Submission No. 028
Received 11 July 2016

Queensland Council for Civil Liberties

Public Health (Medicinal Cannabis) Bill 2016

QCCL Submission to:
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

The submission is divided into two parts. The first part is a personal statement by the writer, based on his partner's experiences with cannabis while she was being treated for metastatic breast cancer.

The second part is a the submission on the Bill before the parliamentary committee, compiled on behalf of the Queensland Council for Civil Liberties

The Council thanks the committee for the opportunity to comment on this Bill. The Council part of this submission is a totally revised and updated version of submissions made to Queensland Health with respect to their Draft Bill.

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

(a) being the first state government to legalise medicinal cannabis;
(b) not limiting the medical conditions and symptoms for which medicinal cannabis may be prescribed; and
(c) providing two pathways for a patient to receive treatment with medicinal cannabis, a single-patient prescriber pathway and a patient-class prescriber pathway.

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

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Smoking, Supply and Safety

A Personal Statement by John Ransley

When my partner was first diagnosed with a small breast cancer in November 2001, all the specialists assured us her disease was classified stage one. A GP read her symptoms as more, and in mid-January 2002, only a couple of months after her lumpectomy, a whole body bone scan re-diagnosed her metastatic disease as stage four. Two weeks later a soft tissue scan confirmed suspicions that the metastases had spread to her lungs and liver. At the same time there was a major complication when she sustained a clean fracture to her right Lesser Trochanter, severing the attachment of a major psoas muscle and requiring a pin to be inserted in her right thigh bone.

She was immediately started on both hormone therapy and a monthly biphosphonate bone therapy to prevent further fracturing. These two therapies worked for about a year, reducing the metastases and strengthening bones weakened by the cancer. They had no major side effects apart from simulated menopause symptoms.

Radiotherapy proved to be much more problematic. The first series of treatments in January targeted metastases in her sternum which had become a source of excruciating pain. The second series targeted two metastases in her lumbar spine and a metastatic area in her left hip, which was judged to have potential for another major fracture. The third series targeted her right thigh bone, to reduce the metastases and allow the bone strengthening treatment to begin. Radiotherapy was judged to be successful as soon as pain ceased from these areas, with the last treatment on 19 March.

Possibly because she had contracted both cholera and typhoid fever during the twelve years she lived in India, my partner was extremely sensitive to nausea. Nausea was, for her, worse even than bone pain. Unfortunately, nearly all the radiotherapy treatments induced extreme nausea, a side-effect acknowledged by her radiology specialist but disbelieved by the staff at QRI. As the radiologist noted the radiation was inadvertently spraying parts of her digestive system. Special shielding provided for her very last treatment proved successful, confirming the effect.

This is where cannabis comes in, not for chemotherapy but—principally—for radiotherapy. Morphine for pain relief—pre-operative for cancer-generated bone pain, post-operative for surgery-related pain—also produced significant nausea. Both kinds of nausea were accompanied by extreme loss of appetite. When the standard anti-nausea medicine Maxolon provided no relief, the oncologist prescribed Zofran, a relatively new and we were told very expensive drug that worked in a different way. The Zofran proved to be of some help, but my partner found that cannabis was far more effective.

Choosing cannabis

Why cannabis? We had both smoked cannabis when we were young and we were well acquainted with “the munchies” effect. In addition, one of my cousins had found it very helpful for managing side-effects from chemotherapy when she was being treated for Hodgkin’s disease in the late 1970s. During this period she was busted twice by South

Australian police, on one of these occasions in the usual heavily armed and intimidating home-invasion style. In each case the charges were dropped by police prosecutors because of her medical condition.

So it was logical for my partner to give it a try. Fortunately, it worked a treat, almost like magic.

Just to be clear, she burnt the cannabis in a joint, mixed with dried peppermint tea powder as a substitute for tobacco, the most popular burning agent. The cannabis was a top-quality flowering heads product provided freely through a friend, almost certainly hydroponic because that produced the most reliable and strongest strain. Unlike when taken orally, smoked cannabis is absorbed into the blood stream very quickly, so it is easy enough to titrate the amount that is required to alleviate symptoms.

We were aware of course that using cannabis was illegal, but believed that her quality of life overrode any other considerations. She stopped smoking joints when her radiotherapy finished. When her cancer returned a year later she was started on the first of two courses of chemotherapy. During these treatments she used cannabis on an as-needed basis, generally immediately following the IV procedure. This time the cannabis was taken through a water bong, which provides an even more precise calibration of dose effect and symptom. Zofran was also made available by her oncologist and so cannabis and Zofran continued to be her two anti-nausea agents until the end. Her oncologist was fully aware she was using cannabis and made it clear he had no objection.

After her second chemotherapy course failed very badly—dramatically accelerating the progress of her liver secondaries as predicted by her radiologist—radiotherapy was delivered direct to her liver. In her last 3 months she was using cannabis about once daily and this enabled her to maintain both her appetite and her spirits. She hated morphine and only agreed to take it intravenously, at home, on the day she died. In the end her body gave way to the combined insults of cancer, chemotherapy and radiotherapy, but she was very grateful that cannabis was available to shield her from unnecessary suffering.

Safety

I would like to stress how safe this was. There were absolutely no adverse side-effects. Partly this may have been because only very small amounts were required to alleviate her symptoms. The smoke taken through a bong was much cooler and therefore more preferable than that produced by the joint, although in both cases high temperatures are needed at the point of combustion to release the cannabinoids that are responsible for the medicinal effect.

The cannabis we obtained had been cultivated to increase the THC component, and I note evidence that THC can mitigate the growth of at least some cancers. There was pretty much no ‘whoopee’ effect from her cannabis use, but to the extent there was it put a sparkle in her eyes and a smile on her face. In her youth she had sometimes enjoyed the mild intoxication effect, so it was not unfamiliar to her. As an adult she had lived a very Spartan and totally drug-free ashram life for twelve years while she studied and taught yoga. She maintained this lifestyle when she returned to Australia.

Supply

It is worth noting it was easy for us to source a supply of cannabis. As part of that cohort of baby boomers who had experimented with cannabis in our youth we could have obtained it from multiple sources, but we chose one particular connection because of a well established reputation as a supplier of a high-quality product.

