



issues background

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NSW Parliamentary Research Service

Medical cannabis

On 22 November 2012 the Legislative Council's General Purpose Standing Committee No 4 received a referral to inquire into the use of cannabis for medical purposes, in particular:

- The efficacy and safety of cannabis for medical purposes.
- If and how cannabis should be supplied for medical use.
- Legal implications and issues concerning the use of cannabis for medical purposes.

The Committee is to report by 14 May 2013.

The purpose of this Issues Backgrounder is to consider the key legal issues that arise in relation to medical cannabis, in particular the relationship between Commonwealth and State laws. The second part of the paper sets out some of the key background sources relevant to the inquiry, parliamentary, scientific and legal. The paper is organised under the following headings:

- Cannabis and the law in NSW
- The relevance of Commonwealth laws
- Australian parliamentary and government sources on medical cannabis
- Medical cannabis in selected overseas jurisdictions
- Selected peer-reviewed scientific research: 2008 to 2013
- Selected peer-reviewed legal, sociological and political research: 2008 to 2013
- Glossary

The Parliamentary Research Service has previously published two papers on the subject of medical cannabis - R Johns, [*Medical cannabis programs: a review of selected jurisdictions*](#), Briefing Paper No 10/2004 and G Griffith and M Swain, [*The Medical Use of Cannabis: recent developments*](#), Briefing Paper No 11/1999. Also relevant is Briefing Paper No 3/1999, [*The Drug Summit: Issues and Outcomes*](#) by M Swain.

It should be noted at the outset that the issue of using cannabis solely for medical purposes is legally distinct from the decriminalisation or non-medical use of the plant.¹

1. Cannabis and the law in NSW

1.1 Cannabis and the criminal law

At present, cannabis is a prohibited plant in all Australian jurisdictions, and its possession, cultivation and trafficking is a criminal offence in all jurisdictions. In NSW, under Schedule 1 of the *Drug Misuse and Trafficking Act 1985*, the list of prohibited plants or drugs includes:

Prohibited plant or drug	Traffickable quantity	Small quantity	Indictable quantity	Commercial quantity	Large commercial quantity
Cannabis leaf	300.0g	30.0g	1 000.0 g	25.0 kg	100.0 kg
Cannabis oil	5.0 g	2.0 g	10.0 g	500.0 g	2.0 kg
Cannabis plant cultivated by enhanced indoor means	-	5	50	50	200
Cannabis plant –other	-	5	50	250	1000
Cannabis resin	30.0g	5.0 g	90.0 g	2.5 kg	10.0 kg

1.2 Cannabis cautioning scheme

Not all possession of cannabis results in criminal proceedings. The cannabis cautioning scheme was an initiative that resulted from the Drug Summit in May 1999² and introduced across New South Wales on 3 April 2000. It gave police the right to issue a caution to adults³ for minor cannabis offences involving personal use. The cannabis offences that are eligible for a caution are the possession or use of up to 15 grams of dried cannabis leaf, stalks, seeds, or heads, or possession of equipment such as bongs for the administering of cannabis. 15 grams is half the amount of a ‘small quantity’ (30 grams) of cannabis leaf under Schedule 1 of the *Drug Misuse and Trafficking Act 1985*. There is a limit of receiving cautions on two occasions.

1.3 Cannabis and medical/scientific research

Although cannabis is a prohibited plant in all Australian jurisdictions, and cannabis and cannabinoid products are not listed as therapeutic goods under the Australian Register of Therapeutic Goods, the customs regime and the therapeutic goods regimes make provisions for limited exceptions in relation to accessing cannabis for

¹ Working Party on the Use of Cannabis for Medical Purposes, [Report of the Working Party on the use of cannabis for medical purposes, Volume 1, Executive Summary](#), p. 17.

² NSW Drug Summit 1999, *Communique*, 21 May 1999, Recommendation 6.7. Related cannabis recommendations are outlined under ‘6. Breaking the Drugs and Crime Cycle’ of the *Communique*.

³ Cautions and warnings are available to juveniles under the *Young Offenders Act 1997*, including for certain drug offences: see section 8.

medical, clinical or scientific research purposes. This is discussed below in a later section.

1.4 NSW Working Party and later developments

In October 1999, Premier Bob Carr announced that the Government would investigate the use of cannabis for medicinal purposes.⁴ The Premier explained that a Working Party would first examine the feasibility of making cannabis available for therapeutic purposes. The Working Party was chaired by the then Executive Director of the National Drug and Alcohol Research Centre, Professor Wayne Hall. The [Report of the Working Party on the Use of Cannabis for Medical Purposes](#) was submitted to the Government in August 2000. The Working Party's key findings were that:⁵

- Some cannabinoid substances may have value in the treatment of a limited range of medical conditions such as HIV-related wasting, nausea caused by chemotherapy for cancer, muscle spasm in some neurological disorders, and pain that is unrelieved by conventional analgesics.
- Research is required to better assess this therapeutic value.
- Crude cannabis cannot be, and is unlikely ever to be, prescribed in Australia.
- There are commercial and regulatory obstacles to the medical prescription of synthetic cannabinoid substances in Australia.

