

**Submission
No 29**

INQUIRY INTO USE OF CANNABIS FOR MEDICAL PURPOSES

Organisation: Australian Drug Foundation

Name: Mr Geoffrey Munro

Date received: 15/02/2013

The Australian Drug Foundation (ADF) understands there is scientific uncertainty surrounding the use of the cannabinoid delta-9 tetrahydrocannabinol (or THC), including the forms, circumstances and the conditions in which it is efficacious, and that its use can be harmful in the short and long term.

The ADF understands that persons who suffer intense pain or other debilitating conditions, and whose conditions are not be relieved by other means, find relief by absorbing THC in one or another of its forms.

The ADF takes into account the national policy of harm minimisation, which implicitly incorporates 'minimising avoidable suffering', and makes three recommendations to the Inquiry.

Recommendations

- 1) That THC, derived either from the cannabis sativa plant or as a pharmacological product, be available to persons who are suffering intense pain or severe disability as a result of life limiting or debilitating diseases, illnesses or ailments, under strict conditions.
- 2) That trials of Sativex and other pharmaceutical cannabinoid preparations are investigated, monitored and supported.
- 3) That continuing research is conducted into the efficacy and safety of cannabis products for therapeutic purposes.

INQUIRY INTO THE USE OF CANNABIS FOR MEDICAL PURPOSES

New South Wales Legislative Council

February 2013

For further contact:

**John Rogerson,
Chief Executive Officer**

EXECUTIVE SUMMARY

The Australian Drug Foundation (ADF) understands there is scientific uncertainty surrounding the medical or therapeutic use of the cannabinoid delta-9 tetrahydrocannabinol (or THC), including the forms, circumstances and the conditions in which it is efficacious, and that its use can be harmful in the short and long term. The ADF understands that persons who suffer intense pain or other debilitating conditions, and whose conditions are not be relieved by other means, find relief by absorbing THC in one or another of its forms. The ADF takes into account the national policy of harm minimisation, which implicitly incorporates 'minimising avoidable suffering', and makes three recommendations to the Inquiry.

RECOMMENDATIONS

- 1. That THC, derived either from the *cannabis sativa* plant or as a pharmacological product, be made available to persons who are suffering intense pain or severe disability as a result of life limiting or debilitating diseases, illnesses or ailments, under strict conditions.**

Conditions under which cannabis could be prescribed for medical or therapeutic purposes are that:

- a) the patient is certified by a medical specialist, or a physician with specific training in the use of cannabis for medical purposes, as suffering from a disease, illness or ailment that is recognised as likely to be ameliorated by the consumption of THC.
- b) the patient's condition has proved resistant to the more conventional therapies and interventions
- c) the patient remains under the supervision of a medical specialist or physician so that their physical and mental health is monitored so that appropriate action can be taken if THC appears to have an unduly detrimental effect on the individual's quality of life.
- d) the patient agrees to use the THC for their own benefit only and not to transfer it to any other person for any purpose.
- e) the patient is informed and is cognisant of the potential hazards inherent in ingesting cannabis products.
- f) a 'medical cannabis review board' is established to determine the diseases, illnesses and ailments that are most likely to respond to the application of THC. Examples of such conditions are pain or other

debilitating conditions associated with terminal illness, neurological disorders such as multiple sclerosis, muscular dystrophy, nausea and vomiting associated with chemotherapy treatment.

- g) membership of the 'medical cannabis review board' should include representatives of relevant medical specialists and general physicians, research scientists with expertise in pharmacology and drug use, and community representatives.
- h) appropriate legislation is passed that would enable
 - i. individual patients to cultivate, possess or consume cannabis products without legal sanction
 - ii. medical specialists and/or trained physicians to prescribe cannabis for therapeutic purposes
 - iii. the establishment and operation of a medical review board for the purpose outlined in 4.1.2 (f)

