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

THURSDAY, 9 APRIL 2015

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

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

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Amended 20 May 2013

The committee met at 1.32 pm.

BROWN, DR PEGGY, Director-General, ACT Health
PENGILLEY, DR ANDREW, Deputy Chief Health Officer, ACT Health
O'DONOUGHUE, MR ROSS, Executive Director, Policy and Government Relations, ACT Health

THE CHAIR: Good afternoon, and welcome to this public hearing of the Standing Committee on Health, Ageing, Community and Social Services inquiry into the exposure draft of the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 and related discussion paper. Dr Brown, can I confirm that you and your team have read the privilege card that is on the table before you and that has also been sent to you by the secretary?

Dr Brown: Yes.

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

Dr Brown: Yes.

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

Dr Brown: We will make a brief opening statement. The ACT government certainly expresses its support for the compassionate intent behind the draft bill, as has been outlined in the discussion paper. But there are a range of issues and perspectives that arise from the draft bill that we believe need further consideration. They include issues from a medical perspective around clinical need and effectiveness, other issues around potential toxicity and adverse effects, and also some indemnity concerns for staff. There are law enforcement perspectives and regulatory issues. There is a public health perspective which I am sure Dr Pengilley will be very happy to expand upon, and then there are some issues around the international experience and the national and cross-jurisdictional issues. We would be very happy to expand upon those at your request.

THE CHAIR: Let us kick off with a question. Page 2 of the submission notes:

> Consideration should also be given to the possible impact on clinical practice of increased presentations by patients who abuse cannabis in areas such as Emergency Medicine, rehabilitation and mental health services.

Why do you associate a medical cannabis scheme with increased presentations by patients who abuse cannabis?

Dr Pengilley: This is something that has been raised by clinicians when we have spoken to them. It depends on whether one feels this will have any impact on the scale of use of marijuana. I think that really goes to the way the bill has been drafted. As Dr Brown has said, we support the compassionate intent of using marijuana, but it is very difficult to envisage a regulatory process that does not actually involve a degree of diversion or a degree of increased use or availability. In that context clinicians are

worried about patients who abuse marijuana turning up more frequently.

It is also an issue if doctors are seen as an avenue for access for people who are abusing, in the sense that if they feel they can get marijuana they may turn up more frequently at a medical practice. This would be analogous to the experience of some doctors with opiates. If you are known to be a person who prescribes opiates freely, if you like, or is inclined to prescribe them, you can have a problem not only with legitimate patients turning up but with people who are not legitimate turning up.

THE CHAIR: Surely the issue of whether patients are legitimate or not and are appropriately prescribed is an issue for the medical practitioner and the Medical Board?

Dr Pengilley: Could you repeat that?

THE CHAIR: Isn't the issue of whether patients are properly prescribed medication such as opioids an issue for the medical practitioner as well as the Medical Board, if there is an abuse of that?

Dr Pengilley: Certainly the prescribing or the endorsing of the use of it is, yes. The issue, as I have said, is whether there is, surrounding any scheme that is introduced, an increased use, availability or diversion into illicit use which will be outside what is prescribed. Whether there is an increase in illicit use implied by increased availability or a failure of the gatekeeper role or diversion—which are things we are concerned about with the current proposal, particularly with the experience of similar proposals in some other jurisdictions overseas—those people would not necessarily have been prescribed. They may well be abusing it. But their interaction with doctors or their interaction with the medical profession, and, as has also been raised, their interaction with law enforcement, could be problematic.

THE CHAIR: We had some evidence from the Public Health Association at a previous hearing that suggested that a moderate quantity of cannabis was readily available for something like $50 within a couple of hundred metres of this building and anywhere else in Canberra. Do you think that the existing illicit use of cannabis for recreational purposes could possibly be impacted by a medical cannabis scheme?

Dr Pengilley: I cannot comment on the availability of it. If you are asking me whether I think the colloquially named war on drugs is an effective way of constraining supply, no, I do not think it is. But what we have seen is that, if you create a legitimate avenue for supply, you have to create a supply to feed that. So if it became a situation of endorsing growers, for example, or a movement towards having to endorse growers to supply a prescription scheme, that could increase the supply and it could increase the ease of supply.

I have to believe that the prohibition has some impact on the availability. It may affect who can access marijuana, whether people choose to and how much they do, rather than the absolute fact of whether it is available at all. But you would have to ask law enforcement about the criminal availability, because I cannot comment on that directly.

THE CHAIR: You have to think that the cost of a medical appointment, in time alone, assuming you were bulk-billed—if that was something that your medical practitioner did—plus the relevant costs of purchasing it through whatever dispensing system was available or growing your own, would have to be greater than the evidence that the Public Health Association presented.

Dr Pengilley: I am not necessarily sure that is true. There are considerations of ease of supply and quality of supply. If you look at, say, California or places that have had medical endorsement but not prescription—not a prescribed supply but medical endorsement which has then been supplied by growers' co-ops supplying that—there has been fairly clear evidence of an increased entrepreneurship and availability of products to fill markets.

It is very difficult for doctors. It is not difficult for most doctors but it is difficult for absolutely everybody in the medical profession to fulfil the gatekeeper role of preventing either an increased supply of people who do not necessarily have watertight evidence of clinical need or diversion into the illicit supply. That is a question of how much is produced, the purity of what is produced and the ease of supply, all of which would be motivators, perhaps, to use a medical supply if it was available, as opposed to what is available criminally at the moment.

THE CHAIR: If there was a legal scheme, do you think GPs would require additional training to access the scheme?

Dr Pengilley: Yes. I do not think there is any doubt.

Dr Brown: I might just come in at that point to say that we held a meeting of the clinical senate that was dedicated to discussing the issue of medical cannabis. I think it is fair to say that there was a lot of concern expressed by those present. It was not just medical practitioners but nursing and allied health staff as well. But there was concern expressed at that meeting in relation to the requirement for people to be upskilled in relation to medical cannabis, if it was to become available, in terms of its clinical indications and dosing. There was concern expressed such as: "How would we actually know what to prescribe, because we don't know what product this person would be accessing? We don't know the active components of that particular batch of marijuana or cannabis that they access." So there was a degree of concern expressed in that forum, and certainly concern expressed about the need for training, should this become legalised.

THE CHAIR: Would you envisage a need, if there was medical cannabis, for a special permit system for doctors to be permitted to prescribe cannabis or do you think the existing regulatory controls are adequate?

Dr Pengilley: If it were to be medical cannabis, that implies doctors have somehow given their opinion that it is a good idea for this patient to take it. That cannot be done within the current prescription system because, as Dr Brown has pointed out—and certainly one of the other concerns is—doctors are being asked to endorse a product when they have no idea what the quality of it is. Some evidence from law enforcement is that because the street supply is aimed towards recreational use, it is a very high THC product with a high psychotropic effect. That is not exactly what you

would want for a number of medical indications.

If you look at areas that have prescription supply, such as the Netherlands, they have actually controlled the THC component of what is available. So doctors would need some way to be able to say, "I think this is reasonable under the law," without actually being said to prescribe it, because they cannot prescribe something of whose quality and content they are unaware.

If I could explore that a little further, it seems to us in public health that essentially this is not proposing a medicinal cannabis scheme. This is proposing legal relief for the compassionate use of illicitly obtained cannabis, which is not something that I particularly object to, but the involvement of the medical profession is in fact a secondary way to make that look like the prescription of a normal pharmaceutical.

Essentially, if you had this and you were saying, "We will not charge you, arrest you or in any way get in the way of you using your own supply of cannabis for a medical purpose so specified," it would actually achieve everything this bill is going to achieve without involving doctors in a scheme which they have some concerns about because it is so different from knowing what they are prescribing, and, frankly, also involving the CHO in a system when it is very difficult to see how we could have the information we need to use that safely.

The only way you could make it medicinal cannabis, or medicinal cannabis in the way the medical profession understands it, is to have a known product that runs through very similar lines to the normal prescription process. Of course, that is, I would note, something that is being debated and has been proposed before the commonwealth at the moment, and it is a scheme that has been applied elsewhere. So, as I believe I said last time, the issue of supply, quality of supply and regularising the supply within a normal medical model is something which I think is pivotal to considering this, rather than just the legal issue.

THE CHAIR: So a supply of dosage controlled strains on prescription, such as is done in the Netherlands, would be helpful?

Dr Pengilley: Yes, it would be extremely helpful for doctors, I think, in knowing what they are prescribing. You may well also still find doctors who do not believe it is indicated, but those who did would know what they were prescribing and we would have better control over the supply.

THE CHAIR: Mr Wall.

MR WALL: We have heard from a number of witnesses—and I think even you, Dr Pengilley, last time you appeared—that there are a couple of pharmaceutical cannabinoid-based products that are available on the market, Sativex and Marinol, that are not in the pharmaceutical benefits scheme. My understanding is that Marinol is available on the special access scheme.