Following the publication of the findings of the NSW Working Party and the outcomes of the subsequent consultation on its recommendations, on 20 May 2003 the Carr Government announced its intention to introduce a draft exposure bill to provide for a four year trial of the medical use of cannabis.⁶ The main options being considered by the Carr Government for the design of the scheme were:⁷

- Decriminalising the growing of cannabis plants or the possession of personal use quantities by eligible patients.
- Government regulating the supply and providing it to patients. The Government could buy the cannabis from an overseas jurisdiction such as Canada, or grow it under 'very carefully supervised conditions' in New South Wales.
- Obtaining Commonwealth Government approval to import the cannabis spray being developed in the United Kingdom, if and when it becomes available.

However, this trial was not pursued and in April 2004, the Carr Government announced that, despite having examined the various options, 'the preferred delivery method—a metered dose inhaler or spray—was years away from being available

⁴ Premier of New South Wales, *News Release*, 'Government to consider cannabis for medicinal purposes', 19 October 1999.

⁵ The list of findings does not appear in exactly the same form in the *Report of the Working Party on the Use of Cannabis for Medical Purposes*, but reflects the content of Volume I: Executive Summary, '2. Key Findings of the Working Party', August 2000. The list is adopted from: Inquiry into the Use of Cannabis for Medical Purposes, *Report on Consultation on the Findings and Recommendations of the Working Party on the Use of Cannabis for Medical Purposes*, July 2001, Office of Drug Policy (The Cabinet Office), p 3.

⁶ Bob Carr, 'Cannabis Medical Use', Questions Without Notice, *NSWPD*, 20 May 2003, p 697, cited in R Johns, [Medical cannabis programs: a review of selected jurisdictions](#), p. 16.

⁷ R Johns, [Medical cannabis programs: a review of selected jurisdictions](#), pp. 16-17.

and the NSW (and federal) government opposed any means that allowed growing in backyards, i.e. decriminalization of cannabis cultivation or purchase on the black market'.⁸

2. The relevance of Commonwealth laws

Options such as those initially considered by the Carr Government, as listed above, could trigger legal considerations at a number of jurisdictional levels, including international law, Commonwealth law and NSW State law.⁹ This section focuses on the legal issues that arise at the Commonwealth level. It also addresses the issue of federal impediments arising if NSW were to source its cannabis supply from within the State. A point to bear in mind is that the legislative impediments that may arise at the Commonwealth level in relation to a proposal by a State to introduce a scheme legalising the use of cannabis for medical purposes depends upon the nature of the scheme envisaged.

2.1 International obligations

Australia is a signatory to international agreements that aim to restrict production, manufacture, export, import, distribution, trade, and possession of narcotic drugs (including cannabis) for medical and scientific purposes. Two key agreements are relevant to the issue of medical cannabis:¹⁰

- the United Nations' Single Convention on Narcotic Drugs (1961) (the Single Convention), which aims to codify all existing conventions and the obligations of signatory states under those conventions; and
- the UN Convention Against Illicit Traffic in Narcotic Dangerous Psychotropic Substances (1988), which extended the provisions of the Single Convention to a range of behaviour and mood altering drugs but distinguished between those which are totally prohibited and those, such as cannabis, which may be used for restricted medical purposes.

As the Commonwealth is responsible for the implementation of international agreements that it enters into and has the power to override inconsistent State legislation to ensure national implementation of Australia's international obligations, the Commonwealth would have to be satisfied that any proposed State scheme would not place Australia in breach of its treaty obligations.¹¹

In reviewing the nature of the obligations imposed by the relevant instruments, the Working Party on the use of cannabis for medical purposes noted that international conventions aimed at limiting the use of narcotic drugs in the community recognised

⁸ C Hughes, [The Australian \(illicit\) drug policy timeline: 1985-2011](#), Drug Policy Modelling Program, National Drug and Alcohol Research Centre, last updated 12 September 2011, p.24.

⁹ For a detailed discussion of legal and regulatory issues that may arise at all jurisdictional levels, see: Working Party on the Use of Cannabis for Medical Purposes, [Report of the Working Party on the use of cannabis for medical purposes, Volume II, Main Report](#), pp. 66-109.

¹⁰ [Report of the Working Party on the use of cannabis for medical purposes, Volume 1, Executive Summary](#), p. 17.