2. That trials of Sativex and other pharmaceutical cannabinoid preparations are investigated, monitored and supported.

3. That continuing research is conducted into the efficacy and safety of cannabis products for therapeutic purposes.

CONTENTS

- 1. AUSTRALIAN DRUG FOUNDATION**
- 2. BRIEF OVERVIEW OF USE OF CANNABIS**
- 3. SPECIFIC RESPONSES TO TERMS OF REFERENCE**
 - 3.1 THE EFFICACY AND SAFETY OF CANNABIS FOR MEDICAL PURPOSES;
 - 3.1.1 Risks of cannabis use for medical purpose
 - 3.1.2 Adverse effects of cannabis
 - 3.1.3 Dependency
 - 3.1.4 Vulnerable groups
 - 3.1.5 Manner of administration
 - 3.1.6 Synthetic cannabinoids
 - 3.1.6.1 Sativex
 - 3.2 IF AND HOW CANNABIS SHOULD BE SUPPLIED FOR MEDICAL USE
 - 3.3 LEGAL IMPLICATIONS AND ISSUES CONCERNING THE USE OF CANNABIS FOR MEDICAL PURPOSES
 - 3.3.1 Consistency with International treaties
 - 3.3.2 Potential Iatrogenic Dependency
 - 3.3.3 Other Potential Iatrogenic Harms
 - 3.3.4 Potential drift of criteria for prescribed cannabis
 - 3.4 ANY OTHER RELATED MATTERS.
 - 3.4.1 Personal Testimony provided to the Australian Drug Foundation
- 4. RECOMMENDATIONS**
- 5. REFERENCES**

1. AUSTRALIAN DRUG FOUNDATION

The Australian Drug Foundation (ADF) is a charitable, non-government, not-for-profit organisation and is widely regarded as one of Australia's leading alcohol and other drugs prevention agencies. For over 50 years the ADF has worked with communities to prevent alcohol and other drug problems. Our focus is prevention and early intervention and our strategies include community action, health promotion, education, information, policy, advocacy, and research. Our vision is an Australia that is composed of 'Healthy People, Strong Communities'.

The Australian Drug Foundation is pleased to have the opportunity to address the Terms of Reference for the inquiry by the New South Wales Legislative Council into the use of cannabis for medical purposes; in particular

the efficacy and safety of cannabis for medical purposes;

if and how cannabis should be supplied for medical use;

legal implications and issues concerning the use of cannabis for medical purposes;

And

any other related matters.

2. BRIEF OVERVIEW OF USE OF CANNABIS

Under Australian law the plant *cannabis sativa* is illegal and its cultivation and consumption is prohibited. Nevertheless products of *cannabis sativa* are used by many Australians: one-third (35.4%) of the population aged over 14 years has used cannabis at least once during their lifetime and 10.3% (1.9 million people) used cannabis in 2010 (AIHW, 2011). Use of cannabis has fluctuated in recent decades and, according to the most authoritative national survey, 'annual usage' peaked at 17.9% in 1998 and subsequently declined to 9.1% in 2008 and increased to just over 10% in 2011 (AIHW,2011).

Cannabis users report a number of perceived benefits including: the pleasure derived from an altered state (e.g. euphoria or relaxation); the social benefits of a shared experience; a way to cope with or escape problems experienced in

everyday life; cognitive benefits and enhanced creativity; heightening of ordinary sensory experiences; and therapeutic value for a physical or mental health problem (Room 2008).

Adverse acute effects of cannabis include anxiety, panic, loss of attention and reduced motor coordination skills while negative health effects include risk of cannabis dependence syndrome and long term heavy smokers risk chronic bronchitis, respiratory cancers and cardiovascular disease. People who begin cannabis use in adolescence face higher risks of some psychosocial effects including cannabis dependence, impaired educational attainment and an increased risk of mental health problems (Hall & Degenhardt, 2003; van Ours & Williams, 2009).

While the majority of users of cannabis consume it for pleasure or relaxation, cannabis has been employed as a therapeutic agent in parts of the world since antiquity (NDARC, 2000). Neither herbal cannabis, nor synthetic forms of cannabis (e.g. dronabinol, nabilone) that are available in some countries as therapeutic agents, are approved by the Therapeutic Goods Administration (TGA) for medical purposes in Australia

Cannabis sativa is a complex plant that contains 500 components, including around 80 chemicals known as 'cannabinoids' (NCPIC, 2011). The best known cannabinoid is delta-9 tetrahydrocannabinol (THC) which provides the main psychoactive effect of cannabis and is responsible for the therapeutic effect in reducing pain, nausea and vomiting, and for stimulating appetite (Hall & Degenhardt, 2003). The psychological effect of THC is mediated by the presence of other classes of cannabinoids, one of which is cannabidiols (CBD). CBD appears to be a non-psychoactive element that reduces anxiety and moderates the psychoactive effect of THC. Cannabis plants with lower doses of CBD are more likely to produce acute adverse outcomes such as anxiety (NCPIC, 2011).

