Submission No. 059
Received 11 July 2016

Public Health Association
AUSTRALIA

# Public Health Association of Australia submission on Public Health (Medicinal Cannabis) Bill 2016

**Contact for recipient:**
Research Director
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
**A:** Parliament House, George Street, Brisbane QLD 4000
**E:** medicinalcannabis@parliament.qld.gov.au

**Contact for PHAA:**
Michael Moore – Chief Executive Officer
**A:** 20 Napier Close, Deakin ACT 2600
**E:** phaa@phaa.net.au **T:** [redacted]

11 July 2016

Submission No. 059
Received 11 July 2016



# Contents

Submission No. 059
Received 11 July 2016



# Introduction

## The Public Health Association of Australia

The Public Health Association of Australia Incorporated (PHAA) is recognised as the principal non-government organisation for public health in Australia and works to promote the health and well-being of all Australians. The Association seeks better population health outcomes based on prevention, the social determinants of health and equity principles. PHAA is a national organisation comprising around 1900 individual members and representing over 40 professional groups.

The PHAA has Branches in every State and Territory and a wide range of Special Interest Groups. The Branches work with the National Office in providing policy advice, in organising seminars and public events and in mentoring public health professionals. This work is based on the agreed policies of the PHAA. Our Special Interest Groups provide specific expertise, peer review and professionalism in assisting the National Organisation to respond to issues and challenges as well as a close involvement in the development of policies. In addition to these groups the Australian and New Zealand Journal of Public Health (ANZJPH) draws on individuals from within PHAA who provide editorial advice, and review and edit the Journal.

In recent years PHAA has further developed its role in advocacy to achieve the best possible health outcomes for the community, both through working with all levels of Government and agencies, and promoting key policies and advocacy goals through the media, public events and other means.

## Vision for a healthy population

The PHAA has a vision for a healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and healthy environment, improving and promoting health for all.

## Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.

Submission No. 059
Received 11 July 2016



# Public Health (Medicinal Cannabis) Bill 2016

PHAA welcomes the opportunity to provide the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the Committee) a submission regarding the *Public Health (Medicinal Cannabis) Bill 2016* (the Bill).

In April 2016, PHAA provided a response to the Queensland Health survey questions regarding the *Medicinal Cannabis in Queensland: Draft Public Health (Medicinal Cannabis) Bill 2016.* Responses to the survey have been supplied as part of this submission.

In addition to responses provided to Queensland Health, PHAA strongly advocates for the reduction of social and health inequities should be an over-arching goal of Government policy. We believe that the Australian Government, in collaboration with State and Territory Governments, should outline a comprehensive national cross-government framework on reducing health inequities. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

To this end we believe the following three points should be considered by the Committee in relation to the Bill:

1. Any restrictions on prescribing and dispensing of Medicinal Cannabis should be through the Therapeutic Goods Administration *not* in the legislation. By requiring prescribers to apply for medicinal cannabis approval to become specialist medical practitioners will cause access equity issues in disadvantaged, rural and remote communities as will restricting access to approved pharmacist and secondary dispensers.
2. Possession of criminal history should not be a factor in approving medical treatment of a patient. Access to health services and medical treatments should be without discrimination on the grounds of a person's legal situation but rather be guided by evidence that supports effective, appropriate and confidential treatment.
3. A significant section of the legislation in this Bill seems to be focused on criminal justice issues rather than provision of medicinal cannabis as a legal treatment option (For example: Part 2 Entry of places by authorised persons, Division 1 Power to enter, page 70; Part 3 External reviews by QCAT, page 115; Chapter 10 Protection from liability, page 118; Chapter 11 Legal proceedings, page 120) .This Bill should focus on medicinal cannabis as treatment for medical conditions not on criminal justice issues.

For further information on public health issues relating to medicinal cannabis, please see the PHAA policy on Medicinal Cannabis in Australia, available here: www.phaa.net.au/documents/item/885 and provided as an attachment to this submission.

