Submission of Families and Friends for Drug Law Reform to the enquiry of the ACT Standing Committee on Health, Ageing, Community and Social Services into the exposure draft of the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 and related discussion paper

About FFDLR

1. Families and Friends for Drug Law Reform(FFDLR) was formed as a direct result of a larger than usual number of heroin related deaths in the Australian Capital Territory between Christmas 1994 and Easter 1995. It believes that prohibition laws introduced more problems than was ever envisioned. It seeks alternative laws and policies that substantially reduce the deaths and minimise the health and social harm to users, families and society.

2. FFDLR's charter includes the following:

- activities that raise awareness of the issues;
- activities that will overcome stereotyping and marginalisation;
- education programs that are directed toward reducing harm and minimising problematic drug use,
- standards and accreditation for drug treatments and interventions;
- provision of adequate and well resourced drug treatments and interventions;
- the important role of families in drug treatment and rehabilitation;
- the search for better drug policies based on evidence;
- cautious and well-researched steps toward changing laws so that they cause less harm;
- removal of criminal sanctions for personal use of currently illegal drugs.

3. It is thus apparent that FFDLR seeks broader decriminalisation of current illegal drugs than is provided for in the current exposure draft. The case to enable “people dying from terminal illnesses, or enduring chronic pain . . . to use cannabis to alleviate the symptoms caused by their illnesses” should not be delayed or complicated by discussion about this broader issue. FFDLR wholeheartedly endorses the underlying rationale of the exposure draft as expressed in the discussion paper namely “that people suffering from chronic pain or terminal illness should have the right to make decisions about their treatment”. FFDLR observes, though, that the illegal status of cannabis and accompanying grossly exaggerated and alarmist propaganda has long impeded the objective scientific assessment of the drug. In short, making the drug available to those whose conditions are alleviated by it should no longer be impeded by debate about whether recreational use of the drug should have been made illegal in the first place.

4. FFDLR can do no better than quote the final words of Pauline Reilly in her moving account of her struggles to make life bearable for her dying husband:

> "The fact that people enjoy cannabis recreationally, and that some abuse its use, should not be the reason to deny the drug to those in need" (Reilly 2001, p. 110)

Origins of medical use of cannabis in the West

5. William Brooke O'Shaughnessy MD FRS (October 1809, Limerick, Ireland - 10 January 1889, Southsea, England), was an Irish physician ". . . whose medical research led to the development of intravenous therapy and introduced the therapeutic use of *Cannabis sativa* to Western medicine."

> "He validated folk uses of cannabis in India, discovered new applications, and ultimately recommended cannabis for a great variety of therapeutic purposes. O'Shaughnessy established his reputation by successfully relieving the pain of rheumatism and stilling the convulsions of an infant with cannabis. He eventually popularised its use back in England. His most famous success came when he quelled the wrenching muscle spasm of tetanus and rabies with resin. While he could not cure tetanus, he did observe that the cannabis mixture reduced their symptoms of spasticity and their suffering" (http://en.wikipedia.org/wiki/William_Brooke_O%27Shaughnessy)

6. In 1842, he returned to England where he introduced *Cannabis indica* to Western medicine (Booth 2003, pp. 89-93).

Families and Friends for Drug Law Reform fully supports the use of cannabis for medical purposes.

7. FFDLR gives unequivocal support for medical use of cannabis for symptomatic if not curative relief for a number of conditions.

8. Following the 1925 Geneva Convention, the use of cannabis has been demonised by the prohibition laws enacted, supposedly to protect society from the so called dangers of cannabis. The underlying philosophy behind those laws is wrong and misleading. The former UK Chairman of the Advisory Council on the Misuse of Drugs, Professor David Nutt, put the whole range of legal and illegal drugs into perspective, indicating that cannabis was in the lower end of dependence and physical harm. Indeed it was much lower than alcohol, a drug that is legally sold and widely consumed.

9. Over the years since the prohibition of “Indian hemp” or cannabis in the 1925 Geneva Convention when "it was virtually unheard of as such in Australia" (Manderson 1993, pp. 71 – 72) that demonisation has increased because of the increasing number of findings by research bodies that reported only adverse consequences visited by cannabis consumption. It has usually been the case that research funding has been provided for those studies that add to the weight of demonisation. Rarely has funding in Australia been given to research that runs the risk of challenging the stated position that the use of cannabis is dangerous. Indeed, the prohibition laws and the consequential propaganda have prevented research into the beneficial aspects of cannabis and have limited its use for medical purposes.