In recent decades *cannabis sativa*, and extracts, have been legitimised for medical or therapeutic use in Canada and in sixteen separate jurisdictions in the United States of America (Bostwick, 2012; Swift et al, 2005). In California an estimated 200,000 citizens have received approval from a physician to cultivate a supply or purchase a supply of cannabis from a certified dispensary in order to manage or regulate an illness, condition or ailment (Room et al).

Although the use of cannabis products for medical or therapeutic purposes is not permitted in any jurisdiction in Australia, they are used 'informally' for that purpose by an unknown number of Australians (NDARC, 2000; Swift et al, 2005). A study in NSW in 2005 reported on 127 adults who self-administered cannabis for a range of conditions and ailments such as chronic pain, depression, arthritis, nausea and weight loss, and some of the respondents had continued that use over many years (Swift et al, 2005).

3. SPECIFIC RESPONSES TO TERMS OF REFERENCE

3.1 THE EFFICACY AND SAFETY OF CANNABIS FOR MEDICAL PURPOSES;

The problem in assessing the efficacy and safety of cannabis for medical purposes is the lack of scientific evidence for its value as a medical or therapeutic agent.

Cannabis has been cited in the medical and research literatures as having useful therapeutic potential for a number of conditions including for epilepsy as an anti-convulsant agent); appetite loss; weight loss; pain relief; nausea and vomiting associated with chemotherapy; the wasting syndrome associated with AIDS; and neurological disorders such as muscle spasms or spasticity due to multiple sclerosis (Hall et al 2000; Jaffe and Klein, 2010; Bostwick, 2012). de Vries and Green (2012) state that smoked cannabis and oral THC are equally effective in controlling nausea and vomiting.

An expert Working Party that reported on the prospect for medical cannabis for the government of New South Wales in 2000 noted that whereas pharmaceutical drugs are expected to demonstrate efficacy in animal studies and randomised controlled clinical trials in humans before they are accepted as fit for medical use, the available evidence for cannabis relied instead on 'uncontrolled clinical observation' and anecdotal reports from patients (NDARC, 2000).

The Working Party reported that cannabinoid drugs were therapeutically valuable for relieving pain, nausea and vomiting, in stimulating appetite and treating muscle spasticity, but warned their contribution was modest and other drugs were more effective for those purposes. However in particular cases cannabis based substances could contribute to a therapeutic outcome because some patients whose conditions do not respond to conventional drugs or therapies may find benefit in preparations that provided THC (NDARC, 2000).

Such was the position adopted by the House of Lords Select Committee (SCOST) in the UK that concluded while evidence was lacking which could authoritatively prove or disprove the suitability of 'therapeutic cannabis', sufficient anecdotal evidence existed for its role in alleviating chronic pain associated with neurological conditions such as multiple sclerosis (NDARC, 2000).

3.1.1 Risks of cannabis use for medical purpose

The use of a psychoactive drug for a medical purpose always carries some risk of a complication, adverse side effect or outcome. The risk is mediated by factors including the pharmacological properties of the substance, route of administration, size and regularity of the dose, and the physical and subjective characteristics of the individual.

3.1.2 Adverse effects of cannabis

Injurious acute effects of cannabis include anxiety, panic, loss of attention and reduced motor coordination skills while negative health effects include risk of cannabis dependence syndrome and long term heavy smokers risk chronic bronchitis, respiratory cancers and cardiovascular disease. Adverse psychosocial effects among people who begin cannabis use on adolescence are risk of cannabis dependence, impaired educational attainment and an increased risk of mental health problems (Hall & Degenhardt, 2006; van Ours & Williams, 2009).

