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 11 March 2013

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The Committee met at 9.40 a.m.

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PRESENT

The Hon. S. Mitchell (Chair)

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

CHAIR: Welcome to the first public hearing of the General Purpose Standing Committee No. 4 inquiry into the use of cannabis for medical purposes, if and how cannabis should be supplied for medical use and the legal implications of such use. Before the inquiry commences I acknowledge the Gadigal people, who are the traditional custodians of this land. I also pay respect to the Elders past and present of the Eora nation and extend that respect to other Aboriginals present. This is the first of two hearings to be held in this inquiry. Today we will hear from representatives of the NSW Ministry of Health, Department of Attorney General and Justice, NSW Police Force, healthcare consumers nominated by PainAustralia and Cancer Voices NSW, Mullaways Medical Cannabis, HEMP Party, Australian Drug Law Reform Foundation and two medical academics: Professor Michael Farrell and Professor Wayne Hall.

I will now make some brief comments about the procedures for today's hearing. Copies of the Committee's *Guidelines for the Broadcast of Proceedings* are available from the Committee secretariat. Under those guidelines Committee members and witnesses may be filmed or recorded by members of the media. People in the public gallery should not be the primary focus of any filming or photographs. I also remind media representatives that in reporting these proceedings, you must take responsibility for what you publish or the interpretation you place on anything that is said before the Committee.

It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of his or her evidence at this hearing. I urge witnesses to be careful about any comments that they may make to the media or to others once his or her evidence is completed, as such comments would not be protected by parliamentary privilege if another person decided to take an action for defamation. 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. I request that witnesses focus on the issues raised by the terms of reference of this inquiry and that they avoid naming individuals unnecessarily. Any messages from witnesses should be delivered through the Committee secretariat. I welcome the first witnesses this morning from the NSW Ministry of Health.

BRUCE BATTYE, Deputy Chief Pharmacist, Pharmaceutical Services, Legal and Regulatory Services Branch, NSW Ministry of Health, sworn and examined:

CHRISTOPHER SHIPWAY, Director, Primary Care and Chronic Services, Agency for Clinical Innovation, NSW Ministry of Health, and

JENNI JOHNSON, Manager, Pain Management Network, Agency for Clinical Innovation, NSW Ministry of Health, affirmed and examined:

CHAIR: Before we commence questions, would any of you like to make an opening statement?

Mr SHIPWAY: No.

Mr BATTYE: No.

Ms JOHNSON: No.

The Hon. AMANDA FAZIO: Are you aware of any research which shows that the use of medical cannabis can be harmful?

Mr SHIPWAY: Not that we are aware of.

The Hon. AMANDA FAZIO: Can you comment on the claimed benefits of medical cannabis, in particular issues such as reducing nausea, increasing appetite and providing pain relief?

Mr SHIPWAY: I might make some broad comments and then Bruce might like to add something to that. The Agency for Clinical Innovation convenes clinical networks to provide advice on clinical variation, innovative models of care and better ways of delivering clinical services in New South Wales. There is both a chronic pain network that is convened by the Agency for Clinical Innovation and a palliative care network that has recently been established. Both of those networks have been involved in processes—the chronic pain network a process of providing advice to the Government in 2011 about what additional services were required to deliver chronic pain services effectively in New South Wales, what new technologies were required and what research was required.

In providing that advice the medicinal use of cannabis never emerged as an issue from that clinical network that needed to be included in that advice to the Government. That is not to say that there are not potentially benefits there—there is certainly research that would indicate that—but our sounding of two or three of the clinical leaders of that pain network prior to attending this hearing was that while there is evidence, it is not sufficiently robust at this stage for the network to consider the medicinal use of cannabis for pain management as a critical area of activity or priority. Mr Battye, do you want to add anything to that?

Mr BATTYE: No.

The Hon. AMANDA FAZIO: In your submission you also noted that the key risk you identified was the diversion of medical cannabis for illegal use. Have you identified any other risks?

Mr SHIPWAY: There are no other risks that I am aware of. Ms Johnson?

Ms JOHNSON: No, we did not make a submission.

Mr SHIPWAY: No, the Ministry did.

The Hon. AMANDA FAZIO: A number of submissions have raised the issue of not wanting to promote people to be smoking anything more because there are enough health implications from the smoking of tobacco. Given that there are alternative methods of providing cannabis for medical use, do you think that it is still a valid criticism to say that people should not use medical cannabis because they might smoke it?

Mr SHIPWAY: The point the submission would have been making was one of how the product is understood amongst the general public—that is, if there is an awareness that there is a medicinal use of cannabis

some members of the public might take that to infer that the use of cannabis in any form might be good for your health or have some efficacious purpose. That is the risk that is being raised by that submission. There is obviously a range of ways in which that could be mitigated but that needs to be taken into account were cannabis to be used for medicinal purposes.

The Hon. TREVOR KHAN: So should we take opioids off the list of drugs used for pain relief—

Mr SHIPWAY: No.

The Hon. TREVOR KHAN: —on the basis of the logic of that argument.

Mr SHIPWAY: Absolutely not.

The Hon. ADAM SEARLE: You are saying it is a public awareness issue?

Mr SHIPWAY: That is the issue that is being flagged—if you are going to do this you need to be aware of how you market that and how you communicate that. In the same way that it is very clear how we communicate about opioids that are regulated and how we communicate around heroin and other illicit drugs.

The Hon. ADAM SEARLE: In the literature and the submissions that Committee members have received it is suggested that in other jurisdictions there are tinctures or sprays. To what degree would they be readily available if New South Wales went down the path of permitting medical cannabis to be legal?

Mr SHIPWAY: Mr Battye, you are better able to speak to this.

Mr BATTYE: I think it should be clarified that when we talk about cannabis we are talking about plant material and when we are talking about the sprays—which I think you might be referring to—we are talking about a pharmaceutical product, which is not plant material but an extract of cannabinoids from cannabis material. In the same way that we do not talk about the opium plant; we talk about morphine and nowadays we talk about synthetic opioids as well.

The Hon. ADAM SEARLE: Are these products readily available overseas?

Mr BATTYE: If you are talking about the cannabinoid spray?

The Hon. ADAM SEARLE: Yes?

Mr BATTYE: Yes, in some jurisdictions that is available for specific indications. The latest information I have is that in Australia the sponsors of the particular product have informed us that the product has been accepted now on the Australian Register of Therapeutic Goods—ARTG—for specific indication only and the company, the sponsor, is now grappling with the process of how that is going to be regulated.

The Hon. ADAM SEARLE: But there is only one product that you know of?

Mr BATTYE: Only one product.

Dr JOHN KAYE: That is Sativex, is it?

Mr BATTYE: Yes.

The Hon. ADAM SEARLE: In the United States 18 jurisdictions permit access to medical cannabis. How is that usually consumed by ill persons in those American States that promote its use?

Mr BATTYE: I would not pretend that I know all about that. I have read probably the same as you and it seems to vary a lot with the various jurisdictions. From what I have read, when it comes to medical cannabis, or medical use of cannabis, the most regulated regime seems to be in the Netherlands where they have set up the Office for Medicinal Cannabis. It is regulated by the licensing of growers. There is a whole regulated regime in place.

The Hon. ADAM SEARLE: The State grows the stuff, does it not?

Mr BATTYE: It is prescribed by doctors and dispensed by pharmacists. There are three distinct products and so on. So we have everything from some of the jurisdictions in the United States to the most regulated one in the Netherlands.

The Hon. ADAM SEARLE: Are those jurisdictions that permit the use of medical cannabis or cannabis-based products dependent on one or two commercially available products or is there sufficient competition amongst available products to make it cost effective for consumers? Or is it quite an expensive form of treatment?

Mr BATTYE: I do not really know that but, once again, I think we need to distinguish between cannabis, which we are talking about, and the normal pharmaceutical product, which is not cannabis.

The Hon. ADAM SEARLE: I guess my question goes more to the pharmaceutical products as opposed to the plant material, which, I understand, is produced in this country. Are you able to get any information for the Committee's consideration about what products are used in those other countries and their costs?

Mr BATTYE: You mean products similar to Sativex?

The Hon. ADAM SEARLE: Yes.

The Hon. AMANDA FAZIO: Or even the system they use in Israel where I believe they are actually using the cannabinoids in tablet form so they can be dispensed at a strength depending on the perceived needs of the patient?

Mr BATTYE: Yes.

Mr SHIPWAY: I am sure we can get that advice for the Committee.

The Hon. ADAM SEARLE: That would be very useful.

Mr BATTYE: We have not got that information readily available.

The Hon. ADAM SEARLE: This is not 20 questions; we are just trying to elicit the information and if, obviously, you do not have it, then you can supply it to us?

Mr BATTYE: Yes.

The Hon. AMANDA FAZIO: I want to verify some information in the attachment to your submission because it comes up perennially when cannabis or marijuana is discussed. Appendix A of your submission talks about one problem of cannabis use being that a predisposition to a schizophrenic condition or to schizophrenia can be triggered by cannabis use. I have been a member of other committee inquiries when people have said, "My family member was perfectly okay and they started smoking cannabis and they became psychotic." Those committee inquiries heard a lot of evidence that someone had to have a predisposition or already have a mental illness for that to happen.

Mr SHIPWAY: Yes.

The Hon. AMANDA FAZIO: I wanted to clarify that because I am quite sure that that will be raised in this inquiry.

Mr SHIPWAY: I think the first point to make again is the point Bruce made, that the available pharmaceutical products are not the same as cannabis that is smoked or consumed recreationally**.**

The Hon. ADAM SEARLE: Yes.

Mr SHIPWAY: The second point I will make is that there are now decades of research and discussion amongst clinicians around exactly what is the relationship between psychosis, other forms of serious mental illness and the consumption of cannabis. We get into very technical debates around correlations, causations et

cetera. The simplest thing to say is that if someone is consuming cannabis recreationally and they notice any untoward psychiatric effect as a result of that consumption, they should cease and talk to their doctor about what happened because it is highly likely that they might be putting their mental health at risk. As to the precise scientific language you want to use as to the relationship, we still have to keep conducting the research around it. Certainly Wayne Hall, who I think is one of your expert witnesses, will be far better placed to talk about the scientific etiology around that phenomenon.

Dr JOHN KAYE: Given that there are, I think, 18 States in the United States that have gone down the route of some form of medicinal cannabis and the Czech Republic, Israel, Netherlands and Canada all have some form, do you see it as part of the department's or ministry's brief to understand what is happening in those countries and the effectiveness or otherwise of the provision of medicinal cannabis?

Mr SHIPWAY: Yes we do, and the ministry certainly monitors a whole range of policy developments that are happening overseas. In terms of prioritising where effort goes in doing that policy research, we would be guided principally by two things. We would be guided by the priorities of the government of the day, and the second thing that will guide us is the advice that clinicians are giving us. Again, the role of the Agency for Clinical Innovation, which is separate to the Ministry of Health, is to convene these clinician networks to provide an arena and place where clinicians can meet and tell the Ministry and the Government what those priorities should be. While we certainly have been aware of the medicinal use of cannabis in America and Europe, in the last two to three years neither our palliative care physicians nor our chronic pain physicians, as a unified group, have said we ought to spend a great deal of time researching this particular phenomenon. Have I sufficiently answered your question?

Dr JOHN KAYE: Yes. Do you see it as an emerging trend in pain treatment if not as a first line drug, at least as a second line drug?

Mr SHIPWAY: There is certainly research into it, and Jenny might like to comment after I have concluded this statement about some of those specific treatments. There certainly is research going on about it. There are clinicians in Australia and overseas who are exploring the value of that treatment. I would not rule it out of hand that it is not potentially an efficacious treatment. But the consultations that we have done with pain clinicians around what you want to have in the New South Wales pain plan, the medicinal use of cannabis did not come up in that consultation process.

Dr JOHN KAYE: So you are not in a position to say that there are necessarily negative aspects of including it in the pain plan?

Mr SHIPWAY: There are not negative aspects of including?

Dr JOHN KAYE: You have not identified any barriers to it being included; it just has not been brought on to your radar yet?

Mr SHIPWAY: Correct.

Ms JOHNSON: I think the opiate issue is far bigger in pain management than the use of cannabis.

The Hon. TREVOR KHAN: Sorry?

Ms JOHNSON: Use of opiates in the community has been a main emphasis.

Dr JOHN KAYE: Are you talking about the recreational use of opiates and the leakage from the medicinal opiate market?

Ms JOHNSON: Yes, and from prescription into non-prescription. That is a whole other issue that has taken precedence in the pain management network. Whilst I think it is widely known that cannabis is used for pain management, I do not think it is advised in any circumstance and that is kind of the scope of how the clinicians operate with the patients who are seeking advice.

Dr JOHN KAYE: You have neatly segued me to another issue I wish to look at which is the issue of the leakage of medicinal opioids into the recreational market. Can you give us a sense of how large that problem is?

Ms JOHNSON: No.

Dr JOHN KAYE: You have raised it as an issue but you do not know how big it is as an issue?

Ms JOHNSON: No.

Dr JOHN KAYE: It has been raised with you by clinicians?

Ms JOHNSON: Yes.

Dr JOHN KAYE: What have they said to you?

Ms JOHNSON: It is more that clients come in using cannabis and asking for advice—

Dr JOHN KAYE: Sorry, I am asking about opioids here.

Ms JOHNSON: Sorry.

Dr JOHN KAYE: We may have misunderstood each other. I was asking about the leakage of opioids from the prescription stream into the recreational market.

Ms JOHNSON: There has been a significant increase in deaths and overdoses from oxycodone in the community since 2000, and there are several reports of misuse around the State.

Dr JOHN KAYE: And this is becoming significant enough to be mentioned to you by clinicians.

Ms JOHNSON: Yes.

Dr JOHN KAYE: So it is clearly on your radar and on the radar of the health authorities in New South Wales specifically because those opioid drugs have high levels of toxicity.

Ms JOHNSON: Yes.

Dr JOHN KAYE: And it is possible to overdose quite easily.

Ms JOHNSON: Yes.

Dr JOHN KAYE: Are you aware of whether the same is true of medicinal cannabis products?

Ms JOHNSON: No, I cannot comment on that.

The Hon. TREVOR KHAN: Cannot comment?

Ms JOHNSON: Cannot comment.

Mr SHIPWAY: I cannot imagine how you would overdose on a medicinal cannabis product.

Dr JOHN KAYE: You may or may not be aware of the comment made in 1988 by the Chief Judge of the Drug Enforcement Agency in the United States where he says, "In strict medical terms, marijuana is far safer than many foods we commonly consume. For example, eating 10 raw potatoes can result in a toxic response. By comparison, it is physically impossible to eat enough marijuana to induce death." The same is not true, clearly, of opioids.

Ms JOHNSON: That is my understanding, yes, but I am not an expert in the use of cannabis or opioids.

Dr JOHN KAYE: So to that extent replacing opioid use, reducing the amount of opioid use, if it could be replaced—I am not saying that it can be replaced—by medicinal cannabis products would actually lead to a reduction in harmful side effects of medical drugs.

Mr SHIPWAY: I think there is a series of assumptions in that particular chain of logic.

The Hon. TREVOR KHAN: Well, pick it apart.

Dr JOHN KAYE: He was going to. He does not need your invitation, Mr Khan.

The Hon. TREVOR KHAN: He may just dismiss it out of hand.

Mr SHIPWAY: The diversion of medicinally available opioid drugs is certainly occurring. We hear about it from clinicians and the injecting centre. First, it is difficult to quantify that into exactly how big a problem it is but it is certainly occurring. Potentially, if other drugs became available which replace those drugs then you have less production of those drugs; obviously that is less drugs that are available for diversion so you might have less diversion. As we know in both the licit and illicit drug markets there is a supply and demand push and pull that goes on. So while it might be true that if there were less opioid drugs on the market because other drugs have become available, it would not necessarily follow that you would not have that same amount of diversion if the demand was sufficiently strong enough. That then gets us into the whole issue of the licit and illicitly available opioids. Potentially, what you have hypothesised could occur but I think there is a whole range of other factors that we would need to take into account.

Dr JOHN KAYE: The other factor goes to the issue of controlling the supply of an illicit drug. It does not necessarily reduce the use of drugs in the community in general. If my hypothesis is wrong or my argument is wrong, it falls from your perspective on the grounds that there is a demand for psychotropic drugs in the community. Controlling one specific psychotropic drug will not reduce that overall demand.

Mr SHIPWAY: Not necessarily.

Dr JOHN KAYE: Not necessarily. So in fact to some extent the whole underpinning of the war on drugs does not work because if you have a war on one particular drug and you reduce its availability then another one will emerge.

Mr SHIPWAY: You have used the term "war on drugs". There is a whole series of regulatory and legislative processes you want to go through as a community represented by parliaments as to how we want to control particular substances and as much as possible the Ministry of Health will seek to rely on evidence as to what works and what does not work. Certainly, legislation making some drugs illegal is one of the tools we can use.

Dr JOHN KAYE: Can we go somewhere else for a moment? Can we talk about the issue of cannabis products and the delivery of cannabis products? Most of the jurisdictions that engage in medicinal cannabis deliver it as dried leaf or dried leaf and bud or some mixture thereof. Some also apply it as tinctures, sprays and pills. Can you comment on the issue of the health risks associated with providing a dried substance for smoking?

Mr SHIPWAY: What we do know about that delivery mechanism is that it can have a higher tar content than tobacco. It often carries higher risks in terms of the health side effects that we get from tobacco consumption, smoking, such as lung cancer, et cetera.

Dr JOHN KAYE: As to your comment about the higher tar content, presumably the person who is consuming medicinal cannabis is having a relatively small dose of cannabis compared to the amount of tobacco used by a cigarette smoker. Somebody who smokes 20 or 30 cigarettes a day will get much more tar than someone who smokes two or three joints a day.

Mr SHIPWAY: That is a reasonable point. It depends on the amount of tobacco that is being consumed by a particular person and the amount of cannabis.

The Hon. AMANDA FAZIO: What about the health risks of people vaporising cannabis for medical use? I know that is an alternative method that is used by a lot of registered users in the United States.

Mr SHIPWAY: I am not aware of the evidence around that but we can certainly take that question back and get you some advice about that.

The Hon. AMANDA FAZIO: That would be good, thank you.

The Hon. TREVOR KHAN: While you are doing that, if you are talking about tar content, if you smoke it through a bong will you get the same tar content as through a cigarette?

Mr SHIPWAY: There is a filtering effect.

The Hon. TREVOR KHAN: I am sure there is.

Mr SHIPWAY: Again, I would have to get advice as to how effective that filtering effect is.

The Hon. TREVOR KHAN: Could you do that?

Mr SHIPWAY: We can do that.

Dr JOHN KAYE: On that point, do the health authorities in New South Wales give advice to people who are using cannabis to use water filtration rather than direct smoking?

Mr SHIPWAY: The principal advice that we give—

The Hon. TREVOR KHAN: —is don't.

Mr SHIPWAY: —is don't and what you have seen in that fact sheet that is attached there.

Dr JOHN KAYE: So you do not give any advice beyond that. I want to go back to my issue and talk about patients who have a relatively short life expectancy, say, patients who have terminal cancer who are suffering symptoms for which the smoking of cannabis may have some palliative influence beyond other drugs. Is it the opinion of the health authorities in New South Wales that we should explore the issue of smoking cannabis even though normally health authorities are opposed to the use of smoking as a delivery mechanism?

Mr SHIPWAY: I do not know whether you are using the term "health authorities" in the singular or the plural. Can we find clinicians in New South Wales who might say this could be a useful thing to do in this particular condition? I am sure that we can. Have the group of clinicians who are committed enough to drive innovation in their chosen clinical fields who work with the Agency of Clinical Innovation to build different and better models of care for delivering services, collectively said we should pursue this? No, they have not at this stage. If we go back to them and asked the question—and again we can certainly do that—as to what would be your advise to this Committee, I think they would say that this area might be worth exploring and researching but it is not the first priority they would have. But I would need to confirm that.

The Hon. CHARLIE LYNN: A previous New South Wales working party on the use of cannabis for medicinal purposes provided a number of reasons as to why cannabis was unlikely to comply with the requirements of the Therapeutic Goods Act. It states, "Drugs cannot be registered except on application from a pharmaceutical company and it is unlikely that any pharmaceutical company would seek to register a natural plant product that cannot be patented." Would you comment on that?

Mr BATTYE: "Pharmaceutical company" is not correct. The terminology used in the therapeutic goods legislation is "the sponsor." It is actually the sponsor of the product which may or may not be the manufacturer. Commonly in Australia it may be the manufacturer but it may also be a marketing arm of the company or, in theory, it could be a government—it could be anyone. It is not necessarily the manufacturing company.

The Hon. CHARLIE LYNN: What they are saying is that anybody could invest in it but they would never own the patent and therefore they would not do it, is that correct?

Mr BATTYE: The system we have with pharmaceuticals is that the companies are there to make a profit, it is a free enterprise economy. If they figure they could make a profit my guess is that someone could apply as a sponsor.

The Hon. CHARLIE LYNN: There are huge profits in illicit drugs; none of them have come forward to try to go legal?

Mr BATTYE: Not as far as I know.

Dr JOHN KAYE: That is an interesting point.

The Hon. CHARLIE LYNN: The report further states that there is very little data from controlled clinical trials on the efficiency of cannabis for treating the recommended conditions.

Ms JOHNSON: That is our advice and understanding.

The Hon. CHARLIE LYNN: The third point in the report states, "There are serious concerns about the safety of smoke cannabis, especially in the treatment of chronic medical conditions." Can you comment on that?

Ms JOHNSON: Can you repeat that?

The Hon. CHARLIE LYNN: It states, "There are serious concerns about the safety of smoke cannabis especially in the treatment of chronic medical conditions."

Ms JOHNSON: I cannot comment. I am not an expert in that area.

Mr SHIPWAY: Are you reading from our submission?

The Hon. CHARLIE LYNN: No. It is outcomes from a previous New South Wales working party report that was put to this Committee.

Mr SHIPWAY: The general point I would make, because I think that working party was six or seven years ago from recollection, is—

Dr JOHN KAYE: It was in 1999.

Mr SHIPWAY: There we go; 14 years ago. Science keeps moving forward. Certainly the clinicians we spoke to last week in preparation for appearing here said there was some evidence in the field of pain control that there may be some efficacy around the use of cannabis. They also said there are a whole range of other issues in terms of availability, safety and whether it was delivering the claimed outcomes that required further exploration. The issue then for them was: Is this an area of research that we as clinicians want to be focused on? The answer we got from two or three of the leading people in the clinical network was no.

I would suggest that Professor Michael Cousins, who is one of the leading chronic pain experts in Australia—I think he is appearing before you next week—will give you far more detailed advice around the clinical evidence as it currently is in 2013. I think the issue for our clinical network is where do you put your clinical and research effort to get the best result for people suffering from chronic pain? The brief answer we got from two or three days of phone calls last week was not necessarily in this area. We can go back to that clinical network and ask for a more considered response to that question and provide that to you.

The Hon. CHARLIE LYNN: The other point they made was quality is also problematic because crude forms of cannabis contain variable amounts of tetrahydrocannabinol [THC] and other cannabinoids. Do you have any comment on that?

Mr SHIPWAY: That can always be the case. I am no expert on the how you grow crops but I am sure there are also ways in which one can have a level of quality assurance around that if an industry emerged and you put some effort into it.

The Hon. TREVOR KHAN: You have spoken, Mr Shipway, about pain relief and you referred to your understanding of the key benefit that may arise from the use of cannabis or a cannabis based product?

Mr SHIPWAY: The two contexts in which I hear it most regularly raised within a health policy setting is around pain relief and/or in palliative care; usually still around pain relief but with someone who is dying.

The Hon. TREVOR KHAN: Putting aside the fact that we may be speaking about a subset of people who are progressing to the end stages of their lives, it seems that a number of the submissions we received deal with a range of other benefits rather than simply pain relief—that is, with regard to restoring appetite, reducing gastrointestinal discomfort and the like. Am I missing the point when these submissions talk about that full range of potential benefits?

Mr SHIPWAY: No, and it is usually in the context of palliative care or deteriorating medical conditions that the use of cannabis is advocated.

The Hon. TREVOR KHAN: If we are talking about palliative care, that is, people who are progressing to the end stages of their lives, can you assist me by explaining why this Committee should be worried about the long-term effects of cannabis that are mentioned in the brochure attached to your submission?

Mr SHIPWAY: I can tell you the genesis of that advice. We have taken advice from all of the policy units within the ministry and one of the policy units is the mental health and drug and alcohol office. I would say that advice has come from them because they will be thinking of what the broader effects on the community are and what does this say in terms of public health messages.

The Hon. TREVOR KHAN: That is a different issue. When you talk about the long-term effects, for example, one of the things that is mentioned is reduced sex drive: Can you tell me how that is something the Committee should take into account when we are talking about patients who are dying of cancer, for instance?

Mr SHIPWAY: I think it is a point well made. We have given you broad advice around the long-term effects of cannabis use. The point you are making is if somebody is dying, sex drive is not going to be of critical importance.

The Hon. ADAM SEARLE: There may be some patients for which it is not a big consideration.

The Hon. TREVOR KHAN: With regard to the long-term effects for somebody who has full-blown acquired immunodeficiency syndrome [AIDS], which of the long-term effects that you list there would be relevant and worrying for a patient who may be considering using cannabis?

Mr SHIPWAY: I will not go back to the document and go through them one by one but I suspect none of them.

The Hon. TREVOR KHAN: If we are referring to somebody who has a severe case of multiple sclerosis, are you telling me that any of the long-term effects that are listed there will be particularly relevant to his or her care?

Mr SHIPWAY: It will depend on what stage of multiple sclerosis you are in. Let us put some principles in place around this. If someone is nearing the end of life and they have weeks or months to live, of course long-term effects are not going to be relevant to them. Some people do have conditions or chronic diseases which are going to be terminal and we can almost certainly say are going to be the cause of their death unless something else comes along—they may have three to five years to live—under those circumstances whatever product it is a clinician is prescribing they will think about what the side effects are of those products. We do that in palliative care with the use of opioids and the impact on respiratory health.

I think it is reasonable if cannabis is being used medicinally to consider the long-term and medium-term effects of that product. It will be dependent on how it is delivered and how that is going to impact on the patient's health. What we have given you is the publicly available advice concerning cannabis use. The points you are making, which are well made, may be relevant to someone who has weeks or months to live. But if we are talking about a longer time we want to think about the side effects of that drug or any other drug. It is good medical practice.

The Hon. TREVOR KHAN: For instance, a mild overdose of one of the opioids may not have a long-term effect; it may have an immediate effect upon the well-being of a patient?

Mr SHIPWAY: Indeed and many clinicians who are palliating someone who is dying from emphysema or chronic lung failure will think very carefully about how they prescribe opioid-based medication and at what point in that process of dying that patient has got up to.