10. There is however ample anecdotal evidence in Australia of people suffering from terminal or chronic illnesses from the use of cannabis and there is sufficient overseas research from countries not afraid to examine the benefits of cannabis.

11. For example, Mather and his colleagues wrote in the *Medical Journal of Australia* on 16 December 2013 (p. 759):

> A German medical review found a preponderance of favourable controlled trials for treatment of a range of conditions including spasticity resulting from disseminated sclerosis (nine favourable, three unfavourable), chemotherapy induced nausea and vomiting (40 favourable, one unfavourable), HIV/AIDS-related cachexia (seven favourable, none unfavourable), cancer-related cachexia (three favourable, one unfavourable), chronic neuropathic pain (12 favourable, two unfavourable) and other chronic (cancer, rheumatism, fibro- myalgia) pain (11 favourable, two unfavourable).

12. Additionally the NSW Legislative Council General Purpose Standing Committee No. 4 reported on 15 May 2013:

> "The Committee considers that in general terms medical cannabis has potential as an effective treatment for some medical conditions with appropriate safeguards in place. Our reading of the evidence gathered during the inquiry – including rigorous scientific evidence – is that cannabis products are emerging as a promising area of medicine, most notably in respect of a number of painful conditions that do not respond to existing treatments. Given this evidence, a compassionate approach' is appropriate here."

The merits of making cannabis available for medical purposes is distinct from the extent to which recreational use of the drug should be legalised

The medical use of cannabis is permitted by the multilateral drug treaties

13. The provision of cannabis for medical purposes is consistent with Australia's international obligations. In the words of the President of the International Narcotics Control Board (INCB) that administers the drug treaties: " Medical cannabis schemes are permitted under specific conditions outlined in the 1961 Convention . . . "(INCB 2013). The core obligation of the Single Convention on Narcotic Drugs of 1961 is "to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession" of the drugs in question (art. 4). It is thus quite clear that "production, manufacture, export, import, distribution of, trade in, use and possession" of them for medical purposes is permitted.

Required regulation of medical cannabis.

14. Article 28 of the Single Convention specifies that if a state permits the cultivation of cannabis it must apply "the system of controls as provided in Article 23 respecting the control of the opium poppy." It is in this area of regulation that he INCB has expressed concern. To quote its President again:

> ". . . medical cannabis programmes must be implemented in full compliance with the provisions of the 1961 Convention. INCB calls on the Governments of all countries where medical cannabis schemes are in place to take the necessary steps to ensure that these programmes are regulated in full compliance with the convention, and to adopt measures to reduce the risk of diversion of cannabis administered under these programmes."(INCB 2013).

15. The combined effect of Articles 28 and 23 of the Single Convention requires parties to establish "one or more government agencies" to control cannabis production. The existing Australian model for this are the arrangements made to regulate the Tasmanian opium poppy

industry. A Poppy Advisory and Control Board is established under the Tasmanian *Poisons Act* 1971 "to oversee and manage the poppy industry in Tasmania, including providing advice to the Minister on any matter relating to the poppy industry" (Tasmania 2012).

16. Section 59H of the Tasmanian *Poisons Act* specifies that the Board consists of a nominee of the relevant Tasmanian Minister, the secretary of the Department administering *the Public Health Act*, the secretary of the department responsible for agriculture and finally, "a person nominated by the Secretary of the responsible Commonwealth department in relation to the grant of licences to manufacture drugs under Part II of the *Narcotic Drugs Act* 1967 of the Commonwealth". Ultimate responsibility for the industry rests with the Minister: "the Board's role is advisory only and the final determination on licence applications is made by the Minister, and may include broad public interest considerations" (Tasmania 2012).

17. Licences to grow poppies in Tasmania have been issued annually since 1966. The industry, involving the cultivation of opium poppy and processing the opiate alkaloids from the dry capsules of the mature plant, has grown rapidly and presently supplies around a half of the world's licit opiates.