Dr Pengilley: Yes.

MR WALL: Do you have any indication or any record or are you able to provide to

the committee examples of how many instances someone in the ACT has accessed that product through that scheme?

Dr Pengilley: No. I am speaking as an ex-employee of the TGA. I used to run this scheme. In fact, there are some signatures for marijuana approvals out there in the files somewhere from me. The special access scheme is administered by the commonwealth. We do not keep records of that.

Dr Brown: Excuse me; it is not that we do not keep records. We do not have an awareness.

Dr Pengilley: We do not have an awareness.

MR WALL: The ACT is not responsible for it.

Dr Brown: We are not privy to the information.

Dr Pengilley: They are issued by the commonwealth. It allows you, if a product is not prohibited, if it is not schedule 9, to import for personal use a pharmaceutical product. The difficulty, to date, has been the state possession laws. In fact, it has always, even before now, been possible to write a special access approval for marijuana or Marinol. The problem is that you also have to write on the letter, "But if you buy it the police may arrest you for possessing it," even though they will not arrest the company for supplying it. I know that is a bit circular, but that is the difference between the supply laws that the commonwealth administers and the possession laws that the states administer. But, yes, these are products which can be imported under the special access scheme and the only issue is that you have got to find a company that allows you to do that. And there are issues of cost.

MR WALL: In your submission you talk about the indemnity issues. Obviously you have touched previously on some of the concerns that physicians and GPs would have in recommending someone to basically go and acquire their own crude cannabis on the streets. But what other legal or potential litigation opportunities would a specialist or a doctor leave themselves open to under the current proposal?

Dr Pengilley: I think that is really an issue for a lawyer. But, broadly speaking, whether it is a prescription or not, our advice is that they are endorsing the use of a product whose quality they do not know and whose effects are uncertain. And if there was an adverse event, directly through toxicity or somebody running off the road or somebody getting something which is much more psychoactive than they had anticipated because it is a different batch, this would potentially be seen as negligence. But that is a broad legal interpretation. You would actually have to ask lawyers that.

Dr Brown: There would also potentially be issues around drug interactions as well.

Dr Pengilley: Indeed, yes. Yes, that is a fair point too.

MR WALL: Do you want to expand on that, Dr Brown?

Dr Brown: If a person is currently taking a number of medications and you add

something to that, and particularly if you do not know exactly what it is that they are taking, it could enhance or mitigate and negate the impact of the other prescribed medications. Again, that then leaves the prescribing practitioner open to claims in that regard.

MR WALL: Talking about cannabis use generally, what would be some of the potential side effects that someone that chose to use it over a prolonged period might face or experience?

Dr Pengilley: It depends on how much and what, and who they are. But, broadly speaking, you can talk about the direct physical effects of smoking. Of course, it is still smoking. People can have allergic reactions, what we call pneumonitis, which is a diffuse allergic reaction in the lungs and looks a bit like pneumonia. People can get fungal infections carried in on the smoke. We have had cases of that. People can get emphysema and long-term effects from the smoking. That is just if you smoke raw botanical anything, marijuana as much as tobacco.

As to the direct psychotropic effects in younger people, particularly heavy use has been associated with a small but measurable increase in psychiatric presentations for things like schizophrenia. Sociologically it is associated with demotivation or sociological harms like failure to attain educational endpoints and so on. That is arguably not important if you are an 80-year-old with cancer, I admit, but this is nonetheless seen in the recreational use of the drug.

In terms of direct toxicity, it is a bit difficult to interpret that because whether something is toxic or not depends on whether you want the effect or not. So, as a pain medication, if you are evaluating it, you would say, "It makes you drowsy and it alters your perception and it does all these things." That could be toxicity for some people. The direct effects of the drug are not necessarily desirable but they are not necessarily harmful if that is what you are looking for as a positive benefit: euphoria or relaxation. But those are certainly effects of the drug, the well-known psychotropic effects of marijuana, which can be interpreted as toxicity for people who do not find them desirable.

MR WALL: Speaking broadly on the known side effects of marijuana compared to other pharmaceuticals, would you say that it has fewer side effects, more side effects or sits somewhere in the middle?

Dr Pengilley: I will try to answer that, but I may defer to Ross because he has got much broader policy experience in harm minimisation. Drugs are not about the pharmacology. They are about the sociological impacts of their use and the interaction they have with society. Do they kill us? Does marijuana have overdose symptoms like opiates? No, it does not, and that is a good thing. Does alcohol cause a lot of harm? Yes, it does. Does that mean that, if we do not have a system that is adequately robust to protect against the possible harms, acknowledging the possible benefits, we will not see significant sociological harms from increased availability or use of marijuana? I do not think it does. It is a non-transitive argument. "This is bad" does not mean "This is good", unfortunately. But I would defer to Ross.

Mr O'Donoughue: I do not have anything specific to add in terms of side effects

comparatives, but I was thinking before of some interesting analogies. There is an emerging phenomenon, a problem in prescribing in Australia generally, of analgesia. Many doctors are confronted with very diffuse symptoms of, say, chronic pain, and people can become dependent on prescription opioid drugs. That is an emerging problem where a licit drug is being used, arguably for a medical purpose: people are reporting chronic pain to their medical practitioner and medical practitioners respond to that by prescribing what they consider to be an appropriate drug. But you then see a massive increase in the use of those drugs and you see the potential for doctor shopping and for people to become inappropriate users of those drugs. While the present bill has a much narrower scope of medical conditions that are indicated, you could sort of see an analogy in the sense of doctors being again presented with somewhat diffuse symptoms and finding they have got a difficult judgement to make.

THE CHAIR: Ms Fitzharris.

MS FITZHARRIS: Thank you, chair. My apologies for being late; I was held up. And my apologies if I ask a question that has already been covered. I want to go to your earlier point about the draft bill being less about the medicinal aspects of cannabis and more about amnesty from prosecution, effectively. With that in mind, would calling it a therapeutic cannabis bill make any difference? Would calling it something different make any difference to the medical profession?

Dr Brown: Changing the name of the bill, from my perspective, would not necessarily change the concerns we have about the scheme that is contained within it, which currently involves the Chief Health Officer in a range of functions about which we have a concern.

MS FITZHARRIS: My next question is related to the role of the Chief Health Officer. I am probably referring here, mostly, to Mr Rattenbury's subsequent submission to the inquiry, where he states that the role of doctors is not to prescribe it but just to confirm that a person is suffering from a legitimate illness and has tried other forms of medication that are not working. Does that make a difference?

Dr Pengilley: It is not that, strictly speaking, as I understand it. I think that is what they have to endorse.

MS FITZHARRIS: My question is probably less around the draft bill than what an amended version of the bill might look like.

Dr Pengilley: Okay. An amended version of the bill, if you want to know what we would like, would regularise the supply within a normal prescription process. I think that is the gold standard. It allows the benefits and not so many of the harms. If you are still looking at the supply issue being in the home-grown or illicit market then I think the issue is: what can doctors really know? I am not being flippant, but it is about the ceremonial use of the medical profession to endorse something. You have to be aware of what we can really know. A doctor can know that the patient has the indication they said they have, although chronic pain, as Ross said, is a difficult one. There is a lot of chronic pain. It is not always biologically diagnosable. Certainly the experience—and I hope I am not quoting this incorrectly—in Oregon, where they had a system not dissimilar from this, was that they found that most of the prescriptions

were going through very few doctors and most of them were going to people under 40, which epidemiologically indicated they were probably not going to people with extremely bad disease, probably not broadly supported in the medical profession, and that is what happened.

The issue is: how does the medical profession as a whole respond? I think what you get is a concentration of doctors who are willing to endorse it and the ecology around that. Then there is the question of what the CHO can know. We are going to get a form which says, "The patient has this. We think it is reasonable that they be prescribed marijuana." We will not have any real way to interrogate that. We are signing off for them taking something they will have to obtain by means unknown. We are also apparently approving the number of plants you can have now. I have difficulty growing spinach. I really have no idea how many plants is a lot of plants and how many you are meant to have. So there is a real problem with just the public health knowledge. We are not horticulturists.

What you are really creating is, to use an ugly phrase, red tape with no real, tangible outcome in terms of information added to the clinical interaction at any stage. I do not think the GPs will know what they are prescribing and why, and certainly we will not. That is being done because, essentially, decriminalising is seen as perhaps a more blatant or less justifiable policy move, but involving the medical profession when it actually does not add any real information or skill does not help.

The issue I would also raise is that we have until recently had a similar system of approving S8 approvals. Those are pharmaceutical products with well-known indications, and it is hard enough to get doctors to comply and to actually interrogate the use, because, as Ross said, there is a lot of misuse. There will be a significant resource impost in running the scheme we are talking about here, a register and processing all these applications. In an environment where we have a lot of other public health issues that we want to direct resources to, this is going to be a large drain on those marginal resources. So the role of the CHO and the medical profession in terms of value-add, in anything other than a cosmetic way, is not clear to me.

