REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 4

INQUIRY INTO THE USE OF CANNABIS FOR MEDICAL PURPOSES

CORRECTED PROOF

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At Sydney on Monday 18 March 2013

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The Committee met at 10.15 a.m.

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PRESENT

The Hon. S. Mitchell (Chair)

The Hon. R. Borsak
The Hon. A. Fazio
Dr J. Kaye
The Hon. T. Khan
The Hon. C. J. S. Lynn
The Hon. A. Searle

CHAIR: Welcome to the second and final public hearing of the General Purpose Standing Committee No. 4 inquiry into the use of cannabis for medical purposes. The inquiry is examining the efficacy and safety of using cannabis for medical purposes, if and how cannabis should be supplied for medical use and the legal implications of such use. Before I commence I would like to acknowledge the Gadigal people who are the traditional custodians of this land. I would also like pay respect to the elders, past and present, of the Eora nation and extend that respect to other Aboriginals present.

Today we will be hearing from a number of witnesses including Professor Michael Cousins, Mr Paul O'Grady, Dr Andrew Katelaris, the Australian Medical Association, the National Cannabis Prevention and Information Centre, the Australian Drug Law Reform Initiative, Family Voice Australia and ACON. A full transcript of what is said during today's hearing will be prepared by our Hansard reporters. The transcript will be available on the Committee's website within the next few days.

Before we commence today I would like to make some brief comments about the procedure for today's hearing. Committee hearings are not intended to provide a forum for people to make adverse reflections about others. The protection afforded to Committee witnesses under parliamentary privilege should not be abused during these hearings and I therefore request that witnesses focus on the issues raised by the inquiry terms of reference and avoid naming individuals unnecessarily. Copies of the Committee's broadcasting guidelines are available from the Committee staff. Under these guidelines, while members of the media may film or record committee members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I would also remind media representatives that they must take responsibility for what they publish about the Committee's proceedings.

It is important to remember that parliamentary privilege does not apply to what witnesses say outside of their evidence at the hearing. I urge witnesses to be careful about any comments they may make to the media, or to others, after they complete their evidence as such comments would not be protected by parliamentary privilege if another person decided to take an action for defamation. Witnesses are also advised that any messages should be delivered through the Committee staff. I ask everybody to turn off their mobile phones for the duration of the hearing.

SAXON SMITH, Vice President, Australian Medical Association of New South Wales, affirmed and examined:

ANDREW TOOK, Director, Medico-Legal and Employment Relations, Australian Medical Association of New South Wales, sworn and examined:

CHAIR: Before we begin questioning would either of you like to make a brief opening statement?

Dr SMITH: Yes, we would. The Australian Medical Association [AMA] of New South Wales does not condone the use of cannabis for nonmedical purposes. It is a harmful drug that causes a range of health and social harms at both an individual and a community level. The AMA New South Wales considers in certain circumstances cannabis may be of medical benefit. For example, in HIV related wasting and cancer related wasting, as well as nausea and vomiting in people undergoing cancer chemotherapy who do not respond to conventional therapies. However, the AMA of New South Wales believes more research needs to be undertaken to determine the medical benefits of cannabis and the AMA New South Wales supports research to examine whether there is any greater benefit from cannabinoids over that of newer antiemetics and newer therapies.

Should cannabis be legalised in the future for medical use any promotion of the medical use of cannabinoids will, in the submission of the AMA New South Wales, will require extensive education of both the medical profession and the general public. In summary, subject to further research being undertaken the AMA New South Wales believes cannabis may have medical benefits in certain circumstances. At this point of time the AMA New South Wales believes further research should be carried out, given the recognised harmful effects of cannabis, to validate these medical benefits.

The Hon. ADAM SEARLE: On page 11 of your submission your association seems to say that its treatment of nausea, vomiting and appetite loss seems to be clearer than use of marijuana for pain relief. Is that a correct reading of your submission?

Dr SMITH: There is growing evidence that certain cannabinoids are effective in the treatment of chronic pain. What we know is that cannabis obviously has psychotropic activities but constituents within cannabis have pharmacological effects which include anti-spastic effects, analgesic effects, antiemetic effects, neuro-protective effects and anti-inflammatory actions. That, as you could understand, potentially reaches a broad range of medical conditions. Looking at the research and looking around the rest of the world it has been used to treat severe spasticity in multiple sclerosis as well as the vomiting effects from cytotoxins in chemotherapy and the loss of appetite and wasting associated with AIDS or HIV, as well as growing evidence in other areas to do with positive effects to do with the retention of bladder function in multiple sclerosis, quite a targeted component, even to do with involuntary movement in Parkinson's disease.

This is a new and evolving space and more research needs to be considered. In particular, the risk associated with the long-term medical use is not well understood at this point in time and needs to be considered going forward. We would submit that looking at synthetic-based cannabinoids which can be more readily managed, delivered and measured would have a more positive outcome as opposed to, for the sake of argument, smoking marijuana because smoking itself has detrimental health benefits.

The Hon. ADAM SEARLE: Having regard to the submissions that we have received, in particular, the submissions of Professor Wayne Hall and Professor Michael Farrell, and also the literature review provided to us by the Australian Drug Law Reform Foundation, their literature says that although there are various benefits claimed for marijuana or cannabinoids, what is clear is its use as an analgesic—pain relief. Would your association accept that is not contested any longer; it clearly does have that benefit?

Dr SMITH: There are people who are more expert in those matters than we would profess to be and within the scope of our submission it is a question that is best directed to them.

The Hon. ADAM SEARLE: You say the constituent elements can have a range of positive benefits but there needs to be more research. In terms of products that are available, we have evidence about a spray called Sativex.

Dr SMITH: Yes.

The Hon. ADAM SEARLE: From my reading, there are others such as marinol and nabilone, but none of those are presently available in Australia, as far as I understand.

Dr SMITH: Correct.

The Hon. ADAM SEARLE: What steps would be to taken to make those available?

Dr SMITH: In Australia at the moment the synthetic cannabinoids of nabilone and another one, which I struggle to pronounce, which is dronabinol, are scheduled by authorities for medical use.

The Hon. ADAM SEARLE: That is the synthetic—

Dr SMITH: These are synthetic cannabinoids that are available for medical use within Australia.

The Hon. TREVOR KHAN: Are they on the Pharmaceutical Benefits Scheme?

Dr SMITH: No, not that I am aware of.

The Hon. ADAM SEARLE: In what circumstances are they available for use in Australia?

Dr SMITH: I was going to say, in particular, as you describe, the mouth spray sativex is being trialled in Australia with respect to cancer and also in the drug and alcohol cannabis withdrawal programs. They are available in a research process in Australia at the moment.

The Hon. ADAM SEARLE: Dronabinol or marinol, which is its commercial name, is a cannabis gel capsule, is it not?

Dr SMITH: I am not aware how it is delivered because I am not specifically familiar with it.

The Hon. ADAM SEARLE: I apologise if you have already said this, but are you aware in what way that is currently available in Australia?

Dr SMITH: I am currently not aware of how it is available.

The Hon. ADAM SEARLE: Could you take that question on notice and let us know?

Dr SMITH: We are not specific experts on the delivery of that drug. There are other members who will be giving evidence who are more expert in those matters.

The Hon. ADAM SEARLE: Thank you.

Dr JOHN KAYE: Thank you for your submission. Firstly, slightly off the topic but relevant to what I want to say later on, do you think the use of opioids as pain relievers in postoperative environments and other medical settings in any way legitimises the use of heroin? I will rephrase that question. By taking away some of the stigma associated with opium-based drugs will it increase the use of heroin in the community?

Dr SMITH: Opioid-based drugs have been readily available as an analgesia for well over 100 years and form the basis of well-managed, controlled, analgesic relief postoperatively around the world. It is difficult to draw a parallel to say whether this normalises or, as you suggest, legitimises the use of heroin in a community setting, which is an illegal drug and not obtained through medical practitioners.

Dr JOHN KAYE: Do you think there is any risk that prescribing cannabis or using cannabis-based drugs would in any way legitimise the recreational use of cannabis?

Dr SMITH: As we have stated in our submission that is why a clear education program for both the community and also the medical profession would be required.

Dr JOHN KAYE: Do you think such an education program would be successful in stopping the legitimisation of cannabis as a recreational drug?

Dr SMITH: I feel that it is difficult to answer that specifically. There are probably other members giving evidence later today who will be more expert in those matters and perhaps will give you a more succinct and fulfilled answer.

Dr JOHN KAYE: You mentioned in your verbal evidence the potential neuroprotective effects of cannabis-based drugs. Can you explain what that means?

Dr SMITH: Again, that is something that will be best asked of those more expert in those matters.

Dr JOHN KAYE: Can you give us a definition of what "neuroprotective" means?

Dr SMITH: I cannot give you a definition of what "neuroprotective" means at this time.

Dr JOHN KAYE: In your evidence you drew a contrast between synthetic cannabinoids versus smoking cannabis. Am I correct in saying that synthetic cannabinoids could be smoked as well and, likewise, products from the cannabis plant could also be ingested in other fashions? The dichotomy here is not between smoking and synthetic. There are two different axes: there is a delivery axis and an origin axis.

Dr SMITH: It is clear that the process is working whether it is a synthetic cannabinoid or an organic variant. It has significant health risks and it is something we feel would be potentially modified by the use of other delivery methods like the available buccal spray of sativex.

Dr JOHN KAYE: As most doctors would be, you are concerned about the delivery mechanism of smoking. Do you have a preferred view between synthetic and organic? I want to find out whether you were specifically saying we would be better off going down the route of synthesising the active ingredients.

Dr SMITH: The role of synthesising the ingredients would allow for a more appropriate delivery. But, more importantly, it would allow a more appropriate measurement process whereby you would have drug levels to target the best outcomes for patients, thereby being more readily able to perform clinical trials to target the best health outcomes for the patients, as well as having post-surveillance mechanisms in place so adverse outcomes can also be recorded and monitored and communicated through the medical profession.

Dr JOHN KAYE: What you are saying is that the synthetic drugs can be more easily titrated than the organic drugs?

Dr SMITH: In theory. Obviously we would defer to those who are more expert in those matters who, I am sure, are giving evidence later today.

Dr JOHN KAYE: As we will do, Dr Smith. This afternoon we are going to hear from a gentleman who claims that cannabadiol [CBD] is effective against astrocytomas, which is a kind of brain tumour that is usually fatal. Do you have any comments to make on the anti-neoplasticity properties of any of the chemicals found in the cannabis plant?

Dr SMITH: I would defer to colleagues who are more expert in those matters.

Dr JOHN KAYE: Is it possible for you to get back to us with answers on notice about some of these issues that you are deferring?

Dr SMITH: As an organisation, we feel there will be people providing evidence who will be more expert in those matters.

Dr JOHN KAYE: In your submission, which is detailed and is very good, you have got 15 sections of which only sections 8 and 15 directly refer to medicinal cannabis. The rest of your submission is more relevant to the issue of recreational use of cannabis. Can you comment on the fact that both of those issues are in your submission in that fashion, rather than explicitly talking about medicinal cannabis? Do you see the two issues as been inextricably linked?

Dr SMITH: At this point in time the issues are linked in that research has grown for the use of cannabis for medical use, which will help over time to separate the two issues, but cannabis for our society has both social and individual harms that are important to delineate and to discuss in this fashion. We are uncertain

of the longer term consequences and adverse effects of cannabis in medicinal uses as well, and that will hopefully become clearer with time and research.

Dr JOHN KAYE: Do you see any difference between the way in which opium, which of course is a source substance for heroin, derivatives of opium and artificial opioids are used for medical purposes and the propositions that we are discussing around cannabis and the derivatives of cannabis being used for medical purposes?

Dr SMITH: As I am sure the Committee is aware, opium formed the basis of the very early drug legislation back in the late 1800s and early 1900s. However, over that time the use of medical-based opioids has formed through controlled and dedicated research to be a basis of analgesia, which is used worldwide. Over time it has come to that; it is an understanding and, more importantly, through synthetic uses of the drugs, minimising some of the side-effects but importantly to be controlled, more managed and more appropriately delivered. To say whether or not cannabis or cannabinoids over time will follow a similar course would be asking to look into a crystal ball. We are uncertain as to where this will go and only further research will help to elucidate that.

Dr JOHN KAYE: To summarise then, it would be fair to say that the AMA's position is one of cautiously putting your toe in the water by advocating some clinical trials?

Dr SMITH: Basically we support that there is growing evidence through clinical trials of the use and benefit of cannabis or cannabinoids in medicine. However, some concerns still remain about the long-term adverse effects because they are uncertain but time will tell.

Dr JOHN KAYE: Long-term adverse effects on the patient or societal long-term adverse effects?

Dr SMITH: Our concern is for the patients at this point in time.

Dr JOHN KAYE: So you are worried about unexpected side-effects of cannabis-based drugs?

Dr SMITH: We know that cannabis has significant effects from its psychotropic activity for inducing psychosis and longer term issues associated with depression and other psychiatric-based illnesses and they are something that needs to be a watching brief at this time as it is explored for medical use.

Dr JOHN KAYE: There are also side-effects associated with opium and opium-based drugs?

Dr SMITH: Yes, there are side-effects with most medications that people can potentially take.

Dr JOHN KAYE: Yet your forebears developed opium into the current range of drugs such as morphine that are regularly used in hospitals?

Dr SMITH: Yes. It has gone further than just using morphine these days.

Dr JOHN KAYE: Sure.

Dr SMITH: The side-effect profile of the opioid-based drugs is well understood and can be well managed. In fact, there are new agents available on the PBS for analgesia which marry an opioid drug with Naltrexone, a drug which helps to minimise and modify the side-effect profile. But again these are things that people will be more expert in. I am sure the chronic pain-based members who will give evidence in the coming proceedings will be able to help answer that question in more detail.

Dr JOHN KAYE: Can I take you to clause 15.5 of your submission which states, "The Australian Medical Association believes any promotion of the medical use of cannabinoids will require extensive education of the public and the profession on the harmful effects of non-medical use of cannabis". Can you elaborate on that by explaining to us how that would work? Presumably there are in the order of a maximum of 10,000 people who would be on a cannabis-based drug for ongoing consumption?

The Hon. TREVOR KHAN: How many people?

Dr JOHN KAYE: I am guessing—some thousands; there are 7.2 million people in New South Wales. You are proposing that we would need to increase efforts on cannabis education across New South Wales?

Dr SMITH: A lot of that would be to do with the manner in which cannabinoids would be available through the medical practitioners, whether it is via some form of restrictive prescription or whatever the legislation will enable these things to happen. They are the things that need to be communicated through the profession firstly but also those in a general community sense as well.

Dr JOHN KAYE: Do you think the availability of morphine and other opioid drugs requires additional education to be conducted into the dangers of heroin?

Dr SMITH: I think you are extrapolating from drugs that have been available for 100 years to what we are discussing now—something that has been an illicit drug with increasing use as an illicit drug within our community. Then as we move towards investigating further through trials and research to its use as medical use it is difficult to say what discussions were had when opium was first moved into the medical world some 50 to 100 years ago.

Dr JOHN KAYE: Or longer?

Dr SMITH: Longer, yes.

Dr JOHN KAYE: There are currently education programs with respect to alerting the public, particularly younger people, about the dangers of cannabis. Under your 15.5 proposition what would change about those programs? Would they have to be bigger, would they have to be more targeted? How would they change if medicinal cannabis were to go ahead in New South Wales?

Dr SMITH: That is something that would have to be discussed at the time assuming cannabinoids are accepted into use for medical use within New South Wales or within Australia as a greater whole and the ways in which they are accessible would need to be educated as opposed to the general community.

Dr JOHN KAYE: So it is about education of medical practitioners but what about education of the general public?

Dr SMITH: Again, it is difficult to say. As we are more likely be talking about synthetic-based cannabinoids they will have drug names, they will have prescription restrictions. I think it is important to take a hand-in-hand approach, highlighting the ongoing issue that we have as a society with respect to the illicit use of cannabis.

The Hon. CHARLIE LYNN: One of the submissions related to the fact that the current debate is influenced by the many headlines we get from the lay press in regard to the harm of cannabis. It states that in most parts of the world it is only possible to obtain funding for research into the harm of cannabis as opposed to a broader consideration of the possible benefits and uses. Could you give us a comment on that in regard to the situation in Australia?

Dr SMITH: As I mentioned earlier when I was answering Mr Searle's question in relation to the availability of synthetic cannabinoids in Australia, we know that they are being trialled in relation to cancer and also in the drug and alcohol/cannabis withdrawal processes at this point in time so obviously they have some availability within controlled trials at this point in time in Australia.

The Hon. CHARLIE LYNN: At some of the earlier hearings there was concern with the long-term detrimental effects of cannabis and in many cases that people were referring to "long-term" is not a consideration; that it helps ease the situation for people who are almost terminal?

Dr SMITH: As is always a balance in clinical medicine where you have a risk-benefit process or a risk-benefit profile when deciding with your patient what is the most appropriate treatment for them at that point in time. Obviously when we are talking about terminal patients you are correct in stating there that their long term is a very short term. However, foreseeably with various potential uses for the cannabinoids, particularly in the multiple sclerosis base there is increasing literature in the chronic pain space they are patients who potentially will be on it for longer periods of time who will then potentially be exposed to the long-term adverse outcomes or adverse effects that need to be further examined.

The Hon. TREVOR KHAN: If we are looking at what this Committee would do I suppose the question of long-term effects would only arise if this Committee were to recommend and the Government were to take up allowing availability to a group of people who would be using it for longer than a few months or a year. Would that be right?

Dr SMITH: That would be a reasonable thing to suggest. As long as there is a robust pharmacosurveillance process in place to be able to capture the information relating to potential adverse effects.

The Hon. TREVOR KHAN: We all know that in terms of identifying when somebody is in the end stages of cancer there is a degree of medical guesswork involved in determining how long somebody is going to survive. That would be right, would it not?

Dr SMITH: There is robust data from years of experience in clinical trials which give approximation of lifespans. Obviously some cancers are significantly more aggressive. If you take pancreatic cancer, the average survival after diagnosis is six months. However, there are various blood-borne or lymphoma-based cancers where people can live 10 years. We have that information available to us, and it comes down to the various treatments that they are on as well. The information is there but obviously there are always people who will be outliers as we look at the data.

The Hon. TREVOR KHAN: But based on the data that is accumulated you would be able to identify a group of people, or people who are suffering from specific cancers, where you would be able to say that, for instance, the impact of long-term effects is not really a relevant criteria if they are prescribed cannabis in some form?

Dr SMITH: The information exists to have an appropriate risk-benefit discussion with the patient for that, yes.

The Hon. TREVOR KHAN: That is in essence a yes, with a caveat. I take you to paragraph 15.1 of your submission, which is on page 17. On the basis of what we have heard to date almost the entirety of the evidence to the advantages of using cannabis at some stage has related to pain. Because I am a lawyer as opposed to a doctor, are you able to describe to me when in terms of position from infection to death a person who contracts HIV under current treatment regimes actually starts to experience HIV-related wasting?

Dr SMITH: I actually would like to refer that to more experts in those matters who I am sure will give evidence to the Committee.

The Hon. TREVOR KHAN: They may not.

Dr SMITH: With the caveat that our experience with HIV as an infection has significantly changed since its first appearance in the world in the 1980s. We are seeing patients who were at that point in time in the 1980s given a relative death sentence and yet they are still with us today through a combination of the growing pharmacology and treatments available to them to keep it in check. It is a space that is continuing to evolve. At what point that they get to the classical HIV wasting is now very variable. It is a difficult thing to answer because of that, because people are now living successfully for decades with their HIV as opposed to originally where they were living significantly shorter periods of time.

The Hon. TREVOR KHAN: I absolutely understand that the treatment of drugs available and the drug regimes have changed very significantly but is there not a point where essentially a person moves from being HIV positive to having full blown AIDS?

Dr SMITH: Yes, it is delineated by contraction of specific AIDS-defining illnesses which are usually defined around what their T-cell count is, which is around the 200 mark which is significantly low. Some of those AIDS-defining illnesses include Kaposi's sarcoma and pneumocystis synchronia, which is a lung infection, and the like. There are AIDS-defining points both on blood tests and also other clinical conditions that they acquire.

The Hon. TREVOR KHAN: Again the reason I am asking this is if the Committee is to recommend something there is a point at which one can identify that a person having HIV moves from having the HIV virus to having AIDS and being identified in classical medical terms as having AIDS.

Dr SMITH: There is clear delineation from moving from being an HIV-positive patient to having the AIDS-defined illness.

The Hon. TREVOR KHAN: I will move off paragraph 15 and go back to 8. You refer to the December 2005 study of the Royal College of Physicians of London and the report they prepared. They referred to the treatment of nausea and vomiting associated with chemotherapy and counteracting the loss of appetite caused by cachexia. What is cachexia?

Dr SMITH: That is AIDS-related or HIV-related wasting. Cachexia is basically loss of your muscle and fat, which happens in other conditions as well such as cancers as well as in the HIV-positive population.

The Hon. TREVOR KHAN: Is the 2005 report of the Royal College of Physicians of London still considered a relevant report for us to rely upon here, or has it become too old for instance?

Dr SMITH: We do consider that it is a substantive and valid reference to be put within the submission for consideration to the Committee.

The Hon. TREVOR KHAN: There are these various cannabis-based drugs that are currently available in Australia. Is that right?

Dr SMITH: Very limited availability largely to do with within the clinical trial setting.

The Hon. TREVOR KHAN: It might be more directed towards Mr Took than yourself, but do I take it that there is no, in a sense, legal or criminal impediment that impacts upon the possession or consumption of those drugs at the present time?

Dr SMITH: Not being expert in the legal matters associated with those I would like to defer that to the experts.

Mr TOOK: Similarly I would defer to the experts who practice in that area.

The Hon. TREVOR KHAN: I suppose I am musing but asking the question at the same time: If the medication can in fact be made available in Australia at the present time it would be the case, it would seem to me, that this Committee does not have to recommend any change in the criminal law to allow those trials to continue on at the present time. Would that be your understanding?

Dr SMITH: I think within the construct of research in the pharmacological area and pharmaceutical area there are often drugs that are not available through the TGA that are in the process of being researched by the very definition, and this is where this is currently sitting.

The Hon. ADAM SEARLE: So they are not available to the public.

The Hon. TREVOR KHAN: But again that in a sense is not a problem that falls to us. That would be a Commonwealth responsibility as best as you would understand.

Dr SMITH: Within the TGA framework, yes.

The Hon. TREVOR KHAN: Of course one of the realities would be that even if the TGA puts it on the list of medications that are available that really still renders it difficult for people to access it if it is not on the Pharmaceutical Benefits Scheme [PBS]. Would that be right?

Dr SMITH: That would be correct.

CHAIR: I am not sure how familiar you are with some of the other submissions that the Committee has received but in the submission of the Australian Drug Law Reform Foundation, who we heard from last Monday, they were advocating basically a trial period where doctors and GPs could apply to a board or someone within the Department of Health to be given the right to prescribe for up to a 12-month period medical cannabis for certain patients. They advocated that could be a method that the Committee could consider. Would you have any comment or view on how that might work in a practical sense?

Dr SMITH: Obviously with some sort of degree of legal infrastructure that would then define the way in which it would work practically. Some degree of limited prescription or qualification processes which are used for many different drugs would be reasonable.

CHAIR: My second question relates to how often this issue is raised among your members. Last Monday we heard from the New South Wales Department of Health and, paraphrasing a little, the indication given was that it is not something that is raised all that often among their clinicians. Is the issue of medical cannabis something that is discussed with some regularity within the Australian Medical Association [AMA]?

Dr SMITH: Yes, it is. We are, at present, at the Federal level reviewing our current position statement on this particular matter. It is something that is reviewed on a time-to-time basis.

CHAIR: Is that published? Is that review made public?

