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Chair
Standing Committee on Health, Ageing, Community and Social Services
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Submission on inquiry into the Exposure Draft of the *Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014* and related discussion paper

Dear Chair and Committee Members

Thank you for the opportunity to comment on the issue of medicinal cannabis.

The Committee is of course already considering the draft legislation and the accompanying discussion paper that I presented to the Assembly last year. However I appreciate this opportunity to provide some further comments, particularly as there have been several recent developments in Australia on the issue of medicinal cannabis.

I make this submission in my capacity as a Greens member of the ACT Legislative Assembly. I am aware that the ACT Government is also making a submission to the Committee. I wish to clarify that the Government submission is made on behalf of the Government's Labor Party members and not on my behalf.

I am confident that the Committee will receive ample information from well qualified contributors on key matters, such as: the scientific evidence supporting the beneficial role cannabis can play in helping people with serious medical conditions; schemes from around the world where Governments have successfully facilitated the provision of medicinal cannabis; and evidence from chronically or terminally ill members of the community who have been assisted by the use of medicinal cannabis when standard medicines have not been helpful or tolerable.

I won't reiterate these matters. Indeed, the Committee can already see this evidence presented in some detail in the NSW Parliament's General Purpose Standing Committee report on the use of cannabis for medical purposes.[1] They are also referenced in my discussion paper.

[1] http://www.parliament.nsw.gov.au/prod/parlment/committee.nsf/0/FDB7842246A5AB71CA257B6C0002F09B

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Rather I would like to emphasise the following key points to the Committee, which I believe are important considerations in addition to my draft legislation and discussion paper.

1. Additional context to the approach taken in my draft bill

Much of the discussion about the bill I have proposed has focused on its perceived imperfections.

A threshold question for the Committee and decision makers is: what level of imperfection is tolerable in exchange for allowing sick and dying people access to a treatment that can assist and help relieve suffering?

In the Australian and ACT context there is a danger that imagining an ideal scheme - eg one with formal government supply of a consistent medical grade cannabis, or one where a perfect 'pharmaceutical' product is developed and prescribed to patients – stymies any other type of beneficial action. In reality, there are several barriers to moving straight to a fully functioning and ideal model of regulation and government supply.

Waiting for the completion of clinical trials, for a process approved through the Therapeutic Goods Administration (TGA), or for an external solution to the supply issue is likely to take many years. There is also a good chance that there will be no action on medicinal cannabis; that there will not be appropriate cooperation or efforts across the various jurisdictions. This has been the history so far in Australia and it has already left us many years behind other countries, which now have well developed schemes to allow people to access medicinal cannabis.

The question remains: what action do we take while waiting for the completion of clinical trials, or for TGA approved drugs, or for a coordinated model of government supply?

The right action for the ACT Legislative Assembly to take - presuming it agrees in principle that people in genuine need should be able to access cannabis to alleviate their suffering - is to move quickly to establish a local regulatory scheme which allows those in need to access cannabis as a treatment. This should occur even as the NSW medical cannabis trials proceed, and even if the ACT was confident that the Federal Government will establish a Federal office to regulate and supply medicinal cannabis.

My view, as reflected in my draft bill, is that we can quickly move to a relatively basic system that permits those in most need to access cannabis as a treatment, and removes the criminal stigma associated with this. This is a pragmatic proposal that should be considered a stepping stone towards a more sophisticated and ideal model. Once the basic scheme is in place we can, over time, improve the scheme as required, and adapt to any evolving circumstances.

If a formal model of quality cannabis supply is developed, for example, it can supersede the basic scheme I have proposed. Such a process occurred in Canada. Canada initially established a scheme based around small individual growers. It has recently refined the system so that large, quality controlled operations produce medicinal cannabis for the Government on contract, superseding the original scheme.

