

Draft Public Health (Medicinal Cannabis) Bill 2016

Supplementary Submission

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for

Queensland Council for Civil Liberties

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Thank you for the opportunity to comment on this Draft Bill. This submission supplements the legal analysis provided by QCCL President Michael Cope, and offers commentary on a selection of related issues which the Council believes are of utmost importance.

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Introduction

At the outset, the Council commends the Palaszczuk Government for:

- (a) being the second state government to proceed with legislation after Victoria; and
- (b) not limiting the medical conditions and symptoms for which medicinal cannabis may be prescribed.

Key recommendation 1

QCCL applauds the Draft Bill's aspiration to legalise access to medicinal cannabis immediately, rather than waiting for an Australian industry to develop as per the Victorian model. However, the Council believes the Bill's reliance on the Commonwealth TGA/SAS scheme for supply of medicinal cannabis products—via importation from overseas in the short to medium term—is so flawed that this objective cannot be realised, at least in any timely or practical way.

The Council's clear and oft-stated preference is for the government to legalise cannabis without any restrictions, and we note that the federal health minister, Ms Sussan Ley, has recently reaffirmed that decriminalisation of cannabis is up to the states.

In the absence of legalisation, one truly obvious amendment to the Draft Bill—assuming the Palaszczuk government is sincere in its intention to facilitate access to medicinal cannabis—is to amend sections 9 and 10 with words to the effect that,

“in the event the patient's doctor and the patient have obtained TGA and Customs permission to import medicinal cannabis prior to lodging an application with the chief executive, approval will be granted without any additional investigation”.

Key recommendation 2

That the Draft Bill be amended to allow the chief executive to grant approval for medicinal cannabis products designed to be administered by smoking or vaporising. It looks like the relevant amendment should be inserted in Section 23, but the parliament's legislation experts will know best. The reasons for this amendment are provided in the submission.

Key recommendation 3

Accepting that is highly probable that the government will proceed with the legislation in its present form, QCCL urges the government to incorporate a 2-year review or sunset clause in the Draft Bill, to provide an opportunity to assess whether its objectives are being met.

Representatives of the Council are of course happy to discuss our concerns with the Minister or before a parliamentary inquiry if needed.

1. Medicinal Cannabis Legislation: State of the Nation

1.1 Legislative Landscape

1.1.1 Commonwealth

Therapeutic Goods Act 1989

This Commonwealth Act precedes the recent moves to legalise medicinal cannabis. The Act establishes the Commonwealth's *Standard for the Uniform Scheduling of Medicines and Poisons* (SUSMP)—the Poisons Standard—which categorises poisons and controlled substances in Schedules 2 to 9, taking account of how a substance is scheduled internationally under the Single Convention on Narcotic Drugs. The current version of the Poisons Standard is No 11, commencing 1 March 2016. The Poisons Standard has no legal effect unless it is adopted through state and territory drugs and poison legislation. All Australian states and Territories have voluntarily incorporated the Poisons Standard into their relevant state legislation, sometimes with minor variations, and automatically update their legislation as the Standard is amended.

Regulator of Medicinal Cannabis Bill 2014

Introduced by Greens 27Nov2014. Referred to Senate Legal and Constitutional Affairs Legislation Committee 12Feb2015. Committee report 11Aug2015. No further action.

TGA Interim Decision to Re-Schedule Cannabidiol from Schedule 9 to Schedule 4

Schedule 4 - New entry with effect 1June2015: Cannabidiol in preparations for therapeutic use except when containing more than 2 per cent of other cannabinoids found in cannabis.

TGA Proposal to Re-Schedule Cannabis and THC from Schedule 9 to Schedule 8.

Initiated 20Jan16. Final decision due before end of May 2016.

Poisons Standard March 2016

1.1.2 Queensland

Health (Drugs and Poisons) Amendment Regulation (No. 1) 2015

Subordinate Legislation 2015 No. 176 made under the Queensland Health Act 1937 by the Governor in Council on 10 December 2015. Amends the Health (Drugs and Poisons) Regulation 1996.

Draft Public Health (Medicinal Cannabis) Bill 2016

A Queensland Government Draft Bill published with a Discussion Paper inviting public submissions.

1.1.3 Victoria

Access to Medicinal Cannabis Bill 2015.

Introduced Victorian Legislative Assembly 8Dec2015, passed 11Feb16. Introduced Victorian Legislative Council 11Feb16, passed with amendments 24Mar16. Amended Bill passed by Legislative Assembly 12April16.

