LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING, COMMUNITY AND SOCIAL SERVICES

(Reference: Inquiry into exposure draft of the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 and related discussion paper)

Members:

DR C BOURKE (Chair)
MR A WALL (Deputy Chair)
MS M FITZHARRIS
MS N LAWDER

TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 31 MARCH 2015

Secretary to the committee:
Mrs N Kosseck (Ph: 620 50435)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

Privilege statement

The Assembly has authorised the recording, broadcasting and re-broadcasting of these proceedings.

All witnesses making submissions or giving evidence to committees of the Legislative Assembly for the ACT are protected by parliamentary privilege.

"Parliamentary privilege" means the special rights and immunities which belong to the Assembly, its committees and its members. These rights and immunities enable committees to operate effectively, and enable those involved in committee processes to do so without obstruction, or fear of prosecution.

Witnesses must tell the truth: giving false or misleading evidence will be treated as a serious matter, and may be considered a contempt of the Assembly.

While the Committee prefers to hear all evidence in public, it may take evidence in-camera if requested. Confidential evidence will be recorded and kept securely. It is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly; but any decision to publish or present in-camera evidence will not be taken without consulting with the person who gave the evidence.

Amended 20 May 2013

The committee met at 9.32 am.

GALLAGHER, DR ELIZABETH, President, Australian Medical Association (ACT)
BRILL, MRS CHRISTINE, Chief Executive Officer, Australian Medical Association (ACT)

THE CHAIR: Welcome to this public hearing of the Standing Committee on Health, Ageing, Community and Social Services inquiry into the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 exposure draft and related discussion paper. Dr Gallagher and Mrs Brill, can I confirm that you have read the privileges card lying on the table before you and sent to you by the secretary?

Mrs Brill: Yes.

THE CHAIR: And do you understand the privilege implications of the statement?

Dr Gallagher: Yes.

THE CHAIR: Good. Before we proceed to any questions, would you like to make an opening statement?

Dr Gallagher: An opening statement about our submission?

THE CHAIR: Yes.

Dr Gallagher: Sure. I am representing the ACT AMA. We have written a response to the submission put forward by the Greens and Shane Rattenbury. AMA ACT are generally supportive of looking into medical cannabis as an option for management or treatment of people with specific diseases that are unresponsive to other measures, but we are definitely not supportive of the type of legislation proposed in the exposure draft. The federal AMA has also put in a submission to the national inquiry. What the AMA in general—and the AMA ACT and AMA federal—are proposing is a nationally consistent and coordinated approach to the management of medical cannabis. We do not want to see different states having different standards and different laws. We think that it is possible and should be looked at as a national issue.

We believe that a collaborative and cooperative approach will offer better support and effective policy. We think that we need to look at targeted research and avoid a reactive and ad hoc response to emotions and stories. We do not really believe that pharmaceutical cannabis should be held to any higher or lower standard for evidence than any other drug that is used for therapeutic purposes in Australia. We believe that we have processes around pharmaceuticals in Australia, through the TGA, that ensure that the therapeutic products are safe and effective. We do not think that we should be bypassing that and undermining the integrity of the pharmaceutical regulatory scheme that we have in Australia.

We think that we need to maintain a very clear distinction between crude cannabis and pharmaceutical cannabis. The proposal put forward here is too unregulated and too ad hoc for us to support. In particular, we do not think that doctors should be

given the responsibility to make a decision as to whether people can grow their own cannabis at home. Certainly doctors would like to know that what they are prescribing is efficacious, that it is quality controlled and that it is actually going to achieve what it sets out to achieve. We also believe that we have a responsibility to patients to make sure that when we are prescribing for them we actually understand all of those fundamental objectives in treatment. I think that is about where I am at. Do you have questions?

THE CHAIR: Yes, I would like to start with some questions. You support a national approach, as you have just said, to medical cannabis, but you are also supportive of the ACT and New South Wales working together on a trial. How do you reconcile those two different positions?

Dr Gallagher: The New South Wales trial is a trial that will be able to be taken out nationally. The ideal would have been an Australia-wide trial, but if New South Wales has one set up then I think the findings should be able to be rolled out across Australia.

THE CHAIR: What sort of role do you see for the TGA in that trial?

Dr Gallagher: We would like to see a quality controlled therapeutic substance. Raw cannabis has a lot of different components and chemicals within it, some of which have a therapeutic advantage and some of which purely give the highs and the psychotropic effects of cannabis, and they may well be quite different. We would really like to be able to get a quality controlled, targeted product out if we are going to use it, rather than just the crude product, which is more like a sledgehammer in terms of its effects.

THE CHAIR: Just going to the difference between crude and synthetic marijuana derivatives, the submission by Drug Free Australia, which you may have had a look at, states that many of the pain conditions for which medical marijuana could be used would be better treated with synthetic marijuana derivatives such as Marinol or Sativex. Do you concur with that argument?

Dr Gallagher: I am not directly familiar with the role of those in pain relief, to be honest. I know that Sativex has been approved by the TGA already for use in Australia for the particular indication of muscle spasticity in multiple sclerosis. I cannot comment on supportive research in terms of pain management for that as I am not familiar with it.

THE CHAIR: But if you are supporting a TGA approved process which is the same as for other pharmaceuticals then the multiple active components which are present with the botanical versions of marijuana are going to be expensive and difficult for drug companies to either synthesise or extract or put together into a dose form which is then approved by the TGA. It would seem that many people argue that this is unlikely to happen.

Dr Gallagher: There are already places in Canada and the Netherlands in particular that manufacture a quality controlled but even more crude form of cannabis, but at least it is quality controlled. In Canada it is produced by one of the pharmaceutical companies, in a quality controlled situation. I think that if we are going to use a drug

then we are better off at least starting with something that we know where it is from, we know what is in it and, because it is produced through a pharmaceutical company and research and development, there is actually research and development going on to monitor it.

THE CHAIR: If I understand you correctly, what you are saying is that there is a role for botanical cannabis provided it is produced in a way where there are consistent effects and a consistent understanding of what is active in it, as is the case in the Dutch system?

Dr Gallagher: Getting the derivatives that we can use that are directly therapeutic would be the ideal, but I realise that that is many years away, potentially, for some of the treatments. At least getting a quality controlled source is very important as a starting point.

THE CHAIR: You mentioned a concern about doctors giving people permits to do their home grown. What are your concerns about that in particular?

Dr Gallagher: It is a big responsibility. It is certainly open to abuse. It could potentially undermine the doctor-patient relationship if the doctor does not think that it is the appropriate thing for the patient. It gives a big responsibility to the ACT Chief Health Officer to oversee all of that. It is just too open to potential abuse. Once the doctor has given permission, they do not actually know how many plants the patient is going to grow and who is going to have access to it. It is too unscientific and too open to abuse.

THE CHAIR: But don't doctors already handle those issues and concerns with a range of other drugs that they prescribe?

Dr Gallagher: They know what they are prescribing because everything that they prescribe has been through a rigorous process with the TGA. There are off-licence indications for some drugs but, again, they are still quality controlled and we still know where they are coming from, what the side effects are and what the risks are.

Mrs Brill: It is like digitalis and foxglove plants. It is about where the digitalis comes from. It is never prescribed in plant form. It is a synthesised pharmaceutical as a particular dose.

MR WALL: Does the AMA have any views on the scope it would ideally like to see a pharmaceutical trial take for the purposes of this product?

Mrs Brill: My understanding is that that has not been clearly enunciated as yet, unless it has gone to the AMA Federal Council. I was not present at the last meeting, so I would not know that. I would imagine that the TGA has a fairly rigorous protocol it needs to follow in any event. That is probably the only comment I could make.

MR WALL: You explore some of the issues about the doctor-patient relationship. Have your members expressed any concern about the current bill, the way it stands, and prescribing or suggesting that a patient head down this road? What is the comfort level of decisions at the moment?

Dr Gallagher: Certainly in general it is not supported at all in this current form or current context.

MR WALL: I guess a decision would largely be driven by the evidence and the research before they were comfortable in suggesting a patient go down this avenue.

Dr Gallagher: Absolutely, and they have to be confident of the quality of whatever it is that they are prescribing.

Mrs Brill: And doctors work on an evidence base.

MR WALL: Going down that road then, what would be the AMA's or your members preferred methods of administration? Obviously crude cannabis is generally a product that is smoked but, as we have heard from other witnesses and I am sure you are aware, there are various forms of administering it, from vapours to tinctures to eating it. What would be a preferred—

Dr Gallagher: I do not know that I am in a position to comment on that at this stage; definitely not smoking.

THE CHAIR: Ms Fitzharris.

MS FITZHARRIS: Thank you for coming in today. Obviously, as Mr Wall says, a lot of the answers to our questions probably cannot be made until—if and when—there is a trial, but if there were to be one, could you say anything now about which conditions it should be prescribed for? Do you have any anecdotal evidence from your membership of people that are currently using it and how effective it is?

Dr Gallagher: No. The answer to the latter part of your question is no. I do not have any experience, nor have I heard of any second-hand anecdotes in relation to the use of cannabis. I guess at the moment the evidence is actually that it is useful in a very, very limited number of conditions. In particular, in the draft put to the Legislative Assembly at the moment, category 3 is just general epilepsy, whereas my understanding is that in fact it is a very small cohort of a specific type of childhood epilepsy where it may be useful.

At the moment there is quite a large trial going on over in the US and I would be quite happy to accept evidence from that large trial. But certainly for just general epilepsy and fitting I do not think there is any evidence at all to support that. As for appetite stimulation in people with terminal cancer, I believe there is some evidence for that, and very limited evidence on chronic pain. I think we really need to tighten the medical indications based on evidence and what has actually been trialled.

THE CHAIR: Is that something that you would like to see in the legislation or do you think that is a decision that should be made between doctor and patient?

Dr Gallagher: What do you mean? In terms of which—

THE CHAIR: Indication figures.

Dr Gallagher: I think in the end it will depend on what sort of product we end up with in terms of fit for use, but I think, yes, it is really important that we do tighten it up because we are talking about a drug that has been illicit, essentially, for 90 years and is the most widely used illicit drug. Therefore, I think it is still very open to misuse and abuse and I think we do need to tighten it up if we are going to legalise it or if it needs to be legalised for very specific purposes.

THE CHAIR: Could you give us some examples of some other drugs which doctors are required to only prescribe for particular conditions?

Mrs Brill: Some of those are specialty related, aren't they?

Dr Gallagher: Yes, and it depends on what the—

THE CHAIR: I do not mean through the TGA or the pharmaceutical benefits scheme but through other legislation.

Dr Gallagher: I am not familiar with them.

THE CHAIR: Thank you. Sorry, Ms Fitzharris.

MS FITZHARRIS: That was my question.

THE CHAIR: Sorry.

MS FITZHARRIS: That is all right. Thank you.

THE CHAIR: Ms Lawder.

MS LAWDER: I think you said earlier that your members are opposed, potentially, to the use of cannabis unless it is in a pharmaceutical form. But have your members had much discussion with, for example, very elderly patients with chronic pain—potentially with a terminal illness as well—about alleviating their pain when they do not have very long to live? Has that entered into the discussion?