Submission No. 059
Received 11 July 2016



# Responses to Queensland Health Survey questions

## Do you support the use of medicinal cannabis in Queensland?

Yes, particularly now that the Commonwealth has legislated to establish a national scheme to make cannabis available for medicinal purposes using an approach that is consistent with Australia's obligations under the international treaties covering this area. Effective implementation requires the active support of the States and Territories.

## What, if any, concerns do you have about the use of medicinal cannabis in Queensland?

PHAA applauds the Queensland Government for working on a framework for regulating the lawful supply and use of medicinal cannabis products in Queensland. While we understand the limitations imposed by the existing regulatory framework and current scheduling of cannabis under Schedule 9 and a cannabis-derived pharmaceutical product (nabiximols) under Schedule 8 of the national classification system, we strongly support a more comprehensive approach to effectively regulate the use of medicinal cannabis products and repealing of the relevant sections of the Regulation such as the requirement for the Chief Health Officer (CHO) to approve treatment prescribed by a medical practitioner to a consenting patient.

At the ACT Inquiry into the exposure draft of the Drugs of Dependence (Cannabis use for medical purposes) Amendment Bill 2014, the Committee was advised that the approval process involving the CHO would "create significant additional demand on health resources" and that "the CHO is being asked to provide an approval with no real knowledge of the cases and no way to interrogate the information being provided in applications. The Committee was advised that there is no need for the CHO to be involved in the decision to prescribe to an individual" a view that PHAA strongly supports.

## If you have any concerns about the use of medicinal cannabis in Queensland, how might these be managed or prevented?

Harm minimization policies applied to medicinal use of cannabis seek solutions that do not impose additional burdens on people who are terminally ill or who are suffering from a chronic illness where alternative medicines are not effective and/or have debilitating side-effects. Penalties associated with possession and use of cannabis, and of administering to another person, currently add to such burdens. NSW for example, has adopted a policy not to prosecute terminally ill people using the drug medicinally, an approach supported by the PHAA.

PHAA supports controlled availability through a tightly regulated, compassionate medicinal cannabis regime managed by medical practitioners and the state/territory health departments, ideally underpinned by national legislation and regulation in conformity with Australia's international treaty obligations.

The ready availability of illegal cannabis in the community for both recreational and medicinal use means that it is unlikely that making it lawful for a relatively small number of people to self-medicate for a small number of health conditions, as part of a tightly controlled medical approach, would have any meaningful impact on illicit cannabis availability or use.

The arguments against permitting terminally ill people to legally access, possess and use cannabis when their doctor supports this, represent an ideological stance, not compassionate medical practice.

### What, if any, special provision should be made for treating patients who are under 18 years of age?

PHAA supports an approach that involves having patients, carers and medical practitioners all involved in the process of seeking authorisation to possess, supply and use medicinal cannabis. In our view, access to legal medicinal cannabis should only be possible for the relatively small number of people suffering specific health conditions for which standard medications have not been sufficiently effective. As per provision of standard medications, treatment of patients who are under 18 years of age should be decided by the patients' medical practitioner in consultation with the patients' legal guardian.

### What, if any, special provision should be made for treating patients with impaired capacity to consent to treatment?

Similarly to the observation above, with regard to adults with impaired capacity to consent - as per provision of standard medications, treatment of patients in this context should be decided by the patients' medical practitioner in consultation with the patients' carer and/or legal guardian.

### What, if any, special provision should be made for treating patients in rural or remote areas?

Limitations to access due to overly bureaucratic regulatory framework should be able to be overcome through appropriate use of modern technology to ensure that people in regional or remote areas of Queensland are not disadvantaged. Equitable access to all health care and treatment should form a key part of the implementation of any health policy.

# Conclusion

PHAA supports the availability of medicinal cannabis in a controlled and appropriately regulated environment.

A compassionate medicinal cannabis regime should mean possession and use of botanical cannabis and synthetic cannabinoids carry no penalty when used by people in situations where conventional approaches have been unsuccessful or are contra-indicated. Such a regime should apply to a person with serious health conditions that their doctors and the state/territory health departments consider may be alleviated through consuming cannabis. The PHAA also believes that it is appropriate for governments to support research into the long term benefits and risks of cannabis compounds for medicinal purposes.

