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MEDICINAL CANNABIS IN NEW ZEALAND: ADDRESSING THE MEDICINAL/THERAPUTIC DIVIDE AND OVERCOMING BARRIERS TO LAW REFORM

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Abstract

Cannabis is classified as an illegal drug under the Misuse of Drugs Act 1975, with use, possession and cultivation illegal unless the requisite governmental approval is obtained. Despite recent regulatory changes, medicinal cannabis remains largely inaccessible, unaffordable and unavailable for ordinary New Zealanders under the current regime.

The central issue running though the medicinal cannabis debate is that individuals want to be able to use cannabis for a variety of health reasons, and not have it strictly controlled as a medicine. In exploring key arguments in favour of, and barriers to, law reform in this area, it is proposed that a wider definition of medicinal cannabis is required which encompasses therapeutic use. After demonstrating that perceived barriers blocking reform are able to be overcome, it is suggested that medicinal cannabis should be included within the upcoming governmental review of therapeutic substances. While it is unclear what shape this new regime may take, the inclusion of medicinal cannabis would allow for continued governmental oversight, alongside avoiding some of the complex processes involved in getting medicines approved and funded in New Zealand. Ultimately, if an individual is deriving a benefit from a relatively harmless, natural substance in a safe and controlled manner as an alternative to more harmful prescription drugs, they ought to be able to do so without fear of criminal repercussions.

Key Words:

Law Reform; Medicinal Cannabis; New Zealand.

Contents

I Introduction

Cannabis is "caught in a dual web of regulations – those that control prescription drugs in general and the special criminal laws that control psychoactive substances, [which] strangle its medical potential".[1] Medicinal cannabis reform in New Zealand is a particularly controversial issue. Cannabis use for medicinal purposes is different and distinct from its recreational use and has become an important topic of conversation, particularly in recent years. Advocates have been petitioning for reform on various fronts for decades, yet as of 2017, affordable, accessible and timely medicinal cannabis remains unavailable for ordinary New Zealanders. Despite this, in light of growing public support and recent overseas trends, change seems inevitable. Thus, the best time for a law reform debate in this area is the present.

The central issue running though this debate is that individuals want to be able to use cannabis for a variety of health reasons, and not have it strictly controlled as a medicine. Therefore, the key claim made in this paper is that our current understanding and definition of medicinal cannabis ought to be widened to include therapeutic uses of the substance. A broader definition of medicinal cannabis would encompass not only individuals using cannabinol products for specific medical conditions such multiple sclerosis, but also, for example, those using cannabis as an appetite simulant when undergoing chemotherapy or for alleviating pains associated with arthritis. The main recommendation following this proposed reconceptualisation is that cannabis should be included within the upcoming governmental review of therapeutic substances. While it is unclear what shape this new regime may take, the inclusion of medicinal cannabis will ensure continued governmental oversight, alongside avoiding some of the complex processes involved in getting medicines approved by medsafe and funded by pharmac in New Zealand.

This paper starts by canvassing the necessary contextual information around the history and definitions underpinning the medicinal cannabis debate, before exploring the current legislative and regulatory framework in New Zealand. It is first argued in the definition section that the current understanding of medicinal cannabis needs to be broadened to encompass therapeutic use. The current approach will be critiqued in the subsequent section, alongside considering other key arguments drawn upon by advocates petitioning for reform. The latter part of this paper focuses on four key barriers which continue to

[1] Lester Grinspoon and James Bakalar *Marijuana, the Forbidden Medicine* (Connecticut, Yale University Press, 1993) at 174.

prevent law reform in this area: international obligations; the current regulatory framework coupled with police and judicial discretion; the burden of proof when trying to approve an already-illegal substance; and the issue of advocacy. Arguments for overcoming these barriers are raised and explored within these sections, as it is only once these are overcome that the reframing of medicinal cannabis as proposed can be undertaken and the debate progress. The penultimate section of this paper draws together the various strands of the debate and proposes a possible solution, given the recommended reframing, is the inclusion of medicinal cannabis within the upcoming governmental review of therapeutic substances.

This paper ultimately advocates for the legalisation of cannabis use for medicinal and therapeutic purposes, but stops short of arguing in favour of full legalisation or decriminalisation of recreational cannabis at the present.

II An Introduction to Medicinal Cannabis

A A Brief History

Throughout the prior decades, cannabis has undertaken a unique journey from a fully legal and frequently prescribed drug, to an illicit substance, largely driven by social, cultural and political factors as opposed to scientific ones.[2] However, early uses need to be taken with a grain of salt, keeping in mind the historical context and abundance of various drugs freely available, used and administered during this time.

Cannabis was one of the first recorded medicines in history, with prescriptions for its use dating back to 1500 BC.[3] Use was initially centred in the Middle East and Asia.[4] In China, the cannabis plant was used to treat a variety of conditions, from malaria and rheumatic pains to constipation and childbirth.[5] Cannabis first appeared in the West as early as the 1840s and was originally prescribed by physicians to treat migraines.[6] By the mid-19th

[2] Eric P. Baron "Comprehensive Review of Medicinal Marijuana, Cannabinoids, and Therapeutic Implications in Medicine and Headache: What a Long Strange Trip It's Been" (2015) 55 J Head & Face Pain 885 at 885.
[3] Giles Newton-Howes and Sam McBride "Medicinal Cannabis: Moving the Debate Forward" (2016) 129 NZMJ 103 at 103.
[4] P. Robson "Therapeutic Use of Cannabis and Cannaboids" (2001) 178 Br J Psychiatry 107 at 107.
[5] At 107.
[6] Baron, above n 2, at 886.

century, cannabis had become a mainstream medicine in Britain, recommended for an ever-increasing number of ailments and conditions.[7] One English Professor, James Mills, in a recent public lecture, has subsequently referred to cannabis during this period as the "Victorian wonder-drug", exemplified by a plethora of Provincial Medical and Surgical Journal reports on its use and treatment for hydrophobia, tetanus, cholera, convulsive disorders and mental illnesses.[8] Cannabis eventually made it from Europe to the United States in the 1860s, leading to discoveries of new areas of application, most notably as a treatment for asthma and bronchitis.[9] Mass preparations began in the late 19th century in order to ensure supply matched the ever-increasing demand.[10]

The decline and eventual prohibition of medicinal cannabis first began in the early to mid-20th century in the United States, with other countries following suit shortly after. Academics have suggested several reasons for this decline, including: issues of inconsistency with the quality and potency of cannabis; the invention of the hypodermic syringe meaning pain relief could be administered more quickly than cannabis (which was not able to be easily administered via injection); and economic reasons, with producing countries facing increased importation taxes.[11] In the 1930s, police in the United States began to wage war on the so-called "marihuana menace", as the availability and use of alternative synthetic drugs increased.[12] The Marihuana Tax Act of 1937 was the first of a number of pieces of legislation which would subsequently inhibit the further development and use of cannabis as a medicine. Consequent international conventions, notably the Single Convention on Narcotic Drugs in 1961, and corresponding domestic legislation in various countries throughout the 20th century cemented cannabis' illegal status, with no exception made for medicinal use. By the time United States President Richard Nixon declared a "War on Drugs" in 1971, which included cannabis, the medical use of it was already in significant decline.

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[7] Robson, above n 4, at 107.
[8] James Mills "Cannabis Britannica: The Rise and Demise of a Victorian wonder-drug" (paper presented to From Gin Lane to the Band of Hope, Museum of London, March 2013).
[9] Manfred Fankhauser "History of Cannabis in Western Medicine" in Franjo Grotenhermen and Ethan Russo (ed) *Cannabis and Cannabinoids: Pharmacology, Toxicology and Therapeutic Potential* (Haworth Integrative Healing Press, Binghamton, 2002) 37 at 46.
[10] At 46.
[11] Tom Decorte, Gary W. Potter and Martin Bouchard *World Wide Weed: Trends in Cannabis Cultivation and its Control* (Ashgate Publishing Ltd, Surrey, 2011) at 59; and Ruth C. Stern and J. Herbie DiFonzo "The End of the Red Queen's Race: Medical Marijuana in the New Century" (2009) 27 QLR 673 at 692.
[12] Michael Aldrich "History of Therapeutic Cannabis" in Mary Lynn Mathre (ed) *Cannabis in Medical Practice: A Legal, Historical and Pharmacological Overview of the Therapeutic Use of Marijuana* (McFarland & Company Inc. Publishers, Jefferson, 1997) 35 at 49.

New Zealand appears to have simply followed international trends in drug prohibition. Cannabis use in New Zealand can be dated back to the end of the 19th century, when it was both widely available and inexpensive under its more known name of "Indian Hemp".[13] The prohibition of cannabis in New Zealand occurred relatively quietly, in line with the changing viewpoints of the international community and in response to international treaty obligations as various drug conventions were formulated.[14] The sale and use of cannabis was first criminalised under the Dangerous Drugs Act in 1927. It is not entirely clear why cannabis in particular was singled out for prohibition whilst opioid-based drugs such as morphine and oxycodone remained legal, though some have suggested it may be due to fierce lobbying by international pharmaceutical companies for these drugs to stay legal.[15] Cannabis was later criminalised under the Dangerous Drugs Amendment Act 1960, with the pertinent statute today being the Misuse of Drugs Act 1975, neither of which contains an express exception for medicinal cannabis use.

The prohibition of cannabis was driven largely by cultural, social and political factors as opposed to medical and scientific evidence about its use.[16] The aforementioned factors which contributed to the decline of cannabis in the United States lend themselves more to the former, as reputable studies which documented the minimal harm and damage of cannabis during this period were either shelved or discredited by the United States Government.[17]. Racism in particular was one of the key factors ushering in prohibition in the early 20th century.[18] Durrant, Fisher and Thun have claimed that laws criminalising drugs more generally were strongly influenced by the targeting of specific stigmatised social groups.[19] It is interesting to note that at the time cannabis was prohibited in the United States, it was the drug of choice of African American and immigrant Hispanics.[20] The history of cannabis prohibition, first in the United States, and later in other nations

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[13] Adrian Field, Sally Casswell, Wananga Runanga and Hauora me te Paekaka "Perspectives on Marijuana Policy in New Zealand" (2000) SPJNZ 104 at 104.
[14] Kevin Dawkins "Cannabis Prohibition: Taking Stock of the Evidence" (2001-2004) 10 Otago L Rev 39 at 39.
[15] Daniel Schwartz "Marijuana was criminalised in 1923, but why?" (3 May 2014) CBC News <www.cbc.ca/news/health>.
[16] Baron, above n 2, at 885.
[17] Stern and DiFonzo, above n 11, at 677.
[18] James B. Slaughter "Marijuana Prohibition in the United States: History and Analysis of a Failed Policy" (1988) 21 Colum JL & Soc Probs 417 at 419.
[19] Russil Durrant, Stephanie Fisher and Maria Thun "Understanding Punishment Responses to Drug Offenders: The Role of Social Threat, Individual Harm, Moral Wrongfulness and Emotional Warmth" (2011) 38 Contemp Drug Probs 147 at 152.
[20] P. J. Cohen "Medical Marijuana: The Conflict Between Scientific Evidence and Political Ideology" (2009) 23 J Pain Palliat Care Pharm 172 at 174.

including New Zealand, suggests the current criminalisation of cannabis and its associated legislative and regulatory framework is not evidence-based, which begins to cast doubt as to its justification today.

