**SUBMISSION**

Prepared by Associate Professor Kate Seear (Faculty of Law, Monash University; Australian Drug Lawyers Network) and Springvale Monash Legal Service

# Joint submission to the Senate Community Affairs References Committee inquiry into the current barriers to patient access to medicinal cannabis in Australia

17 January 2020

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## ABOUT US

This is a joint submission of the Springvale Monash Legal Service (SMLS) and an academic from the Faculty of Law at Monash University (Kate Seear). Associate Professor Seear is also the founder and convenor of the Australian Drug Lawyers Network. Brief background details appear below.

Established in 1973, Springvale Monash Legal Service ('SMLS') is a community legal centre that provides free legal advice, assistance, information and education to people experiencing disadvantage in our community. We are located in South East Melbourne, with offices and outreach locations across the City of Greater Dandenong, the City of Casey, and the Shire of Cardinia. The City of Greater Dandenong is the second most culturally diverse municipality in Australia, and the most diverse in Victoria. People from over 150 different countries reside in Greater Dandenong and 60% of the residents were born overseas. It also has the highest number of resettlements from newly-arrived migrants, refugees and asylum seekers in Victoria. Data from the 2016 Census revealed that Greater Dandenong was the second most disadvantaged LGA in Socio-Economic Indexes for Areas ('SEIFA') ratings. The City of Casey has one of the largest populations of Aboriginal and Torres Strait Islander residents in metropolitan Melbourne, as well as a high number of residents from refugee or asylum seeker backgrounds. Residents speak over 140 different languages and belong to over 120 faiths.

SMLS operates a duty lawyer service at various courts in Victoria, including Dandenong Magistrates Court, the Children's Court and provides legal representation in courts and tribunals such as the Victorian Civil and Administrative Tribunal, Fair Work Commission, Federal Circuit Court, Family Court and VOCAT. For most of our 40 years in operation, SMLS has been running a clinical legal education program in conjunction with Monash University's Faculty of Law, whereby law students undertake a practical placement at the legal service as part of their undergraduate degree. Additionally, as a community legal centre, we offer tailored community development programs, community legal education legal education programs and community engagement activities. For example SMLS has contributed to reforms in family violence laws and practices, access to civil procedure reforms, discrimination towards young community members in their use of public space and their interactions with the criminal justice system, as well as in highlighting the needs of refugees and asylum seekers, particularly unaccompanied humanitarian minors and women escaping family violence.

Associate Professor Kate Seear is an Associate Professor in Law in the Faculty of Law, Monash University. The Faculty of Law at Monash University is part of the 'group of eight' universities. She is a practising solicitor and Academic Director of Springvale Monash Legal Service. She also holds a competitive research fellowship from the Australian Research Council in the form of a Discovery Early Career Researcher Award (DECRA) Fellowship. This fellowship was awarded in 2016 and ran until 2019. It funded A/Prof Seear to undertake a major international comparative study on alcohol and other drug issues/'addiction' in Australian and Canadian law. At the conclusion of this fellowship, A/Prof Seear established the Australian Drug Lawyers Network: a professional network for information and knowledge exchange. A/Prof Seear is also an Adjunct Research Fellow at the National Drug Research Institute, Curtin University. She was previously employed there as a postdoctoral research fellow. She is also an associate member of the DruGS (drugs, gender and sexuality) program in the Australian Research Centre in Sex, Health and Society at La Trobe University. She is a member of the editorial board of the international specialist journal *Contemporary Drug Problems*, and regularly peer reviews papers, by invitation from other experts around the world, on alcohol and other drug law and policy, including for prestigious international journals such as the *International Journal of Drug Policy*. A/Prof is the recipient of numerous grants, awards and prizes for her drug research, including the 2019 Vice Chancellor's Award for research impact (economic and social) at Monash University. This is the top prize awarded to an academic at the university. A/Prof Seear is the corresponding author for this submission.

As noted above, A/Prof Seear is an expert in alcohol and other drug issues, and is the author of numerous books, reports and peer-reviewed academic articles on drug policy, drug law, alcohol and other drug-related stigma and discrimination, human rights and drug policy and medicinal cannabis. SMLS has represented two clients charged with medicinal cannabis offences and has other experience over several decades representing people charged with other drug offences including cannabis use, possession and supply. A/Prof Seear's research and SMLS' advocacy for these clients have helped to formulate about approach to this submission and the recommendations we are making. The submission also benefitted from contributions by Monash Law students who provided research assistance on this project.[1]

## OUR FOCUS IN THIS SUBMISSION

On 14 November 2019, the Commonwealth Senate agreed to hold an urgent inquiry into access to medicinal cannabis in Australia, seemingly recognising that access issues were leading some people to break the law. We welcome the Inquiry into current barriers to patient access to medicinal cannabis in Australia and the opportunity to identify possible areas of law reform with the aim of improving the justice system's responses to those experiencing barriers to accessing medicinal cannabis. This submission considers the current legal frameworks and administrative requirements governing medicinal cannabis, best practice international models, identifies areas for improvement and makes suggestions for law reform.

We are not seeking confidentiality regarding this submission.

The terms of reference for this Inquiry are as follows:

> The current barriers to patient access to medicinal cannabis in Australia, including:
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> (a) the appropriateness of the current regulatory regime through the Therapeutic Goods Administration (TGA) Special Access Scheme (SAS), Authorised Prescriber Scheme and clinical trials;
>
> (b) the suitability of the Pharmaceutical Benefits Scheme for subsidising patient access to medicinal cannabis products;
>
> (c) the interaction between state and territory authorities and the Commonwealth, including overlap and variation between state and territory schemes;
>
> (d) Australia's regulatory regime in comparison to international best practice models for medicinal cannabis regulation and patient access;
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> (e) the availability of training for doctors in the current TGA regulatory regime for prescribing medicinal cannabis to their patients;
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> (f) the education of doctors in the Endogenous Cannabinoid System (ECS), and the appropriateness of medicinal cannabis treatments for various indications;

[1] Those students are: Aran Haupt; Artin Dezfouli; Bianca Levin; Charlotte Coggin; Lauren Sellars; Mathew Choo; Peter Andreakos; Tingting He; and Wing Leung Chung. The final submission is the work of A/Prof Seear and SMLS alone.

(g) sources of information for doctors about uses of medicinal cannabis and how these might be improved and widened;

(h) delays in access, and the practice of product substitution, due to importation of medicinal cannabis and the shortage of Australian manufactured medicinal cannabis products;

(i) the current status of the domestic regulated medicinal cannabis industry;

(j) the impacts on the mental and physical wellbeing of those patients struggling to access medicinal cannabis through Australia's regulatory regime;

(k) the particular barriers for those in rural and remote areas in accessing medicinal cannabis legally;

(l) the significant financial barriers to accessing medicinal cannabis treatment;

(m) the number of Australian patients continuing to rely on unregulated supply of medicinal cannabis due to access barriers and the impacts associated with that; and

(n) any related matters.

Our submission addresses those terms of reference that are within our expertise and experience. As we are based in Victoria, our submission also focuses on elements of the Victorian experience. We make a number of recommendations and these are detailed below.