There is no suggestion that the scheme I have proposed is the ultimate and ideal scheme. It is, however, a pragmatic one that can be implemented now without deferring to other uncertain processes outside of the ACT's control. For these reasons the legislation also has a built in review mechanism, designed to engage stakeholders again after three years to refine the scheme and review its successes or failures.

Within this context, I support the Committee examining the ideal form that a medicinal cannabis scheme could take. But I urge it to recommend the ACT Legislative Assembly still takes immediate action and implements an interim solution, which will assist the ill people who need access to medicinal cannabis now. This is the scheme I have proposed in my draft legislation.

2. Risk of delay / inaction

To expand on the point made above - that Governments in Australia have delayed action on facilitating access to medicinal cannabis - I draw the Committee's attention to a report tabled by the ACT Government in 2005. The "Report on the Medicinal Use of Cannabis" was produced in response to a primate members bill from 2004, which sought to allow access to medicinal cannabis in a way that is very similar to my draft bill.[2] The Government did not support that bill, instead committing to examining the issue of medicinal cannabis further.

The resulting report outlined options that the ACT could take to improve access to cannabis for medicinal use. These options included:

- Establishing a medical cannabis program in the ACT to include cultivation and/or supply of cannabis. The report noted that for cannabis to be supplied in the ACT, application would need to be made to the TGA to exempt the importation and supply from restriction and that approval would be unlikely in the absence of a medical or scientific trial.

- Exempting from criminal prosecution eligible persons possessing small quantities for medicinal use and/or growing a limited number of cannabis plants.

[2] Drugs of Dependence (Cannabis for Medical Conditions) Amendment Bill 2004, presented by Ms Kerry Tucker MLA, http://www.legislation.act.gov.au/b/db_12909/default.asp

My understanding is that in the decade since this report, the ACT did not pursue an exemption from the TGA, and it did not exempt eligible persons from prosecution for possessing or growing a small amount of cannabis for medicinal use.

The Committee might also note that in response to significant public pressure, the NSW Government announced in 2003 that it would establish a four year trial of a scheme to make medicinal cannabis available. In 2004, the NSW Government then announced it was no longer pursuing the scheme, because of the lack of a preferred delivery method (a metered dose inhaler or spray) and because the Government opposed any means that allowed growing in backyards.[3]

There remains a risk that these delays will continue today; that the ACT Government and other jurisdictions will identify imperfections and barriers – such as the lack of TGA approved medicinal cannabis products – and this will become the reason not to act. This would be an unsatisfactory outcome for the community, just as it was 10 years ago.

Clinical trials

The NSW clinical trials also have the potential to delay access to cannabis for people in need. The fact that trials are expected to occur should not be a reason to delay implementing the measures proposed in my bill.

It is important for the Committee to note that the clinical trials proposed by NSW are not expected to commence until 2016.[4] The trials relating to children with severe, drug-resistant epilepsy are expected to last 2-5 years.[5] Trials involving adults are also expected to take several years. This means that results of the trials are unlikely to be available before 2020.

To be clear, I support the clinical trials taking place and I agree that it is useful to gain further, robust clinical evidence about medicinal cannabis. But, the commitment to clinical trials is no solution to the immediate problem we face: that people with terminal or debilitating illnesses need access to cannabis as a treatment now. The trials occurring should not be a reason to delay immediate sensible action that can occur in parallel. As I have emphasised, the ACT could and should enact the relatively simple scheme I have proposed even as clinical trials occur.

[3] NSW Parliamentary Research Service, *Issues Backgrounder: Medical Cannabis*, June 2014 http://www.parliament.nsw.gov.au/prod/parlment/publications.nsf/key/Medicalcannabis/$File/Medical+cannabis,+Issues+Backgrounder+June+2014.pdf

[4] NSW Government Health, Clinical Trials: Medical Use Of Cannabis http://www.health.nsw.gov.au/cannabis/Documents/fs-cannabis-trials.pdf

[5] Ibid

On a related note, I encourage the Committee to look at evidence that is already available about the benefits of medicinal cannabis to certain people with certain illnesses. Even as further trials are conducted, the existing evidence is sufficient to support a carefully controlled scheme that allows those in genuine need to access to medicinal cannabis now.

