IT’S NOT ABOUT COMPASSION

NSW’s Legalisation of Marijuana as Medicine

Drug Free Australia

DRUG FREE AUSTRALIA

NSW's Legalisation of Marijuana as Medicine

Summary of Concerns

Drug Free Australia questions why the NSW Working Party on the Use of Cannabis for Medicinal Purposes:

is responding to the agenda of the well-funded drug legalisation lobby which is working towards the defeat of the United Nations Conventions against illicit drugs via incremental changes which include the legalisation of marijuana for medical purposes, marijuana decriminalisation, heroin injecting rooms and heroin on prescription

is subverting the Federal requirement that no medicinal substance can be made available unless it has first been scientifically shown to be both safe and effective, particularly when smoked marijuana has never been scientifically shown to be a safe effective medicine for the treatment of any condition

is elevating questionable subjective anecdotal evidence over evidence-based medicine while simultaneously espousing a commitment to evidence-based research in every other drug policy area

is making the effectiveness of medicine subject to political vote rather than required scientific rigour

is prepared to accept that smoked marijuana has useful medicinal value when every evaluation of the scientific data states that the risks of long-term smoked marijuana far outweigh any benefits

is calling for a 'trial' of marijuana as medicine despite participants not even being required to be registered or monitored as part of regular clinical evaluations

is recommending potentially massive quantities of raw cannabis to be grown for personal use (and presumably anyone else in the neighbourhood) under medical prescription, deserting the principle of controlled and regulated prescription of therapeutic substances

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QUESTION 1

Drug Free Australia questions why the NSW Working Party on the Use of Cannabis for Medicinal Purposes:

is responding to the agenda of the well-funded drug legalisation lobby which is working towards the defeat of the United Nations Conventions against illicit drugs via incremental changes which include the legalisation of marijuana for medical purposes, marijuana decriminalisation, heroin injecting rooms and heroin on prescription

"The consensus here is that medical marijuana is our strongest suit. It is our point of leverage which will move us toward the legalization of marijuana for personal use, and in that process we will break down the power of the narcocracy to wage a war of terror over things."
Richard Cowan – Director of NORML at the 50th anniversary of the discovery of LSD in San Francisco 1993

"I would establish a strictly controlled distribution network through which I would make most drugs, excluding the most dangerous ones like crack, legally available. Initially, I would keep prices low enough to destroy the drug trade. Once that objective was attained I would keep raising the prices, very much like the excise duty on cigarettes, but I would make an exception for registered addicts in order to discourage crime. I would use a portion of the income for prevention and treatment. And I would foster social opprobrium of drug use."
Soros on Soros: Staying Ahead of the Curve. New York: John Wiley & Sons, 1995 p 200 - George Soros is named in Time magazine as the most influential financial supporter of the drug legalization movement, providing $50,000,000 thus far for legalization efforts globall

"Come up with an approach that emphasizes 'treatment and humanitarian endeavors,' he said, hire someone with the political savvy to sit down and negotiate with government officials, and target a few winnable issues, like medical marijuana and the repeal of mandatory minimums."
George Soros, quoted by Cynthia Cotts, "Smart Money," Rolling Stone, May 5, 1994.

"I and other members of ADLRF (Australian Drug Law Reform Foundation) believe that the present laws regarding illicit drugs encourage the unsafe use of the substances they prohibit,. They should be reformed so that presently illicit drugs are legalised, and each drug regulated in its manufacture, distribution and use so as to minimise the black markets that presently encourage their abuse and encourage the damage that they do to individuals and to society."
Statement by ADLRF member, Peter Watney on Drugtalk, Australia's national drug policy debate listserver, 27 June 2003 10.44 am, defending ADLRF President, Alex Wodak's unwillingness to reply to a particular legalization question posed by Collis Parrett

"(I am sure you have read the recent reports linking cannabis to schizophrenia). As we have managed to reduce the prevalence of smoking (from 70% to 20% in males) and incidence of tobacco related health problems, and also reduced alcohol consumption by about 25% in the last 20 years as well as the number of alcohol related deaths by 20% in the last decade, why do we not tax and regulate cannabis as these controls have been so successful for the legal drugs."

Dr Alex Wodak, President of the Australian Drug Law Reform Foundation and Australia's highest profile advocate of drug legalization - on Drugtalk, 23 November 2002, 9.55 pm

Damning Evidence Against the Drug Legalisation Lobby

Testimony of Barry R. Mccaffrey Director, Office of National Drug Control Policy (ONDCP) before the House Government Reform and Oversight Committee subcommittee on criminal justice, drug policy, and human resources - the drug legalization movement in America - June 16, 1999

Our nation's democratic system of government is founded upon free and open debate. Our nation holds no beliefs or icons above challenge and examination. We all must be willing to lay the facts and our analysis on the table of public scrutiny, and make the case for what we believe.

However, in the marketplace of ideas, just as in other marketplaces, there are people willing to use deceptive claims, half truths and flawed logic to hawk ill-considered beliefs. Nowhere is this problem more clear than with respect to the drug legalization movement.

Proponents of legalization know that the policy choices they advocate are unacceptable to the American public. Because of this, many advocates of this approach have resorted to concealing their real intentions and seeking to sell the American public legalization by normalizing drugs through a process designed to erode societal disapproval.

For example, ONDCP has expressed reservations about the legalization of hemp as an agricultural product because of the potential for increasing marijuana growth and use. While legitimate hardworking farmers may want to grow the crop to support their families, many of the other proponents of hemp legalization have not been as honest about their goals. A leading hemp activist, is quoted in the San Francisco Examiner and on the Media Awareness Project's homepage (a group advocating drug policy reforms) as saying *he "can't support a movement or law that would lift restrictions from industrial hemp and keep them for marijuana."* Katherine Seligman, Legalization Sought for Cousin of Pot, San Francisco Examiner, May 9, 1999, C1 (quoting hemp activist Jack Herer). If legalizing hemp is solely about developing a new crop and not about eroding marijuana restrictions, why does this individual only support hemp deregulation if it is linked to the legalization of marijuana?

<u>Similarly, when Ethan Nadelmann Director of the Lindesmith Center (a drug research institute), speaks to the mainstream media, he talks mainly about issues of compassion, like medical marijuana and the need to help patients dying of cancer. However, Mr. Nadelmann´s own words in other fora reveal his underlying agenda: legalizing drugs. Here is what he advocates:</u>

"Personally, when I talk about legalization, I mean three things: the first is to make drugs such as marijuana, cocaine, and heroin legal..."
(Ethan Nadelmann, Should Some Drugs Be Legalized?, 6 Issues in Science and Technology 43-46 (1990).

"*I propose a mail order distribution system based on a right of access . . .*"
(Ethan Nadelmann, Thinking Seriously About Alternatives to Drug Prohibition, 121 Daedalus 87-132 (1992).

"*Any good non-prohibitionist drug policy has to contain three central ingredients. First, possession of small amounts of any drug for personal use has to be legal. Second, there have to be legal means by which adults can obtain drugs of certified quality, purity and quantity. These can vary from state to state and town to town, with the Food and Drug Administration playing a supervisory role in controlling quality, providing information and assuring truth in advertising. And third, citizens have to be empowered in their decisions about drugs. Doctors have a role in all this, but let's not give them all the power".*(Ethan Nadelmann and Jan Wenner, Toward a Sane National Drug Policy, Rolling Stone May 5, 1994, 24-26.)

"We can begin by testing low potency cocaine products -- coca-based chewing gum or lozenges, for example, or products like Mariani's wine and the Coca-Cola of the late 19th century -- which by all accounts were as safe as beer and probably not much worse than coffee. If some people want to distill those products into something more potent, let them".(Id.)

"But if there is a lot of PCP use in Washington, then the government comes in and regulates the sale". (Ethan Nadelmann, How to Legalize, interview with Emily Yoffe, Mother Jones, Feb./Mar. 1990, 18-19.)

Mr. Nadelmann's view that drugs, including heroin and other highly addictive and dangerous drugs, should be legalized are widely shared by this core group of like-minded individuals. For example, Mr. Arnold Trebach states:

"Under the legalization plan I propose here, addicts . . . would be able to purchase the heroin and needles they need at reasonable prices from a non-medical drugstore". (Arnold Trebach & James Inciardi, Legalize It? Debating American Drug Policy, 109-110 (1993).

International financier George Soros, who funds the Lindesmith Center, has advocated*: "If it were up to me, I would establish a strictly controlled distributor network through which I would make most drugs, excluding the most dangerous ones like crack, legally available.*" (George Soros, 'Soros on Soros', p. 200 (1995).

William F. Buckley, Jr. has also called for the "*legalization of the sale of most drugs, except to minors"*. (William F. Buckley, The War on Drugs is Lost, National Review, Feb. 12, 1996, 35-48.)

Similarly, when the legalization community explains their theory of harm reduction -- the belief that illegal drug use cannot be controlled and, instead, that government should focus on reducing drug-related harms, such as overdoses -- the underlying goal of legalization is still present. For example, in a 1998 article in Foreign Affairs, Mr. Nadelmann expressed that the following

were legitimate 'harm reduction' policies: allowing doctors to prescribe heroin for addicts; employing drug analysis units at large dance parties, known as raves, to test the quality of drugs; and decriminalizing possession and retail sale of cannabis and, in some cases, possession of 'hard drugs'. (See Ethan Nadelmann, Commonsense Drug Policy, 77 Foreign Affairs 111-126 (1998).

Legalization, whether it goes by the name harm reduction or some other trumped up moniker, is still legalization. For those who at heart believe in legalization, harm reduction. It should, however, be emphasized that not all advocates of harm reduction support drug legalization. Nor, does harm reduction, by itself, requires legalization. In fact, aspects of the National Drug Control Strategy, such as methadone treatment, properly adopt harm reduction programs as part of a comprehensive, balanced approach to reducing drug use. Nevertheless, the fact remains that many who advocate harm reduction use it as a subterfuge for legalization. Is too often a linguistic ploy to confuse the public, cover their intentions and thereby quell legitimate public inquiry and debate. Changing the name of the plan doesn't constitute a new solution or alter the nature of the problem.

In many instances, these groups not only advocate public policies that promote drug use, they also provide people with information designed to encourage, aid and abet drug use. For example, from the Media Awareness Project (a not-for-profit organization whose self-declared mission is to encourage a re-evaluation of our drug policies) website a child can link to a site that states:

Overthrow the Government! Grow your own stone! It's easy! It's fun! Everybody's doing it! Growing marijuana: a fun hobby the whole family can enjoy! See www.cannabisculture.com/grow

The linked website goes on to provide the reader with all the information needed to grow marijuana, including a company located in Vancouver, Canada that will ship seeds or plants.

The Media Awareness Project website also includes links to instructions about how drug users can defeat drug tests. See www.mapinc.org ('drug links' 7 and 8 link to the following two websites: www.hightimes.com/ht/tow/tes/index.html and www.cannabisculture.com/usage/dtfaq.shtml). Similarly, the websites of both the Drug Policy Foundation, a self proclaimed drug policy reform group, and the Media Awareness Project, both provide links to a site that gives instructions for how to manufacture the drug 'ecstasy'. See www.mapinc.org which includes as part of its site www.mapsorg/news.html www.ecstasy.org/links/index.html/ which then includes www.hyperreal.org~lamont/pharm/faq/faq-mdma-synth.html

This same information is also found on www.lyceum.org/drugs/synth . ./mdma/synthesis/mdma.mda.synthesis

Careful examination of the words -- speeches, webpostings, and writings -- and actions of many who advocate policies to 'reduce the harm' associated with illegal drugs reveals a more radical intent. In reality, their drug policy reform proposals are far too often a thin veneer for drug legalization. See Richard Cowan, Building a New NORML, High Times, Jan. 1993, p. 67. Mr. Cowan has made clear how harm reduction policies fit into the legalization agenda as follows:

Based on our objective of 'Legalization by 97' we must begin by demanding: 1 -- immediate access to marijuana for the sick. 2 -- The immediate cessation of all attacks on users, growers and sellers of marijuana. 3 -- An immediate end to lying about marijuana and its users. 4 -- Recognition of the economic and environmental importance of hemp, and studies on how it can be best exploited by American agriculture and industry. (Id.)

What do drug 'legalizers' truly seek? They want drugs made legal -- even though this would dramatically increase drug use rates. They want drugs made widely available, in chewing gums and sodas, over the Internet and at the corner store - even though this would be tantamount to putting drugs in the hands of children. They want our society to no longer frown on drug use -- even though each year drug use contributes to 50,000 deaths CSR Inc., unpublished research prepared for ONDCP, 1999. and costs our society $110 billion in social costs. NIDA and NIAAA, The Economic Costs of Alcohol and Drug Abuse in the United States, 1992, NIDA/NIH pub. no. 98-4327, Sept. 1998. And, they want the government to play the role of facilitator, handing out drugs like heroin and LSD.

Let me emphasize, there is nothing wrong with advocating for change in public policy. From civil rights to universal suffrage, much of what makes our nation great has been the result of courageous reform efforts. Our nation benefits from the airing of dissent. However, we all have a responsibility to be honest in debate about our motives. We all have an obligation to be open with the American people about the risks inherent in what we advocate. To date, advocates of legalization have not been so forthcoming.

QUESTION 2

Drug Free Australia questions why the NSW Working Party on the Use of Cannabis for Medicinal Purposes:

is subverting the Federal requirement that no medicinal substance can be made available unless it has first been scientifically shown to be both safe and effective, particularly when marijuana has never been scientifically shown to be a safe effective medicine for the treatment of any condition

Criteria for the acceptance of a drug for medical use:

All active ingredients have to be identified and their chemistry determined. They have to be tested for purity with limits set for all impurities including pesticides, microbe & fungi and their products. These tests have to be validated and reproduced if necessary in an official laboratory.

The cannabis plant contains some 400 chemicals, a multiplicity of ingredients that vary with habitat – impossible to standardise and often contaminated with microbes, fungi or pesticides.[2]

Animal testing will include information on fertility, embryo toxicity, immuno-toxicity, mutagenic and carcinogenic potential. Risks to humans, especially pregnant women and lactating mothers, will be evaluated.

Cannabis has been shown to reduce sperm production.[3] Babies born to cannabis-using mothers are smaller, have learning and behavioural problems and are 10 times more likely to develop one form of leukaemia.[4] The immune system is impaired.[5] Smoking herbal cannabis results in the inhalation of four times as much tar as from a tobacco cigarette.[6]

Adequate safety and efficacy trials must be carried out. They must state the method of administration and report on the results from different groups, i.e. healthy volunteers, patients, special groups of the elderly, people with liver and kidney problems and pregnant women. Adverse drug reactions (ADR) have to be stated and include any effects on driving or operating machinery.

It is envisaged that cannabis would be smoked. No medicine prescribed today is smoked. Concentration, motor-co-ordination and memory are all badly affected.[7] Changes in the brain have been observed[8] and U.S.A. clinics are now coping with more cases of psychosis caused by cannabis than by any other drug.