Dr SMITH: It is only in draft at this point in time and no-one is certain when it is going to the federal council to be considered. Whether it will be adopted and when it will be adopted, I am uncertain.

The Hon. ADAM SEARLE: I wish to return to the issue of terminally ill patients. You have been very careful to say your organisation does not approve of the non-medical use of marijuana or cannabis, and that research has shown that cannabinoids can have certain therapeutic value, at least in some studies. Your caveat about the longer-term effects and the need for further research simply would not apply to people who are terminally ill, would it?

Dr SMITH: Again, you balance that risk-benefit profile with any medication to manage a patient's condition—similar to my answer to the Hon. Trevor Khan.

The Hon. ADAM SEARLE: To put it really sharply, if someone suffering from cancer has been given six months or less to live and is in chronic pain, what medical reservations would your organisation have to those persons having access to medical cannabis?

Dr SMITH: It is whether or not there is clear evidence that supports that it will be successful for those patients. There is no point exposing a patient to any kind of medication without strong clinical research control trials to show that it will be of benefit to them.

The Hon. ADAM SEARLE: But your own submission at paragraph 15.2—

The Hon. TREVOR KHAN: And at paragraph 8.

The Hon. ADAM SEARLE: —and 8 also suggests that some of the studies that you are aware of shows that it has had some therapeutic benefit for people in terms of chronic pain management. What more research needs to be done?

Dr SMITH: Again it is the qualifying adjective of "some" benefit. The degree of benefit needs to be further elucidated, and are you deriving benefit in 10 per cent of patients or are you deriving benefit in 90 per cent of patients, which is a very different risk-benefit profile that needs to be discussed.

The Hon. ADAM SEARLE: But you accept, do you not, that some drugs work with some patients, and even if a drug works in 90 per cent of cases, it may not work on a given patient?

Dr SMITH: Absolutely. Not all drugs do work for the right patients and there are also individual responses of those patients, and potentially individual adverse events or effects for those patients.

The Hon. ADAM SEARLE: But if someone is almost at the end of their life, they are in chronic pain and the treatments they receive are not working, what medical reservations does your organisation have in terms of people in that situation having access to medical cannabis?

Dr SMITH: Again, it is to prove in evidence that it will work and help them where other drugs have failed, and also assuming that there are not other drugs that are available to them as well.

The Hon. ADAM SEARLE: Yes, but those other drugs might be quite expensive, or they might not work, or they may have side effects that are disagreeable to that particular patient.

Dr SMITH: Just as the access to the cannabinoids might have the same problems as well, as you have described.

The Hon. ADAM SEARLE: Sure, but unless they have access, they do not know, do they? At the moment they do not legally have access.

Dr SMITH: That is why we recognise that there is growing medical evidence through robust research showing benefit for cannabinoids. That needs to be considered as we go forward.

CHAIR: Gentlemen, thank you very much for appearing this morning. We may have supplementary questions for you after today's hearing, which the secretariat staff will provide to you. We ask that any responses be returned within 14 days. Thank you.

(The witnesses withdrew)

(Short adjournment)

MICHAEL JOHN COUSINS, Professor, University of Sydney, and Director, Pain Management Research Institute, Royal North Shore Hospital, sworn and examined:

CHAIR: Welcome Professor Cousins. Would you like to begin by making a brief opening statement?

Professor COUSINS: Thank you very much. I am appearing here also as a board member of Pain Australia. Today I am here really from the perspective of the pain medicine specialist. I also practice in palliative care to a lesser extent. The most important thing I am going to say is that there is an urgent need for more options for patients with pain. This includes patients with acute pain, such as pain after surgery or trauma, patients with cancer pain and patients with a very wide range of conditions that are associated with chronic non-cancer pain. There just simply are not enough options to cover the situations that a wide range of patients present with. Some of the current options work for some patients, but they do not work for all of them. So this is an urgent need. I am very much aware because of my proximity to my colleague Emeritus Professor Laurie Mather of the role he played in the 2000 inquiry. I commend the report that came out of that inquiry as providing extremely useful information for this body. Obviously, there have been more studies since that time, but by and large what was said then holds true today.

I also would like to comment on the sort of setting in which an agent such as a cannabinoid might be used. Again, my perspective is from the pain point of view, not other symptoms. It has become apparent and endorsed really throughout the world in national pain strategies that have been developed over the past few years that patients with chronic pain need to be assessed from a bio psychosocial point of view. In other words, they need to have a careful assessment of physical factors that are involved in their pain, psychological factors that are invariably a part of the problem—if they were not at the start, they become so later on—and environmental factors, by which I mean a very broad range of environmental factors. That means that such patients need to be appropriately assessed by someone with the appropriate education and training. That is quite a challenge in this country at the moment because we have not really prioritised pain as an important condition.

As far as non-cancer pain is concerned, the National Pain Strategy that was accepted in 2010 at a National Pain Summit, which involved 150 health care organisations, acknowledged that chronic pain may become a chronic disease in its own right. Once again, this underlines the need for proper assessment. If proper assessment is carried out, it then becomes apparent whether one is dealing with a patient in whom it would be wise and helpful to prescribe opioid drugs, for example, and cannabinoids would be in a similar sort of framework to opioid drugs, or is this an individual in whom it might be much more important to consider non-medication methods of treatment or perhaps a combination of those two treatments. But without that sort of assessment it is very difficult to prescribe such powerful drugs in an effective and safe manner. I heard the discussion just before I came to the chair about the difference between chronic non-cancer pain and cancer pain or other conditions that are untreatable where the life expectancy has now become very short. I think there is an important point there, certainly for the patient who is in a terminal phase or close to terminal phase. One has to be a little more prepared to provide options, as the Baum legislation suggested, that perhaps are not usually available but are available in that setting. I will not say any more about that at the moment.

As far as chronic non-cancer pain is concerned, sadly, although such people have a severe chronic disease that is life threatening—some of them commit suicide because of the severity of the pain—some of them will lead a normal length of life. They certainly will not lead a normal life, but they will lead a normal length of life. I have some concerns about the use of cannabinoids, except in a very well-controlled manner, as to the long-term effects they could have on such individuals. I just highlight that aspect. Finally, speaking here as a clinician, I would like to see a preparation of a cannabinoid or cannabinoids, as is the case with Sativex, for example, which permits dose control, permits proper assessment of the patient in the manner I indicated earlier, permits a prescription to be written for something that is known regarding its effects and side effects, and permits ongoing assessment of that patient and how the prescription of that medicine helped them not only with their pain—this is a very important aspect—but did it help their functioning? Are they interacting with their family better now? Are they possibly able to return to some meaningful work? Are other life activities possible? Overall, is there an improvement in quality of life? It concerns me a little bit in some of the materials that I have been reading that there is an implication that the patient can do this by themselves. I think that is not likely to produce the sort of outcome we would like to see for our patients.

The Hon. ADAM SEARLE: How do you think those other options for pain relief could be regulated or delivered by governments in terms of the framework? What would you suggest would be the most efficient or most effective ways to make those other options available?

Professor COUSINS: We have a national pain strategy, which is extremely detailed, and New South Wales now has a statewide pain care plan which is very strongly based on the national pain strategy. That framework is now in the process of being set up, and the reason it is in the process of being set up is that the New South Wales Government has provided funding to implement a three-tier system of pain management in this State, ranging from tertiary centres to second-tier centres and to primary care level. It is a massive job but it has started and it has received $26 million in funding. So, I expect to see that situation of appropriate assessment of patients improving very smartly.

The Hon. ADAM SEARLE: We have received some evidence, both oral and written, in this inquiry about the need for more research of the potentiality of medical cannabis to be used in circumstances such as pain relief. Do you think more research needs to be done, at least in cases of people who are terminally ill, whether there should be at least limited access to medical cannabis for people in those situations?

Professor COUSINS: I think it is known, yes. I think in terms of getting started, making it possible for patients to gain access to the benefits of cannabinoids, we should be doing something now. There is enough evidence there that pain relief can be obtained with manipulation of the cannabinoid system, if I can put it that way, and we can argue probably all day about what would be the best agent to use for that. We have one available to us, Sativex, which meets the requirements that I identified at the end of my introduction. I agree with what was said in the 2000 report. There is enough evidence, and there is more evidence now. There are at least another two very good studies, well designed, that leave little doubt that pain relief will be obtained by at least some people. In view of the lack of options we currently have, I think it is very important that we take advantage of this option.

On the other hand, and again I refer to my colleague, Professor Mather's submission, there has been too much emphasis on the potentially bad effects of cannabinoids, there is no doubt about that. That will add to the difficulty in educating health professionals and, I suppose, in appropriate circumstances encouraging them to look at this option. But we should put more funding into research of the cannabinoids. I have seen some major examples where a very promising line was being developed and it just did not receive any funding at all.

The New South Wales pain care plan has provided some funding for a lead basic research centre, and that funding has been applied to the Pain Management Research Institute, which I lead. The person doing that research in particular is Dr Chris Vaughan, who has been doing world-leading research into the cannabinoid system and targets within that system, particularly relating to pain control. That is another positive change that has occurred.

The Hon. ADAM SEARLE: Just on that, as a pain relief clinician you say there is sufficient evidence to move in this direction now?

Professor COUSINS: Absolutely.

The Hon. ADAM SEARLE: You mentioned Sativex as a promising option. As we understand it, that is awaiting approval from the Therapeutic Goods Authority. What happens if the Therapeutic Goods Authority does not give approval, or approval is five or more years down the track? What needs to happen now to provide access?

Professor COUSINS: I have no expertise in the legal area at all but it is very clear to me that an appropriate legal framework is needed to do the sorts of things I have a enumerated. Another issue is the cost, and I heard that being debated while I was waiting. That is not easily fixed but there is a pathway to fix that and that is to get the Pain and Disability Assessment Centre to agree there is sufficient lack of options for people in the sort of condition I have described to make a Pain and Disability Assessment Centre ruling that this will be provided with the appropriate description of the circumstances of availability. I would certainly welcome that.

The Hon. ADAM SEARLE: You indicated that we should have as a society invested more into research in this line earlier and you are aware of some examples where promising research was not followed through due to a lack of funding. I do not want to put you on the spot but if you are able, either now or subsequently, to provide the Committee with some details of those, I would be interested to read them.

Professor COUSINS: Happy to do so.

The Hon. ADAM SEARLE: In particular, your assessment as to what systemic issues may have contributed to those forms of research not being pursued?

Professor COUSINS: I think the opioids provide a useful example to look at. Sadly the medical use of opioids is, even now, after all these years of use of opioids for severe pain, is suffering a very negative image from the diversion that is going on, particularly in the USA, but it's happening very much in this country. It is very sad that we still have to use the same agents for medical opioids as are used recreationally. The most popular recreational opioid is now OxyContin and OxyContin happens to be an extremely valuable drug for the treatment of cancer pain and appropriate chronic non-cancer patients. That drug is tarred with the same brush, no matter what setting it is used in, and to me that is a tragic outcome. Up until this criminal diversion situation we made a lot of headway in making patients and their health professionals more comfortable about having a condition that absolutely required the use of such agents. The milieu I predict will be very similar for whatever cannabinoid preparation is approved, if indeed that occurs. It will come into a general adverse milieu of drugs which are not able to be prescribed at the moment.

The Hon. ADAM SEARLE: Thank you very much, that was very enlightening.

Dr JOHN KAYE: Thank you, Professor Cousins, for your introduction. Just to pick up where Mr Searle left off: The issue of diversion of drugs from medical to recreational use—you mentioned the case of OxyContin which has severe side effects—can you contrast the consequences of diversion of a spray packet of Sativex compared to a dosage of OxyContin? What would be the different consequences there?

Professor COUSINS: I do not think Sativex will be terribly popular for diversion. On the other hand, perhaps with medical cannabis it would be, but again there are other sorts of cannabis out there at the moment that is probably easy to get. I would prefer not to answer that question because I am not a specialist in drug abuse.

Dr John Kaye: Fair enough.

Professor COUSINS: That is a better one for them, they are closer to pertinent data.

Dr JOHN KAYE: In your introduction you talked about the importance of the setting in which medicinal cannabis was prescribed. Did you mean with respect to avoiding division or did you mean with respect to controlling the side effects?

Professor COUSINS: I think in terms of managing the patient. You do not just get pain in the absence of anything else and where patients have got into trouble with the long-term administration of opioids is when the prescription is repeated and repeated and the patient is not assessed, a proper history is not taken and a physical examination is virtually never taken. That is not what we want to see for people with severe enough pain problems to need these powerful medications.

Dr JOHN KAYE: To be clear, the importance of setting does not necessarily relate just to medicinal cannabis it relates to any of the palliative drugs you would be using?

Professor COUSINS: Exactly.

Dr JOHN KAYE: The issue is you are making a general plea for better settings arrangements for people with chronic pain?

Professor COUSINS: Yes.

Dr JOHN KAYE: You said at one stage there had been too much emphasis on the adverse side effects of medicinal cannabis. Can you elaborate on that? In what setting has there been too much emphasis?

Professor COUSINS: In the media. This is a powerful setting and it is the same with the opioids. There is a negative connotation of the opioids now after all the press coverage of tolerance and addiction and bad side effects, lots of side effects and there are lots of side effects with opioids, let us not pretend that there are not. There are side effects with cannabinoids if not used appropriately. I think there are a lot of parallels. There are some not entirely parallel.

Dr JOHN KAYE: Did I correctly hear you say that you had concerns about using cannabis based drugs, cannabinoids, for chronic non-cancer pain because you were worried about the long-term side effects?

Professor COUSINS: Yes.

Dr JOHN KAYE: That is correct, that is your position?

Professor COUSINS: Incidentally, it is the same concern I have about the long-term use of opioids. If you have you a 25-year-old person sitting in front of you with a chronic pain problem that very likely is going to go for the rest of their life are you really going to prescribe a drug that is going to be taken for at least 60 years? Then you look at the sorts of things you might predict will happen during those 60 years and that is a very big responsibility. That patient has to be assessed and reassessed very very carefully.

Dr JOHN KAYE: If you did prescribe a cannabinoid for a person who had long term chronic non-cancer pain, what sort of adverse side effects would you be worried about?

Professor COUSINS: There is a lot more work that needs to be done. This is exactly what we were saying previously. We know now that there are some neuroplastic changes in the brain associated with the administration of this and other drugs.

Dr JOHN KAYE: Neuroplastic, you mean changes to brain pathways or do you mean the causing of cancer?

Professor COUSINS: Predominantly changes in different discrete parts of the brain.

Dr JOHN KAYE: Changes in neural pathways?

Professor COUSINS: Anatomical changes. That has been possible by the use of advanced imaging such as functional magnetic resonance imaging [FMRI]. I should say the same is true of chronic pain.

Dr JOHN KAYE: Untreated chronic pain also has neuroplastic outcomes?

Professor COUSINS: Exactly. There is a bit of a difficult trade-off here. We know if you reactivate the patient, get them back to some normal life activities, reduce the pain, we do now know from very recent studies that the neuroplasticity changes in the brain start to revert back to normal. That is a very important finding. It was only published about 12 months ago. I guess we are in a bit of a tight fix with this because we do not know yet whether administering a drug like a cannabinoid long-term could finish up being favourable in terms of reversing the pain-related neuroplasticity changes or might just keep going, particularly if you keep taking the drug, might keep going producing harmful effects in the brain. I do not think we have the answer to that question, but it is one that concerns me.

Dr JOHN KAYE: You used the expression, "there is sufficient evidence," in your introductory statement. I presume that meant that there was sufficient evidence—

Professor COUSINS: —for analgesia.

Dr JOHN KAYE: There is sufficient evidence that it works for analgesia?

Professor COUSINS: Yes.

Dr JOHN KAYE: There is not sufficient evidence concerning long-term side effects?

Professor COUSINS: Exactly. There are studies that point one way and studies that point the other way but long term data is particularly lacking.

Dr JOHN KAYE: If we were to change a law tomorrow or there was to be a change of policy tomorrow that enabled you to use cannabinoid derived drugs you would feel comfortable using them with respect to acute pain?

Professor COUSINS: No, I would not. I think it would be inappropriate to use them in the acute setting, for example pain relief after surgery or trauma. I would be very comfortable with use in the palliative setting.

Dr JOHN KAYE: In the sense of someone who had a reduced life expectancy?

Professor COUSINS: That's right. Someone who has an incurable disease and clearly reduced life expectancy. The difficult area, and there is no clear answer to this, is in chronic non-cancer pain with a potentially normal, in years, life expectancy. But I would be comfortable in that setting with very careful assessment of individuals who might benefit and then appropriate frequent reassessment to assess in particular pain but also improvement in their mental and physical functioning and quality of life and if that is going downhill despite the use of cannabinoids, well then I think there should be a reassessment of whether that should be continued. So in whatever system is set up I think those requirements should be in some way included.

Dr JOHN KAYE: In that context, if you have a patient who has chronic non-cancer pain and a normal in years life expectancy, you have prescribed them a cannabis-based drug and you monitor them. Let us suppose there are adverse effects and you then decide, "We just cannot go on with this". You would then take them off the cannabis-based drug and try some other drug?

Professor COUSINS: Yes.

Dr JOHN KAYE: Would you expect those side-effects to reverse or would you expect permanent damage to have been done?

Professor COUSINS: I would expect them to reverse unless there has been a long-term administration but I do not think that is by any means certain at the moment. But we have to do this all the time. We have to take patients off one drug or another, either because it is not working or there are side-effects that have become intolerable. Cannabis would fit into that sort of paradigm.

CHAIR: In relation to pain relief in your opening comments you said that we do need a wider range of drugs to be available. In your opinion do you think that the next obvious drug or plant-based material to look at for pain relief is cannabis? Is that where the focus should be at the moment?

Professor COUSINS: Look, it is one of the options and we have been expecting there to be a cannabinoid that is a lot more specific than what we have got at the moment which would have a very powerful effect on the cannabinoid system. It is a very complex system, incidentally, so there are lots of points at which intervention could occur; it just has not happened and part of the reason for that is there has not been a big enough effort but many people have agreed that this is a very important target, one of the reasons being that the acute side-effects compared to opioids seem to be somewhat less so it is one of the key targets being pursued at the moment but there are another three or four targets that are right at the Food and Drug Administration level at the moment so one of those is going to arise and that will provide another important option.

The Pharmaceutical Benefits Advisory Committee has just approved a drug for the treatment of neuropathic pain. It previously approved an opioid combination drug that no addict would ever be the slightest bit interested in taking. That was an important step. For the very first time now we have a drug that works for neuropathic pain to some extent—it is not perfect—but at least we have one drug approved. There will be another three or four coming through in the next five to 10 years.

CHAIR: Do you have a view on cannabis being provided in a more crude form, say smoked by people who are in those end stages of their life, in a palliative sense? Do you think that that would be a path to avoid, given the obvious medical concerns about smoking?

Professor COUSINS: I say to my patients if they tell me that they are smoking cannabis, "Look, thanks for telling me. Just be careful to look at whether it is actually helping you or whether you are getting effects that are interfering with you enjoying any quality of life. It is not my role. I can't prescribe it for you in any sort of legal framework" and that is as far as I take it and that is about as far as I would like to take it here. I have made it clear what I think might be the best way to go at the moment.

The Hon. TREVOR KHAN: I am influenced by recent experience with my father who was in a nursing home for, as it turned out, some 3½ years dying, although he had been told before a significant event

that he only had six months to live, so he just seemed to go on. Our experience in terms of those 3½ years of end stage life was that a general practitioner would visit him about once a month to check on how he seemed to be going. He was on a range of medications that would appear to have caused him to frequently fit and the level of care—and I certainly do not denigrate the nursing home—was that a nurse or some form of assistant would come in and change his diaper a couple of times a day. I must say that he was actually a respected patient because he had be a general practitioner in the town for 50 years but if that is the level of care that people get in a nursing home and if others choose to try to end their life at home rather than get lost in a hospital system, I wonder when we talk about a pain plan how that fits in with patients such as my father?

Professor COUSINS: It is a very good question and the real situation at the moment is we have a pitiful level of education for all health professionals right across the board about pain and its management and the national pain strategy identifies that very strongly. Pain Australia is basically acting as a spearhead to try to harness the 150 health organisations that supported the national strategy, so it is a fairly powerful spearhead. But we need to go right back to medical school for doctors, to first degree for nurses and other health professionals so that they are actually taught something about pain; they are taught hardly anything at the moment—one hour in most medical schools is what people get. There would almost certainly have been a lot of what I might call bread-and-butter issues that needed to be assessed for your father to make him more comfortable and no doubt they were not being done.

I am reminded of the furore that went on about heroin and its introduction, and heroin, of course, is two molecules of morphine cobbled together and as soon as it gets into the body it is morphine. So heroin was no magic bullet, but it would be sad if cannabis became a magic bullet and people decided, well, we don't really need to do the things that we have just been discussing because there will be a whole host of things that you would find in that situation that would have added to your father's comfort. The primary care level is the biggest challenge and a very, very positive step has been that Medicare Locals arrangements. Almost half of the Medicare Locals organisations—I think there are about 60 something at the moment—almost half of those who put their hand up said they want help at an educational level and organisational level in setting up multidisciplinary assessment and treatment of pain at a primary care level, and I think that is an amazing response.

CHAIR: Professor Cousins, thank you for your attendance this morning. Committee members may have supplementary questions after the hearing which they would like to put to you and we have resolved that any answers be returned within 14 days. The Committee staff will contact you if that is the case.

(The witness withdrew)

PROFESSOR JAN COPELAND, Director, National Cannabis Prevention and Information Centre, University of New South Wales, affirmed and examined:

CHAIR: Would you like to make a brief opening statement?

Professor COPELAND: I would just like to reiterate, as I put in my submission, that while I am the director of the National Cannabis Prevention and Information Centre [NCPIC] I appear today only representing myself as an academic at the University of New South Wales [UNSW]. I am not representing any organisation that works with NCPIC or indeed our funding body, the Commonwealth.

The Hon. ADAM SEARLE: Do you think that medical use of cannabinoids has a positive role to play in the treatment of chronic pain and other adverse health situations?

Professor COPELAND: I am not a medical doctor or an expert in pain so I will just speak at the general level. I do think that the cannabinoid family of drugs is well and truly under-researched and certainly some of them have potential for medical application. I think the current state of evidence is not particularly strong; I think it is modest at best for two or three conditions and then only as a second line or adjunctive medication. But that does not mean that in the future—I think particularly the two cannabinoids of most interest to me in my research are CBD, cannabidiol, and THCV, cannabivarin. They are both less potent agonists of the cannabinoid system but have some interesting potentials as antianxiety, antipsychotic and other indications. But we are so far from having evidence at this point but, yes, I think they have potential.

The Hon. ADAM SEARLE: You mentioned three conditions or situations where the evidence was strongest for their use. What are those three?

Professor COPELAND: I think the evidence of it as a second line antiemetic for some cancer patients, and the evidence is old. The only time it has been put up against the most potent modern antiemetic it is not shown to be particularly effective in comparison. Nonetheless for some people who may not get relief from other drugs it should perhaps be in the offing for pain, as has been well discussed here. And also of course for Sativex in particular the evidence is increasingly strong as an antispasmodic, antispastic agent for those with multiple sclerosis. That is the indication of course as you know that it has been licensed for in Australia.

The Hon. ADAM SEARLE: You say that the evidence is old and at best modest, but were you here during the evidence given by Professor Michael Cousins?

Professor COPELAND: No.

The Hon. ADAM SEARLE: He is the director of the Pain Management Research Institute at Royal North Shore and he gave evidence that, as a pain relief clinician, he felt there was sufficient evidence to warrant the medical use of cannabinoids.

Professor COPELAND: I am speaking as a scientist reading the scientific literature that the effect size is modest, not large, but that does not mean clinically it might not be very effective for some patients.

The Hon. TREVOR KHAN: What is the difference between one and the other?

