Submission No 28

INQUIRY INTO USE OF CANNABIS FOR MEDICAL PURPOSES

Organisation: HEMP Party Australia, NSW Branch of the HEMP Party of Australia

Date received: 6/02/2013

HEMP Party NSW Submission.

The Submission is entitled: Factors to be Considered in Regulating the Supply of Medicinal Cannabis in NSW.
The submission has been prepared by the NSW Chapter of the Federal HEMP Party.
Second document by Dr Nutt should be appended to submission.

To: The Director

General Purpose Standing Committee No. 4

Parliament House
Macquarie St
Sydney NSW 2000

The NSW Branch of the Federal HEMP Party of Australia respectfully submits the following advice to the *Use of cannabis for medical purposes (Inquiry).*

The Submission is entitled:

Factors to be Considered in Regulating the Supply of Medicinal Cannabis in NSW.

This submission has been prepared for the NSW Chapter of the Federal HEMP Party

Contact: James Moylan (the Federal Treasurer and National Campaign Director of HEMP)

INDEX:

Introduction

In the years since the last inquiry into medicinal cannabis in NSW, in 2004, the nature of the cannabis law reform debate around the world has changed dramatically. For example: right now in any one of 19 US States, any American who has a medicinal cannabis card can simply walk into a retail outlet and purchase their weed. It has become 'no big deal'.

Writing in 2009 one American commentator described Southern California as hosting a 'Green Rush'. From the outset business in the US was very willing to invest in medicinal cannabis. Now, several years later, there are thousands of dispensaries in operation. You can just ring up and get it delivered. You can order it on the web. Growers are now small businessmen rather than 'hoodlums'. Tiny dispensaries have given way to large gleaming shopfronts. Medicinal cannabis, as an industry, has arrived.

Other outcomes are also apparent. Back-alley dealers have disappeared. Kids in school find it harder to buy pot. Fewer kids appear to be seeking out pot. Police officers find talking to children easier. Local municipalities are building schools as less people are going to gaol, fewer arrests are being made, and councils have access to a new stream of revenue. All on the back of a change that has as much to do with a new mindset as it has to do with an alteration in the law.

What is this new mindset? All these positive outcomes are based on the comprehension that drug abuse is a medical, not a criminal problem, and that cannabis and HEMP are not much of a problem at all. This understanding is articulated by a rational appraisal of the relative and potential harms that might attach to each of the recreational and medicinal/therapeutic agents that are in use within our society. This new mindset advocates the fashioning of regulations and laws that address and contain identified harms rather than by simply punishing the drug taker. This new way of conceiving of drug use is often described as a 'relative harms' approach.

The consideration of how to craft appropriate medicinal cannabis regulations can be undertaken in isolation and without regard to cannabis use generally, however it is our submission that to do so will simply replicate the same mistakes that have been observed in many other jurisdictions across the world.

Factors to be Considered in Regulating the Supply of Medicinal Cannabis in NSW.

In most US states where the provision of medical cannabis has been legalised it has also rapidly precipitated an easing of the criminal sanctions relating to possession and personal cultivation. Usually these offences have been downgraded to misdemeanour offences.[1]

This is due to a number of factors acting in unison:

1) These jurisdictions invariably realised that the provision of medicinal cannabis in an environment where the use of recreational cannabis is still illegal leads to the creation of a suite of hugely complex regulations that are largely devoted to preventing cannabis being traded illegally rather than ensuring the provision of cannabis in a suitable form for ill patients.

2) The 'harms' that were proposed as being prevented by keeping recreational cannabis use illegal, when assessed rationally, proved to be largely illusory.

3) The 'harms' that were being inflicted by keeping recreational cannabis use illegal included harms being visited on medicinal cannabis users. In such a regime their medicine is much more expensive than it need be and is also much more difficult to access.

4) The 'harms' associated with the criminalising of cannabis clearly outweighed the 'harms' that the outlawing of cannabis was designed to prevent.

Due to the influence of these factors on legislatures across America, currently about half of US cannabis consumers (both medicinal and recreational) purchase and consume their cannabis legally, and another quarter do so in a legal regime which treats possession and personal use as a mere misdemeanour.

Sérgio Rodrigues, the president of the Portuguese Consumers Association CASA, in a recent video entitled 'Drug Policy in Portugal - The Benefits of Decriminalization' (http://youtu.be/KtNrsSb3-CM) summarised the effects of the complete decriminalisation of drug use in Portugal after ten years. In doing so he enunciates a 'relative harms' mindset:

> "I think it was an important step for us, all the rest of Europe and World should follow it, even if there are some things presently missing, we are not totally satisfied yet. For instance, in the way police intervene with drug users, and in some situations where the law is not complied with.

[1] For example in California, as of January 1, 2011, possession of one ounce (28.5 gms) or less of marijuana has become a mere infraction, punishable by a maximum $100 fine (plus fees) with no criminal record under *Ca Health & Safety Code 11357b*.[1]

> That's our main concern. About the law itself; drug using is not a crime anymore, so the prisons are not loaded with so many drug users that ended up there for just one or two doses, and that's something good.
>
> For us, the drug user is a citizen. If there was till now an interesting victory, that was the dislocation from the justice and delinquent perspective, from the drug user as a criminal, to the ill person, I think that there is still a lot of work to do.
>
> The drug user must be seen, mainly, as a citizen. First of all he is a citizen, with civic obligations, but also with rights. With the right to his personal development, with the right to a free choice concerning his life style, provided that he doesn´t harm anybody, and with right to decide about his destiny.
>
> Punishment is not a way to educate people. So I think that education, the way of people growing up, and developing their self-esteem, comes through many other processes of integration in a community where they feel that people are not excluded from that society. Exclusion is the worst thing that can be done, and we should have already learned this.
>
> We have already experienced many centuries of exclusion in Europe. For a thousand years we have been trying to see if it's possible to overcome exclusion. We are giving people the autonomy and freedom that took one thousand years to develop.
>
> The absolute monarchies just disappeared few years ago. The right to vote for women is very recent. The respect for other religions is very recent. The rights of minorities; it is all very recent.

It is the opinion of the HEMP Party of Australia that all policy and regulation relating to drugs in Australia should be fashioned with regard to the 'relative harm' associated with the substance under consideration. The 'drug user' must be considered, first and foremost, as a citizen with rights to both personal development and free choice.

We submit that if a 'relative harms' approach is taken by the governments of Australia regarding cannabis, they will engage this topic in the same 'best practice' manner as has been employed by enlightened legislatures around the world.

James Moylan
National Campaign Director,
HEMP Party of Australia.
27th December 2012.

Part One: The Recreational Elephant in the Medicinal Cannabis Room

No rational suite of regulations governing the production, distribution, sale, prescription, and/or dispensing of medicinal cannabis can be drafted whilst the recreational use of cannabis remains a criminal offence.

Regarding medicinal and recreational cannabis regulations

In the 'Conclusion' to the 2004 NSW Parliamentary Library Briefing Paper 'The Medical Use of Cannabis: Recent Developments' it was proposed that:

> "Perhaps the one agreed conclusion is that the analysis of the medical use of cannabis should be separate to, and distinct from, the issue of its social/recreational use and the many arguments for and against the legalisation or decriminalisation of cannabis in this wider context."

In other words it was recommended, by one and all, that the medical cannabis issue should be considered in isolation from the consideration of the recreational use of cannabis. The HEMP Party disagrees with this assertion in the strongest possible terms.

No doubt this same proposition will be trotted out once more before this committee of inquiry. Many submissions will urge the Committee to consider *only*;

- matters pertaining to the efficacy and safety of cannabis for medical use;
- if and how cannabis should be supplied for medical use;
- and regarding the legal implications and issues concerning its medical use.

This would be a mistake. History demonstrates that the fashioning of a suite of rational medicinal cannabis regulations cannot adequately be undertaken in the presence of a black market.