Dr Gallagher: No. I think we start to lose objectivity once we start to see pictures of little kids fitting—this sort of story. It really takes away from what we really want, which is a scientific, evidence-based response to problems like this. It is very easy for people to talk anecdotally without proper information to back up those sorts of statements.

I think it is very important if we are going to bring this forward and legislate on a drug that has the potential to be misused and does have potentially adverse outcomes. We already know that alcohol and tobacco are a big issue in our community, and cannabis is also an issue but it is not as widely used. If we start suddenly bringing it up so that a lot more people are using it then I think we are going to start to see more adverse effects and adverse outcomes in a proportion of the community. So I think it is very important that if we are going to introduce legislation it needs to be tight, it needs to be scientifically rigorous and it needs to be controlled. We are never going to

eliminate abuse, but we can reduce it as much as possible.

MS LAWDER: I note that you have said there is no way to control dosage or who gets access to it once the doors are closed. Would you feel that that can also apply to prescription drugs?

Dr Gallagher: Yes, it can, but at least we have the potential to control prescription drugs at a pharmacy level. There is a national registry of S8 drugs and benzodiazepines and things so that the pharmacists can ring and find out how many prescriptions people are getting and so forth, whereas if you actually take it out of that sort of therapeutic environment then you do not have any idea of, as I said, how many plants people have got or who they are giving it to or anything. At least within a therapeutic prescription environment you can keep an eye on that a bit better.

MS LAWDER: Just finally, I think you said earlier that that the AMA nationally were making a submission to the federal inquiry. Is that similar to the position statement that we have here or is there an additional—

Dr Gallagher: Have you got the AMA ACT one or the federal AMA submission?

Mrs Brill: You have got the AMA position statement 2014, I think.

MS LAWDER: Yes.

Mrs Brill: Yes, that is extant. The submission follows on from that. I am not sure if that has been lodged yet or is still in draft form.

Dr Gallagher: That is certainly up on the website, so I assume it has been lodged.

Mrs Brill: So it has been lodged. It is on the AMA website. Dr Gallagher has seen it.

MS LAWDER: Great. Thanks.

THE CHAIR: Any more questions, members?

MS LAWDER: No.

MR WALL: We have heard evidence—I am sure that you and members of the AMA are aware too—of instances where patients have chosen to self-prescribe or self-medicate. I was just wondering if you have got any research, even anecdotally, that can maybe inform the committee of how prevalent a situation that is, where a patient seeks to obtain cannabis.

Dr Gallagher: No information whatsoever, sorry.

MR WALL: No; okay.

Dr Gallagher: And no anecdotal evidence.

Mrs Brill: And they may, in fact, not confide that to their treating practitioner in any

event.

MR WALL: Okay. I guess then the other question would be: to what extent do you believe that the debate for medical cannabis has been evidence based, or driven on a basis of evidence as opposed to ideology or just pure will to see the rules around it relaxed?

Dr Gallagher: I think there is certainly a push from both sides. When this first came up there was a lot of emotion-driven information, a lot of emotion-driven media. It is very easy for people to get swayed by that, by seeing a little child fitting and all that sort of thing, so from our point of view we are really trying to put the brakes on that to make sure that that what we are doing is actually in the best interests of that and also of the majority of the community. We do want any decision to be based on evidence rather than emotion. Once you start making medical decisions just based on emotion for drugs and medication then there is a lot of potential for a breakdown of trust, a breakdown of communication and adverse unmonitored events.

MR WALL: Okay. And in your opinion, Dr Gallagher, where do we sit in that gauge of things at the moment, between evidence-based and the emotive campaign? Where do you think the pendulum is? Is the evidence starting to suggest that this is a road we should go down or do you think that more research still needs to be done?

Dr Gallagher: As I said right at the beginning, the AMA is not against consideration of the use of medical cannabis. In fact, if we can come up with a good product and a good model of distribution then we are very happy to support it for those conditions where there is rigorous scientific evidence to support it. What we do not want to support is the model that is being presented currently through the ACT Legislative Assembly. We also do not want to see different states set up different levels, different standards, because then I think you are going to have cross-border issues, especially here in the ACT, with people coming over from New South Wales if our laws are laxer.

MR WALL: So ultimately treat it as any other pharmaceutical through the same process, the same testing and then have consistency across the country?

Dr Gallagher: Absolutely, and come up with a national approach rather than a state based level.

MR WALL: Okay. Thank you, chair.

MS FITZHARRIS: Chair, could I ask another question?

THE CHAIR: Ms Fitzharris.

MS FITZHARRIS: Does the AMA have a view on alternative medicines as well: how GPs or other specialists might prescribe or talk to a patient about using herbal remedies and alternative therapies that are not on the TGA but that you might be able to get from a naturopath or herbalist or an alternative medical practitioner?

Dr Gallagher: I am not aware of a particular position statement on those.

MS FITZHARRIS: Would doctors generally encourage patients to go down that path? Is there a reasonable evidence base around those therapies now?

Dr Gallagher: No, there is not a good evidence base around it. Certainly in the last 48 hours in the papers there has been a big thing about people forgoing recognised treatments, say, for cancer, and certainly a number of radical diets have been promoted by people claiming to have been cured of cancer. I do not think the medical profession supports the use of any of these as an alternative to recognised drugs that we actually know work.

There have been a number of cases where patients have ended up a lot worse off or with a far more advanced disease simply because they have gone down that track where there was not actually good evidence. I do not think the AMA has got a position statement. I think that that is very much up to individuals. There are certainly some doctors around town that work a lot in the area of nutritional support or alternative therapies as well as integrating that into their medical degrees. But that is a personal choice.

Mrs Brill: A large number of the alternative herbal-type preparations go through a TGA approval process anyway before they can be publicly sold. Doctors, but GPs particularly, want to know if patients are using those preparations for the risk of contraindications with prescribed pharmaceuticals and, indeed, the condition that is being treated.

THE CHAIR: So you would appreciate that at the moment there is difficulty in the discussion that a patient could have with their doctor about using something which is currently illegal, like cannabis, and that the current legislation is a barrier to that discussion?

Dr Gallagher: Working in the area that I do, which is obstetrics and gynaecology, we certainly ask the patients, when they are booked in, whether they are regular cannabis users or how much they do, especially for pregnancy because it can have an effect on pregnancy. I think the majority of people are pretty honest about it, in my profession. Cannabis is the most widely used illicit drug around. One of the things that we need to be careful of is that there seems to be a certain complacency about the risks of cannabis use. But in the same way that we need to be careful of it, because it is so widely used a lot of people are actually quite free to admit that they use in a therapeutic environment where you have doctor-patient confidentiality. I certainly think that a lot of my patients would tell me if I asked.

THE CHAIR: There is also the issue that if medical cannabis was allowed it may interact with the drug driving law. Do you have an opinion on that?

Dr Gallagher: There is evidence that cannabis impairs your ability to react and therefore affects driving safety. So I think we would definitely have to make sure that people that were under the influence were not driving. There is no question about that.

THE CHAIR: In the same way that a range of prescription drugs also inhibit your capacity to operate heavy machinery and drive?

Dr Gallagher: Yes.

THE CHAIR: As there are no further questions, thank you very much for your time.

BUSH, MR WILLIAM MURDOCH, Member, Families and Friends for Drug Law Reform
McCONNELL, MRS MARION, Families and Friends for Drug Law Reform

THE CHAIR: Welcome to this public hearing of the Standing Committee on Health, Ageing, Community and Social Services inquiry into the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 exposure draft. Could I confirm that you have read the privileges card lying on the table in front of you and sent to you by the secretary?

Mrs McConnell: Yes.

Mr Bush: I have.

THE CHAIR: Do you understand the privilege implications of the statement?

Mr Bush: I do.

Mrs McConnell: Yes.

THE CHAIR: Good. Before we proceed to questions, would you like to make an opening statement?

Mr Bush: Yes. Marion McConnell and I are here this morning in place of Brian McConnell who is undertaking his second bout of chemotherapy. Families and Friends for Drug Law Reform is most grateful to the committee for the opportunity to speak in support of the proposal to make cannabis available in the ACT for medical purposes. Families and Friends recalls the moving account by Pauline Reilly of the transformation wrought by cannabis cookies on her husband, Arthur, who was dying of prostate cancer. That cancer had spread into his pelvis, where it could not expand and pressed on the nerves, causing much pain, for the relief of which morphine was the standard response. However, morphine made Arthur stupidly lethargic, killed his appetite and induced constant nausea. Pauline said, "For months I watched my husband slowly slip away, losing weight and having no energy. Once out of bed he sits around dozing or reading. Even the daily crossword puzzle is beyond his powers of concentration. Golf is finished. He is always cold, wanting the fire built up, while I have to strip off a layer or two. His outlook is negative and his dry sense of humour is missing."

That was at Christmas. Four months later, on the advice of friends, she bakes a cannabis cookie, leading Arthur to demand, "Somebody please make me a cheese sandwich." Pauline watches the man who had been her husband for 57 years come slowly back to life. She said, "By the end of June, Arthur is walking several kilometres a day, always accompanied by our dog, Bianca, and sometimes by me, although he is quite capable on his own. He also drives when I am not present." That is a personal experience.

In the United States, where 23 states have now legislated to allow medical marijuana, the prestigious US Institute of Medicine has concluded that for patients such as those with AIDS or undergoing chemotherapy who suffer simultaneously from severe pain,

nausea and appetite loss, cannabinoid drugs might offer broad spectrum relief not found in any other single medication.

Wouldn't cannabis in pharmaceutical pill form, like dronabinol, be adequate? Pauline and Arthur asked his oncologist to investigate its availability, only to find that it is prohibitively expensive as it is not subsidised by the government. In addition, permission is required from the government to prescribe it. In the words of Professor David Penington, it is hard to understand the reluctance of politicians to approve the use of cannabis in situations where there is clear medical evidence that such use could provide striking relief of symptoms. It has been shown in numerous studies here and overseas that cannabis has the capacity to relieve nausea, depression or pain in terminal cancer, improve appetite in people with AIDS and other debilitating diseases and bring relief of muscle spasm in persons seriously disabled by multiple sclerosis.

Families and Friends believes that the committee should be guided by the following six principles: (1) the possible negative effects of cannabis should not be grounds for denying its use to those who may benefit from access to it; (2) the case for making cannabis available for medical purposes should not be confused by reference to arguments for reform of the laws surrounding access to cannabis for non-medical purposes; (3) the supply regime should accommodate the practical needs and facilitate access to cannabis for those who need cannabis for the amelioration of symptoms of their medical condition; (4) arrangements for the supply of medical cannabis should be readily responsive to government regulation, as guardians of the public interest—it should not entrench private financial interests to the extent of creating a commercial lobby that pushes for unregulated supply; (5) a decision by a patient, in consultation with the patient's medical practitioner, to use cannabis for a medical purpose should be respected—use of cannabis to ameliorate symptoms of medical conditions is one primarily for a patient, in full consultation with his or her medical practitioner; and (6) the quest for certainty about the impact of providing cannabis for medical purposes should not be used as an excuse for prevarication while there exists persuasive evidence of efficacy.