Professor COPELAND: We scientists tend to look for statistical significance. In clinical trials, for example, it is not often that the researchers look at quality of life, for example, or how it fits within a particular pattern of other medications or other aspects of the individual which are swamped in a large trial where you are looking at mean differences between two groups. That is the difference.

Dr JOHN KAYE: You are not a medical doctor?

Professor COPELAND: No.

Dr JOHN KAYE: What are you qualifications, if you do not mind me asking?

Professor COPELAND: Sure. I started out and I was a registered nurse and a registered midwife, which has now lapsed because I do not practice anymore. I have an honours degree in science, in psychology, and I am a registered psychologist and I have a PhD in community medicine and public health.

Dr JOHN KAYE: Thank you. Can I take you to page 16 of your submission where you are talking about those States in the USA where medical cannabis has been legalised and you make the assertion that in the USA cannabis use is higher in States where cannabis has been legalised for medicinal purposes.

Professor COPELAND: Yes.

Dr JOHN KAYE: You then reference that to reference number 57, which is Johnson, Burnell-Nugent and Lossignol, "Multicenter, double-blind, randomised, placebo-controlled, parallel-group study of the efficacy, safety and tolerance of THC: CBD extract", et cetera.

Professor COPELAND: Clearly the wrong reference.

Dr JOHN KAYE: That is the wrong reference. Can you tell us which reference does say that, because we have had conflicting evidence on that matter?

Professor COPELAND: I can provide you, I actually brought the references with me because I—

Dr JOHN KAYE: You do not know which reference? I actually went through these references and found it hard to find one that matched that assertion.

Professor COPELAND: I apologise for that but, as I said, I do have the references actually physically with me so you can read them in more detail. I think in summary it is a very controversial topic and the evidence—because I went back to look at it again—that has received the most media attention comes from the most poorly designed studies and from studies that in fact have never been published; they were presented at a conference. I actually contacted the author of one of these which received a lot of media in the US and she said she has not even written it up, and she is a medical doctor and not an epidemiologist. So I am not sure. It is very clear at the national level in the US that there has been a softening of attitudes to the harms associated with cannabis. That came first amongst the young people and the Monitoring the Future surveys and very quickly after that their levels of use increased nationally.

Dr JOHN KAYE: Can I just go back to that. You still have the strong statement, "In the USA, cannabis use is higher in states where cannabis has been legalised for medical purposes." Are you now backing off from that statement? Do you say it is more complex than that or do you still stand by that statement?

Professor COPELAND: No, I stand by that statement. I think the most recent and I think the best paper on this question was published in "Drug and Alcohol Dependence", which is a very high impact journal in our field. They put together a number of surveys which showed clearly that levels of cannabis use and levels of cannabis dependence are higher in those States where medical marijuana is—

Dr JOHN KAYE: Do those studies try to ascertain cause and effect or are they purely correlation studies?

Professor COPELAND: They are correlational studies.

Dr JOHN KAYE: For example, California is one of those States that already had a high level before. Even when it was illegal in California and even when there was a large amount of effort to stamp it out, there was still a very high use of cannabis in California.

Professor COPELAND: Yes and that makes sense that those States where cannabis use is more normalised are more quick to take up these regimes, but nonetheless the levels of use have gone up.

The Hon. TREVOR KHAN: I suppose that is really where it comes from, you say nevertheless the use has gone up. Does the study demonstrate that the increase in usage in the States that have legalised the use of cannabis for medical use has increased at a greater rate than in States that have not?

Professor COPELAND: I am not aware of looking at trends of trajectories of increased use.

The Hon. TREVOR KHAN: That is the problem, is it not? Otherwise it is a selective use of statistics and indeed a misleading use of statistics.

Professor COPELAND: I would not characterise it as a misleading use. I am presenting the data that has been peer reviewed.

Dr JOHN KAYE: Professor Copeland, your entire submission, which it would be fair to say is a fairly intensely anti-cannabis submission—and there is nothing wrong with that, but it is—relies on those sorts of assertions, does it not?

Professor COPELAND: Well, we have to go through a particular case by case, but looking at epidemiological evidence, which is not done by anyone who is for or against the issue, standard epidemiological researchers come to these conclusions, I think.

Dr JOHN KAYE: Let us go to page six of your analysis:

> Cannabis is considered to be a drug of addiction with approximately 8-10% of those who try it becoming addicted.

The reference for that is listed as No. 6, and is a National Cannabis Prevention and Information Centre [NCPIC] internal publication. It is not a refereed article.

Professor COPELAND: Well—

Dr JOHN KAYE: That is exactly right. It is your own "Management of cannabis use disorder and related issues: a clinician's guide", so you had a reference in that to "8-10%", which is higher than some other studies we have seen. You have not referenced that against any other peer-reviewed article or study.

Professor COPELAND: Well, I did not realise that I had to do a fully primary referenced document for this. It was something that I put together quite quickly because I wanted to put something in for this Committee's information. So I apologise that I have not included every primary reference on this, but it is an extremely well-accepted view. In all of the Diagnostic and Statistical Manual of Mental Disorders [DSM] and the International Classification of Diseases [ICD], the literature is very, very strong about cannabis and its potential as a drug of addiction.

Dr JOHN KAYE: Thank you for that. Can I take you to page two of your submission, which states:

> Given the growth of medical marijuana "pharmacies" in the US and now legalisation of cannabis in two American states, the influence of the very powerful and well funded pro-cannabis lobby groups have had a marked influence on community perception of the harms associated with cannabis use among American adolescents …

I have two questions with respect to that: firstly, can you name now, or provide on notice, the identity of any of those very powerful and well funded pro-cannabis lobby groups?

Professor COPELAND: No, of course not. I do not know if you have been to California recently. I have brought with me a couple of examples of the way that cannabis is advertised and the entrepreneurs that are making an extraordinary amount of money out of this business. Of course, there are very strong lobby groups for it to continue to be available as it is there.

Dr JOHN KAYE: I am sorry, you cannot provide for us a name for those lobby groups, but you are saying those lobby groups exist and they are very powerful and well funded?

Professor COPELAND: No, I cannot name particular individuals who members of lobby groups.

Dr JOHN KAYE: I did not ask you that. I asked could you name the lobby groups themselves?

Professor COPELAND: Oh, the National Organization for the Reform of Marijuana Laws [NORML], for example, in the United States.

Dr JOHN KAYE: Okay.

Professor COPELAND: They put an enormous amount of money into the campaigns—millions and millions of dollars.

Dr JOHN KAYE: Okay. That is why I ask, on notice, could you please provide us with the names of the other lobby groups that justify that sentence? Secondly, you go on to say:

> … have had a marked influence on the community perception of the harms associated with cannabis use among American adolescents.

What evidence do you have that that is so—that those campaigns run by groups have actually changed attitudes? What evidence base are you relying on to make that assertion?

Professor COPELAND: The evidence, which you have already not accepted, of the "Monitoring the Future" survey that actually asked this question. Of course, no-one can say it is directly as a result of that, but given the level of normalisation of cannabis use by these groups and the very strong psychological evidence that normalisation of a behaviour affects the likelihood of it being taken up by others, that is the inference that has been drawn.

Dr JOHN KAYE: A lot of the discussion in your submission goes to the American model. I am saying "American model" because there may be variations between states, but what I understand to be in Colorado, California and maybe other states, the American model of cannabis dispensaries is where the raw cannabis product or raw cannabis plant material is provided through a dispensary for registered patients. In your studies, do you see significance in terms of the alleged normalisation process between that and, for example, what the previous witness was talking about, which is a more clinical based approach to cannabis, such as the cannabidiols and the Sativex mouth sprays? Would you extrapolate from what is happening in America to something that we might do here, where we prescribe cannabis-based products, but not necessarily the raw smoking product?

Professor COPELAND: Obviously. There is a huge difference. I myself and my group are the only Australian or anywhere-in-the-world researchers who have used Sativex with a cannabis-dependent population, so clearly I see its application for that and for a range of other conditions. That is a very different question to providing, as in the American clinics, raw cannabis leaf.

Dr JOHN KAYE: Sure. So you would see, in terms of the normalisation impacts, if I may use that expression, of which you are alleging the cannabis dispensaries have had in the United States, you would not see any extrapolation from that to any trial or use of medicinal cannabis in a more prescription kind of setting?

Professor COPELAND: I think it would be markedly less. I have an adolescent son and all of his friends. When I talk with schools and young people, the first thing they say when you talk about cannabis is, "Cannabis is safe. It's medicine." So I think there may be some leakage, but clearly it would help very greatly if it was a prepared pharmaceutical product.

Dr JOHN KAYE: You do not think they might have been trying that on with you because of your professional background?

Professor COPELAND: No, not just—

Dr JOHN KAYE: It would be an unusual conversation to hear.

Professor COPELAND: Not just for me, but my colleagues who work in drug education in schools and health professionals who work in schools and with young people. It is certainly a very prevalent attitude and they latch onto that as their first line of argument, of course.

Dr JOHN KAYE: Can I take you to page 17 and the top of page 18, where I think there is a typo. It states:

> As an Australian cost benefit analysis of legalised-regulated opinion of cannabis …

I presume "opinion" should be "option"?

Professor COPELAND: Page 17?

Dr JOHN KAYE: At the bottom of page 17—the last sentence—and on the top of page 18, under the heading "Conclusions".

Professor COPELAND: Oh, yes.

Dr JOHN KAYE: It states:

As an Australian cost benefit analysis of legalised-regulated [option] of cannabis availability predicted a 35 % increase in the prevalence of use, this should also be considered for any model …

Professor COPELAND: Yes.

Dr JOHN KAYE: Can you tell us a little bit about that study, which I think is a PhD thesis that you may have supervised. Is that correct?

Professor COPELAND: No, no, no. I had nothing to do with it.

Dr JOHN KAYE: It is a University of New South Wales doctoral thesis.

Professor COPELAND: It is in the Drug Policy Modelling Program that Alison Ritter, who is part of the Australia21, and who is not tarred, as I am, with a particular reputation, apparently.

Dr JOHN KAYE: I am not trying to tar anybody. I just want to know what that study was. It was a 35 per cent increase?

Professor COPELAND: Yes. She looked at it—she is a health economist—from a very different perspective and did a range of studies of the costs and benefits of various models of cannabis availability. When she looked at a cannabis legalisation model, where it was highly regulated and similar in some ways to what would be in a medicinal type of program, she found there would be an increase in cannabis smokers in New South Wales from 438,501 to 700,345, which would also lead to 85,000 more new tobacco smokers, which was costed out to 406 additional deaths in New South Wales, and costs of health care and fires of $176 million.

Dr JOHN KAYE: The model that this PhD student was looking at to get the 35 per cent increase in prevalence, can you describe what kind of legalised regulated option was being looked at there?

Professor COPELAND: I do not have that information with me, and I am not an economist.

The Hon. TREVOR KHAN: No, no. That is not the question. It is not a question of whether you are an economist, but it seems to me there is a whole range of different models that are available—a whole range of legalised usage in the United States, the Netherlands model of what we could describe as legalised usage, and there is an Israeli model of legalised usage in very restricted circumstance. The statement that is there refers to a legalised-regulated model and says there is a 35 per cent increase. Because it is a significant assertion that is made, I think it is very important for us to know what is the model that founds your conclusion?

Professor COPELAND: As I said, I would have to refer you to Marion for the details of her modelling.

The Hon. TREVOR KHAN: But it is in your paper in part of your conclusion?

Professor COPELAND: I think it should be flagged as something that should be investigated by this Committee so that whatever model you decide, when you look at the costs and benefits of it that you include these factors in it. I was not meaning to imply that this is the quantum that would be attached to any model you might come up with. I am just saying when you change the policy settings these are the issues that might need to be considered.

The Hon. TREVOR KHAN: You can be assured that for some of us, or perhaps all of us on this Committee, any change in the law that is considered in this area is very serious and the impact upon the broader community is one of the factors we are considering very seriously.

Dr JOHN KAYE: Absolutely.

Professor COPELAND: That is very encouraging. Congratulations. That is great.

The Hon. TREVOR KHAN: Thank you, but in dealing with those matters we look to the witnesses who come before us to be able to assist us with regards to their assertions. Again, a proposition has been put forward that it would lead to an increase of 35 per cent. If that were so, I would run for the hills from any proposal to change the current law. But as you have made the assertion, I am looking for your assistance to tell us what the regulated model is that grounds a 35 per cent increase prediction?

Professor COPELAND: As I said before, I am afraid I cannot tell you the details of the model that she used, but I can provide you with that information.

The Hon. TREVOR KHAN: Excellent, thank you.

The Hon. ADAM SEARLE: On notice, excellent.

Dr JOHN KAYE: One issue that a number of witnesses, yourself included, seem to be pushing us towards is that if we are to recommend going down this direction we should look at products such as Sativex, that is to say, manufactured pharmaceutical products rather than those products that might be, for example, cannabis oils or resins or cannabis itself. Of course, you have done some studies into Sativex, which you have acknowledged in your report. Would you accept that Sativex is probably the most expensive way of delivering a cannabinoid?

Professor COPELAND: Yes.

Dr JOHN KAYE: At the moment the costs associated with that would be borne by the patient. I think we heard that it was $6,000 a year, is that correct?

The Hon. ADAM SEARLE: Yes. One estimate was $500 a month.

Dr JOHN KAYE: At $500 a month, $6,000 a year for the patient. It is not currently covered by the pharmaceutical benefits scheme in Australia, for obvious reasons. Of course, if it is, that would be a burden against the costs of PBS rather than against the cost of the patient. But there is still the cost of such a drug. In your studies have you looked at that issue of the costs associated with going down the route of a manufactured product versus the relatively lower pharmaceutical costs of a less manufactured or less patented product compared to the benefits of Sativex, particularly in a better ability to titrate it?

Professor COPELAND: No I have not.

Dr JOHN KAYE: I think it is fair to say that you have strongly pushed us in the direction of an extract such as nabiximols. Can you provide a justification for pushing us in that direction rather than into the less manufactured version?

Professor COPELAND: I think if you wish a doctor to prescribe a medication, they would want to know what is the composition of that drug, what is the potency, what are the contaminants and that it has been provided in a consistent way. So from one dose to the next the person they would know what medication they were taking. It is a fairly standard medical and pharmaceutical approach that you be aware of what it is you are providing.

Dr JOHN KAYE: You may not be able to answer this, but what is the experience with the American cannabis dispensary model where a variety of cannabis strains or products are available? I have not been to the United States. If I go to America soon I would like to go see a cannabis dispensary model. What is the experience with titration there? Have there been any studies of the variable quality of one particular product? If I fronted up to a dispensary tomorrow and bought however much one buys of the substance and I returned five weeks later, would I get the same thing? Is there repeatability of that? Is there controllability?

Professor COPELAND: That is highly variable. Some of the ways these medications are advertised clearly are to appeal to healthy young men rather than to chronically ill adults. I have been to a number of them and I have a continuing relationship with one of the better ones in California. There are certainly very strong claims made about the different preparations. They are given very glamorous names. Some of them supply their

own; they have their own growing laboratories either on the premises or attached to their service. So they would have probably a more consistent product than others, who just take whatever they can source from the black market to sell in their particular clinics. Some claim that they know which strains are used, particularly the indicas versus the sativas, but no-one I know of has ever tested those. My colleagues at UCLA in California are doing some studies with clients of these clinics to look at the sorts of conditions they present with and their experiences with particular kinds of preparations. But there is no systematic research that I am aware of.

Dr JOHN KAYE: Is it surprising to you that there is no systematic research, given that it is a highly controversial move by these 18 States and one district? I would imagine that people or academics would have been busy going around getting samples and working on them to work out whether there was consistency with dosage.

Professor COPELAND: Yes, it has been a huge public health and medical experiment, which has been almost entirely unresearched. I found it quite shocking when I travelled that these questions have not been addressed. It has been more as a social movement than a medical movement, in my view.

Dr JOHN KAYE: You referred to one dispensary with which you had a relationship and you referred to it as one of the better ones. What were the characteristics that made it better than others?

Professor COPELAND: It was more discreet. It was not one that, in the sorts of materials that I provided, advertised in irresponsible ways. They have a strong interest in scientific research, including the Sativex type, nabiximols-type, preparations. They are not out just to make money; they have a genuine interest in the uses of cannabis products and providing high quality and well-targeted products. Nonetheless, they still provide cannabis to adolescents, which I find concerning.

Dr JOHN KAYE: I presume that this is in California. I thought there was a 21 year age limit?

Professor COPELAND: No.

Dr JOHN KAYE: There is no limit?

Professor COPELAND: There is no limit that I am aware of because it is not a prescription; it is a letter of recommendation from a doctor. There have been some kind of anecdotal studies from various States where prescriptions are for very young children for ADHD, which I find rather concerning. But there tends to be just a small number of doctors that do most of the letters of recommendation for this drug. It is not widespread across the medical community.

Dr JOHN KAYE: Earlier you talked about the advertising, promotion and marketing of cannabis. It is fair to say that for an Australian who has never been to America one of the first things they notice is how heavily all pharmaceuticals are promoted.

Professor COPELAND: Absolutely.

Dr JOHN KAYE: Including things we would never dream of promoting here in Australia?

Professor COPELAND: Yes.

Dr JOHN KAYE: So that promotion is happening in a context of a culture and a society that does tolerate the promotion of pharmaceuticals?

Professor COPELAND: Yes, but the type of advertisement for cannabis is not consistent with, to us, extraordinary pharmaceutical advertising. It is more consistent with product advertising like alcohol. It talks up intoxication, the relationship between partying and drug use. A lot of semi-naked young women are used in a lot of these ads for medicinal cannabis. The golden arches are replicated in restaurants for marijuana products, with green arches. Really not consistent even with pharmaceutical advertising.

The Hon. TREVOR KHAN: Could I tell you what I muse on? I would take the United States experience to be almost a free for all: If you can get a doctor to prescribe or certify that you are a suitable patient, away you go and you can get as much access to the drug as you like. Is that the general picture in the United States or at least in some of the States?

Professor COPELAND: Yes.

The Hon. TREVOR KHAN: In a sense it is creating a guise for recreational use by saying you have a bad back?

Professor COPELAND: Yes. It is cannabis maintenance for those who are dependent—2 per cent of the population in some States are now on a medicinal cannabis program.

The Hon. TREVOR KHAN: We have that model. Let us suppose that the evidence we have received here to date—and I cannot speak for the other members of the Committee, because they will all have their own mind—there is a discrete group of people in our community who may get some benefit from the drug and those people are those in the end stages of cancer, who are suffering from nausea and difficulty eating, and those people who have full-blown AIDS and who are also suffering from a range of conditions but also difficulty in eating. If you had a model that restricted the usage to those people, not chronic long-term pain sufferers but to people in the end stages of life, do you stand by the propositions as to the negative impacts that I seem to glean from your submission?

Professor COPELAND: Clearly, if you are talking about a small number of people, obviously the implications would be—

The Hon. TREVOR KHAN: I cannot say how small that is, because we all die eventually, but if we are talking about people with very serious end stage cancer and full-blown AIDS sufferers, for instance, we are talking and perhaps in the order of, I would imagine, some thousands as opposed to hundreds of thousands under a more expensive chronic pain model?

Professor COPELAND: I certainly would not want to make the life of people in those situations any more difficult than it already is. I think for that group who are in palliative care and who are not getting relief from the mainstream medications or even from Sativex-type preparations whose only psychological relief because they strongly believe that smoked cannabis is the thing that works for them, I think having some kind of compassionate scheme where that is used as an excuse if you like—I cannot imagine people want to prosecute people in that situation. If there is some way legally to have that as an exemption for that small group, I think no normal person would want to take that option away from people. But, as a general cause, I think if cannabinoids are going to be made available they should be in pharmaceutical preparations where there is a known dose and no impurities.

The Hon. TREVOR KHAN: If my line of reasoning might be taken up by some of the others, I think that is the group we are looking at although there may be a difference among the Committee members in that regard. If it is that discrete group there are two alternatives that come for those two discrete groups. One is it will only be in a pharmaceutical prescription and the other is that it be a wider use, that is people would have access to the leaf product in some form. You understand that context of it?

Professor COPELAND: Yes.

The Hon. TREVOR KHAN: Again, I am not harping on it, but do I take it that is not the style of restricted medical access that was envisaged in Dr Marion Shanahan's doctoral thesis?

Professor COPELAND: No, that was the general availability of adults in the New South Wales community.

The Hon. TREVOR KHAN: Do I take it that you would agree with me that if some form of recommendation were made for access for a very discrete group, then recommendations with regard to continued prohibitions on any form of advertising should exist?

Professor COPELAND: Absolutely.

The Hon. TREVOR KHAN: Indeed, do I take it that you would be recommending that there be a boost in the education that goes on with regard to the harmful effects which you justifiably set out in your paper with regard to cannabis?

Professor COPELAND: Yes. Obviously the message has not got through to many groups that there are harms associated with cannabis, including dependence. I have a very tiny budget in order to address that issue. Certainly greater prevention and public health messaging around cannabis would be an important corollary of increased access even for a very small group so there is a clear understanding in the community what is happening.

CHAIR: On page 12 of your submission you detail some of the different cannabis products that have been tested, and Sativex is one of them. The first dot point in your submission on page 12 refers to Donabinol or Marinol. You talk about how that has been used since 1985. About halfway through that paragraph you mention that it has proved successful in reducing cancer pain in specific doses but the side-effects were prominent. Can you tell us a little more about your understanding of what those side-effects were and how that was an issue?

Professor COPELAND: I apologise, there is another error here. It is Dronabinol, with an "r". It is also marketed as Marinol in the United States. It is a synthetic cannabinoid so it lacks some of the advantages of Sativex which has the terpenes and the other products of the plant. People tend not to like taking cannabis orally because it is not well absorbed. So, you have to take quite high doses in comparison to other routes of administration. That means that people think it is not having an effect so they take some more and suddenly they are feeling quite ill. Ironically, while it is an anti-nausea agent, in the wrong dose it can increase the nausea and unpleasant feelings of intoxication. They are the sorts of side-effects that people do not like. We find with Sativex the same thing. Adults with multiple sclerosis tend to only like very low doses of Sativex compared to those doses we use with those who are cannabis dependent, because they do not like the feelings of being intoxicated.

CHAIR: So they are more immediate side-effects as opposed to long-term side-effects?

Professor COPELAND: Yes, just related to toxicity.

Dr JOHN KAYE: Sorry, toxicity?

Professor COPELAND: Toxic, not as in fatally poisonous but more than the intended levels of THC.

Dr JOHN KAYE: Can we go to the issue of tobacco. I am pretty sure I am right in saying you raised the issue of tobacco being mixed in recreational cannabis?

Professor COPELAND: Yes.

Dr JOHN KAYE: I think you talked about some of the harms associated with that. I think you rattled off some figures that were not in here. Those harms were largely to do with tobacco rather than cannabis itself, were they not?

Professor COPELAND: I did some back of the envelope calculations, if you like. Some of the reports of medicinal cannabis users say that they use about a quarter to an eighth of an ounce a week of cannabis, which is about 3½ to seven grams. When we look at our dependent population, they are using about the same amount. Working from the respiratory figures, and I did bring some references with me, each cannabis cigarette equates to about 2½ to five tobacco cigarettes in terms of respiratory harm.

Dr JOHN KAYE: Are you doing that on the basis of tar content?

Professor COPELAND: The range of carcinogenic materials, when you look at the effects.

Dr JOHN KAYE: Including tar?

Professor COPELAND: Including tar. Particularly tar, probably.

Dr JOHN KAYE: Of course, excluding nicotine?

Professor COPELAND: So, it works out that the average medicinal cannabis user is using about between 7½ and 15 cigarettes a day worth of respiratory effects of cigarettes plus they usually mix about 50:50, tobacco and cannabis. So, that is another 7½ to 15 cigarettes worth a day. They certainly have an additional respiratory risk of smoked medicinal cannabis.

