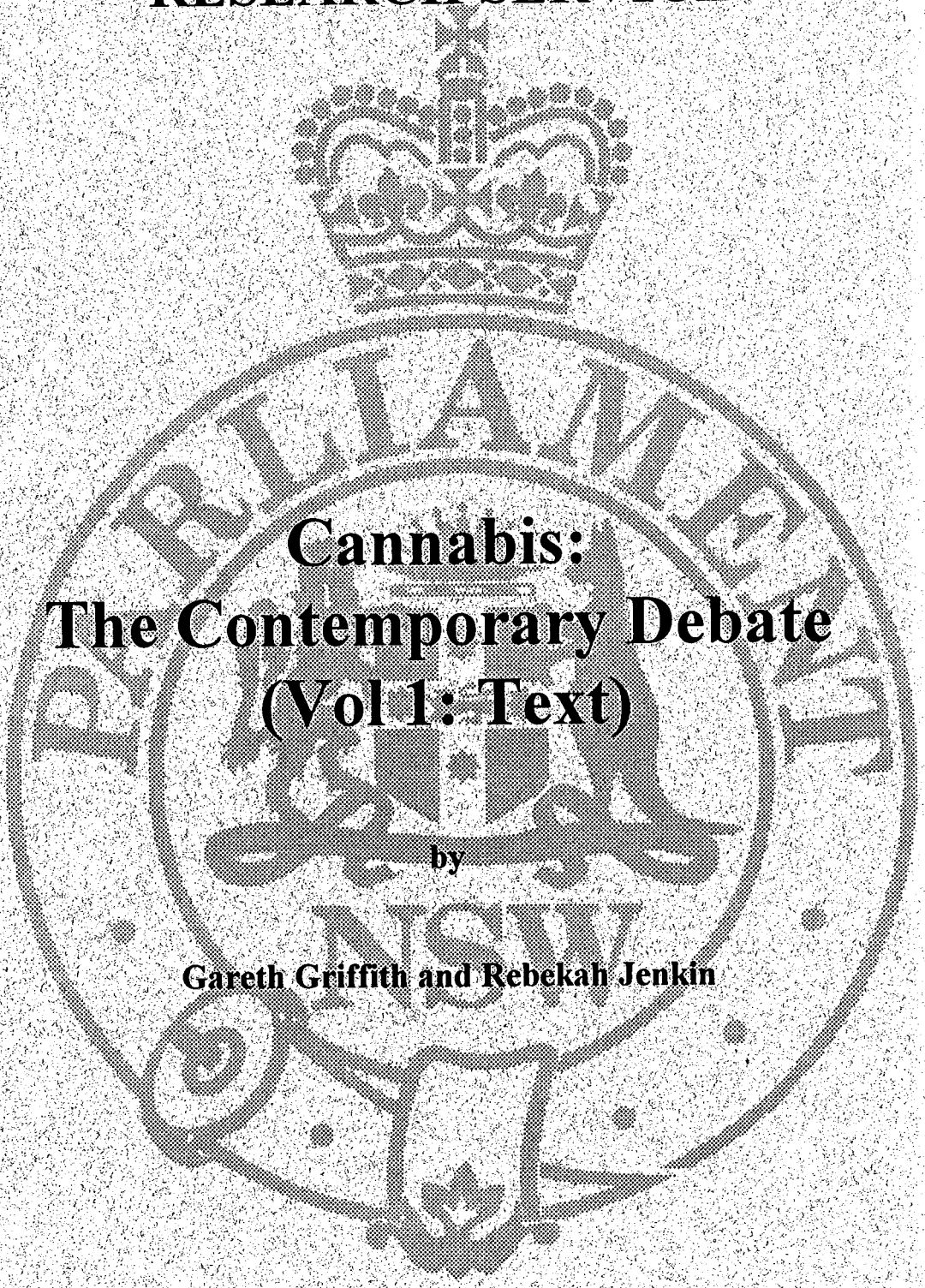

Cannabis: The Contemporary Debate (Vol 1: Text)

by

Gareth Griffith and Rebekah Jenkin

Background Paper No 1994/1

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Introduction

The purpose of this Background Paper is to present a survey of contemporary arguments and research findings concerning the medical, social and legal aspects of the cannabis debate. It does not make recommendations or form conclusions on any of the matters raised.

Part One deals with the botanical, chemical and medical aspects of the debate, followed in **Part Two** by an account of the current law in Australia in relation to cannabis. Public opinion survey findings on the issue of the decriminalisation of cannabis are considered in **Part Three**. **Part Four** presents the range of arguments for and against decriminalisation which are found in the contemporary debate.

1 Cannabis - Botanical, Chemical and Medical Aspects

Cannabis is an herbaceous plant belonging to the hemp family. There is one species of the plant with two subspecies - *cannabis sativa* and *cannabis indica*.[1] *Cannabis sativa* is a tall, cane-like plant cultivated primarily as a source of hemp fibre. *Cannabis indica* is a shorter, shrubbier variety which is usually the main source of the drugs marijuana (also sometimes spelt marihuana), hashish and the numerous other preparations variously known as pot, grass, dope, and by many other colloquial terms. For the purposes of this paper, the term cannabis will be used to denote all forms of the plant.

Cannabis is an annual plant which grows wild in temperate or tropical regions. It is not native to Australia. The seeds of the plant will germinate within a week in moist soil and grow rapidly at a rate of 60 - 70cm per week until they reach a height of 1 - 6m at maturity, usually within 3 - 5 months. It is possible therefore to have two or even three crops of cannabis annually with a concomitant high commercial yield. Although cannabis is frost tender, necessitating glass house conditions if cultivated in some of the colder regions of Australia, in many other areas, especially Queensland and Northern New South Wales, it grows readily without special horticultural attention. The crop of drug reaped from the plant will, however, be enhanced[2] if cultivation is accompanied by irrigation, fertilisation, pruning and exaggerated light exposure.

The cultivation of cannabis is illegal in every State and Territory of Australia

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1 For a brief summary of the botany of cannabis, see G B Chesher, R Malor and P Scheelings, *Some Recent Advances in the Study of Cannabis*, Research Paper 6 of the Royal Commission into the Non-Medical Use of Drugs, South Australia, 1979, p 6.

2 The concentration of active ingredients - cannabinoids - varies across the various plant preparations. The leaves, flowers, bracts have the lowest concentration and the resin the highest. Developments in crop cultivation have resulted in a significant increase in the concentration of cannabinoids in all cannabis preparations when compared to those cultivated in the 1960s.

unless grown under permit for the purposes of research.[3]

History of Cannabis

Cannabis originated and was first exploited for human use in central and east Asia. There is archaeological evidence for the use of cannabis, particularly hemp fibre, dating back to 10,000 BC. By 4,000 to 2,000 BC, in the civilisations of China, India, Mesopotamia and Egypt, cannabis was widely known and cultivated for a variety of purposes, including for the fibre and drug, both as a medicine and as a euphoriant.[4]

Cannabis hemp fibre was widely used as a source of coarse cloth, rope and paper throughout history and contributed significantly to the commercial profitability of many civilisations and colonies including the Americas. King James I of England ordered planting of cannabis for hemp in the early seventeenth century, and from 1750 to the time of the American civil war, cannabis was an important commercial crop in the USA cotton belt. Cannabis fibre was only relatively recently discontinued as a commercial crop throughout the world; commercial and experimental cultivation of cannabis for both fibre production and medicinal extracts persisted until around 1930. At about the same time, the only known use of cannabis as a nutrient - in bird seed - was also discontinued.

Evidence suggests that the medicinal properties of cannabis were well recognised in ancient China where physicians recommended it for the relief of many complaints including constipation, gout, malaria and loss of appetite, and as an aid to childbirth. Widespread use of various forms of cannabis for medicinal purposes only occurred in the Western world during the Napoleonic wars. An Irish physician, W B O'Shaughnessy, actively promoted the use of cannabis as a pain reliever, muscle relaxant and anti-convulsant. He published a book detailing his studies and, subsequently, reports describing the usefulness of cannabis in the treatment of a variety of complaints such as menstrual cramps, asthma, quinsy, coughing, insomnia, migraine and opiate withdrawal appeared in British and European journals.[5]

Cannabis remained registered as a medicine in the USA until 1942 and extracts of cannabis could be found on Australian pharmacy shelves in the 1950s. Cannabis preparations were deleted from the British Pharmaceutical Codex (list of

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[3] Under the appropriate Acts and Regulations, there is provision in each jurisdiction in Australia for authorities or permits to be given for the cultivation of cannabis for the purposes of research - botanical or medical. In reality, however, very few of these authorities are ever issued - currently one is in operation in Tasmania, but it is for the cultivation of cannabis for the hemp fibre not for the drug products.

[4] For brief histories of the cultivation and use of cannabis see either I McAllister, R Moore and T Makkai, *Drugs in Australian Society*, Chapter 5, Melbourne, Longman Cheshire, 1991, pp 96 - 117, or, F Crowley and L Cartwright, *Citizen's Guide to Marijuana in Australia*, Sydney, Angus & Robertson, 1977, pp 10 -13.

[5] Crowley, op cit p 29.

registered and approved drugs) in 1954. The real cause of the demise of cannabis as an acceptable medical treatment, however, was the Prohibition period in the USA.[6] The upsurge of social use of the drug in the 1960s and 1970s further stiffened resistance to the use of cannabis in any medical capacity.

Chemistry of Cannabis[7]

Cannabis is a complex plant which contains many and varied substances, a large number of which may affect various aspects of human physiology. The principle active compounds of cannabis are the cannabinoids which, to date, number more than 60 and the majority of which are psychotropic.[8] The major cannabinoids of interest are Δ^9 (delta-9) tetrahydrocannabinol (THC), cannabidiol (CBD) and cannabinol (CBN). Research into these compounds has occupied the attention of researchers for many decades, but a definitive pharmacologic classification for cannabis has proved elusive. Cannabis has pharmacological characteristics in common with a number of different classes of drugs including LSD, alcohol, nitrous oxide, amphetamines, opiate narcotics, barbiturates and tranquillisers. Thus cannabis can, at different times and doses, be classified as a stimulant, sedative, analgesic and hallucinogen. In addition, cannabis may enhance both the stimulant effects of some drugs, for example the amphetamines, and the sedative effects of others, for example barbiturates. Legally, cannabis is sometimes[9] classified with the opiate narcotics, a classification which implies similarity of undesirability and effects. However, this classification is misleading; although cannabis shares some properties, particularly as a mild euphoric and analgesic, in common with opiate narcotics such as morphine, it is not a narcotic and is no where near as potent or dangerous in its effects on the mind and mood. Cannabis is also not as strongly addictive as the opiate narcotics and its use does not automatically lead to tolerance and dependence. A strong case can be argued therefore for separate pharmacological classification of cannabis and the cannabinoids.[10]

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6 The Prohibition period was enforced from 1919 - 1932 but because of differences between State implementation dates, Prohibition policies were effective from 1920 - 1933.

7 For a detailed description of the chemistry of cannabis see *Cannabis, A Report of the Commission of Inquiry into the Non-Medical Use of Drugs*, Ottawa, Canada, 1972.

8 Psychotropic drugs are any drugs which act upon the central nervous system (brain and spine). Their effects may be positive (ie enhancing) or negative (inhibitory).

9 The 1925 United Nations Geneva Convention on Drugs was extended in 1926 to include Indian hemp, and thus, by implication, cannabis was classified with the narcotics prohibited under the original convention. The United Nations Convention on Narcotic drugs, to which Australia became a signatory in 1961, also included cannabis.

10 Sufficient cannabinoids have been isolated and their activities documented for such a classification to be meaningful and it would ensure that the actions of cannabis were described accurately but without contamination from grouping with drugs that may have a stronger negative social taint. Separate classification of cannabis was in fact one of the recommendations of the Sackville Commission (see Appendix 2 for further details).

Effects of Cannabis[11]

Factors and issues affecting interpretation of research
Body handling of cannabis
Cardiovascular system
Respiratory system
Liver and gastrointestinal system
Hormonal effects
Immune effects
Ocular effects
Central Nervous System (CNS) effects

Factors and issues affecting interpretation of research

Cannabis has been the subject of extensive studies and research for many years. However, a number of practical considerations have limited the reliability of many studies with the result that controversy still rages concerning the exact effects of cannabis on many body systems. Particular factors and issues which increase the difficulty of research into the effects of cannabis include:

1 Cannabis is not a single substance. It contains over 420 substances, at least sixty of which are unique to it.

2 Initial studies were conducted using crude plant extracts of highly variable purity and containing different concentrations of active ingredients.

3 Most cannabis is ingested through smoking rather than orally or by injection. There is thus large variability in the dose of cannabis and it is difficult to mimic the effects of inhalation in humans using animals.

4 The concentration of active compounds in cannabis, particularly of Δ^9 tetrahydro-cannabinol (THC) which is the most potent of the cannabinoids, varies between different parts of the plants[12] and in accordance with climate, geography, plant maturity and cultivation procedure. The average amount of THC in cannabis bought on the street

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[11] For a comprehensive review of the effects of cannabis see the *Canadian Report of the Commission of Inquiry into the Non-medical Use of Drugs*, op cit. More up-to-date information is contained in the South Australian Royal Commission report of the same name (Chesher et al, op cit) and in the book by McAllister et al, 1991, op cit.

[12] Marijuana is usually used to denote cannabis preparations made from the leaves, brachts and flowers of the cannabis plant and hashish preparations made from the resin or oil extracted from the resin. The concentration of THC varies greatly both between and within the two forms. Marijuana contains roughly 0.25 to 5% THC whilst hashish contains anything from 5 to 10%. Cannabis harvested from the sinsemilla variety tends to be the most potent.

thus varies considerably[13] and makes extrapolation of controlled studies to real life extremely difficult.