MS FITZHARRIS: Do you have any sense of what the cost might be?

Dr Pengilley: I could not quote it, but I think we could start at 10 positions. It depends on how many people want it, but if we are going to have to inspect people's backyards for how many plants they have got, if we are going to be ringing people up and saying, "What are you using this for? How much do you want?" we are going to have to be training ourselves in an entirely unknown branch of medicine. It is a lot, and that is potentially hundreds of thousands of dollars which we do not currently need to spend.

MS FITZHARRIS: In that sense, do you see a scheme that potentially has no involvement from the medical profession?

Dr Pengilley: That is kind of what we have now. The issue is the medical impost that it puts people under. You could have a licensing scheme. If there were a register it could be maintained, potentially, by law enforcement or there could just be a card saying, "Yes, I have one of these diseases. Please don't arrest me." Essentially, that is

the same supply and the same conditions of use that you have now. It just makes it easier for people who are caught.

Doctors are, of course, aware people are using this. Going to your original point, doctors are not naive. They know a lot of their patients are using marijuana. They just see it as something that is your choice. It is part of their clinical picture but it is not something they have positively had to recommend or have control over. That would simply be returning to that point. Do I think it has the potential for abuse? Yes. But do I think the involvement of the medical profession mitigates that much in the current scheme? No, I do not.

MS FITZHARRIS: Could I ask a question about supply? Again, referring to an alternative proposal put forward in Mr Rattenbury's submission, he stated:

> … the ACT Government should immediately seek a Federal exemption from restrictions on the import and supply of cannabis. This would allow the ACT to import cannabis …

Is there any other pharmaceutical product that the ACT government imports directly?

Dr Pengilley: No, it is mainly through wholesalers. I am not aware that we do anything directly.

MS FITZHARRIS: So there is no other like product that the ACT government imports—

Dr Pengilley: Not that I am aware of.

MS FITZHARRIS: that it has sought an exemption from the commonwealth on?

Dr Brown: We would have to take that on notice, but there is certainly nothing that springs to mind.

Dr Pengilley: It is quite possible that individual clinicians working for us do, but not us as an organisation.

MS FITZHARRIS: Right, so there would be—

Dr Pengilley: We will take that question on notice.

MS FITZHARRIS: The ACT government would be the only body able to seek a federal exemption from the importation—

Dr Pengilley: Again, it is a question for the lawyers, but my understanding is that the international treaties mean that only a state agency, essentially, can import it.

MS FITZHARRIS: So if the state agency were to import it then the state agency would need to distribute it through some mechanisms there?

Dr Pengilley: Yes, exactly; and they have to ensure that they distribute all of it.

MS FITZHARRIS: Yes, but we currently do not do that with any other product directly?

Dr Pengilley: Not that I am aware of. It would be a highly unusual arrangement; let us put it that way. But in the context of a national scheme that would not necessarily be so anomalous.

THE CHAIR: Ms Lawder.

MS LAWDER: Earlier you mentioned the possibility of doctor shopping. If that were the case, given that this does not involve a prescription for a PBS substance per se, would the existing Medicare Australia regulatory regime pick up that kind of doctor shopping, do you think?

Dr Pengilley: No, I do not think so. The PBAC surveys scripts but they have to be scripts and they have to be Medicare rebatable scripts. If it was not prescribed through pharmacies, our own surveillance of prescriptions would not necessarily pick it up, which is why you would need this fairly cumbersome approval process. It is the only way you would know what was going on. But it would not control it. It would sort of record it. And I am not sure what sort of compliance you would necessarily get.

The issue with doctor shopping, which has been observed in some other jurisdictions that have done this, is that you get a fairly small number of people who essentially see an entrepreneurial clinical opportunity to set up a practice founded on marijuana medicine. Once that is known, then people obviously know that they can go to that practice and that becomes very difficult to control. It is not exclusively a problem with marijuana. It happens with other drugs as well, but I do not think it happens as much as would happen with this.

MS LAWDER: Say everything fell into place and we proceeded with this bill, would that then potentially become a sort of regulatory role for the Chief Health Officer to have to say, "We are getting 90 per cent of these certificates from one particular person"? Would that be a perhaps unforeseen occurrence?

Dr Pengilley: That is, I think, what the scheme is envisaging. The problem is that to do that you would need to have adequate staff and resources to actually take the action, which is a significant regulatory burden. And whilst we might know 70 per cent were coming from one doctor—and that is a fairly clear signal—we will not really know the appropriateness of all those scripts because paperwork does not do that. You really need the person in front of you to actually make that decision.

Dr Brown: I was going to comment on that. Just because a particular doctor prescribes a lot of a particular medication does not mean it is inappropriate. It may be that that is their particular area of expertise. It may be that they deal with people who have chronic pain in this instance or whatever is the indication. So it is not even just as simple as saying, "You have got a lot. Therefore, that is wrong." As Andrew says, it is then about having the capacity to actually go in and investigate and interrogate and understand what is appropriate practice and what is not.

I guess that brings us back to what the scientific literature tells us about what is appropriate or not in this particular space. And whilst there are some indications—this is my understanding; I claim absolutely no expertise in this field but my understanding is there are some indications—they are not particularly strong clinical indications for the use of medical cannabis.

MS LAWDER: I could be wrong, but I think there was in the past and may still be a whole sort of branch in Medicare Australia that does that regulatory investigation.

Dr Pengilley: They still—

MS LAWDER: Doctor shopping, those kinds of—

Dr Pengilley: They still do it for Medicare prescriptions and particularly for expensive drugs. But this would not be a Medicare prescription, so they would have no administrative oversight of it.

MS LAWDER: I guess I am thinking in terms of the Chief Health Officer and if they had to undertake that type of role. It is not necessarily a single person who looks at it.

Dr Pengilley: Yes.

MS LAWDER: You also talked earlier about drug interactions. Would you see that as different to any other drug interaction issues that doctors currently have to look at?

Dr Pengilley: I guess the difference is that they would not know exactly what the patient was taking. The drug interaction for somebody who gets low THC marijuana or marijuana of low potency, which they may well get, and then next week has something of extremely high potency will be different. Drug interactions are, broadly speaking, of two kinds. You can have a strictly pharmacological interaction where it impairs the metabolism of another drug and this is hepatically metabolised—sorry, metabolised in the liver. So there is the potential for that.

But there are also just the effects of the drugs interacting. If somebody is taking valium and marijuana and the potency of one of those is changing radically, then there is the potential for that to have a radical effect on their ability to drive or to fall asleep, or to impair their work, or any of those sorts of things. It will be very unpredictable, and that is the sort of interaction that is more likely.

MS LAWDER: In a way, though, doesn't that make it more worth while to have your doctor involved, whereas currently a patient might not tell their GP? If your GP was involved, your GP might say, "Let's take you off the valium while you are trying this or this."

Dr Pengilley: That is true. It is a reason to have your GP involved, but only if your GP can actually inform the situation. The GP does not know anything about the supply. And if that was a prescribable process then we could train people in: "These are the characteristics of this much marijuana in the context of all sorts of other drugs." Yes, that is exactly why we have GPs involved in all the other prescription decisions. But if you are going to go and obtain something and I do not know what it

is, and it is probably not going to be the same from week to week, then the GP has nothing to work with.

Dr Brown: And the method of partaking of the medical cannabis comes into that equation as well because it can be in a tincture or it can be smoked, it can be vaporised. A range of different methods have been utilised. Again, the GP would need to understand what method was potentially being used and what that might result in in terms of the dose that is being received. And that is a very difficult undertaking when there is no quality assurance around the process.

MS LAWDER: And finally, if I may, in your submission you talked about the need for more definitive evidence, especially about the efficacy of cannabinoids and THCs. Have you looked in any detail at the New South Wales trial and would that provide useful data to satisfy those concerns?

Dr Pengilley: Yes, we have been in officer-level discussions with New South Wales through the development of their trials. I think it is important to say that they are going to have clinical trials, and one that they are going to have is a specific trial in using cannabidiol for epilepsy. There is some use in the relief of chronic end-of-life symptoms. But they are doing that in a clinical setting. They are not trialling this proposal, if you like. Yes, I think it may well provide more clinical evidence quantifying the effect in those roles.

Whether that answers the question of the effect in all the indications that people want to use it for, particularly for chronic pain, I do not know. It is not just that the trials have been done in different methodologies in different ways, and some of them are small and so forth, but it is also that the indications are very different; the people who have tried it and the populations are different. It may well be that the effect is very different depending on how you use it and in whom, which makes it difficult to do a definitive trial. Sorry, that is a bit of a rambling answer. The answer is that it will provide some information but I doubt it will be definitive.