2. Commentary

2.1 Narcotic Drugs Amendment Bill 2016

According to the Explanatory Memorandum:

“The Department of Health, through the newly established Office of Drug Control, will license those who cultivate, produce and manufacture cannabis and cannabis products for medical and scientific use, while the TGA will regulate the manufacture, registration and supply of medicinal cannabis products, in the same way that it does for all other therapeutic goods.”

The MCG Pharma White Paper rephrases this thus (emphasis added):

“In this way, the Office of Drug Control would be responsible for regulating the **operational** side of the medicinal cannabis industry, while the TGA would be responsible for **regulating** the types and forms of approved medicinal cannabis products. “

Greens leader Richard Di Natale responded on 24 February 2016:

"[The Narcotic Drugs Amendment Bill] is one piece of the puzzle but there's a lot more that needs to be done. ... [It] doesn't do anything about the distribution, supply, prescription of the drug ... there's no legislation around how doctors will prescribe it. Ironically, medicinal cannabis is still an illegal drug. We reserve the right to reintroduce our [Regulator] legislation if progress is too slow ... if we don't see the drug make its way to pharmacies and then through to doctors, we will look at reintroducing legislation which does that."

http://www.huffingtonpost.com.au/2016/02/23/medical-cannabis-australia_n_9302936.html

2.2 Regulator of Medicinal Cannabis Bill 2014

In choosing to amend the Narcotics Act, the Turnbull government rejected the model proposed in the Greens-initiated Regulator of Medicinal Cannabis Bill 2014. In a report published August 2015, this model had been unanimously and enthusiastically endorsed by a cross-party committee of senators. Including legislation introduced into the NSW parliament, this is the third occasion in which Greens-initiated legislation to legalise medicinal cannabis has been rejected by the Liberal and National parties.

It is ironic that several parties who were strongly opposed to the Regulator model—Health, TGA, AMA, PGA—will now be involved in implementing the new scheme. The Commonwealth Health Department will have oversight of the manufacture and supply of medicinal cannabis products within Australia. The Therapeutic Goods Administration (TGA) will continue to decide what medicinal products can be prescribed. Members of the Australian Medical Association (AMA) and the Pharmacy Guild of Australia will prescribe and supply medicinal cannabis products to eligible patients.

One of the principal objectives of the Regulator model was to ensure that all Australians would have access to medicinal cannabis under the same set of criteria. Of course this was

subject to states volunteering to participate in the Regulator scheme, not unlike the way they voluntarily adopt the commonwealth Poisons Standard. The wide divergence in the approaches adopted by the first two pieces of state legislation—Queensland and Victoria—supports the argument that,

- a) the Regulator would have been a better way to ensure every Australian was being treated equally; and
- b) that what was legal in one state wouldn't be illegal in another.

In his 2015 submission to the Senate committee, Emeritus Professor Mather commented as follows (emphasis added):

“How to permit and regulate cannabis and cannabis preparations for medicinal use has been a major stumbling-block to present state and territory government inquiries. If this [Regulator] Bill will allow a mechanism for the Federal production, regulation and permission of cannabis use as medicine, including production and research, and allow State and Territory governments to adopt a code of regulation afforded Federally, then surely this seems a beneficial way of precluding inharmonious local legislation and the errors of the past. **A nation-wide code seems both sensible and economical.**”

If the current state and federal legislation does not deliver on the goals of providing access to medicinal cannabis in the same way patients are prescribed mainstream medications, the Council believes the national Regulator model should be revisited.

2.3 Softening of TGA Cannabis Scheduling

The commonwealth Poisons Standard has been law for many years. At the beginning of 2015 practically all forms of cannabis were listed in Schedule 9. Just three rarely prescribed medicinal cannabis products—Dronabinol, Nabalone and Nabiximols—were listed in Schedule 8. Schedule 9 contains ‘prohibited substances’, poisons that may be abused and are therefore highly controlled with detailed and restrictive rules about record-keeping, storage, who may lawfully possess them, and who may lawfully prescribe them. The categorisation of cannabis in Schedule 9 has been a great source of frustration for scientists seeking to carry out research on the medical benefits. According to the GMC Pharma White Paper, one of the attractions of the Regulator model was that it would “bypass the rigid classification and approval system of the TGA”.

Schedule 8 contains poisons that are ‘controlled drugs’. A ‘controlled drug’ is a substance that in principle is able to be made available by a limited range of medical professionals, but may be abused by patients. Cocaine, Morphine, Opium, Oxycodone, Pethidine and related drugs are listed in Schedule 8. Controls are placed on manufacture, supply, distribution, possession and use.

