PUBLIC

THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION A COMMITTEE MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON FRIDAY, 19 SEPTEMBER 2014.

LEGALISED MEDICINAL CANNABIS

Mr ANDREW CLIFFORD, DIRECTOR, AND **Mr BERNARD SIM**, GREEN ACRES HYDROPONICS, WERE CALLED MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Forrest) - Thank you. You have the information about how the committee works and we have received your submission. This is a public hearing. It is all recorded in *Hansard* and will form part of the public record and be on our website. If you wish to give us information in confidence, then you can make that request and the committee will consider it, and that would be kept private. What you say in front of the committee is covered by Parliamentary privilege, but if you speak to the media afterwards outside this room, it is not. So you just need to keep that in mind if you speak to the media afterwards. Do you have any questions before we start?

Mr CLIFFORD - My name is Andrew Clifford. I am one of the directors of Green Acres Hydroponics, along with Rodney Fischer. We have been operating for about five years. We have two branches, one at Mornington and one in Kingston, and we are addressing the committee today on the benefits of medicinal cannabis.

We have been looking into the benefits and disadvantages of it for quite a while. We would like to report and enquire about how we can go forward with this process. The benefits are that that cannabis can be effective in providing relief from chemotherapy, induced nausea, vomiting and anorexia, chronic neuropathic pain, wasting syndrome, treating symptoms of HIV AIDS, and many other ailments.

Globally, cannabis is used for PTSD, cancer, epilepsy, dementia, Tourette syndrome, motor neurone disease, glaucoma, aged care, diabetes, chronic pain, arthritis, chronic insomnia, Crohn's disease and many others as supported by many clinical studies and case reports - I have information on that. This information is supported by the Cancer Council of NSW in its submission to the 2013 NSW Government enquiry into the use of cannabis for medical purposes.

They are also consistent with a report prepared in 1998 by the Drug and Alcohol Services Council of South Australia and many other medical and research professionals around Australia. The side affects of medicinal cannabis have been scientifically studied to say that they are generally mild and non-serious. Any side effects should be compared with other drugs that are likely to be used in these patients, or the nature and severity of the original symptoms.

It can be administered as a tincture - as drops - which is a cannabis extraction and the preferred option, or as creams, pills, eaten in food, inhaled as a vapour, or taken in many other ways. It does not have to be smoked, which is probably the least preferred option.

The disadvantage of medical cannabis is that if it stays unregulated, people with severe pain and suffering - the terminally ill and those with chronic suffering - will have to use medicinal cannabis products that are not fully tested, and will have to break the law in doing so. This is the only relief that these people can get without the drastic side effects of other drugs. Being unregulated, the Government will have no control in the manufacture, distribution and sale of medical cannabis. The preferred option is for the Government to fully regulate and control it.

Tasmania needs to be proactive in this matter as there is a huge economic potential. If it becomes a state that grows medicinal cannabis, as we pointed out in *The Mercury* on Tuesday 9 September, medicinal cannabis could rival the state's $100 million poppy industry. Tasmanian Health Minister Michael Ferguson said he supported a trial.

Growing the valuable crop is championed by all 12 Mayors from southern Tasmania. In a *Mercury* report on the 9 September 2014 and on *Sea FM*, the shadow attorney-general, Lara Giddings, has thrown her full support behind these trials. It is now reported by Newscorp that Prime Minister Tony Abbott is supporting the legalisation of cannabis for medical purposes. Mr Abbott stated:

> I have no problem with the medical use of cannabis, just as I have no problem with the medical use of opiates.

It is also stated that we do not need to run a second separate Australian clinical trial or registration process for medicinal cannabis. If a drug is needed for valid medical purpose and is being administered safely, there should be no question of its legality, and if the drug has been proven to be safe abroad and it is needed here, it should be available.

As stated above, Tasmania needs to act now. Medicinal cannabis will go ahead; it is a matter of when, not if. With the majority of the public fully behind it, with Government support and most medical organisations trying to help the people who need it, Tasmania needs to stop sitting on its hands and go ahead with medicinal cannabis.

With the right guidelines, laws, management programs and procedures in place, medicinal cannabis would be very beneficial for people who need this treatment in Australia, ultimately changing peoples lives for the better.

CHAIR - Thank you for that. Can you explain to the committee what your interest is? I know that you have a company, Green Acre Hydroponics. What do you grow at the moment? If there were an opportunity to grow it, because it has to be regulated, what changes would you need to make to your business to facilitate that?

Mr CLIFFORD - We would definitely need to proceed with other premises, if we were going to grow it for trial or medicinal purposes. We can easily adapt to medical cannabis. We already grow tomatoes and capsicums in our shops in display units and we

are very well versed with growing in the hydroponic style of things. Our company could easily adapt to growing this product.

CHAIR - Have you, at any time, made any approach to the Health minister to participate in a trial of any sort?

Mr CLIFFORD - Not yet, because we did not really know where we stood as far as the law was concerned. We thought this would be the first process. We would see where we stood with this afterwards, then go with the next step.

Also, personally, and Bernie is the same, and through friends and family, we know a lot of people who already use cannabis tincture to relieve for pain and suffering with fantastic results. We have seen it at first hand. As a collective unit, as Green Acres Hydroponics, everyone in the company is 500 per cent behind it and truly believes in its benefits.

CHAIR - Is there anyone in the company who has the scientific expertise to be able to determine what sort of product could or should be grown, and how to go about that? Or do you need to get that sort of expertise in?

Mr CLIFFORD - We have a good understanding. I might pass you over to Bernie at this stage.

Mr SIM - There are many ways it can be produced. With the hydroponic industry, it does not really matter what plants we grow, whether it be tomatoes, capsicums, cucumbers or cannabis; it is all under the same structure and method. You can get different strains available like high CBD strains and low THC strains. There are some strains out there, which are as high as 8 per cent CBD and as low as 4 per cent THC. Ultimately, you are not going to have any psychoactive side effects off those types of strains, but the medicinal values are just incredible.

CHAIR - What qualifications or expertise do you have in that area to be able to judge or understand that?

Mr SIM - Our personal experience is just through the hydroponics industry. Having grown hydroponics for a number of years now, we have the ability to do that. Provided the strains are correct and the facilities are there to extract the cannabinoids and make the medicines, it would not be hard.

Mr CLIFFORD - Officially, no. It is just through feedback from customers and research we have done and so forth.

CHAIR - You are more placing yourselves as people who could grow for a person who was doing the research?

Mr CLIFFORD - Spot on, exactly. Definitely, we could grow and supply equipment and so forth, and be involved in whatever area.

Mr SIM - We also know a number of people, through the business, who already extract cannabinoids and produce their own tinctures and medicinal oil. The feedback from those people has been sensational.

CHAIR - Not in Tasmania?

Mr SIM - Yes, in Tasmania.

Mr CLIFFORD - Definitely in Tasmania, yes.

Mr CLIFFORD - There are probably a dozen people we know who are taking tincture at the moment with fantastic results.

CHAIR - Locally grown and sourced?

Mr CLIFFORD - Yes, locally grown and made here. The whole lot is done here in Tasmania. We have one gentleman who has a disabled son aged about 34. He takes massive fits and because he is an adult, he hurts himself dramatically. He has six or seven fits a day. Since he has been taking the tincture he has been down to one or two fits a week and they are very mild. He says it has changed their lives; they just cannot believe it. This guy comes in tears to tell us his story.

Mr MULDER - I am interested in your experience in being able to grow selective plants with the required amount of hydroponics. I think you have danced around that quite nicely by saying it is the customers for your products.

Mr CLIFFORD - Definitely, yes.

Mr MULDER - I guess that becomes the point. If someone else is going to be doing the research and you guys are just supplying the equipment, you will grow the strains that are produced by other people selectively. Would you actually develop strains if you had a licence?

Mr CLIFFORD - As Bernie said, you can develop particular strains with very low THC but higher medical benefits. Through processes that they go through, they can just about eliminate the THC completely out of the product. It is completely on the medical side with no 'stoned' effect and no major side effects.

Mr MULDER - We have heard evidence that the CBD has does not have the psychotropic effects, but it has great medicinal value. We have also heard that for some conditions it is the pain relief, for which THC is required.

Mr SIM - That is right. Different strains have different qualities. You can get really high THC strains and really high CBD strains. You can get strains that have a one-to-one ratio of CBD and THC. Then again, you have the indica versus sativa strains. The indica strains are really good for pain and sleep, while sativa strains are more beneficial for alertness and daytime use to lower pain and promote comfort levels. So, by selecting the right strains, you can have a whole range of medicines to treat a number of ailments.

Mr MULDER - So this comes down to different products with different mixtures and different ratios of components. What confidence have you that you are going to be able develop strains which have specific contents of this and specific contents of that?

Mr SIM - These strains have already been developed in other countries. They are already available online through seed banks and seed companies. So, it is matter of just literally purchasing the seeds - and there is your strain.

Mr CLIFFORD - It is legally decriminalised in probably about a third of the world, if not a quarter. Countries like Canada, for instance, are very developed in that side of things and very advanced with it.

Mr MULDER - Why hydroponics over ordinary cultivation?

Mr CLIFFORD - With hydroponics there is no environmental impact. It can be grown a lot quicker and a lot bigger, and you have control over it completely.

Mr SIM - There is no disease or environmental factors to wipe out your crop. If you had one outdoors over a 10-acre paddock, and you get a big storm or a big flood, it is all gone. With hydroponics, they have put out the licences in various states of America. They are individual licences to growers to grow for the government. That ensures that they have a good high quality turnover and with hydroponics everything can be regulated.

Mr MULDER - I am quoting here from the *Chicago Tribune* on February 7 this year, which talked about estimating it would require $500 000 USD to set up a production to get a licence to grow and distribute it. Would you like that? What do you think about that type of regime?

CHAIR - There must be a lot of security about these days.

Mr CLIFFORD - Those figures are really hard to counteract because we do not know what procedures they have in place and what their laws and regulations are over there.

Mr MULDER - This is just the government collecting license fees, to be quite frank with you. How keen are you now, to become part of this industry?

Mr CLIFFORD - Regardless, we are fully behind it. It is not just on a business side of things; it is the actual benefits of this amazing drug. It is unbelievable. We are hearing stories every day in the media and there is good reason for that. It is because the benefits are fantastic. You can hear fantastic stories from people who have gone through pain and suffering every day of the week. There are hundreds of them. In Tasmania alone, you can probably pull up 100 people one after another to tell their stories.

Mr FARRELL - This is really quite fascinating, hearing it from the 'grass roots' level of the industry. What percentage would the people that you talk to use if for medicinal purposes? Is it a 25 per cent of your clientele? Just based on the feedback that you receive.

Mr CLIFFORD - We are not actually saying it is any of our clientele at all. Whatever they buy from us, we do not know what they do with it when they walk out the door. We are only ever dealing with vegetables. Just talking to the general public, recreational use in Tasmania is massive. The medicinal side of it has increased dramatically over the last five years or so. I would be saying it is about 15-20 per cent on medical side of it.

Mr SIM - We get more and more over the weeks. Every month there are more people coming in. With elderly people, their son may have given them a joint because they have been in chronic pain, and it was fantastic for them. So they have come in to ask us about how they can go about producing their own, so they don't have to bother their son, so to speak.

Mr CLIFFORD - With the increased the exposure it is getting, more people are coming out of the closet, I suppose. People who have medicated themselves and probably never told a soul now feel they can actually talk about it. They are saying, 'Let us legalise it so we do not have to break the law to do what we do for our pain suffering'.

Mr FARRELL - Anecdotally, you are picking up through the general community, that some are using it to smoke, and others to distil it into oils.

Mr CLIFFORD - Recreational use is definitely high Australia-wide, and probably world-wide. It is purely the medicinal side of it that needs to be looked at.

Mr FARRELL - I am quite familiar with hydroponic tomatoes and capsicums but less familiar with hydroponic marijuana. Has the increase in hydroponics cut down on the amount of - there used to be raids up in the bush years ago and great crops found but you do not seem to hear of that anymore.

Mr CLIFFORD - There are plenty of people who probably still do that. I do not know. I know as much as you on that, to be honest.

Mr MULDER - You don't hear of houses burning down.

Mr CLIFFORD - That is right.

Mr MULDER - High production in the cellars.

Mr CLIFFORD - You get negative and positive reports on everything. On current affairs programs they have shown people from other nationalities in Melbourne doing whole street loads of hydroponics and have wiring going everywhere. That is one very small portion of people who do it. We have orchid growers, we have some very good tomato growers, we have a whole range of different sorts of people who use hydroponics to grow their fruit and vegetables.

Mr SIM - It can be adapted to pretty much any plant that can be grown.

Mr CLIFFORD - That is right. The beauty of hydroponics is, something that was grown in a warm weather area can be grown in Tasmania all year around and it is completely

controlled, and with a tinkering here and there with lights, you can speed your crop up to half the time in bigger yields.

Mr FARRELL - The issue we have had a lot with the committee and looking at effectiveness or otherwise of medicinal cannabis, is a lot of the trials have not been done in the open. While we have the medical experts in who have not done the trials, there has been a great deal of backyard experimentation done with different people.

CHAIR - Quality control around that makes it hard to rely

Mr CLIFFORD - We need to get at least trials under way because without trials or regulations, people will still grow their own. They will self-medicate and they will use unregulated products because their only pain relief is this product. They have tried everything else out there with drastic side effects but this product, with no side effects and instant pain relief, they are going to do it regardless. If they are going to be charged and go to jail, they will probably still do it because they need the pain relief. We all know when we are going through pain and we cannot get any relief from it, we would just about do anything. These people are stuck in a corner and they have no other choice. All we are saying is get a trial going. We could answer all these questions with trials.

Mrs HISCUTT - With the medicinal cannabis, there are three stages. There is the growing and processing and the trials. Are the trials firmly in the medical area?

Mr CLIFFORD - Yes.

Mrs HISCUTT - Are you into the growing area of it?

Mr CLIFFORD - Growing, or supplying the equipment to grow it, which ever way it would pan out.

Mrs HISCUTT - You have been in business for about five and a half years with the hydroponics?

Mr CLIFFORD - Yes.

Mrs HISCUTT - Do you have any other qualifications, like horticulturalists working for you or anything like that?

Mr CLIFFORD - No, we have not. It is purely experience through the hydroponic industry.

Mrs HISCUTT - You are particularly into the growing, to supply to someone else to do the trials on. That is the bit you are addressing?

Mr CLIFFORD - That is right.

Mrs HISCUTT - You have made a lot of comments about chronic pain, but that is all anecdotal and what you have seen?

Mr CLIFFORD - Yes, that is right. I have no professional qualification. It is all through experience and public perception.

Mr ARMSTRONG - You were saying, through seed banks, there are already different strains of cannabis available which are low in THC and more of the CBD. Is that what you are saying, that it has already been tested?

Mr SIM - Yes. There are breeders worldwide who have bred strains and created strains solely for medicinal purposes. There is one, for example, MediHaze, and that is a 4 per cent THC level and 8 per cent CBD level. To make an oil or extraction or tincture or any food, that is going to be highly beneficial for medicinal use. You could have jelly babies, for example, made out of it and there is your pain gone. These strains are available already and highly tested.

Mr ARMSTRONG - That has been one of things they are saying, they have to develop the appropriate plant.

Mr SIM - Already been developed. There is a seed bank called Demon Seeds. You can have a look on there and that gives you all the strains available and gives you a write-up on all the strains. It gives you their CBD content, their THC content and expected yield per plant. All of these studies have already been done and been very successful.

CHAIR - Is that DemonSeeds?

Mr SIM - Yes. DemonSeeds.

Mr ARMSTRONG - That is available on the website.

Mr SIM - Yes, on the website. They distribute many high-grade medical strains. As I said, the MediHaze strain alone is right up in the CBD. Charlotte's Web is one of the most popular strains worldwide for high CBD but any of these strains that you get from there, even high-THC strains, with a cold extraction the THC acids in those do not convert to THC so you don't get stoned if you make a cold extraction because THC needs to be converted from THCA with heat. There are many benefits of it.

Mr ARMSTRONG - You also mentioned the legal framework and you suggest models overseas, especially in the USA, is there any particular model in the USA or are you just giving an overview?

Mr CLIFFORD - That was a generalisation.

Mr SIM - A general overview. Canadian Health has a good structure where they grant licences to individual persons like Andrew and me to have a secure facility. Whether it be a 10-plant, 20-plant or 100-plant licence, these are available for the general public with experience in that field to go ahead and do it. Obviously there would be a probationary period for licence holders and you would have to meet regulation standards and fall into place with all the guidelines, but once that is proven I do not see why it would be any sort of problem at all.

Mr ARMSTRONG - There are none in the USA that really hit you?

Mr CLIFFORD - There is one. There is a website medicalmarijuana.ca and that is the Health Canada medical site. They have a very good licence application page with the plan you'd need to have, which is about your location, your security, your cultivation.

Mr ARMSTRONG - We heard about that one yesterday.

Mr CLIFFORD - It is a very good one. It seems to have all plans in place and you can apply to them and they will come up with a plan for you, or adapt it to where you are and so forth. They are just starting points to work from but you can take the best of quite a few. We do our research. Good starting points.

CHAIR - Just running off the point that Robert was asking about, with the seeds being available and a degree of work being done - Canada, as we were informed yesterday, has a very rigorous regulatory framework for growing, it is looks like you are going into some nuclear plant from the sound of it.

Mr MULDER - No pun intended with the plant.

CHAIR - For Australia and Tasmania to move ahead with the opportunity to grow it, do you know what would have to change in making it legal for you to buy the product from wherever and then grow it? Even if we got the regulations sorted out about the security, your set-up and all that, what needs to change to enable you to get the seed in and grow it.

Mr CLIFFORD - Not a lot. We have got everything in place to do that now.

CHAIR - It is illegal to do that now. Where does the law need to change? Do you know what the barrier is there in terms of the law that needs to change?

Mr CLIFFORD - The law would have to change to allow trials or the growing of plants for trials.

CHAIR - No, no, there is already the power there. The minister can, under the current Poisons Act, approve through an exempted facility like UTAS or something like that, for trials to be undertaken. Assuming that for you in the future, if you are looking beyond that, do you understand where the law needs to be changed to enable you to operate it commercially?

Mr CLIFFORD - I would assume that anyone who was going to grow it would have to be accredited in some sort of way, and have security checks done on them. They would have to go through some sort of course to prove that in what they are doing, they are going down the right line and understand what they are doing and understand the whole process. It would be somewhere down that line as an accreditation.

CHAIR - Just putting in place the necessary regulations?

Mr CLIFFORD - Yes, that is spot-on.

Mr MULDER - Growing it is one thing, but a lot of the literature will tell us that the benefits would be outweighed if it is smoked so therefore the process is towards tinctures and oil-infused bases and things like that. There is also some suggestion that maybe there should be some further processing beyond just growing, cultivating and storing the heads. I am wondering whether you think you would have the ability to take it beyond the step of producing the herbal form of it into a medicine, or would that be something you would suggest would be appropriate for a processing factory downstream?