5 Consumption of cannabis varies greatly from person to person and across social settings. Even in regular users, an accurate estimate of daily or weekly patterns of consumption is difficult and thus it is almost impossible to determine the exact dosage of THC to which users are exposed.

6 Cannabis is frequently used in conjunction with, or following other drugs, licit and illicit, especially alcohol and tobacco. It is thus difficult to separate out the effects of cannabis from the effects of other drugs and interactions between drugs.

7 The illicit nature of cannabis means that surveys of users and consumption are fraught with difficulties; although some users may be incorporated in mainstream society others are not, and particularly amongst young people, use of illicit drugs is often underestimated because of its covert nature.

8 Most studies looking at cannabis use by humans have been short-term studies. Practical limitations severely hamper the completion of longitudinal studies.

9 The emotional arguments for and against cannabis tend to colour both the interpretation of experimental results and their extrapolation to real life.

Body handling of cannabis

Cannabis is a very fat soluble drug. It is thus deposited and sequestered in the fatty membranes and tissues of the body, in particular in organs such as the testes, ovaries and the brain which have a high fat content. The tendency of particular organs and organ systems to retain cannabis in their tissue which is slowly released back into the blood stream and then excreted necessitates that both the acute (immediate) and chronic (long-term) effects of cannabis be examined.

Cannabis is rapidly metabolised once ingested; that is, cannabis is rapidly broken down into different substances which may or may not be chemically active. Many cannabis metabolites are chemically active[14] and thus its effects on the body may be prolonged. Cannabis metabolites are slowly excreted in the faeces and urine. Detection of cannabis metabolites in the blood plasma or urine as a means of measuring cannabis intoxication is fraught with difficulties. The

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[13] The average THC content of cannabis available on the street in Australia is estimated to be around 4%. This figure is higher than that of cannabis available in the 1960s.

[14] At least two cannabis metabolites resemble cannabis in terms of pharmacological activity and also exceed cannabis in potency; thus metabolism of cannabis does not immediately result in the neutralisation of its effects nor the elimination of cannabis entirely from the body.

rapidity with which cannabis is metabolised means that it is rapidly distributed around the body after ingestion and thus quantification is difficult. Secondly, metabolites of cannabis appear in the plasma very soon after ingestion and persist for days if not weeks. Measuring such metabolites does not permit accurate assessment of level of cannabis intoxication. Thirdly, subjective reports of intoxication may indicate that the 'high' has passed but significant concentrations of metabolites may still be present in the blood and urine. Unlike, the 0.05 breathalyser test for alcohol, the correlation between blood or urine cannabis concentrations and degree of intoxication is nebulous. It is thus difficult to use random testing as a means of policing cannabis intoxication.

The two most common methods of using cannabis are smoking or ingesting the various preparations with other foods (for example, so called hash cookies). Smoked cannabis may take the form of either marijuana cigarettes (joints) or hash resin mixed with tobacco, or the dipping of the tip of a normal cigarette in hash oil. Smoking can also be carried out through the use of a water pipe (hookah or bong) to cool the smoke and permit deeper inhalation. Use of a hookah is also supposed to remove the tar and other irritants from cannabis smoke and thus result in less abrasive inhalation. Scientific support of this filtering does not seem to be present in the literature although anecdotal evidence suggests that at the very least smoking cannabis through a waterpipe 'softens' the effect. The sensual effect is more rapid, and control over the quantity of drug delivered greater with smoking. In contrast, unpleasant effects cannot be avoided or 'turned off' with ingested cannabis.

A typical cannabis cigarette consists of 0.75 to 1.0g of cannabis containing roughly 1 to 2% (10 - 20mg) THC. Experienced users inhale about 50% of the active constituent with the rest lost in the side stream smoke or burnt as tar. Inhalation generally lasts about twenty seconds and a 'buzz' is usually felt within two to three minutes. Peak effects are usually felt within half an hour and may last two to three hours. However, there is considerable variation in experience between users and one of the greatest anomalies of cannabis use is that users have to learn to recognise the 'high'; inexperienced users may therefore miss out on any feelings of high or altered sensation until they have 'trained' themselves to recognise the effect!

Cannabis is used primarily for its effects on the central nervous system. However, it also has effects on other organ systems.

Cardiovascular system

Cannabis produces pronounced tachycardia (rapid heartbeat) in humans without any significant changes in blood pressure. In normal healthy people, this effect is not particularly dangerous, although it may alarm the inexperienced user. However, in people with coronary heart disease, particularly angina, the effect of cannabis may be dangerous and even life threatening. Cannabis significantly reduces the time taken for onset of pain after exercise in angina patients and may delay the exhibition of reflex cardiovascular responses required in emergency situations. Smoking cannabis interferes with the delivery of oxygen to the heart and in the face of an increased demand for oxygen, for example during strenuous exercise or times of stress, may pose a medical hazard.

Tolerance to the tachycardia induced by cannabis develops in normal people and long term use may result in a slight lowering of blood pressure.

Respiratory system

Before considering the effects of cannabis on the respiratory system and comparing these effects to those of tobacco, a few caveats need to be made:

1 There are marked differences in the frequency of smoking cannabis and tobacco; cigarette smokers commonly smoke one to two cigarettes per hour, cannabis smokers may only smoke one to two joints per day.

2 The longer interval between smoke exposure significantly decreases the damage any inhaled substance can do to the respiratory tissue.

3 A large proportion of cannabis users are smokers and many are heavy smokers.

Cannabis smoke contains carcinogenic substances. As cannabis is marketed illegally, the tar content of cannabis cigarettes varies enormously. In Australia the tar content of the 'average' cannabis joint is thought to be equivalent to or greater than the tar content of the 'worst' commercially available cigarette. The toxicity of cannabis smoke on human lung cells is roughly equivalent to the toxicity of tobacco smoke; the amounts of ammonia, hydrogen cyanide, benzene and toluene in cannabis smoke are roughly equal to the amounts in tobacco smoke. Thus cannabis smoke has the capacity to severely damage lung tissue and impair lung function. Cannabis smoke is thought to contain around 400% more particulates than tobacco smoke, and as cannabis users also smoke the butt (or roach) they do not have the benefit of a filter to minimise inhalation of undesired particulates from the smoke. Heavy cannabis users may develop chronic bronchitis, emphysema and permanent lung damage. Heavy cannabis users who smoke are putting themselves at greatest risk for the development of lung disease.

Cannabis also acts as a bronchodilator (substance which relaxes the bronchioles in the lung and thus allows the passage of more air) and THC has been proposed and tested on a minor scale for its therapeutic potential in the treatment of asthma. THC aerosols are slower to work than conventional asthma therapies such as ventolin, but the effects seem to last longer.

Liver and gastrointestinal system

There is no evidence to indicate that cannabis use adversely affects liver function. Although cases of liver cirrhosis have been reported in young heavy users, it is difficult to attribute the damage to cannabis as these people were also heavy users of other drugs including alcohol.

Cannabis users regularly report suffering the 'munchies' after smoking or

ingesting cannabis. The 'munchies' usually takes the form of cravings for food, particularly sweet foods. Scientific evidence explaining this phenomenon has been equivocal; cannabis does not alter the blood glucose or free fatty acid levels in the body.[15] However, volunteers who had smoked cannabis consumed significantly more marshmallows than non-cannabis smoking controls and, in another study, the total intake of chocolate milkshakes and subjective reports of hunger and appetite were significantly higher after oral ingestion of cannabis. Long term cannabis use has been associated with an increase in body weight, however, it is difficult to determine whether this is related to lifestyle, to the capacity of cannabis to increase plasma volume in the body or to increased food consumption due to cannabis induced sugar cravings. Another difficulty associated with discerning the effect of cannabis on food intake and appetite is that in animals cannabis acts as an appetite suppressant and promotes body weight loss.

Hormonal effects

Cannabis has a variety of effects on a number of hormonal systems, including the reproductive system. Cannabis depresses the secretion of thyroxine and thyroid stimulating hormone, growth hormone and prolactin. It thus has the potential to interfere with metabolism (through the thyroid hormones), growth (growth hormone) and to decrease lactation (prolactin). THC acts in an oestrogen like manner and thus it markedly affects the secretion of testosterone resulting in lowered testosterone levels and depressed sperm counts. No subjective or apparent reduction in sexual function seems to result from these actions of THC. However, the potential exists for cannabis ingestion to markedly affect the sexual development and growth of pre-pubescent and pubescent youths.

Immune effects

Evidence from a number of studies suggests that cannabis may function as an immune suppressant. However, it is difficult to discern how much of the supposed immune suppression recorded in illicit drug users is due to lifestyle (intake of other drugs, hygiene, irregular and inadequate nutrition, exercise and sleep) and how much is due to cannabis action. Currently, the only possible conclusion is that the effects of cannabis on the immune system are unclear.

Ocular effects

One of the most pronounced and noticeable effects of cannabis is to cause reddening and dryness of the eyes. This is due to the capacity of THC to cause engorgement of the conjunctival vessels resulting in bloodshot eyes. Cannabis seems to have no effect on central visual acuity nor on peripheral vision and there are no apparent changes in depth perception associated with cannabis use.

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[15] Chesher et al, op cit.

Cannabis does decrease the intraocular pressure in the eyes and has been marketed as eye drops in the United States to treat glaucoma. No such cannabis product is yet available on the pharmaceutical market in Australia.

Central Nervous System (CNS) effects

Cannabis is smoked or ingested primarily for its intoxicant effect. After administration of an effective dose of cannabis, the user experiences a fairly predictable set of physiological and psychological changes which last for a few hours and then gradually dissipate. The precise nature of the psychological effects of cannabis do, however, vary in accordance with the mood, personality, expectations of the user, setting and past drug experience. This variance puts particular groups, especially those with pre-existing psychological or mood disorders, at risk of experiencing a bad trip from cannabis. Such people should consider carefully the possible consequences, which may include acute psychosis, before indulging in cannabis consumption. It should be noted, however, that cannabis does not differ from most other psychotropic drugs including alcohol, LSD and heroin in this respect.

The classic signs of cannabis intoxication include dry mouth and dry throat, a feeling of peacefulness and increased empathy, a feeling of altered time perception, usually a slowing of the passage of time but in some individuals time is perceived to pass more rapidly, and an impairment of short term memory. Additional effects of cannabis on other aspects of CNS functioning are described in the following paragraphs.

Effects of cannabis on the EEG

The EEG is the electrical activity of the brain, usually recorded from small cup electrodes placed on the scalp and wired to produce a graphical representation not unlike that of an ECG. Cannabis produces hallmark changes in the EEG associated with euphoriants. In particular cannabis reduces the dominant frequency of the EEG, increases the amount of time spent in alpha activity and decreases beta and theta activity. Although these effects may seem fairly irrelevant to the average user, they are important for two reasons. Firstly, the pattern of EEG changes induced by cannabis is relatively distinctive for that drug and thus enables the differentiation of sources of intoxication, for example, a cannabis induced intoxication can be differentiated from an amphetamine induced intoxication, and appropriate clinical interventions taken. This characteristic also supports the argument for the classification of cannabis in a separate pharmacological category to other drugs with which it has elements in common but also in difference. Secondly, the EEG is a useful measure or picture of brain status and activity. There is thus potential to use the EEG to detect cannabis intoxication or, more importantly, to signal whether use of cannabis is causing any neurological damage. To date, information from studies examining whether cannabis causes permanent neurologic damage have produced uncertain results. In some studies, some neurological damage in the brains of heavy and long term users has been detected, but these results have not been reproduced in other studies or may have been contaminated by the effects of other drugs, licit and illicit, consumed by the patient. Currently, the consensus seems to be that

cannabis may induce permanent neurological damage in heavy, long term users but that other factors such as other drugs used and lifestyle are more likely to have immediate and negative effects on the brain.[16]

Sensory and perceptual effects

Cannabis has analgesic activity, that is, cannabis may increase pain tolerance to a variety of painful stimuli, excluding electrical shock. Cannabis has thus been used with some success in the past to attenuate the signs and symptoms of opiate and alcohol withdrawal.

Cannabis causes marked changes in perception, including skin sensitivity. Small glancing scrapes may be felt as strong and heavy blows, and vice versa. Auditory sensitivity is often enhanced so that intoxicated cannabis users can hear conversations and sounds with remarkable clarity. Cannabis users also show marked changes in their perception of the passage of time - on some occasions time will be perceived as proceeding very rapidly in a manner akin to fast forwarding the video; at other times, everything is perceived to move in slow motion with actions and conversations proceeding laboriously.

The effects of cannabis on perception are distinct from those produced by other illicit drug use and by alcohol intoxication.

Psychomotor effects

The effects of cannabis use on psychomotor functioning have, understandably, been the subject of much research endeavour.[17] Unfortunately, despite all the effort, the findings are not clear cut. Cannabinoids can be readily detected in the urine. Thus, road accident victims and fatalities can be screened for the presence of cannabinoids. However, practically, the result - positive or negative - is of extremely limited value; as mentioned, cannabinoids appear in the urine very soon after ingestion and may persist for days. Also, the urine content gives no indication of degree of intoxication nor of the likely capacity of the individual to drive a vehicle or operate heavy machinery.[18]

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[16] This point remains one of the most contentious in the debate concerning the effects of cannabis and its potential to do harm. Although it can be argued that insufficient evidence has accumulated to warrant the dire warnings of those who believe cannabis is an extremely dangerous drug, it is true that practical and methodological difficulties have precluded the completion of long term and chronic user studies that would go some way towards resolving the issue. The most tenable argument remains a position of cautious optimism - on the face of current evidence, cannabis does not appear to cause pronounced neurologic damage in users.

[17] For a comprehensive review of research in the area see M Henderson, *The Effects of Drugs on Driving*, New South Wales, Road Traffic Authority, 1993, pp 87 - 95. It has a section dealing specifically with cannabis and also objectively outlines the problems with research in the whole area.