## OPENING STATEMENT REGARDING MEDICINAL CANNABIS IN AUSTRALIA

1. Australia, like most other countries around the world, is a signatory to international conventions that prohibit the consumption of certain drugs. There are three main conventions, the first of which was introduced in 1961.[2]

2. In recent years, cannabis has begun to be legalised for medicinal purposes across Australia.[3] This change has come about in part because of emerging evidence detailing the benefits of medicinal cannabis for certain medical conditions. It may be of benefit for certain medical conditions (such as arthritis and intractable seizures), ease the side effects of chemotherapy and radiotherapy, and it may even shrink cancerous tumours.[4] Research is being done on these issues around the world, including at the Lambert Initiative (LI) at Sydney University.

3. In recent years, several countries around the world have begun to relax their drug laws.[5] Access to some drugs (such as cannabis and psilocybin) have been decriminalised or even legalised, and several parliamentary inquiries in Australia are currently underway exploring these issues.

4. As the Committee will be aware, and will no doubt hear through other submissions to this Inquiry, Australia's current legal approach to medicinal cannabis is imperfect. Although we commend

[2] https://www.unodc.org/unodc/en/treaties/single-convention.html
[3] https://www.tga.gov.au/access-medicinal-cannabis-products-using-access-schemes
[4] https://www.liebertpub.com/doi/10.1089/pancan.2018.0019
[5] Seear, K. (2020). Addressing alcohol and other drug stigma. Where to next? *Drug and Alcohol Review*. Available early online: https://onlinelibrary.wiley.com/doi/full/10.1111/dar.13028

parliamentarians at federal, state and territory levels for opening up access to medicinal cannabis in recent years, existing systems are flawed in several respects.

5. We will not repeat the history of reforms and the existing regulatory frameworks here, as these matters will be well known to members of the Committee. Nevertheless, the existing regulatory system is complex and slow, the process for obtaining licences is slow, and medical practitioners are not always knowledgeable about medicinal cannabis and comfortable in prescribing it. Medicinal cannabis products are also relatively expensive (compared to some other medications).

6. Importantly, the cost of medication appears to be prohibitive for all but a few members of the community, meaning that although medicinal cannabis is *technically* accessible, for many Australians, it remains *practically* inaccessible. This has resulted in some people deciding to cultivate their own medicinal cannabis, to access it illegally, or to supply it to others on 'compassionate' grounds.

7. Several individuals have been prosecuted for this, including parents, friends, carers and doctors. Recent high-profile cases include the prosecution of Dr Andrew Katelaris in NSW in 2018 and the prosecution of Jenny Hallam in South Australia in 2019. Dr Katelaris represented himself and was acquitted. Ms Hallam received a good behaviour bond and no conviction.

8. Criminal justice responses to these developments have been inconsistent across Australia. These inconsistencies do not merely reflect differences between individual defendants and their circumstances (e.g. whether they have prior convictions) but fundamental differences in criminal law across the states and territories.

9. For the benefit of the Committee, **we include a table of all publicly reported/known cases where individuals have been prosecuted, as Appendix 1 to this report.** This table contains details of these cases and/or their current status, to the best of our knowledge, including some cases, decided on different grounds, from overseas.

10. The creation of inequalities in access on financial grounds or on the basis of one's jurisdiction is hugely problematic. Further, the use of the criminal law to prosecute sick and dying individuals, their carers, parents, other family members and treating physicians is problematic; it exacerbates, generates and magnifies people's suffering at a time of already significant suffering and vulnerability. The fact that the criminal law generates different outcomes for such individuals (Appendix 1) is even more concerning and raises important questions about health justice.

11. In our opinion, finding ways to address and reduce these inequalities and issues must be a focus for this Committee moving forward.

12. It is also important to note that this Inquiry is being undertaken as a seismic shift is underway in global drug policy. In early 2019, for instance, the heads of all 31 United Nations agencies released a communiqué calling for decriminalisation of drugs and a move away from ineffective punitive approaches.[6] Importantly, the UN's call for immediate change noted that reforms must be shaped by *human rights.* The new *International Guidelines on Human Rights and Drug Policy* recommend all countries undertake a 'transparent review' of drug laws and policies for their human rights compliance, and subject proposed new laws to human rights 'assessment'.[7]

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[6] United Nations Chief Executives Board for Coordination (2019). *Summary of deliberations.* United Nations: New York.
[7] World Health Organization, UNAIDS, UNDP and the International Centre on Human Rights and Drug Policy. (2019). *International Guidelines on Human Rights and Drug Policy.* United Nations: Geneva.

13. In our view, these developments necessitate that the Committee take into account international developments including calls for moves away from punitive approaches to drugs (currently enabled by inequalities in access) and calls for approaches to be based in human rights. As we shall also explain, it is imperative that the Committee give consideration to the current system's capacity to generate or exacerbate stigma, given the proven relationship between stigma and health, social and economic outcomes. We address these issues later in this submission.

*RECOMMENDATION 1: That the Committee takes into account international developments with respect to cannabis, especially the growing international consensus for moving away from punitive responses to drug use, calls for human-rights based approaches to drugs and reforms to access to cannabis in the form of decriminalisation and legalisation.*

1. As noted above, the heads of all 31 United Nations agencies released a landmark communiqué in early 2019 calling for decriminalisation of drugs and a move away from punitive approaches.[8]

2. Existing approaches create inequalities of access and provide incentives for people to cultivate, supply, use and possess cannabis unlawfully.

3. In other words, **existing approaches to medicinal cannabis create the enabling conditions for more punitive responses, which is at odds with both recent international developments and the purpose of opening up access to medicinal cannabis to begin with.**

4. Therefore, the Committee should give serious consideration to decriminalisation or legalisation of cannabis more broadly, given that criminalisation remains the overarching (punitive) framework that impacts on individuals who are unable to access medicinal cannabis under the existing schemes.

5. Decriminalisation is defined as 'the removal of criminal offences for specific penalties'.[9] Decriminalisation is distinct from legalisation and may occur in a variety of ways.[10] A distinction is sometimes drawn between 'de facto' and 'de jure' decriminalisation:

> In a *de jure* reform criminal penalties for use/possession are removed in the law (with optional use of non-criminal sanctions). In a *de facto* reform criminal penalties remain in the law, but can be lessened in practice (eg via police guidelines to not enforce the law).

Research suggests a number of benefits associated with decriminalisation. These include financial savings from reduced law enforcement activities,[11] and improved social outcomes.[12]

[8] United Nations Chief Executives Board for Coordination (2019). *Summary of deliberations*. United Nations: New York.
[9] Hughes, C., Ritter, A., Chalmers, J., Lancaster, K., Barratt, M. & Moxham-Hall, V. (2016). *Decriminalisation of drug use and possession in Australia – A briefing note*. Sydney: Drug Policy Modelling Program, NDARC, UNSW Australia at 2.
[10] Hughes, C., Ritter, A., Chalmers, J., Lancaster, K., Barratt, M. & Moxham-Hall, V. (2016). *Decriminalisation of drug use and possession in Australia – A briefing note*. Sydney: Drug Policy Modelling Program, NDARC, UNSW Australia at 2.
[11] Single, E., et al. (1999). The Impact of Cannabis Decriminalisation in Australia and the United States. South Australia, Drug and Alcohol Services Council. See also Baker and Goh (2004) http://www.bocsar.nsw.gov.au/Documents/r54.pdf
[12] Lenton, S., et al. (1999). Infringement versus Conviction: the Social Impact of a Minor Cannabis Offence Under a Civil Penalties System and Strict Prohibition in Two Australian States. Canberra, Department of Health and Aged Care; Males, M. & Buchen, L. (2014). 'Reforming Marijuana Laws: Which Approach Best Reduces the Harms of Criminalization? A Five-State Analysis', San Francisco: Center on Juvenile and Criminal Justice.