Two very significant softening's of the Poisons Standard have been implemented over the past year. The first is the re-scheduling of cannabidiol from Schedule 9 to Schedule 4, taking effect on 1 June 2015. The second is the re-scheduling of THC and some forms of cannabis from Schedule 9 to Schedule 8, due to take effect by end-May 2016. Prescription and supply of Schedule 8 and Schedule 4 medicinal cannabis continue to be subject to TGA approval.

2.4 Queensland Amendment of HDP Regulation

In Queensland, the *Drugs Misuse Act 1986* makes the production, possession and supply of cannabis an offence where such activities are done ‘unlawfully’, that is, without authorisation, justification or excuse by law. In late 2015 the Palaszczuk government amended the Health (Drugs and Poisons) Regulation 1996 (the HDP Regulation) in the Health Act 1937 to make it lawful for the chief executive to allow Queensland patients access to medicinal cannabis under the TGA scheme, while retaining the status of cannabis as a prohibited Schedule 9 drug. The explanatory memorandum states that this amendment has been subsumed into the Draft Bill.

2.5 Access to Medicinal Cannabis Bill 2015 (Victoria)

The Victorian legislation takes off from Conclusion 4.64 in the VLRC report that “Limiting a Victorian medicinal cannabis scheme to products that have been approved by the TGA would reinforce the status quo.” And that, apart from clinical trials “... there is no scope for the Victorian Government to expedite the approval of medicinal cannabis products under current Commonwealth law.”

Similarly, in relation to importation, the legislation has been guided by Conclusion 5.26 in the VLRC report that “As a means of meeting all or most of the demand for medicinal cannabis under the scheme, importation is not feasible in the current international environment.”

Accordingly, apart from explicitly defining cannabis in terms of the Commonwealth Narcotic Drugs Act 1967—an unexceptional definition—the legislation rejects TGA oversight and sets out the arrangements and rules by which medicinal cannabis products will be cultivated, manufactured, prescribed and dispensed to Victorians.

This will inevitably cause delays, but the Victorian government is not wasting any time. According to a *Herald Sun* report dated 12 April 2016, the ‘Minister for Agriculture Jaala Pulford revealed a small-scale, strictly controlled cannabis cultivation trial at a Victorian research facility was set to begin in April.’

And in an *ABC* report dated the same day, Health Minister Jill Hennessy was quoted as saying the drug would be available in a variety of forms, including tinctures, oils, capsules, sprays and vaporisable liquids, and the Government would set up an Office of Medicinal Cannabis to oversee the manufacture of the drugs and would educate doctors and patients about their role and eligibility for the scheme.

2.6 Draft Public Health (Medicinal Cannabis) Bill 2016 (Queensland)

The Queensland Bill approaches regulation from a very different perspective to that of Victoria, focussing almost exclusively on arrangements for patients to be prescribed and supplied with medicinal cannabis products, which will be manufactured, imported or supplied under a law of the Commonwealth. It also makes provision for clinical trials. Further commentary on the Queensland Bill is set out in Section 3.

2.7 Clinical Trials

The MCG Pharma White Paper provided the following useful summary in March 2016:

In December 2014 the NSW Government announced it would invest \$9 million over a five-year period on clinical trials of cannabis products. The trials seek to investigate the use of cannabis and cannabinoid-based products in treating symptoms stemming from a range of conditions. The program comprises three trials, each focusing on particular conditions for which standard treatments have not been effective. The QLD, VIC and TAS Governments have partnered with NSW to participate in these trials.

The first set of trials, beginning in 2016, is for children with severe, drugresistant epilepsy. This has been organised as a result of a partnership with Sydney Children's Hospital Network and GW Pharmaceuticals, who announced in October 2015 that they would be providing *Epidiolex* – a pharmaceutical grade cannabis product containing refined CBD extracted from medicinal-grade cannabis – to the NSW Government for these trials.

The second and third set of trials will focus on adults with terminal illness, with a focus on improving quality of life through mitigating symptoms of chronic pain and chemotherapy-induced nausea and vomiting.

The Council's problem with clinical trials is twofold. According to expert submissions to the Senate Committee considering the Regulator Bill as well as submissions to other inquiries, there is already enough high quality overseas research demonstrating the efficacy and safety of a number of medicinal cannabis products including herbal products. The second problem is that the clinical trials may take up to five years to be completed, and will then be subject to further delays while governments consider how they will deal with the findings. The Council acknowledges that further research is always valuable, but considers the delays to be unacceptable.