[18] G Chesher, 'The Scientific Basis for our Drink-Driving Laws: Why we can't approach cannabis and prescribed drugs in the same way', *Current Affairs Bulletin*, March 1992, pp 4 - 11.

The only reported studies examining the cannabinoid content of Australian road fatalities and injuries were carried out in NSW and Tasmania. Both studies reported that around 6% of injured drivers had cannabinoids in their urine. Similar studies in New Zealand have reported that around 4% of drivers involved in accidents have cannabinoids in their urine. Studies in the US tend to report slightly higher percentages for the general population - 7.8 - 9.5 - and studies examining young drivers have reported that around 32 - 37% of drivers test positive to cannabis in their body fluids. As pointed out, caution needs to be taken when interpreting these results. It should be noted that a significant number of drivers have been found to also be positive to the presence of alcohol, suggesting that one of the problems may be a combination of drug usage with driving rather than just cannabis use. In addition, it is important to note that none of these studies examined the cannabis content of non-crash drivers.

Research examining the effects of cannabis and cannabinoids on performance skills across a range of tasks in both the laboratory (simulated driving) and field (on the road) settings has produced equivocal results.[19] Subjective ratings of degree of intoxication with cannabis roughly correspond to those reported with alcohol, thus cannabis users are aware of being affected by the drug. The effects of cannabis on performance on various psychometric tasks are, however, quite distinct from the effects of alcohol. Cannabis in a dose dependent manner[20], to various degrees and with considerable variability, delays reaction time, impairs perceptual motor control, decision-making, attention and signal detection and diminishes tracking accuracy. All of these capacities have face validity when considered in the context of the cognitive and perceptual requirements for driving or operating heavy machinery. Thus cannabis use would be expected to severely and adversely affect driving competence and proficiency. Studies examining the effects of cannabis on driving do not, however, support this conclusion wholeheartedly, and certainly not in a straightforward manner.

Simple stimulator studies conducted in the 1960s and 1970s seemed to indicate that cannabis use has no adverse effects on driving. However, more sophisticated studies have recently produced contradictory evidence. Cannabis use was found to impair a range of driving skills and perhaps to lead to more crashes. The effects of cannabis were less than those of alcohol and in small doses, cannabis appeared to be antagonising (reducing) the effects of alcohol. Cannabis also seems to reduce risk-taking; drivers who were given cannabis exhibited a much greater following distance than drivers given alcohol or a combination of the two drugs and, unlike alcohol, cannabis use did not consistently impair performance.[21]

Actual on-the-road studies have also produced somewhat ambiguous results.

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[19] For a comprehensive review of the cannabis and driving literature see H Moskowitz, 'Marijuana and Driving', *Accident Analysis and Prevention*, 17, 323-345, 1985.

[20] Dose-dependence of a drug on any test basically means that as the dose of drug increases, the extent of effect observed also increases. Thus, for example, small doses of cannabis have only a minor effect on attention span, with higher doses inducing progressively greater effects until eventually a plateau or total intoxication is reached.

[21] Henderson, op cit, p 91.

Subjects given alcohol or cannabis hit more witch's hats than control drivers, however, cannabis drivers drove at a slower speed than control drivers. Other studies have also suggested that drivers under the influence of cannabis tend to compensate for perceived drug intoxication by driving more slowly[22] and that the combination of alcohol and cannabis is by far the most lethal combination in terms of affects on driving performance. In one study where trailing police officers were used to rate the driving performance of drivers given either cannabis, alcohol or both, the officers rated the driver given both drugs impaired 60% of the time, those given just alcohol impaired 50% of the time, those given cannabis impaired 32% of the time and control drivers impaired 15% of the time.[23]

The evidence seems to indicate therefore that although cannabis does produce significant and detectable effects on performance across various tasks that are related to driving or operating heavy machinery, translating the extent of these effects to impairment experienced in the actual driving situation is difficult. Although Moskowitz in his 1985 review concluded that there was 'more than sufficient experimental evidence to conclude that cannabis seriously impairs psychomotor skills required for driving',[24] the difficulties lie in determining whether the impairments actually result in more accidents or risk of accidents. Furthermore, the real problems with cannabis use in situations where alertness and control are required may be that other drugs are used with cannabis or that the age and experience of the user are the factors which really tip the balance. Cannabis is likely to be used in combination with alcohol, and that combination is much more lethal in adversely affecting driving competence. Also the most common users of cannabis are the young, particularly young males who are perhaps also more likely to indulge in risky behaviour.

Cognitive and intellectual effects

Cannabis does impair cognitive and intellectual skills, particularly those that relate to short-term memory and attention. Cannabis has no apparent effect on long-term memory nor on the retention of information learnt prior to drug ingestion. It does, however, affect the acquisition of new information and the storage of that information in memory. Cannabis does not seem to affect the actual reception of information, rather attention given to information and concentration seems to be adversely affected and result in cognitive problems. Although the extent of the cognitive effects of cannabis may seem relatively minor and may indeed be less than those influenced with alcohol intoxication, it is the case that the most common users of cannabis are the young and thus cannabis use has the potential to significantly impair educational achievement and to interfere with future life

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22 Henderson, op cit, p 93.

23 Henderson, op cit, p 94.

24 Moskowitz, op cit.

prospects if taken on a regular basis.[25] Although motivation may overcome some of the adverse effects of cannabis, the susceptibility of the young to its adverse effects and the capacity of cannabis to significantly interfere with learning should be noted.

Cannabis and schizophrenia

It is a relatively widely held belief that cannabis induces schizophrenia[26] or at the very least induces psychosis. Whilst it is true that schizophrenia has been diagnosed in a number of individuals suffering cannabis intoxication and that individuals who are susceptible to suffering any psychological or psychiatric condition are more likely to experience 'bad trips' or more adverse effects in response to ingesting cannabis, it is simply not true to state that cannabis causes schizophrenia. High doses of cannabis may produce a schizophrenia-like syndrome depending upon the personality structure of the individual involved. Also, the use of cannabis during stressful times in emotionally vulnerable people and those predisposed towards developing psychiatric disorders entails running the risk of suffering long lasting adverse effects.

Evidence for distinctive and permanent cannabis induced psychoses is patchy at best. Temporary psychosis experienced by cannabis users is probably due to chemical changes or damage to the brain cells which results in mental confusion. Symptoms of such damage include slowed time sense, difficulty with recent memory and inability to complete thoughts. As with most drug intoxications, it is a question of how much drug over what period of time. Users who push from acute intoxication into chronic intoxication may experience mental decompensation due to saturation with cannabinoids. Such intoxication, however, results in a functional not toxic psychosis which will pass with time.

Cannabis may aggravate existing emotional disorders and cannabis may also interfere with the psychosocial maturation of young people, but, in fact, any mind or mood altering drug, including alcohol, which is ingested on a regular basis will do this and, just as chronic use of alcohol will stunt emotional growth, so will chronic cannabis use.

Reports have also appeared in the literature concerning the existence of an anti-motivational disorder in association with cannabis use.[27] Although the anecdotal evidence is prolific, there seems to be very little, if any, scientific verification. At most it seems likely that a combination of social, personality and drug usage factors may result in cannabis users displaying lethargy or lack of interest in normal day-to-day activities such as work or school. Similarly, reports

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[25] For an anecdotal rather than scientific discussion upon this point see L Byrski, Chapter 11, 'Marijuana: it makes me feel so good', in *Pills, Potions, People; Understanding the Drug Problem*, Melbourne, Dove Communications, 1986, pp 109 - 121.

[26] For example, see the comments entitled 'Reformers' case is flimsy indeed' in the *Sunday Telegraph*, 31 October 1993.

[27] Byrski, op cit p 109.

of cannabis induced organic brain syndromes are also exaggerated. Moderate to heavy cannabis use may affect the limbic system of the brain[28] with the result that chronic cannabis users display dysphoria (drowsiness) instead of euphoria. No other symptoms of organic brain disease associated with cannabis use have been substantiated.

Cannabis tolerance and dependence

The development of tolerance to cannabis appears to be dose related. For example, those Jamaicans who smoke around 500mg of cannabis on a regular basis are much more likely to develop tolerance to the drug's effects than those Australians who smoke around 20 - 40mg. Thus tolerance develops in association with higher and more frequent dosage.

Tolerance to particular effects of cannabis, for example the cardiovascular effects, has been noted. However, tolerance to the psychological effects seems to occur in a much more ad hoc and unsystematic manner. Thus even regular cannabis users can experience a high after smoking just one joint. In this sense, cannabis is quite unlike many of the harder drugs such as heroin.

Physical dependence on cannabis has been reported, but usually only in association with continuous intoxication. Symptoms of physical withdrawal include restlessness, irritability, perspiration, fevers and chills, nausea and tremulousness. It has been observed in a number of studies that such symptoms are commonly reported in response to withdrawal from even low grade usage when users are questioned closely, but that such symptoms are probably dismissed as the flu or a hangover by users who experience them outside the research setting.[29] Symptoms of cannabis withdrawal appear within hours of cessation of drug use.

Psychiatric classification of cannabis use

It is interesting to note that mental and behavioural disorders due to cannabis use are defined as psychiatric conditions according to both the European and American systems of psychiatric disease classification. Under the American system (DSM-III-R),[30] there are two specific entries pertaining to cannabis under the broad category of Psychoactive Substance Use Disorders - 304.30 Cannabis Dependence and 305.20 Cannabis Abuse. The diagnostic criteria for both conditions are set out in Appendix 1. A diagnosis of cannabis dependence requires the presence of at least three of the described symptoms and includes a

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[28] The limbic system of the brain is responsible for awakening and sleeping the body. Drugs or injuries which impair the limbic system may result in impaired sleep and wake patterns, lack of or excessive arousal and altered attention.

[29] Chesher et al, op cit, p 96.

[30] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, third edition, revised, 1987.

severity scale. The criteria for cannabis abuse exclude by definition patients who have had or have a diagnosis of cannabis dependence and requires persistence of the symptoms for at least a month.

Under the European system, (ICD-10)[31] there is broad classification of mental and behavioural disorders due to psychoactive substance use with specific diagnoses made in accordance with the particular drug. For example, there are separate classifications for alcohol, cannabis and amphetamines. Ten subdivisions apply in relation to each drug listed. The classification code for cannabis is F12.- and the subdivisions are .0 Acute intoxication, .1 Harmful use, .2 Dependence syndrome, .3 Withdrawal state, .4 Withdrawal state with delirium, .5 Psychotic disorder, .6 Amnesic syndrome, .7 Residual and late-onset psychotic disorder, .8 Other mental and behavioural disorders, .9 Unspecified mental and behavioural disorder. The particular criteria for each of these subdivisions are also contained in Appendix 1.

Although the existence of such classifications does not automatically mean that cannabis use should be seen as comprising a psychiatric problem, it does suggest that sufficient and compelling scientific research evidence is available to convince the world's psychiatric experts that with some people, in some situations, cannabis use is a problem that requires psychiatric treatment and consideration on a medical level.

Poisoning associated with cannabis use

Recently, a new and serious problem has emerged in relation to cannabis use. Due to the illicit nature of cannabis use and thus the criminal activities associated with commercial crops, there are no government controls on methods of agriculture employed in cultivation and no means of assessing the purity and chemical content of the product sold. Several cases of acute poisoning associated with cannabis use have recently been reported and these appear to be the result of indiscriminate and dangerous use of defoliants, insecticides, pesticides and weedkillers on cannabis crops.[32] All such substances are subject to strict controls and regulations when used on legal foodstuffs and primary produce. Such controls are, of course, absent when dealing with an illegal crop. It is difficult for this problem to be tackled in any effective way; government and policing agencies have their work cut out for them detecting and destroying crops and are in no way able or likely to be able to regulate the purity of the end product of an illegal crop, users are also not in a position to achieve change as it is only upon ingestion of the cannabis that symptoms of poisoning are experienced and suspicion of contaminated material gleaned. As long as cannabis remains an illegal substance, users run the risk of being sold contaminated or low grade material and suffering either short or long term health effects.

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[31] World Health Organisation, *The ICD-10 Classification of Mental and Behavioural Disorders*, Geneva, 1992.

[32] L E Hollister, 'Health Aspects of Cannabis', *Pharmacological Reviews*, 38, pp 1 - 20 has a discussion of this problem.

Therapeutic applications of cannabis

As mentioned earlier (page 2), cannabis has been used widely to treat a variety of conditions and ailments. Currently in Australia, cannabis is not registered therapeutically in any capacity. In America, however, a preparation of THC has been marketed under the trade name of Marinol and the generic name of Dronabinol. The drug is restricted for use to treat nausea and vomiting associated with cancer chemotherapy and radiation therapy. Two synthetic THC derivatives are also on the market for the same purpose in the USA and Canada. St Vincent's Hospital in Sydney does import one preparation of a synthetic cannabinoid - Nabilone - manufactured in the United Kingdom, Canada and Ireland by Eli-Lilly, to treat nausea and pain in terminally ill patients under the SAS special access scheme. However, there are no applications pending for approval and registration of any cannabinoid derivatives or synthetic preparations in Australia.

Various reports in the literature suggest that cannabis or THC may be effective in the treatment of a number of other complaints. A relatively extensive list of putative therapeutic applications has been suggested,[33] but the use of cannabis for the treatment of glaucoma, provided a topical preparation can be devised successfully, appears to be the only likely candidate for registration for use anywhere in the world in the near future. At this stage it also appears unlikely that any further developments concerning the use of cannabis as a bronchodilator in the treatment of asthma, or as a muscle relaxant in the treatment of spasmicity and as an anticonvulsant to treat epilepsy are unlikely. In addition, it appears unlikely in the current climate that any research on potential therapeutic applications of cannabis will be carried out in Australia. Permission to do such experiments must be granted upon individual application to the State body concerned and as of December, 1993, there were no applications pending consideration.