*RECOMMENDATION 2: That any reforms to medicinal cannabis legal frameworks need to consider human rights, incorporating our international human rights obligations and the specific implications for those jurisdictions in Australia that have human rights charters.*

6. As noted earlier, the UN's call for immediate change noted that reforms must be shaped by human rights.

7. In recent years a number of key stakeholders including international figures and organisations have expressed concern that existing drug laws and policies enable human rights breaches.[13] The prosecution of people for certain drug offences also raises important human rights questions.

8. Human rights considerations are especially important in Victoria (where we are based), Queensland and the ACT, as all three of these jurisdictions have introduced human rights charters. These impose specific obligations to consider human rights. In 2006, Victoria became the second Australian jurisdiction (after the Australian Capital Territory) to introduce a human rights charter (formally known as the *Charter of Human Rights and Responsibilities Act 2006;* hereinafter referred to as 'the Charter').

9. The Charter ascribes human rights obligations to various 'public authorities', including, per section 4(1)(d), the Victorian police.

10. Charter obligations imposed on public authorities are both substantive and procedural.

11. Victorians do not have an obligation to prove that their human rights should be upheld; rather, there is an obligation on public authorities to consider and uphold human rights in the work that they do. If they purport to limit human rights in any way, they can do so only in accordance with section 7 of the Charter and they have the obligation to demonstrate how any limitation of rights is justifiable in accordance with the criteria detailed in that section.

12. Similar processes exist for other legislation that imposes human rights obligations.

13. Further, only some rights are capable of being limited. Some rights (such as the right to freedom from torture and cruel, inhuman or degrading treatment) are thought of as absolute rights, meaning that they cannot be limited.

14. The Charter recognises a number of rights potentially relevant to medicinal cannabis access schemes, including the right to recognition and equality before the law (section 8), the right to life (section 9) and the right to protection from torture and cruel, inhuman or degrading treatment (section 10).

15. To the extent that individuals find themselves in the predicament they are in (i.e. unable to practically access medicinal cannabis) due to a combination of illness/disability and reduced financial means, the prosecution of them raises questions about compliance with section 8 of the Charter (the right to equality before the law). That is, a wealthier person facing diagnoses of the kind some people have received may not have had any difficulty accessing medicinal cannabis and thus not been at risk of prosecution.

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[13] See for example: International Centre on Human Rights and Drug Policy, UNAIDS, World Health Organization and the United Nations Development Program (2019). *International Guidelines on Human Rights and Drug Policy*. United Nations Development Program; UNAIDS (2016) *Do no harm: Health, human rights and people who use drugs*. UNAIDS. Available at: http://www.unaids.org/sites/default/files/media_asset/donoharm_en.pdf

16. Put simply, the fact that some people are exposed to prosecution purely because they are unable to afford to access medicinal cannabis offends on public policy grounds, and it may also constitute a violation of fundamental human rights including the right to equality before the law.

17. There is a substantial body of jurisprudence suggesting that some protected rights (including the right to life) place positive obligations on government, including the obligation to preserve life (by virtue of section 9 of the Charter). The UNHRC and the ECtHR have made clear that the right to life entails more than a negative duty to refrain from arbitrarily taking life, but also includes an obligation to take positive steps to safeguard life.[14]

18. Arguably, therefore, barriers (including financial barriers) to vital, lawful medical treatment and care may put lives at risk thus calling into question compliance with section 9 of the Charter.

19. The right to protection from torture and from cruel, inhuman or degrading treatment (section 10) is a right that extends beyond stereotypical or 'common sense' understandings of torture (e.g. of detainees being interrogated in times of war). The nature and meaning of these rights has evolved over time and continues to do so.[15] It places obligations on governments and authorities to avoid 'intense physical and mental suffering' or treatment that arouses 'feelings of fear, anguish and inferiority capable of humiliating and debasing them'[16] including in the provision of health care.

20. Many have argued that the refusal to provide treatment to people, or unequal access to treatment that generates or exacerbates suffering can be a violation of the right to protection from torture and from cruel, inhuman or degrading treatment.[17]

21. The inability of some people to practically access medicinal cannabis thus raises questions about compliance with section 10 of the Charter, in the first instance, and with other equivalent observations in other jurisdictions. The decision to prosecute individuals for accessing lawful treatment raises even more questions about compliance with section 10. As noted earlier, section 10 is an absolute right and cannot be limited.

22. In addition, we suggest that there are potential inconsistencies with section 14 of the *Victorian Charter*[18] (and similar provisions elsewhere), which allow for freedom of thought, conscience, religion and belief.

23. This section was adapted from Article 22 of the UN's *Universal Declaration of Human Rights*[19], which Australia ratified in 1948, asserting that economic, social and cultural rights are indispensable for

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[14] For example, the UNHRC has stated that: 'the right to life has been too often narrowly interpreted. The expression 'inherent right to life' cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures'**:** General Comment 6, *Article 6: The Right to Life* (1982), U.N. Doc. HRI/GEN/1/Rev.1 at 6 (1994), [5]. See further Joseph, Schultz and Castan, *The International Covenant on Civil and Political Rights: Cases, Commentary and Materials* (2nd ed, 2004), Chapter 8, especially [8.01], [8.39]-[8.64]. The same interpretation has been applied to the equivalent right to life under the European Convention on Human Rights, see eg *LCB v UK* (1998) 4 BHRC 477, 456 [36]; *Osman v UK* (1998) 5 BHRC 293, 321 [11]; *Keenan v UK* (2001) 10 BHRC 319, 348-9 [88]-[90].

[15] World Organization Against Torture (OMCT), The Prohibition of Torture and Ill-treatment in the Inter-American Human Rights System: A Handbook for Victims and Their Advocates (2006), p. 107, citing Inter-American Court of Human Rights, Cantoral-Benavides v. Peru, Series C, No. 69 (2000) para. 99; ECHR, Selmouni v. France, Application No. 25803/94 (1999), para. 101.

[16] http://www.bailii.org/cgi-bin/format.cgi?doc=/eu/cases/ECHR/1978/1.html&query=(Ireland)+AND+(v)+AND+(the)+AND+(United)+AND+(Kingdom)

[17] See, for example: Lines, R. (2017). *Drug Control and Human Rights in International Law.* Cambridge University Press: Cambridge.

[18] *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 14.

human dignity and development of the human personality[20]. In November 2015, the Supreme Court of Mexico ruled that the prohibition of producing, possessing and consuming cannabis for personal use was unconstitutional as it violated Mexico's human right to the free development of one's personality.[21] In an important statement about how to balance this right with other considerations, the Court noted that:

> That right [to the free development of one's personality] is not absolute, and the consumption of certain substances may be regulated, but the effects provoked by marijuana do not justify an absolute prohibition of its consumption.[22]

This ruling was influenced by similar decisions in Uruguay[23] and Canada[24], which legalised the use of cannabis for personal use in 2013 and 2015 respectively.

