

# DRUG FREE AUSTRALIA

## **No pathway to recreational cannabis use**

1. Australians don't want laws promoting or tolerating the recreational use of cannabis
2. Lax medical cannabis laws were the pathway to legalised recreational use in the US, so it is imperative that Australia not make this error
3. De facto legalised recreational use has been the result of lax medical cannabis laws in the US
4. In any Australian calculus, the harms of cannabis use must always balance modest medical benefit
5. The UK recognised the limitations of cannabis on chronic pain and advises it only as a last resort
6. Current costs of using medical cannabis are comparable to costs when it was illegally obtained
7. Cannabis clinics in Sydney agree there are no major impediments to obtaining medical cannabis

**Central Issues  
&  
Compiled Evidence**

# DRUG FREE AUSTRALIA

## Seven Central Issues for the Senate Inquiry

### 1. Australians don't want laws promoting or tolerating the recreational use of cannabis

According to the 2016 National Drug Strategy Household Survey, a survey of around 25,000 Australians, a vast majority (86%) of Australians do not approve the recreational use of cannabis

It can safely be concluded that Australians do not want more recreational cannabis use, but LESS. Medical cannabis availability, if not legislated carefully and enforced correctly, can create significantly more recreational cannabis use

While 85% of Australians support 'medical marijuana' in the same survey, Drug Free Australia contends that none would approve of any lax medical cannabis regime which promotes de facto recreational use

### 2. Lax medical cannabis laws were the pathway to legalised recreational use in the US, so it is imperative that Australia not make this error

Colorado and Washington were the first states to legalise recreational use, having previously legalised medical cannabis. Within a year of legalisation in 2014 cannabis use by those aged 12-17 had risen 20% against decreases of 4% for all other states, rising 17% for college age young people against 2% for other states – all despite cannabis being illegal for all under age 21. Adult use rose 63% against 21% nationally

According to the US SAMHSA household survey, those reporting they had used cannabis in the last month before survey increased by a staggering 245,000 between 2010 (when medical cannabis was commercialised) and 2015. This 43% increase in frequent cannabis use creates a vast new population susceptible to the multitude of harms presented by cannabis - psychosis, depression, suicide, driving and work accidents, amotivational syndrome, immunosuppression, permanent harms to the unborn as well as cardio and pulmonary conditions

When comparing three year averages before and after legalisation, cannabis-related traffic deaths rose 62%. Hospitalisations related to cannabis went from 6,715 in 2012 to

11,439 in 2014. Notably, black market criminals found new sanctuary in Colorado, attracted by lower risks of enforcement. Governor Hickenlooper last year introduced House Bill 1221 to address the 380% rise in arrests for black market grows between 2014 and 2016

Colorado's experience is a cautionary tale of what Australia must necessarily avoid. Ineffective medical cannabis laws will only promote what Australians clearly do not want

**3. De facto legalised recreational use has been the result of lax medical cannabis laws in the US – Australia must avoid the same**

The US has witnessed a medical cannabis rort where recreational users feign chronic pain maladies to access high quality cannabis availability thereby effectively 'legalising' the constant use of cannabis for what is in reality only recreational use. Australia must do everything in its power to avoid this recreational user pathway

In light of 86% of Australians not approving of recreational cannabis use, the legalisation of cannabis for recreational use in Colorado and other US States gives voluminous evidence on why the Federal Government must ensure that medical cannabis is not used as a pathway to legalised recreational use in this country

**4. In any Australian calculus, the harms of cannabis use must always balance modest medical benefit**

Cannabis is an addictive drug which causes psychosis, suicide, violence, vehicle deaths and a long list of other individual and social harms. Any medical benefit from the use of medical cannabis for any Australian individual must outweigh these harms, particularly when pot activists are agitating for a loosening of very reasonable and equitable regulatory requirements which are identical for all medicines within Australia

**5. The UK recognises the limitations of cannabis on chronic pain and advises it only as a last resort**

- 6. Current costs of using medical cannabis are directly comparable to costs when it was illegally obtained**
  
- 7. Cannabis clinics in Sydney agree there are no major impediments to medical cannabis**

*The evidence supporting each of the seven central issues nominated here is found in the following pages.*

# Table of Contents

**SEVEN CENTRAL ISSUES FOR THE SENATE INQUIRY ..... 1**

*Compiled Evidence*

**Australians don't want laws promoting the recreational use of cannabis ..... 5**

The vast majority of Australians do not approve of cannabis use ..... 5  
 Australians want LESS drugs, not more ..... 6  
 Medical cannabis a key to the 'more drugs' strategists ..... 6

**Lax medical cannabis laws a pathway to recreational use in the US ..... 7**

The results of cannabis legalisation is what Australians do not want ..... 8  
 Use of cannabis by those aged 12-17 rose 20% in first year ..... 8  
 College-age use rose by 17% ..... 10  
 Adult use rose by 63% ..... 11  
 Cannabis related fatalities rose by 62% ..... 13  
 Hospitalisations related to cannabis rose markedly ..... 13  
 Legislation introduced to cut black market criminality ..... 14  
 Colorado added 245,000 extra cannabis users in 5 years ..... 14  
 245,000 extra users became susceptible to these cannabis harms ..... 15

**De facto legalised recreational use the result of lax medical cannabis laws ..... 16**

Medical cannabis relatively ineffective for chronic pain ..... 16  
 The US sort of claiming medical cannabis for pain ..... 17  
 Inquiry must examine cannabis quantities prescribed for pain ..... 18  
 Diversion to minors for recreational use well documented in the US ..... 18

**Australian calculus - the harms of cannabis use must balance modest benefits .. 20**

Review indicates many harms but mostly only modest medical effectiveness ..... 20  
 New medical indications must be part of a trial ..... 21

**The UK recognises the limitations of cannabis on chronic pain ..... 29**

UK more conservative than Australia on demonstrated benefits ..... 29

**Current costs of medical cannabis directly comparable to illegal cannabis ..... 31**

Cost of pharmaceutical cannabinoids identical to illegal cannabis in Australia ..... 31  
 Cost must be brought down via efficiencies, not by relativising TGA standards ..... 32

**Cannabis clinics in Sydney agree no major impediments to medical cannabis ..... 33**

Access to medical cannabis adequate according to clinics ..... 33

**Recommendations ..... 34**

## **CENTRAL ISSUES FOR THE SENATE INQUIRY - 1**

### **Australians don't want laws promoting or tolerating the recreational use of cannabis**

**According to the 2016 National Drug Strategy Household Survey, a survey of around 25,000 Australians, a vast majority (86%) of Australians do not approve the recreational use of cannabis**

**It can safely be concluded that Australians do not want more recreational cannabis use, but LESS. Medical cannabis availability, if not legislated carefully and enforced correctly, can create significantly more recreational cannabis use**

**While 85% of Australians support 'medical marijuana' in the same survey, Drug Free Australia contends that none would approve of any lax medical cannabis regime which promotes de facto recreational use**

### **The vast majority of Australians do not approve of cannabis use**

The Australian Government's Australian Institute of Health and Welfare (AIHW) conducts the National Drug Strategy Household Survey every three years, surveying close to 25,000 Australians each time. This very large sample gives the survey a great deal of statistical validity.

The last survey was in 2016, and Table 9.17 (from its statistical data found at <https://www.aihw.gov.au/reports/illicit-use-of-drugs/2016-ndshs-detailed/data> ) indicates Australian approval or disapproval of the regular use of various illicit drugs.

As can be seen from the Table displayed below, 86% of Australians do not approve of the regular use of cannabis. This recognition should drive all legislative responses to medical cannabis, where Australians clearly do not want the proliferation of a dangerous intoxicant given that medical cannabis preparations are amenable to recreational use.