Therefore, the most difficult problem that will be faced by this inquiry will not relate to deciding whether or not cannabis might be a valuable medicine (as this assessment is entirely outside of the committee's jurisdiction and pay grade and has already been made elsewhere by scientists, doctors, & millions of patients worldwide). Rather the most difficult problem that will be faced by this committee will relate to the fashioning of

transitional regulations that will enable patients to gain access to their preferred medicine even while cannabis use for non-medical purposes still attracts criminal penalties.

Why describe these initial regulations as 'transitional arrangements'?

In jurisdiction after jurisdiction, all around the world, the developing of regulations and practices enabling a medicinal trade in cannabis has initially focused on putting up Chinese Walls to insulate the legal trade from an illegal 'black market'. However these factors do not provide for rational precepts to guide the development of best practice regulatory and prescriptive guidelines. Rather they foster a focus on the difficulties presented by the particular prevailing political conditions. So, in jurisdiction after jurisdiction, all around the world, similar mistakes have been made and can be identified.

The following identifiable faults are manifestly evident in medicinal cannabis regulations wherever the recreational use of cannabis remains a criminal offence:

- ☒ The cost of the material input is grossly inflated.
- ☒ Regulations and paperwork are ludicrously abundant.
- ☒ Physicians are in the frontline acting as 'gatekeepers' for recreational users.
- ☒ Citizens are encouraged to lie to gain access to recreational drugs.
- ☒ Citizens are encouraged to regularize their consumption of cannabis by treating it as a required therapeutic agent.
- ☒ Pharmaceutical companies are required to erect elaborate security systems to guard their production and storage of an herb.
- ☒ Many people who might find work in the legal industry are precluded from the emerging industry (as they have a criminal conviction).
- ☒ The court system is asked to arbitrate on medical matters.
- ☒ The medical & therapeutic market bleeds into the black market.
- ☒ The black market bleeds into the medical & therapeutic market.
- ☒ The regulations are focused on protecting and policing proprietors at the expense of facilitating and enabling patients.
- ☒ The medical cannabis industry has been targeted by organized crime groups.
- ☒ The cost of policing cannabis use will increase rather than decrease.

Part Two: Costs.

"Approaches which explicitly reject an evidence-based public health approach, but instead focus on incarceration and criminalisation of addicts, continue to utterly fail, at enormous financial and human cost."[2]

The HEMP Party of Australia urges the inquiry to commence their deliberations with a clear cognisance of the nature of the actual harms and attendant costs that might be attributed to the use of cannabis in our country.

What harms are Australian governments protecting us from?

For most of the social intoxicants the 'harm' attending the use of the drug is easily quantifiable. However with cannabis, measuring the cost of any personal or social 'harm' that might be inflicted is problematic; this is because there is no appreciable 'harm' being caused by the use of the cannabis in our society.

Quantifying the costs of Cannabis Abuse to Society.

The costs of Direct Harms.

Unlike alcohol or hard drug abuse there are no appreciable 'direct harms' attending the use of cannabis. Even though there are apocryphal stories in the public discourse of great physical and psychological harms being inflicted, and that there are victims aplenty being warehoused in our medical system, these tales are entirely a residue in our social discourse resulting from so many years of cannabis use being deliberately demonised. Whenever these stories are investigated, and these 'victims' are searched for; they are entirely unable to be located.

The costs of Indirect (secondary) Harms – Medical.

In an effort to combat this embarrassing lack of evidence of any actual 'direct harm', the cannabis debate has endlessly focussed on 'secondary' (or indirect harms) that might attend cannabis use. When John Howard commissioned a report (particularly designed to concord with his own personal opinions) the following secondary aspects of cannabis use were identified as representing a variety of possible 'harms'.[3]

---

[2] Professor Nutt, in his essay entitled '*Hypothesising an alternative: Applying the scientific process to drug policy*'

[3] In a review of cannabis law in Australia that was written to inform the *Federal Ministerial Council on Drug Strategy* that met on the 15th of May, 2006.

> "The physical harms of cannabis include [1] an increased risk of accident when driving under the influence of cannabis, [2] respiratory problems when cannabis is smoked, and [3] cardiovascular problems in those who are vulnerable. [4] Cannabis intoxication can cause cognitive deficits such as poorer memory and attentional problems (as might any intoxicant), but there is not enough evidence to conclude that these deficits persist after cannabis use is stopped for at least a few weeks. Cannabis represents [5] one of many risk factors for the development of psychotic disorders such as schizophrenia, such that heavy cannabis use may trigger psychosis in those who are predisposed to suffering from such disorders."[4]

Note that factors 1, 3 & 5 are simply secondary risk factors relating to the consumption of any legal or illegal intoxicant. Further, that [4] 'cannabis intoxication' might possibly cause short-term 'cognitive deficits' is rarely described by the users of cannabis as representing a 'harm' (more often they call it 'getting stoned').

The only identified 'harm' that is not entirely illusory is the fact that smoking can cause respiratory problems. This is certainly a matter that should be weighed in assessing relative harm (see Part Three of this document).

The costs of Indirect (secondary) Harms – Legal.

The only appreciable secondary harms attaching to the use of cannabis in our society relate solely to the illegal status of the herb.

Cannabis use is relatively harmless; however cannabis illegality has caused, and continues to cause, extensive harm to many individual Australian citizens for no identifiable personal or social benefit.

Cannabis illegality costs the Australian taxpayer:

- more than 2 billion dollars a year in foregone taxation revenue,[5]
- more than 3 billion dollars a year on customs, police, courts, prisons, etc.,

Cannabis illegality costs some individual Aussies much more than others. The HEMP Party of Australia is aware of individual citizens who have:

---

[4] McLaren, J., Mattick, R. P., *Cannabis in Australia: Use, supply, harms, and responses* (2006). Monograph series No. 57. Drug Strategy Branch, Australian Government Department of Health and Ageing Drug and Alcohol Research Centre, University of New South Wales, 2006 28.

[5] Estimate c/o Dr John Jiggens.

- suffered massive and lasting impairment whilst in prison on cannabis charges,
- been bankrupted due to excessive fines for cannabis cultivation (for medicinal use),
- committed suicide following being charged for growing cannabis,
- suffered family break-ups due to policing pressure.

Quantifying the costs of Alcohol Abuse to Society.

One recent study estimates that:

> "The total social costs of alcohol abuse (both tangible and intangible) in [Australia during] 2004/05 are estimated to be, at a minimum, $15.3 billion, with a further $1.1 billion attributable to the joint consumption of alcohol and illicit drugs." [6]

Of course these figures fail to take into account the profound emotional and psychological distress that is visited upon hundreds of thousands of Australians each year as a result of alcohol abuse.

Mitigating the negative effects of alcohol, pharmaceutical, cocaine, heroin, amphetamine, and tobacco abuse currently costs our society many billions of dollars every year.

Mitigating the negative effects of cannabis abuse currently costs our society nothing.

The continuing illegality of cannabis costs our society at least five billion dollars a year in futile expenditure and foregone revenue.

[6] Collins D, Lapsley H. *The avoidable costs of alcohol abuse in Australia and the potential benefits of effective policies to reduce the social costs of alcohol*. National Drug Strategy Monograph Series no 70. Canberra: Commonwealth of Australia, 2008 6.

Part Three: Relative Harms.

The HEMP Party advocates that all Australian governments adopt a 'relative harms' approach whenever considering drug law reform and in the crafting of appropriate regulations.

A rational scale to assess the relative harm of drugs.

In a famous paper published five years ago in the Lancet, *Development of a rational scale to assess the harm of drugs of potential misuse,* Professor Nutt of the UK codified the 'relative harm' approach.[7]

This approach is predicated on treating drug policy and treatment as medical concerns and not criminal matters. The following extracts from this seminal work will assist the reader in comprehending the science driven basis of the 'relative harm' model.

Development of a rational scale to assess the harm of drugs of potential misuse.