THE CHAIR: Thank you. We might get some questions going. In jurisdictions which have already legislated for medical marijuana, such as Colorado in the United States, have there been, in your opinion, any noted health gains for users of medical cannabis?

Mr Bush: As I understand it, the symptomatic relief has been demonstrated there, as mentioned by Professor Penington, and also in his submission to you, and in the passage I read out, and also in an article by Professor Mather and others that is referred to in our submission. The evidence, as I understand it, is strong. We are not qualified scientifically or medically to make that statement. We simply repeat that there is a significant body of evidence that is enough to proceed in relation to a drug where the harms that have been established overwhelmingly affect young people and not the population that would largely stand to benefit from the use of medical cannabis and in relation to which the unwanted side effects, the unwanted implications, are trivial compared to the suffering that people undergo from pain and nausea—relief of nausea and issues such as concentration and whatnot.

Mrs McConnell: I would agree with what Bill said. I could add something from a personal experience, which I did not expect I would be having. My husband is now undergoing chemotherapy for a very serious cancer, something which we certainly did not expect to happen. He has gone through one dose now. To see the way he suffered, the side effects of that chemotherapy, certainly would make me think that if there was something that was going to alleviate that suffering we probably would not hesitate to do it. The illegality of it, of course, adds a dimension that causes more worry and concern for people that may feel that medical cannabis could alleviate some of the symptoms.

Chemotherapy kills the body. It kills the body and then brings it back to life, virtually, if you are lucky. It is a very nasty drug and it is a very harsh treatment. If there is some alleviation that can be given to people, I think it is morally wrong if we do not allow that to happen. People are using it now; it is being used now. So it is not such a huge step, then, to have these people under a doctor's supervision and make it much easier for them.

THE CHAIR: Some people in the community argue that legalising medical marijuana would be a wedge—a wedge in which there would be a future push to legislation for recreational use. Do you think legalising medical marijuana is going to normalise recreational cannabis use?

Mr Bush: I too have read that fear, Mr Chairman. One needs to be absolutely clear. I think the argument, as I have read it, is that it is a Trojan horse that will undermine the international drug regime. But the drug convention—the 1961 Single Convention on Narcotic Drugs—makes it absolutely clear that certain drugs, including cannabis, are prohibited from use except for medical or scientific purposes. There is a clear acknowledgement in the conventions that permits the medical use of these substances. I have just referred to morphine. Morphine is immediately transformed in the body into the same thing as heroin is.

The concern of the International Narcotics Control Board, which is the control body, as you know, that administers the single convention and the other drug conventions, has not been that medical marijuana or cannabis not be permitted, but they want very firm, effective controls on the production and administration of that scheme. That is something that we think is desirable too. So the issue of illegality cuts both ways.

I am sure there are some people who do see it as a means to perhaps move the barriers towards greater and greater liberalisation in the sense that, inevitably, if something is not permitted now and then you permit it, that is moving a boundary. But it is—how to say it? Perhaps I will just stop there.

Mrs McConnell: Could I just add that perhaps we may even see a reduction in recreational use. A lot of people—I do not know how many; this is just from what I understand—use cannabis now to alleviate pain and suffering and other conditions. I would see those people then coming under this scheme, this medical cannabis scheme, where they are under the supervision of a doctor, which a lot of them would want to be. A lot of them would prefer to have the direction of their doctor to help there. Some of these people that are using cannabis recreationally now, as we call it, are actually

using it medically as well and would move into that. So it could even mean less recreational use. I think it has been shown in some research overseas that there has actually been less use, but I would have to look that up for you.

Mr Bush: And certainly, as we understand it from Professor Kilmer, who I hope you have heard from, and who was speaking at a forum here, there has been a substantial reduction in the United States in the use of opiates in states where medical cannabis is permitted. You have to look at the relative danger of drugs. In the medical literature there have been two reported deaths from overdose of cannabis—two. In relation to opiates there have been and continue to be hundreds and hundreds. So we are talking of relative risk. Human life is risky and it can be extremely painful. When there is strong evidence that we can ameliorate suffering then we should do so.

I come back to the point about illegality. Illegality is a reason, maybe, that some see a need to push the boundaries in relation to medical cannabis, but equally illegality has been a ground for pushing back on objective medical research. I think we just heard that from the AMA. It has been illegal for 90 years, and that has swayed community attitudes and the research community. There just has not been the research about its benefits. The negative findings in relation to cannabis, which I mentioned to you, have been only in recent years. When cannabis was prohibited by legislation in the United States in the mid-30s there was no medical evidence—no credible medical evidence whatsoever—of its harmful effects.

That has all come as a result of the discoveries in neuroscience in the 1970s and 80s. So the illegality has distorted the objective association, the objective assessment, of cannabis for good and for bad.

THE CHAIR: Mr Wall.

MR WALL: Thank you, chair. What is the Family and Friends of Drug Law Reform's position on whether a trial should go ahead to show how an individual or a carer might acquire cannabis for the treatment of pain or for whatever condition it might be? The proposed model obviously is to grow your own or acquire it by other means. What thoughts does your organisation have?

Mr Bush: I think our submission attempts to address that. The guiding principle is to make things easier for people who need the drug to get it, and that is an association of the quality. There are varying levels and there is a vast range of particular chemicals, I believe, in cannabis plants, and the balance between them varies. So you need careful horticultural knowledge to do it. The stresses of trying to grow cannabis in a Canberra winter—I leave it to you. The book by Pauline Reilly about her husband illustrates it. They were in coastal Victoria—much milder—but the cannabis plant was in a position where they managed to grow it after not wanting to deal with criminal suppliers. It was about ready when Arthur died. So you are adding a layer of stress unless you provide a means to ready access of material, in the most accurate grade of assessment that you can, with the least amount of hassle for the people who obtain it.

MR WALL: So what you are suggesting is that state-grown, or under the controlled guidelines of a pharmaceutical company, for instance, would be a better model for supply and production?

Mr Bush: There is legislation, as you know, for the federal government to provide for the production of cannabis. It is before a Senate committee. That would be a means that would satisfy the INCB in terms of its concerns—the rather chaotic arrangements across those 23 states in America and the various means of producing medical cannabis. You want a system that provides a product you can rely upon and that requires a central growing system. Our concern is that you do not want commercial interests to push the boundaries of what is a desirable extent to which the cannabis should be allowed. That is a decision for you. It should not be a decision that is influenced by simple commercial considerations to push for more and wider production of the product.

MR WALL: So do you believe that cannabis in whichever form it is grown should be put through the same rigorous testing and peer review system that any other pharmaceutical is required to pass, both under international and federal laws, to test its efficacy?

Mr Bush: Evidence can be used to facilitate things; evidence can be used to block things. It is a question of risk assessment. I cited to you work by Professor Mather and Professor Penington and the US Institute of Medicine. There is substantial evidence that it works for particular populations, and that is what I heard the AMA say. But the AMA is seeking enormous certitude, and that enormous certitude will effectively mean a barrier for years, if not decades, before you manage to get the necessary evidence. I think the committee needs to be very careful about how it uses the evidence argument. Yes, we are all for evidence—this is what we stand for—but what is sufficient evidence? The search for absolute certainty becomes a barrier to sensible decision-making.

MR WALL: You raised the issue of certitude. Under the system we have at the moment, doctors and physicians are amongst some of the most trusted people in our community, and the therapies and medicines that they often prescribe have been through very rigorous evidence-based testing. Are you saying that that same level of evidence-based research and the assurance of the consequences and unintended consequences that are well documented before it is rolled out to the whole community should be bypassed in the instance of cannabis?

Mr Bush: That certitude that you refer to, Mr Wall, is consistent with a huge number of overdose deaths. In our submission there are the remarks of a visiting professor who founded the Cochrane review. This is the international system that reviews medical trials of particular drugs or issues. His view was that there will be no end of deaths from licit pharmaceuticals. The fact is that there are very serious side effects. If you use that as the criterion for whether you would allow any particular medication you would probably eliminate a quarter of the drugs in the pharmacotherapy—even ones like Panadol that can destroy and lead to severe liver damage, as Dr Bourke, I am sure, would know about. The fact that there are side effects is not a ground for not making a drug available when there is substantial evidence of use.

MR WALL: Just one final question if may, chair. Is the scope of who qualifies for access to cannabis a decision that should be made by a legislature or a decision that should be made by a treating specialist or physician or GP?

Mr Bush: Are you saying that there should be a motion before the Assembly in relation to permitting any particular member of the community who may need cannabis to have access to it?

MR WALL: Not on an individual by individual basis, Mr Bush, but should the conditions by which an individual can access medicinal marijuana be set forth in legislation or should it be a decision made by a doctor or a specialist?

Mrs McConnell: The draft legislation does list certain conditions that it can be prescribed under, doesn't it?

MR WALL: But the proposed model is that if you have a diagnosis of one of those conditions you can apply for an exemption to access medicinal marijuana.

Mrs McConnell: And I guess that is good. I think that the doctors in the paper are given some leeway on conditions. But it seems to me that a doctor is the one that knows the patient and knows whether medical cannabis or other treatments are going to be the best for the condition they have. It is a little bit hazy because of the illegality in one sense and then how you treat it in another. So there is a bit of a grey area perhaps, but I see them both working together, the legislation and the doctors working together to come up with the best—

Mr Bush: But fundamentally it should be a decision between the patient and their medical adviser. That is the guiding principle. That is the basic principle we propound. So there is a role for the Assembly in terms of setting a boundary—we acknowledge that—but this is a fast-moving field. As I mentioned, the research has been skewed. Because of the illegality of the drug, it has been skewed in that way in recent years—in favour of the identification of the harms of cannabis.

It would be advisable, I would suggest, for the committee to consider a review process to keep in mind the possibility that the conditions that are specified in the legislation could be adjusted up and down. Whether that, from a legal point of view, would mean it is better for those conditions to be specified in disallowable regulations than the legislation itself I think is a consideration for you.

MR WALL: Thank you.

THE CHAIR: Ms Fitzharris.

MS FITZHARRIS: Thank you for coming in. Obviously this is a complex issue and our job is to look at the current legislation but also to consider what is put before us in terms of how a scheme is designed, and there are some inherent contradictions in some of that. I think you are right to some extent that it is about managing the risk. For example, you say that it should be a decision between a doctor and a patient, but doctors, by and large, as professionals, will want a clear evidence base so that they know exactly what the patient is ingesting, in whatever form they do it.

I think the evidence around smoking cannabis in any form is overwhelmingly negative but there are many other forms in which it could be taken. There is, I think, a

little bit of a contradiction there about saying, "Do not be uncritical of doctors wanting high levels of certainty." I think in our community we need doctors to have certainty and we need them to know that there is some rigour and some evidence about how they prescribe a particular treatment to a patient. But then you also suggest that the ultimate decision should be between a doctor and a patient. In a community sense it is going to be extremely difficult for doctors to have that certainty unless they have an evidence base. So can you reconcile that in some way?