If we had not been part of that minority cohort, we would have probably not known that cannabis had any medicinal benefits. These days people most often discover medicinal cannabis by researching the internet. Back in 2001 people's main sources of information were the media, books and magazines, and word of mouth. The media's coverage was almost 100 percent negative and promoted the view that cannabis was a terrible drug on a par with heroin, making it very unlikely to attract passing interest as a medicine.

I raise this issue because of a recent experience at a public lecture by University of Queensland cannabis researcher Wayne Hall. At the end of the lecture I had risen to speak about my partner's experience. Afterwards a practising GP—also a baby boomer—approached me to describe a family member's three-year suffering as he died from cancer, completely unaware of the potential medical benefits of cannabis. I suspect this is not an unusual situation, even though a cursory internet search these days would bring up a lot of good information about medicinal cannabis.

This brings me to the Haslam family.

The Tamworth Haslam family is where the current national movement to legalise medicinal cannabis started. Dan Haslam is another example of a person who underwent three years of unnecessary suffering because of ignorance about the medicinal benefits of cannabis. 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 substance, '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.*

My partner discovered a similar level of symptom relief from smoked cannabis. Anecdotally, this is a common experience, but up till now it has only been available to those people able to access a reliable supply from the illegal market. People without those contacts are forced to seek help from their GenX and GenY friends and family members, or, worse, approach

strangers on the street: even, as one Queensland mother did, take a sick child overseas in order to access a cannabis medicine. But before these people can begin their search for a supply, they have to undergo a big change in their thinking about cannabis. Dan Haslam's parents are a classic example: both are very politically conservative, and his retired father had even been the head of the Tamworth drug squad. Their acceptance of the efficacy of medicinal cannabis for their son was not only life-changing in the sense Lucy Haslam describes, but life-changing in their attitude to the war on drugs that had partly sustained Dan's fathers' livelihood.

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Personal Experience

I'm old enough now to have known hundreds of people who safely smoked cannabis for its intoxicating effects. This is consistent with the estimate by the VLRC Report last year that 75,000 Australians use cannabis every week, which translates on a per population basis to about 15,000 Queenslanders. Obviously, most of this consumption is not causing problems for the overwhelming number of users, otherwise it would show up in emergency departments in big numbers.

Personal qualifications

Although my interest in medicinal cannabis has been informed by personal experience, my approach to law reform has always striven to honour the best available science and be guided by the best available researchers. My master's degree in science was awarded by the University of New England for a largely self-generated theoretical and practical research thesis which was very well 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.

For about 25 years now QCCL has taken the position that cannabis should be completely legalised. In that time I have personally made 4 submissions to various parliamentary committees advocating legalisation and lately, advocating legalisation of medicinal cannabis as a special case.

(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. The QCCL Submission (2010);
- Senate Inquiry into the Regulator of Medicinal Cannabis Bill (2014). The QCCL Submission 2015.
- Draft Public Health (Medicinal Cannabis) Bill (March 2016). Supplementary QCCL Submission to the Queensland Health, 14 April 2016.

(b) Spokesperson for QCCL before parliamentary committees.
(c) Spokesperson for QCCL at medicinal cannabis forums in Brisbane, 2015.

John E Ransley
Brisbane, 8 July 2016

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QCCL SUBMISSION

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QCCL CONTENTIONS

President Nixon's 'War on Drugs' had nothing to do with the dangers posed by cannabis and everything to do with his agenda to gaol his hippy-left political opponents. Appendix J

President Nixon's classification of cannabis as an illegal drug on a par with heroin had not the slightest relationship to any credible contemporary medicine or science. Appendix J

Unlike everyday over-the-counter medicines like aspirin and paracetamol, cannabis has never killed anyone.

Organic cannabis products, however consumed, are very safe. Appendix G.

Illegal cannabis use for both medical and non-medical purposes in Australia is remarkably safe. It is authoritatively estimated that about 750,000 Australians use it every week. Appendix E.

Because only very small amounts are needed, medicinal cannabis is safer than cannabis used recreationally, by at least an order of magnitude. Appendix G.

Smoking or vaporising cannabis for medicinal purposes is very safe. Appendix H.

The rising tide of Queensland police arrests of low level users, possessors and suppliers is a scandal and contradicts the government's tentative steps towards legalisation of medicinal cannabis. Appendix F

Current Queensland drug law sanctions prohibiting production and supply are too draconian.

Waiting for Australian medicinal cannabis trials to be finished before taking action on medicinal cannabis is a waste of time and an insult to patients who may gain great benefit. Appendix D.

The Queensland Bill to legalise medicinal cannabis is inferior to the Victorian legislation because it doesn't honestly address the question of supply. Appendix B.

Terminally ill persons who can benefit from medicinal cannabis deserve special treatment to protect them from arrest by police.

The Public Health Bill is extremely bureaucratic and rules driven, reflecting the 'War on Drug's prohibitionist philosophy of Queensland cannabis legislation.

If they win their court case against the TGA's refusal to grant an import licence, a private NSW company will be able to prescribe an imported CBD medicine using their in-house doctor, and supply it to patients anywhere in Australia including Queensland. The company's customer care representative says they have already registered thousands of patients. Appendix K.

QCCL SUBMISSIONS

Most Important

1. Adopt Victorian Model

The Council's clear and oft-stated preference is for the Palaszczuk Government to legalise cannabis without any restrictions. This would easily be the best way to ensure every Queenslander who could benefit from medicinal cannabis would be able to access it, which the Health Minister has claimed is the intention of the Bill.

Short of this is decriminalisation. Although the Council firmly believes full legalisation will happen within the next few years, we acknowledge that it is unlikely at this moment of time. However, genuine decriminalisation would be a significant step forward, and the Council notes the federal health minister, Ms Sussan Ley, has recently reaffirmed that decriminalisation of cannabis is up to the states.

At the very least genuine decriminalisation would dramatically reverse the trend for increasing numbers of Queenslanders—over 20,000 in 2013-2014—to be arrested for mostly minor cannabis-related offences.

The Bill before parliament does not contemplate decriminalisation but according to the Minister's second reading speech, "establishes arrangements so that people who need access to medicinal cannabis products can obtain and use them in Queensland."

QCCL submits 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.

Accordingly, the Council's strongly urges the Palaszczuk Government to rewrite the Bill along the lines of the Victorian medicinal cannabis legislation. That is, reject TGA oversight and legislate a Queensland framework of arrangements under which medicinal cannabis products will be cultivated, manufactured, prescribed and dispensed for Queenslanders. If the Palaszczuk government did this, Queenslanders would be enormously grateful.