The PHAA appreciates the opportunity to make this submission and would be happy to elaborate should that be considered appropriate.

Please do not hesitate to contact me should you require additional information or have any queries in relation to this submission.

Michael Moore BA, Dip Ed, MPH
Chief Executive Officer
Public Health Association of Australia

Submission No. 059
Received 11 July 2016

# Public Health Association of Australia: Policy-at-a-glance – Medicinal Cannabis in Australia

**Key message:** PHAA will –

1. Advocate to governments, health sector professional associations and the public for legislative and regulatory action to make medicinal cannabis legally available throughout Australia.
2. Advocate for a medicinal cannabis regime that, as a short-term interim measure, removes penalties for possession, consumption and supply of personal-level quantities of cannabis when used medicinally as part of a compassionate regime.
3. Advocate for a national approach to medicinal cannabis that includes establishing a legal supply chain of herbal cannabis, cannabis extracts and, where medically appropriate, synthetic cannabis products.

**Summary:** Legal medicinal cannabis regimes operate in many overseas jurisdictions, reflecting research evidence and clinical experience that some of the contents of the cannabis plant have therapeutic values, for some patients, including but not restricted to the terminally ill. Many people have found the drug helpful for palliating distressing disease symptoms and relieving adverse side-effects of medication, in cases where standard medical care is not sufficiently effective. There is good evidence for efficacy for some medical indications but not for others. PHAA supports the current initiatives, at both the Commonwealth and State/Territory levels, to establish legal medicinal cannabis programs and further research on the risks and benefits of medicinal cannabis use.

**Audience:** Federal, State and Territory Governments, health and law enforcement policy makers, professional medical associations and health service consumers.

**Responsibility:** PHAA's Health Promotion Special Interest Group (SIG).

**Date policy adopted:** September 2015

[redacted]

Submission No. 059
Received 11 July 2016

# Medicinal Cannabis in Australia

***The Public Health Association of Australia notes that:***

1. Abstaining from illicit drugs avoids the harms arising from their use. It is important that effective prevention programs are adopted which prevent and delay the onset of any drug use. Given that not everyone will abstain from illicit drugs, it is critical that we also adopt PHAA supports policies which minimise the harm associated with illicit drug use to individual consumers, their families and the broader community. *(PHAA Illicit Drug Policy Adopted September 2013)*

2. Harm minimisation policies applied to medicinal use of cannabis seek solutions that do not impose additional burdens on people who are terminally ill or who are suffering from a chronic illness where alternative medications are not effective. Penalties associated with possession and use of cannabis currently add to such burdens.

3. Widespread public and media interest in medicinal cannabis[1] exists in Australia including in parliaments in a number of jurisdictions (including the Federal Parliament) which are actively considering proposals. The focus is on using cannabis to assist in alleviating unnecessary suffering caused by illness or adverse consequences of treatment.

4. Under international treaties that have been incorporated into Australian domestic law, nations may permit the import, export, supply, use, consumption, etc. of cannabis in all its forms for 'medical and scientific purposes'.[2]

5. Many Australians currently self-medicate with cannabis, or medicate family members with the drug. Some of them do so with the tacit or overt support of their doctors.[3] In doing so they are behaving illegally as importing, cultivating, supplying and possessing cannabis is illegal in all Australian states and territories, as is self-administration in all but one of them.

6. No sound estimate is available of the number of people in Australia who use cannabis for medicinal purposes, nor of the number who could benefit from doing so. However, a recently published study of 1,514 people prescribed opioids for chronic non-cancer pain revealed that 16% had used cannabis for pain relief and one quarter reported that if they had access to cannabis they would use it for pain relief.[4]

7. Widespread public support exists for changing legislation to permit the use of botanical cannabis (marijuana) for medical purposes (69% of people aged 14 years or older nationally in 2010) and for a clinical trial in this area (74%).[5]

8. The attitudes towards medicinal cannabis expressed by Australian and international professional bodies are mixed. For example, the Cancer Council NSW '...supports limited exemptions from criminal prosecution…for cancer patients who have been certified by an approved medical practitioner as having particular conditions, and who have been counselled by such a practitioner about the risks of smoking cannabis'.[6] The Australian Medical Association

'…acknowledges that cannabis has constituents that have potential therapeutic uses' and notes that 'Therapeutic cannabinoids that are deemed safe and effective should be made available to patients for whom existing medications are not as effective'.[7] The AMA also notes that 'Any promotion of the medical use of cannabinoids will require extensive education of the public and the profession on the risks of the non-medical use of cannabis'.