3.1.3 Dependency

A cannabis withdrawal syndrome has been identified whose symptoms include craving cannabis, decreased appetite, sleeplessness, restlessness, and anger and aggression (MHCA, 2006) Dependency on cannabis can affect up to 10% of users (NDARC, 2000; Room et al, 2008) although it is less common than dependency on tobacco and alcohol Room et al, 2008). Risk of dependency is identified as a concern by one-fifth (21%) of Australian 'informal' medicinal cannabis consumers (Swift et al, 2005).

3.1.4 Vulnerable groups

Certain subpopulations face a heightened risk of cannabis related problems. They include young people, as the initiation of cannabis use before age of 17 years appears to increase risk of a range of adverse outcomes; people with a pre-existing psychiatric condition or a family history of psychosis, for whom cannabis

use may trigger a psychotic episode; and young people who are subject to conduct disorders (Room et al, 2008). People belonging to those groups are advised to avoid use of cannabis.

3.1.5 Manner of administration

A major problem for the use of cannabis for medicinal purposes is the difficulty in providing a safe and effective route of administration. Recreational and medicinal users of cannabis typically ingest cannabis by smoking it in cigarette-like joints or bongs or water pipes, with or without a mix of tobacco, or orally, after cooking it in foodstuffs (Swift et al, 2005). According to Swift's study of informal medical users of cannabis, smoking was the most common form of administration as nine out of ten (91%) had done so; six out of ten (61%) had mixed cannabis with tobacco; half (49%) had eaten cannabis in cooked food and 8% used a vaporiser (Swift et al, 2005).

Some informal users of cannabis to cope with intense and often enduring pain or for purposes such as control of nausea or vomiting that is a side effect of chemotherapy or for the serious effects of ailments such as multiple sclerosis report that cannabis products, often marijuana, are an effective remedy, and sometimes are the only effective remedy, for their condition (Swift et al, 2005.) Some studies have reported both 'natural' cannabis and synthetic oral THC were superior to placebo in controlling nausea and vomiting caused by chemotherapy and that smoked cannabis was as effective as oral THC (de Vries & Green, 2012). In addition, in the course of developing this statement the ADF was sent a testimony by one individual who outlined her own case for 'medicinal marijuana', which we have included as section 3.4.1 below.

However both smoking and eating illicitly sourced cannabis are fraught as the dose of THC that is ingested in each case cannot be known beforehand, as the potency of the plant and its herbal products (as measured by amount of THC contained in the products) can vary widely (Swift et al, 2005). Another complication is some medical users report dislike the intoxicating effect of cannabis (the euphoric 'high' sought by recreational users) that can occur regardless of manner of administration and can be difficult to predict or control because the concentration of THC, and the CBD that moderates the effects of THC, is unpredictable (Swift et al, 2005).

Each route of administration has its own hazards. Smoking cannabis is harmful to the lungs and upper respiratory system: cannabis contains many of the carcinogenic substances found in the tar of smoked tobacco and the lungs retain to 30% more tar from cannabis smoke than tobacco smoke (Lamarine, 2012). Long term smoking of cannabis is associated with respiratory symptoms indicative of obstructive lung disease, increased risk of various cancers, and of cardiovascular disease due to higher levels of carbon monoxide in the blood (Lamarine, 2012).

While oral ingestion of cannabis avoids aggravating the lungs and respiratory system some medicinal users complain that eating cannabis leads to a slow and inefficient delivery and thus does not always achieve the desired therapeutic effect. By smoking cannabis the individual is often able to titrate the dose more accurately because smoking allows a rapid absorption (de Vries & Green, 2012); however variations in THC levels can mean the achievement of a therapeutic dose by smoking is not guaranteed.

As medical personnel are unlikely to recommend smoking as a form of delivering THC, Hall and Degenhardt suggest there is an imperative is to develop other delivery mechanisms such as sublingual, nasal sprays, deep lung aerosols, and nasal gels. However those authors report there is little incentive for pharmaceutical companies to develop them as the market is small and the financial returns are likely to be uneconomic (Hall and Degenhardt, 2003).