This is the Council's most important submission. Appendix B.

2. Legalise Smokable Cannabis

The Bill be amended to allow the chief executive to grant approval for medicinal cannabis products designed to be administered by smoking or vaporising. The reasons for this amendment are provided in the submission. Appendix H.

3. Legalise organic CBD medicines

The use of organic CDB oils and CBD tinctures to treat childhood epilepsy and other conditions does not involve smoking or intoxication. The June 2016 TGA rescheduling of conforming CBD medicines to Schedule 4 means they can be legally prescribed in all Australian states. Currently these medicines are not produced in Australia. Licensing to

import them is subject to TGA approval, over which the Queensland government has no control. The Council submits the Bill should be amended to remove all Queensland Health oversight of CDB medicines, given they now fall under the jurisdiction of the TGA. They are very safe. Appendix K.

4. Make terminal illness a complete defence

The Council submits the Bill should be amended to make terminal illness a 'complete defence' against police prosecution. A 'complete defence' would mean the onus would be on the police to prove the user was not terminally ill. In 2015 the Premier and Police Commissioner indicated Queensland police would be instructed to exercise their discretionary powers not to prosecute cannabis offenders who were terminally ill. Unfortunately discretion makes users fearful that they will fall on the wrong side of the particular police officer who is exercising it. Only legislation will fix this problem. Appendix B.

Secondary Submissions

5. No doubling up

That Clauses 9 and 10 in the Bill be amended 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".

6. Delete references to criminal history for patients

The Bill be amended to incorporate the changes proposed by the Council to Queensland Health and not accepted. In particular, the Council's strong view is that only medical criteria are relevant when determining whether a patient should be prescribed medicinal cannabis. These criteria cannot include references to a patient's criminal history and details of charges as opposed to convictions. Clauses that contemplate refusal of treatment on such grounds should be expunged from the Bill. Appendix C.

7. Adopt QCCL's principles concerning inspector powers

Over a series of submissions to various committees the QCCL has developed some principles concerning the appropriate powers for inspectors. In the Council's view legislation should reflect the fact that the powers of inspectors serve different ends and those different ends need to be reflected in different types of powers and safeguards. The legislation should recognise the distinction between the powers that an inspector should have to:-

1. investigate where a person is possibly exposed to some sanction be it criminal or otherwise.
2. monitor compliance with a regulatory scheme or funding program.
3. deal with emergency situations.

The application of these principles to the Bill is discussed in Appendix C.

8. Let doctors prescribe

The Minister should open up the categories of doctors authorised to prescribe medicinal cannabis. In his first reading speech the minister announced that only specialists in paediatric neurology, oncology and palliative care will be entitled to prescribe medicinal cannabis under the patient-class prescriber pathway. The Council submits that this is too restrictive for three reasons. First, because the government Bill has avoided restricting medicinal cannabis to a particular list of medical conditions, the announcement contradicts that. Second, because most patient care is managed by GPs with occasional guidance by specialists: restricting prescription to specialists would likely make medical oversight very expensive. Third, with perhaps one or two exceptions, it is highly likely there are no specialists in Queensland with any particular expertise in medicinal cannabis. In fact it is just as likely that there are GPs with more expertise than the nominated specialists. The minister's speech referred to "medical practitioners" for the so-called single-patient prescriber pathway, a term which presumably includes GPs. The Council submits that all registered medical practitioners should be able to prescribe medicinal cannabis under both pathways, in accordance with the patient-doctor model that already exists. Appendix B.

9. Two-year sunset clause

The Bill be amended to incorporate a 2-year r sunset clause to provide an opportunity to assess whether it actually delivers medicinal cannabis to all those Queenslanders who could benefit.

QUEENSLAND BILL

Objective of the 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 Bill. One is its 'complexity and regulatory burden', arguably the inevitable result of cannabis prohibition; the other is its reliance on a Commonwealth supply of medicinal cannabis. The supply issue is discussed first.

Supply Issue

Lots of Queenslanders use cannabis medically: someone has got to supply them. Growing your own is one possibility but many people either don't have the skills, the garden to grow it in, or are prevented by ill-health from trying. There is currently no legal supply. So the illegal market has stepped up with a plentiful supply of medium to high quality products, subject to the patient or the patient's representative being able to make a connection.

Yet the Palaszczuk government seeks to treat all current suppliers as if they are "organised crime", according to the Byrne report. This policy position has been reinforced by the recent announcement that the maximum penalty for internet-facilitated supply will be increased by 5 years. Even if this is some sort of COAG bureaucratic inter-state consistency measure, the message is the same. It goes in the opposite direction to the Public Health Bill to make medicinal cannabis available to Queenslanders.

Subsections (1)(i) and (2)(c) of Clause 24 in the Bill use the same wording formula:

> (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 Council submits the Bill does not honestly address the issue of supply, leaving it completely up to the Commonwealth. Under recent changes to Commonwealth law, this means supply must come from either importation or Australian production, both overseen by the Therapeutic Goods Administration. The TGA has recently rescheduled conforming CBD medicines to Schedule 4, effectively legalising prescription in all Australian states, but this is a hollow gesture as it only applies to an Australian manufactured product, of which there are none and none expected for years. The only source of an alternative supply is from overseas, but under its licensing wing the TGA continues to block importation of conforming CBD medicines, except on a drip-by-drip basis through its special access scheme (SAS).

Importation of cannabis products with a medically useful THC component is likewise restricted to the special access scheme.

As demonstrated by the experiences of Lanai Carter—documented on the MCAG Facebook page—obtaining TGA approval via the SAS is such a daunting and tortuous process that it will discourage all but the most persistent patients or their carers from applying. Whether the rescheduling of non CBD cannabis medicines from Schedule 9 to Schedule 8 will make this process any easier will only become apparent over the next year or two.

Even if TGA approval is granted, it is very difficult to import medicinal cannabis from overseas because of limited supplies and export prohibitions by key governments.

These and other considerations led the Victorian Law Reform Commission to make a compelling case that Commonwealth oversight would effectively prevent most Victorians from accessing a supply of medicinal cannabis, causing the Victorian government to set up its own medicinal cannabis industry with the clear intention of completely bypassing Commonwealth management. The Victorian government has reportedly initiated cannabis cultivation with the intention of developing a supply for Victorian patients.