Dr JOHN KAYE: The issue, of course, with tobacco is that it is highly addictive?

Professor COPELAND: Yes, so they end up with two dependencies.

(The witness withdrew)

(Luncheon adjournment)

PAUL FRANCIS O'GRADY, Individual, sworn and examined:

CHAIR: Welcome, Mr O'Grady, and thank you for appearing before the Committee. Would you like to make an opening statement?

Mr O'GRADY: Please, I would. Madam Chair, I think you are the only person I do not know here and have no relationship with, and who perhaps knows less about my story than anyone else, but I am an early HIV-diagnosed person and I have recently had cancer, so there are two aspects, I suppose, to this presentation. I think one of the important things is to recognise that every individual has a different reaction to pharmaceutical drugs and substances. I have always been on the top end of reactions. I was a person who could never take azidothymidine [AZT], which was the first successful drug in dealing with HIV. It was a drug which would nuke me: the more I took it, the worse I got.

The first pharmaceutical drug I could really take was a drug called ritonavir, but that involved me staying home for three months and dealing with the side effects. Those side effects were nausea. I could draw a line down the centre of my head, and one side was fine but the other side was not. So I have always had adverse reactions to the drugs that I had to take, or tried to take. In my most recent incarnation, having to deal with both chemotherapy and radiation, I spent I suppose the best part of nine months or 10 months in St Vincent's. The radiation burns were like nothing I had ever experienced before. I could not keep anything down, or in. I got down to 40 kilograms. I was pretty border line.

Someone sent me some liquid marijuana. St Vincent's has always been a place of wonderful care. It is a place that, when I first went there, believed in and gave advice in the notion of total care. I think it is important to remember that everyone's make-up is different and everyone reacts differently to different substances, and what works for one does not necessarily work for someone else. I think that it is important, when one is trying to make public policy, that we remember that Australia is a world leader in sensible public policy. For me, marijuana works. It works in terms of nausea and it works in terms of trying to activate an appetite. When you are down to 40 kilograms, it is important to get food into you and it is important to try to retain food.

I can understand people's sensitivities about how something like this might operate. I accept that it is not necessarily something for everyone, but I do think there is a place for it and I do believe in public policy, which works across a whole range of types of care. I see this as being one part of total care. I think I am the beneficiary of both a general practitioner [GP] and a hospital, which has provided me with the opportunity for total care. I do not think I would be here today, if that was not the case. I might leave my comments there. I am happy to answer any questions.

The Hon. ADAM SEARLE: We have been hearing some evidence from doctors and others that there is a substantial body of evidence now for the medical use of cannabis or cannabinoid products. From your presentation, obviously it sounds like you would advance that opinion. At least in your own personal experience, it has proved beneficial. But there has been some resistance to the idea of leaf matter or smoking, and there has been the advocacy around other forms of products, such as liquid forms, capsules or sprays. Do you have any particular view about the vehicle by which these are most effectively utilised?

Mr O'GRADY: I suppose if you smoke it you are more conscious of the immediate impact—eating and digestion is much harder to gauge and liquid is something that really I do not think I ever quite mastered. I believe in evidence-based policy, but it is a bit hard to have evidence-based policy if you really do not have any statistics to work from. I return to the theme of different horses for different courses. Obviously, you would be better not to smoke it from a lung perspective. When I was crook, that was actually something that was really hard because my body was so fragile. I believe that you should have a system that suits the individual and that you can create a system whereby you seek to assist the person in the most productive way, whichever way that might be.

The Hon. ADAM SEARLE: This morning we heard evidence from Professor Cousins of the Pain Management Research Institute at Royal North Shore Hospital. He expressed his view as a pain management clinician that there was an urgent need for more pain management options available to people in the medical profession, such as himself. But at the same time we heard evidence also from the Ministry of Health that from its pain management network it was not hearing any clamour or not much for the medical application of cannabis or cannabinoid products. These two views seem to be discordant. From your experience or knowledge are you able to assist the Committee with your understanding of what views might be in the pain management community, if I can use that term?

Mr O'GRADY: I thought I had been through a bit, but I had been through nothing when it came to radiation pain. It is the most excruciating and mind-numbing experience. It is one of those bizarre things: when you actually are getting it you do not feel anything, but with the cumulative effect, if you excuse the language, I reckon I could have fried eggs on my behind. I finished radiation I think in about January last year. Those burns still have not healed. I am still dealing with the effect of radiation burns. I had never, ever, ever experienced anything like the pain that radiation gave me. It is that whole notion of nearly killing you to save you. It is that totally bizarre concept. Now, my radiation doctor, who is a sort of bizarre man—I did not really see him—came back in the end and said, "Well, look, you know, I didn't think you'd be here so I haven't bothered to come to see you." Lo and behold, I am here. I pay great credit to the nurses and doctors of St Vincent's who got me through that period. I do not think too many people really thought I would be around, but the pain of radiation was just excruciating and for me marijuana works. I am not saying that is the same for everyone, but for me it works. From my perspective, a holistic treatment is important. My GP and the nurses of St Vincent's and the institution of St Vincent's have allowed me that opportunity for total care. All I can say is that for me it is productive.

The Hon. AMANDA FAZIO: One issue that is of particular concern to me is the added layer of stress placed on people who suffer in great pain—are severely ill or terminally ill— of having to use a form of medication that is illegal. Has that been at the back of your mind when you have been using a treatment that you know is illegal?

Mr O'GRADY: Again I preface all this with this comment: I could not have experienced a more wonderful group of people than the people of St Vincent's. However, on this occasion when they discovered liquid marijuana in the fridge, they went berko. The difference between the way in which St Vincent's behaves today and what it did in the early nineties is worth looking at. I suppose I see it in this context: When I was first a patient of St Vincent's the Sisters of Charity nuns were in charge whereas these days there are not too many nuns around and they do not actually run the hospital. We have gone from the notion I think of total care to ticking squares and ticking boxes. As a structure we are much more fearful of things than we used to be. In my lifetime it is interesting to see how that has changed. I can understand nurse unit managers being concerned. It is a perfectly reasonable position to take, but I think it is a bit bizarre that in my lifetime when we have seen so many advances in so many things we have moved backwards from that notion of total care. I think I am eternally grateful to my original GP and for the treatment room of St Vincent's who, when I first went there, had that notion of total care.

Dr JOHN KAYE: Thank you for coming and giving such honest testimony; it is extremely useful for us. You said that when St Vincent's discovered liquid marijuana in the refrigerator in your ward they went berko, as you put it. Was that because you were self-medicating or because you had an illegal substance?

Mr O'GRADY: I think it is a bit of both. I think it may come down to the knowledge of an individual. People are fearful of things that they do not necessarily know a lot about. To be honest, it was my first experience of it and I probably did not handle it as well as I should have. But to be honest also, I was not really capable; I was pretty crook. It is just totally soul destroying to sit down to try to eat and you get a spoonful in and not only does it come out of your top end, but also it comes out of your bottom end too. When you go meal after meal after meal and you cannot keep anything down, on that odd occasion when you looked at yourself in the mirror, it was totally frightening.

Dr JOHN KAYE: Liquid cannabis helped that?

Mr O'GRADY: It takes that edge off the nausea.

Dr JOHN KAYE: So that you could keep something down for long enough so that you could absorb something?

Mr O'GRADY: Long enough so that you want to eat.

Dr JOHN KAYE: You put on weight at that stage, did you?

Mr O'GRADY: I dropped to 40 kilograms. In my worst stage I was 40 kilograms. I am now 74 kilograms. So, I suppose the worse time was, I do not know, maybe February of last year. By the time I got out of hospital I was pretty feeble but I was on the way back.

Dr JOHN KAYE: Did you have any side effects from the use of cannabis?

Mr O'GRADY: I do not think so, except good. It gave me an appetite. With nausea and dealing with chemotherapy and a whole variety of drugs, it is about trying to keep a cap on your oesophagus. If you can get enough food down you and keep it down and keep eating, grazing as people like to call it, the grazing is crucial because it breaks the cycle and it is about trying to break that cycle.

Dr JOHN KAYE: You got stoned from it, presumably?

Mr O'GRADY: No. Well, I suppose technically yes but there is a big difference between eating it, where I have always found it very hard to work out what the right level is. It is not about trying to be stoned. It is about dealing with the nausea, activate the appetite and progress.

Dr JOHN KAYE: But you did not notice any side-effects? Do you think it was beneficial or adverse to your mental health? I mean your mental state of mind, how you felt about life?

Mr O'GRADY: If you can eat and you can keep something in you—

Dr JOHN KAYE: You feel so much better.

Mr O'GRADY: And you are not a pain in the backside to the nurses because you can start functioning again.

Dr JOHN KAYE: Did you get any relief from the pain as a result of the cannabis or was that other drugs?

Mr O'GRADY: I find that incredibly hard to answer. There are so many drugs in you. I can see myself—you can talk to Lynda Voltz about this—where I am just so psychotic with pain.

The Hon. TREVOR KHAN: What are we asking Lynda, about psychosis?

Mr O'GRADY: As an observer of me in that period, and bringing her children in to see me. I can see myself lying in that bed just been totally—you know—and I hated morphine because you had this other person inside your head and I loathed being in that state.

Dr JOHN KAYE: So you really did feel like you were out of control when you had the morphine but when you took the liquid cannabis you did not have any of those feelings of loss of control and otherness that people report?

Mr O'GRADY: No.

Dr JOHN KAYE: You are out of hospital now and you are looking fabulous. You did not have any lasting ongoing addiction problems or craving problems for cannabis?

Mr O'GRADY: No.

Dr JOHN KAYE: So, through that period you obviously used it fairly regularly to get yourself eating again?

Mr O'GRADY: Yes.

Dr JOHN KAYE: Once you were eating again you were able to control the use of it entirely?

Mr O'GRADY: You were on the up.

Dr JOHN KAYE: And once you were on the up it was no longer relevant to you, and there were no other lasting side-effects that you can detect now?

Mr O'GRADY: No.

Dr JOHN KAYE: The cannabis you had you described as liquid cannabis. That is plant that has presumably been heated?

Mr O'GRADY: I would blame Quentin Dempster for it.

Dr JOHN KAYE: Naming people is not our activity. You do not name members of the media.

Mr O'GRADY: Just let me continue. I did an interview with him bagging my great friend Ian Macdonald and as a result of that someone sent me some. It arrived in the mail and I have absolutely no idea who that was. I do not have a process for that.

Dr JOHN KAYE: Are you aware of other people who were in a similar position to you or similar chemotherapy, radiotherapy, nausea, weight loss and who tried a similar drug and reported similar results?

Mr O'GRADY: Yes, but, like all things, it is horses for courses. It does not necessarily suit everyone, I accept that.

Dr JOHN KAYE: So, for some people this did not work?

Mr O'GRADY: No, but for some it does. I just think from a public policy perspective one should seek to have the widest possible—

Dr JOHN KAYE: That was Professor Cousin's point exactly, that we need a wider variety of drugs to deal with pain. That is totally consistent.

Mr PAUL LYNCH: Thank you, Paul, I think this is the best evidence-based testimony we have had. You obviously have a very strong sense of survival, in my view, given what you have survived now. One would like to think you will be around for a long time. When you were in the condition you were in, did you think about the long-term impact of what this might have?

Mr O'GRADY: No, because to be honest with you, you are living from minute to minute. You are trying to get through this hour or this day. I suppose my most constant thought through that process is why am I going through this. If anyone could explain to you the pain of radiation—I had experienced chemo-type drugs before for C&V and things like that—but the combination of chemo and radiation, I had 31 bouts of radiation. If anyone could explain to you the pain involved, there is no way in the world you would do it. It was very much about trying to get through the day really.

Mr PAUL LYNCH: I imagine that somebody with your strength of mind would be able to delay that and handle it when and if it happens?

Mr O'GRADY: I have to say I was extremely lucky to share a room with a man who had brain cancer. He used to say to me during the night you need more pain relief, you need more pain relief. At that point, having someone else around who had, frankly, gone through a lot worse than I had was a great help. That poor man died but he was really very useful to me understanding what I was going through and what I would go through.

The Hon. TREVOR KHAN: We have had a submission from ACON, and in its submission it refers to the possible interaction of cannabis with such medication as Atazanavir. Have you or anyone that you know experienced adverse reaction from the combination of the use of cannabis and other medications you may be on?

Mr O'GRADY: Yes, but, as I say, everyone reacts differently to drugs. I have always been on the high end of reaction. So, yes, people always talk about caution, not mixing substances and alcohol and all those sorts of things. I suppose I have always had a fairly conservative approach. If you are using X and you are going to use Y, you do it in very small quantities to gauge the impact. I have always thought and I have always behaved in a conservative fashion to see what it does to you. If you can manage that that is cool, if you cannot manage that, well then don't.

The Hon. TREVOR KHAN: Is cannabis in one form or another continuing to be part of what I will describe as your treatment regime?

Mr O'GRADY: Yes.

The Hon. TREVOR KHAN: In what form are you now using? You do not have to answer?

Mr O'GRADY: Smoking. That is not my favoured form but it is the easiest and I find it much easier to gauge that impact than eating it, which everybody would say is the best way, because I do not use it to get stoned. I use it to wipe out that nausea or to bump the food intake. Whilst medical people would say you should eat it I have never found that balance easy to get. So it is much easier to smoke than it is to ingest because I am not about wiping myself off.

The Hon. TREVOR KHAN: When you smoke it do you smoke it as a joint or do you use a bong?

Mr O'GRADY: A bong. It is a small quantity.

The Hon. TREVOR KHAN: For the purposes of the transcript, why do you prefer a bong to a joint?

Mr O'GRADY: Because there is less of it. It is cooler, so it does not burn your throat and it is always my throat that goes first. If I get infections it always starts in my throat. I wear a scarf a lot to keep it warm and I still do. That is how I practice.

The Hon. AMANDA FAZIO: Have you ever thought about using a vaporizer?

Mr O'GRADY: I have never really explored it.

The Hon. AMANDA FAZIO: I have only seen it on documentaries?

Mr O'GRADY: I would not know where you find it but it is not something which I really know anything about.

CHAIR: Unfortunately, that is the end of our time. I know the other Committee members have also conveyed this, but thank you for coming and speaking to us. There is a lot of difference between written submissions we have received from people who use cannabis medicinally to hearing your story. The Committee members may have supplementary questions for you. If that is the case the Committee staff will contact you directly.

The Hon. TREVOR KHAN: Can I make a further observation? There is a lot of difference between Mr O'Grady's evidence and the so-called expert evidence from some of our witnesses.

The Hon. ADAM SEARLE: I think Charlie Lynn's observations are accurate.

The Hon. CHARLIE LYNN: Yes.

(The witness withdrew)

MARGARET HALL, Australian Drug Law Reform Initiative, affirmed and examined:

BEN MOSTYN, Australian Drug Law Reform Initiative, sworn and examined:

CHAIR: I would like to welcome the witnesses from the Australian Drug Law Reform Initiative. Would either of you like to make a brief opening statement?

Ms HALL: I am an adjunct lecturer at the University of NSW. I am a PhD candidate. I am submitting tomorrow.

CHAIR: Thank you for being here today.

Ms HALL: I will briefly introduce Ben who is going to speak in detail about the legislative side of things. The Australian Drug Law Reform Initiative [ADLRI] supports the Committee and it has been particularly interesting to hear people like the last witness giving very strong evidence about the potential benefits of such a scheme. I would like to applaud the Committee and ADLRI supports that. We emphasise that in any of the suggestions we make the situation in relation to the operation of the drug laws is too complex, to put it mildly. I know the Committee has ascertained that from the appearance of Penny Musgrave, among others. As a part of our submission ADLRI would suggest to the Committee that perhaps what needs to happen is a review of the area rather than fixing things on a piecemeal basis. Particularly the interaction, as I am sure you are focused on, between Commonwealth and State laws, which are complex to say the least.

What ADLRI would like to present to the Committee is despite that complexity there is clearly a way forward for the State of New South Wales to recognise the suffering of some of the people who have appeared before the Committee and the fact that there is abundant evidence now that such programs around the world are benefiting people in their situation. We would like to present to you a simple way we think this can be achieved. In all of these social policy areas, I know I am speaking to the converted here, it is important to take it slowly and step by step. What ADLRI is proposing is a research model. There are provisions in most of the legislation to allow that happen without significant legislative change. Clearly there are some uncertainties in the interaction between the different levels of Government but I am sure those matters will be sorted out.

The laws were set up with these exemptions and this situation in mind: That if a substance did appear which could be used in a beneficial way for the community then the exemptions in the drug laws could be utilised. I think we should use that. The other thing I would like to say before I hand over to Ben, is that we have excellent precedence for such an approach. It is not as though we do not have other areas of social policy in which we have large exemptions, where there is a prohibitionist attitude overall but an area—for example the safe injecting room is an obvious one and the needle and syringe exchange—where law enforcement authorities have had to deal with the contradictions inherent in a complex and challenging area. The interaction between law and health is always going to be complicated and difficult. As a former legal practitioner and social worker I would plead for a multi-agency approach to this. It is not just a legal problem, it is not just a health problem, it is a correctional problem as well. Obviously our jails, which is my area of interest, are full of just this problem.

I think we can deal with it in a way that takes it away from that very moralistic and highly antagonistic approach which we have had in the past. There needs to be a much more sensible evidence-based approach. I encourage the Committee to consider adopting, in the first instance anyway, a research program which would enable the suggestions we have made in terms of registration and monitoring which would provide not only some relief to some of the patients but also ongoing evidence which is sadly lacking, especially when you look at some of the overseas studies. There really is not a lot of evidence out there. As a criminologist and as an academic I would also put a plea in for further research into these areas. I hand over to Mr Mostyn to talk more about the details. He has gone into a lot of detail. I do not know if you have his second submission.

Mr MOSTYN: I do not have an opening statement as such. I did prepare some supplementary submissions a little bit in response to the transcript from last week. I could either hand those out now or speak to them and then hand them out at the end.

The Hon. ADAM SEARLE: That sounds good.

Mr MOSTYN: I have about 10 copies.

CHAIR: If we could get them now and the Committee staff can circulate them.

Mr MOSTYN: There are quite a few attachments which are just various pieces of legislation that may assist as I talk to them. One caveat is it does appear to be a bit more complex than I first thought when I wrote the initial submissions. I think the complexities with the interaction between State and Commonwealth law were discussed last week but I am happy to try to discuss that today.

The Hon. AMANDA FAZIO: I wanted to ask you a question that I have asked a lot of people. Are you aware of any negative impacts from people using marijuana medicinally?

Mr MOSTYN: No, but I have to say that I have no knowledge one way or the other about that topic.

Ms HALL: I was a former drug and alcohol worker before I became a criminal lawyer and so I have worked in the area a long time. I have known lots of drug users, lots of legal drug users and illegal drug users. To my knowledge I have never heard of anyone, apart from some personal experiences of paranoia perhaps, but given the illegal status of the drug, then you have to factor in those sorts of considerations as well, but certainly no physical symptoms that I can recall— interactions with other drugs is a different matter but by itself, no.

The Hon. ADAM SEARLE: Just on that and looking at the proposal your organisation makes about a medical marijuana clinical trial with registered patients and the like, in circumstances where, for example, the Government was not interested or did not immediately embark upon a trial, what does your organisation think of the idea of people with terminal illness or other chronic pain management problems being able to, as it were, legally cultivate and use—

Ms HALL: Yes, seek exemptions.

The Hon. ADAM SEARLE: Yes, like an exemption from prosecution. Would that work?

Ms HALL: The problem with that is that they will still be apprehended obviously, which I think would be better avoided, if possible. Having been a criminal lawyer for some time any interaction with police is to be avoided, certainly for very ill people and any involvement in the criminal process also. Obviously we have mentioned in our initial submission the need for a backstop perhaps. This is already there in the common law anyway with the defence of necessity perhaps, although it is very, very limited.

The Hon. ADAM SEARLE: I was going to say the defence of necessity is very narrow.

Ms HALL: Very narrow indeed and perhaps there needs to be some attention to bumping that up in the legislation.

The Hon. ADAM SEARLE: One of the arguments we have heard is that whether it is for pain relief or nausea or what have you, for a range of the uses that cannabis or cannabinoids are said to be useful for there are other pharmaceutical products which may or may not be agreeable to people—

Ms HALL: Yes.

The Hon. ADAM SEARLE: So in that circumstance the defence of necessity would be probably very hard to make out?

Ms HALL: That is right, it is difficult because the pharmacological evidence is still not quite in in relation to that and it does seem to be part of a menu rather than the only thing that you can do but certainly for some people it may be the only thing, as you have heard perhaps.

The Hon. ADAM SEARLE: Yes, okay, thank you.

Ms HALL: But maybe if it is not a life and death situation that could make it much more difficult.

The Hon. ADAM SEARLE: Or they would have to prove that these other treatments did not work for them and that they had tried them?

Ms HALL: That is right, and that the risk is so extreme.

The Hon. ADAM SEARLE: So as sort of a safety net an exemption from prosecution may well be part of a solution?

Ms HALL: That is the way I would certainly see it. I think it certainly should not be relied upon as the first line of the way to deal with people who are involved in such program.

The Hon. AMANDA FAZIO: Mr Mostyn, in your supplementary submission you talk about the exemption under New South Wales law for possession and cultivation. Is that an alternative to a clinical trial model?

Mr MOSTYN: No, I do not think it is an alternative. I think to get the exemption you probably would need to be part of a scientific trial because it seems under section 10 of the Drug Misuse and Trafficking Act the Department of Health can grant authorities which exempts people from that Act but it does have to be for the purpose of scientific research, instruction, analysis or study. One of the most important things I could say today is if you look at attachment 1 to the supplementary submissions, that is an example of a card that we, I think, recommended in our original submissions which kind of shows how the Department of Health can issue authorities to authorise people to be exempt from the Drug Misuse and Trafficking Act, so I assume that the writing there is on the back of the card, so some sort of texts like that on an identification card appears to be enough to allow people to possess marijuana for the purposes of a trial and to be exempt from prosecution under the Drug Misuse and Trafficking Act.

The Hon. AMANDA FAZIO: Ms Hall, you touched on an issue that I have also been asking people about and that is the added layer of stress that is put on people who are already ill by having to use a medication that is illegal?

Ms HALL: Yes.

The Hon. AMANDA FAZIO: Do you have any experience of clients with that—

Ms HALL: Oh yes.

The Hon. AMANDA FAZIO: —and could you talk about that?

Ms HALL: Yes, I had a personal friend actually who died of ovarian cancer last year and who was urged quite strongly by a lot of people to try it and would not because she was concerned about the legal implications of it and I have certainly heard of other people in her situation as well. She was suffering constant nausea and I think she was 30 kilograms by the time she died, so, yes, I have had some personal experience with that too. And I think there will be quite a lot of people, particularly women of my age—I am not being sexist—who are just not prepared to go there at this point.

The Hon. AMANDA FAZIO: We heard some evidence last week from Cancer Voices and another pain group, a user group, that they believe their memberships would have had a reluctance to use cannabis leaf. When you were looking at these trials and stuff that you were proposing do you have any preference for the form in which the cannabis is available or just whatever suits people best?

Ms HALL: There seems to be very conflicting evidence about that. All I can say is from a user's point of view the best way to get it would be the easiest way and cheapest way and I would be very reluctant to put even more stress on people by imposing a great deal of expense upon them for a pharmaceutical product when it can be produced extremely cheaply. Obviously there are the administration problems and you have heard from a lot of health people about those but, as you say, there are the vaporisers and things like that. I know the Israelis are doing great work on titration of doses and things like that, so it is in train; there are things happening worldwide about these things. We certainly would not be stepping out of the box, if you like, trying different ways of administering it and I think listening to the people who are the patients is the only way forward in that respect. They need to be the ones to say what is the best way to administer it, not the lawyers and the doctors.