2.8 Cannabidiol Business

At least one business has been established to import and market cannabidiol in a profit-oriented model. According to a 6 April 2016 phone conversation with their customer care representative, *Medicinal Cannabis Clinic Pty Ltd* was created to take advantage of the TGA re-scheduling of cannabidiol to Schedule 4 with effect 1 June 2015. The representative said they have about 2000 patients on their books, they have a private doctor who can write prescriptions for all these patients, and they have an overseas supplier. Although—as a message on their website makes clear—the TGA had blocked their licence to import, their lawyers were currently negotiating with the TGA to approve importation. She claimed that when their licence was approved, MCC would be able to dispense cannabidiol medicines to all Australians, regardless of where they lived.

3. Queensland Draft Bill

3.1 Objective of the Draft Bill

From the Queensland Government Discussion Paper p9:

“The purpose of the Bill is to create a new regulatory framework, under which medicinal cannabis products may be prescribed and dispensed to patients in Queensland. A key objective of the Bill is to minimise the complexity and regulatory burden of the scheme on patients, medical practitioners and pharmacists while ensuring the quality, safety and efficacy of medicinal cannabis products where possible.”

The Council has two fundamental problems with the Draft Bill. One is its bureaucratic complexity, arguably the inevitable result of cannabis prohibition; the other is its reliance on a Commonwealth supply of medicinal cannabis. The supply issue is addressed first.

3.2 Medicinal cannabis supply

Subsection (2)(c) of Section 23 states:

- (c) the medicinal cannabis to which the approval will apply—
 - (i) has, or will be, manufactured or imported under a law of the Commonwealth; and
 - (ii) is, or will be, able to be supplied, for the purpose of treating the patient, under a law of the Commonwealth.

The subsection thus envisages sourcing of medicinal cannabis either via importation from overseas or from a product manufactured in Australia. As discussed at length in submissions to the VLRC report, it is very difficult to import medicinal cannabis from overseas both because of limited supplies and export prohibitions by some key governments.

However, the more important problem is the requirement for prior TGA approval of the cannabis medicine. As demonstrated by the experiences of Lanai Carter—documented on the MCAG Facebook page—this is such a daunting and tortuous process that it will discourage all but the most persistent patients or their carers from applying. Whether the anticipated rescheduling of some medicinal cannabis substances from Schedule 9 to Schedule 8 will make this process any easier will only become apparent over the next year or two, but the Victorian government has already decided it is not a viable mechanism of supply, and will instead arrange its own supplies by licensing cultivation and manufacture in Victoria.

The Commonwealth amendments to the Narcotics Act provide for potential Australian cultivators and manufacturers to apply for licences through the Health department. It can be anticipated that an Australian industry will take at least a couple of years to produce medicinal cannabis products that might be available to Queenslanders. Under the terms of the Queensland Draft Bill these products must either already have been approved by the TGA, or have the capacity to be approved by the TGA.

In the meantime, it seems clear that Queensland patients seeking to import cannabis medicines from overseas will have to undergo a similar TGA procedure to that described by Lanai Carter.

3.3 Why so bureaucratic?

As noted by Michael Cope the Draft Bill is extremely bureaucratic, negating the stated objective “to minimise the complexity and regulatory burden of the scheme”. Some 140-plus pages have been expertly drafted by parliamentary legislators to cover every possible contingency in the prescription and dispensing of medicinal cannabis in Queensland, including long lists of sanctions for when breaches, both minor and bureaucratic, occur.

The principal reason for the extraordinary level of regulation and multiple sanctions proposed by the legislation can only be the illegal status of cannabis. There are far fewer rules and regulations surrounding the prescription of opioid pain killers and other potentially lethal prescription drugs than are contemplated for cannabis in this legislation. (The same in-principle criticism applies to the Victorian legislation.)

But why is it illegal? Can this be addressed? Have there ever been any plausible medico-scientific reasons for classifying it as a “narcotic” like heroin? The Council believes it is worth looking at this issue a bit closer, because eventually the world-wide movement to legalise cannabis will reach Australia, and legislators will need to be agile and innovative to respond to that.

4. Cannabis Prohibition

4.1 Narcotic Substance

The Council’s view is that the illegal status of cannabis is the main stumbling block to providing ready access to medicinal cannabis for all the Australians who may potentially benefit. It is the reason why medicinal cannabis users continue to be regarded with suspicion by medico-legal authorities, when they should be dealt with in the same straightforward manner as any other persons seeking medicines to alleviate health problems.