B Definitions and Distinctions

The debate surrounding medicinal cannabis is frequently caught up with the debate around recreational use, with some opponents fearing that legalising medical use will be the "thin edge of a wedge" to legalise cannabis more generally.[21] Further complicating the matter is that lines between different uses of cannabis are often blurred.[22] Some medicinal users also use cannabis recreationally, whilst others may self-prescribe cannabis without medical recommendation or advice.[23] For the purposes of this paper, a distinction will be drawn between three primary types of cannabis use, medicinal, therapeutic and recreational. These will be defined and explored in the following paragraphs, after some more general information about the cannabis plant is outlined. It will be argued that, going forward, the definition of medicinal cannabis should be broadened to encompass therapeutic use, due to their continual amalgamation by advocates in the law reform debate.

Cannabis comes from the cannabis sativa plant, an annual herbaceous plant which is part of the Cannabaceae family. The plant contains three primary products which are able to be extracted or derived: the dried leaves and flowering tops which are known as raw cannabis; the pressed secretions of the plant known as cannabis resin; and cannabis oil, which results from distillation or extraction of the active ingredients of the plant.[24] The cannabis plant contains over 500 distinct compounds, only some of which are psychoactive, with the primary two compounds being tetrahydrocannabinoils (THC) which is the main psychoactive component, and cannabidiols (CBD), which is thought to contain the most medicinal properties.[25] CBD has both anxiolytic and anti-psychotic properties and can also

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[21] Wayne Hall, Louisa Degenhardt and Michael Lynskey "The Health and Psychological Effects of Cannabis Use" (2001) 44 Monograph 130 at 137.
[22] Newton-Howes and McBride, above n 3, at 103.
[23] Peter Roy-Bryne, Charles Maynard, Kristin Bumgardner, Antoinette Krupski, Chris Dunn, Imara I. West, Dennis Donovan, David C. Atkins and Richard Ries "Are Medical Marijuana Users Different from Recreational Users? The View from Primary Care" (2015) 24 Am J on Additions 599 at 599.
[24] *Cannabis: A Short Review* (United Nations Office on Drugs and Crime, March 2012) <www.unodc.org> at 2.
[25] "What are Canabinoids" (23 October 2015) Leaf Science <www.leafscience.com>.

moderate some of the psychoactive effects of the THC.[26] However, there is a wide variation of THC and CBD concentrations, both within specimens of the same marijuana strains and between different strains.[27]

Medicinal cannabis, under a strict definition, is generally believed to refer to cannabis in its processed form, particularly cannabis oil, which has been approved for use in New Zealand by medsafe. Commonly, this form of cannabis will be high in CBD, with very little or no THC, achieving the desired medical outcome without creating a euphoric effect.[28] Scientific evidence has continued to accumulate, with studies showing CBD has been successfully used in treating a variety of diseases, conditions and illnesses. In particular, medicinal cannabis has been used as a means of treating (either solely or alongside other prescribed substances) epilepsy, multiple sclerosis, parkinson's disease, autism, fibromyalgia, huntington's disease, tourette's syndrome, motor neuron disease, cervical dystonia, glaucoma, crohn's disease and alzheimers.[29] The key difference with therapeutic use is that patients will be recommended medicinal cannabis from their health practitioner and receive detailed instructions on dosage and use after it has been approved. Due to the necessity for medical evidence to support cannabis as a treatment for the individual's condition, medical users will not self-prescribe the drug. It is believed to treat, rather than temporarily relieve, such illnesses and conditions.

The Ministry of Health defines therapeutic purposes as bringing about a "physiological response to prevent, diagnose, monitor, alleviate, treat or cure a disease, ailment, defect or injury".[30] There is a lesser meaning in law which understands therapeutic substances as ones not confirmed to work, but people wish to try it regardless due to their belief in its effectiveness. While CBD is understood to contain the most medicinal properties, therapeutic users of cannabis commonly rely on the synergy between the compounds, favouring its use in its natural and unmanufactured form.[31] There is research to support therapeutic attributes of the whole cannabis plant.[32] Cannabis has been proven to offer

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[26] Newton-Howes and McBride, above n 3, at 104.
[27] Thomas B. Strouse "Cannabinoids in Medical Practice" (2016) 1 Cannabis & Cannabinoid R 38 at 38.
[28] Matt Gonzales "Medicinal vs Recreational Marijuana: Laws, Misconceptions and the Future" (27 June 2017) Drug Rehab <www.drugrehab.com>.
[29] Newton-Howes and McBride, above n 3, at 104; Law Commission *Controlling and Regulating Drugs* (NZLC IP16, 2010) at 296; Baron, above n 2, at 891; and "Medical Marijuana FAQ" Web MD <www.webmd.com>.
[30] "Therapeutic products regulatory regime" (14 June 2017) Ministry of Health <www.health.govt.nz>.
[31] Newton-Howes and McBride, above n 3, at 104.
[32] Stern and DiFonzo, above n 11, at 678.

therapeutic benefits in a variety of situations, including for mood-relieving, muscle relaxing, sedation, energising, appetite stimulation and pain relief.[33] Individuals may use cannabis as a means of symptom relief, such as for pain management of conditions such as arthritis, to counter the side effects of other medications such as appetite loss due to chemotherapy or help with issues such as insomnia or post-traumatic stress disorder. Whilst there are reservations about the health effects of smoking cannabis, it is important to note that raw cannabis is able to be consumed in a variety of ways, including via vapourisation or inhalers, or with food or beverages.[34] Thus, whilst it provides a benefit to the user, it differs from medicinal cannabis as therapeutic users self-prescribe and administer the drug when relief is required in its raw, unprocessed form. Therapeutic users do not want to go through the complex procedures in getting medicinal cannabis approved and funded by the relevant agencies in New Zealand or have to subject to strict governmental controls.

Lastly, the recreational use of cannabis may be understood as where individuals use cannabis solely to obtain the euphoric effect (or "high") caused by the THC, with no consideration as to its medicinal or therapeutic properties. The presence of CBD is immaterial. The focus of this paper is on the law reform issues for medicinal and therapeutic use, so recreational use is not discussed in detail.

This paper proposes that a wider definition of medicinal cannabis should be adopted. A wider definition would include medicinal uses of cannabinols, which are approved by medsafe for prescription in New Zealand, but go broader to also encompass therapeutic uses of the substance. A wider definition is particularly beneficial as the lines between the traditional understanding of medicinal and therapeutic uses are often blurred. Advocates argue for the legalisation of medicinal use but are frequently, in reality, seeking therapeutic use without the strict governmental controls. This issue of advocacy is explored later in the paper as a barrier to law reform. The primary justification for a reconceptualisation of the current understanding of medicinal cannabis comes from the idea that the individual, irrespective of whether the drug has been scientifically or medically proven to help them, is in fact obtaining or genuinely believes they may obtain, a benefit. It is argued that if an individual is deriving a benefit or relief from a relatively harmless substance (as an

[33] Decorte, Potter and Bouchard, above n 11, at 65.
[34] Blair Henry, Arnav Agarwal, Edward Chow, Hatim Omar and Joav Merrick "Medicinal Cannabis: Miracle or Myth?" (2016) 9 J Pain Manage 341 at 341.

alternative to other more dangerous prescription drugs) they ought to be able to do so without fear of criminal repercussions, provided use occurs in a safe and controlled manner and is for genuine therapeutic or medical purposes. Therefore, when medicinal cannabis is subsequently referred to within this paper, it will incorporate this wider definition.

III The Current Legal and Regulatory Framework in New Zealand

A Misuse of Drugs Act 1975

Illicit drugs in New Zealand, including cannabis, are governed by the Misuse of Drugs Act 1975. The Misuse of Drugs Act follows the same broad structure as the Single Convention on Narcotic Drugs 1961, which also serves as a framework for a majority of domestic drug laws internationally.[35]

The Misuse of Drugs Act makes a distinction between more and less harmful substances via a classification system. Raw forms of cannabis, such as the cannabis plant and seeds are classified as Schedule C controlled drugs, while cannabis preparations, defined as any preparation containing tetrahydrocannabinols produced by subjecting the cannabis plant material to any form of processing, including cannabis oil, are classified as Schedule B controlled drugs. The seriousness of penalties imposed increases the higher the classification of the drug.

Dealing drugs is covered under s 6 of the Misuse of Drugs Act. Under s 6, it is an offence to import or export, or produce or manufacture any form of cannabis, alongside being an offence to supply or administer, or offer to supply or administer, or otherwise deal in any Class B form of cannabis, or to perform the same conduct in respect of someone under 18 or sell or offer to sell someone 18 or over for any Class C form of cannabis. The maximum penalties for these offences depend on the classification of the drug. If the offence concerns a Class B drug, the maximum penalty is 14 years imprisonment, while for the same offence, if it were a Class C drug, the maximum penalty is 8 years imprisonment. It seems abstruse to have a situation where someone importing a form of medically-processed cannabis oil may face 14 years imprisonment, whilst a person importing raw

[35] Neil Boister "Decriminalising Personal Use of Cannabis in New Zealand: The Problems and Possibilities of International Law" (1999) 3 Y B NZ Juris 55 at 57.

cannabis would only face 8 years, though this unfairness is often remedied via police and court discretion, as will be explored later in this paper.

Section 7 of the Misuse of Drugs Act covers the offences of possession and use. It is an offence to procure or have in one's possession, or consume, smoke or otherwise use any form of cannabis, or to supply or administer or offer to supply or administer any Class C form of cannabis to any other person or otherwise deal in any such form of cannabis. The maximum penalty for both Class B and C drugs under s 7(2)(b) is imprisonment for a term not exceeding 3 months or a fine not exceeding $500, or both. However, there is a judicial note that custodial sentences are to be avoided unless there are previous convictions or exceptional circumstances which would make such a sentence appropriate. Reflective in the penalty, possession and use are generally believed to be the least serious drug-related offences.

A final offence commonly evoked in the medicinal cannabis debate is cultivation, criminalised under s 9 of the Misuse of Drugs Act. Under this section, it is an offence to cultivate prohibited plants, of which the cannabis plant is the clearest example. A breach of this section attracts a maximum penalty of 7 years imprisonment.

Due to the classification of cannabis preparations as a Class B controlled drug, a license is required before these may be manufactured or imported, with no exception for medical research. Products which are not of a pharmaceutical grade or preparation will not be approved for use in clinical trials in New Zealand.[36] It is a lengthy and convoluted process to get drugs approved by medsafe and funded by pharmac, particularly when the starting point is an illegal substance. Medicines must reach a high standard before approval, demonstrating a positive therapeutic effect while avoiding serious side effects, proven via double blind clinical trials.[37] It can be seen that the current legislative system and illegal status of cannabis prohibits medical and scientific research being conducted in New Zealand and the Government has been reluctant to rely on overseas evidence in this area.[38] Broader law reform issues are raised when considering the various steps involved in the law reform process. From needing to firstly legalise and reclassify the substance, followed by obtaining the necessary approval and funding, any reform related to the medical field is

[36] Ministry of Health "Prescribing Cannabis-based Products" (23 August 2017) <www.health.govt.nz>.
[37] Chris Wilkins "The Case for Medicinal Cannabis: Where There is Smoke There May Well Be Fire" (2016) 129 NZMJ 11 at 11.
[38] NORML "Patients and the Law" <www.norml.org.nz>.

inherently difficult. The process is further explained later in this paper, as a barrier to law reform. Hence, the recommendation is made to consider cannabis as a therapeutic substance, thus falling under a different, and somewhat less intricate, legislative and regulatory framework.

The Misuse of Drugs Act is not an exhaustive piece of legislation containing all of the applicable law surrounding cannabis. Regulations by the Ministry of Health also need to be considered as, unlike the Misuse of Drugs Act, they provide a certain scope for medicinal cannabis products to be approved for use in New Zealand.