It is essential to note that the content of THC (Tetrahydrocannabinol – the psychoactive ingredient in cannabis) is on average ten times higher than it was in the 1960s.[9] The fat-soluble THC lingers in the body for weeks[10] and the ability to drive safely is impaired for at least 24 hours after smoking cannabis.[11]

Although ten times as many people use alcohol, cannabis is implicated in a similar number of road accidents.[12]

The drug must be accepted by qualified experts. Their detailed reports need to take account of all the relevant scientific literature and the potential of the drug to cause dependence.

There are numerous accounts of both psychological and physical dependencies in cannabis use.[13] Some 77,000 people are admitted annually to hospitals in U.S.A for cannabis dependence, 8,000 of them as emergencies.[14] To date there are over 12,000 scientific publications relating to cannabis.[15]

THC has already undergone all the medical tests. It is available on prescription in tablet form for the relief of nausea from chemotherapy and appetite stimulation in AIDS patients. However marinol (USA) and nabilone (UK), synthetic forms of THC and identical in action to it, are not the first drugs of choice among oncologists in Washington D.C. ranking only 9th in the treatment of mild nausea and 6th for more severe nausea.[16] The warning on nabilone reads:

"THC encourages both physical and psychological dependence and is highly abusable. It causes mood changes, loss of memory, psychoses, impairment of co-ordination and perception, and complicates pregnancy".

Other Cannabinoids: Cannabis contains around 60 cannabinoids that are unique to the plant. Some of these could be similarly extracted, purified and tested for safety and efficacy. In the report "Therapeutic Uses Of Cannabis" (BMA, 1997) the British Medical Association said:

"It is considered here that cannabis is unsuitable for medical use. Such use should be confined to known dosages of pure or synthetic cannabinoids given singly or sometimes in combination."

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15. Mississippi University Library.
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PEER-REVIEWED STUDIES DEMONSTRATING THE DANGERS OF CANNABIS

Note: the drug legalisation lobby frequently dismisses this large body of evidence as junk science, but it is crucial to note that almost every study listed below is from a peer-reviewed medical or scientific journal, where the methodology, cogency and reliability of conclusions are checked by an expert panel of academics or scientists. Drug Free Australia thanks the Lambton Families in Action website for this list which was submitted to the US Congress.

Addiction / Gateway / Drug

American Journal of Drug & Alcohol Abuse 1994 Nov.20(4):459-81. (Developmental vicissitudes that promote drug abuse in adolescents.)

Bailey SL, Flewelling RL, Rachal JV. Journal of Health and Social Behavior. 1992; 33:51-66. (Predicting continued use of marijuana among adolescents: the relative influence of drug-specific and social context factors.)

Center on Addiction and Substance Abuse at Columbia University (CASA), March 10, 1994. (This analysis proves that, for too many children cigarettes are a drug of entry into the world of illicit drugs.)

Center on Addiction and Substance Abuse at Columbia University (CASA), March 10, 1994. (A 12- year-old who smokes is 30 times more likely to have used illicit drugs than a child of the same age who doesn't smoke.)

Center on Addiction and Substance Abuse at Columbia University (CASA), Oct. 27, 1994. (Children who use marijuana are 85 times more likely to use cocaine than non-marijuana users. 90% of children who used marijuana, smoked or drank first. Children who drink are 50 times more likely to use cocaine than non drinkers.)

Center on Addiction and Substance Abuse at Columbia University (CASA), Oct. 27, 1994. (Children who use gateway drugs - tobacco, alcohol and marijuana - are up to 266 times more likely to use cocaine than those who don't use any gateway drugs.)

Center on Addiction and Substance Abuse at Columbia University (CASA), Oct. 27, 1994. (Children who smoke daily are 13 times more likely to use heroin than children who smoke less often.)

Center on Addiction and Substance Abuse at Columbia University (CASA), Oct. 27, 1994. (Compared with people who used only one gateway drug [tobacco, alcohol and marijuana], children who used all three are 77 times more likely to use cocaine.)

Center on Addiction and Substance Abuse at Columbia University (CASA), Oct. 27, 1994. (Study concludes: Nearly 90% of cocaine users had smoked, drank and used marijuana first.)

Chait, et al. 1981. Psychopharmacology 75 (1). (Cross tolerance between marijuana and barbiturates has been demonstrated. This means marijuana users also develop a tolerance for the addicting barbiturates, even before they use any barbiturates. This is more evidence of significant addictive potential of marijuana.)

Chen, et al. 1997. Drug and Alcohol Dependence (46). (Of 9,000 daily users of marijuana, 35% of the adolescents and 18% of the adults met the American Psychiatric Association's criteria for dependence (addiction), suggesting that teenagers are much more vulnerable than adults to developing and addiction to marijuana.)

Clark DB, Levent K, Moss HB. Early Adolescent Gateway Drug Use in Sons of Fathers with Substance Use Disorders. Addictive Behaviors 1998; 23: 561-566. (Preadolescent tobacco use and conduct disorders were highly predictive of early adolescent cannabis use achieving 100% sensitivity and 76% specificity.)

Compton DR, Dewey WL, Martin BR. Advances in Alcohol and Substance Abuse. 1990;9:129-147. (Cannabis dependence and tolerance production.)

Crowley TJ, Macdonald MJ, Whitmore EA, Mikulich SK. Cannabis dependence, withdrawal, and reinforcing effects among adolescents with conduct symptoms and substance use disorders. Drug and Alcohol Dependence 1998; 50:27-37. (Research from the University of Colorado examining the presence of marijuana dependence in adolescents who are seen for conduct disorders has demonstrated not only the presence of a clear marijuana dependence syndrome in adolescents, but also marijuana withdrawal. Most patients claimed serious problems with cannabis, and 78.6% met adult criteria for cannabis dependence. The drug produces both dependence and withdrawal and potently reinforces cannabis taking.)

Devane WA. Science. 1992; 258: 1946-1949 et al. (Isolation and structure of a brain constituent that binds to the cannabinoid receptor.)

Duffy A, Milin R. J. Am. Acad Child Adolesc Psychiatry. 1996;35:1618-21. Case Study: Withdrawal Syndrome in Adolescent Chronic Cannabis Users. (Documents clear withdrawal syndrome that jeopardized treatment.)

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Soderstrom CA, Smith GS, Dischinger PA, McDuff DR, Hebel JR, Gorelick DA, Kerns TJ, et al. Psychoactive substance use disorders among seriously injured trauma center patients. Journal of the American Medical Association 1997; 277:169-1774. (39.7% of patients had urine positive for drugs other than alcohol and nicotine. Lifetime [current] drug dependency rates were cocaine 16.4% [10.6%], marijuana 14.8% [6.5%], opiates 13.8% [10%], hallucinogens 2.3% [0.4%], stimulants 1.9% [0.3%])

Soderstrom CA, et al. Cannabis; Physiopathology, Epidemiology, Detection. CRC press 1993;79-91. (Marijuana and alcohol use among 1023 trauma patients.)

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Varma VK, Malhotra AK, Dang R, Das K, Nehra R. Drug and Alcohol Dependence. 1988;21: 147-152. (Cannabis and cognitive functions: a prospective study.)

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Zwerling and associates. Journal of the American Medicine Association, vol. 264, pp.2639 -2643,1990. (Marijuana users had 55% more industrial accidents, 85% more injuries and a 78% increase in absenteeism. The mean absence rate from the job was 7.1% for marijuana users compared to 4% for non-users.)

QUESTION 3

Drug Free Australia questions why the NSW Working Party on the Use of Cannabis for Medicinal Purposes:

is elevating questionable subjective anecdotal evidence over evidence-based medicine while simultaneously espousing a commitment to evidence-based research in every other drug policy area

QUESTION 4

is making the effectiveness of medicine subject to political vote rather than required scientific rigour

It must be noted that the NSW Working Party on the Use of Cannabis for Medical Purposes chiefly relied on two major international studies on medical marijuana as is noted in the Executive Summary, Volume 1, August 2000.

> *In light of the evidence, the Working Party has agreed with the conclusions of the British House of Lords and the United States Institute of Medicine that some cannabinoid substances may have value in the treatment of a limited range of medical conditions, namely, HIV-related wasting, nausea caused by cancer chemotherapy, muscle spasm in some neurological disorders, and pain that is unrelieved by conventional analgesics. The Working Party has made recommendations on the type of research that is required to better assess the therapeutic value of cannabis and cannabinoid substances in these conditions.*

Briefing Paper 11/99 for the NSW Working Party entitled "The Medical Use of Cannabis – Recent Developments" (Gareth Griffith & Marie Swann) recognizes that the Institute of Medicine Report is the more scientific of the two studies relied on:

> *In recent months two major reports on the medical use of cannabis/marijuana have been released: the first in November 1998 by the House of Lords Select Committee on Science and Technology, the second in March 1999 by the United States Institute of Medicine (IOM). The purpose of this paper is to present an overview of these reports, as well as to offer some background to the debate concerning the medical use of cannabis/marijuana in the US and UK. Note that of the two main reports under discussion in this paper, the IOM report is the more technically detailed in its consideration and review of the available scientific data. It is, in effect, a scientific report produced by scientists.*

However, the briefing paper and the Working Party accept the recommendations of the House of Lords study, which unlike the US Institute of Medicine Report, gives heavy weight to anecdotal evidence over scientific studies, and pragmatically recommends smoked marijuana as medicine on the basis that 'everyone is already using it.'

While the rigorously scientific US study condemned the lack of safety in use of smoked marijuana, it did note in its Summary of Chapter 4 that:

> *Until a nonsmoked rapid-onset cannabinoid drug delivery system becomes available, we acknowledge that there is no clear alternative for people suffering from chronic conditions that might be relieved by smoking marijuana, such as pain or AIDS wasting. One possible approach is to treat patients as n-of-1 clinical trials, in which patients are fully informed of their status as experimental subjects using a harmful drug delivery system and in which their condition is closely monitored and documented under medical supervision, thereby increasing the knowledge base of the risks and benefits of marijuana use under such conditions.*

In light of the drug legalization lobby claiming that the Institute of Medicine report supported their calls for the open legalization of smoked marijuana as medicine, John A. Benson, Co-Principal Investigator, in a press statement announcing the release of the report, clarified:

> *"While we see a future in the development of chemically defined cannabinoid drugs, we see little future in smoked marijuana as a medicine."*

The British House of Lords report, which guided the conclusions of the NSW Working Party, took little note of the placebo effect guiding anecdotal accounts concerning the supposed benefits of cannabis.

Due to a placebo effect, a patient may erroneously believe a drug is helpful when it is not.

This is especially true of addictive, mind-altering drugs like marijuana. A marijuana withdrawal syndrome occurs, consisting of anxiety, depression, sleep and appetite disturbances, irritability, tremors, diaphoresis, nausea, muscle convulsions, and restlessness. (1)

Often, persons using marijuana erroneously believe that the drug is helping them combat these symptoms without realizing that actually marijuana is the cause of these effects. Therefore, when a patient anecdotally reports a drug to have medicinal value, this must be followed by objective scientific studies.

For instance, in 1990, Dr. J. P. Frankel conducted a study of the effect of smoked marijuana on his patients with Parkinson's Disease because one of the patients had claimed the drug to be beneficial. Dr. Frankel's study showed that the drug did not improve the symptoms of Parkinson's Disease in any patient, including the patient who had originally believed it useful. (2) Similarly, anecdotal reports had claimed that marijuana caused improvement in multiple sclerosis. However, a scientifically-controlled 1994 study by Dr. H. S. Greenberg showed that smoking marijuana makes symptoms of multiple sclerosis worse. (3)

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SUMMARY OF SCIENTIFIC STUDIES ON MARIJUANA AS MEDICINE

The tables below constitute a summary of all scientific studies on the medical value of marijuana or cannabinoids up to 1999, as summarized in the United States Institute of Medicine report for that year.

PAIN RELIEF

Experimentally Induced Acute Pain

Study	Cannabinoid	Trial Type	Testing modality	Delivery system	Result	Study design	Side Effects
Clark WC, Janal MN, Zeidenberg P, Nahas GG. 1981. Effects of moderate and high doses of marihuana on thermal pain: A sensory decision theory analysis. *Journal of Clinical Pharmacology* 21:299S—310S.	THC		Thermal pain		Unsuccessful - *increase* in pain sensitivity		
Hill SY, Schwin R, Goodwin DW, Powell BJ. 1974. Marihuana and pain. *Journal of Pharmacology and Experimental Therapeutics* 188:415—418.	THC		Electrical stimulation		Unsuccessful - *increase* in pain sensitivity		
Libman E, Stern MH. 1985. The effects of delta-9-tetrahydrocannabinol on cutaneous sensitivity and its	THC		Tourniquet pain		Unsuccessful - *increase* in pain sensitivity		

relation to personality. *Personality, Individuality and Difference* 6:169—174							
Raft D, Gregg J, Ghia J, Harris L. 1977. Effects of intravenous tetrahydrocannabinol on experimental and surgical pain: Psychological correlates of the analgesic response. *Clinical Pharmacology and Therapeutics* 21:26—33.	Tetrahydro-cannabinol		surgical pain – tooth extraction		Unsuccessful - no analgesic effect	Poor - study suffered from several serious limitations: the tooth extraction included treatment with the local anesthetic lidocaine, the pain during the procedure was assessed 24 hours later, and there was no positive control. Levonantradol (a synthetic THC analogue) was tested in 56 patients who had moderate to severe postoperative or trauma pain. They were given intramuscular injections of levonantrodol or placebo 24 hours after surgery. To control for previous drug exposure, patients with a history of drug abuse or addiction and those who received an analgesic, antiinflammatory, tranquilizer, sedative, or anesthetic agent within 24 hours of the test drug were excluded from the study. On average, pain relief was significantly greater in the levonantradol-treated patients than in the placebo-treated patients. Because the authors did not report the number or percentage of people who responded, it is not clear whether the average represents consistent pain relief in all levonantradol-treated patients or whether some people experienced great relief and a	

						few experienced none.	

Animal studies - There is available data from animal studies indicate that cannabinoids could be useful analgesics. In general, cannabinoids seem to be mild to moderate analgesics. Opiates, such as morphine and codeine, are the most widely used drugs for the treatment of acute pain, but they are not consistently effective in chronic pain; they often induce nausea and sedation, and tolerance occurs in some patients. Recent research has made it clear that CB_1 receptor agonists act on pathways that partially overlap with those activated by opioids but through pharmacologically distinct mechanisms. Therefore, they would probably have a different side effect profile and perhaps additive or synergistic analgesic efficacy.