"Current approaches to counter drug misuse are interdiction of supply (via policing and customs control), education, and treatment. All three demand clarity in terms of the relative risks and harms that drugs engender." …[8]

"However, the process by which harms are determined is often undisclosed, and when made public can be ill-defined, opaque, and seemingly arbitrary. In part, this lack of clarity is due to the great range and complexity of factors that have to be taken into account in estimation of harm and the fact that scientific evidence is not only limited in many of the relevant areas but also evolves progressively and in unpredictable ways."[9]

"Here, we suggest a new system for assessing the potential harms of individual drugs on the basis of fact and scientific knowledge. This system is able to respond to evolving evidence about the potential harm of current drugs and to rank the threat presented by any new street drug."[10]

---

[7] David Nutt, Leslie A King, William Saulsbury, Colin Blakemore, 'Development of a rational scale to assess the harm of drugs of potential misuse' *Lancet* 2007, 369, 1047–53. **A complete copy of this important paper is included in the appendices to this submission.**

[8] *ibid* 1047.

[9] *ibid*

[10] *ibid*

Categories of harm

"There are three main factors that together determine the harm associated with any drug of potential abuse: the physical harm to the individual user caused by the drug; the tendency of the drug to induce dependence; and the effect of drug use on families, communities, and society."[11]

	Parameter	
Physical harm	One	Acute
	Two	Chronic
	Three	Intravenous harm
Dependence	Four	Intensity of pleasure
	Five	Psychological dependence
	Six	Physical dependence
Social harms	Seven	Intoxication
	Eight	Other social harms
	Nine	Health-care costs

Table 1: Assessment parameters

Assessment of harm

'Table 1 [above] shows the assessment matrix that we designed, which includes all nine parameters of risk, created by dividing each of the three major categories of harm into three subgroups, as described above. [A panel of expert p]articipants were asked to score each substance for each of these nine parameters, using a four-point scale, with 0 being no risk, 1 some, 2 moderate, and 3 extreme risk. For some analyses, the scores for the three parameters for each category were averaged to give a mean score for that category. For the sake of discussion, an overall harm rating was obtained by taking the mean of all nine scores.'[12]

Results

'Use of this risk assessment system proved straightforward and practicable, both by questionnaire and in open delphic discussion. Figure 1 shows the overall mean scores of the independent expert group, averaged across all scorers, plotted in rank order for all 20 substances. The classification of each substance under the Misuse of Drugs Act is also shown. Although the two substances with the highest

[11] *ibid*
[12] *ibid* 1049.

harm ratings (heroin and cocaine) are class A drugs, overall there was a surprisingly poor correlation between drugs' class according to the Misuse of Drugs Act and harm score.'

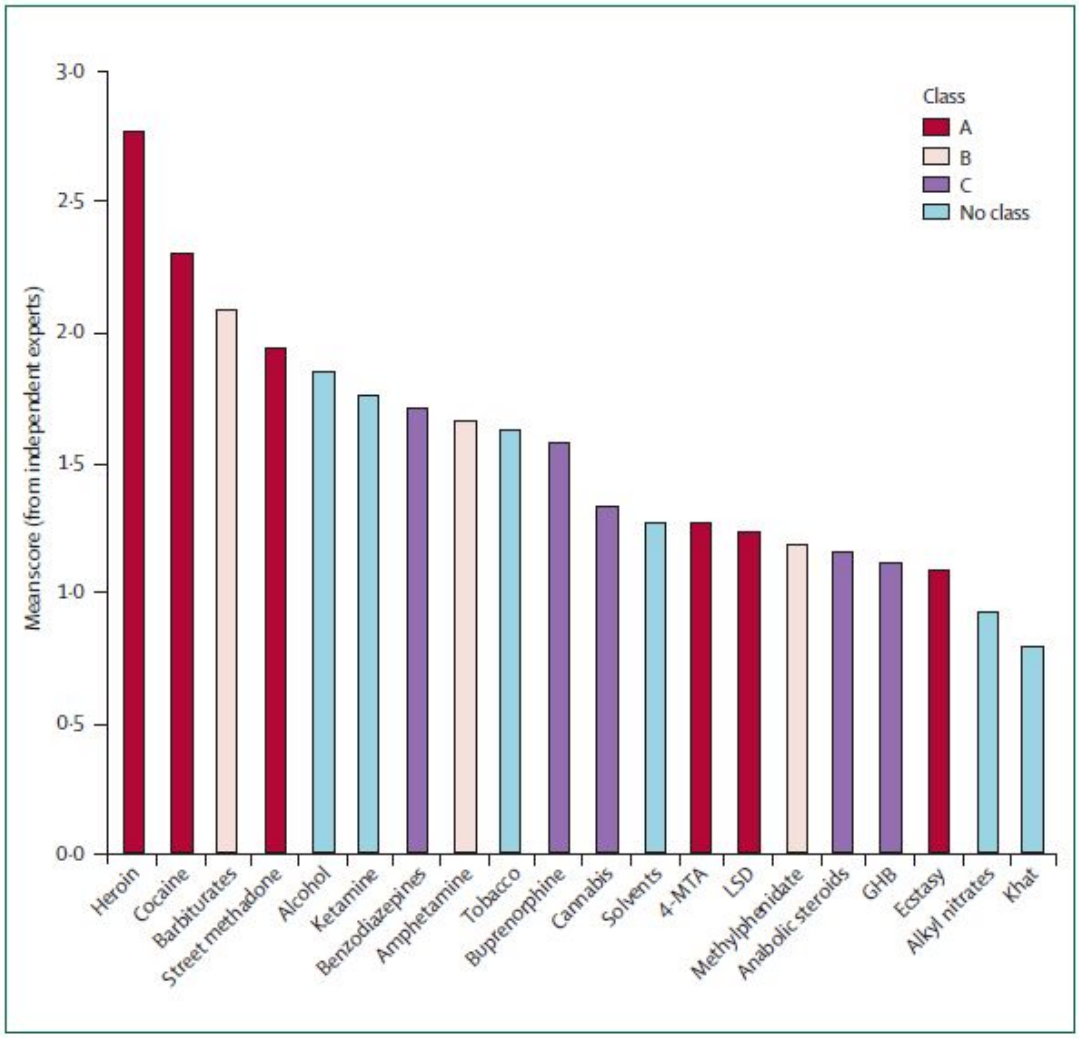

Figure 1: **Mean harm scores for 20 substances**
Classification under the Misuse of Drugs Act, where appropriate, is shown by the colour of each bar.

Discussion

'Our findings raise questions about the validity of the current Misuse of Drugs Act classification, despite the fact that it is nominally based on an assessment of risk to users and society. The discrepancies between our findings and current classifications are especially striking in relation to psychedelic-type drugs. Our results also emphasise that the exclusion of alcohol and tobacco from the Misuse of Drugs Act is, from a scientific perspective, arbitrary. We saw no clear distinction

between socially acceptable and illicit substances. The fact that the two most widely used legal drugs lie in the upper half of the ranking of harm is surely important information that should be taken into account in public debate on illegal drug use. Discussions based on a formal assessment of harm rather than on prejudice and assumptions might help society to engage in a more rational debate about the relative risks and harms of drugs.'[13]

"There is good evidence that decriminalisation does not radically increase drug use and can reduce some measures of harm, as shown by a balanced review of the first ten years of the Portugal experience of decriminalisation."[14]

"An increase in the availability of some drugs may actually lead to a reduction in the use of other more harmful drugs, so reducing net harms to society. We saw a noteworthy example of this in the past few years with the advent of the stimulant mephedrone. As this became popular, cocaine users seem to have switched to mephedrone and cocaine deaths fell by almost a quarter."[15]

[13] *ibid* 1052.

[14] Professor Nutt, in his essay entitled '*Hypothesising an alternative: Applying the scientific process to drug policy*'

[15] Professor Nutt, in his essay entitled '*Hypothesising an alternative: Applying the scientific process to drug policy*'

Part Four: 'Sending the wrong message'.

The cannabis law reform debate has traditionally been focused on a restricted number of questions which seem to be the mainstay of the anti-cannabis law reform lobby. These questions are asked repeatedly and at every opportunity, not in an attempt to elicit information, but rather as a way of making and publicising false assertions.