**Table 9.7: Personal approval of the regular use by an adult of selected drugs, people aged 14 years or older, 2007 to 2016 (per cent)**

Drug	Males				Females				Persons			
	2007	2010	2013	2016	2007	2010	2013	2016	2007	2010	2013	2016
Tobacco	15.8	17.4	17.3	18.1	12.9	13.3	12.2	13.2	14.4	15.3	14.7	15.7#
Alcohol	51.7	51.5	51.7	52.4	39.0	38.9	38.6	39.8	45.3	45.1	45.1	46.0
Cannabis	8.7	11.0	12.6	17.8#	4.6	5.3	7.0	11.2#	6.7	8.1	9.8	14.5#
Ecstasy	2.6	3.0	3.3	3.9	1.5	1.7	1.6	1.8	2.0	2.3	2.4	2.9#
Meth/amphetamine <sup>(a)</sup>	1.5	1.5	1.6	1.6	0.9	0.9	1.1	0.8	1.2	1.2	1.4	1.2
Cocaine/crack	1.8	2.2	1.9	2.0	1.0	1.2	1.3	1.4	1.4	1.7	1.6	1.7
Hallucinogens	2.1	3.2	4.5	5.1	1.2	1.6	1.7	2.4#	1.7	2.4	3.1	3.7#
Inhalants	1.0	1.3	0.9	0.9	0.7	0.8	1.0	1.0	0.8	1.0	0.9	1.0
Heroin	1.3	1.5	1.3	1.3	0.7	1.0	1.1	1.0	1.0	1.2	1.2	1.1
Pharmaceuticals <sup>(a)</sup>	15.6	23.3	24.5	28.7#	11.9	21.4	21.9	26.9#	13.7	22.4	23.2	27.8#
Prescription pain-killers/analgesics <sup>(a)</sup>	n.a.	13.4	13.0	13.2	n.a.	12.6	12.2	12.1	n.a.	13.0	12.6	12.7
Over-the-counter pain-killers/analgesics <sup>(a)</sup>	n.a.	14.4	14.8	19.5#	n.a.	14.3	14.2	18.7#	n.a.	14.3	14.5	19.1#
Tranquilisers, sleeping pills <sup>(a)</sup>	4.8	7.2	9.5	10.1	3.4	5.7	6.8	8.5#	4.1	6.4	8.2	9.3#
Steroids <sup>(a)</sup>	2.5	3.0	3.0	3.0	1.0	1.4	1.5	1.8	1.7	2.2	2.2	2.4
Methadone or buprenorphine <sup>(a)</sup>	1.1	1.5	1.3	1.6	1.0	1.0	1.2	1.1	1.0	1.2	1.3	1.3

# Statistically significant change between 2013 and 2016.  
(a) For non-medical purposes.  
Note: The list of response options changed across survey waves. Comparisons should be interpreted with caution.  
Source: NDGHS 2016

Australian attitudes are similar with the recreational use of opiates, where 99% are against their recreational use. Yet few Australians would challenge the use of opiates in a medical setting. Likewise, Australians are supportive of cannabis in a medical setting, where it is used for conditions it generally alleviates.

**Table 9.17: Support<sup>(a)</sup> for measures relating to cannabis use in medical settings, people aged 14 or older, by sex, 2010 to 2016 (per cent)**

Measure	Males			Females			Persons		
	2010	2013	2016	2010	2013	2016	2010	2013	2016
A clinical trial for people to use marijuana to treat medical conditions	73.6	75.3	86.0#	74.4	74.0	88.1#	74.0	74.7	87.1#
A change in legislation permitting the use of marijuana for medical purposes	68.7	70.0	83.5#	68.9	68.2	85.4#	68.8	69.1	84.5#

## Australians want LESS drugs, not more

With 97-99% of all Australians not giving their approval to the use of heroin, cocaine, speed/ice and ecstasy, and 86% not giving their approval to the regular use of cannabis, it is clear that Australians do not want these drugs being used in their society.

## Medical cannabis a key to the ‘more drugs’ strategists

NORML's Keith Stroup famously said, "*We will use the medical marijuana scam as a red herring to promote the legalisation of marijuana.*" This has been the precise strategy of the recreational cannabis lobby, and a major part of their scam has been to sell spurious benefits for cannabis. Another strategy has been to use medical cannabis as a de facto legalisation of recreational use.

It is crucial that any legislation must carefully gauge the impact of any changes to medical cannabis availability in light of Australians' aversion to recreational use.

## **CENTRAL ISSUES FOR THE SENATE INQUIRY – 2**

**Lax medical cannabis laws were the pathway to legalised recreational use in the US, so it is imperative that Australia not make this error**

Colorado and Washington were the first states to legalise recreational use, having previously legalised medical cannabis. Within a year of legalisation in 2014 cannabis use by those aged 12-17 had risen 20% against decreases of 4% for all other states, rising 17% for college age young people against 2% for other states – all despite cannabis being illegal for all under age 21. Adult use rose 63% against 21% nationally

According to the US SAMHSA household survey, those reporting they had used cannabis in the last month before survey increased by a staggering 245,000 between 2010 (when medical cannabis was commercialised) and 2015. This 43% increase in frequent cannabis use creates a vast new population susceptible to the multitude of harms presented by cannabis - psychosis, depression, suicide, driving and work accidents, amotivational syndrome, immunosuppression, permanent harms to the unborn as well as cardio and pulmonary conditions

When comparing three year averages before and after legalisation, cannabis-related traffic deaths rose 62%. Hospitalisations related to cannabis went from 6,715 in 2012 to 11,439 in 2014. Notably, black market criminals found new sanctuary in Colorado, attracted by lower risks of enforcement. Governor Hickenlooper last year introduced House Bill 1221 to address the 380% rise in arrests for black market grows between 2014 and 2016

Colorado's experience is a cautionary tale of what Australia must necessarily avoid. Ineffective medical cannabis laws will only promote what Australians clearly do not want

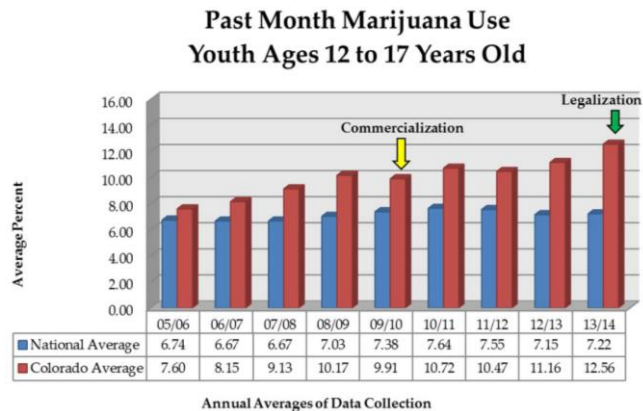


## The results of cannabis legalisation is what Australians do not want

If there is any measure of what loose medical cannabis regimes lead to, **Colorado and Washington in the US give the clearest picture.** In 2014, Colorado and Washington introduced fully legalised recreational use of cannabis, with cannabis use by teens and college-age young people quickly increasing. Adult use doubled within three years, as detailed below. Likewise, various measures of harm also quickly increased.

### Use of cannabis by those aged 12-17 rose 20% in first year

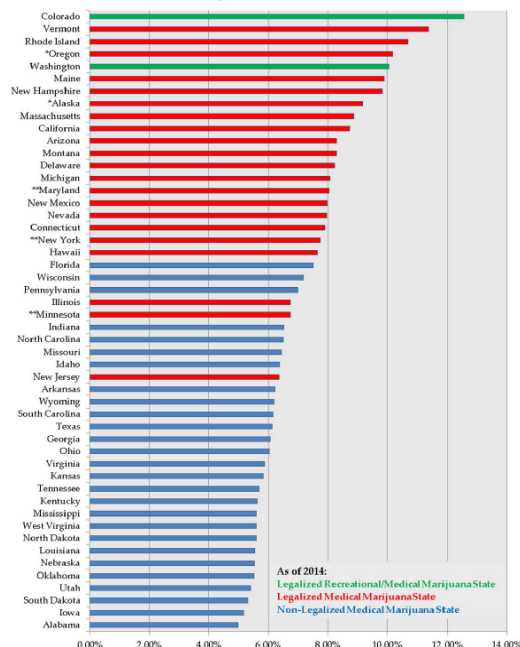
The legalisation of recreational use of cannabis in Colorado and Washington in 2014 has led to increasing drug use in those states. It is illegal for any under the age of 21 to use cannabis, especially given the effect of cannabis on the developing adolescent brain. But use in Colorado by those aged 12-17 rose substantially against decreases of 4% in other states, despite use already being elevated by the legalisation of medical cannabis.



SOURCE: SAMHSA.gov, National Survey on Drug Use and Health 2013 and 2014

In 2013/14 Colorado youth ranked #1 for cannabis use in the United States, up from #4 in 2011/12 and from #14 in 2005/6. In the graph below states with legalised medical cannabis are marked red, and green for recreational use.