Chronic Pain

Study	Cannabinoid	Trial Type	Testing modality	Delivery system	Result	Study design	Side Effects
Noyes Jr R, Brunk SF, Baram DA, Canter A. 1975a. Analgesic effect of delta-9-tetrahydrocannabinol. *Journal of Clinical Pharmacology* 15:139—143.	Oral doses of THC in pill form – 5mg, 10 mg, 15 mg, 20 mg	double-blind, placebo-controlled study of 10 subjects measuring both pain intensity and pain relief	Cancer pain	Oral pill	Successful - The 15- and 20-mg doses of THC produced significant analgesia. There were no reports of nausea or vomiting. At least half the patients reported increased appetite. Side effects should however be noted for these higher doses.	there were no positive controls--that is, other analgesics that could provide a better measure of the degree of analgesia produced by THC.	With a 20-mg dose of THC, patients were heavily sedated and exhibited "depersonalization," characterized by a state of dreamy immobility, a sense of unreality, and disconnected thoughts. Five of 36 patients exhibited adverse reactions (extreme anxiety) and were eliminated from the study. Only one patient experienced this effect at the 10-mg dose of THC.
Noyes R, Jr, Brunk SF, Avery DH, Canter A. 1975b. The analgesic properties of delta-9-		single-dose study		Oral pill	Successful - the analgesic effect of 10 mg of THC was equivalent to that of 60 mg of codeine; the effect of 20 mg of THC was equivalent		Similar to study above, though THC was more sedating than codeine.

tetrahydrocannabinol and codeine. *Clinical Pharmacology and Therapeutics* 18:84—89					to that of 120 mg of codeine. (Note that codeine is a relatively weak analgesic.) In a separate publication the same authors published data indicating that patients had improved mood, a sense of well-being, and less anxiety.		
Staquet M, Gantt C, Machin D. 1978. Effect of a nitrogen analog of tetrahydrocannabinol on cancer pain. *Clinical Pharmacology and Therapeutics* 23:397—401.	Nitrogen analogue of THC		Two trials: one compared this analogue with codeine in 30 patients, and a second compared it with placebo or secobarbital, a short-acting barbiturate.		Successful- for mild, moderate, and severe pain, the THC analogue was equivalent to 50 mg of codeine and superior to placebo and to 50 mg of secobarbital.		
Holdcroft A *et al. Pain relief with oral cannabinoids in familial Mediterranean fever*. Anaesthesia, 1997, 52, 483	Cannabis oil capsules, standardised for THC content	placebo-controlled trial of cannabis	A patient with severe chronic pain of gastro-intestinal origin (diagnosed as familial Mediterranean fever)		Provisional success due to being a single patient study - . the patient's demand for morphine was substantially lower during treatment with cannabis than during a period of placebo treatment	Single patient study	

Migraine headaches

Study	Cannabinoid	Trial Type	Testing modality	Delivery system	Result	Study design	Side Effects
El-Mallakh RS. 1987. Marijuana and migraine. *Headache* 27:442—443.	THC			Smoked	Unsuccessful - it presents three cases of cessation of daily marijuana smoking followed by migraine attacks--not convincing evidence that marijuana relieves migraine headaches.		

SUMMARY – PAIN RELIEF

1. There is not yet enough evidence from human studies.

2. There is solid evidence from preclinical research that cannabinoids reduce pain in animals.

3. There is no evidence that marijuana or cannabinoids relieve migraine headaches.

4. Research should be done to learn:

   a) if cannabinoids can enhance the pain-relieving effects of opiate drugs

   b) which cannabinoids might be useful pain medications.

NAUSEA AND VOMITING (emesis)

Note: Many of the reported clinical experiences with cannabinoids are not based on definitive experimental methods.

Study	Cannabinoid	Trial Type	Testing modality	Delivery system	Result	Study design	Side Effects
Chang AE, Shiling DJ, Stillman RC, et al. 1979. Delta-9-tetrahydrocannabinol as an antiemetic in patients receiving high-dose methotrexate: A prospective, randomized evaluation. *Annals of Internal Medicine* 91:819—824.	THC		patients receiving methotrexate		Limited Success - THC was found to be superior to a placebo in patients receiving methotrexate, **an agent that is not a strong emetic.** However this study is moderated by the following study.	Small number of patients	
Chang AE, Shiling DJ, Stillman RC, Goldberg NH, Seipp CA, Barofsky I, Rosenberg SA. 1981. A prospective evaluation of delta-9-tetrahydrocannabinol as an antiemetic in patients receiving adriamycin and cytoxan	THC		patients who were receiving a chemother-apeutic drug that is more likely to cause emesis than anthrax-cycline		Unsuccessful - the antiemetic effect was poor.	Small number of patients	

chemotherapy. *Cancer* 47:1746—1751.							
Orr LE, McKernan JF, Bloome B. 1980. Antiemetic effect of tetrahydrocannabinol. Compared with placebo and prochlorperazine in chemotherapy-associated nausea and emesis. *Archives of Internal Medicine* 140:1431—1433.	THC		Comparison between THC and Compazine (prochlor-perazine – which in the 80's was one of the more effective anti-emetics		Very limited success - THC and prochlorperazine given orally showed similar degrees of efficacy. Even when administered in combination, THC and prochlorperazine failed to stop vomiting in two-thirds of patients.	These studies often used various chemotherapeutic agents.	
SE, Cronin CM, Zelen M, et al. 1980. Antiemetics in patients receiving chemotherapy for cancer: A randomized comparison of delta-9-tetrahydrocannabinol and prochlorperazine. *New England Journal of Medicine* 302:135—138.	THC		Comparison between THC and Compazine (prochlor-perazine – which in the 80's was one of the more effective anti-emetics		Very limited success - THC and prochlorperazine given orally showed similar degrees of efficacy. Even when administered in combination, THC and prochlorperazine failed to stop vomiting in two-thirds of patients.	These studies often used various chemotherapeutic agents.	
Gralla RJ, Tyson	THC	carefully	Comparison		Unsuccessful - complete	No patient had	

LB, Borden LB, et al. 1984. Antiemetic therapy: A review of recent studies and a report of a random assignment trial comparing metoclopramide with delta-9-tetrahydrocannabinol. *Cancer Treatment Reports* 68:163—172.		controlled double-blind study	between THC and antiemetic drug metoclo-pramide		control of emesis occurred in 47% of those treated with metoclopramide and 13% of those treated with THC. Major control (two or fewer episodes) occurred in 73% of the patients given metoclopramide compared to 27% of those given THC.	previously received chemotherapy therefore anticipatory emesis was not a factor. All patients received the same dose of cisplatin and were randomly assigned to the THC group or the metoclopramide group.	
Steele N, Gralla RJ, Braun Jr DW. 1980. Double-blind comparison of the antiemetic effects of nabilone and prochlorperazine on chemotherapy-induced emesis. *Cancer Treatments Report* 64:219—224.	Synthetic THC – nabilone and levonantradol		Comparison of the antiemetic effects of nabilone and prochlorper-azine on chemother-apy-induced emesis.		Very limited success - efficacy was observed in several trials, but no advantage emerged for these agents. Nabilone and levonantradol reduced emesis but not as well as other available agents in moderately to highly emetogenic settings.		
Tyson LB, Gralla RJ, Clark RA, et al. 1985. Phase I trial of levonantradol in chemotherapy-induced emesis. *American Journal of Clinical Oncology*	Synthetic THC – levonantradol		Trial of levonantra-dol in chemother-apy-induced emesis.		Very limited success - efficacy was observed in several trials, but no advantage emerged for these agents. Nabilone and levonantradol reduced emesis but not as well as other available agents in		

8:528—532.					moderately to highly emetogenic settings.		

Chemotherapy-Induced Nausea

Note: Although many marijuana users have claimed that smoked marijuana is a more effective antiemetic than oral THC, no controlled studies have yet been published that analyse this in sufficient detail to estimate the extent to which this is the case.

Study	**Cannabinoid**	**Trial Type**	**Testing modality**	**Delivery system**	**Result**	**Study design**	**Side Effects**
Vinciguerra V, Moore T, Brennan E. 1988. Inhalation marijuana as an antiemetic for cancer chemotherapy. *New York State Journal of Medicine* 88:525—527.	Smoked marijuana	Open trial on 56 cancer pat-ients who were unres-ponsive to convention al antiemet-ic agents	patients asked to rate the effectiveness of marijuana compared with results during prior chemother-apy cycles	Smoked	Moderately successful - 34% of patients rated marijuana as moderately or highly effective	The study's relative value was difficult to determine because no control group was used and the patients varied with respect to previous experiences, such as marijuana use and THC therapy. Did not report data on the time course of antiemetic control, possible advantages of self-titration with the smoked marijuana, or the degree to which patients were able to swallow the pills. Patients with severe vomiting would have been unlikely to be	Inability of nearly one-fourth of the patients to tolerate the administration of marijuana by smoking

						able to swallow or keep the pills down long enough for them to take effect	
Levitt M, Faiman C, Hawks R, et al. 1984. Randomized double-blind comparison of delta-9-THC and marijuana as chemotherapy antiemetics. *Proceedings of the American Society for Clinical Oncology* 3:91.	Smoked marijuana/ THC in pill form	double-blind, cross-over, placebo-controlled	study comparing smoked marijuana with THC in pill form in 20 patients who were receiving various chemother-apeutic drugs.	Smoked/THC pill	Limited success - only 25% of patients achieved complete control of emesis; 35% of the patients indicated a slight preference for the THC pills over marijuana, 20% preferred marijuana, and 45% expressed no preference	Did not report data on the time course of antiemetic control, possible advantages of self-titration with the smoked marijuana, or the degree to which patients were able to swallow the pills. Patients with severe vomiting would have been unlikely to be able to swallow or keep the pills down long enough for them to take effect	

SUMMARY – RELIEVING NAUSEA AND VOMITING

1. Neither smoked marijuana nor cannabinoids are as effective as current medicines that stop nausea and vomiting in cancer chemotherapy patients.

2. Cannabinoids, however, might be effective in:

   a) those few patients who respond poorly to current antiemetic (anti-nausea) drugs

   b) or more effective in combination with current antiemetics.

3. Research should be pursued for patients who do not respond completely to current antiemetics.

4. A safe (non-smoking) delivery system for cannabinoids should be developed.

5. Until then, the harmful effects of smoking marijuana for a limited period of time may be outweighed by marijuana 's antiemetic benefits for those few cancer patients for whom current antiemetics do not work.

6. Doctors should evaluate such patients on a case by case basis and provide marijuana to them under close medical supervision for a limited period.

WASTING SYNDROME & APPETITE STIMULATION

Malnutrition

Note: A major concern with marijuana smoking in HIV-infected patients is that they might be more vulnerable than other marijuana users to immunosuppressive effects of marijuana or to the exposure of infectious organisms associated marijuana plant material.

Study	Cannabinoid	Trial Type	Testing modality	Delivery system	Result	Study design	Side Effects
Beal JE, Olson RLL, Morales JO, Bellman P, Yangco B, Lefkowitz L, Plasse TF, Shepard KV. 1995. Dronabinol as a treatment for anorexia associated with weight loss in patients with AIDS. *Journal of Pain and Symptom Management* 10:89—97. Beal JE, Olson R, Lefkowitz L, Laubenstein L, Bellman P, Yangco B, Morales JO, Murphy R, Powderly W, Plasse	Synthetic THC - Dronabinol (Marinol)	Short-term (six-week) and long-term (one-year) therapy		pill	Moderate success - associated with an increase in appetite and stable weight, and in a previous short-term (five-week) clinical trial in five patients, dronabinol was shown to increase body fat by 1%. However, megestrol acetate (Megace) is a synthetic derivative of progesterone that can stimulate appetite and cause substantial weight gain when given in high doses (320—640 mg/day) to AIDS patients. Megestrol acetate is more effective than dronabinol in stimulating weight gain, and dronabinol has no additive effect when used in combination with megestrol acetate		HIV/AIDS patients are the largest group of patients who use dronabinol. However, some reject it because of the intensity of neuropsychological effects, an inability to titrate the oral dose easily, and the delayed onset and prolonged duration of its action. Dizziness and lethargy reported

TF, Mosdell KW, Shepard KV. 1997. Long-term efficacy and safety of dronabinol for acquired immunodeficiency syndrome-associated anorexia. *Journal of Pain and Symptom Management* 14:7—14. Struwe M, Kaempfer SH, Geiger CJ, Pavia AT, Plasse TF, Shepard KV, Ries K, Evans TG. 1993. Effect of dronabinol on nutritional status in HIV infection. *Annals of Pharmacotherapy* 27:827—831.							

Malnutrition – Cancer Patients

Study	**Cannabinoid**	**Trial Type**	**Testing modality**	**Delivery system**	**Result**	**Study design**	**Side Effects**
Gorter R. 1991. Management of anorexia-cachexia associated with	Synthetic THC – Dronabinol (Marinol)			pill	Successful - has been shown to improve appetite and promote weight gain		Cannabinoids have also been shown to negatively affect the immune system and

cancer and HIV infection. *Oncology (Supplement)* 5:13—17.							this could be contraindicated in some cancer patients (both the chemotherapy and the cancer can be immunosuppressive). Dizziness and lethargy also reported

Anorexia Nervosa

Study	**Cannabinoid**	**Trial Type**	**Testing modality**	**Delivery system**	**Result**	**Study design**	**Side Effects**
Gross H, Egbert MH, Faden VB, Godberg SC, Kaye WH, Caine ED, Hawks R, Zinberg NE. 1983. A double-blind trial of delta-9-THC in primary anorexia nervosa. *Journal of Clinical Psychopharmacology* 3:165—171.	THC				Unsuccessful		Caused severe dysphoric reactions in three of 11 patients. Furthermore, such patients might have underlying psychiatric disorders, such as schizophrenia and depression, in which cannabinoids might be hazardous

SUMMARY – MALNUTRITION AND WASTING SYNDROME

1. No published research shows marijuana or cannabinoids are effective in treating malnutrition or wasting in AIDS patients.

2. A standard drug is more effective than THC in stimulating appetite in AIDS patients.

3. Cannabinoids modulate the immune system, which could be a problem in patients whose immune system is already compromised.

4. A major concern is that HIV-infected patients who smoke marijuana may be more vulnerable to the immunosuppressive effects of marijuana or to infectious organisms found in the plant material.

5. Cannabinoids, in combination with other drugs, might help increase appetite, help reduce nausea and vomiting caused by protease inhibitors, and help reduce the pain and anxiety associated with AIDS and cancer in late stages of these diseases.

6. There are medications that are more effective than marijuana for treating the nausea, appetite loss, pain, and anxiety associated with wasting, but these drugs are not equally effective for all patients.

7. A rapid onset form of THC should be developed and tested for these patients.

8. Smoking marijuana is not recommended. The long-term harms from smoking make it a poor delivery system for patients with chronic diseases.

9. For terminally ill patients who get relief from no other drugs, the medical benefits of smoking marijuana may outweigh the harms.