- ☒ "Doesn't legalizing cannabis send the wrong message?"
- ☒ "Won't legalizing cannabis lead to more drug use in our society?"
- ☒ "Won't legalizing cannabis lead to more teenage use of cannabis?"
- ☒ "Doesn't cannabis use increase the frequency of mental illness?"
- ☒ "Isn't cannabis just a gateway to other more dangerous drugs?"

"Doesn't legalizing cannabis just send the wrong message?"

What messages are being sent by our current drug laws?

If our statutes truly reflect a 'message' that we want to tell our society then our contemporary drug laws say that:

- Cannabis and heroin are equally dangerous.
- Cannabis use is more dangerous than alcohol use.
- Smoking tobacco is better for you than smoking cannabis.

So many citizens naturally conclude that:

- The law is nonsensical (and can be ignored), and / or,
- Our government is either malicious or misinformed (or both).

"Won't legalizing cannabis lead to more drug use in our society?"

This question variously asserts that all drug use is 'wrong' and that providing easier access to cannabis, as it will lead to more drug use, must be 'wrong'.

This morally articulated argument is incorrect in at least three ways.

Wherever cannabis access has been liberalised:

- ☑ there has been a decline in usage across all monitored age cohorts,
- ☑ there is a measurable reduction in the abuse of more harmful recreational agents,
- ☑ there is a reduction in the *overall* harm caused by recreational drug use within our society.

A recent paper appearing in the *Harm Reduction Journal* in December of 2009, entitled 'Cannabis as a substitute for alcohol and other drugs: A dispensary-based survey of substitution effect in Canadian medical cannabis patients', concluded that

> '[t]he substitution of one psychoactive substance for another with the goal of reducing negative outcomes can be included within the framework of harm reduction. Medical cannabis patients have been engaging in substitution by using cannabis as an alternative to alcohol, prescription and illicit drugs.'[16]

As cannabis is relatively harmless, that cannabis use might displace the use of other recreational agents within Australia must be considered a positive outcome that will attend any regulatory easing. The making available of medicinal cannabis in Canada has caused a measurable reduction in the abuse of more harmful recreational agents.[17] It is anticipated that exactly the same outcome will be observed in NSW.

"Won't legalizing cannabis lead to more teenage use of cannabis?"

No. All the evidence points in the opposite direction.[18]

"Doesn't cannabis use increase the frequency of mental illness?"

This is a nonsensical question usually asked to suggest a causative connection that does not exist. Rates of mental illness in Australia, particularly schizophrenia, have remained

---

[16] *ibid* 1.

[17] Lucas, Philippe & Reiman, Amanda. 'Cannabis as a substitute for alcohol and other drugs: A dispensary-based survey of substitution effect in Canadian medical cannabis patients' *Harm Reduction Journal* 2009, 6:35.

[18] Anderson, Mark. Hansen, Benjamin. Rees, Daniel. 'Medical Marijuana Laws and Teen Marijuana Use' The Institute for the Study of Labor, IZA Discussion Paper No. 6592 (May 2012).

relatively stable for many decades and there is no apparent correlation between the rate of cannabis use and the incidence of mental illness (including schizophrenia).

However, regardless of the actual answer to this question the implicit assertion contained within does need to be considered.

The implication contained within this question is that if cannabis use might shown to be causatively associated with mental illness then it should be banned. However even when a drug has been absolutely demonstrated, beyond any reasonable doubt, to act as a precursor to episodes of mental illness; this has not led our public policy in the past to require that a drug be made illegal.

Right now there are many drugs widely available that have been causatively linked to episodes of mental illness. Many of these drugs are used by our children. The following excerpt is from an article that appeared in the UK's Daily Mail on the 22nd of August 2006. It was entitled: 'Ritalin to carry mental health warning'.

> Several drugs to treat attention deficit hyperactivity disorder must include new warning information about the risk of heart problems and psychotic behavior, U.S. health officials said on Monday.
>
> The drugs, which include GlaxoSmithKline Plc's **Dexedrine** and Novartis AG's **Ritalin**, must include a warning about the possible risk of sudden death and serious heart problems, Food and Drug Administration spokeswoman Susan Bro told Reuters.
>
> The drugs, stimulants that can raise blood pressure, must also include warnings about the risk of behavioral problems such as aggression and mania, she said. Bro could not confirm whether other ADHD drugs - Johnson & Johnson's **Concerta** and Eli Lilly and Co.'s **Strattera** - also were ordered to carry the warnings.[19]

Alcohol (like many other commonplace drugs) has been demonstrably and causatively linked to episodes of mental illness.

[19] UK Daily Mail 22 August 2006. 'Ritalin to carry mental health warning'

- Alcohol dependence co-occurs with mental illness more often than most clinicians realize: >20% of those with mental illness also suffer from alcohol abuse or dependence.
- Alcohol use disorders can cause or exacerbate a wide variety of psychiatric syndromes, from schizophrenia to the anxiety disorders.
- Alcohol dependence, abuse, or misuse can cause or exacerbate Cluster B personality disorders, and alcoholism itself can be mistakenly diagnosed as a personality disorder.
- Treatment of alcohol dependence and a co-occurring mental illness necessitates a coordinated plan which addresses both problems. [20]

The relationship between the nature of the law and the reality of drug use and abuse in our society is complex. People often hold opinions relating to drug use that are based on ideological rather than rational grounds. So questions are often asked, not as a means of clarifying the issue, but rather as a way of once more tendering assertions that have already been considered and soundly debunked.

[20] Laurence M. Westreich, MD. 'Alcohol and Mental Illness' *Primary Psychiatry*. 2005 12(1) 41-46.

Part Five: the legal context.

Aussies have been civilly inoculated to the concept of cannabis as medicine via our constant digestion of mainstream media products originating in the US. We have also been civilly inoculated to the reality that cannabis is relatively harmless whether it is used for medicine or for recreation. And since exactly the same problems that prompted the US experience are evident here; doing nothing is simply a recipe for civil dissention.

There is no need for overly complex legislation and/or regulation. If all existing penalties attaching to cannabis use within NSW are lifted then all those who need access to medicinal cannabis will be able to gain that access almost immediately.

A Proactively Managed Transition is Required

In many ways it is downright embarrassing that places like Colorado and Washington State (and Portugal and Mexico etc etc) are so far ahead of Australia. Once upon a time Australia led the world in our civil regulations. We were the first country in the world to introduce universal suffrage. We were amongst the first to enshrine 'one-vote-one-value' as the law of our land.

In Australia a majority of both progressive and conservative citizens all agree that cannabis use should carry no penalty; yet our politicians remain reluctant to even discuss the problem. Aussies of a progressive bent expected that after the fall of the Howard incumbency the incoming administration would swiftly move towards catching up with the rest of the world. They were woefully disappointed. Aussies of a conservative persuasion remain frustrated that our country continues to waste vast sums of money on utterly futile interdiction and eradication efforts, and in locking up people for no apparent social or personal benefit.

In the Americas the transition through illegality to tolerance, to industry sector, has already occurred. In nineteen US States the supply of medical cannabis has now become a significant element in the overall retail sector. In two US States recreational use of cannabis is currently legal and in California, where possession of up to an ounce is merely a civil misdemeanour (carrying a small fine), it will soon be legalised.

Australia will catch up, but every day that we tarry is another day in which more Australian citizens will suffer for lack of medicine, or will be gaoled, or fined, or humiliated in public, all for no reason.

International Law.

In 1961 the Single Convention on Narcotic Drugs came into effect.
Cannabis is in Schedule IV of the Convention.
Australia is a signatory to the Convention.

Australian authorities have often pointed to these facts and asserted that our ratification of this instrument therefore *requires* Australia to criminalize all aspects of cannabis use.

This is not so: it can be argued that the opposite is in fact the case.

Article 2 of the Single Convention directs that a signatory shall consider the *prevailing conditions* in their country. And, *if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the production, manufacture, export and import of, trade in, possession or use of* Schedule IV drugs.