24. Crucially, there is evidence that many people who consume medicinal cannabis do so for reasons connected to freedom of thought, conscience, religion and/or belief. For people living with chronic medical conditions and/or facing terminal illness, there is sometimes a need to process one's pending death, and to address spiritual issues, existential crises or other psychological suffering. Where people cannot practically access medicinal cannabis and where it may be helpful to their psychological wellbeing and state of mind to do so, there may be a breach of these human rights obligations.

25. The Victorian Law Reform Commission in 2015 noted that 'users of medicinal cannabis'[25] should be protected from criminal charges, yet the current scheme does not afford this privilege to ill patients who cannot financially afford to access the drug through legal means. This arguably constitutes discrimination in law against those who, for whatever reason, are unable to access cannabis through the scheme but rely upon the drug for a 'medicinal' purpose. The explicit disapproval of smoking the drug in dried form, even for a 'medicinal' purpose, may also constitute discrimination against those who only have access to cannabis in this form.[26] Affording patients who cultivate their own 'medicinal cannabis' the same legal immunity as those obtaining the drug through the current scheme would improve accessibility for patients of varying socio-economic backgrounds.[27]

26. All of these issues raise a key question: is the criminalisation of some people for medicinal cannabis possession, use, cultivation and/or supply fundamentally at odds with our human rights obligations? While we acknowledge, of course, that human rights can be limited and must be balanced, access to medicinal cannabis throws up a set of unique issues that make it harder for governments to justify existing approaches on human rights grounds. In any event (or in addition) governments should at least be giving consideration to whether and how their existing approaches (including the prosecution of individuals as described in more detail below) can be justified on human rights grounds. This extends to decisions to prosecute vulnerable, sick and suffering individuals, in particular.

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[19] *Universal Declaration of Human Rights, GA Res 217A (III), UN GAOR, 3rd sess, 183rd plen mtg, UN Doc A/810 (10 December 1948) ('UDHR').*
[20] UDHR, UN Doc A/810, Art 22.
[21] Elizabeth Malkin and Azam Ahmed, 'Ruling in Mexico Sets into Motion Legal Marijuana', The New York Times (online, 4 November 2015) <https://www.nytimes.com/2015/11/05/world/americas/mexico-supreme-court-marijuana-ruling.html>
[22] Ibid.
[23] Simon Maybin, 'Uruguay: The world's marijuana pioneer', BBC News (Online, 4 April 2019). <https://www.bbc.com/news/business-47785648>
[24] Government of Canada, *Cannabis Laws and Regulations,* (2 October 2019) <https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/laws-regulations.html>.
[25] Victorian Law Reform Commission, *Medicinal cannabis* (Report, October 2015) 16.
[26] Ian Freckleton, 'Medicinal cannabis law reform in Australia' (2016) 23(3) *Journal of Law and Medicine* 497, 506.
[27] Ibid 128.

27. We thus strongly recommend that the Committee explicitly consider whether existing approaches are compliant with human rights and ensure that any reforms or amendments made account for human rights.

*RECOMMENDATION 3: That state and territory-based regulatory regimes be amended to ensure consistency of access and outcome, wherever possible. This includes a consideration – to the extent it is possible at the Commonwealth level – for a recommendation that each state and territory consider uniformity in approaches under the criminal law.*

28. A complete and effective implementation of the regulatory framework of therapeutic goods provided by the Commonwealth Act depends on the complementary legislations enacted by the states and territories. Although States and Territories voluntarily implement the SUSMP through their legislation, particular medicinal cannabis products might be scheduled differently. Further, medical practitioners are subject to different procedural requirements for prescribing medicinal cannabis. For example, prescribers are required to seek approval from state or territory health department and TGA. These factors may lead to differences in access depending on one's jurisdiction.

29. As noted earlier, several people have been prosecuted in recent years for medicinal cannabis offences (see Appendix 1). As we also noted earlier, prosecutions have generated a variety of results, and at least one case (Katelaris) resulted in an acquittal.

30. There are numerous possible reasons for this, including significant differences between the states and territories in terms of criminal offences, available penalties and the availability of drug diversion. The current state of Australian drug law and policy, including differences in penalties, offences and diversionary schemes, was recently documented in a comprehensive report prepared by A/Prof Seear and colleagues for the Commonwealth Department of Health.[28]

31. In effect, differences between jurisdictions – both in terms of access to medicinal cannabis and in terms of criminal law responses to those who fall foul of the law – mean that differences in access to medicinal cannabis and differences in criminal justice approaches will have disproportionate impacts on justice outcomes. In turn, there will be important differences in the physical and mental health outcomes for those so prosecuted.

32. As with any criminal prosecution, there may be other social and economic impacts, too. For instance, one of the clients we represent has been advised that if found guilty, her insurer will terminate her home insurance, thus compounding her already precarious state. Those prosecuted may also receive criminal records, impacting their employment opportunities, future earning capacities, and so on.

33. As an associated point, one of the most important impacts of criminalisation is stigma. Drug-related stigma is a widely documented phenomenon, and one that is proven to have multiple and sometimes lifelong adverse effects.[29] It is not only a product of criminalisation, although the ongoing

[28] See: Hughes, C., Seear, K., Ritter, A. & Mazerolle, L. (2019). *Criminal justice responses relating to personal use and possession of illicit drugs: the reach of Australian drug diversion programs and barriers and facilitators to expansion.* Drug Policy Modelling Program Monograph Series; National Drug and Alcohol Research Centre, University of New South Wales, Sydney.

[29] See for instance: Lancaster, K., Seear, K. & Ritter, A. (2018). *Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use.* Drug Policy Modelling Program Monograph Series; National Drug and Alcohol Research Centre, University of New South Wales, Sydney; Fraser, S., Pienaar, K., Dilkes-Frayne, E., Moore, D., Kokanovic, R., Treloar, C. and

criminalisation of drugs is a key factor. A/Prof Seear and colleagues have developed a framework for assessing the stigmatising potential of drug laws.[30]

34. We argue, based on this and associated work, that existing punitive approaches are stigmatising, increase people's suffering and isolation, can impact relationships with vital services (e.g. health care services and police) and may exacerbate harms otherwise understood to stem from drugs themselves.

35. It is important that the Committee act to reduce the risk of further stigmatisation, given the widespread evidence of this phenomenon and its proven adverse impacts. These adverse impacts are likely to be even more problematic when experienced by people who are already marginalised (e.g. by virtue of chronic or terminal illness).

36. The impact of criminal records is also widely documented and well-known, and may intensify the risk of unemployment, homelessness and poverty. This is an especially concerning problem for people already living with disability, chronic illness or terminal illness.

37. People (including those with chronic or terminal conditions) charged with medicinal cannabis offences may face lengthy terms of imprisonment in some jurisdictions, with or without the availability of diversion in exchange for a guilty plea. We urge the Committee to address these issues including through a recommendation that states and territories consider expanding diversion opportunities in line with A/Prof Seear's aforementioned recent research.