10. THC is ineffective in treating anorexia.

NEUROLOGICAL DISORDERS

Muscle Spasticity – Multiple Sclerosis

Study	Cannabinoid	Trial Type	Testing modality	Delivery system	Result	Study design	Side Effects
Greenberg HS, Werness SA, Pugh JE, Andrus RO, Anderson DJ, Domino EF. 1994. Short-term effects of smoking marijuana on balance in patients with multiple sclerosis and normal volunteers. *Clinical Pharmacology and Therapeutics* 55:324—328.	Smoked marijuana	double-blind placebo-controlled	study of postural responses in 10 MS patients and 10 healthy volunteers	Smoked	Unsuccessful - marijuana smoking impaired posture and balance in both MS patients and the volunteers.	Survey data do not measure the degree of placebo effect, estimated to be as great as 30 percent in pain treatments. Furthermore, surveys do not separate the effects of marijuana or cannabinoids on mood and anxiety from the effects on spasticity.	The 10 MS patients felt that they were clinically improved. The subjective improvement, while intriguing, does not constitute unequivocal evidence that marijuana relieves spasticity
Clifford DB. 1983. Tetrahydrocannabinol for tremor in multiple sclerosis. *Annals of Neurology* 13:669—671. Petro D, Ellenberger Jr C. 1981. Treatment of human spasticity with delta 9-	THC	3 open clinical trials testing a total of 30 patients			Successful - spasticity was less severe after the THC treatment	Based on patient report or clinical exam by the investigator	THC was not effective in all patients and frequently caused unpleasant side effects

tetrahydrocannabinol. *Journal of Clinical Pharmacology* 21:413S—416S. Ungerleider JT, Andrysiak TA, Fairbanks L, Ellison GW, Myers LW. 1987. Delta-9-THC in the treatment of spasticity associated with multiple sclerosis. *Advances in Alcohol and Substance Abuse* 7:39—50.							
CN, Illis LS, Thom J. 1995. Nabilone in the treatment of multiple sclerosis [Letter]. *Lancet* 345:579.	Nabilone				Successful - spasticity was also reported to be less severe		
Animal studies - There are no supporting animal data to encourage clinical research in this area, but there also are no good animal models of the spasticity of MS. However, in an MS like disease iin mice (experimental autoimmune encephalomyelitis), low doses of cannabinoids alleviate the muscle tremor seen in such animals. Cannabinoids also suppress spinal cord reflexes in animals Basic animal studies have shown that cannabinoid receptors are particularly abundant in areas of the brain that control movement and that cannabinoids affect movement and posture in animals as well as humans. The observations are consistent with the possibility that cannabinoids have antispastic effects, but they do not offer any direct evidence that cannabinoids affect spasticity, even in animals.							

SUMMARY – MUSCLE SPASTICITY

1. There is little research evidence to support claims that marijuana reduces muscle spasticity in Multiple Sclerosis.

2. Research should be conducted to determine whether cannabinoids might relieve symptoms associated with MS.

3. Marijuana should not be smoked by patients with MS, a chronic disease.

SPINAL CORD INJURY

Study	Cannabinoid	Trial Type	Testing modality	Delivery system	Result	Study design	Side Effects
Hanigan WC, Destree R, Truong XT. 1986. The effect of delta-9-THC on human spasticity. *Clinical Pharmacology and Therapeutics* 39:198. Maurer M, Henn V, Dittrich A, Hoffman A. 1990. Delta-9-tetrahydrocannabinol shows antispastic and analgesic effects in a single case double-blind trial. *European Archives of Psychiatry and Clinical Neuroscience* 240:1—4.	Oral THC	double-blind study	study of a paraplegic patient with painful spasms in both legs		Successful - suggested that oral THC was superior to codeine in reducing muscle spasms	Limitations of one patient	

SUMMARY – SPINAL CORD INJURY

1. Animals research indicates that areas of the brain that control movement contain abundant cannabinoid receptors.

2. Clinical trials testing the effects of cannabinoids on muscle spasticity in spinal cord injury should be considered.

3. If THC is proven to relieve spasticity, then a pill might be the preferred delivery route for nighttime use.

4. An inhaled form of THC, if found to be effective, might be appropriate to relief acute episodes of spasticity.

MOVEMENT DISORDERS

Dystonia

Study	Cannabinoid	Trial Type	Testing modality	Delivery system	Result	Study design	Side Effects
Consroe P, Sandyk R, Snider SR. 1986. Open label evaluation of cannabidiol in dystonic movement disorders. *International Journal of Neuroscience* 30:277—282.	Cannabidiol (CBD)	preliminary open trial			Moderate success - suggested modest dose-related improvements in the five dystonic patients studied		

Huntington's Disease

Study	Cannabinoid	Trial Type	Testing modality	Delivery system	Result	Study design	Side Effects
P, Laguna J, Allender J, Snider S, Stern L, Sandyk R, Kennedy K, Schram K. 1991. Controlled clinical trial of cannabidiol in Huntington's disease. *Pharmacology,*	Cannabidiol (CBD)	double-blind crossover study (CBD and placebo) of 15 Huntington's disease patients			Unsuccessful - symptoms neither improved nor worsened with CBD treatment		

Biochemistry and Behavior (New York) 40:701—708. Sandyk R, Consroe P, Stern P, Biklen D. 1988. Preliminary trial of cannabidiol in Huntington's disease. Chesher G, Consroe P, Musty R., Editors, *Marijuana: An International Research Report.* Canberra: Australian Government Publishing Service.		who were not taking any antipsychotic drugs					
Animal studies suggest that cannabinoids have antichoreic activity, presumably because of stimulation of CB_1 receptors in the basal ganglia.							

Parkinson's Disease

Study	**Cannabinoid**	**Trial Type**	**Testing modality**	**Delivery system**	**Result**	**Study design**	**Side Effects**
Frankel JP, Hughes A, Lees AJ, Stern GM. 1990. Marijuana for Parkinsonian tremor. *Journal of Neurology, Neurosurgery and Psychiatry* 53:436.	Smoked marijuana			Smoked	Unsuccessful - no improvement in tremor after the five patients smoked marijuana--whereas all subjects benefited from the administration of standard medications for Parkinson's disease (levodopa and apomorphine)		
Animal studies - Hyperactivity of the subthalamic neurons, observed in both Parkinson's patients and animal models of Parkinson's disease, is hypothesized to be a major factor in the debilitating							

bradykinesia associated with the disease Furthermore, although cannabinoids oppose the actions of dopamine in intact rats, they augment dopamine activation of movement in an animal model of Parkinson's disease. This suggests the potential for adjunctive therapy with cannabinoid agonists.

Tourette's Syndrome

Study	Cannabinoid	Trial Type	Testing modality	Delivery system	Result	Study design	Side Effects
Hemming M, Yellowlees PM. 1993. Effective treatment of Tourette's syndrome with marijuana. *Journal of Psychopharmacology* 7:389—391. Sandyk R, Awerbuch G. 1988. Marijuana and Tourette's syndrome. *Journal of Clinical Psychopharmacology* 8:444—445.	marijuana	four case histories			Questionable Success - indicating that marijuana use can reduce tics in Tourette's patients. In three of the four cases the investigators suggest that beneficial effects of marijuana might have been due to anxiety-reducing properties of marijuana rather than to a specific antitic effect.		

SUMMARY – MOVEMENT DISORDERS

1. There is no research evidence that marijuana or cannabinoids are helpful in reducing symptoms that occur in movement disorders.

2. The anxiety-reducing aspects of marijuana and cannabinoids might be beneficial to some patients with movement disorders.

3. However, chronic marijuana smoking is a health risk for chronic conditions such as movement disorders.

4. Animal studies should be undertaken to determine if cannabinoids might play a role in movement disorders.

5. Clinical trials of isolated cannabinoids should be undertaken.

EPILEPSY

Study	Cannabinoid	Trial Type	Testing modality	Delivery system	Result	Study design	Side Effects
Ng SKC, Brust JCM, Hauser WA, Susser M. 1990. Illicit drug use and the risk of new-onset seizures. *American Journal of Epidemiology* 132:47—57.	marijuana	case-controlled study			Inconclusive – see Study Design. Ng and co-workers concluded that marijuana is a protective factor for first-time seizures in men but not women	This was a weak study. It did not include measures of health status prior to hospital admissions for the patients' serious conditions, and differences in their health status might have influenced their drug use rather than--as suggested by the authors--that differences in their drug use influenced their health.	

SUMMARY - EPILEPSY

1. Neither marijuana nor cannabinoids are effective in treating epilepsy.

ALZHEIMER'S DISEASE

Study	Cannabinoid	Trial Type	Testing modality	Delivery system	Result	Study design	Side Effects
Volicer L, Stelly M, Morris J, McLaughlin J, Volicer BJ. 1997. Effects of dronabinol on anorexia and disturbed behavior in patients with Alzheimer's disease. *International Journal of Geriatric Psychiatry* 12:913—919.	Dronabinol (Marinol)	Eleven Alzheimer's patients were treated for 12 weeks on an alternating schedule of dronabinol and placebo (six weeks of each treatment).		pill	Successful - treatment resulted in substantial weight gains and declines in disturbed behavior		No serious side effects were observed

SUMMARY – ALZHEIMER'S DISEASE

1. Further clinical research should be conducted to determine if cannabinoids have a role in stimulating appetite in Alzheimer's patients with severe dementia.

2. Because short-term memory loss is a common side-effect of THC, the effect of cannabinoids on memory in Alzheimer's patients who are less severely disturbed must be contemplated.

GLAUCOMA

Study	Cannabinoid	Trial Type	Testing modality	Delivery system	Result	Study design	Side Effects
Hepler RS, Frank IM, Petrus R. 1976. Ocular effects of marijuana smoking. In: Braude MC, Szara S, Editors, *The Pharmacology of Marijuana.* New York: Raven Press. Pp. 815—824. Jones RT, Benowitz NL, Herning RI. 1981. Clinical relevance of cannabis tolerance and dependence. *Journal of Clinical Pharmacology*	Marijuana			Eaten or in pill form	Successful - IOP was reduced by an average of 25%		

21:143S—152S.							
Alm A, Camras CB, Watson PG. 1997. Phase III latanoprost studies in Scandanavia, the United Kingdom and the United States. *Survey of Ophthalmology* 41:S105—S110. CB, Alm A, Watson P, Stjernschantz J. 1996. Latanoprost, a prostaglandin analog, for glaucoma therapy: Efficacy and safety after 1 year of treatment in 198 patients. Latanoprost Study Groups. *Ophthalmology* 103:1916—1924. Crawford WJ, Merritt JC. 1979. Effects of tetrahydrocannabino l on arterial and-intraocular hypertension. *International Journal of Clinical*	Smoked Marijuana with 2% THC			Smoked	Limited success as below - IOP was reduced by an average of 25% after smoking a marijuana cigarette that contained approximately 2% THC--a reduction as good as that observed with most other medications available today. But the effect lasts only about three to four hours. Elevated IOP is a chronic condition and must be controlled continuously.		

Pharmacology and Biopharmacy 17:191—196. Hepler RS, Frank IM, Petrus R. 1976. Ocular effects of marijuana smoking. In: Braude MC, Szara S, Editors, *The Pharmacology of Marijuana.* New York: Raven Press. Pp. 815—824. Hepler RS, Frank IR. 1971. Marihuana smoking and intraocular pressure. *Journal of the American Medical Association* 217(10):1392. Merritt JC, Crawford WJ, Alexander PC, Anduze AL, Gelbart SS. 1980. Effect of marihuana on intraocular and blood pressure in glaucoma. *Ophthalmology*							

87:222—228. Walters TR. 1996. Development and use of brimonidine in treating acute and chronic elevations of intraocular pressure: A review of safety, efficacy, dose response, and dosing studies. *Survey of Ophthalmology* 41(Suppl. 1):S19—S26.							

SUMMARY - GLAUCOMA

1. Both cannabinoids and marijuana lower intraocular pressure (IOP).

2. However, both also lower blood pressure, which might reduce the flow of blood through the optic nerve and actually increase the progression of glaucoma.

3. Many effective medications are available to treat glaucoma at a cost of about US$60 per month.

QUESTION 5

Drug Free Australia questions why the NSW Working Party on the Use of Cannabis for Medicinal Purposes:

is prepared to accept that smoked marijuana has useful medicinal value when every evaluation of the scientific data states that the risks of smoked marijuana far outweigh any benefits

QUESTION 6

is calling for a 'trial' of marijuana as medicine despite participants not even being required to be registered or monitored as part of regular clinical evaluations

The NSW Working Party reviewed 2 reports on the medical use of marijuana - the British House of Lords (1998) report and the United States Institute of Medicine report (1999). However five other reports were noted. These were issued by:

the Health Council of the Netherlands (1996)
the American Medical Association House of Delegates (1997)
the British Medical Association (1997)
the US National Institute of Health (1997)
the World Health Organization (1997)

A summary of relevant conclusions from these five reports were included in the Institute of Medicine Report, as is printed below. While all reports noted the benefits of clinical trials into possible medical uses for cannabinoids, only the British House of Lords report recommended loosely regulated use of smoked marijuana. **The NSW Working Party has demonstrably made recommendations at odds with six out of these seven studies.**

Smoked Marijuana and Use Of Plants As Medicine

US Institute of Medicine

In deciding whether marijuana should be smoked as medicine, society must weigh the reality of this crude drug-delivery system against the benefits it might bestow. Chronic smoking of marijuana increases a person's chances of developing cancer, lung damage, and problems with pregnancies, including low birth weight. Therefore, it simply is not an acceptable long-term option. Smoking should be allowed only for short-term use among patients with debilitating symptoms, or who are terminally ill and do not respond well to approved medications.

Even in these cases, marijuana use should be limited to carefully controlled settings. Patients who are prescribed marijuana should be enrolled in short-term clinical trials that are approved by an oversight strategy such as institutional

review boards, and involve only those patients most likely to benefit. They should be fully informed that they are experimental subjects and are using a harmful drug-delivery system, and their condition should be closely monitored and documented under medical supervision.

Health Council of the Netherlands

The committee believes that physicians cannot accept responsibility for a product of unknown composition that has not been subjected to quality control.

AMA House of Delegates

No specific recommendations made, but related issues are discussed in the general recommendation and drug development sections.

British Medical Association

Prescription formulations of cannabinoids or substances acting on the cannabinoid receptors should not include either cigarettes or herbal preparations with unknown concentrations of cannabinoids or other chemicals.

National Institutes of Health

Smoked marijuana should be held to standards equivalent to other

medications for efficacy and safety considerations. There might be some patient populations for whom the inhalation route might offer advantages over the currently available capsule formulation. Smoking plant material poses difficulties in standardizing testing paradigms, and components of the smoke are hazardous, especially in the immunocompromised patient. Therefore, the experts generally favored the development of alternative dosage forms, including an inhaler dosage form into which a controlled unit dose of THC could be placed and volatilized.

World Health Organization

Not discussed in the context of medical use, although many health hazards associated with chronic marijuana smoking are noted.

Drug Development

Health Council of the Netherlands

Not discussed.

AMA House of Delegates

The National Institutes of Health should use its resources to support the development of a smoke-free inhaled delivery system for marijuana or THC to reduce the health hazards associated with the combustion and inhalation of marijuana.

British Medical Association

Pharmaceutical companies should undertake basic laboratory investigations and develop novel cannabinoid analogs that may lead to new clinical uses.

National Institutes of Health

NIH should use its resources and influence to rapidly develop a smoke-free inhaled delivery system for marijuana or THC. A recommendation was made for the development of insufflation/inhalation devices or dosage forms capable of delivering purer THC or cannabinoids to the lungs free of dangerous combustion byproducts.

World Health Organization

Not discussed.

Physiological Harms

Health Council of the Netherlands

No recommendations made.