Mr Bush: I think that was a question that was uppermost in my mind as I was being wheeled in for open-heart surgery and the assistant surgeon went through the range of possible negative outcomes that could arise from the procedure that I was about to undertake. I was not in a particularly alert position to give it the sort of profound consideration that I might have done, but I was prepared to rely upon the best available evidence. The best chance of my surviving was to undergo the procedure that was about to be inflicted upon me. So I am not sure that you can quite draw the line as clearly as you suggest between risk and uncertainty.

MS FITZHARRIS: To the extent that the doctor will have no certainty if it is an uncontrolled scheme—that is, grown at home or procured through means where the doctor has no knowledge of quantity or quality or the frequency with which someone takes it—do you see there that it is difficult?

Mr Bush: I think that is clear in our submission. We favour control centrally—some sort of central control, whether in the ACT or a unified one in Australia as a whole, just as exists in relation to the poppy straw industry in Tasmania. That is a relevant example. Or we can import from countries where it is controlled. That can be done too. Of course that requires commonwealth legislation and complementary legislation from New South Wales to allow the product to be transported to the ACT. So any change is fun for lawyers.

MS FITZHARRIS: Just one more question on that. The AMA, I think you may have heard, advocated strongly for a national system. Do you have a view on whether we should wait for a national system where everyone agrees, or should we launch ahead and have our own and then ultimately end up with a fragmented system like they have in the US? What do you see as an ideal path?

Mr Bush: "Wait, wait, wait." This is something that we get quite impatient for; where there is a real need. I come back to the concept of substantial evidentiary support for something: then we should go ahead. You have also got to bear in mind that there is a bill for the commonwealth government that I think would answer a lot of the concerns about quality and control from the commonwealth point of view. But the platoon should not march at the pace of the slowest person. We have got six, seven, eight jurisdictions in Australia. Some will move faster than others, and we do not want, I would submit, to be the last and deny relief to people where there is strong evidence to suggest that they will get relief. It is cruel.

It is drawing the line between the evidence—and again the AMA come back to it—and emotion, but emotion is what spurs us to take action when there is harm and hurt involved, when we see that our loved ones are suffering and they need not suffer. It is cruel not to permit relief that they may have. For an 80-year-old at the point of death

to be denied it because they might get lung cancer or something like that—they will die long before that will occur. The risks have to be realistically assessed, and that is best done coming back to the doctor-patient relationship.

MS FITZHARRIS: Thank you.

THE CHAIR: Ms Lawder.

MS LAWDER: Thank you. Thanks for your submission and for sharing your personal story. I note that on page 6 of your submission you talk about possible models and you have used the Netherlands example. Are you suggesting that that would be a preferred model for Australia or did you also consider the Canadian model?

Mr Bush: I did not. The Dutch one, I believe, is a fairly effective way of controlling quality. They can be a source for the import of cannabis, specified qualities, into Australia. I really do not know enough about the Canadian one.

MS LAWDER: But you are quite comfortable with the Dutch model?

Mr Bush: We have not done any individual research on it. It is basically on the basis of the recommendation of Professor Mather and his colleagues that we mentioned it as an option. I think the committee needs to closely consider the best system. As I said, we do not think that growing in a Canberra climate is the ideal or that growing is the best way to do it, because it is going to add to the stresses of very stressed people if they have got to try and cultivate this stuff and wait for three or four or five months for it to mature.

MS FITZHARRIS: Did your organisation make a submission to the federal inquiry?

Mr Bush: We have, yes.

MS FITZHARRIS: You have. Was it pretty much the same as you are making here?

Mr Bush: It does make similar points, yes.

MS FITZHARRIS: Is this based on a position statement or policy of your organisation? How did you come up with this? Did you have a consultation process amongst your membership to develop your submission?

Mr Bush: Families and Friends has been going now for 20 years. We have monthly meetings. We have talks on particular drug issues. At that time it is open to all the members to come. Some of those meetings have dealt with the provision of medical cannabis for medical purposes.

Mrs McConnell: We have extensive discussions in our monthly meetings.

Mr Bush: This is the first time we have actually had to formalise our position in relation to this. We have not been trying to push this one in order to push what is clearly our larger agenda, which is to gain a more evidence-based objective view in

relation to the regulation of illicit drugs generally.

THE CHAIR: Drug Free Australia argues that illnesses treated with medical cannabis can be safely treated with existing cannabinoid medications, including Marinol and Sativex. Do you think those compounds are able to more directly treat pain-related problems than medical cannabis in its botanical form?

Mr Bush: I simply do not know.

Mrs McConnell: There are a couple of issues on that. I think people suffering nausea and so forth have trouble keeping the pills down. I am not sure on this, but the one that is a spray is extremely expensive. There may be some papers on that.

Mr Bush: It is a very good question. Some of you may have heard Professor Mather talk at the Assembly gathering. There are about 40 particular cannabinoids within the cannabis plant. CBT and THC are the two main ones. As Professor Mather referred to, there is a so-called entourage effect of these other drugs. This is where a lot of the uncertainty in relation to cannabis arises. You have the relative purity of Marinol and Sativex and things like that, but how much of the benefit of natural cannabis comes from the so-called entourage effect of the interplay between this large range of particular drugs and their effect? It is really a ground for serious research, but it is going to take years and years to reduce that level of uncertainty. As Marion said, I have read stuff, but I really cannot say that there are side effects in relation to the pharmaceutical preparations that do not apply to the natural product. I really cannot say anything more than that.

THE CHAIR: As I heard before, you recognise the increased health risks which come from smoking as a method of taking cannabis. If there was legal cannabis legislation, do you think there should be restrictions on the method of administration—say, for instance, that it has to be a vaporiser or used as a food product?

Mr Bush: It comes back to risk as assessed by the patient and his or her physician. If there are means of delivery that avoid the carcinogens that are associated with actual combustion to do with smoking, fine. As I just said, you can think of many examples where there is a risk of untoward effects arising from smoking, but the condition and the life expectancy they have are such that that is a trivial risk. That is why it needs to be put into the assessment, I would have thought, of the physician and the patient. Smoking is, I believe, a very effective way of getting the relevant constituents of cannabis into the brain quickly; it is much quicker and easier. There may be circumstances where that is a desirable course to follow.

As we heard from Professor Kilmer, there is a vast array of delivery systems, but we certainly do not want chocolate cannabis confectionery and things like this, as he said. This is where the commercial things can go wild. The committee must come down very hard on that sort of thing. The evidence is strong that cannabis can affect young developing minds. That is where the main harms have been shown to exist in relation to teenage cannabis use.

THE CHAIR: Thank you for coming in to see us today and also for your submission. The secretary will provide you with a proof transcript of today's hearing when it is available. If there are any concerns with the transcript, you can contact the secretary and talk to her about it.

Sitting suspended from 10.48 to 11.03 am.

COLQUHOUN, DR ROSS, Vice Chair, Drug Free Australia
CHRISTIAN, MR GARY, Secretary/Research Coordinator, Drug Free Australia

THE CHAIR: Good morning, Mr Christian and Dr Colquhoun. Welcome to this public hearing of the Standing Committee on Health, Ageing and Community and Social Services inquiry into the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 exposure draft and related discussion paper.

Just a reminder to have your mobile phones switched off or put to silent. When you speak, please speak directly into the microphones so that Hansard can hear you. When you speak for the first time, please state your name and the capacity in which you appear. Only one person is to speak at a time.

Could I confirm that you have read the privileges card lying on the table in front of you?

Dr Colquhoun: Yes.

Mr Christian: Yes.

THE CHAIR: Do you understand the privilege implications of the statement?

Dr Colquhoun: Yes.

Mr Christian: Yes.

THE CHAIR: Before we proceed to questions, would you like to make an opening statement?

Dr Colquhoun: Yes, thank you. My name is Dr Ross Colquhoun and I am deputy chair of Drug Free Australia. I am appearing here in that capacity today. Gary Christian is the secretary of Drug Free Australia. I have been asked to speak first and I will speak about the alternatives to smoking cannabis that are already available and also talk about the harms that are quite evident from the research related to the use of cannabis.

From the outset, first of all, I would like to point out that my doctorate is not medical; my thesis was on drug treatment. So I come from a reasonably knowledgeable background. I also have a master's degree in neuroscience, so I have got some knowledge in that area as well, but not a medical degree.

To begin with, DFA takes the position of opposition to any legalisation of illicit drugs in Australia. I know this inquiry is not about regulation, decriminalisation or legalisation of illicit drugs, including cannabis, but we believe this is a Trojan horse as such, the thin end of the wedge and an admission by the proponents of medical cannabis to produce the result of recreational use of cannabis being legal in this country. So we oppose that.

Having said that, we also believe there is overwhelming evidence against any increase

in the availability of cannabis for medical purposes, particularly the variety that is smoked, and we say that for a number of reasons. The first thing—we think it is a deliberate omission—is that there are already preparations of cannabis containing THC and CBD that are available, that are registered with the TGA, and a third one, Epidiolex, which will be available, no doubt, in due course. These medications have been available for some years and can be accessed by any medical practitioner under the special access scheme or under the importation of drugs scheme.

You will refer to pages 6 to 12 of our submission that talk about Marinol, Sativex and Epidiolex. As you see, there are doctors who are registered. I think some 100 doctors already in New South Wales can legally prescribe these medications for known conditions, such as nausea and wasting diseases associated with AIDS et cetera. So there seems to us no reason why you would go beyond the use of these medications and legislate to legalise a form of cannabis that is lacking in known purity, constituency or safety when we already have drugs that are available that have been through the regulatory processes, have been extensively trialled and are currently available.

Given that, there is very small demand for these medications. In fact, the companies that have marketed them in Australia have withdrawn from supplying them in Australia and they now need to be imported under a doctor's prescription. It can be done quite legally.

As to why there is very small demand, there are unknown factors, but I think the three major ones are that doctors are not prepared to prescribe a drug that has known side effects and for which there are other, better medications with better track records in terms of alleviation of the sorts of symptoms that cannabis is shown to alleviate to some extent.

The second reason would be that the patients themselves may well be resistant to using the drug, if they have in fact tried it, because of the side effects—the drowsiness, hallucinations, the uncomfortableness, problems with sleep and so on and the withdrawal effects from the drugs that may well be prohibiting their desire to use those drugs.

The third reason is cost. At the moment Marinol is around about $2,500 a month and Sativex is around about $500 a month, which may be a significant factor in them not being used.

On page 12 there is a list of recommendations that DFA have drawn up for the Legislative Assembly to consider. First of all is that the Legislative Assembly publicise the fact that there are these pharmaceuticals that are readily available. For what reason this has been ignored by the proponents of medical cannabis we do not know, except that we believe it is the thin end of the wedge in terms of legalising other forms of cannabis, particularly the recreational use of cannabis. Next is that the Legislative Assembly publicise that there are legal sources of cannabis and that those alternatives are much better and safer and trialled, compared to other forms of cannabis, particularly smoked cannabis.

We also need to streamline the import process. Maybe if there is sufficient demand it

could be that those drugs become available in Australia and stocked here so that it speeds up the processes of TGA approval and authorities for the drugs.