As an example: several significant inquiries have already reviewed the evidence for medicinal cannabis – including inquiries by the UK House of Lords Science and Technology Committee, the American Institute of Medicine, and two NSW committees – and all have supported its use for several conditions. A recent German medical review[6], cited in the Medical Journal of Australia, assessed the controlled trials that had already been conducted around the world and found the majority were favourable. The positive results related to conditions including:

- chemotherapy-induced nausea and vomiting (40 favourable trials, one unfavourable);
- HIV/AIDS-related cachexia (seven favourable trials, none unfavourable);
- chronic neuropathic pain such as cancer, rheumatism and fibromyalgia (11 favourable trials, 2 unfavourable).

3. "Untraditional" medicine.

An issue that is sometimes raised in opposition to the use of medicinal cannabis is that cannabis has not been formally approved as a medicine via the TGA. Related to this are concerns from the medical community that they will be prescribing or recommending a treatment of an unknown quality and dosage.

While these are legitimate concerns, I believe they need to be put in a broader context. Medicinal cannabis, in the scheme I have proposed, should not be thought of as a conventional medicine. Doctors are not expected to prescribe or even recommend taking the medicine. The scheme should be considered more as an amnesty from criminal laws for genuinely ill people using cannabis, with a doctor providing supporting validation that the person's illness is legitimate and that they have tried conventional medications.

It would not usually be the case that the Government would support a process outside of the TGA, or that doctors would participate in this unconventional form of patient care. However, this is a specific and unique situation where for various reasons the conventional medical system has not been able to meet patients' needs. The scheme will be highly regulated and will only involve people who are terminally or seriously ill and who have tried conventional medicines.

[6] Grotenhermen F, Müller-Vahl K. The therapeutic potential of cannabis and cannabinoids. *Dtsch Arztebl Int* 2012; 109: 495-501 cited in Laurence E Mather et al, *Medical Journal of Australia* 2013; 199 (11): 759-761 (https://www.mja.com.au/system/files/issues/199_11_161213/mat10728_fm.pdf)

Any medicinal cannabis scheme should also be accompanied by a comprehensive education campaign that involves the medical community and the broader community. It can clearly address any perception that the Government or clinicians are endorsing the use of cannabis more broadly. The Committee might also note that this education campaign could contain clear advice about the harmful effects of consuming cannabis by smoking, and the alternative options available such as vaporisation.

The Netherlands' Office for Medicinal Cannabis provides some examples of guidance information that can be provided for health care professionals[7], as well as public information on vaporisers/inhalers.[8] This type of Government-endorsed guideline should be helpful and reassuring to health care professionals who may be unsure about their obligations or require further information on medicinal cannabis. The Netherlands' guidelines, for example, contain detailed information on medicinal cannabis including pharmacological properties, methods of administration, and recommended dosage information.[9]

If there is any concern that clinicians could be liable in any way for their role in providing a declaration in support of a patient's application, an amendment could be added to the bill to explicitly provide them with an indemnity. The Committee can see examples in other jurisdictions; for example California's Proposition 215 ("The Compassionate Use Act of 1996") provides protection to doctors recommending or approving the medicinal use of cannabis by a patient from any state criminal or civil liability.[10] Indemnity could also be provided to carers under the scheme. It should be noted that my proposed ACT scheme is different to the Californian scheme, in that doctors would provide supporting documentation only and the ACT Chief Health Officer would ultimately makes the decision to approve a patient's use of medicinal cannabis.

4. Supply and production issue

The issue of supplying cannabis for medicinal use remains a challenge. The ideal outcome is that patients are able to access a consistent and 'pharmaceutical grade' of cannabis for medicinal use. This is unfortunately not available.