Australian product

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 few years to produce medicinal cannabis products that might be available to Queenslanders. 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.

The Council notes the government has held some discussions with Queensland farmers who have expressed an interest in cultivating cannabis for medical purposes. Anecdotal evidence is that the high costs of both security fencing and security staff has already deterred some interested farmers, and there is also the expertise that must be acquired to produce a novel crop. But the Bill doesn't seem to contemplate a Queensland industry.

Overly Bureaucratic

The Bill is overly bureaucratic and process-driven, clearly negating its stated objective "to minimise the complexity and regulatory burden of the scheme". 226 clauses plus a 14-page dictionary 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.

It is notable 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.)

The principal reason for the extraordinary level of regulation and multiple sanctions proposed by the legislation can only be the illegal status of cannabis. Despite the small steps towards legalisation of medicinal cannabis contemplated by the Bill, the illegal status of cannabis continues to be the main obstacle to providing access to medicinal cannabis for all the

Queenslanders 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 a dangerous drug equivalent to heroin. As recently revealed by one of Nixon's closest confidants, there was no pretence this decision was based on any medical or scientific considerations. It was a totally cynical move designed to disrupt and gaol his political opponents in the anti-Vietnam war movement (see Appendix J). .

Legalise Smokable Medicinal Cannabis

On the basis of all the commentary to this point, and the additional commentary in Appendix H, the Council strongly urges the government to vary the Bill so as to legalise 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. The signal provided by the amendment would be gratefully received by thousands of Queenslanders.

If instead the Queensland government chooses to press on with the Bill as currently framed, it seems very likely the legislation will fail in terms of its own objectives, particularly the implied but unstated objective of delivering medicinal cannabis to each and every Queenslander who could potentially benefit from it. 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.

Terminal Illness Provision

At some time in the last 12 months or so, Premier Palaszczuk and the Queensland Police Commissioner made a joint public announcement to the effect that police would be instructed to use their discretionary powers to waive prosecution for terminally ill persons using cannabis medicinally, in any mode including smoking and vaporising. (Unfortunately I can't find the reference, but I clearly recall the announcement). Most if not all Australian premiers made similar statements following the introduction of the NSW TICs scheme.

It is a small progression from this announcement to amending the Public Health Bill to include clauses making this clear in law. The new section would be worded to provide a 'complete defence' from arrest and prosecution for the terminally-ill who use cannabis for medical reasons. A 'complete defence' would mean the onus would be on the police to prove the user was not terminally ill.

The widely acknowledged failure of the NSW TICs scheme has shown that terminally ill patients using cannabis will not register for a scheme that keeps them in a legal limbo, breaking the law but hoping that the police will take mercy on them if they are caught. This is particularly an issue in any community that is small enough for most people to be known to the police, eg country towns. Police in small communities tend to develop friends and non-friends, and are not likely to look kindly on the latter if they discover them breaking the law.

Likewise, the discretionary powers announcement by Premier Palaszczuk and the Queensland police commissioner, no matter how well intentioned, is not enough to settle similar anxieties by affected Queenslanders. Only changing the law will achieve this.

There is a kind of precedent. The TGA has always treated the terminally ill as a special category. Hence the provision to allow importation of untested pharmaceutical-style drugs into Australia for terminally ill patients when all other treatments have failed. The re-scheduling of all cannabis drugs from Schedule 9 to Schedule 8 would seem to open up similar possibilities for cannabis medicines.

In an AAP news item dated 28 February 2016 Health Minister Cameron Dick is reported to have said he "wants Queensland to lead Australia on the road to making medicinal cannabis available to stricken patients." *

If the minister really wants Queensland to reclaim the lead from Victoria and NSW in medicinal cannabis reform, the 'complete defence' amendment would go some way towards this. Terminally ill Queenslanders would be extremely grateful.

* http://www.brisbanetimes.com.au/queensland/queensland-considers-medicinal-cannabis-laws-20160228-gn5szd.html

John E Ransley
ON BEHALF OF THE QUEENSLAND COUNCIL FOR CIVIL LIBERTIES
Brisbane, 8 July 2016

APPENDIX A

Medicinal Cannabis Legislation: State of the Nation

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 12, commencing 1 June 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 Decision to Re-Schedule all Cannabis- and THC-related entries from Schedule 9 to Schedule 8. Initiated 20Jan16. Finalised 31 May 2016.

Poisons Standard March 2016

Narcotic Drugs Amendment Bill 2016
Introduced by Turnbull government 10Feb16. Passed both houses 24Feb16. Summary:

"Bill Amends the *Narcotic Drugs Act 1967* to: give effect to certain of Australia's obligations under the Single Convention on Narcotic Drugs, 1961 (the Single Convention); establish licensing and permit schemes for the cultivation and production of cannabis and cannabis resin for medicinal and scientific purposes, and for the manufacture of narcotic drugs covered by the Single Convention; provide for monitoring, inspection and enforcement powers for authorised inspectors and for the secretary to give directions to licence holders and former licence holders; and enable the secretary to authorise a state or territory government agency to undertake cultivation and production of cannabis and manufacture of medicinal cannabis products; and the Therapeutic Goods Act 1989 to make a consequential amendment."

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 in March 2016 with a Discussion Paper inviting public submissions by 1 April 2016.

Health (Drugs and Poisons) Amendment Regulation (No. 2) 2016
Subordinate Legislation 2016 No. 67 made under the Health Act 1937. Authorised by the Parliamentary Counsel 26 May 2016. Accompanied by Explanatory Notes.

Public Health (Medicinal Cannabis) Bill 2016
Tabled in the Queensland Parliament by Minister for Health Hon CR Dick 10 May 2016.

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.

APPENDIX B

Comments on National Medicinal Cannabis legislation

Queensland Amendments to HDP Regulation 2015, 2016

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 an Australian first, in late 2015 the Palasczcuk government amended the Health (Drugs and Poisons) Regulation 1996 (the HDP Regulation) in the Health Act 1937 "to give the chief executive of Queensland Health discretion to approve the use of medicinal cannabis products for the treatment of a person where an approval to access the product has been given by the Commonwealth Therapeutic Goods Administration": Health Minister First Reading of Bill, 10 May 2016.