Our fifth recommendation is that we ask the Legislative Assembly to consider vigorously lobbying the commonwealth government to have Marinol, Sativex and, in due course, Epidiolex placed on the PBS scheme to reduce the cost of it. If that is the major barrier to people using it, a PBS listing might facilitate much wider use of the drug in those life-threatening situations where people are suffering nausea and loss of appetite and so on, where there is some evidence to show that cannabis is of some value.

The second point I wanted to raise was that of the side effects of cannabis, particularly smoked cannabis. They are well documented. There is no argument about the fact that cannabis has harmful effects, including brain damage through long-term heavy use. The MRI studies demonstrate that. It affects coordination, particularly driving and use of machinery and so on, and that makes it a dangerous drug for people to have in their system if they are operating machinery or driving a car. It affects memory. There is no doubt about that—short-term memory. Studies have shown a reduction in the size of the hippocampus and the amygdala over long-term use. Certainly short-term use causes short-term memory problems that seem to recover after a period of not using cannabis, but longer term use results in brain damage.

I might point out that there is a book that has just been published by academics with very, very well-renowned credentials in this area—Jan Copeland, particularly, of the national cannabis prevention and treatment bureau part of NDARC. In this book are well documented the harms related to cannabis, particularly the cognitive impairment that people experience and evidence of the MRI studies showing resulting harm. Psychologically, cannabis causes problems, and it is quite clear in the evidence now that it causes depression or makes depression worse amongst those people who smoke cannabis. It causes anxiety, and the risk of suicide amongst people who are cannabis users is around about 2½ times the population and about 3½ times amongst people aged 18 to 24. For those reasons you can imagine that doctors would be very reluctant to prescribe a drug with those sorts of side effects.

The other issue that we need to consider is the addictive potential. It is undoubtedly the case that prolonged use of cannabis causes dependency, with normal tolerance and withdrawal syndromes that are common to other drugs. We risk experiencing what has happened with morphine, which has a far better evidence base in terms of its value pharmaceutically, where we end up with a population of people dependent on cannabis who develop tolerance and who will need more and more of the substance. As with morphine, you find that doctors become increasingly less likely to prescribe it because of the increasing dose and because of their concerns about TGA scrutiny—Department of Health scrutiny as well. Therefore, they withdraw prescriptions and people end up on the black market seeking this drug.

For those sorts of reasons, the Legislative Assembly should seriously consider that legislating to introduce another form of cannabis is highly irregular.

I will pass over to Gary Christian to complete our submission. Thanks very much.

Mr Christian: The Australian community largely affirms most recreational activities and pursuits for fellow Australians, yet when it comes to the regular recreational use of cannabis 90 per cent of Australians, according to the 2013 household surveys, do not give their approval. Such non-acceptance of cannabis use by a large majority of Australians is not naive either. Thirty-five per cent have tried it at some time. Almost all know someone whose life has been negatively affected by the substance. We could quite safely say, then, that a majority of Australians find recreational cannabis use self-indulgent and, where they know the harms, irresponsible.

Medical use of cannabis is not recreational use—we recognise that—but there is a nexus between the two. Sixty-nine per cent of Australians approve the legality of cannabis for medical use. But most Australians are not medical practitioners and do not even have a vague clue about what conditions it might alleviate. Unfortunately, with the non-existent public debate on medical cannabis which the Australian media seems to have serendipitously denied the public, the latter approval percentages are based on ignorance and can carry no weight until such a robust debate has been had.

In such a debate, Australians would need to know that 74 per cent of teenagers surveyed when entering rehab in Colorado for cannabis addiction said that they had sourced their cannabis from medical marijuana. A CVS2 report, which I have tendered, on 25 February this year uncovered medical marijuana patients selling cannabis to schoolkids in Los Angeles, in broad daylight within walking distance of schools. In light of already legal use of pharmaceutical medical cannabis by all Australians or for them, this diversion of cannabis for recreational use both to vulnerable minors and others makes the ACT proposed legislation immediately untenable.

Australians do not want recreational cannabis use, but this proposal will deliver it for minors, who are most vulnerable to cannabis harms, according to the evidence. The ACT proposal, in concert with existing ACT legislation, would allow up to nine cannabis plants, as far as we can see, as a non-trafficable quantity. However, our evidence shows that one plant can produce 2,500 grams of useable cannabis a year, yielding $30,000 on the street, while most medical marijuana patients require no more than 370 grams a year—one-seventh that amount. I have also given evidence for that.

Just one plant is a trafficable quantity. One plant is already like giving an open chequebook to all and sundry, but only naivety would believe that no-one will ever exploit that trust. Further, such indeterminacy around the amount a patient can have available to them, especially in light of diversion to minors and others, makes this legislation even more untenable.

When pharmaceutical medical cannabis is already legally available to us all, at the same cost as cannabis is purchased legally from a dealer, the ACT proposal juxtaposes a litany of regulation and policing costs which simply are not necessary. Pharmaceutical cannabis can be prescribed by a doctor, purchased and imported legally with little risk of diversion, with no cost to the ACT taxpayer. Home-grown cannabis requires government departmental costs of regulation, chief medical officer time making determinations, requiring policing because of well-evidenced diversion issues. How will police ensure that no more than nine plants are grown? And to what size? How will police ensure that it is not diverted? If police resources are already

stretched, where does the money come from to provide more policing? How will the TAC content be regulated, particularly in light of an 18 February article in *The Lancet*, which I have tendered, showing that daily users of certain varieties have a five times higher incidence of psychosis? Pharmaceutical cannabis is already regulated in terms of strength and dosage. Why create problems that we do not need, to create costs for the taxpayers?

The proposed legislation is also outside of the United Nations conventions. It does not meet the strictures for secure cultivation by a national agency, nor does it meet reporting requirements, yet pharmaceutical medical cannabis does meet these requirements. This legislation wants to break solidarity with 200-odd nations worldwide who are signatories to the 1961 single convention. For what? Why?

Doctors operate by the ethic "do no harm", and they do not support this proposal because it is based on a delivery system that the majority of patients will use—that of smoking—where most of them will prolong their tobacco career as well because it is more convenient using it that way. But are not politicians best guided by the same principle—do no harm?

I have two mates who are both bipolar. Both were early initiators to cannabis in their teens. They have had disastrous marriages and their relationships and future look no better. One may never hold a job. For every genuine medical cannabis patient in the ACT who seeks to alleviate their condition there will be another recreational user with a cannabis-caused condition that has no cure and little alleviation. I look at my mates and the others around them who are affected—the families, the kids—and I ask whether entirely unneeded legislation to legalise something which is already legal, entailing all the issues of diversion and the entrenching of recreational use, should be supported by a caring, compassionate legislature.

THE CHAIR: It is time for questions, I think. I take it that your opposition to the proposed model is around the possibility of diversion of medical cannabis for recreational use?

Mr Christian: Yes, plus it is superfluous. We already have it, so why would we bother? Diversion is a major issue, yes.

Dr Colquhoun: I think the evidence suggests that cannabis in a smoked form is harmful and it far outweighs any medical benefit that might be gained. Certainly, there are other drugs that work better for most of these conditions that are properly regulated, trialled and approved.

Mr Christian: You can also go for gummi bears; we know that from the US. But it is already available—pharmaceutical. The dosage, strength and purity are known. So why would we go down that track?

THE CHAIR: Do you accept that there is an opinion that botanical cannabis contains a range of active ingredients—

Mr Christian: We accept that.

THE CHAIR: which can produce superior effects in some conditions?

Mr Christian: We do not accept that.

THE CHAIR: You do not accept that?

Mr Christian: We accept the first proposal, the first statement, but Sativex is a whole-plant extract. It has everything. I do not know of anybody who says that crude cannabis can offer something that Sativex cannot. Marinol, yes; that is just synthetic THC. That is a different story.

Dr Colquhoun: Epidiolex and CBD. Even the epilepsy representative group do not accept that CBD is the preferred treatment, although it seems to work with a small group of people—small children with repetitive fits.

Mr Christian: Treves syndrome and so on.

Dr Colquhoun: By and large, there are much better treatments available. The medical community would agree with us, and certainly the evidence would support our position.

THE CHAIR: What is your opinion about the Dutch scheme for medical marijuana?

Mr Christian: It is outside the UN conventions. I have also tendered something from the United Nations saying that it is, and there are concerns with Canada as well. Canada is not reporting, as is required by the single convention. Those concerns are already voiced by the United Nations.

THE CHAIR: Do you think there is a risk of diversion in the Dutch scheme, through the way they are managing medical marijuana?

Mr Christian: Our view is that medical marijuana is already legally available to all Australians. It is very unlikely to be diverted. You put crude cannabis in the hands of people and it can be diverted.

THE CHAIR: We already have a range of risks for legal prescription drugs of diversion. What are the similarities and differences between those risks and the risks that you propose would be there with medical marijuana?

Dr Colquhoun: There are two issues. One is the benefit gained. It seems a very small number of conditions might benefit from cannabis. When you set that against the known side effects, the psychological and behavioural impairment deficits and the addictive potential, you would have to say that the side effects far outweigh any known benefits.

A drug like morphine, for example, has serious side effects and, in fact, there is a huge diversion of that now with most people with opiate or opioid addiction using prescribed opiates rather than heroin. There is trouble enough with that, with people becoming addicted to it and then ending up on methadone or buying illegal heroin. I cannot see, given the very small benefit, why you would go down that track with a

drug like cannabis, particularly when there are legal forms of it available.

THE CHAIR: Wouldn't the logic of that argument dictate that we should ban opioids?

Dr Colquhoun: Certainly medical communities are reviewing the benefits of morphine for pain relief, given the side effects and the risk of death and the diversion rates. The belief now is that long-term pain relief should not rely on opiates for that reason. There is certainly a review of drugs of that type as to whether the benefits outweigh the side effects.

Mr Christian: I think there is a bit of a consensus, at least amongst some who have looked at the matter, that diversion of Sativex is not that likely. It is not that sexy and it is very likely not to happen. A New South Wales working party looked at that issue and felt that it was less of a risk.

THE CHAIR: From what you have just said, am I supposed to conclude that you do agree that there probably is an argument to ban opioids?

Dr Colquhoun: I think the UN conventions and so on allow the production of medicinal products and pharmaceuticals from illicit drugs, and certainly morphine comes under that rubric. There is a vast difference between growing the crop, as suggested with cannabis, and using it as a raw product. The processes that a raw opium plant goes through to end up with morphine are quite different from using the raw product, which is suggested in this legislation. The real control comes through the action of doctors. The fact that they carry the responsibility for the outcomes of prescribing particular medication means they act with some caution and caution that is tempered by the sorts of trials and known side effects that come from the regulatory process.

We already have legal cannabis available that has gone through those processes. Certainly smoked cannabis in a raw form could never, ever be legally registered in that way because of the unknown purity and concentration of the constituents. Therefore, it would be highly unlikely doctors would prescribe that, carrying the responsibility for any outcomes.

THE CHAIR: If the responsibility should be for doctors to prescribe something, why should we stand in the way of their access to a product which may be of benefit, as you say, to a very limited number of patients?

Mr Christian: I think that is the point we made before. I do not know of any literature out there which says that crude cannabis has any greater benefit than a whole-plant extract used as an oral spray. I have not seen anything. It is a complete product; all the cannabinoids are intact, in other words.