B Regulations

The Government has adopted a narrow definition of medicinal cannabis in its regulations, limiting it to cannabis-based products low in THC and high in CBD. The Ministry of Health is clear that it does not support the use of unprocessed or only partially processed cannabis leaf or flower preparations for medicinal use.[39] Therefore, cannabis-based products within these regulations would be considered a Class B controlled drug, with Ministerial approval generally required before they are able to be prescribed, supplied or administered under regulation 22 of the Misuse of Drugs Regulations 1977. Approval from the Ministry of Health is not required for prescriptions of Sativex® for spasticity related to Multiple Sclerosis or for cannabidiol-based products where the level of other naturally occurring cannabinoids is less than 2% of the cannabinoid content, following a recent regulatory change.[40] It is unclear how this will work in practice, but it generally allows CBD to be prescribed to patients by their doctor and supplied in a manner similar to any other prescription medicine. The key issue is that this new regulation is focused solely on a narrow definition of medicinal cannabis, with any scope for therapeutic uses excluded.

Outside of these specific exceptions, there is a process for allowing medicinal cannabis to be prescribed in New Zealand. A medical specialist can petition the Minister of Health, with the Hon Peter Dunne MP dealing with these issues before his retirement from politics in August 2017, who must approve all applications if patients meet the strict criteria. There

[39] Ministry of Health, above n 36.
[40] Ministry of Health, above n 36.

are three types of cannabis-based products that can be considered for approval in New Zealand:[41]

1. Pharmaceutical grade products that have consent for distribution in New Zealand. Consent for distribution means that the product has been determined by Medsafe to meet acceptable safety and efficacy requirements for distribution in New Zealand.

2. Pharmaceutical grade products that do not have consent for distribution in New Zealand, for example, a product that has been manufactured by a pharmaceutical company overseas.

3. Non-pharmaceutical grade products, that is, products that are not manufactured to internationally recognised pharmaceutical manufacturing standards. They may, or may not, have been intended to be used as medicines.

Other cannabis-based pharmaceuticals, such as Cesamet, Marinol and Elixinol can be approved on a case by case basis by the Minister. In two recent cases, Mr Dunne approved the one-off use of Elixinol for Alex Renton in June of 2015, and in April 2016 he also approved the one-off use of Aceso Calm Spray (a non-pharmaceutical grade CBD product) for a patient suffering from severe Tourette's syndrome.

As will be further explained in the following section, despite the allowance for individuals to petition the Ministry of Health for approval to use medicinal cannabis, due to the complexities of the system and issues of cost and accessibility, applications are rarely made, and even more rarely granted.

IV The Case for Change

Throughout the past decade, an increasing number of individuals, groups and bodies have argued in favour of legalising medicinal cannabis. Groups such as the New Zealand Drug Foundation, Green Cross, United in Compassion and NORML all regularly petition for change in current unsatisfactory legislative and regulatory framework. The Law Commission in its 2011 Report on *Controlling and Regulating Drugs* was also supportive of changing the current law. The Commission emphasised that whilst more comprehensive research and clinical trials were necessary, medicinal cannabis should be legalised,

[41] Ministry of Health, above n 36.

ensuring improved access and that users no longer face criminal repercussions.[42] Doctors have been another group largely supportive of change. In the first reading of Metria Turei's MP Misuse of Drugs (Medicinal Cannabis) Amendment Bill, introduced in 2006 and drawn from the members' ballot in 2009, support from the medical profession was cited. Ms Turei claimed the New Zealand Medical Association strongly supported research into the benefits of using cannabis for medical purposes, as did the New Zealand Pharmacy Guild.[43] A prior doctor's survey revealed that 6% of doctors had recommended their patients try cannabis, with 10% indicating they currently had patients they believed would benefit from it.[44] Some commentators have gone further, with Strouse arguing that physicians who display willful ignorance about cannabinoids is akin to a form of patient abandonment.[45] Medicinal cannabis has been a political issue in prior elections and the September election was no different, with the Labour, Mana, Maori, Green, United Future and Opportunities Parties all displaying a desire to at least review and eventually reform our current laws. At an individual level, there is growing public support for allowing the medicinal use of raw or processed cannabis, indicative of public dissatisfaction with the current approach.[46]

This section will canvas several of the key arguments drawn upon by aforementioned parties, considering arguments in favour of law reform and reasons for the disenchantment with the current approach. These arguments provide important contextual information for the upcoming section on barriers to law reform, as it may be seen that the same broad areas have been used both by advocates as arguments *for* change, and opponents as arguments *against* change. Additionally, the case for change begins to allude to some of the reasoning used in later sections to show why the barriers to law reform might not be considered so insurmountable. Overcoming these barriers is essential in allowing the debate to progress and the ability to consider the therapeutic substances avenue going forward.

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[42] See Law Commission *Controlling and Regulating Drugs* (NZLC R122, 2011).
[43] (1 June 2009) NZPD 655 at 4850.
[44] At 4850.
[45] Strouse, above n 27, at 43.
[46] Edward A. Shipton and Elspeth E. Shipton "Should Doctors Be Allowed to Prescribe Cannabinoids for Pain in Australia and New Zealand" (2014) 48 ANZJ 310 at 313; and "Most NZers support medical marijuana – poll" (30 March 2016) Radio New Zealand Health <www.radio.co.nz>.

A Scientific and Medical Evidence

Advocates for reform have consistently drawn upon scientific and medical evidence as to the benefits of both raw and processed cannabis in treating various illnesses, conditions and ailments. There are concerns that the current state of the law reflects 19th and 20th century social, cultural and political reasoning for criminalisation. It is contended that the classification of cannabis under the Misuse of Drugs Act 1975, which is over 40 years old, is outdated, as it ignores existing evidence-based approaches to the medical and therapeutic uses of cannabis compounds.[47] Some of this evidence has already been referred to in the preceding definitions section.

A recent Australian article by Farrell, Buchbinder and Hall used a Cochrane search strategy to identify randomised control trials of medicinal cannabis between 2008-2013 as a means of examining its safety and effectiveness. A Cochrane review is a systematic review of primary research in human health care and policy, internationally recognised as the highest standard in evidence-based health care research.[48] Cannabis has performed better than placebos in trials assessing conditions such as muscle spasticity, neuropathic pain in multiple sclerosis and cancer pains.[49] The authors concluded that the evidence for medicinal cannabis was favourable, noting that "helping patients who wish to use cannabis for symptomatic relief to live as comfortably and productively as possible is an important and valuable goal of palliative and rehabilitation treatment".[50] Evidence supporting cannabis' effectiveness in nausea and vomiting associated with chemotherapy, specific pain syndromes and multiple sclerosis is largely undisputed, whilst for other conditions, including hepatitis C, Crohn's disease, Parkinson's disease and Tourette's syndrome, some contradictory research exists.[51]

It is near impossible to reach absolute consensus within the scientific community, with one only needing to turn their mind to the climate change debate as a recent and topical example. It is therefore unrealistic for opponents of reform to expect such a consensus within the area of medicinal cannabis. Advocates focus on reputable studies, reports and

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[47] Michael Farrell and Bruce Ritson "Cannabis and Health" (2001) 178 BJ Psychiatry 178 at 178.
[48] "What is Cochrane evidence and how can it help you?" Cochrane <www.cochrane.org>.
[49] Michael Farrell, Rachelle Buchbinder and Wayne Hall "Should Doctors Prescribe Cannabinoids" (2014) 348 BMJ 1 at 2-3.
[50] At 3.
[51] Sue Hughes "Medical Marijuana: Where is the Evidence?" (6 July 2015) Medscape <www.medscape.com>.

successes of cannabis in overseas clinical trials alongside individual success stories in arguing cannabis ought to be legalised for medicinal purposes.

B Inhibition of Research

Any review of the evidence surrounding medicinal cannabis inevitably leads to a conclusion that further research and randomised control trials are necessary.[52] A second argument in favour of change which is commonly raised by advocates is that reform would allow New Zealand-based research, studies and clinical trials into the uses, benefits and possible side effects of using medicinal cannabis to take place, as such is currently inhibited by the criminalisation of cannabis under the Misuse of Drugs Act.

The criminalisation of cannabis has created a "chilling effect on the very medical research that is now required to support the use of cannabis as a medicine".[53] This chilling effect has subsequently translated into a disincentive for pharmaceutical companies to conduct the requisite research and development.[54] The issue with our current approach is that whilst the Government claims to require New Zealand-based research,[55] any form of use, possession, cultivation or processing of cannabis is illegal under the Misuse of Drugs Act, with no exceptions for research. Resultantly, to date, no cannabis research has occurred in New Zealand. Similar issues have occurred in overseas countries, where medicinal cannabis is better regulated, due to the associated stigma of cannabis as a result of its criminalisation. A flow on effect for New Zealand if reliance is ever required on international research can result. An example may be considered. In Minnesota, a professor, after securing nearly $10 million dollars in funding to research whether cannabis could ease the pain experienced by people with sickle cell anemia, was unable to launch her study due to encountering strict controls due to the status of cannabis.[56] From having to register with the federal drug enforcement administration, to modifying her clinic to ensure vapors could not seep out, Professor Gupta found that "at every level, [my] research has

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[52] S. T. Wilkinson, R. Radhakrishnan and D. C. D'Souza "A Systematic Review of the Evidence for Medical Marijuana in Psychiatric Indications" (2016) 77 J Clin Psychiatry 1050 at 1050.
[53] Wilkins, above n 37, at 11.
[54] Law Commission, above n 29, at 30.
[55] NORML, above n 38.
[56] Susy Frisch "Medical Cannabis: United States Researchers Battle for Access to the Plant" (2014) 349 BMJ 6997 at 6997.

been impeded because of the bureaucracy".[57] Even if research was approved in New Zealand, it is likely similar problems would be encountered if other laws and regulations remained unchanged.

Advocates claim that a reconsideration of the legal classification of cannabis would help to facilitate the research and development of cannabinoid-based medicines, alongside investigating other possible uses.[58] If research was supported and facilitated, the Government would have strong New Zealand-based evidence to rely on throughout the law reform debate.