3.1.6 Synthetic cannabinoids

Synthetic cannabinoids that are developed artificially in pharmaceutical laboratories offer access to THC for therapeutic purposes without the risk attendant on smoking herbal cannabis. In the USA, Canada and the UK, Dronabinol is available in the form of capsules or drops to control nausea and vomiting associated with chemotherapy (de Vries & Green, 2012). Nabilone, also a synthetic form of THC is more potent than Dronabinol and has a longer half-life than other forms of THC (de Vries & Green, 2012). However, Dronabinol has serious drawbacks as patients have found difficulty in titrating an effective dose with the oral form of administration (Hall & Degenhardt, 2003).

3.1.6.1 Sativex

Sativex is a synthetic cannabinoid preparation which combines THC with cannabidiol in order to increase its therapeutic potential and decrease its psychoactive capacity. Sativex's efficacy has been tested in several studies with mixed results: one study concluded Sativex was useful in reducing spasticity in multiple sclerosis patients despite some adverse effects, while other studies have reported it performed no better than placebo in controlling pain (Lamarine, 2012). Sativex is approved in Canada and the UK for multiple sclerosis patients for whom other anti-spasticity medication is not effective and it is under consideration in the UK as an alternative to opioids to control cancer related pain (de Vries & Green, 2012; Swift et al 2005). Currently, the delivery of Sativex in the form of an oral spray, to relieve chronic pain in advanced cancer patients, is being evaluated in a pharmaceutical research project in Australia and other countries (Cancer Council, 2012).

3.2 IF AND HOW CANNABIS SHOULD BE SUPPLIED FOR MEDICAL USE

International research evidence suggests THC, either in the natural form of herbal cannabis products or in synthetic form, provides subjective benefit to people who suffer from painful or distressing symptoms of certain diseases, including treatments for certain diseases, and whose symptoms are not relieved by conventional means.

The Australian Drug Foundation believes that it is appropriate for people in that situation to have access to THC should they need it to alleviate painful or distressing chronic symptoms of disease and ill health. This position accords with Popper's view that 'minimizing avoidable suffering' is the starting point for public policy and it is consistent with Australia's national drug policy of harm minimisation (Magee, 1997).

Such a scheme would require a medical specialist to make a determination that a patient met the criteria that they suffered from an illness or condition for which THC may be indicated, that they had not responded positively or did not gain relief from therapies previously applied, and they understood the potential effects and risks attached to use of cannabis.

Designated conditions for which cannabinoids could be made available include life limiting illnesses such as terminal cancer, or other terminal illness; chemotherapy

effects; neurodegenerative disorders such as multiple sclerosis. Patients with such conditions are generally under the supervision of medical specialists who are in a position to monitor the patient and to intervene if the patient's condition should deteriorate unduly as a result of medication.

We note the proposition by Hall and Degenhardt (2003) that until pharmaceutical cannabinoids which have a minimum psychoactive effect are available, patients with a designated medical condition could be exempted from the criminal law to grow cannabis for their own use at their own risk. This is a compassionate policy that would ensure a patient with a debilitating condition could gain a supply of cannabis without coming into contact with the black market and not suffer the fear of arrest or legal sanctions (Swift et al, 2005). However this course requires a person with a serious illness to have the capacities (knowledge, skills, tools and property) to cultivate and prepare their own supply of cannabis. Every such person may not have such capacities. A corollary of the approach would be to allow such a patient to nominate another person in lieu of themselves to cultivate a supply only for the purpose of alleviating the patient's symptomology.

In order to prevent this approach from morphing into a *de facto* legalisation of cannabis, and to thereby prevent a breach of Australia's international treaty obligations, the diversion to other parties of cannabis produced for the use of an individual with a medical dispensation would need to be declared an offence under the requisite legislation.

3.3 LEGAL IMPLICATIONS AND ISSUES CONCERNING THE USE OF CANNABIS FOR MEDICAL PURPOSES

3.3.1 Consistency with International treaties

As a signatory to the 1961 Single Convention on Narcotic Drugs and the 1988 Vienna Convention, Australia is required to prevent the illicit production, trafficking and use of all proscribed narcotic drugs including cannabis.

However the treaty does not preclude Australia, or an Australian jurisdiction, from the medical use of cannabis. A signatory to the Convention retains the right to produce, distribute and supply a narcotic drug such as cannabis for 'medical or scientific purposes'; so in effect an Australian state can utilise cannabis for medical purposes or to conduct a scientific trial on the effect of cannabis (NDARC, 2000).