Patterns and Surveys of Cannabis Use

Patterns of cannabis use vary greatly between individuals and across social settings. The extreme differences in the concentration of active constituents present in hashish and marijuana also make estimates of use difficult. Although cannabis was subject to legal restrictions from early in the twentieth century, its use did not become widespread until the late 1960s when it became strongly associated with the youth counterculture epitomised by Woodstock. There is thus a dearth of information on the use of cannabis until the 1970s and even then the data that is available tends to relate to younger people rather than to the population at large.

Illicit drug surveys report that cannabis is the most common illicit drug used in Australia.[34] Longitudinally, on the basis of survey information that is available,

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[33] Hollister, op cit, pp 13-16.

[34] Department of Health, Housing and Community Services, *Statistics on Drug Abuse in Australia*, 1992, p 33 and McAllister et al, op cit, p 103.

the use of cannabis has been steadily increasing across all age groups since the first survey was completed in the 1970s to reach a plateau in the late 1980s. The steepest increase in cannabis use is in the 20 - 29 age group; in 1973 roughly 20% of respondents reported having tried cannabis, by 1985 this figure had increased to over 55% although there was a slight decline in use recorded for this group in the 1988 survey. The percentage of 14 - 19 year olds who had ever tried cannabis also increased over this time period from around 10% in 1973 to almost 30% in 1988. Cannabis use in the 30+ age group also increased at a similar rate.

The data from the 1991 National Campaign Against Drug Abuse (NCADA) survey[35] indicated that 31.7% of the Australian population over the age of 14 had tried cannabis at some time, with 5.4% reporting having used it in the previous week. Thirteen per cent reported having used cannabis in the past year. These figures show only a slight increase in cannabis use since the 1988 survey and seem to indicate a levelling of the cannabis use curve which has also been reported overseas. The figures for the 20 - 29 age group in the 1991 survey also were slightly lower than the 1988 figures and suggest that there is still a slight downward trend in usage amongst this age group.

Two findings consistently emerge from population surveys of drug use; substantially more males than females report having tried or used all illicit drugs including cannabis, and the highest rate of experimentation with illicit drugs occurs in the age range 14 - 24. Thirty-eight per cent of males compared to 26% of females reported ever having tried marijuana in the 1991 NCADA survey and 17% of males reported having used it in the last year. The corresponding figure for females was 9%. Of males aged 14-24, 38% reported having used marijuana in the past year with 20% of females in the same age group likewise reporting current use. It should be noted, however, that use of cannabis is not restricted to young males. Furthermore, socio-economic status does not seem to play a large role in determining whether someone will use or try cannabis,[36] although there is some evidence to suggest that socio-economic status does play a role in determining the likelihood of incurring a cannabis-related conviction.[37]

School surveys of cannabis use have become an increasingly popular means of attempting to gauge the extent of the drug problem overall in Australian youth. The 1992 NSW School Survey indicates that almost one in five boys aged sixteen have tried cannabis compared with only 8% of girls. In stark contrast, however, are the figures from the Sydney survey amongst young illicit drug users[38] which showed that 93% of 581 respondents had smoked marijuana in

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35 The most recent Australia wide statistics on drug use are contained in the NCADA *Statistics on Drug Abuse in Australia*, 1992, published by the Commonwealth Department of Health, Housing and Community Services. This is one of a regular series of population surveys completed triennially with data available since 1985.

36 McAllister et al, op cit, p 101.

37 Criminal Justice Commission Advisory Committee on Illicit Drugs, *Cannabis and the law in Queensland*, Queensland, July 1993.

38 Drug and Alcohol Directorate, *Results of a Street Intercept Survey of Young Illicit Drug Users in Sydney*, NSW Health Department In House Report Series, 1992.

the last three months. A survey of street kids[39] reported similar findings with 96% of respondents reporting that they had tried cannabis. School surveys are renowned for under-reporting the use of drugs, licit and illicit, as some young people who take drugs have already dropped out of school and others may be reluctant to acknowledge having taken drugs within the school environment.

[39] Drug use amongst street kids was surveyed for the first time in the *1991 NCADA Household Survey*. Eighty two street kids participated in the survey and reported vastly different patterns of drug use and exposure when compared to youths surveyed elsewhere.

2 Cannabis and the Law in Australia

Historical overview

The law relating to cannabis in Australia reflects our federal system of government, with the scheme of legislation operating at a Commonwealth, State and Territory level. This network of laws is complex, sometimes overlapping and not always consistent. A common feature, however, is that cannabis is regarded as a proscribed substance in every jurisdiction.

This was not always the case. Commentators note that in the nineteenth-century different attitudes prevailed where drugs generally were concerned. In particular, the lines between medical and non-medical use, or between use and abuse, were 'indistinctly drawn'.[40] The result was that until 1900 or so there were very few legal controls on the sale or use of drugs in Australia, including cannabis. Over the twentieth-century this situation changed, though only gradually and as a response to disparate factors, often with a significant international dimension.[41] The first commission of inquiry into cannabis, the British East India Hemp Drugs Commission, was commissioned in 1893 (see Appendix 2). According to the Queensland Advisory Committee on Illegal Drugs this and subsequent inquiries had little to do with the process of classifying cannabis as an illegal substance in the period 1890-1940: 'the conferring of an illegal status upon cannabis was rather a secondary consequence of international efforts to control the production of opium'.[42] When picking out the critical factors involved in the process of prohibition, a report of the National Campaign Against Drug Abuse pointed to pressure from international bodies dominated by the United States.[43]

The *Hague Convention* of 1911-12 and the League of Nations sponsored *Geneva Conventions* of 1925 and 1931 established the framework for Australia's early drug laws.[44] The use of opium, morphine, heroin and cocaine was limited to medical purposes by the *Hague Convention*. The *Geneva Convention* of 1925 added cannabis to the list, requiring, among other things, the prohibition of the

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40 D Manderson, *From Mr Sin to Mr Big - A History of Australian Drug Laws*, Melbourne, Oxford University Press, 1993, p 10.

41 For a general account of the legal history of Australian drug laws, including analysis of the 'emotive campaign against the Chinese community' at the turn of the century, see T. Carney, 'The History of Australian Drug Laws', *Monash University Law Review*, 7, June 1981, pp 165 - 204.

42 Advisory Committee on Illicit Drugs, *Cannabis and the Law in Queensland - A Discussion Paper*, July 1993, p 6.

43 National Campaign Against Drug Abuse, *Comparative Analysis of Illicit Drug Strategy*, 1992, p 1.

44 *International Opium Convention 1911-12*, The Hague; *International Opium Convention: Agreement Concerning the Suppression of, the Manufacture of, Internal Trade in, and use of, Prepared Opium 1925*, Geneva; *Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs 1931*, Geneva.

non-medical use of 'Indian hemp' or cannabis. The Commonwealth in 1926 acted to control cannabis importation under the *Customs Act 1901*. Victoria legislated to control cannabis use in 1927. For New South Wales, cannabis, defined as 'Indian hemp (Cannabis Indica)', was added by proclamation in 1935 to the list of prohibited substances under the *Police Offences (Amendment) Act 1908*. South Australia dealt with the drug in its 1934 *Dangerous Drugs Act*; Queensland followed suit in 1937. These laws were passed at a time when, in the view of the Queensland Advisory Committee, 'there was no perceived problem with cannabis use' in Australia.[45] It seems that the cultivation of cannabis for personal use remained legal in Western Australia till 1950 and in Tasmania till as late as 1959 when it was prohibited under the *Dangerous Drugs Act*.[46] The Commonwealth in the meantime had acted in 1956 to introduce an absolute prohibition on the drug.

It is acknowledged that cannabis use and cultivation remained uncommon in Australia in this period. Indeed, the first case of an illegal cannabis crop was reported as late as 1957. The situation changed dramatically in the 1960s. Cannabis arrests rose almost 1000 per cent between 1966 and 1969.[47] Already in the mid-1960s drug laws in all jurisdictions were being overhauled to comply with the obligations incurred under the 1961 United Nations *Single Convention on Narcotic Drugs*.[48] The United States was the principal instigator of the 1961 Convention which in turn reflected the regulatory regime established under the *Harrison Narcotics Act 1915* and the *Federal Marihuana Bill 1937*.[49] The Convention placed cannabis in Schedule IV alongside heroin and other 'particularly dangerous' narcotics. In New South Wales cannabis was proscribed under the 1966 *Poisons Act* as a drug of addiction, whilst remaining a prohibited drug under the *Police Offences (Amendment) Act 1908*, to be treated for the purposes of Part VIA of the Act in the same manner as heroin.[50]

The use of cannabis proportionate to other drugs rose dramatically during the early 1970s, with cannabis related convictions in New South Wales climbing from 365 in 1970 to 4300 in 1977, thus constituting 72% of total drug related

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45 *Cannabis and the Law in Queensland*, op cit, p 7.

46 The Act was proclaimed to commence on 1 August 1961 by Statutory Rule No 110 of that year. The sale of cannabis was proscribed at an earlier date under the First schedule of the *Poisons Act 1916*. It was added to the Schedule by the *Proclamations Confirmations Act 1937*.

47 Manderson, op cit, p 144.

48 Manderson, op cit, p 136. The Convention is also considered, albeit from a different standpoint, in E Walters, *Marijuana - An Australian Crisis*, 2nd Ed, Moorabbin, Associated Printers, 1993, p 124. The Convention was ratified by Australia in 1967.

49 *Cannabis and the Law in Queensland*, op cit, p 7.

50 Cannabis was prohibited under Part IV of the *Poisons Act 1966* where it was treated as a drug of addiction. The *Police Offences (Amendment) Act 1908* was amended by proclamation in 1966, declaring that Part VIA would apply to cannabis in the same manner as it applied to diamorphine (heroin) - *New South Wales Government Gazette* no 77 of 5 August 1966, p 3103.

convictions.[51] Also, both users and sellers were turning to cultivation, thus requiring a different kind of legal response. As the public debate intensified so penalties increased, in particular in relation to trafficking. New South Wales in 1970 introduced a separate and higher penalty of up to 10 years imprisonment for the offence of 'supplying or selling' cannabis and other drugs.[52]

The crackdown against drug trafficking was consistent with the international trend in the law in this period. At the same time a few jurisdictions, notably a number of States of the United States,[53] and the Netherlands, experimented with more 'liberal' regulatory models for the possession of small amounts of cannabis for personal use. Amendments to the *Opium Act* in the Netherlands in 1976 amounted to 'de facto decriminalisation' of such minor cannabis offences. A distinction was drawn in the legislation between 'drugs presenting unacceptable risks' (for which severe penalties are prescribed) and 'hemp products' (for which possession of a quantity up to 30g incurs only a small fine). There was a further tendency for prosecutors to refrain from instigating criminal proceedings against cannabis users.[54] The 'experiment', which is discussed further at page 34, remains in force today in the Netherlands. One Dutch commentator notes that a 'pragmatic approach to the drug problem' has been adopted in the Netherlands, adding that the 'aim of our policy is the reduction of risks and health damages'.[55]

A feature of the response in Australia to the developing drugs issue was the appointment of various government inquiries. A majority of the Senate Standing Committee on Social Welfare in its 1977 report, *Drug Problems in Australia - An Intoxicated Society*, recommended that the personal use of cannabis should not be defined in law as a crime, that the penalty should be 'solely pecuniary' and that no record of conviction should be kept. The South Australian *Royal Commission into the Non-Medical Use of Drugs* (the Sackville Commission) which reported in 1979, recommended a 'partial prohibition model' for cannabis under which cultivation for personal use and small-scale distribution in private to adults would not be a criminal offence. Recommended, too, was the re-classification of cannabis for legal purposes, separately from opiate narcotics. Around the same time a Royal Commission in New South Wales under Mr Justice

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51 Manderson, op cit, p 163.

52 *Poisons (Amendment) Act 1970.*

53 The Queensland Advisory Committee on Illicit Drugs explains that this is best seen in the light of gradual swings in the degree of criminalisation rather than, as is often portrayed, 11 States pursuing their own path. All States reduced penalties on consumption related offences in the period 1969-72. Then, following publication of the National Commission on Marijuana and Drug Abuse in 1972, some States followed up the recommendation of decriminalising consumption-related offences - *Cannabis and the Law in Queensland*, op cit, p 75.

54 R Sarre, A Sutton and T Pulsford, *Cannabis: The Expiation Notice Approach*, Office of Crime Statistics, South Australian Attorney-General's Department, 1989, p 1.

55 E L Engelsman in *Drugs Policy: Fact, Fiction and the Future* by R Fox and I Mathews, Sydney, Federation Press, 1992, p 201. Engelsman explains that the approach is called 'normalisation'. The term does not carry a moral connotation in this context, according to Engelsman. It means only that the drug problem is considered to be a 'normal' problem, one of the various health and social problems a society is faced with and which it tries to control.

Woodward reported on *Drug Trafficking* in the State, and a further *Australian Royal Commission of Inquiry into Drugs*, under Mr Justice Williams, reported a year later. Unlike the Sackville Commission, both these were far more supportive of the orthodox approach to law enforcement where cannabis was concerned. The Woodward Commission recommended that the possession and use of cannabis should not be decriminalised and that research should be undertaken to determine the drug's effect on driving performance, with a view to developing practical tests for the detection and prosecution of cannabis intoxicated drivers. The Williams Commission recommended there be no relaxation of the prohibition on cannabis for at least 10 years after the establishment of National and State Drug Information Centres, following which time a concerted review of cannabis laws should occur.[56]

Out of this debate there arose a variety of legal responses to cannabis. The mid-1980s saw further increases in penalties relating to trafficking in cannabis and other drugs. For example, the New South Wales *Drugs Misuse and Trafficking Act 1985* saw the creation of a new offence of 'commercial' drug supply, cultivation and manufacture. Laws in the different jurisdictions diverged most notably in relation to offences for possession of small amounts of cannabis. These fall along a continuum with South Australia and the ACT at one end. Since 1986 and 1992 respectively, the laws in these jurisdictions have permitted an 'on the spot fine' to be issued for simple marijuana offences. A criminal conviction is not recorded where the fine is paid. Queensland is at the other end of the continuum, with the possession of even small amounts of cannabis attracting severe penalties. The law in New South Wales, by way of contrast, has been described as 'the middle of the road approach'.[57] Commenting on these developments, Makkai and McAllister say, 'There are now significant differences in public policy on the personal use of marijuana among the Australian States'.[58]

In 1988 Australia became a signatory to the United Nations *Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* which, amongst other things, requires participating nations to prevent the illicit cultivation of plants containing narcotic or psychotropic substances. The cannabis plant is specifically included.[59] The Convention was ratified on 16 November 1992 and entered into force in Australia on 14 February 1993. The Commonwealth passed the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990* to give effect to the Convention. Cannabis is defined to be a 'narcotic drug' under

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[56] The findings and recommendations of the various commissions of inquiry are set out in Appendix 2.