C Process, Cost and Access under the Current Regulatory Framework

Opponents to the law reform of medicinal cannabis frequently argue that it is already available under the current regulatory framework. However, advocates supporting reform strongly disagree, drawing on issues of cost, accessibility, and complexities involved throughout the process, which accumulate in making medicinal cannabis largely inaccessible for the ordinary New Zealander. The Law Commission found in their inquiries, when working on a review of the Misuse of Drugs Act, that as of December 2009 only 14 authorisations had been granted, with only three people actually going on to use the product due to it not being funded.[59]

The process under the current regulatory system has been described as "incredibly convoluted" by the New Zealand Drug Foundation.[60] Though the recent regulatory changes have meant that doctors will be able to prescribe certain products, issues of cost and accessibility remain, alongside a possible reluctance by doctors to prescribe it due to its illegal status. Julie Anne Genter, a Green MP whose medicinal cannabis bill was drawn from the ballot in June of 2017, commented that this recent regulatory change only went part of the way, as it did not guarantee "medicinal cannabis products would be affordable for the average New Zealander".[61] As cannabis is not able to be processed in New Zealand, cannabinoids need to be sourced from overseas, with issues of exportation and importation

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[57] At 6997.
[58] Diane E. Hoffman and Ellen Weber "Medical Marijuana and the Law" (2010) 326 NEJM 1453 at 1453.
[59] Law Commission, above n 29, at 299.
[60] New Zealand Drug Foundation "Viewpoints: Should New Zealand allow Medicinal Cannabis" (May 2014) <www.drugfoundation.org.nz>.
[61] Jo Moir "Parliament to debate medicinal cannabis after Green party MP's bill drawn" (8 June 2017) Stuff <www.stuff.co.nz>.

making it difficult to access in a timely manner, even if it is prescribed. Cost is particularly an issue in New Zealand, as medicinal cannabis is not subsidised due to a lack of funding by pharmac, and is often required on a long-term basis, with few New Zealanders able to afford the cost of a commercially produced pharmaceutical product.[62] Sativex, for example, approved by medsafe but not funded by pharmac, is estimated to cost users around $600-$1200 per month.[63] Issues are heightened by the fact that raw cannabis in New Zealand is relatively cheap, and thus becomes a preferred option due to its lower cost and easy accessibility.[64]

Therefore, advocates argue that if medicinal cannabis was legalised in New Zealand, issues of process, cost and accessibility would be mitigated. It is not suggested that pharmac should fund non-approved medicines, rather it is proposed that by legalising medicinal and therapeutic uses in New Zealand, those in need would benefit from reduced cost and increased accessibility as cultivation could be controlled by the Government. Rather than going through the black market, where quality is not assured, as many chose to do under the current regulatory regime, individuals would be able to access safe, timely and inexpensive cannabis from medical practitioners suited to their needs and requirements.

D Vulnerability of Users to Criminal Sanctions

A further argument in favour of law change and in critique of the current system is that the illegal status of cannabis leaves medical and therapeutic users vulnerable to criminal sanctions.[65] While police and judicial discretion is prominent within this area and goes some way towards mitigating this issue, other problems are created, as will be explored further when considering barriers to law reform.

As individuals are largely unable to access medicinal cannabis from reputable sources due to the current legislative and regulatory framework and the aforementioned issues associated with this, individuals often turn to raw, unprocessed cannabis from the black market.[66] Individuals may then face criminal sanctions, despite only trying to access and use the drug for medical and therapeutic purposes. A closely controlled licensing and

[62] Law Commission, above n 29, at 301.
[63] At 301.
[64] Drug Foundation, above n 60.
[65] Law Commission, above n 29, at 30.
[66] At 301.

exemption model would help to ensure individuals seeking access to medicinal cannabis are not diverted into this illegal drugs market.[67] Additionally, if medicinal cannabis is able to be easier accessible via reputable sources, the use of cannabis in alternative forms to smoking may be encouraged. CBD-rich products are often contained in oils or sprays, which allows for the proper titration of dosage alongside eliminating the major health risks caused by inhaling smoke and helps to lesson any intoxicating effects created by THC.[68] Without fear of criminal sanctions, individuals would be more inclined to process raw cannabis into oils and inhalations, avoiding the health risks associated with smoking.

The Law Commission, concerned with the criminalisation of medical and therapeutic users, recommended in their 2011 Report that cannabis users should not be prosecuted where the police are satisfied that their use is directed towards pain relief or managing the symptoms of chronic or debilitating illnesses.[69] This recommendation, like others made in the Report in relation to medicinal cannabis, has yet to be formally adopted. An official information request was made by Shane Le Brun to the Minister of Police in 2015, inquiring whether the police were following the Law Commission recommendation of not prosecuting in cases where they are satisfied the cannabis was being used for medicinal purposes. The Minister of Police, the Hon Michael Woodhouse MP, refused the request under s 14(1)(i) of the Official Information Act 1982 on the basis the information was not held by his office, transferring the request to the New Zealand Police. The Police responded that the Law Commission's suggestion has not been specifically considered by them.[70] Further, they stated there were no guidelines, either regionally or nationally about when to, or when not to, prosecute individuals claiming their cannabis use is for medical purposes, thus refusing the request under s 18(e) as the information requested does not exist.[71] The Police Commissioner confirmed this stance when providing a statement to Radio New Zealand, stating "while there are no specific national guidelines for officers, discretion is always available […] which is dependent on the time, place and particular circumstances of any cannabis offence".[72] As police do not keep records as to when an

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[67] At 301.
[68] *Cannabis: A Short Review*, above n 24, at 27.
[69] Law Commission, above n 42, at 307; and "Law Commission rejects decriminalisation of drugs, favours cautioning regime" New Zealand Law Society <www.lawsociety.org.nz>.
[70] New Zealand Police "Official Information Request Response: Guidelines around the Prosecution of Medicinal Cannabis Users" (15 January 2015) FYI <www.fyi.org.nz>.
[71] New Zealand Police, above n 70.
[72] Teresa Cowie "Medical Cannabis Campaigners: Police approach 'all over the place'" (28 April 2017) Radio New Zealand <www.radionz.co.nz>.

individual is *not* arrested or charged for an offence, it is difficult to determine how often this occurs. In 2015, 1,726 people were convicted of cannabis possession or use,[73] though when considering the national annual prevalence rate is 10.2%,[74] this seems relatively low and indicative of high levels of discretion. Indeed academics have recognised that since the 1990s there has been a general decline in arrests, prosecutions and convictions for cannabis use in New Zealand, primarily accredited to police discretion, diversion schemes and pre-charge warning systems.[75]

The lack of clarity around the use of medicinal cannabis in New Zealand is problematic, with the threat of arrest and prosecution continuing to leave users vulnerable alongside issues of inconsistency raised by the lack of national guidelines and wide scope of police discretion. Advocates argue this mitigates the goal of having consistent and predictable laws.

A related point raised by advocates is that the current system is not working. Cannabis use, medicinal or otherwise, continues to occur at a high prevalence rate irrespective of its illegal status. Over 42% of those aged over 15 have tried cannabis at least once, with 11% using it in the past year.[76] Clearly, a significant majority of these individuals have not faced the criminal or penal sanctions. Research conducted in 2012-2013 found that 5% of those aged over 15 reported using cannabis for medical purposes, particularly for conditions that were hard to manage, such as pain, anxiety and depression, however this was admitted rather than actual use.[77] Public figures in New Zealand have publically spoken about their use in the context of serious illnesses, such as Sir Paul Holmes and Martin Crow.[78] Despite being vocal about their cannabis use, criminal or legal repercussions did not follow, suggesting the police and judiciary are turning a blind eye to these types of behaviours when satisfied the cannabis is being used for personal medical use. It is not good practice to have a law which is largely unsupported and not followed by both individuals and law enforcement bodies.

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[73] New Zealand Drug Foundation "Drug Law Reform" <www.drugfoundation.org.nz>.
[74] Newton-Howes and McBride, above n 3, at 103.
[75] Chris Wilkins and Paul Sweetsur "Criminal justice outcomes for cannabis use offences in New Zealand 1991-2001" (2012) 23 Int J Drug Policy 505 at 505.
[76] New Zealand Drug Foundation "The Sky hasn't fallen on Australia" (March 2017) <www.drugfoundation.org.nz>.
[77] Megan Pledger, Greg Martin and Jacqueline Cumming "New Zealand Health Survey 2012/13: Characteristics of Medicinal Cannabis Users" (2016) 129 NZMJ 29 at 36.
[78] Newton-Howes and McBride, above n 3, at 103.

Whilst some users may avoid repercussions, it is problematic when individuals are punished for medicinal use, particularly given the severity of sanctions under the Misuse of Drugs Act. It is this constant state of vulnerability under which users live that advocates are concerned about and seek to address. Whether an individual is arrested, charged and sentenced should not depend chance in getting a favourable police officer or judge. Advocates believe a legislative change would ensure a consistent approach based on accepted, certain and clear law.

E International Precedent

Local support for changing the medicinal cannabis laws in New Zealand occurs against a backdrop of increasing international use of cannabis in therapeutic and medical settings via an array of models, some as simple as removing criminal sanctions for patients who use cannabis for medical purposes, while other countries have allowed the use of medicinal grade processed cannabis.[79] Advocates frequently point to the international community as a form of precedent in reforming our current laws, to highlight the various models and frameworks available, and as a means of pointing out how backwards our current regime is.

Various countries have reformed their laws to allow medicinal cannabis to be prescribed, supplied and administered in one form or another. To date, these countries include Portugal, the Netherlands, Romania, Austria, Germany, Italy, Chile, Spain, Finland, Colombia, Croatia, Argentina, Denmark, France, Israel, Macedonia, the Czech Republic, Uruguay, Jamaica, Canada, 28 states in the United States, and the Australian States of Western Australia and New South Wales. In Canada, for example, medical cannabis was first made available in 2001, with laws updated in the Access to Cannabis for Medical Purposes Regulations 2016 which treat cannabis like any other psychoactive drugs used for medical purposes. However, the typical recommendation by Canadian physicians is that medical cannabis should not be a first line therapy and documentation should show that conventional therapies were attempted but ultimately unsuccessful on the patient.[80] Canada's framework illustrates medicinal cannabis does need not be freely handed out for

[79] Newton-Howes and McBride, above n 3, at 104.
[80] Canadian Medical Protective Association "Medical Marijuana: Considerations for Canadian Doctors" (2014) <www.cmpa-acpm.ca>.

any condition, rather internal guidelines can dictate and control its use. In California, one of the states in the United States to have legalised medicinal cannabis, doctors are able to recommend it for any medical use if they believe that the patient may benefit.[81] This approach allows for broader prescription and use than in Canada. Countries which have not yet legalised medicinal cannabis, such as the United Kingdom, still have robust research and development programmes in place in order to determine the medical efficacy of the various compounds contained in cannabis before giving further consideration to law reform.[82] It is notable these various degrees and experiments of law reform have occurred despite a vast majority of these countries being signatories to the Single Convention on Narcotic Drugs 1961.[83]

Metiria Turei, in introducing her Misuse of Drugs (Medicinal Cannabis) Amendment Bill in 2009, cited "well-documented" research and existing frameworks in Israel, Germany, Canada and the United States.[84] She argued that the use of medicinal cannabis was supported by the American Medical Association, the United States Institute of Medicine, the Federation of American Scientists, the United Kingdom Royal College of Physicians and the World Health Organization (WHO).[85] The Law Commission also drew on international research in their Report, suggesting that overseas evidence which suggests a medicine is safe and effective could still be the most effective treatment for a patient with a particular condition, even where no clinical trials have occurred in New Zealand.[86]

Advocates claim that international countries not only pave the way for reform by setting out model frameworks and a means around the various international drug conventions, but also illustrate New Zealand is remaining archaic in its drug laws, contrary to its usual projected image of a proactive and progressive nation. New Zealand is currently in a unique position to be able to learn from overseas examples and pick and choose elements of various models or frameworks to suit local circumstances.

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[81] Farrell, Buchbinder and Hall, above n 49, at 1.
[82] *Cannabis: A Short Review*, above n 24, at 27.
[83] At 22.
[84] NZPD, above n 43, at 4850.
[85] At 4850.
[86] Law Commission, above n 29, at 66.

V Barriers to Law Reform

There are numerous barriers considered to prevent medicinal cannabis law reform, with the prior section providing a useful introduction to some of the themes common across the debate. For the purposes of this paper, four primary barriers have been selected, firstly as they highlight some of the difficulties of this particular law reform issue, needing to traverse both medicines and illicit substance laws, and secondly they are found to be the most common arguments drawn upon by opponents. The barriers to be considered are: international obligations; the current regulatory framework coupled with police and judicial discretion; the burden of proof when trying to approve an already-illegal substance; and the issue of advocacy. Whilst this paper focuses on the desirability of widening the definition of medicinal cannabis and bringing it within a therapeutic substances regime as this is found to be the central issue running through the debate, these barriers must be explored, rationalised and overcome before the debate can progress. This will be done by considering reasoning and arguments as to why they should not be considered such insurmountable barriers in the first place. Indeed for some of the barriers, notably the issue of advocacy, the therapeutic recommendations are directly relevant in helping to mitigate and overcome issues.