A further amendment was made to the HDP Regulation on 26 May 2016, prompted by an interim TGA decision to reschedule medicinal cannabis from a schedule 9 poison to a schedule 8 medicine (which took effect 31 May 2016). The rescheduling opened the way nationally for appropriately qualified specialists to prescribe medicinal cannabis products. Queensland Health has nominated specialists in paediatric neurology, oncology and palliative care medicine to be the first Queensland specialists thus authorised, under a new model termed the "patient-class prescriber pathway". This pathway gives these specialists an as-of-right authority to prescribe without the need to obtain any further state approval. The amendment allows Queensland patients to take advantage of the rescheduling, without having to wait for the passage of the Bill, which is not anticipated to be debated until later in the year.

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-australi_n_9302936.html

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—C/W 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) ensuring 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.

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 rescheduling of all remaining forms of cannabis from Schedule 9 to Schedule 8, taking effect 31 May 2016 in Poisons Standard 12. Health Minister Sussan Ley has stated the second rescheduling was a necessary requirement to enable Australian cultivation and manufacture as provided by the 2016 amendments to the Narcotics Act. Prescription and supply of Schedule 8 and Schedule 4 medicinal cannabis continue to be subject to TGA approval.

One for-profit company, Medicinal Cannabis Clinic Pty Ltd, has been established to take advantage of the TGA re-scheduling of cannabidiol to Schedule 4. The business model envisages a large-scale mail order service providing an imported CBD product to eligible patients in all Australian states, with prescriptions written by an in-house doctor. See Appendix F for more details

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 was 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.

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

The Draft 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.

Public Health (Medicinal Cannabis) Bill 2016 (Queensland)

This is the Bill now before the Queensland Parliament. It is mostly unchanged from the Health Department's Draft Bill, with the most significant amendments being the introduction of two kinds of prescription processes, the single-patient prescriber pathway which will require approval by chief executive of Queensland Health on a case-by-case basis, and the patient-class prescriber pathway, giving selected specialists an as-of-right authority to prescribe without the need to obtain any further state approval. These amendments were prompted by the TGA's decision with effect 31 May 2016 to reschedule medicinal cannabis products from Schedule 9 poisons to Schedule 8 medicines, opening up prescription to any appropriately qualified medical practitioner.

APPENDIX C

QCCL Submissions to Queensland Health

On 31 March 2016 QCCL President Michael Cope made the following submission to the Director General Queensland Health with respect to the DRAFT BILL. The submission was not accepted but is reproduced here.

Just to be clear, NONE of QCCL's suggested amendments were incorporated into the redrafted Bill before parliament. Unfortunately, this response or lack thereof was anticipated in QCCL's supplementary submission dated 14 April 2016.

In this copy of Michael Cope's submission, the clause numbers have been updated to reflect the revised numbering in the Bill before parliament. (There are some minor changes in wording but none that are relevant to the substance of the submissions.)

****

Public Health (Medicinal Cannabis) Bill 2016
Submission by Michael Cope

The process contemplated under this legislation is extremely bureaucratic and process driven. The focus of the legislation should be the treatment of ill people. In California, you can see a doctor and walk out of the pharmacy the same day with a prescription. Why can we not have that system in this country?

The legislation also needs to address the need to make changes to the drug driving laws to take account of the availability of cannabis as a medicine. For the record, we maintain our position that the current drug driving laws are inappropriate given there is no scientific basis to establish a connection between the amount of drug in a person's system and that person's capacity to drive.

CHAPTER 3 APPROVALS

Clause 11
Whilst the government adheres to a Prohibitionist model the logic of accessing the criminal history of an applicant to hold an approval to make the product is inescapable. However, it is our view that it is not necessary even from that point of view to review the criminal history of any other person in the process. In particular, it is our strong view that the only relevant criteria in the case of the patient are medical. Accordingly we particularly object to clause 10 subparagraph (c).

Clause 22 (4)

We are concerned about the breadth of this provision. Obtaining written opinions from a specialist medical practitioner has the prospect of being expensive. We submit that this provision should restrict the capacity of the Chief Executive to request additional medical opinion after the first opinion to circumstances dictated by the treatment of the patient.

Clause 24 (1) (h)

This comment follows on from our submission in relation clause 11. The relevant questions for the patient are whether they need to be treated and whether the treatment will be effective.

Clause 27

Chief Executive should be given an express power to extend the times contained within this section.

Clauses 28 and 29

We object to these clauses.

Firstly, we object absolutely to the release of details of charges as opposed to convictions. In the Council's view the appropriate balancing between the rights of the community and the rights of a person suspected of an offence to get on with their life is to limit any disclosure that is to be made to matters of which a person has been convicted.

Secondly, we object, as we have previously said, without qualification to the examination of criminal history of any person except the manufacturer.

Finally, we say that if that submission is rejected in all cases the only criminal history which should be accessible should be that allowed under the Criminal Law (Rehabilitation of Offenders) Act which is relevant to the application in question. In the Council's view the Criminal Law (Rehabilitation of Offenders) Act 1986 represents an appropriate balancing of interests between the rights of a person who has been convicted of an offence to be rehabilitated and the protection of the community. We see no justification in the circumstances of this legislation for the setting aside of that Act.

****

CHAPTER 7 MONITORING, INVESTIGATIONS & ENFORCEMENT

Powers of Inspectors

Over a series of submissions to various committees the QCCL has developed some principles concerning the appropriate powers for inspectors. In preparing these principles the Council has had regard to the fourth report of the Senate Standing Committee for the Scrutiny of Bills – Entry and Search Provisions in Commonwealth Legislation 6 April 2000 and the Report of the Victorian Parliament Law Reform Committee – The Powers of Entry, Search, Seizure and Questioning of Authorised Persons – May 2002

In the Council's view legislation should reflect the fact that the powers of inspectors serve different ends and those different ends need to be reflected in different types of powers and safeguards.

The legislation should recognise the distinction between the powers that an inspector should have to:-

4. investigate where a person is possibly exposed to some sanction be it criminal or otherwise.
5. monitor compliance with a regulatory scheme or funding program.
6. deal with emergency situations.

The Council says that:-

1. In first category of case a search warrant issued by judicial officer should be a prerequisite of an entry and search.

2. In the second category where the Authority wants to carry out an audit of compliance with guidelines, regulations or similar applied to an organisation we would accept that there is a proper basis for authorising entry under the legislation without consent and without a warrant so long as there is reasonable notice and it is to be carried during business hours. The inspectors need to be required to identify themselves properly and to identify the purposes for which they are conducting the search. Refusal to consent or allow entry would form the basis of an application for a warrant. In these sorts of situations the inspectors would only be allowed to go in and audit and inspect. They should not be authorised to seize things or arrest people.