Mr SIM - As I said before, individual people are already doing their own processing on a small scale and that could be escalated quite easily. In some states of America, if you operate a dispensary, you have to supply your own dispensary. That means growing your own produce, making your own remedies, so you would have to get knowledgeable people on board. It would be a matter of hunting out people who are already doing it, with some sort of amnesty of course, and having their products even tested to find out who is on the right track or who has the best results going, and then look at escalating that onto a bigger scale - instead of just a little cook pot on their stove they could have a big boiler in the corner.

Mr MULDER - You are not trying to destroy a cottage industry, are you?

CHAIR - Okay, we are out of time anyway but do you want to make any closing comments from our discussion?

Mr CLIFFORD - I am pretty happy with what we have covered.

Mr SIM - It would be nice to see something change and give people this freedom and the choice to have this as medication.

Mr CLIFFORD -I think for a lot of the questions we are to-ing and fro-ing here, trials can answer all these questions. Let us start the trials and take it from there.

CHAIR - Thank you very much for your time.

THE WITNESSES WITHDREW.

DISCUSSION BY PHONE WITH **Ms CHERIE O'CONNELL**

CHAIR - Cherie, we have received your submission, which was quite extensive, about your little girl, Tara. We have read the submission but it would be helpful to have an update on how you reached the position of using medicinal cannabis and the challenges that may have presented.

Ms O'CONNELL - In 2012 Tara was terminal and we were told to take her home and just love her until the end came but we were not prepared to leave it at that so we did some investigation and found out about Mullaways Medical Cannabis. She was the first child in the country and, thankfully, for us it has worked. Tara is now 578 days seizure-free, so a little over 17 months, and that is our basic story.

Our biggest challenge at the moment has been access to services because this is still a grey area of the law. The product we use is under the schedule 9 limit but because it is a grey area we cannot access respite, child care, or send Tara away to anyone else.

CHAIR - Are you happy to talk us through about what other medications you have tried. I understand that Tara has Dravet Syndrome.

Ms O'CONNELL - Yes.

CHAIR - Could you tell us why you started looking?

Ms O'CONNELL - We tried 17 different medications and many different combinations within those 17 drugs. The best seizure control we ever had was about 60 seizures a day and the worst up to 500. We never got more than six days in a row seizure free with the private medical cannabis. She was not a candidate for surgery so we could not go down that road. The only way she could have done the ketogenic diet, which is another option, was through a PEG feed because she required thickened fluids and they contained starch which is contradicted for that diet. For her, our options were very limited. We had tried everything that mainstream medicine could give us.

CHAIR - As far as accessing the product, you said you get it through Mullaways Medical Cannabis. Has that presented challenges and do you have any concern about the reliability of the consistency of the product because it is unregulated?

Ms O'CONNELL - We do not have a concern with the consistency. Their product prior to 2009 was extensively tested and was quite consistent. It has been tested a few times since then through police raids and again it has been fairly consistent and the results are what speak for it. If we were getting inconsistent results I would say the product probably is inconsistent. It would be great to be able to know what is in every batch and that is our biggest thing is that we do not know, and not only with Mullaways. There are so many people out there doing this and you do not know what you are giving your kids so it is an important step for us to at least be able to get lab testing. For us, the biggest challenge is in having to access Mullaways.

We receive it through the mail so you have to preplan when you are going to run out. I have never done it but I know of others who have accidentally broken a bottle and then you have to wait until the next one can come in the mail - you cannot just pop down to the chemist - and that is a big challenge.

CHAIR - When you said that it has been extensively tested, are you talking about the plant that Mullaways use or the product they produce?

Ms O'CONNELL - The tincture was tested a number of times prior to 2009 but after that the labs they were using said they could no longer do it because it contains an illegal substance.

CHAIR - The testing that was done through the police raids, was that done in Australia or is that still overseas?

Ms O'CONNELL - The police results from a very recent one, up on their website from Queensland Police, showed it contained a 0.0038 per cent THC.

CHAIR - Is it is illegal because it is called cannabis, of any strain, as opposed to a commercial product that does not have the effects that the concern about being a prohibited substance has? Is that a fair comment?

Ms O'CONNELL - The truth is no-one can give us a straight answer. Is it legal or is it illegal? The finished product comes under legal limits, but because it is manufactured from cannabis it is that grey area of, it cannot be legal if it is grown from an illegal plant. That is where we need either licensing for people to be able to grow it and therefore make a legal product, or we need some sort of exemption and say okay at least make the product legal so that families can get on with their lives and have this administered.

CHAIR - Would the best way to achieve that be to go through the tried and tested Therapeutic Good Administration, the body that approves medications for any purpose, regardless of whether it is synthetically produced medication or botanical based drug or whatever? Should we go through that path, because that takes time?

Ms O'CONNELL - It does take time and whether a plant as a whole product will ever pass the TGA regulations, I am not sure. Mullaways have an application in with the TGA, but unless they have a licence to grow the plant they cannot complete that process. That is where everything goes around and around in circles. You cannot do this unless you do that, but you cannot do that because of that. We go around and around and get nowhere. I think if it was going through TGA, it should be as a vitamin supplement, herbal supplement kind of category rather than a medication, because it is a plant. It is not synthetic, it is not going to be exact every single time. It is going to be very close, but I do not think they are going to pass the medication regulation through TGA because it is very strict.

CHAIR - I will take you back to the comment you made about the circular nature of this and you said Mullaways have an application in with the TGA, but they cannot complete that because they do not have a licence to grow it?

Ms O'CONNELL - Yes.

CHAIR - The reason they cannot get a licence to grow it, even for research purposes is -

Ms O'CONNELL - What I am told, and I am not Mullaways, so I can only tell you what I have been informed, in order to get a licence to grow it you need to have a doctor supporting the trial, but the doctors who have shown any support are very concerned about losing their licence to be a doctor, and so therefore things go around and around in circles. Yes, you have a few doctors who show interest, but they are too scared to put their name to anything.

CHAIR - This is Victoria, and things might be slightly different in Tasmania, but a doctor of medicine you are talking about, as opposed to a researcher?

Ms O'CONNELL - Yes. There are lots of different things you will be told. Because it is such an area of controversy, something new pops up every time they reapply, whether it be how big a fence is around it, or that they need a doctor supporting it. There is always something new that pops up to say you have not quite met this. It does not move forward.

CHAIR - We had another mum in yesterday talking about a similar situation, slightly different condition, but similar symptoms and for her one of the challenges was not having the opportunity for other people to administer the medication, and you have indicated the same thing.

Ms O'CONNELL - That is our biggest issue. We have had it administered in the past in a government-funded respite. It is administered in a government school, but that is all. Everywhere else, they will not do it, they cannot do, it and we cannot even take our child to hospital. If she is to have a seizure or have something else go wrong and she needs to go to hospital, it cannot be given on the grounds of the hospital. We, as the parents, are forced to make the decision whether our child's situation, right now, is life threatening enough to require going to hospital because we know they cannot given her medication while they are there.

CHAIR - The challenge is if she breaks her leg.

Ms O'CONNELL - It does not matter what it is, as soon as we go on the grounds of the hospital we cannot give it there.

CHAIR - You said they give it to her in a public school.

Ms O'CONNELL - Yes, they do. As you would see from our report our doctors have charted it and have written it on all their records, so as far as our school is concerned they have the authorisation from the doctor to administer it and they cannot go against what the doctor says.

CHAIR - You talked about needing a doctor to support a trial or anything; you have a very compelling letter from her senior clinical neuropsychologist. Is she someone who would be willing to support you through this or not?

Ms O'CONNELL - Honestly, I do not know. We were the first persons that she has ever seen who have used medical cannabis and she was quite shocked. She did not expect Tara to ever improve like she has. Basically her IQ was going down every time we saw her and to now have a number rather than too low to score is just amazing for our child. Also, my understanding is that a neuropsychologist is different to a medical doctor. I do not understand it all fully and I am not sure where she stands on the issue.

CHAIR - It says she has 'Dr' in front of her name but it she may have a PhD, perhaps.

Ms O'CONNELL - Yes.

CHAIR - There are similar challenges here in Tasmania, that having the support of someone to conduct this sort of trial and research is necessary, by the sound of it.

Ms O'CONNELL - Yes. I am all for trials but I want to make it very clear that the pharmaceutical ones like Sativex that are already available are not suitable for kids with epilepsy and not suitable for children in general. The manufacturer says 16 is an absolute minimum. We need something for kids. Kids are dying so we do need something to happen fairly soon. That is why so many parents across this country have made the decision to do it without regulation because really we have no choice. It is that or watch our children die.

CHAIR - You have been fairly public in this then. Have the police taken any interest in your activities?

Ms O'CONNELL - No, not at all. I have spoken at forums where police have been present. In my workplace I regularly deal with DHS and they are all aware of our use of medical cannabis and we have not had any problems at all. At one time I had a complaint put in to police relating back to my workplace, someone trying to have a go at me because I had reported them for their abuse of their children, and the police rang me up to clarify some issues and I said, 'Look, they probably have an issue because of us using medical cannabis'. We made it quite clear to him and he said he did not have any problem with that and closed the case. That is the only time we have ever had any contact with police in regard to it but it turned out that it was not an issue relating to that anyway. It was relating to someone who was not happy with something within my workplace.

CHAIR - One of the issues around that is, I assume there is a law in Victoria that says it is illegal to give this product or possess it, so the police are choosing to ignore a part of the law. Doesn't that undermine the rest of it?

Ms O'CONNELL - I think the big thing with us is that we have the doctors putting it on charts so we have doctor support. Even if the police did take it today and test it, it would come back as being less than schedule 9 requirements. Even the police then do not know what to do with it because what is it? Can you anymore call it cannabis if the THC is that low? They do not even know where to class it.

CHAIR - As I understand it, currently all cannabis products regardless of their levels of various components, of which there are many, are schedule 9.

Ms O'CONNELL - No, there is an exemption. If you read the federal law on schedule 9, anything under 0.1 per cent THC is exempt from that schedule. What we are using is dramatically below that level.

CHAIR - The Sativex that is used for MS has been approved and there are a couple of others that have been, but they are not suitable for children and other conditions.

Ms O'CONNELL - Yes.

CHAIR - There is a framework that has recognised those. I think it took a while as well. I wonder whether there is a way to fast-track this approach, which is what I am hearing you say, that families are desperate.

Ms O'CONNELL - Every day I open up my Facebook account and read of another child who has died and that is something that we shouldn't have to be doing. Many of them are waiting to be able to access medical cannabis and those parents have been left with the 'what if'. What if I jumped ahead and tried it? That is not something that they should have to live with. We are lucky, we have our supply and I went public, not for us but for every other family out there who needs access.

But there are people who are dying because people are sitting on their hands and can't make any decisions. Yes, things take time and I understand that, but these kids don't have much time so it needs to be done in as fast a way as possible, obviously within regulations.

CHAIR - We know the medical professions rightly expressed concern about being sure that a drug has the benefits it is claimed to have and there are limited long-term adverse outcomes - all drugs can have adverse outcomes, some of them we know, some you are willing to take. With things like chemotherapy, you know it is going to make you crook but the idea is you don't die, that is the trade-off.

But the problem with doing some research in this area is that it is difficult to do research on an illegal product. To the medical profession who rightly voiced concerns about having proper safety and quality in health care broadly and particularly in the delivery of medications, what do you say to those people who say we need to go through this long and rigorous process when there are children like your own and others out there who are potentially at risk of dying if they don't get a treatment that seems to work?

Ms O'CONNELL - That is basically it. We know the side effects of many of the pharmaceuticals. Tara had things like a heart murmur caused by medication. She had swallowing problems caused by medication, she had mobility problems.

Is it okay to say that we had better use the pharmaceuticals because we know the side effects of those? To me, dying a slow death because of medications is no different to just letting them die.

We know that, for some, medical cannabis is going to work and we know that it doesn't cause death. Frankly, the side effect of not giving this to many of these children is death.

In situations where there is no time to go through all those trials, there should be a clause or something so that we can have compassionate grounds to allow that to be used whilst trials are ongoing for long-term use for those that aren't quite as urgent.

CHAIR - Have you approached your Victorian Minister for Health and any other relevant ministers or government officials to try to get this compassionate exemption?

Ms O'CONNELL - I have been working very closely with Daniel Andrews from the Opposition here in Victoria. I am yet to get a meeting with our Health minister. I have written to him numerous times and requested meetings and have telephoned his office a number of times but I haven't had a response at this point to be able to meet with him.

I have met with numerous MPs et cetera. We are doing everything we can with the fact that we have been public to try to move it forward but it is a slow process.

Mrs HISCUTT - It is an amazing story.

Ms O'CONNELL - The main thing is: don't let these kids die. Give us a chance. I don't think our kids' lives should be any less important than anyone else's children. As a parent, everyone will do whatever they can to save their kids and we are no different. We are just trying to be parents to the best ability and unfortunately the law is not allowing us to save our own kids.

CHAIR - Yes, a tough story. Thanks for sharing it, Cherie, and we wish you all the best.

Ms O'CONNELL - Thank you very much for your time.

THE WITNESS WITHDREW.

PUBLIC

Mr KEN WALLACE DORSEY, MEDCANN TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Welcome, Ken. The proceedings are being recorded by *Hansard* and they will form part of the public record, so everything you say is recorded. The media are here as well. What you say here is protected by parliamentary privilege but if you speak outside to the media afterwards, it is not. If there is any evidence you want to provide of a confidential nature in camera, you can make that request and the committee can consider it, otherwise it is all public. Do you have any questions?

Mr DORSEY - This is an opportunistic one. I believe in it but it is also opportunistic in that if someone has a terminal illness why would anyone want to stop them from doing something that gives them relief? That is illogical to me. The girl we just heard - why would anyone want to stop them and why would there be a law to prevent that? That is illogical to me, so I believe that way. Do I believe that cannabis is a cure-all to everything? God, no, but it helps some people, and why would anyone want to stop it helping someone?

I think we have to look at the reality of the facts. According to the National Household Drug Survey, 35.4 per cent of the Australian population reported using cannabis some time in their life. I suggest that most people would know someone, or has been at a party, where cannabis has been used. We get about 80 per cent on that. So if you want to know someone that has used cannabis at some time so that we can make this 100 per cent, I did for about 15 years, and it hasn't slowed my progress in life. I have been to three universities - this is the third country I have lived in. I have three companies; I have just bought a building in Burnie and I have five houses and a farm. So, has it affected my life? Not dramatically.

With 10.3 per cent of the population using it in the last 12 months, more than 700 000 used cannabis in the previous week; 46.9 per cent of 20 to 29-year-olds reported ever using the drug. The restrictions for growing plants for personal use has been decriminalised in the Australian Capital Territory, South Australia and the Northern Territory. Deaths attributed to the use of cannabis are extremely rare and generally involve a pre-condition. So it is not going to kill you.

I keep hearing about the security factor here. You can grow cannabis indoors; you can lock it up. I can drive down the Bass Highway and pick poppies. It is not hard; I just have to get across a barbed-wire fence. Three thousand poppies were stolen last year. A person died from poppies. This is according to the ABC report. You are not going to overdose if you steal someone's crop. It is not going to kill you.

The crop value in the US: in 42 of 50 states, it is the top selling crop in their states. It is greater than the value of corn, wheat and artichokes put together. I don't know why they threw artichokes in but I guess they made up the number. Corn to the US economy is $23.3 billion; wheat, $7.5 billion; and artichokes, $53.7 million. The illegal selling of cannabis is greater than all of those.

You were talking to these guys a minute ago about, 'Are they horticulturists?'. I am guessing but probably 20 per cent of people on unemployment are growing something.

So it doesn't take a horticulturist. It is about putting a seed in the ground and watering it. There are differences between male and female plants and it takes a bit of knowledge. The seeds are of great value; the hemp isn't worth anything much. It is worth something but as far as the Canadian industry shows, the seeds are worth a lot of money. Seeds are easily and readily available; seeds are in a lot of the products we buy. My wife has to have an oil skin thing. I can go to the Purple House in Forth and buy hemp oil seed things.

For the medicinal part, it is ridiculous that it is not legal. It makes no logical sense that we would stop someone with a terminal illness from finding some relief. I don't know in what world you guys live if you think that is logical, because it is not going to kill them. What harm is it going to do to them? If they find relief in it and it gives them some pain relief and some joy at the end of their life, then please. Otherwise what do they do? We shoot them up with morphine, because that is the only other relief. Or you overdose on Panadol Fortes.

If we get back to opiates, three people die a day from prescription opiates. If you want to turn it over to doctors, 16 000 died in the last year from prescription opiates. Some 440 000 went to emergency rooms of hospitals in the US on prescription opiates.

Decriminalising it would be the easiest thing to do. People are going to self-medicate; they are already self-medicating. It is probably the largest cash crop in Tasmania too, maybe behind poppies, I am not real sure - because there is no way to quantify it because there are only so many people who are going to admit to it. It is readily available in every country in the world. Romania is one of the largest growers of cannabis in the world - it is illegal. It is readily available anywhere in the world.

I admit to smoking cannabis when I was younger. I was here in the 1970s and it was readily available in Smithton and Burnie. 'You've got longer hair, do you want some?'. 'Yes'. That was pretty basic. It is still the same. My sons picked up a hitchhiker not so long ago and he asked them if they wanted a smoke. 'Where did you get that?'. They bought it in Deloraine. I think we are hiding from the facts that it is readily available. People are self-medicating now. The only thing that is in the way is the government in a lot of ways.

The trials - a waste of time. They have been done all over the world. We can make ourselves feel better and we can do these trials and say that we have done them and we have taken all precaution to make sure that no-one is injured, but the bottom line is that the trials have already been done. You just heard the witness on the phone - I went to the medical marihuana march; everyone talked about the trials they were doing. It is already happening. The only thing that is not happening is the legalisation or decriminalisation even for medicinal purposes.

I said this is an opportunistic one. I have land, I have friends with land; we have sheds - I am not growing anything in the sheds now, but it is not hard to do this.

Mr MULDER - The guys at the back with hydroponics can help you.

Mr DORSEY - Yes, the guys with the hydroponics. I know they are selling them and no-one grows them hydroponically - everyone is growing lettuce and tomatoes. If you think about what people are saying it is really comical. 'Oh yes, we're selling hydroponic systems all over Tasmania. They go into people's roofs to grow lettuce.' It is not that I take this flippantly but you think about this seriously and you step back for a minute and take off your parliamentary hat and say, 'Really, what is happening in society right now?'. It is happening, without you.

Why I say that this is opportunistic is that I think I can make a lot of money and I think Tasmania can make a lot of money. I think this is probably our next cash crop that can turn this state around. I travel the state all the time. I was in Launceston yesterday - depressing. Rosebery might be the most depressing place on the planet right now; even the newsagent is closed. Burnie - another shop bit the dust this week. Devonport is hurting. We don't have any industries, we don't have any new ideas. We keep thinking that if we cut down more trees and dig more holes we are going to make more money. We have to diversify what we are doing - this is just my opinion - and go into new markets. Colorado expects to pick up $20 million in tax this year. It is a billion-dollar industry. Washington, in the first month, has picked up a million dollars in tax. This makes sense.