A International Obligations

The first barrier to be considered is international obligations. Various international drug conventions prohibit the possession, cultivation and use of cannabis. This links in well with the prior section on the use of international precedent and research by advocates as an argument in favour of law reform. This section will firstly consider why international obligations operate as a barrier, noting New Zealand's perceived reputation as a "good international citizen". Secondly, three overseas countries will be considered, Australia, the United States and the United Kingdom, exploring the various frameworks that they have adopted and how they have rationalised this breach of international law. The absence of repercussions is significant. Finally, drawing on these overseas examples, ways around this barrier for New Zealand will be considered, concluding that international obligations, in the context of reform, are not as insurmountable as opponents would suggest.

Opponents perceive international obligations to be a key barrier to medicinal cannabis law reform due to New Zealand positioning itself as a "good international citizen", obediently following international law and United Nations recommendations. The consideration of international law is crucial within the law reform debate, as any "domestic variation of the policy of prohibiting cannabis does not take place in an international vacuum".[87] New Zealand is a signatory to the Single Convention on Narcotic Drugs 1961, the Convention on Psychotropic Substances 1972, the Protocol Amending the Single Convention on Narcotic Drugs 1972 and the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988. These treaties are not self-executing, but New Zealand has ratified and adopted them into domestic law via various pieces of legislation, most notably the Misuse of Drugs Act 1975. Boister has argued that the effect of this international system of drug control is that it is structured in such a way that signatory states do not have the authority to decide unilaterally that cannabis should be dealt with in a non-penal way due to cannabis having bona fide medical applications.[88] The binding nature of treaties and the obligation to perform them in good faith is encapsulated in art 26 of the Vienna Convention on the Law of Treaties 1969. Resultantly, New Zealand cannot act contrary to these international treaties it has voluntarily consented to as this will classify as a breach of their international obligations. Opponents fear that sanctions may result from a breach of international law and are against any medicinal cannabis law reform due to this complex international framework.

As the United Nations lacks an enforcing body, sanctions emanate from other contracting states. To date, no other country which has legalised medicinal or therapeutic uses of cannabis has faced sanctions. There is a "medical and scientific uses" exception contained in these various drug conventions, though, interestingly, this exception is rarely evoked by countries due to their actions not being challenged in the first place.[89] To illustrate how legal change has been enacted despite international obligations, three countries closely related with New Zealand, Australia, the United States and the United Kingdom, will be considered. Australia and the United States have both legalised medicinal cannabis in some of their states, whilst the United Kingdom, despite being one of the few countries alongside

[87] Boister, above n 35, at 56.
[88] At 80.
[89] See preamble and arts 1, 2, 4, 9, 12, 19 and 49 in the Single Convention on Narcotic Drugs 1961 which all contain provisions relating to "medical and scientific use" and art 7 of the Convention on Psychotropic Substances 1971.

New Zealand not to have undertaken law reform in this area, still has a comprehensive research regime in place.

Australia provides a useful area of study due to its close ties with New Zealand and the fact that their medicinal cannabis reform occurred very recently. Australia is a federation comprised of six states and territories, all of which are partially self-governing, so has adopted its own approach to medicinal cannabis.[90] On the 1st of November 2016, medicinal cannabis became a controlled medicine in Australia, regulated by the Office of Drug Control (ODC) and the Therapeutic Goods Administration (TGA).[91] This followed a recommendation from the parliamentary committee to the New South Wales Government in 2013 that the medical use of cannabis should be allowed for patients with terminal illnesses and certain other conditions, such as those who have moved from an HIV infection to AIDS.[92] Despite this change being prima facie inconsistent with international drug conventions, of which Australia is a signatory, the Government has claimed that due to continuous regulation via the OCD, Australia continues to satisfy its international obligations.[93] New Zealand could look to this interpretation as a possible means of overcoming the perceived international obligations barrier. Following the parliamentary change, it was left up to individual states to decide issues such as whether the use of medicinal cannabis will be allowed and who may dispense it, alongside the most appropriate dosage.[94] Medical cannabis can currently be prescribed in New South Wales and Western Australia, with all other states and territories to follow in late 2017, with the exception of the Northern Territories. Australian businesses are able to apply for a license to either conduct research or cultivate cannabis for medicinal use.[95] Queensland will allow specialists to prescribe medicinal cannabis for multiple sclerosis, epilepsy, cancer and HIV/AIDS, in New South Wales cannabis will primarily be available for end-stage illnesses, and in Victoria, for children with severe epilepsy.[96] Additionally, research which is laboratory-based and non-clinical (does not involve administration to humans) is allowed, provided the researcher is able to explain the purpose of the research to ODC and

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[90] Drug Foundation, above n 76.
[91] "Medicinal Cannabis products: overview of regulation" (17 June 2017) Australian Government Department of Health <www.tga.gov.au>.
[92] Shipton and Shipton, above n 46, at 310.
[93] "Medicinal Cannabis products", above n 91.
[94] Drug Foundation, above n 76.
[95] Drug Foundation, above n 76.
[96] Drug Foundation, above n 76.

there are controls in place, alongside obtaining appropriate permission from the state.[97] Clinical trials on the other hand require approval from a Human Research Ethical Committee and to notify the TGA.[98] Australian-based research has become significantly easier following this law reform.

The situation in the United States is similar to Australia due to different states having different legislative frameworks in place. At a federal level, cannabis remains a prohibited substance under the Controlled Substances Act 1970. However, the use of cannabis for medicinal purposes is currently legal in 29 states, with California being the first to change its law in 1996 under Proposition 215. The legislation and regulations in these states are varied, with some states legalising full medicinal and recreational use, some decriminalising personal use and possession and others having more strict regimes for medicinal cannabis in force, distinguishing between psychoactive and non-psychoactive medical cannabis products. International obligations are weighted similarly to individual state law, with the Supremacy Clause of the United States Constitution placing international treaties on the same level as federal laws.[99] Bennett and Walsh have commented that United States officials have emphasised their "decades-long commitment to the accords' broader objectives, while highlighting the flexibility reserved to parties in seeking to achieve the treaties' aims" when maintaining that their legislative changes are consistent with treaty obligations.[100] Other studies which have considered this divergence from international law have suggested the justification comes from arguments based on individual and public health, the safety of citizens and the positive human rights obligation.[101] Regardless, some commentators have been critical, considering the United States should explore options which would better align its evolving domestic approach to cannabis with international obligations.[102] It is interesting that the country whom initially prompted the prohibition of cannabis and 'War on Drugs' was one of the first countries to legalise medicinal use, avoiding any international repercussions and paving the way for smaller nations to follow suit.

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[97] "Medicinal Cannabis products", above n 91.
[98] "Medicinal Cannabis products", above n 91.
[99] Biji Panicker "Legalisation of Marijuana and the Conflict with International Drug Control Treaties" (2015) Chi Kent J Int'l & Comp I XVI at 1.
[100] Wells Bennett and John Walsh "Marijuana Legalization is an Opportunity to Modernize International Drug Treaties" (2014) EPM Brookings 1 at 3.
[101] See Rasbound University "International law allows for the legalisation of cannabis" (30 May 2016) Science Daily <www.sciencedaily.com>.
[102] Bennett and Walsh, above n 100, at 5.

The United Kingdom, in contrast to Australia, the United States and various other countries, has not yet legalised medicinal cannabis. They have a similar legislative and regulatory system in place as New Zealand. Relevant medicinal cannabis law is contained in the Misuse of Drugs Regulations 2001 and the Misuse of Drugs (Amendment No. 2) (England, Wales and Scotland) Regulations 2013. Cannabis is not recognised as having any therapeutic or medicinal value under English law with the exception of the cannabis-based product Sativex, which may be legally prescribed and supplied in specific limited circumstances for patients with Multiple Sclerosis.[103] However, in April of 2017, in what was described as the "first case of its kind", cannabis oil was prescribed, unchallenged, to an 11-year-old boy to treat his life-threatening epilepsy.[104] Despite the legislative framework prohibiting such a course of action, the doctor whom prescribed the drug justified his decision saying "we had a child here who had benefitted and the child's welfare was paramount […] it bides us some time so our authorities can properly consider this".[105] Later in 2017, the Bailiwick of Jersey, an island located near the coast of Normandy, which sits outside of the United Kingdom as a British Crown Dependency, announced its intention to legalise cannabis for medicinal purposes following a report which affirmed its therapeutic benefits.[106] Such actions suggest dissatisfaction with the current regime and support for reforming these laws. Furthermore, in July of 2017, Britain opened its first medical cannabis research facility which will allow for the application of key phytocannabinoids to be explored, starting with use for cancer patients.[107] The allowance for research in the United Kingdom provides a unique precedent for New Zealand, particularly given the similar domestic and international legislative frameworks both countries are operating under.

The presence of medicinal cannabis frameworks in Australia and the United States, alongside a number of other countries, provides the clearest reason why international obligations ought to not be a barrier for New Zealand. Even the existence of a research facility in the United Kingdom suggests the international drug conventions are not being strictly upheld and administered. International law is premised on support from the

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[103] "The Law on Medical Cannabis in England and Wales" Release <www.release.org.uk>.
[104] Stephen Walter "Medical marijuana prescribed to 11-year-old boy on NHS in first case of its kind" (23 April 2017) Telegraph UK <www.telegraph.co.uk>.
[105] Walter, above n 104.
[106] James Rodger "Jersey to become first place in UK to legalise medicinal cannabis" (4 May 2017) Birmingham Mail <www.birminghammail.co.uk>.
[107] Rob Waugh "Britain opens its first official weed research facility for medical marijuana" (20 June 2017) Metro <www.metro.co.uk>.

international community. In situations such as this, where a large number of contracting states have enacted regulatory and legislative regimes counter to international drug conventions, obligations cease to be enforceable.

New Zealand claims to be a "good international citizen", but it has not been immune from accusations of breaching international obligations previously. Amnesty International found the Immigration Amendment Bill, which passed its final reading in June 2013, breached New Zealand's international obligations under the Refugee Convention and various human rights instruments by allowing for mass detention of refugees, subsequently claiming that this action risked "jeopardis[ing] New Zealand's international reputation".[108] However, this legislative change was in line with other international countries at the time, notably Australia, which was struggling with an influx of refugees, leading to the formation of detention centers. It is also possible to argue that the Government's lack of good faith in following the Treaty of Waitangi 1840 in the years following its signing were in breach of various conventions such as the International Convention on Civil and Political Rights and its clauses on minority protection, with only recent efforts to rectify the situation. Additionally, there were accusations in 2016 that the Government's failure to provide disabled children with an enforceable right to education breached international law contained in art 4 of the United Nations Convention on the Rights of Persons with Disabilities.[109] The key point is that New Zealand has previously gone against international law in line with other countries and without facing sanctions, as opposed to the argument that we can continue to breach international laws because the precedent is there. As mentioned, by following other contracting states, the fear by opponents to law reform of sanctions being imposed becomes moot.