¹¹ *Ibid.*, p.17; Working Party on the Use of Cannabis for Medical Purposes, [Report of the Working Party on the use of cannabis for medical purposes, Volume II, Main Report](#), p. 109.

the possibility of there being exceptional circumstances in which the use of narcotic drugs may be necessary 'for medical and scientific purposes'.¹² In the view of the Working Party, international legal commentary indicated that the term 'medical and scientific purposes' was sufficiently broad to encompass the prescription or certification of cannabis for the treatment of medical conditions. The Working Party concluded that—so long as proposals for the medical use of cannabis were grounded on evidence of their therapeutic value—the controlled availability of cannabis or cannabinoids for medical or scientific purposes would not place Australia in breach of any international treaty obligations.¹³

2.2 Commonwealth legislation

Commonwealth legislation has a significant bearing on proposals to introduce a scheme legalising the use of cannabis for medical purposes, primarily with regard to the importation of cannabis and the regulation of therapeutic goods. The Commonwealth's ability to legislate in relation to such matters derives from its constitutional powers with regard to trade and commerce and external affairs.¹⁴

The key pieces of Commonwealth legislation that are activated by proposals for the introduction of a scheme dealing with medical cannabis are listed below:¹⁵

- *Criminal Code Act 1995* (Cth)
- *Customs Act 1901* (Cth)
- *Customs (Prohibited Imports) Regulations 1956* (Cth)
- *Narcotic Drugs Act 1967* (Cth)
- *Therapeutic Goods Act 1989* (Cth)
- *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990* (Cth)

2.2.1 Importation¹⁶

The importation of cannabis for personal medical use is illegal under Commonwealth law.

Cannabis is listed as a "border controlled plant" under s.314.5, in Part 9.1 of the *Commonwealth Criminal Code Act 1995* (Cth). Under the *Criminal Code* it is an offence to:

(1) import or export "border controlled drugs" or "border controlled plants" (sections 307.1-307.4)

¹² Ibid.pp. 68-9

¹³ Ibid. p. 71.

¹⁴ Ibid., p. 72.

¹⁵ [Report of the Working Party on the use of cannabis for medical purposes, Volume 1, Executive Summary](#), p. 18.

¹⁶ The following information is taken from: Working Party on the Use of Cannabis for Medical Purposes, [Report of the Working Party on the use of cannabis for medical purposes, Volume II, Main Report](#), pp. 72-76; and, R Douglas, 'Import/export offences', *The Laws of Australia*, Thomson Reuters, 2009.

(2) possess unlawfully imported border controlled drugs or plants (sections 307.5-307.7)

(3) possess unlawfully imported border controlled drugs or plants, reasonably suspected of having been illegally imported (sections 307.8-307.10)

(4) import or export border controlled "precursors" intending, or believing that someone else intends, that it will be used to manufacture a controlled drug (sections 307.11-307.13).

Section 51A of the *Customs Act 1901* (Cth) provides that: substances or plants that are determined to be "border controlled" drugs, plants or a border controlled precursor under the Commonwealth *Criminal Code* are also taken to be prohibited imports under the *Customs Act*. Section 50(3) of the *Customs Act* allows the *Customs (Prohibited Imports) Regulations 1956* (Cth) to establish a system of licences and permissions in relation to the importation of prohibited goods.

The *Customs (Prohibited Imports) Regulations 1956* (Cth) (the Regulations) establishes a system of licenses and permissions to enable the authorisation of the importation of cannabis for medical or scientific purposes.

Under regulation 5(1) a person wishing to import a drug must apply in writing for both a licence (r.5(1)(a)(i)), and a permission (r.5(1)(a)(ii)) from the Secretary of the Department of Health and Aged Care (Cth)(r.5(4)). Examples of potential licensees include drug companies, universities, police and government departments.

Schedules to the *Customs (Prohibited Imports) Regulations* designate categories of prohibited imports. Opioids, including cannabis, cannabinoids and cannabis resin, are listed in Schedule 4. The *Regulations* treat cannabis in the same way as other drugs listed in Schedules I or II of the Single Convention. For drugs listed in Schedule I and II of the Single Convention (including cannabis) a permission to import must specify a quantity of a drug that, together with already authorised and anticipated imports, "exceeds the amount that, in accordance with the requirements of the Single Convention, has been determined to be the maximum amount of that drug that may be imported into Australia during the relevant year" (r.5(12)).

This maximum amount is determined by the Department of Health and Aged Care (Cth) in accordance with Australia's obligations under the Single Convention and is notified annually to the International Narcotics Control Board (INCB). One of the reasons for this notification is to prevent a build up of stocks in excess of those required for medical and scientific purposes.

For cannabis to be legally imported into Australia, the Department of Health and Aged Care (Cth), would have to notify the INCB of an estimated maximum amount for cannabis and the INCB would notify other parties to the convention. According to a report published by the INCB, as of September 2011, Australia had notified the INCB of an estimated maximum amount of 1,500grams of cannabis.¹⁷

¹⁷ International Narcotics Control Board (INCB), [Estimated World Requirements, of Narcotic drugs in grams for 2011 \(September update\)](#), 2011, p. 1.

The *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990* is intended to implement the provisions of the 1988 convention in relation to trafficking in narcotic drugs and psychotropic substances. The Act criminalises certain defined activities that constitute an offence against a law of the Commonwealth, a State or Territory, or a foreign country (s.9). As it is “not intended to exclude or limit the operation of any other law of the Commonwealth or any law of a State or Territory” (s.5(1)), it should not affect lawful activities involving cannabis or cannabinoids.