Mr MULDER - Is this medical marihuana you are talking about, or recreational marijuana, because you are talking about both, it seems.

Mr DORSEY - There is a line there. Medical marijuana in Colorado was making a lot of money, but for recreational purposes people have gone away from it because it is cheaper to buy it on the street than to buy it legally. It is confusing. If you want to just do it for medical purposes, that makes sense. There is no reason not to; it is illogical.

CHAIR - People use it for recreational use for the THC.

Mr DORSEY -Yes.

CHAIR - Most of the evidence we have had is that the majority of people use it for medicinal purposes, depending on what the condition is that they are seeking to treat. It is because of the CBD and low THC often. So it is not just about having a plant grow; it is about having a specific plant grow. With the complexity on recreational use, you are not talking about the same product.

Mr DORSEY - That's easy. We are complicating a simple subject. The guys from hydroponics told you, 'You get the seeds, the seeds are readily available. You can just grow it as hemp, as cannabis with low CBD and THC, or you can grow it with high THC. That is not difficult. It is readily available. We are going over old ground that has been done. Twenty-three states in the US now have it legal for medicinal purposes. California has become a bit of a joke because you tell them you are not feeling very well and they give you a prescription.

CHAIR - But the prescription has a low THC level. They are not going to get the high they expected if they want it for recreational use.

Mr DORSEY - No, that's true.

CHAIR - Surely regulation around it is important to provide consistency of product, particularly if you want to treat somebody.

Mr DORSEY - That is for medicinal purposes; I agree with you.

CHAIR - We are not talking about recreational use here.

Mr DORSEY - You have a plant and with a plant you get variables. There are always variables and the crops are going to be different. If you grow wheat it is different every year. I grow tomatoes. One year I get a great crop, the next year I don't. This year, the same plants - great taste, bad taste. So with a plant you are going to get variances, and that's a known. With something synthetic it is going to be exactly the same.

CHAIR - Focusing on medicinal cannabis, which is what the terms of reference of this inquiry are about, it is going to be meaningful for the people who are seeking to use it - particularly for young children, as we heard - because they do need a consistent product otherwise they don't get consistent results. But it does work for them. Don't we need to focus on a properly regulated process so that people do get consistency of product? The last thing you want is a parent giving a child a drug that they think is going to help them and it doesn't, when the last lot they got did, and suddenly there is a situation where the child is having seizures again.

Mr DORSEY - The current legislation does not allow you to give them anything.

CHAIR - That's true, but we are talking about the way forward here.

Mr DORSEY - In two years when you go through the processes and have the trials and do everything that you are going to do, there might be consistency of product. How many children might die during that period? It's a tricky one and I don't envy you because it is a tricky decision.

CHAIR - I don't think we should cloud the issue of the medicinal cannabis with the recreational use, the same as clouding it with the industrial hemp argument as well. The general public are often only as informed as the newspapers, and the media, so it is important that we, as leaders in our community, speak about these issues in a way that clarifies matters for people. Once we start mixing it all in together and suggesting that people just grow it, doesn't it confuse the whole issue?

Mr DORSEY - No. I understand what you are saying about consistency; that is a very important thing. But regarding clouding the issue, people are self-medicating without the consistency and they are going to continue to do so regardless of what you do.

CHAIR - Hence the need to focus on a consistent approach.

Mr DORSEY - It is nice to deal with what you would like everything to be but it is easier to deal with what is.

Mr MULDER - Aren't you arguing that we don't need companies like yours, people are growing it anyway and then they can smoke it, use it or produce it as they see fit?

Mr DORSEY - Well, that's a tricky one because they already are.

Mr MULDER - You see nothing wrong with that.

Mr DORSEY - I see it much larger than this. This isn't about Tasmania; this is export markets. This is growing it in a perfect environment so that we can export a product and that we have a product to sell outside Tasmania, as well as in Tasmania. With that you need the regulations and the consistency.

Mr MULDER - Picking up on that point, what is so unique about the Tasmanian environment if we are going to grow it hydroponically?

Mr DORSEY - That's if you're going to grow it hydroponically, exactly - nothing. Are you going to grow it all hydroponically? That is very costly.

Mr MULDER - How do you propose to grow it?

Mr DORSEY - In hot houses, and you can grow it naturally.

Mr MULDER - Are you going to grow it yourself or are you just going to source it from all the cottage growers?

Mr DORSEY - I do not know any cottage growers.

Mr MULDER - Your supplier, for example?

Mr DORSEY - No, I haven't smoked since I've had children and I have never been drunk with my children. I can't say that I have never drank wine around them, but that is two things I just don't agree with. Since I've had children I stopped. That is a personal choice.

Mr MULDER - I think what the chair is trying to say to you is this is the committee about the medical use of cannabis, so please try not to confuse it by heading down the path of industrial or recreational or whatever other use you might think is wonderful.

Mr DORSEY - I have a tendency to jump around in my life.

Mr MULDER - We are talking about the use of medicinal cannabis to deal with people for whom traditional medicine is inappropriate and we would really like to get the perspectives of your experience and your company's expertise in relation to medicinal cannabis.

Mr DORSEY - This is an opportunistic submission. I think that there is no great trick to growing cannabis, medicinal or otherwise.

Mr MULDER - By medicinal we mean with known concentrations of CBD and THC as required.

Mr DORSEY - Yes; all you have to do is access the seeds. The guys from the hydroponics told you how to do that. That is easy. That has already been done. It is a trip to Colorado for a week and working with the people there. You do not need specialist training, and then someone else would process it. It is just a supply.

CHAIR - Has your company put any submissions in to undertake any growing trials or anything like that?

Mr DORSEY - No. Once you guys started looking at it, I thought this is something that we can do very easily. This is a way for Tasmania to make a lot of money and something that I personally believe in.

CHAIR - How long has your company been in existence? In business?

Mr DORSEY - A month.

CHAIR - This is only a new thing.

Mr DORSEY - Yes, like I said, it is opportunistic. The research is there. I have two other companies and I have about 25 employees. This isn't hard. I think we are trying to complicate something that is very simple.

CHAIR - Thanks, Ken.

Mr DORSEY - Thank you for listening to people.

THE WITNESS WITHDREW.

PUBLIC

Mr KEITH JAMES RICE, CHIEF EXECUTIVE OFFICER, AND **Mr GLYNN FRANCIS MARK WILLIAMS**, PRESIDENT, POPPY GROWERS ASSOCIATION, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thank you. I am sure you are aware that the proceedings are recorded by *Hansard* and form part of the public record. There is also media here as it is a public hearing. I note in your submission that there was some aspects you might want to discuss in camera. You can make a submission to the committee and the committee will consider that request, otherwise it is all public. You are protected by parliamentary privilege while you are before the committee, but should you speak to the media afterwards then what you say to them is not.

Mr WILLIAMS - Poppy Growers Tasmania thanks the Legislative Council for this opportunity to put forward its concerns about the notion of medicinal cannabis and cannabis more broadly in Tasmania.

Poppy Growers enthusiastically supports a very cautious, considered, measured assessment of cannabis as a drug and, indeed, cannabis as a crop. In our summary we express the very clear concern that the approach to cannabis, which is not measured and which is not fully cautious of all of the risks, may affect the reputation of Tasmania as a secure, ordered and reliable licit drug-producing region, which may have untold adverse consequences on the interests of Tasmanian farmers and of Tasmania more broadly.

Tasmania enjoys world leadership in the production of a novel drug crop. The security of cannabis as another and distinct narcotic drug crop with its ready-made opportunities for diversion into the black market and street market for illegal drugs contrasts very markedly with negligible levels of diversion with poppies. Whilst it is true that there have been, and may be in the future, opportunistic grabs of poppy heads, we do not have a black market for opiates in Tasmania. That is something to be enormously proud of.

There are public health concerns about the reputation of drug crops as a risk to health, and public health concerns about the perceptions of risk about cannabis. There is information that we have put in our submission which highlights studies taken in other western countries that indicate that the increased prominence and publicity to cannabis, particularly medicinal cannabis, deflates risk perceptions and broadens the market potential for people to take up cannabis, because it is a medicine so it won't hurt you. Yet there are many statistical examples of how it is a gateway drug, for instance, that will lead to many social and health problems.

We say that there are many unknown market implications with the perception of cannabis growing in Tasmania, not only at a national level but also at an international level. In our submission we have highlighted the attention given to cannabis, medicinal and recreational cannabis, in other jurisdictions, particularly with recent prominence, like Colorado and Washington states in the US, and Canada.

The growing of drug use in any society is of particular concern to the United Nations. We take the view that given the focus of the International Narcotics Control Board on Tasmania with its best-in-world track record for opiates, if there was a botched, flimsy

and open-ended flirtation with medicinal cannabis then that could attract rebuke or worse.

In summary, we support the Government's cautious and careful analysis of all of the facts surrounding the growing of cannabis, an illicit drug, for medicinal purposes in Tasmania.

CHAIR - Glynn, what you have made a case for is that it is important that, in view of the public interest in this, not just in Tasmania but in Australia and around the world, that we actually progress with a regulated process here to avoid some of the risks that you have identified. What we have heard from other countries, and in particular from Canada, is that to grow a crop there and process it is like getting into almost the most secure place on earth. Every plant is monitored so if it was moved an alarm went off and things like that, much more so than the poppy industry. I know it is still difficult to get into GlaxoSmithKline; you cannot just walk into the processing plant there either. There are similarities. What is happening in Canada seems at least of the level of what is required in a poppy processing plant, and I would argue that it is more rigid.

Mr WILLIAMS - Cannabis is not legal in Canada; it is just not illegal. There is a particular legal argument that I appreciate where someone said, 'I have a particular illness'. Whether it was palliative or chronic pain, I don't know, and he won the right, if you like, the constitutional recognition to have that as his treatment. If you look at what Health Canada is trying to do to clean that up then you see that cannabis has so many side effects it has not been approved as a legal drug. The real question for any proponent for cannabis as a medicinal product, whether it is a trial or commercially, is what are you going to do to establish this as a stable dose, a regular dose, and who is going to test it on women, on men and people of different ages. If it has not been done satisfactorily in Canada, which has been playing with this for 10 or 15 years, to get it accepted as a drug, then with the greatest of respect to any proponent in Tasmania, I struggle to see what they are going to do to get those trials up and working.

What is their backing? What is their financial backing? What is the long-term investment plan? What is the clinical trial being proposed? In all of the debate so far it has been extremely frustrating to see that none of those answers have been given, yet there has been the absolutely false impression given to the public that this is going to be a boon crop to Tasmanian farmers, because nothing could be further from the truth.

Even if this was accepted as something that could be sold and prescribed by a pharmacist in years to come, the market in Tasmania is so small that if you grew this stuff it would be smaller than Canada, which has a bigger population than us, and in Canada it is basically grown in one big shed. It is never going to be a broadacre crop. If it went beyond that the opportunities for diversion are horrendous. We support industrial hemp, but you know it is the same plant. Industrial hemp, if it is to be successfully grown in Tasmania, and I hope it will be, needs to be grown under safeguard so that farmers or others aren't tempted to divert it. I believe you have heard evidence today where people have confused the issue of medicinal and recreational. What is the real market? Is it recreational? That is something that has to be absolutely controlled and prevented. There are so many things that have not been put out there -

CHAIR - This is the process we are looking at, Glynn. In the terms of reference we were very clear. I have had to say a number of times in a number of forums and perhaps other members of the committee have, too, that this is not about industrial hemp, not about recreational use; it is about medicinal cannabis. There is a body of evidence that shows beneficial effects and it also shows more research is needed. That is predominantly the same with just about any drug and to say it has to be complication-free or side-effect free is a complete nonsense, wouldn't you agree? Opiates have side effects.

Mr WILLIAMS - How many medical insurers have been involved today that are saying, yes, we would back someone who would prescribe a drug that will increase the risk of schizophrenia multiple times if you are a certain age.

CHAIR - I think you need to be careful here. Have you got the background of evidence to say that? We have had a psychiatrist sit across the table from us -

Mr WILLIAMS - Yes. There was something in the *Lancet* the other day about these things. These things are out there. The question I have, which is a rhetorical one in a sense, has not been answered by the proponents for this cause. I understand you are looking at the regulatory structure, but how credible was the proposal in the first place?

CHAIR - We are not looking at a particular proposal, Glynn. You are confusing the issue here. We are not looking at a proponent's proposal; that is not the purpose of this committee. That is a matter for the government. This committee is looking at what are the barriers to administering it -

Mr WILLIAMS - I do fully appreciate what you are saying.

CHAIR - Let's not focus on a proponent. It is nothing to do with a proponent.

Mr WILLIAMS - One of the barriers is what is actually being put forward. You have to start somewhere and that is a very practical barrier.

Mr MULDER - We are not looking at a proposal. One of the problems we have is no-one has put forward a proper proposal, so how could we be conducting an enquiry in to a non-existent proposal? Neither are we conducting an enquiry into some airy-fairy idea about things. We are looking at the specific barriers to the medicinal use of cannabis. You have raised some of them, but not from your area of expertise, more from the area of expertise of the medical fraternity. You are free to have an opinion on that. What we are particularly keen to hear from you in terms of your experience with growing a licit narcotic is what are the barriers to having the same thing done with cannabis. Sure, some of the medical reports are relevant to that. The issues I would like to hear about are some of the statements in your submission, which talk about the risks associated with medical cannabis that would have untold adverse consequences. We would like to get to those. Chasing down a non-existent proposal and criticising it does not seem to me to be very productive of the work of this committee or for your time.

Mr WILLIAMS - Okay, I appreciate where you are coming from. What I need to advertise is that for Tasmania's farmers the linkage to the pharmaceutical company, the processor, is absolute. We do not grow poppies without linkage to an established pharmacological

pipeline. Without that pharmacological pipeline it does not exist in Tasmania. Farmers need the pharmaceutical company, the processor, to be involved in the crop at all. Without that it is in a sense a hypothetical scenario.

Mr MULDER - We have heard from the medical experts that one of the reasons we have not done any trials on this, one of the reasons we have not had that pharmacological pipeline behind it, is because the drug companies cannot see any money in it and therefore are not investing in the research that you are now criticising is missing. Part of the problem is the pharmacological pipeline.

CHAIR - Or lack thereof.

Mr MULDER - No-one is interested in establishing the pharmacological pipeline because there is not megabucks in it, like there is in poppies.

Mr WILLIAMS - Maybe it is not because of bucks but because there are too many other practical concerns and barriers. I know there are pharmaceutical companies in the US which have devoted a lot of research to high-end analgesics, opiate analgesics, who have invested in synthetic cannabinoids and other derivatives which might be found in the plant. I think it is a real interest in pharmacy, but if it is not working or has problems they are not going to go there.

Mr MULDER - Isn't it also a fact that the pharmacological work has actually resulted in the United States cutting back on some of its opiate importations?

Mr WILLIAMS - They are changing the scheduling because people have been abusing it. It is a well known fact now that there a more people dying from abuse of prescription drugs than in gun crime or motor vehicle accidents.

Mr MULDER - Or marijuana use.

Mr WILLIAMS - Yes. I do not know about ice and mixing it with alcohol and all the other things, but it is a factor and that is having a very direct market impact on Tasmanian farmers this year and in years to come.

Mr RICE - From the poppy grower's point of view all of the product that we produce that is the base material for plant management goes to registered pharmaceutical companies across the world. It is all accredited before it can come out of those companies for personal use as a medication. That is governed by, as this committee would well know, the United Nations Commission on Narcotic Drugs. When you go through the single convention on narcotic drugs, opiate raw material, cocaine, cannabis are all within the schedule. Our concern is that any entry into the cannabis market should be in conformity with the UN convention so it does not in any way jeopardise the poppy industry in that regard. That is really our principle concern - any security arrangements - and Australia is a signatory to that convention. Tasmania has always been, as the grower of this particular crop, held up as a world example of security arrangements, of adhering to the convention. We would request from this committee, or in your deliberations, that you consider there is going to be a form of recognition of medicinal cannabis for prescription to patients, those who require it. In my opinion there are some absolute tragic - perhaps

not the right word - emotional cases out there where there is evidence that it does ease their pain. We recognise that within our submission. We would argue that it should be delivered through a normal registered medical practitioner, and the substances and the scientific evaluation is through the Therapeutic Goods Association as it works its way down. So it has all those accreditations where a medical practitioner would feel, if the circumstances warranted it, they could prescribe that medication, and a registered chemist would be able to dispense that medication.

Mr MULDER - On page 10 of your submission you talk about poppy growers' hard-won reputation with international praise for its security.

Mr RICE - Yes.

Mr MULDER - What is that security that attracts such high international praise?

Mr WILLIAMS - That security manifests in many ways. In a governmental sense you would appreciate that it manifests itself through the Poppy Advisory and Control Board, which, given the unique situation of the farming community in Tasmania, has very close connections with the farmer group. It translates through into very close connections, sometimes love, sometimes hate, but generally extreme cooperation with the licensed processors who have the privilege to grow the drug and export it out of Tasmania and out of the country.

Mr MULDER - What particular security arrangements are attracting such high -

Mr WILLIAMS - The proof is in the pudding. I want to underscore the point that we do not have a history of diversion of crop. Interferences with the crop, despite a few opportunistic grabs which have had fatal consequences, is down and down and down. We really do have the runs on the board.

Mr RICE - I understand your question to compare us to other countries throughout the world that grow a legal poppy crop. It is recognised through our licensing system and through our accreditation of growers. I acknowledge that you can drive up the Midlands and get over the fence and take some if you have a will to do so. Given the regulatory regime that is in place with poppies, that is what is recognised at the UN.

Mr MULDER - You go on to say that Tasmania cannot afford to compromise its reputation. If we put in the same internationally renowned security measures around the marijuana crop, then we are in a unique position to take advantage of that reputation that you have built by applying it to medicinal cannabis.

Mr WILLIAMS - With the greatest respect you have overshot the point. Whilst I have talked about things that are not necessarily to do with farming, they are extremely relevant when you look at where the international treaty sits. If I take you back to page 3, and the extract from the foreword to the report from INCB President, Raymond Yans:

> INCB is concerned about some initiatives aimed at the legalisation of the non-medicinal and non-scientific use of cannabis.

I am going to stop there because it is really important to me as a Tasmanian poppy farmer as to what definition of 'medicinal' and 'scientific' you come up with. If you come up with a definition that is an open door, then we are absolutely open to attack and deservedly so. As he goes on to say:

> Such initiatives if pursued will pose a grave danger to public health and wellbeing, the very thing the states in designing the convention intended to protect.

If you go back to the opiate problem in the US, there are class actions underway against a big pharma chasing big dollars because of the embrace of the treatment of chronic pain, which is different to someone facing palliation, a terminal illness. Because it has headed into chronic pain and has been so used it has run into problems.

If you want to have a definition for medicinal use, which is someone facing palliation because the two oncologists have said they are not going to live, that is very different from someone saying, 'I have chronic lower back pain', or 'I have a soft tissue injury.' You have to look at this level of detail to link back to the security and the reputation of our poppy industry.

