Clinical Memorandum

Therapeutic Use of Medicinal Cannabis Products

July 2026

Authorising Body:	Practice, Policy, and Partnerships Committee
Responsible Committee(s):	Committee for Evidence-Based Practice/Faculty of Addiction Psychiatry
Responsible Department:	Policy and Advocacy
Document Code:	CM PPR Therapeutic use of medicinal cannabis products

Purpose

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has developed this clinical memorandum to provide information for psychiatrists about the medicinal use of cannabis products.

Key messages

- Regulatory changes to improve access to medicinal cannabis (MC) products in Australia and New Zealand have been based on a perception of low risk or harm rather than evidence of efficacy. RANZCP is concerned that potential harms, particularly the over prescribing of high potency THC-containing MC products, have been overlooked.
- There is insufficient evidence to support MC as a treatment for any mental health condition, and no substantial evidence to support its use outside of properly approved clinical trials for these disorders. Despite this, over 35% of MC prescriptions in Australia to date have been for the treatment of mental health conditions [1]. Equivalent data for NZ are not available.
- Of particular concern is that >43% of mental health prescriptions in Australia have been for Category 5 (>98% THC:CBD) products - the highest potency MC. The majority of MC clinical trials have been conducted using products with less than ~12% THC, whereas products containing up to 30% THC are routinely prescribed. High concentrations of THC cause significant harms and have no proven clinical benefits.
- As with all controlled substances, the prescription of MC outside a clinical trial requires careful evaluation of use, should only occur in rare circumstances after other treatments have been tried without benefit, and with all safety and efficacy outcomes recorded. Guidance is available from the TGA [2], Ministry of Health (NZ) [3] and AHPRA [4], and should be reviewed before prescribing.
- Prescription of MC for any condition should take into consideration the risks of use including potential for misuse, worsening of underlying conditions, increased risk of certain cancers, respiratory issues, development of dependence, side effects, and polypharmacy [5]. Formulations intended for smoking or vaping should not be prescribed.
- There is a clear need for the current TGA Authorised Prescriber and Special Access Scheme pathways to be revised to prevent commercial exploitation of unapproved medication access, especially via vertically integrated providers.
- The use of high potency MC products carries significant risk of psychosis, and may be associated with higher rates of violent behaviour, especially domestic violence [6].

Definitions and Scope

Cannabis is the term given to products derived from elements of the cannabis plant used for medical or recreational purpose. Cannabis is known by a range of alternative terms (e.g. marijuana) but most medical producers and legislation use 'cannabis' as the preferred term. *Medical cannabinoids* include a variety of chemical compounds, some synthetic and some extracted from the cannabis plant, which have been developed for medical use.

The cannabis plant contains many cannabinoids; the best known of which are delta-9 tetrahydrocannabinol (THC) and cannabidiol (CBD). [7] THC is the psychoactive part of cannabis that produces a 'high'. CBD has no psychoactive properties.

The terms medicinal cannabis and cannabinoids are used interchangeably when referring to the products derived from the cannabis plant for a medical purpose. This document predominantly uses the term 'medicinal cannabis', as that is the term used by both the Therapeutic Goods Administration (TGA) in Australia and the Ministry of Health in New Zealand. Due to the limited number of medicinal cannabis products registered on the ARTG & MedSafe, the term 'medicinal cannabis' (MC) in this document should normally be interpreted as 'prescribed cannabis' (i.e., internationally commercially available cannabis products that have been prescribed by Australian and New Zealand clinicians), rather than pharmaceutical products whose efficacy and safety have undergone comprehensive evaluation.

This memorandum does not relate to the decriminalisation of cannabis for general cultivation or recreational use.

Background

There is a global trend towards increasing use of cannabis-based products for therapeutic or medical reasons. [8] Governments at both Commonwealth and state and territory levels in Australia, and in New Zealand, have implemented legislative and policy change to allow the cultivation, manufacture, prescribing and dispensing of MC products in Australia [7] and New Zealand [9] for the management of certain medical conditions.

Given the public interest in MC, psychiatrists and other medical doctors are increasingly being asked to prescribe these products. Prescribing and use of MC requires careful consideration of relevant issues. Since MC was down-scheduled by Australian and New Zealand regulators, online telehealth businesses have emerged, often employing their own clinicians to prescribe their products and advertising to patients directly via social media. There have also been reports of Australian Veterans (whose MC is funded by the RPBS) being financially incentivised for referring other Veterans for MC prescriptions.