To ensure it has at least exhausted all avenues in pursuit of assisting ill people in need, 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 from a country that produces consistent and pharmaceutical-grade cannabis, and allow it to supply it for medical purposes.

[7] http://www.cannabisbureau.nl/en/doc/pdf/Information%20for%20Health%20Care%20Professionals%20(version%20October%202013)_18980.pdf
[8] http://www.cannabisbureau.nl/en/MedicinalCannabis/Doctorsandpharmacists/Vaporisers/
[9] http://www.cannabisbureau.nl/en/doc/pdf/Information%20for%20Health%20Care%20Professionals%20(version%20October%202013)_18980.pdf
[10] http://www.cdph.ca.gov/programs/MMP/Pages/CompassionateUseact.aspx

The Netherlands is one country that operates a Medicinal Cannabis Office and could supply cannabis. It has monopoly control over the production of cannabis, guarantees a consistent product, and oversees a controlled scheme for the product's export for medical and scientific use.

The ACT should also explore its potential for licensing and locating legitimate businesses that produce cannabis for scientific and medical purposes. Australian companies are already seeking to establish these businesses in Australia but have encountered regulatory difficulties and a lack of support from Governments. The ACT Government should explore the benefits that these businesses could bring to our jurisdiction, as well as the safeguards and conditions that would be necessary to ensure they operate safely and appropriately. The Government can look to Tasmania's poppy industry for a comparison. Tasmania's poppy industry is now worth $120 million a year to farmers.[11]

Businesses producing pharmaceutical grade cannabis for medical or scientific purposes would currently find their business outside of Australia. However, in the future, as the use of medicinal cannabis potentially becomes supported in Australia, the businesses would be well placed to supply a need in Australia. By supporting these businesses, the ACT would be well placed economically, as well as well placed to source medicinal cannabis for its own scheme.

5. Alternative options

Lastly, although I believe that the approach I have proposed is workable, pragmatic and appropriate – and is necessary if we are take a suitable compassionate approach to ill people in need - I acknowledge that the Committee or Government may choose not to support it. In this case I urge them to at least endorse an amended version of the scheme. This would be a pragmatic approach that at least will still provide a positive outcome to people who need it, and will at least be a starting point for medicinal cannabis reform.

If the Committee does not support the scheme as proposed, it may consider one or a combination of the following alterations more palatable:

a) Sunset clause

The scheme could be implemented as proposed but could be amended to include a sunset clause. The scheme would automatically expire after, say, 3 years of operation. The scheme would not continue unless the Assembly again considered the matter and passed legislation. This would allow for the scheme to operate as a trial with a clear mechanism for wrapping it up if problematic issues emerge.

[11] Fiona Breen, "Tasmania vows to fight to keep poppy monopoly as other states look to cash in", Landline, http://www.abc.net.au/news/2014-02-22/tasmania-vows-to-fight-to-keep-poppy-monopoly/5273638

b) Terminally ill patients only

The scheme I have proposed sets out three categories of potential patients who could access medicinal cannabis, including people with terminal illnesses, people with specified chronic illnesses, and people with other illnesses.

If the Committee has concerns about an expansive scheme, it could support a scheme that only allows patients with a terminal illness to access medicinal cannabis.

c) Amnesty from prosecution only, with no license to grow

The Committee may support a scheme that provides genuine patients with some form of indemnity from prosecution for cannabis possession, but does not allow them to grow cannabis. Such a scheme would leave patients to source cannabis themselves – as many currently do – but would ensure police do not charge them with relevant offences (though they would still be liable for offences such as supplying cannabis to others).

This could be supported by an approval process equivalent to the one already proposed in my bill. For easy administration, eligible patients could be entered on a register and hold an identity card that they could show to police if questioned.

Although I support a more comprehensive scheme and believe that a simple amnesty from prosecution does not go far enough, I recommend that the Committee support such a change in the very least.

Sincerely,

Shane Rattenbury MLA
ACT Greens Member for Molonglo

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