Mr MULDER - Just in terms of that security, there is a chain. You talk about this single convention which also has identical arrangements that states must put in identical arrangements for the health, welfare, and the use of property, as they are for poppies. The pharmacological train that you talk about is a point, but opiates are in trouble even though they have such a lovely chain - the misuse of opiates. Then you talk about the security, and you made a statement that poppies by themselves are not as easy to use as a recreational drug.

Mr WILLIAMS - They are not.

Mr RICE - Not straight out of the paddock.

Mr MULDER - A fairly slow cook and you will get yourself a nice cup of tea.

Mr RICE - A pretty high chance of death is a pretty good deterrent. If you were using the poppy plant in other traditional ways -

Mr MULDER - More of a deterrent than a notice on the fence.

Mr WILLIAMS - We do not have an opium industry in Tasmania for very deliberate reasons, because opium is transportable in many other ways and easier to deal with.

Mr MULDER - Now draw a parallel for the use of cannabis. For starters, I doubt whether there would be invasions of greenhouses and things like that since it is so readily available in the community anyway. Secondly, even if someone did jump into it and dried it, as you put in your submission, a couple of leaves, dry smoke and inhale, that is not likely to have the same consequences as if you jumped over a fence and got some poppy heads, boiled them down and misused them.

Mr WILLIAMS - For the immediate user it is not likely to have the same consequence. What is it going to do otherwise? Is it a good thing to have 17-year olds jumping fences to get poppies? No. Is it a good thing for more and more 17-year olds to be chasing another crop which has other social effects. I would argue no. We might come from different positions on that, but we treat this with the greatest of respect. The submission is that there are real concerns here. They are big concerns and people are looking at us all the time. The INCB looks at Tasmania every year - probably at the moment every day - so it is something that we want to make sure is best practice. Again, it gets back to the point that whatever is decided in Tasmania, or Australia - because constitutionally it is more a federal issue - it has extreme relevance for us growing a particular crop.

Mr RICE - If all of those security arrangements that are currently in place for the poppy industry were put in place for medicinal cannabis and had the rigour behind that, and it was in accord with the single convention on narcotic drugs, and I would imagine that would govern your thoughts in that regard, then from the poppy industry's point of view the security arrangements would be a matter for government. We would have some say over that but our concern that we are seeking to raise with this committee is that those issues are addressed in respect of the convention. That is why we are supporting the Government's very considered and cautious approach to this particular item. We note what is reported to be the Premier's statement yesterday that he considers it could be a national matter and could be discussed at COAG. Australia is a signatory to the single convention in this regard. If it was conforming with those conventions, I cannot see why this committee would seek to do otherwise.

Mr MULDER - That is the point, though. Article 28, the control of cannabis, has the same cultivation controls as those that relate in article 23 to the cultivation of the opium.

Mr RICE - That is what we want to bring to the attention of this committee from where we are coming from.

Mr MULDER - That is where our reputation is well deserved.

Mr RICE - Yes, that is where our reputation sits, quite rightly.

Mr MULDER - It actually provides us with a competitive advantage in the medical game.

Mr RICE - In my view, it does.

Mrs HISCUTT - I was going to ask about the single convention also.

CHAIR - You have been gazumped again.

Mrs HISCUTT - That is all right. I do not know if you want to add anything more to that. I really thought the convention would have aided this happening and yet you seem to be using it as a barrier.

Mr RICE - Most definitely not. No, and quite to the contrary. You are quite right in saying that it aids the argument. When we were coming before this committee, we knew what the terms of reference were that you were seeking to address. We wanted to bring well to

the fore the reputation of the poppy industry and its adherence to the convention of which cannabis sits in the same schedule. The same would be applied on any recommendation coming out of this committee. They are the same conditions that apply to the poppy industry. They have entered a convention and the Commonwealth is happy in that regard. That is what we were wanting to bring to you as our input into this inquiry. If that is to happen, then there can't be any repercussion back on the poppy industry because we are in accord with the convention.

Mrs HISCUTT - As you said, Glynn, this is medical cannabis and the trial is not going to be broadacre, as a lot of people seem to think. There are not going to be millions of dollars coming in at this stage. Regarding the convention and security in terms of the medical cannabis trials and the growing thereof, do you see any problems with security?

Mr WILLIAMS - It has to be fully secure. What underpins the convention is the use of drugs for beneficial purposes, not recreational ones. So if there are security gaps and if drugs are being diverted into recreational use, then that is what all the countries or signatories have said is a bad thing. You cannot escape the definition of what is a medicinal purpose.

Mr RICE - To come back to your question - no. It would be up to the parties and the government of the day to determine what are suitable security arrangements that adhere to and bring it in accord with the convention, so there is no any diversion into the illicit market.

CHAIR - Do you have concerns that the Government might move in that direction? We can make recommendations and findings in this committee but we cannot implement policy. What I am hearing from you, and what I am reading here, is that you are concerned the Government in its wisdom might put in place a regulatory framework that threatens and does not abide by the international obligations.

Mr RICE - We are asking that you acknowledge that when make a recommendation to Government - that that sits up there and everything must be in accord with it. We are concerned with what the Government might do if it was to ignore the convention. We are bringing the convention and the position of poppies to your attention so you can address that within your -

Mrs HISCUTT - Would you appreciate being informed as to the security arrangements? Did you comment thereon?

Mr RICE - Most definitely. We seek to be engaged in -

Mr MULDER - And that comes to the point. You have lots of experience and a hard-won reputation. Why would you be recommending any different from the level of security involved that you have for the poppy industry?

Mr RICE - Certainly, we would not be recommending anything whatsoever and, depending on the crop and the circumstances, they may be different security arrangements. It is not to point the finger at anybody. It seems like we are teaching them how to suck eggs but we need to put that on the record so the committee is well aware of our concerns.

CHAIR - Can I clarify this? Your comment here in your submission says, 'In reference to the single convention, Tasmania by embarking on a cannabis pathway could place its poppy farmers and narcotic processors in a very embarrassing position and one that could lead to rebuke or worse'. That would only be the case if the single convention was ignored?

Mr RICE - Precisely.

Mr WILLIAMS - Yes, and the single convention in all its aspects. I get back to the fact that you have to look at what is medicinal, what is scientific and what security measures will be in place to prevent diversion to other things. If you have an open-ended definition of what is medicinal, then everyone could be using it. If you have a targeted, truly clinically-researched proposition of what is medicinal, that is a different ball game and that is what we would be expecting.

CHAIR - It could require, for example, a registered medical practitioner to prescribe a product that is dispensed through a pharmacy.

Mr RICE - Precisely.

Mr MULDER - Some jurisdictions have a list of medical conditions for which either the CBD or the THC concentrate is effective. The capacity is there. The frameworks are there. We have to be careful that we are not saying they do not exist, and therefore we cannot do this.

MR WILLIAMS - It is about what is medicinal, not scientific. If you get mission creep, and broadening - this a starter and next we will get wider legalisation. That is a big problem.

Ms FORREST - The slippery slope argument doesn't always apply.

Mr MULDER - So, you recommend this committee gets its head around the issue and picks up a model of medicinal use compared to recreational use. We have taken that on board.

Mr RICE - In regard to the commission, no doubt you have a copy of that report. I have the necessary quote for you in paragraph 374. I will not bore you with what is happening in the US

CHAIR - Can you say the name of that report for *Hansard*?

Mr RICE - It is the International Narcotics Control Board Report 2013. I am referring to paragraph 374. I will not read it all out, but it speaks about the United States and what is happening with various states. The paragraph I would like to read into transcript is -

> The Board reminds all governments in jurisdictions having established 'medical cannabis programs' or considering to do so, that the single convention on narcotic drugs of 1961 sets out the specific requirements for the establishment, administration and monitoring of such programs and notes that many existing programs are not in line with the provisions of the treaty.

That is all we are asking.

Mrs HISCUTT - Would you be able to give professional opinions to help with that?

Mr RICE - Yes.

CHAIR - To put in place all the necessary regulations?

Mr GAFFNEY - Tasmania has a good reputation with the poppies and it is mainly because of the regulatory framework. When we talk about 17-year old users jumping over fences, we have to be aware that most recreational cannabis use in the state is not just by 17- and 18-year olds. It is right across the board. Most 17-year olds are too lazy to jump over a fence anyway.

I have spoken to quite a few farmers who are poppy growers and a lot of them have no issue with what is being suggested. They think it is heading in the right direction. How do come to a consensus within your organisation about what direction your papers will go? I am finding it very interesting because I am getting mixed messages from other people I know within the poppy industry about the relationship that should exist.

On one hand, I imagine what we are trying to do here is trial something in a locked shed - very well secured, very appropriately regulated, and very strictly controlled. I can imagine a film crew from somewhere coming over and saying, 'This is how strictly they are running the cannabis trial in Tasmania, and over here to the left you have a field of poppies where last year 2 000 heads were taken'. It is a bit of a conundrum. On one hand, you guys are worried about the regulatory framework or the management of this trial. On the other hand, you have a field of poppies with a two-string barb wire fence. There were 2 000 heads taken last year and 3 deaths in the last 10 years.

You guys are concerned about how this may impact on your industry, but the cannabis industry is saying you need to tighten things up.

Mr RICE - It is interesting that you are saying it will be controlled, it will be in a high security area, and it will be in a covered situation. That is the first time we have heard that. We do not know that and the industry does not know that. That is why we have come to this committee, to let you know they are our concerns. That is what we would like to put to the committee. Our members do not know that. Some farmers are not that keen on over regulation, but others understand the reasoning and why we have the regulation, to protect our international reputation.

We have a full committee of management of 16 farmers, drawn from all growing areas of the state, and various sub-committees under them. We can go to our members in each of the districts of the state, to gather their opinions, within two or three days. It is a very inclusive organisation. It is not the president and I making decisions for everyone. We are inclusive, both with our journals and in our one-to-one conversations, through a delegated committee system.

Mr GAFFNEY - If Tasmania were to embark on cannabinoid trials, are you concerned there could be a focus on the state and a flow on impact to the poppy industry - that you would have to look at some of your security measures? We do not want it to cost farmers any more to grow to things, do not get me wrong. But do you think pressure might be put on farmers in your industry to have tighter security measures. And I understand our security is better than anywhere else in the world, because that is what all the reports say.

Mr RICE - That is quite a legitimate question. It is something we are reviewing all the time and we are very conscious of having had five fatalities since 1990. You speak about 3 000 heads - you could get 3 000 heads in a small box. We are taking off millions, if not trillions, of heads. I do not want to trivialise that, because any possible diversion is always of concern to us. But most of them are taken to use as flower arrangements in homes, and so forth. Notwithstanding that, we have seen three fatalities in the last three years. Two have been attributed to poppies, and one is yet to come before the coroner.

We take that enormously seriously - how we can better inform the public about the dangers of illegal access to this crop. Clearly, if there were new arrangements in regard to medicinal cannabis, and we were seen to be short in our security arrangements, we would most definitely be addressing that, post haste. We would hope to be up to standard before it came to that.

Mr WILLIAMS - If it was not truly medicinal, there is enormous opportunity for damage to brand Tasmania. We have secured our brand because of the way that, as a community, we have dealt with poppies. Drugs are used in Tasmania, and I see the negative consequences of drug use. I have seen that as an employer and I have seen that as a legal practitioner. There is potential for damage to brand Tasmania if this is not done the right way, and that is what our focus has been. If it is going to happen, it has to be the right way.

CHAIR - There was terrible publicity when the last young person - a Danish tourist - died. I was intrigued by the comment on your submission that 'there remains a community respect for poppies, which might also be charactised as a blissful ignorance to the dark side of poppies. Although flirtation, and death from it has proven a real factor to contend with'.

You also mentioned in the submission the media campaign you ran about this issue. So I do not think there is really a 'blissful ignorance'. We have identified that people can die from experimentation with poppies. Whilst diversion from medicinal cannabis would be inappropriate, the risk to the state's reputation is not the same as for possible death when someone steps over the fence and gets a poppy head and makes some tea. It is surely more damaging than someone breaking into a factory or plant where they are growing cannabis and smoking a bit. It may not have any THC of note in it anyway. You do not even get the high.

Mr WILLIAMS - It is blissful if you leave it alone and if people respect leaving this alone, that is a good thing. It is a damage to Brand Tasmania when there is prominence given to an ice epidemic, when people who want to invest in farms in Tasmania form the assumption that the workforce has problems. That is damage to Brand Tasmania and that is something that upsets me on a daily basis.

CHAIR - That is again, completely separate to this issue of cannabis being grown for medicinal purposes and the risk of any diversion into the general public.

Mr WILLIAMS - With respect, there is a link which is if you are going to do this, if there is such a public demand to do this, think about how you are going to do it. Think about the mechanism. Link it back. Assess what is medicinal. Assess what is clinical. Assess what is scientific and do it the right way.

CHAIR - And exactly why the reason our terms of reference are framed the way they are where they use a scientific-based approach, quality control, consistency, reliability, ongoing research.

Mr WILLIAMS - That is of great comfort to us.

CHAIR - We were not looking at anything else.

Mr WILLIAMS - We are on the same side.

Mr ARMSTRONG - You talk about security for the cannabis trials. From what we have been told there are already seeds available with low THCs, the highest CBD, so would you need the same security if it has the low THC, because then it is not the drug that the normal cannabis user wants?

Mr WILLIAMS - I could not comment. That is too technical but individuals may have different perceptions which would suggest the need to have very stringent security because of the opportunity to take it and experiment. I could not comment any further on what is proposed or what is available.

CHAIR - Thank you. We have used up our time. Unless you want to make any closing comments which you are welcome to.

Mr WILLIAMS - No, we have covered the territory and we thank you for the opportunity to put our views forward.

Mr RICE - If you have any more questions for us we are happy to answer them now or into the future. Thank you, once again, for your time but you have addressed our concerns and we hope we have addressed your concerns with our submission. In that regard we are looking for something to inform the committee, and that is what you have mentioned in the terms of reference and we are aware there is international governance on this and you are clearly aware of that and intend to adhere to those in any recommendations that might come out. We are very heartened by that approach.

Mr MULDER - I take it from that, that you are supportive of trials provided they are medical and they take due concerns of the security and other issues required from the conventions.

Mr RICE - Yes.

THE WITNESSES WITHDREW.

PUBLIC

Ms NEROLI MAY ELLIS, BRANCH SECRETARY, AND **Ms ROSEANNE MARY O'KEEFE**, BRANCH COUNSELLOR AND INFORMATION OFFICER, AUSTRALIAN NURSING FEDERATION TASMANIA BRANCH, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome, Rosie and Neroli. The hearing is recorded by Hansard and it will become part of the public record. The transcript is put on our website. Everything that you say while you are in front of the committee is covered by parliamentary privilege but if you speak to the media afterwards, you are not covered.

Ms ELLIS - We appreciate the opportunity to speak and present our views to the committee. It is something that is very near and dear to our hearts as nurses. We are both registered nurses and Rosie is working as an oncology nurse and is also an ANF representative, so she brings a wealth of experience to answer the clinical questions around the therapeutic benefits of medicinal cannabis and treating symptoms in regards to some of the types of clients that we deal with potentially.

ANF Tasmanian Branch represents around 7 500 nurses, midwives and carers in Tasmania. We have called for submissions from our nurses in regards to this and we have full support and fully support a trial of medicinal cannabis and the decriminalisation to enable that. We are very clear that it is important that this is a clinical trial and well regulated and we would like to go further into how we see the regulations in the current Poisons Act et cetera enabling and protecting both of us as regulated professionals and also protecting the public in regards to the administration if decriminalised and following protocols.

We clearly do not support the indiscriminate use of cannabis, we clearly do not support inappropriate mechanisms and I would like to go through how we would see it working in real life in Tasmania. The way we see medicinal cannabis being administered is through a vaporised dose so it is not going to be indiscriminate use and smoking in the ward. It would be, as in any other medications, like butanol for asthma, it would be a metered dose that could be administered safely and effectively in a ward situation or in a home situation, wherever required.

I am going to refer to my colleague to speak about the therapeutic benefits in seeking relief of symptoms for medicinal purposes and we probably will be covering a fair bit in our submission in regard to that, but just to give you some background of how it would work in reality and benefit. Our submission has also been based on evidence from international research, the knowledge that has been utilised internationally for around 20 years, and we see that there are real benefits for therapeutic use.

CHAIR - Just before we go to Rosie, Neroli, you have addressed in your submission what you see as a great deal of evidence and literature that is available and we did hear from Dr Eric Ratcliff from the Royal College of Psychiatrists yesterday. He felt that there needed to be a further literature review because there are gaps and a lot of the literature did suggest that more research needs to be done. Do you think that there needs to be a full literature review - and he suggested it would only take a month or so if you got someone onto it - and to look at where the potential gaps are? Do we need to conduct any clinical trials or should we be just be looking at getting on with it?

Ms ELLIS - In our document on page 6 of 11, we did a fair bit - not as extensive as a full literature search, we did a desk-top literature review in regard to this. The major review by John Morgan does say that the medicinal properties of cannabis are well documented in the modern scientific literature, but it may be beneficial to do a further review if that is required by the committee. Certainly the desk-top analysis and the fact that it has been in place for so many years and 20 states of the United States are already using medicinal cannabis - argument, yes.

CHAIR - Thank you.

Ms O'KEEFE - First of all, I would like to make note that medicinal cannabis is not in any way, shape or form supposed to be a treatment for anything, really. It is supposed to be a supportive therapy and by that I mean purely symptom control.

The main areas that we found, through the research, it is beneficial in is chronic pain, nausea and vomiting and chemotherapy-induced nausea and vomiting as well. I have a bit of experience with the chemotherapy-induced nausea and vomiting. It is, as we have found through the literature, often more resistant to the standard antiemetics that are available and it is absolutely heartbreaking to watch the patients go through that and we cannot do anything about it as they have already had everything that is currently available. There is excellent research available to suggest that it would be beneficial in these people, especially.

CHAIR - Just on that Rosie, we had a pain specialist and another physician here yesterday speaking about some of the research looking at nausea and vomiting particularly related to chemotherapy that was done prior to the introduction of Ondansetron. Their comments were that with any risks we need to have research now comparing cannabinoids in their effectiveness against chemotherapy-related nausea and vomiting with Ondansetron, for example. You are talking about these patients who you look after, and is Ondansetron not working for them?

Ms O'KEEFFE - It does work for some people but it does have some significant side effects with it as well, constipation being one of the major ones which can also be a side effect of the chemotherapy itself. In that respect the cannabinoids are found to have minimum side effects through what the literature has said. I don't know if it would be worth doing that kind of comparative study, I am not sure.

Ms ELLIS - The research and the symptom relief that is in medicinal cannabis, though, certainly seems to not have nearly the same amount of side effects and we see it actually improving appetite, improving nutrition. Wasting is one of those side effects of chemotherapy, inducing vomiting.

CHAIR - What you are saying, Neroli, is the benefits of the appetite stimulant and the nutritional value, which is an issue for people having chemotherapy, are not one of the benefits of Ondansetron, which is purely an anti-emetic?