Evidence

- In April 2026, the largest ever systematic review and meta-analysis of MC use in mental health was published and concluded that there was some, generally low-quality evidence that cannabinoids can reduce symptoms of insomnia, autism spectrum disorder, and tics or Tourette's syndrome. Meta-analysis found no benefit of cannabinoids for opioid use disorder, tobacco use disorder, cocaine use disorder, bipolar disorder, anxiety, ADHD, psychotic disorders, PTSD, OCD, or anorexia nervosa. There are no creditable RCTs assessing MC in depression. Cannabinoids were associated with a greater risk of any adverse events but not of serious adverse events. The authors concluded that 'Given the scarcity of evidence, the routine use of cannabinoids for the treatment of mental disorders and SUDs is currently rarely justified." [10].

- There is currently only good evidence for use of MC in certain forms of childhood epilepsy.[11]

- Despite growing community and scientific interest, a recent systematic review identified limited and generally poor-quality evidence for the efficacy of cannabinoid-based products in neuropsychiatric and neurodevelopmental disorders in children and adolescents including anxiety disorders, autism spectrum disorder, foetal alcohol spectrum disorder, intellectual disability, mood disorders, post-traumatic stress disorder, and Tourette syndrome.[12] A systematic review looking at cannabis use in autism spectrum disorder highlighted potential promising effects but identified the need for RCTs to clarify findings.[13] Large rigorous RCTs are required to inform clinical care. [12]

- The somnolent properties of MC may have some medical use, potentially sparing use of benzodiazepines and z-drugs, and should be thoroughly examined in clinical trials. [14]

- High-quality RCTs are required to establish the efficacy & safety of MC in the treatment of insomnia disorder.[15] ANZCA Faculty of Pain Medicine advises the scientific evidence for the efficacy of cannabinoids in the management of people with chronic non-cancer pain remains insufficient to justify endorsement of their clinical use. [16]

- In the absence of clinical evidence demonstrated by high-quality RCTs, clinicians must balance patient expectations with the potential for harm when using MC products without regulatory approval outside the evidence base.

Regulation and Access to MC

- Regulatory legislation in Australia and New Zealand allows for the supply of MC products that are non-smokeable, medicinal-grade products, with Australia limiting supply to pharmaceutical grade products. Currently Sativex (nabiximols) is approved for supply in Australia by the TGA and by Medsafe in New Zealand, as a treatment for multiple sclerosis. Also, in Australia, low dose cannabidiol products included on the Australian Register of Therapeutic Goods (ARTG) can be made available over the counter with pharmacist approval. Given the developing evidence and political priorities in this area, regulations are subject to change.
- In Australia, access to MC is through a clinical trial, or prescription can be made via special TGA pathways for unapproved medicines, either the Special Access Scheme (SAS) or the Authorised Prescriber (AP) pathway. Unapproved MC products are placed into Categories 1 – 5 depending on their active ingredient concentrations. Each state and territory also have different laws governing access, with state-based authorities required in some states.
- In New Zealand a Medicinal Cannabis Scheme is administered by the Medicinal Cannabis Agency. Any medical doctor in New Zealand can prescribe unapproved MC products that meet the quality standard with no restrictions on the medical condition to be treated in line with prescription guidelines. [17]

Usage Trends in Australia and New Zealand

- Australian data on MC prescribing demonstrates a considerable increase in the uptake of MC prescribed for mental health conditions. TGA data (2018-July 2025) [18] shows the following concerning data regarding the use of MC in mental health conditions:
    - ~50% of patients prescribed products intended for smoking or inhalation despite the established dangers of smoking. Vaping has been found to cause similar effects as smoking on lung function and cardiovascular function [19], and linked to oral and lung cancers [20].
    - >43% of patients were prescribed >98% THC:CBD products (Category 5), the strongest available formulations.
    - MC prescriptions for mental health are increasing significantly year on year, despite the absence of safety and efficacy data.
    - Of the 5772 prescriptions for MC given to paediatric patients in Australia to July 2026,

4395 (84%) have been for mental health conditions.

- The regulatory framework appears to have attracted consumers with little or no prior illicit cannabis use (for medical or non-medical reasons), as well as transitioning a group of patients from illicit to prescribed MC products. [8]
- In New Zealand, there has been a fourteen-fold increase in the number of MC product packs supplied under the MC Scheme (MCS) since Q2 2020, with THC-dominant products surpassing CBD containing products in early 2023. By Q2 2024, over 70,000 packs were being supplied to NZ patients every three months. Most of the products under the MCS (27 out of 47 in 2024) are now in flower form (to be smoked or infused as a tea), a shift away from the early oral liquid formulations [21].