The Hon. AMANDA FAZIO: Mr Mostyn, in part 3 of your supplementary submission you talk about how people might actually obtain cannabis for medical use. Given that supply was one of the issues that seem to

have helped make sure that the 2000 working party went nowhere, can you explain a little bit how you think this would overcome problems with the supply of cannabis?

Mr MOSTYN: Leaving to one side at the moment where the cannabis might come from, but if the New South Wales Parliament wanted to set up a system where marijuana or some other form of cannabis was supplied to patients who qualified for it, firstly it is, as I am sure you are all aware, a very complicated area of law so I cannot really give you any definitive answers. These submissions are more based on possible areas of further exploration. Firstly it is important to know that under section 25 of the Drug Misuse and Trafficking Act the Department of Health can give an exemption to the drug supply laws. It is possible under current New South Wales legislation for someone to supply drugs and be free of criminal prosecution.

What I found most interesting in the Commonwealth Therapeutic Goods Act is that under section 9 of that Act the Commonwealth Minister can make arrangements with a State Minister for the evaluation of therapeutic goods. It may be possible without too much effort to approach the Commonwealth Minister and see if they would, I guess, be happy for the New South Wales Government to conduct such an experiment on the therapeutic value of cannabis.

Dr JOHN KAYE: Thank you for your submission. I am still sorting through your primary submission and your supplementary submission so forgive me if I ask something which is already in your supplementary submission. In your primary submission your proposed model was: If I have a card I can possess the substance authorised under section 10 (2) (b) of the Act and you would also extend that to growing for myself. But I think you would recognise there are a number of people for whom that is just not appropriate. There are people for whom growing plants is not always necessarily successful. Some of us just do not have green thumbs and other people who may have had green thumbs earlier on may now be too sick to do so.

Do I take it that your supplementary submission says that under section 24 of the Act it is possible to authorise somebody to supply? For example, if I have an incurable illness and I am authorised, my partner could be authorised to grow the plants and supply me. Is that correct?

Mr MOSTYN: That is correct but I think, as the evidence of Penny Musgrave from last week suggested, when someone does supply it the Commonwealth Therapeutic Goods Act appears to maybe be triggered. Therefore they may then have authority to stop that because you have not done it correctly under that Act. I do not know the Therapeutic Goods Act in enough detail to know if there are exemptions and if just giving it to a friend would exempt you from that, but Penny Musgrave seemed to say that that would probably then start triggering the complicated Commonwealth interaction.

Dr JOHN KAYE: Various jurisdictions in the United States have pursued the issue of recreational cannabis by making it an instruction to their police that it is the last matter to be investigated. That is, possession of recreational cannabis below a certain amount is the last matter they should investigate. Indeed there have been defences conducted in Californian courts where a person has been charged by the police for possession of a personal amount of marijuana and they have gotten off because it was claimed that there was another crime that occurred and the police had not pursued that. Is such a thing possible in New South Wales? Without changing the law, just to—

Ms HALL: Yes, certainly. Whether it is possible in terms of politics is another matter.

Dr JOHN KAYE: That is our problem. We are asking you the legal problems; we deal with the politics here.

Mr MOSTYN: As I am sure you are aware we have got the Cannabis Cautioning Scheme, which is more than policy, I think. I think that is legislated.

Dr JOHN KAYE: It is legislated.

Mr MOSTYN: I note that the Auditor General's report from about two years was very positive on the impact of that. To some extent I suppose we already have that in New South Wales and so medical marijuana patients who have less than 15 grams may have the benefit of the Cannabis Cautioning Scheme.

Dr JOHN KAYE: But that is still discretionary with the police, is it not? If the police take a dislike to you or you have had a prior—

Mr MOSTYN: Yes, there are qualifying factors. But that is the important thing to note as well, it is at the discretion of the police. I think the Auditor General's report did note that the discretion was being applied differently in places like Newtown and Surry Hills to rural and remote areas. I think in Surry Hills and Newtown 100 per cent of people were getting cautioned whereas in other places they were not. That is even with legislative amendments the police still have a lot of discretion. If it was only going to be a policy change in New South Wales Police it would almost certainly still leave a lot of discretion to the police. Secondly, if it was only policy but the law still stated—as it currently does—that you can face two years in prison for marijuana possession that would still be the law, so the legislation would trump any policy.

Ms HALL: By the same token we have done it with needle and syringe exchange and we have done it with the safe injecting room.

The Hon. TREVOR KHAN: No, we have not done it with the safe injecting room.

Dr JOHN KAYE: The safe injecting room is legislation. It is protected by legislation.

Ms HALL: True, but there is certainly a zone around the injecting room where police exercise their discretion in a rather health-related way. I think that there is certainly plenty of precedence for police having to come to terms with complex policy areas like this.

Dr JOHN KAYE: In your primary submission you talk about the statutory defence of necessity. Mr Searle, who has unfortunately left the room, was quite dismissive of that. That is not supposed to be pejorative to Mr Searle. I think you agreed with him. Is it possible to create a definition of necessity that would protect medical cannabis users?

Ms HALL: Clearly. It is a common law defence. There is lots of precedent for it historically. It has certainly been used in medical areas and that is the main focus in the case law in the last probably 10 or 20 years. Certainly the legislature could tighten that up and make sure that it applies in that more limited way.

Dr JOHN KAYE: Sorry, more limited?

Ms HALL: Less limited.

Dr JOHN KAYE: Less limited but specifically targeted.

Ms HALL: Yes, more targeted. I do not see any reason why not. And I cannot see any reason why courts would not be able to interpret it that way anyway, given the existence of the program, et cetera.

Dr JOHN KAYE: Mr Mostyn, what are your views on this?

Mr MOSTYN: I do not know much about the defence of necessity but obviously I think if it was put in legislation then that would be the legislation so that would apply.

Ms HALL: It would only be a backstop. It really could not be the primary line of defence for somebody in the situation though. It would be quite disadvantageous for them I think. For a start you would be at trial by then anyway, having gone through all the criminal justice processing. I do think that it would be an absolute last resort. I would think that things like retrospective registration would be a better idea in terms of preventing unfairness to people.

Dr JOHN KAYE: Talk us through retrospective registration.

Ms HALL: Some of the States in the US—I cannot remember exactly which ones—have provisions which allow for the court to deem the person in fact to be registered if they fulfil the criteria for the program and have not been able to register for whatever reason. From what I can read, and I have not read very much about it, there was not a particularly high standard involved. It was if the person was sick and did not know about it and did not get registered. I think there are two or three States in the US—I think Nevada might be one of them—which have a provision for that just again as another backstop.

It would certainly be preferable for people for the registration process to be easy. I would certainly urge the Committee to look at the Canadian example and not go that way, because apparently the lawyers have got their hands all over that and it costs about $1,000 to get an assessment from a doctor there. There are lots of ways of going about this where those sorts of protections for the patient, I suppose, could be put in place in the first instance. Really we are only talking about things which should be there for back-up purposes.

Dr JOHN KAYE: Both your primary and supplementary submissions address the issue of people using parts of the plant.

Ms HALL: Yes.

Dr JOHN KAYE: Is there a reason for that? We have had other submissions from people in the medical fraternity who are more interested in the manufactured product—from either synthetic cannabinoids or from highly processed plants—for reasons of titration and so on.

Ms HALL: Neither of us has a pharmacological background, so we cannot comment extensively on that. My main concern is to make it as available as possible to people who need it. Putting aside the very complex pharmacological regulatory network is obviously a better way to go. There is plenty of evidence for that throughout the world. I have heard from some users that it is not as good and does not do the job as well. That is from my relatively uninformed point of view. My main concern is access and it may be much more expensive and difficult to get.

Dr JOHN KAYE: I refer to the issue of diversion. One of the issues constantly raised, particularly by those who are more concerned about the risks of recreational cannabis, is diversion if we allow people to use plant material. In that case there is a greater opportunity for a patient to divert to the recreational market.

Mr MOSTYN: The simple answer is that the criminal law already covers that; that is, it would remain illegal. The models we are proposing where people are authorised to possess cannabis would obviously not authorise them to pass it on to other people. That would still be a criminal offence of supply under the Act. There are laws in place to deal with that. As was noted during the hearing last week, there is enough of a black market for marijuana that a small number of people using it medically would have very limited impact.

The Hon. TREVOR KHAN: I am troubled by the concept of a clinical trial. I would have thought that a clinical trial would envisage someone being in charge.

Ms HALL: Yes.

The Hon. TREVOR KHAN: For a clinical trial to work, one would normally identify the subjects at the start of the control.

Ms HALL: Yes.

The Hon. TREVOR KHAN: And there is a control group.

Ms HALL: Not always.

The Hon. TREVOR KHAN: And there is an end date. If you are to meet those normal standards for a clinical trial, how do you fit that into what you have described in other parts of your evidence of making it readily available?

Ms HALL: I am not saying it should be readily available. It should be available to those who need it. There seems to be a potential for missing an opportunity that has been taken up elsewhere to allow that and also to do some more rigorous evaluation, which has not happened much in other schemes.

The Hon. TREVOR KHAN: How do you operate a trial where, in essence, you are allowing people to fall into the scheme on an ongoing basis?

Mr MOSTYN: Because the secretary of the Department of Health would have to issue these cards—in effect, issue a licence—they could create quite a good database. Perhaps a condition of being issued the card

could be participating in a trial. The Department of Health could probably collect data from these people using this licensing system and that could create some sort of scientific research.

The Hon. TREVOR KHAN: Are you not inviting the Department of Health to engage in what is a legal fraud?

Mr MOSTYN: Section 10 of the Drug Misuse and Trafficking Act has clearly created this exemption that drugs can be used.

The Hon. TREVOR KHAN: That is more like a clinical trial.

Ms HALL: It is much broader than that.

Mr MOSTYN: It would be up to the department.

The Hon. TREVOR KHAN: I draw your attention to the exemption under section 25 (4) (b), which I assume is similar.

Mr MOSTYN: They are almost identical.

The Hon. TREVOR KHAN: It refers to "a person acting in accordance with an authority granted by the secretary of the Department of Health where the secretary is satisfied that the supply of the prohibited drug is for the purpose of scientific research, instruction, analysis or study.

Ms HALL: Yes.

The Hon. TREVOR KHAN: That is not what we are talking about.

Ms HALL: Yes we are; that is what we are proposing. We are not proposing an across-the-board program that does not involve a very prominent research component. We are proposing a research program.

The Hon. TREVOR KHAN: Are you not talking about the provision of the material to people who need it?

Ms HALL: Absolutely; that is my agenda.

The Hon. TREVOR KHAN: That is not a research trial.

Ms HALL: What we are proposing is a research trial. I would love to see it available to everyone who needs it. Anyone who has seen a person die of cancer without any nausea relief would want that. I am absolutely convinced that it is a very good thing for people in that position. However, I also acknowledge that this State is possibly not ready for that. This is a good way of providing more evidence that is not available yet. New South Wales is a different jurisdiction from the other jurisdictions where it is occurring. I do not think there is anything backdoor or dishonest about it. We are saying that the legislature has clearly envisaged this situation arising where a drug with significant valuable health properties becomes available where the knowledge was not previously there. This is what the legislature intended when it inserted those exemptions.

The Hon. TREVOR KHAN: The legislature intended to make an exemption for the purposes of scientific research, instruction, analysis or study.

Ms HALL: That is what we are proposing.

The Hon. TREVOR KHAN: Not for the ready availability—

Ms HALL: I am not suggesting we make it readily available. I am saying that if we are going to use this substance in our clinical trials then it would be preferable to have it in the cheapest and most readily available form—

The Hon. TREVOR KHAN: I am not disputing that proposition.

Ms HALL: That was the only context in which I expressed those sentiments—that is, that I would like to make it easily available. My only concern was the cost to the community. We must think about that in terms of the form in which it will be used. There is obviously a cost component. Making it easily available will facilitate the research component rather than make it difficult.

The Hon. TREVOR KHAN: If we are able to convince the Minister for Health to allow the secretary of the Department of Health to undertake a clinical trial, would it satisfy your requirements if there were a trial of, say, 100 people for two years? Is that what you are envisaging?

Ms HALL: I am not a medical person. I do not know how many people the medical fraternity would consider to be an adequate clinical trial.

The Hon. TREVOR KHAN: I am not trying to be smart. I am asking whether that is what you are envisaging.

Ms HALL: I am not either and I really do not know. I would imagine it would be as many people as they can get to increase the validity of the study. It is certainly not my area of expertise. Someone in the health area would be better placed to answer that question. The provision is there in the legislation and it does not require a lot of additional legislation to support it. It is certainly envisaged by the legislation and this is a perfect opportunity to use it.

CHAIR: Thank for your attendance this afternoon. The secretariat will forward any supplementary questions Committee members may have. The answers to them and any questions on notice should be provided within 14 days.

(The witnesses withdrew)

GRAEME ALLAN MITCHELL, State Officer (NSW and ACT), Family Voice Australia, and

DAVID MICHAEL PHILLIPS, National President, Family Voice Australia, sworn and examined:

CHAIR: I welcome witnesses from Family Voice Australia. Before we begin questions, would either of you like to make an opening statement?

Dr PHILLIPS: Yes, I will make a brief opening statement. I want to make comments on three matters: Family Voice, cannabis and medicine. On Family Voice, we are a Christian voice for family, faith and freedom. We are a Christian organisation that is working with and receiving support from all mainstream Christian denominations. We are politically neutral. We have no connections with any political party. We seek, in presenting evidence on such occasions as this, to present a policy which is evidence based for the good of the whole community. The area of drugs is something to do with human dignity, which we have addressed on many occasions over the years. It is one of the things we have been regularly involved in.

On cannabis, I want to just flag that cannabis is a dangerous substance. I will touch briefly on some of the dangers that we are aware of. Firstly, there is evidence that it is a significant trigger of schizophrenia, and that of course increases the costs to the public of psychiatric care and hospital. Secondly, it is particularly hazardous to young people. Neurological studies indicate that from about puberty on to mid-twenties, the human brain is undergoing rapid development, and new pathways and connections are being made in the brain. If cannabis is taken at that time, it modifies the development of those pathways and can make permanent changes to the mental capacity of people. One of the illustrations is that there is evidence of a reduction of the intelligence quotient [IQ] of about eight points.

Thirdly, in relation to taking cannabis by smoking it, cannabis smoke has as many or more carcinogens as tobacco smoke. We all know the medical hazards associated with tobacco smoking and the costs associated with that, with very expensive treatments for cancer. Cannabis offers the same sort of costs to the community through cancers induced by smoking. Motor skills are affected and it increases the risk of road accidents. Where studies have been done, the numbers of the rate at which people have accidents when they are under the influence of cannabis is much higher than average road users, so that produces further costs to the community in terms of road accidents.

The implications of all these things are that there is a significant financial and social cost to the community of the abuse of cannabis. How does that relate to the matter before the Committee of medical use of cannabis? There is evidence. A study has been of the states where the medical use of cannabis is permitted in the United States and those where it is not. Roughly, the use of marijuana in those permissive states is approximately double that of the other states, and the abuse of the drug is also approximately double that in other states.

The Hon. TREVOR KHAN: Can you give us a reference to that?

Dr PHILLIPS: I can do that in a minute. So there does seem to be evidence of significant diversion or leakage into the general community. Secondly, in the nineteenth century it was well known that there were patent medicines promulgated by people wandering the streets, and they had all sorts of wonderful supposed cures for everything under the sun—generally known as snake oil salesmen—and most of them contained opiates or whatever. They did nothing for the patient apart from give them a bit of a high. We have moved on from that. We are in the twenty-first century. Now we do not give people indiscriminate access to whole-plant products where we believe there is some beneficial substance. For example, the famous one is willow bark, which was found to be of benefit. Studies extracted aspirin, and that has since been identified and manufactured separately.

If there is anything of benefit among the cannabinoid range, then those chemicals should be identified and produced or manufactured separately, and subject to proper clinical trials where their risks can be assessed, the side effects can be assessed, and they can be administered properly. In terms of delivery, smoking for any drug should not be considered as a means of delivery. Smoking is hazardous in its own right because smoke in all forms is dangerous to the lungs. There are a lot of other options: there are pills, there are mouth sprays, nasal sprays, patches and a lot of other ways of delivering drugs, which are far superior to smoking them. Finally, in relation to the question of any of the cannabinoid family that prove to be beneficial for medicinal purposes, the development, the testing, exploration and control of availability and so on should be done through the Therapeutic Goods Administration [TGA] under Federal law, and State governments should not seek to bypass

Therapeutic Goods Administration of tests, trials and anything else. The State Government should not get involved in trying to undermine the proper pharmacological processes and testing that is done under the auspices of the Therapeutic Goods Administration. Thank you.

The Hon. AMANDA FAZIO: Will you explain to the Committee why FamilyVoice felt compelled to put a submission into this inquiry?

Dr PHILLIPS: We have long been concerned with matters of human dignity. One of the things that undermine human dignity is compulsive or addictive behaviour—there are a variety of those. We have addressed issues of addictive drugs; we have addressed also addictive gambling, particularly in the form of poker machines, because that diminishes human dignity; it does not serve people well.

The Hon. AMANDA FAZIO: Speaking of human dignity, would you support the expansion of a range of options available for treating people who are chronically ill or terminally ill in terms of supressing nausea, increasing appetite and providing pain relief?

Dr PHILLIPS: Within the framework that I outlined of proper pharmacological processes. The TGA has been set up to assess a range of possible regimes for treating that. I have spoken, for example, to the Director of Pain Management at the Flinders University, South Australia, and he has advised that in his experience with proper pain management he is able to provide a regime that can satisfy the needs of any patient. That will range with different patients—his comment is that it will range depending on the attitude of the patient. Pain management usually has other effects such as a reduced level of activity. Some patients will prefer to be medicated to remove the pain even if it means their level of conscious interaction is reduced; others will prefer to bear the pain and have greater interpersonal engagement. Basically there are a range of options already; if it is to be extended it should be under the auspices of the TGA.

Mr MITCHELL: Might I just add, that Dr Phillips was not able to hear the testimony of Professor Cousins this morning but I did. I think we would agree entirely with what Professor Cousins said in terms of alleviation of pain.

The Hon. TREVOR KHAN: What Professor Cousins said is quite the reverse of what Dr Phillips just said. You can either have one duck or one dinner but you cannot have both.

Dr PHILLIPS: Could you please explain—

The Hon. ADAM SEARLE: It was quite clear that Professor Cousins was talking about the positive and urgent need to have a wider range of options for pain management, including the use of cannabinoids—that is as I understood his evidence.

Mr MITCHELL: I understood him to say that, and I personally agree with that.

The Hon. AMANDA FAZIO: The point of difference is that most of the evidence that the Committee has received from people so far in this inquiry say that medicinal cannabis should be used in whatever form is most appropriate for the person, whether it be using leaf material that is smoked or vaporised, using extracts or using a pharmaceutical product like Sativex. Is it possible then just to say that you support the use of medical cannabis in a pharmaceutical form as a treatment option for people with serious illness and terminal illness?

Dr PHILLIPS: Yes. There is always ongoing research in developing new pharmaceuticals and I do not want to be heard as saying that I am opposing that. If new drugs can be developed within the proper, standard pharmaceuticals procedures and testing regimes I am happy for there to be an extension of drugs and regimes available, but within that constraint of proper pharmaceutical assessment.

The Hon. AMANDA FAZIO: The stuff that has gone through the TGA?

Dr PHILLIPS: Yes.

The Hon. ADAM SEARLE: The Committee has heard concerns about the abuse of cannabis being more applicable to recreational rather than medical use. In terms of your submission, a lot of the observations you make about driving under the influence would apply to existing prescription drugs as well, would it not?

Dr PHILLIPS: Yes.

The Hon. ADAM SEARLE: And alcohol abuse?

Dr PHILLIPS: Yes.

The Hon. ADAM SEARLE: No-one is suggesting that one should drink and operate heavy machinery, for example?

Dr PHILLIPS: No.

The Hon. ADAM SEARLE: So your observations are no different?

Dr PHILLIPS: No.

The Hon. ADAM SEARLE: In terms of the maintenance of human dignity, the Committee has heard evidence that existing options for pain relief, treating nausea or options for stimulating appetite in a range of illnesses do not work for everyone and synthetic cannabinoid products are not readily available in Australia. The Committee has heard also that people are suffering. Would it not be a step towards maintaining human dignity at least in the case of the terminally ill, for example, to allow people to use cannabis for medical purposes while they are awaiting the development and availability of pharmaceutical products?

Dr PHILLIPS: My understanding is that the medical profession in general terms are not obliged to administer any and every request that a patient might make. The medical profession are there to offer advice and on occasion where a patient may ask for something quite inappropriate it is the professional duty of the medical profession to say, "I am sorry, I am not prepared to recommend this medical treatment for you even though you have asked for it." I did hear earlier Mr O'Grady's comments. When he was asked had he tried alternative delivery means such as nasal sprays or patches or pills or whatever, he said he had not really tried that, he just like smoking the stuff basically.

The Hon. ADAM SEARLE: With respect, that was not his evidence.

Dr PHILLIPS: Well he had not tried alternative delivery means. He said that quite clearly.

The Hon. ADAM SEARLE: I think he was not aware—for example, he was not aware of where you get a vaporiser from. As for the other alternative methods, I do not recall him being asked about those. In any case it is a matter of record that nasal sprays and patches in this space are not commercially available to people in this country. They are simply not available. So I think the proposition you are seeking to advance is not sustainable.

Dr PHILLIPS: If that is the case that such things as proper, pharmaceutically-delivered nasal sprays and patches are not available—

The Hon. ADAM SEARLE: —at present they are not.

Dr PHILLIPS: —that could be explored.

Dr JOHN KAYE: In your introductory remarks you talked about a reduction in IQ of eight points for young people who use cannabis. I did not quite get down what you said. Will you please repeat what you said?

Dr PHILLIPS: That is what I said. There is evidence that the IQ of young people—

Dr JOHN KAYE: IQ of young people who?

Dr PHILLIPS: Young people who have taken cannabis during their teen years, as young adults they have an IQ up to eight points less than would be expected.

Dr JOHN KAYE: That is a strong statement. On what study do you base that?

Dr PHILLIPS: I have a stack of paper here. I do not think I can turn it up immediately. I can take that as a question on notice.

Dr JOHN KAYE: Were you basing that on a study that was done some years ago of 1,037 people in New Zealand who were enrolled in a birth cohort?

Dr PHILLIPS: Possibly. The Ferguson study in New Zealand has—

Dr JOHN KAYE: Are you aware that that study talked about early and persistent cannabis use?

Dr PHILLIPS: It would be persistent cannabis use, yes, I acknowledge that.

Dr JOHN KAYE: Early and persistent cannabis use.

Dr PHILLIPS: Yes.

Dr JOHN KAYE: And heavy cannabis use. The evidence you gave the Committee made me think that you believed that a kid who had a couple of joints was facing an eight-point decline in their IQ. That is not what you are telling the Committee, are you?

Dr PHILLIPS: No, thank you for that. I am talking about early and persistent. So someone who starts mid-teens, 15 or something and uses it on a regular basis, that is the kind of person who suffers from a reduction in IQ.

Dr JOHN KAYE: You then quoted a professor of pain management from Flinders University—whom I do not think you named and that is all right—who said he could satisfy the needs of any patient with existing and available drugs?

Dr PHILLIPS: Yes.

Dr JOHN KAYE: Did he put that to you in writing or did he just say that?

Dr PHILLIPS: That was actually part of a study done on euthanasia some years ago. In considering the question of euthanasia and whether palliative care could manage the effects of pain we had a meeting with the Director of Pain Management at Flinders and that was what he said on that occasion.