AMA House of Delegates

No recommendations made.

British Medical Association

Further research is needed to establish the suitability of cannabinoids for immunocompromised patients, such as those undergoing cancer chemotherapy or those with HIV/AIDS.

National Institutes of Health

Risks associated with smoked marijuana must be considered not only in terms of immediate adverse effects but also long-term effects in patients with chronic diseases. The possibility that frequent and prolonged marijuana use might lead to clinically significant impairments of immune system function is great enough that relevant studies should be part of any marijuana medication development research.

Additional studies of long-term marijuana use are needed to determine if there are or are not important adverse pulmonary, central nervous system, or immune system problems.

World Health Organization

Further studies are needed on the fertility effects in cannabis users in view of the high rate of use during the early reproductive years. Further clinical and experimental research is required on the effects of cannabis on respiratory function and respiratory diseases. More studies are needed to show whether cannabis affects the risk of lung malignancies and at what level of use that may occur. In addition, more studies are needed to clarify the rather different results of pulmonary histopathological studies in animals and man.

More clinical and experimental research is needed on the effects of cannabis on immunological function. More clarity should be sought concerning the molecular mechanisms responsible for immune effects, including both cannabinoid receptor and nonreceptor events.

The possibility that chronic cannabis use has adverse effects on the cardiovascular system should have a priority in epidemiological research.

Research on chronic and residual cannabis effects is also needed. The pharmacokinetics of chronic cannabis use in humans are poorly described, and this lack of knowledge restricts the ability of researchers to relate drug concentrations in blood or other fluids and observed effects.

Question 7

Drug Free Australia questions why the NSW Working Party on the Use of Cannabis for Medicinal Purposes:

is recommending potentially massive quantities of raw cannabis to be grown for personal use (and presumably anyone else in the neighbourhood) under medical prescription, deserting the principle of controlled and regulated prescription of therapeutic substances

The NSW Working Party on the Use of Cannabis for Medicinal Purposes is recommending that 5 marijuana plants be legalised for medical use per individual. Two of these plants can be greater than 25 cm in height.

But this creates the potential for massive, marketable yields, and Drug Free Australia questions how the police could possibly regulate the non-distribution of such plant material when they already have little success in regulating the private use of marijuana.

MASSIVE, ABUSEABLE QUANTITIES

The Victorian Police Association disclosed one cannabis plant yields five crops a year of 500 grams per crop totalling 2500 grams. – *Letter, The Police Association to DJ Perrin, 26 April 1996 p 3*

The Woodward Royal Commission disclosed that a three month old cannabis plant will produce at least 500 grams of harvestable leaf or a crop of 2000 grams a year.

Just 25 grams of marijuana produces 86 joints with 3% of THC, so one plant can produce up to 8600 marijuana joints every year. *(Marijuana An Australian Crisis).*

AND A GREEN LIGHT FOR PUBLIC MISCHIEF

- The assertion that all medical marijuana is headed for seriously ill patients is misleading. Statistics from the California Branch of the National Organization for the Reform of Marijuana Laws (NORML) shows that a survey of Californians reports the top three reported uses of medicinal marijuana:

  40% Chronic Pain
  22% AIDS-Related
  15% Mood Disorders
  (23% All other categories)

- Local and state law enforcement counterparts cannot distinguish between illegal marijuana grows and grows that qualify as medical exemptions. Many self-designated medical marijuana growers are, in fact, growing marijuana for illegal, "recreational" use.

- Elected law enforcement officials, i.e. Sheriffs and District Attorneys in California have been targeted by the "marijuana lobby." Political action by groups such as NORML have endorsed and supported candidates favorable to medical marijuana. NORML tracks local elections and takes credit for the defeats of anti-marijuana candidates. Last year the DEA arrested a major marijuana trafficker in Humboldt County who was an undeclared candidate for sheriff.

- The DEA and its local and state counterparts routinely report that large-scale drug traffickers hide behind and invoke Proposition 215, even when there is no evidence of any medical claim. In fact, many large-scale marijuana cultivators and traffickers escape state prosecution because of bogus medical marijuana claims. Prosecutors are reluctant to charge these individuals because of the state of confusion that exists in California. **Therefore, high-level traffickers posing as "care givers" are able to sell illegal drugs with impunity.**

- The California NORML website lists federal defendants for the largest indoor marijuana cultivation operation in the U.S., which occurred in Northern California, as "green prisoners." While unscrupulously claiming to be "medical marijuana" defendants, in fact these two individuals were dangerous, armed fugitives believed to be responsible for drug-related murders and other violence.

- DEA's San Francisco Field Division coordinates the statewide Domestic Cannabis Eradication/Suppression Program (DCE/SP). The number of plants eradicated and assets seized represent the largest totals in California history.

Source - DEA Information Sheet

APPENDICES

Appendix A – Just who does use medical marijuana?
(from the US Institute of Medicine report)

Appendix B – Information on Drug Legalisation Strategy

Appendix C – Recommendations of the NSW Working Party on the Use of Cannabis for Medicinal Purposes

APPENDIX A

JUST WHO *DOES* USE MEDICAL MARIJUANA?

There have been no comprehensive surveys of the demographics and medical conditions of medical marijuana users, but a few reports provide some indication. In each case, survey results should be understood to reflect the situation in which they were conducted and are not necessarily characteristic of medical marijuana users as a whole. Respondents to surveys reported to the IOM study team were all members of "buyers' clubs," organizations that provide their members with marijuana, although not necessarily through direct cash transactions. The atmosphere of the marijuana buyers' clubs ranges from that of the comparatively formal and closely regulated Oakland Cannabis Buyers' Cooperative to that of a "country club for the indigent," as Denis Peron described the San Francisco Cannabis Cultivators Club (SFCCC), which he directed.

John Mendelson, an internist and pharmacologist at the University of California, San Francisco (UCSF) Pain Management Center, surveyed 100 members of the SFCCC who were using marijuana at least weekly. Most of the respondents were unemployed men in their forties. Subjects were paid $50 to participate in the survey; this might have encouraged a greater representation of unemployed subjects. All subjects were tested for drug use. About half tested positive for marijuana only; the other half tested positive for drugs in addition to marijuana (23% for cocaine and 13% for amphetamines). The predominant disorder was AIDS, followed by roughly equal numbers of members who reported chronic pain, mood disorders, and musculoskeletal disorders (Table 1.1).

The membership profile of the San Francisco club was similar to that of the Los Angeles Cannabis Resource Center (LACRC), where 83% of the 739 patients were men, 45% were 36—45 years old, and 71% were HIV positive. Table 1.2 shows a distribution of conditions somewhat different from that in SFCCC respondents, probably because of a different membership profile. For example, cancer is generally a disease that occurs late in life; 34 (4.7%) of LACRC members were over 55 years old; only 2% of survey respondents in the SFCCC study were over 55 years old.

Jeffrey Jones, executive director of the Oakland Cannabis Buyers' Cooperative, reported that its largest group of patients is HIV-positive men in their forties. The second-largest group is patients with chronic pain.

Among the 42 people who spoke at the public workshops or wrote to the study team, only six identified themselves as members of marijuana buyers' clubs. Nonetheless, they presented a similar profile: HIV/AIDS was the predominant disorder, followed by chronic pain (Tables 1.3 and 1.4). All HIV/AIDS patients reported that marijuana relieved nausea and vomiting and improved their appetite. About half the patients who reported using marijuana for chronic pain also reported that it reduced nausea and vomiting.

Note that the medical conditions referred to are only those reported to the study team or to interviewers; they cannot be assumed to represent complete or accurate diagnoses. Michael Rowbotham, a neurologist at the UCSF Pain Management

Center, noted that many pain patients referred to that center arrive with incorrect diagnoses or with pain of unknown origin. At that center the patients who report medical benefit from marijuana say that it does not reduce their pain but enables them to cope with it.

Most--not all--people who use marijuana to relieve medical conditions have previously used it recreationally. An estimated 95% of the LACRC members had used marijuana before joining the club. It is important to emphasize the absence of comprehensive information on marijuana use before its use for medical conditions. Frequency of prior use almost certainly depends on many factors, including membership in a buyers' club, membership in a population sector that uses marijuana more often than others (for example, men 20—30 years old), and the medical condition being treated with marijuana (for example, there are probably relatively fewer recreational marijuana users among cancer patients than among AIDS patients).

Patients who reported their experience with marijuana at the public workshops said that marijuana provided them with great relief from symptoms associated with disparate diseases and ailments, including AIDS wasting, spasticity from multiple sclerosis, depression, chronic pain, and nausea associated with chemotherapy. Their circumstances and symptoms were varied, and the IOM study team was not in a position to make medical evaluations or confirm diagnoses. Three representative cases presented to the IOM study team are presented in Box 1.1; the stories have been edited for brevity, but each case is presented in the patient's words and with the patient's permission.

The variety of stories presented left the study team with a clear view of people's beliefs about how marijuana had helped them. But this collection of anecdotal data, although useful, is limited. We heard many positive stories but no stories from people who had tried marijuana but found it ineffective. This is a fraction with an unknown denominator. For the numerator we have a sample of positive responses; for the denominator we have no idea of the total number of people who have tried marijuana for medical purposes. Hence, it is impossible to estimate the clinical value of marijuana or cannabinoids in the general population based on anecdotal reports. Marijuana clearly seems to relieve some symptoms for some people--even if only as a placebo effect. But what is the balance of harmful and beneficial effects? That is the essential medical question that can be answered only by careful analysis of data collected under controlled conditions.

TABLE 1.1 Self-Reported Disorders Treated with Marijuana by Members of San Francisco Cannabis Cultivators Club

HIV	60
Musculoskeletal disorders and arthritis	39
Psychiatric disorders (primarily depression)	27
Neurological disorders and nonmusculoskeletal pain syndromes	9
Gastrointestinal disorders (most often nausea)	7
Other disorders : Glaucoma, allergies, nephrolithiasis, and the skin manifestations of Reiter syndrome	7
Total disorders	149
Total number of respondents	100

TABLE 1.2 Self-Reported Disorders Treated with Marijuana by Members of Los Angeles Cannabis Resource Center (LACRC), According to Center Staff[a]

HIV[b]	528	71
Cancer	40	5.4
Terminal cancer	10	1.4
Mood disorders (depression)	4	0.5
Musculoskeletal (multiple sclerosis,		
arthritis)	30	4.1
Chronic pain and back pain	33	4.5
Gastrointestinal	7	2.3
Neurological disorders (epilepsy,		
Tourette syndrome, brain trauma)	7	0.9
Seizures or migraines[c]	13	1.8
Glaucoma	15	2.0
Miscellaneous	42	5.7
Total number	739	100

TABLE 1.3 Summary of Reports to IOM Study Team by 43 Individuals

Symptoms	Dominant Disease	Symptoms	Dominant Disease
Anorexia, nausea, vomiting	AIDS	Pain	Migraine
	AIDS		Injury
	AIDS		Injury
	AIDS		Epilepsy and postpolio syndrome
	AIDS		Trauma and epilepsy
	AIDS		Degenerative disk disease
	AIDS		Rheumatoid arthritis
	AIDS and cancer		Nail-patella syndrome
	Cancer		Reflex sympathetic dystrophy
	Testicular cancer		Gulf War chemical exposure
	Cancer and multiple sclerosis		Multiple congenital cartilaginous exostosis
	Thyroid condition[a]		Histiocytosis X
	Migraine		
	Wilson's disease	Muscle spasticity	Spasticity[a]
			Multiple sclerosis
Mood disorders	Depression		Multiple sclerosis
	Depression		Multiple sclerosis
	Depression and anxiety		Paralysis
	Depression and anxiety		Spinal-cord injury
	Manic depression		Spasmodic torticollis
	Manic depression	Intraocular pressure	Glaucoma
	Posttraumatic stress		
	Premenstrual syndrome		
		Diarrhea	Crohn's disease

[a]Not specified.
NOTE: This table lists the people who reported to the IOM study team during the public workshops, or through letters, that they use marijuana as medicine; it should not be interpreted as a representative sample of the full spectrum of people who use marijuana as medicine. Each dominant disease represents an individual report.

TABLE 1.4 Primary Symptoms of 43 Individuals Who Reported to IOM Study Team

	Symptom Frequency		Multiple Symptoms	
Primary Symptom	No. of Reports[a]	% of Total Symptoms Reported	No. Who Reported (primary) Additional Symptoms	% of Those Who Reported Primary Symptoms
Anorexia, nausea, vomiting	21	31	13	62
Diarrhea	4	6	3	75
Intraocular pressure	2	3	1	50
Mood disorders	12	18	7	58
Muscle spasticity	12	18	7	58
Pain	16	24	13	81
Total	67		44	66

[a]Forty-three persons reporting; 20 reported relief from more than one symptom.

Appendix B

Information on Drug Legalisation Strategy

Article from the West Australian on US Funding of WA Cannabis Decriminalisation – (separate pdf file downloadable from this same site)

Article from Time Magazine on Legalisation Strategy – November 2002 (separate pdf file downloadable from this same site)

Legalisation Lobby Funding of Medical Marijuana Initiatives in the United States

Defeat of Legalisation Lobby Initiatives in the United States – December 2002

Weekendextra

Saturday November 30, 2002

The billionaire, drugs and us

Why George Soros cares about WA's cannabis laws

Coverstory

The billionaire, drugs and us

Why is US billionaire George Soros so interested in the reform of WA's drug laws? **Norman Aisbett** finds out.

REGULAR letter writers to *The West Australian* in recent years have come to include a spokesman for an influential lobby group for drug law reform.

That's not so surprising, except that Robert Sharpe and the Drug Policy Alliance are based in far-off Washington in the US.

Mr Sharpe misses no chance to wade into the debate on the need for softer drug laws relating to cannabis in WA and chides anyone with a contrary opinion.

He declares the "war on drugs" is lost and a waste of costly resources that could be used elsewhere; that illicit drug use does not warrant jail or a criminal record; that only crime gangs win from "prohibition" by being able to charge high prices; that cannabis is less dangerous than both tobacco or alcohol, and more.

Anti-drug campaigners Geraldine Mullins (left) and Wendy Herbert.

The Drug Policy Alliance, formed in 2001 by the merging of two major US drug legalisation groups, the Lindesmith Center and the Drug Policy Foundation, is backed by some very powerful figures.

George Soros, for one. He is the billionaire US currency speculator and philanthropist who reportedly once caused the British pound to plummet and in 1997 had Malaysia's Prime Minister, Mahathir Mohamad, blaming him for the South-East Asian economic collapse.

In the past eight years he has churned about $50 million of his earnings into the cause of wringing change out of hard-line US drug laws.

With his support, the alliance runs an international grants scheme for projects on "drug policy studies" and invites applications on its website. It also gives special awards for areas such as medical and legal work and political leadership. Several award recipients in Australia have got up to $10,000 each.

Apart from Mr Soros, 72, the other big backers of the alliance are John Sperling, who made billions by creating the University of Phoenix college system, and Peter Lewis, retired CEO of the Cleveland-based Progressive Corporation Insurance Company.