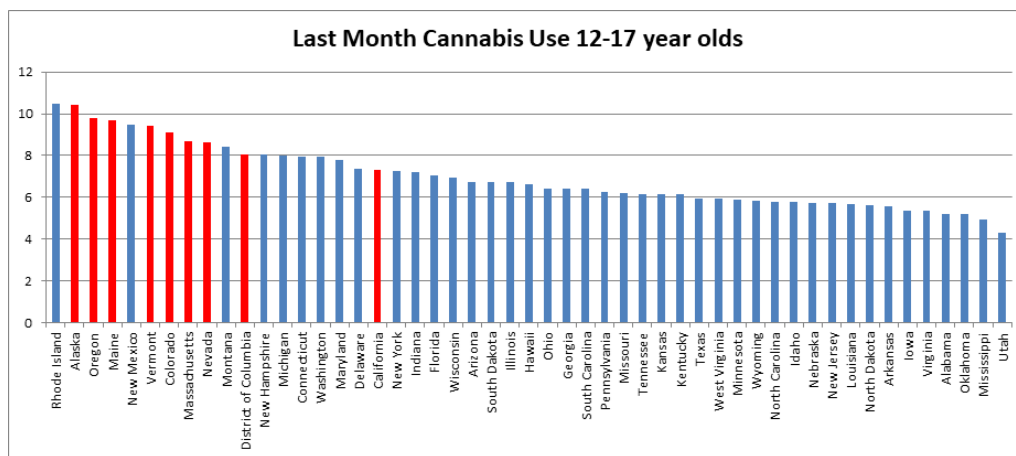
Past Month Usage, 12 to 17 Years Old, 2013/2014



SOURCE: SAMHSA.gov, National Survey on Drug Use and Health 2013 and 2014

NOTE: \*Oregon and Alaska voted to legalize recreational marijuana in November 2014  
\*\*States that had legislation for medical marijuana signed into effect during 2014

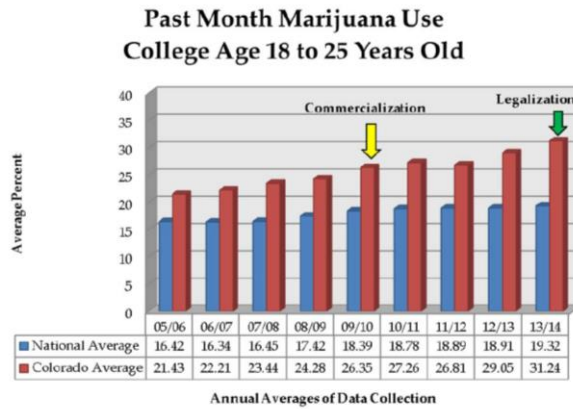
In the following 2 year period, drug use fell such that Colorado recent use for this age group fell to 7<sup>th</sup> in the nation. This was because other states had legalised cannabis in the intervening years, and Colorado was passed by states most of which had legalised cannabis use or were in the process of doing so. Below is the graph for all states with those states that had legalised cannabis by 2016 in red, or where legalisation legislation was already in process.



The most likely explanation for the marked decreases for this age-group is that they are under the institutional control of schools, whereas older age-groups are not subject to similar kinds of institutional control.

### College-age use rose by 17%

Against increases of 2% nationally, use of cannabis by those of college age rose by 17% within the first year of legalised cannabis use.



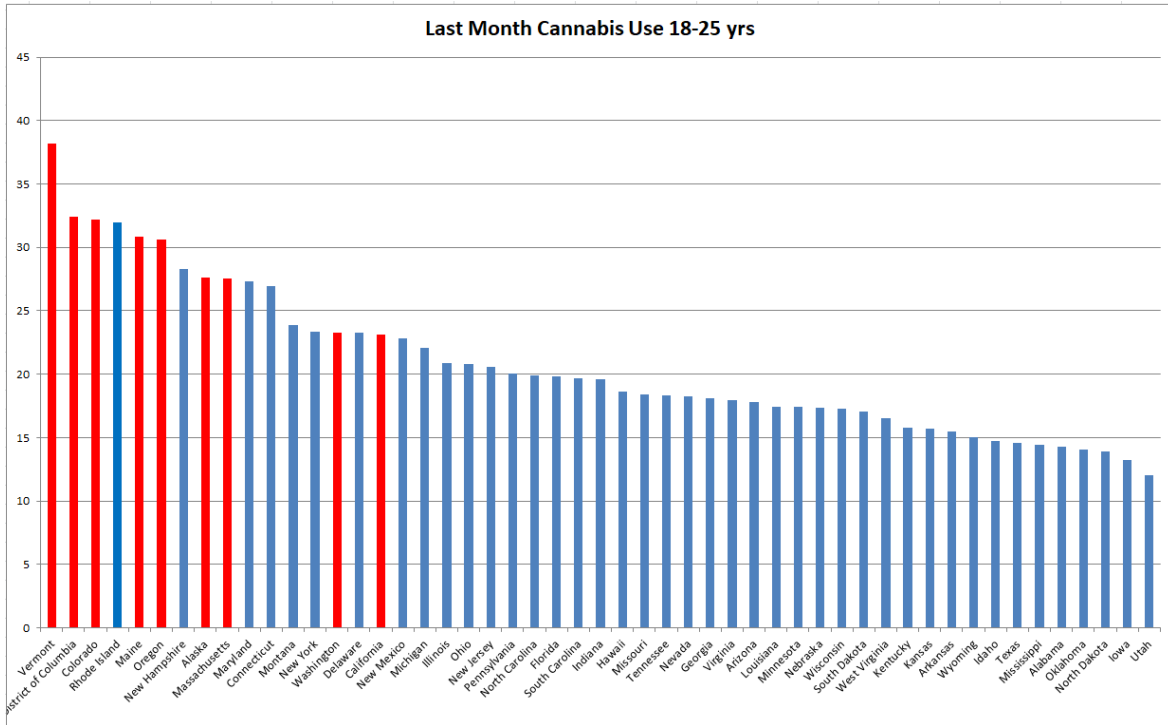
SOURCE: SAMHSA.gov, National Survey on Drug Use and Health 2013 and 2014

In 2013/14 Colorado college-age students ranked #1 for cannabis use in the United States, up from #3 in 2011/12 and from #8 in 2005/6.

### Past Month Usage, 18 to 25 Years Old, 2013/2014



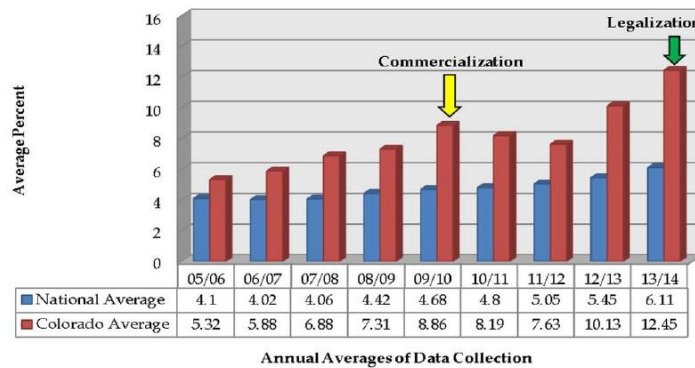
In 2015/16 against increases of 6% nationally, use of cannabis by those of college age rose by 3% (from 31.24% to 32.20%) between 2013/2014 and 2015/2016. In 2015/2016 Colorado college-age students ranked #3 for cannabis use in the United States. States ranking #1 (Vermont) and #2 (District of Columbia) were states that had legalised cannabis or were in the process of legalising (denoted by red below).



### Adult use rose by 63%

Adult use increased by an alarming 63% in the first year after legalisation against increases of 21% nationally.

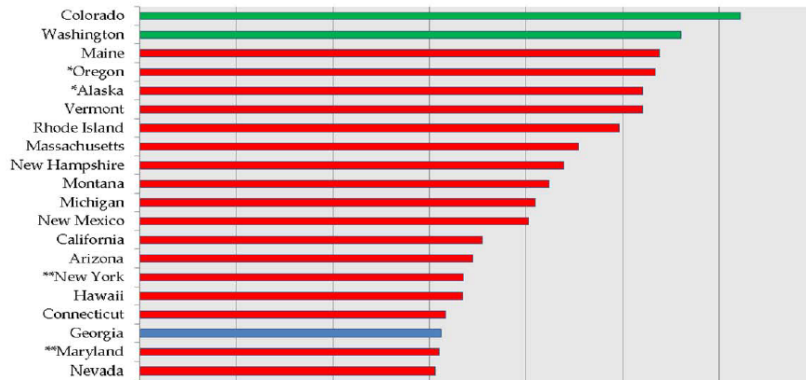
### Past Month Marijuana Use Adults Age 26+ Years Old