Dr JOHN KAYE: Of course, that contradicts evidence we heard today, particularly by Professor Cousins, who was talking very strongly of the need for additional pain management tools. As you know, Professor Cousins is a very well-respected academic in this field. I am confused as to what the professor said to you. Did he actually say, "We don't need the new drugs; we're okay?"

Dr PHILLIPS: I do not think any doctor would ever say that. They would always be open to the option of new drugs and new pain management methods. It was really said in the context where people are saying palliative care is not good enough. We need euthanasia because there are some cases where palliative care is not enough. That was the context.

Dr JOHN KAYE: Are you suggesting that he was promoting palliative care when he made that remark?

Dr PHILLIPS: Yes.

Dr JOHN KAYE: Rather than necessarily giving you a scientific answer?

Dr PHILLIPS: It was based on his understanding as a specialist in palliative care and he said—

Dr JOHN KAYE: Have you personally dealt with people who have had radiotherapy?

Dr PHILLIPS: Yes.

Dr JOHN KAYE: What was their experience of the efficacy of the drugs they were given to dull the pain?

Mr MITCHELL: Might I answer that?

Dr JOHN KAYE: No, it is just to Dr Phillips.

Mr MITCHELL: Sorry. Okay.

Dr JOHN KAYE: Certainly after Dr Phillips has answered.

Mr MITCHELL: Sure.

Dr JOHN KAYE: Dr Phillips made the remark. I just want to drill down his remark because I find the statement given to us extraordinary. I just want to go to that point.

Dr PHILLIPS: I am largely basing that on the advice I have had, as I mentioned, from an expert in palliative care and he is dealing with patients who would be in a variety of situations, including radiotherapy and cancer treatment, which can be somewhat horrendous.

Dr JOHN KAYE: Would you be prepared to give us his name?

Dr PHILLIPS: I can take that as another question on notice.

Dr JOHN KAYE: Thank you very much. Mr Mitchell, I am sorry. I did not mean to cut you off, but I just wanted to get that answer.

Mr MITCHELL: Because my colleague was perhaps struggling to come up with an example, I just wanted to say to the Committee that my wife actually had radiation treatment in 2009 for cancer. Her experience was that the drugs available were very suitable and adequate to suppress the side effects of the radiation. She had a good outcome.

Dr JOHN KAYE: I am pleased to hear that.

The Hon. TREVOR KHAN: You do not discount Mr O'Grady's evidence regarding it, do you?

Mr MITCHELL: No. As a matter of fact, I am loathe to rely on individual anecdotes, but it was just that question from Dr Kaye prompted me to quote that. I think it is a danger in forming public policy to rely too much on individual anecdotes and cases like that without necessarily getting the bigger picture, the broader picture of impacts on society.

The Hon. TREVOR KHAN: I absolutely agree with that, but you do not discount—

Mr MITCHELL: No, not at all.

Dr JOHN KAYE: Dr Phillips or Mr Mitchell, do you accept that a community of people who have advanced state HIV or who are in the late stages of cancer and cancer-related chronic pain are using cannabis or, actually, to use your language, using marijuana to self-medicate? Do you accept that proposition?

Dr PHILLIPS: It sounds plausible.

Dr JOHN KAYE: And that those people report that they are achieving some degree of relief from their symptoms—pain, nausea, loss of appetite and in some cases neurological symptoms?

Dr PHILLIPS: Probably if you asked people in the nineteenth century who were taking opiates, they would report that they felt a lot happier whatever illnesses they had when they were taking a regular supply of opium.

Dr JOHN KAYE: Indeed they were, and as a result we now have the opioid family of drugs to try to refine that. But my question to you is: Do you accept that that is the case, people are self-medicating using marijuana, to use your language—that is, using the cannabis plant material illegally?

Dr PHILLIPS: There are people who do all sorts of things and report all sorts of outcomes, but that is not what I would consider to be a sound basis for the development of public policy.

Dr JOHN KAYE: Nor do I.

Dr PHILLIPS: We are trying to address public policy questions.

Dr JOHN KAYE: I am not advancing that. Do you accept also that to take that away from those people without some kind of replacement would actually lower their level of human dignity?

Dr PHILLIPS: If there are alternatives, then their human dignity should be able to be sustained with alternative therapeutically tested means.

Dr JOHN KAYE: In your submission you mentioned nabiximols; in fact, you suggest that there can be a regime? To paraphrase your recommendation, you are open to the idea that under sufficient rigorous scrutiny—the same rigorous scrutiny as for other kinds of therapeutics—nabiximols, to which we refer as Sativex, which, of course, is a brand name of the generic nabiximols, would be okay provided there were appropriate safeguards?

Dr PHILLIPS: My understanding of Sativex is that it is a balance of THC and CBD, which are two of the active ingredients and to some extent in some aspects they balance each other. My understanding is that Sativex has been through some kind of pharmacological trial.

Dr JOHN KAYE: Are you aware of the cost of Sativex?

Dr PHILLIPS: No I am not.

Dr JOHN KAYE: We were told that it was about $600 a year.

The Hon. AMANDA FAZIO: No, $6,000

The Hon. TREVOR KHAN: No, $500 a month.

Dr JOHN KAYE: We were told that the pharmaceutical version was about $500 a month, about $6,000 a year. Are you suggesting for someone who is pretty much at the end of their life suffering heavily that we should deny them access to a plant they can grow for almost nothing but that it is okay because they can spend $500 a month to buy a pharmaceutical product?

Dr PHILLIPS: If someone is approaching the end of their life and they are suffering from very severe conditions, the total cost of their medical care may well be well above that price.

The Hon. TREVOR KHAN: But most of their medication is funded under PBS.

Dr PHILLIPS: Yes.

The Hon. TREVOR KHAN: Getting it passed by the TGA is only half the equation. You have to get it through the TGA and then on to the PBS.

Dr PHILLIPS: Yes.

The Hon. TREVOR KHAN: We have a string of cancer drugs that are not on the PBS and people are calling out for access to those medications, but they cannot afford them. I hear what you say, but tell me how someone is going to afford $500 a month if they are lying prostrate in bed dying?

Dr PHILLIPS: You say there is a long list of drugs that are not on the PBS?

Dr JOHN KAYE: Yes, but most of those cancer-related drugs to which Mr Khan referred come with a patent—are developed by international pharmaceutical companies and have a genuine associated cost. To my knowledge, we may be corrected later this afternoon, none has a low-coast alternative, whereas it is possible that

for people in that situation cannabis-leaf material—marijuana as you refer to it—may be a low-cost alternative. Are you comfortable with denying people access to that?

Dr PHILLIPS: It is no different from the process that is used in relation to all new drugs and I do not see why an exception should be made. There may well be other drugs in the pipeline which the Hon. Trevor Khan has indicated and it is up to government policy to determine what will be put on the PBS. I am sure if you got a different set of patients saying they want this drug or that drug or something or other, or a medical professional who would like to prescribe one or other of the drugs that are not on the PBS, I think the question is not unique to this situation.

Dr JOHN KAYE: I cannot think of another—maybe you can help me—pharmaceutical where there is a herbal comparator that has enjoyed the same degree of acceptance by various communities of people who are severely ill. Can you name another one where there is a grow-it-yourself or a relatively low-cost alternative? If there were, the PBAC would have got onto it straight away, because that is how the PBAC—as you would be aware, the PBAC does not respond to public outcry. It responds to cost effectiveness of a drug.

The Hon. ADAM SEARLE: Or commercial interest.

Dr JOHN KAYE: After 2003, that is true.

Mr MITCHELL: Can I respond by saying that I think the difference is that cannabis has such a widespread recreational use and that makes it somewhat unique and therefore there are all sorts of dangers that come with promoting its wider use, even if it is in situations as you describe. I heard you ask the question earlier of another witness about diversion. Diversion evidently is quite a serious problem. I have a paper here before me that suggests—again, this is United States information—that approximately 74 per cent of the adolescents had used someone else's medical marijuana. So there is a serious—

Dr JOHN KAYE: Can you table that paper?

Mr MITCHELL: Yes, I am happy to do that.

The Hon. TREVOR KHAN: Which State does that relate to?

Mr MITCHELL: The study was done in Colorado and the subjects of the study were young people aged 14 to 18 years.

The Hon. TREVOR KHAN: But you would agree that what you would have to look at is the scheme of so-called control that exists in Colorado.

Mr MITCHELL: Sure.

The Hon. TREVOR KHAN: —to determine how available the drug generally is.

Mr MITCHELL: Can I just generalise rather than speaking specifically about this paper? If there is any increase, even if it is not 74 per cent, if it is 50 per cent, if it is 20 per cent—

Dr JOHN KAYE: Hang on. You converted a percentage of supply to an increase.

Mr MITCHELL: Yes.

Dr JOHN KAYE: They may have been getting their supply elsewhere and they just found the medicinal cannabis—

Mr MITCHELL: True.

Dr JOHN KAYE: —and in some senses that might have been an improvement because they got a cleaner regulated supplier—

The Hon. TREVOR KHAN: I do not like that argument.

The Hon. ADAM SEARLE: You could be talking about displacement rather than overall increase in usage.

Dr PHILLIPS: There is another paper which says—

Dr JOHN KAYE: I am sure there is but we are wondering a long way from the question I put to Mr Mitchell in the first place.

The Hon. ADAM SEARLE: Is not this risk like a fallacy? At the moment with opioids there is a recreational use, which is highly illegal, and there is a perfectly well accepted medical use.

The Hon. TREVOR KHAN: And there is very significant diversion. If you now look at recreational users of opioids, a very significant proportion of the opioid use is from diversion of prescription medications.

Mr MITCHELL: We do not allow people to grow opium poppies in Australia so they can grow their own opium.

The Hon. TREVOR KHAN: That, with respect, is non-responsive to the issue. What happens in Australia is that prescription opioids are available because we need them for pain management. There is a down side to the availability of those prescription opioids in the fact that some are diverted. That has not led to a suggestion that we should withdraw all opioids from the market—

Dr PHILLIPS: No.

The Hon. TREVOR KHAN: —which in a sense is the outcome of your argument.

The Hon. ADAM SEARLE: The risk of diversion is deemed to be acceptable, given the overall benefit.

Dr PHILLIPS: The other paper to which I referred a moment ago—

The Hon. TREVOR KHAN: Do you want to respond to Mr Searle's observation?

Dr PHILLIPS: I think the observation that Mr Searle made was that it was just replacing one source of supply with another, whereas the paper that I am referring to—

The Hon. TREVOR KHAN: No, that is not what he said at all.

Mr MITCHELL: May I respond to the question? I think that is a matter of judgement in the end, with respect. Yes, the benefits that flow to sufferers who are at the absolute end of their lives and in extreme pain, and the risk of diversion, it is a matter of balancing those and I guess that is what the Committee must do in its report to the Parliament at the end of the day.

Dr JOHN KAYE: Mr Mitchell, you are taking a utilitarian point of view.

Mr MITCHELL: Yes.

Dr JOHN KAYE: What you are saying is that because the harm of diversion is there we will deny these individuals who are at the end of their life access—

Mr MITCHELL: I am not saying—

The Hon. TREVOR KHAN: I do not think he is saying that at all.

The Hon. ADAM SEARLE: He is saying that it is a balancing act.

Dr JOHN KAYE: He is saying that a greater harm would be done than the good that would be done for those individuals.

Mr MITCHELL: I am not drawing a conclusion about that. I am saying that that is something the Committee should deal with and consider.

Dr JOHN KAYE: The submission to which you speak specifically draws that conclusion in recommendation one. I am trying to get behind your recommendation one. The argument you have presented to me is that the risk of diversion is too great so we have to deny these people access to something that may be of benefit to them at a price which they can afford.

Mr MITCHELL: I guess the concern that FamilyVoice would have would be that—I am taking a different approach to answering that question—there is quite a significant push in many societies, especially Western societies, to legalise drugs or to decriminalise them and that is just generally the trend. Just observing that trend, noting that there are dangers in such a path. I am not saying that there are not legitimate uses for medical treatment, but such a course should be followed only with great caution and looking at all the likely broader impacts on the community.

Dr JOHN KAYE: Are you stepping back from your recommendation one?

Mr MITCHELL: I will have to refresh my memory.

Dr JOHN KAYE: Your recommendation one is "no consideration to be given to allowing any exemption from laws regulating cannabis and marijuana under the guise of medical use". That is a strong recommendation. I understand your recommendation two is kind of a modification of that. If we fail to adopt recommendation one, we should go to recommendation two. But that is a pretty full-on statement.

Dr PHILLIPS: Recommendation one concerns a supply of plant products.

Mr MITCHELL: Yes.

Dr PHILLIPS: So we are saying—

Dr JOHN KAYE: Sorry, in your submission I understood you took section two is no medical use for marijuana. Section one is cannabis derived or related products. I understood you took a different view. Your language was marijuana was a smoking material and cannabis was a more generic term for the plant and the products that can come from it.

Dr PHILLIPS: I said at the very beginning in my opening statements that the supply of plant products, complete products, which is a nineteenth century approach to medication, where there is no identification of the active ingredients, no clinical trials, no assessment of risks, no assessment of side effects, is something that is not part of twenty-first medicine and should be totally opposed. If we are talking about plant products or extracts of complete plant products, which are untested, no risk assessment, then we are saying no. If we are saying, can there be active ingredients such as THC or CBD or there may be other things in the cannabinoid family and they can be put through the same rigorous pharmaceutical testing regime where their efficacy in relation to the other alternative regime seeking to achieve the same outcomes, their relative efficacy compared with current drugs, their side effects in relation to current drugs, their risks on other aspects of health in relation to current drugs, if they come up as a shining light at the end of those trials, then we are saying yes.

Dr JOHN KAYE: I understand what you are saying. You are saying that is fine. But I am talking about something different. I am talking about a group of people—I put this question to you before—who are currently self-medicating—I think it would unwise for us not to recognise that a lot of self-medication goes on, a lot of it is destructive, a lot of it is constructive, but there are people who are self-medicating with currently illegal cannabis or marijuana, as you have used it here, for whom it seems to them to be the only way they can afford to get relief from the impacts of either their cancer or their other chronic illness or their other fatal illness or the treatment for those illnesses. The proposition I put to you was would you deny them access to that, and the answer came back that consideration would have to be given to the other harm that was done, a kind of utilitarian balancing of the two, I think was where Mr Mitchell was going.

Dr PHILLIPS: You are putting to us a loaded question: Would you deny these poor people who are crying out for this. In the Northern Territory people are self-medicating by sniffing petrol.

The Hon. TREVOR KHAN: They are not self-medicating.

Dr PHILLIPS: They are self-medicating. They feel they have a need for escape from their current woes so they are sniffing petrol. The fact that someone or a group of people self-medicating in a way that is risky—

The Hon. ADAM SEARLE: With respect, we are not talking in the current inquiry about people who are escaping from their woes. We are talking about people with chronic or, indeed, terminal illnesses. The situation you describe in the Northern Territory of people sniffing petrol is such a quantum leap from where we are now, you are really diminishing the seriousness of this inquiry with that comparison.

Dr PHILLIPS: The point I was attempting to illustrate with a somewhat dramatic and, I accept, an extreme example is, just because a patient goes to a doctor and says: I want this treatment and I think I am entitled to it, is not an adequate reason. The medical profession is there to provide their medical expertise and they will on occasion say I can recommend these other ways of managing or treating your condition but they do so in terms of evidence-based medicine. We are saying we support evidence-based medicine and just because there is a group in the community who are self-medicating in a way that is not recommended does not mean that the community should give them what they ask for.

Dr JOHN KAYE: Even if it was providing them with extraordinary levels of relief that they would not otherwise get? You present yourself to us as a Christian voice. From a Christian perspective, someone can get relief and are doing relatively little harm to other people, you would deny them that?

Dr PHILLIPS: Again it is a loaded question. In a completely different context, there are people who have body identity dysphoria. They believe they would be better off without a leg or without an arm and they go along to a surgeon and say: I believe I should not have my left leg. Will you please amputate it? How does the medical profession respond to that? Do they then say okay, we will admit you to hospital and amputate your leg? I would hope that a responsible medical practitioner would respond to that patient by addressing the question of why they think they would want their leg amputated. It is not for a patient to determine his own medical treatment, it is up to the medical profession.

The Hon. TREVOR KHAN: Is that right?

Dr JOHN KAYE: That is a new one on me. So the view of Family Voice Australia is that patients have no rights at all?

Dr PHILLIPS: That is not what I said.

Dr JOHN KAYE: Well, you said it is not up to a patient to determine their own medical treatment, it is up to a doctor.

Dr PHILLIPS: My understanding of standard medical practice is that a doctor is not obliged to administer any treatment requested by a patient.

Dr JOHN KAYE: Nor did we say that.

Dr PHILLIPS: That is what I was saying.

Dr JOHN KAYE: My question was almost the opposite to that.

Dr PHILLIPS: Can I please have the record corrected that that is what I am saying?

The Hon. ADAM SEARLE: Dr Phillips, we will just turn that on its head. What about where a medical practitioner forms a view that existing avenues for pain relief are not working for a particular patient and that they could benefit from the medical use of cannabis. In that circumstance would you accept that it would be perfectly valid and viable for the patient to acquire and use medical cannabis, for example, for pain relief in dealing with a terminal illness?

Dr PHILLIPS: Are you suggesting that the medical profession should engage in illegal conduct?

The Hon. TREVOR KHAN: It was just so obvious that that was coming.

The Hon. ADAM SEARLE: You keep prefacing everything by saying doctors would not prescribe this or a patient should not decide their own treatment, it should be a matter for the doctor. We are looking at possible changes to the legal regime and I am just trying this idea out on you, given where you are coming from. If you had a circumstance where people could use medical cannabis if their doctors, not so much prescribed it but saw there was a benefit in their using it to treat their condition, would that be an acceptable way of regulating it from your perspective, if a medical professional said yes, this person is dealing with a terminal illness, existing pain management methods are not working for them, they could benefit from medical cannabis and therefore the person could use it?

Dr PHILLIPS: What I am seeking to uphold is the regulation, the practice, we have in Australia where doctors can prescribe drugs that have been approved by the Therapeutic Goods Authority. If the Therapeutic Goods Authority has approved something like Sativex and that has passed all the clinical trials and that is available for him to prescribe, then there is every reason why he should prescribe it.

The Hon. TREVOR KHAN: Dr Phillips, not everything that a doctor tells a patient to do has to be by way of prescription. For instance, a doctor may say: You would really benefit from going out for a walk every morning because you are so fat. There is nothing in the Therapeutic Goods Authority that deals with patients taking walks. The Therapeutic Goods Authority deals with prescriptions. The question Mr Searle put to you is not dependent on whether cannabis is a prescription drug. Some of the other evidence we have heard from the medical profession—you are not a doctor of medicine, are you?

Dr PHILLIPS: No, I am a physicist.

The Hon. TREVOR KHAN: That evidence suggests that some patients may get a benefit from the use of cannabis. It is not a question of the Therapeutic Goods Authority. The question Mr Searle asked is dependent on the opinion of the doctor as to what may help that patient. Let us answer that instead of sliding sideways.

Dr PHILLIPS: If the question is heroin is illegal to use or sell or take and the doctor thinks the patient would like to take heroin to relieve his condition, should the doctor recommend heroin?

The Hon. TREVOR KHAN: I can answer that for you, seeing my father before he died was a doctor who had some experience of a whole range of opioids, and his opinion would have been some patients would have greatly benefited from the use of heroin as opposed to some of the synthetic opioids. That was his opinion but he did not prescribe it for his patients. Again, what you are doing, Dr Phillips, is sliding sideways. If there is evidence before this inquiry that doctors think some patients may benefit not only in pain relief but also in the return of their appetite and the like, if that is the medical evidence that exists before this inquiry, answer the question why should that not be available to the patient? It is not dependent upon the Therapeutic Goods Authority.

Dr PHILLIPS: What you seem to be suggesting is that the doctor recommends to the patient that the patient pursue an avenue of purchasing and using drugs which are currently proscribed as illegal drugs in Australia.

The Hon. ADAM SEARLE: With respect, that is not what we are suggesting at all. We are looking at the legal regime that applies now and we are looking at the evidence before this Committee about whether the medical use of cannabis should be permitted, that is, made legal. One of the gateways, or one of the ways in which this may be done, which I understand is done in some places overseas, is where a medical practitioner forms the view that a given patient could benefit, then it becomes legal for that patient to use medical cannabis. That is a potential approach. I am saying, given that it would be contingent upon a medical practitioner's view, would that meet some of your concerns? We are not talking about moving to a prescription situation.

Dr PHILLIPS: This is a parliamentary question, as to whether Parliament should change the law.

The Hon. ADAM SEARLE: That would be a matter for our recommendation and ultimately would be a matter for the Parliament.

Dr PHILLIPS: Yes, this Committee's recommendation. It is a public policy question and in our view, public policy is best determined on the basis of properly obtained evidence.

The Hon. ADAM SEARLE: Yes and we heard evidence this morning that the evidence was clear that cannabinoids have a valid and useful application for medical purposes. We heard that from the Director of the Pain Management Institute at Royal North Shore Hospital.

Mr MITCHELL: The point I would like to make to the Committee, which is perhaps slightly different, is that I think there are dangers in the American model where 18 states are growing their own and where there is the risk of diversion that we have talked about. There is evidence that legalised medical marijuana is associated with a lower perception of riskiness in society and higher rates of marijuana use amongst adolescents—that is what I think it is important to consider.

The Hon. TREVOR KHAN: You are speaking to the converted. I do not think anyone here is talking about an American model. That is not where we are coming from.

Dr JOHN KAYE: This all started because I asked a question with respect to a relatively small number of cancer patients for whom leaf product—buds or whatever—were providing them with some relief. I just wanted to know what your position on it was.

Dr PHILLIPS: I have said no to leaf products and yes to active ingredients, properly assessed to a therapeutic pharmaceutical standard, a pharmaceutical assessment process, such as the Therapeutic Goods Administration [TGA].

CHAIR: That concludes the time that we have available to you as witnesses. Mr Mitchell, you mentioned a paper earlier that you said you were happy to table. Could you please provide a copy of that to the Committee staff?

Mr MITCHELL: I have one here that I will leave.

CHAIR: Any questions taken on notice and supplementary questions that Committee members may have will be provided to you by the Committee staff and we ask that they be returned within 14 days.

(The witnesses withdrew)

(Short adjournment)

DEAN PRICE, Policy Adviser, ACON, affirmed and examined:

NICOLAS PARKHILL, Chief Executive Officer, ACON, affirmed and examined:

CHAIR: I would like to welcome the witnesses from ACON. Before we begin questioning would either of you like to make a brief opening statement?

Mr PARKHILL: Yes. ACON is glad to be here today to discuss the important issues related to the medical use of cannabis. The submission we provided to the Committee was a joint submission from the Australian Federation of Aids Organisations, the National Association of People with HIV Australia, Positive Life New South Wales and ACON. In terms of HIV in Australia we are lucky that there have been advances in the treatments that are available to people living with HIV. This has resulted in better health outcomes for people with HIV and we do not see the level of pain, distress, illness and, indeed, death that was experienced in the early days of the virus or the initial period of time when new treatment opportunities were becoming available in Australia. However, we do acknowledge and recognise that not every person living with HIV is doing well on anti-retroviral treatments and that a significant amount of people do continue to experience debilitating side effects such as HIV wasting.

ACON also recognises that members of the communities we serve, the gay, lesbian, bisexual and transgender communities, also experience other diseases, including cancer and multiple sclerosis and that they too experience severe chronic pain when other treatments have failed. We note that groups such as the Cancer Council of NSW, Cancer Voices NSW, Pain Australia and the Australian Medical Association (NSW) and others have in some way been supportive of the availability of cannabis for medical purposes. We note that some submissions have raised issues faced by people at the end stage of disease and would like to see a compassionate approach adopted. As raised in our submission, we support the availability of cannabis for medical use.