What does the Single Convention oblige Australian Governments to do?

The Australian government is obliged under Article 2 to make an assessment as to whether '*prevailing conditions*' might indicate that the outlawing of any of the *Schedule IV* 'drug' might be '*the most appropriate means of protecting the public health and welfare*'.

If the answer of our government to this question is positive, then it is obliged to *prohibit the production, manufacture, export and import of, trade in, possession or use* of the item listed in Schedule IV.

Note that this assessment must be undertaken relative to 'prevailing conditions'. The Article requests that signatories make their assessment of '*the most appropriate means of protecting the public health and welfare*' relative to contemporary (i.e., *prevailing*) social norms, knowledge's, mores, and beliefs.

In Canada, Croatia, the Czech Republic, Israel, Mexico, the Netherlands, Peru, Portugal, Spain, Switzerland and in parts of the United States legislatures have recently undertaken assessments as to the *prevailing conditions* within their countries and have determined that the complete outlawing of many previously prohibited substances is now unwarranted. These governments have all decided that prevailing conditions have

changed significantly since cannabis was prohibited absolutely, and that there were now more appropriate means of *protecting the public health and welfare* than by maintaining an outright prohibition on the use, sale, and cultivation of cannabis.

In the United States many individual states have revisited their laws regarding cannabis. Here, again, many legislatures have come to a judgment that in light of the 'prevailing conditions' in their jurisdictions *the most appropriate means of protecting the public health and welfare* is to remove all criminal sanctions regarding the use of cannabis as a medicinal agent.

In two States, Colorado and Washington, the legislatures have decided that the most appropriate means of protecting the public health and safety is to completely re-legalise cannabis. As noted earlier: International Law not only provides jurisdictions with the facility to make such changes - but in using the term '*prevailing conditions'* it actually casts upon lawmakers an obligation to regularly update their assessments relative to contemporary social conditions.

It is the contention of the HEMP Party of Australia that any assessment of the prevailing conditions in our country, if undertaken conscientiously, will demonstrate that the prohibition of cannabis has failed utterly. Therefore the most appropriate means *of protecting the public health and welfare* in our country is to remove the criminal sanctions associated with the use, cultivation, or sale of cannabis.

There are no apparent international law impediments stopping any Australian State from legalising either the recreational or the medicinal use of cannabis.

The medicinal use of cannabis can be regulated in NSW via an amendment to the *Drugs Misuse Act* along with the passing of complimentary legislation. As there is no federal legislation covering the field, and since the proposed amendments and new legislation are unlikely to conflict with existing federal law, they would be entirely valid.

However there is no need for overly complex legislation and/or regulation. If all existing penalties attaching to cannabis use within NSW are lifted then all those who need access to medicinal cannabis will be able to gain that access almost immediately.

Part Six: dispensing & prescription guidelines.

An agreed scale of variation and grading?

There has been some quantitative work undertaken in sampling seizures of cannabis towards trying to correlate the type and potency of the seized drugs with the stated intent of the user (ie – recreational / medical).

Executive Summary from the HOME OFFICE CANNABIS POTENCY STUDY 2008:

- This study was funded by the Home Office. It arose from a recommendation in the 2006 Cannabis report of the Advisory Council on the Misuse of Drugs (ACMD).
- The proportion of herbal cannabis has increased markedly in recent years.
- In 2002 it was estimated that it represented around 30% of police seizures of cannabis, but by 2004/5 had reached 55%.
- Twenty-three Police Forces in England and Wales participated in the study. Forces were requested to submit samples confiscated from street-level users. In early 2008, they submitted 2,921 samples for analysis to either the Forensic Science Service Ltd (FSS) or LGC Forensics at Culham (LGC F).
- Initial laboratory examination showed that 80.8% were herbal cannabis and 15.3% were cannabis resin. The remaining 3.9% were either indeterminate or not cannabis.
- Microscopic examination of around two-thirds of the samples showed that over 97% of the herbal cannabis had been grown by intensive methods (sinsemilla). The remainder was classed as traditional imported herbal cannabis.
- Regional variations were found in the market share of herbal cannabis. Thus North Wales, South Wales, Cleveland and Devon and Cornwall submitted proportionately fewer herbal cannabis samples, whereas Essex, Metropolitan and Avon and Somerset submitted proportionately more. These differences were statistically significant at the 0.1% confidence interval.
- The mean THC concentration (potency) of the sinsemilla samples was 16.2% (range = 4.1 to 46%). The median potency was 15.0%, close to values reported by others in the past few years.
- The mean THC concentration (potency) of the traditional imported herbal cannabis samples was 8.4% (range = 0.3 to 22%); median = 9.0%. Only a very small number of samples were received and analysed.
- The mean potency of cannabis resin was 5.9% (range = 1.3 to 27.8%). The median = 5.0% was typical of values reported by others over many years.
- Cannabis resin had a mean CBD content of 3.5% (range = 0.1 to 7.3%), but the CBD content of herbal cannabis was less than 0.1% in nearly all cases.

- There was a weak, but statistically-significant, correlation ($r = 0.48$; $N = 112$; $P < 0.001$) between the THC and the CBD content of resin.[21]

A similar wide variation in THC/CBD intensities and proportions has been detected in seizures in the US:

> Upon analysis by GCMS, the potency of the 42 sinsemilla samples was determined to range from 10.2% to 31.6% THC, with a mean of 19.4%. These results were surprisingly high, given that the average potency of marijuana in the U.S. has been typically estimated at around 3% to 4% by NIDA, with higher grade sinsemilla ranging towards 10% - 15%. The highest potency recorded came from a sample of hashish, which registered 68.6%. Yet even a sample of Mexican commercial grade registered a surprisingly high 11%, twice what we had expected. All of this cast a troubling shadow of doubt on our test results, although it appeared likely that we were dealing with highly potent varieties. …
>
> In contrast, the CBD levels observed were surprisingly low. Only four of the sinsemilla samples had more than 0.3% CBD, and 35 of them had only trace amounts (<0.1%). However, one sample had an astoundingly high CBD content of 28.0% (plus 11.6% THC). Another registered 5.6% CBD and 13.4% THC. …
>
> As for CBN, the majority of samples showed only trace amounts. The highest level detected was 1.4%, and only one other sample tested above 1%. CBN is a breakdown product of THC, so high CBN levels are expected in old, degraded samples.[22]

Implications for Australia

A review of the models currently in use in other locales does not provide for an uncomplicated list of statutes, codes, and charts amenable to any sort of easy translation to suit Australian conditions.

Scientific work in overseas jurisdictions points to a need to not only encompass considerations relating to THC potency, but also levels of CBD and the relative age of the plants used as source materials (via CBN), also several more amorphous factors such as ‘harshness’ and ‘aroma’.

Requisite technical processes and methodological abilities are available, here, within NSW. What is not available is an agreed upon scale of variation and grading, formulated

[21] Sheila Hardwick Leslie King *Home Office Cannabis Potency Study 2008.*

[22] Dale Gieringer, Ph.D. ‘Medical Cannabis Potency Testing Project’.

in a manner sufficient to meet the requirements of the Australian therapeutic goods environment.

The Therapeutic Goods Administration has detailed requirements regarding the sourcing, grading, processing, purity, weight, packaging, and documentation relating to all medicinal substances that might be distributed in our country. Most of these requirements can easily be met regarding medicinal cannabis. What is lacking are descriptive and definitive classifications enabling the sorting of various grades of cannabis relative to precise prescriptive directions.

A wide variability in the source stock available for medicinal cannabis production is probable (going by overseas experience) but this is something that can be suitably controlled for if careful attention is paid to all the potential variations that might be of import in the generation of an applicable Australian Standard for medical cannabis (and thence associated regulations governing the dispensing of the drug).

In an Australian Standard:

- the THC and CBD levels need to be located within a preferred potential therapeutic range.
- testing for CBN is indicated as a control for old or overly mature stock.
- a subjective assessment of the quality of the source stock (aroma/harshness) should be incorporated.