[57] Select Committee on HIV, Illegal Drugs and Prostitution (ACT), *3rd Interim Report - Marijuana and other illegal drugs*, 1991, pp 30-35.

[58] T Makkai and I McAllister, 'Public opinion, politics, and the legal status of marijuana in Australia', *Journal of Drug Issues*, 23, 1993, pp 409 - 427.

[59] Advisory Committee on Illicit Drugs, *Cannabis and the law in Queensland - a discussion paper*, July 1993, at 27.

Schedule 2 of the Act (read with section 3).[60]

In addition, both cannabis and cannabis resin are deemed to be 'narcotic substances' under the Commonwealth *Customs Act 1901* (section 4 read with Schedule VI) and declared a prohibited import and export (section 233B). The penalties for a cannabis offence are (i) a maximum sentence of life imprisonment where commercial or trafficable quantities are involved (more than 100kg and 100g respectively) and the offender has previously been convicted of another such offence, (ii) a fine of up to $4,000 or imprisonment for up to 10 years, or both, and (iii) in any other case a fine of up to $2,000 or imprisonment for up to 2 years, or both.

The current law[61]

New South Wales

The principal statute in New South Wales is the *Drug Misuse and Trafficking Act 1985*, under which cannabis is a prohibited substance. For this purpose a distinction is made in the 'Definitions' (section 3) between 'prohibited drug' and 'prohibited plant'. Included under the definition of 'prohibited plant' is *(a) cannabis plant*, which is further defined to mean 'any growing plant of the genus Cannabis'. Separately defined are 'cannabis leaf', 'cannabis oil' and 'cannabis resin', all of which are included under the definition of 'prohibited drug'.[62]

Certain exceptions are made, for example, in relation to the possession of cannabis for the purpose of scientific research or under a lawful prescription, but otherwise dealings with cannabis, in any form, are proscribed. Thus, cultivation, manufacture, production, supply, possession and administration of cannabis is prohibited. Some offences are prosecuted summarily, others on indictment. As amended in 1988, this legislative schema further increased penalties against drug peddlers and traffickers by strengthening the distinction between drug users, on one side, and commercial suppliers and traffickers, on the other.

Under the Act, the offence of possession of a prohibited drug is prosecuted summarily (section 10), as are offences of administration (sections 12, 13 and 14) and of possession of equipment for the administration of prohibited drugs (section 11). Related offences, for example, aiding or abetting an offence of

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[60] Included in the Schedule are cannabis, cannabis resin and cannabis oil. The text of the Convention is recited in the Act. Section 2 provides that the Act would only commence after the Convention had entered into force in Australia. The Act was proclaimed to commence on 14 February 1993.

[61] See Appendix 3 for a list of relevant legislation and for extracts from relevant legislation. For a discussion of legal interpretation in relation to the *Drug Misuse and Trafficking Act 1985* and related legislation see P Zahra and R Arden, *Drug Law in New South Wales*, Sydney, Federation Press, 1991.

[62] Cannabis plant, leaf, oil and resin are included in Schedule 8 of the *Poisons Act 1966* where they are expressed to be either prohibited plants or drugs. They are included in the Schedule 'in addition to drugs of addiction'. This Schedule is included in Appendix 3.

possession or administration of a prohibited drug, are also prosecuted summarily (sections 19 and 20). These offences attract the penalty of a fine of $2,000 or imprisonment for a term of 2 years, or both (section 21).

Offences attracting prosecution on indictment include the cultivation, supply or possession of a prohibited plant (section 23), the manufacture, production or supply of a prohibited drug (sections 24 and 25), plus such associated offences as conspiracy (section 26). The penalties vary according to the quantity of prohibited substance involved.

The relevant 'quantities' are set out in Table 1, following Schedule 1 of the Act:

Table 1: Extract from Schedule 1 of the NSW *Drug Misuse and Trafficking Act 1985*

Prohibited plant or prohibited drug	Column 1	Column 2	Column 3	Column 4	Column 5
	Traffickable quantity	Small quantity	Indictable quantity	Commercial quantity	Large commercial quantity
Cannabis leaf	300.0g	30.0g	1000.0g	25.0kg	100.0kg
Cannabis oil	5.0g	2.0g	10.0g	500.0g	2.0kg
Cannabis plant	·	5	50	250	1000
Cannabis resin	30.0g	5.0g	90.0g	2.5kg	10.0kg

Where the offence involves the cultivation, manufacture, production or supply of a 'small quantity' of either the cannabis plant or drug, then the penalties are a fine of $5,000 or imprisonment for 2 years, or both. These indictable offences are punishable summarily without the consent of the accused (section 30).

Where an 'indictable quantity' of cannabis plant or drug is involved, the penalties are a fine of $10,000 or imprisonment for 2 years, or both. These indictable offences are punishable summarily with the consent of the accused (section 31).

Offences dealt with on indictment but involving 'less than a commercial quantity', involve a fine of $200,000 or imprisonment for 15 years, or both, where the offence relates to cannabis oil or resin. Where the offence relates to cannabis plant or leaf, the penalties involve a fine of $200,000 or imprisonment for 10 years, or both (section 32).

The same distinction between, on one side, cannabis oil and resin and, on the other, cannabis plant or leaf, operates in relation to offences involving 'commercial quantities', where the penalties are a fine of $350,000 or imprisonment for either 20 or 15 years, or both (section 33(2)). For offences involving a 'large commercial quantity', the penalties are a fine of $500,000 or

imprisonment either for life or for 20 years, or both (section 33(3)).

Under section 29, which is an evidentiary provision, possession of a 'traffickable quantity' is deemed to be for supply.

Under section 40A(1), which was inserted in 1986, the onus of proving that a substance is fibre of cannabis leaf from which the resin has been extracted lies on the accused.

Driving under the influence of cannabis is also an offence, under the *Traffic Act 1909* (section 5(2) read with the definition of 'drug' in section 2(1)). Where death or grievous bodily harm is caused in these circumstances, the *Crimes Act 1900* provides for the further offence of culpable driving (section 52A).

Other jurisdictions

The laws in other jurisdictions share many of the essential features found in the New South Wales model. As noted, exceptional features are found in the South Australian and ACT laws in relation to the personal use of cannabis, and for this reason these jurisdictions are considered separately. Otherwise there is a degree of uniformity, in particular in terms of the severity of the law where drug trafficking offences are involved.

The distinction between personal and non-personal use, or between users and suppliers, applies therefore in most jurisdictions. In **Victoria**, for example, under the *Drugs, Poisons and Controlled Substances Act 1981*, possession of a small quantity of cannabis (less than 50 grams) for private consumption carries a fine of $500, which is considerably less than for other 'drugs of dependence'(section 73(1)). On the other hand, trafficking in a commercial quantity (100 kg) of cannabis carries a penalty of a fine of $250,000 and imprisonment for up to 25 years (section 71(1)(a)). The scheme in relation to small quantities of cannabis is qualified by section 76 which provides that adjourned bonds may be given in certain cases; for instance, where the offence is one of possession, use or cultivation and where the offender has not previously been convicted of a drug-related offence or been dealt with under the section. The power to grant a bond is at the discretion of the Magistrate who must take the character of the offender and the public interest into consideration. Of section 76, a report of the ACT Legislative Assembly titled *Marijuana and Other Illegal Drugs*, comments:

> The implications of this section are that if offences concerning small quantities of cannabis which are not for the purpose of trafficking, then they are decriminalised to the extent that a conviction may not be recorded for first-time offenders. There is still a judgement of guilty, however, so that if an offender is convicted of a subsequent offence then he or she will not be able to take advantage of this section a second time.[63]

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[63] Select Committee on HIV, Illegal Drugs and Prostitution (ACT), *3rd Interim Report - Marijuana and other illegal drugs*, 1991, p 33.

This last element is unique to the Victorian legislation. Having said that, the operation of section 76 would appear to be similar in effect to section 556A of the New South Wales *Crimes Act 1900* which gives the court the power, without proceeding to conviction, to make an order either dismissing the charge or discharging the offender conditionally on his entering into a recognisance to be of good behaviour. This section applies where the charge has been proved, but regard is had to the offender's character, age etc, or to such factors as the trivial nature of the offence. The important point in this context is that section 556A has the potential to modify the operation of the criminal law in relation to cannabis offences. However, unlike section 76 of the Victorian legislation, the provision in the New South Wales *Crimes Act* does not identify cannabis offences in express terms, leaving it entirely to the courts to decide whether, in the appropriate circumstances, it is expedient to release the offender on probation with no record of conviction.

The approach taken in New South Wales reflects, in most respects, that adopted in Tasmania, Western Australia and the Northern Territory. In **Tasmania** the prohibition of cannabis is regulated under the *Poisons Act 1971* and the *Criminal Code*, with the penalties depending on the quantities and purposes involved. Under the *Criminal Code*, the court has discretion in imposing penalties. The report of the ACT Legislative Assembly notes that in Tasmania minor offences (possession of less than 25g or 5 plants) have been dealt with by fines of $100.[64] Under the **Western Australian** *Misuse of Drugs Act 1981* cannabis offences are categorised as either indictable or simple, the distinction being between offences of manufacture, sale and supply, on one side, and possession and use, on the other. Schedules VII and VIII set out the quantities deemed to be for the purpose of drug trafficking, namely, 3kg of cannabis, 100g of cannabis resin and 250 cannabis plants. A person convicted of two or more serious or indictable drug offences involving these amounts is declared by the court, on the application of an appropriate officer, to be a drug trafficker (section 32A).[65] In the **Northern Territory** special penalties are imposed under the *Misuse of Drugs Act 1990* for the supply of cannabis to children, namely, imprisonment for 25 years or life imprisonment for supplying a commercial quantity, and 14 years for a lesser amount (section 5).[66]

The **Queensland** legislation was characterised by the report of the ACT Legislative Assembly as a 'stringent' model of prohibition. The current law for that State is outlined in a Discussion Paper released by the Queensland Advisory Committee on Illicit Drugs in July 1993. The relevant statute is the *Drugs Misuse Act 1986*. Section 5 provides a penalty of 20 years imprisonment for trafficking in cannabis. Section 6 provides a penalty of 15 years imprisonment for supplying

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64 Ibid, p 36. The report notes that the information is based on 'advice provided by the Police Department of Tasmania'.

65 *Misuse of Drugs Amendment Act 1990*. The term 'appropriate officer' is defined by section 3 of the *Crimes (Confiscation of Profits) Act 1988*.

66 Under Schedule 2 a commercial quantity is held to be 20 or more cannabis plants, 100g of cannabis resin, 100g of cannabis seed and 25g of cannabis oil. Cannabis is deemed to be a 'dangerous drug' under the statute, but it is not included with heroin and cocaine in Schedule 1 to which more severe penalties apply.

cannabis, but 20 years imprisonment if an adult supplies to a child, an intellectually handicapped person, a person in an educational or correctional institution, or to a person who does not know that he or she is being supplied with a drug. Production of cannabis carries a prison term of 15 years under section 8, or 20 years if the quantity equals or exceeds 500 grams or 100 plants. The penalties for possession are expressed in the same terms in section 9. These provisions are modified by section 13 of the Act which permits minor cannabis offences to be dealt with summarily where persons otherwise liable to a maximum penalty of 15 years for supplying, producing or possessing cannabis are, in the Magistrates Court, liable to a maximum penalty of 2 years imprisonment. The Discussion Paper notes in this context that 'It is only the major dealers who become liable for the larger penalty when prosecuted upon indictment before a superior court'. It remains the case, however, that the minimum penalty for any cannabis offence is imprisonment for up to 2 years. Cannabis is classified as a 'dangerous drug' under the *Drugs Misuse Act 1986.*

South Australia

It is sometimes supposed that small scale or 'simple cannabis offences' relating to private consumption by adults have been decriminalised in South Australia. Strictly speaking, this does not seem to be the case, though it is true to say that the Cannabis Expiation Notice System, introduced 30 April 1987 by the *Controlled Substances (Amendment) Act 1986,* does remove some of the criminal stigma attached to the use of cannabis to the extent that the situation may be described as one of de facto decriminalisation.

The Expiation Notice System was introduced by section 45a of the *Controlled Substances Act 1984*[67], read with the Controlled Substances (Expiation of Simple Cannabis Offences) Regulations. Section 45a(2) provides for the issuing of an expiation notice to a person (not being a child) alleged to have committed a simple cannabis offence. This amounts to an on the spot fine in the form of a 'prescribed expiation fee' which, if paid within 60 days, allows the offender to avoid prosecution in court and with it the possibility of a criminal record. The expiation notice is not unlike a traffic fine. Section 45a(5) states that payment of the expiation fee is not an admission of 'guilt', thus complicating the debate as to whether a criminal or civil offence is at issue.

The fines involved under the Expiation Notice System are roughly equivalent to those previously imposed by magistrates.[68] The fines are:

- possession of less than 25 grams of cannabis ($50);
- possession of less than 100 grams of cannabis ($150);
- possession of less than 5 grams of cannabis resin ($50);
- possession of less than 20 grams of cannabis resin ($150);
- use of cannabis or cannabis resin in private place ($50);
- possession of equipment for use of cannabis or cannabis resin ($50);

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[67] See Appendix 3.