While we have stated in our submission we would like to see this achieved through allowing the personal growth of a limited number of plants, or supply through certified growers or producers, we are not fixed to one model over another. We want to see a system that allows reasonable availability to a small number of people who are in specific circumstances. Any system that is implemented must be: Economically accessible to people who are already experiencing a high economic burden due to their treatment; safe, in relative terms of their existing health conditions; and one that makes it easy for people to understand their position with regard to the law.

ACON would hope that the introduction of any new scheme allowing the medical use of cannabis would be accompanied by targeted education addressing community understanding of what the changes mean. We are not lawyers and cannot critique the legal challenges between State and Federal laws. We look to others for expertise in this area, including the Australian Drug Law Reform Initiative and the Australian Drug Law Reform Foundation submissions. Thank you, once again, for the opportunity to present today and we are happy to answer your questions.

The Hon. AMANDA FAZIO: I wanted to clarify a couple of things. Is ACON now just an organisation for advocating for the gay, lesbian, bisexual and transgender community with AIDS? It is not clear from this submission. I wanted to make sure that the Committee is getting perspectives from a cross-section of the community that are suffering from HIV. Other groups, such as Positive Life NSW, are not exclusively for the gay, lesbian, bisexual and transgender community with AIDS?

Mr PARKHILL: That is right. ACON's most significant focus, particularly when it looks at prevention around HIV, is targeted towards gay men. Eighty per cent of transmissions on an annual basis are gay men. From a prevention perspective that is where a substantial amount of our resources are dedicated. When it comes to providing care or support services we would provide care and support services for anyone that is living with HIV who is experiencing difficulties. We do not say, "I am sorry you are not gay, lesbian, bisexual, transgender, intersex, we are not going to provide care and support services to you." We would provide services to anyone in need. In relation to other population groups around prevention needs that might exist outside gay men, there are other organisations funded in New South Wales to address their needs, including the NSW Users and AIDS Association, Positive Life NSW, which is the peak voice representing positive people's needs, and organisations like Pozhet, which are also funded by the NSW Ministry of Health to specifically address that

population's needs. By and large, given the epidemiology and that 80 per cent of the risk sits with gay men that is where the most substantial amount of our resources are dedicated.

The Hon. AMANDA FAZIO: In your submission you state that a study undertaken by Latrobe University reported that 18 per cent of people with HIV report using cannabis as a complementary therapy. I have not read that study. Does that study say whether any adverse impacts have been reported by those people or have they all found it to be useful medication in helping with the sorts of things we traditionally hear about such as nausea, appetite suppression and pain relief?

Mr PARKHILL: Unfortunately the study does not go into that level of detail so it does not report on those people's experience of the use of cannabis in a medical context, but that is certainly what we hear through our care and support services, whether it be counselling or provision of in-home support—people use cannabis in a medical context to alleviate those issues.

The Hon. AMANDA FAZIO: You mention two approaches in your submission. At the bottom of the second page you talk about people being allowed to grow a certain number of plants for medicinal personal use and over the page you talk about the proposal that came out of the Drug Summit to have a clinical medical trial. Which would be your preferred way to go? Do you think we need to have a clinical trial in New South Wales or do you think the evidence is in and we should just be able to have some system of registered users?

Mr PARKHILL: It is important to do this properly and to ensure that the evidence base behind it is sound. I think our position would be that we would advocate for a staged approach and one that is perhaps built on a clinical trial. That is the approach we take not only to prevention but also care and support for people with HIV and I think that would make good science and good evidence supporting public policy in the longer term, recognising that this can be a contentious issue. Having a further evidence base would be useful in the longer context.

The Hon. AMANDA FAZIO: One of the things I have been trying to get information about, and we have got a little anecdotally, is whether people who have HIV/AIDS and who are self-medicating with cannabis at the moment feel a greater level of stress because they are being forced to resort to using a medication that is in fact illegal. Do you have any comments on that?

Mr PARKHILL: Unfortunately only to add that I am not aware of any research that has been done that unpacks how people feel in relation to their use in a medical context. Anecdotally, I do not think that operating in a framework of self-care and self-medication outside a legal framework would be helpful in reducing anxiety and stress.

The Hon. AMANDA FAZIO: Are you aware of the different regimes overseas where medical cannabis is approved for use?

Mr PARKHILL: I am aware of them; I think it would be fair to say not to a great degree in relation to the level of awareness and the intricacies around those models.

The Hon. AMANDA FAZIO: Are you aware how many people you deal with who have HIV/AIDS have told you or reported to you that the currently available legal medicines do not give them the relief or the treatment they require?

Mr PARKHILL: The HIV medications?

The Hon. AMANDA FAZIO: Yes.

Mr PARKHILL: Once again, the research systems and the data we have available to us are not great. It is hard to get a sense of the impact treatments are having for the HIV populace. Certainly we know they are getting better all the time and the advances we have seen over the past decade in relation to the treatment of HIV have been significant, thank goodness. We also know there is a significant proportion of people—who we often see because the living well often do not present for services from ACON; it is usually those who are not doing so well—that our counsellors and volunteers in home-based care are seeing. It is hard to quantify that number other than to say it is a significant part of the population that is still struggling with their health issues in relation to HIV and that treatments are not delivering equitably across the board.

Dr JOHN KAYE: Thank you for your submission. You refer in your submission to the "HIV Futures 6: Making Positive Lives Count" study which suggests 18 per cent of people living with HIV are self-medicating in some form or another using cannabis. Is it your estimation from the client base that you deal with that that is an underestimation or an overestimation or is it consistent with what you are seeing?

Mr PARKHILL: Once again, speaking from an anecdotal perspective, that would be consistent, but perhaps I could take that on notice and seek advice from our counselling staff.

Dr JOHN KAYE: I am not seeking to pry.

Mr PARKHILL: Sure. That would generally seem consistent.

Dr JOHN KAYE: In the literature medicinal cannabis or cannabinoids are mostly focused on nausea, pain and AIDS-related wasting disease. Are those the three reasons people self-medicate? What are they looking for?

Mr PARKHILL: Yes. I would say they would be the main drivers. Certainly nausea from HIV medications could be one reason. It would depend on where a person was at in the spectrum of their disease progression or their health status. Certainly someone more at the end stage of life might be experiencing all three of those conditions. HIV wasting, which you referred to, is certainly another issue that we hear of why people would be medicating with cannabis.

Dr JOHN KAYE: Would most doctors who treat your clients be able to have a conversation with their patients about self-medication or do you think there is a barrier there to that conversation?

Mr PARKHILL: I think that is a changing landscape. I think for some time in Australia we have been very fortunate that we have had a very skilled and expertise network of doctors who are able to respond to the needs of HIV clients and they have tended to be in inner metropolitan areas of Sydney and Melbourne, certainly Sydney where the impact of the virus has been greatest. That is starting to shift with a larger body populace of HIV positive people and we see other people seeing less specialised general practitioners, if you like. I think certainly those people who are seeing general practitioners with a specialty in HIV would absolutely be able to have that conversation—a very sophisticated and mature conversation. I think that is slowly starting to change with the workforce, particularly the general practitioner workforce as it relates to HIV medicine.

Dr JOHN KAYE: And is that because your clientele with HIV are living in a less concentrated way around certain inner city areas but are spreading out?

Mr PARKHILL: That is right, absolutely.

Dr JOHN KAYE: So they do not have access to a general practitioner who would see eight or 10 AIDS patients a day?

Mr PARKHILL: Absolutely, and I would have to just qualify that by saying absolutely the majority people with HIV still do tend to live in larger metropolitan areas but that is starting to shift.

Dr JOHN KAYE: Do you have a sense that those people who do have conversations with their doctors are alert to the issues about negative interactions with other AIDS drugs?

Mr PARKHILL: I could not speak to that exactly but I would imagine that those with a specialty and with longer term clients or patients that they have been seeing for a while those issues certainly would be coming up in the breadth of the conversation that is taking place. Specifically, if someone was self-medicating with cannabis and there were perhaps problems with that use, then that would be being discussed with the treating clinician.

Dr JOHN KAYE: Do you have a sense of where most of your self-medicating patients are getting their cannabis from? Would they be growing it themselves, buying it on the street or getting it through friends? It is impossible to know?

Mr PARKHILL: That would be impossible to know, yes.

Dr JOHN KAYE: California also has a large gay male, people living with HIV community. Presumably you are aware of trends in California and particularly given that California is one of the 18 states that has medicinal cannabis through dispensaries, are you aware of any study that tells us the percentage of people living with HIV-AIDS in California who are accessing those medical cannabis dispensaries?

Mr PARKHILL: I am actually not aware but if I could take that question on notice and do some additional research, I would appreciate that.

Dr JOHN KAYE: Yes, I would really appreciate that. Do you have any anecdotal evidence coming out of places like California of the impacts of medicinal cannabis availability?

Mr PARKHILL: Once again I would like to take that question on notice and be able to do a thorough research of that, if I can.

Dr JOHN KAYE: Those are my main questions at the moment, thank you.

CHAIR: I just wanted to take you back to your opening statement. If we were to go down this path you talked about reasonable availability to a small number of people with certain illnesses. Common themes that seem to come up throughout the hearings both today and last Monday talk about full-blown AIDS, which is a phrase that one of my colleagues used earlier, and end-of-stage cancer and whether the cannabis was a crude or pharmaceutical form. In your submission and from your research you say that there are a lot of people living with HIV who have not yet progressed to AIDS who are using cannabis in some form or another for medicinal purposes. If the Committee were to recommend a tipping point such as saying that we were only using it at certain stages in terminal illnesses, how would that affect people who are not necessarily living with AIDS yet but are still living with the HIV virus and what does that mean with respect to the long-term effects, if that makes sense?

Mr PARKHILL: Without wanting to jump to what guidelines would look like, I would suggest that guidelines would need to be in place that would need to be referenced to medical expertise, which I do not have, but recognising that there is a broad-spectrum of people living with HIV. Many of those people are doing quite well with those treatments, some are not, and some are experiencing different health conditions and progressing, if you like, to AIDS. I would imagine that there would need to be in place guidelines around determining what that access would look like.

CHAIR: I think that is part of the concern. Certainly other witnesses have talked about the long-term effects of cannabis use and, as you say, thankfully with modern medicine people can live quite well with HIV for a number of years but if part of their care is to use cannabis—whether it is self-medicated or not—then the Committee would need to consider in terms of guidelines some of those long-term effects which are not applicable to, say, somebody who is dying of cancer and has weeks or months to live, which might need to have a bit of a different scope put on it in relation to HIV patients?

Mr PARKHILL: Absolutely, I would agree with that, and I think the situation has certainly changed since this became a policy issue for ACON in that people with HIV were all going to die at that stage and even with the introduction of new treatments they were not as effective and the side-effects of those treatments were quite severe. That has been a changing space but certainly we do recognise that there still is a population group within the HIV population that do require access to medicinal cannabis to alleviate some of their illness and suffering.

The Hon. AMANDA FAZIO: Dr Kaye touched on this a little bit. Given that from my understanding most HIV-AIDS patients are prescribed a cocktail of medicine so they are not on three different sorts of things a day; they can be on about 12 different types of medications a day, do you think it would therefore be advantageous if their doctors were able to recommend cannabis for medical use because they would be aware of what the likely combinations of cannabis with those other drugs would be? Would it actually make it safer for people with HIV-AIDS rather than self-medicating?

Mr PARKHILL: I would absolutely say that that would be the case.

The Hon. AMANDA FAZIO: You mention in your submission on page 2, the second last paragraph, that cannabis can interact with specific HIV medications. Can you tell us a little bit more about that? What are the adverse indications from mixing those drugs?

Mr PARKHILL: There really is only one piece of research looking at this. As you can imagine it is very hard to do a controlled study around this issue and the study that mentions that is described there is the only one so what we would be advocating for is a great deal more research looking at the way HIV medications interact with cannabis, particularly some medications. In terms of the side-effects—

Mr PRICE: I cannot remember off the top of my head what those interactions were. I can easily get them for you.

The Hon. AMANDA FAZIO: Okay. If there were to be a trial of the use of medical cannabis in New South Wales would you advocate or support that a subset of that trial be for people suffering with HIV-AIDS because while they might have some common symptoms that would benefit from the use of medical cannabis say to people suffering from multiple sclerosis or some forms of cancer, because they are on this other cocktail of drugs perhaps the research would need to be more targeted in their case?

Mr PARKHILL: I would absolutely advocate for people living with HIV to be included in that clinical trial and I would imagine that the study design would be able to accommodate for different disease states and also medications.

CHAIR: I want to ask you something that has been asked of a couple of the medical witnesses. In respect of how often this issue is raised anecdotally in their organisations, the Department of Health indicated to us that their clinicians do not regularly bring up the issue of medical use of cannabis. This morning the Australian Medical Association effectively indicated that, at a Federal level, their organisation is working on an updated position paper. In your experience, and I am happy for either or both of you to make a comment, how often is this issue of having access to cannabis for medical use raised with your clients who use ACON's services?

Mr PARKHILL: "HIV Futures 6" is a not a piece of research that was undertaken by us, but it is always there as a question. It does get discussed by clients who we are interfacing with, if you like. In respect of where it sits in the policy schedule of priority for us, it has not been a lead policy issue for us over recent years because there has not been that space, if you like, put forward by Government for this issue to be discussed. That is why, absolutely, this process is a very welcome process for us. While it might not be making headlines, I think it is still very much a community issue, particularly for those people who are in need of medical cannabis. I am sure you would all appreciate that policy runs in cycles or can run in cycles. The 1999 Drug Summit created a space for this and there was some movement in this area. There has been a level of frustration on our behalf that that did not move towards the next phase. Also, that statement is laid with the context that the needs of positive people is changing with advances in treatment. Having said all of that, it is still a policy issue in great need of attention for us.

CHAIR: Thank you very much for appearing this afternoon. The Committee has resolved that the answers to any questions that you have taken on notice and any other supplementary questions that members may have could be provided within 14 days, and the Committee staff will contact you in relation to those questions.

Mr PARKHILL: Wonderful. Thank you for your time.

(The witnesses withdrew)

DR ANDREW KATELARIS, affirmed and examined:

CHAIR: Before we begin questioning, would you like to make a brief opening statement?

Dr KATELARIS: I would. I appear before this Committee as an individual, although I do give voice to the scores of people I have treated with medical cannabis and the thousands of people I would like to treat with medical cannabis once this restrictive regime has gone. I have had a long involvement with cannabis that goes back to the 1980s. Principally I became engaged in the issue via environmentalism, specifically against forest protection. Back in 1988, Harris Daishowa had chain logged some of my favourite bushwalking areas and tore to pieces Brown Mountain and Tantawangalo. I joined activist groups and considered things like sabotage and all the rest of it. On reflection, I realised that was a short-term and unproductive way to proceed.

The Hon. TREVOR KHAN: Very wise.

Dr KATELARIS: Principally being trained as a researcher, I did some research. The simple question I asked was, "What was paper made from before we chopped down trees to make paper?" I went to the Mitchell library and although I cannot name the librarian, there was a most helpful librarian and she, without a shadow of a doubt, answered, "It was hemp." She said, "Most of the old books in this library are made from hemp." She took me down to the dusty basement and, through a lot of old cardboard boxes, found this article from 1938 in *Popular Mechanics* called "The New Billion-Dollar Crop". I would like to table that.

Document tabled.

The evidence given here is that the prohibition has always been with us. That is not true. The prohibition against cannabis only started in 1937 in the United States and it was predominantly an action by corrupt, racist police and politicians to destroy the hemp industries and to allow the petrochemical synthetics, especially nylon, a place in the market. The issue of health concerns were largely manufactured. In fact, there was hardly a usage problem at the time. It was more a reason for clamping down on Mexican immigrants and Negro jazz musicians. We made a documentary in the 1990s called "Billion Dollar Crop". We lifted the title off the *Popular Mechanics* article. It explored the politics of the prohibition. I urge you all to see that. It is available on YouTube, "Billion-Dollar Crop". It will give you a useful background to the politics of the current regime of which we are groaning under. We heard from our Australian Medical Association, but the American Medical Association, in 1937, made an impassioned plea against the prohibition, saying that cannabis, in the form of a tincture, was an important part of the pharmacopeia, and in no way needed any restrictive legislation. Again, I would like to table that.

The Billion Dollar Crop went to ABC's *True Stories* series and was shown three times, which is a record for an ABC documentary, I am told. Based on the public reaction we got, I was able to secure a licence to grow hemp plants. Hemp, as distinct from cannabis, is a cannabis plant that produces less than a defined amount of tetrahydrocannabinol and is predominantly used for industrial purposes, that is, for the production of seed or fibre or for horticultural purposes.

In 1990 I did a study tour of Europe, specifically Holland, where they had a large Hemp for Paper research proposal supported by the Government there. They established, as was already known from the historical literature, that hemp produced an excellent paper and a range of other side effects. Indeed, the Dutch equivalent of the CSIRO, the DLA, showed that by using hemp as a rotation crop, you could dramatically reduce the amount of toxic chemicals used in their rotation of grains and potatoes, so the industrial uses went forward from there.

I returned to Australia full of enthusiasm and confidently believing once the political masters in this country had been fully apprised of the facts we would have no trouble getting hemp growing in Australia. I was very wrong. It took several years and a lot of agitation before we got the first very limited patch of growing under 23 (4) (b) of the Drug Misuse and Trafficking Act. That is a very interesting little section. It says that you can grow an otherwise prohibited plant for scientific research or evaluation. Those terms were mentioned in relation to I think a section 10, but I am only familiar with—

The Hon. TREVOR KHAN: No, section 25 talked about it.

Dr KATELARIS: It turns out that there is a designated person but I waited two years for the Department of Health to nominate the designated person who then turned out to be Andrew Wilson, the Chief Health Officer. We proceeded reasonably to establish experimental hemp crops and begin the long process of developing suitable cultivars, or cultivated varieties, of hemp in this country. In about 2000 or 2001 I actually met with Andrew Wilson, the Chief Health Officer, and discussed the issue of having a preliminary medical cannabis growing so we could do things like extraction methodology, shelf-life stability and other sort of basic important parameters that were needed. Dr Wilson agreed that it was an important and valuable scientific research proposal and a licence was given. Unfortunately he retired the next year and, without going into all the details, his replacement, Greg Stewart, cancelled the licences on what I believe was spurious and malicious grounds. When I complained publicly he then cancelled my hemp licences.

Because of the importance that we actually attach to growing hemp in Australia— which I think is even of greater importance than the medical use, which is important in itself, but it is much more important because it involves the future of the country, it involves the health of the waterways and the soil—we stayed with that. Again without going into all the details because it is off the topic here, in 2008 the Industrial Hemp Act was finally enacted. All the predictions we made about how hemp would do in Australia have been borne out in practice. Trial sites around the country and especially in New South Wales have returned fibre yields of over 20 tonnes per hectare of dried stem material, which is dramatically above the European benchmarks. We are developing now seed harvesting technology.

I am the author of Food Standards Australia New Zealand [FSANZ] application 1039 to have hemp seed accepted as a human food in Australia. Unfortunately we are the only country on earth not to take this step. I would like to tender some information on that subject. There are copies for each of the members. The only country on earth not to have hemp seed. We have received and this Committee has taken evidence from the Department of Health but the Department of Health has been at the forefront of actually blocking any move to have the normalisation of hemp seed in this country, which is in itself a disgrace.

My involvement with medical cannabis, really I have been both a medical cannabis patient and a medical cannabis prescriber and provider in a number of forms. Having failed or having had our medical cannabis growing licence cancelled, but determined because of the overwhelming evidence from patients themselves—and let me say this right at the beginning: the centre of the medical universe is the patient. It is not some tin pot expert or some department bureaucrat. The centre of the medical universe is the patient. If the patient takes a substance and says that it helps them, as far as I am concerned it does help them. We do not need a double-blinded, placebo-controlled crossover to say it helps that particular person. Our patients are not guinea pigs and they are not to be treated as guinea pigs.

The several experts or evidence givers have reinforced the message over and over that the Therapeutic Goods Administration [TGA] should be the proper agency to control drug supply in this country. Let us look at the job they have done so far. Vioxx, a non-steroidal anti-inflammatory drug went through all the TGA testing yet it was withdrawn after 300 people died as a direct result of its pharmacological actions. The opioids, this was only from this weekend's paper, "Opioid overdoses a growing killer—and many of them come from doctors' prescriptions". These went through the TGA process but they have certainly come back to bite us. In the 1960s the TGA approved benzodiazepines as a safe, non-addictive alternative to barbiturates. Wrong. In excess of 10 per cent of Australian adults are now somewhat dependent on these benzo drugs and finding it very hard to get off.

There has been much talk of standardisation of dosage of pharmaceutical preparations and the rest. My first experience with prescribing cannabis actually was very simple kitchen chemistry where we would boil up the herb, the heads of the herb, and either use butter or, better, copha to extract the cannabinoids which are then separated from the boiled water in the fridge and then mixed into chocolate. They can be divided into squares and it is very easy then to titrate the dose. It is a very simple matter for a patient and most of the patients I have dealt with have much greater intelligence than most of the people I have heard giving evidence here. That is not meant as a joke. That is a painful experience. It is a very simple matter. Even with batch to batch variation of this relatively crude way of presenting it, in a day or two all the patients could comfortably titrate their dose with no problem whatsoever.

Dr JOHN KAYE: Even across different crops?

Dr KATELARIS: Yes. Having said that, there is some subtlety. They might say, "That last batch was not so good", or, "Gee, that was a corker, Andrew. What did you have in that?" So there are differences. There

are some subtle differences at the fine levels in the terpene content and the minor cannabinoids, but in terms of just getting basic relief and not suffering overdose it is a very simple matter.

We have heard over and over about the dangers of cannabis. The old chestnut of schizophrenia. Anyone who has looked at the problem of mental health and drug use cannot have looked very closely at its association with cannabis. I quote this: In the 1950s cannabis was barely known in this country. About 1 per cent of the population suffered from schizophrenia. In the 1980s and 1990s, 20 to 30 per cent of the population have been exposed to cannabis but the incidence of schizophrenia is still 1 per cent. There cannot be a causal association. You can certainly find amongst those 30 per cent who are using cannabis in the 1 per cent a crossover of the Venn diagram, that is not difficult.

GW Pharmaceuticals have treated many thousands of people over a series of years. They have never seen—never seen—a single case of schizophrenia. I would like to table this, the psychiatric effects of Sativex by Phil Robson, and you can go through that. It is self-explanatory. Certainly from people who know what they are doing who have handled thousands of patients they simply have not seen it. No evidence that cannabis causes long-term psychiatric problems, Thomas from the British Journal of Psychiatry. Again I table that. This is only a tiny amount of the literature that is available when one cares to look for it. Shall I go on?

CHAIR: If it is okay with you, Dr Katelaris, we might start the questioning from members.

The Hon. AMANDA FAZIO: I was just interested, in terms of the medicinal use of cannabis which variety is the one that is most beneficial, sativa or indica?

Dr KATELARIS: Firstly the majority of cannabis available now is hybridised between the two of them. It is rare to have a pure sativa or a pure indica. In the current American sort of hippy literature they talk about sativa for daytime use and indica at night. That may well be. There are certain standout cultivars but now, because there is so much hybridisation between them, there is no real pure indicas or sativas; there is indica predominant and sativa predominant. What we have found is that people prefer them in different ways.

With the compassionate access scheme that operates in the States in the United States where people can go along to a shop front and have a selection of 15 or 20 different cultivars, or cultivated varieties, they can look at the White Widow series, which are mostly indica, they can look at the Thai Buddha, which is mostly sativa, and after a very little amount of experimenting the patients gravitate to those varieties that suit them best. But that is a question that can be answered only by extracting the data from what the patients are selecting. It is a very easy question to answer if we could merely get access to that range of selection and let the patients tell us what is good for them.