Role of the Commonwealth

18. The Commonwealth is responsible for ensuring that Australia lives up to its international obligations and thus will have a role in any scheme to make cannabis available for medical purposes to ensure that the scheme complies with the requirements of the Single Convention on Narcotic Drugs. In this connection, the International Narcotics Control Board has found fault with the regulatory system for medical marijuana or cannabis schemes in the United States. In this context it has commented that some schemes:

> " . . . pose a challenge in some countries. If medical cannabis schemes are not adequately regulated, they can contribute to increasing levels of cannabis abuse, such as in some states of the United States of America. Evidence suggests that, in some jurisdictions, registered 'patients' do not present medical histories that warrant such prescribing or dispensing. Such a situation could be considered as a step towards the legalization of cannabis for recreational use by proponents of initiatives to legalize the possession of drugs for non medical or not scientific use. To put it plainly, if such "medical" schemes are not well managed and supervised (as requested by the 1961 Convention) they could be seen as 'back-door legalization' for recreational use. Gravely, if medical cannabis schemes are not adequately regulated, they can contribute to increasing levels of cannabis abuse.

Alternative supply arrangements for medicinal cannabis

19. Practical difficulties discussed below in the way of patients cultivating their own supply of cannabis point to the desirability of making arrangements for access to a centrally cultivated source of the substance. Mather and his colleagues point out that cannabis medication needs to be reliable: "Dose titration by patients requires a reliable medication and mode of administration. As patients differ in their symptoms and response . . . "(Mather *et al* 2013, p. 760)

Homegrown by patients

20. A theoretical option is for patients or their carers to be permitted to grow their own cannabis plants. This is probably impractical for many users in need of the relief that cannabis can bring. Prof Mather and his colleagues report that "Patient satisfaction from legal selfsourced supplies of home-grown cannabis in Canada was reported as 'poor'" (Mather *et al* 2013). Cultivating cannabis requires some skill and patience. The plant does not reach maturity for about 5 to 6 months. In Pauline Reilly's account of the struggle that she and her dying husband had to access the cannabis that made his last days bearable and worth living were two cannabis plants that she managed to coax into life from seeds. They came to maturity months after her Arthur had died. This was in coastal Victoria, a much more benign climate than sub zero Canberra. Such considerations render impracticable the cumbersome licensing requirements in division 2.3 of the exposure draft and the fact that under s. 21 a *cannabis cultivation licence* may be granted for only a year at a time.

21. The practical obstacles to patients or their carers growing their own plants can be summarised as follows:

- The supply of cannabis may not be ready when it is needed.
- The Canberra climate during winter poses particular difficulties in terms of cultivation.
- It requires gardening skills that those in need of the plant may not have;
- it will be difficult for home cultivators to source the strain of cannabis with the balance of active ingredients optimal for the condition of the patient.

22. The conclusion to be drawn from these considerations is that the ACT should adopt a system that permits access to cannabis from a centralised source while at the same time removing penalties from those who have managed to cultivate their own supply for their medical needs. As Prof. Mather and his colleagues note, "Quality control is imperative." Pauline Reilly attests to the importance of a reliable supply of cannabis of known quality: of her husband's last days she describes him alternating between hallucinations and sleepiness: this is "the curse of not having proper control of the medication. If there were proper clinical studies for the controlled use of the natural material, I would not be in this constant state of trying to balance his pain against somnolence." She adds philosophically that "As the pain and nausea are under control, which is the whole purpose of using cannabis, the occasional hiccup probably does not matter" (Reilly 2001 p. 88).

Centralised cultivation in the ACT

23. Were the ACT to consider establishing a regulated supply of cannabis from plants cultivated in the ACT, the Tasmanian administrative arrangements would be directly applicable. They provide for the regulation of poppy cultivation and the harvesting and processing of it. The disadvantage of this course would be the fairly onerous administrative burden.

Centralised cultivation somewhere in Australia

24. Given that a number of Australian jurisdictions are considering permitting the medicinal use of cannabis, efficiency would be promoted by agreement that one jurisdiction be designated as the

source of supply in Australia. In this way the significant costs of selective breeding of appropriate strains of the plant could be shared between jurisdictions. Effectively this was done in the context of the cultivation of poppy straw in Tasmania: " . . . in 1972 the Commonwealth and State Governments agreed to restrict production of poppies to Tasmania for reasons of security" (Tasmania 2009).