9. Government regulated medicinal cannabis programs exist in European and North American nations. The approach taken in many of the USA programs where controls are loose, with blurred boundaries between supply for medicinal and recreational purposes, provides a model of how *not* to manage these programs.[8] In contrast, the approach taken in the Netherlands, where a government agency, the Office of Medicinal Cannabis, tightly regulates the service, is an example of how the program can be operated in a safe and effective manner.[9] Medicinal cannabis has been approved for use in more than a dozen countries including the USA, Canada, UK, Denmark, the Czech Republic, Austria, Sweden, Germany, Spain, Canada, Italy, Israel and New Zealand.

10. Various attempts have been made in the past in Australia to legislate for medicinal cannabis programs that aim to mitigate the sufferings of people with diverse health conditions, but none reached the implementation phase.[10]

11. Both scientific research and numerous case reports indicate a range of health conditions for which cannabis has been demonstrated to be beneficial at palliating the symptoms of serious illness or the adverse side-effects of their treatment. These include, but are not limited to, cancer, HIV infection, multiple sclerosis and epilepsy.[11] The most recently published systematic review concludes that 'There was moderate-quality evidence to support the use of cannabinoids for the treatment of chronic pain and spasticity. There was low-quality evidence suggesting that cannabinoids were associated with improvements in nausea and vomiting due to chemotherapy, weight gain in HIV, sleep disorders, and Tourette syndrome'.[12] Research into medicinal uses of cannabis is limited, with few high-quality trials having been conducted, partly owing to US Government restrictions on making the drug available for medical research purposes.[13] In some jurisdictions, medicinal cannabis is used to treat a host of indications, a few of which have evidence to support treatment with cannabis and many that do not.[14]

12. Only one form of pharmaceutical cannabis is included in the Australian Register of Therapeutic Goods (nabiximols, Sativex®) for just one indication (symptom improvement in patients with moderate to severe spasticity due to multiple sclerosis). In addition, the synthetic cannabinoids dronabinol and nabilone are listed in Schedule 8 of the Poisons Standard. These medications are expensive in Australia, limiting access to them for disadvantaged people.

***The Public Health Association of Australia affirms the following principles:***

4. With regard to medicinal cannabis, the policies and practices of the Commonwealth, State and Territory governments are largely out of step with the attitudes and behaviour of much of the general public, and much professional opinion. Some state governments are now facilitating clinical research into medicinal cannabis, and NSW has adopted a policy not to prosecute terminally ill people using the drug medicinally,[15] an approach supported by PHAA.

5. It is now timely for Australian governments to give serious consideration to options for a tightly-regulated, compassionate medicinal cannabis regime managed by medical practitioners and the state/territory health departments, ideally underpinned by national legislation and regulation in

conformity with Australia's international treaty obligations.

6. The ready availability of illegal cannabis in the community now for both recreational and medicinal use means that it is unlikely that making it lawful for a relatively small number of people to self-medicate for a small number of health conditions, as part of a tightly controlled medical approach, would have any meaningful impact on illicit cannabis availability or use.

7. Any medicinal cannabis regime should ideally be supported by provisions for the supply of cannabis to people authorised to use it, and this should not entail obtaining the drug from illicit supply sources. However, this principle should not prevent the removal of penalties for medicinal use as part of a staged approach.

8. The arguments against permitting terminally ill people to legally access, possess and use cannabis when this is supported by their doctor, represent an ideological stance, not compassionate medical practice.

9. Considerations of facilitating a relatively small number of dying, chronically and acutely sick people to use cannabis as part of a carefully controlled compassionate medical treatment regime need to balance the potential benefits of this for patients and their families (which are relatively high) with the potential negative aspects (which are relatively low).[16] The side effects of using cannabis to provide relief from the symptoms of some chronic illnesses, or in certain age groups, need to be taken into account in assessing these trade-offs.