THE CHAIR: The ACT government supports the compassionate intent behind the draft bill. In your conclusion, on page 11, you list a series of issues that need to be addressed. Perhaps you could be really clear on what you would be recommending on those issues that would be most applicable to your directorate, which are supply and prescribed medical conditions. We will start with supply. The conclusion talks about the model currently in place in the Netherlands. From the evidence that you have already given around doctor liability for outcomes, issues around understanding what the effects of a particular product might be, should the committee construe that a Netherlands-type scheme would address those issues?

Dr Pengilley: It does not make doctors non-liable. Doctors are generally liable for everything they prescribe. But what it would allow you to do is—

THE CHAIR: Or do not prescribe.

Dr Pengilley: Or do not prescribe, exactly. So it would allow you to quantify what was being supplied, as a basis for education, as a basis for doctors knowing what they are doing. I guess the issue of liability, just because they do not know what they are

prescribing, would be controlled. I think it would increase the confidence of the medical profession, or at least those who wish to pursue training in using this pharmaceutical, in knowing what to train in. There is a body of evidence on that much of a known substance having this much effect, not an unknown quantity of an unknown subject having a certain effect. The simple answer is: yes, I think it would.

THE CHAIR: We have heard plenty about the dangers of combustion, smoking of these products, which may or may not be relevant, as you say, if you are 80 with terminal cancer. However, we have also heard a lot of evidence about vaporisation and other forms of extracting the active ingredients. Would you envisage a supply scheme simply providing the botanical, as the Netherlands one does, or would you anticipate an ideal situation of further refinement?

Dr Pengilley: I think that is a question almost of the policy issue we are addressing. I do not think there is any doubt that there is clinical evidence that the pharmaceutical products that are registered work. They can be used by doctors and, if they are acceptable to their patients, they can be prescribed. The issue is that there are obviously some people who do not find that acceptable, and what those people wish to obtain is the botanical product. So I guess the supply problem we have is the botanical product, not refined products, which are already available, more or less. Given that that is the supply problem we are addressing, then, yes, I think that is what we would be supplying, and that would be in a quantified form.

I have heard in various debates and discussions around this issue the statement: "It is a plant. Therefore, it cannot be a pharmaceutical." That is only true if you grow the plant and do not test it. You can do quite detailed chemical tests to say, "This has exactly this much THC and this much cannabinoid and it is this many grams." And if that is the case, then the fact that it is a plant is kind of irrelevant. It is a certain amount of product. Yes, I think that is what you would be looking at.

Dr Brown: Can I just say in addition to that that I think the answer to your question may well be informed by further experience in this field. For example, if the clinical trials are proposing to use tinctures for the treatment of childhood epilepsy—and I am not sure whether that actually is the case—and if there is a body of evidence that says, "A tincture should be available," then that may well inform what supply is actually provided. At the moment, again, we do not necessarily have a strong evidence base to say, "You should have it in this form or this form or this form."

Dr Pengilley: That being the case—sorry, I probably should have answered in regard to the New South Wales trials—they are not using botanical cannabis. They are using refined product—

THE CHAIR: You will need to speak up.

Dr Pengilley: Sorry. The New South Wales trials are, as far as I understand, using a refined product. They may answer that question of whether cannabidiol is particularly effective. But there is already a product, Epidiolex, which is cannabidiol oil. If you wish to access these refined products, they already exist. It is the botanical access. The question of whether you need the botanical access is a clinical question and that is kind of where the debate on the medicine is. But if we were to address the issue in this

bill then that would be the supply of the botanical product.

THE CHAIR: Further on the supply issue, do you see a role for the Chief Health Officer in a Netherlands-type scheme where the doctor prescribes it and it is dispensed from some state-controlled pharmacy? Is there a need for oversight, given the fact that you have already told us that there will be some doctors who will be prescribing much more than others? Is there any real need for state oversight of overall prescription levels?

Dr Pengilley: It is an interesting question and I can only answer off the top of my head. There is a population health interest in surveilling how much is being used, whether there is doctor shopping and whether there is inappropriate prescribing going on. The issue, however, is there is no need for the CHO to be involved in the decision to prescribe to an individual. We would probably envisage a scheme under that sort of system of tracking numbers of prescriptions per pharmacy and per doctor, all of which can be done through the computer system we currently use and which would be very similar to the SA model. So it would be surveillance and monitoring. There is always the complaint response element, and AHPRA would also have a role in that. But I certainly do not think we would want to get into the decision to prescribe in that case, because it would be like every other pharmaceutical.

Mr O'Donoughue: If I could just comment, chair? The licensed cultivation model would, on the face of it, seem more likely to comply with the international convention, which seems to talk about authorising an agency to oversight licensed cultivation and then the agency being the receptor of the product and being responsible for its distribution. On the face of it, the kind of scheme we are talking about—something like the Netherlands—would seem to be more consistent with the single convention than the bill itself has proposed.

Dr Pengilley: It is worth pointing out that in the Netherlands marijuana is still illegal. They get around that by having this agency model and by having a fairly broad tolerance for people using it illicitly. But it is not actually legalisation; it is just a supply system.

THE CHAIR: Turning to the issue of prescribed medical conditions, which is very much a part of the proposed legislation, is this something that you envisage as still being in the type of scheme that we are talking about now as an appropriate thing, or do you think you should just leave it to the doctor-patient relationship to work out who gets what for what?

Dr Pengilley: I will answer, if I may.

Dr Brown: Sure.

Dr Pengilley: All registered pharmaceuticals have indications and, of course, medicine uses off-label indications fairly extensively, because it is generally true of clinical practice. I think it would be important to have indications. What is different about this is there is a potential for people to deceptively obtain the product by presenting with symptoms that are not legitimate or not real. I am not saying that is the bulk of patients or, indeed, that it excludes people having a legitimate need.

The problem with having no indications and just leaving it to general use is that you have that potential for somebody to essentially set up a very permissive system for chronic pain or something like that where you come in, you have these symptoms and you have access. Again, this is undermining a legitimate system we have seen in some other jurisdictions. That is where you start to get very large quantities being supplied perhaps illegitimately, and also the potential for diversion.

I think ideally there would be specified indications. Meeting those indications would be the doctor-patient relationship. We would be holding doctors to that as the standard of care: "This is what we expect you to use it for. We do not expect you to use it for headaches, ingrown toenails and so forth."

THE CHAIR: Specified by whom?

Dr Pengilley: If it is in a regulatory system, it is normally the TGA that write the indications. I know they have absented the field, unfortunately, but it would be whatever regulatory agency was running this. If it was the ACT, I guess we would have to specify that. That could be something we would have to specify in our own legislation, but ideally a national scheme would have that national regulator that would be able to say, "This is a legitimate use and this is not."

Dr Brown: Again, if we were to go down that street I think we would be looking for consultation with our clinical colleagues before proceeding.

THE CHAIR: Mr Wall.

MR WALL: Just on that point, to follow on: should it ultimately be someone like the chief medical officer or should it be left up to the legislature to come up with those conditions?

Dr Pengilley: I think, as Dr Brown said, this very much needs to be a discussion with the clinicians.

MR WALL: I just wanted to confirm that. I know that the former health minister indicated that the ACT would look to partake in the New South Wales trial. Is that still the position of the ACT government?

Dr Brown: What we indicated was that we would be keen to collaborate with New South Wales. As Dr Pengilley has indicated, our senior officers have been a part of the ongoing discussions, but to the best of my knowledge there has been no actual opportunity for us to participate. At this point in time I am not sure that their trials are actually underway.

Dr Pengilley: The New South Wales government has offered an expression of interest to facilitate the trial. Individual clinical groups still have to run the trials. The one involving epilepsy we could nominally be involved in, but the problem is that we probably would not have a trial site here. That would be something being run out of the kids' hospital, and it is a fairly small number of kids that would be appropriate for that in the ACT. If somebody was interested we would have to work out whether they

went to Sydney and whether we could get one of our investigators here to be involved, and there may be a cost involved in that. But that has not come up yet. The other ones, as far as I know, have not gotten up yet. They are proposed, but I do not think they are running yet.

MS FITZHARRIS: I have a couple of questions about what a workable scheme could look like. You mentioned a regressive approach with having a register because you are now looking at electronic monitoring of prescriptions. But in the absence of anything other than the botanical form itself, it would be impossible to electronically monitor, wouldn't it?

Dr Pengilley: If it went through our normal prescription system, we could electronically monitor it because presumably it would have to go through a pharmacist to dispense, either one of our pharmacists or a community pharmacist.

MS FITZHARRIS: So there is a form of register or monitoring of use that is workable?