Ms O'KEEFE - It is a purely an anti-emetic. The other thing that is sometimes used in conjunction with chemotherapy and other supportive therapy, are steroids. Sometimes it

is given as an appetite stimulant. They also have significant side effects which could also be avoided through using cannabinoids.

The other things we have noted is that it could even be useful for spasticity to do with multiple sclerosis. For seizures as well. There is some evidence to suggest it is useful there as well as in neurological disorders such as Parkinson's, MS, motor neurone disease, Tourette's syndrome, those sorts of things.

Ms ELLIS - One of the issues that has been raised with us when we have had these discussions around dependence, and the concern of what we see potentially as the side effects of dependence, we would say the majority of the current narcotics being used for pain relief also build up dependence as you need to track them up. As the pain increases you need to increase the level of the narcotic so the dependence is equal if not more than the stronger narcotics that are currently being used for pain control.

I don't know if there are any other questions in regard to the clinical benefits and the symptom relief in regard to how it would be utilised from the research, otherwise we might move on.

Mr FARRELL - I was trying to find the submission we had from a gentleman who had cancer back in 1975 and he was being treated in England and he got on to cannabis to help him through the chemo and he stated that the feelings of guilt he had when he went back into the ward and there were a lot of people being nauseous and he felt guilty that he did not feel that way. When he came back to Hobart, he said he found it so helpful that he would go to the Royal Hobart and have his treatment and normally he would get home and self-medicate with some cannabis but he found at times that he needed it earlier so he would have a joint outside the Royal Hobart Hospital which was a really interesting story and one of the many submissions we have had. There is a lot of interesting reading.

I do not know if you have a feel of how often that may happen. It seemed to be something that has been happening for some time.

Ms O'KEEFE - It would not surprise me.

Mr FARRELL - It is a hard one to answer, I know.

Mr MULDER - You are not obliged to say anything unless you wish to.

Ms O'KEEFE - I have known some patients who have said that it is beneficial.

Mr FARRELL - I would imagine some of the side effects from chemotherapy must be fairly drastic.

Ms O'KEEFE - I have met a few patients throughout my short career that have said it is the only thing that helps them.

Mr ARMSTRONG - In the summary of your submission, you say medical cannabis is now legally available in 20 states in the United States of America, Canada and the United

Kingdom and that therapeutic benefits of medical cannabis and cannabinoids is substantial' although not without risks and adverse effects. Can you tell me what the risks and the adverse effects are?

Ms ELLIS - With any medication that is being taken, error is always going to be some sort of risk. We are probably generalising there, but there may be some potential in regard to dependence but no more, in fact less, than the current narcotics being used. They are the sorts of things that we are going to say for this. It is not without any risk at all but it will always be controlled.

Mr ARMSTRONG - And the effects?

Ms ELLIS - We see the effects far outweigh any adverse risk. The effects are to actually increase someone's appetite, and to make them enjoy life more. It controls nausea and vomiting, compared to the narcotics that have to be used. So if you can replace some of those current narcotics, it means someone is going to have less nausea and vomiting, and less wasting. So there are definitely therapeutic benefits from utilising medicinal cannabis. It would probably be in addition to narcotics, but there would be fewer other narcotics required.

CHAIR - Thank you.

Ms ELLIS - The second term of reference concerns the supply chain and the regulations around the situation where narcotics are being utilised and how this could slot into the current flow. Obviously, the distributing pathway would have to be licensed. We understand the situation around poppies and probably will not speak too much about the current legislation in aiding the growth of a narcotic. The supply chain is the important issue in ensuring that it is treated as any other narcotic through a pharmacy, and prescribed by doctors. We fully support a clinical trial with UTAS, as proposed by Tasmanian Health. We see that as absolutely vital for the whole of Australia - to have that clinical trial to really provide further evidence to the current international evidence around the effects of medicinal cannabis.

The method of actual administration is vaporised cannabinoids. This has been successful in previous clinical trials and research, and we have noted those trials. We note that the same vaporised approach in a clinical situation is being utilised by a number of other medications such as morphine. So morphine is occasionally provided as ordered through a vaporiser. So the dosage can be absolutely monitored, titrated, ordered and prescribed. It is completely rigid in regard to that control mechanism and has already been utilised with morphine vaporisation.

I will move into the legal barriers and the legal implications. As nursing professionals, we are regulated by AHPRA. We are regulated heavily in regard to our practice but particularly in a mistake perspective. We are regulated in the administration of medications through the State Poisons Act and Regulations which absolutely clarify things. I have a list of them here. There is a whole list on how we actually store our narcotics, how we check them, how two people need to be present to check out the double-locked drug, to actually then administer and double-check the administration. So there is a whole range of very strict protocols and procedures, regulated by law, that we

are mandated to follow, and do follow. If we do not follow those, our registration is in jeopardy. To decriminalise medicinal cannabis would actually enable us to safely practice as prescribed by our medical colleagues with regard to drug charts, etc.

Under section 52, it talks about the growing and protection of prohibited plants. There is obviously that section in the Tasmanian Act that will already enable that. So we see that there are Tasmanian regulations and controls in place that already could be utilised to actually enable a trial of clinical cannabis. Certainly, as professionals, we would then be protected to administer it safely and utilise it to patients' and clients' best outcomes. We are here as advocates for patient care and also as advocates for our members, being nurses, to be protected in regard to this. The supply chain and the order in the administration, we would see them as being highly protected and we would only administer under such protection.

CHAIR - Neroli, one of the things that has been raised by a couple of the mothers of young children we have spoken to - those with rare and intractable forms of epilepsy - is that they have been able to access this product, event though it is illegal and administered to their children. However, when they go to other places - into respite or other places like that - the staff there are not willing to administer it because of these restrictions. I do not know whether you hear much about this because these people are more outside the hospital setting. From the nurses who work in these other areas, do you hear this as a challenge? How big a problem are we talking about?

Ms ELLIS - We have heard this as we cover nursing in the community sector and carers as well. In a home environment, it is difficult because we know and see the benefits. Yet we cannot assist the patients when they come into respite because of the current legislation. As regulated professionals, it would jeopardise our registration if we supported the family in that situation. It would be untenable for us to do that.

CHAIR - What could be the outcome?

Ms ELLIS - If you had a trial of medicinal cannabis, the child would go into respite. It would be ordered on the medication chart and the nurses could openly given that under those controls of the regulations relating to narcotics. It would be completely legal for nurses to administer and they would welcome being able to administer those medications.

CHAIR - For the benefit of the committee - I know the answer but I want it on the record - if a nurse who is regulated did, out of compassion, gave a child the medication provided by their parents, what would be the process? You said their registration is in jeopardy. What is the process?

Ms ELLIS - There would be criminal charges against that nurse and also they would be reported AHPRA, which is our national regulation body. They would have to go before a tribunal and, because it is a potential criminal act, they would be potentially deregistered and never be able to practice nursing again. That is the harshness of the current situation. As patient advocates, we know it is in their best interests. That is the hardest thing - to be torn between current constraints as opposed to what we know is in the wellbeing of people.

We anecdotally know that people do use this underground or at home. That is a very difficult position for people to be in - to have to take illegal narcotics, knowing that it is in the best interests of their family.

CHAIR - Do you want to go to another point, Neroli?

Ms ELLIS - It is pretty much contained in our submission. A lot of the research that we looked at is footnoted so you can refer to that. As patient advocates, we are convinced that a safe, controlled trial of medicinal cannabis is the best outcome for Tasmanians. We see it as an opportunity for therapeutic gains. We also see it as an opportunity for further research and evidence to be garnered. As a potential option for Tasmania, we would like to see it earlier rather than later.

CHAIR - Neroli, could you argue that if a literature review shows there is a significant body of evidence that it has identified the medicinal benefit and quantifies the risks that to proceed with a trial is unnecessary? Is that a possibility - that we should look at amending various pieces of legislation and trying to get the Therapeutic Goods Administration to act?

Ms ELLIS - We have had a long debate about that and we have come to the position that we would like to see a clinical trial put in place. We believe that can be done sooner rather than later and we also believe that UTAS have the capacity. We cannot speak on their behalf but we would like to see the clinical trial go ahead.

Ms O'KEEFFE - It could also make a smoother transition. If you go through the trial process it may be a smoother transition and more palatable to the general public and government.

CHAIR - It is taking the people with you.

Ms O'KEEFE - Yes.

CHAIR - Thank you very much for your time and your submission. We appreciate that.

THE WITNESSES WITHDREW.

PUBLIC

Ms JANNETTE PATRICIA SMITH, CHIEF EXECUTIVE OFFICER, ALCOHOL, TOBACCO AND OTHER DRUGS COUNCIL TASMANIA INC. AND **Dr RAIMONDO BRUNO**, BOARD MEMBER, ATDC, ASSOCIATE PROFESSOR, UTAS SCHOOL OF PSYCHOLOGY, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Thanks for joining us and for your submission. So that you are aware of the proceedings of the committee, everything that is said today is recorded by *Hansard* and it will become part of the public record and published on our website and our transcripts. Also, there is media here. They have shown great interest which is great. You are also covered by parliamentary privilege while you are before the committee but if you speak to the media afterwards you are not covered at that time. You have to keep that in mind. If you want to provide any evidence to us in confidence, you can make that request and the committee will consider that, otherwise it is all public.

Ms SMITH - First, I would like to say how pleased the Alcohol, Tobacco and Drugs Council are to see the inquiry underway. We think it is an incredibly important issue to be discussed. We are also grateful to have been invited to come and speak to our submission.

The Alcohol, Tobacco and Drugs Council Tasmania is the peak body that represents the non-government prevention and treatment services in Tasmania. Our member base deliver treatment and prevention services across the state and we are actively involved and have a unique understanding of the use, and the associated links, of all things associated with the use of cannabis.

The Alcohol Tobacco and Drugs Council does not currently have a policy position on the legal status of cannabis for non-medical use so we are not in the position of advocating for legalisation of non-medical use. We do, however, believe that it is absolutely essential to examine and build an evidence base for all of the drug policy that we consider in this state.

The provision of cannabis for medical use in Tasmania should be considered in the broader context of what is happening internationally and in other jurisdictions in Australia and we have made some reference to some of that work in our submission.

The ATDC has noted that many commentators claim there is only anecdotal or very limited research supporting the therapeutic benefits of cannabis and this does not correspond with the research we have seen and we have heard about, and this is from experts from both across the country and internationally and my colleague, Dr Raimondo Brun has a vast amount of experience and knowledge in the areas of this research and will perhaps have an opportunity to speak to you about that today.

We welcome this inquiry as we expect that it is going to provide government with a far more objective assessment to the current evidence and provide direction as to where future investigation is necessary. Any discussion about drugs seems to elicit opinions that are based upon community values, personal beliefs, and moral arguments and where there is low acceptance of the use of psychotropic drugs, or strong views about personal freedoms, opinions often vary sharply and quite often what we see is the evidence that is

sought, and then promoted, is about substantiating those personal and primarily value based positions.

The ATDC is hopeful that the Tasmanian Government and our community will have the courage to demonstrate leadership in health and drug-related policy in this area. It does take courage but it takes leadership and that is something we would encourage this Government to think about.

It is important to acknowledge that with any change comes the potential for risk. However, we also think that risk can be managed if we engage in rational and thorough policy development. For example, ATDC consider it very important that we should go down the path of introducing a medical cannabis trial. If we do that then the information and education provided to the community needs to be very clear about the role of medical cannabis, the difference between medical and recreational use of cannabis, and the potential harms from abuse of the use of cannabis.

My final comment in this introduction is that throughout this inquiry it is essential we maintain the focus on the reason why we are all sitting here today and engaged in this current discussion and that is mainly to provide an appropriate medical treatment at the right time to those in our community who have few, if any, alternatives to alleviate the often devastating symptoms of their illness. Thank you very much for that opportunity to provide an introduction.

CHAIR - One of the issues that has been raised is around the research - what has been done and what has not been done, where are the gaps? There are some saying that there is a dearth of research and there are others saying there is plenty of it and some saying that we need to do a full literature review to see where the gaps are and all research, I think without fail, says that further research is needed. I do not think we are ever going to get a piece of research that says anything but that in most cases because research always raises questions as well as answers.

Raimondo, I would appreciate you talking about the research that you are aware of, or been involved in, and can you give us a good understanding of where the gaps might be and what would be best sought through a trial here?

Mrs HISCUTT - Chair, before he starts would you mind asking him to list his qualifications?

CHAIR - Yes, perhaps you could tell us about your background.

Dr BRUNO - I am an associate professor in the School of Psychology at the University of Tasmania. I have been involved in drug and alcohol research in Tasmania, looking at drug markets, the impact of substance use and medications on cognition; psychopharmacology for about 15 years so I have a good understanding of both the illicitness of substances and the effects they have on public processes and health.

In relation to the evidence base, there is high quality evidence that supports their effectiveness for a small number of conditions. For conditions such as neuropathic pain, spasticity associated with multiple sclerosis, inflammatory pain such as rheumatism, nausea, vomiting and appetite suppression, there is good randomised control trial

evidence that supports their effectiveness. They have not been head to head trials against existing medications but they have been well run placebo controlled studies that we rate at the highest level of quality of evidence.

This is for a constrained number of disorders. Questions remain in terms of whether some types of preparations are more beneficial than others. We are still trying to understand, at a neurochemical level, the way that the endocannabinoid system works in the brain and the body and how that might contribute to treatment outcomes.

We have some good quality evidence that suggests in favour of implementing some procedures to allow people to access this medically for a constrained number of medical complaints, under controlled circumstances. We have that in relation to Sativex, which is already available in Australia.

CHAIR - A number of people have appeared as witnesses or made submissions, who have children with rare forms of intractable epilepsy. A randomised controlled trial on children in that circumstance would be next to impossible, I would think.

Dr BRUNO - Yes.

CHAIR - How do we evaluate the drug's suitability for that type of condition? It might not be a huge percentage of the population, but for these individuals it is life or death.

Dr BRUNO - We know that some of the core chemicals in cannabinoids are anti-epileptic in animal models. We do not have the strong evidence base available in humans and, as you say, you need a very large number of people to do that. It would be opportune if people administering cannabinoids for this sort of purpose were to pull together a network of people across Australia and internationally to gather the evidence. There would need to be a national or international clinical trial to provide that evidence base.

CHAIR - You would not be able to do a randomised controlled trial for those people, would you?

Dr BRUNO - You could. It would be possible.

CHAIR - Not with placebos.

Dr BRUNO - Probably not with placebos. It would be questionable, ethically.

CHAIR - You could do it with a conventional regime of treatment for convulsions and cannabinoids, perhaps?

Dr BRUNO - Yes.

CHAIR - Are there gaps in the research that you are aware of that need to be addressed before a regulatory framework to administer cannabis as a medicinal product could be set up?

Dr BRUNO - If you want to take a cautious view then you would limit the range of disorders for which it is available - the range of indications - to those where there is a promising evidence base. Either from gold standard clinical trials or, if you wanted to be a little more open, things where there is good level 2/ level 3 evidence that suggests in favour of its use. We already have good regulatory frameworks we can apply.

People tend to conflate the debate about cannabis for medical purposes, with cannabis for intoxication. When people are using cannabis for medical purposes they are using very low doses so they are not getting to intoxication levels, and they are not getting the adverse events you might see with those sorts of intoxication levels. The evidence on safety at those sorts of levels is equivalent to placebo, and certainly on a par or less than most medications that we regulate in this area.

We have been doing a very large cohort study across the country with people that have chronic pain. These people are on average around their fifties and sixties - they do not have huge histories of substance use. Around one in six had used cannabis for pain and one in four would use cannabis for pain if it was available, and these are not people with extensive histories of substance use. In Tasmania we have very high rates of prescriptions for opioids and very high levels of chronic pain. In American jurisdictions where you have medical cannabis for certain pain conditions, the death rate associated with opioids is around 25 per cent less than other jurisdictions. That would be of immediate benefit to the Tasmanian community.

CHAIR - As I understand it, for a clinical trial to be conducted in Tasmania, the minister needs to grant approval to an exempt institution such as UTAS. Correct me if I am wrong, but they also need a medical practitioner who is willing to assist with the trial? Are you a medical practitioner?

Dr BRUNO - No.

CHAIR - Do you have a PhD?

Dr BRUNO - Yes.

CHAIR - Okay. It seems there may be a reluctance for doctors to get involved in this. Are you aware of anyone who may be interested - you do not have to name them? Is this a barrier - that medical practitioners seem to be reluctant to get involved?

Dr BRUNO - In my reading of the AMA, they seem to be neutral to positive towards cannabinoids for medical purposes, and certainly there would be numerous doctors who would be amenable to prescribing them, if an appropriate regulatory and safety framework supported it.

CHAIR - They are protecting their registration?

Dr BRUNO - And the patient. And reporting for diversion. UTAS has done large numbers of studies like this, incorporating clinicians in the field.

CHAIR - Do you think UTAS is the appropriate body, or the Menzies Research Centre?

Dr BRUNO - The Menzies and UTAS are one big happy family.

CHAIR - They are all one big happy family now? Okay, that is fine.

Dr BRUNO - Yes.

CHAIR - Menzies is part of Faculty of Health, isn't it?

Dr BRUNO - Menzies or UTAS, it does not matter who does it, we have the skills to do it. We could run it as part of a trial in Tasmania, or we could be a site as part of a national program. It seems there are a number of jurisdictions considering a trial, and it would be sensible to pool skills.

Mr MULDER - Rather than a clinical trial, are we talking about just monitoring its controlled use by people whose doctors suggest they might benefit from it.

Dr BRUNO - Yes. It would be appropriate to follow up when any new medication comes into the market. You want to do post marketing surveillance to monitor it.

Mr MULDER - Some people think you need a clinical trial with placebos and all those sorts of things, but we are not talking about that kind of trial here - we are talking about post market monitoring of the product.

Dr BRUNO - There are a number of conditions where the evidence base is such that you could proceed to administer it, and do post market surveillance. There are some conditions where the evidence base is not as strong, and you would want to do a randomised controlled trial to justify its use.

CHAIR - You made some comments in your submission about cannabis use:

> … by increasing access to cannabis and introducing a medicinal cannabis scheme, levels of recreational use will increase and greater harm will be felt by users. However, studies have shown there is no concrete evidence that passing medicinal cannabis laws increase the cannabis use generally. Other drugs, morphine, cocaine, ketamine and amphetamine, are used medically today, while recreational use remains prohibited. It is not uncommon to have a class of drugs that are both illicit and used for medical purposes.

Some of the people who expressed concerns about going down this path are worried about the diversion risk of the product, claiming it is easier to divert the raw product, the grown plant, than to divert poppies which require more attention if you are going to dry it and smoke it or vaporise it.

Are these concerns? You would suggest not. The research does not suggest that. Can you point us to research that demonstrates that concern is a bit unfounded?