The Hon. TREVOR KHAN: I go back to page 1 of your submission and the diversion issue. Are you able to identify how much cannabis is grown and, perhaps in a related sense, used in New South Wales?

Mr SHIPWAY: The Ministry of Health and the New South Wales health system do not keep that data and I would suggest that that question is better directed to someone from either a justice agency or the police.

The Hon. TREVOR KHAN: Do you know what the level of penetration is amongst young adults of the use of cannabis? Do you have those sorts of statistics?

Mr SHIPWAY: If we go back to the school surveys, I think for 16-year-olds, those who have ever used cannabis, it is more than 50 per cent. Those who use on a regular basis, which is defined usually once in the last month, is well below 50 per cent—

The Hon. TREVOR KHAN: We would hope so.

Mr SHIPWAY: But it is certainly higher than 10 per cent. I would have to go back to the published report of the secondary schools survey to be completely accurate about those figures.

The Hon. TREVOR KHAN: Would you be in a position to provide that?

Mr SHIPWAY: Yes, that is easily provided; it is publicly available.

The Hon. TREVOR KHAN: I suppose the next question is, if there is quite a deal of cannabis being consumed by teenagers and young adults in our society at the present time, you would agree with me that they are not getting it from diversion from medical use. Is that right?

Mr SHIPWAY: Correct.

The Hon. TREVOR KHAN: They are getting it from illicit sources. Is that right?

Mr SHIPWAY: Correct.

The Hon. TREVOR KHAN: Are you able to explain to me therefore why, if cannabis were made available for a discrete group of people who are in the end stages of their life, it should be a significant issue that the cannabis being provided to that subset is suddenly going to be diverted to this larger group of people that are already smoking their heads off?

Mr SHIPWAY: The policy consideration will be dependent on how that particular product is delivered, so if we are talking about a product like Sativex then clearly it will not be diverted for those purposes.

The Hon. TREVOR KHAN: I accept that.

Mr SHIPWAY: If it is a market like some of the markets that we see in the United States, then it is a product that you smoke and you consume in the same way that it is used recreationally. The policy consideration then needs to be, if this becomes legally available to a limited market of people, is there any potential for diversion; is there any potential that it would increase the consumption of that product illicitly.

The Hon. TREVOR KHAN: That is not really the question because we know that in terms of prescription drugs there is a potential for diversion. Surely the question is whether it creates an additional significant health issue.

Mr SHIPWAY: I thought your initial question was could it be diverted and what is the evidence for that.

The Hon. TREVOR KHAN: Yes, but where you say is there a potential, that is not really the point. The question is how much of a problem it creates by that potentiality of diversion.

Mr SHIPWAY: I think that is the point that the submission is seeking to make, that there is potentially this problem and it ought to be a consideration.

The Hon. TREVOR KHAN: You describe it as a key risk, do you not?

Mr SHIPWAY: It could be a key risk.

The Hon. TREVOR KHAN: Do you get any statistics from the injecting centre with regard to the drugs that are used and the like?

Mr SHIPWAY: I would have to take that question under advisement and get some advice from the Mental Health and Drug and Alcohol Office about that.

The Hon. TREVOR KHAN: Can you do that? The reason I ask is that I think Marianne Jauncey would tell you that now the major source of illicit drugs being injected there is in fact prescription drugs, so you might find that out because again it weighs on how we view some things, I suspect.

Dr JOHN KAYE: Most of which would be opioids, presumably.

The Hon. TREVOR KHAN: Yes.

The Hon. TREVOR KHAN: You are saying that is correct, are you, Ms Johnson?

Ms JOHNSON: Yes, I believe so.

CHAIR: Thank you for attending. The Committee has resolved that answers to questions taken on notice be returned within 14 days. The Committee Secretariat will contact you in relation to those questions, and also perhaps others that Committee members may have for you after today's hearing.

Mr SHIPWAY: Thank you.

(The witnesses withdrew)

(Short adjournment)

PENELOPE MARY MUSGRAVE, Director, Criminal Law Review, Department of Attorney General and Justice, affirmed and examined:

CHAIR: Would you like to make an opening statement?

Ms MUSGRAVE: No.

CHAIR: For your information, the time for questions has been equally divided between the Opposition, the crossbench and the Government members. We will begin with questions from the Opposition.

The Hon. AMANDA FAZIO: Ms Musgrave, I have just one question for you, following on from some discussions we had with our last witnesses. Would it be possible, if somebody were to genetically engineer cannabis to make it of better quality for medicinal use, to then patent that; and would that then give them a financial incentive to apply to have that patented cannabis use registered?

Ms MUSGRAVE: I suspect I am not the most appropriate person to respond to that question; it probably needs some technical expertise. What I can say though is that there is that regulatory framework in place to apply for registration under Commonwealth legislation. I cannot comment on whether somebody would be motivated to do that by some commercial incentive.

The Hon. ADAM SEARLE: In relation to the legal obstacles or impediments to New South Wales permitting the legal use of medical cannabis, what are those key impediments that this Committee should bear in mind in its deliberations?

Ms MUSGRAVE: There is one fundamental impediment, which is that cannabis is a prohibited drug under both the State and the Commonwealth schemes. But, having said that, depending on the model selected, there are avenues for exemption and precedents for exemption. So, under the existing New South Wales legislation, there are exemptions for scientific research, for example. You have to take into consideration that we now have in Australia a two-tier system of drug regulation—at State level and at Commonwealth level. So you then have to turn your mind to the Commonwealth Criminal Code to look at the offence provisions there. But again exemptions exist, if it has been permitted at State level, for all offences bar importation. When it comes to importation, you then need to turn your mind to a number of pieces of Commonwealth legislation, and whether exemptions can be given for that particular drug to be imported; and that is when you get into the Therapeutic Goods Act, the Customs Act permissions and quite a complex scheme of licensing.

The Hon. ADAM SEARLE: Let us leave aside notions of importation, what are the key regulatory considerations for the medical use of cannabis?

Ms MUSGRAVE: There are two sides to the equation. First of all, there is the prohibition, and I think it is quite clear there is a prohibition; and then it is looking at the means by which you can fit into an exemption; and those exemptions do exist. So if say a number of submissions are proposed to trial, if a trial was proposed for scientific or medical research reasons then exemptions would apply to prosecution if the person possessing or using the cannabis fell within the terms of that trial and was an authorised person to be using under that trial.

Dr JOHN KAYE: I am sorry, could you say that again?

Ms MUSGRAVE: What I said was that there is an exemption for a trial, and you would have to make sure that the participants were part of that trial and were authorised to possess or use as part of that trial. There is also a submission suggesting there should be a form of prescription, and again there are exemptions if pursuant to a prescription. The real question is: Is there any part of the chain of use that does not fall within the exemption? I think the question that has been identified in the past is the supply end of that chain. So under New South Wales legislation there are different parts of what I will call the supply chain that are criminalised; so supply, possession, use, and administer are all facets of that chain that are criminalised. So, under any trial or any scheme of prescription you have to look at a supply source that is also covered by an exemption.

The Hon. ADAM SEARLE: That is the tricky part.

Ms MUSGRAVE: That has been the more confronting part. But in New South Wales we do have precedents for legislative models that could cover the supply part of the chain, and that would be say the Hemp

Industry Act, which is simply a licensing scheme for a designated person or organisation to meet certain criteria: they are licensed, it is regulated, there are offence provisions for acting outside the licence, and that could cover that supply end of the chain.

Dr JOHN KAYE: So you are saying we would need to change the legislation to do that?

Ms MUSGRAVE: You would have to introduce a new piece of legislation to do that, yes.

The Hon. ADAM SEARLE: But just leaving the issue of supply to one side, it would be possible, would it not, for New South Wales, for example, to decriminalise or have no prosecutions for persons who are suffering fatal illnesses to possess and use small quantities of marijuana?

Ms MUSGRAVE: Yes. You could do it very quickly using existing exemptions under the trial provisions of the Drug Misuse and Trafficking Act. If it was not a trial, it would require an amendment to the Drug Misuse and Trafficking Act to put in some sort of authorisation scheme. So you would need to have a system where somebody makes a decision that a certain person falls within a class of people who are eligible to have the drug, and a system of identification. But there would need to be legislative amendments to the Drug Misuse and Trafficking Act.

The Hon. ADAM SEARLE: Could it not simply be done at the prosecutorial end if someone could show that they are in fact fatally ill?

Ms MUSGRAVE: You could do that. I think some overseas jurisdictions have taken that policy position that police will not prosecute. There is always a degree of uncertainty about doing it that way, and it is always subject to shifts in policy which can happen very often without community engagement. There is some security in a legislative amendment in that people know, and they also know the parameters of what they can do more clearly because it is stated in the legislation.

The Hon. TREVOR KHAN: And may expose people to arrest and questioning even if a prosecution is not subsequently undertaken?

Ms MUSGRAVE: That is right. The legislation is a more transparent mechanism.

The Hon. ADAM SEARLE: Whatever is in that legislation?

Ms MUSGRAVE: Yes, that is right.

The Hon. ADAM SEARLE: What about the interaction with Commonwealth law? If, for example, New South Wales decided to say, in legislative form, that it was a complete defence to a prosecution if the person is terminally ill and they possess or have administered cannabis for pain relief, would that require any consent from the Commonwealth?

Ms MUSGRAVE: No, there are defences under the Commonwealth offence provisions for those offences, bar importation, if it is legal under State legislation. If the State legislation authorises it or allows it there is a defence to the Commonwealth prosecution.

The Hon. ADAM SEARLE: All bar importation.

Ms MUSGRAVE: All bar importation because obviously the States cannot legislate in that space.

The Hon. TREVOR KHAN: So you could have a commercial quantity and still have a—

Ms MUSGRAVE: I would have to double check that. I focus very much on amounts at the low end of the scale and I do not have the legislation here. I can double check and get back to you.

Dr JOHN KAYE: Crucially, and supply?

Ms MUSGRAVE: Yes, and supply. Importation is the exception. The reason for my hesitation was that there is also the offence of possessing parts of a plant and instructions about how to grow it. That is the one that caused me to hesitate and I will check. I am quite happy to take it on notice and get back to you with the

relevant Commonwealth offence provisions and the defences for each of those for something that is authorised under State law.

The Hon. AMANDA FAZIO: My colleague was asking you about people who are terminally ill. How would you see a similar sort of regime working for people who have a long-term degenerative illness, for example, people suffering from multiple sclerosis, or for people who have survived cancer but have ongoing problems with things like continuous nausea and lack of appetite, for which it is also claimed that medical cannabis is beneficial?

Ms MUSGRAVE: It sounds very trite to say this, and I do not mean it to be, but it is very much a drafting issue. We have looked to the findings of this Committee and any expert group to inform how the exemptions or the defences under the legislation were drafted. If it is quite a finite group it might be possible to define it in the legislation. If a wider group is preferred, an additional layer of authorisation might need to be built into the legislation. There may need to be the involvement of a panel of experts or a review committee.

Essentially you have two possible models: a defined group in the legislation, say someone who has been certified as terminally ill, or, if a wider group is preferred you could have an authorisation from a class of people, that is, medical specialists or certain practitioners who are applying a set of criteria that are set by the Department of Health or an advisory panel or something like that. I am sorry, I have given you a very confused answer but the bottom line is it is all possible within the legislation; it is just a matter of how much you have to build into the legislation to achieve that purpose. You can have the criteria built in.

Dr JOHN KAYE: So all of that would be possible—

Ms MUSGRAVE: Yes.

Dr JOHN KAYE: —without contradicting Federal legislation. We could do all of that here in New South Wales, For example, we could set up a panel of experts who advise the Director General of the Department of Health who can publish a list of conditions for which medical cannabis is an appropriate prescription drug. We can have the drug grown, manufactured, processed and supplied here in New South Wales entirely under New South Wales law without having any problems with the Commonwealth?

Ms MUSGRAVE: Except for one aspect. When you use the word "prescription" we start having an interface with the Commonwealth because the Therapeutic Goods Act regulates the use and supply of therapeutic goods, which has a very wide definition. If, for example, New South Wales wanted to start with a trial, that is a separate issue because it is a trial for scientific or medical purposes. As soon as you start talking about using, supplying or possessing for therapeutic purposes you have to turn your mind to whether or not that is permissible under the Therapeutic Goods Act.

Dr JOHN KAYE: Then we would need to have the drug registered under the Therapeutic Goods Act.

Ms MUSGRAVE: That is right.

Dr JOHN KAYE: As long as we are conducting a trial, which I presume involves ongoing assessment and so on—

Ms MUSGRAVE: I think the need for a trial and the feasibility of a trial are possibly something you should ask other experts who come before the Committee.

Dr JOHN KAYE: Sure, but legally as long as it was a trial we could even prescribe the drug in New South Wales?

Ms MUSGRAVE: I do not know that you could prescribe it. I think it is supplying it to authorised people as part of the trial. My hesitation comes because it is very much in the health regulatory framework, which is quite complex.

Dr JOHN KAYE: Are we 100 per cent safe if we stay away from the issue of writing out a prescription with a provider number? So long as we do not do that can we provide the drug here in New South Wales through alternative mechanisms?

Ms MUSGRAVE: If I can use a slightly different form of words, if you are supplying, possessing and using as part of a trial to authorise people you would be able to do it within the exemptions under the New South Wales framework, which would also provide a defence to the offences under the Commonwealth legislation. I do think there would be some merit is seeking some evidence from the Commonwealth authorities that administer the Therapeutic Goods Act just to clarify that. They also have an exemption for trial purposes. Even though the Therapeutic Goods Act sits as an umbrella over all of this, it has to be remembered that they have the exemption for scientific purposes, plus they are essentially a scheme for seeking registration so that that therapeutic good can be distributed.

The Hon. AMANDA FAZIO: Would there be any legal impediment if New South Wales wanted to enter into one of these trials and it said it wanted the trial to go for 20 years or something like that? I am a big fan of longitudinal studies.

Ms MUSGRAVE: I think there would be some issue about whether or not that was genuinely a trial.

Dr JOHN KAYE: This is the State that ran the medical injecting centre trial for 10 years.

The Hon. ADAM SEARLE: That is correct.

The Hon. TREVOR KHAN: It seems to me we are coming to this position: If we are talking about a product like Sativex, that will require the active involvement of the Therapeutic Goods Administration [TGA].

Ms MUSGRAVE: I suspect that is right.

The Hon. TREVOR KHAN: Would a product like Sativex require some change in the law in New South Wales to allow its use or does its approval by the TGA avoid any issue in terms of New South Wales legislation?

Ms MUSGRAVE: If it has been approved by the Therapeutic Goods Administration and it is being distributed by prescription it does not require an amendment to New South Wales legislation to be legally used.

The Hon. TREVOR KHAN: We will put that sort of group of drugs to one side. What if we are talking about changing New South Wales legislation alone? Is somebody who has a terminal illness and essentially has a potplant in the backyard that they are harvesting and either by themselves or through a carer using the product going to be all right?

Ms MUSGRAVE: Are you asking me whether that is the issue? Yes, that is the grey area.

The Hon. TREVOR KHAN: In relation to that group we are talking about leaf or oil or some product of the plant.

Ms MUSGRAVE: Yes.

The Hon. TREVOR KHAN: In those circumstances, if it is to be certified in some way by a doctor—if it is going to be a doctor—and not prescribed, they would be saying, "This person is terminally ill and therefore it is appropriate that they have a smoke."

Ms MUSGRAVE: You would actually have to put in a specific legislative exemption for those people to be able to use it, because it is not a trial and it is not a prescription. You would need something new to cover them and what that amendment would be is something that this Committee will probably come to a conclusion on.

The Hon. ADAM SEARLE: That could be done by way of providing in the Statute a complete defence in certain circumstances.

Ms MUSGRAVE: That is right, and the terms would be that the person is authorised by a medical practitioner as being of a certain class.

The Hon. ADAM SEARLE: Or as terminally ill.

Ms MUSGRAVE: Or it could be an authorisation by the Director General of the Department of Health. There are a number of ways you could approach it. It is an achievable amendment.

The Hon. ADAM SEARLE: Whichever way you did it you would have to spell it out clearly in the legislation.

Dr JOHN KAYE: By not importing it and by not calling it a prescription we can more or less entirely avoid Federal legislation, provided we have legislation here in New South Wales which authorises the use of the material in that fashion or which creates a defence for the use of the material in that fashion.

Ms MUSGRAVE: My only concern is the coverage of the Therapeutic Goods Act, because it is all about therapeutic use.

The Hon. TREVOR KHAN: What I think I am coming to in terms of my question is that if we go down the alternative State route, in terms of the last witnesses we had, we cannot get away from the issue that we are in some way going to be talking about a leaf product. That seems to be, does it not?

Ms MUSGRAVE: I do not know that the answer to that. I am sorry. I may not be understanding you.

Dr JOHN KAYE: I think Mr Khan's question is if it is a processed product, if it is created as a pharmaceutical, then do we get caught by the TGA as against something which is just provided in a raw form?

Ms MUSGRAVE: I suspect that the witnesses from Health might have been better placed to answer this question than I am.

The Hon. TREVOR KHAN: No, they were not.

Ms MUSGRAVE: The Commonwealth Act is very much intended to cover the field. It is a protective Act. It is saying: We are going to monitor and regulate substances going out to the community to make sure they comply with standards. There is a provision in there and, I am sorry, I know I have got it here but I am not going to waste your time trying to find it—

The Hon. TREVOR KHAN: You can take that on notice.

Ms MUSGRAVE: It extends the definition of "therapeutic good" to include the things that are involved in the manufacture of that good. So, unfortunately, I suspect that the leaf would be caught. It is a very technical area and I suspect that the Commonwealth would be best placed to give advice on that, but I would be concerned about that.

The Hon. TREVOR KHAN: Can I just go one bit further and say in terms of the process if we were to do it solely under State law then what the medical practitioner would be doing is not in a sense prescribing—that is, indicating a dosage and the like. They would simply be giving a blanket certification that the person, because they fall within the class, can use the product. You are talking about a self-medication regime in essence.

Ms MUSGRAVE: What they may actually be doing is simply certifying that that person falls within a class and then the legislation says that people within that class are allowed to possess a quantity of leaf and/or plants and so it comes back to the supply issue. The medical practitioner is not supplying it as a therapeutic good, a commercial organisation is not supplying it to the people as a therapeutic good; they are growing the therapeutic good themselves. But at some point someone has to supply something to those people, i.e. seeds. That is why I suspect all these inquiries have always come to the point of supply.

The Hon. TREVOR KHAN: They find them all the time, I think is the answer. But let us suppose that somebody is really crook. The legislation would have to go further. I am suggesting to you, if we said this was a good idea you would have to have an exemption under the legislation for a supplier to a person who is certified as falling within the class.

Ms MUSGRAVE: That is right but then you would hit the therapeutic goods problem, because someone is supplying a therapeutic good.

The Hon. TREVOR KHAN: Is it a therapeutic good if you buy a bit of leaf?

Ms MUSGRAVE: That is the question, and it is very wide.

Dr JOHN KAYE: The definition in the Therapeutic Goods Act is very wide.

Ms MUSGRAVE: It is.

Dr JOHN KAYE: You are saying it is likely to catch that.

The Hon. ADAM SEARLE: The State legislation could avoid that issue by simply not dealing with the supply issue.

Ms MUSGRAVE: And then you have got the black market issue, because where are those seeds going to come from?

The Hon. ADAM SEARLE: I understand they grow wild.

Ms MUSGRAVE: The benefit of overcoming that problem is you do have a known identifiable safe source of seeds and, to be frank, instructions and equipment, all of which fall foul of various provisions. So it would facilitate the use of medical cannabis by terminally ill people to cover off them on the supply issue.

The Hon. ADAM SEARLE: Going to the issue of the certification by a medical practitioner, is that vital? As a matter of fact someone is either in the class or out of the class. If you have given an exemption—whether it is an exemption or a defence—for persons in a class that is just a question of fact. You would not need a certification in advance of usage in that situation.

Ms MUSGRAVE: It is purely coming down to certainty and clarity. In some jurisdictions I think they have even got a photo identification card. It means there is no risk of arrest and having to sort out the facts in a hearing.

The Hon. ADAM SEARLE: I think that happens in the United States.

Ms MUSGRAVE: I think that is right.

The Hon. TREVOR KHAN: Police bursting in through your front door with a search warrant, you would like to stop them at that point.

Ms MUSGRAVE: If somebody is actually holding a certification then the issue is resolved at the point of inquiry rather than at the point of a hearing, which is always beneficial.

Dr JOHN KAYE: We have been around the traps and maybe you could take this on notice, but can you summarise for us what are the options available to New South Wales to provide medicinal cannabis or to authorise the use of medicinal cannabis without cutting across Federal law?

Ms MUSGRAVE: Can I suggest I do take it on notice because then I can give you the definition of therapeutic goods under the Commonwealth legislation. Essentially what I return to you will cover off on the three things which we have spoken about, which is a trial, amendments to the Drug Misuse and Trafficking Act to provide an exemption or defence for a class of persons, or the third way is by way of prescription using the Commonwealth channels.

Dr JOHN KAYE: But in those first two you are suggesting we do not need to go through the Commonwealth channels; we could do it here in New South Wales.

Ms MUSGRAVE: The only impediment being that initial point of supply, and that comes back to the definition of therapeutic goods. When the person actually has the plant in their house and they are just giving it to themselves you are avoiding that Commonwealth umbrella, but at some point that person must have been supplied with something by someone to start growing that plant.

The Hon. ADAM SEARLE: And that is where you are saying New South Wales would have difficulty legally going it alone?

Ms MUSGRAVE: There would be an answer to the question. It is simply a matter of whether or not you have to make an application to the Commonwealth authorities to seek some exemption in order to do it. It is just a matter of unravelling the regulations that cover it.

Dr JOHN KAYE: I think probably we need to put this on notice. We are asking you a fairly substantial question on notice to come back to us with what the options are that we could pursue at the State level.

Ms MUSGRAVE: And the interface with the Commonwealth.

Dr JOHN KAYE: And, for each of those, the interface with the Commonwealth.

Ms MUSGRAVE: I just have a word of warning that there is a limit to the extent of the advice I can give on the Commonwealth angle because I am just very aware that it is a very complex framework that sits in the Health portfolio and not even in the Attorney General's portfolio, so it is quite foreign to me. I suspect whatever models are under consideration, at some point you end up with an interface with the Commonwealth.

Dr JOHN KAYE: You might be aware of the working party's report in 2000, which was the working party that former Premier Carr set up. As I understand it they actually concluded that the controlled availability of cannabis or cannabinoids for medical or scientific purposes would not place Australia in breach of any international treaty obligations. I guess we are now only at the level of Commonwealth versus State; there are no international issues around it.

Ms MUSGRAVE: I think that is right, because the question in front of you is limited to medical use and so my understanding is that it does not fall foul of the international conventions because of that targeted use.

Dr JOHN KAYE: All we have got to do is contend with the Commonwealth then.

Ms MUSGRAVE: I would suspect that is the case.

The Hon. CHARLIE LYNN: Just going back to the previous working party report, when they talk about the supply options for the New South Wales Government in light of relaxing Commonwealth law they say:

> As cannabis is not currently registered on the ARTG, licensed cultivation could only be legally sanctioned under the Therapeutic Goods Act regime if it were part of a clinical or scientific trial. However, the cost of establishing a regulatory body to oversee the licensing of cannabis cultivation for medical and research purposes would be considerable.

Do you have any idea or can you give us any indication of what that cost would be?

Ms MUSGRAVE: I cannot. What I would refer the Committee to though is since that working party report the Hemp Industry Act has been introduced and essentially it regulates people with licences to produce low-THC hemp. That might be a useful place in terms of costing such a scheme. That evidence is now available rather than having to speculate about the cost.

The Hon. CHARLIE LYNN: Earlier the people from the Ministry of Health alluded to the messages that go out in regard to safe use. We used an analogy earlier about those people who have a terminal condition and grow their own pot. Will they be arrested and, if they are arrested, how long will it take to get to court before they die anyway? Are we being real here?

Ms MUSGRAVE: I am not sure that is a question I can properly answer.

Dr JOHN KAYE: You are not qualified to comment on the reality of upper House members. I think that is a good qualification not to have.

The Hon. TREVOR KHAN: On that point, opium is grown in Tasmania, is it not?

Ms MUSGRAVE: That has always been my understanding. I have not actually seen any material about it.

The Hon. TREVOR KHAN: Indeed, it is commercially grown in Tasmania.

Ms MUSGRAVE: I had always understood it had been grown for a very long time and I thought for scientific and controlled purposes. I do not know whether it is commercially grown.

The Hon. TREVOR KHAN: Could you have a look at the regime that applies in Tasmania?

Ms MUSGRAVE: I suspect it is monitored at a Commonwealth level.

The Hon. TREVOR KHAN: There must be a Commonwealth involvement. I am sure the product produced goes through the therapeutic goods administration system.

Dr JOHN KAYE: State legislation.

The Hon. TREVOR KHAN: State and Commonwealth.

Ms MUSGRAVE: I am asking you questions about whether or not it is regulated by the Commonwealth.

The Hon. TREVOR KHAN: That is all right.

Ms MUSGRAVE: I might speak to the representatives from the Ministry of Health about that as well. My knowledge is that it always came through the analytical laboratories using it as a test or trialled substance, so they may have some information about it. I am happy to liaise with them.

The Hon. TREVOR KHAN: Perhaps I am asking a rhetorical question but if indeed opium is grown in Tasmania for a variety of purposes, you cannot really point to any particular negative messaging that comes out of that enterprise, can you?

Ms MUSGRAVE: I would not draw any conclusions about it.

Dr JOHN KAYE: Can I take you back to Mr Lynn's question, which I understand is this: In a situation where somebody has end-stage cancer and their carer is cultivating a single plant for them to alleviate pain and nausea associated with metastasising cancer, that would still be illegal in New South Wales, would it not?

The Hon. TREVOR KHAN: Absolutely.

Ms MUSGRAVE: At the moment it is illegal. Any amendments would have to cover both the person who is suffering the terminal illness and someone who was administering that or cultivating it for them.

Dr JOHN KAYE: If the police became aware that this was happening—for example, a neighbour might say, "I saw a couple of cannabis plants"—

Ms MUSGRAVE: A very green leafy plant on the balcony.

Dr JOHN KAYE: The police could then go in with a search warrant and prosecute those individuals.

Ms MUSGRAVE: I note you have Nick Bingham from the police coming this afternoon. I am sure he can take you through the sorts of things that they would turn their mind to, but technically yes.

Dr JOHN KAYE: Is there a way we can get into the data to understand how often that happens?

Ms MUSGRAVE: It is probably a question best asked of police whether or not they have any capacity to capture that data on their systems. Obviously if they do not, it will be purely anecdotal. The people you have coming this afternoon are experienced and can probably give you some anecdotal feedback. It may be that there is an entry within the system or there may be policies in place; I do not know.