All three reportedly admit to having smoked cannabis. Mr Soros once said: "I have tried marijuana (cannabis) and I enjoyed it but it did not become a habit and I have not tasted it in many years."

According to a recent Time magazine cover story, Mr Sperling, 81, once smoked pot to combat pain associated with the cancer he fought in the 1960s. Mr Lewis, 68, is a prominent campaigner for the legalisation of the medical use of marijuana. Two years ago he was charged with importing 146 grams of cannabis into New Zealand. He was released without conviction on the basis of donating $53,000 to a drug rehabilitation program.

But why are these men, through the vigilant Mr Sharpe, so keen to encourage cannabis law reform in WA?

Mr Sharpe was happy to explain when Weekend Extra inquired by phone. He said the tough anti-drugs policies of successive US governments were the most "Neanderthal" in the world and threatened to make America the last nation to get liberalised laws.

"From a selfish perspective of wanting to change US drug laws, we need reform in Australia, or some other English-speaking country, to help us pressure our legislators, while also believing it's right for Australians.

"Americans are very ethno-centric. If Thailand were to end the drug war (i.e. soften its laws), Americans might never hear about it, except for a network of drug policy reform advocates.

"But if Australia were to dramatically change its drug laws, it would be all over CNN and would impact the debate in the US so much more."

Mr Soros started the Lindesmith Center in 1994 as a project of his Open Society Institute. It was named after Alfred Lindesmith, the first prominent American to challenge conventional thinking on drug policy.

Its partner in the alliance, the Drug Policy Foundation (DPF), was founded in 1987.

The executive director of the alliance is fast-talking Harvard PhD Ethan Nadelmann, who has visited Australia twice.

He would presumably be pleased with developments here. In 1987, South Australia decriminalised the law relating to prescribed amounts of cannabis, and the cultivation of a set number of cannabis plants, and similar legislation is imminent in WA.

Under the legislation, expected to be introduced in parliament early next year, the possession of less than 15g of cannabis and up to two plants for personal use will incur a $100 infringement notice; 15g to 30g and less than three plants will draw a $150 fine.

Police will retain the right to lay criminal charges for small amounts if they suspect someone is dealing.

HOW this was achieved is an intriguing tale of more than a decade of indefatigable politicking by a network of disciplined activists, who include academics, health professionals and the Australian Parliamentary Group for Drug Law Reform.

The latter group includes 18 WA politicians. Among them are Minister for Planning and Infrastructure Alannah MacTiernan, Agriculture Minister Kim Chance and Greens MPs Christine Sharp, Giz Watson and Jim Scott.

Drug law reformers have also used "subversives" to win a sympathetic ear from the Australian media, according to Bill Stronach, executive director of the Australian Drug Foundation, a Victorian-based education group that gets private and government funding.

In 1992 in Washington he boasted to an international conference on drug policy reform that his organisation had "employed journalists not to churn out press releases but to get in there as subversives and work with their colleagues in the mainstream press.

"And that's done through developing very slowly, and very gently, a level of trust, a level of credibility.

"So we have 24-hour availability of those journalists [illegible] over the last eight months, over 50 per cent of the mainstream printed and radio and television reporting on alcohol and drug issues has been generated by the foundation or filtered throught it."

When Weekend Extra contacted him, Mr Stronach laughed off the comments as "the worst choice of words I ever made". He had simply hired two or three journalists to deal with the media because "journos can talk much better to journos".

In 1997, Mr Soros said: "My sole concern is that the war on drugs is doing untold damage to the fabric of our society. (It is) a utopian dream. Some form of drug addiction or substance abuse is endemic in most societies. Insisting on total eradication of drug use can only lead to failure and disappointment."

With that, he echoes the reformist mantra, worldwide.

He joined the cause after founding the Open Society Institute in 1989. The institute's charter was to fund a global network of Soros foundations to "transform closed societies into open ones and to protect and expand the values of existing open societies".

Its main focus was the East European states made independent by the collapse of the Soviet empire. (Mr Soros was born in Hungary. He is Jewish and as a youth had to flee nazi persecution during World War II. He migrated to the US in 1956.) He began to spend big to help turn several such States into Western-style democracies.

He then decided America's own open society was eroding and turned to domestic causes such as immigrants rights, euthanasia and drug reform. In 1994, he entered the drug debate by founding the Lindesmith Center, and emerged as a strong proponent of "harm reduction" and decriminalisation of the personal use of drugs.

Despite his public statements to the contrary, he has also given encouragement to the bigger goal of legalisation. Ethan Nadelmann, who runs the Drug Policy Alliance, is an even more strident advocate of the legalisation of drugs, and not only cannabis.

But the first and most achievable policy goal of the alliance and other reformers was the recognition by health authorities of "harm reduction". This involves an acceptance that some people will use drugs regardless of laws and must therefore be helped to do so safely; and that illicit drug use is a health issue, not a criminal matter.

Mr Soros started the International Harm Reduction Development Program in 1995, with the main focus on former Soviet bloc countries – at a time when this approach was also gaining acceptance in many Western nations, including Australia, where like-minded health professionals had begun to promote it in the 1980s.

Advocating measures like methadone programs, needle exchanges, safe injecting rooms, harm reduction is viewed by critics as being the stepping stone to the next reformist goal: decriminalisation.

'Without doubt, the drug-reform movement in Australia is closely allied to the Soros-supported movement in the US, so our efforts are dwarfed by comparison.'
— Geraldine Mullins, co-founder of the Australian Parent Movement.

This does not mean legalisation, only that a prosecuted drug user does not incur a damaging criminal record. This should become the case in WA next year.

Opponents of harm reduction policies and decriminalisation include parents of addicts. They argue it sends mixed messages and only helps to sustain a user's addiction, and can even result in their death.

They say abstinence is vital and urge a "tough love" approach with mandatory treatment in an environment that removes addicts from access to any drugs. They see drug courts, plus family and community support, as vital. Drug courts allow the option of mandatory treatment to fines or jail.

Geraldine Mullins, co-founder of the Australian Parent Movement, speaks for them all when she expresses concern about Mr Soros:

"He is powerful and he provides a lot of money for an international battle in which Australia is integral and is seen as being one of the most winnable reform targets.

"Without doubt, the drug-reform movement in Australia is closely allied to the Soros-supported movement in the US, so our efforts are dwarfed by comparison.

"To make things worse, those responsible for public health in Australia have been cleverly drawn into promoting strategies dressed up as compassion but are really about creating chaos in the system and opening the way for cannabis to eventually be sold like alcohol and tobacco.

"We all know the terrible social costs of alcohol and tobacco."

Wendy Herbert, spokeswoman for the WA Coalition Against Drugs, agrees health officials have done too little to highlight the risk of addiction and mental illness in cannabis use.

She says the proposed laws will be a "green light" to normalising the practice.

"We believe most children can be taught to say 'no' if given information and family support, and not merely information to supposedly help them use drugs safely. No drugs are safe.

"We need a 'say no' approach backed by the law and by education and intervention for young people through mandatory counselling that involves families.

"People with an entrenched drug problem should be subjected to mandatory rehabilitation orders, perhaps via the Drug Court, to return them to a drug free state, which most will welcome when achieved. For all this to happen, the illegality must stay. Very, very few people get criminal records for simple drug use anyway."

IN his 1995 autobiography, George Soros initially states he is "agnostic" on the big question of legalisation.

But later in the book, he says he could imagine the legalisation of "less harmful and less addictive" drugs might help society by reducing criminality "by around 80 per cent".

He says cannabis is non-addictive but that is wrong. Studies have proved up to 10 per cent of regular users can develop dependency.

". . . I would have a strictly controlled distribution network for such drugs and keep prices low enough to destroy the drug trade," he says in the book.

"Once that was attained, I would keep raising the prices, very much like the excise duty on cigarettes, but I would make an exception for registered addicts in order to discourage crime."

Part of the tax income would go on prevention and treatment work, and he would foster "social opprobrium" of drug use.

But Mr Soros also had an eye to public opinion and had gauged it not ready for legalisation. He said attempts to go against the "prevailing consensus" would be only counter-productive.

Mrs Mullins says the controlled sale of drugs, with tax receipts used to treat health problems, is putting the cart before the horse.

"It's what we do with the Quit campaign," she said. "Why introduce a new drug and repeat the syndrome? The scary part is that his logic appeals."

Dr Alex Wodak, director of Alcohol and Drug Services at St Vincent's Hospital and a leading Australian drug law reformer, says cannabis is a "relatively harmless drug that should be sold on a taxed and regulated basis like alcohol and tobacco".

Currently, only criminals and corrupt police were benefiting. They would be eliminated from the equation if the sale of cannabis were taxed and regulated.

But he would not say the "L" word.

"The status of a drug [illegible] tell you how it's controlled," he said. "Cocaine is an illegal drug that can be used legally in medicine and alcohol is a legal drug that can be used illegally. So I am choosing my words carefully."

No doubt, with polls showing 60 per cent of Australians opposed to the legalisation of cannabis.

At the Drug Policy Alliance's US office, Ethan Nadelmann frankly says it's all about tactics.

"Our policy is to tax and regulate the sale of marijuana. The reason we don't like to say legalisation is that, to the public, it sounds like you are condoning. If you ask people if they want to legalise cannabis, 20 per cent will say yes. But when you ask if they would support a policy to tax, control and regulate it like alcohol, 40 per cent will say yes.

"So (people) are responding to the connotation of a word, rather than to the substance of the policy."

Meanwhile, Mr Soros has campaigned hard for the legalised use of cannabis as a medical palliative, apparently because he thinks it is a winnable first step.

He has funded legislative efforts in several US States, with some success. But an Arizona bid ended remarkably in 1996.

A Bill became law until legislators realised it was written to include not just cannabis but 116 other Schedule One drugs, including LSD and heroin. Another Bill was quickly passed to scrap the whole idea.

The affair had Republican member, Mike Gardner, wondering aloud: "Why should a New York millionaire (Soros) be writing the laws in Arizona?"

Mr Soros replied, via the media: "I live in one place but I consider myself a citizen of the world. I have foundations in 30 countries and I believe certain universal principles apply everywhere — including Arizona."

GRAPHIC: KEN LEUNG

What cannabis does

AT THE basic level, cannabis can cause feelings of mild euphoria, relaxation, time distortion and intensification of ordinary sensory experiences. People can also become quiet and reflective, or sleepy. These effects are due to the proactive agent in cannabis, known as THC (Delta 9-tetrahydrocannabinol).

But there can be many other effects, including serious risks, especially where regular to heavy use is involved. They fall into two categories, of acute and chronic effects.

Acute effects are those that occur after a small dose or a small number of times of use.

They include heightened appetite (the "munchies"); reddening of the whites of the eyes; feelings of anxiety, panic and paranoia; impairment of short-term memory and concentration span, such that it becomes dangerous to drive a motor vehicle or operate machinery; and possible psychotic symptoms, such as hallucinations.

Chronic effects are those which can occur after a period of regular use (daily use over a period of years or decades).

These include possible cannabis addiction; probable respiratory diseases; memory damage and decline in other intellectual skills which can particularly affect school performance and occupational performance in adults; risk of giving birth to low-weight babies; toxic psychosis; and increased risk of developing schizophrenia.

There can also be a loss of energy and motivation, known as amotivational syndrome; depression; reduced libido; and irregular menstrual cycles.

THCs do have anti-nausea properties which reportedly make the drug useful in some clinical settings. But it can be fatal when combined with alcohol because it suppresses the vomiting reflex in teenagers who smoke a joint or two and drink heavily.

Because of its ability to boost appetite, cannabis has been used as an anti-anorexic agent for patients with AIDS wasting syndrome.

But because of potentially serious side effects, the prescription drug in question, Marinol, comes with an information sheet warning that it can cause several of the acute effects mentioned above, including "full blown psychosis".

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EW POLITICS OF POT

cal purposes*

hould be fined, not jailed

CAN IT GO LEGIT? How the people who brought you medical marijuana have set their sights on lifting the ban for everyone

By **JOEL STEIN** LAS VEGAS

THE DRUG CZAR IS READY FOR PRO wrestling. He already has the name, and now he's got the prefight talk down cold. In every speech he makes in Nevada, where Bush appointee John Walters has traveled to fight an initiative that would legalize marijuana, he calls out his three sworn enemies as if he were Tupac Shakur. The czar has a problem with billionaire philanthropists George Soros, Peter Lewis and John Sperling, who have bankrolled the pro-pot movement, and he wants everyone to know he's ready for battle. At an Elks lodge meeting in Las Vegas, he ticks off their names and says, "These people use ignorance and their overwhelming amount of money to influence the electorate. You don't hide behind money and refuse to talk and hire underlings and not stand up and speak for yourself," he says. By the end of a similar speech at a drug-treatment center in Reno, he says, "Let's stop hiding. I'm here. Where are you?" The czar is bringing it on.

Before the new czar was appointed in December, it was the government's preference not to address the legalizers. But the pro-pot movement has gained so much ground they can't be ignored as a fringe element. Americans, it turns out, aren't conflicted in their attitude toward marijuana. They want it illegal but not really enforced. A TIME/CNN poll last week found that only 34% want pot to be totally legalized (the percentage has almost doubled since 1986). But a vast majority have become mellow about official loopholes: 80% think it's O.K. to dispense pot for medical purposes, and 72% think people caught with it for recreational use should get off with only a fine. That seeming paradox has left a huge opening for pro-pot people to exploit. Eight states allow medical marijuana, and a handful of states have reduced the sentences for pot smokers to almost nothing.