Ms SMITH - I think that is a reference to comment in the submission. The point we are trying to get at is that many commentators make the point, not only of that diversion, but

also the notion that medicinal cannabis can lead to a perception that there will be gateway to other drug use. In whatever model is adopted, there needs to be that clarity around the regulation and the supply. The production and supply, if there is a prescribing of the medicinal cannabis, needs to take into account factors that will be barriers to diversion. In the same way as we see with the prescribing of opioid, there is a lot of discussion around how we manage that. It is not about the poppies so much. If we look at pharmaceutical opioids, there is a lot of concern around diversion. But we put into place mechanisms and regulation to control that and we also need to be clear that is the same approach we take with medicinal cannabis.

CHAIR - It should not require a different approach.

Ms SMITH - No, because we are talking about it being prescribed for a medical condition, therefore that has been diagnosed, therefore we have prescribing regimes and then we go into the supply and that is all stuff we can regulate.

CHAIR - Further on, you said that according to the USA Institute of Medicine, and this is a quote from research on page 7, 'Except for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated by the medication.' We talked about this yesterday, that cannabis seems to have been demonised to the extent that it is suddenly this larger than life, much more risky drug than anything else we have ever come across. I accept and acknowledge that every medication has an affect which often has a side effect and that is the nature of it. It is a matter of weighing up the benefits and risks and potential outcome.

That comment would suggest that even though there may be side effects from using cannabis medicinally, it is no worse or better than any other medication generally. Is that what they are suggesting in that research?

Ms SMITH - Yes. What it is getting at is that regulatory administration is incredibly important because what we see at the moment is that a number of people will smoke cannabis. We know all the inherent problems and harms that are caused from smoking the product. If we were in a position where there was the prescribed medical cannabis and there were also preparations of it that did not require smoking, then you reduce the potential harms that are associated with that. We have a range of different things that are going on there and one is around that there is potential side effect. But as Dr Raimondo Bruno has been saying, we also know that the levels of THC within the medicinal cannabis are designed to be lower to reduce those harms. I am pretty sure that is an evidence base that is relatively strong.

Dr BRUNO - The more recent review of the literature show there is not. There are side effects reported when people are in clinical trials, where they are getting medicinal cannabinoids, but often they are not significantly different to the ones that are reported during placebo events.

CHAIR - Interesting, isn't it?

Dr BRUNO - Yes, and there is a whole literature on placebos. If you look at pharmaceutical opioids and anti-depressants and most psychiatric medications, they have a huge cost

benefit to play off against and every medical practitioner is always weighing up the risk benefit ratio for their clients on an ongoing basis.

Mr FARRELL - In your submission you mention you have recently invited Dr Kilmer to come to Tasmania. I do not know if he has accepted the invitation.

Ms SMITH - He has attended, he was here in May 2014. Dr Kilmer is a Director of the RAND Institute in California, and has done a lot of policy work in the area of both medicinal cannabis and changes to the international scene of the legalisation within California, Colorado, Washington and Uruguay. When he spoke with us, and there were a number of other national experts who came to talk to us, we are doing very much what you guys are doing - trying to inform ourselves about the policy positions that are happening in the world.

He talked about the fact that medicinal use of cannabis had provided some very positive outcomes and impacts within the United States, but also that there were a number of things that needed to be thought about when moving down that track. The RAND Institute does not advocate a particular position but suggested to us that when we look at this issue in Australia, we consider those bigger picture policy issues such as how we produce and supply and promote and price this type of substance.

Mr FARRELL - It is interesting because through this inquiry it has become evident that all the elements are out there, to look at doing a trial. There are the people that are on the medication. There is an amazing number of experts in the growing of the product and an understanding of what makes it up. There is a lot of fairly strong backyard knowledge. I notice in Dr Kilmer's eight Ps, one of the Ps is profit motivation. I know drug companies need to make money, because of research to sell their product, but it seems to us so far there has been a heck a lot of research that has gone on informally. Does it have to be a large scale trial to see how it would work or could it be done by utilising what already exists locally with your knowledge and with the university.

Dr BRUNO - I think we need to separate out knowing what conditions and what type of preparations are going to work best for particular medical conditions. You need to have that evidence base to be confident that you are doing a benefit to patients. For those indications where there is good evidence, post marketing surveillance would be appropriate. The biggest question is how you implement it in a way where it is not cost prohibitive for people to access. The Dutch model was one of the better ways I have seen that has been implemented internationally.

CHAIR - I want to take you back to looking at appropriate legislation. In your submission you talk about the proposed ACT legislation. I do not know if they have moved with that, but I will read your comment in your submission and ask you to speak to that.

> It is reported that cannabis is an easily accessible illicit drug and if appropriate legislation is developed in relation to production and supply for medical purposes, it is unlikely this will significantly increase the risk market. For example, the proposed ACT legislation establishes a restrictive and highly regulated cultivation licensing scheme which will safeguard against abuse. Cultivation licences are limited to a person or nominated

> individuals who have received a permit based on their medical condition. Details of people permitted to cultivate cannabis, the location of cultivation and the place where cannabis is kept, are all recorded on a register managed by the Chief Health Officer.

And it goes on with the information. Where have the ACT got to with that?

Ms SMITH - Unfortunately, I cannot tell you where they are at this point. I must admit I have been following the New South Wales enquiry. One of the reasons why we wanted to draw your attention to the ACT was to demonstrate that it is possible to design a model for the provision of cannabis that is highly restricted and very well-controlled and regulated. I have not heard any recent news that things have progressed to the same level as New South Wales, which has leap-frogged across what is going on in the country.

CHAIR - What are New South Wales now proposing, as far as you are aware?

Ms SMITH - To run to a clinical trial, but I am not sure of the details. It is very recent but the indications that we have heard through the media and colleagues in New South Wales is that they are looking at reducing the time frame and moving very quickly to a trial.

CHAIR - As I understand it, all that needs to happen is for the minister to grant a permit to the institution and it can start.

Ms SMITH - I believe so.

CHAIR - You did make a point about prevention, education and treatment. If a medicinal cannabis scheme is introduced in Tasmania, it would be central for the Tasmanian Government to engage with service-delivering, prevention, education and treatment programs to people who use drugs. We need that anyway, don't we?

Ms SMITH - Without a doubt.

CHAIR - I think it is a bit lacking up my way, particularly if you look at what is happening at Circular Head and other places at the minute. Why do you believe that if it was introduced, it would need separate, additional -

Ms SMITH - It is not about something separate. We want to be very clear that the community needs to understand the potential risks and harms of recreational cannabis use, or, more likely, cannabis abuse. We also must not send mixed messages out into our community about drugs. At the moment - and I think over the last 50 years - we have been spending a lot of time demonising cannabis. It has become an illicit substance that has been placed in the 'do not go' zone. If we now turn around and say, 'In fact this has therapeutic qualities and we think that it should be available', we also need explain that this is not then a green light to start putting it into the kitchen cupboard. This is actually about a medical treatment.

CHAIR - A drug like any other drug.

Mr MULDER - That is why it is done on prescription and under medical supervision. It sends a message.

Ms SMITH - Exactly, that is right. I think it is really important that we take that opportunity to engage with the community and those who are looking at experimenting with drug use, particularly young people, about what some of the associated risks are with long-term recreational use of cannabis. There is some evidence that we do not want to increase that. You are absolutely right that this is something that needs to be across the board and should be happening right now.

CHAIR - How under-resourced is this sector?

Ms SMITH - If we are looking at prevention and education to the community, the level of resourcing is minute, in my opinion. We talk all the time about prevention, promotion and early intervention in preventing the longer-term burden of disease associated with the use of alcohol, tobacco or drugs. We have recently been able to secure about $65 000 from the Government to invest in prevention, promotion and early intervention. It is not a significant amount of money when you talk about half a million Tasmanians who need to hear some of these messages. There is some work that is going on there but with treatment programs we also know that there is a significant demand for services that is not being met. There are people in our community who I think would engage in services if they were more available, particularly when we talk about regional service delivery. We know that there are many communities, particularly in the north and the north-west, where services are very thin on the ground.

CHAIR - Craig alluded to the fact that there does not seem to be a lot of money in this drug. You do not have the amount of IP, I suppose. You can't patent a naturally occurring product that already exists.

Ms SMITH - I am sure a pharmaceutical company would try.

CHAIR - They would. I know they are trying to patent our genes and things like that. It is an issue that I guess Craig was alluding to.

Dr BRUNO - If it is made available, there need to be multiple options where it can be regulated and access provided. Not everybody who has the indication for the medical use is going to be interested or able to go out and grow a small number. There need to be multiple modes of access. One of the benefits of the Dutch model, for example, is that the cannabis is well regulated and the actual content is clear. You know the amounts of THC. You know the amount of cannabidiol. Getting the ratios of those right is going to be important for the particular conditions.

Mr MULDER - That is quite surprising because they have an unregulated recreational market. Yet they can still get this right in terms of the medicinal market, despite having an unregulated recreational market. I think that is the point. Medicinal cannabis because of its quality, its known effects and the regulatory framework around it, becomes a better product. It is interesting that we keep getting dragged off into this idea that, 'You will let the cat out of the bag and you will increase recreational usage'. The Dutch showed that there are different markets and different clients.

Ms SMITH - It is about the way that they have set up their model and the way that they distribute, produce, control and regulate. That is the thing. If we are smart about that in this early stage, then it is possible.

CHAIR - Do you want to make any closing comments? Is there anything you would like to add that we have not covered?

Ms SMITH - No, I think we seemed to have touched on most of the points within our submission. I think that the Council are particularly interested to see the work that has already been done continue through collecting that evidence base and moving toward trialling this. It would be a shame if Tasmania did not take the opportunity to show some leadership in this area when we have so many people who are well-informed and really interested. We have skills and capabilities within our educational and research institutes that would be well worth taking advantage of.

CHAIR - There was one other question. I did ask this of another witness about the recommendations that you made. You noted in the third dot point that the Tasmanian Government should consider amending the Misuse of Drugs Act 2001 to allow for medicinal cannabis use. How does that need to be amended?

Ms SMITH - Our understanding of the act is that possession of botanical cannabis is an offence. Depending upon which model is adopted, if a person in their home were to have a certain amount of cannabis - the botanical product - they would potentially sit in breach of the law. We would anticipate that there would need to be some kind of change to the legislation to allow them to possess it. We have very good diversion programs, such as the illicit drug diversion program. It is a police diversion program that gives them some discretion, but there are certainly limitations to that. A person may be apprehended with cannabis on three occasions and after the third occasion it is a chargeable offence. We certainly would not want to see that happen to someone who was legitimately using a medical product.

CHAIR - This is where part of the challenge lies. I understand New South Wales is looking at a similar sort of approach at the moment to exempt and provide a defence for people who have a terminal illness but how do you define 'terminal illness'? I do not think it is an area that needs to be looked at but if you confine it to terminal illness then it potentially excludes some or you end up bringing in a whole lot of people who perhaps you did not intend to. Is there a better way of looking at it? 'On the advice of a medical practitioner' or 'may benefit from' or something like that rather than saying 'you have to have ...' - and even if you narrow it down to conditions that it has been shown through research to have a beneficial effect for some people.

Ms SMITH - That is right. We also know that we do need to respect that discretion of a medical practitioner to be able to make an assessment working with their patient around what is the most effective treatment for their condition. Whilst creating strong regulation around the supply and the production of cannabis, there can still be some flexibility and capacity for discretion in the way that relationship between the doctor and patient works.

I think it is really important we do not allow ourselves to see all the barriers through our legislative process rather than looking for those solutions. It is really easy for us to say, 'It's actually just all too hard', and that is what we certainly do not want to see happen.

CHAIR - Thanks for your time.

Ms SMITH - Thank very much and good luck with it all.

THE WITNESSES WITHDREW.

Mr PETER SKILLERN, TASMANIAN FARMERS AND GRAZIERS ASSOCIATION, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - This is all recorded on *Hansard* and it is a public hearing and will become part of the public record and published on our website. If you wanted to discuss something in private, you can request that and the committee would consider that and then arrange a private hearing if you needed to. What you say here is covered by parliamentary privilege, but if you speak to the media afterwards it is not, so please bear that in mind.

Mr SKILLERN - I will not reiterate the whole submission but from the TFGA's point of view it was never our intention to become involved in the debate about the use of medicinal cannabis. That is a debate that the Government and the community at large can have. After a mature debate, if the decision is taken to move ahead with medicinal cannabis trials and/or growing of cannabis for medicinal purposes, Tasmanian farmers stand ready to assist in whatever way possible.

One of our major concerns is the way this debate has muddied the waters around the industrial hemp issue and to some extent has contributed to retarding the growth of that industry. It is not the only issue but it has become a bit of an issue in recent times. We have concerns around the impact on the industrial hemp industry moving forward.

One of the things we believe is that the establishment and growth of an industrial hemp industry would actually set a good foundation for the future in any decision around medicinal cannabis. Having said that, the reality is that cannabis for medicinal purposes will never be a broadacre crop that we can see in Tasmania. It will be very much a niche market and one would imagine that the regulatory requirements around medicinal cannabis would be such that there would be a high infrastructure cost for any farmer in growing it. On that basis, each farmer would have to make a decision as to whether they were prepared to foot the bill for those infrastructure costs relative to the returns from the crops - as they do with every other crop. I am happy to take questions.

CHAIR - Peter, in your submission and in your opening remarks you commented on the negative impact you think this debate is having on industrial hemp, and the confusion -

Mr SKILLERN - Confusion is a better description, yes.

CHAIR - There was an enquiry about that a year or so ago. The Government has every opportunity to progress that should they wish to - this not a place for them to hide. Surely those risks can be ameliorated by the TFGA making very clear, unequivocal statements in the media, as the Government can, and anyone else who speaks about it. Is that not a fair comment?

Mr SKILLERN - That is a fair comment. If the committee were look at the public record, the TFGA has made that demarcation on numerous occasions. Unfortunately, within the public arena and within the media, there is ongoing confusion about the difference between industrial hemp and cannabis, irrespective of whether it be for medicinal purposes or recreational purposes. Notwithstanding our continued efforts to clarify that message, it has failed to resonate in those areas where we need it to. As a result, in many

people's minds the two issues are one, when in fact they are quite separate, as you rightly point out. You could almost argue they are two separate plants.

CHAIR - I suggest to you the lack of action on industrial hemp has nothing to do with the present enquiry. The Government has the responsibility to progress that, don't they?

Mr SKILLERN - I am not suggesting it is this issue alone, but it is another compounding factor in over two decades of trying to get this industry off the ground. The reality is that the industrial hemp industry, when allowed to progress, could, in time, equal the current poppy industry. There is no question about that. You are correct in your comments - the state Government has been very supportive in trying to get this industry off the ground. They are heavily lobbying their federal counterparts to get the issue overturned in COAG - the issue with using hemp products for food, which will be the difference between making it a commercial crop or not a commercial crop.

We have been having discussions with them about the regulatory regime in which industrial hemp is currently grown, which is quite restrictive for a crop that has no narcotic elements whatsoever. There are a couple of issues there. I didn't mean for it to be construed that this committee's enquiry is somehow restricting the industry. I am saying that the debate in the community about medicinal cannabis has muddied the waters in what was already a murky debate over industrial hemp.

CHAIR - I takes some good leadership to change things.

Regarding the potential impact on agriculture and other sectors in Tasmania you say that 'other matters that need to be considered in the current debate are the impacts that may occur if such use of cannabis is approved, and the negative impact that the current debate is having on the potential growth of the agricultural sector in Tasmania'. Is this referring just to the industrial hemp issue, or do you think other areas of potential growth in the agricultural sector could be negatively impacted?

Mr SKILLERN - That comment specifically refers to the industrial hemp issue.

CHAIR - That is the only concern? You do not have concerns about other agricultural activities?

Mr SKILLERN - The only other issue could possibly be with poppies. People need to be cognisant of the fact that there is the 1972 international agreement that we will need to work through if medicinal cannabis is to be trialled or grown. And, it also has to be approved by the Therapeutic Goods Administration process.

CHAIR - The requirements under the United Nation Single Convention on Narcotic Drugs, 1961, and the amending protocol, apply equally to opioids as they do to cannabinoids. So if we were to apply the same principle, would not that remove the risk to the poppy industry?

Mr SKILLERN - Potentially it would deal with the issues, but we have put that in the submission to flag that these things need to be considered.

We are not taking a position on the use or non use of cannabis for medicinal purposes. We are merely flagging that there are some issues that need to be given serious consideration.

If, after community debate, a decision is made to move forward with legalising cannabis for medicinal purposes, there will be a process to go through. It is not going to happen overnight.

CHAIR - You also mentioned the situation in Canada in your submission:

> Health Canada's own estimates expect that the number of licensed medical marijuana consumers will increase almost ten-fold in the next decade to approximately $309 000 as more evidence of the drug efficacy emerges and more doctors become willing to prescribe it to patients. Health Canada estimates that by 2024 the legal marijuana supply may have annual revenues of $1.3 billion. This more regulated approach delivers a standardised product that spreads benefit through the community. Licenced producers, authorised under Health Canada's new marijuana for medical purposes regulations - MMPR - legislation will grow, process and package dry cannabis from secure facilities, much as they now do in Tasmania with opium poppies.

I think you are recognising that there is potential for another industry in Tasmania.

Mr SKILLERN - Correct.

CHAIR - Have any of your members made any comment on this issue, or indicated a particular willingness to engage in this type of industry, should it become an option?

Mr SKILLERN - In cannabis, as opposed to industrial hemp?

CHAIR - Yes.

Mr SKILLERN - No, I can't say that we have had any comment. Industrial hemp is a different story. It comes back to the recognition that, even if this goes ahead, the regulatory constraints will be much more stringent - more stringent than poppies - for the obvious reasons.

CHAIR - What are the obvious reasons? I don't know that they are obvious. They are not obvious to me.

Mr SKILLERN - They are very clear. If someone jumps the fence into a poppy crop they can't just take the poppy heads and have a consumable drug. That isn't the way it works, particularly with thebaine. In fact, if you try that it is likely to result in some very unfortunate results. But if a farmer is growing marijuana or cannabis in a broadacre situation, people could jump the fence, take the product, and dry it and use it within a relatively short space of time. One would imagine that cannabis growing will have a quite different regulatory regime around it, to ensure that type of activity can't take place. That might mean growing it in poly-houses with security in fencing, or

something like that. Clearly, there is going to be a greater infrastructure requirement with growing medicinal cannabis than there is for poppies, and what we are advocating for industrial hemp.

Mr MULDER - You say you can't jump over the fence, grab a few poppy heads and turn them into something. But you can. You can boil them down for poppy juice and the consequences of ingesting that are infinitely more serious than jumping the fence, and drying and smoking a few cannabis leaves. Maybe the regime for cannabis needs to be less stringent than it is for poppies, or maybe the regime for poppies needs to be improved.

Mr SKILLERN - With respect, if you try that with thebaine, you will probably end up dying.

Mr MULDER - Exactly, that is right.

Mr SKILLERN - But my point was not about that result. My point was about the availability of the drug, whichever drug it may be, whether it be a cannabinoid or an opiate. With poppy tea, you end up with a result you don't expect, but if you grab some cannabis leaves you will get the result you expect.