Dr JOHN KAYE: Would it be more a matter of an individual who is before the court saying, "Your Worship, I have this plant because I have end-stage cancer." Would that be captured in the court records at all?

The Hon. TREVOR KHAN: No.

Ms MUSGRAVE: It would not be captured in the court's records.

The Hon. TREVOR KHAN: The normal comment is, "I have a bad back."

Ms MUSGRAVE: It would be dealt with in the Local Court. No data is collected as to the basis of submissions in mitigation.

Dr JOHN KAYE: We do not know whether or not people who are currently self-medicating are being prosecuted?

Ms MUSGRAVE: No.

The Hon. CHARLIE LYNN: I would not assume that the pursuit of terminally ill patients would be high on the police agenda.

The Hon. AMANDA FAZIO: They are. There have been reported cases in northern New South Wales.

Dr JOHN KAYE: I have anecdotal evidence of one individual who was supplying to a terminally ill patient, who was caught by sniffer dogs in a railway station and who copped a criminal penalty.

Ms MUSGRAVE: I am not aware of any academic research in the area on that issue.

Dr JOHN KAYE: Would it mitigate the sentencing before a magistrate?

The Hon. TREVOR KHAN: I can give evidence on that—overwhelmingly so.

Ms MUSGRAVE: I was going to give a slightly more qualified answer to say that it is open to receive that evidence in mitigation on sentence and there are sentencing options that could be applied; for example, a section 10, no conviction recorded. Unfortunately, there will not be any higher court authority on whether or not it is an appropriate consideration on sentence, because I doubt those matters ever go up on appeal and they are not heard as indictable matters. There is capacity within the court to apply a section 10 in that situation.

The Hon. TREVOR KHAN: The problem is the person is being dragged before a court.

Ms MUSGRAVE: That is the consequence of not providing a legislative exemption.

The Hon. ADAM SEARLE: As I understood your earlier evidence, Ms Musgrave, from a policy perspective it would be desirable that whatever the policy content is it should be spelled out in legislation.

Ms MUSGRAVE: That is right. It also goes to the issue of having people being able to identify themselves as being part of an authorised class so they can resolve the issue at the time of inquiry.

CHAIR: Following on from that, would the cannabis cautioning scheme that is operating at the moment be applicable in some of these circumstances?

Ms MUSGRAVE: It would be applicable in some of those cases, yes, depending on the quantity that they held.

CHAIR: Do you have any data on how often that is brought into effect, or is that something better focused to the police?

Ms MUSGRAVE: In respect of using the cannabis cautioning scheme relating to this cohort of people?

CHAIR: Yes.

Ms MUSGRAVE: No, I do not think that was covered. The Auditor-General's report on the cannabis cautioning scheme is a couple of years old now. From memory, it did not break that down. I can go back and check that.

CHAIR: I wanted to ask one more question in relation to a trial. I know that the Hon. Amanda Fazio touched on it and asked, "Could you have a trial for 20 years?" That seems as if it is blurring the lines of what a trial may be. Again, it might be something better directed to health, but are there other examples or circumstances that you know about of other drugs that have been brought in on a trial basis and generally how long they are in effect for? Is there any rough time frame that has been previously used for other similar products?

Ms MUSGRAVE: What we are talking about is a trial of the administration and a trial to determine whether you have the cohort right. All clinical evaluations are effectively trials. There is plenty of precedent for that happening. We are talking about something slightly different, that what you are testing is the process rather than the drug or the narcotic itself. It is slightly different. In this space there is a lot of precedent for scientific and clinical trials.

CHAIR: There are no further questions. Thank you for attending this morning. The Committee has resolved that answers to questions on notice be provided within 14 days. The secretariat staff will let you know what questions you have taken on notice and perhaps any others that might come from Committee members throughout the course of today.

Ms MUSGRAVE: Thank you.

(The witness withdrew)

SALLY CROSSING, Deputy Chair, Cancer Voices NSW, and

LESLEY ANN BRYDON, Chief Executive, Painaustralia, affirmed and examined:

CHAIR: I welcome our witnesses this morning from Painaustralia and Cancer Voices NSW.

Ms CROSSING: I appear for Cancer Voices NSW and I am also somebody with cancer, so I guess my appearance has a dual role.

Ms BRYDON: Painaustralia is a national network of healthcare professional and consumer bodies that are concerned with improving access to pain management for all Australians. I am also somebody who lives with non-cancer chronic pain, although I have also had cancer in my life.

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

Ms CROSSING: Yes. Firstly, let me tell you a little bit about Cancer Voices NSW. We provide the independent voice of people affected by cancer in this State to improve the cancer experience of the 40,000 people diagnosed each year with our disease. We were established in 2000, and we are active in the areas of diagnosis, information, treatment, research, support and care. To achieve this, we work in partnership with decision-makers who provide these services, ensuring that the patient's perspective is heard from planning to delivery.

Our position is that of a volunteer organisation comprising people with cancer. We see our role as principally to examine and comment on what impact such use will have on people with cancer. We see major benefits specifically for relief of symptoms and side effects, which often are not well managed now. We fully support the placement of controls to ensure appropriate prescribing protocols, and safe and efficient delivery to people for whom it has been prescribed; or, I understand, from listening to the previous speaker, there are various other ways of doing it. I am speaking today for a lot of people—those who have cancer. Some of us will die of our disease and some will not. Regardless, the comfort of knowing that a helpful drug has been added to the fairly limited offerings we now have would be very welcome.

I am in that situation. While I am stable now, the chances of my metastatic breast cancer progressing—a very odd word, when you think about it—towards an unpleasant end of life are statistically very high. So I have a personal stake in this as well as wanting to tell you about the needs of many others like me. Cancer Voices, representing as we do the views of people affected by cancer, supported the previous attempt by this Parliament when considering legislating sensibleness into development of legislation. We are here to ask you—you have the power to do this—to recommend that an amendment is made to the relevant Act, with adequate safeguards in place. We all recognise that some in the community are worried about leakage. We do not see addressing that as at all insurmountable. Our society has done it with more potent drugs.

For us, enabling the medical use of cannabis is common sense and kindness. The only moral question for us is that we should find a way to alleviate the suffering of others, as long as it does not act against the public interest. Your inquiry has come at a seminal time in the community's attitude to the use of cannabis for medical purposes, even, may I say, to the legislation and regulation of cannabis generally; although the two issues, it should be stressed, are quite separate, and should be treated quite separately during the inquiry. While we watch the Americas and Europe gradually seeing the benefits of treating cannabis like alcohol, let’s focus is on the present compelling matter—allowing cannabis to be used as a medical drug for those symptoms it can alleviate. To be honest, this seems to us to be self-evident.

Ms BRYDON: Painaustralia was formed in the wake of the development of the National Pain Strategy, and that strategy was developed in 2010 by 150 healthcare and consumer bodies who all believe that no-one in this day and age in Australia should live, or indeed die, in pain. We had the first pain summit in the world in this country. Indeed, the work we did informed the International Pain Summit, which was held in Montreal later in 2010. From that international meeting, which involved about 80 countries, there came two important manifestos, and that was the Declaration of Montreal, which calls for access to pain management to be a fundamental human right—I have copies of that here, which I would like to table—and a document called "Desirable Characteristics of National Pain Management Strategies" for all countries, which is based substantially on the work that was done in Australia.

We know as a consequence of the investigations made during the development of the National Pain Strategy that some 80 per cent of people with chronic non-cancer pain do not have access to adequate pain management. That is a very complex story in its own right. There is very poor education of healthcare professionals and indeed of consumers themselves. However, some 50 per cent of people with cancer pain are thought not to have access to adequate treatment. As Sally says, many of them suffer pain and indeed die very agonising deaths.

Our submission has supported the access to patients with intractable pain to medical cannabis products. Listening this morning, I am very conscious now of the complexities of our Federal system. Our position has been largely one from a national point of view, so I do understand what you are grappling with here rather better as a result of that. But since we began our investigations into this, we have also become aware of trials in the United Kingdom with a therapeutic product called Sativex, which you discussed this morning, and that that has proven to be quite effective for people with multiple sclerosis [MS] in particular to treat spasticity and the associated pain. I have a separate submission from Miss Sue Hodges, who was to appear today and who has made a statement, which I would like to table.

Also I am aware of trials in Australia at Peter MacCallum, Royal Melbourne and John Hunter hospitals in their palliative care department, which is trialling the drug as part of a global study. My discussions with the researchers this week suggest that they think the preliminary evidence is that the drug is now proving effective. They will have evidence in a couple of years time that the drug will be valuable to people with cancer pain and in palliative care for other conditions. We are not aware of any work being done at this stage for other forms of non-cancer chronic pain.

I would like to touch on the legal and regulatory considerations. Again, if these trials do prove the efficacy of Sativex and similar therapeutic products, clearly the legislative environment in which they become available is very important, but so is the cost to the consumer. It is not fundamentally sensible to be doing these sorts of trials without ensuring that the end result will be of benefit to people who need it. Consideration should obviously be given to the development of clinical guidelines for the use of the product and the conditions in which it can be used. There should also be a comprehensive education program for healthcare professionals, carers and consumers themselves to limit any likelihood of misuse or diversion. Cost is also an issue; it is important that these things are made accessible to people.

In the case of multiple sclerosis, as I said I have a statement from Ms Sue Hodges. It describes very vividly the experience of someone who lives with this terrible disease and who has had no pain relief from any form of currently available medication. She has tried to get access to Sativex in Australia but, of course, is unable to do so. On the other hand, she has had no desire to use homegrown cannabis. She would feel far more comforted in having a therapeutic product available. There are possibly many like her, but I respect the fact that others may feel differently. I seek leave to incorporate that statement.

Leave granted.

STATEMENT BY MS HODGES

Re: STATEMENT BY SUE HODGES TO THE LEGISLATIVE COUNCIL INQUIRY INTO THE USE OF CANNABIS FOR MEDICAL PURPOSES

As a person who lives with Multiple Sclerosis (MS), I thank the Committee for this opportunity to put forward a statement to the Inquiry. Regrettably, I am unable to appear in person.

I was diagnosed with MS in 1983, and the relentless pain has been with me now for 7 years. It has destroyed my quality of life and the only time I have relief is when I am asleep.

My left leg is badly affected-the tightness/spasm is particularly painful from the knee to the buttock muscle. It is therefore difficult to lift this leg and to walk. Because of this, my balance has now been affected and any attempt at exercise only makes my condition worse.

I have been prescribed a range of medication: pain blockers, analgesics and muscle relaxants, none of which have helped me. Some have had very severe and intolerable side effects.

I became aware of clinical trials that have been conducted in the United Kingdom with compound products derived from natural extracts of the cannabis plant.

The trials which have demonstrated positive results in treating spasticity and associated pain in patients with MS, involved an oral spray called Sativex.

I discussed the possibility of obtaining a prescription for the medication with my Neurologist, who investigated the evidence and availability of the medication on my behalf.

Our enquiries revealed that Sativex has been approved for use in the treatment of MS spasticity in some 20 countries. However, it is not legally able to be prescribed in Australia.

On the evidence available to us, I believe there is a very good chance that a cannabinoid product could help improve my condition, and importantly help alleviate my pain.

As a law-abiding citizen, I have no wish to attempt to obtain the medication illegally. I would certainly not wish to self-administer any such medication without appropriate medical supervision.

I am grateful to the NSW Legislative Assembly for opening up this Inquiry. I sincerely hope the Committee will give very serious consideration to the plight of people like me whose lives are affected, and often ruined, by this debilitating disease.

Over 23,000 Australians live with MS. A high proportion of us suffer from some form of spasticity and pain. In many cases, the pain is mild to severe.

I appeal to the Committee to recommend that appropriate regulation be put in place in Australia to allow access to approved, evidence-based, therapeutic cannabis products for medicinal purposes, and in particular, for the treatment of spasticity and pain in people with MS.

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The Hon. AMANDA FAZIO: I refer to the issue of the additional stress experienced by cancer and pain sufferers in using medicinal cannabis at present because it is illegal and the fear of arrest. Have you had any discussions with people in your organisations about this issue?

Ms CROSSING: I have never come across anyone who has wanted to and not done it because of concerns about that. However, obviously no-one wants to talk about it.

The Hon. AMANDA FAZIO: But there is a large number of people who self-medicate?

Ms CROSSING: Yes, but they do not talk about it very much—they just do it.

Ms BRYDON: I know from Ms Hodges' evidence that she was reluctant to use products that are not properly titrated and prepared. There would be a fear factor, but I would have to say that it is anecdotal. Many people would be worried about using them. The therapeutic product has a particular mix of cannabinoids that limits the side effects and in particular the hallucinogenic factors that have to be considered in the use of the homegrown drug.

The Hon. AMANDA FAZIO: Ms Crossing, can you provide more detailed information about the symptoms and side effects that you believe cannabis may relieve for cancer sufferers? We have heard about decreased nausea, increased appetite and so on.

Ms CROSSING: They fall into two categories that members have probably already heard about. They are antiemetic, which reduces vomiting and gastrointestinal discomfort caused mainly by treatment but also by the disease itself. That means it may disappear once the treatment is completed, particularly with chemotherapy and radiotherapy. On the other hand, the disease may continue to cause gastrointestinal discomfort. The second area is analgesic; that is, the control or reduction of chronic pain post treatment and possibly during treatment, but more concentrating on post treatment and the pain caused by the progression of the disease.

The Hon. AMANDA FAZIO: Ms Brydon, I am interested in your comment in the submission about the need for impartial and restrained debate on this issue. Can you elaborate and say why you think it is so important?

Ms BRYDON: PainAustralia's position is that we support evidence-based medicine. We made it clear that whatever usage of the product was recommended the product should be adequately reviewed by a pain medicine specialist, an addiction medicine specialist and a pharmacological expert. We believe the complexity of this debate means we need to have comprehensive input. Obviously legal and regulatory input is important. But fundamentally it is a consumer voice that needs to be heard in the debate.

Ms CROSSING: The problem with impartiality is the mixing up of the two issues: the medical use of cannabis and the decriminalisation of cannabis generally. Too many people in our community immediately think

that it is the thin end of the wedge or the beginning of the slippery slope. It should be impartial because emotional responses are very different if they are thinking about its complete legalisation.

The Hon. ADAM SEARLE: You mentioned that the experience of one your members was that she was not able to obtain satisfactory pain relief through current—

Ms BRYDON: Not without severe adverse side effects. Ms Hodges' submission includes an extensive list of the mediations she has used. Apart from anything else, it is also a very costly list. Her hope is that there may be other options available to her. She seems to have exhausted all the legal options at this point.

The Hon. ADAM SEARLE: How widespread is this experience that relief from pain is costly and/or unsatisfactory because of other health effects?

Ms BRYDON: I do not believe that we have any accurate data on that. We know that an estimated 23,000 Australians live with multiple sclerosis and that the disease varies enormously from one person to another. It perhaps reveals another area where research and further study is needed. There are many gaps in our knowledge about these things. If we were to do a survey of our stakeholder group we could ascertain that for the Committee.

The Hon. ADAM SEARLE: That would be interesting and useful.

Ms BRYDON: My colleague Professor Cousins is appearing before the Committee next week. He is a world-leading pain medicine specialist and has a comprehensive knowledge of what is happening globally. There may be data available. However, in virtually all of the studies we do with regard to chronic pain the Australian data is reflected in other countries. Suffice to say, it is an area of huge neglect across the board.

Ms CROSSING: We would be happy to work with you on that survey.

Ms BRYDON: I am sure that MS Australia, which has recommended Ms Hodges to represent its position today, would also be very pleased to assist in conducting that survey.

Dr JOHN KAYE: Thank you for your evidence and for sharing your experience with us. I refer to the issue of self-medication. A number of people are currently self-medicating with cannabis; in fact, I know of a number of people who have self-medicated or who are self-medicating. Sadly, many are now dead. Do you have a sense of how widespread it is?

Ms CROSSING: Sadly no.

Dr JOHN KAYE: But you are aware of cases?

Ms CROSSING: I am aware it happens, but we do not know of any individual cases. Our organisation, although we have been talking about this for years, we are a volunteer advocacy organisation, not a support group or a practical help group. We are there to try to influence decision makers like you to do what people with cancer would like to see happen. Our members have always supported—in fact, we based our position that we are taking today and have been taking for some years—the more policy kind of responses, agreement, approval and support that we do something about trying to change a situation. As far as individual cases, I cannot really help you.

Dr JOHN KAYE: So you are not aware of any data that exists that gives a sense of the levels of self-medication that occurs in Australia?

Ms CROSSING: Not in Australia, because we heard this morning there is not any so far as we can tell. I know that was general use of cannabis that the Ministry of Health was talking about. But there are other jurisdictions where cannabis has been used medically for a long time in the United States, which I would suggest would be a better area to look at than here where we do not really seem to have put our minds to this as perhaps we should have.

Dr JOHN KAYE: Do either of you have a sense of which direction we should be heading towards, either a leaf product or the side-effects kind of processed product?

Ms CROSSING: My personal view is I would rather have processed products—but that is not an organisational view—because it is safer. If you have end-stage cancer or even middle-stage cancer with pain, or multiple sclerosis or full-blown AIDS, cultivating anything is going to be fairly difficult for you and your carers. Why not have the option of both? Some people might prefer leaf but personally I would prefer to have a product that I knew was registered and safe and accessible.

Ms BRYDON: If I could say, PainAustralia's position is very much that we advocate for approved therapeutic products to be made available legally.

Dr JOHN KAYE: By therapeutic products, in Israel—

Ms BRYDON: Well, Therapeutic Goods Authority approved, and I understand the complexity of that.

Dr JOHN KAYE: Sure, but that is a separate issue to the question I asked. The Therapeutic Goods Authority could in theory approve doses of leaf, for example. The question is, is there a sense, among your community, which would be more appropriate or is the suggestion a choice of either?

Ms CROSSING: Most people would not have a clue what to do with the leaf unless you had experience with cannabis when you were younger and experimenting. There are various other ways of delivering it too. In America they have strips of things you can chew. There are a whole lot of products that they already deliver to you in the right amount of active ingredient, whereas with leaves in the backyard cooking up brownies and things—

Ms BRYDON: I also think with the oral spray the delivery mechanism helps to minimise the side-effects. I personally would not want to smoke a joint, for example. I find that abhorrent. I think it is really important that the delivery system is really simple, particularly for people who are ill and they know what dose they are getting. That is critical.

The Hon. CHARLIE LYNN: I suppose there are two categories we are talking about. One is the chronic pain sufferers and the other category is the palliative care. For the chronic pain sufferers, something that was safely prescribed, for want of a word, by prescription, whether it be legal, that is the sort of thing you are looking for?

Ms CROSSING: Absolutely. Like any other drug that is used. We have been through this before and I cannot reel off the list of drugs but obviously morphine, codeine, which is opium, which is a much more "dangerous" drug, that has been very well regulated for many years and is deliverable in relatively safe and different levels of active ingredient. The trouble is you feel dreadful as a result.

The Hon. CHARLIE LYNN: I have had the advantage of that being administered, so I agree with that, yes. So I suppose if you are suffering chronic pain you are not as concerned whether it is going to be addictive; all you want is relief? Therefore, as you said before, it is the thin end of the wedge, the start of the slippery slope. That is the challenge we have?

Ms BRYDON: I think people with chronic pain are certainly concerned about addiction. We know from experience it is a concern to people but there are also many people who take daily opioids for pain who we would not regard as addicted. I think when it is taken in a controlled way that is adequately supervised, medically supervised, we do not regard that as addiction. But the compulsive searching for a drug, which is what I would call addiction, is not what most people with chronic pain wish to experience. But, as I say, it is not necessarily the case that somebody who needs daily opioids—and we have many of them—would consider themselves an addict, and we certainly would not.

The Hon. TREVOR KHAN: Could I take you back to the evidence given this morning by representatives of the Ministry of Health. I think their statement was generally to the effect that the use of cannabis or cannabis-based products is just not on the agenda. That is a general description of their position. How do you come here and tell us that there is an issue when our public servants are saying it is just not a relevant issue?

Ms BRYDON: Can I respond to that? Jillian Skinner last year announced a statewide pain plan and Mr Shipway, I think, is aware of that. So, it is a complete puzzle to me. Chronic pain is very much on the agenda for New South Wales.

The Hon. TREVOR KHAN: I do not think anyone is doubting that. The question is the issue of cannabis as a possible reliever, if we just deal with the pain issue.

Ms BRYDON: There are so many other issues around pain that need to be dealt with. This is one small consideration in the whole sphere of issues around the management of chronic pain. There is a huge need for education of health care professionals. There is a huge need to destigmatise people who live with chronic pain. All too often they are seen as being weak, unable to cope, their condition is simply not understood. Our priority has been to try to look at making pain services available to the people who need them. That includes a high level of self-management of chronic pain. These days we know so much more. We know about the power of the brain in managing chronic pain. We know there is much people can do themselves. So, the cannabis issue is minute. If it is not on Mr Shipway's agenda it is not particularly surprising.

Dr JOHN KAYE: But it is enough on your agenda to get the two of you here today.

Ms BRYDON: The cannabis issue in our sphere is a small part of what is a big problem. Yes, it is not to be ignored, which is why I am here, but I assure you I have a lot more to do at home, which is where I work. PainAustralia is an unfunded organisation. We get no Government funding. I got into this role because I realised just how neglected the whole area is. Forty years ago we looked upon people with depression as being weak and unable to cope. We now know that depression is a serious biological condition. So too is chronic pain and there is a great deal that needs to be done to address it.

The Hon. TREVOR KHAN: Ms Crossing?

Ms CROSSING: I was going to say it is not a small issue for us. We are not just focusing on pain; we are focusing on all issues affecting people with cancer. We look at the full thing. It is one of many issues but it is an important issue. One of the good things about this issue is that it is something that could be easily fixed. I do not think the community is against the idea, in fact, the community is probably highly for it. It is a bit like dying with dignity, voluntary euthanasia, the community wants it but everybody has been too scared to do something about it, legislatively.

This is a much softer issue than that because it does not raise religious and political concerns. It is a simple issue and it is just a matter of being kind and helpful to people who need the help, in a safeguarded manner. Getting back to the question, we have been discussing it in our organisation for many years and it is one of the issues that we have on our website as one of the 25 position statements but it is an important one. As I said, it is a doable one and that is why I am here today.

CHAIR: Following on from that and not trying to put words in your mouth but before you said that while you do not have any data in terms of who might be using cannabis for self-medication, there is a consensus that people are using it but using it quietly. Is that part of the problem in terms of the information not getting through to the Department of Health because there is a lot of anecdotal evidence but because people are quiet about it, for obvious reasons, perhaps there is a disconnect in terms of the use getting through and that is as big an issue as any?

Ms CROSSING: Yes and also it has not been on the agenda of the Ministry of Health. The Ministry of Health decides what it is going to look at and it tends to be the regular run-of-the-mill, medical things. It is not a legal department and does not get involved in such things. This is the trouble with this issue, it falls between medical and legal and neither side is quite prepared to run with it. Although it was interesting to hear the representative of the Attorney General's Department because she made it very clear that legislators have to decide which route to follow but there are a number of quite straightforward routes to make it work well and safely. Do not worry about the Ministry of Health.

The Hon. TREVOR KHAN: I am referring to your submission, Lesley, but I think it is relevant to you both. I lost my father a few months ago after some three years of battle so I think I know the answer myself, but one of the statements is made: "PainAustralia would support the access of patients with intractable pain to registered therapeutic products" - clearly, your point. It continues: "And where other analgesic medications have been ineffective or not tolerated". Are you able to give us a description of how patients go through different regimes of medication and the effect that that has on some people?

Ms BRYDON: I can talk about personal experience. I have chronic non-cancer pain. My pain is primarily from very advanced arthritis. I have had five lots of surgery, joint replacements and so on and, as a consequence of the surgery, I have developed neuropathic pain which is the result of nerve damage during the surgery. I have a great deal of difficulty with drugs such as Oxycontin, Endone or morphine, because I have also had bowel cancer and, as a consequence, I have great difficulty taking medications which have such a direct effect on the gut. So, for me, I have been lucky in that the newer drugs like Gabapentin and the recently available Lyrica which are actually antipsychotropic drugs - I hope that is the right expression - I have been lucky in that they largely help me. I still have to deal with side effects, however, but not to the point where I would go seeking, although if I felt there was something available that was not going to cause that, I would seek it.

Suffice to say, I have been medicated with antidepressants, I take daily Panadol and there is not much that I have not tried but they all have a side effect with me. I know that, in the case of Ms Hodges' experience, she has had many more drugs because there are other drugs that are used for multiple sclerosis but, in every case, experienced some adverse effects. The adverse effects can be just as unpleasant sometimes - perhaps not just as unpleasant - severe pain is pretty bad. But when you suddenly realise that you have reached the end of the line and there is nothing further available to you, it is a very depressing situation. We know that some 50 per cent of people who live with chronic pain also experience depression and are driven down the antidepressant path. If there were simpler solutions available that could work for other people, obviously having these options would be desirable in our view.

Ms CROSSING: Pain killing drugs, as Lesley said, are very strong chemical potions with usually quite severe side effects. I do not think you should force somebody who needs to have either their gastrointestinal vomiting or pain symptoms addressed, to have to go through those very strong drugs before they get to the stage where there is nothing left and they are finally allowed to have a bit of medical cannabis. I think that the cannabis should be available at the same time because there is a lot of anecdotal evidence, although no hard data unfortunately as we heard this morning. You will hear more about that next week but if there is something that can do the job without substantial side effects, why don't we offer it to people?

CHAIR: I want to go back to the issue of what form of cannabis could be provided for a medical purpose and you talked about a pharmaceutical product rather than the raw plant. Some of the other submissions that we have received from various people for the inquiry have talked about the cost factor and that crude cannabis could be a cheaper product than one from a pharmaceutical company. Do you think that, for those you represent, the cost of the medication would be an issue and is the form that should be recommended something that the Committee should consider, if we go that far?

Ms BRYDON: From my point of view, cost is absolutely an issue but quality is perhaps an overriding issue.

Ms CROSSING: Again, I think we should look at the jurisdictions where a range of products are available and see what they cost. Also, there is no patent over cannabis. It has not been developed for years by large pharmaceutical companies which need to charge 100 per cent for their research and development and their marketing. I imagine that, if it is processed, there would be some overheads in that area. Cost, of course, always does impact on people but I am suggesting that firstly, we check out what the range of costs are and secondly, that the costs would not be anything like the sorts of drug costs that we face.

The Hon. TREVOR KHAN: My question is directed to Lesley but of course Sally, you are entitled to comment. What we talked about with the earlier witnesses has essentially been people who have been in their terminal stage where - I can only speak for myself - I can envisage that the availability of a product which is otherwise illegal might be justified in those circumstances, if we deal with people with chronic pain, that is a group that includes, for instance, somebody who has developed a severe back condition, perhaps at the age of 20 as a result of their work. That would be right, wouldn't it ?

