Submission to the ACT Legislative Assembly Standing Committee on Health, Community and Social Services

Request for the Liberation of Ganja under an alternative model to that proposed in the exposure draft of the Drugs of Dependence (Cannabis Use for Medical Purposes) Amendment Bill 2014 and related discussion paper

[redacted]

26/06/2015

Dear Honourable Members of the Committee,

I respectfully submit this document to the committee for your consideration, despite the submissions period having expired.

Cannabis (ganja) has been an integral part of my lifestyle, academic focus, and mental health management for the past 7-8years. The legalisation movement thus far has seen a failure of science to overcome an entrenched system of injustice and ignorance/scientific illiteracy. I met with one of your members this week, after recently becoming aware of the bill proposed by Mr Rattenbury. Therefore, I do not think it is necessary to provide the committee with any further studies or peer-reviewed scientific literature in support of the legalisation and utilisation of cannabis – I am aware that the case has already been presented to you by others. Suffice to say that the weight of scientific evidence validates the use of cannabis as a pharmaceutical drug, and given worldwide current trends, and the historical/ethnocultural uses of the herb I you to consider my alternative legalisation proposal.

I believe it is unethical to continue the prohibitionist restriction of the availability of cannabis and I will outline my personal story – as it is a convincing example of how the current legislative, judicial and medical attitude towards ganja is more harmful than the substance itself. The private details of my life play second fiddle to the systemic injustices – which have been a terrible impost on me. Then, I will address some of the possible issues with legalisation that were raised in the 9th April Committee meeting transcript, and finally outline a 5 year plan – focusing on education and gaining public support for changes before expansion of any cannabis use.

I enjoy many benefits from my ganja use, the most important being mood stability and anxiolysis (relaxation) on the background of my bipolar condition. Some strains of cannabis I have used in the past have contributed to my anxiety or mood instability, and impaired my executive judgement. Currently, I have access to a cannabis strain with a better tailored phytocannabinoid profile. This is interacting very therapeutically with my underlying mental health condition, and my psychiatrist has no concerns with my ongoing consumption of ganja. Ganja is now recognised as a medical/pharmaceutical substance, but through time and across many cultures, it has been a culinary herb with no known toxic dose to man, and many medical/social/religious applications. It has a positive impact on my mental health (which is why I choose to break the law) and I use ganja in varying doses as required. I modulate my intake, and include periods of abstinence from the drug when buildup and negative side-effects become prominent. This is because I approach it with a medical, rather than thrill seeking attitude. Ganja is a far less harmful substance than the medically prescribed psychotropic medicine I was on previously, and the side effects/health complications I have developed as a result of taking my prescribed psychiatric medicines have been debilitating and in some cases will stay with me for the rest of my life. The side effects of ganja consumption have usually involved me relaxing, laughing, eating, enjoying the company of friends or nature/entertainment and good sleep.

I have drafted this document while under the influence of ganja (about 2-3g of dried cannabis flower/24hrs). I did this intentionally to demonstrate that when managed pharmaceutically, the side effect profile of ganja does not cause sufficient impairment or other negative side effects to warrant its prohibition, given it has so many proven medical applications.

Marijuana and the public

Marijuana has low dependance forming potential in a pharmacological sense, and is certainly less addictive than nicotine, alcohol or caffeine (though it is habit forming/psychologically addictive), and significantly less harmful (on a public health scale) than any of the other currently legal or 'illicit' social and recreational drugs used in society (alcohol, tobacco, amphetamines including ice, cocaine and its derivatives, MDMA and other party drugs, and the other hallucinogenics).

With sufficient public education, and guided by science, pharmaceutically harvestable raw cannabis for medical use or as a social recreational drug, can be produced by the user and there would be no public health harm to the user or community in general. It can be grown by anyone (and is done so freely even under prohibition) - legalisation is not going to result in any significant change in street level availability. Criminality associated with the drug trade and the gateway nature of cannabis as a first illicit drug would be abolished. I hypothesise that at a public health level, alcohol abuse and other illicit drug abuse may actually fall as cannabis use becomes normalised.