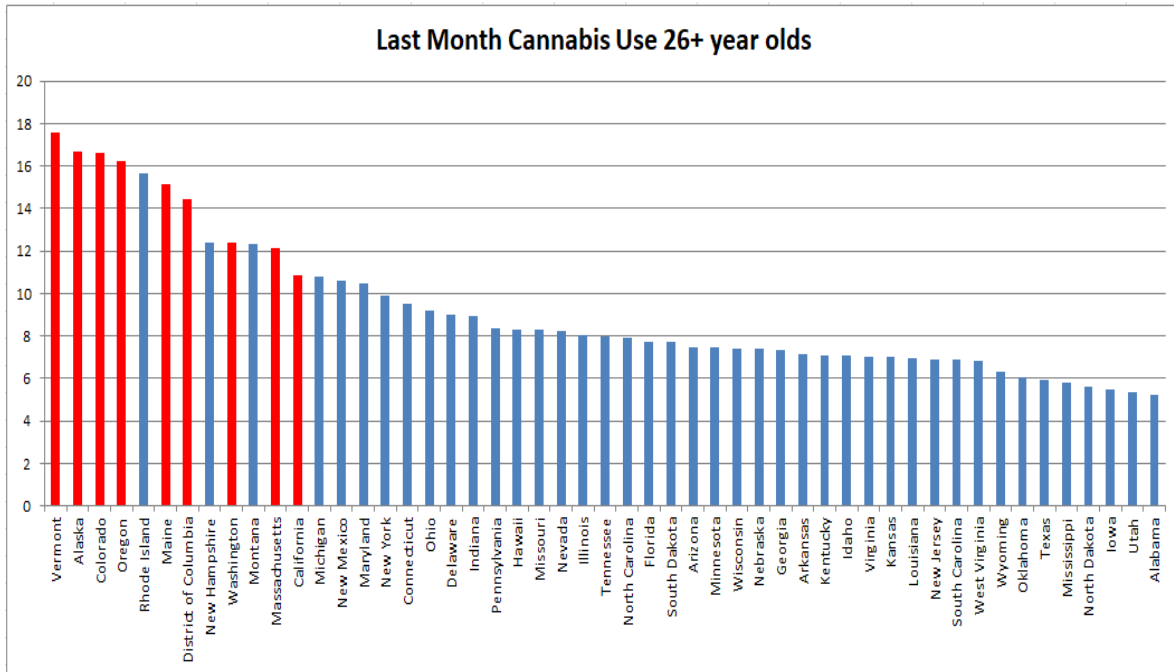
SOURCE: SAMHSA.gov, National Survey on Drug Use and Health 2013 and 2014.

In 2013/14 Colorado adults ranked #1 for cannabis use in the United States, up from #7 in 2011/12 and from #8 in 2005/6. States marked red are those states that had legalised cannabis for medical use.

Past Month Usage, 26+ Years Old, 2013/2014



In 2015/16 adult use increased by 33% (from 12.45% - 16.62%) against increases of 49% nationally. In 2015/2016 Colorado adults ranked #3 in the United States. The impact of various states legalising cannabis can be seen on the United States' skyrocketing consumption. States ranking #1 (Vermont) and #2 (Alaska) ahead of Colorado were states which had legalised cannabis or were in the process of legalising (denoted by red below).



Cannabis legalisation, as has been graphically shown, creates considerably more use, not less use as Australians want.

## Cannabis-related road fatalities rose by 62%

Road fatalities related to cannabis use rose by 62%, from 71 to 115 persons in the two years following 2014 when recreational cannabis use was legalised.

Traffic Deaths Related to Marijuana*			
Crash Year	Total Statewide Fatalities	Fatalities with Operators Testing Positive for Marijuana	Percentage Total Fatalities (Marijuana)
2006	535	37	6.92%
2007	554	39	7.04%
2008	548	43	7.85%
2009	465	47	10.10%
2010	450	49	10.89%
2011	447	63	14.09%
2012	472	78	16.53%
2013	481	71	14.76%
2014	488	94	19.26%
2015	547	115	21.02%

\*Fatalities Involving Operators Testing Positive for Marijuana

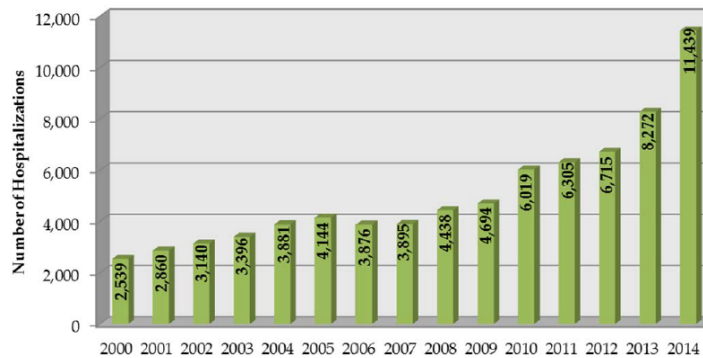
SOURCE: National Highway Traffic Safety Administration, Fatality Analysis Reporting System (FARS)

## Hospitalisations related to cannabis use rose markedly

The number of hospitalisations likely related to cannabis increased 32% in the two year average (2013-14) since Colorado legalised recreational marijuana compared to the two-year average prior to legalisation (2011-2012).

Hospitalisations moved from 6,715 to 11,439 since 2013.

### Hospitalizations Related to Marijuana



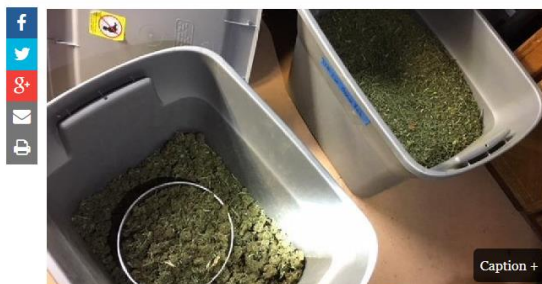
SOURCE: Colorado Hospital Association, Hospital Discharge Dataset. Statistics prepared by the Health Statist and Evaluation Branch, Colorado Department of Public Health and Environment

## Legislation introduced to cut black market criminality

Governor Hickenlooper introduced House Bill 1221 in 2017 to address the 380% rise in arrests for black market grows between 2014 and 2016 – see below.

### 📰 Collateral Impact: The Unintended Consequences of the Legalization of Pot

By: David Olinger, Special to The Gazette · February 17, 2018 · Updated: February 22, 2018 at 2:34 pm



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Four years after legal recreational marijuana went on sale in Colorado, Gov. John Hickenlooper says the black market for marijuana in the state is shrinking and predicted that it "will be largely gone" in a few years.

But new statistics show that arrests for the production of black market pot increased by 380 percent in the 2014-16 time frame, and Colorado law enforcement agencies say they are battling a boom in illegal marijuana cultivation by sometimes violent groups of criminals who rake in millions of dollars by exporting what they grow.



#### Related:

- 📰 Collateral Impact: Study finds Colorado marijuana dispensaries are giving bad advice to pregnant women
- 📰 One Colorado Springs school district among top 10 in state for most marijuana incidents reported
- 📰 Collateral Impact: Colorado schools on front line as debate swirls over legalization's effect on teens' pot use
- 📰 CSU-Pueblo researchers study links between marijuana and community violence

<http://gazette.com/collateral-impact-the-unintended-consequences-of-the-legalisation-of-pot/article/1621232>

House Bill 1220 would aid law enforcement in detecting black market operations and might eliminate Colorado's dubious distinction as the best place in North America to produce pot for widespread distribution. It would limit grows on residential property to 12 plants, with an exception for medical marijuana patients or primary caregivers in compliance with local laws that allow exceptions.

House Bill 1221 would establish an annual \$6 million grant program to reimburse local governments for training, education and enforcement related to black market grows. These bills may not go far enough, and the \$6 million in HB 1221 does not approach what local authorities need. But the two bills are a good start in what should be an urgent effort to stop the unseemly and dangerous proliferation of black market pot.

<http://gazette.com/editorial-pass-bills-to-curb-black-market-marijuana-in-colorado/article/1598339>

## Colorado added 245,000 extra cannabis users in 5 years

From 2010, when Colorado introduced the commercialisation of medical cannabis (with an explosion of medical cannabis user numbers) to 2015, the state added 245,000 extra frequent cannabis users. This is a **43% increase** in cannabis use during those years for all surveyed age-groups.

Year	Population	Frequent Users
2010	5,029,196	573,919
2015	5,448,055	819,179
Change		245,260

### **245,000 extra users became susceptible to these cannabis harms**

While the harms of cannabis have not been studied for as many years as the harms of tobacco and alcohol, it is already well-established that cannabis combines the harms of intoxication from alcohol with the particulate damage of tobacco. Cannabis presents a wide variety of additional harms which are detailed in Section 4.



## CENTRAL ISSUES FOR THE SENATE INQUIRY – 3

### **De facto legalised recreational use has been the result of lax medical cannabis laws in the US - Australia must avoid the same**

The US has witnessed a medical cannabis rort where recreational users feign chronic pain maladies to access high quality cannabis availability thereby effectively 'legalising' the constant use of cannabis for what is in reality only recreational use. Australia must do everything in its power to avoid this recreational user pathway

In light of 86% of Australians not approving of recreational cannabis use, the legalisation of cannabis for recreational use in Colorado and other US States gives voluminous evidence on why the Federal Government must ensure that medical cannabis is not used as a pathway to legalised recreational use in this country

### **Medical cannabis relatively ineffective for chronic pain**

Medical cannabis is chiefly used in Australia and the US for patients who claim that it is needed to combat chronic pain. **But the science is very clear that cannabis is relatively ineffective in and of itself for the alleviation of chronic pain.**

The most extensive 2018 review of the effectiveness of medical cannabis on chronic pain in the online medical journal *Pain* examined 103 journal studies comprising almost 10,000 chronic noncancer pain (CNCP) patients. The review found that at a 30% pain reduction threshold medical cannabis was only marginally more effective than placebo.