2.2.2 Therapeutic Goods Act 1989 (Cth)¹⁸

Under Part 4(A) (s.31) of the *Poisons and Therapeutic Goods Act 1955* (NSW), Commonwealth therapeutic goods laws apply in NSW. Hence, the Commonwealth has extensive powers in relation to the use of therapeutic goods within NSW. Cannabis as a crude plant product is very unlikely to ever be registered as a therapeutic good in Australia. Without being registered as a therapeutic product on the Australian Register of Therapeutic Goods (ARTG), cannabis may not be produced, prescribed, or marketed for use as a therapeutic product.

The Therapeutic Goods Act establishes the ARTG, which records therapeutic goods approved for supply. The Act also makes special provision for unregistered goods that are intended for use in clinical trials. There are currently no cannabis or cannabinoid products registered on the ARTG. Two products – nabilone (a synthetic cannabinoid) and dronabinol (synthetic THC) – are available in Canada, the US and the UK, but there does not appear to be any evidence indicating that the pharmaceutical companies who supply these products overseas have attempted to pursue their registration in Australia.

Under therapeutic goods legislation, before any product can be marketed in Australia it must be registered on the ARTG. Consequently, a product containing any cannabinoid from a natural or synthetic source would have to be registered. To obtain approval for registration, the application must provide pharmaceutical, toxicological and clinical information. This information is carefully evaluated by the Therapeutic Goods Administration (TGA) to establish the quality, safety and efficacy of the product put forward for registration. As this is an expensive and lengthy process applications are not usually lodged unless the sponsor considers the product commercially viable. Owing to the health risks associated with smoking, cannabis *in smoked form* is unlikely to ever comply with TGA requirements. Since cannabis is a crude plant product, even if it were administered in ways other than smoking, it would still be unlikely to comply with registration requirements under the Therapeutic Goods Act.

The NSW Working Party on the use of cannabis for medicinal purposes provided the following reasons as to why cannabis was unlikely to comply with requirements under the Therapeutic Goods Act.

- Drugs cannot be registered except on application from a pharmaceutical company and it is unlikely that any pharmaceutical company would seek to register a natural plant product that cannot be patented;

¹⁸ The following text is largely taken from: Working Party on the Use of Cannabis for Medical Purposes, [Report of the Working Party on the use of cannabis for medical purposes, Volume II, Main Report](#), pp. 76-80.

- There are very few data from controlled clinical trials on the efficacy of cannabis for treating the recommended conditions;
- There are serious concerns about the safety of smoked cannabis, especially in the treatment of chronic medical conditions;
- Quality is also problematic, because crude forms of cannabis contain variable amounts of THC and other cannabinoids.

The Working Party concluded that, as a result, it would not be possible to manufacture cannabis products for use as a therapeutic good.

Under s.19 of the *Therapeutic Goods Act 1989* (Cth) there are two ways the Secretary of the Department of Health and Aged Care may authorise the importation and/or use of a drug not registered on the ARTG. These are: the Personal Import Scheme and the Special Access Scheme.

Personal Import Scheme

Under this scheme individuals may import for medical uses (and at their own expense) a drug that is not registered on the ARTG. They may import no more than 3 months' supply at the maximum dose and must have a doctor's prescription for the medication, where this is required by State law. Since, however, narcotic, psychotropic and other drugs subject to the Customs (Prohibited Imports) Regulations may not be imported under the Personal Import Scheme, this is not a viable option.

Special Access Scheme

Under this scheme, certain categories of patients may obtain access to a drug. The controls applied depend on the category of patient for whom the drugs are intended.

- *Category A (patients who are terminally or seriously ill with life-threatening conditions)*: These patients do not have to obtain TGA approval to use/import the drug; in effect, the treating doctor approves the use.
- *Category B (patients who are suffering from a life-threatening condition, even if they are not critically ill)*: These patients need TGA approval to use. Drugs approved for use by patients in this category have generally been the subject of at least Phase 1 clinical trials in humans.
- *Category C (patients who are suffering from a serious but not life-threatening illness)*: These patients also need TGA approval to use the drug. Drugs approved for use by patients in this category must have been put through exhaustive clinical trials to test their efficacy and safety for human use. Normally the drugs would have been subjected to all the clinical trials needed to support a marketing application.

It was under the Special Access Scheme that the synthetic cannabinoid, dronabinol, was imported and used for the treatment of HIV wasting syndrome. The NSW Working Party on the use of cannabis for medicinal purposes concluded that this was not a viable option to consider as the costs of obtaining access to such drugs was prohibitive for the majority of eligible patients.