Cannabis is illegal because President Nixon decreed in the late 1960s that it should be classified as an illegal drug so dangerous that recreational and medicinal users should be pursued vigorously by law enforcement and if caught, locked away in prisons for long periods of time. So started the ‘War on Drugs’, and the United States, through its effective control of United Nations drug policy, ensued this war would be extended to all corners of the world. As described in Des Manderson’s excellent book *‘From Mr Sin to Mr Big’*, Australia joined the ‘war’ enthusiastically, completely failing to question either the science or the public policy.

At the time of writing this submission most forms of cannabis are classified as narcotic substances and are listed in Schedule 9 of the Poisons Standard. There are some exceptions: cannabidiol has been listed in Schedule 4 since June 2015, and the synthetic formulations nabalone and dronabinol are listed with nabiximols, a non-synthetic medicinal cannabis marketed as Sativex, in Schedule 8. Health Minister Ley is confident that by the end of May 2016 the TGA will act to move some cannabis-derived medicines into Schedule 8, a

necessary requirement to enable Australian cultivation and manufacture as provided by the 2016 amendments to the Narcotics Act. However, because of the minister's stated opposition to medicinal herbal cannabis that is designed to be smoked (or vaporised), those forms of cannabis will remain in Schedule 9, as "narcotics".

4.2 Nixon's Big Lie

The categorisation of cannabis as a narcotic drug subject to extreme criminal sanctions is neither medical nor scientific. As already noted it is a relic of the Nixonian 'War on Drugs', a purely political exercise as explained in the following extract from an article in the April 2016 issue of *Harpers Magazine*. As they say in a popular TV program, the claim that cannabis is a narcotic "Is In Fact a Lie" and a very big lie indeed:

"In 1994, John Ehrlichman, the Watergate co-conspirator, unlocked for me one of the great mysteries of modern American history: How did the United States entangle itself in a policy of drug prohibition that has yielded so much misery and so few good results? Americans have been criminalizing psychoactive substances since San Francisco's anti-opium law of 1875, but it was Ehrlichman's boss, Richard Nixon, who declared the first "war on drugs" and set the country on the wildly punitive and counterproductive path it still pursues. At the time, I was writing a book about the politics of drug prohibition. I started to ask Ehrlichman a series of earnest, wonky questions that he impatiently waved away.

'You want to know what this was really all about?' he asked with the bluntness of a man who, after public disgrace and a stretch in federal prison, had little left to protect. 'The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.' "

<https://harpers.org/archive/2016/04/legalize-it-all/>

In his excellent 1980 book on drugs, FA Whitlock, the former Professor of Psychiatry at the University of Queensland, made a similar point for the Australian context:

"... a problem was declared to exist by official decree, and a good deal of subsequent official action seems to have been designed to make sure that a self-fulfilling prophecy came true."

The Disinformation Machine—that cannabis is a dangerous drug requiring draconian criminal sanctions to stop recreational use—has been working in overdrive ever since. For decades politicians from all parties have either airily dismissed the science, or, worse, lavishly funded faux-researchers who promised to give cannabis a negative report —94 percent of the funding according to a CNN survey referenced in the QCCL submission to the senate committee.

The same Disinformation Machine has been carried over into the consideration of cannabis as a therapeutic agent, thus denying its benefits for millions around the world.

4.3 Medicinal Cannabis is very safe

Laurence Mather sets the record straight:

“In Australia, as elsewhere, many people, including some of whom are patients already under medical care, use cannabis as a medicine, despite its illegality. They do so to relieve distressing symptoms from a number of serious medical conditions, especially when the conventional medicines have been ineffective or accompanied by unacceptable side effects. This is not to say that cannabis is free from side effects—no medication is—but studies examining its side effects have reported that side effects, if occurring, are minimal and acceptable, especially when compared to the untreated symptoms of the condition or with the side effects of conventional medicines that may be used to treat the condition.”

*Laurence E Mather, Emeritus Professor of Anaesthesia, University of Sydney
(Submission 17 Senate Inquiry into the Regulator of Medicinal Cannabis Bill 2014.*

The Victorian Law Reform Commission Report on Medicinal Cannabis agrees:

“23. The point made by many submissions to the Commission is that the proven level of adverse effects, even from unmonitored recreational use of herbal cannabis, is of modest dimensions. Unlike the experience of opiate drug use, no deaths have been attributed to cannabis use.”

Executive Summary page xix

In the long history of medicinal cannabis legislation, every time a relaxation has been contemplated the spectre of the ‘war on drugs’ has reared its ugly head, and, usually successfully, initiatives have arisen to block and impede change.