Ms BRYDON: Potentially, yes.

The Hon. TREVOR KHAN: Some people may feel it somewhat harsh, dealing with the issues of the long term effects with the Ministry of Health people, if what was to be recommended was the availability of cannabis for people with chronic pain, then that would be a group of people which is much, much wider, would it not?

Ms BRYDON: One in five Australians lives with chronic pain.

The Hon. TREVOR KHAN: So in a sense, do I take it that you are inviting us to look towards the provision of cannabis to a very large group of people?

Ms BRYDON: No, not at all. I am aware that perhaps I have strayed into personal views here.

The Hon. TREVOR KHAN: No, no, no.

Ms BRYDON: I do represent an organisation where we do have a wide range of medical and multidisciplinary healthcare expertise available, and indeed legal, as well as consumer representation.

The Hon. TREVOR KHAN: You can cope with that disadvantage.

Ms BRYDON: But for something like chronic back pain there are proven ways of managing that, a lot of them around self-management and it is usually a bio-psychosocial approach, that is, it is a psychological, physical and medical approach, but are far more successful than, say, the use of a single drug or a single form of medication. We would not be advocating that and certainly not at this point. The priority would be to have the cannabis products available to those people who perhaps really need them and that is at the far end of the spectrum where either they are in the terminal stages or whether they have a form of cancer with intractable pain, HIV-AIDS, various MS or various conditions where there are no other options or very few other options for them. We are certainly not advocating it for broader use.

The Hon. TREVOR KHAN: I was not being critical in any way; I was just asking so that we define where we are going.

Ms BRYDON: No, no, no, because we would first be looking at all of the available options and ensuring that people had adequate access and information to what is needed to manage that.

The Hon. TREVOR KHAN: Thank you very much.

Ms CROSSING: Can I just add that I would like to agree. I think what we are talking about here should be stage one. Put it in place, see how it goes and then some years will go by; we will get more information about how helpful medical cannabis may be for wider indications. I was reading in the Bloomberg report yesterday that in Silicon Valley where there are people who are putting all that data into Google and Wikipedia and everything else they are working 12- and 14-hour shifts and have various aches and pains in the arms and they use—I do not know whether it is legal or illegal but no-one prosecutes them for it—a very low-level thing; it is one of those things that you chew, which relieves the pain but keeps the brain clear.

Things are changing all the time. As people use various different kinds of products that contain cannabis we will learn more. I have to keep under my cancer hat here and not my citizen of the wider community but let us do it in stages.

CHAIR: Are there any further questions from Committee members? No. Thank you, ladies, for your attendance here this morning. I ask you to keep in mind that the Committee has resolved that any answers to questions on notice be provided within 14 days and the Committee secretariat will contact you to talk about any questions you may have taken on notice and perhaps any further questions Committee members may have, if that is okay with you.

Ms CROSSING: Thank you for hearing us.

(The witnesses withdrew)

ANTHONY DAVID BOWER, Director, Mullaways Medical Cannabis, sworn and examined, and

KEVIN JOHN CHARLESWORTH, Advisor, Mullaways, Medical Cannabis, affirmed and examined:

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

Mr BOWER: Yes I would like to thank everyone for inviting us down here to put our point across for the sick and suffering people in Australia. I hope that we can achieve something here and find some kind of starting ground where we can continue on and actually help the sick people in this country.

The Hon. AMANDA FAZIO: Mr Bower, will you explain the background to your company?

Mr BOWER: I suppose in a way it started being a compassion thing. I hate seeing people suffering. It is like seeing a bloke attack a woman; that is not allowed. It gets the hair up on the back of my neck. What I was seeing was the suffering of a lot of sick people in this country. I thought it was about time somebody needed to stand up for them. It is that simple, and I had nothing to do at the time.

The Hon. AMANDA FAZIO: Will you explain a little bit more about how you believe medical cannabis can help people with things like multiple sclerosis or arthritis?

Mr BOWER: A lot of the people I help they tell me that. It is not what I believe; it is their fact—what they tell me about the side-effects they get from the drugs that people take. The anti-inflammatories that are found in cannabis are very strong. You know we have a cannabinoid system in our body that is controlled by cannabis. So it is sort of, you know, it is just there. It is common knowledge that those two link together and they work. Science tells us that cannabis has all these things in these cannabinoids—that are contained in there—so I do not see where anybody really should have to explain that point. I sort of think that it is done over so many times.

The Hon. AMANDA FAZIO: Will you tell us a little bit about the products that your company makes such as the tinctures and things like that?

Mr BOWER: I make non-psychotropic tinctures for people mainly because a lot of the elderly people who use tinctures—and a lot of our elderly are the ones who are sick and in pain—do not like the psychotropic effect that it gives. A lot of people use cookies believe it or not, they do not smoke. They cook the butter up and then make cookies out of it. They get a very similar effect from the cookies as smoking. So it is very high in THC and not in THCA, which is non-psychotropic. What I make is high in THCA—the non-psychotropic side—and very low to minimum in the psychotropic THC. It seems to be the cannabinoids are combined, all of them together basically. We do not know what cannabinoid controls what thing in your body so basically by giving you all of them you are covering the one that you need.

The Hon. AMANDA FAZIO: Have you got a licence to grow cannabis?

Mr BOWER: I paid for a licence in New South Wales, yes, four years ago. They have never replied. They have never acknowledged that they have taken my money. I even heard Bruce Battye sit here and say that he had never heard of me. Now that is an outright lie under oath.

The Hon. AMANDA FAZIO: Where do you source the cannabis to make your tinctures?

Mr BOWER: I grow it.

The Hon. AMANDA FAZIO: On page 9 of your submission you talk about a development in Israel, which is an interesting development I believe in the use of medical cannabis. Would either you or Mr Charlesworth like to tell the Committee a little bit more about that?

Mr BOWER: The trials have been going on over there for quite a while in Israel—they are government run—on chronically ill people, chronic pain. They do smoke. A lot of it is smoking over there.

Mr CHARLESWORTH: Smoking, edibles and cream.

Mr BOWER: There are edibles. What they are trying to get to people is what I do—a non-psychotropic form—but, unfortunately, they are in the wrong country.

Mr CHARLESWORTH: What they have found is that smoking cannabis works for these people, from children to the elderly, for a whole range of medical problems. Now smoking is not our premium choice but it works. These people that were in pain now are not in pain. They are using less opioid medication, which causes severe side-effects for them as you heard those women here talking about, and many of the submissions highlight these things, especially like hepatitis C where you are on Interferon. You cannot get off Interferon for two years when you start it; I can stop cannabis tomorrow. You are talking about—and this is what they are showing in Israel—cannabis working for a whole range of illnesses for these people and it has reduced the opioid intake required, which therefore is reducing the health bill not only on the State but to the individual. Now this is a very important thing. For instance, Sativex, mentioned in the submission's here, $500 per month in New Zealand—that is $6,000 per year—for a sick person on a pension that is a lot of money.

Mr BOWER: What we want to do is to get a cheap medicine to people. I am not one of these drug companies that are after a heap of money. What I want to do is to get a cheap medicine out that people can afford.

The Hon. ADAM SEARLE: Will you explain how the tincture works? How do you apply it? Is it under the tongue?

Mr BOWER: Yes, under the tongue. We have found that is the best method. The spray, while people think that is a good method, is actually not. That lady that was saying that she would prefer something; she would not have been to use it because she has arthritis. A lot of people spray this in the eye. They do not know whether they have it in the mouth. You spray yourself in the eye with that stuff, you cannot see for hours. It burns your eyes out.

The Hon. ADAM SEARLE: What other medicines are you aware of in different countries? How is this product delivered differently—I think you mentioned creams or tablets?

Mr CHARLESWORTH: That is right. Quite frankly, it is just the limitation so far of being allowed to research this stuff. Some countries, like Israel, probably the Netherlands as well, are moving forward in these areas. But it has been restricted in scientists being allowed to look at these subjects. The tincture that Mr Bower has developed, in Europe he could get a grant to develop this tincture. This is the safest. It has been tested by the health department and found to have no prohibited substances in it. So what are the long-term health benefits of this or the problems to your health for taking something with no prohibited substances in it? I would say minimal.

Mr BOWER: The actual export value of this is what really needs to be looked at because this does not need to go under trial. This is a legal medicine. It does not have to be trialled. These are cannabinoids that your body makes naturally.

Mr CHARLESWORTH: And Mr Bower has not tried to get away from it.

Mr BOWER: The export value of this medicine to the rest of the world is incredible.

Dr JOHN KAYE: Why does it not need to be trialled under the Federal system?

Mr BOWER: They are legal cannabinoids. It does not need to. Unless I lift the strengths up to much higher than what I need to go, which is like Sativex—they are about 600 to 800 times stronger—it does not need to go under trial. They are natural cannabinoids. We know that you make cannabinoids. We know you have them. We know you are lacking them if we do a blood test. We know if they are in here and I give them to you and they are legal, we do not need to trial that because it is going into your system. We can do a blood test and we can say, "Yes, it's in there. Now it's changed and it's this." But we can get it in there that easily. And they completely legal. Cannabinoids are legal. It is the THC psychoactive that is the illegal part, and that is minute in the plant. If people eat the plant just raw or fuse it, they are not going to get the psychoactive thing. It does not happen. If sick people are genuinely sick, you cannot have too much medicine. Your body rejects cannabis at a massive rate. It only takes on small percentages.

Dr JOHN KAYE: The issue with your tincture is that you do not heat the plant to make the tincture?

Mr BOWER: No.

Dr JOHN KAYE: Therefore you do not do the conversion?

Mr BOWER: No.

Mr CHARLESWORTH: Does not convert it.

Dr JOHN KAYE: There is no conversion to THC?

Mr BOWER: No.

Mr CHARLESWORTH: Generally their theory is 95 per cent THCA, the acid, and non-psychotropic 5 per cent THC in the natural form. That is the plant, until you heat it or, as scientists do, chop it up, destroy all the properties, heat treat it and then make a medicine.

Dr JOHN KAYE: There is no recreational value of your drug at all?

Mr BOWER: No. I could give you a gallon each. You could take it home and drink it. You would come back tomorrow and say, "Gee I had a good night's sleep and I feel good" but that is about it. That is about all you would do.

Dr JOHN KAYE: A product such as yours would not in any way feed the recreational market?

Mr BOWER: No, quite the opposite.

Dr JOHN KAYE: It is completely divorced from the recreational market?

Mr BOWER: Quite the opposite. What we are finding through the people we give it to is that it actually slows the cannabis use. It slows the alcohol use. It slows the drug use of all other opioids.

Dr JOHN KAYE: Why is that? Do you have a physiological explanation for that?

Mr BOWER: I would like to. I am not a scientist.

Mr CHARLESWORTH: There is research to show cannabinoid imbalance. Cannabinoid imbalance leads to pathological illness, mental and physical.

Mr BOWER: Yes, I would say that is a fair percentage.

Dr JOHN KAYE: From a legal perspective the difficulty with your product is not the product itself, it is the genesis of the product—the materials from which you make the product, that is, the actual cannabis plant?

Mr BOWER: Yes, and that is my specific breed for medical reasons.

Mr CHARLESWORTH: It is a natural process.

Mr BOWER: These are much stronger in the terpenes and myrcenes. They are much higher.

The Hon. TREVOR KHAN: If the police were to turn up at your front door—

Mr BOWER: They have.

The Hon. TREVOR KHAN: I am sure they have—and take away some of your vegetable matter and get it tested, they are testing only for THC, are they not?

Mr BOWER: Yes.

Mr CHARLESWORTH: And they came back no prohibited substances found.

The Hon. TREVOR KHAN: Is that right?

Mr BOWER: Yes.

Mr CHARLESWORTH: Yes, and the New South Wales health department.

The Hon. TREVOR KHAN: Your product is legal at the present time?

Mr BOWER: Yes. It has been tested by Nimbin police and by NSW Health. It is legal.

The Hon. TREVOR KHAN: I take it then you have made no admissions against interest so far in your evidence?

Mr BOWER: You have seen the people here. What interest did they show in what you are doing? That is what NSW Health is about. They are not interested in helping people at all.

Mr CHARLESWORTH: What you have to understand is that we have the holy grail of the clinical trial and therapeutic goods. Now this is good and we do not say we get away from this, but there are two million Australians with rare diseases that will never get a clinical trial. There will never be a drug put through Therapeutic Goods for them because there is no profit in them for large pharmaceutical companies. This is a failing in our system.

Dr JOHN KAYE: Except for somewhere back in history where somebody was breeding the plants you currently grow, there is no interaction even at the plant stage? If I took one of your plants and smoked it, it would not give me a high?

Mr BOWER: Oh, no. It will, yes, definitely.

The Hon. TREVOR KHAN: Because it goes through the conversion.

Dr JOHN KAYE: Because it converts. But the issue is that New South Wales police can only test on the THC content in the plant?

Mr BOWER: That is right. They do not test the plant. They just say that is this and then it is up to you to prove it the other way.

Mr CHARLESWORTH: His tincture was tested.

Mr BOWER: And if they have already destroyed it, how are you going to do that. They are pretty confident all the time that they can destroy it by half past seven in the morning.

Dr JOHN KAYE: Have you asserted intellectual property rights over your plants?

Mr BOWER: Yes.

Dr JOHN KAYE: Do you have a patent on that?

Mr BOWER: I have been trying to but, again, that is where NSW Health has been holding me up. They will not let me register it through IP Australia, even though it passed all the—

Dr JOHN KAYE: NSW Health has stopped you registering those through Intellectual Property?

Mr BOWER: Yes, 100 per cent stopped me from doing it.

Dr JOHN KAYE: You require their support?

Mr CHARLESWORTH: A licence to research cannabis.

Mr BOWER: I need to grow the things that IP Australia relies on. I actually have to set the first grow up because they have been done before here in Australia for high THC. I need to grow 40 plants of two different breeds and compare them. That is what they call the dust test—comparative growth. I do that twice and then that plant then breeds and they are mine. I do not have to have a patent on the medicine. I own the plant. You cannot make the medicine without this plant. It is not possible to do. If I make another medicine from another plant—I have four other breeds—those medicines will belong to the company.

The Hon. CHARLIE LYNN: You can patent this?

Mr BOWER: I do not have to patent it. I own the plant. I am an Indigenous Australian. I cannot patent any medicine. It is against my beliefs.

The Hon. CHARLIE LYNN: I am just looking at one of the objections from something I referred to earlier from a New South Wales working party.

Mr BOWER: I can patent mine, yes.

Dr JOHN KAYE: Legally you could?

Mr BOWER: Legally I can patent it, yes.

The Hon. CHARLIE LYNN: There is nothing to stop you from patenting it legally?

Mr BOWER: No.

The Hon. CHARLIE LYNN: That is one of the first issues of the New South Wales working party to which I referred earlier?

Mr BOWER: Yes. I actually use a completely different method that does allow me to patent certain parts of the whole thing.

Mr CHARLESWORTH: Not patenting it does not stop you from making the medicine. It just opens you up to competition.

Mr BOWER: Yes. I am not interested in owning something. What I want to do is give that to other people so they can make it too. That makes it cheaper for people and easier to access. Now we have a standard where we can work on, scientists can work on. Science can repeat itself. At the moment science cannot repeat itself. You can get them to do a test today, go and ask them to do it tomorrow, they cannot repeat it.

Mr CHARLESWORTH: You must use the same drugs that you used in your previous test. If you are getting your drugs from the police confiscation of street pot, that has nothing to do with medical. The quality of street pot is just ridiculous.

Mr BOWER: That is one of the reasons that people are getting sick and why these things are happening. There is no quality out there whatsoever. There is nothing out there, no standards for people and no education to go along with it. There is absolutely nothing out there for people to help them in any way.

Dr JOHN KAYE: I have one last question for you. Six thousand dollars a year for Sativex, equivalent treatment for equivalent symptoms using your tincture. What would be the cost to the consumer?

Mr CHARLESWORTH: Initially our preliminary design—and this was some years ago—based on funding everything ourselves with no help from the government was $50 a month, so it would be $600 a year. We have since revised that because we see it as a preventative, not as a save your life at the end. So it is more like a family of four, to rebalance their cannabinoids—this is from my conversation—but if a family of four wanted it, we believe you could easily do this for $1,200. It is the cheapest, safest product on the market. Well, it will be one day.

Mr BOWER: And we can, as it moves on, bring that price down.

Mr CHARLESWORTH: Especially if you open up international markets.

The Hon. CHARLIE LYNN: What would you like to see come out of this inquiry?

Mr CHARLESWORTH: Some people helped.

Mr BOWER: Like I said, I think if we can find some common sense, we can find some common ground and then we can move forward. I get hundreds and hundreds of emails every week from people who are dying, their kids are dying, their brothers, their fathers. Something needs to be done. While it does not affect me—and that is why I am here, because that sort of thing does not worry me—these people are suffering. Something needs to be done. Something needs to be moved ahead. If we were to get Bruce Battye to do his job, then we could move this ahead within six months or in 12 months we could actually have people getting cannabinoid medicines, legal ones. If you want them through the TGA we will run them through the TGA. We have done all this. We are ready to go. I am approved through the TGA to do it. Everything is in place to go and has been for four years.

Mr CHARLESWORTH: And he cannot move to that stage until he can get a licence to research in New South Wales and he has submitted two large submissions.

Mr BOWER: At the moment I cannot even get New South Wales health to agree to let me grow two plants so that I can go to Wileys in Queensland, the consultants. They will take it up there, they will work out how to extract it. This is the best way to extract it now; now we go ahead and build the plant. Two plants, not allowed to do it. That, in my mind, is corrupt. It is 100 per cent. And I see him sit here and lie, so I know he is corrupt. Drugs have brought this corruption into every part of our lives. It does not stop anywhere.

CHAIR: I must caution you about some of your language. It is probably not appropriate to be making those sort of comments in this forum.

Mr BOWER: They are facts; they are true. Whether you like them or not, it is a fact and I speak the truth.

CHAIR: I am making that comment for your benefit.

Mr CHARLESWORTH: The other major thing here is the criminalisation of these sick people. This is just not acceptable. You can see that nearly all the submissions are in favour and many, many of them from small people telling you they are self-medicating. Alcohol and drug services, the great submission by Dr Ian Webster, who laid it out. The poor man's analgesic. The parliamentarians, the doctors at the top need to pay attention because when you do a clinical trial, what is it based on? What these people are telling you.

Mr BOWER: And you cannot do a clinical trial on 90 per cent of cannabis products because the person you are giving it to knows. You cannot give them a placebo; they know.

Mr CHARLESWORTH: Designing a double-blind clinical trial for smoking cannabis is just not possible.

Mr BOWER: It works for all the people who get it, and the ones who do not get it know straight away because it does not work. They do not get any effect whatsoever. The trials is a lot of the reasons why they have never been done into cannabis is that they cannot be done. You can do everything to regulate products like I have but realistically I do not have to put that through the TGA. The Government asked me to do that. Again, it is just way outside what the Government is here to do. You are not supposed to have to go through all this stuff just a register a medicine.

Mr CHARLESWORTH: The New South Wales Government is responsible for issuing the licences.

Mr BOWER: That is not the way you go about it. I am supposed to go and fill in a form. I am supposed to pay my money to do it, and then the Government is supposed to do its job. Four year, 4½ years I have been waiting. Nobody, bar for John, has talked to me.

Mr CHARLESWORTH: He sent hundreds of letters. He sent off three New South Wales Premiers, three New South Wales health Ministers, a Prime Minister, and he has written over 100 letters to New South Wales parliamentarians, Federal parliamentarians.

Dr JOHN KAYE: Can I ask you to contrast your product to Sativex—

Mr CHARLESWORTH: It is much stronger and it is a political product.

Dr JOHN KAYE: —in terms of not the delivery method but the chemical composition?

Mr BOWER: Sativex has a lot to do where they are, where they make it in England. They are growers. They do not understand the cannabis, so they end up with a high CBD product.

Dr JOHN KAYE: So CBD is cannabidiol.

Mr BOWER: Yes. What we are finding, I do not produce CBDs. None of my medicines have CBDs in them. Science tells you that CBD can fight cancer and it fights injuries in the plant. It goes around the plant to fight those sorts of things. That is actually CBDA. It is like THCA. When it is in the plant it travels around and it can help cancers, injuries to the plant and so on. Because of the way they grow and their extraction method, they take that out and they convert it to CBG. They have dropped the A. They have mixed all of the anti-inflammatory acids, anything that was in the CBDA is now gone and combined, the same as heating THC. THC and THCA are both in the plant. When you heat it, which is your extraction method to bring it out, you convert the non-psychotropic THCA to psychotropic. You have lost all of the components of THCA, the things that help with your cancer and your pain. You have converted them all over to psychotropic which is one thing.

Dr JOHN KAYE: So Sativex is closer to smoking a joint than your mouth tincture?

Mr BOWER: Yes. Basically, it is the same as smoking a joint and that will depend, when you spray it in your mouth, on whether the CBD gets to your receptor first or the THC. For CBD, this is why they have such mixed results. If the CBD gets there first it uses the receptor, locks it and it closes. It does nothing whatsoever. Now your THC, which does something, is passing past that receptor and cannot be used.

Dr JOHN KAYE: That is a matter of personal physiology.

Mr BOWER: Your body will naturally take it on. I think it is just basically how it gets into your system; how fast one bit gets there compared to the other one.

Mr CHARLESWORTH: They have focussed on CBD because it is non-psychotropic. It gets around the prohibition legislation that is in place and they have made it 2.5 milligrams, which is half the supposed safe dose where you do not know whether you have had the placebo or you have had any cannabis. So 2.5 they consider safe. What they are finding is that it is way too high.

Dr JOHN KAYE: What changes to the regulatory regime in New South Wales would you like to see?

Mr BOWER: I was listening to the lady talk earlier. I really do not think we need to put all these things in place. I think there is a special access scheme in New South Wales that already allows it. You do not have to do anything at all. I am surprised she did not bring it up that the scheme is already in place. She should have brought that up straight away and said it is there, there is a special access scheme it is called and you do not need permission. It does not have to go through the TGA. It does not have to be registered.

Dr JOHN KAYE: That special access scheme is in New South Wales?

Mr BOWER: It is New South Wales and Federal. New South Wales comes under Federal in health, so we run compliant with Federal. Whatever you agree with here they agree with there and whatever they agree with you agree with: We run compliant with Federal in New South Wales.

Dr JOHN KAYE: Such harmony, unheard of.

Mr BOWER: I know it is not like that but that is the way it is in law. New South Wales in law complies with the Federal Therapeutic Goods Administration [TGA].

Dr JOHN KAYE: It is called a special access scheme?

Mr BOWER: Yes.

Mr CHARLESWORTH: And it is a secret and yet it is supposed to be there for people who need access to drugs that the TGA does not provide.

Mr BOWER: The laws were put in place for it but nothing ever went past that. I think there was a law put in place to help the carers of people.

Mr CHARLESWORTH: What we would like to see in legislation is that people get a medical cannabis card so they aren't criminalised and the police do not waste their time chasing medical cannabis patients around and putting them through the court system. This is not right. This is simple to do. You do not even need a rego sticker any more. A little card, that is all we need. They can swipe it, they then know the person is registered with the government and they go on their way. We need to protect people from becoming criminals. Curtin University addiction studies has taught, or used to, that the greatest harm that can happen to a person in their life who uses cannabis—and far exceeds any other harm that will happen to them—is getting a criminal record; Curtin University addiction studies.

Mr BOWER: A while ago I heard you saying about drugs going to the streets, to the black market. I have some photos. This is in Tasmania.

Mr CHARLESWORTH: Security on the poppy fields in Tasmania.

CHAIR: For the benefit of Hansard could you not speak over the top of each other. It is particularly difficult today with our technical issues.

Mr BOWER: That is a photo of the opium crops grown in Tasmania. That is the protection. The drug companies are worried about cannabis getting out on the street and all the rest of it and it being diverted to the illegal market, but that is what stops you getting opium in Tasmania, a cow fence—a simple cow fence and a sign saying this "can cause death". We are going through all of this to stop people growing cannabis. In my submission I have 21 electric wires on the fence and that was knocked back. This is what keeps our opium crops off the street here in Australia. That is not in other countries.

The Hon. TREVOR KHAN: It is unclear as to whether it is the fence that causes death.

Mr BOWER: We export 40 per cent of the world's opium products. Forty per cent of the world's opium products are grown in Australia.

Dr JOHN KAYE: Forty per cent of the legal product?

Mr BOWER: Forty per cent of the legal opium product exports all around the world are grown here in Australia. Where is our big illicit drug trade in this and who is stopping it? You have to jump this fence to stop this drug trade.

Dr JOHN KAYE: In your submission, Mr Bower, you suggest three layers of licences: Licences for grower, farmer and manufacturer; a licence for the dispenser—

Mr CHARLESWORTH: They are options for you to consider.

Dr JOHN KAYE: —and a research licence and a card for the users, is that correct?

Mr BOWER: Yes.

Dr JOHN KAYE: The user has a card that, if there is an issue with possession or use of the substance, they can show to the police?

Mr BOWER: Yes, and that is registered through the normal government things where a doctor can ring up or send an email to somebody and that can be set up easy enough and paid for by the people that are growing or dispensing the licences.

Dr JOHN KAYE: Taxes?

Mr CHARLESWORTH: And it could be so much more than this because tied to this card can be the amount of cannabis a doctor has set them to use. When they get the cannabis from the government supplier they swipe their card and it is registered and it goes on to the database so we can see what the best methods are and what treatments work best. It gives us balances and checks. It is not just give people cannabis and let them go.

Mr BOWER: I do have other medicines that I have not put out to people yet that can be developed real easy. It is the same thing; you can actually save a lot of money for the health system, you can help a lot of people, you can get money and people can get work out of it. All this has to be grown and cannabis is not like the opium product where you get a machine in and harvest it. If it is going to be used for medical purposes it involves a lot people and hands-on work. Again it is not something where you have to worry about it because it is nonpsychotropic so handling cannabis is not a problem. There are no issues with it.

Dr JOHN KAYE: That is true for your product.

Mr BOWER: They are all the same.

Mr CHARLESWORTH: It is true for any cannabis. If you look at any videos showing Israeli operations, or other places, they are all handling it.

Mr BOWER: Just handling it.

Mr CHARLESWORTH: It is not psychotropic.

Dr JOHN KAYE: If a worker in the field were to steal a bud, for example?

Mr CHARLESWORTH: Went home and smoked it.

Mr BOWER: The normal things would be in place to stop that the same as any business. You do not go into a gold mine and walk out with a handful of gold. I am pretty sure they weigh you on the way in and weigh you on the way out.