2.3 Supply options for the NSW Government in light of existing Commonwealth law

The NSW Working Party concluded that it was not clear whether some or all of the legislative impediments at the Commonwealth level could be overcome if the cannabis being used were to be sourced and supplied in New South Wales alone. In addition to importing cannabis products by fulfilling requirements under the *Customs (Prohibited Imports) Regulations 1956* (Cth) and applying to access cannabis products through the Special Access Scheme under the *Therapeutic Goods Act 1989* (Cth), it may be possible for the NSW Government to:

- i) Licence companies/authorities to cultivate cannabis for medical and research purposes. The 1961 Single Convention permits parties to cultivate cannabis under the control of government agencies (art 28(1)). As cannabis is not currently registered on the ARTG, licensed cultivation could only be legally sanctioned under the Therapeutic Goods Act regime if it were part of a clinical or scientific trial. However, the cost of establishing a regulatory body to oversee the licensing of cannabis cultivation for medical and research purposes would be considerable.
- ii) Decriminalise privately cultivated amounts of medical cannabis that neither threaten the “public health and welfare” nor contribute to the “illicit traffic”, without placing Australia in breach of its international obligations under the Single Convention. Australia’s international treaty obligations would not necessarily be compromised if a regulatory model giving legal exemptions to individuals with certain medical conditions to grow their own cannabis plants were to be adopted in New South Wales. If such a model were adopted, it would need to focus on distinguishing between cultivation for medical or recreational purposes. For example, to qualify for exemption, individuals might be required to present medical documentation (e.g. certification from medical practitioner) diagnosing a condition for which cannabis is an effective treatment and stating that the person may benefit from its use. In addition, the number of plants allowable per person should be restricted to the number considered necessary for them to maintain treatment of a specified health condition. A legislative framework would have to be developed to provide exemptions for specific individuals or class of individuals requiring cannabis or cannabinoids for personal therapeutic use. Consideration may also need to be given to the issue of whether legislative exemptions should be extended to carers or concerned individuals.
- iii) Supply by cannabis dispensaries (“buyers” or “compassion” clubs) to patients without remuneration (the supply of cannabis on a commercial basis as a therapeutic good would contravene the Therapeutic Goods Act as cannabis is not a registered therapeutic good). The NSW Working Party also concluded that in order to preserve the distinction between recreational and medical use of cannabis, as a matter of public policy, government regulation is the most responsible and appropriate way of sanctioning the supply of cannabis to those in need.

While, in theory, the legal options outlined above may be available to a State government, until a scheme is legally tested, it is not clear whether a State scheme would survive legal challenge or legislative attempts to override from the Commonwealth. The NSW Working Party concluded that the Commonwealth could in theory legislate (for example, using its external affairs powers) to proscribe any such State model and penalise its participants. Whether the Commonwealth would in fact act on that power is another matter.

3. Australian parliamentary and government sources on medical cannabis

For a timeline for all Australian jurisdictions see the [Australian \(illicit\) drug policy timeline: 1985-2012](#)

3.1 Commonwealth

Commonwealth of Australia, [Legislative Options for Cannabis Use in Australia](#), Monograph No.26, 1994, pp.96

Maurice Rickard, [The Use of Cannabis for Medical Purposes](#), Department of the Parliamentary Library, Research Note No.13, 15 September 2003

3.2 Australian Capital Territory

Standing Committee on Health and Community Care, [Cannabis Use in the ACT](#), Report No.7, December 2000, pp.81

In 2004, the [Drugs of Dependence Amendment Bill 2004](#) was introduced in the ACT with the backing of the Greens and Democrats. The Bill, which was defeated, would have allowed eligible medical users or nominated caregivers to grow cannabis. A key argument against the Bill was that the proposed system did not establish a supply source for the growing of cannabis. Concern was also expressed about the costs involved in regulating such a scheme.

In his speech to the Legislative Assembly, Simon Corbell, the Minister for Health, stated that:

Mr Speaker, I'm please to indicate to members that if the government is returned at the October election, it would be prepared to provide a detailed report to the new Assembly within six months of the Assembly sitting to examine in detail the threshold issues which I have outlined today. However, Mr Speaker, at this stage the government cannot support the legislation.¹⁹

On 18 October 2005, Simon Corbell tabled the [Report on the Medicinal Use of Cannabis](#) in the ACT Legislative Assembly.

¹⁹ Legislative Assembly for the ACT, *Minutes of Proceedings*, 25 August 2004

3.3 South Australia

Drug and Alcohol Services Council South Australia, [Therapeutic Uses of Cannabis](#), May 1998, pp.51

On 23 July 2008, the [Controlled Substances \(Palliative Use of Cannabis\) Amendment Bill 2008](#) was introduced in the South Australian Legislative Council. The Second Reading can be found [here](#) (page 3582). The Bill was not passed.

3.4 Western Australia

In 1999, two Private Members Bills were introduced by the Hon. Dr Christine Sharp, both titled the Poisons Amendment (Cannabis for Medical and Commercial Uses) Bill 1999 – ([Bill No. 20](#) & [Bill No. 68](#)). The Second Reading of Bill No. 68 may be found [here](#). Neither Bill was passed.

4. Sources on medical cannabis in selected overseas jurisdictions

4.1 USA

Selected US resources include:

- The White House, Office of National Drug Control Policy – [Marijuana](#);
- Federal Drug Enforcement Agency – [The DEA Position on Marijuana](#);
- US National Library of Medicine – [Marijuana](#);
- National Conference of State Legislatures – [State Medical Marijuana Laws](#); and
- University of California, San Diego – [Center for Medicinal Cannabis Research](#).