Dr Pengilley: We would have to do further work on that. Certainly, electronic monitoring of things that go through the normal prescription process is the most workable, because we have a system set up to do that for existing drugs. Certainly, a paper based or a standalone register which is completely outside the medical process of prescribing is the least workable. What is in the middle, I do not know. Certainly, the more it becomes an individual officer thing within Health, the more resource intensive and heavy it is going to be. I am not trying to be bureaucratic or obstructive but you have to understand how many people it could take to run this, in an environment of constraint, when we have other major risk factors that we are really trying to control.

MS FITZHARRIS: How much do you think the absence of an evidence base is to do with the fact that it is an illegal substance? Is there a bit of chicken and egg there? How do you develop a market for it when it is illegal and there are too many difficulties? To what extent will any kind of scheme in itself start to generate enough evidence so that you can start to build a picture over time?

Dr Pengilley: It is a very difficult question. The fact it is illegal has obviously impacted the sorts of trials that can be done. Nonetheless it has been fairly extensively used in a number of places. Again, the Netherlands experience—and I am not Dutch, so I am not trying to fly the flag for them—is that they have done quite a lot of research into their program and the evidence is that they have fewer prescriptions in an older patient group. That would suggest it is being targeted appropriately and with less diversion. So that sort of systems evidence is done.

There may be no clear answer. There are drugs which only work in some people. I know, having been a regulator, that it is very difficult to make population regulatory decisions if only 10 per cent of the population benefits, but they benefit a lot. So, for me, the efficacy issue does not need to be resolved. What needs to be resolved is the mitigation of the disadvantages sufficient to gain the advantages, and that is what we are majorly concerned about.

If there are people who have dreadful terminal illnesses or have intractable chronic illnesses who benefit from it then it is not for any of us to say that it does not work. But on a population level the population health problem, as with all regulatory systems—firearms, and all of them—is about how you structure that so that you do not get disadvantages in others.

MS FITZHARRIS: Do you have a view on each state going off on their own and doing their own thing versus a national approach? There is always tension in that.

Dr Pengilley: A national approach would be ideal, as it is with all—

MS FITZHARRIS: As it is with everything.

Dr Pengilley: As it is with prescription medicines in general. But that may be difficult.

THE CHAIR: If there was a national approach we probably would not be here.

Dr Pengilley: Yes, that is quite true.

Dr Brown: Notwithstanding Dr Pengilley's comments about the evidence around the efficacy of these—and I support what he said—I would make the point that we do not necessarily have to generate that evidence in Australia either. I think we should be looking at the international evidence. There is a growing body of evidence in this space and I think we should be prepared to embrace that, as we do in most other fields.

Dr Pengilley: Particularly the evidence of the different kinds of regulatory schemes that have been used. There are good systems approaches. The clinical evidence is one issue but the approach by government is actually quite a lot of experience.

THE CHAIR: Ms Lawder.

MS LAWDER: I will ask what I hope will be a reasonably short question, given the time. In your conclusion and elsewhere in your submission, you talk about the operation of plant and machinery. Doesn't that apply just as much to other medications?

Dr Pengilley: It can. Again, the issue is the unquantifiable nature of it and the perhaps quite fluctuating nature of it, given the uncertain supply. This was actually raised by law enforcement, in that it has a significant legal problem, which is: if you know you are taking something which might impair you then you are liable if you have an accident. If you do not then you are not. How much you can know about the effect of this drug on your system before taking it, if you do not know what the quality is, is the issue. But it is a fair point; it is an issue with a number of drugs. But it is a quantifiable issue with a number of drugs.

MS LAWDER: To follow up from that, obviously I am not a medical practitioner in any sense. For people with a terminal illness, at what point might they stop driving or operating plant or machinery? If they are going to the point of taking medicinal cannabis, might they already be at the point where they are probably not driving anymore?

Dr Brown: That is entirely a possibility. This is a somewhat challenging space. Sometimes people will self-declare that they do not feel they are fit to drive or they might just abstain from driving. They might surrender their licence. Many times, however, there is not a shared perception around this. It might be that the medical practitioner feels that someone is not fit and the individual themselves says, "No, I think I am fit."

There are some guidelines available around assessing fitness to drive. We in fact have a service here in the ACT for driver assessment. But it is still quite a grey area. As I say, often there is a mismatch between the opinion of one and the perception of the individual. If you are talking about someone who is 80 and has a terminal illness and is using cannabis for pain relief, for example, or relief of spasm, it may well be that they have a level of insight and elect not to drive. But if we are talking about someone much younger, say under 40s, as Dr Pengilley said, the experience in the US is that there is a high percentage of people under 40 using this for non-chronic pain type indications. They are unlikely, as a general comment, to say, "I'm going to stop driving as well as taking this medication." So it does present some challenges.

Mr O'Donoughue: With respect to the way the bill is structured at the moment, there is only one category that is a terminal category. The other two categories are either people with chronic conditions or undefined other conditions. As Dr Brown says, it could be very young people who have very long lifetime expectancy who would come under the scheme.

THE CHAIR: It is now 2.30. The committee will adjourn for a short break and resume in 15 minutes. Thank you for your attendance today. If you have taken any questions on notice, could you please get the answers to the committee secretary as soon as possible. The secretary will provide you with a copy of the proof transcript of today's hearing when it is available.

Sitting suspended from 2.30 to 2.44 pm.

LAMMERS, MR RUDI WILLIAM, Chief Police Officer, ACT Policing

THE CHAIR: Welcome, Mr Lammers, 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.

There are just a few housekeeping matters which you will be fully aware of. Mobile phones are to be switched off or put into silent mode for everyone in the room. Witnesses need to speak directly into the microphones for Hansard to be able to hear and transcribe accurately. 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. Can you confirm that you have read the statement on the table in front of you?

Mr Lammers: Thank you. For the record, Rudi William Lammers, Chief Police Officer for ACT Policing. Yes, I have read the statement, thank you.

THE CHAIR: And you understand the privilege implications?

Mr Lammers: Yes.

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

Mr Lammers: Yes, thank you, chair; I would like to make a brief opening statement.

Firstly, thank you for the opportunity to contribute to this important community discussion. ACT Policing is sympathetic to sufferers of terminal illness and supports legally available methods to relieve pain and suffering.

Any decision to introduce cannabis for medical purposes must be preceded by careful and full consideration of the strong regulation and enforcement framework that must be in place, including the cultivation, production, distribution and therapeutic benefits and, importantly, balanced against any potential harm and risk to the community of impairment caused by the use of the drug.

ACT Policing does not oppose the draft submission. However, there are some significant issues relating to the existing legislation which require careful consideration, in my view. For example, consideration needs to be given to current laws, including the ACT Criminal Code 2002 and the ACT Drugs of Dependence Act 1989. Both of these pieces of legislation provide for the prosecution of persons who use cannabis. This includes cultivation, possession, supply, transport, and the use of cannabis. Any ambiguity in the proposed legislation and in a medicinal cannabis scheme needs to be settled with respect to the way in which police, regulators and the judicial system manage and enforce its production, distribution and use.

ACT Policing strongly supports federally regulated cultivation but opposes cultivation by individuals or groups of residential properties or private corporations. ACT Policing supports a regulatory framework for persons accessing medical cannabis,

with medical cannabis available only on prescription and dispensed through pharmacies.

Under section 20 of the Road Transport (Alcohol and Drugs) Act 1977 it is an offence for a person to drive a motor vehicle on a public street or in a public place if that person has a prescribed drug in their blood or oral fluid. Delta 9 Tetrahydrocannabinol, or TCH, which is present in cannabis, is a prescribed drug under the Road Transport (Alcohol and Drugs) Act 1977. Because technology does not yet exist to test levels of THC, the merest presence of THC in the blood gives rise to an offence when driving or otherwise in control of a motor vehicle, and that is of particular concern to ACT Policing.

The proposed legislation for cannabis for medicinal purposes does not and should not change existing drug driving laws, and if any amendments need to be made they need to be considered very early so that ACT Policing has time to respond to changes to legislation that run in concert with any other changes that might be envisaged.

ACT Policing does not support any proposal that would permit impaired driving that adds to road death or road trauma, and the system should be considered that, when medical cannabis is prescribed but not necessarily administered, the prescribing medical practitioner advises the ACT Road Transport Authority that a drug has been prescribed and that appropriate measures have been or will be put in place to safeguard against that person driving a motor vehicle when he or she is impaired because of the use of medical cannabis.

ACT Policing also have some concerns regarding mental health and the use of cannabis. We are concerned about the causal link between cannabis use and mental health, including the potential impact on public safety. ACT Policing suggest the inclusion of an additional section in the submission that incorporates advice from health professionals as to how the link between cannabis use and mental health will be monitored and will be addressed for persons participating in a medical cannabis scheme. Thank you, chair. Those are my opening comments.