The conclusion for the study read as following,

It seems unlikely that cannabinoids are highly effective medicines for CNCP. There is moderate- to high-grade evidence supporting use of nabiximols to achieve modest reductions in pain as adjunctive therapy in MS-related pain. However, NNTBs were high and NNTHs low, with high rates of dropout for AEs, and long-term efficacy and safety is unknown. We also found minimal evidence that cannabinoids are effective in improving other important domains in people with CNCP such as emotional and physical functioning. **Cannabinoids are unlikely to be a**

**monotherapy for CNCP.** People living with CNCP often have complex comorbidities,<sup>9,70</sup> and multidisciplinary treatment that includes physical and psychological therapy rather than reliance on medicines alone is likely to be most effective.

Clearly, this extensive study found that cannabis is useful only as an adjunct therapy. This has major implications for prescribing, as well as for the TGA oversight of applications within Australia.

Systematic Reviews and Meta-Analyses

**PAIN**



**Cannabis and cannabinoids for the treatment of people with chronic noncancer pain conditions: a systematic review and meta-analysis of controlled and observational studies**

Emily Stockings<sup>a,\*</sup>, Gabrielle Campbell<sup>a</sup>, Wayne D. Hall<sup>b,c</sup>, Suzanne Nielsen<sup>a</sup>, Dino Zagic<sup>a</sup>, Rakin Rahman<sup>a</sup>, Bridin Murnion<sup>d,e</sup>, Michael Farrell<sup>a</sup>, Megan Weier<sup>a</sup>, Louisa Degenhardt<sup>a</sup>

**Abstract**

This review examines evidence for the effectiveness of cannabinoids in chronic noncancer pain (CNCP) and addresses gaps in the literature by: considering differences in outcomes based on cannabinoid type and specific CNCP condition; including all study designs; and following IMMPACT guidelines. MEDLINE, Embase, PsycINFO, CENTRAL, and clinicaltrials.gov were searched in July 2017. Analyses were conducted using Revman 5.3 and Stata 15.0. A total of 91 publications containing 104 studies were eligible (n = 9958 participants), including 47 randomised controlled trials (RCTs) and 57 observational studies. Forty-eight studies examined neuropathic pain, 7 studies examined fibromyalgia, 1 rheumatoid arthritis, and 48 other CNCP (13 multiple sclerosis-related pain, 6 visceral pain, and 29 samples with mixed or undefined CNCP). Across RCTs, pooled event rates (PERs) for 30% reduction in pain were 29.0% (cannabinoids) vs 25.9% (placebo); significant effect for cannabinoids was found; number needed to treat to benefit was 24 (95% confidence interval [CI] 15-61); for 50% reduction in pain, PERs were 18.2% vs 14.4%; no significant difference was observed. Pooled change in pain intensity (standardised mean difference: -0.14, 95% CI -0.20 to -0.08) was equivalent to a 3 mm reduction on a 100 mm visual analogue scale greater than placebo groups. In RCTs, PERs for all-cause adverse events were 81.2% vs 66.2%; number needed to treat to harm: 6 (95% CI 5-8). There were no significant impacts on physical or emotional functioning, and low-quality evidence of improved sleep and patient global impression of change. Evidence for effectiveness of cannabinoids in CNCP is limited. Effects suggest that number needed to treat to benefit is high, and number needed to treat to harm is low, with limited impact on other domains. It seems unlikely that cannabinoids are highly effective medicines for CNCP.

**Keywords:** Cannabis, Chronic noncancer pain, Neuropathy, Systematic review, Meta-analysis, Number needed to treat

<https://doi.org/10.1186/s12916-018-1141-8>

**The US rort of claiming medical cannabis for pain**

US statistics show how recreational users have been able to use medical cannabis availability for self-reported 'pain' to feed their recreational use. For instance, 90% of medical cannabis patients in Arizona claim pain as their malady, while 4% use it for cancer.<sup>[i]</sup> In Colorado, it is 94% for pain and 3% for cancer,<sup>[ii]</sup> while in Oregon 94% claim to use it for pain.<sup>[iii]</sup> Only 2% of patients across 7 US states in 2014 used cannabis for verifiable illnesses such as AIDS wasting or MS.<sup>[iv]</sup>

<sup>[i]</sup> Arizona Department of Health Services (Apr. 14, 2011-Nov. 7, 2012) Arizona Medical Marijuana Act Monthly Report

<sup>[ii]</sup> Colorado Department of Public Health and Environment (Dec. 31, 2012) Medical Marijuana Registry Program Update

<sup>[iii]</sup> Oregon Health Authority (Oct. 1, 2014) "Oregon Medical Marijuana Program Statistics

<sup>[iv]</sup> Kevin Sabet et al. "Why do people use medical marijuana? The medical conditions of users in seven U.S. states" The Journal of Global Drug Policy and Practice (Volume 8, Issue 2 Summer 2014)

**Drug Free Australia notes that there are no laboratory tests for pain, which makes it a prime candidate for ruse and deception due to its subjective nature and the impossibility of objectively verifying or disproving it.**

There are well established profiles for patients of chronic pain across all Western countries, where patients are more predominantly women and those aged 60 and above. For instance, a 2001 study by Sydney University's Pain Management Research Centre found 54% of patients were women, with men suffering in their sixties and women in their eighties.<sup>[v]</sup>

**Yet the profile for medical cannabis pain patients in the USA is very different.** A 2007 study of 4,000 medical cannabis patients in California found that their average age was 32, three quarters were male and 90% had started using cannabis while teenagers,<sup>[vi]</sup> an identical age and gender profile to that of recreational users across the US.<sup>[vii]</sup>

**This discordant profile means that medical cannabis in the various states of the US has mainly amounted to a quasi-legalisation strategy for recreational use of cannabis via subterfuge and ruse.**

## **Inquiry must examine cannabis quantities prescribed for pain**

**This Federal Senate Inquiry must ask the question as to why medical cannabis is so popularly used for a condition for which it is relatively ineffective.** If medical cannabis in Australia is being used for feigned chronic pain as a way of accessing cannabis preparations for de facto legalised recreational use, then the quantities prescribed for pain may need regulatory body recommendations.

Drug Free Australia recommends that the Inquiry carefully reviews the quantities being prescribed for chronic pain and examine whether there is a similar possibility of rorting our systems as has happened in the US.

## **Diversion to minors for recreational use well documented in the US**

A problem that desperately needs to be assessed by this Inquiry is whether there is evidence of diversion of medical cannabis by adults to minors in this country. As part of this Inquiry drug rehabilitation centres need to be surveyed regarding minors accessing treatment for addiction, asking specifically where these young people are accessing their cannabis. With cannabis oils now being proliferated with the wider availability of medical cannabis, teens can use these oils with vape pens (despite this delivery method being illegal in Australia), or may gain access

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<sup>[v]</sup> Blyth et al. "Chronic Pain in Australia: A prevalence study" (Jan. 2001) Pain

<sup>[vi]</sup> Thomas J. O'Connell and Ché B Bou-Matar (Nov. 3, 2007) Long term marijuana users seeking medical cannabis in California (2001-2007): demographics, social characteristics, patterns of cannabis and other drug use of 4117 applicants. Harm Reduction Journal

<sup>[vii]</sup> Gogek, Ed (2015-08-03). Marijuana Debunked: A handbook for parents, pundits and politicians who want to know the case against legalization pp104.5. InnerQuest Books

to other preparations which can be used with bongs etc. This is a very important safeguard to implement

Below is the experience of Colorado after looser medical cannabis laws governing availability were introduced in 2009.

### 74% of rehab teens using diverted medical cannabis by 2012

*J Am Acad Child Adolesc Psychiatry.* 2012 July ; 51(7): 694–702. doi:10.1016/j.jaac.2012.04.004.

#### Medical Marijuana Use among Adolescents in Substance Abuse Treatment

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#### Abstract

**Objective**—To assess the prevalence and frequency of medical marijuana diversion and use among adolescents in substance abuse treatment and to identify factors related to their medical marijuana use.

**Method**—This study calculated the prevalence and frequency of diverted medical marijuana use among adolescents (N = 164), ages 14–18 ( $\bar{x}$  age = 16.09, SD = 1.12), in substance abuse treatment in the Denver metropolitan area. Bivariate and multivariate analyses were completed to determine factors related to adolescents' use of medical marijuana.