CHAIR: That concludes the questions for today. Thank you for appearing before the Committee this afternoon and if there are any questions on notice that come from the Committee the secretariat will inform you and we would like a response in 14 days.

Mr BOWER: No worries.

(The witnesses withdrew)

(Luncheon adjournment)

NICHOLAS BINGHAM, Superintendent of Police, Commander, Drug Squad, NSW Police Force, affirmed and examined:

PATRICK PAROZ, Superintendent of Police, Commander, Drug and Alcohol Coordination, NSW Police Force, sworn and examined:

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

Mr BINGHAM: No, thank you.

The Hon. ADAM SEARLE: I understand this may be difficult given the job of the Police Force is to uphold and enforce the existing law, but based on your professional experience, particularly in the Drug Squad, do you have or are you able to express any views about any potential drawbacks in permitting the medical use of cannabis or cannabis-based products for pain relief for people who are, say, terminally ill or suffering from other chronic pain?

Mr BINGHAM: I guess, not being a medical person and being a police officer, as alluded to, we are about law enforcement and the protection of the community. It appears there is some evidence that cannabis does have some therapeutic qualities, in particular in regards to pain relief and also stimulating appetite in cancer patients and other patients with chronic pain, et cetera. But our perspective is all about law enforcement and harm minimisation. I guess from a law enforcement perspective we are also seeing plenty of evidence that cannabis has some adverse effects on the people who use it. There is ample evidence out there now to show that in relation to mental health issues it has an impact on a significant proportion of people with mental health issues. It is not a drug that usually causes volume crime, such as when you have methamphetamines and heroin. People who are addicted to those types of drugs are usually involved in volume crime.

The Hon. ADAM SEARLE: Or crack?

Mr BINGHAM: We do not see crack in Australia but we see something similar with ice. Certainly ice is another one of those drugs. Until recently I do not think I saw cannabis having an impact in relation to violent crime but I believe there are some studies out that show some people have been charged with crimes of violence, assault, et cetera, and a significant number of them use cannabis as well.

The Hon. ADAM SEARLE: As well? In combination with other drugs in relation to violent crimes or just in isolation?

Mr BINGHAM: Just in isolation is my understanding. It has been separated from other drugs. In relation to the medicinal use of cannabis, certainly from the New South Wales perspective there would have to be some fairly stringent regulatory regimes in place if it were to be considered, such as the same regimes that normal pharmaceuticals go through—your S4 drugs, your S8 drugs, and any other therapeutic drug for that matter. There would need to be some fairly stringent regimes and findings. It will also have to be regulated in the same sort of manner as other drugs.

It would have to go through the Commonwealth poison standard and be put into a schedule there to be adopted into New South Wales legislation. Another issue would be there would need to be legislation consistent across the country. It would not work in one State if it was not in the other States. There are also the impairment issues of cannabis users—driving, working. If the psychoactive ingredient is taken out, I think a lot of joy is gone for a lot of cannabis users. Certainly not for the legitimate cannabis users, who are taking it solely for chronic pain, anti-nausea or for appetite stimulant.

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The Hon. ADAM SEARLE: If you took that psychoactive element out, it would not be able to be used in those ways, would it?

Mr BINGHAM: I do not know the pharmacotherapy of it. I would think it is probably unlikely. Sorry, for the euphoria effect, you mean?

The Hon. ADAM SEARLE: Yes.

Mr BINGHAM: Yes, you are right. It would be useless.

The Hon. ADAM SEARLE: Whatever use was left over would only be medicinal uses?

Mr BINGHAM: It would be useless without that psychoactive component. I do not know how the pharmacotherapy of the THC psychoactive component is affected in relation to your appetite suppressant, the therapeutic properties.

The Hon. ADAM SEARLE: From a law enforcement perspective do you have any data that you can share with us about the degree to which people who do use cannabis for medicinal reasons, for pain relief or for the treatment of nausea and other effects of illness are caught up in the law enforcement measures currently?

Mr BINGHAM: Anecdotally, the North Coast of New South Wales seems to be the cancer capital of the world and I say that flippantly only because every time we work up in that area on cannabis eradication programs quite a lot of the people that we speak with who have small crops say they are using it for—

The Hon. TREVOR KHAN: Pain relief.

Mr BINGHAM: For pain relief and medicinal purposes. We have not seen a lot of evidence in that regard. I do accept though that it does have some of those qualities but whilst it is a prohibited drug we certainly need to take some sort of action. I guess if you look at some of the experiences in the United States where there are 18 states in the United States and Washington DC, the incidence of cannabis use has gone up with those states that have medicinal cannabis and that is something that needs to be taken into account.

The Hon. ADAM SEARLE: Do you mean an increased use not related to medicinal use?

Mr BINGHAM: That is right.

The Hon. ADAM SEARLE: Is that empirically? Can that be empirically demonstrated?

Mr BINGHAM: That is. I could not point you to the reference but I could find it for you if you need that.

The Hon. ADAM SEARLE: I would be interested to see that and feel free to take it on notice.

Mr BINGHAM: Sure.

The Hon. ADAM SEARLE: Because obviously if that was the case that would be something we would need to bear in mind; anything that pointed to an increase in recreational use as opposed to purely medicinal use?

Mr BINGHAM: Sure.

The Hon. TREVOR KHAN: It would be useful, of course, if that data is comparative, that is, it not only deals with the states where use for medical purposes has been legalised but also states where there has been no change in the law, that is, whether there is an underlying trend for increasing usage that is unrelated to the medicinal use of cannabis?

Mr BINGHAM: Sure, that would be useful.

The Hon. AMANDA FAZIO: In relation to the cannabis cautioning scheme are you aware of any people who have been picked up through that scheme who have said they have been in possession of cannabis for medical purposes?

Mr BINGHAM: I am not.

Mr PAROZ: I am not aware of any. We have recently had an audit done in relation to the workings of the cannabis cautioning scheme and that issue was not raised at any time during that whole audit process so I would suggest that if it has been raised it has not been raised on a wholesale basis.

The Hon. AMANDA FAZIO: We heard evidence this morning from people about the use of cannabis extracts in forms of tinctures, ointments, chewable strips, tablet form and Sativex, the nasal spray. If those sorts of forms were introduced in New South Wales, that would not have any impact at all on your policing activities in terms of going after commercial and recreational cannabis users, would it?

Mr PAROZ: One of the things that New South Wales police would be looking for were this to progress is that the medicated form would have to be easily identifiable and differentiable from the normal product, otherwise that would make any enforcement issue very difficult if they were similar but if it was packaged differently, set up differently, used differently, such as the nasal spray type process, then obviously there are clear differences. An example of how that currently works is with methadone for people on methadone to help them get off heroin it is in a syrup form but other people get it through tablets, so there are two very clearly identifiable and different ways of using the same drug.

Mr BINGHAM: And just building on that, the Sativex product is a recognised pharmaceutical product whereas the tinctures, potions, et cetera, that you mentioned are not and they are products that are manufactured from illicit cannabis crops so, firstly, it is an illegal product. If you possess any of those products, apart from Sativex where you would have a prescription, then you are possessing cannabis and you are committing a crime and certainly the person who is cultivating those crops and making those tinctures is committing a crime.

The Hon. AMANDA FAZIO: There was one other issue but I have forgotten it at the moment so I will come back to that a bit later.

Dr JOHN KAYE: Superintendent Bingham, in your evidence you just stated there were studies which highlighted mental health issues and studies which highlighted cannabis as, I think you were implying, the sole drug involved in violent crime.

Mr BINGHAM: That is my understanding.

Dr JOHN KAYE: I do not wish to put you on the spot but can you provide the Committee on notice with those studies?

Mr BINGHAM: Sure.

Dr JOHN KAYE: The citations of those studies?

Mr BINGHAM: I can, yes.

Dr JOHN KAYE: Would there be more than one on each of those? Is there a range of studies?

Mr BINGHAM: I am not aware. I was briefed this morning on that and they are two of the instances I was advised of.

Dr JOHN KAYE: We would like lists of those because you may or may not be aware that the mental health impacts of cannabis is a contested area?

Mr BINGHAM: Sure.

Dr JOHN KAYE: You would also be aware that the issue of correlations between people using drugs and people committing violent crimes is also a contested area— correlation is not causation. You have implied that in both cases they are causative. We would like to see those studies that suggest they are causative. Likewise with the increase in cannabis use, we would like to see the studies on which you have based the increase in cannabis use because there are also studies that suggest that use in those states where cannabis has been made available for use amongst high school students aged 16 has actually gone down. Are you aware of such studies?

Mr BINGHAM: No.

Dr JOHN KAYE: As I understand it you are involved directly in apprehending people involved in crimes related to cannabis, is that correct?

Mr BINGHAM: That is right.

Dr JOHN KAYE: Can you briefly tell the Committee what you do?

Mr BINGHAM: I am head of the Drug Squad and we run what is called a cannabis eradication program for six months of every year and we do targeted intelligence-based investigations into areas, particularly on the North Coast, which is a prime growing area, from the mid North Coast to the border. We will basically go on search and seizure missions, locate crops and pull them out. Our main emphasis on those missions is to find crops and destroy them; it is not to arrest people, although occasionally we do find people in crop sites and we will arrest them for cultivation and also more incidentally than anything we will find people with very small crop sites that are obviously for personal use but as they are cultivating a prohibited drug they also end up in the mix and are charged. I also have corporate responsibility for the whole of New South Wales in relation to all drug crime and I am involved in strategies in relation to law enforcement. I am also involved heavily in strategies for the national drug strategy and harm minimisation—demand reduction and supply reduction.

Dr JOHN KAYE: Earlier you made a slightly flippant reference regarding the issue of people caught with crops that clearly are for personal use, many claiming they were for medicinal purposes.

Mr BINGHAM: Yes.

Dr JOHN KAYE: When those matters get to court do you have an idea how many people plead? How many of those caught for small amounts actually say, "This is because I" or "somebody close to me" or "somebody I am caring for has a disease or a condition that is treated by cannabis"?

Mr BINGHAM: I honestly could not tell you. Cannabis is the most widely seized and consumed drug in the country—in fact, in the world. It accounts for two-thirds of our drug seizures. Cannabis alone far outweighs, say, our four other main illicit drugs. I cannot have any idea of the excuses they are using in court, but I would suggest that most cannabis offenders plead guilty and most probably would have a mitigating factor. Excuse me, if the person behind me continues to guffaw, I am wondering if something can be done about that, please.

CHAIR: I ask all members of the public gallery not to make any commentary that is audible to the witnesses. If that continues, they will be asked to leave the hearing.

Mr BINGHAM: Thank you.

The Hon. AMANDA FAZIO: Are you able to tell us what proportion of arrests and charges laid for cannabis possession relate to possession of cannabis leaf versus hash versus hash oil?

Mr BINGHAM: I have not got the figures, but I can say without any shadow of a doubt that the far vast majority relates to cannabis leaf or bud in the herbal form as opposed to the oil or resin form.

The Hon. AMANDA FAZIO: I would appreciate it if you could take that question on notice.

Mr BINGHAM: Do you want those figures?

The Hon. AMANDA FAZIO: Yes.

Mr BINGHAM: Sure. I will take that on notice. Whether I can get you those figures, I am not sure we can extract that data—if we can separate the cannabis oil from the resin. I think we probably can.

The Hon. TREVOR KHAN: Are you able to indicate, say, over the past 10 years—not an accumulated figure and, obviously, you will take this on notice—how much cannabis is being seized per annum in New South Wales?

Mr BINGHAM: I can get those figures for you. I cannot tell you at the moment, but in relation to plants I can give an approximate figure over the last 10 years for cannabis plants and then there is all the herbal cannabis on top of that. Our eradication program over the last 10 years has seized around about 120,000 plants.

Each plant equates into a couple of ounces of cannabis product and we value a plant at around $2,000 a plant. That is just the outdoor eradication program.

The Hon. TREVOR KHAN: Obviously, some significant hydroponic crops are being seized as well?

Mr BINGHAM: Yes, certainly. In the last few years hydroponically grown crops, or indoor crops—there are very few hydroponic crops—are into the thousands as well. Generally, they produce more cannabis, perhaps not better cannabis. There is a study that we have done—well, we have not done; we have supported with NDARC. The National Drug and Alcohol Research Centre has done a study that suggests that indoor grown cannabis and hydroponically grown cannabis as opposed to outdoor cannabis has the same potency. The perception out in the cannabis world is that hydro is more potent.

The Hon. TREVOR KHAN: That is not necessarily in the cannabis world; I think that seems to be the community understanding generally.

Mr BINGHAM: Sure.

The Hon. CHARLIE LYNN: Superintendent Bingham, you mentioned earlier your strategy to find plantations and destroy them, not so much the people who have the plantations. Can you give us more information? I would have thought going after those who are actually growing, selling and dealing would be a priority?

Mr BINGHAM: Ideally, that is what would be nice to happen. However, we are out there to locate the crops and just take them out of the ground. We have not got the resources or the time to sit on crop sites for days on end to wait for the growers to come in.

The Hon. CHARLIE LYNN: That is not a big disincentive?

Mr BINGHAM: That is the cannabis eradication program. That is separate to our normal mainstream investigations. We still do mainstream investigations in crop sites where we use all our traditional and covert methods to identify the crop growers. But our cannabis eradication program, which goes from November through March each year, is basically a search and seizure mission.

The Hon. CHARLIE LYNN: For me this would be a common-sense matter: If you know someone who is a chronic pain sufferer or has a terminal disease, I would not imagine they would be high on your priority?

Mr BINGHAM: Absolutely not, no.

The Hon. CHARLIE LYNN: They are silly because they have a pot in their backyard.

Mr BINGHAM: I mentioned earlier that whenever we come across those small crop growers for personal use, and it is obviously for personal use, it is always as an aside. It is not someone or someplace we have targeted. It is generally as a result of a flyover of the helicopter from point A to point B on our intelligence-based mission and they inadvertently come across a small crop.

The Hon. CHARLIE LYNN: I imagine when the sniffer dogs locate someone that a fairly common first reaction would be, "It's for my friend who's a chronic pain sufferer"?

Mr BINGHAM: Generally when a sniffer dog comes across somebody, it does not always result in a seizure because a person may have been in or near a cannabis user and a dog may give an indication just because there is a smell of cannabis on a person. But generally speaking, when someone is found with a small amount of cannabis on them they pretty well admit to it straight away that it is for their personal use and they are entitled to a cannabis caution, depending on their background.

The Hon. TREVOR KHAN: Let me put this regime. The Parliament or let us say I propose that there be a small subset of people identified as terminally ill. The medical profession is given the opportunity of certifying that those people can use a cannabis product—leaf, oil, whatever—for their personal use; that there is restriction that they are entitled to grow, say, one or two plants and that they otherwise are not entitled to possess anything more than a small quantity; they would carry a card that identifies them as falling within that

group and perhaps their carer is entitled to a similar style of card if they assist them in growing, say, a plant or couple of plants. What impact will that have on the use of cannabis in the recreational population in New South Wales?

Mr PAROZ: I cannot predict what impact it might have, but the New South Wales police position would be that we would prefer to see any medical use of marijuana in a different form.

The Hon. TREVOR KHAN: I understand what you said before. Essentially, I am testing the proposition that it necessarily must be in a different form by asking what impact it would have if somebody has a restricted capacity of holding a small quantity or growing a couple of plants because they are dying, in pain and cannot eat because they vomit the whole time. How will that impact?

Mr PAROZ: I would suggest it would have the same implication as pharmaceutical drugs that are misused and abused at the moment. They go through the same process, but we have a lot of problems in the community from drugs that are misused through prescription. They still cause significant problems. So I would suggest you would have exactly the same problem if medical use of this drug is not put through some rigorous process.

Mr BINGHAM: I guess you have the obvious issue of illicit diversion: growing a cannabis plant and cannabis products being diverted to the illicit market.

The Hon. TREVOR KHAN: I will get to that. That is one of the reasons I asked about the quantity of cannabis in our community. If you have a restricted class of terminally ill people who are certified as terminally ill, are you genuinely saying that those crook people who are dying will form the basis of a significant additional input of cannabis into our community?

Mr BINGHAM: It is a hypothetical question, obviously, but when an outdoor plant is worth $2,000 and an indoor plant is worth $5,000 I am sure there certainly is some scope for diversion to the illicit market regardless of how sick you are.

The Hon. TREVOR KHAN: Fair dinkum?

Mr BINGHAM: I would think so.

The Hon. TREVOR KHAN: Someone is in the end stages of dying of cancer and you see it as more than a hypothetical problem that those people will divert the drug?

Mr BINGHAM: With respect, you asked the question. You wanted an answer. I have given you the answer. That is it.

The Hon. AMANDA FAZIO: Given that for 20 or 30 years in South Australia it has been legal for people to have five or six plants for their personal use, when you talk to your South Australian colleagues at national police meetings or national drug policy meetings, have you ever discussed that with them and what impact that has had on supply issues of marijuana in South Australia and the amount of police resources that are not being used to the same extent as we are using them here in New South Wales?

Mr BINGHAM: Absolutely. That caused South Australia a nightmare. You are talking about illicit diversion and that is an excellent example. You have five hydroponically or indoor grown plants worth $5,000 each and the outlaw motor cycle gangs getting a foot hold going from house to house paying people to grow five plants. South Australian cannabis is now known as the best cannabis in the country. It is sent all over the country because of the quality.

The Hon. AMANDA FAZIO: You do not think it has any social impacts in terms of the police—the police in South Australia have told you that they have to spend more time in investigating cannabis growing because of this system or is it saving them resources?

Mr BINGHAM: Cannabis investigations in South Australia are very high on the agenda because of the prevalence of it and because of the organised criminal activity involved in cannabis growing.

Dr JOHN KAYE: Can I just take you back to the issue of people, you used the word "excuse" people, who plead when they are caught that it is basically medicinal cannabis product. You have a number of sniffer dogs around railway stations and public places so you would be capturing or interrogating a number of people who are carrying small amounts of cannabis. You said before that the overwhelming majority were saying it was for their own personal use. Are there any people to your knowledge who say that it is for medicinal purposes for themselves or others?

Mr BINGHAM: Just to clarify, I am not in charge of the dog squad that is another area. We do not actually use drug sniffer dogs and the drug squad itself is generally involved in higher level drug investigations. I do not personally have any knowledge of people being caught by sniffer dogs and using that excuse. I imagine it would be out there, I cannot see why it wouldn't.

Dr JOHN KAYE: Can I ask you to take that on notice?

Mr BINGHAM: I could take it on notice but I do not know where I would find that information. I would have to trawl through many thousands of Computerised Operational Policing System [COPS] reports. There is no facility to trawl through a COPS report or define a field in COPS report.

Dr JOHN KAYE: It is not searchable in that form?

Mr BINGHAM: That is right. It would have to be searched in a narrative form.

The Hon. TREVOR KHAN: If, hypothetically, people were saying actually I am keeping it for somebody else for their medicinal purposes one of their problems is that they are likely to be charged with supply?

Mr BINGHAM: Yes, they are.

The Hon. TREVOR KHAN: They are more likely to say it is for their own personal use in those circumstances?

Mr BINGHAM: Absolutely.

The Hon. TREVOR KHAN: There is a significant difference in the penalties that apply for suppliers as opposed to possession for personal use?

Mr BINGHAM: Yes.

Dr JOHN KAYE: How much money do you spend each year on the helicopters?

Mr BINGHAM: You would have to ask the Aviation Support Branch that question. I do not know.

Dr JOHN KAYE: You have officers in those helicopters?

Mr BINGHAM: Yes, we do.

Dr JOHN KAYE: Can you take that on notice and ask the Aviation Support Branch?

Mr BINGHAM: Yes. I can ask them that.

Dr JOHN KAYE: You put officers in those helicopters?

Mr BINGHAM: Yes, we do.

Dr JOHN KAYE: How many officer hours are expended on that program?

Mr BINGHAM: It is generally a week long program. It is generally eight officers from the drug squad. There can be up to 20 officers involved in that operation. If you extrapolate those figures for an eight or nine hour day it is somewhere thereabouts.

Dr JOHN KAYE: Do you think those figures would change at all if a medicinal cannabis regime was introduced that involved leaf product and maybe the supply of leaf product if not plants? You seem to be concerned about the volume of material produced by plants. If we had a supply regime, do you think that would be affected by that at all?

Mr BINGHAM: No, I do not think so. Our aim is to target what we call commercial crops. We are not out to target people with two or three plants in the backyard. Although I did say incidentally we do come across those.

Dr JOHN KAYE: Putting aside the helicopter raids for a moment. If we purely looked at your total drug detection prosecution activities and if we had a regime where small amounts of leaf or smokeable materials were supplied to a relatively small number of people who were at end stage cancer or metastasizing cancer or a small number of people such as multiple sclerosis sufferers for whom other drugs are not working: Do you think that would interact with your job at all?

Mr BINGHAM: No. We are not targeting drug users—very rarely. Of course drug users get caught up with dog sniffer operations and targeted operations at festivals and things like that. Even in those operations when people are arrested for drug possession they are not the target of the operation, New South Wales police focus on the suppliers. It does happen that users get caught up in it.

Dr JOHN KAYE: If New South Wales were to engage in a legalised supply of medicinal cannabis you are confident that could be separated out from the illegal supply and not interact with your work?

Mr BINGHAM: that is a difficult question to answer. I can only say that we would not be a targeting them.

Dr JOHN KAYE: They would be legal so you would not be targeting them. You are aware that opium is grown legally in Tasmania?

Mr BINGHAM: Yes.

Dr JOHN KAYE: Does that have any impact on your work with respect to heroin and other opioids here in New South Wales?

Mr BINGHAM: No.

Dr JOHN KAYE: It would be reasonable to extrapolate from that statement that it would be unlikely that a regulated supply chain to a relatively small number of people from a legally grown crop sequestered away from other crops and clearly marked as a regulated crop would not interact with drug detection work?

Mr BINGHAM: I would not think so. The only concern I would have is when you use the opium poppy crop comparison it is difficult to synthesise heroin from an opium plant but it is easy to chop off a cannabis leaf and smoke it.

Dr JOHN KAYE: It is possible to smoke opium almost directly from the opium poppy, is it not?

Mr BINGHAM: I would not know. I would not think so. You need to extract the resin from the poppy and it becomes a gum, and then you need to turn it into opium, then morphine and then heroin. There are a whole range of processes to go through.

Dr JOHN KAYE: Certainly getting heroin is an industrial process but getting to smokeable opium is not. It was done for centuries.

Mr BINGHAM: They have been doing it for thousands of years but I do not know how to do it.

The Hon. CHARLIE LYNN: Do you?

Dr JOHN KAYE: No, I do not.

CHAIR: Stick to the terms of reference.

Dr JOHN KAYE: I will do so. I take it what you are saying is that you are uncomfortable with the idea of individuals being able to grow their own plants for medicinal cannabis supply but less uncomfortable with the idea of cannabis being provided to individuals provided it is done so in a regulated fashion?

Mr BINGHAM: Yes.

Dr JOHN KAYE: That is simply a quantity matter, is it? You said before you are worried about $2,000 worth of material being grown in somebody's back garden.

Mr BINGHAM: It is not so much the quantity it is the possibility of illicit diversion that is the issue.

Dr JOHN KAYE: Your key concern is illicit diversion. You would be relatively comfortable with a process that did not create opportunities for illicit diversion such as supply of a quantity that was really only relevant to an individual?

Mr BINGHAM: I do not think I am comfortable with that. Our position is that any form of cannabis needs to be in a pharmaceutical form that has gone through the rigours of pharmaceutical examination so that it is a drug that is going to be therapeutic for the patient and not cause cancer and not cause mental illness—if that is what it does cause.

Mr PAROZ: One of the biggest issues is that smoking of any sort is a health risk. That is one of the issues that arise with medicinal use of cannabis. Ideally it would be in some other format and not in the same form that a person who wants to smoke marijuana wants to use it because smoking in itself is not good for your health.

The Hon. ADAM SEARLE: For people who are terminally ill that may not be so much of a problem.

Mr PAROZ: If they are terminally ill they are probably not going to be growing their own plants either, they would probably want something in an easier format to use. It is all hypothetical and you could go around in circles forever.

The Hon. ADAM SEARLE: It depends whether the other products are readily available. Earlier today we heard evidence of one product, a spray, currently being considered by the Therapeutic Goods Administration. But that is only one product, which I understand is quite expensive.

Dr JOHN KAYE: Sativex.

The Hon. ADAM SEARLE: Yes. I think one estimate was that the cost of supply was $500 a month.

Dr JOHN KAYE: Yes, that is about right.

The Hon. ADAM SEARLE: That is pretty steep. They might also need something a bit cheaper.

Mr BINGHAM: If it is a medical question and if it is about quality of life, that is a question for others to answer. But you would like to think the cost would not come into it if it is about quality of life.

The Hon. ADAM SEARLE: Well, it is about affordability, surely. If someone is permanently ill and not working, cost does become a consideration, one would think.

Mr PAROZ: I guess it is a matter for the pharmaceutical benefits scheme to adopt that pharmaceutical type of treatment.

The Hon. CHARLIE LYNN: Superintendent Bingham, you mentioned resources. If you had more resources would you find more cannabis plantations?

Mr BINGHAM: Yes, we would. We could spend the whole summer up on the North Coast and find plants every day. Are we having an impact? Maybe I will pre-empt that. Yes, we are. If we did not go up there, the place would just be overrun with cannabis.

Dr JOHN KAYE: So your suggestion is that the market is a long way from saturation; that is to say, what you are saying is that if you were not interceding with the drug crop on the North Coast the market would continue to grow to absorb the entire North Coast plantation, which is the image you suggested to us?

Mr BINGHAM: The risk is that if we did not undertake those operations there would be more cannabis available and the price would go down, and that may encourage other people who would not otherwise normally use cannabis to purchase it because it is such a low price.

The Hon. TREVOR KHAN: Or increase their dosage?

Mr BINGHAM: It could do.

The Hon. AMANDA FAZIO: When somebody is arrested for possession of cannabis is there a point at which the physical amount that they have on them precludes their claiming that it is for personal use, and it trips over to deemed supply? And what is that amount?

Mr BINGHAM: I think, from memory, a deemed supply is 300 grams, which is quite a lot of cannabis. When you think 300 grams, it is probably a shopping bag full of cannabis.

The Hon. AMANDA FAZIO: It might just help us when we are considering things later to know what the current laws are on that issue.

The Hon. TREVOR KHAN: I think it is more useful, is it not, rather than looking at the deemed supply, to look at the small amount quantity?

Dr JOHN KAYE: Which is 30 grams.

Mr BINGHAM: Thirty grams is just over an ounce; and an ounce is about the size of a sandwich bag full of cannabis product.

The Hon. AMANDA FAZIO: That is at the point where they cannot get a caution?

Mr BINGHAM: A caution is up to 15 grams.

CHAIR: In relation to the cautioning scheme, do you have data on how many people per annum are given a let-off under that scheme, for lack of a better term?