25. The Netherlands provides a similar national model for cannabis:

> The Netherlands Ministry of Health, Welfare and Sport procures medicinal grade cannabis from an authorised agricultural company that cultivates the plant in compliance with current European standards and is subject to strict quality control. It is dispensed by a qualified pharmacist in its raw botanical form (milled vegetable matter) by prescription. Patient information includes instructions for use with a vaporiser or preparation as a tea. A short video illustrates the entire process." (Mather et al 2013, p. 760).

Importation of medicinal Cannabis from overseas

26. Mather and colleagues suggest that to assure quality, "medicinal cannabis for local use could be purchased through official channels, perhaps initially from overseas" (Mather et al 2013 p. 760). Licensing requirements for the importation and manufacture of poppy materials and products are imposed by Commonwealth law under the *Narcotic Drugs Act* 1967 (for manufacturing and wholesale dealing) and the *Customs (Prohibited Imports) Regulations* 1956 (for Importation). These requirements must be met before importation or manufacturing can occur (Tasmania 2012)

Public support

27. FFDLR notes that 69 per cent of people in a recent Australian Institute of Health and Welfare survey indicated that they support legislation to allow medical use of cannabis, matched with 74 per cent of participants showing support for clinical trials investigating the benefits of cannabis for medical conditions.

Civil disobedience

28. Despite the laws, people do use cannabis for relief of pain and suffering. This is an act of civil disobedience conducted on a grander scale than governments and law enforcement would admit. People will continue to do this and government and this committee would be well advised to progress this bill so that already suffering citizens are not subjected to further trauma that could be inflicted by arrest and prosecution. These legal considerations form additional, inhumane stress factors for those already under enormous stress.

Sufficient evidence

29. On balance, there is sufficient clinical evidence from Australia and overseas and research evidence from overseas to say that this form of treatment under supervision from the patient's doctor as provided for in the exposure draft, should be allowed. In the cases initially provided for in the legislation there can only be benefits flowing to the patient. For those with terminal conditions there will be no long term consequence but only relief from nausea and pain. For those with chronic conditions provided the patient is made fully aware of the consequences and the patient makes a conscious decision in favour, there should be no argument against the use of cannabis.

Undesirable side effects

30. In comparison with other drugs, various surveys have placed cannabis at the lowest level for undesirable side effects (Room *et al.* 2010 p. 41) Even so, Emeritus Professor Laurence Mather of the University of the Sydney has acknowledged that cannabis can have unwanted as well as wanted effects but urged that patients themselves should decide "what dose gives the best balance between wanted and unwanted effects" (Mather et al 2013). That a drug has undesirable side effects is common. Prof Peter Gotzsche, a co-founder of the Cochrane collaboration, the world's foremost body assessing medical evidence, has raised the alarm about the significant mortal danger of using prescribed medications: "he estimates about 100,000 people in the United States alone die each year from the side-effects of correctly used drugs" (Corderoy 2015). His comments related to "many of our most commonly used drugs, from painkillers to antidepressants." In contrast there are no recorded deaths from cannabis poisoning "it is physically impossible to eat enough marijuana to induce death"(Reilly 2001 p. 39 and similarly Room *et al.* 2010 pp. 40 – and 42) .The unwanted side-effects attributed to cannabis use for many patients are trivial. Pauline Reilly who at 82 baked cannabis cookies for her husband dying of prostate cancer, wryly observed of a couple of recognised side-effects, namely loss of short-term memory and lethargy: "ask any older person about short-term memory loss and lethargy, both [are] extremely common occurrences":

> "It is true that the use of marijuana carries with it loss of short-term memory, alteration of heart rates, impaired judgement and motor skills, and the possibility of anxiety, paranoia and lethargy. (Ask any older person about short-term memory loss and lethargy, both extremely common occurrences.) Some old patients will withdraw from use of THC, disliking the "high" necessary to achieve the results. Sometimes this has meant discontinuing other therapy, (for example, radiation therapy and chemotherapy). Better patient preparation and better control of those could avoid his rejection" (Reilly 2001 p. 39).

31. What is more, the World Health Organization concluded in a suppressed report "not only that the amount of dope smoked worldwide does less harm to public health than drink and cigarettes, but that the same is likely to hold true even if people consumed dope on the same scale as these legal substances" (Concar 1998 p. 4) and similar conclusions of several surveys in Room *et al.* 2010 pp. 40-43).