Table 1 provides a representation of one possible grading scale.

Table 1. An Australian Standard for grading medical cannabis source stock?

Grade	THC range	CBD range	CBN acceptable	aroma/harshness higher the better
6	0 – 9%	10 – 15%	< .33%	?/10
5	9 – 15%	> 15%		
4	16 – 20%	> 15%		
3	21 – 25%	> 15%		
2	26 – 30%	> 15%		
1	> 30%	> 15%		
F	0 – 9%	0 – 5%		
E	9 – 15%	0 – 5%		
D	16 – 20%	0 – 5%		
C	21 – 25%	0 – 5%		
B	26 – 30%	0 – 5%		
A	> 30%	0 – 5%		
CBD1	0 – 5%	> 20%	N/A	
CBD2	0 – 5%	> 30%		
CBD3	0 – 15%	> 20%		
CBD4	0 – 30%	> 30%		

Such a scale might also act as a heuristic agent for medical services practitioners, enabling particular therapeutic indications to be matched to a corresponding appropriate grade of medicinal cannabis.

Pharmacopeia practice.

It is essential that any Cannabis Dispensary (trial or otherwise) only provide cannabis to those particular patients meeting the precise requirements dictated as sufficient to obtain a prescription. Prescription verification procedures must be mandatory and defined in regulation. Any leakage or illegal provision of cannabis to non-patients will act to discredit the dispensary model and will undoubtedly be counterproductive in a number of ways.

All cannabis stocked within a Dispensary Pharmacopoeia must be of a defined strength (potency), type (strain), and weight. Every gram must be traceable directly, via a paper trail, back to the grow-up process. This paper trail must be plainly reviewable and amenable to audit.

Procedures, regulations, and rules, overseeing Dispensary operations should be formulated in association with medical advice and this process largely guided by the best-practice of institutions currently operating dispensaries in California and Canada.

In some instances the Californian experience might prove to be the best guide (relating to the institutional practices of dispensary and grow-up) whereas other aspects of the project might be better off looking to the Canadian experience (regarding the integration of the project within the established medical environment in Australia).

Best practice?

No entirely successful models for meeting the needs of providing source stock for cannabis pharmacopeia seem to exist, however some simple observations might be made:

- Dispensaries must be able to licence individuals or corporations to grow cannabis source stock for their pharmacopeia.
- TGA regulations should be formulated regarding the process of dispensing medicinal cannabis.
- TGA guidelines should be formulated regarding the testing and grading of medicinal cannabis.
- The TGA should formulate Australian Standards regulating and defining grades of medicinal cannabis.
- Medical authorities should formulate prescription / recommendation methodologies utilising Australian Standards that define grades of medicinal cannabis (and their associated therapeutic attributes).
- Any medical cannabis regime in Australia must encompass a legal facility for patients to grow their own cannabis at home.
- Provision must be made to assist patients in assessing and quantifying the potency and characteristics of cannabis produced at home.

Part Five: HEMP Party Recommendations

The HEMP Party of Australia is satisfied that the production of therapeutic agents, foodstuffs, and agricultural products within our country are all regulated adequately relative to the particular requirements of that segment of Australian industry.

We see no reason why these successful and effective modes of control, regulation, and taxation, need be reinvented when it comes to the use of cannabis for food, industrial utility, therapeutic use, or recreation.

RECOMENDATIONS

[Rationale underlying the HEMP Party recommendations regarding medicinal cannabis]

Because –

All those who need access to medicinal cannabis in NSW will be able to gain that access almost immediately if the penalties attaching to cannabis use within NSW are lifted,

&

As the use of cannabis is undeniably less harmful than is the use of many currently available 'controlled substances' (see Part Three: Relative Harms.' p. 11),

&

As the crafting of appropriate regulations governing the production, distribution, and sale of therapeutic preparations containing cannabis cannot be adequately undertaken whilst the recreational use of cannabis remains illegal (see 'Part One: The Recreational Elephant in the Medicinal Cannabis Room', p 6),

&

As the only harms associated with the use of cannabis are secondary (indirect) harms relating to the current illegal status of the herb (see 'The costs of Indirect (secondary) Harms – Legal.', p. 9),

&

As there are no legal obstacles that might stop the NSW legislature from reclassifying cannabis as a controlled therapeutic agent (within the framework of the Drugs Misuse Act and other enactments and regulations of the Parliament), (see Part Five: the legal context., p 19),

&

As the immediate cessation of 'the war on cannabis' strategy will instantly save Australian taxpayers three billion dollars a year (see 'The costs of Indirect (secondary) Harms – Legal., p 9),

The HEMP Party of Australia recommends:

1) That all matters relating to cannabis cultivation, consumption, and use, must be treated as civil and health matters.

The inquiry should declare, emphatically, that the current suite of regulations and laws relating to cannabis in NSW are counterproductive and must be changed immediately.

NSW should:

a) Declare that the personal use of social intoxicants is a health and welfare issue and not a criminal matter.

b) Commission a harm/costs mitigation assessment relating to the use of all social intoxicants within the state.

i) Gathering such information as is recommended as being appropriate by an appointed commission of experts.

ii) Directing the NSW Law Reform Commission, the NSW Police Force, and NSW Health Department in consolidating a 'Drug Law Policing and Social Benefit Report' for each year.

2) That all penalties attaching to the use and cultivation of cannabis by individual citizens, at home, for personal consumption, should be lifted.

The inquiry should recommend that

i) Cannabis be rescheduled in all NSW enactments to accord with a rational assessment of the relative harm that attaches to the use of the herb.

ii) The TGA develop grading and processing guidelines for cannabis dispensaries.

iii) The NSW Government enact interim transitional amendments to the Drugs Misuse Act enabling the dispensing of cannabis products at pharmacies and/or licensed cannabis dispensaries (see Appendix for suggested interim amendments).

3) Transitional restrictions:

The enactment of the following interim transitional restrictions will provide access to medicinal cannabis for virtually all NSW residents who require cannabis as a therapeutic agent:

i) Each adult citizen allowed to cultivate up to ten (10) fully mature (tertiary growth stage) cannabis plants at home.

ii) Each adult citizen allowed to possess, at home, up to one (1) kilogram of processed cannabis flowers (heads).

iii) Each citizen allowed to carry upon their person, in public, up to fifty (50) grams of processed cannabis flowers (heads).

iv) That all therapeutic preparations containing cannabis be excluded from the schedules.

- With therapeutic preparations containing cannabis that have been produced or otherwise prepared for commercial or clinical utility, being regulated by the Therapeutic Goods Administration.
- With therapeutic preparations containing cannabis produced at home for personal use being exempt from regulation.

HEMP Party Policy regarding Cannabis Law in Australia

The commercial production, distribution, and sale of cannabis should be regulated like all other commodities within our community.

- **As a recreational agent** the social use and commercial production and distribution of cannabis should be regulated and taxed in the same way as wine.
- **As a therapeutic agent** its social use and commercial production and distribution should be overseen and regulated by the Therapeutic Goods Administration (TGA) and its distribution and sale regulated and taxed in the same manner as all other therapeutic goods.
- **For all other uses** (industrial, hempseed oil, hemp meal, fibre, stockfeed, etc etc) the commercial exploitation of cannabis as a crop should be governed by appropriate regulations formulated and overseen by an industry association (i.e., the HEMP Farmers Association of Australia).

Regarding cannabis for personal use and cannabis cultivation for personal consumption:

As there is no level of cannabis production at home that might occasion any appreciable personal or social harm the HEMP Party believes that it is inappropriate to regulate the production of cannabis at home for personal use.

The appropriate level of regulation of the personal use of cannabis at home is none.

The appropriate level of regulation for the growing of cannabis at home, for personal consumption, is none.