**Results**—Approximately 74% of the adolescents had used someone else's medical marijuana and they reported using diverted medical marijuana a median of 50 times. After adjusting for gender and race/ethnicity, adolescents who used medical marijuana had an earlier age of regular marijuana use, more marijuana abuse and dependence symptoms, and more conduct disorder symptoms compared to those who did not use medical marijuana.

**Conclusions**—Medical marijuana use among adolescent patients in substance abuse treatment is very common, implying substantial diversion from registered users. These results support the need for policy changes that protect against diversion of medical marijuana and reduce adolescent access to diverted medical marijuana. Future studies should examine patterns of medical marijuana diversion and use in general population adolescents.

## CENTRAL ISSUES FOR THE SENATE INQUIRY – 4

### **In any Australian calculus, the harms of cannabis use must always balance modest medical benefit**

**Cannabis is an addictive drug which causes psychosis, suicide, violence, vehicle deaths and a long list of other individual and social harms. Any medical benefit from the use of medical cannabis for any Australian individual must outweigh these harms, particularly when pot activists are agitating for a loosening of very reasonable and equitable regulatory requirements which are identical for all medicines within Australia**

### **Review indicates many harms but mostly only modest medical effectiveness**

The world's most extensive review of cannabis journal studies by the US National Institutes of Health (NIH) (previously the Institute of Medicine [IOM]) indicates that there are many harms accruing from the use of cannabis, while there are a handful of evidenced uses for medical conditions.

It is the harms of cannabis that make government regulation of cannabis necessarily rigorous. These harms include:

- Cannabis is an established gateway to other dangerous drugs, adding an additional gateway beyond the two existing legal drugs
- Cannabis users are 50% more likely to develop alcohol use disorder
- Cannabis use is associated with a doubling the chance of psychosis
- Cannabis use is associated with a greater risk of depression
- Cannabis is associated with Amotivational Syndrome
- Cannabis use is associated with a 3 fold risk of suicidal ideation
- VIOLENCE AND AGGRESSION are a documented part of its withdrawal syndrome
- Brain Function
  - Verbal learning is adversely affected
  - Organisational skills are adversely affected
  - Cannabis causes loss of coordination
  - Associated memory loss can become permanent
  - Cannabis is associated with attention problems
- Drivers are 16 times more likely to hit obstacles
- Miscarriage is elevated with cannabis use
- Fertility is adversely affected

- Newborns are adversely affected with appearance, weight, size, hormonal function, cognition and motor function adversely affected through to adulthood
- Cannabis use causes bronchitis
- Testicular cancer is associated with cannabis use
- Cannabis is also associated with cardio-vascular stroke and heart attack, with chance of myocardial infarction 5 times higher after one joint

On the other hand, cannabis has been shown to alleviate the following conditions, however for anything other than epilepsy-like syndromes, the effects are modest, where up to a dozen other available medications are often preferred by patients above medical cannabis.

As per the summary from the 468 page NIH review below, these conditions are:

1. **Chronic pain – modest effect only**
2. **Nausea**
3. **Multiple Sclerosis (MS) – modest effect only**
4. **AIDS wasting**
5. **Tourette Syndrome**
6. **Post Traumatic Stress Disorder (PTSD)**
7. **Traumatic brain injury, intracranial haemorrhage**
8. **Childhood Epilepsy** (these latter conditions were confirmed in US Epidiolex trials which were completed after the 2017 NIH review)

## **New medical indications must be part of a trial**

Drug Free Australia has historically supported the viability of medical cannabis in Australia on the proviso that any newly identified medical indications for cannabis are studied as part of a clinical trial, whether that be with lone individuals or cohorts.

It is imperative that this be the case, with many claims for cannabis previously evaporating in the trial setting.

As with any other medicine in Australia, cannabis preparations must be subjected to the same rigour and be pharmaceutically standardised in terms of dose, strength and purity. Anything less is to make exceptions for an addictive and otherwise dangerous substance.

Cannabis preparations must continue to be subject to the strictures the TGA applies to any other medicine in this country.

**Following pages – US National Institutes of Health 2017 review on cannabis studies - Annex**

**ANNEX**

**Report Conclusions<sup>5</sup>**

*Chapter 4 Conclusions—Therapeutic Effects of Cannabis and Cannabinoids*

**There is conclusive or substantial evidence that cannabis or cannabinoids are effective:**

- For the treatment of chronic pain in adults (cannabis) (4-1)
- As antiemetics in the treatment of chemotherapy-induced nausea and vomiting (oral cannabinoids) (4-3)
- For improving patient-reported multiple sclerosis spasticity symptoms (oral cannabinoids) (4-7a)

**There is moderate evidence that cannabis or cannabinoids are effective for:**

- Improving short-term sleep outcomes in individuals with sleep disturbance associated with obstructive sleep apnea syndrome, fibromyalgia, chronic pain, and multiple sclerosis (cannabinoids, primarily nabiximols) (4-19)

**There is limited evidence that cannabis or cannabinoids are effective for:**

- Increasing appetite and decreasing weight loss associated with HIV/AIDS (cannabis and oral cannabinoids) (4-4a)
- Improving clinician-measured multiple sclerosis spasticity symptoms (oral cannabinoids) (4-7a)
- Improving symptoms of Tourette syndrome (THC capsules) (4-8)
- Improving anxiety symptoms, as assessed by a public speaking test, in

- individuals with social anxiety disorders (cannabidiol) (4-17)
- Improving symptoms of posttraumatic stress disorder (nabilone; a single, small fair-quality trial) (4-20)

**There is limited evidence of a statistical association between cannabinoids and:**

- Better outcomes (i.e., mortality, disability) after a traumatic brain injury or intracranial hemorrhage (4-15)

**There is limited evidence that cannabis or cannabinoids are ineffective for:**

- Improving symptoms associated with dementia (cannabinoids) (4-13)
- Improving intraocular pressure associated with glaucoma (cannabinoids) (4-14)
- Reducing depressive symptoms in individuals with chronic pain or multiple sclerosis (nabiximols, dronabinol, and nabilone) (4-18)

**There is no or insufficient evidence to support or refute the conclusion that cannabis or cannabinoids are an effective treatment for:**

- Cancers, including glioma (cannabinoids) (4-2)
- Cancer-associated anorexia cachexia syndrome and anorexia nervosa (cannabinoids) (4-4b)
- Symptoms of irritable bowel syndrome (dronabinol) (4-5)
- Epilepsy (cannabinoids) (4-6)
- Spasticity in patients with paralysis due to spinal cord injury (cannabinoids) (4-7b)
- Symptoms associated with amyotrophic lateral sclerosis (cannabinoids) (4-9)
- Chorea and certain neuropsychiatric symptoms associated with Huntington's disease (oral cannabinoids) (4-10)

- Motor system symptoms associated with Parkinson's disease or the levodopa-induced dyskinesia (cannabinoids) (4-11)
- Dystonia (nabilone and dronabinol) (4-12)
- Achieving abstinence in the use of addictive substances (cannabinoids) (4-16)
- Mental health outcomes in individuals with schizophrenia or schizophreniform psychosis (cannabidiol) (4-21)

*Chapter 5 Conclusions—Cancer*

**There is moderate evidence of *no* statistical association between cannabis use and:**

- Incidence of lung cancer (cannabis smoking) (5-1)
- Incidence of head and neck cancers (5-2)

**There is limited evidence of a statistical association between cannabis smoking and:**

- Non-seminoma-type testicular germ cell tumors (current, frequent, or chronic cannabis smoking) (5-3)

**There is no or insufficient evidence to support or refute a statistical association between cannabis use and:**

- Incidence of esophageal cancer (cannabis smoking) (5-4)
- Incidence of prostate cancer, cervical cancer, malignant gliomas, non-Hodgkin lymphoma, penile cancer, anal cancer, Kaposi's sarcoma, or bladder cancer (5-5)
- Subsequent risk of developing acute myeloid leukemia/ acute non-

- lymphoblastic leukemia, acute lymphoblastic leukemia, rhabdomyosarcoma, astrocytoma, or neuroblastoma in offspring (parental cannabis use) (5-6)

*Chapter 6 Conclusions—Cardiometabolic Risk*

**There is limited evidence of a statistical association between cannabis use and:**

- The triggering of acute myocardial infarction (cannabis smoking) (6-1a)
- Ischemic stroke or subarachnoid hemorrhage (6-2)
- Decreased risk of metabolic syndrome and diabetes (6-3a)
- Increased risk of prediabetes (6-3b)

**There is no evidence to support or refute a statistical association between *chronic effects* of cannabis use and:**

- The increased risk of acute myocardial infarction (6-1b)

*Chapter 7 Conclusions—Respiratory Disease*

**There is substantial evidence of a statistical association between cannabis smoking and:**

- Worse respiratory symptoms and more frequent chronic bronchitis episodes (long-term cannabis smoking) (7-3a)