THE CHAIR: Thank you, Mr Lammers. We might go to the issue that you raised about driving laws. You did say that, whilst the effects of cannabis may have worn off, there could still be traces of the material in the driver's system which would then show up in surveillance or testing. Is that something that could be dealt with by changing concentrations, or is there some way to technically get around that so that people who have traces of cannabis in their bloodstream which might result from a medical cannabis scheme would then be able to drive, be tested but not run afoul of the law?

Mr Lammers: There are two specific parts to that question—firstly, whether or not there is the capacity to regulate the potency of the drug in the manufacturing stage and, secondly, whether or not we have the technology, which we do not at the moment, to test the level of potency. Our roadside drug testing method at the moment—when we do buccal swabs and we test the saliva and drug presence in those swabs—just detects the presence; it does not detect the level or the potency of the drug.

You could have a very high administered dose or a very minor dose and they would

still register as a prescribed drug for the purpose of that testing, and the penalty is exactly the same whether or not you have a high THC or a low THC level in the drugs.

THE CHAIR: How does that differ from currently legally prescribed drugs?

Mr Lammers: At the moment, if legally prescribed drugs do cause impairment then that is a matter for investigation after an incident, but we do not test for legally prescribed drugs; we only test for illicit drugs, including cannabis. The drugs we predominantly test for are ice, cannabis and heroin. We also test for cocaine.

THE CHAIR: And those are separate tests?

Mr Lammers: There is one swab that provides us with a result against all drugs that we are looking for, so we do not have separate tests, no.

THE CHAIR: Is it theoretically possible, if someone was a part of a legal medical cannabis system and you pull them over, for you to say, "If you are part of the scheme we are not going to test you for cannabis because we know that is in the same zone as other legal drugs which we do not test for either." What do you think about that?

Mr Lammers: I would imagine the technology may exist that allows us to differentiate between drugs, but the roadside testing of drugs that we do at the moment does not differentiate between drugs. It simply is an indicator that the type of drugs we are screening for is in the bloodstream or in the saliva. If a test existed that allowed us to test uniquely for cannabis then that is something that we would consider, but that of course would need to be coupled with an authority to have taken the drug in the first place.

THE CHAIR: Exactly.

MS FITZHARRIS: The results are immediate on the roadside testing; is that right?

Mr Lammers: They are not as immediate as roadside testing for alcohol. They take somewhere between five and 10 minutes, so it is not a great delay.

MS FITZHARRIS: So with people who may currently be on the two legal cannabis products, Marinol and Sativex, would your testing pick those two up?

Mr Lammers: It would currently pick up any form of cannabis or derivative of cannabis.

MS FITZHARRIS: Do you have a sense of how far away the technology is to measure the dosage?

Mr Lammers: No, but advice provided to me as recently as early this month was that it has not been explored to a stage where we could reliably be told that it is going to occur in the near future. So there has not as yet been a market for it.

THE CHAIR: Clearly, you envisage problems with legal backyard cultivation. Perhaps you could elaborate on that.

Mr Lammers: If cannabis is going to be prescribed and it is going to be in a form that is useful to patients then we want to make sure that there is good regulation around that. There is a great range of potency of cannabis grown in people's backyards, for which we regularly arrest and prosecute.

There could be simply a difference between the potency of the leaves and the potency of the heads, for instance, with cannabis. There is no way of regulating that if it is grown in a backyard. The only way you could really do that is if it is grown under strict supervision and controls and then produced in a way where the potency could be controlled. Those people who home grow cannabis do not often have any idea about how potent their drug is.

THE CHAIR: Perhaps you could tell us more about the sorts of problems you might encounter with people who have a mental illness and are also under the influence of cannabis.

Mr Lammers: We already know that alcohol is a contributing factor to behaviour when coupled with mental health and we also know that alcohol and drugs are a contributing factor when coupled with mental health. Finally, we also know that drugs coupled with mental health issues evoke a behaviour in people that is much more extreme than a mental health condition alone.

If there was a regulation around the way in which medicinal cannabis was produced and there was sufficient testing and research done that shows the effect of medicinal cannabis on people of all types of mental health then that would give us some comfort in terms of how a person might behave if exposed to medicinal cannabis.

Parallel to that, we have absolutely no idea, in terms of the range of behaviours, of people with mental health issues and home grown cannabis because, as I said, the difference in the potency can be quite extreme. It is very unpredictable. We want some assurances that there has been full consideration given to those people in the community who have mental health issues, so that if they were administered therapeutic cannabis it would not have an effect that exacerbated their mental health condition.

THE CHAIR: Mr Wall.

MR WALL: From a law enforcement perspective, what issues do you see in either a grow-your-own, which I think you have already touched on partially, and the other option of the draft bill, which is source your own cannabis, be it from your mate down the pub or at the bus interchange or wherever it may be? What are the issues there from a law enforcement perspective?

Mr Lammers: Any system that falls outside very strict regulation is going to lead to production of cannabis in a way that continues to be unsafe and unregulated. It will also produce a huge impost on us in terms of people who will complain about their neighbour growing cannabis only to find out that the cannabis may or may not be for medicinal purposes. Largely it is about the regulation of control over the production of the substance and the heath factors involved in producing it in your own home and

your own kitchen.

As we have seen with the production of ice and the way in which that is produced out of people's car boots and kitchens, with no controls over it at all, the propensity for there to be a much higher black market demand for cannabis leads to us having a great deal of concern around non-regulated production and supply of cannabis, and by that I mean in people's homes, flats and residences.

MR WALL: What is the makeup of the current supply chain or what are the origins of cannabis that is available on the streets at the moment?

Mr Lammers: Cannabis comes from a number of different areas. As opposed to some of the more illicit drugs, it is produced within Australia and not imported. Quite often it is done hydroponically, and we are detecting grow houses all the time. It is also grown in people's backyards in pot plants. The plants are given to people, they move around and they change hands from one person to another quite regularly—all done, of course, illicitly.

We detect the growth of marijuana and the possession of marijuana regularly in the ACT. A lot of it is grown very locally, and, as I said, a lot of it is grown in house, but because borders throughout Australia are quite porous, the potential to get cannabis from New South Wales is quite high as well. There is lots of land in the ACT on which cannabis can be grown, and we have a specific part of ACT Policing, the rural patrol, that is always on the lookout for illicit crops grown in and around our forests. A greater problem is the indiscriminate growing of cannabis in people's backyards and in their cellars and in their roof spaces.

MR WALL: Is the purity of what is available on the street generally just raw cannabis or are there instances where it might be mixed with other substances?

Mr Lammers: It depends. Cannabis can quite often be refined to a much more potent level. What type of plant is cultivated and what part of the plant is harvested and produced will affect the potency of the plant. How long it is dried for and how it is produced and under what conditions it is propagated, produced, and harvested all make a big difference. All of this leads to our argument that there is no control over cannabis that is grown outside a regulated environment.

MR WALL: And how easily accessible is cannabis in the ACT?

Mr Lammers: Cannabis is quite reasonably accessible in the ACT.

MS FITZHARRIS: Currently you can possess a small amount of cannabis in the ACT and you are subject to a fine; is that right—a cannabis offence notice?

Mr Lammers: That is right; it was decriminalised last year.

MS FITZHARRIS: In those instances where police may come across people who are given a cannabis offence notice, do any of them ever claim, to your knowledge, that they are using it for medical purposes?

Mr Lammers: Not to my knowledge. In fact, to be more accurate, a lot of people say it is for personal use. Whether they elaborate on whether or not it is a true medical condition I do not know but, as you can imagine, when we do find cannabis, people will come up with the most extraordinary reasons why they have it in their possession. It would not be beyond the realms of belief for people to say, "I'm doing it for medicinal purposes."

MS FITZHARRIS: Under the scheme, one of the alternatives put forward about growing it is to be able to possess it for medical purposes. Are you able to weigh up, from your point of view, what enables people to grow it in their backyard for medical purposes—or prohibiting that but enabling them to possess it for medical purposes? I guess it is the trade-off between people who may feel they need it for medical purposes buying that from someone else as opposed to growing it themselves. Do you see one being slightly better than the other?

Mr Lammers: From our position, which is a law enforcement position, the drug is illegal whether it has been decriminalised or not. When you pass a certain threshold in terms of the quantity, it becomes a criminal offence and, as you quite rightly said, there is a fine levied against people who possess a certain amount for their own use. It is prohibited, though, to produce it for sale in any form or any quantity. That defeats any argument that a person might have where they had 10 or 20 plants in their backyard. By any measure, that is not reasonable for personal use. Simply because it is for personal use does not make it any less lawful.

MS FITZHARRIS: So if you had an instance where there was a scheme which enabled you to possess it for medicinal use, you would still have to purchase it from somebody else who could not then be given immunity, because they may have two quite separate supplies?

Mr Lammers: No, because if you have purchased it from someone, someone has committed the offence of selling it.