38. As highlighted in the attached Appendix, the cases heard before the Australian courts in the last decade show a trend in sentencing judgments, namely, the taking into consideration of external factors influencing the actions of those in possession of medicinal cannabis. Examining specifically the cases of *Lee,*[31] *Bower,*[32] *Pallett,*[33] and *Hallam*,[34] the following factors were considered in the sentencing of the accused:

    i) The benefits of medicinal cannabis on the patients;
    ii) The accused's desire to provide chronic pain relief;
    iii) No attempt by the accused to obtain financial gain; and
    iv) Impact of a conviction on future work of the accused in the growing of medicinal cannabis.

39. As these examples make clear, judicial officers have seemingly acknowledged the dire state of inaccessibility of medicinal cannabis for Australians. There is still a risk, despite the apparent leniency shown by some judges and magistrates, of very disproportionate outcomes.

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Dunlop, A. (2017). Addiction stigma and the biopolitics of liberal modernity: A qualitative analysis. *International Journal of Drug Policy*. 44, 192-201; Australian Injecting and Illicit Drug Users League. (2011). *Why wouldn't I discriminate against all of them?: A report on stigma and discrimination towards the injecting drug user community*. Canberra: Australian Injecting and Illicit Drug Users League; Lloyd, C. (2013). The stigmatization of problem drug users: A narrative literature review. *Drugs: Education, Prevention, and Policy, 20*(2), 85-95; UKDPC, (2010). *Getting serious about stigma: the problem with stigmatising drug users*. London: UK Drug Policy Commission (UKDPC); Corrigan, P.W., Kuwabara, S.A. and O'Shaughnessy, J. (2009). The public stigma of mental illness and drug addiction: findings from a stratified random sample. *Journal of Social Work, 9*(2), 139-147; Simmonds, L. and Coomber, R. (2009). Injecting drug users: A stigmatised and stigmatising population. *International Journal of Drug Policy, 20*(2), 121-130; Radcliffe, P. and Stevens, A. (2008). Are drug treatment services only for 'thieving junkie scumbags'? Drug users and the management of stigmatised identities. *Social Science & Medicine, 67*(7), 1065-1073; Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review, 24*(2), 143-155.

[30] Seear, K., Lancaster, K. and Ritter, A. (2017). A new framework for evaluating the potential for drug law to produce stigma: Insights from an Australian study, *Journal of Law, Medicine and Ethics*. 45(4), 596-606.

[31] See Case # 4 in attached Appendix.

[32] See Case # 5 in attached Appendix.

[33] See Case # 6 in attached Appendix.

[34] See Case # 7 in attached Appendix.

40. One reason for this is the availability of criminal law defences. As we noted earlier, Dr Andrew Katelaris was acquitted in New South Wales, having argued that the defence of necessity applied to his case.

41. In Victoria, however, the common law defence of necessity has been repealed. The only defence now available to Victorians seeking to excuse criminal responsibility for a life-saving act is that of 'sudden or extraordinary emergency'.[35] However, in Victoria, as affirmed in the case of *DPP v Pallett*,[36] the use of medicinal cannabis for pain relief does not constitute an 'emergency' situation.

42. These differences as between jurisdictions mean that in some parts of Australia some people face the prospect of acquittal, but in other locations, they do not. These vastly different possibilities seem to be at odds with the Commonwealth government's original intentions regarding opening up access to medicinal cannabis: **for all Australians on equal terms**.

43. For a vital and life-saving medication, **we are essentially witnessing postcode injustice**. It should be addressed as a matter of urgency by the Committee, including because of the impact of non-access and/or subsequent prosecution on people's mental and physical health and wellbeing.

44. Under the Victorian Charter, and as noted earlier, Victorians have the right to be protected from torture and cruel, inhuman or degrading treatment. The prosecution of individuals for the use, cultivation or possession of medical cannabis without providing legal protection through the defence of medical necessity may breach this right. Specifically, it was held in a Canadian judgment of *Hitzig v The Queen,* that 'a law which requires law-abiding citizens who are seriously ill, to go to the black market to remedy an acknowledged medical need is a dehumanising and humiliating experience'. Thus, it is argued that due to the exorbitant financial cost of medicinal cannabis, further prosecuting otherwise law-abiding citizens for seeking a medical remedy without providing them legal protection before the law through the defence of necessity, is inhuman and degrading treatment and a breach of the Charter.

45. All jurisdictions should thus consider reintroducing a defence of medical necessity. We suggest that the reintroduction of the common law defence of necessity may alleviate the humiliating and degrading treatment of patients suffering from the requisite 'prescribed medical condition[s]',[37] who cannot afford medicinal cannabis under the current system.

46. All jurisdictions might wish to consider some further legal protection or defence. One possibility is that people who have obtained a prescription for medicinal cannabis should have a full defence from prosecution.

47. Further, it is contended that consideration should be given to whether such defences can be extended to others, such as the carers of eligible patients.

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[35] *Crimes Act*, Vic 1958, s322R.
[36] See Case #6 in attached Appendix.
[37] *Access to Medicinal Cannabis Act*, VIC, 2016, s.3.

*RECOMMENDATION 4: Consider opportunities to improve public access to medicinal cannabis through placing it on the Pharmaceutical Benefits Scheme or otherwise expanding availability, including through improvements to the regulation of licensing*

48. Many medicines prescribed by doctors are subsidised by the Commonwealth Government under the Pharmaceutical Benefits Scheme (PBS). However, there are no medicinal cannabis products subsidised by the PBS. The cost of medicinal cannabis varies depending on various factors including the condition being treated, the type of product and the dosage prescribed by the doctor. The TGA-approved products available to patients are extremely expensive, as we noted earlier.

49. According to Professor Iain McGregor, the high price of medicinal cannabis is a major reason why Australian patients still depend on the black market. He notes:

> Most of the people are extremely poor because they live on social welfare or pensions. People cannot afford pharmaceutical products that are on offer in the federal scheme. It would cost $60,000 a year to treat an epileptic child with 1,000 milligrams of cannabidiol a day.[38]

This is equivalent to approximately $120 a day for just 1 gram of cannabidiol. It is evident that without the subsidy, patients have no choice other than to bear the full cost of the medication themselves. For many Australians, the high cost of medicinal cannabis has left the product out of their reach. For others trying to manage symptoms of their illnesses, it means seeking help outside of the law.

50. Although not our area of expertise, we understand that some experts believe that it is unlikely that any medicinal cannabis will ever make its way onto the PBS. If this is so, we urge the Committee to consider alternative options for access and/or ways to reduce the cost of medicinal cannabis.

51. We understand that there are presently significant delays to obtaining licences and that this may impact both the availability of and pricing for medicinal cannabis. We urge the Committee to take advice from other experts and from health economist Professor Simon Eckermann in this regard.

52. We understand that there are presently no statutory timeframes for reviewing and approving access to licensing, and have heard reports of some waiting more than 700 days to have their licensing application processed.

53. Urgent consideration should be given to providing further funding to the Office of Drug Control to improve the speed of application processing, and to otherwise improving industry capacity to supply.

54. Consideration should also be given to the introduction of statutory timeframes (i.e. deadlines) such that license applications are processed more quickly.

[38] Iain McGregor, 'Is medicinal cannabis on the rise in Australia?' Bedrocan (Web Page, 30 October 2018) <https://bedrocan.com/is-medicinal-cannabis-in-australia-on-the-rise/>.