4.4 What is cannabis, really?

Not a narcotic, and not a pharmaceutical product either. Medicinal cannabis has much more in common with the alternative medicines found in health food shops. It also has a lot in common with the substances sold in ‘Happy Herb’ shops, whose proprietors promote their stock for both health benefits and mild psychoactive properties. In the last couple of decades alternative medicines have been increasingly stocked in pharmacies, revisiting, as Laurence Mather writes, a traditional role:

Until some 50 years ago, pharmacists’ formularies and pharmacopoeias were replete with both extemporaneous and proprietary preparations consisting of herbal medicines (eg, tincture of opium, extract of belladonna). Nowadays, they largely contain totally synthetic substances, purified single substances, or semi-synthetic derivatives of substances extracted from some or other biological matrix (eg, from animal parts, a mollusc, a fungus or a tree). Notwithstanding, contemporary pharmacists’ shelves are replete with what we would normally term ‘complementary medicines’, and very many of these are tinctures and extracts of various plants, albeit standardised to some or other degree.

Mather goes on to describe how cannabis medicines were an integral part of the mainstream pharmacopoeia from the nineteenth century until 1949, after which “the demise of cannabis pharmacotherapy was completed politically for reasons that were neither medical nor scientific.”

5. Prohibition Against Smoking

Cannabis is so safe that nobody has ever died from ingesting it in any of the many ways it can be taken. The MGC Pharma White Paper quotes the estimate from the VLRC report that 750,000 Australians use cannabis every week and that 35% of Australians over the age of 14 have used it within their lifetime. Although most of this weekly usage must be recreational, public submissions to the various cannabis inquiries suggest that tens of thousands of these users are taking cannabis for medicinal reasons. One such was Lucy Haslam’s son Daniel.

5.1 ‘Amazing’ street cannabis

The Tamworth Haslam family is where the current movement to legalise medicinal cannabis started. It is worth revisiting the Haslams to be forcefully reminded of the extraordinary efficacy of even a few puffs of a joint made from that much-maligned herb, ‘street cannabis’. Here is how Lucy Haslam’s describes that first encounter:

“At the point where Daniel tried cannabis, he was three years into this treatment. The chemotherapy was not working. They were saying he needed to go back to the original chemotherapies that they had tried, which did not last very long with him because the side effects were so severe ... [The next time Daniel had chemotherapy], he had a couple of puffs on a cannabis joint, and it was amazing. I really cannot understate that. It was as near to a miracle as I have ever seen ... He would come home with a chemotherapy pump on, so he would be out of the clinic but effectively still hooked up to chemotherapy, and he would be [extremely white] for days. He had a couple of drags; the colour came back to his face, and he just went: ‘Wow! I’m hungry. Mum, can I have something to eat?’ ... This was such an incredible change. It was life-changing for all of us.”

Case Study 1 – Mrs Lucy Haslam Senate Committee Report on the Regulator of Medicinal Cannabis Bill 2014, p37.

Of course there had been many attempts before the Haslams to either legalise cannabis altogether, or just to legalise medicinal cannabis. Parliaments had invited public submissions, commissioned expert reports and drafted legislation, all for nothing, possibly because the initiatives came from the left side of politics.

The key to the Haslam family’s success seems to have involved a combination of Lucy Haslam’s compelling testimony, her conservative politics, her husband’s former career as head of the Tamworth drug squad, and her ability to convince conservative politicians—the local National Party MP and the Liberal Party NSW premier Mike Baird—about the merits of her son’s cause. Sometimes there is no greater force than a mother’s love for her child.

As noted at the beginning, the author's partner discovered a similar level of symptom relief from smoked cannabis. Anecdotally, these are very common experiences.

5.2 Victorian legislation prohibits smoking

Clause 70 of the Victorian legislation was amended by the upper house to read in part that (2) "The Health Secretary must not approve under subsection (1) a medicinal cannabis product that is designed to be administered by smoking" and that (3) for the purposes of subsection (2), smoking does not include vaporising."

This amendment picked up a recommendation against smokable medicinal cannabis in the VLRC report. Appendix A of this submission reproduces the VLRC arguments for this recommendation and meets them with opposing arguments.

Note that the ban on "vaporising" does not extend to 'vaping' cannabis oil as in e-cigarettes, which is explicitly allowed in the Victorian legislation according to the minister's press release.