10. Current evidence suggests that adverse effects of short-term use for medical indications are generally modest, but further research is needed to evaluate adverse effects of long-term use including risk of dependence, exacerbation of cardiovascular disease and precipitation of psychotic disorder, especially in younger people. Potential adverse side-effects include included asthenia, balance problems, confusion, dizziness, disorientation, diarrhoea, drowsiness, dry mouth, fatigue, hallucination, nausea, somnolence and vomiting.[17]

11. PHAA supports research into both the benefits and side-effects of use of medicinal cannabis and pharmaceutical cannabinoids

12. Any Australian regime should clearly distinguish between lawful medicinal use and unlawful use for recreational and other purposes.

***The Public Health Association of Australia believes that the following steps should be undertaken:***

Australian governments, collaboratively with members of the affected communities (including families and carers) and public health, medical and law enforcement experts, continue or initiate careful policy work on how to introduce a compassionate, palliation-focussed, medicinal cannabis regime within their respective jurisdictions.

13. The starting point be the proposals currently being considered by the Commonwealth, NSW, Victorian and ACT legislatures for medicinal cannabis to be available to terminally ill people in circumstances where their doctors and the state/territory health department agree that cannabis may provide palliation benefits to the patient.

14. The compassionate medicinal cannabis regime go further than serving only terminally ill people, with possession and use of botanical cannabis and synthetic cannabinoids also carrying no penalty when used by people with other serious health conditions that their doctors and the

state/territory health departments consider may be palliated through consuming cannabis, in situations where conventional approaches have been unsuccessful or are contraindicated.

15. Considering that pharmaceutical cannabis is legally available in Australia in only one form and for only one narrow indication, the regime also needs to include provisions for the removal of penalties in very limited circumstances for the use of botanical cannabis and its extracts ingested through various routes of administration including smoking (for adults only), vaporisers and food products.

16. The regime include provisions providing no penalty for the person with the health condition in question to possess an amount of cannabis that is deemed to be for personal use (i.e. less than the trafficable quantity threshold). The regime should also specify no penalty to that person - or a third party nominated by the person and/or the relevant authorities (doctor/s and health department) - to cultivate, possess, supply and/or administer personal-use quantities of cannabis product to the person authorised to receive it.

17. Governments explore the feasibility of making medicinal cannabis available from other sources, e.g. importing pharmaceutical-standard cannabis from overseas-based producers and/or licensing medicinal cannabis production in Australia.

18. Governments support research into the long term benefits and risks of cannabis compounds for medicinal purposes.

***The Public Health Association of Australia resolves to undertake the following actions:***
The Board and Branches, with advice from the Health Promotion Special Interest Group, will:

19. Monitor policy work, legislation and research on medicinal cannabis in each jurisdiction.

20. Advocate to governments, health sector professional associations and the public for legislative and regulatory action to make medicinal cannabis legally available throughout Australia.

21. Advocate for a medicinal cannabis regime that, as a short-term interim measure, removes penalties for possession, consumption and supply of personal-level quantities of cannabis when used medicinally as part of a compassionate regime approved by doctor or health department.

22. Advocate for a national approach to medicinal cannabis that includes establishing a legal supply chain of herbal cannabis, cannabis extracts and, where medically appropriate, synthetic cannabis products.

**ADOPTED 2015**

***First adopted at the 2015 Annual General Meeting of the Public Health Association of Australia. The latest revision has been undertaken as part of the 2015 policy review process.***

[1] Terminological note: 'cannabis' refers to the plant *Cannabis sativa*. 'Cannabinoids' include cannabis and synthetic and semi-synthetic substances that produce pharmacological effects similar to those produced by cannabis (Mather, LE *et al.* 2013, '(Re) introducing medicinal cannabis', *Medical Journal of Australia*, vol. 199, no. 11, pp. 759-61). For ease of communication this Position Statement uses the term 'medicinal cannabis' to cover both botanical cannabis and other cannabinoids.

