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MEMBER: Mr LANGBROEK

Mr LANGBROEK (Surfers Paradise—LNP) (8.06 pm): I rise to speak to the Public Health (Medicinal Cannabis) Bill 2016. I thank the committee for its work in assessing this bill.

Earlier this year, the federal government passed a number of changes to Commonwealth legislation that opened the door for the states and territories to enact legislation that would aid the availability of medicinal cannabis to approved patients in certain circumstances. Such changes included an amendment to the Commonwealth Therapeutic Goods Act 1989—the TGA—and the Commonwealth Narcotic Drugs Act 1967. The amendment to the TGA down-scheduled some cannabis derivatives from a schedule 9 to a schedule 8 when used for medical purposes. The down-scheduling for scientific or medicinal purposes is intended to ensure that those qualified have access to the substance for medical and scientific research while maintaining strict controls so that it is not manipulated for illicit purposes. Further, the Narcotic Drugs Act 1967 was amended in February to establish a national licensing scheme.

This framework facilitates the cultivation of cannabis for strictly medicinal or scientific purposes in Australia or, as Minister Ley described, it `provides a secure supply chain from farm to pharmacy that will give patients access to medicinal cannabis products'. In effect, these changes mean that the states and territories can allow selected patients in their states access to medicinal cannabis if they decide to do so.

In light of these changes federally, the bill before us today—and I quote the explanatory notes—creates `a new regulatory framework under which medicinal cannabis products may be prescribed and dispensed to patients in Queensland while also preventing their unauthorised use'. Under this bill, the term `medicinal cannabis' is defined as `a cannabis product...used...for human therapeutic purposes' but is not a product that is already registered that is part of the cannabis plant, derived from the cannabis plant, or a drug that has or is intended to have a substantially similar pharmacological effect to a part of the cannabis plant or something derived from the plant.

Specifically, this framework consists of two pathways for a patient to receive medicinal cannabis, the first being a single patient prescriber and the second a patient class prescriber. The single patient prescriber allows medical practitioners to submit an application with the chief executive of Queensland Health for approval to prescribe medicinal cannabis to a patient. The bill provides that the chief executive may consider a number of factors when deciding whether to approve medicinal cannabis for a patient.

According to the report, some of these factors include, but are not limited to, the patient's medical condition and symptoms, the form and dosage of the medicinal cannabis proposed and the patient's
032 history of drug dependence.

The second option, which is the patient-class prescriber, waives the abovementioned approval process by allowing specific practitioners an as-of-right to prescribe medicinal cannabis to patients. The committee report indicated that the list of eligible patient conditions under this pathway could grow as more research is conducted or made available. Both processes would still require applicants to seek approval through the Therapeutic Goods Authority, the TGA, and is thus a two-step process.

Some concerns were raised - and I note the minister has attempted to address those - about the potential duplication of the process under the state of Queensland's bill, the bill before us now, and the Therapeutic Goods Act. As my colleague the member for Caloundra and deputy chair of the committee rightly pointed out in his statement of reservation—

The question raised needs to be fully explained as to whether a duplication exists, more importantly if the duplication exists why it exists and critically if that duplication does exist what steps the government is taking to rectify the concern raised.

The director of the Legislative Policy Unit in the Department of Health also stated on 29 August before the committee that—

As the situation stands at the moment, the TGA would go through its own consideration of the patient's details, diagnosis and circumstances and its own consideration of the clinical justification for the drugs being sought. In that sense there is a duplication

of the considerations occurring at state and Commonwealth level, but, as Ms Forrester has said, we are working with the TGA, as are other jurisdictions, to streamline that consideration. The end goal would be perhaps we get to a point where, if there is state approved access, the TGA would then endorse that approval.

I note that the minister has attempted to explain how that is going to work in a practical sense, but they were the concerns raised by the committee and by the member for Caloundra in the statement of reservation.

The bill as it currently stands does not sufficiently outline what steps will be taken to ensure that this duplication is addressed. I would like the minister to advise how a streamlined process would be negotiated, either with the federal Department of Health or at a COAG level, notwithstanding the explanation that he has just given in his second reading speech. Can I also say that the LNP opposition is supporting this bill.

I note other concerns raised during the committee process include the time scales associated with obtaining medicinal cannabis, the cost of obtaining medicinal cannabis and the current requirement to import medicinal cannabis products and restrictions on varying the dose of medicinal cannabis prescribed to patients. However, it is not recommended that these concerns hold up the passage of the bill. I also acknowledge the committee's recommendation to remove references to criminal history from clauses 10 and 11 and omit clauses 28 to 31.