Selected State Medical Marijuana Programs:

- [California](#);
- [Connecticut](#);
- [Delaware](#);
- [Massachusetts](#);
- [Oregon](#); and
- [Washington](#).

A US website – [ProCon.org](#) – provides a Table summarising the legalisation of medical cannabis in 18 US States and the District of Columbia (see below). Further details, including hyperlinks to the legislative measures introduced to legalise the use of cannabis for medical purposes, can also be found on the [website](#).

Table 1: Medical Cannabis in the USA: 18 States and the District of Columbia²⁰

State	Year Passed	How Passed (Yes Vote)	Fee	Possession Limit	Accepts other states' registry ID cards?
1. Alaska	1998	Ballot Measure 8 (58%)	\$25/\$20	1 oz usable; 6 plants (3 mature, 3 immature)	unknown ¹
2. Arizona	2010	Proposition 203 (50.13%)	\$150/\$75	2.5 oz usable; 0-12 plants ²	Yes ³
3. California	1996	Proposition 215 (56%)	\$66/\$33	8 oz usable; 6 mature or 12 immature plants ⁴	No
4. Colorado	2000	Ballot Amendment 20 (54%)	\$35	2 oz usable; 6 plants (3 mature, 3 immature)	No
5. Connecticut	2012	House Bill 5389 (96-51 House, 21-13 Senate)	*	One-month supply (exact amount to be determined)	No
6. DC	2010	Amendment Act B18-622 (13-0 vote)	**	2 oz dried; limits on other forms to be determined	unknown
7. Delaware	2011	Senate Bill 17 (27-14 House, 17-4 Senate)	\$125	6 oz usable	Yes ⁵
8. Hawaii	2000	Senate Bill 862 (32-18 House; 13-12 Senate)	\$25	3 oz usable; 7 plants (3 mature, 4 immature)	No
9. Maine	1999	Ballot Question 2 (61%)	No fee	2.5 oz usable; 6 plants	Yes ⁶
10. Massachusetts	2012	Ballot Question 3 (63%)	TBD ⁷	Sixty day supply for personal medical use	unknown
11. Michigan	2008	Proposal 1 (63%)	\$100/\$25	2.5 oz usable; 12 plants	Yes
12. Montana	2004	Initiative 148 (62%)	\$25/\$10	1 oz usable; 4 plants (mature); 12 seedlings	No
13. Nevada	2000	Ballot Question 9 (65%)	\$200 +fees	1 oz usable; 7 plants (3 mature, 4 immature)	No
14. New Jersey	2010	Senate Bill 119 (48-14 House; 25-13 Senate)	\$200/\$20	2 oz usable	No
15. New Mexico	2007	Senate Bill 523 (36-31 House; 32-3 Senate)	\$0	6 oz usable; 16 plants (4 mature, 12 immature)	No
16. Oregon	1998	Ballot Measure 67 (55%)	\$200/\$100 ⁸	24 oz usable; 24 plants (6 mature, 18 immature)	No
17. Rhode Island	2006	Senate Bill 0710 (52-10 House; 33-1 Senate)	\$75/\$10	2.5 oz usable; 12 plants	Yes
18. Vermont	2004	Senate Bill 76 (22-7) HB 645 (82-59)	\$50	2 oz usable; 9 plants (2 mature, 7 immature)	No
19. Washington	1998	Initiative 692 (59%)	***	24 oz usable; 15 plants	No

Notes: **(a) Residency Requirement** - 16 of the 18 states require proof of residency to be considered a qualifying patient for medical marijuana use. Only Oregon has announced that it will accept out-of-state applications. It is unknown if Delaware will accept applications from non-state residents once the program is established.

(b) Home Cultivation - [Karen O'Keefe, JD](#), Director of State Policies for Marijuana Policy Project (MPP), told ProCon.org in a Nov. 7, 2012 email that "Some or all patients and/or their caregivers can cultivate in 14 of the 18 states. Home cultivation is not allowed in Connecticut, Delaware, New Jersey, or the District of Columbia and a special license is required in New Mexico. In Arizona, patients can only cultivate if they lived 25 miles or more from a dispensary when they applied for their card. In Massachusetts, patients can only cultivate until the department issues regulations unless they get a hardship waiver."

(c) Patient Registration - Karen O'Keefe stated the following in a Nov. 7, 2012 email to ProCon.org: "Affirmative defenses, which protect from conviction but not arrest, are or may be available in several states even if the patient doesn't have an ID card: Rhode Island, Michigan, Colorado, Nevada, Oregon, and, in some circumstances, Delaware. Hawaii also has a separate 'choice of evils' defense. Patient ID cards are voluntary in Maine and California, but in California they offer the strongest legal protection. In Delaware, the defense is only available between when a patient submits a valid application and receives their ID card."