Australia would be obliged to prevent diversion or leakage of cannabis from the medical project or scientific trial to the general community, as usage of cannabis in those circumstances would be illicit and would contravene Australia's international treaty obligation.

3.3.2 Potential Iatrogenic Dependency

As cannabis is capable of causing dependence, particularly among regular users, and consumers of 'medicinal cannabis' might ingest the substance for substantial periods, they would risk acquiring a cannabis dependency. This risk is not peculiar to cannabis – many prescribed psychoactive drugs, such as benzodiazepines and opioids, are dependency producing and their prescribers are charged with helping their patients to avoid developing an addiction. Patients who would qualify for use of cannabis for medical purposes would need to be fully informed of the risk and understand how they could avoid it. Under the terms of therapeutic use of cannabis outlined above, where in some cases it would amount to an aspect of palliative care for terminally ill persons, the risk of dependency may be of minor concern.

3.3.3 Other Potential Iatrogenic Harms

Cannabis is known to be capable of causing acute harms and chronic harms (see section) depending on a variety of factors including dose and frequency of use, and the risk is mediated by a range of personal and family factors. Cannabis is not alone in that regard as many pharmaceutical drugs are capable of causing harm, even when they are consumed as prescribed by a medical professional. As in the case of risk of dependency potential patients need to be fully informed of the risk and understand how they could avoid it, while the supervising medical professional would be required to exercise their clinical skill and judgment to assist the patient.

3.3.4 Potential drift of criteria for prescribed cannabis

Programs of Medical Marijuana Use (MMU) operate in eleven states of the USA where persons who gain a recommendation from a physician are exempted from the enforcement of the law and can cultivate, buy or consume cannabis for a therapeutic reason (Room et al, 2008). However there are signs that the criteria for prescription of medical marijuana has widened to include ailments including sleeplessness, anxiety and depression in addition to the indicated illnesses of

multiple sclerosis, HIV-AIDS, glaucoma and epilepsy. One report suggests the provision of medical marijuana in California has led to 'virtual legalisation' as 200,000 people are prescribed medical marijuana (Room et al, 2008).

A survey of child and adolescent psychiatrists in California enumerated a number of perceived problems with the system (Jaffe & Klein, 2010). Concerns included the prescription of cannabis for Attention Deficit Hyperactivity Disorder and bipolar disorder, that are not indicated for cannabis; physicians failing to provide adequate supervision of patients for whom they prescribed medical marijuana; the sharing by parents of their prescribed medical marijuana with their children; children gaining access to 'medical marijuana' via prescription without the knowledge of their parent. The psychiatrists reported their adolescent patients were inclined to regard cannabis as less risky and were more inclined to use it following its availability for medical purposes (Jaffe & Klein, 2010). One caveat is the respondents represented a fraction (14%) of child and adolescent psychiatrists in California, so the results are not necessarily representative of the profession in the state.

In the opinion of the ADF it is important to restrict the availability of cannabis for a medical purpose to the amelioration or reduction of specific chronic or terminal illnesses, so that the practice retains integrity as a therapeutic intervention.

3.4 ANY OTHER RELATED MATTERS.

3.4.1 Personal Testimony provided to the Australian Drug Foundation

The following statement was forwarded to the Australian Drug Foundation by a member of the public who wanted to explain her reliance on a form of cannabis (marijuana) to relieve her painful and debilitating ailment. We have included her entire statement in our submission as a primary source account. We suggested to the author that she could also submit the statement to the Inquiry directly, and she might have done so. For the purpose of not disclosing her identity we have omitted her name and age.

"I come from a small country town and have recently moved to the city for a change in lifestyle and to be closer to my medical team. At the age of 13 I was officially diagnosed with Emery-Dreifuss muscular dystrophy (EDMD). It is a rare childhood-onset degenerative muscle disease seen almost exclusively in males (except for in my case).