MS FITZHARRIS: And to give immunity further down the supply chain that is where you start to get—

Mr Lammers: In that case, where does the immunity stop? It would have to stop at the seller and then you would have to look at the way in which he or she has produced the drug. We lose absolute control, and the seller has no idea about the way in which the grower or the provider—and the provider might be a third party as well—has produced the cannabis and whether it is even safe, whether or not the dried cannabis has been mixed with something else that is a bit more innocuous or deadly. The buyer has absolutely no idea until it is used.

MS FITZHARRIS: Do you see some of the implications? Are you aware of cases where people have used it and clearly been surprised and detrimentally affected by the use of it because it had some other product in it?

Mr Lammers: It is not uncommon for a drug dealer to rip off a drug buyer. We have known instances of cannabis being mixed with all sorts of things, such as grass—and I mean literally the type that you mow—and tea. Some of the teas that it has been

mixed with could be sourced from places where there are impurities in the teas, or toxins. There is no way of absolutely being certain that the product you are getting is pure and unadulterated, which raises concerns for us in terms of the potential use and the risk for the person taking it.

MS LAWDER: I note your concerns about driving a car while using medicinal cannabis. It is mentioned that the RTA can undertake a medical review of a person's licence status. That is already the case. There is a suggestion that people could be subject to a condition while they are consuming medicinal cannabis. As a follow on from that, how common is it when you do road blitzes that people are driving without a licence—irrespective of medicinal cannabis; just specifically people who are driving without a valid licence?

Mr Lammers: I do not have those figures in front of me, but I could easily provide them to you.

MS LAWDER: What I was thinking was that there may be some people who the RTA say should not be driving. There are always people that chose to drive without a licence anyway.

Mr Lammers: Of course, and daily we pick up people for all sorts of traffic offences. Coupled with those traffic offences they might have a disqualified licence, a cancelled licence, a suspended licence or, in fact, no licence at all—and it does happen.

MS LAWDER: Do you know how common it is that the RTA say that people cannot drive? How frequently does that happen?

Mr Lammers: It depends on the way in which the RTA receives that information. Quite often the courts will cancel or suspend a licence. That information is passed to the RTA and then those people are notified that their licence is suspended or cancelled. We are then in turn notified that there is a driver that is either cancelled or suspended. So if one of my officers comes across a person, again, we are armed with the same knowledge that the courts and the RTA have.

MS LAWDER: Currently, if the RTA wrote to me and said, "We're suspending your licence," am I supposed to mail my licence back to them?

Mr Lammers: They give you the option of surrendering your licence either to a police station or the RTA.

MS LAWDER: My next question is about mental health consumers potentially affected by cannabis. I am not really sure, but I would have thought that things like ice, heroin and cocaine interacting on people with a mental illness might cause more violent activity, but from what you were saying earlier cannabis can also?

Mr Lammers: We have found that any type of drug, acting in concert either with alcohol or a mental health condition, can lead to a change in behaviour that is often violent. From past experience, with people that have passed through our ACT Policing watch house who may have been affected by alcohol and also by ice, the propensity for violence is much greater. I really do not want to categorise a mental

health condition of any type, but with some mental health conditions the use of drugs and the use of alcohol exacerbates the particular condition. It can have a number of different effects on people and one of the effects is that they become more violent, irrational and unpredictable.

That applies equally to cannabis—to a lesser extent than ice, because ice has some very peculiar effects on people that tend to make them much more violent. That behaviour, when coupled with alcohol and some sort of mental health issue, is even worse. Cannabis, perhaps to a lesser scale, still has the potential to react badly in a person with a mental health illness.

MS LAWDER: Given that this bill is intended for compassionate relief of chronic pain and/or terminal illness, you are perhaps not in a position to say whether there are many people who may be suffering a terminal illness who might be users of other drugs. That is just something I am thinking about.

Mr Lammers: I have had some experience over the years of people suffering a terminal illness who had tried all the legal medication at their disposal and may well have benefited from something different. They were at the end of their resourcefulness in terms of finding something that would help with their suffering and would quite happily have turned to another legally available drug. In some cases, particularly if the drug was for a child who was in some pain, the parent would probably want to do everything possible to minimise the distress of a child. But they would balance that, as I would as a parent, against whether or not what they were giving them was also safe. If I had the choice between something that was legally available, prescribed by a medical practitioner, and would affect the wellbeing of my child, I would opt for that against something that was much cheaper and readily available on the streets that was unpredictable in nature and that was potentially unsafe.

THE CHAIR: Returning to the government's submission, which talks about supporting the compassionate intent behind the draft bill, and then going to some of the conclusions, we have talked about criminal diversion and the recommendation that medical cannabis users be issued with a photographic licence. Can you elaborate on how that would help police?

Mr Lammers: I think there is a great deal more work to be done on the detail here. Although I have looked to some extent at the spirit behind the draft bill and I agree that an alternative to what we have now is worthy of exploration, the technicality behind how we would identify a person who has been legally prescribed cannabis really needs to be fully explored because it also draws into question how we actually do that. When the RTA issue a drivers licence there are a lot of safeguards behind the issue of the licence. It would need to be a statutory body that has the same access and information that the RTA has.

The information that is provided on the licence, if that is what we are going to use, needs to clearly identify a number of things. That includes things like when the cannabis was prescribed, for what use and for what period of time, and whether or not there was a view from the medical practitioner and there was some advice given to the patient as to whether or not he or she should be even driving a motor vehicle.

There are a lot of things that go into this. We know that cannabis stays in the bloodstream a lot longer than alcohol. I keep saying that it depends on the makeup of the person and the metabolism—how much they have eaten that day, how much they exercise and to what extent cannabis is actually removed from the system over a period of time. It would not be unusual for a person to have cannabis in their bloodstream for months after they have taken just one dose of cannabis. So regulations around whether or not they ought to drive at all need to be considered.

If a medical practitioner is minded to prescribe medical cannabis to a person because of the nature of their illness, it is ACT Policing's view that, in concert with that, there need to be very strict controls on whether or not they pose an additional risk to the public by driving a motor vehicle. We need to be very strong in terms of what is enacted to make sure that the public is protected. If that means that advice needs to pass to a body like the RTA that precludes a person from driving after they have had even one dose of medicinal cannabis for a period of time that puts them outside a danger period then it would be my submission that that is what needs to happen.

THE CHAIR: Is that what we do with other legally prescribed drugs at the moment?

Mr Lammers: No, in many cases we do not do that. With a lot of the legally prescribed drugs there are simply warnings on the packet that indicate that you ought not to operate heavy machinery. We rely very heavily on advice from the doctor to the patient to make sure that they, as best as possible, mitigate any risks after they have taken the medication. But certainly, to my knowledge, there is no information passed between the prescribing doctor, the pharmacy that dispenses the medication and those who control the behaviour of the people in terms of their driving, and that includes the police and the RTA. So this would be something that would be different.

THE CHAIR: So am I to take it that you are advocating that this proposal for notification of RTA of drugs which may affect people's driving should be expanded to other—

Mr Lammers: No, I am not advocating that at all. I am simply saying that in terms of this trial we already know the detrimental effects of cannabis and we know that from many years of experience, and in this particular issue we are debating whether or not there need to be controls around the use of cannabis and the extraneous effects on a person driving a motor vehicle. We already know that if a person gets into a car under the influence of cannabis their driving will be impaired to some extent, and the community need to be protected against that. Whether or not that extends to other prescribed drugs I am not qualified to make a comment.

MR WALL: Part of the risk of a medicinal marijuana trial, regardless of what form it might take, is a leakage from what might be a legitimate use under the scheme into the illicit market. What safeguards should be considered to minimise that?

Mr Lammers: The safeguards need to begin at the approval stage and the authority stage for a person to produce. There need to be rigid controls around the manner in which cannabis is grown, harvested, processed and produced. There need to be regulations around its potency. There need to be strict controls around where it is

grown, how it is grown, how it is contained, how it is shipped, in terms of quantity harvested and quantity produced. There need to be strict controls around its transport to whomever is going to be the person who further refines, packages it up for sale, puts warning labels on it, and then at transit and passage from that particular place to a pharmacy for on-sale.

There need to be strict controls around which pharmacies can actually dispense cannabis and for what purpose. I know the bill articulates three particular instances in which it can be prescribed. They need to be regularly checked and audited. There is the additional question of who administers. Is it left up to the person to administer themselves, particularly in terms of a child? It would be unreasonable, if a child is terminally ill and has been prescribed medicinal cannabis, for them to administer that themselves, particularly if they are young. So the onus is then on the family or a carer to administer that.

What safeguards are there going to be around that administering of cannabis to make sure that they do not inadvertently overdose when they provide it? The potency of cannabis has to be to such an extent that there is a high safety margin built in, as we see with things as simple as paracetamol, where it is more difficult to overdose on that. We need all those sorts of safeguards in place. If all of that was in place, together with the responsible use of cannabis, it would limit the opportunity of other people getting access to it in a way which is unlawful.