Address of some previously expressed concerns of the committee:

Below, I have attempted to help the committee address issues raised in the transcript of the 9th April meeting of the committee.

- Wide spread cannabis consumption will allow an improvement in chronic pain management, and consequently a reduction of prescription opioid drug abuse. Prescription opiate abuse and diversion is a significant cause of drug/medical morbidity.
- 25% of ED presentations over weekend hours involve alcohol (acute injury and violence, intoxication, alcoholic liver failure, mental health). The legalisation of cannabis has NOT caused a spike in acute ED, or overall mental health service utilisation in overseas jurisdictions where it has been permitted. Anecdotally, freely available cannabis may even divert some people away from other illicit drug use. There has been no increase in psychosis presentations or schizophrenia on a population basis following legalisation of cannabis overseas, and no population health level changes have been detected despite the soaring prevalence of cannabis use in some samples. The known adverse reactions from cannabis intoxication (euphoria/giggles, anxiolysis, impaired memory and motor co-ordination, binge eating) are not fatal or life threatening (compare to conventional psychiatric medications with complicated and potentially dangerous adverse interactions). I concede that there is a poor scientific knowledge base from which to speak due to the restrictions on research over the past decades.
- As with alcohol, cannabis can have an adverse effect on the developing brain, and paediatric prescriptions should only be permitted for specific medical indications (Dravet's syndrome, cancer palliation etc), or after case by case clinical/ministerial approval.
- Fatigued driving (24hrs without sleep) is equivalent to driving with a BAC of 0.08 – but is not a prosecutable offence. Cannabis influenced drivers do not have a significantly higher mortality rate – partly because they report, and can objectively be seen, self regulating their driving (slower, more cautious) rather than the aggressive/risk taking driving seen under the influence of other substances. Strict policing of impaired drivers must still be enforced.
- To allay concerns about raw cannabis products: medical use can be restricted to extracts for nasal sprays, use in a vaporiser or for a dabbing rigs etc. These can be assayed and standardised (ordinary compounding pharmacies can easily produce these). When plant material is purified (hash or kief extraction, or solvent/oil/resin extraction) the final product is almost pure active ingredient (and inert carrier) with no carcinogenic, tar or plant material remaining. These methods are accessible to even the home grower. Raw cannabis consumption through edibles removes the harm associated with smoking, and in any case, the tar/carcinogenic nature of cannabis smoke is believed to be less dangerous than that of tobacco. These factors support raw cannabis being the preferred model of access rather than prescription pharmaceutical products.

A final word of perspective, the harm in the recreational drug use sector is increasingly occurring from new amphetamines and amphetamine like derivative party drugs and 'synthetic highs' or 'trips' that mimic cannabis or LSD with tweaked molecular structures to avoid legal detection. There is less control and knowledge of the composition or effects of these largely unknown substances, and deaths have been widely reported. Raw cannabis cannot kill anyone. Prohibition of cannabis currently encourages the proliferation of alternative highs.

5-year Plan and an alternative legalisation model

When politically enacting a social agenda, it is critical to move with the public tide of opinion. This means that an extensive discussion and education campaign targeting not only the public, but also the health, legal and policing sectors is the first logical step. To this end the committee must to prepare a brief of the science, and outline the proposed legalisation model(s) for public discussion and education. A referendum on the legislation process should only occur after public debate has allowed the medical science to overpower the misinformation and myths surrounding cannabis in the public sphere

Immediate legislative or judicial action to decriminalise compassionate medical use of cannabis for palliative care, and specific diagnoses is required. Initially this could be limited to the conditions listed in the terms of reference, and allow scope for clinical research to begin.

Preferably there would be a push for federal legalisation of cannabis nationally, to prevent a situation similar to what has occurred in the US.