Dr JOHN KAYE: A caution.

CHAIR: Yes.

Mr PAROZ: There certainly is data for cannabis cautions. I have not got that data to give off the top of my head, but I can provide that.

CHAIR: That would be good, because one of the things that have come out of the deliberations today, particularly from some of the consumer advocate groups, is that, as you mentioned quite strongly, you are not out to target those individual users, but sometimes they get caught up in some of your other raids. They say a lot of people they know do not talk about it, but anecdotally they are aware that there is a bit of a don't ask, don't tell policy. I wonder how that would correlate with how many people are actually being caught incidentally and are being cautioned, because that might help the Committee determine exactly how much use there is happening without it being known.

Mr PAROZ: The data that I can get is for people who have received one cannabis caution and those who have received two or more, and I can also give you data regarding juvenile cautioning.

CHAIR: That would be helpful.

Mr BINGHAM: The cannabis cautioning program is a diversion program, to keep people out of the criminal justice system. So it is not about locking people up; it is about giving them information about where they can go to get assistance with their cannabis problem. So we are not out just to arrest everybody.

The Hon. TREVOR KHAN: I do not think anyone is suggesting that.

Mr BINGHAM: I just wanted to clarify that, just in case there was a misconception about the cautioning program.

CHAIR: There being no further questions, I think you for appearing this afternoon. For your information, the Committee has resolved that any responses to questions on notice be supplied to the Committee within 14 days. The Committee secretariat will contact you with the questions that you have taken on notice and perhaps others that Committee members might like to ask.

(**The witnesses withdrew**)

MICHAEL BALDERSTONE, President, The HEMP Party, New South Wales Branch, sworn, and

JAMES MOYLAN, National Campaign Director, The HEMP Party, New South Wales Branch, affirmed and examined:

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

Mr BALDERSTONE: If I could briefly say that we are coming from the opposite end to your last guests. I have been a long-term user of cannabis, and very happy to talk about it. Because I have been living in Nimbin a long time we have been seeped in the culture of cannabis users. So feel free to ask questions—I'm game!

The Hon. AMANDA FAZIO: Thank you for the submission you have put in. At pages 27 and 28 of your submission you have some recommendations. Would you like to talk to us a little bit about how you came to draw up those recommendations?

Mr MOYLAN: Certainly. Here, of course, the Committee will be looking at pragmatic ways to undertake a medicinal cannabis trial in New South Wales. The HEMP Party has a wider brief on this matter, so we commence by pointing out that you can provide access to every medicinal cannabis user who needs quite simply by transferring cannabis use from criminal penalties to civil penalties. The Californian model would work very well. In California you do not find people going without their medicinal cannabis. A lot of what this Committee will be trying to do has to do with navigating the requirement to build huge Chinese walls between legal and illegal cannabis use. It certainly occurred to me, when I was listening to the previous witnesses, that you are spending so much time worrying about the leakage of cannabis from legal to illegal utilisation. Mr Bingham started with the comment that they are worried about harm minimisation.

What harm would be caused by this leakage? You could put a tonne of cannabis in a room, put a sign out the front saying "All you can eat, line up here," and you could have people coming in until that tonne is eaten and there will not be an individual who is harmed by it. There might be a few belly-aches, there would be a few green-outs, but no-one would be physical harmed by it. We seem to be spending a lot of time worrying about Chinese walls and barriers to protect against something that can cause absolutely no harm. The crafting of appropriate regulations will always have to take into account for the HEMP Party that elephant in the room—the fact that cannabis is harmless. In medical terms it is harmless. All of the other drugs that you are talking about here, OxyContin, et cetera, if there is a leakage, yes, people die. When there is a leakage with cannabis nothing happens. Absolutely nothing. No harm to the society will be visited.

All of the harms associated and constantly discussed relative to cannabis are not primary harms, you will notice. We are not talking about people smoking cannabis going insane, people smoking cannabis falling over and dying. They are not primary harms. We spend forever searching for secondary harms. We have spent forever trying to tie cannabis down whether or not it causes mental illness. Why? No, we have got lots and lots of good data that says there is corollary but no causative relationship.

But when you look at all of the rest of the drugs, every other drug in our society, alcohol causes mental illness, absolutely no doubt about it. You can go out and find a dozen articles that say that alcohol causes mental illness. In the little input that you get with every packet of Ritalin, which we give to our children, it says that this will cause psychotic episodes in a number of people. Why is it that with only cannabis we spend forever trawling through the possibility of some genetic harm 40 years down the track whereas we do not as a public interest consideration do this with any other drug in our society? I would say it all has to do with the moral panic that we have developed relating to it, but that is a whole other story.

The Hon. AMANDA FAZIO: I commend you for your initiative in providing draft legislation for us to consider as an attachment to your submission. Can you tell us the model that that was based on? Is that based mainly on the Californian example?

Mr MOYLAN: If you do not mind me tabling I will provide the Committee with a discussion paper. It has not only the draft legislation that you are talking about, which is very particularly incredibly tight. This is not the legislation that the HEMP Party would want. This is a demonstration that it can be done. It is all there ready to go. It is based on our injecting room legislation in New South Wales, because it is there, it is extant,

and it works. It incorporates all of the required checks and balances that the New South Wales Government requires.

The reason that we provided you with the proposed amendments is that in the same document that I have provided there are a scale of 1 to 5 of dispensary trials that can be undertaken. The 1 and 2 can be undertaken with just regulation—changes, declarations or alterations to regulations. Above that you are in alterations to State government legislation. Above that it is Commonwealth legislation.

Dr JOHN KAYE: Where do we see that? Is it in your submission?

Mr MOYLAN: No, in the document that I have just tabled.

Dr JOHN KAYE: Where do we see that list of different regimes?

Mr MOYLAN: You will see it from pages 16 to 18. Model 1 is a restricted medical trial.

Dr JOHN KAYE: I have got it, thanks.

The Hon. AMANDA FAZIO: I think you were here this morning when we heard evidence from PainAustralia and the Cancer Voices group. They said that they believed that their membership would prefer not to have cannabis leaf but to actually have a pharmaceutical product derived from cannabis. Does the HEMP Party have a view about whether it should be restricted to one or the other, or whether there should be a range of legal cannabis products available, including leaf through to say a tablet with a prescribed dosage?

Mr BALDERSTONE: It is tricky for the HEMP Party because really we think the law is the crime and drug use should be a health issue, cannabis use should be a health issue. I do not altogether agree with Mr Moylan earlier saying it cannot possibly hurt you because certainly under prohibition cannabis can hurt people it seems and I think it does not suit everybody. But I think one of the big psychosis dramas that I have seen is especially young people smoking in a state of fear. And they are. The first time people smoke cannabis often it is hidden, it is secret, they are frightened of their parents finding out, their schoolteachers, anyone. As a psychiatrist once said to me, it is manure for your imagination, cannabis. So people can go off on a tangent and can get into trouble. I think if you have got a predisposition to mental illness it can cause problems. Having said that, no-one has ever died from cannabis use in the history of the plant.

The other big drama with cannabis use which is fairly unique in Australia is we have got a culture of people smoking with tobacco, which is just crazy. I remember talking to Della Bosca about this a lot. If we could give education to people you would tell all the young people whatever you do, do not mix it with spin, they call it. Because you buy a gram of pot for 20 bucks, there are 10 kids, they spin it out with three or four grams of tobacco and it goes much further. Before you know it kids are waking up in the morning, "I want a cone." It is the nicotine. It is a real issue. We have tried really hard to educate people but it is not happening out there. And cannabis being expensive, it continues to happen. A lot of young people I see end up with a cigarette habit because they have started smoking bongs. So there are health problems under prohibition big time. Anyway, what was your question?

The Hon. AMANDA FAZIO: My question was about different products.

Mr BALDERSTONE: I think it is fantastic if you can make tincture. In America since they have made medical cannabis I think you said it is in everything. It is in drinks, in lollies. You can put cannabis into anything at all. Put it in your soup, put it anything, which is probably better than smoking. Why people like smoking is it is an instant titration, so you can feel straightaway when you have had enough. If you eat it any way it takes about an hour to affect you, so you have either had too much or too little. That is why people like smoking. It is worth understanding that.

The Hon. AMANDA FAZIO: The one issue I have seen in documentaries is people who do not want to smoke it in States in the United States where it is legal can use a vaporising system.

Mr BALDERSTONE: Vaporising is terrific I think.

The Hon. AMANDA FAZIO: Does that give the automatic relief of pain or whatever the same as smoking?

Mr BALDERSTONE: I think it is very similar. It is probably not quite the same but it is very similar and you do not take in the smoke. It is popular. It is a little bit complicated; you have got to have the machine and all the rest of it. Obviously I think if you can eat it and work the dosage out that is terrific.

Dr JOHN KAYE: Is that possible?

Mr BALDERSTONE: Absolutely.

Dr JOHN KAYE: You can titrate the dose through eating it?

Mr BALDERSTONE: Yes. In time you will work out what dose you need. A lot of medical cannabis users I know have worked out their system. They work out a dose, they make cookies, they have one in the morning, one in the evening.

Dr JOHN KAYE: But that requires a known stream of cannabis, right?

Mr BALDERSTONE: Trial and error. In the end it is trial and error and you work out your dose.

Dr JOHN KAYE: But if you change suppliers?

Mr BALDERSTONE: Different strength of cannabis. One of the worst things of prohibition is there is no quality control. You have got no idea how strong the cannabis is, whether it is full of chemicals. Mr Bingham, who was sitting here, and is catching lots of cannabis, is pushing it indoors. The helicopter raids have really—he is right, if they did not come there would be more cannabis, but it has pushed probably 90 per cent of New South Wales cannabis indoors, which is not as healthy a product I think. Not because it is different cannabis, and someone said it is just as strong. The same seed outdoors as indoors grows the same strength, but it is grown in a bath of chemicals. Myself, I have smoked cannabis indoors and got a headache straightaway which I would never get from cannabis, because of the chemicals.

The Hon. TREVOR KHAN: All because it was indoors?

Dr JOHN KAYE: Grown indoors is what he meant to say.

The Hon. AMANDA FAZIO: In your research into medical cannabis internationally which regimes, which models, do you think are the best models and perhaps the ones that we should be looking at?

Mr BALDERSTONE: Mr Moylan will know more than me but just first up I reckon you should look at the whole lot. If New South Wales is thinking of doing something the smart thing to do would be to look at all the other countries that have done things and learn from them. California started medical cannabis in 1996, so it has been going a long time. They have evolved now where they have turned it into not a criminal offence, it is a civil offence. Anyone can carry I think one ounce, over 21 years of age. So they have evolved. Other States have got different things. I quite like the Canadian model, which really put the growing in the hands of the medical users or their carers, and took it out of organised crime. But they changed their rules as they went along because it is a new thing. Now doctors give it to you, depending on what your case is. They will let you grow a certain amount. So it is a moving feast, if you like. It is a new ballgame. Whatever trial or whatever you guys recommend, it has to be able to change.

The Hon. AMANDA FAZIO: What about the New Jersey model where the dispensaries are run by what we call non-government organisations and not-for-profit organisations so that there is no real financial incentive for anybody to make money out of the medical cannabis system?

Mr MOYLAN: The Help End Marijuana Prohibition [HEMP] Party is not in favour of non-profit, mainly because the history in the United States proper demonstrates that Americans have a facility for hypocrisy that we seem to lack.

The Hon. TREVOR KHAN: Oh, I think we do pretty well.

Mr MOYLAN: Right, yes.

Mr BALDERSTONE: It is trouble, though. They have had trouble making not-for-profit things and then chasing all the people making profits. It is not quite as much profit as Mr Bingham said, but there is certainly lots of profit to be made.

Mr MOYLAN: Certainly the Californian experience with their grow-ups is probably the simplest and easiest way to approach the supply end, which is to particularly license individuals to provide to dispensaries a certain weight of cannabis. You can get then more complex models, such as the Canadian model where it commenced with aggregates of licenses. One person would go out and grow cannabis for, say, 20 or 30 or 70 patients. They would aggregate the licences and be able to grow for that. A lot of these seem to be unnecessarily complex and seem to involve a great deal of regulation and paperwork that just seems unnecessary.

If you identify a grower, someone who is suitable and fits all the criteria that the Government decides, and you license that individual to grow discreetly, then it suffices. It does exactly the same thing with much less difficulty and much less of that confusion about "How many people am I representing? How many licenses?"—blah de blah de blah. And, of course, as I have pointed out, we are not talking about oxycontin here. We are not talking about heroin. We are talking about something where, if there is a slippage—and at $2,000 a plant, I have to get those bloody plants! Really, my God—$5,000 a plant indoors? My God, I do not know what this bloke is talking about, really.

Mr BALDERSTONE: I will tell you frankly. He said two ounces, on average, you are paying. An ounce is about $250. That is the black market price at the moment.

Mr MOYLAN: So how they get $2,000 a plant is beyond me. Well, I know exactly why: they are funded on how much they get out.

The Hon. ADAM SEARLE: They plants have a really good yield.

Mr MOYLAN: We did some back-of-the-envelope calculations before we came here: 120,000 plants they have managed to get in, what, 10 years, he said? We are growing in Australia somewhere around 2,000 tonnes of cannabis every year. Right? Two thousand tonnes. One hundred and twenty thousand plants would be a poofteenth of that. The interdiction efforts of our Police Force do nothing. What they do is they make sure that they keep the working class, the exposed grower and the people who are exposed to police from growing or using cannabis. White middle-class collar-wearing people have no difficulty.

Mr BALDERSTONE: I think it is true though. They do keep a lid on it. I think if there were no helicopters, there would be people growing a lot of plants. Mind you, nearly all the police confiscations are from information, so if you start growing paddocks full, the neighbour will soon ring up on you.

Mr MOYLAN: Yes.

Dr JOHN KAYE: I want to talk to you about your submission. I congratulate the HEMP Party on its submission. It is a very comprehensive and well-argued document. If I can summarise it this way, it says: We are really wasting our time talking about medicinal cannabis unless we talk about deregulation of cannabis, or at least some kind of move towards addressing the issue of the recreational market.

Mr BALDERSTONE: I certainly think that. I really do think that. I hear what you are saying. Yes, we might have a trial of people nearly dying or with cancer. Well, it is just such a tiny piece. You are only addressing such a tiny piece of it. But, having said that, it would be better than nothing and it is the beginning. I would be so grateful for anything. We started the HEMP Embassy in Nimbin about 20 years ago because there were so many troubles around prohibition and people not knowing what to do. We get several phone calls every day from people with cancer particularly because the word is out: It can give you some relief. So it is a big area. I do not know how big that would be, but I would give it to doctors. I think: Let doctors decide who should have a go. But I appreciate you are in a tough position.

Dr JOHN KAYE: Mr Balderstone, from your perspective, which is a sensible perspective to have, you think that the current prohibitionist stands on cannabis are not working.

Mr BALDERSTONE: I think they cause a lot of harm.

Dr JOHN KAYE: And they cause a lot of harm.

Mr BALDERSTONE: Yes.

Dr JOHN KAYE: I understand where you are coming from, but just for a minute turn it around and think of it from the perspective of somebody who has cancer and who may never have used cannabis before and has no interest in recreational drugs, but they find themselves with cancer and they find themselves with nausea and pain, and their pain and their nausea are resistant to other drugs. From their perspective, can you envisage a way in which we can get to them the benefits of medicinal cannabis without interacting with the recreational market for cannabis?

Mr BALDERSTONE: What has happened in a lot of those States—I think it is 19 American States now—is that a doctor will issue you with a card, you would go to a dispensary and be able to buy a limited quantity of cannabis. That makes total sense to me and would work. I quite like what Jim said before. I think it would be tempting to license the growers and suppliers from among the medical world, I suspect. That would be the easiest way to do it. I have not got a problem with that at all.

Dr JOHN KAYE: The argument you put forward is that it will require a lot more costs because of prohibition. It will push up the cost of medical strength.

Mr BALDERSTONE: Absolutely.

Dr JOHN KAYE: Is not the same true of codeine, for example? Codeine is more expensive because we have a prohibition on opium and on opioids, other than for medicinal purposes.

Mr MOYLAN: I would tend to disagree a bit with that. Codeine is a formal pharmaceutical. It is owned by pharmaceutical companies, and licensed by pharmaceutical companies, and manufactured and distributed. It is not a therapeutic agent in the same fashion as most herbs are therapeutic agents. Codeine will kill you. If you take too much codeine, it will kill you. As I pointed out, you need a ton of hemp and you are not going to die, right? They are different classes of drugs. This is why, whenever considering cannabis, you must pull back and consider right at the base what are the harms that you are protecting the society from?

Dr JOHN KAYE: The point to your statement then, Mr Moylan—and I must say I personally agree with it very strongly—is that leakage from a medicinal cannabis chain would have far lower impacts, or almost no impact at all, compared to leakage from the codeine oxycontin chain, or all the opioid chains, which could and indeed do have substantial health impacts.

Mr MOYLAN: Most certainly. I would agree wholeheartedly with that.

Mr BALDERSTONE: Could you spell out what you mean by "leakage"?

Dr JOHN KAYE: I know where you are headed, Michael.

Mr BALDERSTONE: I am not sure exactly what you mean.

Dr JOHN KAYE: By "leakage", I mean a diversion of product at some stage of the production, supply and consumption chain into the non-prescription market.

Mr BALDERSTONE: Well, it is not going to be much different to now—put it that way—is it?

Dr JOHN KAYE: That was my next question to you. I was trying to elicit this evidence from previous witnesses. It is fair to say that there is a fair amount of cannabis around New South Wales at the moment.

Mr BALDERSTONE: It is, yes. I have to tell you, in living in Nimbin for 30 years now, I have just watched the popularity of cannabis go through the roof.

The Hon. TREVOR KHAN: I do not know that necessarily Nimbin is a representative sample of New South Wales, though, is it?

Mr BALDERSTONE: But people come to buy it there. We have become a cannabis market. It is very interesting watching people come from all over the place, and all ages and all sorts, to get it—a lot of it

medicinally. I think, recreationally, you can buy pot anywhere, if you know the game. But people think, "Nimbin—I can get drugs", you know. So, a lot of people, older people especially, who have never tried pot before, come to Nimbin and want to try it. It is just because of the reputation, I think.

Mr MOYLAN: By the way, I do not live in Nimbin. I live in Lismore.

Dr JOHN KAYE: Let us leave Nimbin out of it for now. My point is that from your understanding across New South Wales there is an adequate supply of cannabis?

Mr BALDERSTONE: I do not think that is true, certainly not for a lot of people who would like to medically try it. The stigma attached to being a cannabis user is immense. In yesterday's *Sun-Herald* story, the 88-year-old woman in an aged care home with a shocking disease still will not give her name. That shows the stigma. Only an idiot from Nimbin will say, "I'm a pot smoker" because you have already decided I am sort of. The stigma is huge. Access to it is extremely difficult and I think supply is limited.

Dr JOHN KAYE: But there is a massive quantity of it. I guess my point is a small amount of leakage, under my definition, into the recreational cannabis market would not make a lot of difference at the moment?

Mr MOYLAN: We could talk about this in volume terms. If we are talking about a limited trial where we are considering perhaps in the range of 100 to 200 kilograms of cannabis—

Dr JOHN KAYE: Which is a lot.

Mr MOYLAN: Which is a fair amount of cannabis, but when we are looking at a limited trial of perhaps two ounces per individual per month over a period, that gives you another facility to provide 700-odd people for six months. In that sort of instance we are talking perhaps about one ounce a month out of that, which is less than a drop in a bucket. We come back to the price of it. The reason cannabis costs so much is because it is a criminal offence. If you shift cannabis from a criminal offence to a civil penalty, suddenly the price drops and there is not that incredible warrantable reason for the leakage.

The Hon. TREVOR KHAN: Mr Moylan, we are talking about the medical use of cannabis. We are not talking about the legalisation of cannabis here. It is not within the terms of reference, apart from anything else.

Mr MOYLAN: Indeed.

Mr BALDERSTONE: There is one advantage I think in the medical cannabis trial; you really do deglamorise it a bit. I think cannabis has got very glamorised for young people especially. It is illegal and rebellious. If it is a medicine is not so groovy. I think that is a big thing.

The Hon. CHARLIE LYNN: Earlier you said there is no harm in cannabis, as I recall. If cannabis was legal and it was sold in a cigarette packet, what warning would have to go on that packet? Would there be a need for any warning to say it is harmful to your health?

Mr BALDERSTONE: I think smoking is obviously not the best way to get the drug into you. Having said that, though, it has expectorant qualities, which means it opens you up and gets rubbish out of you. I do not know of any research. Doctors and everyone keep saying we cannot legalise it until we have had research. You cannot do research while it is illegal. It is a catch 22. One of the great benefits of doing a medical cannabis trial is that we will research everyone, keep records of everyone. There is no research in Australia. You cannot do research. Everyone keeps saying to us: Do your research. You cannot do research. To answer your question, I would suspect they would put a warning: Smoking is no good for you, but we will do some trials.

Mr MOYLAN: Probably anyone who is liable to psychosis in any form is not best off. Cannabis is not for everyone.

Dr JOHN KAYE: We do not do that for alcohol, do we?

Mr MOYLAN: No, we do not.

Dr JOHN KAYE: We should.

Mr MOYLAN: We should.

Mr BALDERSTONE: You can put a warning: Alcohol is not for everyone.

Mr MOYLAN: The Hemp Party, regarding all drugs, believes we should be undertaking a relative harms approach, as I noted in my submission. This is a rational modality of approaching drugs looked at scientifically. I commend Professor Nutt's *Lancet* study, "Considering the Rational Harms of Drugs". Prior to putting together that study, that is the sort of approach we urged Australian governments to take, where they got a panel of experts, quantified what those experts believe was the harm visited by all of the recreational drugs in society, quantified it relative to a whole number of aspects, and then put them out in a scale.

As Dr John Kaye and other people have pointed out rightly, alcohol is right up there in every instance. We do not seem to approach drugs in our society with a relative harms approach. If we did, exercises such as this would demonstrate such incredible futility. We are sitting around spending so much time discussing spending ever more money regarding the recreational drug that has the least harmful effect of any of them. Right now, any of the $2 billion that is spent on interdiction, jailing, all of the helicopters around Australia, could be put to very good use with alcohol, with speed, with heroin, with drugs that do actual damage to individuals in our society. While I understand this Committee is devoted to medicinal cannabis—

The Hon. TREVOR KHAN: That is right.

Mr MOYLAN: I know—it is our stance that you cannot divorce medicinal cannabis use from recreational cannabis use in our society. To attempt to do so means you are not approaching the issue in a realistic way.

Mr BALDERSTONE: I think we have made that point clearly enough. One more thing, Mr Lynn: The American Government has a really limited cannabis supply that it has allowed for a long time. It sends people tins of ready rolled joints. So, it was not worried about the smoking effect. Mixing with tobacco is the lethal thing, and a majority of Australian cannabis users smoke with tobacco, I have to say, which is a tragedy. There is no education saying don't.

Mr MOYLAN: I am a lawyer. The Drugs Misuse Act—and I have spent quite a bit of time with the Drugs Misuse Act—provides the facility for prescription, and all the New South Wales Government has to do is direct the Therapeutic Goods Authority to list it.

The Hon. TREVOR KHAN: Direct?

Mr MOYLAN: Direct it.

The Hon. TREVOR KHAN: So you are saying the New South Wales Government has the capacity of directing—

The Hon. ADAM SEARLE: It is a matter of practice?

Mr MOYLAN: Yes, it is just a matter of practice. You only have to direct it to list it.

The Hon. ADAM SEARLE: But the authority could refuse if it wished to? It is not legally bound?

Mr MOYLAN: It is not legally bound to but I believe in this instance if you had a government directing the Therapeutic Goods Authority, I cannot see why it would refuse.

The Hon. ADAM SEARLE: There could be a range of policy reasons why it would, but getting back to the purpose of the inquiry, which is medical cannabis, obviously there is the issue of smoking, and some of the literature suggests smoking has other health risks associated with it. There is some talk in the literature of vaporisers or sprays or tinctures. Does your organisation have any particular view as to which would be the most effective method for medical cannabis were it to be legalised?

Mr MOYLAN: We are a political organisation, and that is very much a health issue. We absolutely understand that smoking is not good for you—smoking anything is not good for you. We do not hold out that

cannabis is deemed good for you. If it was set up as a limited trial, the nature of the form of the titration provided would have to be in concert with the medical people. They are the people who understand that. One note I would make, Sativex is grossly overpriced. For the same amount of stone as you get out of a bottle of Sativex—it is $300 to $500 for a suite of Sativex—whereas it is $50 to $100 for raw cannabis. And that is using street prices where most of these individuals who would be taking part in trials, I would suggest, would probably grow their own because, as people have pointed out, it is a cost situation.

If it is a choice between going out and purchasing a pharmaceutical or just putting a seed in the ground, I know which one I would do. Sativex provides exactly the same chemical makeup as the plant and I think it has a lot to do with groups such as ACON and the like have not been habituated to cannabis and cannabis is a big scary thing, so when it is in a nice little package like that, which is a pharmaceutical package, then it is a known item.

The Hon. ADAM SEARLE: We did hear some evidence earlier today around that issue, that some consumers would prefer to have the safety of something from a bottle as opposed to smoking something.

Mr BALDERSTONE: Especially older people who have not smoked and would much rather take a tincture or a pill or whatever.

Mr MOYLAN: And as the direction of this is for the medicinal use by sick people, of course then it is the manner in which the treating physicians believe that it is best delivered, I would say would be our answer.

The Hon. AMANDA FAZIO: I know that the Hemp Embassy shop in Nimbin sells materials, magazines and books on the use of hemp. Do you get many inquiries from people about the use of cannabis for medical purposes and if so what sort of conditions do they tell you they are suffering from?

Mr BALDERSTONE: I cannot get over how much cancer is around. I honestly am shocked by how much cancer suddenly is in our society and I think I said before the word is out that cannabis can be good for cancer, so every day there are people like that— arthritis and not sleeping; people not being able to sleep love cannabis. The Tibetans call it sleeping medicine, so you get a good sleep; MS, but there is a variety of things, all sorts of things, chronic pain, all sorts of levels, the old back pain, the classic that you said before. I do not know. It works for people. I just can see that clearly. The Hemp Embassy is run by volunteers. They would spend half their time talking to visitors about it. People really do want to know about it.

The Hon. AMANDA FAZIO: I know you have a fairly comprehensive website which has information about using cannabis for medicinal purposes. About how many hits does your website get a month or a year?

Mr BALDERSTONE: Good question; I do not know. I do know people say it is the most hit of any website in Nimbin and half the town is on computers.

The Hon. AMANDA FAZIO: Could whoever does your web design find that out and let us know?

Mr BALDERSTONE: Yes, I could tell you exactly.