3. We accept that circumstances may arise which make it impractical to obtain a warrant before an effective entry and search can be made. However, impracticality should be assessed in the context of current technology given the provisions allowing for electronic applications for a warrant. If an official exercises a power to enter and search in circumstances of impracticality, that official must then, as soon as reasonably possible, justify that action to a judicial officer.

We now seek to apply these principles to the Bill:

1. In many respects the Bill adequately balances the right to privacy with the public interest in law enforcement.

2. **Clause 110 (1)(d)** should be modified in accordance with the second principle enunciated above to make it clear that the entry is to be solely for the purpose of carrying out an audit for compliance with rules, guidelines or other statutory requirements applied to the organisation. It might be said that that limitation is implicit. However, we would prefer it were actually stated in the section to avoid any doubt.

> **Parliamentary BILL - Changed to reflect new distinction between two kinds of prescribers:**
>
> The Draft words "for which an approved prescriber practices medicine," have been replaced by: **"*in relation to which a single-patient prescriber or a patient-class prescriber practices medicine*,"** – reflecting the introduction into the Bill of the single-patient and patient-class prescriber distinction.

3. **Clause 115** should make it mandatory that the inspector obtains written consent or makes an electronic recording of the consent to the entry and the consent is by a person authorised to do so. In the case of a business that should be an owner, director or manager. The consent of, for example, the receptionist should not be enough.

4. **PART 2 DIVISION 2** should be qualified by a provision stating that evidence obtained during an inspection by consent is only admissible in relation to a proceeding under the legislation pursuant to which the inspector was acting at the time of the inspection.

5. **Clause 121**. It seems to us that this section narrows the test for setting aside a search warrant from that at common law. It is our submission that this section should be removed and the common law applied.

6. **PART 3 DIVISION 1.** Having regard to clause 117 of the Bill it follows from our statement of principles above that before a vehicle can be inspected, absent circumstances making the obtaining one impractical, a warrant should be a prerequisite. Of course if it is alleged impractical circumstances exist then the action will have to be justified to a judicial officer after the event. We would be particularly concerned about the concept of inspectors engaging in chases. Serious issues have arisen because of police car chases. We would have thought that this alone would deter the granting of such powers. We submit that the offences provided for in this Bill do not justify Inspectors engaging in inherently dangerous high speed car chases.

7. **Clause 128 (4).** The QCCL is concerned based upon complaints it has received from members of the public and the experience of legal practitioners who are members of the Council that the police frequently detain computers for long periods of time. In contemporary society access to a computer is a critical part of life both for social and financial reasons. Furthermore, it is relatively easy for a forensic image to be taken of any computer or similar device. The legislation should provide that the inspector is required to return the device within say seven (7) days absent a Court Order extending the time. It should be a prerequisite to obtaining an Order that the inspector demonstrates that it has not been reasonably practical to obtain a forensic image or that for some reason a forensic image is inadequate for the purposes of the investigation.

8. **Clause 133**. Provision needs to be made for innocent third parties such as financial institutions to apply to the Court to obtain the release of anything seized so that they can vindicate their rights. An innocent third party such as a financier should have a separate right to obtain the release of the goods and if the inspector will not agree to seek a Court Order in that regard. This right should of course extend to liquidators and receivers.

9. Individuals executing **search warrants** should be required to report to the Court. The legislation should contain provisions similar to that in Section 21 of the Search Warrants Act 1985 (NSW) requiring the person to whom the warrant is issued to furnish a report in writing to the Court who issued it stating whether or not the warrant was executed and setting out the results of the execution or setting out the reasons for why the warrant was not executed.

10. **Clause 148**. We object to this provision as an unjustified abrogation of the privilege against self- incrimination.

11. **Clause 149**. We object to sub-clause 2 on the basis that it violates the privilege against self-incrimination.

12. **Clause 162**. Whilst we accept that given clause 151 this is a comparatively minor incursion into the privilege against self-incrimination we record our in-principle objection to

it. In our view derivative use immunities are no substitute for the privilege. The type of offences dealt with in this legislation in no way justify the abolition of the privilege.

MICHAEL COPE, PRESIDENT
For and on Behalf of the Queensland Council for Civil Liberties
Brisbane, 31 March 2016

APPENDIX D

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.

APPENDIX E

Byrne Report: Queensland Organised Crime

On 17 April 2016 the *Sunday Mail* published a report quoting Attorney General Yvette D'ath to the effect the Palaszczuk government would implement the so-called Byrne Report into organised crime in Queensland. She was reported in part as follows:

"Attorney-General Yvette D'Ath is expected to roll out new legislation as early as August in a bid to enact the recommendations of Michael Byrne QC's Commission of Inquiry into Organised Crime. Under the changes, drugs such as cannabis, morphine and ketamine will be considered the same as heroin, ecstasy and cocaine under a plan to scrap the current drug schedule and reclassify all drugs as dangerous."

http://www.couriermail.com.au/news/queensland/queensland-government/pot-heads-into-heroin-ecstasy-and-cocaine-territory/news-story/0b9c7c264875fc5b7b5b20f69ed724c8

Naturally, this raises a couple of obvious questions:

1. Does the Byrne report provide a fair description of the positive benefits of cannabis?
2. Does the Byrne report provide any medico-scientific evidence that would justify the classification of cannabis as an extremely dangerous drug?
3. Does the Byrne report discuss the benefits of cannabis as a medicine?

On pages 124-126 the Byrne report has a discussion on "Effects of cannabis on the user". In relation to question (1) a rough estimate is that 50 words are used to acknowledge the "general feelings of wellbeing" associated with cannabis use, out of about 1500 words in all, the balance being negative effects.

On question (2), this section of the Byrne report findings can be summarised as follows:

- No causal link has been established between cannabis and the development of schizophrenia;
- No causal link has been established between cannabis and anxiety;
- The cannabis link with depression is weak;
- Combining cannabis use with alcohol significantly increase adverse effects such as "psychotic" experiences;
- Cognitive impairment rates barely rate a mention;
- No conclusive evidence exists linking heavy use of cannabis with chronic bronchitis;
- There is no conclusive evidence that cannabis is a gateway drug; and
- Occasional users are unlikely to suffer ill-effects.