Emery-Dreifuss muscular dystrophy is characterized by a classic triad of symptoms. These include early-onset, contractures, very slow progressive muscle weakness and degeneration involving the upper arms and lower legs, and cardiac (heart) muscle disease usually the disease is inherited but in my case it was a new mutation causing EDMD causing the disease in a me with no family history. New mutations account for approximately 10% of cases of EDMD. All the above characterized classic traits in EMED are found in me. At the age of 18 I had a pacemaker implanted due to Arrhythmias and heart block that lead to fainting or it could have been worse even sudden death. I am treated with Anti-arrhythmia drugs, diuretics, ACE inhibitors, and blood thinners. I will be on these medications the rest of my life.

“From a young age I have had problems with back pain due to scoliosis, this is due to the back muscles not being strong enough to support the spine in place. This causes ongoing pain and discomfort. Straining my shoulder muscles is a common problem with me and when this happens I am required to be hospitalised to maintain the pain with strong pain medication. The pain can continue for up to a month for the muscle to recoup. This consists of Endone, every 3 to 4 hours, Panadol and ibuprofen. This pain is unbearable and my body reacts in vomiting and nausea.

“Taking Endone for a long period of time causes major problems in the way that I cope day to day. Endone is a potent medication that is easily addictive and the only way for me to cope when taking Endone is to sleep and stay in bed, my body physically responds and does not function as normal. The medication does relieve the pain but for only a short period of time and then the Endone wears off.

“Medication I also take on a daily basis includes Nexium, Zoloft, Plavix, and Antenanol. I refuse to take Panadol, Endone or Ibuprofen to treat my pain and choose to use Marijuana to treat my pain.

“I have started smoking Marijuana in joint form to treat my pain, I have found that this is effective in managing my pain as it last longer in the body and I am still able to function without wanting to sleep and

vomit from the treatment, it relaxes other parts of my body and provides relief from the day to day strains of life. The difficult issue with using Marijuanas a treatment is that it is illegal and not easily assessable unless you have connections. If Marijuana was prescribed by a doctor it would make life much easier. I don't understand how doctors can prescribe lethal narcotics to individuals and not blink an eye but Marijuana that is less harmful is against the law and not prescribed.

"I have recently started taking Marijuana in cookie and brownie form as this does not entail the use of tobacco and the addictive nicotine that is contained in a joint.

"An easy and accessible use [of] Marijuana as a spray would be an easy and suitable way of treating pain in a quick manner no matter where you are. Tablet form would also be suitable if it was pure and not mixed with chemicals.

"I have also considered Marijuana a "no no" in my life but I found that I could not tolerate any other form of pain medication and decided to try it. I don't like the fact that I am breaking the law and sneaking around but if it is the only way to be able to treat my pain in a manner that allows me to function in everyday life I will. I advocate strongly for Marijuana to be legalised in the treatment of pain."

4. RECOMMENDATIONS

The Australian Drug Foundation (ADF) understands there is scientific uncertainty surrounding the use of THC, including the forms, circumstances and the conditions in which it is efficacious, and that its use can be harmful in the short and long term. The ADF also understands that persons who suffer intense pain or other debilitating conditions, and whose conditions are not be relieved by other means, find relief by absorbing THC in one or another of its forms.

Based on the view that the national policy of harm minimisation implicitly incorporates 'minimising avoidable suffering', the ADF makes three recommendations to the Inquiry.

1. That THC, derived either from the *cannabis sativa* plant or as a pharmacological product, be made available to aid persons who are suffering intense pain or severe disability as a result of life limiting or debilitating diseases, illnesses or ailments, under strict conditions.

Conditions under which cannabis could be prescribed for medical or therapeutic purposes are that:

- a) the patient is certified by a medical specialist, or a physician with specific training in the use of cannabis for medical purposes, as suffering from a disease, illness or ailment that is recognised within the scientific medical literature as likely to be ameliorated by the consumption of THC.
- b) the patient's condition has proved resistant to the more conventional therapies and interventions
- c) the patient remains under the supervision of a medical specialist or physician so that their physical and mental health is monitored so that appropriate action can be taken if THC appears to have an unduly detrimental effect on the individual's quality of life.
- d) the patient agrees to use the THC for their own benefit only and not to transfer it to any other person for any purpose.
- e) the patient is informed and is cognisant of the potential hazards inherent in ingesting cannabis products.
- f) a 'medical cannabis review board' is established to determine the diseases, illnesses and ailments that are most likely to respond to the application of THC. Examples of such conditions are pain or other debilitating conditions associated with terminal illness, neurological disorders such as multiple sclerosis, muscular dystrophy, nausea and vomiting associated with chemotherapy treatment.
- g) membership of the 'medical cannabis review board' should include representatives of relevant medical specialists and general physicians, research scientists with expertise in pharmacology and drug use, and community representatives.