Dr JOHN KAYE: An issue brought up earlier—and I approach this from the medical cannabis perspective—is cannabis consumption and psychiatric disorder, mental illness. Inevitably you get caught up with this argument between correlation and causation. Correlation is not necessarily causation; other things can cause things to be correlated. You have been around cannabis a long time, not just yourself using it but also other people; you are been around a large number of users. Can you give the Committee some guidance through all this because there are some papers that say there is a connection and there are papers that say there definitely is not a connection?

Mr BALDERSTONE: At Nimbin we get a fair share of weirdos. They are nearly all poly-drug abusers, I find, people who will use anything, whatever they can get their hands on. There is an interesting thing about cannabis. When you get blood tested, say, you know—anyway, cannabis stays in your blood for about two months; it stays in your urine for about six weeks, so people can go out on the weekend and party and take all sorts of drugs but by Monday or Tuesday everything is out of your system except cannabis. There was a Victorian hospital report that said like 10 per cent of their beds were due to cannabis. I thought, "What's this about?" It was all done on the blood tests. When people are admitted to hospital they get a blood test, cannabis

comes up, so that has distorted a lot of figures and it is important thing for people to understand, I think. I cannot remember—what was your question?

Mr MOYLAN: Mental illness.

Dr JOHN KAYE: I think you answered it.

Mr BALDERSTONE: Mental illness, yes. Poly-drug abuse is huge. The other thing, though, is that it is not for everyone; it is definitely not for everyone and I have seen some young people—parents come to me of young people who have had their first cone of cannabis and flipped out and it definitely happens. Like I said before, they are doing it down a back lane, mixed with tobacco, through a plastic bong, hydroponic pot in a state of total fear; not everybody is going to handle it. I actually think that causes a lot of mental health problems. But it is not for everybody.

Mr MOYLAN: I was talking to a lady in Newcastle three months ago who is a high level schizophrenic to the point where she is under huge medication load to the point where the side-effects of that medication load are debilitating to say the least. She has fitting all the time; she cannot lead a normal life. She smokes cannabis; she smokes cannabis because it relieves a lot of the symptoms of the side-effects of the drugs that she is on. She does not have to just deal with all of the problems of being schizophrenic under a massive drug load; having to deal with that but also has to deal with the stigma in our society of being a schizophrenic using cannabis. Of course, she only mentions it to her very closest friends.

I have to agree 100 per cent with Mr Balderstone that, yes, if you are susceptible to mental illness, cannabis use can be a precursor to an instance of mental illness but if you are susceptible to mental illness, something will be a precursor. It will be alcohol, it will be a pharmaceutical drug, it will be stress. The difference is causation, correlation. There is a correlation between an individual having a predisposition to mental illness and they will form that mental illness with one or a number of environmental factors pushing them along. Often when it is cannabis it is very easily identifiable whereas when it is environmental pressures or stress, it is not so easily identifiable. That said, people who are liable to suffer mental illnesses who are reasonably healthy now should stay away from all drugs.

Mr BALDERSTONE: Two things on that: all the old herbalists say that they list cannabis always as one of the most popular medicines and it was always used for mental illness so I find that people with mental illness really like cannabis too, which is a touchy area anyway. The other thing is research I have seen and figures John Jiggins has been doing a lot of work on is that since 1950 when cannabis use has increased amazingly there is no increase in mental health figures. I am not saying there is not any but that is an interesting one; cannabis use has grown enormously but mental health figures have not.

Mr MOYLAN: Might I also point out that alcohol, as I mentioned earlier, is not just correlated, it causes mental illness, and not only alcohol—Dexedrine, Ritalin, Strattera, Concerta all have in their boxes "this causes psychosis".

The Hon. TREVOR KHAN: Mr Moylan, we are again straying from what we are trying to do.

Dr JOHN KAYE: To be fair, this is relevant because the reason I asked the question is that one of the issues raised are the harms for patients who take medicinal cannabis. The point has been made that many of those people we would initially target would be at the end of their lives anyway.

Mr BALDERSTONE: Absolutely.

Dr JOHN KAYE: And would be in terrible straits so it is worth the risk. One of the issues is people with multiple sclerosis who suffer terrible pain and there is anecdotal evidence and some studies that suggest cannabis and cannabis products can alleviate that pain. The question then is: Would there be a regime we could put in place to tell that one would not precipitate an episode of psychosis in those individuals?

The Hon. TREVOR KHAN: But the evidence regarding what Ritalin or alcohol will do does not impact upon that outcome. We continue to stray into other areas.

The Hon. AMANDA FAZIO: That is okay. We can have that discussion later.

Mr BALDERSTONE: There is one thing though about psychosis. The research shows that people who have a bad reaction to cannabis recover. If they do not go back to using cannabis, they recover okay it seems.

The Hon. AMANDA FAZIO: An issue of concern to me throughout this inquiry is that the majority of people who are currently seeking to use cannabis medicinally are doing so illegally under current laws.

Mr BALDERSTONE: Yes.

The Hon. AMANDA FAZIO: That must add another level of stress on them?

Mr BALDERSTONE: Huge.

The Hon. AMANDA FAZIO: What have you heard from people who are self-medicating with cannabis at the moment? It seems to be quite cruel that those who are already suffering have an extra layer of suffering put on them because the way they want to medicate themselves is illegal.

Mr BALDERSTONE: I just cannot emphasise enough how horrible it is being labelled a criminal for being a cannabis user. If you are sick and want to use cannabis, people do not want to break the law. Most people do not want to break the law. So that is a huge thing. The other one is in your hip pocket. If you want to smoke an ounce of cannabis a week and you want good quality cannabis, then it is $250 a week. If you are on a pension, that is taking you out. I have watched kids miss out, people cannot pay their rent, cannot keep a car registered, all sorts of things, because they want to use cannabis. It is a huge impact: the cost factor as well as the paranoia factor.

The Hon. AMANDA FAZIO: I know a few incidents have been reported in northern New South Wales newspapers, but how many cases are you aware of where people who use cannabis for medicinal purposes have been arrested for possession?

Mr BALDERSTONE: To be fair to Nick Bingham, he is right. It is sort of so beyond the police managing cannabis use now that they really just target suppliers. A sniffer dog search is not going to tell who is medical or not. Everyone is in the same basket. If the police search you and find some, it is irrelevant to them if you are a medical user or not. Increasingly though, magistrates, if you have a letter from your doctor, are very light on you.

CHAIR: Time for questions has expired. Thank you for attending. The Committee has resolved that any questions taken on notice be returned within 14 days. The secretariat staff will contact you about any questions and will include any others that Committee members may have, if that is okay.

Mr MOYLAN: Thank you.

Mr BALDERSTONE: Thank you.

(The witnesses withdrew)

(Short adjournment)

EVERT RAUWENDAAL, Member, Australian Drug Law Reform Foundation,

ALEX WODAK, President, Australian Drug Law Reform Foundation, and

VIVIENNE MOXHAM-HALL, Secretary, Australian Drug Law Reform Foundation, affirmed and examined:

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

Mr RAUWENDAAL: Yes, I am happy to make an opening statement. The Australian Drug Law Reform Foundation is of the view that people should have access to a variety of evidence-based treatment. Medicinal cannabis has proven therapeutic value when used to manage conditions such as multiple sclerosis [MS], neuropathic pain, AIDS related wasting and a number of other conditions. We believe that doctors should be able to recommend and counsel their patients regarding the use of medicinal cannabis and that current legislation prevents doctors and medical professionals from offering medicinal cannabis to patients that might benefit from taking it. We think that the cultivation of cannabis for medicinal purposes should be regulated. We also believe that cannabis should be dispensed by qualified health care professionals, probably pharmacists.

The primary benefit of medicinal cannabis is to alleviate distressing and severe symptoms that may not be adequately managed by existing medications. We note that there is an overwhelming support in the community for medicinal cannabis, roughly 70 per cent according to the latest household survey, and that probably 90 per cent of the submissions made to this inquiry are also supportive. We do not think that people should be punished for using medicinal products and we also note that the global drug policy framework does not forbid the medical use of cannabis or many of the other substances that are listed as prohibited for recreational use.

The Hon. AMANDA FAZIO: On page seven of your submission you talk about a number of major official inquiries into medicinal cannabis and I was wondering if in any of those inquiries you have referred to they have identified any potential harm from the use of medicinal cannabis?

Dr WODAK: There are always harms in medicinal agents. The real question when you are trying to evaluate the possible place of a medicine in the pharmacopeia is not whether it has harmful side effects but how severe those harmful side effects are, how frequent and what the balance is, most importantly, between benefits and harms. When cannabis is used medicinally there is far more control over it than when it is used recreationally. We should not simply translate from what is said about the harms of recreational cannabis use and extrapolate that to medicinal use because it is likely to be used in smaller quantities, with more purity and more consistency and with the patient instructed as to how to take it.

The Hon. AMANDA FAZIO: We have heard from a number of witnesses during the course of the day about a range of different ways in which people could take medicinal cannabis, for example, smoking cannabis leaf, vaporising it, tinctures, tablets and chewable strips: Do you believe that any of those would be preferable if we were to enter into a legalised system of medical cannabis use or do you think there should be the whole spectrum available and people choose whichever suits them best?

Dr WODAK: As a doctor it will not surprise you that I am not enamoured of the notion that we should dispense a medicine dissolved in smoke that gets inhaled into someone's lungs. However, if a person only has a few weeks of life left I think most doctors can put aside their discomfort about the use of the medicine in that fashion and accept that. There is a real problem about giving cannabis medicinally orally, that is, as tablets. There are several problems: One is that the absorption is very poor through the gastro-intestinal system, the absorption is erratic and unpredictable, what happened yesterday might be different to today or tomorrow and patients like predictability.

The other problem is that many of the reasons why patients want to take medicinal cannabis is for intractable nausea and vomiting following cancer therapy where conventional medicines have not worked. The last thing someone who feels nauseous wants to do is put something into their mouth. Under those circumstances what we are left with are two major routes of administration that we would prefer. One is inhalation of cannabis vapour rather than smoke.

The cannabis is put into a sealed chamber, heated to subcombustable temperatures and the cannabis vaporises and the patient inhales the vapour. Those machines exist, they are affordable and they are getting

smaller and more efficient. That is our preference. The second possibility is the buccal spray. There is now a pharmaceutical product produced by G W Pharmaceuticals, which is now owned by Bayer Pharmaceuticals, and that is on the market in several countries and is available in Australia for limited use under clinical trials, not for general use.

The Hon. AMANDA FAZIO: That is Sativex.

Dr WODAK: That is Sativex. Sativex is the trade name; nabiximols is the generic name. The problem with that is that most pharmaceutical products are very expensive, especially one like this, which is still in the developmental phase. The patient population that is likely to be taking medicinal cannabis is likely to be very poor because they are likely to have had several years of severe illness and therefore not be able to be employed; therefore I think it is important to try to keep that medicine as inexpensive as possible.

That can be done either by making sure that the product itself is inexpensive, or by subsidising it. As far as I know, there is no State subsidy of pharmaceuticals; all the subsidy is at the Commonwealth level. I cannot imagine the Commonwealth rushing in to subsidise a New South Wales scheme, therefore I think we are looking at patients funding their own treatment. Therefore I think we should try to aim for a product that is as good as possible but also is as inexpensive as possible.

The Hon. AMANDA FAZIO: We heard some comments this morning from people saying they would prefer to have medicinal cannabis in forms such that they knew exactly the dosage they were getting, and who felt that by using cannabis leaf, whether smoking it or vaporising it, they would not know that because the strength could vary. Do you have any views on that?

Mr RAUWENDAAL: I guess the main point to make is that the cultivation of cannabis can be standardised and that plants can be grown for medicinal products with known qualities, and consistent qualities. I refer you to something in our submission that the cannabis provided by the Dutch government is of known characteristics and is standardised, is grown in a controlled environment, is purged of microbes and fungus, and is labelled like other medicinal products with dosages.

The Hon. AMANDA FAZIO: In your recommendations, at page 3 you have a proposed model of how a system of medicinal cannabis could operate in New South Wales. One part of that is that the medicinal cannabis could be obtained from another government jurisdiction where it is grown legitimately, and you mention The Netherlands. How could we overcome the problem of the Federal Government not wanting to allow cannabis to be legally imported into the country?

Dr WODAK: We are blessed now in Australia with several excellent forms of communication between the Commonwealth, States and Territories. I am referring here to the Council of Australian Governments, the Australian Health Ministers conference, what used to be called the Standing Committee of Attorneys General, and then the senior officers in Health and senior officers in Attorney General meet. So we have many forums where the problem you are referring to could be resolved if there was a will to do that. There are many, much more difficult problems that do get resolved every day than this one. I am sure, if there was a willingness to do it, it would be possible to do it. We are talking about people's grandmothers and grandfathers, and uncles and aunts, and mums and dads. As Evert mentioned, 69 per cent of the Australian people want this. I think if senior officials in Australian political life stood up against this, and that became known, life would become uncomfortable for them. I think a lot of Australian people these days want to see something sorted out.

Our submission is for a very modest beginning, so that people who are opposed to this, for whatever reason, can see that this is a sensible, reasonable and compassionate thing to do, and we should do it. In 2013, if Australia is a compassionate, civilised country, we should be looking after people who need this to lead a more comfortable life. Thirteen years ago in this Parliament a report was commissioned and prepared which recommended proceeding, and New South Wales has not proceeded for 13 years. In that time, the evidence to proceed has got a lot stronger, and it is time we went ahead and did it. New South Wales, if I may say so, has often been at the forefront of important changes and reforms in Australia, especially in the health field, and I think we should forge the way in this area as well.

If other States and Territories do not want to do this, then so be it. But I think it would be one of those reforms that will be quickly seen as a sensible one. This is now becoming very common throughout the world; there are now about a dozen countries that already provide medicinal cannabis, and the sky has not fallen in

anywhere; there have been no real problems. Of course there have been criticisms, but there has been no serious major criticism of anything that has been done.

The Hon. AMANDA FAZIO: I had the experience once of going to one of those national ministerial drug policy meetings, and I came back horrified at how reactionary and conservative the people were at that meeting. So, if we went to page 3 and looked at your recommended model for delivery, if you substituted importing the marihuana from overseas, and instead somehow you legitimised it being grown in New South Wales, would you see that model working? And can you tell us how you actually came up with that model?

Dr WODAK: We investigated this. Evert did most of the investigating. And we read about a scheme that has been developed in The Netherlands. There is actually a video link to that in our submission which takes about three minutes; and I defy anybody who sees that link of only three minutes not to be impressed by it. These are people who go about the business of prepared plant cannabis for medicinal use in a very professional way. As Evert said, the plants are cultivated so that they are consistent from one batch to the next; they are grown under the same conditions; they have a fastidious system of purifying the extracts. The link ends with the pharmacist sitting down with a patient in the pharmacy, and the pharmacist is explaining it all, like they should with all other medications. It is really a model for how all pharmaceutical products should be treated. I have spent 30 years as a doctor in New South Wales, and I have come to appreciate just how important the regulation of medicines is, and I think we can cope with this.

The Hon. ADAM SEARLE: In those overseas models, are the psychotropic effects of the substance taken out, with only the beneficial effects left? Is that possible?

Mr RAUWENDAAL: I guess you can grow different cannabis plants with different ratios of active chemicals. Yes, I would imagine it is possible to reduce some of those psychoactive chemicals. I am fairly sure that some of those psychoactive chemicals do in fact have medicinal properties as well, when taken in high enough doses.

The Hon. ADAM SEARLE: I note the regime that you propose on page 3 of your submission. Obviously that is not presumably beyond our wit or wisdom but it is a fairly significant change from where we are today. The other model that is canvassed on page 12, the exemption from prosecution, I note there is said to be a couple of drawbacks for it but do you see that it is at least a fruitful starting place? That people with, say, terminal illnesses should be able to access or grow their own cannabis for medical purposes and that should be a complete defence to any criminal prosecutions? Would that at least be a starting point in this area?

Dr WODAK: We talked about this a lot, about these options, before we came to the option we decided was preferable. The problem we had with the idea that people would cultivate their own product is that we are talking about people with advanced breast cancer or HIV or multiple sclerosis. I cannot see them rushing out to buy a few cannabis plants and nurture them. They are not well enough. Some of them will be and that is fine, but the people who are not well enough should not be forced to do something like that.

There is also a cultural aspect to this. I think many people in their sixties and seventies and older who might need medicinal cannabis are going to find that very weird and we should make them feel comfortable with this. I think doing this through a medicinal process helps them to feel that they are not suddenly abandoning a lifestyle they are comfortable with and taking up some kind of alternative lifestyle that they have never been interested in. I think we have to take all of those factors in.

This is not about a medicine that is going to transform health care in Australia overnight. This is about something that is going to be of modest benefit to people with a few conditions. It is not for everything. We are not proposing that. We are recommending we start off with something that is fairly small, gets tried for a few years then gets evaluated and if it is not working or it is producing a lot of unpleasant unintended negative consequences it should be scrapped. On the other hand, if it is producing a lot of benefit without many harms perhaps it needs to be expanded. Let us start off small and see how we go.

The Hon. ADAM SEARLE: We heard some evidence earlier today of that nature—that is, some older people not being comfortable with the idea of using the plant material and wanting a pharmaceutical product of the kind they are more familiar with. Are there enough products that are commercially available overseas for that to become a viable option for us in Australia? Then what about the cost implications? Are these medicines relatively expensive overseas or are they relatively inexpensive? Just on one, we heard the supply of the spray was something like $500 a month, which if you had to use it every month would be quite a considerable cost.

Dr WODAK: That is what happens with most new pharmaceutical products: at the time of their introduction the price is prohibitive and usually gets subsidised or gets dealt with in trials. That is one of the things that worry me. If the Nabiximols was introduced at a very affordable price I would say let's have all options available. But if people with advanced cancer or advanced HIV are going to be asked to pay those sorts of sums I think they are not going to have that kind of money available. We should not really ask people at that stage in their life to fork out money of that sort of size essentially when they are dying. I think we should try and keep them comfortable at affordable prices.

There are other things that come into this as well when we are talking about this. One of the uses of medicinal cannabis is for people with intractable nausea and vomiting after cancer chemotherapy. The main drug that is used now costs about $500 a day, I believe, Ondansetron. It is very expensive. The patient needs to stay in hospital and have an intravenous drip. Now, the alternative is that they could be at home with their grandkids, they could have medicinal cannabis, they would not have to have a drip, and the whole thing would be accomplished for a fraction of that price and we would save the expenditure on a hospital bed. I think the more you look at this the stronger the case is for allowing this as one of the options for an evaluation period.

The Hon. AMANDA FAZIO: My first question is just to clarify in recommendation 3 where you are talking about the conditions that you think would be suitable for medicinal cannabis, in point 3 you say "disseminated sclerosis accompanied by severe spasticity". Is that just a more technical name for multiple sclerosis?

Dr WODAK: Yes. Disseminated sclerosis is the medical term that is used for what laypeople refer to as multiple sclerosis. I am sorry.

The Hon. AMANDA FAZIO: That is okay. My second question is would there be potential for people who did not want to use cannabis leaf to use oil extracted from cannabis, or would that not work?

Dr WODAK: I think we are getting into very technical areas. I do not think we would have a problem if there is an array of choices for people. Choice is to be encouraged. I think if some people prefer to use oils so much so be it. But again we have the problem that we have to make sure if it is taken by mouth that the absorption is efficient and predictable. If I knew that oil was definitely efficient and predictable then I would not have a problem with it. But again we have the problem that people who have severe nausea and vomiting probably will not want to take anything by mouth.

Dr JOHN KAYE: Thank you for your submission. It is very detailed and it is quite a contribution to the deliberation of this Committee. My first question has to do with health impacts. You quite honestly said that of course there are health impacts but you have to balance these things out. In some cases we prescribe drugs like OxyContin that have massive side effects. How would you compare OxyContin to some of the medicinal cannabis products?

Dr WODAK: The theory for OxyContin, which is an extended release prescription opioid, is very attractive. That is to say, previously people with severe chronic non-cancer pain were treated very often with short-acting drugs and they had spikes of pain relief followed by periods of withdrawal. There is a great logic in having extended release opioids. Ten or 15 years later we now realise that the problem with prescription opioids is that while they are very good drugs for treating severe acute pain—heart attacks, broken arms and legs—and very good for treating cancer pain, they are not as effective for chronic non-cancer pain. They do not provide as much pain relief and they cause many more problems.

Where medicinal cannabis fits into this is that pain is a very significant issue in Australia. This chronic pain is probably going to get more serious as the nation ages and gets heavier and the bones and joints wear out more. We are going to have more musculoskeletal pain and we are getting more and more worried with the problems with opioids. The evidence for medicinal cannabis being useful in pain is growing. We are not yet at the point where we can say that you should stop using opioids and start using medicinal cannabis but we are at a point where we could say that for some people with certain kinds of pain maybe we should start to look at medicinal cannabis. Neuropathic pain, a particular kind of pain due to interruption in the nerve fibres, is a good example of this. If somebody has an amputation, very often they get a complication in that they feel pain or discomfort in the amputated limb, which is no longer there. But they feel it.

Dr JOHN KAYE: Phantom pain.

Dr WODAK: Phantom pain, exactly. Conventional medicines are very poor at dealing with that, and medicinal cannabis shows considerable promise in that kind of pain. People with diabetes sometimes get that kind of pain.

Dr JOHN KAYE: In evidence presented to us from officials of the Department of Health this morning, they said that their pain clinicians and palliative care clinicians did not mention medicinal cannabis to them at all. When they went back to them and asked them, they said, "Yes, maybe, but it is not a high order issue for us." Is that just a lack of knowledge of the possibilities, or are there genuine reasons why the palliative care and pain clinician community does not have a proactive interest in medicinal cannabis?

Dr WODAK: It is not accepted in Australia as part of the range of possibilities, so they would not be reading about it and they would not be hearing about it. It is different in the dozen or so countries where it is an option. There is certainly a lot of active research on this. In the pharmaceutical world, there is a considerable amount of interest in it in the sense that one of the major pharmaceutical companies in the world, Bayer Pharmaceuticals, bought up GW Pharmaceuticals, which had specialised in this area. Presumably they had done their sums and worked out that they were going to make some healthy profits out of this area.

In the venture capital market, I know that when GW Pharmaceuticals' float looked for venture capital in this area, they received much more money than they set out to raise. So in the hard-headed world of business, people wonder what all the fuss is all about. They see that this is going to be, as is often said, what the opiates were in the twentieth century for medicine, the cannabinoids will be for the twenty-first century.

Dr JOHN KAYE: Thank you for that. One of the issues that has been raised with respect to medicinal cannabis is that it is a gateway to increased recreational use of cannabis. We all have our own opinions on recreational use of cannabis and how we should deal with that legally, but leaving that aside, do you agree with the proposition that a model of medicinal cannabis would somehow or other stimulate the recreational use of cannabis, or weaken the barriers against recreational cannabis?

Mr RAUWENDAAL: I do not think so, and the evidence that we have looked at does not indicate that the availability of medicinal cannabis leads to an increase in recreational cannabis use. I could read you something.

Dr JOHN KAYE: Rather than doing that, because our time is a little bit short, would you actually like to table something?

Dr WODAK: You can table it, but maybe I could just say, to answer that, that right now today in New South Wales hospitals, we use medicinally cocaine, morphine and amphetamines. Until 1953 we prescribed heroin until it was banned by the Commonwealth. So these drugs are used today for medicinal purposes while their recreational use is clearly prohibited. The three international drug treaties—the 1961 single convention, the 1971 Convention on Psychotropic Substances and the 1988 convention on drug trafficking—prohibit the recreational use of about 250 substances, of which cannabis is one. They also stipulate that the medicinal and scientific use of the same drugs will not be interfered with. In terms of the international drug treaties, this is very much a separate issue.

Dr JOHN KAYE: So going ahead with a medicinal cannabis regime in New South Wales is not the first step towards legalising cannabis.

Dr WODAK: It is a separate issue. A dozen countries have gone down this road already with medicinal cannabis and no country has, as yet, made cannabis available legally.

Dr JOHN KAYE: This morning we heard evidence that in the United States, where there is a completely different model from the one you propose where cannabis was made legal and applies, there was an overall increase in the use of cannabis. Is that consistent with the evidence you have?

Mr RAUWENDAAL: No, it is not.

Dr JOHN KAYE: What is the evidence that you have?

Mr RAUWENDAAL: The evidence we have is from the *Annals of Epidemiology*. They found from their study, which was performed in 2012, very little evidence that passing medical marijuana laws increased reported use among adolescents or any other age group. There were also some figures published by the *California Paediatrician*, and they indicated that the data is very reassuring that in almost all cases, medical marijuana legalised for adults does not lead to an increase in the recreational use of marijuana by adolescents. The American Medical Association states that trends in emergency room visits for marijuana do not support the view that State authorisation for medical cannabis leads to an increased signals of substance misuse.

Dr WODAK: I wonder if I could just add to that that it is not generally known that, despite the fact that cannabis is prohibited in Australia, it is relatively easy to obtain. The Commonwealth Department of Health commissions a survey every year that is conducted among drug users, and they ask them how easy or difficult it was to obtain heroin, cocaine and amphetamine, and they also include cannabis in that survey. The 2011 figures were that 94 per cent of respondents in that sample said that cannabis was easy or very easy to obtain—that is hydroponic cannabis—and 78 per cent said that bush cannabis was easy or very easy to obtain.

In the University of Michigan study that has been done every year of high school seniors—that is 17-year-olds—asking the same kind of question, over 80 per cent of every year since 1980 of the sample have said that cannabis was easy or fairly easy to obtain. So despite the fact that cannabis is prohibited in the United States and in Australia, it is still pretty easy to obtain. It is hard to imagine that its availability could be increased.

CHAIR: The first of my two questions relates to the recommendations on page three of your submission. In Recommendation 4, you refer to potentially having doctors registered in New South Wales applying for approval for a 12-month period to prescribe to patients that they believe meet the criteria. Did you mean by that that the doctor can be allowed to prescribe for a 12-month period, or 12 months per individual patient?

Dr WODAK: The second.

CHAIR: One of the issues that has been coming up from time to time today and in other submissions, while there are differing views on how wide-ranging medical cannabis could be made in terms of who it was available to, certainly terminal patients is a category that seems to keep coming up again and again. I imagine that if you were to limit it to a 12-month period, that would probably eliminate some of the concerns about long-term use as well. Is that the intention behind that recommendation?

Dr WODAK: Yes, that is the intention, and this recommendation grew out of my experience. I chaired the medical committee under the 1966 Poisons Act. I chaired that for about 20 years. Doctors registered in New South Wales who are dealing with a patient, who is addicted to drugs or who has a history of drug addiction, and who want to prescribe a drug of addiction to that person can apply to this committee. That committee makes a recommendation to the Director General of Health NSW. I have seen at close quarters how well that system works. It is a way of responsibly trying to find a balance between letting people have whatever they want and keeping some kind of control over it under very difficult circumstances. I do not think, particularly in the early stages, New South Wales people are going to want an open slather system, but on the other hand I think they are going to want to see that grandma or grandpa is looked after properly.