Under the bill the chief executive of Queensland Health will also grant dispensing approvals as part of the framework. This will allow selected pharmacists to supply medicinal cannabis to authorised persons. The bill also allows a person to apply to the chief executive for an approval to include medicinal cannabis in clinical trials. It is important to note that any use or distribution of cannabis outside this framework will continue to be illegal under the Drugs Misuse Act 1986 which labels cannabis as a dangerous drug. The bill also does not allow for people to grow their own cannabis, even if it is for therapeutic purposes. The bill also provides provisions to prevent misuse, namely, it introduces 28 new offences, provides the chief executive the power to cancel, suspend, vary or impose conditions on an approval and appoints authorised persons to investigate, monitor and enforce compliance. The 28 new offences include performing a regulated activity with medicinal cannabis without authorisation and misusing a lawful direction for the use of medicinal cannabis. These offences can carry maximum penalties between 100 penalty units, or $12,191, and 750 penalty units, or $91,425.

To give an historical overview of the situation in relation to cannabis, the topic of cannabis and the validity of specific compounds as an effective medicine for some conditions has been debated for some time. In fact, cannabis has been used for medicinal purposes since 4,000 BC in China, with other textual records evidencing use in Greece, China, India, Egypt and the Middle East in 2000 BC.

The substance was introduced in Australia at the request of Sir Joseph Banks in 1788 when the First Fleet arrived. At this time the primary use of hemp was to grow rope for the British Navy and, in some instances, for cigarette production. Reports show that cannabis was introduced into Western medicine in 1839 by Sir William Brooke O'Shaughnessy, a British doctor who recognised some benefits of using the substance as a treatment option while serving in the army in India. Following his initial study on the effects of cannabis as a treatment on animals, Sir William Brooke O'Shaughnessy pioneered the drug as a form of relief from the symptoms of then fatal or debilitating diseases including rabies, epilepsy and rheumatism. He reported that it stimulated appetite, eased pain and lessened neurological symptoms such as shaking. However, once Sir O'Shaughnessy's cannabis supply and research was transferred to British pharmacist Peter Squire for commercial medical use, the drug was popularised and widely used for many symptoms. These included pain associated with childbirth and excessive coughing. It had also become popular because of its euphoric properties.

The turn of the century spurred a paradigm shift from an era when self-medication and even the use of cannabis as a treatment was common practice to a time defined by prohibition and multilateral bans on psychoactive drugs. This resulted in a decrease in the medicinal use of cannabis due to the increasing availability of other medications as well as resistance to social use. During this time international legislation played a large part in influencing Australian domestic policy, particularly the United States of America's prohibition efforts. This resulted in Australia becoming a signatory to the 1925 Geneva Convention on Opium and Other Drugs. It must be noted that in the early 20th century cannabis was not viewed as a primary target for these controls which mainly focused on opium.

In 1926 the federal government introduced restrictions on the use, sale and possession of cannabis and banned importation. These efforts were echoed by states and territories shortly after. Victoria was the first Australian state to legislate a control on cannabis use in 1928 and in 1937 we saw Queensland enforcing similar controls with the introduction of the Health Act. Whilst extracts of cannabis were still included in some medicines available in pharmacies in 1950, an increase in non-medical use

of cannabis solidified efforts to restrict the drug not only in social instances but also for medical use during the 1960s. I note that something similar happened with the use of cocaine in my profession of dentistry. Because of concerns with the use of cocaine due to its addiction problems, other derivatives that have been developed, such as novocaine and lignocaine, are what dentists currently use.

Australia became a signatory to the United Nations Single Convention on Narcotic Drugs 1961 which amalgamated prior international agreements. These multilateral commitments by member nations resulted in legislation which fostered increased controls of narcotics and psychotropics in Australia. It must be noted that these agreements do not restrict any scientific or medical use or research. Non-medical use of cannabis was not a major social issue in Australia until the 1960s. The increase in the use of recreational cannabis is attributed to social issues and generational disagreements often now attributed to issues such as the Vietnam War. The political dialogue on cannabis use then turned to focus on illicit recreational use, with US president Richard Nixon declaring a war on drugs in 1971. The Howard government followed suit in 1997, implementing a tough-on-drugs policy in November that year. Premier Joh Bjelke-Petersen here in Queensland was an early supporter of this crackdown.