Dr Colquhoun: I think more so that the doctors take responsibility for prescribing particular medication knowing that it has been properly trialled, it is registered and there are known side effects and known dosage levels and so on that are considered to be safe in terms of the benefit that might be derived from it. Doctors do not act alone. They really have to be reassured that these drugs have been properly tested, with

known dosage and strength levels and, therefore, they willingly take on the responsibility. A lot of doctors will not prescribe benzodiazepines and opiates and things like that, or they certainly prescribe them with a lot of reticence, because of the risks entailed because of the side effects.

THE CHAIR: Mr Wall.

MR WALL: Thank you. I am curious as to the views that both of you could offer. Given that there is already a cannabis-based pharmaceutical product available, why do you think there is such a desire or pressure to legislate for crude cannabis for medical purposes?

Dr Colquhoun: I think the agenda is quite clear, and it has been expressed today. The real agenda is the regulation, legalisation, decriminalisation of illicit drugs. This is the Trojan horse that legitimises the use of an illicit substance under the guise of it being a medical product.

Mr Christian: As stated by the movement. They say it is their ruse to get the full legalisation of cannabis. I think it is very clear.

MR WALL: Largely you believe this just to be the thin end of the wedge—

Mr Christian: Yes.

MR WALL: in progressing this.

Mr Christian: Yes; we will make it that simple.

Dr Colquhoun: It sets up an oxymoron. If something is legal and unregulated and untrialled and so on and used willy-nilly by people for medical purposes then there is a very small step and people say, "Well, it must be safe, so let's use it recreationally." That is certainly the experience overseas. There is a very large diversion of medical cannabis in that form to non-medical patients.

Mr Christian: That is the message proponents want to get across to people—that it is safe. It is not.

Dr Colquhoun: It is not, no.

MR WALL: Given that the pharmaceutical products that are available are not yet listed on the PBS, cost is something you did cite. Do you see there is any benefit to a controlled trial of crude cannabis in any form to ascertain whether or not there are—

Dr Colquhoun: We do not see how that could be approved—a drug that is of unknown strength and dosage and quality—and how it could be properly trialled, because you do not know that the product that is going to be used actually corresponds with the product that is trialled.

MR WALL: The suggestion in the question was a controlled trial, so ultimately a product that is perhaps grown to a standard and rigorously tested for consistency.

Mr Christian: There are already trials. There have already been quite a lot of studies, and we have outlined every one of the studies up to 1999 in our document. Plenty of studies have looked at crude cannabis versus Marinol—all those kinds of things. I do not think there is any real point at this stage. You can do studies, as they want to do in New South Wales. We spoke to them. They want to make their own Sativex, if you like; they want to make their own product. That is fine; that is great. Pharmaceutical—not a problem.

Dr Colquhoun: The other point that was made was that smoked cannabis gets to the brain very quickly. So does an oral spray, through the mucous membranes and so on. There is no advantage in smoking it and there are certainly massive disadvantages in terms of possible lung disease, bronchitis and all the rest of it.

THE CHAIR: Ms Fitzharris.

MS FITZHARRIS: Thank you. Going back to your comments about the real agenda, I guess that is a contestable for you about what the real agenda is.

Mr Christian: Sure; we accept that.

MS FITZHARRIS: I guess one of the things for me, reading through the submissions, was that we had the opportunity to talk to members of the New South Wales upper house. The people that provided the anecdotal evidence to this committee and provided it to the New South Wales committee were not in any way linked previously with the—

Mr Christian: No; we accept that.

MS FITZHARRIS: How do you reconcile that? Can you accept that there probably is an agenda for that from some groups? Is there a form of scheme that you see—

Mr Christian: Absolutely, and I would be down on the media for their role. Their role is to inform the public. They have not informed the public that there is legally available medical cannabis.

MS FITZHARRIS: For one or two very specific conditions.

Mr Christian: Yes. So there are people out there who are using cannabis because they do not know better. They are ignorant of what is available to them.

MS FITZHARRIS: As I understand it, they could not have used Sativex because it is only prescribed for one condition.

Mr Christian: No. If you have a look at our paperwork, we have letters from the TGA which say it can be used across the spectrum.

Dr Colquhoun: Off-label.

Mr Christian: Off-label. A doctor can still prescribe it. That is TGA advice directly

via email.

MS FITZHARRIS: So the issue there is its affordability for patients.

Mr Christian: Yes, I think it comes back to affordability. If you could get the critical mass and demonstrate to the government that PBS was applicable, it would only be a small amount, I would imagine, that would be spent by the government.

Dr Colquhoun: I think you make a good point too about the limitations on the use of Sativex. That means that used off-label the doctor has to take responsibility for any adverse outcomes and is, therefore, not protected by any TGA approval for off-label use. Certainly extending the uses to which it might be put would probably mean that doctors would be far more ready to prescribe it. There might be a barrier there to prescribing it, but not one that doctors are normally too concerned about. If they believe a product is in the best interests of the patient and there is an adverse outcome then generally the doctor has grounds for defence of that decision and is normally supported in that.

MS FITZHARRIS: So you are supportive of a therapeutic form of cannabis that has been through rigorous—

Mr Christian: Yes. First, it has been trialled and, again, it is measured dosage, strength and purity. It is like any other medication in Australia.

MS FITZHARRIS: Do you think its illegality has prevented research and product development?

Mr Christian: Yes. I have no doubt it has, but I think there is quite a large body of research which is out there nevertheless.

Mr Christian: I think the major reason why it is not researched more widely is that it is not in great demand; therefore pharmaceutical companies do not stand to make a lot of money out of it and they do not seek the resources—

MS FITZHARRIS: Is it possibly not in demand because it is illegal?

Dr Colquhoun: It is legal. I think there is little demand because of the cost, because of the side effects and because doctors are reticent to prescribe it because there are other, better drugs, in their knowledge, that are available.

Mr Christian: And we did point out that in the surveys by the US Institute of Medicine 95 per cent of medical cannabis users are recreational users who now use it medically. That was on their surveys—quite a lot of people.

Dr Colquhoun: With the view that they are dealing with withdrawal symptoms, and particularly someone gravely ill who is dealing with cannabis withdrawal issues may well demand access to the drug to deal with withdrawal. Certainly there is a case, a compassionate case, to suggest that someone suffering from withdrawal who is in stages of a terminal illness should have access to it. Our argument is that there are legal forms of it that they can get access to that any doctor would no doubt be willing

to prescribe. But price is probably a real issue, and, as we suggest, a PBS listing may well be an important reform.

THE CHAIR: Ms Lawder.

MS LAWDER: I was looking through your references and suggestions for further reading. I know in the main body of your submission you have some more recent references; for example, the Colorado trial or the study they have undertaken. But in your references, 2008 was the most recent reference that you have. Have you looked at any more recent reports or trials?

Dr Colquhoun: You cannot get any more recent than Jan Copeland's new book, which I would recommend that the committee read. It is about treatment for cannabis dependence and how to quit. There is a large section written fairly simply but backed up by research about the psychological and physical impairment involved in cannabis use and things like what they call greening out, which is a sort of psychotic response to overdosing on the drug, and the possibility of death through potassium imbalance in the blood through cannabis use and so on. It is a very well-informed book, and certainly 2015 is pretty recent.

THE CHAIR: Just for the *Hansard*, Dr Colquhoun, could you tell us the title of the book and the author, please?

Dr Colquhoun: It is called *Quit Cannabis: An expert guide to coping with cravings and withdrawal, unscrambling your brain and kicking the habit for good*, with the subtitle "Proven techniques to help you quit … forever". It is written by Jan Copeland with Sally Rooke and Etty Matalon.

MS LAWDER: I understand that a lot of your concern about the proposed legislation is about leading towards a legalisation of recreational use. But we have heard evidence from some individuals and organisations about the beneficial effects of cannabis for particular medical conditions. Again, I understand you have talked about Sativex and CBD and some of the other legalised drugs available through the medical profession. But what would you say to people like those individuals who gave their personal stories about what they felt, what they believed were the beneficial effects?

Mr Christian: I would say to them, "You have legally available to you now, right now, pharmaceutical medical cannabis which you can access. Go and get hold of it."

Dr Colquhoun: There is a cost constraint, but buying illegal cannabis is probably not a lot—

Mr Christian: It costs exactly the same. It costs $12 a gram for illegal cannabis. It costs the same for Sativex—$500 a month for both, whichever way you go. So it is no more than what you are paying now; put it that way.

Dr Colquhoun: In other words, Sativex and Marinol could be a lot cheaper than illegal cannabis. That would make it a lot more available. But whether the side effects make it tolerable or not and whether doctors are willing to prescribe it, we may need to extend the conditions under which Sativex can be legally prescribed or not

prescribed off label. I think if we really advertise and make people aware that these drugs are available, they are PBS prescribed and their conditions were extended, many people who are suffering now would be only too glad to be able to access those medications, know that they exist and have access to them at a reasonable price.

MS LAWDER: Thank you.

MR WALL: One final question. In your submission you included correspondence that you had received from the Therapeutic Goods Administration in relation to Marinol and Sativex.

Mr Christian: Yes.

MR WALL: It states that Marinol is currently available under the special access scheme. Do you have any information or details that you are able to provide to the committee as to how many instances there have been where permission has been granted under the SAS for a patient to use that product?

Mr Christian: It was back in 1997. This is in the New South Wales working party paper, which you can access, and we reference it. It said that there were 100 practitioners back at that time, and Marinol was being prescribed as a trial at that time. I do not know that there has been anything since 1999 that I have ever read about or heard about.

Dr Colquhoun: The TGA would have those records, because when there is a category A or category B medication they need to be notified under category A and there might be some life-threatening conditions under which that category would apply. Under B there has to be an authority given. So they would have records of all cannabis prescriptions written.

MR WALL: I was just curious as to whether you accessed that information or not.

Dr Colquhoun: We could probably access that information. I think that should be available from the TGA. But our information is that the demand for it is very, very low, for the reasons that I have suggested: doctors, side effects and price.

Mr Christian: I think as an illustration of that, MS Australia actually did publicise that Sativex was available to people for spasticity. You can see the press release on the internet. I am sure they let all of their members know. GW Pharmaceuticals had a presence in Australia but withdrew because nobody took it up.

THE CHAIR: Thank you for your submission and testimony here today. The committee appreciates the time and effort that you have put into it. The secretary will provide you with a copy of the proof transcript of today's hearing when it is available. If there are any concerns with the proof transcript, you may take them up with the secretary. Thank you very much for coming in today.

Dr Colquhoun: Thank you so much for inviting us.

MOORE, ADJUNCT PROFESSOR MICHAEL JOHN, Chief Executive Officer, Public Health Association of Australia
McDONALD, MR DAVID NEIL, Secretary, ACT Branch, Public Health Association of Australia

THE CHAIR: Good morning, Professor Moore and Mr McDonald. Welcome to this public hearing of the Standing Committee on Health, Ageing and Community and Social Services inquiry into drugs of dependence.