[68] R Sarre et al, op cit, p1.

- possession of equipment offence accompanied by other possession or use offence ($100); and
- cultivation of ten or less cannabis plants ($150).[69]

Two notable exceptions apply with respect to expiation notices. One is that they are not issued to persons under eighteen who are required to appear before a children's court or aid panel. The other is that consumption of cannabis in public (including use of cannabis in a vehicle parked publicly) is not expiable and renders an offender liable for a fine up to $500.[70] Driving under the influence of a drug (including cannabis) is an offence under section 47 of the *Road Traffic Act 1961*, with a first time offence incurring a twelve months minimum license cancellation, a $400-$700 fine, or imprisonment for up to three months.

Further, under the *Criminal Injuries Compensation Act 1987*, all expiation notices bear an additional levy of $5 to be paid into a fund to assist victims of crime.

In South Australia severe penalties continue to apply for non-expiable cannabis offences. Indeed, looked at in its totality the legislative scheme is something of a combination of a tough and tender approach to the prohibition of cannabis, with the relatively 'liberal' regulation of users contrasting with the heavy crackdown on suppliers. Thus the 1986 amendments provided for three categories of cannabis offences, namely, 'simple cannabis offences' and small and large scale trafficking offences. Penalties for the last 2 categories of offence were in fact increased in 1986, in keeping with the Australia-wide trend towards harsher treatment of commercial drug suppliers. It was explained in the second reading speech that the Government remained 'trenchantly opposed to trading or trafficking in cannabis or hard drugs'.[71] Further amendments to the Act occurred in 1990, with the effect of introducing both new categories of offence and reducing tenfold the quantities of cannabis deemed to constitute large scale trafficking. Currently, section 32(5a) of the *Controlled Substances Act 1984* provides the following amounts of cannabis or cannabis resin for this purpose (unless a lesser number is determined by regulation):

- for cultivation of cannabis plants - 100 plants;
- for any other offence involving cannabis - 10 kilograms; and
- for an offence involving cannabis resin - 2.5 kilograms.[72]

These quantities apply to the offences under section 32(5) relating to the manufacture, production, sale, supply or administration to another of a prohibited substance. Specific offences for sale etc of cannabis or cannabis resin to a child,

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[69] Controlled Substances (Expiation of Simple Cannabis Offences) Regulations 1987. The regulation relating to the cultivation of 10 or less cannabis plants must be read in conjunction with section 32(6) of the *Controlled Substances Act 1984* which applies where there is doubt about the purpose for which the 10 plants were grown. A person may be liable under the section to a fine of up to $500. The Regulation goes on to state that 'an expiation notice must be in the form set out in the schedule to these regulations'.

[70] R Sarre et al, op cit, p 4.

[71] South Australian Parliamentary Debates, HA, 23 October 1986, p 1445.

[72] *Controlled Substances Act Amendment Act 1990.*

or for possession of these substances 'within a school zone' for the purpose of sale etc are provided for. Where the quantity involved is equal to or more than the prescribed amount, the penalty is both a fine of up to $1,000,000 and life imprisonment (or such lesser term as the court thinks fit). In any other case, the penalty incurred is a fine not exceeding $400,000 or imprisonment for up to 30 years, or both.[73] Other offences under section 32 are as follows:

- where the offence involves a quantity of cannabis or cannabis resin which equals or exceeds the prescribed amount - a penalty of both a fine up to $500,000 and imprisonment for up to 25 years;[74]
- where the quantity of cannabis or cannabis resin involved is one-fifth or more of the prescribed amount - a penalty not exceeding $50,000 or imprisonment for 10 years, or both;[75] and
- where the quantity of cannabis or cannabis resin is less than one-fifth of the prescribed amount - a penalty up to $2,000 or imprisonment, or both.[76]

Section 32(6) adds that where a person is found guilty of cultivating not more than 100 cannabis plants and the court is satisfied that the plants are for private use, then it may limit the penalty to a fine of up to $500. This section must be read in conjunction with regulation 5(e) of the Controlled Substances (Expiation of Simple Cannabis Offences) Regulations 1987, providing for an expiation notice for the cultivation of 10 or less plants. Interpretation of section 32(6) turns on the purpose for which the cannabis plants were grown.

Australian Capital Territory

A similar 'tough and tender' legislative model has been adopted in the ACT, again with the distinction made between non-personal and personal use respectively. In 1992 the ACT Parliament amended its *Drugs of Dependence Act 1989* so as to introduce by section 171A 'offence notices' for simple cannabis offences. These notices are similar in form, substance and effect to the South Australian cannabis expiation notices. A fine of $100 applies to a simple cannabis offence, involving cultivation of not more than 5 cannabis plants or possession of not more than 25 grams of cannabis. Due payment of the fine means that a person is not regarded as having been convicted of the alleged offence. Unlike the law in South Australia, however, in the ACT payment of the fine does seem to be an admission of guilt.[77]

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[73] *Controlled Substances Act Amendment Act (No 2) 1990.*

[74] *Controlled Substances Act Amendment Act (No 2) 1990.*

[75] *Statutes Repeal and Amendment Act (Courts) Act 1991*, s.16.

[76] *Statutes Repeal and Amendment (Courts) Act 1991*, s.16.

[77] ACT Parliamentary Debates, LA, 19 August 1992, p 1803. It was said in the Second Reading Speech that, 'Paying the fine is, in effect, an admission of guilt; but there will be no court appearance and no criminal record'.

Serving of an offence notice is dependent on the police officer involved having a 'reasonable' belief that only a simple cannabis offence has been committed. Special provision is made for children, with police officers being directed in appropriate circumstances to serve offence notices on the child's parent or guardian.

Other cannabis offences operate on a hierarchical scale of severity depending on the quantity and purpose involved. Cultivating more than 5 plants carries a penalty of $5,000, two years imprisonment or both (section 162(2)(b)). Cultivation for sale or supply carries penalties up to imprisonment for life (section 162(3)), the severest penalty attaching to the cultivation of more than 1,000 plants. Possession of more than 25 grams of cannabis carries a penalty of $5,000 or imprisonment, or both (section 171(1)(b)). Section 165, which deals with the sale and supply of cannabis, carries penalties ranging from imprisonment for life (where a 'commercial quantity' is involved) to a fine of $5,000 or imprisonment for 2 years, or both. Sale or supply of less than a traffickable quantity to a child carries a penalty of $10,000 or imprisonment for 5 years, or both.

Cannabis law enforcement in New South Wales

The statutory penalties for drug offences in New South Wales can be compared with the actual penalties handed down in the lower courts where the great majority of small-scale cannabis offences are dealt with. The general point is that maximum sentences are very rarely imposed. In 1989, 69% of those tried before Magistrates were fined only and another 13% were given absolute or conditional discharges. Only 5.3% were sent to prison. For possession, which is by far the most common charge, 75% of defendants received a fine only, with just 4% being imprisoned.[78]

The Judicial Commission's Sentencing database for the period from January 1991 to December 1992 confirms this pattern.[79] Analysed here are sentencing patterns from the lower courts for particular offences under the *Drug Misuse and Trafficking Act 1985*. In each case the defendant pleaded guilty and no other offences were involved.

(i) *Section 10(1) - possession of cannabis:* For those under 21 **with no prior conviction**, from a total of 897 cases, 81% of offenders (723) received a fine only, with 83% of these falling between $100 and $300. In only 43 cases (6%) did the fine equal or exceed $500. One person was imprisoned. A similar pattern emerges for the other age categories, with the qualification that the rates of imprisonment increase slightly, as do the size of the fines, especially for those offenders over 30 years. From 1327 cases for the 21-30 age group, 82% were fined (1090) but ten offenders received prison sentences. 10% of the fines were $500 or over for this category, with this figure rising to 20% for those between

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[78] L Spender (ed), *The Law Handbook*, 4th Edition, Sydney, Redfern Legal Centre Publishing, 1991, p 623.

[79] See Appendix 4 for copies of the actual statistics.

31 and 40 (from a total of 391 cases, including 3 imprisonments), and to 26% for the 40+ category (from a total of 83 cases, there being no imprisonments).

Interestingly a steady rate of between 7 to 9% of cases in all the above categories were dealt with under section 556A of the *Crimes Act 1900*. The charge was proved, therefore, but no conviction was recorded.

For those under 21 with a prior record, from a total of 524 cases, 87% received a fine only. The fines were on average marginally higher, though 75% of these were still between $100 and $300. Significantly, 13 persons were imprisoned from this group. A predictably similar trend of increasing severity is found in the other age categories. In all these, 3% of offenders were imprisoned, with figures of 58 from 1802 cases for the 21-30 group, 24 from 758 cases for the 31-40 group, and 5 from 156 cases for the 40+ group.

Predictably again only 1% of cases in each category were dealt with under section 556A. More relevant here is section 558 of the *Crimes Act 1900*, allowing for deferral of sentence. For example, 5% of cases in the 21-30 category were dealt with under this section.

(ii) Section 23(1)(a) - cultivation of cannabis plants: Fewer cases are involved overall here. Only in the 40+ category with no prior record did the number increase (to 123 cases). Again, most offenders with no prior conviction were fined only, the percentage ranging from 58% to 65% for those 30 years or under. On average the fines were higher than under section 10 (1). Amongst the under 21 group 55% of fines were still between $100 and $200, but 34% were $500 or more. The fines were higher in the older age groups, with 31% at $1,000 or more in the 30-40 age group. Imprisonment was very rare, only 5 cases from all categories combined, and 3 of these were in the 21-30 age group.

On the other hand both section 556A and 558 were used quite extensively, with the figures ranging between 6% and 11% for the first, and between 14% and 24% for the second provision.

Offenders with a prior record were dealt with more severely. Most were still fined but these were a good deal higher on average, with, for example, 22% at $1,000 or over for those 30 years or under. At most 3% from a total of 758 cases in the 21-30 group were imprisoned and only 1% were dealt with under section 556A in the same age group. Figures for section 558 ranged between 12-19%.

(iii) Section 25(1) - supply of cannabis drug: As one would expect, harsher penalties were imposed for this more serious offence. The percentage of offenders receiving fines only, whether with or without a prior record, fell to 13-28% across all age groups. Prison sentences were far more common, climbing from 4% for those under 21 with no prior record to 26% for the 40+ group with a prior record. Section 556A was used sparingly, peaking at 6% from a total of 85 cases for first time offenders under 21, compared to a figure of 22% of cases dealt with under section 558 for the same group. For this, as for the other offences considered here, the 21-30 age group was the largest category, with 172 cases without, and 247 cases with, prior convictions.

The number of cases recorded in relation to offences under section 23(1)(b) - supply of cannabis plants - and section 23(1)(c) - possession of cannabis plants - are too few to be of statistical value. Only 21 cases were recorded for the latter where there was no prior conviction, and 22 cases involving a prior record. 'Fines only' remained the dominant penalty imposed by the courts.

Decriminalisation and cannabis use

A key issue in the cannabis debate is whether de facto decriminalisation has led to an increased rate of cannabis use in some or all of the relevant jurisdictions.

The experience of the pragmatic, 'normalisation' policy in the Netherlands is often discussed in this context. Much of the research tends to point to a relatively positive outcome. For example, a study by Dr F Ruter, professor of criminal law at Amsterdam University, shows that between 1976 and 1986 cannabis use among 17 to 18 year olds declined from 10% to 6% in Holland (while it increased to 14% in West Germany where a hardline drug policy was in force).[80] These findings, showing a relatively low rate of cannabis use in the Netherlands, tend to be supported by other studies, including one cited in *Drugs, Crime and Society*, the 1989 report of the Parliamentary Joint Committee on the National Crime Authority. The report comments on research suggesting that 4.2% of 10-18 year olds had ever used cannabis and only 1.8% were current users. 'In Amsterdam a survey in December 1987 of 4,370 persons 12 years and older found that only 22.8% had ever used cannabis and that 5.5% had used cannabis in the last month', to which the report adds, 'These are lower than the comparable Australian percentages'.[81] Other research suggests a stable pattern of cannabis use in the Netherlands[82] and tends to support the argument that decriminalisation does not appear to increase cannabis use.[83] It is further argued that the Dutch experience has shown that there is 'nothing inevitable about the drugs ladder in which soft drugs lead to hard drugs'.[84]

Critics of the 'normalisation' policy contest these findings, saying among other things that they present an official gloss used to conceal a disturbing reality. Writing from one end of the spectrum of the cannabis debate, Elaine Walters cites a survey by the Pompidou Council which found that 'marijuana use among 15-17 year olds doubled in the years 1984-1988.' Walters goes on to say that Government approved cafes selling "hash" rose from around 20 in 1981 to 500

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80 M Dean, 'The Dutch Soft-Drug Policy', *The Lancet*, October 1989, p 993.

81 *Drugs, Crime and Society*, op cit, p 99.

82 D J Korf, 'Cannabis retail markets in Amsterdam', *The International Journal on Drug Policy*, 2, 1990, pp 23 - 27.

83 G Van de Wijngaart, 'The Dutch Approach: Normalisation of Drug Problems', *The Journal of Drug Issues*, 20, 1990, pp 667 - 678.