**There is moderate evidence of a statistical association between cannabis smoking and:**

- Improved airway dynamics with acute use, but not with chronic use (7-1a)
- Higher forced vital capacity (FVC) (7-1b)

**There is moderate evidence of a statistical association between the cessation of cannabis smoking and:**

- Improvements in respiratory symptoms (7-3b)

**There is limited evidence of a statistical association between cannabis smoking and:**

- An increased risk of developing chronic obstructive pulmonary disease (COPD) when controlled for tobacco use (occasional cannabis smoking) (7-2a)

**There is no or insufficient evidence to support or refute a statistical association between cannabis smoking and:**

- Hospital admissions for COPD (7-2b)
- Asthma development or asthma exacerbation (7-4)

*Chapter 8 Conclusions—Immunity*

**There is limited evidence of a statistical association between cannabis smoking and:**

- A decrease in the production of several inflammatory cytokines in healthy individuals (8-1a)

**There is limited evidence of no statistical association between cannabis use and:**

- The progression of liver fibrosis or hepatic disease in individuals with viral hepatitis C (HCV) (daily cannabis use) (8-3)

**There is no or insufficient evidence to support or refute a statistical association between cannabis use and:**

- Other adverse immune cell responses in healthy individuals (cannabis smoking) (8-1b)
- Adverse effects on immune status in individuals with HIV (cannabis or dronabinol use) (8-2)
- Increased incidence of oral human papilloma virus (HPV) (regular cannabis use) (8-4)

*Chapter 9 Conclusions—Injury and Death*

**There is substantial evidence of a statistical association between cannabis use and:**

- Increased risk of motor vehicle crashes (9-3)

**There is moderate evidence of a statistical association between cannabis use and:**

- Increased risk of overdose injuries, including respiratory distress,

among pediatric populations in U.S. states where cannabis is legal (9-4b)

**There is no or insufficient evidence to support or refute a statistical association between cannabis use and:**

- All-cause mortality (self-reported cannabis use) (9-1)
- Occupational accidents or injuries (general, nonmedical cannabis use) (9-2)
- Death due to cannabis overdose (9-4a)

*Chapter 10 Conclusions—Prenatal, Perinatal, and Neonatal Exposure*

**There is substantial evidence of a statistical association between maternal cannabis smoking and:**

- Lower birth weight of the offspring (10-2)

**There is limited evidence of a statistical association between maternal cannabis smoking and:**

- Pregnancy complications for the mother (10-1)
- Admission of the infant to the neonatal intensive care unit (NICU) (10-3)

**There is insufficient evidence to support or refute a statistical association between maternal cannabis smoking and:**

- Later outcomes in the offspring (e.g., sudden infant death syndrome, cognition/academic achievement, and later substance use) (10-4)

*Chapter 11 Conclusions—Psychosocial*

**There is moderate evidence of a statistical association between cannabis use and:**

- The impairment in the cognitive domains of learning, memory, and attention (acute cannabis use) (11-1a)

**There is limited evidence of a statistical association between cannabis use and:**

- Impaired academic achievement and education outcomes (11-2)
- Increased rates of unemployment and/or low income (11-3)
- Impaired social functioning or engagement in developmentally appropriate social roles (11-4)

**There is limited evidence of a statistical association between sustained abstinence from cannabis use and:**

- Impairments in the cognitive domains of learning, memory, and attention (11-1b)

*Chapter 12 Conclusions—Mental Health*

**There is substantial evidence of a statistical association between cannabis use and:**

- The development of schizophrenia or other psychoses, with the highest risk among the most frequent users (12-1)

**There is moderate evidence of a statistical association between cannabis use and:**

- Better cognitive performance among individuals with psychotic disorders and a history of cannabis use (12-2a)
- Increased symptoms of mania and hypomania in individuals diagnosed with bipolar disorders (regular cannabis use) (12-4)
- A small increased risk for the development of depressive disorders (12-5)
- Increased incidence of suicidal ideation and suicide attempts with a higher incidence among heavier users (12-7a)
- Increased incidence of suicide completion (12-7b)
- Increased incidence of social anxiety disorder (regular cannabis use) (12-8b)

**There is moderate evidence of *no* statistical association between cannabis use and:**

- Worsening of negative symptoms of schizophrenia (e.g., blunted affect) among individuals with psychotic disorders (12-2c)

**There is limited evidence of a statistical association between cannabis use and:**

- An increase in positive symptoms of schizophrenia (e.g., hallucinations) among individuals with psychotic disorders (12-2b)
- The likelihood of developing bipolar disorder, particularly among regular or daily users (12-3)
- The development of any type of anxiety disorder, except social anxiety disorder (12-8a)
- Increased symptoms of anxiety (near daily cannabis use) (12-9)
- Increased severity of posttraumatic stress disorder symptoms among

individuals with posttraumatic stress disorder (12-11)

**There is no evidence to support or refute a statistical association between cannabis use and:**

- Changes in the course or symptoms of depressive disorders (12-6)
- The development of posttraumatic stress disorder (12-10)

*Chapter 13 Conclusions—Problem Cannabis Use*

**There is substantial evidence that:**

- Stimulant treatment of attention deficit hyperactivity disorder (ADHD) during adolescence is *not* a risk factor for the development of problem cannabis use (13-2e)
- Being male and smoking cigarettes are risk factors for the progression of cannabis use to problem cannabis use (13-2i)
- Initiating cannabis use at an earlier age is a risk factor for the development of problem cannabis use (13-2j)

**There is substantial evidence of a statistical association between:**

- Increases in cannabis use frequency and the progression to developing problem cannabis use (13-1)
- Being male and the severity of problem cannabis use, but the recurrence of problem cannabis use does not differ between males and females (13-3b)

**There is moderate evidence that:**

- Anxiety, personality disorders, and bipolar disorders are *not* risk factors

for the development of problem cannabis use (13-2b)

- Major depressive disorder is a risk factor for the development of problem cannabis use (13-2c)
- Adolescent ADHD is *not* a risk factor for the development of problem cannabis use (13-2d)
- Being male is a risk factor for the development of problem cannabis use (13-2f)
- Exposure to the combined use of abused drugs is a risk factor for the development of problem cannabis use (13-2g)
- Neither alcohol nor nicotine dependence alone are risk factors for the progression from cannabis use to problem cannabis use (13-2h)
- During adolescence the frequency of cannabis use, oppositional behaviors, a younger age of first alcohol use, nicotine use, parental substance use, poor school performance, antisocial behaviors, and childhood sexual abuse are risk factors for the development of problem cannabis use (13-2k)

**There is moderate evidence of a statistical association between:**

- A persistence of problem cannabis use and a history of psychiatric treatment (13-3a)
- Problem cannabis use and increased severity of posttraumatic stress disorder symptoms (13-3c)

**There is limited evidence that:**

- Childhood anxiety and childhood depression are risk factors for the development of problem cannabis use (13-2a)

*Chapter 14 Conclusions—Cannabis Use and the Abuse of Other Substances*

**There is moderate evidence of a statistical association between cannabis use and:**

- The development of substance dependence and/or a substance abuse disorder for substances, including alcohol, tobacco, and other illicit drugs (14-3)

**There is limited evidence of a statistical association between cannabis use and:**

- The initiation of tobacco use (14-1)
- Changes in the rates and use patterns of other licit and illicit substances (14-2)

*Chapter 15 Conclusions—Challenges and Barriers in Conducting Cannabis Research*

**There are several challenges and barriers in conducting cannabis and cannabinoid research, including**

- There are specific regulatory barriers, including the classification of cannabis as a Schedule I substance, that impede the advancement of cannabis and cannabinoid research (15-1)
- It is often difficult for researchers to gain access to the quantity, quality, and type of cannabis product necessary to address specific research questions on the health effects of cannabis use (15-2)
- A diverse network of funders is needed to support cannabis and cannabinoid research that explores the beneficial and harmful health effects of cannabis use (15-3)
- To develop conclusive evidence for the effects of cannabis use on short-

and long-term health outcomes, improvements and standardization in research methodology (including those used in controlled trials and observational studies) are needed (15-4)

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<sup>1</sup> As of March 2016, the Health and Medicine Division continues the consensus studies and convening activities previously carried out by the Institute of Medicine (IOM).

<sup>2</sup> See <https://www.nap.edu/search/?year=1995&rpp=20&ft=1&term=marijuana> (accessed January 5, 2017).

<sup>3</sup> *Adverse Effects of Vaccines: Evidence and Causality* (IOM, 2012); *Treatment of Post-traumatic Stress Disorder: An Assessment of the Evidence* (IOM, 2008); *Veterans and Agent Orange: Update 2014* (NASEM, 2016).

<sup>4</sup> Agencies may include the CDC, relevant agencies of the National Institutes of Health (NIH), and the U.S. Food and Drug Administration (FDA).