The Law Commission has emphasised that it is possible to change the law and continue to largely conform to the international drug treaties. The Commission proposed in their Report that as international drug conventions require the cultivation of cannabis to be only undertaken by Government organisations or those with an approved license, the best option would be to license cultivators in same way as other dealers of controlled drugs, rather than

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[108] "New law allowing mass detention a failure for human rights in New Zealand" (14 June 2013) Amnesty International <www.amnesty.org.nz>.
[109] John Gerritsen "Special ed breaching international law – report" (5 September 2016) Radio New Zealand <www.radio.co.nz>.

allowing medical users to cultivate cannabis for their own use.[110] It is possible to work within the existing framework, drawing on international countries as precedent.

A recent report by Bennett and Walsh framed cannabis legalisation as an opportunity to modernise international drug treaties.[111] Given the views and actions of the international community and signatories to these treaties, perhaps it is due time to reconsider these laws. It is remarkable that the World Health Organisation's Expert Committee on Drug Dependence, charged with the scientific and medical review of substances which fall under the 1961 and 1971 Conventions, have never engaged in a formal review of the place of cannabis within such Conventions.[112] Such a review is certainly overdue.

The New Zealand Drug Foundation has referred to these countries that have legalised medicinal cannabis, particularly Australia, as "robust models that we can draw on to make our medicinal cannabis regime up to international best practice".[113] Ms Turei has emphasised that if a medicinal cannabis regime was enacted in New Zealand, it would be merely following the example of numerous other countries, rather than being a world leader or trail-blazer.[114] If other countries have been able to navigate the existing international laws to legalise medicinal cannabis without repercussion, such laws should not be considered a barrier for reform, particularly as New Zealand has breached various conventions in line with overseas nations in the past.

B The Current Regulatory System and Police and Court Discretion

A second important barrier in the medicinal cannabis debate is claims that New Zealand already has an adequate system in place. It is believed that under the current regulatory system, individuals are able to be prescribed medicinal cannabis, with police and judicial discretion mitigating any remaining issues of unfairness. This section will firstly explore how the mere existence of the current system, and the prevalent discretion within this area, acts as a barrier to reform, followed by reasons why the status quo is inadequate and problematic. Analogies will be made with abortion law in New Zealand, as advocates are

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[110] Law Commission, above n 29, at 302.
[111] Bennett and Walsh, above n 100, at 1.
[112] *Cannabis Regulation and the UN Drug Treaties: Strategies for Reform (Transnational Institute, June 2016) <www.tni.org>* at 4.
[113] Drug Foundation, above n 60.
[114] NZPD, above n 43, at 4850.

facing a similar barrier, with many claiming that the existing system is working well in practice, ignoring or ignorant of the underlying issues. The conclusion is that the current system and discretion is not working well in practice and is actually creating a number of other issues, notably that police and judges are repeatedly circumventing the law, indicative of a lack of faith in the system more generally. Following this line of reasoning, having a pre-existing system should not be considered a barrier in the way of medicinal cannabis reform.

The current regulatory system coupled with police and court discretion acts as a key barrier due to many relying on the well-known idiom "if it ain't broke, don't fix it". The Prime Minister, the Hon Bill English MP, in expressing his refusal to review the current laws, has commented that "there [is] already a compassionate and legal route for patients to get cannabis products – if they need them […] as far as we can see, that's going to work pretty well and we don't want to take it any further".[115] Opponents to reform believe, particularly under the recent regulatory changes, that individuals in need can easily access the drug as required. Police and judicial discretion mitigates any remaining issues, with medicinal cannabis users unlikely to face arrest or prosecution. Thus, it is the mere presence of an existing regime in place which acts as a barrier to law reform, alongside creating a complex framework, within the confides of which, change must occur.

The existing regulatory framework should not be considered a barrier to law reform as it is not working well in practice, alongside creating a number of other issues. It was noted when considering arguments in favour of reform that despite medicinal cannabis being prima facie available, it remains unaffordable and inaccessible for the ordinary New Zealander. The Law Commission was particularly critical of the current regulatory regime, believing the ministerial power to effectively veto the use of certain types of controlled drugs as medicines, even where they are considered the most appropriate treatment and have been prescribed by a qualified health professional, is inappropriate.[116] Under the current system, medicinal cannabis is only available for a very limited number of conditions, with any possible therapeutic uses ignored altogether. Additionally, the continued illegal status of cannabis inhibits any New Zealand based research, despite countries such as the United Kingdom not considering this to be a barrier.

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[115] Dan Satherley "NZ doesn't want a 'marijuana industry' – English" (3 April 2017) Newshub <www.newshub.co.nz>.
[116] Law Commission, above n 42, at 296.

A case study may be considered to illustrate the aforementioned issues with the current system. In 2015, Alex Renton, a 19 year old teenager from Nelson, was hospitalised, suffering from a type of prolonged seizures known as "status epilepticus", the cause of which was unknown. He spent three months in Wellington Hospital in a medically induced coma in the Intensive Care Unit. His situation attracted widespread media attention because his mother, Rose Renton, petitioned for the use of CBD to reduce his seizures and eventually bring him out of his coma. Conventional treatments involving over 43 other types of drugs had not worked, so his family applied to the Associate Minister of Health to approve the use of a medicinal cannabis oil known as Elixinol. His family spoke of the procedural difficulties in getting the drug approved, including a "long battle with medical staff for backing" and the time spent sourcing and shipping the drug from the United States.[117] The unwillingness of doctors to prescribe the drug suggests this use was therapeutic as opposed to a medicinal, making the governmental approval particularly interesting. Despite initial signs of progress, Alex passed away a couple of weeks after he was given the Elixinol. Rose Renton later revealed that she provided Alex with cannabis oil before Government approval was granted, commenting in an interview that "a mother would do anything".[118] Ms Renton was aware the drug was illegal without the proper approval but did not care, emphasising the importance in having a choice of treatments.[119] This case study highlights firstly the difficulties in getting drugs approved and accessed under the current regulatory framework, but also epitomises a therapeutic example of use, where the doctors were reluctant to recommend medicinal cannabis, but Ms Renton wanted to try everything she could to help her child.

Analogies can be drawn with the current debate in abortion law reform, as advocates have faced a similar barrier due to the existence of a perceived functioning framework already in place. Similarly to the Misuse of Drugs Act, abortion law has remained largely unchanged since 1977.[120] Abortion is criminalised under s 187A of the Crimes Act 1961 unless (prior to 20 weeks) "continuing the pregnancy would result in serious danger to a woman's physical or mental health". In practice, this requires a woman to have her abortion authorised by two certified medical practitioners whom consider it to be medically necessary. The Justice Minister, the Hon Amy Adams MP, has said that whilst the law may

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[117] Pete George "Medicinal Cannabis Petition Presented" (12 October 2016) Your NZ <www.yournz.org>.
[118] "Cannabis oil given to Alex Renton before Government approval" (20 July 2015) Stuff <www.stuff.co.nz>.
[119] "Cannabis oil given to Alex Renton", above n 118.
[120] See ss 183-187 of the Crimes Act 1961 and the Contraception, Sterilisation and Abortion Act 1977.

be outdated, it is "workable within the present day medical and social settings".[121] The claim that there is a sufficient legislative system in practice which works well when coupled with medical profession discretion acts as one of the key barriers to reform in this area. However, similarly to the medicinal cannabis debate, it operates on the assumption that the current system is in fact sufficient, ignoring the nearly 1,500 abortions that have been denied to women in the past decade, identified by the Abortion Supervisory Committee.[122]

Moving on from the legislative and regulatory system as it exists on paper, police and judicial discretion should also be examined, as it contributes significantly to how the system operates in practice. Discretion is generally believed to be positive, but as will be explained, negative impacts have resulted within the medicinal cannabis area.

Police discretion is often understood as a fair means of taking individual circumstances of the offence and offender into consideration, issuing alternative sanctions such as warnings or cautions in lieu of a formal arrest. Discretion is particularly common in minor drug offences, such as those involving cannabis. Opponents to law reform may argue that discretion mitigates any residual issues with the current system, such that it is rare that medicinal cannabis users will be arrested and prosecuted. However, this fails to recognise the inherent issues which arise when discretion is prevalent. There are widespread inconsistencies between officers, each with their own opinions and prejudices, and no "formal promulgation of any directive from the Police Commissioner or from the hierarchy", meaning that discretion does not always turn out to be fair.[123] Discretion mitigates both predictable law enforcement and the goal of having understandable and consistently applied law.[124] As people tend to hold strong views on medicinal cannabis, whether an individual is arrested and subsequently charged with an offence under the Misuse of Drugs Act is largely dependent on having a favourable-opinioned officer. In a recent Radio NZ interview, pro-medicinal cannabis campaigners called for police discretion to be replaced by national guidelines. They critiqued the inconsistent approach to the policing of medical cannabis cases, as it is currently up to individual officer to

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[121] Stacey Kirk "Forty-year abortion law, described as 'offensive', in fact still good, says Government" (17 March 2017) Southland Times <www.stuff.co.nz>.
[122] Henry Cooke "Hundreds of Kiwi women told their abortions were 'not justified'" (13 March 2017) Stuff <http://www.stuff.co.nz>.
[123] Cowie, above n 72.
[124] Harold E. Pepinsky "Better Living Through Police Discretion" (1984) 47 Law & Contemp Probs 249 at 265.

decide how to proceed when confronted with these situations, meaning while some sick persons are let off, others are dragged before the courts.[125] Ross Bell, the executive director of the New Zealand Drug Foundation, has also spoken out about the need for police to adopt a more coordinated approach.[126] Thus, while discretion seems like a fair method of ensuring the law continues to reflect public opinion, it is only fair if a consistent application is adopted to ensure all citizens are treated equally. The lack of any formal guidelines within the area suggests this is not the case.

In contrast to police discretion, judges have a narrower discretion as individuals who appear before them have already been arrested and changed. Judicial discretion operates due to the leniency judges have in handing down sentences, ranging from discharge without conviction and fines, to imprisonment and preventative detention. In a New Zealand-based longitudinal study, Wilkins and Sweetsur found that individuals prosecuted for cannabis use between 2000 and 2008 were less likely to be convicted than those changed in 1991 to 1999, with discharge or diversion now the more likely outcome.[127] These statistics are indicative of a growing judicial discretion for cannabis offences more generally. As records are not kept distinguishing when an individual is charged with recreational or medicinal cannabis use, it is difficult to determine exactly how prevalent discretion is in medicinal cases, but it is likely to be widespread in line with changing public opinion.

There are numerous examples of judicial leniency towards medicinal cannabis users. In 2017, a 64 year old man, Arthur Leslie Richardson, was charged with possession and cultivation of cannabis. In a police raid on his South Taranaki home, police found over 120 cannabis seedlings and 23 cannabis plants in a sophisticated cultivation set up with tailored LED lights, fans, timers and thermometers, alongside 80 grams of dried cannabis.[128] Mr Richardson pleaded guilty, but claimed he was supplying the cannabis to a group of "elderly clients" for medicinal purposes, alongside using it himself for pain relief for shoulder and back injuries.[129] Judge Chris Sygrove ordered a pre-sentence report ahead of sentencing in the Hawera District Court. Mr Richardson voluntarily made a $5000 donation to the Salvation Army and was sentenced to 100 hours community service with

[125] Cowie, above n 72.
[126] Cowie, above n 72.
[127] Wilkins and Sweetsur, above n 75, at 505.
[128] Deena Coster "Drug dealer's homegrown dope supply used for medicinal use" (24 January 2017) Stuff <www.stuff.co.nz>.
[129] Coster, above n 128.

the judge commenting while this was a serious criminal activity, the defendant was using the cannabis for his and his friends' personal medical use rather than undertaking a commercial operation and was a first time offender.[130] Possession, cultivation and supply of even a class C drug can attract a maximum penalty of 7 years imprisonment for cultivation and 8 years for supply.