²⁰ ProCon.org. [18 Legal Medical Marijuana States and DC](#). ProCon.org. Retrieved February 18, 2013, from <http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881#CTfee>

The states with no protection unless you're registered are: Alaska (except for that even non-medical use is protected in one's home due to the state constitutional right to privacy), Arizona, Connecticut, Montana, Vermont, New Mexico, and New Jersey. Washington, D.C. also requires registration."

(d) Maryland - Maryland passed two laws that, although favorable to medical marijuana, do not legalize its use. [Senate Bill 502](#), the "Darrell Putman Bill" (Resolution #0756-2003) was approved in the state senate by a vote of 29-17, signed into law by Gov. Robert L. Ehrlich, Jr. on May 22, 2003, and took effect on Oct. 1, 2003. The law allows defendants being prosecuted for the use or possession of marijuana to introduce evidence of medical necessity and physician approval, to be considered by the court as a mitigating factor. If the court finds that the case involves medical necessity, the maximum penalty is a fine not exceeding \$100. The law does not protect users of medical marijuana from arrest nor does it establish a registry program.

On May 10, 2011, Maryland Governor Martin O'Malley signed [SB 308](#), into law. SB 308 removed criminal penalties for medical marijuana patients who meet the specified conditions, but patients are still subject to arrest. The bill provides an affirmative defense for defendants who have been diagnosed with a debilitating medical condition that is "severe and resistant to conventional medicine." The affirmative defense does not apply to defendants who used medical marijuana in public or who were in possession of more than one ounce of marijuana. The bill also created a Work Group to "develop a model program to facilitate patient access to marijuana for medical purposes."

(e) Several states with legal medical marijuana have received [letters from their respective United States Attorney's offices](#) explaining that marijuana is a Schedule I substance and that the federal government considers growing, distribution, or possession of marijuana to be a federal crime regardless of the state laws. These letters have caused some states to delay or alter implementation of their medical marijuana programs.

4.2 Canada

Cannabis (or marihuana) is included in Schedule II to the [Controlled Drugs and Substances Act](#) (CDSA), and, as such, is regulated as a controlled substance in Canada. This means that all activities – for example, possession of marihuana, possession for the purposes of trafficking, production, importation, exportation, trafficking, and possession for the purposes of exporting – are illegal, except as authorized by regulation.

However, the *Marihuana Medical Access Regulations* allow access to marihuana to people who are suffering from serious and debilitating illnesses. The best source is the Health Canada [website](#) which sets out how the Medical Marihuana Access Program operates. As of 31 December 2012 the following statistics applied to the Program.

- Number of persons who hold an Authorization to Possess Dried Marihuana in Canada: 28,115
- Number of persons who hold a Personal-Use Production Licence in Canada: 18,063
- Number of persons who hold a Designated Person Production Licence in Canada: 3,405
- Number of persons in Canada who have indicated they will access dried marihuana and/or marihuana seeds from Health Canada for medical purposes: 5,283

4.3 Israel

Israel has a medical cannabis scheme, under which medical cannabis is supplied to patients who are approved by the Israeli Ministry of Health through licensed growers in Israel who cultivate cannabis plants on a not-for-profit basis. Some information is available on the Ministry of Health [website](#). A broader overview, historical and contemporary, is found on this ENCOD [website](#). An article from *The New York Times* of 1 January 2013 setting out recent developments in Israel can be found [here](#).

4.4 New Zealand

An authoritative overview is found in the April 2011 report by the New Zealand Law Commission titled, [Controlling and Regulating Drugs: A Review of the Misuse of Drugs Act 1975](#). It states (page 19):

Cannabis and cannabis-based products have historically been used for medicinal purposes. There is continuing debate about the nature and extent of their therapeutic benefits. However, a number of jurisdictions, particularly in North America, now authorise the use of cannabis for some therapeutic purposes.

In New Zealand, the current licensing scheme and exemptions from prohibition appear to adequately deal with cannabis-based medicines. The more difficult issue is whether there should be greater access to unprocessed cannabis for therapeutic uses. Cannabis-based medicines can be expensive (if they are not publicly funded) and may not be considered effective for all those who could benefit medically from cannabis use.

There are significant differences of opinion on whether unprocessed cannabis should be available for therapeutic use. Until randomised control trials are undertaken we do not think it will be possible to resolve the differences of view about the safety or efficacy of raw cannabis. As a matter of principle, we take the view that cannabis should not be a special case, but should be treated in the same way as other controlled drugs that can be used medicinally. It should therefore be subject to the same evidence-based testing as other controlled drugs before being made available to the public as a medicine.

Given the strong belief of those who already use cannabis for medicinal purposes that it is an effective form of pain relief with fewer harmful side effects than other legally available drugs, we think that the proper moral position is to promote clinical trials as soon as practicable. We recommend that the Government consider doing this.

In the meantime, while trials are being conducted, we think that it would be appropriate for the police to adopt a policy of not prosecuting in cases where they are satisfied that cannabis use is directed towards pain relief or managing the symptoms of chronic or debilitating illness.