<sup>5</sup> Numbers in parentheses correspond to chapter conclusion numbers.

## CENTRAL ISSUES FOR THE SENATE INQUIRY – 5

### The UK recognises the limitations of cannabis on chronic pain and advises it only as a last resort

#### UK more conservative than Australia on demonstrated benefits

Because the United Kingdom's public is better versed in the real harms of cannabis due to a more proactive BBC, the UK takes a more conservative stance on cannabis, insisting on the rigour of clinical trials for any medical indication, with no access to medical cannabis without a trial.

Drug Free Australia has previously recommended a similar Australian regulatory skepticism to that of the UK in regards to requests for medical cannabis as a sole treatment for chronic pain. The UK approach is explained in the media article below.

As per <https://www.christian.org.uk/news/doctors-told-dont-give-out-cannabis-based-drugs-for-chronic-pain/>,

#### **Doctors told: Don't give out cannabis-based drugs for chronic pain**

Cannabis-based drugs should not be prescribed to manage chronic pain, draft official guidance says.

The National Institute for Health and Care Excellence (NICE) made the draft recommendation after finding the "potential benefits offered were small compared with the high and ongoing costs".

The guidance follows concerns about medical cannabis from senior medical experts including the head of NHS England.

#### ***None recommended***

NICE said its recommendations were focused on understanding the drugs' safety and cost effectiveness.

It considered the use of cannabis-based products for chronic pain, spasticity in people with multiple sclerosis, chemotherapy-induced nausea and severe epilepsy.

While it did recommend considering one such drug for a specific type of vomiting, [no cannabis-based drugs were recommended for pain or spasticity](#). NICE called for more research on epilepsy.

***'Lacking'***

Paul Chrisp, a senior director at NICE, said before the analysis the organisation believed a “robust evidence base for these mostly unlicensed products was probably lacking”.

“Having now considered all the available evidence it’s therefore not surprising that the committee has not been able to make many positive recommendations about their use.”

Dr Keith Ridge, Chief Pharmaceutical Officer at NHS England, said related recommendations released by the NHS “aim to help us develop the evidence base to understand how safe these products are”.

***'Mistake'***

In May, the head of NHS England warned that medical cannabis risks “normalising drug use” in the UK.

Simon Stevens said: “I think we have to be careful, as we have a legitimate national debate on medical cannabis, that we don’t look back in a decade’s time and wonder whether we inadvertently made a big mistake.”

Dame Sally Davies, England’s Chief Medical Officer, warned in March that people believed medicinal cannabis can cure multiple illnesses but it should only be prescribed as a “last resort”.

## CENTRAL ISSUES FOR THE SENATE INQUIRY – 6

**Current costs of using medical cannabis are directly comparable to costs when it was illegally obtained**

### **Cost of pharmaceutical cannabinoids identical to illegal cannabis in Australia**

The cost of cultivated **crude** cannabis in the United States for medical cannabis patients was about \$500 per month as is reflected by NORML in the US in its 2009 Recommendations to the Obama Administration on marijuana dispensaries, which stated that,

There is little doubt as to why cannabis dispensaries are multiplying at such a rate. The price of cannabis in dispensaries ranges from \$12.50 to \$25 per gram (28 grams per ounce). The average “medical” user with a chronic medical condition may consume from 1.5 to 3.0 grams per day.<sup>31</sup> Therefore, the monthly cost to patients **ranges from \$562 (1.5 grams/day at \$12.50/gm) to \$2,250 (3 grams/day at \$25/gm)**. Since the herbal cannabis, which is of varying strains and quality, has not received FDA approval, none of this expense is covered by a patient’s health insurance, and there is no assurance of quality control or accurate dosage information.  
[http://norml.org/pdf\\_files/Marijuana\\_Dispensaries\\_Recommendations.pdf](http://norml.org/pdf_files/Marijuana_Dispensaries_Recommendations.pdf)

**This presents the same cost to patients as purchasing illegal cannabis from a dealer, which in 2015, before medical cannabis legislation was completed in Australia, was between \$12.00 and \$12.50 a gram.**

Sativex, by comparison, cost on average \$500 per month for New Zealanders back at that time - see page 38 of the NSW General Purpose Standing Committee No. 4 Report – The Use of Cannabis for Medical Purposes.  
[http://www.parliament.nsw.gov.au/prod/parlment/committee.nsf/0/fdb7842246a5ab71ca257b6c0002f09b/\\$file/final%20report%20-%20the%20use%20of%20cannabis%20for%20medical%20purposes.pdf](http://www.parliament.nsw.gov.au/prod/parlment/committee.nsf/0/fdb7842246a5ab71ca257b6c0002f09b/$file/final%20report%20-%20the%20use%20of%20cannabis%20for%20medical%20purposes.pdf)

It is clear that any patient currently purchasing cannabis in Australia is paying no more than if they were purchasing illegally grown cannabis. Drug Free Australia recommends that the Federal Government not be misled about the comparability of medical cannabis costs.



## **Cost must be brought down via efficiencies, but not by relativising TGA standards**

The current call by cannabis activists is to relativise TGA standards for the sake of cutting costs. Such a call would never be acceptable for any other medicine available in Australia and should be rejected on that ground alone.

Illegal tinctures and oils already abound despite the legal provision of medical cannabis, but those who provide them are not bound to quality control or the higher costs of regulation and security, nor of clinical trials, which is entirely unfair to those companies that abide by the regulatory frameworks. The Australian Government is bound to defend those abiding by law, and the TGA should pursue any illegal manufacture of medical cannabis products being sold to Australians.

Federal and State governments should nevertheless attempt to reduce costs via efficiencies and economies of scale, but never relativise regulations and rigour where they currently exist.

## CENTRAL ISSUES FOR THE SENATE INQUIRY – 7

### Cannabis clinics in Sydney agree there are no major impediments to obtaining medical cannabis

#### Access to medical cannabis adequate according to clinics

In mid-August 2019 Drug Free Australia spoke with the management of two cannabis clinics, one in the Sydney CBD and the other in North Sydney. Drug Free Australia also spoke with an in-house doctor of one of those clinics.

The discussions were in response to claims on the Channel 7 Sunday Night program early in August that medical cannabis was very difficult to access for needy Australians.

Responses from both clinics were the same, that access to medical cannabis was much improved over the previous 12 months, with streamlining of Federal and State requirements. To the question of what conditions would not pass muster with an Open Access application to the TGA the answer was that the TGA was very amenable if due cause could be demonstrated and they expected no problem for any verifiable condition. The clinics agreed that the bar was not set too high in their estimation. Their advice was entirely at odds with the claims of the Channel 7 program, and this must be carefully noted by the Senate Inquiry.

Further discussion with one of the clinics highlighted the importance of having a patient's GP involved in the prescription of cannabis, given that a patient's GP best knows what other medications have been prescribed. This local GP information is vital to a clinic's onsite doctors who need to be very aware of negative interactions between medications, amongst other things. Drug Free Australia has previously warned against Australia adopting the 'pot doctor' approach of some US States, whereby 90% of prescriptions are written by a handful of doctors.

Drug Free Australia again urges that the Federal Government not be deterred from ensuring that cannabis is treated like every other medicine regulated by the TGA. **Attempts to relativise regulatory frameworks are in most instances going to be driven by pot activists whose endgame goal is the legalisation of home-grown cannabis for medical purposes, with the longer term goal of legalised recreational use.**

## **RECOMMENDATIONS**

- 1. That the Senate Inquiry ensure there is no loosening of any requirement for medical cannabis to meet the same TGA standards as any other medicine within Australia. Efforts to relativise TGA guidelines are in many cases intentioned attempts to provide a pathway to recreational use under the guise of medical use – see p7ff**
- 2. That the Senate Inquiry examine the number of approvals of medical cannabis for chronic pain in light of cannabis' ineffectiveness as a sole therapy for chronic pain, and that it also review the quantities prescribed for chronic pain to ascertain whether there is a similar possibility of rorting our systems as has occurred in the US – see p16ff**
- 3. That the Senate Inquiry establish a reporting system for all drug rehabilitation centres nationwide, whereby all minors entering rehab for cannabis addiction are asked how they obtained their cannabis. If, as in the USA, large percentages of minors are obtaining diverted medical cannabis for recreational use, that the Senate Inquiry seek proper remedies – see p18**
- 4. That the Senate Inquiry review the UK approach to chronic pain with a view to suggesting better approaches in Australia – see p29**
- 5. That the Senate Inquiry survey the street costs of purchasing illicit raw cannabis leaf/bud and compare this to the costs of pharmaceutical preparations of medical cannabis – see p31**
- 6. That the Senate Inquiry make direct representations to cannabis clinics about the accessibility of medical cannabis for verifiable conditions via the TGA Special Access provision – see p33**