As for question (3), unless it's hidden away somewhere in the report's 550 pages, there is absolutely no discussion of the medical benefits of cannabis.

Comments

For the three questions, the answers are no, no and no.

Question (1)

It is striking that the space devoted to the positive aspects of cannabis use—about 3%—closely reflects the extraordinary bias that has been documented in cannabis research funding, both internationally and in Australia. Thus, for example, a 2013 search through the US National Library of Medicine that pulled up 2,000 "more recent" papers found that about 94% were devoted to researching cannabis harms (Gupta 2013). In the UK Professor David Nutt commented in a 2009 public lecture that "It is very easy to get research money to show that drugs are harmful but it's very hard to get research funds to show that they may not be so" (Nutt 2009). And in Australia, two pharmacology professors from the University of Sydney—Iain McGregor and Dave Allsop—told the *Australian Financial Review* earlier this year they had "spent two decades conducting cannabis research. For all that time they could only get funding to study its dangers; no one had offered to fund the testing of its benefits." (Katelyn's Oil 2016).

Gupta makes the point that because 95-100% of the research has been designed to find harms it has created a highly distorted picture. This has been intentional on the part of the funding bodies because the case for making cannabis illegal is laughable. In a separate but related comment, Nutt adds that a lot of the scientific reporting about drugs is biased and/or of very poor quality, including even papers published in so-called "top" scientific journals.

It is only in the last decade or so this imbalance has begun to be redressed by the publication of research into the beneficial effects of cannabis for various medical conditions.

Question (2)

The discussion of potential harms from cannabis use is fairer than most of the reports we get from the drug-war-law-enforcement complex, but it is odd that two of the clearest and most scientifically credible reviews of cannabis harms—the ACMD study (2008) and the Beckley Foundation study (2008)—are not even referenced.

Leaving that aside, Nutt et.al (2007) proposed the only way to arrive at a truly harm-based assessment is to assess the cannabis harms against "the harms of drugs that people know and use".

Matrix of Harm

Nutt and his colleagues asked panels of relevant experts to rate 20 of these familiar drugs on a "matrix of harm", based on three factors: a) the physical harm to the individual user; b) the tendency of the drug to induce dependence; and c) the effect of drug use on families, communities and society. Alcohol, valium and tobacco were rated in the top 10 group, 5th, 7th and 9th respectively. Cannabis was rated 11th. In its discussion the paper makes it clear the one to twenty rating is not a steady progression but is rather more like a logarithmic scale, stating "there is a rapidly accelerating harm value from alcohol upwards", that is, in order of increasing harms, street methadone, barbiturates, cocaine to heroin (1). The analysis demonstrates there is absolutely no equivalence between cannabis and heroin, on what is probably the most objective rating of comparative harms in the literature.

There is nothing in the Byrne list of possible harms that makes an argument that cannabis should be illegal, let alone be given equal status to heroin as a dangerous drug. The report

doesn't even directly address that argument, having apparently bought the law-enforcement conventional wisdom that because governments have decided cannabis should be illegal, they must have had good reasons (see Appendix I, The Big Lie: President Nixon's War on Drugs).

Nor does the Byrne report make any attempt to rate cannabis harms against alcohol, an obvious choice because the intensity of its intoxication is comparable to that of cannabis. Forget for the moment the alcohol-inspired assaults and king-hit fatalities and motor vehicle accident fatalities associated with alcohol. Alcohol use and abuse can by itself cause all the harms to users that are claimed for cannabis use and abuse, and more. Alcohol harms are at least an order of magnitude worse, probably two (100x). For example the Byrne report barely addresses the claim that cannabis abuse can cause negative cognitive effects, a favourite of all the wilder claims made by drug-free advocates. But it is well-known that binge drinking in teenagers can cause serious and easily measurable cognitive impairments, as demonstrated to chilling effect by the ABC Catalyst TV program, in 2005 and 2007 episodes. That is the standard that is completely missing from the Byrne Report.

A link to the Queensland Government's formal response to the Byrne report is listed in the References.

APPENDIX F

Queensland Cannabis Prosecutions

The MGC Pharma White Paper quotes an 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 (MGC 2.2).

According to the Australian Crime Commission *Illicit Drug Data Report* the number of national cannabis arrests for 2013-14, the most recent reporting period, was 66,684. Which means that about 90% of the 750,000 users avoid arrest by police in any one year. In the Council's view these numbers as a scandal, not just because of the Council's position that cannabis should be legal, but also because consumer arrests in this reporting period accounted for 87% of all national cannabis arrests. Clearly enormous police and justice system resources are being expended on small scale offences.

There appear to be no reliable numbers on the proportion of users who are using cannabis for medical reasons, although it is likely the 750,000 number includes tens of thousands who are. One such is Glen Andrew Gregory from Rockhampton, whose media story is reproduced below.

> **Caught with a cannabis plant in backyard**
> **Madeline McDonald | 14th Apr 2016 4:41 PM**
>
> YOU WON'T find garden gnomes or rose bushes in Glen Andrew Gregory's backyard but you will find a cannabis plant. At 8.35am on March 25 police went to Gregory's Park Avenue address to conduct a search of his home when they observed a small cannabis plant growing in his backyard. Police Prosecutor Acting senior constable Josh McLennan told the court Gregory, 33, admitted to watering the plant daily.
>
> "The plant was 70cm high and was freshly trimmed," Acting Snr Const McLennan said. "Police located Gregory on the top floor of the dwelling and conducted a search of inside the residence where they found a large number of cannabis seeds in his bedroom at which Gregory admitted to using to grow another plant like the one outside. "Police also found a large amber coloured glass water pipe cone piece, a pair of scissors with cannabis residue, a hairdryer and a bowl. Gregory admitted to using the scissors to cut the cannabis and the hairdryer to dry the cannabis out."
>
> The court heard Gregory had a number of previous offences relating to dangerous drugs, including prior producing offences. Gregory's defence lawyer Jun Pepito told the court Gregory sustained a back injury four years ago and self-medicated. "He consumes drugs to relieve the pain," Mr Pepito said.
>
> But Magistrate Michael O'Driscoll wasn't allowing for any excuses. "You know as well as I do that dangerous drugs are illegal in the state of Queensland as you have numerous previous drug offences," Magistrate O'Driscoll said. "You were before the court in 2003, 2004, 2006 and in 2007 on the same charges as you are today. Now, we're here in 2016 still going around the same circle in relation to dangerous drugs. "Regardless of your medical condition, if you come back before the court you're facing a term of imprisonment."