The midterm election Nov. 5 has lighted up the issue even more. While control of

*From a TIME/CNN poll conducted Oct. 23-24 among 1,007 adult Americans. Margin of error is ±3%

Photographs for TIME by William Mercer McLeod

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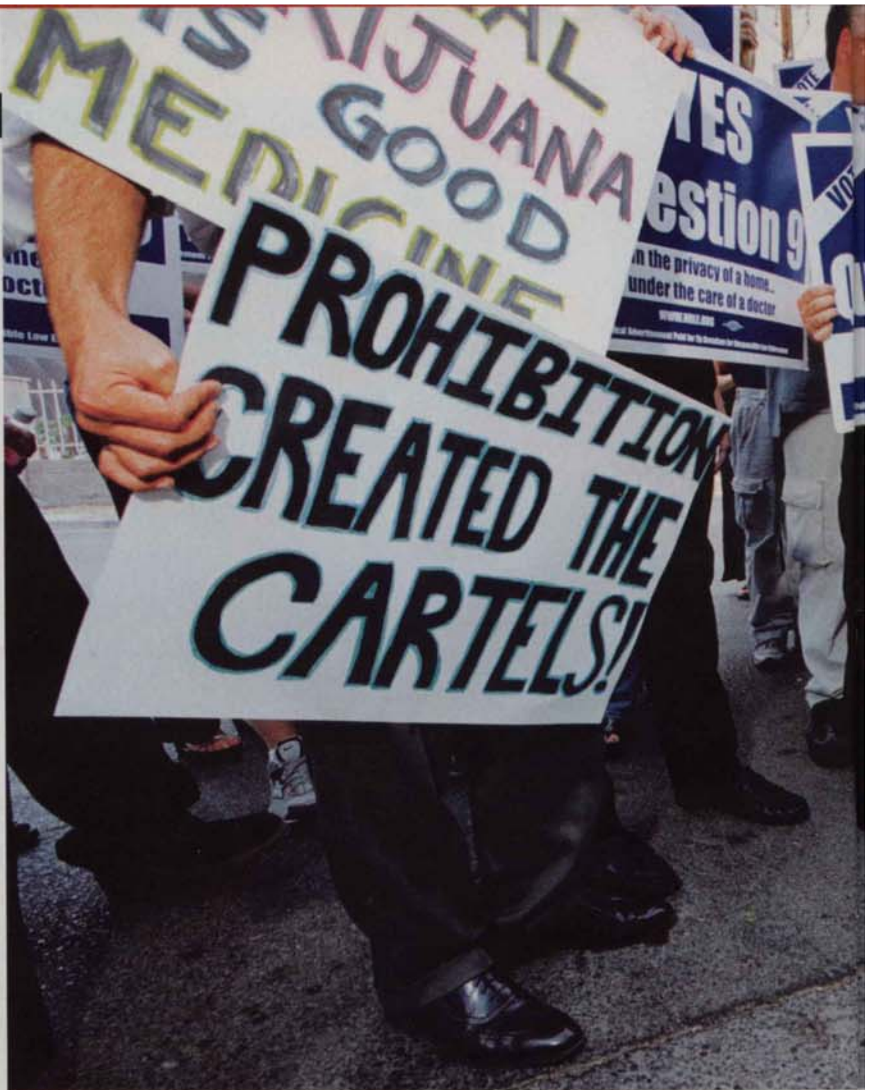
the House hangs in the balance and the race for the Senate is a dead heat, the political trend for marijuana is clear: it's gaining. The most interesting battles on the November ballot are over pot initiatives: to allow the city of San Francisco to grow and distribute medical marijuana, to replace jail with rehab in Ohio and decriminalize marijuana use in Arizona. Many of these proposals are relatively modest, but the pro-pot forces are also raising the stakes. In spite of the electorate's contentment with the paradox of loose enforcement, some particularly powerful people on both sides have taken extreme viewpoints in an effort to end the political stalemate and force Americans to choose. Either pot is not so bad and should be legal, or people should be arrested for smoking it. The battlefield for the showdown is Nevada, where Question 9 would allow adults to possess up to 85 g of pot for personal use. In fact, the state government would set up a legal market for buying and selling pot. To almost everyone's surprise, the race is too close to call.

While the pro-pot forces have pushed their agenda at the polls, opponents have tried to use legal muscle to fight back. After a Supreme Court decision last year reiterating that federal drug laws trumped state ones, the Drug Enforcement Administration sent federal agents to California to bust medical-marijuana growers, a move that tended to outrage California voters who had approved this use. In fact, as the Administration pushes harder against the pro-pot forces, pot supporters seem to gain ground.

Among the biggest pro-pot players, medical marijuana was actually kind of a ruse. Sure, there are sick people who really feel they need marijuana to numb pain, relieve the eye pressure of glaucoma, calm muscle spasms or get the munchies to help with AIDS wasting. But they are not the people who put the debate into high gear. A few years ago, the Drug Policy Alliance—an organization founded by billionaire philanthropist Soros, who wants to legalize marijuana and reform drug laws by replacing jail time with rehab—decided it would fund only those initiatives that could be won. So the group ran a bunch of polls to find out how America feels about the drug wars, and the reformers came up way short on everything but three policies: people preferred treatment over incarceration in some cases, people hated property forfeiture, and an overwhelming majority felt that medical marijuana should be legal.

So Soros & Co. set out to pass medical-marijuana legislation. The fight has done quite well, especially when the Federal Government, to their surprise, took the bait and started arresting paraplegics and little old ladies in front of TV news cameras. In fact, they've done well enough that some pro-pot people feel it is time to drop the ruse and fight for full legalization.

A gust of inspiration is coming from Britain, which is experimenting with a "seize and warn" policy instead of arresting pot smokers, and from Canada, which is talking about similar moves. In opening Parliament on Sept. 30, Ottawa announced it would consider "the possibility" of pot decriminalization—meaning that the government would replace criminal convictions, stiff fines and even jail terms with the equivalent of a traffic ticket for people caught with 30 grams of less of pot. Cagily, though, the government didn't say when. But the change would bring some reality to the current situation, in which cops and prosecutors rarely pursue simple possession cases, and when they do, judges usually register conditional or absolute discharges.



DRUG CZAR

JOHN WALTERS

The director of the White House Office of National Drug Control Policy, Walters worked for William Bennett under Reagan in the Department of Education and under George H.W. Bush as deputy drug czar. He believes the drug war is working

PRO-POT MONEY

GEORGE SOROS

A billionaire from financial speculation, Soros funds tons of charities, notably promoting democracy in post–Soviet bloc countries but also including programs on dying with dignity and the Drug Policy Alliance

PRO-POT PARTY: Outside a TV-news studio in Las Vegas, demonstrators rally in favor of legalization while the drug czar is interviewed inside

Still, the decriminalization talk has furrowed a few brows among feds in Washington, who are warning that the northern border could be tightened if Canada goes ahead with its promise. The progress of the U.S. pro-pot movement, on the other hand, has probably relaxed a furrowed brow or two in Canada, which is a major exporter of marijuana. British Columbia alone produces some $4 billion worth of very high-quality pot yearly, sending as much as 95% of it to the States.

With so many winds blowing the right way, the blunt-friendly pot crusaders in the U.S. feel it's time to take off the camouflage and fight. And where else would you try that but in Nevada? That's why the czar is in Vegas, sitting in a room at the Venetian Hotel guarded by U.S. marshals. The czar, a smart, likable, earnest man who believes he can help Americans by fighting the drug war, is derided by the opposition as "Bill Bennett's Mini-Me." Indeed, he worked for Bennett under Reagan in the Department of Education and then as Bennett's deputy drug czar in the first Bush Administration. When George W. appointed him, the President told the czar to watch the movie *Traffic* as a way to understand the problem. The czar, who told TIME he has never smoked pot, believes marijuana to be not only a gateway drug but also incredibly detrimental in its own right—causing driving accidents, domestic violence, health risks and crippling addiction. He thinks the legalization argument is absurd, especially when proposed by libertarian Republicans who are so doctrinaire he finds them to be outside his party. It doesn't take long for him to get back to the three billionaires: "It's unprecedented, the amount of money put in by such a small amount of people over one issue."

The marijuana legalizers, including the billionaires Walters vilifies, don't have much kinder things to say about him. In fact, for old rich men, they can sound a lot like Tupac. One of them, Sperling, 81, is founder of the highly profitable nationwide chain the University of Phoenix. He has spent $13 million on drug-reform campaigns and lots of other money on other pet projects, including cloning his cat. "Mr. Walters is a pathetic drug-war soul who is defending a whole catalog of horrors he's indifferent to," Sperling says from his office in Phoenix, Arizona. "He's driven by a Fundamentalist Christian sense of morality that sees any of these illegal substances used as evil." Sperling says he smoked pot to combat pain associated with the cancer he fought in the 1960s.

Lewis, 68, former CEO of Progressive, an insurance company, doesn't despise the czar quite as much, but he has been battling him even harder. The reasons for Lewis are more straightforward. He has been referred to by colleagues as a "functional pothead." He spends half the year on a $16.5 million, 77-m yacht, where he smokes pot regularly; he even got arrested in New Zealand on drug charges a few years ago. He is one of the main backers of the radical Nevada proposal, having given heaps of money to the Marijuana Policy Project, which is running Question 9 there. "I learned about pot from my kids and realized it was a lot better than Scotch, and I loved the Scotch. Then I went to my doctor, and he said, 'I'm thrilled. You're drinking too much. You're much better off doing pot than drinking.'"

Soros (who has smoked pot but no longer does) declined to be interviewed, and like the rest of the troika, he won't debate Walters. They are probably refusing his offer for two reasons: one, they would likely lose, since none of them are politicians; and two, if you were going around the world on a 77-m yacht, would you list "Drug Czar" as one of your ports of call?

JOHN SPERLING

After making billions creating the University of Phoenix, Sperling backed anti-aging and saltwater agriculture causes. He has donated $13 million to drug-reform campaigns, winning all 17 ballot initiatives he has backed

PETER LEWIS

Retired CEO of the insurance company Progressive and a scotch drinker turned regular pot user, billionaire Lewis gives money to the Marijuana Policy Project, which is spearheading the fight to legalize the drug in the State of Nevada

FROM LEFT, WILLIAM MERCER MCLEOD FOR TIME; TOMAS MUSCIONICO—CONTACT; ERIC O'CONNELL; CHRIS STEPHENS—THE PLAIN DEALER

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So instead they fight federal policy with initiative after initiative, concentrating on California. Their side got a major media boost in September, when federal agents busted Santa Cruz's Wo/Men's Alliance for Medical Marijuana in an early-morning raid, dragging paraplegics and cancer patients who were legally growing pot, according to California statutes, to jail in a federal building in San Jose for breaking federal law. "I opened my eyes to see five federal agents pointing assault rifles at my head. 'Get your hands over your head. Get up. Get up.' I took the respirator off my face, and I explained to them that I'm paralyzed," said Suzanne Pheil, 44, a paraplegic disabled by childhood polio. The pro-pot people had basically been waiting for her to get arrested, punching every phone number on their media list minutes after she was taken away. Pot people, surprisingly, can move pretty fast when they want to.

The bust couldn't have gone better for the pot folks. California attorney general Bill Lockyer fired off an angry letter to DEA chief Asa Hutchinson, who wrote back saying that the law treats marijuana the same as heroin. "During the Clinton years they didn't do this," says Lockyer. "It disappointed me that they would be using precious resources to act like a bunch of bullies." San Jose police chief William Lansdowne was so annoyed by the raid that he withdrew his officers from the local DEA task force, ending 15 years of close work. Even Governor Gray Davis, who has been quiet on the marijuana issue, spoke out against the feds' bust. A week after the raid, Santa Cruz officials gathered at city hall to supervise public distribution of marijuana to members of the Wo/Men's Alliance for Medical Marijuana in front of TV crews, a way to give Washington the finger.

But to many Republicans, this looks like bad politics for Bush. In Nevada, popular Republican Governor Kenny Guinn refuses to take a stand on Question 9, the pot-legalization amendment to the state constitution, saying he'll go with whatever the people vote for. And he won't really have to worry about it for a while, since the constitutional amendment will go into effect only if Nevadans vote yes on Nov. 5 and again in 2004. So Guinn may be smart to stay out of the debate, because the rhetoric from both sides has gone out of control.

The drug czar's latest commercial, which was actually focus-grouped with teens and their parents, shows two teens getting stoned in their father's study, talking apathetically about a bunch of stuff. One pulls out a gun from his dad's drawer, the other asks lazily if it's loaded, and the gun-toting teen shrugs and shoots the other kid. "The suggestion is not to say too many children are being shot in their dens who are marijuana users," Walters said. "It's meant to show that marijuana alters your ability to use judgment." In the other camp, many of the workers lied to voters in the course of gathering signatures to get Question 9 on the ballot, saying it was a medical-marijuana proposition, according to several pro-pot Nevadans. The two camps even fight regularly about how many joints can be made from 85 g of pot, the proposed legal maximum. The pro-pot people claim 80, while the anti-pot people carry around bags of 250 joints to illustrate their case. Yes, moms across the state are spending large parts of their nights rolling parsley and oregano.

The Marijuana Policy Project in Nevada has a chance partly because it is far better organized than its scattered opposition. The project made a smart move in hiring Billy Rogers, a Democratic political consultant from Texas, to run the Nevada campaign. Rogers' office is situated in a Vegas strip mall, just above an Asian massage parlor, which is right next to a children's tutoring center, which is all you need to know to understand why the project is staging this fight in Nevada. The office looks more like a sorority fund drive than a '60s dorm room. Posters drawn by children depict images like a teddy bear with a heart labeled VOTE YES ON 9. Rogers is still at work at 1 a.m., editing a commercial. "In college we'd sit around and talk about this—that when we grew up, we were going to change these laws. And now we're doing it," he says. Rogers, who says he hasn't smoked pot in 15 years, doesn't have a personal connection to the fight, but it's pretty easy to get him into a James Carville mood. When he talks about Walters' oft repeated claim (an assertion shared by the National Institute on Drug Abuse) that marijuana has much higher levels of tetrahydrocannabinol (THC) than it used to, that, in Walters' words, "it's not your father's marijuana," Rogers goes ballistic. "It's a plant. What—it's not your father's broccoli? Its genetic structure hasn't changed in 30 years," he says, eating steak for a late-night meal. "These guys will say anything. If I had a billion-dollar budget, I'd say anything to stay in business."

STIRRING THE POT

States that allow the use of medical marijuana

States with largely symbolic medical marijuana laws (provisions that are dormant or cannot be implemented)

November ballot initiatives on medical marijuana

Other marijuana-related ballot initiatives

States that introduced legislation in the past session that either stalled in committee or did not pass

Striped states represent overlapping categories
Sources: Marijuana Policy Project, Drug Policy Alliance

Note: Washington, D.C. and Ohio have ballot initiatives calling for drug treatment instead of jail

MIKE FIALA—AP

PAUL FUSCO—MAGNUM

FIERY ISSUE: Members of a collective get medical marijuana in Santa Cruz, Calif.; a lawman burns an illegal crop in Kentucky

That's one of the major conspiracy theories of the pro-legalization movement—a rant right out of the Eisenhower era, that the government is keeping pot illegal so it can maintain its giant drug-war bureaucracy. Its advocates also believe—as put forth directly in the pro–medical marijuana commercials of billionaire independent New York gubernatorial candidate Tom Golisano—that politicians are in the pocket of the pharmaceutical companies, who fear marijuana is such good medicine that their own products will suffer. The pro-legalization forces also believe, more convincingly, that the right wing of the Republican Party connects drug use with sin and radicalism and the failure of the family. "I've known John Walters for about 10 years, and I don't think this is about drugs for him," says Ethan Nadelmann, head of the Drug Policy Alliance. "John is a reactionary ideologue. It's the broader battle about what we tell kids about life. It's a vehicle for promoting a tougher, meaner approach to life and government."

Even some Republicans are ready to legalize medical marijuana. Texas Congressman Ron Paul, a doctor and onetime Libertarian Party presidential candidate and a former doctor, has been fighting for medical marijuana. "From a humanitarian standpoint, people should never be denied this kind of help," says Paul. Hutchinson stands behind the decision to prosecute. "Why would they want to authorize behavior under state law that is still a violation of federal law?" says Hutchinson. "It endangers a population, to me. It gives the green light on the one hand and a go-to-jail ticket on the other."