Despite the fact that international treaties continued to enforce prohibition throughout the 1980s, the federal government's focus turned to harm reduction during this time, launching the National Campaign Against Drug Abuse. It was not until the 1990s that rhetoric returned to discuss the medicinal use of cannabis. The earliest official report in Australia was in 1994, when the New South Wales government acknowledged that 'synthetic preparations (of cannabis) were being used in the United States of America, Canada and Ireland to treat nausea and pain in terminally ill patients'. Further, the 1999 New South Wales Working Party on the Use of Cannabis for Medical Purposes report stated that 'some cannabinoid substances may have value in the treatment of a limited range of medical conditions' and suggested 'a regime for limited compassionate provision of cannabis to patients who may benefit from its use'. Internationally, in 1978 New Mexico was the first jurisdiction in the USA to legalise medicinal cannabis, with 20 other states reportedly legalising or decriminalising its use in the USA since that time. Further, in 2001 Canada introduced a medicinal cannabis program, whilst in 2003 the Netherlands made a provision to make medicinal cannabis available to terminally ill patients. Medicinal cannabis has also been approved for use in varying degrees in Austria, the Czech Republic, Denmark, Germany, Israel, Italy, New Zealand, Spain and Sweden.

033 Whilst international frameworks and legislation could provide precedent for a framework for Queensland, at the public departmental briefing the Chief Medical Officer, Dr Jeanette Young, rightly pointed out that frameworks that liberate the use of cannabis have been implemented with little research, particularly on the effectiveness of cannabinoids as treatments and the long-term effects on a user. She also mentioned that research is limited to a couple of compounds out of the numerous compounds contained in cannabis. Therefore, it is not advisable to replicate those international models.

First and foremost, the LNP remains supportive of trials to ensure that medicinal cannabis products that we make available to the public work and that they are safe, particularly for children who are taking those medicines during their early developmental stages. According to Dr Young, some research has been conducted that indicates that a small group of children with Dravet syndrome, Lennox-Gastaut syndrome and forms of drug-resistant epilepsy have responded to Epidiolex, which is a cannabidiol or CBD. It has also been found that tetrahydrocannabinol, or THC, masks or changes the patient's perception of symptoms and thus can be of some assistance to terminally ill patients. As a result of this, in 2014 the New South Wales government established the Terminal Illness Cannabis Scheme, which allows terminally ill adults over the age of 18 to register for limited quantities of cannabis for medicinal use.

In Queensland, high-profile cases where individuals have unlawfully sourced cannabis for medicinal purposes can be attributed to an increase in public discussion on the topic. Such cases include the prosecution earlier this year of a man who was providing cannabis oil to his terminally ill daughter because he claimed it assisted with her appetite and, in his words, 'calmed her'. That has prompted significant public debate regarding the current legislation, which has criminalised medicinal use, as well as the validity of cannabis and cannabinoids as a pharmaceutical drug. In that case, the father was charged with three counts of supplying dangerous drugs to a minor and two counts of possessing dangerous drugs. Part of his bail conditions included a ban on seeing his daughter, a two-year good behaviour bond and a $500 fine. No conviction was recorded. In making his decision, Justice Peter Flanagan considered factors including—

... the doctor's evidence; Mr Koessler's positive references and his belief that he was helping his daughter; and the risk that the cannabis oil could have harmed Rumer but that it did not.

Other common law cases include R v Stone 2006 QCA 103, R v Burgoyne 2005 QCA 28 and R v Brown 1997 QCA 170.

It is difficult to estimate demand in Queensland, or nationally for that matter. Currently there are 10,588 people with HIV AIDS with severe pain, 15,875 multiple sclerosis patients with severe muscle spasticity and pain, almost one million cancer treatment sessions per year and a small number of life-threatening childhood epilepsy sufferers in Australia who may be candidates for such alternative treatments. Epilepsy Queensland estimated that 94,000 Queenslanders have epilepsy, with 30 per cent unable to manage their conditions through medications currently available to them. In their submission to the committee, MS Australia highlighted that while Sativex, which is a mouth spray containing THC and cannabidiol, has proven to assist with some symptoms, it is currently unavailable because of the scheduling of cannabis products. The organisation also noted that Sativex can have some undesirable side effects. In that instance, under the proposed framework a medical professional can discuss with the patient to determine the best treatment to manage their condition.

With regard to cultivation, whilst not contained in the bill the committee recommended that the Queensland Department of Agriculture and Fisheries prioritise its investigation of options for obtaining a licence to cultivate and manufacture medicinal cannabis in Queensland. The committee rightly noted that the bill would be reviewed after two years of operation to ensure it meets the needs of patients, health service providers and enforcement agencies, and complements related developments in this rapidly evolving policy space, particularly with regard to the proposed domestic cultivation, production and manufacture of medicinal cannabis.

We support this bill, which will ensure that Queenslanders with treatment-resistant conditions have access to the medication they need. However, I would like to stipulate the LNP's reservations with regard to the current duplicative and complex process in place for someone to be approved for treatments containing cannabis and the need for the government to work with the federal health department to transmit that to patients in Queensland and the wider community and to develop a more efficient process.