4.5 United Kingdom

The prohibition of cannabis under the criminal law in the United Kingdom is explained in the Home Office website on "[drugs and the law](#)". Prohibited drugs are classified as Class A, B and C depending on their likely capacity to cause harm. In January 2009 cannabis was reclassified from Class C to Class B.

Between 1997-98 and 2001-02 three relevant parliamentary reports were published, as follows:

- House of Lords Science and Technology Committee, [Ninth Report](#), Session 1997-98.
- House of Lords Science and Technology Committee, [Second Report](#), Session 2000-01.
- House of Commons Home Affairs Committee, [Third Report](#), Session 2001-02.

The law in respect to the medical use of cannabis does not appear to have altered substantially since that time. However, it is reported on the BBC Health [website](#) that “Wide-scale trials testing the safety and efficacy of...cannabis extracts (or synthetic forms of them) are currently underway in the UK and elsewhere”. The same report states that:

The first cannabinoid medicine derived from whole plant extracts (from the cannabis sativa plant) came into use in the UK in 2010 for people with moderate to severe spasticity in MS who haven't responded to other treatments.

On 29 October 2010 it was reported in [The Guardian](#) that:

The Home Office sent emails to members of the public wrongly stating that some people were legally permitted to import medicinal cannabis to Britain, potentially putting anyone who acted on the flawed advice at risk of arrest or prosecution.

4.6 Czech Republic

On 16 February 2013 it was [reported](#) in *The New York Times* that legislation had been passed in the Czech Republic making it legal to use cannabis for medical treatment:

The legislation had been approved by both houses of Parliament. It allows marijuana to be imported and later grown locally by registered firms licensed for such activity, which had been illegal. Patients will need a prescription from a doctor to get the drug at pharmacies, and the treatment will not be covered by health insurance.

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- Grant, I. et al., 2012. [Medical marijuana: clearing away the smoke](#), *The Open Neurology Journal*, Vol 6, pp. 18-25
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Note: Most hyperlinks connect to a full-text version of the article. All other articles are available upon request from the NSW Parliamentary Library.

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Note: Most hyperlinks connect to a full-text version of the article. All other articles are available upon request from the NSW Parliamentary Library.

7. Glossary

Analgesic: a pain-relieving drug.

Cannabis: most botanists consider that there are three distinct species of cannabis: cannabis sativa, cannabis indica, and cannabis ruderalis. An alternative view is that cannabis indica and cannabis ruderalis are particular varieties within the cannabis sativa species (ie. cannabis sativa var. indica and cannabis sativa var. ruderalis). The Australian Illicit Drug Guide recognises the three distinct species and states that, ‘Cannabis sativa is the species cultivated for marijuana, hashish and hash oil. It contains a higher concentration of the psychoactive agent known as THC.’

Cannabis resin: an abundant sticky resin that is secreted by the female plant and covers the flowering tops and upper leaves.

Cannabinoids: there are approximately 400 chemicals in the cannabis plant, 61 of which may be called cannabinoids. It is the cannabinoid receptors in the brain that mediate the psychoactive effects of cannabis. The major psychoactive cannabinoid is delta-9-tetrahydrocannabinol (THC). Cannabidiol (CBD) is another example of a cannabinoid, but it does not have the same psychoactive effects as THC. Others include cannabinol (CBN), cannabitrinol (CBT), and cannabinidiol (CBND).

Delta-9-tetrahydrocannabinol: the main psychoactive chemical in cannabis. Abbreviated as THC.

Dronabinol: synthetic delta-9-tetrahydrocannabinol (THC), taken in capsule form, and marketed under the brand name 'Marinol' in the United States of America.

Hashish: dried cannabis resin, formed into small blocks, ranging in colour from light brown to almost black.

Immature/mature cannabis plant: most of the jurisdictions in the United States that allow patients or their caregivers to grow cannabis for medical purposes specify the maximum number of 'mature' plants that may be possessed. This usually means a plant with flowers and buds. An immature plant has no observable flowers or buds.

Marijuana: the dried leaves and flowers (heads) of the cannabis plant. Marijuana is usually smoked in a cigarette ('joint') or using a water pipe ('bong').

Marinol: the brand name or trade name in the United States for dronabinol, a synthetic form of THC.

Nabilone: another synthetic cannabinoid, with similar effects to THC. It has been registered for therapeutic use in the United Kingdom.

Placebo: an inactive drug that is indistinguishable in appearance from the active drug with which it is being compared. A 'placebo-controlled' clinical study means that a proportion of participants are unknowingly taking a substance with no active ingredient. A 'placebo effect' occurs when patients feel improvement because they think they are receiving treatment.

THC: the common abbreviation for delta-9-tetrahydrocannabinol, the main psychoactive ingredient in cannabis.

Usable marijuana: this expression appears in numerous medical cannabis laws in the United States, to describe the quantity of marijuana that may be possessed for medical purposes. It refers to the dried leaves and flowers of the plant, and usually excludes the stalks and roots of the plant. Seeds may be included or excluded as usable marijuana, depending on the jurisdiction.

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