> Gregory pleaded guilty to one count of producing dangerous drugs, one count of possessing dangerous drugs and one count of possessing utensils in Rockhampton's Magistrate Court this morning. He was fined $1800 and a conviction was recorded.
>
> http://www.themorningbulletin.com.au/news/caught-with-a-cannabis-plant-in-backyard/2996791/

The $1800 fine for one plant is appalling on any scale and is not in any way defensible just because of the victim's history of repeat offending. It is accepted expert pain medical practice to give considerable weight to patient pain reporting, and that compassionate approach appears to have been dismissed in this case. Although I have not been able to find any statistics, the severity of the fine is unlikely to represent an outlier as most magistrates strive to adhere to precedents.

Appendix E references a 17 April press report by Attorney General Yvette D'ath. The following text is another extract from the report:

> All drugs will attract the current penalties for schedule 1 substances such as heroin under the Drugs Misuse Act meaning criminals caught trafficking, producing or supplying cannabis could be sentenced to an extra five years in prison with the maximum sentence increasing from 20 to 25 years.
>
> Sentencing will still be dependent on the quantities of the drugs involved and the circumstances of the offence. Extra penalties will also apply for those using the internet to peddle and obtain drugs with the Government to move to make the use of the internet an aggravating factor attracting an extra five years in prison.
>
> "Simplifying the way illicit substances are scheduled under the Drugs Misuse Act recognises that all drugs are dangerous and pose a risk to health and public safety," Ms D'Ath said. "The Government accepts the view of the Commission of Inquiry into Organised Crime, that streamlining the way that drugs are classified will create a more transparent scheduling regimen for drug offending.
>
> "It also brings Queensland into line with other Australian states. It means courts can sentence on the basis of the quantity of the drug and circumstances of the offending rather than the classification of the drug itself."
>
> http://www.couriermail.com.au/news/queensland/queensland-government/pot-heads-into-heroin-ecstasy-and-cocaine-territory/news-story/0b9c7c264875fc5b7b5b20f69ed724c8

The Council supports the reclassification to the extent that it restores sentencing decisions to the courts. However, the Council makes two observations. First, there is a contradiction between the move to increase penalties for supply at around the same time as the government has a Bill before parliament to legalise the prescription of medicinal cannabis—a Bill, moreover, that doesn't address the issue of supply. Second, the relaxation of draconian cannabis prohibition implied by the Bill sits alongside the fact that thousands of Queenslanders are arrested every year for minor cannabis offences, and these arrests are increasing. In the ACC report cited above the 2013-14 cannabis arrest number for Queensland is 20,219, a 10% increase over the previous year.

APPENDIX G

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." [Emphasis added]
>
> *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." [Emphasis added]
> *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.

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."

APPENDIX H

Prohibition of smokable medicinal cannabis

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. The relevant clauses from the VLRC executive summary are as follows, with commentary by the writer:

> 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 between smoking and lung conditions 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 depressed mood 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 between licit and illicit are not science-based or merits-based arguments for prohibiting smoked cannabis therapy. They are simply artefacts of the Nixonian 'War on Drugs' (Appendix J). It matters little 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.

* 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.

APPENDIX J

The Big Lie: President Nixon's War on Drugs

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."

Nixon made cannabis the most important component of his '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

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 one survey referenced in Appendix E.

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.

APPENDIX K

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.

Update 15June16: The prominent dialogue box on their website advising the TGA had blocked their licence to import and the company's lawyers were negotiating with the TGA has been removed. It has been replaced with a much less prominent message stating:

"Products coming soon. We are currently finalizing our import licence. Once this is complete we will be ready to produce our cannabis derived medications in our own registered compounding pharmacy."

There was no response to a voicemail phone inquiry 15June16. The following email exchange then took place:

John Ransley [per MCCA website]
jeransley@bigpond.com
07 3844 6236
My inquiry goes to the availability and legality of your cbd product, especially as it concerns Queensland.

****

From: Jonathan (Medical Cannabis Clinic Australia)
[mailto:support@medicalcannabisclinic.zendesk.com]
Sent: Saturday, 18 June 2016 11:16 PM
To: John Ransley
Subject: [Request received] Offline message from John Ransley

##- Please type your reply above this line -##
Thank you for contacting MCCA.
Your request (2057) has been received and is being reviewed by our support staff.
For your information we are still waiting for our importation license to be approved. With the increase in attention, we are finding it hard to keep up with customer service. We will attempt to get back to you as soon as possible.
To add additional comments, reply to this email.

From: Courtney (Medical Cannabis Clinic Australia)
[mailto:support@medicalcannabisclinic.zendesk.com]

Sent: Monday, 20 June 2016 11:02 AM
To: John Ransley
Subject: [Medical Cannabis Clinic Australia] Re: Offline message from John Ransley

##- Please type your reply above this line -##
Your request (2057) has been updated. To add additional comments, reply to this email.

Courtney (Medical Cannabis Clinic Australia)
Jun 20, 11:02 AEST
Hi John,
Unfortunately, we are still unable to supply the CBD based medications due to the TGA blocking our license to import. When the medication does become available it will be 100% legal within all states of Australia. We do have a court date set for the 20th and 21st of September 2016. We should hopefully have an answer then.
Please register, as this will enable us to update you as our case progresses and inform you as soon as we are able to supply our products. Below is the link to register:
https://www.medicalcannabisclinic.com.au/store/vip/medical/index/
Once registered you will also have access to further information regarding treatment.
Please let me know if I can be of any further assistance.
Kind Regards,
Courtney
Customer Service Team | Medical Cannabis Clinic Australia

****

Update
An email request for further information has not been answered at the time of writing. However a phone call by Courtney 7 July 2016 affirmed the TGA was still blocking their licence to import and their September court case was appealing this decision. She reiterated that because of the June 2015 rescheduling of CBD medicines to Schedule 4, her company would be able to legally supply a conforming CBD medicine to patients in all Australian states, including Queensland, provided the medicine was **locally sourced**. Unfortunately, she noted, there is no local product and no prospect of one being available for an indefinite period. She added that her company was receiving a very high volume of inquiries and is a leader in the field.

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