I have a few housekeeping matters. As you will be aware, mobile phones should be switched off or turned to silent. Please speak directly into the microphone so that Hansard can hear and transcribe you accurately. When you speak for the first time, can you state your name and the capacity in which you appear. Only one person is to speak at a time.

Can I confirm that you have read the privileges card on the table in front of you?

Prof Moore: Yes.

Mr McDonald: Yes.

THE CHAIR: Could you let me know that you understand the privilege implications of the statement?

Prof Moore: Yes, I do understand.

Mr McDonald: I understand.

THE CHAIR: Before we proceed to questions, would you like to make an opening statement?

Prof Moore: Thank you, Mr Chair. We would like to do so. I am Michael Moore. I am the CEO of the Public Health Association of Australia. I am an adjunct professor at the University of Canberra. I think the most important thing for us is to look at medicinal cannabis in two aspects. The first one is how it would be used with regard to people with a terminal illness. We think this is very straightforward. You are not worried about side effects; therefore whatever the Assembly could do in removing any penalty associated with the use of medicinal cannabis for people who are in terminal illness should be quite straightforward.

Secondly, when we are talking about chronic disease, it becomes much more complex, and the bill in front of us does address that.

I should point out that David McDonald and I appeared yesterday before the Senate committee and we did tell them that we would be appearing before this committee. We think that many of the issues that are wrestled with in this bill actually are addressed by that Senate committee in a national way, and David will wrestle a bit more with those issues for you, particularly around the issue of international treaties.

I would like to also address very briefly the idea that this is somehow a Trojan horse

or a slippery slope. In fact, in the ACT since 1992 cannabis has been decriminalised, with a single penalty point for use of or growing of small amounts of cannabis, so around a $100 on-the-spot fine. This is hardly a Trojan horse. However, we do know from discussions with people in the forum that was held here that there are some people who (a) cannot grow it and (b) who, even though they are terminally ill, resist using cannabis because it is still illegal. So whilst we see the argument around the slippery slope, we think it may actually apply in other jurisdictions but is not a particular issue for people in the ACT.

I am very happy to hand over to David for a brief opening statement and, by and large, see what we can do to answer questions from the committee.

Mr McDonald: Thank you very much for the invitation. I am David McDonald. I am a fellow of the Public Health Association of Australia. I am the secretary of the ACT Branch of the Public Health Association. I am a visiting fellow at the National Centre for Epidemiology and Population Health at ANU, and I am also a social scientist. I work at the points where the disciplines of public health and criminology intersect. In my work as a policy adviser through my consultancy company, I frequently have occasion to give advice to ACT government agencies and others, such as ATODA, about aspects of drug policy.

As Michael has indicated, we probably think it is better to spend more time having dialogue than us essentially going through what is already in our submission. But the thrust of our submission clearly is supportive of the exposure draft, supportive of the underlying principles of the exposure draft: that it be a compassionate approach which operates in parallel to the way we deal with medicines that are being produced through medical science and that it be, in essence, two parallel streams operating at once, reflecting different kinds of needs and different kinds of opportunities and different kinds of evidence about what works for whom under what kinds of circumstances.

I tried to read the 126 pages of the DFA submission, but I instantly knew that I had already read most of it before because, as we have heard, a lot of it is old and it has been used over and over again. But one of the key points that opponents of a compassionate therapeutic cannabis regime make is that in the USA it has actually caused problems. One of the thrusts of our submission is that we can learn so much from the US experience. We can learn what not to do. People are absolutely right in pointing to studies that have shown that there have been increasing levels of cannabis use in some of the jurisdictions that have legal medicinal cannabis programs.

What that tells us about is the need for strong and careful regulation and its enforcement. It does not say that medicinal cannabis programs—as if there were one model—are necessarily good or bad. The devil is in the detail. Certainly, the US experience shows us some models of tight regulation and other models of atrocious regulation that have led to adverse consequences.

As Michael indicated, there are some things that, if you wish, we could talk about with regard to the commonwealth legislation and how it interrelates with the commonwealth bill and how it interrelates with the bill that you are looking at and aspects to do with international conventions insofar as that is relevant, but there are

other issues as well that are very local to us here in Canberra that also probably need further attention.

THE CHAIR: One of the things we have heard about relates to the issues around diversion. Do you have a particular view of that with regard to the seeming alternative schemes of home-grown or grown-in-your-own-backyard, as opposed to the pharmacy-delivered versions, such as the Dutch model?

Prof Moore: Let me start, Mr Chair, with the observation that somebody who wishes to get cannabis in the ACT can get cannabis in the ACT. I know I could get it in 15 minutes. The penalties are not so great. That has not caused a complete flooding of cannabis, as was predicted back in 1992 when that legislation went through. I think we have a very different situation than in the United States. When medicinal cannabis was introduced, cannabis was completely illegal and the penalties associated with it were quite high, just as penalties associated prior to 1992 included a conviction which meant that you would not be able to join the public service and an array of other penalties that ran with it. The chances within the ACT of diversion are actually quite slim. There is no particular reason why that would be the case.

Mr McDonald: I agree. We have the opportunity to build a regulatory framework that is going to deal directly with this issue of the potential for diversion. We can do so, as I hinted before, by seeing some of the programs or regulatory models that have not worked well in other jurisdictions. We just heard from previous speakers their concern about diversion and the flaws in the bill that you are considering. Clause 19 of the bill is absolutely clear about the conditions of licensing. The conditions, one could easily imagine, could cover the number of plants and the nature of security, dealing directly with the diversion issue through those conditions of the individual licences. I think that is one of the strengths of the exposure draft—that it enables regulators to put in place a regime that is appropriate to our local circumstances and, indeed, appropriate to the circumstances of particular sick people and their families or their other carers who may be cultivating the product.

THE CHAIR: Do you think that if a medical marijuana system was introduced GPs would require additional training or even a permit system to be able to license and prescribe it?

Prof Moore: I actually think there are going to be very few people who are interested in using medicinal cannabis in the long term. I think there will be some who are interested in using it with regard to terminal illness and chronic disease. However, this is hard to predict because at the moment we do not know the complete efficacy of its treatment because it is so hard to study. We do know it has an impact across a range of conditions that are set out in the bill. The difficult challenge is to know how many people will actually use it for those conditions. That having been said, it is very clear that for some people it does make a significant difference. That is why we ought to make it available.

To answer your question directly, I imagine that there will be some training available in the normal way when medical practitioners use something new. They seek to find the most effective way to make it available to patients as part of their normal training. I would assume that they would be looking at side effects and all those things before

giving advice to their patients.

Mr McDonald: If I may add to that: professional education would be necessary. In the well-controlled programs in the USA, that is an integral part of what they do. The medical practitioners have to know the authorised conditions and the kinds of patients under the legislation and regulations as a starting point and then, secondly, the matters that Michael has referred to about side effects and matching the intervention to the particular patient's needs.

We can add to that with some experience from elsewhere. In Rhode Island, which has quite a good, well-controlled program—it is a small jurisdiction; the population is about twice that of the ACT—they started their program a few years ago. I think it was in about 2006. They had 300 GPs enrolled in the first three years. That was a model which is similar to ours, where people have to source their own cannabis. That was before they introduced dispensaries. The uptake was quite rapid and was well managed by the health department and the Rhode Island medical authorities. There are a couple of messages there. One is there are not likely to be very many GPs who actually get into it because of the size and nature of our community. Secondly, with education, they should be able to do that well.

A thing that is linked to it, though, in terms of the content of the exposure draft is this threshold issue that I am sure you have put your minds to in some detail about exactly what we are asking or inviting or providing the GPs authority to do. There is the vexed issue of the word "prescription" and how that is interpreted in medicine and in health law compared with a recommendation, compared with simply certification that advice has been given about the strengths and weaknesses, and the bill comes down in a certain way on that. But I am sure this is one of the real threshold issues.

The drug policy modelling program a couple of weeks ago—that is, the University of New South Wales—which is one of the world's best drug policy research programs, issued a paper, policy guidance, to policymakers with regard to medicinal cannabis programs. It points out that the two dimensions, the two parameters, under which we have to build a regulatory system are, one, patient authorisation and, two, access to the drug. So this question about patient authorisation and the role of the GP is critical.

If it is a hard-core traditional medical approach of a medical prescription, the doctors will not touch it. That is what I think we could safely predict. If it is something at the other extreme, which is essentially what the current draft is indicating—that is, it is seeking to strengthen the patient-doctor relationship, build that discussion, build that communication and then, in essence, hand over the authorisation to the chief medical officer—that is a very different approach and one which I suspect will be more attractive to our Canberra medical practitioners and their patients.

THE CHAIR: Mr Wall.

MR WALL: Thank you. Just to go back to some of your opening statements: as with most aspects of community and society, most people will always do the right thing. In the context of the model proposed under the Greens discussion paper, what proper regulation, to use your words, Mr McDonald, do you propose should be introduced to safeguard the balance of the community from cannabis that is cultivated for medicinal

purposes entering the black market?

Mr McDonald: We maintain the bulk of our existing penalties. We retain the drug driving offences, we retain the possession offence, we retain the self-administration offence et cetera. We have a regulatory regime currently in place that is undoubtedly having an effect of preventing some people from using cannabis who would otherwise use it. That is one of the observations of criminological research. That framework stays in place for the vast majority of the people in our community.

As Michael has said, cannabis is widely available and not expensive in the ACT; $20 a gram is the median price for hydroponic cannabis in the ACT. It is readily available both physically and financially. We cannot see that a small number of people in a program could lead to any significant, any measurable, impact on the availability and use of cannabis at the population level.

In summary, what I am saying, Mr Wall, is that we maintain the existing regulatory framework, which is working. With a tight licensing system of who is in the medicinal cannabis program, we should not have any significant leakage.

MR WALL: So you believe the existing framework is effective and is working?

Mr McDonald: Yes, definitely. The existing framework is undoubtedly deterring some people from using cannabis who would otherwise use it. It is enforced. In the ACT some 85 per cent of all contacts with the criminal justice system related to drugs are cannabis consumers—not traffickers, not high-scale producers but cannabis consumers. We find a lot of policing and court activity relating to cannabis. The operation of the simple cannabis offence scheme that Michael talked about is well bedded down. We have got good diversion programs for young people who are apprehended. Putting all these things together, we have got a pretty good system here in the ACT.

Prof Moore: I think it is worth saying that we are talking about drug policy. We were, by and large, looking for the least-worst solution. There is nowhere in the world that has a perfect solution for these. I concur with Mr McDonald that this is working extraordinarily well compared to other jurisdictions across the world.

MR WALL: I am just concerned about your earlier comments, Professor Moore. If you are saying that it is, in fact, working well, either you know some unsavoury people that I do not, in terms of your comment that you could access it within 15 minutes—personally, I do not think I would know where to start—or it is quite prevalent in the community and the regulations and the safeguards are not necessarily as effective as they should be.

Prof Moore: We do frame our thinking around harm associated with the drugs. Of course, in the past, and in other jurisdictions, the much greater harms—cannabis has its harms—were to do with the level of penalties associated with the drug.