5.3 Draft Bill should allow smokable medicinal cannabis

On the basis of all the commentary to this point, and the additional commentary in Appendix A, the Council strongly urges the government to vary the Draft Bill so as to allow Queenslanders access to smokable and vaporisable forms of medicinal cannabis. This variation would surely fall within Health Minister Ley's definition of decriminalisation, which she allowed was up to the states. Even if supply constraints made it difficult to implement initially, the signal provided by the amendment would be gratefully received by thousands of Queenslanders.

6. QCCL Commends Pennington Model

The following text outlines a model that QCCL commends to the Queensland government. The Council doesn't support his suggestion of health food shops as potential sale points but pharmacies would certainly be suitable as they already have federal government-monitored IT systems in place to prevent "doctor-shopping". It includes a grow-your-own option to overcome the supply problem already discussed:

"The real question is whether a person who is suffering pain and distress can access cannabis on their own initiative, following medical consultation as to their symptoms. They can access other herbal remedies from authorised providers such as health food stores or a pharmacist. If legislation permits sale to people suffering from a condition diagnosed by a doctor and scheduled in legislation, there should be no problem with provision of cannabis by this route without waiting for completion of a clinical trial. This is especially the case with Dravet syndrome patients where a formal clinical trial with the proprietary CBD concentrate may take several years to complete.

We should ensure that cannabis is provided only to approved users who should be registered. As there is no legal supplier, users should have permission to grow their own plants—up to 10 at any one time—but be forbidden from selling their product. Any proposal for commercial production should be subject to strict control, with

analysis of THC, THC-A and CBD content by a government toxicology laboratory for both cannabis oil and the leaf product. Venues for sale, presumably pharmacies or health food shops, should be registered. People between the ages of 15 and 25 years should be excluded as recipients, except where it is provided specifically for a cause covered by legislation. The legislation should also make cannabis available for medical research.

In summary, use of cannabis should be decided by the patient, following medical advice about the condition from which they seek relief, with patients being registered under state legislation.”

Extract from article by David Pennington on ‘Medical Cannabis’ in the Medical Journal of Australia (2Feb2015). Article was part of Professor Pennington’s submission to the Senate inquiry into the Regulator of Medicinal Cannabis Bill 2014. David Pennington is one of Australia’s foremost experts in the field of medical education and health care.

https://en.wikipedia.org/wiki/David_Pennington

If instead the Queensland government chooses to press on with the Draft Bill as currently framed, it seems very likely that the legislation will fail in terms of its own objectives, particularly the implied but unstated objective of delivering medicinal cannabis to each and every Queenslanders who could potentially benefit from it, rather than a very small cohort such as children with intractable epilepsy. If the legislation does fail, it will have failed for the usual reason all lawmakers’ attempts to legislate around cannabis have failed: a failure to listen to the community.

John E Ransley

ON BEHALF OF THE QUEENSLAND COUNCIL FOR CIVIL LIBERTIES

Brisbane, 14 April 2016

Note on Qualifications of Writer

- (a) Two submissions to Queensland parliamentary enquiries on cannabis and a third submission to the Senate committee inquiry on medicinal cannabis:
 - Cannabis and the Law in Queensland: A Personal Assessment (1993);
 - Queensland Parliamentary Inquiry into Addressing Cannabis-Related Harm in Queensland QCCL Submission (2010);
 - Senate Inquiry into the Regulator of Medicinal Cannabis Bill (2014). QCCL Submission 2015.
- (b) Spokesperson for QCCL before parliamentary committees.
- (c) Spokesperson for QCCL at medicinal cannabis forums in Brisbane, 2015.
- (d) Master's degree in science UNE via a largely self-generated theoretical and practical research thesis which was very received by internal and external examiners. Although no longer a practising scientist I have continued my conversation with science, maintaining and expanding my understanding of how science works in a number of fields; and
- (e) Personal experience of partner's use of 'street' herbal cannabis via a water bong for symptoms caused by her chemotherapy and radiotherapy treatment for her terminal metastatic cancer 2002-2004. Despite her having access to the best anti-nausea medications available at that time, she discovered that cannabis was the only effective remedy for her considerable distress. Because of its immediate effect, smoked cannabis enables the dose to be closely calibrated to the symptoms.

APPENDIX A

Prohibition of smokable medicinal cannabis in VLRC report

The 2015 Victorian Law Reform Report on medicinal cannabis has considerable merit apart from one glaring exception, where it recommends against allowing smoked and vaporised cannabis to be used medicinally. This recommendation was subsequently adopted in the Victorian legislation. The relevant clauses from the VLRC executive summary are as follows:

24. As the effects of cannabis depend to some extent on the form in which it is administered, any Victorian medicinal cannabis scheme would need to make a variety of forms available. International experience shows that otherwise patients will rely on illicit supplies.