[2] United Nations Office on Drugs and Crime 2013, *The International Drug Control Conventions*, <http://www.unodc.org/unodc/en/commissions/CND/conventions.html>.

[3] For example: http://www.canberratimes.com.au/act-news/medical-marijuana-supplier-raided-after-tip-off-from-chief-minister-20140730-zyoz7.html and Adler, JN & Colbert, JA 2013, 'Clinical decisions. Medicinal use of marijuana-polling results', *New England Journal of Medicine*, vol. 368, no. 22, p. e30.

[4] Degenhardt, L, Lintzeris, N, Campbell, G, Bruno, R, Cohen, M, Farrell, M & Hall, WD 2015, 'Experience of adjunctive cannabis use for chronic non-cancer pain: findings from the Pain and Opioids IN Treatment (POINT) study', *Drug and Alcohol Dependence*, vol. 147, pp. 144-50.

[5] Australian Institute of Health and Welfare 2011, *2010 National Drug Strategy Household Survey report*, 2nd edn, Drug Statistics Series no. 25, cat. no. PHE 145, Australian Institute of Health and Welfare, Canberra.

[6] http://www.cancercouncil.com.au/1978/cc-publications/health-strategies-reports-submissions/position-statements/cancer-council-new-south-wales-medical-use-of-marijuana-fact-sheet/

[7] See Available from https://ama.com.au/position-statement/cannabis-use-and-health-2014 .

[8] Sabet, K & Grossman, E 2014, 'Why do people use medical marijuana? The medical conditions of users in seven U.S. states', *Journal of Global Drug Policy and Practice*, vol. 8, no. 2. (Note: this is sound research, albeit published in a low-status, advocacy-focussed, online journal.)

[9] Netherlands Office of Medicinal Cannabis http://www.cannabisbureau.nl/en/ .

[10] NSW Parliamentary Research Service 2014, *Medical cannabis*, Issues Backgrounder no. 5, Parliament of NSW, Sydney.

[11] Grotenhermen, F & Muller-Vahl, K 2012, 'The therapeutic potential of cannabis and cannabinoids', *Dtsch Arztebl Int*, vol. 109, no. 29-30, pp. 495-501; Borgelt, LM *et al.* 2013, 'The pharmacologic and clinical effects of medical cannabis', *Pharmacotherapy*, vol. 33, no. 2, pp. 195-209, Volkow, ND, Baler, RD, Compton, WM & Weiss, SRB 2014, 'Adverse health effects of marijuana use', *New England Journal of Medicine*, vol. 370, no. 23, pp. 2219-27, Hakkarainen, P *et al.* 2014, Growing medicine: small-scale cannabis cultivation for medical purposes in six different countries', *The International Journal of Drug Policy*, online ahead of print.

[12] Whiting, PF *et al.* 2015, 'Cannabinoids for medical use: a systematic review and meta-analysis', JAMA, vol. 313, no. 24, pp. 2456-73.

[13] Bostwick, JM 2012, 'Blurred boundaries: the therapeutics and politics of medical marijuana', Mayo Clinic Proceedings, vol. 87, no. 2, pp. 172-86.

[14] Hill, KP 2015, 'Medical marijuana for treatment of chronic pain and other medical and psychiatric problems: a clinical review', *JAMA*, vol. 313, no. 24, pp. 2474-83.

[15] Government of NSW 2015, 'Terminal Illness Cannabis Scheme', http://www.nsw.gov.au/sites/default/files/miscellaneous/sc000197_cannabis-scheme-sheet.pdf.

[16] This has been the experience of the Netherlands' Office of Medicinal Cannabis which manages a tightly-controlled program, making pharmaceutical-standard herbal cannabis available to authorised patients in that country through pharmacies, and elsewhere in Europe. See http://www.cannabisbureau.nl/en/ . And see Carter, GT *et al.* 2011, 'Cannabis in palliative medicine: improving care and reducing opioid-related morbidity', *American Journal of Hospice and Palliative Care*, vol. 28, no. 5, pp. 297-303.

[17] Whiting, PF *et al.* 2015, 'Cannabinoids for medical use: a systematic review and meta-analysis', *JAMA*, vol. 313, no. 24, pp. 2456-73.