In another case, Fiona Porter publically complained about the discrepancies in penalties between her own case and that of Rebecca Reider.[131] Ms Reider was facing up to 8 years imprisonment for importing cannabis to New Zealand for her chronic pain condition, but was discharged without conviction by Judge Peter Hobbs.[132] She had never applied for governmental permission to use a cannabis-derived CBD product as she thought she was unlikely to be successful (though the reasons for this view are unknown) and regardless, was unable to afford it with the funding she was already provided for other medications.[133] Ms Porter was charged with cultivation after growing cannabis to treat her multiple sclerosis on the very same day and was fined $500.[134] Ms Porter expressed that she felt like she was dealt "an injustice from the system" when she heard Ms Reider would have no criminal record.[135] Whilst both individuals were dealt far lesser sentences than what was the maximum available to the judge, issues of inconsistent treatment are evident.

The current regulatory system and discretion should not be relied upon as a barrier impeding law reform as is not working well in practice and creates a plethora of other issues. The high levels of discretion which police and judges are choosing to exercise in medicinal cannabis cases is problematic as it indicates a lack of faith with the current legislative and regulatory scheme, such that they are choosing to circumvent the law. This is particularly problematic given these are the very groups tasked with upholding and enforcing the law in the first place. This is clearly a law which does not align with public opinion and is in need of reform. Medicinal users are left vulnerable under the current system as if the views of police officers and judges change and become less lenient, they will be left in a precarious legal position as prior precedent was not based on a strict

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[130] Catherine Groenestein "Convicted cannabis grower gives $5000 donation to church" (17 March 2017) Stuff <www.stuff.co.nz>.
[131] Adele Redmond "Differing sentences for medicinal cannabis 'an injustice'" (9 March 2016) Stuff <www.stuff.co.nz>.
[132] *New Zealand Police v Reider* [2016] NZDC 3335 at [23].
[133] Redmond, above n 131.
[134] Redmond, above n 131.
[135] Redmond, above n 131.

interpretation of the law.[136] Issues of inconsistency and unpredictability will continue to cause tensions in this area without reform. It is desirable to have laws which reflect public opinion and will be enforced, upheld and generally respected, otherwise there is a risk that the legislative institutions and processes which are in charge of law making and reform will be undermined. These issues make the current regulatory system and police and judicial discretion a barrier which is easily overcome.

C Process of Approval and the Burden of Proof

The penultimate barrier, the burden of proof, is a more implicit obstacle faced by medicinal cannabis advocates. It refers to the issue that the starting point for reform is that cannabis is classified as an illegal substance, thus the burden in proving its efficacy and safety is higher due to this stigma when contrasted with other non-illicit substances which have been introduced and approved. This section will firstly consider the current processes and bodies involved in approving medicines in New Zealand, before considering, mirroring the prior sections, why this might be considered a barrier and how it can be overcome.

There are two key bodies which play a role in approving medicines for use in New Zealand. These bodies have separate and distinct roles, with medsafe generally considered to be "the regulator" and pharmac as "the funder".[137] Medsafe, a part of the Ministry of Health, must approve all medicines before they are able to be prescribed in New Zealand. Medsafe applies internationally agreed standards of safety, efficacy and quality, and evaluates data from clinical trials in deciding whether to approve or reject a medicine.[138] The process of approving drugs is lengthy, with the initial evaluation taking up to 200 calendar days to complete, followed by further requests for information.[139] Whilst medicines approved by medsafe will be available for New Zealand patients, whether they are subsidised by the Government is determined by pharmac.[140] Pharmac is a New Zealand governmental agency which decides how District Health Boards should spend money on

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[136] Hoffman and Weber, above n 58, at 1456.
[137] Pharmac "Medsafe, Pharmac with Different Roles in Medicine" (14 February 2006) Scoop Health <www.scoop.co.nz>.
[138] Pharmac, above n 137.
[139] "Safety Information: Medsafe's Evaluation and Approval Process" (4 July 2013) Medsafe <www.medsafe.govt.nz>.
[140] Pharmac, above n 137.

medicines and which pharmaceuticals to publically fund in New Zealand.[141] One factor making New Zealand unique to other overseas countries is that it has an agreed pharmaceutical budget, with any new spending needing to fit within this while enabling drugs already funded to continue to be available.[142] Pharmac is comprised of a committee with experience in examining clinical evidence, and similarly to medsafe, considers the clinical evidence of the drug, but also undertakes a cost and benefit assessment and economic analysis of the product.[143] The issues with this dual system becomes apparent when Sativex is considered. It is one of the few cannabis-based products able to be prescribed in New Zealand, as it is approved by medsafe, however, it is not funded by pharmac, meaning it remains too costly for many individuals. Whilst pharmac has claimed to be open to funding medicinal cannabis products, Sarah Fitt, Director of Operations said the Pharmacology and Therapeutics Advisory Committee has advised the Government there is not yet sufficient evidence that Sativex is effective.[144] It seems strange given its approval by medsafe, whom following their procedures, clearly considered it to be a safe, efficient and high quality drug, though this speaks to the different standards and procedures between the two bodies.

The current illegal status of cannabis under the Misuse of Drugs Act and its interplay with the current complex process in approving and funding medicines in New Zealand makes this a key barrier to law reform for medicinal cannabis. Grinspoon and Bakalar have commented on cannabis being caught between laws governing medicines and criminal laws, which seriously impacts on its medical potential.[145] The Ministry of Health have emphasised that prescribing controlled drugs is much more tightly controlled than prescribing other medicines, "reflecting the need to restrict access to, and minimise the misuse of, controlled drugs".[146] One of the key reasons that pharmac has previously declined funding for cannabis-based medication is that it claims the risk of inappropriate use is too high.[147] Such reasoning employed by pharmac and the Ministry of Health is problematic for several reasons. Firstly, it ignores the fact that raw cannabis is not only

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[141] "About Pharmac" <www.pharmac.govt.nz>.
[142] Pharmac, above n 137.
[143] Pharmac, above n 137.
[144] Craig Hoyle "First Kiwi approved for new cheaper medicinal cannabis treatment" (13 November 2016) Stuff <www.stuff.co.nz>.
[145] Grinspoon and Bakalar, above n 1, at 174.
[146] "Controlled drugs" Ministry of Health <www.health.govt.nz>.
[147] "Pharmac bid to fund medical cannabis shut down by clinical advisors" (16 November 2015) <www.nzdoctor.co.nz>.

relatively inexpensive, but freely available in New Zealand, irrespective of the current legislative framework. Assuming by inappropriate use, the committee is meaning recreational use, this will continue irrespective of the legalisation of medicinal cannabis and it is unlikely recreational users will bother getting cannabis prescribed by a medical practitioner when it is so accessible currently. Secondly, it ignores the complicated cultural, social and political history which saw cannabis prohibition become entrenched in the first place without due consideration to medical and scientific evidence, whilst other drugs such as opioids, alcohol and tobacco remained legal. Thirdly, inappropriate use, even for medicinal cannabis, is inevitable. Already, a small minority of the population are misusing approved prescription drugs such as tramadol, oxycodone and ritalin, yet these substances remain available. The key difference is that these drugs came from a neutral starting point, despite their associated risks and harms, with criminalisation inherently easier than decriminalisation. Stern and DiFonzo have commented that cannabis has "never quite been able to shed its identity as a dangerous, mind-altering substance" meaning that its "fight for scientific legitimacy has been far more laborious than that of other drugs".[148]

It is unfortunate that the stigma associated with cannabis since it was criminalised in the 20th century has led to a difficulty in getting it subsequently approved and funded when contrasted to other freely available prescribed drugs which did not face a starting point of illegality. In regards to overcoming this barrier, recognition needs to be given to the factors which led to cannabis being criminalised in the first place, overseas models and the necessity of reframing. Serious consideration needs to be given to removing cannabis from the Misuse of Drugs Act 1975, thus reducing its stigma and providing it with the neutral starting point which other medicines have been granted.

D The Issue of Advocacy

The final barrier to be considered is the issue of advocacy. Advocates for reform claim to support the legalisation of strict medicinal use, but often use research, examples and case studies of therapeutic uses when making out their case or proposing change. This blurring of definitions leads to what ought to be a narrow law reform debate continuing to face broad challenges. Advocacy becomes a barrier where advocates are unclear on exactly

[148] Stern and DiFonzo, above n 11, at 693.

what they are arguing in favour of, as they open themselves up to criticisms about promoting a wider agenda, having underlying motivations and more specifically, accusations they are trying to legalise recreational cannabis. This section will consider how the issue of advocacy has operated as a barrier in three particular case studies where advocates have blurred the distinction between medicinal and therapeutic use. Ways of overcoming this barrier will be considered alongside this, notably the benefit of a medicinal cannabis reframing by adopting a broader definition and the importance of honesty in what is being proposed. Such will ensure that "Trojan horse" claims lose their force, as exactly what is being advocated for is being addressed openly right from the beginning.

The first case study to consider is Ms Turei's advocacy in the aforementioned Misuse of Drugs (Medicinal Cannabis) Amendment Bill, drawn from the members' ballot in 2009. The bill appears to prima facie support a narrow medical cannabis system, however, when examining its framework and Ms Turei's arguments when introducing it in the first reading, it appears to be much wider. Firstly, the bill allowed patients to cultivate their own cannabis for medical use.[149] This was seen as endorsing the use of cannabis in its raw form, which is inconsistent with a strict definition of medical cannabis which generally promotes the extraction of CBD and removal of THC into processed products. Secondly, Ms Turei drew on case studies concerning therapeutic uses of the drug, such as a tetraplegic man using cannabis for pain relief who was jailed in 1999 for possession and cultivation of six small seedlings and faced appalling conditions in prison, including not being toileted for days.[150] Lastly, the broad and "impressive array" of conditions specified in schedule 4 of the bill was an area of concern for many MPs.[151] Conditions such as asthma, arthritis, eating disorders, migraines, nausea associated with chemotherapy, depression and even "pain" were included.[152] Within this bill, a blurring or misunderstanding of the distinction between medical and therapeutic cannabis is clear. The bill was defeated 84 to 34, primarily due to claims that the clear underlying motive appeared to be the legalisation of cannabis more generally, with the medical path a mere "red herring".[153] Whilst it was claimed that the bill was strictly trying to establish a medicinal cannabis regime, its encompassing of broader therapeutic uses without being

[149] NZPD, above n 43, at 4850.
[150] At 4850.
[151] At 4850.
[152] Misuse of Drugs (Medicinal Cannabis) Amendment Bill 2009, sch 4.
[153] NZPD, above n 43, at 4850.

clear about this from the beginning was a huge barrier evident in the first reading. It is possible that if the bill had openly acknowledged the intention to legalise both therapeutic and medicinal uses, perhaps the result might have been different, as this could helped to mitigate claims that recreational cannabis use was being supported "on the sly", when this was clearly not the case.