84 M Dean, op cit, p 993.

in Amsterdam alone in 1993 and around 3,000 throughout the Netherlands.[85]

Similarly problematic are the research findings applying to those States in the United States which enacted decriminalisation measures during the 1970s. One example cited by Paul Christie, who is Senior Research Officer with the South Australian Drug and Alcohol Services Council, is the analysis of the change in the law in Ohio in 1975. It seems cannabis use increased slightly between 1974 and 1978 amongst adults aged 18 to 34 years. The researchers interpreted the increase as insignificant and therefore supportive of decriminalisation, but as Christie points out (quoting E W Single), 'the very same data might well have been used to support the opposite conclusion.'[86] The Queensland Advisory Committee cites national survey results from the United States showing that, 'in terms of percentage increases, there is little to distinguish States with severe, moderate and decriminalised legislative regimes'.[87] Again, these surveys are not without their difficulties. In particular, as Christie comments, attempts at evaluating the impact of changes to cannabis laws in the United States are 'hampered by lack of reliable baseline data from the period before the change were made'. Nonetheless 'a fairly consistent' pattern has emerged according to Christie, exemplified in the following statement from E W Single:

> the so-called 'decriminalisation' of marijuana does not appear to have had a major impact on rates of use, as many feared it might have. On the other hand, it has resulted in substantial savings to drug enforcement with resources generally redirected toward the enforcement of laws regarding other drugs.[88]

According to Christie there is some basis for suggesting that a broadly similar conclusion can be drawn in an Australian context. Whilst noting the limitations of the available data, he concludes that 'no consistent pattern' of differences between South Australia and other States in cannabis use is discernible which might be attributable to the introduction of the Cannabis Expiation Notice system in 1987. One source used by Christie are surveys showing rates of cannabis use amongst high school students between 1986 and 1989 in South Australia and New South Wales. Overall, 'modest declines' in usage rates were indicated in both States in relation to percentages of students who had used cannabis at some time in their life. Fifteen year olds were an exception, where there was a slight increase in the rate in South Australia (from 33% in 1986 to 37% in 1989, while in New South Wales there was a fall from 31% in 1986 to 26% in 1989).

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85 E Walters, op cit, p 123. Walters cites J N Santamaria, 'Comments on the great legalisation debate', *Drug and Alcohol Review*, 11, 1992, pp 183 - 186. Santamaria in turn cites, as the original source, a paper by Marguerite Ugland, secretary of Europe Against Drugs, presented to the PRIDE Conference in Nashville, 12 March 1991.

86 P Christie, *The effects of cannabis legislation in South Australia on levels of cannabis use*, p 9. Paper presented at "The Window of Opportunity" First National Congress, University of Adelaide, South Australia, December 1991.

87 *Cannabis and the Law in Queensland*, op cit, p 45.

88 Single, 1989, quoted in P Christie, December 1991, op cit, p 2.

Comparable 1992 survey results for New South Wales suggest a reversal in this downward trend. There had been a significant increase in the percentage of students who report that they have ever tried cannabis. After a decline in use among girls from 22% in 1983 to 15% in 1989, the rate increased to 21% in 1992. For boys the rate of use remained steady at around 25% between 1983 and 1989 but rose to 30% in 1992. Between 1989 and 1992 the percentage of students who reported regular (at least weekly) use of cannabis had also increased significantly, from 3% to 5% among girls and from 7% to 10% among boys.[89] 1992 survey results for South Australia are not yet available.

A further source used by Christie are the NCADA national community surveys. Results of a 1991 NCADA survey comparing cannabis use in South Australia and other States are reproduced in the report of the Queensland Advisory Committee.

Table 2: Percentages of Respondents who Reported that they had Tried Cannabis 1985-1991

		Age Group (Years)		
		14-19	20-39	40+
SA	1985	27.8	46.7	7.1
	1988	25.5	46.3	6.2
	1991	40.0	56.5	9.0
Other States	1985	31.4	49.9	8.1
	1988	28.5	49.2	9.2
	1991	35.8	52.5	10.9

Note: All figures are percentages. Caution needed when interpreting these figures due to small size of South Australian samples.

Source: Christie, P. 1991, *The Effects of Cannabis Legislation in South Australia on Levels of Cannabis Use*, Monitoring Evaluation and Research Unit Drug and Alcohol Services Council, Adelaide; *NCADA Social Issues Survey 1991, (Computer file)*.

Due to the small size of the South Australian sample, the Advisory Committee noted that 'there may be little statistical significance in variations of few percentage points from the average of other States'.[90]

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[89] A Cooney, S Dobbinson and B Flaherty, *Drug Use by NSW Secondary School Students - 1992 Survey*, 1993, p 5.

[90] *Cannabis and the Law in Queensland*, op cit, p 42.

This is one among a number of comments made on the methodological problems in this field, including this more general statement:

> Evidence from around the world on the impact of decriminalisation has tended to support a view of negligible or modest consumption increases following decriminalisation, although there are complications with widely varying means of "decriminalisation", disputes over what is meant by "modest" and many difficulties in finding comparable research material from both before and after legislative change.

Bearing these difficulties in mind the Advisory Committee concludes, 'In aggregate, the material to hand would seem to support a tentative view that legislative or enforcement regimes are not primary determinants of overall levels of cannabis use.'[91]

What emerges from the research in this field is a sense of the difficulties involved in the production of reliable findings, which in turn underlines the complexities at issue here. The formulation of public policy might be assisted by more accurate and up to date information, preferably comparative in nature, dealing with those matters discussed above, as well as with the social and law enforcement costs incurred by different legal approaches to cannabis use. The Queensland Advisory Committee suggests that, in some cases at least, the methodological problems may be insuperable. For example, it comments that it 'did not attempt to do any accounting of social costs arising from drug law enforcement because it did not consider there was any valid basis for doing so.'[92]

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91 Ibid, p 48. It is noted that there are no comparable 'jurisdictions where there are no restrictions on cannabis use and in the absence of such data it is impossible to say what would happen to levels of use were all restrictions to be removed'.

92 Ibid at 96.

3 Cannabis and Public Opinion

Surveys

There have been quite a number of surveys of the views of the Australian population at large concerning the legalisation of cannabis. McAllister et al concluded that 'over the past twenty years, around one-third of the population has consistently favoured legalising marijuana'[93]. Community support for the legalisation of cannabis in Australia seems to have peaked around 30% in the early 1980s and at a slightly lower per cent in America some five to ten years earlier. The 1985 Social Issues Survey[94] reported that overall 32% of those surveyed (2,791 respondents) were in favour of the legalisation of cannabis, 60% were against and the remainder were undecided. More interesting perhaps is the strong relationship between a pro-legalisation view and the age and gender of respondents. Males in general were more likely to say that cannabis should be legalised and nearly 50% of males aged 20 - 39 years were pro-legalisation. In contrast only 38% of similarly aged women were like minded, and both women and men over the age of 40 were significantly less in favour of the legalisation of cannabis.

The Social Issues Survey also sought respondents' opinions concerning the nature of offence appropriate for smoking and/or possession of cannabis. Almost 30% of all respondents thought that smoking or possession of cannabis should not be an offence and a further 48% thought that it should be a fineable offence only. The remainder of respondents (24%) thought that it should be a jailable offence. Again more males than females opted for the decriminalisation of cannabis; however, more females than males thought that if cannabis smoking and possession of small amounts was to be an offence it should be a fineable one not a jailable one. Thus females seemed to think that legalisation of cannabis was not desirable but that minor cannabis offences should be dealt with by the courts in a more lenient fashion.

The table below contains the results of the 1988 NCADA Survey which asked people to rate on a six point scale their attitude to the legalisation of cannabis.

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[93] McAllister et al, op cit, p 100.

[94] For full details of this survey see McAllister et al, op cit, p 101.

Table 3: Attitudes Toward Legislation of Marijuana by Age and Sex, 1988*

Smoking of marijuana should be legalised	All	Female			Male		
Age		14-19	20-39	40+	14-19	20-39	40+
Disagree (%)	65	66	57	80	49	43	78
Disagree a bit	10	6	14	6	18	13	6
Agree a bit	12	9	16	7	11	19	6
Agree	14	20	13	7	22	25	10

* 'Strongly disagree' and 'disagree quite a lot' have been collapsed into the one category; 'Strongly agree' and 'agree quite a lot' have been collapsed into the one category.

Source: 1988 NCADA Survey.

A number of notable points emerge from this survey. Firstly, it appears that support for the decriminalisation of cannabis has dwindled since the 1985 Social Issues Survey, although it should be noted that this survey is five years old and public opinion could have changed in either direction since that time. Secondly, the difference between males and females concerning legalisation seems to have abated somewhat, although more males than females still support legalisation. Thirdly, the age of respondents still seems to be related to their view; those aged 20 - 39 were most likely to support legalisation of cannabis regardless of their gender. On this latter topic, it is interesting to note that there is evidence to suggest that the age affect is actually an artefact of simply having tried the drug. Research by Makkai and McAllister[95] has demonstrated that over 60 per cent of those aged in their early 20s who had tried cannabis thought it should be legalised compared to only 30 per cent of those who had not tried the drug. Across all age groups, roughly twice as many people who had tried cannabis thought it should be legalised in comparison to those who had not tried the drug. In the older age ranges this two fold difference increased to as much as four fold.

[95] Makkai and McAllister, op cit, p 121.

Another interesting survey was the 1990 Australian Election Survey[96]. This survey assessed differences between candidates and voters in their attitude to the legalisation of cannabis. As can be seen from the table below, there are distinct partisan differences in both voters and candidates opinions. Liberal-National Party candidates and voters were much more likely to favour continued prohibition of cannabis than Labour and Democrat candidates and voters.

Table 4: Candidate and Voter Attitudes to the Legislation of Marijuana, 1990*

		PARTY				
	Total %	Labor		Liberal-National		Democrats
Candidates						
Strongly favour illegal	13	5	(4)†	30	(22)†	6
Favour illegal	18	10	(12)	44	(65)	7
Depends	13	19	(22)	6	(4)	18
Favour legal	31	40	(38)	16	(9)	37
Strongly favour legal	25	26	(24)	4	(0)	32
Total %	100	100	(100)	100	(100)	100
(N)	(423)	(114)	(50)	(128)	(46)	(139)
Voters						
Strongly favour illegal	20	16		26		12
Favour illegal	30	27		34		24
Depends	18	20		15		23
Favour legal	22	25		18		27
Strongly favour legal	10	13		7		14
Total	100	100		100		100
(N)	(1,928)	(804)		(849)		(247)

* The exact question was: 'Here are some statements about some legal issues and about some more general social concerns. Please say whether you strongly agree, agree, disagree or strongly disagree with each of these statements ... The smoking of marijuana should not be a criminal offence.' Figures in brackets are for major party candidates who were elected in the federal election.

† The numbers in brackets represent the actual percentage of candidates who were elected. For example, 5% of the Labour candidates who stood for election strongly favoured smoking cannabis remaining an illegal act whilst 4% of those actually elected held the same opinion.

Source: 1990 Australian Election Survey, candidate and voter samples.

[96] McAllister et al, op cit, p 103.

Current debate

In recent months the cannabis debate seems to have gained new impetus. A number of prominent Australians, including politicians from all major parties, were signatories to a charter[97] calling for the decriminalisation of cannabis. Although such resurgence of interest in the issues surrounding the cannabis debate has occurred in the past with no resulting change to legislation, the current level of interest in the topic across all levels of Australian society suggests that cannabis is an issue that has yet to be resolved to the satisfaction of all concerned.

[97] The charter is set out in Appendix 5.

4 Decriminalisation - Arguments For and Against

The Woodward Commission of 1979 opened its discussion of 'cannabis and the law' with a comment on the philosophical background to the debate. The report states, 'At the root of the controversy surrounding the recreational or non-medical use of drugs are fundamental differences in social philosophy and attitudes'. Having established on this basis the various interventionist and non-interventionist approaches, the report then cites with approval this statement of principle from the Canadian Le Dain Commission of 1972:

> The criminal law may properly be applied, as a matter of principle, to restrict the availability of harmful substances, to prevent persons from causing harm to himself or to others by the use of such substances and to prevent the harm caused to society by such use. In every case the test must be a practical one: we must weigh the potential for harm, individual and social, of the conduct in question against the harm, individual and social, which is caused by the application of the criminal law, and ask ourselves whether, on balance, the intervention is justified. Put another way, the use of the criminal law in any particular case should be justified on an evaluation and weighing of its benefits and costs.[98]

The statement remains a good introduction to the debate for and against decriminalisation of cannabis. In it we find the major concerns at issue, embodied in the concepts of self-harm, harm to others and social harm, linked as these are to consideration of the appropriate goals and sanctions of the criminal law. Many issues are raised here. These can be grouped for the purpose of analysis under three headings - medical, social and legal.

Using these categories as a guide, arguments on behalf of decriminalisation are considered first. In this context, the scope of the case for decriminalisation is confined to small quantities of cannabis for personal use only. Also, unless the contrary is stated, the model of decriminalisation applied here is the de facto decriminalisation model adopted in South Australia and the ACT.

The purpose of this section is not to evaluate competing claims, and certainly not to choose between them. Rather, this section seeks to set out the range of arguments found in the contemporary debate.

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[98] *New South Wales Royal Commission into Drug Trafficking Report 1979* (the Woodward Commission), pp 161 - 162.

Arguments for decriminalisation

(i) Medical arguments for decriminalisation

- Compared with other licit drugs, especially alcohol and tobacco, cannabis is a relatively harmless drug and certainly the evidence to date suggests that the medical risks associated with cannabis use are significantly less than those associated with alcohol and tobacco use. The extent, frequency and amount of cannabis use common in the community is also less than that observed with either alcohol or tobacco and as such any medical risks associated with cannabis use are less because of reduced ingestion. Legalisation of cannabis would thus correct an anomalous situation where a less dangerous drug is illegal and more dangerous drugs are legal.

- Cannabis may have a much greater therapeutic potential than either tobacco or alcohol. Cannabis preparations or derivatives could potentially be used to treat a variety of disorders and the legalisation of cannabis would enable proper investigation of its therapeutic potential and perhaps the utilisation of cannabis as a commercially viable crop for medicinal purposes.