Among cops and other law enforcers, there are sharp divisions too. Some conservatives, like Joseph D. McNamara, a former San Jose police chief and now a Hoover Institution fellow, call for an end to the criminalization of marijuana. "Most of the police officers I hired during the 15 years I was police chief had tried it," says McNamara. Like many pot legalizers, he believes the system, which he says arrests more people for marijuana than for any other drug, is racist. "Ninety million Americans have tried marijuana. When you look at who's going to jail, it is overwhelmingly disproportionate—it's Latinos and blacks." Even so, the topic is radioactive in the police profession. Andy Anderson, who was head of his state's largest cop organization, the Nevada Conference of Police and Sheriffs, said his board members voted 9-0 to endorse the pro-pot initiative so they could focus on more serious crimes. A few days later, Anderson was forced to resign. The voice for Nevada cops then became Gary Booker, the chief deputy district attorney in charge of the vehicular-crimes unit, until he told members of the press he thinks Soros is pro-legalization because he bankrolls drug cartels. When talking to TIME at the Elks lodge where he introduced the drug czar, Booker said, awkwardly trying to explain away his statement: "The word cartel was used, not drug. A cartel is a group of businessmen who control price, and that's what we've got here. Three or four guys are controlling the thing." He too stepped aside from the role of Nevada police spokesman.

The pro-pot people feel that victory—even if it comes not this year and not in Nevada—is inevitable: each year there are fewer members of the pre-boomer generation, who tend not to distinguish between heroin and pot. In 1983, only 31% of Americans surveyed had tried pot, while the new TIME/CNN poll puts the figure at 47%. And though pot use among teens is down from its '70s highs, the number of parents who sneak joints when their kids are asleep is a fresh phenomenon. But from polls, the pro-pot forces also know that Americans still cling to pot's forbidden status, which is why their people are working so hard. "You would think you would get a change, but you're not going to," says Charles Whitebread, a law professor at the University of Southern California who has written extensively on marijuana law. "Even though it did nothing to them, the fear that it will somehow pollute their children has made some of the people who used marijuana extremely freely now say, 'Oh, gee, I wouldn't be in favor of the change in the legal status of marijuana.'" It may be that the major dividing line between the pro- and anti-legalizers is not party affiliation but parental status. And even among parents, moms seem more against pot than dads.

So, barring another wave of '60s-like radicalism or a lot more poorly thought-out paraplegic busts by the feds, Americans' complicated feelings about pot aren't going to be reconciled overnight. And recent studies showing that marijuana can have addictive properties, though in a small percentage of cases, is going to make some parents more nervous about their kids turning into potheads. While alcohol and cigarettes may be more dangerous, a lot of parents would rather smell beer on their kid's breath than have a 29-year-old living at home, eating Cheetos and watching *SpongeBob*. ***—With reporting by Matt Baron/Chicago, Laura A. Locke/San Francisco, Viveca Novak/Washington and Sean Scully/Los Angeles***

CONTRIBUTORS

MEDICAL MARIJUANA BALLOTS

CALIFORNIA AND ARIZONA

Arizona Residents contributed a total of $432,457 to Arizonans for Drug Policy Reform, the group that sponsored Proposition 200. Most of that money came from a single donor, John Sperling, who contributed $430,000. Interested parties outside the state contributed $1,085,240 during the same period. The New York office of the Drug Policy Foundation gave $200,000 to the campaign. Financier George Soros of New York contributed $430,000. (Soros recently gave the Drug Policy Foundation more than $10 million.) Peter Lewis of Ohio contributed $330,000. Total funds raised for the campaign are $1,517,697.

Californians for Medical Rights, which sponsored Proposition 215, raised $1,842,902. Proposition 215 will remove criminal penalties and sanctions for the possession or cultivation of unspecified amounts of marijuana for any medical problem "for which marijuana provides relief" if the person has a verbal recommendation from a doctor to use the drug. Of the total amount raised in California during this reporting period, $311,545 came from California residents, including $194,750 from the Life AIDS Lobby in Sacramento. Out-of-state residents contributed $1,442,900. Large contributions came from George Soros of New York ($550,000), Peter Lewis of Ohio ($500,000), John Sperling of Arizona ($200,000), and the Dennis Trading Group of Illinois ($100,000). Laurance Rockefeller, with no address listed, contributed $50,000.

The following table summarizes campaign contributions to both state efforts:

Contributor	Arizona	California
In-State Residents	$ 2,457	$ 9,795
John Sperling	$430,000	$0
Life AIDS Lobby(Sacramento)	$ 0	$194,750
George Zimmer	$ 0	$50,000
Marsha Rosenbaum	$ 0	$25,000
Alameda Medical Marijuana PAC	$ 0	$19,500
Gail Zappa	$ 0	$5,000
Tara Foundation	$ 0	$5,000
Ellen Rosenbaum	$ 0	$2,500
Total In-State	**$432,457**	**$311,545**
Out-of-State Residents	$240	$1,900
Drug Policy Foundation, D.C.	$200,000	$ 0
George Soros, New York	$430,000	$550,000
Peter Lewis, Ohio	$330,000	$500,000
John Sperling, Arizona	$ 0	$200,000
Social Policy Forum, D.C.	$100,000	$ 0
Dennis Trading Group, Illinois	$ 0	$100,000
Laurance Rockefeller	$ 0	$50,000
James Edward Zimmer, Texas	$ 0	$25,000
Richland Hills Company, Florida	$ 0	$10,000

Richard Wolf, Florida	$25,000	$5,000
Robert W. Hail, Nevada	$ 0	$1,000
Total Out-of-State	**$1,085,240**	**$1,442,900**
Contributions Less Than $100	$ 0	$12,962
Loans, In-Kind Contributions	$ 0	$75,495
Total Contributions	**$1,517,697**	**$1,842,902**

Defeat of Legalisation Lobby Initiatives in the United States December 2002

They Just Said No

By Jim McDonough

Source: Washington Times <http://www.washtimes.com/>

Among the seismic shifts of Nov. 5 was the quashing of a phalanx of pro-drug electoral ruses. A well-financed, meticulously organized nationwide effort by advocates of drug decriminalization went down to stinging defeat in a number of state contests.

* Nevada voters rejected (61 percent) an effort to legalize the sale and use of three ounces or less of Marijuana.

* Ohio voters rejected (67 percent) a so-called right-to-drug-treatment initiative that would have been a decriminalization of drug use.

* Arizona voters rejected (57 percent) a proposal advancing so-called "medical" marijuana smoking.

* South Dakotans rejected (63 percent) a proposal to legalize, process, and market hemp.

The debacle for the legalization movement was even more disastrous than election day implied. Earlier in the year, the "reform" movement withdrew in disarray from Florida after a year of heavy spending, having failed to obtain more than 20 percent of the signatures necessary to put a mislabeled "right to treatment" amendment on the ballot. Interestingly, the entire treatment community in Florida rejected this thinly camouflaged

decriminalization overture, and Florida's governor had already increased funding for genuine treatment by 60 percent over the prior three years.

Meanwhile, in Michigan, where the decriminalization cabal had purchased the requisite signatures to advance another right to treatment initiative, the Michigan Supreme Court correctly spotted technical errors in the proposal's wording and barred it from the ballot. Despite a massive and organized effort, a high-financed campaign (outspending the opposition 12-1 in Nevada, 4-1 in Ohio, etc.) could not effect one state law that would have weakened existing anti-drug laws.

The legalizers were reduced to city fighting (i.e., Washington - where the initiative remains unfunded; San Francisco, etc.). The net result was a broad-based rejection of the drug normalization campaign begun in the mid-1990s.

Beginning in 1996 in the nation's West, drug decriminalization advocates found the opening that they had long sought to wage a "war on the war on drugs." Perceiving a political opening created by a supposed sense of exhaustion on the part of an uninformed public, a trio of wealthy social gadflies (financier George Soros, businessman John Sperling and insurance maven Peter Lewis) teamed well-heeled brain trusts with street soldiers readily available from the old pro-drug movement to establish a beachhead in the nation's political and legal system by over-running dispirited and under-funded, and over-worked "outposts" of law enforcement, social health organizations, and public officials.

Advancing boldly into America's heartland in 2001 with their marijuana and right to treatment initiatives, the drug legalizers now find their new offensive smashed, perhaps irretrievably. How did this happen? They ran into a broad resistance movement by an emerging national coalition of grass-roots prevention, education and treatment specialists allied with concerned parents, neighborhood leaders and public officials dedicated to halting the spread of illicit drug use.

Although the anti-drug coalitions were outspent everywhere by the pro-drug crowd, fundamental truths combined with passion and conviction to trump a large campaign chest.

The tactics of the National Organization for the Reform of Marijuana Laws - use opinion polling to craft "acceptable" initiatives, convince the mass of voters that they are wrong to oppose legalization, approach drug legalization incrementally, line up a string of victories, invoke "medical" sympathy, exaggerate numbers of "peaceful" pot smokers behind bars, and so on - failed. They failed because legalizers based their campaign on the flawed premise that a gullible electorate could be misled by smoke and mirrors.

In the end, the mirrors cracked and the smoke cleared: No medicine is smoked; only a handful of "peaceful" marijuana users end up with a prison sentence (e.g., 0.14 percent of the Florida prison system, or 107 out of 74,000 - and each of them a plea bargain); the overwhelming harm is done by the drugs, not the laws to protect against them. The barrage of lies and half-truths backfired, and the voters voted accordingly.

No wonder Rob Kampia, the head of the Marijuana Policy Project, admitted the morning after the election that he could not try "to dress up a pig" (in his words). They had tried that for too long - and it no longer worked. They vow to come back next time. But if camouflage, incrementalism and exaggeration continue to fail, they will find it hard to overcome the innate good sense of the American voter.

Jim McDonough is the director of the Florida Office of Drug Control. He previously served as director of strategic planning at the Office of National Drug Control Policy.

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APPENDIX C

Recommendations of the NSW Working Party on the Use of Cannabis for Medicinal Purposes

Recommendation 1
While recognising the limitations of currently available pharmaceutical preparations of cannabinoids, the Working Party recommends that they should be subject to further clinical trials of safety and efficacy as described below.

Recommendation 2
The Working Party recommends that the New South Wales Government through the Australian Health Ministers' Forum explore avenues for greater flexibility in new medication registration by the TGA based on the clinical needs of special populations.

Recommendation 3
The Working Party recommends that the Government consider funding or otherwise facilitating surveys of current medical users of cannabis and their carers to obtain an indication of how many persons are at risk of criminal prosecution for medical use of cannabis.

Recommendation 4
The Working Party recommends that the Government consider funding or otherwise facilitating surveys of potential medical users of cannabis and cannabinoids to obtain an indication of how many persons would wish to use cannabinoids for medical purposes under a more favourable regulatory regime.

Recommendation 5
The Working Party recommends that randomised controlled clinical trials, and controlled studies in individual patients, be conducted on the therapeutic efficacy of cannabis and cannabinoids.

Recommendation 6
It urges the NSW government to consider funding or otherwise facilitating research for this purpose.

Recommendation 7
The Working Party recommends that the NSW Drugs Misuse and Trafficking Act 1985 be amended to ensure that there are no legal obstacles to the conduct of such trials.

Recommendation 8
That additional research be conducted into the basic chemistry and pharmacology of cannabinoids with the aim of developing cannabinoids that have therapeutic effects and that may be delivered more safely and effectively than by smoking cannabis.

Such research could be undertaken through the following avenues:

- either investigator-initiated or proposal requests from the National Health and Medical
- Research Council peer-reviewed system;
- funding from the Ministerial Council on Drug Strategy/ Intergovernmental Committee on Drugs;
- small grants provided by the State government for researchers to develop more detailed
- proposals to be funded through mechanisms for peer-reviewed research.

Recommendation 9
The Working Party is in sympathy with the motivation and spirit of the recommendations in the Institute of Medicine and House of Lords reports. Accordingly, it recommends the introduction in NSW of a compassionate regime to assist those suffering from the range of illnesses identified above to gain the benefits associated with the use of cannabis without facing criminal sanctions, pending the development of safer and more efficient methods to deliver cannabinoids.

Recommendation 10
That the Government consider licensing the supply, including the importation, of cannabis, but only for the purposes of the clinical trials proposed in Recommendation 5.

Recommendation 11
That a person should not be prosecuted if they have the prior medical certification from an accredited medical practitioner that they suffer from a medical condition that may benefit from cannabis use.

Recommendation 12
That the onus be placed on the medical user of cannabis plant material to establish evidence of medical certification before use.

Recommendation 13
That the conditions included under this certification should be:

- HIV-related wasting and cancer-related wasting;
- pain unrelieved by conventional treatments;
- neurological disorders including (but not limited to) multiple sclerosis, Tourette's syndrome,
- and motor neurone disease;
- nausea and vomiting in cancer patients undergoing chemotherapy which does not respond to conventional treatments.

That, as this list may need to be amended in the light of further medical research, it should be specified by regulation rather than by primary legislation.

Recommendation 14
That certification be extended to the possession and use of small amounts of cannabis for medical use by patients.

Recommendation 15
That the "small" amount of cannabis for the possession and use exemption should correspond to the small amount in the NSW Drugs Misuse and Trafficking Act 1985. At present this is 30 grams of cannabis leaf, 5 grams of cannabis resin, and 2 grams of cannabis oil.

Recommendation 16
That certification be extended to the growing of small amounts of cannabis for medical use by patients in their own homes.

Recommendation 17
That, although the "small" amount of cannabis, as defined under the Drugs Misuse and Trafficking Act is five plants, consideration be given to lowering this limit for medical certification by allowing cultivation of up to five plants under 25 cm but only two above that height.

Recommendation 18
That no consideration should be given to altering the law to allow "compassion clubs" to operate legally.

Recommendation 19
That the possession, supply, administration and cultivation of cannabis for personal medical use by patients with one of the specified conditions only be considered lawful if the patient possesses a

certificate to this effect from an accredited medical practitioner; and that this certificate should be renewed every six months.

Recommendation 20
That "accredited medical practitioners" be trained in the following.

1. Certification of patients with:

   - HIV- or cancer-related wasting;
   - nausea secondary to chemotherapy that is unresponsive to conventional treatments;
   - neurological disorders such as multiple sclerosis;
   - pain that is unresponsive to conventional treatment.

2. Counselling patients about the health risks of cannabis smoking.

Recommendation 21
That legislative safeguards be established to ensure that no civil or criminal liability is incurred by any person authorised to medically certify cannabis, or assist in the proper medical certification of cannabis for recognised therapeutic purposes, if the certifier had reasonable grounds to believe that the patients had given informed consent.

Recommendation 22
That certification which renders lawful the possession, supply, administration and cultivation of cannabis be extended to carers of patients who are too ill or debilitated to obtain cannabis or to cultivate cannabis plants for their own use, as long as stringent criteria for extending this certification are met.

Recommendation 23
That, if the recommendations in this report are adopted, the NSW Government conduct educational campaigns to inform the following people:

- patients who may qualify for certification;
- medical practitioners;
- the public in general.

of the benefits and possible risks of cannabis use for medical purposes, and of the implications of any legislative changes which may have to be introduced.

Recommendation 24
That the Government consult with patients, carers, prescribers and other affected parties on the proposed changes and conduct a formal evaluation of the operation of the legislation after a trial period of two years.