*RECOMMENDATION 5: Increase training and education on medicinal cannabis for medical practitioners, including on topics such as patient safety, mental health risk, side effects, legal issues, stigma, quality and cost, and take steps to address stigma.*

55. We advocate for development and delivery of training and education on medicinal cannabis. Medical practitioners must be empowered to relay informed advice to their patients regarding the use, applications, side effects and costs of medicinal cannabis.

56. Applying to prescribe medicinal cannabis involves providing a clinical justification for using this treatment, as well as supportive safety and efficacy data.[39] However, recent Australian research suggests that many medical practitioners feel insufficiently informed about the efficacy of medicinal cannabis and its interactions with other drugs.[40] Therefore, they do not have access to the information required for making an application[41] or may be reluctant to do so.

57. Despite this, patients commonly make inquiries about medicinal cannabis, indicating a considerable gap between medical practitioners' ability to provide patients with advice and treatment, and the patients' interest in the treatment.[42] Prescribers are also concerned about other factors including patient safety, mental health risk, side effects, addiction, legal issues, stigma, quality and cost.[43]

58. Moreover, prescribers must also detail how they intend to monitor their patients' responses to the treatment.[44] However, because some medical practitioners do not feel informed, they also feel incapable of monitoring their patients once they commence treatment.[45]

59. Some medical practitioners are also unsure about how to legally gain access to medicinal cannabis,[46] creating another impasse for patient access.[47]

60. We also note, with disappointment, reports by our clients and others (documented in submissions to this Inquiry) of persistent stigmatising attitudes held by some doctors.

61. As noted earlier, stigmatising attitudes in health care are well-known and widely documented and it is essential that multiple measures be undertaken to combat stigma and discrimination against people who use cannabis.[48]

62. Other prescribers are aware that access is time consuming and difficult and report that many patients are consequently illegally self-medicating with cannabis.[49] Australian research in the area is largely limited to surveys of health professionals.[50] Nevertheless, medicinal cannabis has been proven to

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[39] Therapeutic Goods Administration, *Special Access Scheme* (18 September 2019) <https://www.tga.gov.au/form/special-access-scheme>.
[40] Denesh Hewa-Gamage, 'A cross-sectional survey of health professionals' attitudes toward medicinal cannabis use as part of cancer management' (2019) 26 *Journal of Law and Medicine* 815.
[41] Lambert Initiative for Cannabinoid Therapeutics, *How to get medicinal cannabis* The University of Sydney <https://sydney.edu.au/lambert/how-to-get-medicinal-cannabis.html>.
[42] Hewa-Gamage, above n39, p. 821.
[43] Ibid 816.
[44] Therapeutic Goods Administration, above n 38.
[45] Lambert Initiative for Cannabinoid Therapeutics, above n 40.
[46] Hewa-Gamage, above n 39, p.821.
[47] Ibid.
[48] Lancaster, K., Seear, K. & Ritter, A. (2018). *Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use.* Drug Policy Modelling Program Monograph Series; National Drug and Alcohol Research Centre, University of New South Wales, Sydney
[49] Hewa-Gamage, above n 39.
[50] Hewa-Gamage, above n 39, p.816.

have great therapeutic potential for symptomatic relief of life-threatening conditions, including cancer,[51] consequently improving certain patients' quality of life.[52]

63. Legislating and funding more training and education for medical practitioners, as well as conducting thorough research to ascertain the efficacy of medicinal cannabis, may increase their ability to prescribe it. This should be a priority moving forward.

We respectfully invite you to consider these submissions and invite you to contact our office to discuss this matter further.

Yours sincerely,

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[51] Tony Bogdanoski, 'Accommodating the medical use of marijuana: Surveying the differing legal approaches in Australia, the United States and Canada', (2010) 17 *Journal of Law and Medicine* 508, 508.
[52] Ibid.

## APPENDIX 1: Table summarising all relevant known cases in Australia (and UK)

| No. | Case Name | Jurisdiction | Case status | Facts | Charge/s | Plea | Outcome |
|---|---|---|---|---|---|---|---|
| 1 | Lynch v Commissioner of Police | QLD | Open 2017 - Present | Debra Lynch suffers from a rare terminal auto-immune disease (scleroderma), PTSD, anxiety, insomnia and panic attacks.[53]<br><br>Lynch uses medicinal cannabis to manage these symptoms.<br><br>Arrested in June 2017. | Possession and production of a prohibited drug (s8; s9 Drug Misuse Act 1986 QLD) | Lynch initially pleaded guilty and then submitted a 20-page affidavit to change her plea which was accepted by the judge.[54]<br><br>Lynch argued medical necessity as she needs cannabis for life-threatening and terminal illnesses.[55] | The case is currently adjourned until 26 February 2020.[56] |
| 2 | R v Barry Futter[57] | NSW | 2018 - closed | Ubuntu Wellness Clinic/Church of Ubuntu is a not-for-profit medicinal cannabis growing dispensary in Newcastle.<br><br>Police raided the clinic and seized 215 cannabis plants. The Clinic was providing small cannabis plants to patients to grow at their own homes to treat conditions such as cancer and relieve symptoms of extreme epilepsy, | Trafficking a commercial quantity and drug supply (s29; s25; 25A Drug Misuse and Trafficking Act NSW 1985) | BJ Futter pleaded guilty to one count of cultivating a large commercial quantity of a prohibited plant by enhanced indoor means and one count of drug supply.[59] | Ellis J:<br>Imposed a conditional release order without conviction, on the condition that BJ Futter enters into a 12 month good behaviour bond.[60] |

[53] Greendorphin, 'Court Case Deb Lynch President Medical Cannabis Users Association Australia' (Newsarticle), November 6 2017, https://greendorphin.com/court-case-deb-lynch-president-medical-cannabis-users-association-australia/
[54] Ibid.
[55] Lynch v Commissioner of Police [2019] QDC 099
[56] Sydney Morning Herald, 'Gran with an auto-immune disease calls for cannabis to be legal' (Newsarticle), November 20 2019, https://www.smh.com.au/national/queensland/gran-with-an-auto-immune-disease-calls-for-cannabis-to-be-legal-20191120-p53cd3.html
[57] Church of Ubuntu, 'Submissions R v Barry Futter' October 17 2018, https://www.churchofubuntu.org/church-of-ubuntu-legal-update/submissions-r-v-barry-futter-17th-october-2018/