MR WALL: To compare what you have just detailed to what currently exists for pharmaceutical products that are legally prescribed by a GP or a specialist and dispensed through pharmacies, how effective is that supply chain in preventing that from happening?

Mr Lammers: In my view in Australia we have some of the highest standards in the world in terms of the rigorous testing of pharmaceutical products—sometimes even years and years of testing before they are released and years of clinical trials before they even hit the market. I would suggest that something akin to the rigour of those clinical trials needs to occur with something like cannabis. It should not be left to chance.

Putting in place a trial that simply talks about its production, distribution and use is one thing, but certainty around the quality of the drug produced and the consistency in quality of the drug produced through a number of different manufacturers has to be well considered, so that you know that if you are getting it from two or three pharmacies under the same prescription, each and every time you are getting exactly the same drug.

MR WALL: Regarding that supply chain, I am worried that if we do go down a state grown, state distributed model for a trial, some of that product is potentially going to find its way onto the black market. From your experience in law enforcement, to what extent does that happen with prescription medicines that exist already?

Mr Lammers: A reasonably good example of that is the way in which drugs like pseudoephedrine have been used to produce illicit drugs. Once that was established and once laws were passed with respect to precursors, a lot of that was tightened up,

but it still does not stop a person going in and using a prescription, buying a couple of packets of tablets and turning those into something like ice.

There are rigorous safeguards in place to protect us from that. The same sorts of safeguards around the distribution, supply and prescription of cannabis need to be put in place in the manner in which I have described to limit the opportunity of it falling into the wrong hands. I also note that, if I have read it correctly, the bill does not provide for any penalty provisions for misuse of therapeutic cannabis. It talks about a lot of other things but it does not necessarily point to what penalty provisions and what sorts of things are in place that would dissuade a person from using not only the process in producing but also the distribution and the prescription unlawfully, which to some extent might go to answering your questions around what would be the consequences and how would we find out if it was used in a manner that was outside the process or a scheme.

MS FITZHARRIS: It is probably fair to say that you are in the best position to confirm that your members tend to, in the community, play not just a straightforward law enforcement role; they play part social worker, part mental health worker, part counsellor, part compassionate ear to lend to people in need. If this scheme were to go ahead as proposed in the bill, what would the lived experience be like for your members in actually seeing this through and would it change in any substantive way the role of your members out in the community?

Mr Lammers: That would depend on how it was introduced and what safeguards were put in place, but I do envisage that, irrespective of what happens, if there is a suggestion that it can be grown in a house, for instance, the number of complains we are going to get from neighbours and others is going to rise exponentially. If there is sufficient comfort in the community that the controls around the production of cannabis are only by those authorised to produce, and there is some sort of state hierarchy in doing that, the problem for us will not be great. But if it is produced locally, in homes and businesses, I anticipate a tremendous rise in the number of responses to complaints against the production of cannabis.

MS FITZHARRIS: Are you aware of what the AFP Association's view might be on it?

Mr Lammers: No, I am not aware of what their views are.

MS FITZHARRIS: Do you have a sense of what it might cost in terms of the law enforcement resources that might be additionally required or how it might add to the current workload?

Mr Lammers: Although we have not done a lot of analysis on the cost, we do know that if there was not a very regimented approach to the way in which cannabis is prescribed, every time we pull up a motorist at a random drug testing station the logistics of working through whether or not the person had the right sort of authority to possess and use cannabis, without even going to the question of who prescribed it, would be very resource intensive.

If a person is still driving a motor vehicle—and my view on this is that they ought not

to be driving a motor vehicle while using cannabis in any form, whether it is prescribed through this trial or available off the streets—and if they are pulled up with cannabis in their system then there needs to be a very quick and accurate way of determining that the cannabis was medically prescribed. As I said earlier, there is a lot of detail to consider here about how that might work.

MS LAWDER: The ACT government submission says that supply is not currently addressed by the draft bill, but the national bill proposes a scheme very similar to that in the Netherlands which does address the issues of supply and is the preferred approach of the ACT government. That also means there would be leakage across the border with New South Wales if there was such a national bill. Can I confirm that that is ACT Policing's specific view as well—the need to address the supply issue and have a national scheme?

Mr Lammers: One of the things that ACT Policing, which is of course part of the Australian Federal Police, has been concerned about for a long time is the supply chain of all types of drugs—the porous nature of our borders and our global borders. We have been heavily focused on how we actually stop supply. If supply is made easier because of a legitimate process then there still need to be mechanisms and safeguards in place to detect the supply and not unreasonably or unnecessarily use up our resources to chase down things that are for all intents and purposes lawful.

With respect to the model that they have adopted in the Netherlands, I know that we have cited the Netherlands as a way of prescriptions being administered through a legitimate pharmacy and also having some controls. There is of course a wide use of cannabis in the Netherlands that is relatively uncontrolled, so it is important to differentiate between the two—between the cannabis that is available throughout a lot of places in the Netherlands, to varying degrees of potency and various degrees of safety in terms of what is in the cannabis, compared to a regulated approach and a prescribed approach to the distribution, supply and purchase of cannabis through legitimate outlets, which is the Dutch model.

In terms of the ACT alone, the view of ACT Policing is that whatever is introduced needs to have some commonality right across every border in Australia—so a national approach, notwithstanding that it might be an ACT and New South Wales trial. Whatever is finally decided cannot offend what other states and territories might have in mind. We would have people who would travel from as close as Queanbeyan in New South Wales into the ACT, or a little bit further, from the Victorian border, and it would be unreasonable and counterproductive if different laws and different regulations applied to different states.

MS LAWDER: You touched a little on pseudoephedrine. Do the police get involved much in other misuse of prescription drugs, where someone else in the household or a relative might take drugs intended for another person? Is that a police matter?

Mr Lammers: Every now and again those things are brought to our attention but they are usually after the event. So it may well be that a prescription drug that has been used unwisely or in excess might have led to a motor vehicle collision or in particularly serious cases a fatality and post mortems indicate a high degree of that prescription drug. It is a matter for the coroner as to whether or not that higher level

prescription drug which might have caused sleepiness or drowsiness of some kind affected their capacity at the time of the fatal collision. As I said earlier, I am not a medical practitioner so I cannot speak about the individual effects it might have on some people, but I do know it has different effects on different people.

MS LAWDER: I am thinking perhaps of where it might be diverted. Some drugs may be taken by another family member, not the person that the prescription was written for. Does that get reported to the police or is it more of a Medicare or GP matter?

Mr Lammers: To my knowledge it is not reported very often

MS FITZHARRIS: Am I right that methadone is dispensed in a number of select pharmacies around the city? Do you have any law enforcement issues around those in particular?

Mr Lammers: The distribution of methadone over the last few years has tightened up considerably. At one stage it was provided by hospitals alone through methadone clinics. We found that there were some anomalies in the way in which methadone was provided to patients. Usually this was following withdrawal from heroin, which was more common back when methadone programs started.

Regulations around the supply of methadone have tightened up considerably. Methadone needs to be taken on the premises in a prescribed dose which is quite carefully regulated. What was the case in previous years was that patients would take methadone away, they would take some of it and then they would sell the remainder. That does not happen anymore. So the environments within the ACT that now provide methadone to patients are well regulated.

MS FITZHARRIS: So they have to have it on site?

Mr Lammers: They have to take it there and then.

MS FITZHARRIS: So there are generally no other issues with other people coming in?

Mr Lammers: No. That was the case before, when the methadone program was in its infancy and we trusted the drug users to take the methadone away and dispense it themselves. We have changed that process because we know that did not work.

THE CHAIR: One of the suggestions that Professor Kilmer made at a recent seminar in Canberra was that if you want to reduce diversion of medical cannabis into recreational cannabis, which is a large part of what we have been talking about this afternoon, you have to set the price for medical cannabis above the price for illegal cannabis. What do you think about that idea?

Mr Lammers: I think that any price point that makes it difficult for parents to administer lawfully a prescription drug to their child needs to be carefully considered. If the cost of cannabis that is prescribed through a pharmacy is so high that a parent is forced to find a different method of supply, I think that would be a tragedy. The price of cannabis already is relatively low; it does not cost much to grow and produce

cannabis. Therefore, in my view, the cost of providing lawful cannabis through a chemist ought to be sufficiently priced to make it accessible to those who need to use it. History has shown that when we price things beyond the reach of people, we drive the problem underground and we encourage purchasing through black markets.

THE CHAIR: There being no further questions, thank you. If there are any more questions on notice, we will forward them to you. There was one question taken on notice. The secretary will provide you with a copy of the proof transcript of today's hearing when it is available. Thank you very much for your attendance and for answering our questions.

The committee adjourned at 3:31pm.