32. Pauline Reilly summed up the relevance of side-effects perfectly when she asked: "Who could truthfully object to a terminally ill man recovering some quality of life from the use of forbidden fruit? And if he does become addicted what does it matter? Anything is better than his previous twilight state of physical and mental pain"(Reilly 2001 p. 20).

No evidence of increased recreational use

33. There is little or no evidence to suggest that the passage of this bill into law will cause an increase in personal use of cannabis for recreational purposes. An analysis of three waves of telephone survey data investigating the impact in California of *the Compassionate Use Act* compared attitudes and use rates among 16 to 25-year-olds in selected communities in California and 10 controls states. "They concluded that medical marijuana policy had little impact on youth and young adult marijuana-related attitudes and use in the selected communities in California and beyond" (Room *et al.* 2010 p. 125). At worst the statistics of such illegal use would remain the same but more likely it would reduce because medical use would no longer be considered illegal.

The urgency

34. There is a degree of urgency in allowing medicinal use of cannabis. We are a compassionate society and if the use of cannabis can relieve suffering immediately then it should be allowed. Indeed, I understand that in a number of States of the USA where cannabis is permitted for medical use, cannabis is shown to have provided more relief and had milder side effects than stronger analgesics and that the utilisation of those stronger analgesics (generally opiates) has declined. The experience of Arthur Reilly narrated by his wife Pauline explains why:

> "The prostate cancer has spread into his pelvis, the most painful condition. The growing cancer cannot expand the bone, putting pressure on the nerves,. Morphine supplied by prescription in large quantities, is the conventional drug for relief of pain in cancer. But it makes Arthur stupidly lethargic, kills his appetite, and induces constant nausea. Nausea suppressants prove useless. Another of the evil effects of morphine is either stubborn constipation or violent, uncontrollable diarrhoea; the two are never in equilibrium" (Reilly 2001, p. 11)

During a recent stay in hospital I made friends with a man who had unsuccessful surgery for an aggressive bowel cancer. He was in the terminal stages and nursing staff had some difficulty balancing his pain medication. On one occasion the interaction of this medication was so severe that he awoke not knowing where he was, not knowing who he was, not recognising anyone and he panicked and asked for priest to give him the last rites. It seems to me that his was a case for which medical cannabis could have helped. It could have reduced the need for such a combination of powerful opioids and could have prevented such a confused state. This man said that he was not afraid of dying but did not want the pain nor the adverse reactions of the current medication.

Support for removal of criminal sanctions for medical use

35. FFDLR supports the provisions in Division 2.2 of the draft bill. These provisions appear to be adequate for the initial stages of the introduction of the legislation. In the longer term other conditions will need to be included and their inclusion by way of regulation would be suitable.

36. Currently the use of cannabis for any purpose is a criminal offence and there is no doubt that there would in the future be people using cannabis for medical purposes who have not sought permission under this legislation. There is little benefit to the person or the government by prosecuting those people. There would be benefit in providing in the bill a provision of a defence from arrest for those possessing cannabis for personal medical use and similarly a defence for the carer of a person who uses for medical purposes.

Support for supply to person using medicinally

37. FFDLR supports the initial provisions in the bill for cultivating cannabis for medical use however supply of the drug can be problematic, particularly for the elderly or those who would use a

variety of cannabis that had a different combination of THC and CBD. The bill allows growing of plants for personal medical use however this can be problematic for a number of reasons:

- inability to cultivate the plant
- insufficient space for growing eg flat or apartment dwellers
- inability to grow a constant supply given the ACT's climate
- inability to source seeds or plant stock
- unsuitable supply sourced from the black market
- inconsistent quality and purity

38. The solution to these problems may be overcome by the bill's provisions for an agent to cultivate on behalf of the user. However a situation can arise whereby a person on compassionate grounds supplies cannabis without (for whatever reason) formal approval. A suitable defence at law should be provided for in the bill.

Support for further research and development of medicine - provided cost not prohibitive

39. There is no doubt that further research will be needed in the development of cannabis or its derivatives as a medicine. FFDLR believes that the medical use of cannabis should be carefully monitored not just from the point of view of the patient but to contribute to research and development. It is vital though that the quest for evidential certainty should not be used as a pretence for further delaying access to relief that is already well attested. In other words, research and development should not be an excuse for delaying cannabis use medicinally in its present form and the outcome of that research and development should not result in prohibitive costs for the patient.

B McConnell

President

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