- h) appropriate legislation is passed that would enable
 - i. individual patients to cultivate, possess or consume cannabis products without legal sanction
 - ii. medical specialists and/or trained physicians to prescribe cannabis for therapeutic purposes
 - iii. the establishment and operation of a medical review board for the purpose outlined in 4.1.2 (f)

2. That trials of Sativex, and other pharmaceutical cannabinoid preparations, are investigated, monitored and supported.

3. That continuing research is conducted into the efficacy and safety of cannabis products for therapeutic purposes.

5. REFERENCES

- Australian Institute of Health and Welfare 2011. *2010 National Drug Strategy Household Survey report*. Drug Statistics Series no. 25 Cat. no. PHE 145. Canberra: AIHW.
<http://www.aihw.gov.au/publication-detail/?id=32212254712>
- Bostwick JM. 2012 Blurred boundaries: The therapeutics and politics of medical marijuana, *Mayo Clinic Proceedings* 87:2; 172-186. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538401/>
- Cancer Council New South Wales. 2012. *Position Statement on Medical use of Cannabis*.
<http://www.cancerCouncil.com.au/wp-content/uploads/2010/09/Position-Statement-on-Medical-Use-of-Cannabis-FINAL.pdf>
- de Vries K. & Green AJ. 2012. Therapeutic Use of Cannabis, *Nursing Times*. 108:9; 12-15.
- Hall W. & Degenhardt L. 2003. Medical Marijuana Initiatives Are They Justified? How Successful Are They Likely to Be? *CNS Drugs*. 17: 10; 689-697.
<http://www.ingentaconnect.com/content/adis/cns/2003/00000017/00000010/art00001>
- Jaffe SL. & Klein M. 2010. Medical marijuana and adolescent treatment, *The American Journal on Addictions*. 19: 460-1. <http://onlinelibrary.wiley.com/doi/10.1111/j.1521-0391.2010.00063.x/abstract>
- Lamarine RJ. 2012. Marijuana: Modern medical chimaera, *Journal of Drug Education*. 42:1; 1-11.
<http://baywood.metapress.com/app/home/contribution.asp?referrer=parent&backto=issue,1,6;journal,2,166;linkingpublicationresults,1:300320,1>
- Magee, B. 1997. *Confessions of a philosopher*. Weidenfeld & Nicholson, London, GB.
- Mental Health Council of Australia. 2006. *Where There's Smoke...Cannabis and Mental Health*. Mental Health Council of Australia
<http://www.mhca.org.au/index.php/component/rsfiles/download?path=Alcohol%20and%20Other%20Drugs/Where%20There's%20Smoke%20Cannabis%20and%20Mental%20health.pdf&Itemid=539>
- National Cannabis Prevention and Information Centre. 2011. Fact Sheet 20 *Cannabinoids*. National Cannabis Prevention and Information Centre.
<http://ncpic.org.au/ncpic/publications/factsheets/article/cannabinoids>
- National Drug and Alcohol Research Centre. (2000). Report of the Working Party on the Use of Cannabis for Medical Purposes Vol II Main Report., Sydney, Australia.
http://www.ndarc.med.unsw.edu.au/sites/ndarc.cms.med.unsw.edu.au/files/ndarc/resources/medical_cannabis_v2.pdf
- Room R, Fischer B, Hall W, Lenton S, Reuter P. 2008 *Cannabis Policy: Moving Beyond stalemate*. Beckley Foundation, GB. http://www.beckleyfoundation.org/pdf/BF_Cannabis_Commission_Report.pdf

Swift W., Gates P., Dillon P. 2005. Survey of Australians using cannabis for medical purposes, *Harm Reduction Journal*. 2:18 <http://www.harmreductionjournal.com/content/2/1/18>

van Ours JC. & Williams J. 2009. *Cannabis use and mental health problems*. Discussion Paper No. 2009-60. CentER, Tilburg University. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1436901