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| | | | | particularly in children.[58] | | | |
| 3 | Case against: Michael Lambert[61] | NSW | 2017 - Closed | Lambert is a father of a young girl with severe epilepsy (Dravet Syndrome).<br><br>CBD was found to improve seizures.<br><br>Lambert cultivated cannabis for his daughter's use.<br><br>Seven cannabis plants, leaves and oils were found. | Two counts of possession of a prohibited drug and one count of production of a prohibited drug (s10; s24 Drug Misuse and Trafficking Act 1985) | Lambert pleaded not guilty and during his two-year legal fight in Gosford Local Court argued a defence of medical "necessity".[62] | Magistrate Williams handed down his decision stating that "this movement by government to explore the possible benefits of cannabis does not provide a platform for everyone who may believe in cannabis, even on the most honest grounds, to circumvent the law," to which he then handed down his sentence.[63]<br><br>Guilty of 2 charges of possession and production.<br><br>No conviction and put on a section 10 good behaviour bond per *Crimes (Sentencing Procedure) Amendment (Sentencing Options) Act 2017*. |
| 4 | Case against: Malcolm Ronald Lee[64] | NSW Newcastle District Court | 2015 - Closed | Lee was supplying local cancer patients with cannabis.<br><br>Lee was found to be in possession of 116 cannabis plants and large amounts of cannabis oil when his home was raided by police.<br><br>Lee was said to supply cancer patients with medical cannabis, | Three charges, including possession and production of a prohibited drug (s10; s24 Drug Misuse and Trafficking Act 1985) | Lee plead guilty to three offences, including manufacturing a commercial quantity of a prohibited drug.<br><br>The prosecution did not request a custodial sentence as there was no harm to the community and no financial gain made by Lee. | Judge Roy Ellis:<br>Imposed a 2-year good behaviour bond on Lee.<br><br>Took into consideration (i) the benefits of medicinal cannabis, (ii) that Lee was not trying to obtain any financial gain; and (iii) that Lee was attempting to help people suffering from chronic pain.<br><br>The Judge further noted that Lee should help with the state government's terminal illness cannabis scheme.[66] |

[59] Church of Ubuntu, 'Submissions R v Barry Futter' October 23 2018 https://www.churchofubuntu.org/wp-content/uploads/2018/10/Submissions-R-v-Barry-Futter-%E2%80%93-23rd-October-2018.pdf
[60] Church of Ubuntu, 'Legal Update' November 1 2018 https://www.churchofubuntu.org/church-of-ubuntu-legal-update/
[58] ABC, 'Police Seize Medical Cannabis Plants from Newcastle Unit' Dec 1 2016 https://www.abc.net.au/news/2016-12-01/police-seize-medicinal-cannabis-plants-from-newcastle-unit/8085128
[61] Full case citation is unknown.
[62] Daily Mail, Michael Lambert faces drug charges following parents record Sydney University donation, August 12 2016, https://www.dailymail.co.uk/news/article-3735605/Michael-Lambert-faces-drug-charges-following-parents-record-Sydney-University-donation.html
[63] Daily Telegraph, Medical cannabis martyr guilty but escapes conviction, June 14 2017, https://www.dailytelegraph.com.au/newslocal/central-coast/medical-cannabis-martyr-guilty-but-escapes-conviction/news-story/db8c9d9fe732ffd26427bd35db4659f5
[64] Full case citation unknown.

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| | | | | paying Lee half of the street value.[65] | | | |
| 5 | Case against: Anthony David Bower[67] | NSW; Port Macquarie District Court | Closed - March 2018 | Tony Bower was found in possession of 280 cannabis plants in New South Wales.<br><br>Bower, provided medical cannabis to hundreds of families across Australia for chronic pain relief and terminal illness management. | Charged with dealing in the proceeds of crime, cultivating prohibited plant, and possessing and supplying a prohibited drug (*Drugs Misuse and Trafficking Act* 1985). | Bower pleaded guilty to all offences. | Judge Leonie Flannery:<br><br>18 month intensive Corrections Order; servable by way of home detention, following a home detention assessment.<br><br>In sentencing Bower, Flannery J noted (i) the quantity and size of the cannabis plants and extensive set-up on Bower's property; (ii) Bower's desire to provide relief to patients suffering from chronic pain; and (iii) the medicine produced by Bower contained lower levels of Tetrahydrocannabinol (THC), accepted to be a feature of medicinal cannabis.<br><br>Flannery J accepted that Boiwer "acted out of compassion for people" and acknowledged that no supply of cannabis in an illicit form was evident.<br><br>An Intensive Corrections Order reflected the seriousness of Bower's offence.[68] |
| 6 | Director of Public Prosecutions (Victoria) V Elizabeth Pallett<br><br>and<br><br>Director of Public Prosecution | Victoria County Court | Closed - November 2016 | The Palletts were found in possession of 15.5kg of cannabis on their property.<br><br>The Palletts provided cannabis products to clients who suffer from | Charged with possession, cultivation and drug trafficking offences (*Drugs, Poisons and Controlled Substances* Act 1981 (Vic)). | Palletts pleaded guilty to all charges. | Jury found the Palletts guilty of one count of cultivating the drug Cannabis, deemed a narcotic plant under the *Drug Misuse and Trafficking Act 1985* (Vic).<br><br>Sentenced $1000 fine, ($500 to each Atthew and Elizabeth).<br><br>Judge Bill Stuart did not record any criminal |

[66] Newcastle Herald, 'Cannabis supplier Malcolm Lee's moral win' 16 October 2015 https://www.newcastleherald.com.au/story/3428620/cannabis-suppliers-moral-win/

[65] ABC, 'Medicinal cannabis supplier escapes jail time for trafficking' 16 October 2015 https://www.abc.net.au/news/2015-10-16/medicinal-cannabis-supplier-escapes-jail-time-for-trafficking/6861554

[67] Full case citation unknown.

[68] ABC, 'Medicinal cannabis producer and advocate Tony Bower avoids jail for cultivating a commercial quantity of a prohibited drug' 5 March 2019 https://www.abc.net.au/news/2019-03-05/medical-cannabis-producer-tony-bower-escapes-jail/10869800

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| | s<br>V<br>Matthew Pallett (Victoria) (2016)[69] | | | medical conditions such as chronic pain, MS, cancer, epilepsy and Crohn's disease. | | | conviction, taking into account the impact of a conviction on the Pallett's future involvement with the growing of medicinal cannabis under the Victorian law.<br><br>Medical necessity was unsuccessfully argued, as the pain of the patients receiving the medicinal cannabis was not deemed an "emergency situation".[70] |
| 7 | Case against: Jenny Lee Hallam | South Australia: Adelaide District Court | Closed - 2017 | Hallam's property was raided by police in January 2017; cannabis oil product were found on the property.<br><br>Hallam claimed that she provided the cannabis products, namely cannabis oil, to terminally ill people.<br><br>Hallam suffers chronic back injury and nerve damage daily | Charged with possessing and manufacturing of a controlled drug (s.33J;33L Controlled Substances Act 1984 (SA)). | Hallam pleaded guilty to possession and manufacturing of a controlled drug. | Judge Rauf Soulio:<br>Good behaviour bond, no conviction recorded.<br><br>Soulio J took into consideration that Hallam (i) was making a financial loss from the production of cannabis oil, and (ii) there was strong evidence that the recipients of Hallam's oil were benefitting from the medicine.[71]<br><br>Hallam did not claim medical necessity as it was impractical to bring to court all of the patients she treated with cannabis oil.[72] |
| 8 | Case against Andrew Katelaris | NSW: Downing Centre District Court | Closed - 2018 | Andrew Katelaris is a doctor who was deregistered in 2005 for providing medical marijuana to sick children.[73]He is | Supply (being 10.6245kg of cannabis leaf) and manufacture of cannabis leaf contrary to section 25 | Katelaris represented himself in court and pleaded not guilty to the charges against him arguing a defence of medical | The jury found Dr Andrew Katelaris not guilty of the charges relating to the supply and manufacture of medical cannabis.[75] |

[69] Full case citation unknown.
[70] The Age, 'Pensioner cannabis growers fined $1000, escape criminal convictions' 10 November 2016 https://www.theage.com.au/national/victoria/pensioner-cannabis-growers-fined-1000-escape-criminal-convictions-20161110-gsmfia.html
[71]ABC, 'Cannabis oil advocate Jenny Hallam spared conviction for supplying medicinal cannabis' 7 November 2019 https://www.abc.net.au/news/2019-11-07/cannabis-oil-advocate-jenny-hallam-spared-conviction/11680772
[72] Sydney Criminal Lawyers Blog, 'A Healer, Not a Dealer: Jenny Hallam Pleads Guilty to Drug Charges', 21 February 2019 https://www.sydneycriminallawyers.com.au/blog/a-healer-not-a-dealer-jenny-hallam-pleads-guilty-to-drug-charges/.
[73] The Daily Telegraph, 'Dr Pot Andrew Katelaris allegedly caught with cash and cannabis' 31 May 2017 https://www.dailytelegraph.com.au/news/nsw/dr-pot-andrew-katelaris-allegedly-caught-with-cash-and-cannabis/news-story/894ed162ebfb767d089370bfbca05ac1.