- Legalisation of cannabis would enable governments to control adequately both the tar content of cannabis cigarettes and also monitor the cultivation techniques used to produce cannabis crops so that uncontaminated and high quality cannabis preparations were available for sale. As long as cannabis remains an illicit substance, it is impossible to minimise the content of harmful substances in cannabis preparations or to monitor or control the amount of active THC in preparations. Legalisation should therefore not only ensure a cleaner crop but also reduce the health risks associated with ingesting an inadequately purified substance.

- Legalisation of cannabis would help ameliorate the public health problems associated with illicit drug use. Lifestyle factors contribute greatly to the poor health of many drug users; legalising cannabis which is one of the most commonly used illicit drugs would enable health workers to concentrate resources on the hard drugs such as heroin.

- Cannabis is not a narcotic and should not be classified as such. Default association of cannabis with narcotics tends to lead the public to believe that cannabis is a more harmful substance than it is and also tends to result in the common medical grouping of all drug users.

- Harm minimisation. The aims of harm minimisation tend to concentrate on a pragmatic approach to the drug problem, based on the assumption that there will always be people who want to use drugs such as cannabis and the aim of governments should be to reduce the harm drug use imposes on society. Harm minimisation concentrates upon:

- reducing illegal drug use
- reducing the rate of premature death associated with illegal drug use
- improving the physical health of illegal drug users
- decreasing the spread of infection associated with illegal drug use
- improving the social functioning of illegal drug users
- decreasing the criminal activity associated with illegal drug use.[99]

Decriminalisation of cannabis would direct resources away from the identification and conviction of illicit drug users and back into treating the various medical, social and psychological problems which are common amongst long term drug users.

- The 'gateway' theory of drug use has been proven incorrect. It is true that many illicit drug users start to use cannabis before they use other harder drugs, but most users also smoke and drink alcohol and there is no evidence for a causal link between cannabis use and later harder drug use.[100]

(ii) Social arguments for decriminalisation

- The criminalisation of small-scale cannabis use means that users, often persons who are otherwise law-abiding, come into contact with wholesale dealers in illicit drugs. The advantage of the South Australian expiation notice system is that it effectively decriminalises the cultivation of cannabis for personal use, thereby going some way towards undercutting the black market which has developed around the recreational use of cannabis. Further mention is made in this context of the separation of small-scale dealing and use of cannabis from large-scale trafficking and the associated criminal activity, especially in the heroin market.[101] The danger therefore is that the current policy may expose users to 'hard' drugs and more serious criminal activity.

- Following this, it is suggested that it is the illegal status of cannabis which could make it a 'gateway' drug to the use of other, more harmful drugs.[102]

- An argument advanced in the Netherlands was that the very illegality of cannabis makes it a symbol of rebellion for the young and may encourage its use amongst this critical group.[103]

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[99] Harm minimisation has found favour as an approach to the 'drug problem' in a number of Australian jurisdictions including the ACT.

[100] For a discussion on this topic with reference to the relevant statistics see McAllister et al, op cit, Chapter 5.

[101] P Christie, *The Effects of Cannabis Legislation in South Australia on Levels of Cannabis Use*, Drug and Alcohol Services Council, August 1991, p 6.

[102] *3rd Interim Report - Marijuana and other illegal drugs*, op cit, p 48.

[103] *Ibid*, p 45.

- Research suggests that de facto decriminalisation does not result in increased rates of usage, or, alternatively, that any increase may only be modest. The floodgates argument is empirically false. The 1992 survey of cannabis use among high school students in New South Wales certainly does not support the contrary proposition that criminal sanctions reduce the rate of use for this group.

- Legal changes in South Australia and the ACT, admittedly controversial at the time they were introduced, have not in fact excited public outrage or disquiet.

- It is often submitted that the profits to be made from illicit trade in cannabis promote corruption within law enforcement agencies.[104]

- A criminal record gained as a result of cannabis use can severely restrict educational and job opportunities, it is argued, with serious consequences for career choice and advancement.

(iii) Legal arguments for decriminalisation

- The dominant 'prohibition' model of legislation in this field has failed in its goal of preventing widespread cannabis use, especially amongst the young. Criminal sanctions have not proved to be an effective deterrent. It is almost certainly the case that actual apprehension rates are insignificant compared with the total number of cannabis users in the community.

- Conviction for the possession of even a small quantity of cannabis leaves the person with a criminal record, a measure which is said to be out of proportion to the seriousness of the offence, carrying as it does the stigma of criminality and leaving quite large numbers of people with a criminal record who might never otherwise have trouble with the law.

- Sentencing patterns and research support the view that those apprehended for cannabis use are not representative of cannabis users generally. The Queensland Advisory Committee found that 'apprehended offenders are overwhelmingly young, single, unemployed or unskilled males'.[105] More privileged groups are markedly under-represented, therefore, to that extent it can be said that cannabis laws are not equitably enforced. This is not necessarily the outcome of discriminatory enforcement by the police. Rather, it can be explained by the 'differential visibility of offences and offenders'. The report by the Parliamentary Joint Committee on the National Crime Authority (1989) said, 'it is argued that the law has been brought into disrepute because the private nature of much drug-taking behaviour means that it is only the young and poor drug offenders who take drugs in public places who are likely to be

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[104] *Drugs, Crime and Society*, op cit, p 82.

[105] *Cannabis and the law in Queensland*, op cit, p 75.

prosecuted. The rich who indulge their vice in private homes escape detection'.[106]

- The 'prohibition' model is expensive and time consuming for the police and the courts, diverting resources from other more pressing areas of the law, including the apprehension and prosecution of serious drug trafficking offences.

- The policy behind the law is ill-defined. Possession and use offences are concerned with the issue of self-harm and its avoidance. Supply and trafficking offences are concerned with the avoidance of harm to others and social harm. The important difference between these is recognised in most jurisdictions, if only in a pragmatic sense in terms of the varying penalties incurred by these offences. This is the case in New South Wales, for example. At one level, the aim of the policy in relation to trafficking is basically to punish the wrongdoer by imposing severe penalties and thus deterring other potential offenders. At another level the overriding purpose of deterrence is to minimise the harm such offences may cause in society at large by reducing the availability of illicit drugs. A similar combination of goals, namely punishment and harm minimisation, seem to inform the prohibition against cannabis use and possession, though here of course the penalties are less stringent. The question really is whether this is an appropriate legal response. Is the law in fact informed by the goal of punishment? Should it be? Alternatively, if harm-minimisation is the real purpose of the law, is that goal attained by sanctions involving possible imprisonment of offenders and the imposition of a criminal record, with all the implications that must have for job prospects and general advancement in life? On this basis, it is claimed that the criminal sanctions of the 'prohibition' model cause more harm to users than cannabis itself. At the very least, it is argued, the aim of the existing law should be clarified, even if the argument for de facto decriminalisation is itself rejected.

- It is argued that the system of criminal prosecution for small-scale cannabis offenders involves an increased encroachment on civil liberties in the name of drug enforcement.

Arguments against decriminalisation

(i) Medical arguments against decriminalisation

- Cannabis is an intoxicating substance. It is mood and mind altering and the use of such substances should not be encouraged. Arguments that cannabis is a less dangerous substance than alcohol and tobacco are irrelevant as society, given the knowledge it holds today, may well not have regarded either of these two substances as benignly as previously

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[106] *Drugs, Crime and Society*, op cit, p 87.

and criminalisation of both tobacco and alcohol may well be desirable if unlikely.

- Many drug users are poly drug users with almost all hard drug users first experimenting with cannabis before moving on to other drugs. The National Centre for Epidemiology and Population Health survey of illicit drug users reported that 91% of drug users had used more than one drug in the last 1-3 months. 63% had used more than three drugs in the last 1-3 months and heroin users took an average of four drugs. The majority (76%) of heroin users smoked cannabis and took amphetamines (50%). Many also took benzodiazepines (46%) and cocaine (28%). Cannabis is also the most commonly used illicit drug in Australia.

- So called differentiation of drugs into hard and soft drugs is misleading and inaccurate. Cannabis is a drug with as much potential to do harm as heroin and labelling it as soft is only glossing over the facts.[107]

- Those most vulnerable to the appeal of illicit drug taking are the young. The young are also most susceptible to the adverse effects of drugs. The emotional maturation, learning and development of our youth is put at risk if society condones and thereby passively encourages experimentation with illicit drugs. Cannabis is a prime example because cannabis adversely affects memory and learning and thus jeopardises the future of young people who experiment with it.

- There is insufficient evidence concerning the long term and chronic effects of cannabis use. Until such a time as adequate and proper research has been done in this area it would be premature and dangerous to legalise cannabis.

- Cannabis impairs the capacity of individuals to perform tasks requiring attention, concentration and alertness. As such it is dangerous to use cannabis and drive, fly a plane or operate heavy machinery. As cannabis intoxication cannot be adequately detected and quantified in relation to the amount of active substance in the body fluids, for example using a breathalyser, it would be dangerous to legalise cannabis and leave police with no means of detecting if drivers were driving under the influence of cannabis.

- Cannabis has profound and severe additive effects when used with a variety of other drugs. Not only are tobacco smokers who use cannabis increasing their chances of suffering respiratory disease, but those who combine alcohol or other drugs and cannabis run the risk of suffering adverse effects including psychosis and permanent brain damage. Cannabis can also interact with various prescription drugs and legalisation of cannabis could well result in more people suffering lethal drug effects.

- The anti-motivational side effects of cannabis severely hamper the chances of those who take the drug, especially the youth, to live normal

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[107] For an extensive discussion on this point see Walters, op cit.

lives. How can a society which is, for example, actively discouraging young people from smoking and drinking, also encourage those same young people to take up another drug. Legalising cannabis would send exactly that message to our youth.

(ii) Social arguments against decriminalisation

- It is argued that the decriminalisation of cannabis sends the wrong message to the young in particular, conveying to them the impression that cannabis use is sanctioned by society or, conversely, that society does not look upon cannabis use as a serious issue involving the use of a harmful drug. Increased social acceptance of cannabis will result in a diminished perception of the risks involved.

- The 'gateway' argument holds that cannabis use opens the way to the use of 'hard' drugs, notably heroin. Research suggests that most heroin users started their drug-taking habits with cannabis and cigarettes. Elaine Walters cites various studies from the United States in this context. For example, a study called 'Stages in Adolescent Involvement in Drug Use' showed, among other things, that whereas 26% of cannabis users became involved with other prohibited psychotropic drugs, only 1% of non-drug users and 4% of alcohol and cigarette users did so. Walters concludes, 'Although there is no pharmacological link between using marijuana and progressing to the use of other drugs, these surveys and other studies clearly indicate the "progression" of drug use'.[108]

- Decriminalisation would result in increased rates of cannabis use, especially among the young, due both to changing perceptions and levels of availability. Following the 'gateway' argument, this in turn would lead to an increase in the use of 'hard' illicit drugs.

- Experience with alcohol and tobacco has shown that the legality of these substances has led to their widespread use in the community, and the widespread prevalence of alcohol and tobacco related health and social problems.[109] Banning cannabis but allowing alcohol and tobacco may be inconsistent, but that inconsistency, which can be explained by largely historical factors, should not be used as an argument on behalf of cannabis legalisation. At present, cannabis is still only used by a comparative minority and its continued prohibition helps to prevent its use becoming widespread and entrenched.

- The expiation notice system increases opportunities for supplying/dealing in small amounts of cannabis, making this more feasible and less subject to prosecution in court. Also, penalties are not increased for second and

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[108] Walters, op cit, pp 68 - 69.

[109] P Christie, August 1991, op cit, p 7.

subsequent offences.[110]

- The present system of prohibition has the effect of pushing up cannabis prices, thus discouraging its use. It is reported that Australian consumer cannabis prices are very high by developed world standards. It is estimated that since the 1970s the price of retail cannabis in this country has inflated to the extent of about 1,000 per cent.[111] This is a direct consequence of the drug's illegality and must act as a constraint on demand.

- It is claimed that there will be an increased risk to the public from drivers under the influence of cannabis.

(iii) Legal arguments against decriminalisation

- Decriminalisation would undervalue the seriousness of drug taking, thereby undermining the symbolic and educative value of the law.

- The savings forecasted for the courts in South Australia have not eventuated. Sarre et al found it had been difficult to demonstrate any clear benefits to the workloads of the court system in the first nine months of the scheme. The authors found that 'of notices resolved, nearly half (45%) are still going to court because of failure to expiate.'[112]

- Alternatively, under an expiation system people will be discouraged from going to court to dispute offences, resulting in a situation in which the police are both 'judge and jury' in relation to most cannabis offences.

- The police would find it difficult to prosecute individuals dealing in small quantities of cannabis; face problems in verifying the identities of offenders; and be confronted with problems in locating offenders if the expiation fee was not paid.[113]

- Other practical difficulties which would face the police include the problem of weighing and analysing the quantity of cannabis in the possession of an offender. It is argued in this context that the South Australian system has led to an increase in complaints against police.[114]

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110 *3rd Interim report - Marijuana and other illegal drugs*, op cit, p 47.

111 *Cannabis and the law in Queensland*, op cit, pp 97 - 98.

112 R Sarre et al, op cit, p 37.

113 Ibid, p 35.

114 M Riley, 'Too soon to legalise dope - police body', *The Sydney Morning Herald*, 23 October 1993. The view is attributed to Assistant Commissioner, Jeff Jarratt.

- It is argued that experience in the Netherlands and elsewhere shows that decriminalisation can markedly increase the drug market, as individuals who would normally respect the law are encouraged to consider experimentation with illegal substances.[115]

- The deterrent value of an expiation approach is much less than that of the existing system of criminal prosecution.[116]

- The legalisation of cannabis for personal use would be contrary to Australia's international obligations as a signatory to several United Nations Conventions. A proposal of this kind would, therefore, raise very complex legal difficulties. The decriminalisation option (as in the South Australian model) may be less problematic from a technical, legal standpoint, yet it would still be against the spirit if not the letter of the relevant Conventions and contrary to the mainstream of world opinion.

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[115] Ibid.

[116] P Christie, August 1991, op cit, p 6.

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