Mr MULDER - Surely we need higher level security arrangements for things that have a greater consequence than we do for things that have a lesser consequence. You seem to be arguing the opposite.

Mr SKILLERN - No, I was asked the question about cannabis and I am responding to that. One would assume - and perhaps the Government will have a different view - that cannabis would have a high requirement in terms of security.

Mr MULDER - Only in terms of risk management. What about the consequences?

Mr SKILLERN - That will be a decision for the Government and the regulatory regime that Government sets up will have a significant influence on whether farmers need to put in greater infrastructure, whether that be security or whatever it may be, and that will then determine whether they proceed with growing the crop. I am talking about purely from an economic point of view.

Mr MULDER - On the basis of risk being the multiplication of likelihood and consequence, you would have to concede that there is a greater risk of interference with poppy crops than there would be with marijuana crops.

Mr SKILLERN - Again, that would be a perception of the members of the community and whether they perceive taking poppy capsules as dangerous or whether they perceive taking marijuana leaves as an easy, quick access to drugs.

Mr MULDER - Not to labour the point, but three deaths from interference with poppy crops in 10 years and no deaths from interference or misuse of marijuana crops would suggest that poppy crops are the greater danger, irrespective of community perception.

Mr SKILLERN - I am not aware that we are growing broadacre marijuana crops in a legal sense in the state so I am not sure how you can draw that conclusion.

Mr MULDER - I am saying the use of marijuana.

Mr SKILLERN - You would be in a better position to make that statement that I am.

Mr MULDER - Thank you.

CHAIR - The only other thing, from the evidence we have received, that you may or may not be aware of and I accept that, is that the plants are quite different and even within the medicinal cannabis options for plants, some have very low THC levels. What the recreational users seek and where the diversion tends to occur is the high THC products to give the psychoactive effect that people are looking for.

If crops are being grown along the lines of industrial hemp and they would have basically no or very limited levels of THC and thus would have no desired psychoactive effect, then you could argue that you would need less security, as you suggested for a crop like industrial hemp, if there is no potential harm.

Mr SKILLERN - If that was the case, yes, I can see that point.

CHAIR - Not no potential. There is always potential harm but less potential harm.

Mr SKILLERN - I do not think anybody, frankly, is in a position to make those statements at this point in time and I am not in a position to make a statement of behalf of the sector at this stage. As I said, this process is fairly straightforward. The Government and the broader community have to have a mature debate about this issue. If at the end of the day the majority of the community, and supported by the Government, decides to have legalised medicinal cannabis trials, then our sector will stand ready to do what we can to proceed in growing that. To hypothesise about what that might look like at this early stage, I think is very difficult. It is a situation where we will need to see what regulatory frameworks are put around that. Individual farmers, as they do with every other crop now, will make a decision based on what that regulatory framework is and what that requires them to do and what the costs associated with that are, relative to the economic return that they receive.

CHAIR - Are you aware of any other jurisdictions around the world that have a regulatory framework for industrial hemp, for example, or for poppies or growing of opioids or cannabinoids that would be a model that could be perhaps replicated rather than trying to reinvent the wheel?

Mr SKILLERN - No, I do not have that knowledge.

Mrs HISCUTT - No, it is just good that there is support from the TFGA.

CHAIR - We do take on board the need to separate. That is why we are very clear in any statements we have made.

Mr SKILLERN - We do appreciate that. It is a matter of getting that message out there, unfortunately, into the broader community.

CHAIR - You have to keep saying it.

Mr SKILLERN - We do have to keep saying it. I was on radio this morning saying it and I will continue to say it until people understand that they are two separate issues and virtually two separate crops.

Mr MULDER - Actually, there are three separate things we are dealing with. One is the industrial hemp, the other is for recreational use and the third is for medicinal use. They are different products even though the last two aren't necessarily different crops but there are different issues altogether and different regulatory regimes.

Mr SKILLERN - I accept that.

CHAIR - Thank you, unless you want to make any closing comments. It is refreshing that you do not seek to comment on all the medical side of it when you do not have the background knowledge in that. That is good.

Mr SKILLERN - That wouldn't be right. We won't go there.

THE WITNESS WITHDREW.

PUBLIC

Ms LISA JANE ESTREICH, HEMP AUSTRALIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - The hearing is recorded through Hansard. It is part of the public record and is a public hearing. If you wanted to give any evidence in camera or in confidence you can make that request to the committee and we could consider that. You are covered by parliamentary privilege while you are before the committee but if you speak to the media afterwards that cover does not extend outside the committee hearing.

Ms ESTREICH - I have been involved in the industrial hemp industry in this state since 1999. During this time we have made some clear advancements regarding specific varieties suitable for our climate, growing, harvesting and processing. Under our industrial hemp licences we can grow and harvest the seed and fibre but seed and leaves are still restricted or prohibited even though it is from a certified low-THC crop or technically a non-drug crop. I hold a licence to be able to hold, buy and sell *Cannabis sativa* seed.

There are still many restrictions for medical cannabis but I would also say that there are still a lot of restrictions for industrial hemp. To clarify, I would like to make use of the following definitions as I believe they will provide a clearer pathway which will enable specific legislative changes according to the definition of the product or the production. Medical or medicinal cannabis is a broad term used for all elements derived from the flowering heads or tops of the Cannabis species. That can be cannabinoids, terpenes, flavonoids, basically any product. To separate that then we have medical/medicinal marijuana. It is a term used for products which have higher levels of THC. It has psychotropic elements due to the high levels of THC. It also comes from the flowering heads of what is technically a drug plant and commonly known as marijuana.

Industrial hemp extracts is a term used for all non-psychoactive cannabinoids such as CBD, CBC, CBG and many other compounds that are not a poison or drug. These non-psychotropic cannabinoids come from the flowering heads of industrial hemp plants with low, allowable, legislated, and negligible levels of THC. Our current allowable limit of THC in dry plant matter is 0.35 per cent. Queensland legislation generally states in their licensing, particularly for research purposes, that plants with over 3 per cent THC are classified as drug plants. Only 10 per cent of the Cannabis species have drug levels of THC. So should this enquiry recommend changes, then it is these THC levels that need to be identified within the specific categories.

If we are to accept these definitions then we also have to look at the terms of reference and re-evaluate each point according to the definition. To confirm, we would have two categories under the medicinal cannabis umbrella: a category with high THC, and usually lower levels of CBD; and a category that is from the existing legislated hemp crop, that is, low to no THC and higher levels of CBD. Each one of these categories provides specific medical benefits. Without clear and concise definitions it will always be difficult to legislate, regulate, set quality standards, prescribe and administer but most importantly the starting point is production and how we can produce them. My involvement in this has always been from the industrial hemp perspective. I am not a scientist, I do not have a medical background but I am passionate about this industry and in this state.

Like most people, my education in this industry continues. Medical marijuana, which has high levels of THC and is psychotropic, is used for pain relief and palliative care. Production methods vary, as does how it is administered. Is it worse than existing legal drugs on the market? I do not believe so. It is still possible to provide measured doses and prescribe according to patient needs. The misconception in all this media hype is that it is grown broad acre. It is my understanding that marijuana is grown in hot house conditions with continuous growing schedules, security, and the consistency of THC levels.

While a note from comments made yesterday that Canada has expanded or is in the process of rapidly expanding its medical marijuana production, also note that in Canada in the early days of industrial hemp seed production, they went into a boom bust production which saw their industry severely affected for a number of years. Canada also have direct competition with the US states who are going into producing these types of products. Maybe Canada is gearing up to propose supply for Australia.

Industrial hemp extraction, which is other cannabinoids, or without the high level of THC, is used for healing and prevention. As these cannabinoids are not psychotropic or have elevated levels of THC, we believe they should not be considered as a drug. It was interesting to note comments yesterday about discussions on rescheduling. This is great to hear and maybe we should look at it as more of a nutraceutical potential.

Industrial hemp extractions can be grown broad acre and so production is the same as our existing industrial hemp crops. However, we need the law to allow for the extraction of the cannabinoids which includes the low levels of THC which is currently not allowed under schedule 9. Existing legislative frameworks do not allow for any of the above to be commercially grown.

CBD is non-psychotropic and it can also counter the psychoactive effects of THC. It would therefore be reasoned that CBD, with its non-psychoactive compounds, should not be scheduled the same as THC. There are so many studies we have used as scientific investigations are being performed overseas and we must look to them as the basis of where these products can assist us from both the legislative and the medical research point of view. There is one website I can refer you to which is the International Association of Cannabinoid Medicines. They are quite informative and they give a lot of input and it is cannabis-med.org.

To bring Canada into the equation again there were some recent news articles which stated that their industrial hemp production was missing out on the lucrative CBD production as they, like us, cannot collect the CBD from their seed crops. This would not be our first option because to produce CBD from an existing industrial hemp seed crop would be more complicated than getting CBD extracted.

We want to be able to produce industrial hemp extracts in Tasmania in an economy where our primary producers are looking for alternative crops and where employment avenues are reducing. Government needs to look at the potentials this whole industry could provide.

On a daily basis, I receive calls from Australian sufferers who have many different ailments, including cancer, tumours and degenerative diseases and the list goes on. They are seeking assistance as an alternative because the existing drugs are not working or they are grasping for that last straw. 'What do they have to lose' is what some of them say.

When I have made inquiries to the government and this is part of the calling of this enquiry, I was advised that scheduled cannabis drugs already exist in Australia and, yes, there are a couple, but they have limited prescribing and limited benefits. Sativex, I understand, is one per cent THC and one per cent CBD. Research coming from overseas is showing that lower levels of THC and higher levels of CBD have much better outcomes. Scheduling is already in place for specific drug names by international pharmaceutical companies, so the theory is legislative changes can be made to allow for cannabis products, whether they be medical marijuana or industrial hemp extracts.

As existing medical treatments and drugs appear to be losing the constant battle of treating a myriad of life-threatening conditions, people are turning to alternative treatments. By not allowing legitimate production, and the continued prohibition of cannabis products, we will only see an increase of the illegal importation or production of uncontrolled treatments. As backyard production continues due to the demand, problems will exist of quality assurance, dosages, misinformation and this becomes more of a danger to the population. In one call I received recently, I was told by the caller they had been advised to get cannabis or hemp oil with a 20 per cent THC. As you can imagine, I thought it was ridiculous, and I told them I thought they would not be conscious at this level.

The barrier to this industry is the current legislation and the constant misinformation being generated largely by the media. The current scheduling is archaic. Without even considering this enquiry, the simple fact that hemp is still not approved for food in Australia, is ludicrous. If hemp is finally approved, 15 years after the first application, we will see some legislative changes. However, this may still not be for the whole industrial hemp plant. Industrial hemp, which still has no THC, is treated like heroin and even stricter.

CBD and other non-psychoactive cannabinoids should not be included on the schedules at all, as it is not a chemical compound that has negative effects. Non-psychotropic cannabinoids should not be listed the same as tetrahydrocannabinols and therefore not be prohibited or restricted in the same manner, particularly if grown under existing industrial hemp licensing. We need the law to allow for the extraction of the cannabinoids which includes, for our industrial hemp industry, the very low levels of THC. The government also needs to address the legislative changes, particularly in regard to the non-psychotropic cannabinoids, through the TGA.

In the meantime, we need to be allowed to commence or continue research from the ground up. I believe that we in the industrial hemp industry have been stalled in achieving this because of the definition of an exempted public institution for research purposes, under the schedule 9 interpretations. I was very happy to see yesterday, and in discussions today, that UTAS and the Menzies Centre would be able to perform trials. UTAS, as it currently stands, does not have the protocols, the standards, for the testing

procedures in place to be able to do CBD and THC testing. I will qualify this by saying that all our THC testing for our industrial hemp crops have to sent to the mainland.

I am also hoping this Government is supportive of the industrial hemp industry, that they will see the advantages of exploring and assisting us further in this agricultural industry, to bring it to its full potential.

CHAIR - May I take you back to the comments about UTAS's capacity, can you reiterate what the challenges are there? It is clear from the poisons act that the minister can exempt an institution to carry out any trials. UTAS is our only body.

Ms ESTREICH - From our point of view, we have been seeking to test industrial hemp, and we have our THC testing already in place. The forensic labs in New Town stopped being able to do our testing in about the year 2000.

CHAIR - Why was that?

Ms ESTREICH - Due to them not having up-to-date standards and because of the low level of hemp crops at the time, it was not feasible for them to continue and they did not want to keep doing THC testing. Through Hemp Australia's associated companies on the mainland they are heavily involved with plant sciences and analytical services set up through Southern Cross University. They do our THC testing for us and they are also expanding to be able to take on board the full CBD testing. They can do some CBD testing now but it is not definite. It is not a finite result, so they are currently changing their protocols to be able to provide a much more definitive result for testing for CBD.

UTAS at the present time do not have the protocols in place. The associated companies have done trials for UTAS because they are involved in plant breeding. They have been doing tests and trials with UTAS and with TIA as well. In the recent test just completed - I think it was early this year or late last year - they did not have the potential to do any of the testing for us and it went back to Southern Cross.

CHAIR - We will have to talk to UTAS about some of that, I think. So that is in TIA as well?

Ms ESTREICH - TIA have done some trials for the other associated companies. This has been financed by that other company. Any of the trials that have been done have been financed privately.

CHAIR - Can you tell me a bit more about Hemp Australia? You are the Tasmanian branch of the Hemp party.

Ms ESTREICH - No, we are not! Hemp Australia is a Tasmanian-registered business. We have been involved in many different areas. Basically our parent company is Ecofibre Industries. They have been instrumental in growing hemp crops here since 1999, and on a continual basis performing trials with TIA and UTAS. They have been trialling a number of different varieties and finding what grows here better. Through their other associated industries on the mainland, they are involved heavily in plant breeding. They hold many cannabis licences, including research licences through Queensland. The

Federal Police provide them with a lot of marijuana or seed crops because they are doing genetic testing and have access to seed banks all over the world. Part of that is doing a trial to find out how each species, or each variety, may react to different latitudes throughout the world, which is part of the crop testing done with UTAS.

CHAIR - We have had some evidence today about the seed bank. There are a number of seed banks around the world, are there?

Ms ESTREICH - The Demon seed bank that I heard of today? Yes, from a marijuana point of view. This is where I believe that we need to be able to differentiate between medical marijuana and industrial hemp extractions, and at what points. Your illicit industry today is not looking at 5 per cent. They are looking at 15, 20, or 30 per cent THC. In the seed banks that they are providing, what THC levels are they addressing? As I said, the research licensing in Queensland is anything over 3 per cent and the psychotropic effects of those other products are hugely increased in what would be needed in this medicinal industry.

The lady this morning who was stating that her product was tested at .035 per cent of THC actually backs the point that we do not need to go to huge amounts of THC. So, if you are looking at the illicit drug trade and utilising their seed bank varieties, it is obviously not necessary to go to those levels.

CHAIR - In terms of research, you seem to have focussed particularly on the growing of it and the qualities of the product, and finding products that can provide different levels of CBD, THC and other components. Have you looked at any of the research in terms of the efficacy in treating medical conditions? Or is that not an area that you tend to look at?

Ms ESTREICH - It is not an area that I have been focussing on personally. However my managing director, who is also associated with all of these other companies, is travelling the world, providing seed to the United States, and providing information that they require to have their industries continue. We are not doing medical trials ourselves.

CHAIR - You have a watching brief on it, I guess. Is that how you describe it?

Ms ESTREICH - I suppose so, yes. He has more of that than I do because my current perspective has been Tasmania and the industrial hemp production. We have been heavily involved in trying to get hemp food going. That has been our directive and direction.

CHAIR - You may not be able to answer this, but that is fine. Are you aware of any gaps in the research when looking at the potential health or medical benefits of cannabis? People may anecdotally claim it has a beneficial effect on their medical condition. Are there any gaps in the research that need to be looked at?

Ms ESTREICH - I think that there is so much information currently out there. Unfortunately, a lot of the trials have been done using a product called [inaudible], which is the 1 per cent THC and 1 per cent CBD. So that is not truly giving an indication of the broad spectrum of the availabilities. The website that I gave you is very thorough in a lot

of the work that it is doing. It will explain whether it is a THC or a CBD balance and things like that. I think it is giving a lot of good information there. There is just so much broad information out there that it is very difficult to be able to analyse technically, from a layman's point of view, what works and what does not. But it is obvious that CBD does work, and it is not necessary to have the high THC that goes with it.

CHAIR - You have obviously done a lot of work in the area. It is helpful to have someone who actually understands the product and the differences with it. A lot of people come with their anecdotal evidence and their views of the subject, but when you actually get involved in the research, that is very helpful.

Mr MULDER - This is an observation on that THC/CBD issue. Although CBD is talked about with medical cannabis, there is also - especially in terms of analgesics and things like that - a high demand in the medicinal area for the THC compound. So it is not quite as easy to separate the medicinal from the recreational as we might think.

Ms ESTREICH - I also think that there are issues in the terminology. As explained yesterday by the government, you have an MMPR, so it is medical marihuana. 'Medical cannabis' is an umbrella, but 'medical marihuana' differentiates that you are looking at high THC.

Mr MULDER - I think this is one of the problems with our schedules. It talks about the plant rather than its constituent parts, and perhaps the thing we need to do is start to break that definition apart to decide based on the relative concentrations of the chemicals we are looking for, and then treat them according to those.

CHAIR - We have head evidence from the medical profession about some conditions that require some THC to have an effect where others it does not necessarily.

Ms ESTREICH - That is right. That is why I am saying the THC is often used more for palliative care and severe pain relief.

CHAIR - And some spasticity.

Ms ESTREICH - Well, for spasticity there is still a certain amount that can be done at a CBD level without as high a level of THC. That is coming out more. As things keep progressing - in the industry we keep reinventing the wheel and we are not progressing any further and that is the difficult part of it. We are predominantly seeing that from the food industry because every single time we have come back, and 15 years ago, in the year 2000, ANZFA, as they were then known, stated that hemp for food was seen as applicable and nutritional, yet political viewpoints and the confusion with marijuana have kept that industry still. We still sit here now and this application for food has been going on for years now. Each time it has come back to a police issue or a drug testing issue. What if this person has THC and has a drug test of THC? There is no THC within the seed.

CHAIR - So why are we even having a discussion? That is the question. We go around in circles and we end up back where we started.

Ms ESTREICH - We are going around in circles and we keep reinventing it the whole time.

Mr MULDER - That is the nature of the wheel, apparently.

CHAIR - Some could argue then, from what you have said, that it is enough. We should always continue to do research because things change and emerge over time and all research pretty much says that further research is needed and that is the nature of it. At what point do we say, 'We have enough to know' and it is clearly identified in industrial hemp for food, but even some would argue in the medicinal marijuana - if you want to call it that to separate the two - we have enough to know that you can regulate that component. There are benefits to be had. One of the reasons there is not enough research, and some people want to claim that, is because it is a prohibited substance and it makes it hard to conduct research on in a large enough cohort to give you results that can be relied upon. Do you think there has been enough? Do we need someone to show a bit of leadership and make a decision?