CHAIR: Is it your opinion that a committee like that could provide timely advice? If someone is literally within the last weeks or months of their lives, what sort of turnaround would need to be looked at?

Dr WODAK: That committee meets about every six weeks or so and can also consider urgent requests out of session. Urgent requests to that particular committee did not come up all that often. They are likely to come up more often with this. A system could operate that could provide a quick turnaround if that was needed. But most of the time you can see ahead what is going to happen. Most doctors should be able to see what is going to happen. But with cancer chemotherapy and things like that, I grant you it may be that permission is needed very quickly.

CHAIR: My final question relates to public support for medical use of cannabis. I think you used the figure of 69 per cent in your earlier evidence?

Dr WODAK: That is correct.

CHAIR: Dr Wodak, you have been involved in this area for a long time. Do you think over, say, the last 14 years since the last working party put together its report, there has been an increase in public support in direct correlation to stronger evidence that is now available or has it always been at about that figure?

Dr WODAK: That figure came from the National Drug Strategy Household Survey which was carried out by the Commonwealth Department of Health and Ageing. The survey is conducted every three years. The data was collected in 2010, where that figure comes from, and was published in 2011. We could check on that. I have not looked up the earlier figures, but generally things are moving in that direction. Community support for things like a needle/syringe program and methadone program, where there are arguably some kinds of similarities, is growing and it is roughly at those kinds of levels now.

(The witnesses withdrew)

WAYNE HALL, University of Queensland Centre for Clinical Research, sworn and examined:

MICHAEL FARRELL, National Drug and Alcohol Research Centre, affirmed and examined:

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

Professor HALL: I do not think so. You have the submission. I think it is probably easiest to proceed to questions.

Dr JOHN KAYE: Professor Hall, you are truly a veteran of the issue of medicinal cannabis, having served on the 1999-2000 working party and the report. Between 2000, when that report was published, and 2013, has anything changed which would make you wish to change the recommendations of that working party?

Professor HALL: Yes. I think the biggest change has been the work of GW Pharmaceuticals and development of medicinal cannabinoids that are now approved for use in the United Kingdom, Canada and a number of other countries. When that committee met and made its recommendations there was no activity. I do not think GW Pharmaceuticals had been formed. We were certainly encouraging of efforts to develop medicinal cannabinoids but we did not see at that time much pharmaceutical interest. So, our recommendations were really about making cannabis available in its crude form for individuals who wanted to use it, mindful of international drug control treaties and pharmaceutical regulatory obstacles.

Dr JOHN KAYE: But you saw at that time a need to make raw cannabis available. Would you now say that you could no longer make raw cannabis available but only products like Sativex, or do you see both being advisable?

Professor HALL: I think the preference would be for pharmaceutical products, which would eliminate a lot of problems that arise in attempting to produce a medicinal form of cannabis plant, particularly if it is smoked. Generally, I think there is a need to meet the needs of individuals who are seriously ill with these conditions who might want to smoke cannabis. I think one of the questions asked earlier of the preceding witnesses was are you very much in favour of the law recognising medical necessity as a defence against criminal prosecution. The combination of that and making available pharmaceutical cannabinoids such as Sativex would be a way of assessing the scale of demand. One of the things that is difficult to know is how many people are interested in using those products. There clearly are some. I am sure they are featured in the submissions this Committee has received. It is just a question of how many and what sort of costs the Government might be prepared to bear to make the drug available.

Dr JOHN KAYE: We have had evidence today that Sativex-like drugs are far more expensive than just providing high-quality crude cannabis, as it were?

Professor HALL: We do not know that is the case. If you look at the Canadian experience with the medical cannabis program, it has proved to be incredibly expensive. It is the taxpayer who is paying. It is a very expensive program to administer, to a very small number of patients.

Dr JOHN KAYE: And the expense there has been—

Professor HALL: The expense is in the controlled cultivation of product. To comply with international drug control treaties the Government has to supervise and control the growing of cannabis and its sourcing and supply. If it were to allow people to grow their own, as the Canadians have done, that is in direct contravention of the international drug control treaties. The irony in this area is that the only Government that has introduced medical cannabis in a way that complies with treaties is the Netherlands, as I think Dr Wodak was pointing out in his evidence.

Dr JOHN KAYE: In terms of the efficacy of medicinal cannabis, and our understanding of its ability to relieve pain, nausea, glaucoma, has that changed since the year 2000?

Professor HALL: The main evidence is in the area of multiple sclerosis, neuropathic pain, and that is because that has been the primary therapeutic target for trials of Sativex in the United Kingdom. I think the evidence has not really changed on cannabis as a treatment for nausea and vomiting in cancer patients, and I do not think it is likely to because we have much more effective agents now than cannabis. There might be a case

for making it available as an option for patients who fail to respond to drugs like Ondansetron that Dr Wodak mentioned.

Dr JOHN KAYE: So, you are saying advances in other treatments for nausea associated with cancer treatments?

Professor HALL: Yes, really reduced the need to use it. GW Pharmaceuticals did not apply to register its product for that use. The same would be true of AIDS-related wasting because we have effective treatments that prevent that. They were the two indications for which THC was approved back in the 1980s as a medical treatment in the United States and the United Kingdom. It was not very effective in those sorts of indications and we now have much more effective drugs. So the area of interest with the pharmaceutical companies in cannabis now is in the treatment of neuropathic pain and that is the major indication for which these drugs are approved.

Dr JOHN KAYE: So that is issues to do with things like multiple sclerosis?

Professor HALL: Yes, primarily, and that is because there are no other treatments. I think that is a sensible commercial decision that they have made but here is a condition for which there is no effective treatment. Sativex or the cannabinoids appear to be an effective treatment for that, so that is the indication that they have pursued and that is the indication for which they have sought regulatory approval.

Dr JOHN KAYE: What about second-line treatment for other conditions such as nausea?

Professor HALL: I think there is a case to be made for that and if the drug were to be—

Dr JOHN KAYE: So you think there is a case to be made?

Professor HALL: Yes, on the grounds of choice. To address your question earlier about the cost of Sativex, we have a Pharmaceutical Benefits Scheme here which would subsidise the cost of drugs if they were shown to be effective so that is not an obstacle to patient use.

Dr JOHN KAYE: It is not an obstacle to patient use but it is an obstacle at the Pharmaceutical Benefits Advisory Committee [PBAC] level?

Professor HALL: Yes, it requires evidence of efficacy and cost effectiveness, which is the same for all drugs, and I think that is the sort of standard we should apply here. And the alternative, which is the Government providing it, is a special access scheme for patients where you are basically ignoring the standard regulatory process and the standard evidence required for public subsidy.

Dr JOHN KAYE: Professor Farrell, have you been watching developments in the 19 states in America that have medicinal cannabis legislation?

Professor FARRELL: I have not visited them but I have actually been reading about them.

Dr JOHN KAYE: Are you seeing any evidence that those medicinal cannabis models are responsible for an increase in consumption of cannabis in the recreational market?

Professor FARRELL: I am not aware of data in either direction but it has to be said that it is a very different model from the point of view that it is a way to access cannabis for a range of very non-specific conditions, which is quite different to the discussion we have had in the United Kingdom and in Australia around making effective medications available for defined conditions and I think it is quite a different approach and on one level it seems a ready solution but on another level it creates a lot of problems, particularly around medicalising the load of access to recreational cannabis use.

Dr JOHN KAYE: Are you aware of the model that the Australian Drug Law Reform Foundation proposed in their submission?

Professor FARRELL: I know Professor Wodak very well but I am not aware of the full details of it.

Dr JOHN KAYE: Their model is effectively around prescription. Do you see that as a model which would not have the problems associated with the American models?

Professor FARRELL: The issue—and we deal with this a bit in our submission—which is whether the issues with this is that medications particularly around the regulatory system are required to meet particular standards particularly in the context of the pharmaceutical industry and the protection of the individual consumer and over the last many decades one of the important aspects of the regulatory system has been the protection of the individual against large industry in many ways or in combination with large industry and the problem with this is it straddles that system; it does not fit within the quality control system that we would normally expect of medications and that is a big shortcoming. This is a topic myself and Professor Hall dealt with in the House of Lords scientific inquiry into cannabis and one of the issues in it is people understanding the sheer technical complexity of the medicines regulatory system.

Dr JOHN KAYE: Is the United Kingdom medicines regulatory system as complex as the Australian one?

Professor FARRELL: It is pretty similar.

Dr JOHN KAYE: So you are effectively advocating that we go through the whole process, the TGA process and the PBAC process?

Professor FARRELL: I think when we are talk about medications for conditions I would be inclined to say we have built that system up very carefully and we should be very careful about exceptionalism in relation to that system.

Dr JOHN KAYE: I have to leave shortly so I apologise for that.

The Hon. AMANDA FAZIO: Given that you both have a lot of expertise in this area are you aware of any harmful side-effects or negative health impacts of people using cannabis medicinally?

Professor HALL: If you are talking about short-term use, which would be the sort of use that someone might engage in if they were being treated for cancer and we were using it to manage nausea and vomiting, most of the adverse effects seem to be fairly mild. I think we quoted in our submission the Institute of Medicine report, which was one of the more thorough ones—it is getting a bit dated now but they looked at the evidence. I think the major effects that people do not like are the sort of psychoactive effects. A lot of older adults do not like feeling high, spacey and so on. They are not life-threatening or serious health effects but they are often major reasons why people discontinue use.

The unknown question is what the effects might be of people using these drugs over long periods of time, and that might be the case, for example, with multiple sclerosis where people might be using these drugs daily over months or years where there is a lot less certainty about what the adverse effects would be there. I think, as we pointed out, we know a lot more about the adverse effects of recreational use on young adults. What is unclear is how relevant that is to medicinal use in older adults with chronic conditions. The honest answer is the acute effects I think are probably fairly minor and no worse than a lot of other medicines we tolerate and use. The longer term effects are much less certain.

The Hon. AMANDA FAZIO: On page 20 of your submission you talk about the issue of people smoking medical cannabis. Would those problems be overcome by the use of vaporisers?

Professor HALL: They would probably be substantially reduced because people would not be inhaling smoke and tar and so on. We do not have enough studies comparing the respiratory risks of vaporisers with, say, smoking the crude plant product but it is plausible that there would be a substantial reduction in risk.

The Hon. AMANDA FAZIO: For a long while people have spoken about the use of medical marijuana to help with the effects of glaucoma. On page 9 of your submission you do not seem to think that is the case. Can you just elaborate on that?

Professor HALL: I think the major reason that pharmaceutical companies have not really invested in doing research on that has been—it is certainly true that THC reduces intraocular pressure, which is one of the potential benefits of its use in glaucoma, but in order to get those effects people have to use very large doses and

for a lot of people that means getting pretty stoned and they do not like it. There was experimentation with water soluble analogues of THC, that is, drugs that produce similar effects but can be dissolved in water, which THC cannot be, which could be applied directly to the eye but I do not think any of that has led anywhere in terms of effective medicine. Most of the interest has been in the indications for cancer chemotherapy and for age-related wasting and more recently for multiple sclerosis.

The Hon. AMANDA FAZIO: On page 14 through to page 18 you talk about the different medical models that are being used overseas, firstly in the United States, then Canada and the Netherlands. Do you have a preference? Do you believe that any one of those three systems is superior to the others?

Professor HALL: I think the Netherlands system would probably be a better one because, as I understand from what we heard of the evidence from Dr Wodak, that was the one the Law Reform Foundation was advocating. That certainly comes closest to the standard pharmaceutical regulatory system we have at the moment and it is something that could be put in place if, say, GW Pharmaceuticals were to apply to have Sativex registered for medical use in Australia. That would just be following the standard sort of process and it would be a prescription medicine like any other.

The Hon. AMANDA FAZIO: Is that the main reason you chose that one? We heard evidence earlier today that many people were worried about diversion of medicinal marijuana or cannabis into the general population. They seemed to think that was a big problem in California?

Professor FARRELL: Given the ubiquity of cannabis, the idea of being concerned about major diversion issues and the cost of these medications will not be such. We do not even know from the point of view of the formulation they would have what the end user attractiveness would be. I do not think that would be a big issue in the balance of things.

Professor HALL: The only qualification I would add would be that the California model does not do any of that. Basically, it allows anybody to purchase cannabis if they can persuade a doctor to write a letter saying that they have a condition, which, in the doctor's opinion, might benefit from using cannabis. Under those sorts of circumstances you end up with a very liberal regime and it becomes a bit of a joke that it is medicalised. That is not true of all American States because they vary in the way in which they regulate it. But California is a bit of an extreme in the case of very overly liberal forms of provision. But I think it is possible, as Professor Farrell has said, to provide cannabis for medicinal use in a way that does not run any major risk diversion.

Professor FARRELL: The other downside of the American model and potentially where you draw too much medical resource into accessing non-medical cannabis is that it is not a good use of professional time and it has the potential to not have support from that profession and to create a range of problems around that, which are quite important to consider.

The Hon. AMANDA FAZIO: Other submissions have different models suggesting a person would go to their regular doctor and get a referral, in effect, to say this person should be authorised to use cannabis medicinally. That would then go to another body, whether it was some sort of health department or review team or whatever. Do you think that would be an adequate checking mechanism to stop the Californian explosion of the use of medical marijuana taking place?

Professor HALL: I think it could be done that way. In fact, the committee I chaired back in 1999-2000 came up with something along those sorts of lines. The problem I think that has been unrecognised is that doctors are reluctant to prescribe a drug that is not approved and has not been through the regulatory process. That was one reason we recommended in that case that doctors not prescribe cannabis, but they certify that a patient has a particular condition that makes them eligible for using cannabis. If those conditions are reasonably tightly defined as they are in many American States that would be one way of minimising the risk of broadening the indications, as has happened in California.

The Hon. AMANDA FAZIO: Professor Hall, why do you think the recommendations in the 2000 report were never acted on?

Professor HALL: The big question was supply. We recommended that people be given an exemption from criminal prosecution. The concern was that if you allow people to use medical cannabis, where are they going to get it. We were implicitly saying, "Well, it's out there, it's on the black market, people could purchase at

their own risk." But I think the then Premier and other senior people in the Government were concerned that this was encouraging people to resort to the black market and they preferred to provide the cannabis directly to patients, which is pretty much what has happened in Canada. The problem with that system is that, as I think I said in answer to an earlier question, it gets to be very expensive for government to control cultivation, supply, preparation, oversight and distribution of the cannabis.

The Hon. ADAM SEARLE: Except in the Netherlands; does not the Government have a contractor that produces it for the Government?

Professor HALL: Yes. The Netherlands has a different model, but you still have to purchase it and you have licensed suppliers to produce cannabis under licence and supervision. But I do not know what the cost of that is. I do not think it would be any cheaper than the Canadian model. The large part is that it is cheap and easy to grow the plant; it is the regulatory apparatus that requires the supervision and all the rest that goes with it that makes it expensive.

The Hon. ADAM SEARLE: In which case it sounds like the cheapest option is to allow people to grow their own?

Professor HALL: Yes. Well, that is also contrary to the international drug control treaties. If you give people an exemption from criminal prosecution, you basically leave it up to them to find wherever they can cultivate it. Presumably, if there was a criminal exemption for use for medical purposes, a magistrate or judge would probably look upon cultivation for personal use as falling within that protection.,

The Hon. ADAM SEARLE: Returning to what you said earlier about the doctor not prescribing but certifying, if legislation, for example, permitted or gave an exemption from prosecution for persons who were either terminally ill or had a chronic health issue that was listed, say, in the legislation, then the doctor would be called upon only to certify that the person had that condition?

Professor HALL: Yes.

The Hon. ADAM SEARLE: And that would be it?

Professor HALL: Yes, that would be it. The committee had a good representation of a variety of medical professionals: palliative care physicians, general practitioners and others. That was the view: there was no enthusiasm for the idea of writing a prescription for cannabis because it is a drug that had not been through the regulatory process.

The Hon. ADAM SEARLE: Has anything occurred in the past decade or so that would cause you to reconsider the recommendations of that working party?

Professor HALL: I think, as I said earlier in answer to the previous question, the availability of medicinal cannabinoids could be prescribed.

The Hon. ADAM SEARLE: As an alternative?

Professor HALL: Yes, as an alternative. If we could go down that route, I think that would potentially deal with a lot of the problems that we attempted to in that working party.

The Hon. ADAM SEARLE: Subject to availability and cost, of course?

Professor HALL: Yes. Those are big ifs. The company would have to be interested in having it approved or registered here.

The Hon. ADAM SEARLE: And there would have to be a sufficient market for that to be cost effective?

Professor HALL: Yes.

The Hon. AMANDA FAZIO: Professor Farrell, ages ago I read the House of Lords report, but I cannot remember it now. What did it recommend about the use of medicinal cannabis?

Professor FARRELL: Interestingly enough, despite our recommendation, and I was doing the work partly with the Department of Health at the time, which was for them not to deviate from the primary regulatory system, in their infinite wisdom close to the end of their deliberations they recommended that doctors be allowed to prescribe cannabis on, what was it called?

Professor HALL: On an individual patient basis. So for an individual patient they could prescribe it for a limited period.

Professor FARRELL: And it was not taken up by the Government at all and it did not really make any progress whatsoever because, despite the technical difficulties we discovered, they did not try to find any way through them. They decided to just make a broad political recommendation. So it was very hard for our Government to actually act on it because it was not given support, unlike the reports here.

The Hon. AMANDA FAZIO: What was the recommendation before the House of Lords changed it?

Professor HALL: The other thing it did was make a lot of recommendations encouraging the medical research council to fund clinical trials on cannabinoids. In fact, GW Pharmaceuticals came out of the House of Lords in a lot of ways. Geoffrey Guy, who is the principal for that company, gave evidence to the inquiry. He ended up setting up a company that supplied the product to clinical investigators who gave evidence to the inquiry. A lot of the clinical trials of Sativex were really consequences of the House of Lords inquiry. That has been an important inquiry even though the original recommendations were not accepted by the UK Government at the time. A lot of good came out of it. In fact, one of the reasons we are here I think is because of the availability of medicinal cannabinoids that the inquiry inspired.

Professor FARRELL: I would concur with that. In actual fact, what was happening in the run-up to the House of Lords inquiry was a lot of debate around efficacy and effectiveness. Our push really was to say that there needed to be proper investment and research around this so that we could actually have reliable facts that could progress it. In fairness, GW Pharmaceuticals had actually started before that, but it developed it and it is a separate independent entity. It was made easy for people to do. Before that the view had been that there were a lot of obstacles in the system for people wanting to undertake research on this and a lot of those obstacles were removed so it was possible to do good clinical studies.

The Hon. CHARLIE LYNN: I have a question on the cost benefit basis that you referred to earlier. Has anybody done any research into what the cost benefit of this is?

Professor HALL: I do not know of any formal cost benefit analyses. There are analyses of the effectiveness of Sativex and there is reasonable evidence there. If it was approved by the Pharmaceutical Benefits Advisory Committee [PBAC] for listing on the Pharmaceutical Benefits Scheme [PBS] here that is exactly the sort of analysis that would need to be done. I do not think it would be difficult to do. It would mean translating the improvements in quality of life in patients with multiple sclerosis into some sort of quantitative measure that you could then put a value on and if it proved to be valuable, as valuable as medicines that have already been approved, then it would be given a tick and put on the PBS.

The Hon. CHARLIE LYNN: And the cost of the regulatory system?

Professor HALL: Of putting it through? I have lost contact with that, I think governments are now trying to recover those costs from companies. It is also possible for non-government organisations, for professional societies and for charities to apply to have drugs listed on the PBS and I know of a couple of instances where that has happened. Even if GW Pharmaceuticals weren't prepared to stump up the money to put it through the process it would be potentially possible for other interested parties to apply to do that. In that case there might well be some reduction in fees charged.

CHAIR: I wanted to ask about the effect upon people who may be predisposed to mental illness. We have talked about that today. There are a couple of schools of thought: First, perhaps this is an area that should only be considered for those with terminal illnesses and in palliative care, whereas others seem to think it could be more wide-ranging. There have been differing views as to whether those who are predisposed to mental illness could experience a negative effect if they are prescribed a medical form of cannabis: Do you have any views on that issue?

Professor HALL: Michael is a psychiatrist.

Professor FARRELL: It is a very controversial area and the data on it is pretty tight. In terms of major mental illness the risks are pretty modest. In the context of the conditions we are talking about the data that is much more interesting is to actually know how many people—we guess rather than know—despite all our discussion, will not want this medication because of some of the subjective effects. It is not necessarily putting them at risk of major mental health problems. The psychosis risk, particularly in the adult population, I would not see in any way as a determining factor. The issues around anxiety, mood disorders and subjective unpleasant experiences are much more likely to influence people to decline use rather than major mental health issues.

The major mental health issue data we have relates particularly to people starting use before 15 and having a positive family history of psychosis. The issue for us here probably is going to be if we see efficacy around neuropathic pain—and we are seeing significant problems around the use of opioids and other medication—it may be that some of the cannabinoids become substantially preferable to some of the long-term side effects of some of the existing medication. If that were the case it would give quite a big push to some of the cannabinoid options.

CHAIR: My final question is directed to you, Professor Hall, but I am happy for Professor Farrell to also answer. I know you have been asked about the previous working party you chaired. In terms of what you would hope to see this Committee come up with in its deliberations on this inquiry, do you have a preferred outcome you would like to see?

Professor HALL: I think a combination of things. If you were looking at a regulatory response to patients in need at the moment allowing medical use as a defence against criminal prosecution is a reasonable step to take. It is within the prerogative of State governments to undertake that step. You could advocate for and encourage trials of Sativex or Sativex type products, because there are others under development in Australia, and perhaps look to government funding some clinical trials of those substances to see what interests there might be amongst patients with some of these conditions. I would not be very much in favour of trying to circumvent existing regulatory process by setting up a special access for cannabis. Some combination of those two would go a fair way to addressing the concerns amongst patients with chronic illness who want to use cannabis for medicinal reasons and their families.

Professor FARRELL: I would concur. The other point is that it is very important that people with chronic conditions who find benefit from it not be subject to the heavy hand of the law and that they be protected from it. If there is a light-handed way to do that it would be helpful.

The Hon. AMANDA FAZIO: I was discussing the issue of medicinal cannabis with Ethan Nadelmann from the Drug Policy Alliance in New York and he was of the opinion that the model being used in Israel was the best model and people should be referring to that. You did not mention the Israeli model in your submission and I was wondering if you could say what you think about it and whether it is practical or others are superior?

Professor HALL: I do not think we know enough about the Israeli model, it was only implemented recently and I have not seen and information published on it. I do not know enough about the details. As I understand it they were really breeding plants with higher levels of cannabidiol, which is the non-psychoactive component that appears to have some therapeutic benefits. I would not rule out the Israeli model. It would certainly be worth exploring and looking at but I do not know enough about how it has been implemented or how it works to offer an opinion.

Professor FARRELL: The point that is technical from the Committee's point of view, but one of the interesting things the research is showing is how many subcomponents are active and different types of effects there are within the cannabis plant and the importance of separating those out and understanding them as different effects and looking to see what is the optimal effect, which is different to mushing it all up and putting it in a pipe and smoking it.

The Hon. AMANDA FAZIO: I saw an interview with the chief researcher who is running that project and they were saying that they wanted to be able to prescribe medical cannabis in the same way you might be prescribed any other drug. For example, you get a 5-milligram or 10-milligram dose and they wanted to be sure that what you were getting was the precise strength that you needed, which seemed to me would require a huge amount of processing compared to people vaporising leaf matter?

Professor FARRELL: Yes and no. The important question is do we set different standards for one drug from all drugs? What precedent do we set for that and how much do we expose people to potentially unwanted and uninvestigated effects if we let that go on? My view is that it is potentially a dangerous precedent.

The Hon. TREVOR KHAN: This may not be an appropriate comparison, but with a drug/medication like Ventolin you sort of wander into the chemist, who might ask you for a blue card but chucks the puffer over the counter at you and says, "Don't use it too often." If we talk about the precise use of medication and precise dosages, that is a drug where there is, really, no precision in the use or dosage of the product that is supplied, beyond the fact that one puff appropriately consumed will have some impact. Why is not cannabis like that?

Professor FARRELL: It is a very good example. I am not a respiratory physician, but I know there are a lot of concerns around Ventolin related deaths, and there is a lot of concern around misuse of Ventolin. It is a clear example of having good guidance for patients on what they do, and being very clear about not to deviate too much from that; and for the practitioners to be aware of the risks and to be monitoring them. Ventolin is a very good example of where we are pretty much skating on the slightly difficult edge of things in terms of benefits versus drawbacks.

The Hon. TREVOR KHAN: But if we look at, for instance, in some way allowing people in the end stage of their life access to a product, perhaps not with precision, the prospects of the Ventolin style deaths caused by overuse, I would suggest, is pretty unlikely, is it not?

Professor HALL: I think that is true. But I think that can be addressed by allowing the medical defence. So, if people want to assume the risks, that is fine, particularly if they have a terminal illness and it is a way of relieving them of any symptoms. I have no problem with that. I think the problem would be in attempting to legitimise that use and allowing the use without having done any evaluation or put it through any regulatory process. I think that was Professor Farrell's point.

Professor FARRELL: When I started we used to prescribe Brompton's cocktails, which had a mixture of cocaine and brandy and a bit of morphine in it for a person in terminal care, and they were very popular and very good for palliative care. Things have moved on a bit. We also used to prescribe glasses of sherry for some of the old ladies in the evening. But you just do not do that nowadays. So there has been a shift in culture.

The Hon. TREVOR KHAN: I understand the concept of a shift in culture, as I said when another witness was here earlier. Over 3½ years I watched my father die. Despite the precision of the prescription of the medication, the medication was making him mighty crook at times. The only thing that made that better is that he was so crook that it was a bit hard to tell which was the cause of the particular problem. If the precise prescription medication is seen as producing some miracle outcome, I have got to put my father forward as an example where I am far from being convinced that his outcome was better than the slightly more relaxed approach to self-medication.

Professor FARRELL: I think we are back to an area here of quality of palliative care and listening to palliative care physicians about how things are managed. One of the issues is where people have used cannabis for a good part of their life and got ill, and enabling a humanitarian and compassionate approach of those people's access to things that put them at ease. But that is quite different from talking about specific medications for specific conditions.

CHAIR: I thank you, gentlemen, for appearing before the Committee this afternoon. Committee members may have further questions that they might like to send to you on notice. The secretariat will advise you about those. We would ask that responses be returned within 14 days.

(**The witnesses withdrew**)

(**The Committee adjourned at 5.14 p.m.**)