Bibliography

Anderson, Mark. Hansen, Benjamin. Rees, Daniel. 'Medical Marijuana Laws and Teen Marijuana Use' The Institute for the Study of Labor, IZA Discussion Paper No. 6592 (May 2012) <http://ftp.iza.org/dp6592.pdf> 4/02/2013

Collins D, Lapsley H. *The avoidable costs of alcohol abuse in Australia and the potential benefits of effective policies to reduce the social costs of alcohol*. National Drug Strategy Monograph Series no 70. Canberra : Commonwealth of Australia, 2008

David Nutt, Leslie A King, William Saulsbury, Colin Blakemore, 'Development of a rational scale to assess the harm of drugs of potential misuse' *Lancet* 2007, 369, 1047–53.

Laurence M. Westreich, MD*. '*Alcohol and Mental Illness' *Primary Psychiatry*. 2005 12(1) 41-46.

Lucas, Philippe & Reiman, Amanda. 'Cannabis as a substitute for alcohol and other drugs: A dispensary-based survey of substitution effect in Canadian medical cannabis patients' *Harm Reduction Journal* 2009, 6-35.

McLaren, J., Mattick, R. P., *Cannabis in Australia: Use, supply, harms, and responses* (2006). Monograph series No. 57. Report prepared for Drug Strategy Branch, Australian Government Department of Health and Ageing Drug and Alcohol Research Centre, University of New South Wales

Medical Cannabis Programs: A Review of Selected Jurisdictions by Rowena Johns Briefing Paper No 10/04 (August 2004)

The Medical Use of Cannabis: Recent Developments by Gareth Griffith and Marie Swain, NSW Parliamentary Library Briefing Paper No 11/99. (August 2004.)

UK Daily Mail 22 August 2006. 'Ritalin to carry mental health warning' http://www.dailymail.co.uk/health/article-401801/Ritalin-carry-mental-health-warning.html

Appendix. Possible cannabis dispensary enabling legislation.

Drugs Misuse and Trafficking Act (New South Wales) Amendment (Medicinal Cannabis) Act 2010.

1 Name of Act

This Act is the *Drugs Misuse and Trafficking Act (New South Wales) Amendment (Medicinal Cannabis) Act 2010*.

2 Commencement

This Act commences on a day or days to be appointed by proclamation.

3 Amendment of the Drugs Misuse and Trafficking Act 1985 No 8.

The *Drugs Misuse and Trafficking Act* 1985 No 8 is amended as set out in Schedule 1.

Schedule 1. Amendments of *Drugs Misuse and Trafficking Act* 1985

[1]

Insert:

8B Definition of "medical cannabis"

(1) Preparations or admixtures containing, in whole or part (as stipulated in Schedule 1 of this Act):

(a) Cannabis leaf,

(b) Cannabis oil,

(c) Cannabis plant cultivated by enhanced indoor means.

(d) Cannabis plant—other,

(e) Cannabis resin,

If produced, grown, possessed, administered, or self-administered pursuant to Sections 10 (2) (c) & (d), 11 (2) (e), 12 (2), 13 (3), 14 (2), and subject to Sections 15, 16, 17, 18 of this Act, shall be deemed "medical cannabis".

[2]

Insert:

22A Medical Cannabis

(1) Subject to the provisions of Section 8B (1) nothing in this Act renders unlawful the holder of a valid prescription for medical cannabis:

(a) cultivating or taking part in cultivating, medicinal cannabis, or

(b) manufacturing or producing, or taking part in manufacturing or producing, medical cannabis, or

(c) possessing medical cannabis mixtures, admixtures or preparations.

[3]

Insert:

Part 5 – Cannabis Dispensaries.

Division 1 - Preliminary.

46A Operation of Part 5.

(1) This Part operates to allow the responsible authorities to issue various licences, in respect of various premises, allowing the holder of said licence to dispense medical cannabis pursuant to this Act.

(2) Nothing in this Part prevents the responsible authorities:

(a) from issuing a further licence to a person other than the holder of an earlier licence.

46B Substantiating compliance and legislative review

(1) The responsible authorities may arrange for a review to be conducted at any time of:

(a) the operations of any cannabis dispensary, and

(b) the provisions of this Part and of any regulations made for the purposes of this Part,

in order to ascertain whether the provisions of this Part (or any other provisions of this Act or the regulations) should be amended.

(2) The review is to commence as soon as practicable after the date of assent to the *Drugs Misuse and Trafficking Act (New South Wales) Amendment (Medicinal Cannabis) Act 2010*, and is to be completed by [_____].

(3) A report of the outcome of the review is to be tabled in each House of Parliament as soon as practicable after its completion.

46C Prescriptions

(1) Any licensed medical practitioner in NSW shall be authorised to define and issue a prescription for medical cannabis.

(2) Upon issuing a prescription for medical cannabis notification shall be made to the NSW Health Department and the details of the prescription shall be entered into a database compendium.

(3) The NSW Health Department shall provide those holding a licence for a cannabis dispensary with access to a database compendium listing all currently valid medical cannabis prescription holders.

(4) The NSW Health Department may authorise and undertake a review at any time into the prescribing of medical cannabis by particular medical practitioners.

(5) Following a validly conducted review pursuant to subsection (4) the NSW Health Department may refuse to endorse particular defined medical cannabis prescriptions.

46D Definitions

In this Part:

"cannabis dispensary" means the premises that are the subject of a cannabis dispensary licence.

"child" means a person who is under the age of 18 years.

"director", means an individual nominated by the cannabis dispensary licence holder to be the individual in charge of the licensed premises.

"internal management protocols", in relation to a licensed dispensary, means the protocols finalised for the centre as referred to in section 46F or, if the protocols are amended or replaced as referred to in section 46M, the protocols as so amended or replaced.

"law" includes common law.

"licence" means a licence in force under this Part.

"prescribed drug" under this Part means medical cannabis as stipulated in 8B of this Act.

"qualified health professional" means a medical practitioner, or a person having qualifications or experience specified or described by order of the Minister published in the Gazette.

"responsible authorities" means the Commissioner of Police and the Director-General of the Department of Health.

"staff", in relation to a cannabis dispensary, includes:

(a) all persons engaged to provide services at the centre, whether under a contract of employment or otherwise, and

(b) all persons authorised to provide voluntary assistance at the centre in accordance with the centre's licence conditions and internal management protocols.

The employer of a person referred to in paragraph (a) or (b) is the person by or on whose behalf the person so referred to is engaged to provide services or authorised to provide voluntary assistance, as the case requires.

"supervisor", in relation to a cannabis dispensary, means the director of the centre or another individual nominated by the director to supervise the centre.

Division 2 – Dispensary licences.

46E Licences

(1) The responsible authorities may issue a licence authorising the holder of the licence to conduct activities specified within this Part as a cannabis dispensary.

(2) Nothing in this Part entitles a person to be issued with a licence, and the responsible authorities may refuse an application for any reason listed within this Part, or for any other reason.

46F Restrictions on issue of licence

(1) A licence for the conduct of premises as a cannabis dispensary must not be issued unless the responsible authorities are of the opinion:

(a) that the internal management protocols for the proposed centre have been finalised and are of a satisfactory standard, and

(b) that there is a sufficient level of acceptance, at community and local government level, for the establishment of a cannabis dispensary at the premises, and

(c) that the premises are suitable for use as a cannabis dispensary, having regard to all relevant matters including the following:

(i) public health and safety,

(ii) the visibility of the premises from the street,

(iii) the proximity of the premises to schools, child care centres and community centres,

(iv) any matters prescribed by the regulations for the purposes of this section.

(2) If a community drug action plan is in force in relation to the area within which the premises of the proposed cannabis dispensary are situated, the responsible authorities must have regard to that plan in forming an opinion as to the matters referred to in subsection (1) (b) and (c).

(3) Without limiting subsection (1), a licence for the conduct of premises as a cannabis dispensary must not be issued unless the responsible authorities are of the opinion:

(a) that any building work that is carried out for the purposes of the centre will be carried out in accordance with the *Building Code of Australia*, and

(b) that any building that is used for the purposes of the centre will comply with the *Building Code of Australia*.