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| | | | | also a pro-cannabis campaigner. In 2017, police raided his home and seized a quantity of cannabis and cash suspected of being from proceeds of crime. | of the *Drug Misuse and Trafficking Act 1985* ('DMT Act');<br><br>Supply of a large commercial quantity of cannabis oil (8.1975kg) (s25 DMT Act);<br><br>Manufacturing or producing a large commercial quantity of a prohibited drug (being the same 8.1975kg of cannabis oil) (s24 DMT Act);<br><br>Dealing with suspected proceeds of crime by being in possession of around $10,000 in cash. | necessity.[74]<br><br>His defence was based on the notion that the needs of his patients were so serious that it was necessary for him to break the law in the way that he did in order to provide his patients with life-saving cannabis medicine. | |
| 9 | *R v Quayle* [2005] 1 WLR 3642 | EWCA Crim: England and Wales Court of Appeal (Criminal Division) (UK) | Closed - 2005 | Initial case facts: Mr Quayle is 38 years old and is a bi-lateral below-knee amputee. He suffers from severe and chronic pain. He was found to be cultivating cannabis plants at his home for | Charge:<br><br>Cultivation of a cannabis plant in contravention of s.6(1) of the *Misuse of Drugs Act 1971*. | Quayle wanted to raise a defence of medical necessity: 'he did grow cannabis, but did so out of necessity and uses it for personal use to alleviate pain'.[76]<br><br>However, the Court refused to | Decision at first instance: The Court imposed a four-month prison sentence suspended for six months.[77]<br><br>Decision on appeal (Mance LJ, Newman and Fulford JJ)[78]:<br><br>Appeals were dismissed.<br><br>The court of appeal held that |

[75] Ibid.
[74] Paul Gregoire, 'Not Guilty on All Charges: An Interview With Medicinal Cannabis Crusader Dr Andrew Katelaris', *Sydney Criminal Lawyers* (Blog Post, 30 November 2018) <https://www.sydneycriminallawyers.com.au/blog/not-guilty-on-all-charges-an-interview-with-medicinal-cannabis-crusader-dr-andrew-katelaris/>.
[76] The Guardian, 'Is there a medical marijuana defence?' (News article), October 21 2009, https://www.theguardian.com/commentisfree/libertycentral/2009/oct/21/medical-marijuana-defence
[77] Ibid.
[78] *R v Quayle* [2005] 1 WLR 3642.

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| | | | | his own personal use. | | put Quayle's defence of necessity to the jury and so Quayle pleaded guilty.<br><br>Appeal:<br><br>Quayle appealed the court's decision to prevent him from raising the defence of necessity.<br><br>Quayle's appeal was heard with five others. | the defence of necessity was not available in these cases for two main reasons:<br><br>1. Parliament had put in place a legislative scheme for the supply of drugs. This provided for controlled drugs to only be prescribed by medical practitioners. In the court's view, the 'necessitous medical use on an individual basis … is in conflict with the purpose and effect of the legislative scheme'. Allowing such unqualified persons to prescribe the drugs to themselves or others 'would involve obvious risks for the integrity and the prospects of any coherent enforcement of the legislative scheme'.<br><br>2. The elements of necessity defence were also not satisfied. The circumstances of pain to which Quayle and the others were responding, was not extraneous to them and so was not open to objective assessment by the courts. The court doubted whether this kind of chronic pain could constitute the kind of risk of serious injury that the law required in order to make out the necessity defence; and the requirement that the risk be 'imminent and immediate' was not established as there was deliberate and continuous violations of the law by these individuals over a period of time.<br><br>A human rights argument was also raised by Quayle. He relied on Article 8 of the European Convention on Human Rights (right to |

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| | | | | | | | respect for private life). However, there was not enough evidence before the court to support this argument. |
| 10 | *R v Altham* [2006] 1 WLR 3287 | EWCA Crim: England and Wales Court of Appeal (Criminal Division) (UK) | Closed - 2006 | The defendant had been in a serious car accident which resulted in severe injuries to his hip and he has been experiencing chronic pain ever since.<br><br>He tried various forms of pain relief prescribed by his doctor which were either ineffective or had intolerable side effects.<br><br>He tried cannabis and found that it was the most effective form of pain relief for him and so he decided to use it on a regular basis.[79] | Charge:<br><br>Unauthorised possession of 5 grams of cannabis resin. | The defendant raised the defence of necessity.<br><br>However, the court held that the defence of necessity could not be raised following the decision in R v Quayle. Consequently, the defendant pleaded guilty. | Appeal:<br>The defendant appealed against the judge's ruling arguing that denial of the defence amounted to a breach of Art 3 of the European Convention of Human Rights because his medical symptoms amounted to inhuman or degrading treatment. Article 3 prohibits in absolute terms subjecting anyone to inhuman or degrading treatment. Therefore, if the only way to avoid the symptoms was to break the law, then the state was subjecting him to inhuman or degrading treatment.<br><br>Argued that the Misuse of Drugs Act 1971 had to be read subject to a defence of medical necessity in order to avoid the law being incompatible with article 3.<br><br>Held:<br>The appeal was dismissed and his conviction was upheld.<br><br>The court rejected his argument on the following bases[80]:<br><br>it was not 'treatment' by the State that resulted in the pain that the defendant experienced. Rather, it was his road accident. Therefore, the State was not responsible for the harm done to the defendant;<br><br>the defence of necessity was contrary to the legislative scheme and parliamentary intent. |

[79] The Guardian, 'Is there a medical marijuana defence?' (News article), October 21 2009, https://www.theguardian.com/commentisfree/libertycentral/2009/oct/21/medical-marijuana-defence
[80] Ibid.

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| | | | | | | | Scott Baker LJ:<br>'In our judgment the state has done nothing to subject the appellant to either inhuman or degrading treatment and thereby engage the absolute prohibition in Article 3.<br>…The defence of necessity on an individual basis as advocated by this appellant, as it was by the appellants in Quayle, is in conflict with the purpose and effect of the legislative scheme'.[81] |

[81] 'R *v Altham* [2006] 1 WLR 3287 Court of Appeal', E-law resources (Web Page) <http://www.e-lawresources.co.uk/cases/R-v-Altham.php>.