A second case study to consider, which has already been discussed, is the Alex Renton case in 2015 and his mother, Rose Renton's petition to parliament in 2016. Since Alex's passing, his mother Ms Renton has been fighting for reform of New Zealand's medicinal cannabis laws. In 2016, Ms Renton presented a petition to parliament with more than 17,635 signatures calling for medical cannabis to be legalised. Despite claiming the petition was limited to strict medical use, further examination of the language of the petition, urging reform of the law to allow access to "safe, affordable and quality medicinal cannabis" as New Zealanders are "suffering and dying because they cannot access it"[154] suggests an implicit, wider interpretation of medicinal cannabis which also encompasses therapeutic use is being sought. Given that Alex Renton's doctors were reluctant to recommend cannabis as a medication in his case, it is arguable Ms Renton is petitioning for therapeutic cannabis reform more generally. Ms Renton also staged a protest outside the offices of Nelson MP Nick Smith on the one year anniversary of her son's death. Mr Smith responded that he has been unaware of the protest as he was in Christchurch at the time, but reiterated the common belief that medicinal cannabis activists were actually advocates for broader liberalisation, using medicinal cannabis as a "Trojan horse" for wider recreational use.[155] Analogies with the criticisms faced by Ms Turei in parliament are clear. As per parliamentary procedure, the Health Committee must undertake an inquiry into the petition, which was presented by Damien O'Connor to the Committee on October 12th in 2016. This inquiry has not yet been released. As an individual advocating for reform, Ms Renton could avoid "Trojan horse" style arguments if she is more open about what she is trying to legalise, particularly given her past experience with the drug and choice to self-prescribe it on behalf of her son.

The Law Commission in their 2011 Report, which advocated for medicinal cannabis reform, made several comments to suggest that they also favoured wider therapeutic use

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[154] "Sign the Rose Renton Petition for Medicinal Cannabis" (22 March 2016) NORML <www.norml.org.nz>.

[155] Tim O'Connell "Mother still battling for Alex Renton, one year after teen's death" (2 July 2016) Stuff <www.stuff.co.nz>.

which perhaps contributed to its lack of adoption by the government. In their 360 page report, titled 'Controlling and Regulating Drugs: A Review of the Misuse of Drugs Act 1975', tabled in parliament on the 3rd of May 2011, a total of 144 recommendations for reforming New Zealand's drug laws were made, ultimately concluding that the Misuse of Drugs Act is out of date and in need of reform. The Commission recommended medicinal cannabis should be treated as a medicine and brought under the Medicines Act 1981, but also made comments suggesting they supported therapeutic uses of the drug too.[156] Most significantly, the Commission saw no reason why cannabis should not be utilised in its raw form as a therapy by people suffering a chronic or debilitating illness, though clinical trials would be required.[157] The Government did not adopt any of the Law Commission's medicinal cannabis recommendations, with Associate Minister of Health, Peter Dunne noting "it is the government's view that it is not its role to initiate clinical trials on cannabis leaf or any other product or substance", reiterating the satisfactory nature of the current regime.[158] It is possible that the recommendations made by the Commission became too broad due to the introduction of therapeutic arguments and uses as well. Looking forward, it would be useful to see a Law Commission Report focused solely on medicinal cannabis (as opposed to the Misuse of Drugs Act and psychoactive substances regime) and how medicinal cannabis could be encompassed within a therapeutic substances regime in the future. The Commission would need to set out in the beginning that a wider definition of medicinal cannabis is to be adopted.

How the case for medicinal cannabis reform is advocated has the potential to be a huge barrier if it opens itself up to claims of an ulterior motive or agenda, or general dishonesty. The medicinal cannabis debate is consistently plagued with accusations of trying to legalise cannabis more generally, with the association between recreational and medicinal use hard to shake. As highlighted in this section via considering the three advocacy case studies, issues may be able to be overcome if a wider definition of medicinal cannabis as including therapeutic uses is explicitly defined from the outset, speaking directly to the proposed reframing made in this paper. As the four key barriers perceived to be preventing law reform in this area are able to be rationalised and overcome, the next section briefly

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[156] Law Commission, above n 42, at 309.
[157] Law Commission, above n 29, at 302; and Law Commission, above n 42, at 306.
[158] Peter Dunne "Next Government will overhaul the Misuse of Drugs Act" (8 September 2011) <www.beehive.govt.nz>.

explores the recommendation of including medicinal cannabis within the upcoming therapeutic substances review by the Government.

VI Moving Forward

The Government is currently working on a new regulatory regime to govern therapeutic substances in New Zealand, with an intention to eventually replace the current Medicines Act 1981 and its corresponding regulations.[159] The Therapeutic Products Bill is currently being drafted, with consultation on the exposure draft expected to be completed by the end of 2017. The goal of this proposed regime is to ensure that the system remains "flexible enough to ensure effective control over the quickly evolving technology used in therapeutic products, while also being as efficient and cost-effective as possible".[160] It is argued that medicinal cannabis should be included within this review under its broader definition which encompasses therapeutic use. This section will briefly highlight the issues with the existing therapeutic framework, showing that reform is necessary, before making the argument that medicinal cannabis should be encompassed within the upcoming review. In short, it is hoped that this will simplify access for individuals in need whilst ensuring a degree of governmental control is retained. By incorporating medicinal cannabis within the review, its appropriate place and scope is able to be examined in detail as part of the law reform process.

When considering the current framework for therapeutic substances in New Zealand, it becomes clear it is increasingly convoluted, particularly due to its interaction with the medicines framework. An earlier Therapeutic Products and Medicines Bill, introduced by Hon Dr Jonathan Coleman in 2006, was referred to the Government Administration Committee in 2007, however, in their final report, the Committee was ultimately unable to reach agreement and therefore did not recommend that the bill be passed.[161] Resultantly, the current system and its piecemeal approach is subject to regular criticism. Furthermore, people seem to be against governmental regulation over their commonly used products. Presently, there is a pre-marketing product approval system in place for any changed or new therapeutic products. If a product fall within the definition of medicines or medical-

[159] "Therapeutic products", above n 30.
[160] "Therapeutic products", above n 30.
[161] Therapeutic Products and Medicines Bill, Report of the Government Administration Committee 103-1 (published 15 June 2007) at 3.

related products, it will be brought under the Medicines Act.[162] To exemplify the flaws with the current system, an example may be considered, though it is not suggested that medicinal cannabis is exactly comparable to this. St John's Wort is a drug used to help with some types of depression by raising serotonin levels and operates as an example of a substance which has slipped through the cracks of the current regime and is now freely available in pharmacies and supermarkets. It is known to interact with a variety of prescription drugs, notably the contraceptive pill, and if combined with other certain drugs, has the potential to trigger psychotic events, autonomic dysfunction and motor effects as the body struggles to cope with increased levels of serotonin.[163] Despite these dangers, it is not registered as a medicine in New Zealand and instead considered to be a herbal or therapeutic supplement.[164] As medicinal cannabis has not previously been raised or considered within the context of a therapeutic substances debate, though the reasons for its omission are not entirely clear, its inclusion within this review would be both timely and opportune given the need for reform in this area.

Medicinal cannabis already seems to fulfil the requirements of a therapeutic product under its current definition. Under s 4 of the Medicines Act, a product will have a therapeutic purpose if it may be used in "preventing, diagnosing, monitoring, alleviating, treating, curing, or compensating for, a disease, ailment, defect, or injury; or influencing, inhibiting, or modifying a physiological process; or testing the susceptibility of persons to a disease or ailment".[165] Research and individual experiences have illustrated that medicinal cannabis may be used for many of these purposes, a common examples being its use in alleviating pains associated with arthritis. Medsafe has also outlined that typical indicators that a product has a therapeutic purpose will include that a product will, can or may prevent or treat a disease or condition or give relief from symptoms of a disease or condition alongside statements of traditional therapeutic use, or use by ethnic groups for a therapeutic purpose.[166] Providing relief from symptoms or conditions is a central application by individuals of medicinal cannabis. Therefore, the inclusion of medicinal

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[162] At 17-21.
[163] Lee Suckling "Are herbal treatments for mental health issues myth or magic?" (April 6 2017) Stuff <www.stuff.co.nz>.
[164] Sandra Ponen "St John's Wort" (6 February 2017) Health Navigator <www.healthnavigator.org.nz>.
[165] "Guideline on the Regulation of Therapeutic products in New Zealand: Overview of Therapeutic product regulation" (October 2014) Ministry of Health <www.health.govt.nz> at 4.
[166] At 5.

cannabis would not require a reconsideration or extension on what is currently understood as a therapeutic product.

The biggest barrier to the inclusion of medicinal cannabis within the therapeutic substances review comes from its continued classification as an illicit substance under the Misuse of Drugs Act. Contrary to opponent's beliefs, cannabis is a largely safe drug, particularly when contrasted with prescription drugs such as opioids and legal drugs such as alcohol and tobacco. These drugs are not only freely accessible, but habitually abused, yet this has not led to their criminalisation. In the frequently citied multi-criteria decision analysis study by Professor Nutt, alcohol was found to be the most harmful drug with an overall harm score of 72, whilst cannabis measured less than half of this with a score of 20, with most harm occurring to the user as opposed to "others".[167] Unlike alcohol or prescription drugs, there has never been a recorded fatal overdose of cannabis.[168] As previously argued, cannabis prohibition is a product of its social, cultural and political history as opposed to any serious harms and dangers associated with its use. Given its shaky foundations within the Misuse of Drugs Act in the first place, medicinal uses of cannabis should be removed from domestic drug legislation and users should no longer be criminalised. The classification of medicinal cannabis as a therapeutic product and its inclusion in the upcoming review would recognise evidence in favour of its benefits and follow international trends of legalisation, alongside allowing for continued governmental control with assurances as to safety, quality and correct information about dosages.

A reframing and redefining to a broader understanding of medicinal cannabis is essential going forward. Examining precisely how a new therapeutic products regime may look in the future goes beyond the scope of this paper, which is primarily aimed at considering law reform arguments and barriers in the medicinal cannabis debate. However, with the review and consideration of a proposed therapeutic products regulatory regime already underway, while it is not entirely clear what form this new regime may take, it is essential for medicinal cannabis to be included so experts are able to give due regard as to the best framework and model for the future.

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[167] David Nutt, Leslie King and Lawrence Phillips "Drug harms in the UK: a multicriteria decision analysis" (2010) 376 Lancet 1558 at 1561.
[168] Kim Bellware "Here's How Many People Fatally Overdosed on Marijuana Last Year" (28 December 2015) Huffpost <www.huffingtonpost.com>.

VII Conclusion

With the upcoming review into therapeutic substances, a recent election in which medicinal cannabis featured as a regular policy pronouncement, and a favourable tide of changing domestic and international public opinion, it is the perfect time to consider how to ensure medicinal cannabis is available and accessible to ill New Zealanders.

This paper firstly provided contextual information as to the history and current legislative and regulatory framework in New Zealand, proposing a broader definition of medicinal cannabis which would also encompass therapeutic use. It then canvased the primary arguments drawn upon by advocates in favour of change, which linked in well with the subsequent exploration of the barriers currently blocking law reform in this area, notably, international law, the current framework coupled with police and judicial discretion, the burden of proof and issues of advocacy. Specific counterarguments were considered in contending that these barriers should not prevent law reform in this area, alongside proposing that the reframing of medicinal cannabis operates as another possible means of overcoming the advocacy barrier in particular. It is clear that the current system with its issues of cost, accessibility and inconsistency is not working well in practice and change is necessary. The ultimate recommendation is that, under a broader definition, medicinal cannabis ought to be included within the impending governmental review into therapeutic substances, as when contrasted with other legal drugs it is relatively safe and proven to be beneficial in treating a variety of conditions, illnesses and ailments. Such a change would allow for issues with the current system to be mitigated alongside ensuring continued governmental control over the substance to safeguard its use for genuine medicinal and therapeutic uses and not for recreational use.

It is true that cannabis "may not be quite the medical miracle that advocates believe it to be … [but] it is, however, a substance of far greater therapeutic and practical value than our policymakers will allow".[169]

[169] Stern and DiFonzo, above n 11, at 764.

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