The government should commit to establishing a Centre of Excellence covering the medical, scientific, agricultural, permaculture, social, and public health dimensions of cannabis. This institute would,

- have clear research priorities and goals
- work with the various world class scientific, agricultural and educational institutions and expertise present in the nation's capital to further the scientific understanding of cannabis.
- provide pharmaceutical grade cannabis as a cash crop for the ACT (similar to the opium poppy cultivated in Tasmania)
- gather cannabis genetics to establish a cannabis strain library – to ensure a balanced and widely representative sample of cannabis cultivars are available for research and medical use. (Note: cannabis genetically expresses a wide range of phytocannabinoid profiles, the balance between the active cannabinoids, terpenes/terpenoids and other phytopharmaceuticals in each strain affects its therapeutic/recreational potential)

In my proposed final model of availability, a scheme for legal access to cannabis would look like the following:

If a person expresses interest in accessing cannabis, or is recommended by a medical professional to trial its use,

- they must be be assessed by their GP appointment to screen for underlying psychiatric/medical conditions, and referred to
- a government licensed drug education course: covers the positive and negative physical and psychological effects, possible risks and the implications of these, and various methods of consumption.
- first use psychosis could be monitored by having a first sample dose taken under supervision at the conclusion of the course (under the care of trained drug counsellors)
- only after a follow up assessment after a period of weeks should a person be granted a license to purchase or grow their own supply.
- seeds would be available to the licensed public for cultivation by the end user, or grower collectives.

This way the public would have access to world-wide best practise evidence based medicine pertaining to ganja, and an export industry producing pharmaceutical cannabis and knowledge exports could be established, while maintaining public health and safety. The entire industry should be a combined public/private-for-profit venture, with regulation devolved to an independent not-for-profit organisation chartered to monitor the cannabis industry.

The economic argument in favour the proposed model of legalisation is strong. The international cannabis economy is estimated to be valued in the billions of $USD (largely due to prohibition, it is the largest cash crop in many regions of cultivation). My legitimising the industry (similar to US jurisdictions like California, and Washington state and the Netherlands) the profits can be pulled out of the black market and criminal world and taxed. The issue of intellectual property covering patents and gene technology is one that must be addressed if research partnerships are sought – my preference is for the open academic model (rather than IP/patent protection and private profit) to dominate.

Conclusion

If marijuana legalisation does not proceed in this round of discussion in the ACT, I will be emigrating to a jurisdiction that will allow me to pursue my interests and love for this plant.. I will take with me a HECS debt, my skills as a medical clinician, educator and researcher, and my myriad other contributions to society. Nature cannot be made illegal, this plant will continue to grow in backyards and undisclosed outdoor locations, or in hydroponic houses throughout this country regardless of the decision of this committee.The best harm minimisation approach is to educate the public and allow people to exercise some personal responsibility, while ensuring the appropriate medical safety nets are in place (just like we have for alcohol, tobacco and ice addiction).

I am eager to be involved when legislation does proceed, and my goal is to establish a world leading medical cannabis industry and to ensure quality medicines tailored to a person's needs can be provided or grown freely, while minimising harm from drug use. I hope the committee will see these arguments and proposed framework for change in a positive light and will open up community discussion about how to proceed with comprehensive legalisation of cannabis, instead of the model proposed within the Terms of Reference.

Appendices:

Draft talking points for a Memorandum of understanding on Medical Cannabis

Current and historical legislation pertaining to cannabis use (and also the public understanding of, and abuse of cannabis as a recreational illicit substance) has been misinformed.

In light of current medical/scientific knowledge, change must occur to allow the medicinal use of cannabis.

After public consultation this should expand to include recreational use as has successfully been introduced in several overseas jurisdictions.

The committee recognises the untapped medical possibilities, economic and employment opportunities, and scope for academic endeavour that the legalisation of medical cannabis would open up.