The Hon. AMANDA FAZIO: In paragraph 4 of your submission you refer to a synthetic THC drug called Marinol, which you say is not much chop. However, it has been prescribed in the United States since the 1970s. For what conditions is it prescribed?

Dr KATELARIS: That is tetrahydrocannabinol; Marinol is its trade name. It is a synthetic delta-9-THC. But evidently the chemists did not get the racemic mixture right. That means the bends of the molecule.

Dr JOHN KAYE: The confirmation of the molecule?

Dr KATELARIS: Yes.

Dr JOHN KAYE: The allotrope of the molecule?

Dr KATELARIS: Yes. Evidently it is not right. The point I am making is that we have a dangerous drug with no medical indications in minds of most of the people giving evidence here, yet it went through the American Food and Drug Administration process decades ago and has been used with no problems. It is simply not very effective.

The Hon. AMANDA FAZIO: But why was it being prescribed?

Dr KATELARIS: It was prescribed mostly for cancer chemotherapy and the nausea associated with it.

The Hon. AMANDA FAZIO: The Committee heard evidence last week from Tony Bower about the tincture that he makes. You say in paragraph 14 of your submission that you think it is a good product. What experience have you had in prescribing it to people?

Dr KATELARIS: Even though I began by making our relatively crude chocolate-based dispense preparations, I contacted Tony, or he contacted me—I cannot remember which—and I asked whether I could get access to the tincture for my patients. Every few months I would go to his place and collect a box of it in 10 millilitre dropper bottles, which I would distribute to patients on the basis of need. We never had enough to satisfy the need. We did not go out looking for patients; generally after we had spoken on the radio or more rarely appeared on television, patients would contact us. It was like Sophie's choice deciding who would get it because there was much more demand than supply. We really had to decide based on severity. Tony's tincture was very well accepted by patients. I have treated only scores of patients, not more, but that is a supply issue.

The Hon. AMANDA FAZIO: What conditions did they have?

Dr KATELARIS: A wide range of conditions, and all of them have been mentioned. Terminal patients were the major group. I provided a little bit of relief in the final stages.

Dr JOHN KAYE: Pain relief?

Dr KATELARIS: More than that. Terminal patients are generally given a cocktail of benzo drugs and opiate drugs. Constipation is not very glamorous and it is a major issue. If you have bowel cancer or some peritoneal problem, it is a horrible additional burden. Probably the most spectacular and reproducible effect we demonstrated was dramatically reducing the amount of opiates the patient needed to get good pain control. A week ago, following the first hearing, medical groups pushed to make marijuana illegal. I do not favour the use of the work "marijuana". It is a slang Mexican term that was introduced to the vocabulary by the Americans in the 1930s to obfuscate the connection between cannabis and hemp, which the Americans knew to be a safe and effective medicine. It was described as a dangerous new plant from Mexico. The prohibition started as a lie and it continues to be a lie.

The 88-year-old mentioned was my first patient. She had shocking pain that was iatrogenic or doctor-caused. The patient had suffered an adverse but predictable reaction to a statin drug and had developed a shocking myopathy—that is, muscle wasting and weakness. She went from being a feisty, well 78-year-old to a wheelchair-bound cripple with constant pain. I am not complaining about Professor Cousins, but she went through his pain clinic three times. By the time she made an emotional appeal to me after hearing me on the radio she was on 80 milligrams of morphine and suffering cruel constipation, complete mental fuzziness and had no quality of life whatever. After three days of careful titration, we brought the morphine dose down to 20 milligrams. She was using less than six drops of Tony's tincture and she had much better pain control. That is one case.

We had a number of elderly patients with advanced osteoarthritis—hips grinding down to bare bone—who were too sick or too old to have joint replacement therapy. Of course, if you do not have private health insurance you wait a long time and have your operation cancelled many times, so it is not really an option. That was a big indication as well. The categories are certainly reducing opioid dependence and opioid needs. There are many other indications, but we had to start with ones that were relatively simple.

Dr JOHN KAYE: What about multiple sclerosis?

Dr KATELARIS: I have treated a couple of multiple sclerosis patients. I have spoken at length to Dr Geoffrey Guy, who runs the Sativex company. He made it very clear that it not only alleviates the symptoms of multiple sclerosis but also gives those who respond their lives back. When your life is dominated by bladder and muscle spasms and unsteadiness, there is no real quality of life. The two patients I personally treated did very well.

The Hon. AMANDA FAZIO: What is your preferred method of delivery for medicinal cannabis? Would it be leaf, resin, oil, tinctures or pharmaceutical products?

Dr KATELARIS: As I said, the centre of the medical universe is the patient and it is the patient's choice. A lot of nonsense has been spoken about smoking. I have provided a quote stating that people taking massive, Bob Marley quantities of cannabis do not suffer as a result of smoking cannabis as long as it is not

associated with tobacco. The irony was that the National Institutes of Health, which did the study, set out to prove that cannabis caused emphysema and lung cancer. Regrettably—in their terms—they found that it actually protected people from lung cancer and did not cause emphysema because of its intracellular antioxidant effect. It is an anti-inflammatory compound.

The Hon. AMANDA FAZIO: Another witness said that the worst thing you can do is to mix tobacco and cannabis together.

Dr KATELARIS: Michael Balderstone made the point that most of the dependence on cannabis is simply a masked tobacco addiction. There is nothing worse than kids putting a 50:50 cannabis/commercial tobacco mix in a bong. Members should remember that the unscrupulous individuals who run the tobacco companies have added ammonia and many other products to their tobacco to release the nicotine more rapidly to make it more addictive. Cannabis breeding has produced plants with 15 per cent to 22 per cent readily available now. A dose for a medical cannabis patient may be one our two puffs from a tiny pipe two or three times a day. That is nothing like smoking 40 cigarettes a day. The smoking thing is a nonsense. As you have tried to point out to many witnesses, a person in their last three months of life is not going to worry about getting emphysema, which they will not anyway.

The Hon. AMANDA FAZIO: Do vaporisers deliver medicinal properties in a different way or is it simply less rough on the lungs?

Dr KATELARIS: Vaporisers come in every shape and size. We have been experimenting with vaporisers since about 2000. We have made them out of old soldering irons, glass jars and so on. Some of the new vaporisers are absolutely brilliant. There are now battery-operated units that can fit comfortably into your hand. However, once again, some patients prefer them and some like to smoke; some actually like the physical action of smoking. It is not for us to say how they should do it. There has been this sanctimonious, nanny-state idea that we have to control this vile impulse of dying people no matter what they want to do. Is one better than another? It depends on the patient.

The tincture is ideal, for instance, for people in a nursing home, where they would find it almost impossible to smoke pot or to use a vaporiser; so the tincture is ideal in those regards, right? Eating—in America there is a subset of medical cannabis patients that prefer brownies, right? Who are we to say what they are to prefer? So it really is an individual choice. What I would prefer is everything is laid out before them, just as it is in the American compassionate access schemes, and let them decide. I have a very strong position against an exclusive manufactured base for medical cannabis. GW has done a great deal of good work scientifically to bring a product to the market, but it is a very simple matter to assay the potency of cannabis and give people the dose that they want. As I said, they can find it very simply, even from a block of chocolate in a two-day titration trial. Does that answer your question?

The Hon. AMANDA FAZIO: Yes, thank you.

Dr KATELARIS: But I will say this—because you have asked the question of three others and you did not ask it of me, but you may in the future—about does it add another layer?

The Hon. AMANDA FAZIO: Of stress, yes.

Dr KATELARIS: Absolutely.

Dr JOHN KAYE: I think she knew you would say that.

Dr KATELARIS: Absolutely, but it is at many different levels. Firstly, there is the enormous stress of police interdiction, and despite the lying testimony—and I say that despite the admonition you said of not getting personal—Paroz and Bingham lied about the cost. They said $2,000 and $5,000 per plant—absolute complete lies.

CHAIR: Dr Katelaris, I think you should be careful with your comments.

Dr KATELARIS: I am careful. I say this advisedly, right? That is a lie.

The Hon. AMANDA FAZIO: Perhaps you could say inaccurate.

Dr KATELARIS: And repeating lies does not make them accurate, right?

CHAIR: Okay.

Dr KATELARIS: He also lied when he said there is very little concentration on individual medical cannabis patients. I have a photo here I would like to show you of "Smoulder", a 70-year-old cerebral palsy victim living up at Nimbin, who has been repeatedly accosted by police. This is a man who has the worst athetoid movements. He writhes on the ground.

The Hon. TREVOR KHAN: Right. What does it mean?

Dr KATELARIS: When I first met "Smoulder" about 20 years ago, I felt very sorry for him but I did not know to do. A few years later I learnt that he had actually got his driver's licence, and I could not believe it, right? I actually went and saw for myself that once "Smoulder" got access to some cannabis, his movements normalised for four hours to the point where he passed a driving test—unbelievable. I will show you that photo.

Dr JOHN KAYE: Do you think he is unusual?

Dr KATELARIS: "Smoulder" is unusual for a cerebral palsy to be alive, right?

Dr JOHN KAYE: At that age.

Dr KATELARIS: Yes. His response is that—

Dr JOHN KAYE: But do you think there are generalisations—

Dr KATELARIS: He is a standout. He is an absolute standout in terms of cannabis response, if that is what you mean.

Dr JOHN KAYE: You think he has an unusual sensitivity to cannabis.

Dr KATELARIS: And this is important because what I have said is that there are different types of people. My experiences with medical cannabis—and it is only in general terms and it is only on a relatively small number of people, like in the hundreds rather than the thousands—are that about a third of the patients respond dramatically, about a third of them get useful benefit, and about a third either do not like it or it does not suit them, or something like that. "Smoulder" is at the far end of that bell curve. He really is a standout.

Dr JOHN KAYE: Sure.

Dr KATELARIS: But he is there, nonetheless. There, just pass that around. The stress—you have got the stress of police interdiction. That is the first thing. The next thing is the stress of having to find and buy the pot, and the expense is huge. People living on sickness benefits get less than $300 a week. That will be required for a month's supply of herb on general terms. That is 25 per cent of their income, which is huge. The next thing is the stress of losing their supply. For "Smoulder", that looks like a fairly innocent little old, "Oh, they're just going to take his pot", but they are condemning him now to a month of pain and writhing on the ground, right? So I do not think I can—

The Hon. TREVOR KHAN: Does he have the name ""Smoulder"" for any particular reason?

Dr KATELARIS: I do not know.

The Hon. TREVOR KHAN: I could imagine.

Dr KATELARIS: Yes, but it is not a laughing matter, though.

The Hon. TREVOR KHAN: No, no.

Dr JOHN KAYE: Thank you for your evidence so far. You have already answered more questions than I had to ask you, but that is okay. I want to go to one issue in particular, which is the antineoplasticity

benefits of cannabis. We have had a number of written submissions that refer to the cancer-curing agencies of cannabis. I do not want to spend too much time on this. I just want you to talk very briefly about the issue of astrocytomas.

Dr KATELARIS: Okay. It is mentioned specifically in my submission.

Dr JOHN KAYE: It is very briefly, but we had evidence from Cannabis Science Australia—written evidence, not spoken evidence—where the individual who wrote the submission suggested that she had a squamous cell skin cancer and she treated it with just raw cannabis oil, and that resulted in a cure.

Dr KATELARIS: Okay. Now, my experience is this: There has been a lot of internet traffic by a man called Rick Simpson in Canada and what they call the Rick Simpson method. Now the Rick Simpson method of cancer treatment involves taking approximately a pound—because they are American, we cannot go into metrics—of cannabis and reducing it with a solvent, whichever type of appropriate solvent you have, and producing about 60 or 70 milligrams of oil and then treating a person over about six weeks with that oil. He claimed a number of different cures of a range of different metastatic cancers. When I first heard this, I thought, "Well, that's nice, but I wonder if it's true?"

Because a number of people approached me for my opinion as to whether this could be true, I went to great pains to try to locate patients who had been so treated. But because they are operating in an illegal environment, most of them ran for cover. I got as close as one person, in fact, from Cannabis Science who had interviewed a couple of patients. So I had a second-hand confirmation that it actually effected some sort of cure, but that is a long way from actually being satisfied with what happened.

Now, last year I was approached by the husband of a sick patient in tears. The husband was in tears. He knocked on my door in the morning and said, "Look, I don't know what else to do." This is the story. This lady is 70 years of age. She has had breast cancer on and off for 12 years. This is now her third recurrence. At this stage there was a local recurrence with invasion into the brachial plexus. The brachial plexus is the major nerve of the arm. Tumour invasion into the nerves is one of the ugliest things you can get because it is unremitting electric pain down the arm and it is paralysed as well. He was in tears saying, "The doctors have given up. I don't know what to do. Can you help?", right? And I said, "Well, mate, we're up against it, but"—and I went through the Rick Simpson treatment. And I said, "Are you prepared to go that route?", and he said, "Have you got any other suggestions?", and I said, "I don't, so we may as well." I procured a pound of high-quality medical cannabis and reduced it to the Rick Simpson oil and treated her. To cut a long story short, she made a dramatic recovery. This is from the witness of my own eyes.

Dr JOHN KAYE: You treated her orally?

Dr KATELARIS: Yes.

Dr JOHN KAYE: She ingested it?

Dr KATELARIS: Yes. What we did with the 70 milligrams of oil, we actually encapsulated them.

Dr JOHN KAYE: And she swallowed them.

Dr KATELARIS: Yes, three times a day. How it was a tetrahydrocannabinol [THC] rich oil, and during the treatment, especially for the first two weeks of the treatment, there was significant sedation.

Dr JOHN KAYE: Which is probably a good thing, given the pain she was in.

Dr KATELARIS: Yes. At the stage when I started the treatment, I was confident that we could have some beneficial effect on the neuropathic pain because even though she was on fentanyl and other narcotics, neuropathic pain responds very poorly to narcotics. So I was quite comfortable in doing the treatment because I expected the pain to get better, and I was hoping it would demonstrate the anti-tumour effect. The response was beyond my wildest expectations in that she is well now and the movement of the arm is now starting to recover. But the only reason why we have not treated more patients is that to go and buy a pound of cannabis on the black market is not only expensive but fraught—

Dr JOHN KAYE: With the danger of arrest.

Dr KATELARIS: With arrest, and then, being caught concentrating it would probably have seen me in jail. That being the case, it is worthwhile enough to take that sort of risk—whatever it takes to shake the walls of this prohibition and get a bit of compassionate common sense into the policies in this place.

Dr JOHN KAYE: With that, you have mentioned astrocytomas in your submission, and here you have mentioned a metastasised breast cancer that went into a nerve, and you have mentioned Rick Simpson, but is there any—I do not want to use the word "respectable" because that is pejorative—

Dr KATELARIS: Yes.

Dr JOHN KAYE: But is there any peer reviewed—

Dr KATELARIS: Official?

Dr JOHN KAYE: —official inside the academy science that supports this?

Dr KATELARIS: There is a large literature based on animal models and cell culture work looking at the mechanisms by which cannabis exerts, or the cannabinoids exert, their anti-tumour effect, right? There is a vast amount. If you want to put me on notice to that, I will bring it to you, but there is a vast amount. It is interesting that when I was doing my Doctor of Medicine [MD] thesis at St Vincent's Hospital, I studied the process of apoptosis, which is an energy-dependent cell suicide. It appears that the cannabinoids are a unique class of selective apoptosis-inducing agents. So in the tissue culture which has been done in labs all around the world, if you put tumour cells and normal cells together and then add some tetrahydrocannobinol and cannabidiol, you can watch the apoptosis selectively removing the tumour cells.

Dr JOHN KAYE: This is across tumour cell types?

Dr KATELARIS: It certainly is. I would have to say when you said "evidence of curing astrocytoma", the reason why we chose that was because current therapies are universally poor. I have had a fair bit of experience in the treatment of astrocytoma from working at North Shore Private and things like that. I am known to the oncologists there and able to, with support from this group and the Parliament, actually initiate treatments without too much complication.

Dr JOHN KAYE: Can I go back to the issue of the tincture and the palliation for people in end stage cancer, people who are old and so on. Can you report any adverse side-effects? You have treated people with a variety of different cannabis products.

Dr KATELARIS: Yes.

Dr JOHN KAYE: Can you report any adverse side-effects?

Dr KATELARIS: They are minimal, for a start. Some people—and it depends if you call it "adverse"—because we keep a fairly close eye on them after we are initiating, especially if they are a person with no recreation or drug experience—and some after three or four say, "Yes, I just don't like it or it just doesn't suit me". They are a small majority. There is only one person that we had a problem with, an elderly lady living by herself who got quite confused but she misrepresented the instructions to have one drop rather than a dropper full and she was taking rather more than we had expected but that settled within 24 hours. It has been said—and repeating a lie does not make it true—that there are long-term problems with cannabis. There is no organ-specific toxicity of cannabis—just let me finish this because I think it is important.

Dr JOHN KAYE: Sure.

Dr KATELARIS: We talked about neuroprotective effects, although it was not clearly defined. A neuroprotective effect was determined by Israeli Government scientists—they were military scientists—where they were looking for ways of treating head injury and by analogy stroke as well, and they found that if you use largish doses of cannabis after stroke or head injury or other form of neurotrauma you actually reduce what they call the watershed area—that is the grey area that may die or may live—and you can actually reduce the morbidity that follows with a head trauma. That is what the neuroprotective effect is.

Dr JOHN KAYE: There are two meanings of long-term effects. One is the effect of long-term use; the other is the long-term effect of use. For example, your patient who had an effective overdose, she had too much and became disoriented. She recovered from that so she had no long-term impacts from that?

Dr KATELARIS: That is right.

Dr JOHN KAYE: But the issue that was being raised this morning was more the situation of somebody who had chronic non-cancer pain, so they were not going to die from it—they had a long life expectancy if not a very high-quality of life—and the question there was: Would you use cannabis-based drugs on a person such as that because they were likely to live for a long time—

Dr KATELARIS: I understand the question.

Dr JOHN KAYE: —and would side-effects emerge over that long time?

Dr KATELARIS: I will answer the question by referring to research that was done in the Golden Age before politics and the lying Murdoch press actually governed what we said, what we heard and believed. The Indian Hemp Commission study, I think, of 1890 looked at the question of cannabis use in India. It was a three-year study involving hundreds of doctors and thousands of people—and these are heavy users over a long time. The conclusion was there is no long-term mental or physical degeneration associated with cannabis. I would put them to proof to find organ-specific damage from cannabis or, as our Christian representative here was talking about IQ point derangement, it just was not seen.

Dr JOHN KAYE: We are getting a bit off topic but there is a New Zealand study of the eight percentage point drop in IQ.

Dr KATELARIS: There are a lot of studies and let me answer one study with another: Professor George Patton got headline news here a few years ago by proving that adolescent or young women who used cannabis ended up with depression later in life. Do you all recall that?

Dr JOHN KAYE: Yes.

Dr KATELARIS: Right. I actually was to debate Patton on television, I think it was on *A Current Affair* at one stage but in the preliminaries I asked him a simple question: Did you control for the effect of being busted and having a criminal record as a cause of depression? He hadn't? So the only thing he proved was that if you arrest someone and give them a criminal record they are more likely to end up depressed. It is not a laughing matter. We are led by mongrels and fools in this country, and I say that advisedly.

Dr JOHN KAYE: Am I correct in saying that phenomenon is not just you saying that; there is a body of research which suggests that the greatest harm from cannabis use is interaction with the police?

Dr KATELARIS: With the law. The Indian Hemp Commission study was only the first of the big honest studies. There was the Le Giardia study in New York. Are you familiar with that? They have studied them in Athens and in Jamaica. They have looked at people who smoked massive quantities of cannabis. In fact, cannabis confers a survival advantage over alcohol. They found there was a 24-year survival advantage for Jamaicans who smoked pot rather than used alcohol. It is not a toxic drug. It is a unique pharmaceutical with an unparalleled safety profile.

The Hon. CHARLIE LYNN: After all the information you have given us are there any downsides to cannabis use and, if so, what are they?

Dr KATELARIS: We live in what I consider a pharmaco-fascist State, and the lure by international corporations that manufacture dangerous drugs and then use a snow job of false statistics to get them pedalled onto the market. The major disadvantage of cannabis being introduced would be a dramatic reduction in the use of synthetic pharmaceutical drugs and an improvement in the health of the population. I cannot, from my experiences over 20 years, find any significant harm. Having said that, if a person's life is off the rails and they are overusing cannabis—see the devil is in the dose; it is not the drug—say you have a teenager who is not doing so well at school or whatever and he takes to the bong in the morning rather than getting up, going to school and doing his work. That is dysfunctional but that is a dysfunctional element in the person's life; it is not caused by the drug.

Dr JOHN KAYE: How do you know what is the cause and effect in that?

Dr KATELARIS: I have had experiences with people that you counsel and all the rest of it. Once you get their life back into some sort of order, you get them onto some sort of fitness thing and you improve their diet, it goes away even in the presence of cannabis.

The Hon. CHARLIE LYNN: They use terms like "mind-altering drug effects". What is your comment on that?

Dr KATELARIS: Cannabis is a very subtle drug. Alcohol is a relatively crude drug—if you drink enough of it you go through a series of stages ending up in unconsciousness. Cannabis is a subtle drug and it varies significantly on the dose. At the sub-psychedelic doses there is just a subtle increase in energy at least for three or four hours before a sort of restful state of slumber usually ensues. There is sometimes a flow of creative ideas or a tendency to see things in a positive way. At the much higher doses, the psychedelic doses, you get the hallucinations and visual sort of effects and all the rest of it. It varies on the dose and the strain. "Mind altering"—everything alters your mind. Caffeine alters your mind; alcohol certainly alters your mind in a negative way.

The Hon. ROBERT BORSAK: So does Parliament.

Dr KATELARIS: Parliament? It sort of blunts the mind.

The Hon. ROBERT BORSAK: It depends on what House you are in.

Dr KATELARIS: You would be no stranger to the use of the media to demonise things they do not want.

The Hon. ROBERT BORSAK: Yes, most definitely.

Dr KATELARIS: Law-abiding hunters have been demonised as mad Rambos.

The Hon. ROBERT BORSAK: That is right—drugs.

Dr KATELARIS: Yes, all sorts of things.

The Hon. ROBERT BORSAK: Lunatics.

Dr KATELARIS: The Murdoch press really is the carry-on of the Randolph Hearst press of the 1930s. As I said in my submission, they are even using the same words and phrases. It is an affront against civilisation and humanity.

The Hon. ROBERT BORSAK: It is not the Murdoch press that causes me problems; it is the Fairfax press.

Dr KATELARIS: Oh yes.

CHAIR: We are moving outside the terms of reference.

The Hon. ROBERT BORSAK: I am on the same page as you, just a different paper.

Dr KATELARIS: Yes.

The Hon. AMANDA FAZIO: My mother always told me that hemp was outlawed in the United States in the 1930s because it was a fix by the cotton industry?

Dr KATELARIS: Almost right; it is the nylon industry. Actually, look at *Billion Dollar Crop* and if your mum is still alive show her. It is the nylon industry under DuPont. The Randolph Hearst press was sold chemicals to make tree paper for the first time by the DuPont Corporation. There was a circular cooperation but it was not cotton. So did Dr Robson in the 1998 House of Lords report. He said:

The present situation is an affront to humanity.

That is what I consider this prohibition; restricting access to medical cannabis by whichever model is an affront to humanity. If you have read my submission, whatever model you choose, I would really like some strong emphasis to be given to allow us to use our hemp crops, which are already growing, to extract a CBD-rich oil to allow us to do the clinical trials hopefully as early as this year.

CHAIR: Thank you for appearing this afternoon. Any questions you have taken on notice or supplementary questions that Committee members might have will be provided.

Dr KATELARIS: I would be pleased.

CHAIR: We ask that they be returned within 14 days.

Dr KATELARIS: Indeed. Thank you very much.

(The witness withdrew)

(The Committee adjourned at 5.00 p.m.)