(4) In subsection (3), **"building"**, **"Building Code of Australia"** and **"building work"** have the same meanings as they have in the *Environmental Planning and Assessment Act 1979*.

46G Duration of licence

(1) Unless sooner surrendered or revoked, a licence has effect for the whole of the stipulated period.

(2) The holder of a licence may, after consultation with the responsible authorities or their representatives, surrender the licence.

46H Conditions of licences generally

(1) A licence is subject to such conditions as may be imposed from time to time by the responsible authorities, either in the licence or in a separate order in writing served on the holder of the licence.

(2) Conditions of the kind referred to in subsection (1) may not be imposed without prior consultation with the holder or proposed holder of the licence.

(3) A licence is also subject to such conditions as are imposed by or under this Part or the regulations.

46I Statutory conditions of licences

The following provisions are conditions of a licence for a cannabis dispensary:

(a) No child is to be admitted to that part of the centre that is used for the purpose of the dispensing of prescribed drugs.

(b) The centre's internal management protocols are to be observed.

46J Contraventions

(1) A contravention of this Division or the regulations in relation to a cannabis dispensary, or of the licence conditions for a cannabis dispensary, may be dealt with:

(a) by one or more of the following:

(i) a warning or reprimand administered in writing by the responsible authorities,

(ii) a fine (not exceeding an amount equal to 50 penalty units) imposed by the responsible authorities,

(iii) suspension of the licence by the responsible authorities for a specified period or until further notice, or

(b) by revocation of the licence by the responsible authorities.

(2) If the contravention also gives rise to an offence:

(a) the fact that action has been taken under this section in relation to the contravention does not prevent a penalty from being imposed for the offence, and

(b) the fact that a penalty has been imposed for the offence does not prevent action from being taken under this section in relation to the contravention.

(3) A fine imposed under this section is payable to either responsible authority within the period specified by the responsible authorities, and is to be paid into the Consolidated Fund.

(4) If a licensee fails to pay a fine imposed under this section (in whole or in part), the responsible authorities may suspend or revoke the licence.

(5) Nothing in this section prevents the responsible authorities from amending or imposing a condition as a consequence of a contravention referred to in subsection (1).

(6) The responsible authorities are authorised to suspend or revoke a licence for the purposes of this section.

(7) A contravention referred to in subsection (1):

(a) does not limit the operation of section 46O, except to the extent that the contravention gives rise to an offence under the regulations made for the purposes of this Part, and

(b) does not limit the operation of section 46P.

(8) A contravention relating to the admission of a child to a licensed dispensary is not committed if the licensee establishes that, having regard to the relevant provisions of the centre's internal management protocols, it was not apparent to the centre's staff that the person concerned was a child.

46K Reviews of licence

(1) The responsible authorities may arrange for the ongoing or periodical review of any cannabis dispensary.

(2) The responsible authorities must arrange for the review of the economic viability of a cannabis dispensary if they are satisfied that the service activity level of the centre has dropped below 75 per cent of the service activity level prescribed by the regulations.

(3) Regulations referred to in subsection (2) may express the level of service activity as a specified number of client visits in any period or may express that level in any other manner.

(4) The responsible authorities may revoke a licence if, after considering the results of a review under subsection (2), they are of the opinion that the cannabis dispensary has ceased to be economically viable.

Division 3 – Internal management protocols

46L Matters for consideration in relation to internal management protocols

In considering the internal management protocols for a proposed cannabis dispensary for the purposes of section 46F, the responsible authorities must have regard to whether provision needs to be made to ensure that any or all of the following requirements are met:

(a) The centre must be under the supervision of a supervisor.

(b) The supervisor must have a general oversighting role of the centre's dispensary operations and responsibility for ensuring the adequacy of the dispensary procedures used in the centre. This paragraph does not prevent the supervisor from being personally involved in dispensary activities in the centre.

(c) All staff directly supervising activities, or undertaking activities, in the dispensary must undergo a National Criminal History Record Check (NCHRC) and details of this review must be made available to the NSW Health Department on demand.

(i) No persons with a criminal history encompassing two (2) convictions within a period of (10) ten years antecedent to the date of review shall be employed within a cannabis dispensary.

(ii) No persons with a criminal history encompassing two (2) convictions within a period of (10) ten years antecedent to the date of review shall be issued with a licence to operate a cannabis dispensary.

(d) The dispensary must contain or have satisfactory access to:

(i) primary health care referral services, and

(ii) drug and alcohol counselling referral services, and

(iii) drug and alcohol education services.

(e) Procedures are to be established to enable staff to ascertain in appropriate cases whether a person attempting to fulfil a prescription is a child.

(f) At least one member of staff:

(i) must be a person with satisfactory qualifications or experience in drug and alcohol counselling, and

(ii) must be in attendance at the centre, or available on call to attend the dispensary, at all times that it is being used as a dispensary.

(g) The health and safety of staff and users of the centre are to be protected, having regard to the design and services of the dispensary.

(h) Services are to be available and procedures established to ensure compliance or ability to comply, at or in connection with the dispensary, with the relevant requirements of:

(i) this Part, and

(ii) the regulations, and

(iii) the centre's licence conditions, and

(iv) any other provisions of the centre's internal management protocols.

(i) Any requirements prescribed by the regulations for the purposes of this section.

46O Exemption from criminal liability for persons engaged in conduct of cannabis dispensary.

Despite any other provision of this Act or of any other Act or law (other than a provision prescribed by the regulations):

(a) it is not unlawful for a person to engage, participate or otherwise be involved in the conduct of a licensed cannabis dispensary, and

(b) in particular, a person who is engaged, participates or is otherwise involved in the conduct of a licensed cannabis dispensary does not commit any offence prescribed by the Act or regulations, just because of that fact.

46P Exemption from civil liability in connection with conduct of licensed cannabis dispensary

(1) Anything done or omitted to be done in connection with the conduct of a licensed dispensary does not subject:

(a) the person by whom that thing was done or omitted, or

(b) any other person (including the licensee, the State and any Minister of the Crown in right of the State),

to any action, liability, claim or demand if the thing was done or omitted to be done in good faith for the purpose of executing this Part, and was not done or omitted to be done in a reckless or grossly negligent manner.

(2) This section does not affect any rights or obligations as between a member of the staff of a licensed dispensary and his or her employer.

Division 5 – Miscellaneous

46Q Application of Environmental Planning and Assessment Act 1979

(1) Development for the purposes of a cannabis dispensary is permissible without the need for development consent under the *Environmental Planning and Assessment Act 1979*.

(2) Part 5 of the *Environmental Planning and Assessment Act 1979* does not apply to or in respect of development for the purposes of a cannabis dispensary.

46R Certificate evidence

In any legal proceedings under this Act, a certificate purporting to be signed by either of the responsible authorities:

(a) that premises specified in the certificate were or were not, on a date so specified, a licensed cannabis dispensary, or

(b) that a person specified in the certificate was or was not, on a date so specified, engaged in the conduct of a licensed cannabis dispensary, or

(c) that a person specified in the certificate was or was not, on a date so specified, entered on the prescription register as the holder of a valid medical cannabis prescription,

is prima facie evidence of the fact stated in the certificate without proof of the signature or of the official character of the person purporting to have signed the certificate.

46S Regulations

Without limiting section 45, the regulations may make provision, for the purposes of this Part, for or with respect to any of the following matters:

(a) the standards for a cannabis dispensary, including the elaboration of internal management protocols for a cannabis dispensary,

(b) the provisions to be observed in the operation of a licensed cannabis dispensary,

(c) the rules of conduct to be observed by persons using a licensed cannabis dispensary,

(d) the qualifications of persons engaged in the conduct of a licensed cannabis dispensary,

(e) the functions of persons engaged in the conduct of a licensed cannabis dispensary,

(f) the preparation, form and content of a community drug action plan,

(g) the maintenance and amendment of a community drug action plan,

(h) the public and community consultation processes to be undertaken with respect to the development and review of a community drug action plan.