Ms ESTREICH - I think there is a lot of information from the international point of view to make a starting decision to say 'yes, we can do this'. If we don't look at it then the Government has a duty of care to be able to provide something as an alternative. I do not believe that the opiates of today are doing the jobs that people are seeking or needing. As I said, there are a number of people out there who are suffering and, as a last-case scenario, what do they have to lose? If they were offered a trial to say we are going to do a CBD or whatever trial, I think that they would grasp that because they know full well -

CHAIR - They do for more harmful drugs anyway. They have trials with experimental drugs, people still volunteer for them, particularly when they are desperate.

Ms ESTREICH - That's right. And that last-resort scenario.

CHAIR - Do you think there is an issue here? We have had quite expensive drugs like - I am not sure if you are familiar with Ondansetron, a fairly new and quite effective antiemetic to deal with nausea and vomiting, and it is used in chemotherapy treatment. It does not always work for everybody, but it is certainly better than what we used to have. It is quite expensive. There is this constant push to have these new drugs that are shown to have benefits in a range of treatments to be put on the PBS. There is always a cost-benefit assessment there from the Government's point of view to say well if we can put it on the PBS it will cost *x* million dollars but it will keep this many people out of hospital and it will save us *x* plus $2 million or whatever. In considering that, do you have any idea about the cost of production of medicinal marijuana and it is part of the pushback when some of the drug companies stand to lose market share?

Ms ESTREICH - I cannot provide you how much it is to be able to produce it because even as an industrial hemp, we cannot even try to test our own product. We are finding it difficult to get that exempted institution even to test our own product as to what our CBD levels are in the crops that we already grow. I do not have any costing for the medical marijuana either. Under hothouse conditions and the security conditions for the THCs and whatever is necessary to even get it to that, we have not been able to do that. I am not involved in any of the extractions. Some of the extraction processes are being trialled, played with, at the moment interstate. But from an international level, as

Australia, we have to take onboard more of what has been achieved overseas and use that as a basis rather than starting right at the beginning. We have to use that as the basis and grow from there.

The other day there was mention of bringing these extracts in, whether from the mainland or overseas. I happened to be on the internet the other night and for your information, the company that is producing it in Europe and distributes through the US states that a 10 ml tube, stated as being 18 per cent CBD, is $US495. If you buy three, you can save $US250.

CHAIR - Someone is making some money.

Ms ESTREICH - How does that even fit into the scheduling? Coming back to GW Pharmaceuticals, they are starting to trial this new Epidiolex and they have been given the DEA approval to do that for epilepsy. That is going to have the lower THC content and I think they have stated that it is 98 per cent CBD with nearly zero THC. They are looking at that.

CHAIR - Will that be a consistent product, should they produce it and that will be done through the TGA?

Ms ESTREICH - This is still in the US. They have only recently been given a request to trial a pharmaceutical version. How long that trial would then take, who would know.

CHAIR - And the process that sits behind that.

Ms ESTREICH - Yes. They have information there, they have medical research there to do that, so why couldn't we move to that in Australia anyway? They obviously have the standards there.

Something else that is of interest - and because I do not have a pharmaceutical, scientific background - there are US patents that were put in place way back in the 1950s and the information provided in those US patents is about cannabinoids as antioxidants and neuroprotectants. The information is quite detailed and could form a basis, and there are other patents listed at the end of that, for medical research now.

CHAIR - Rather than starting back at the beginning of the road, you could start halfway up it. Thank you very much, Lisa, we really appreciate that. Is there anything you want to add in closing?

Ms ESTREICH - Thank you for the opportunity to address the committee and if there is any other information that I cannot provide, my managing director and his associated companies can. I know he would be more than happy to provide that information.

CHAIR - Where are you actually based?

Ms ESTREICH - I am in Tasmania and he is in Queensland and he has associations through New South Wales and Queensland.

CHAIR - Is he involved in the New South Wales places that are trying to get a trial going there?

Ms ESTREICH - I don't believe so, not for the medicinal side of things.

CHAIR - Thank you very much.

THE WITNESS WITHDREW.

Professor RAYMOND MICHAEL LOWENTHAL WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Thank you for coming along, Ray. The committee is being recorded and will be part of the public record. If you want to speak in private, you can make that request to the committee and we will consider it. That transcript would be only available to committee members, not to the public. You are covered by parliamentary privilege when before the committee but if you speak outside this arena, you are not.

Prof. LOWENTHAL - The main thing that concerned me when I heard what people were saying in the media was that they were talking about clinical trials. I do not know a lot about cannabis but I do not know a lot about clinical trials. I think people are perhaps a bit naive and do not fully understand what is involved in doing a clinical trial of any drug. From my point of view, I can't see why cannabis should be treated any differently to any new drug. Any test has to be done thoroughly, according to all sorts of recognised complex scientific methodology. If you put cannabis aside for the moment, when a new drug comes along that is proposed to be available to Australians, it has to go through a complex process of being approved. It is a two-stage process. First of all, it goes to the TGA - Therapy Goods Administration - where a whole lot of evidence is put before a committee. I used to be on that committee in the days before computers. They used to supply us with papers so high, giving documentation of how the drug has been tested, whether it is safe, and what its effects are. If that is approved, then the drug is available to be prescribed in Australia. But there is a second stage as to whether it gets on the Pharmaceutic Benefits Scheme. It has to be shown to be not just effective but cost-effective. We are not looking at the second phase for the cannabis, but even the first stage is a very complex process.

To prove that a drug is effective you have to test it against the best drug we have at the moment, or against a placebo, if there isn't already a drug. You have to have a significant number of patients to test it on, so that the results in the end will be meaningful statistically. Usually that involves hundreds of patients, but not always. If the effect is dramatic, it may require fewer people. But a typical drug that comes on the market in Australia here will get hundreds of patients. To have a drug approved in Australia and the world can cost hundreds of millions of dollars to develop. So how could people in Tasmania take part? There is no way in the world, in my opinion, that you could do a thorough, meaningful trial of a drug such as cannabis in Tasmania alone. What you can do is what we have done for cancer and leukaemia. We cooperate with other hospitals, nationally and internationally. That way you the sufficient numbers to be able to determine whether the results you are seeing are meaningful and reliable. I cannot see how any kind of meaningful trial can be carried out in Tasmania alone.

I did notice the other day that the New South Wales government is proposing to do some kind of trial. It might be possible for Tasmanians to participate in that, depending on exactly what they proposed to do and how they proposed to do it.

It is not just the logistics, it is also the cost. The cost of running these trials is substantial for new drugs. For pharmaceutical drugs, of course, the pharmaceutical industry often supports these trials and so does the government. But you are still looking at a substantial cost. I am not saying whether cannabis is effective or not. I am just saying

that people need to understand what would be involved if you wanted to do a trial. Quite a number of trials have been done with cannabis in the literature. One of the criticisms is that most of these trials are small. There are not very large numbers of patients. That means statistically they are often unreliable. That is one of the problems with trying to assess whether cannabis is useful for any particular indication or not.

CHAIR - For children with rare forms of intractable epilepsy, to actually do a randomised controlled trial and to get ethics approval to proceed would be next to impossible.

Prof. LOWENTHAL - Exactly.

CHAIR - Take the case of a randomised controlled trial with cannabinoids, as opposed to conventional anti-convulsive medications. If a child starts having seizures very frequently again, the chance of compliance would be reduced for participation in a trial. When we have got parents who are absolutely desperate, and when their child is on a 'do not resuscitate' order and they can see a benefit, how do we assist these people?

Prof. LOWENTHAL - What I did not mention about running a trial is that, before you even get the trial started, you have to draw up a protocol that documents exactly what you are going to do, and whom you are going to test. You have to get ethics approval, which you have just mentioned, before you can do it. Epilepsy is not my field, but there is no way that you could do a trial with epilepsy by withdrawing the standing treatment. You will never do that. What you might do is compare the standard treatment with the standard treatment plus cannabis, and see whether you can document that. But on a single patient, it is almost impossible to cut the assurance of exactly what you are dealing with.

CHAIR - Is there a magic number in this?

Prof. LOWENTHAL - No, there is no magic number. We have to always consult with statisticians because it depends on how big the effect is that you expect to see. When talking about epilepsy, if you expect to see a complete stoppage of all of the seizures, then, of course, you would not need very many patients to prove it. But if you expect to see a 10 per cent reduction in the number of seizures each day on average, or over a certain period, then you need a much larger number of patients to prove it. A 10 per cent improvement over what one has is often all one is looking for with new drugs. So these trials to show that often involve hundreds of patients.

CHAIR - It is difficult when you have got a pretty rare condition.

Prof. LOWENTHAL - Exactly. You have to deal with rare conditions in a different way. If someone says that they have a new drug for leukaemia or for breast cancer or something, where you have got hundreds of patients, it would not be hard to run a trial.

CHAIR - It would be easier to get the numbers.

Prof. LOWENTHAL - Much easier. But if you have a rare condition, then you may have to do things differently - relax the criteria, and do it in a less strict way. There are mechanisms for rare diseases for drugs to be provisionally approved or approved for restricted purposes and that happens with rare cancers for example. We have to contact

Canberra authorities and get approval and they may allow a drug to be available for a rare condition.

CHAIR - They could do that for these children?

Prof. LOWENTHALL - They could.

CHAIR - Can you explain the process around that for rare cancer?

Prof. LOWENTHAL - You would obviously have to have some evidence that it would work. There are several different processes. One is that a drug may be approved for very restricted purposes so if we have a patient in front of us I would have to ring a TGA number in Canberra to get approval. Sometimes drug companies will make drugs available for rare conditions and you go to the pharmaceutical company. I don't know what the equivalent would be for cannabis. It would be much better if the whole process was handled as if we were looking at a new drug. It could be handled through Canberra so whatever was done applied to the whole country.

Mr MULDER - The period of extension between a full clinical trial for a new product that has not been trialled yet - it might have been found to be effective on laboratory rats or something - is there a difference between that and the post market assessment of a product that is already widely used in the community and therefore you [inaudible] in assessing it and the only real difference would be that you would now have control, quality, and doses of the relevant chemicals, that you were assessing their impact on, treating it as a widely used remedy rather than the full clinical drug trials which we have heard evidence before that the only time you can get down to those is if you get a major pharmaceutical company prepared to put the millions of dollars in to firm up a product over which they can make mega bucks because they can patent it, which they cannot do with this product. I am wondering whether there is another way of doing trials which are not technically clinical trials but will at least assess the effectiveness of the product in dealing with particular disorders?

Prof. LOWENTHAL - Post marketing trials, on the whole, have been failures. The theory is that you could do it but, generally speaking, if you are looking at, and putting cannabis aside, a standard drug. Once that drug has been approved, if I can be cynical again, the drug company is not interested in giving any more details about it once it is on the market because they might find out it is not as good as they thought.

CHAIR - Or it harms people.

Prof. LOWENTHAL - Or it harms people, exactly. Although, in theory, that is the way you could do things, in practice it is not widely adopted. You could do it. You still want some very precise method drawn up of metering the effect. If all you are looking at is 10 per cent of the cases, or 10 per cent of people who are taking the drug, you will not get a proper indication of whether it works. You have the cannabis because people use it so widely. If you ask people to report whether it helps or not you get a very biased view because presumably people would report the cases where they think it works and not report the cases where they do not.

Mr MULDER - If we picked up the Dutch model, basically it has controlled the quality of the product. It is licensed through the Ministry of Health, Wellbeing and Sport, I think, and you are given controlled dosages which GPs supply and possibly administer. Would we then not be in a position to say, at least, that we have the evidence from those that have used it because you have the doctor deciding whether or not he wants to go down that path?

Prof. LOWENTHAL - It would be better than nothing. The big problem is to get thorough coverage because one of the big criticisms of a lot of trials that are reported is that they are biased and people tend to report the good results and not report the bad results or not report the side effects. If you are going to get a proper and thorough result you would have to ensure you have as thorough coverage as possible but in theory, I agree with you.

Mr MULDER - That would be a good model to say to the doctor, yes, when you prescribe this thing you must report it because you are using it. You must report the dosages and you must report the effects on that and the idea would be you would let that run for about four or five years and then you might say we still need, on a case-by-case basis. You can't go through clinical trials as a means of going out there. The anecdotal evidence that we hear is pretty heart wrenching. It is a bit hard to say because this has not been through a complex and proper treatment you cannot take it. It is like suggesting to people that you can't drink water unless it has been through a clinical trial.

Prof. LOWENTHAL - I am not familiar with the Dutch model in detail but as you have described it, it sounds quite reasonable.

Mr MULDER - There is an office that licenses its cultivation. It requires quality assessment and the beauty of it is they have a recreational market where there are no quality controls which they can benchmark against.

CHAIR - You may not wish to comment on this but in your practice as an oncologist we have had some anecdotal evidence that people who are suffering from the side effects of some of the nasty poisons we give people to try and keep them alive they resort to self medication using cannabis. Did you ever have patients telling you they were doing that?

Prof. LOWENTHAL - So what goes around comes around. I have been around long enough to know. About 30 years ago there was a push very similar to this that cannabis should be used and it was being particularly pushed for chemotherapy induced nausea and vomiting. There are quite a number of controlled trials which show that it does have a beneficial effect. It reduces it. Most of these trials, as far I know all of them, were done many years ago, when cannabis, of one sort or another, was compared with the best drugs we had at the time - 30 years ago - Stemetil and drugs like that. It was found that cannabis in various forms had an effect that was similar to that of Stemetil, the old drug, and sometimes even a little bit better. Since then our ways of managing nausea and vomiting caused by chemotherapy has improved tremendously with some new drugs which are much more effective than the old ones. I have not seen any comparisons of these newer drugs with cannabis so I cannot say how they would go but from the way they worked 30 years ago, I would guess that cannabis is not nearly as good as the newer drugs.

However, in response to your particular question, yes, I did have people years ago that took cannabis for the nausea and vomiting. One of the issues they reported, and this is anecdotal, was people who were used to using marijuana found it helpful. People who were not used to using it often did not like the kind of psychological effects they got from the cannabis of what is called euphoria or strange feelings. I have had people anecdotally who say it helped them.

CHAIR - I know you are not an expert in cannabis, so you may not wish to comment too much on this, but we understand there are products now that have a much lower THC level and thus avoid a lot of those hallucinogenic, psychoactive effects but they do get the other benefits of the nausea control, the appetite stimulant, and things like that because as you would know people cannot eat when they are spewing their heart out and they have some wasting as a result. There is maybe an opportunity to do trials with those, not just growing your own pot in the backyard which probably has a high THC and that is why it is being grown for the recreational use to get a more targeted product and then trial that against drugs like Ondansetron that have side effects too and don't, as I understand it, have the appetite stimulant and nutritional benefit that cannabinoids can have and is expensive as well,. You are not aware of any research that has been done along those lines?

Prof. LOWENTHAL - No, I am not. I suppose the question is whether even though Ondansetron and that class of drugs are very effective, they are not 100 per cent effective and so should we have additional options such as cannabis. I would not be against that but I would like to see it done in some kind of controlled way so that you know in the end whether it is working or not and what the side effects are.

CHAIR - It is about good palliative care, isn't it, providing options to patients?

Prof. LOWENTHAL - Yes, exactly.

CHAIR - As people say, if they are dying what do they have to lose?

Prof. LOWENTHAL - You raise the issue of palliative care. Within the PBS and the drug approvals in Canberra, there is a special category of drugs for palliative care. There is already a system where drugs for palliative care can be made available for patients with a lesser standard of proof than is used for drugs generally, so that system already exists.

CHAIR - In terms of palliative care, these are things New South Wales is trying to grapple with at the moment. I have only read what is in the media so I don't know any more than that, but looking at people with a terminal illness. How to define terminal illness and that system you are talking about, people having palliative care. What point? Palliative care, in my mind, should start pretty much at diagnosis if the illness is going to kill you, even though you might be relatively well at the time. Most of us tend to think of palliative care as the person lying in the bed on their last few days, but I think it should be a much longer process. How does that work?

Prof. LOWENTHAL - I have forgotten the exact wording now. You would have to look it up, but there used to be a pharmaceutical benefits book, which is now all online, but there is a special category of drugs that are available on the PBS for palliative care

patients. I cannot remember the definition but I think a doctor has to certify that the patient is. I would not swear to you - you would have to look it up. It is an easy process.

CHAIR - What are we looking up?

Prof. LOWENTHAL - The Pharmaceutical Benefits Scheme has details.

CHAIR - It is on the PBS site.

Prof. LOWENTHAL - I think it is a fairly simple process as far as I know. A doctor just has to certify the patient has to -

CHAIR - Even though it is an illegal product?

Prof. LOWENTHAL - Illegal, no. I am talking about drugs that are approved by the TGA and then allowed on the PBS.

CHAIR - A treating physician could not contact or whatever you need to do to enable that person to use cannabis?

Prof. LOWENTHAL - No. The drugs that are approved under this process are listed. They are pre-approved. You cannot use a drug that is not on the list.

CHAIR - It is a bit limited, but there are processes there. If a cannabinoid of some sort was rescheduled to schedule 8, thus approved through that process, then you could access it that way.

Prof. LOWENTHAL - Yes, then it would also be under the PBS and so the cost would be very small.

CHAIR - You have been very helpful, thank you.

Mr MULDER - It is nice to hear from someone with experience, knowledge, and without an axe to grind.

Mr ARMSTRONG - In your conclusion, scientific evidence of cannabis is very limited. Would it be true to say with some people, though, it would have a better affect than other people? It is like any drug, isn't it, some drugs work on some people and do not on others, so that would be the same with cannabis?

Prof. LOWENTHAL - I presume so. The problem is to assess its beneficial effects, when the trials have been on the whole quite small. If you look at the trials that are reported they often had 13 patients, 21 patients, whereas for a thorough trial of a new drug you are talking about hundreds, so it is very hard to draw a conclusion when you only have such small numbers.

Mr ARMSTRONG - You would do a trial over hundreds of people?

Prof. LOWENTHAL - That is the idea.

Mr FARRELL - On point 2 you mentioned before how it may stop nausea and vomiting in some patients, and in your submission it can cause excessive and life threatening vomiting.

Prof. LOWENTHAL - Yes, paradoxically it has been reported.

CHAIR - It is a bit like opioids being used to treat pain and it gets to a point where the pain gets worse.

Prof. LOWENTHAL - I was quoting other reports.

CHAIR - Unfortunately, we do not have a magic wand in medicine.

Prof. LOWENTHAL - They have a lot of reviews. This is an issue that is worldwide at the moment and there have been quite a lot of reviews published. I am sure you have seen it on the internet, there are a lot of very thorough reviews and most of them are very cautious. When they come down they say that the evidence that it is beneficial is limited. On the evidence of harm, they seem to be on the whole reasonably safe, but there are side effects, so it is very hard to decide exactly. I do not envy you. It is very hard to find a middle way.

CHAIR - That is why we are doing it this way, rather than -

Prof. LOWENTHAL - I did not want people to go rushing off to do futile trials, wasting their time, energy and money doing something where, in the end, you would not get any useful information.

CHAIR - Thanks very much for you time, we appreciate it.

THE WITNESS WITHDREW.