Mr McDonald: Could I add something to that? We did smile about the comment about availability, but it is a major concern for all of us that, with the kind of regulatory framework that is envisioned in the exposure draft, people have to source

the cannabis themselves. They have to source the seeds from the very beginning. They have to source expertise around growing the product. The product is of unknown characteristics in terms of the balance between the active ingredients. That certainly is a concern. Some people are in the position that you have just explained; they would not know where to start in gaining access to cannabis, even if they had a licence.

What we will probably see happen, as has happened in other jurisdictions, is that a regulatory framework is put in place and a communication network is built up among this small number of people who have this terribly tragic health condition. They talk to each other and they help to build a community that shares information about how to get started and how to actually get the best benefits possible from the therapeutic regime.

THE CHAIR: Ms Fitzharris.

MS FITZHARRIS: Thank you. Just going back to the comment you made before—that the devil is in the detail—there is obviously some detail in the exposure draft, but submissions and evidence offer up alternatives as well. Again, going back to your comments about prescription and what that means, where I feel a little bit stuck is what I think is widespread community acceptance, saying that it is something between a patient and their doctor. It absolves everybody else of responsibility, whereas we know that the Assembly may well have responsibility in debating this and forming views around the design which will be informed by this hearing in particular.

The AMA, as the professional body, were saying this morning that they want to see an evidence-based, rigorous scheme that gives doctors certainty around prescribing something to their patients. I think we also know that you may not always see the same doctor; you may not even necessarily go to the same clinic. That is a situation that has improved a lot over the past few years, but that devil is in that detail. How do you think we design something that doctors by and large are comfortable with, so that the community also has a level of certainty that there is a rigorous enough framework around it but so that we are not maybe waiting 15 years for all the trials to finish?

Prof Moore: My reading of the legislation is that the actual final decision is made by the Chief Medical Officer.

MS FITZHARRIS: Of the current exposure draft, yes, that is right.

Prof Moore: The current exposure draft. So what you have actually done is said, "We have a relationship between the doctor and the patient and that is how you get a recommendation to the Chief Medical Officer, who is then protected under the legislation." So the doctors themselves are not actually prescribing the cannabis. It also says that, because we have got such a tight regulatory system around it, we actually do consider cannabis still to be a serious drug that is used under certain circumstances, but the circumstances really have to be rather dire to get that style of approval. So I think, unlike what has happened in California and in other places where it was very much a free-for-all, you are actually still saying, "No, this is a serious drug; it has serious side effects." And it does. Therefore we go through a process like that.

But what you have also done is not left the doctor holding the baby. It is a case of then taking it out of the doctor's hands, other than their making a recommendation, in conjunction with the patient, to the Chief Medical Officer. That is how I read the legislation.

MS FITZHARRIS: Do you think that is a reasonable burden to put on the Chief Health Officer?

Prof Moore: The Chief Health Officer can then not only look at the particular situation of the particular patient, which would come into place, but would actually look at whether there is a particular medical practitioner that is constantly demanding or recommending that people have access to medicinal cannabis. He could then have a conversation. I think it is a quite reasonable thing to put onto the Chief Health Officer or chief medical officer, whichever it is. The opportunity to take a population view, which is what a Chief Health Officer does, as well as an individual view, is there because that is then recorded in a reasonable way. Of course, the Chief Health Officer has the ability to delegate that to one of his or her staff. One would assume it would be a medical practitioner. But I also suspect that there will be not so many cases that the Chief Medical Officer cannot deal with them.

MS FITZHARRIS: On that point, you mentioned before that very few people will likely use a scheme. But in your position statement you say that many Australians currently self-medicate. It is hard to know, but then you are saying there are few. I know it is really difficult, but when there are comments like "many Australians use it", a lot of people might think of millions. We do not know, but we do not think it is in the millions or hundreds of thousands, do we?

Mr McDonald: We have got new evidence from a study from the National Drug and Alcohol Research Centre published at the end of last year, which you are perhaps familiar with. It is the Australian study of chronic non-cancer pain sufferers. They studied 1,500 people who had been prescribed opioids for chronic non-cancer pain. Of those studied, 16 per cent reported using cannabis for the treatment of their pain. That is in conjunction with the standard treatment that they have. What they reported was greater pain relief in combination with opioids and opioids used alone.

One of the pleasing things about it was that the people who reported using it tended to be younger and with higher levels of pain than the others. In other words, the people who could best benefit from taking the whole cannabis plant seemed to be the ones that were using it rather than the mass of people, the bulk of people, who were suffering severe or chronic non-cancer pain.

When we used that soft language in our submission, saying "many people", we actually meant to be reflecting what you are saying—that we simply do not have solid figures around those numbers. That is why I am suggesting that what we do know now, this new information about this cohort of people being prescribed opioids for chronic non-cancer pain, gives us a starting point for thinking about the numbers.

MS FITZHARRIS: From your point of view as a public health association, how important is it that the community is on board with a proposal like this across the country and/or in the ACT? Where do you think the community more broadly sits at

the moment?

Prof Moore: I think there is a reasonable amount of evidence in the popular media doing surveys with regard to the use of cannabis and people who are terminally ill. For us, that is really straightforward. Even if you believed that it was a placebo effect and people who are terminally ill still got some relief from it, why would you be concerned? For us, that one is fairly straightforward.

The real issue for us is not necessarily where the community is at any given stage; there are times when we would say that what we believe is appropriate is not fully supported by the community, and I think we would seek to begin to change community attitudes. We apply that at the moment to some alcohol policies. With the widespread availability of alcohol we would like to see a much greater restriction on advertising. I do not know that the majority of people would support that. We can see the harm associated and we would say that it is time to be moving on those areas. So we do not necessarily say, yes, we only do this because we have widespread community support. We very carefully develop our policies—there are 60 or so of them on our website—and then we will sometimes try and change community opinion.

In this case there are various pieces of surveys that have been conducted of a range of calibres. For medicinal use of cannabis, there seems to be community support, but that is not a key factor for us.

THE CHAIR: More questions? Ms Lawder.

MS LAWDER: In your submission you spoke about a compassionate, palliation-focused approach. I do not think we had a submission from the palliative care association but have you spoken specifically about that type of approach with the palliative care association? Are they a member of your association?

Prof Moore: In fact, the former CEO of Palliative Care Australia was on our board, and I have had informal discussions—but only informal discussions. I certainly am not in a position to speak on their behalf. But I am sure that Palliative Care Australia would be quite responsive to a request from the committee.

Mr McDonald: If I could add to that, we are using the term "palliative care" and "palliation" really in two different ways, as you know. We often use it to refer to end-of-life palliation—

MS LAWDER: It reminded me about that.

Mr McDonald: Yes. The technical definition is the relieving of symptoms without necessarily curing or treating the causes. Where we use it in that submission, we are generally focusing on that second compassionate approach to helping people with relief of unpleasantness.

Prof Moore: It might be for quite some time. Sometimes when people think of palliative care they think of the last two weeks of life. In fact, palliative care may go much, much longer than that, in the way that David describes.

MS FITZHARRIS: Just reflecting on some comments we have had about a national scheme and weighing up whether we wait for the national system to be bedded down or whether we are an early mover, do you have views on that?

Prof Moore: We do know that New South Wales is likely to move reasonably quickly on this as well. When we appeared before the Senate committee yesterday we did say that we were going to appear here as well and had made a submission here. It seems to me that there are some really significant benefits of being part of a national scheme where negotiations are going on between jurisdictions and the national scheme, particularly in regard to supply. I think the big question here is how you get an appropriate supply of the appropriate strains of the drugs. David could give much more detail than I could about which ones have more THC, which ones have more CBD, what the balance is and what is more suitable for a particular condition. That information is available.

Somebody who is growing their own or accessing through the black market will have no idea what is in the THC, but we do have some really interesting information that has come out of the Netherlands. I think a time will come when that negotiation works very well between federal and state jurisdictions. I say "state and territory jurisdictions". We should be keeping pressure on the federal parliament and the federal government to make that sort of legislation. But in the meantime there is no reason why the ACT cannot make that first step with regard to just ensuring there is no penalty for somebody—I think it is a simple piece of legislation—who is in palliative care and is using cannabis, or for their carer who is supplying very small amounts. We already have personal amounts defined for our expiation notice system.

MS FITZHARRIS: Do you have a view on the categorisation of conditions that is in the current exposure draft and whether that is about right?

Mr McDonald: Yes. Our view is that in the ideal world we would not have that kind of categorisation; it would be a matter of discussion between the family and the patient and the doctor, and they would work out between themselves what is the most appropriate type of health care for that person. But we acknowledge that we are not in that particular world now; there are political and community concerns that require something far, far tighter than that. So on that basis we accept the importance of the tiers.

We have some concerns about the way it is drafted with regard to children. We believe that is unnecessarily restrictive. I am talking about the category 3 provisions relating to children—they are unnecessarily restrictive—but they are matters at the margin. But we are certainly supportive of the policy thrust underlying that, of having the very clear statement in category 1 about those conditions, the more open approach but with tighter regulation in category 2, and then category 3 being dealt with in another way.

Chair, could I just add something about the national regulator of cannabis policy?

THE CHAIR: Of course.

Mr McDonald: We have read—when I say "we", you and I have read—the ACT

Health submission. The thrust of ACT Health's submission, from my point of view, is that this is difficult work; it is difficult in terms of legislation, difficult in terms of regulation and difficult in terms of some of the burdens that it could place upon them.

The bill that is currently being considered by the Senate I think really does relieve quite a number of their concerns. One of the most attractive things about the commonwealth bill is that it envisages a partnership between the commonwealth and the states, and that there will not be a national system of medicinal cannabis unless it is done on a partnership basis because of the different constitutional responsibilities of the states and territories compared with the commonwealth.

The idea that the commonwealth bill is drafted in such a way as to be in strong compliance with the international treaties, the two key conventions, is a very attractive aspect. The fact that it separates therapeutic cannabis from the TGA system and therefore does not impact adversely on the integrity of our medicine system, that it is setting up a parallel approach, and the fact that it applies only to participating jurisdictions mean that there is a real opportunity now for us to move here in the ACT, within our own constitutional provisions, knowing that there is this overarching support through the commonwealth framework if that bill goes ahead in anything like its current form.

Prof Moore: From our perspective, we would be encouraging the committee to basically write to the federal committee and say, "We have looked at your piece of legislation. In fact, it would be a very positive move to have this in place to ensure the most effective systems going into jurisdictions that maintain the general drugs of dependence approach but can deal effectively with our medicinal cannabis and at the same time respect our international treaties."

It would also allow, basically, the particular supply of appropriate cannabis for an appropriate need. That in itself would be a very important consideration, I think, for people with chronic conditions, as opposed to those with terminal conditions, and eventually, of course, for those with terminal conditions as well.

THE CHAIR: Thank you. The committee's hearing for today is adjourned. The secretary will provide you with a copy of the proof transcript of today's hearing when it is available. If you have any concerns, please take them up with the secretary. Thank you for your time, coming in today. Thank you for your submission. If the committee have further questions, we may pass them to the secretary and then pass them on to you and your organisation. Thank you very much for coming today.

Prof Moore: Our pleasure. We will be happy to help in any way we can. Thank you.

The committee adjourned at 12.21 pm.