QCCL COMMENT: 24 makes the useful point that unless state legislation delivers medicinal cannabis in a form acceptable to patients, they will access the illegal market (which is very easy to access).

25. However, the Commission recommends against patients being permitted to smoke medicinal cannabis. It is not persuaded by the submission made on behalf of the cannabis community of Victoria, which echoed the views of many who attended public consultations in presenting reasoned arguments for permitting smoking as an efficient, effective, practicable and accessible method of THC delivery.

COMMENT: 25 at least acknowledges two key things: “reasoned arguments for permitting smoking” which “echoed the views of many who attended public consultations.”

26. Cannabis is commonly administered by smoking and is the preferred method for many users, notably when used for recreational purposes. It has been said, however, that fewer than half of the regular users of cannabis in Australia smoke it.

27. Although the findings are inconsistent, there has been some association between smoking and lung conditions, and cancer risks that have not been observed for other modes of administration.

COMMENT: The claimed association with smoking is a red herring. The association has not been proven, not least because assessment has always been confounded by the fact that cannabis is commonly mixed with tobacco to facilitate smooth combustion. A summary of the evidence was included in the April 2010 QCCL submission to the Parliamentary Inquiry into Addressing Cannabis-Related Harm in Queensland. Similar criticisms apply to the cancer claim.

28. The Commission’s primary concern is that providing smokable products as a medicine under a government scheme would be inconsistent with the public health policy to reduce smoking in the community.

COMMENT: It is very concerning that clause 28 is the Commission’s “primary concern”. As noted by David Pennington, one major group of patients who stand to benefit from smoked or (preferably) vaporised cannabis “are often, for example, in the later stage of a battle with painful cancer, finding problems with morphine, other analgesics and nausea with

chemotherapy.” Respiratory problems 20-30 years down the track are the least of their problems (as I can personally testify when my partner used bong cannabis to relieve symptoms associated with treatments for her terminal metastatic cancer disease). Another category of patients are those where orthodox treatment is successful, but smoked/vaporised cannabis is their best antidote to the symptoms of nausea, loss of appetite and depression that develop while undergoing chemotherapy and/or radiotherapy. There may also be patients suffering from a variety of chronic conditions who prefer the smoked form of therapy and a compassionate government would make allowances for them. Chronic conditions such as chronic pain will generally be better served by the cannabinoid oil concentrates.

29. Another key concern of the Commission is the impact that supplying dried cannabis under a medicinal cannabis scheme would have on the risk of diversion. Although there could be an illicit market for any product produced under the scheme—particularly a product with significant THC content—it is likely that the demand for dried cannabis would be strongest because of its popularity for recreational use. While probably more expensive, the licit product would have been produced under controlled conditions, free of contaminants.

COMMENT: Apparently the second most important concern. In his MJA article Professor Pennington cites research demonstrating that removal of prohibition does not affect community patterns of cannabis use. The illegal market is so mature in Australia that quality cannabis products can be relatively easily accessed, and users often develop long term trusted relationships with dealers/producers. The Commission overstates the value of controlled production and contaminants in licit cannabis because these issues are part of the ongoing conversation in the illegal market. The commission understates the issue of expense, given the pharma-medical-model of medicinal cannabis delivery being contemplated by Australian governments shows alarming signs of being captured by pharmaceutical companies who will charge a premium for their product. GW's only TGA approved drug, Sativex, for example, costs about \$1500 a month.

30. In addition, the Commission was told that, to continue to enforce the prohibition on recreational use, law enforcement agencies would need to be able to distinguish between licit and illicit cannabis, and this would be extremely difficult if licit dried cannabis were made available under the scheme.

COMMENT: This clause in particular, but also the preceding clause 29, clearly embodies the circular reasoning that has been referred to earlier in this submission. That is, because smoked cannabis is illegal it must be bad for you. Diversion and the ability to distinguish are not science-based or merits-based arguments for prohibiting smoked cannabis therapy. They are simply artefacts of the Nixonian ‘War on Drugs’. What does it matter if some diversion occurs, even if diversion is very unlikely because of costs and the draconian level of monitoring envisaged in the state and federal legislation. In the words of the Leonard Cohen song “everybody knows” that cannabis is a much safer medicine than just about any of the alternatives, and unlike those alternatives, has never caused a death, even with high overdoses.

The Council reiterates its position that smokable and vaporisable forms of medicinal cannabis should be available in the Queensland legislation.

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