Risks and Side Effects

Medical risks

- There is very limited clinical evidence to support the safe and therapeutic use of MC products that contain THC. It should also be noted that CBD is the desired product that the SAS and AP schemes set out to provide as MC [22]. The majority of clinical trials using MC have been conducted using products with less than approximately 12% THC, and the highest recorded in observational studies was 22.6% THC [23], meaning that products with higher THC levels are experimental with no evidence of benefit. Formulations containing over 30% THC are available for prescription in ANZ. There is ample evidence that higher concentrations of THC can cause significant harms to patients, and as such there is no reason to go outside the already limited evidence base [24]. Use of products with >15% THC have been shown to increase the risk of psychosis by up to five times in daily users [25,26], whereas there is no increase in the risk of psychosis for users of traditional hashish, which contains approximately 5% THC. High THC products have no proven clinical benefits [27], and many proven harms [28]. If THC is to be prescribed for indications such as excessive vomiting, a ceiling on the concentration of THC (12%) should be implemented.
- Cannabis use by pregnant women has been shown to cause birth defects [29] and other harms including but not limited to, more than doubling the risk of stillbirth [30], decreasing birth weight, increasing the need for neonatal intensive care treatment [31], impairment of foetal brain development [32], and cause paediatric acute lymphoblastic leukaemia [33]. Use of MC in pregnancy and breastfeeding is to be avoided and should not occur without regular MDT review and individual HREC approval.
- The TGA advises that MC is not appropriate for people with a previous history of psychosis, or concurrent active mood or anxiety disorder. Despite this, ~37% of MC prescriptions have been for mental health disorders, of which 80% were for anxiety [1].
- A Population Attributable Fraction study across 11 countries showed that if high THC products were unavailable (defined as >10% THC – relatively low by ANZ standards), between 12-50% of first-episode psychosis cases could be prevented [26].
- In a longitudinal study of over 7 million patients between 2006-2016, the average THC content of cannabis consumed increased from ~13% to nearly 30%. The proportion of cases of schizophrenia attributable to cannabis use disorder increased four-fold compared to control during this time, indicating a probable causal link [34].
- Adolescent cannabis use is associated with increased risk of psychosis [35]. MC use in young people, particularly given the potential causal association between teenage use and later schizophrenia, is of concern [28,36]. There is also evidence of potential negative impact – if used at sustained higher doses on certain aspects of neurocognitive functioning. [37].
- Given the impact of cannabis on the developing brain, MC cannot be safely recommended for the treatment of paediatric ADHD or autism spectrum disorder [38]. Children under the age of 18 should only be prescribed MC in Oral Liquid, Oil, Solution or Capsule formulations as a

treatment of last resort under the supervision of a Specialist with MDT support and with individual HREC approval.

- Given the challenges with quantifying illicit cannabis use vs MC, data are lacking for rates and correlates of MC-associated psychotic symptoms warranting clinical attention, such as events requiring emergency medical treatment [39-41]. In 2022-23 Australia recorded a higher rate of cannabinoid-related hospitalisations (25 per 100,000 people) than opioid-related hospitalisations (20 per 100,000 people), predominantly with a principal diagnosis of mental and behavioural disorder (92%), and 40% having a principal diagnosis of psychotic disorder. [42]
- Widespread smoking and/or vaping of prescribed medical cannabis products brings inherent health risks to oral, lung and general health [19, 20, 43].

Professional practice and societal risks

- THC can impact on concentration and fine motor control, and have negative effects on driving ability or the use of machinery [36]. Side effects from MC products generally depend on the amount of THC in the product. Whilst THC blood levels associated with MC are often much lower than those associated with recreational cannabis use, the blood level associated with significant impairment is yet to be determined, and there is no 'safe' threshold. Drivers detected with THC in their blood stream are likely to be prosecuted for driving under the influence of drugs, irrespective of their level of perceived or actual impairment, and these issues must be discussed with patients prior to prescribing MC.
- MC products are increasingly being prescribed for anxiety and other mental disorders when there are primary evidence-based treatments, such as cognitive behavioural therapy (CBT), which are not completed before a MC prescription. This puts patients at risk as they are not receiving standard of care, and puts prescribers at medicolegal risk for bypassing proven treatments in favour of experimental products.
- Polypharmacy and MC drug-drug interactions carry risk, especially when patients may be concurrently managed by psychiatrists and other healthcare providers.
- The high level of prescribing from online and telehealth clinics presents a particular challenge, and requires diligent use of real time prescription monitoring systems. Such systems need to be designed to place shared responsibility on prescribers to better identify potential harm, and processes to communicate between healthcare providers. The rapid growth of 'vertically integrated services' where MC manufacturers or wholesalers employ prescribers and pharmacists, and market their services directly to patients via social media is of significant concern.
- Manufacturer and supplier direct to practice 'education' should be treated with caution. As MC manufacturers are not promoting ARTG-registered products, they operate outside the strict legal requirements for the promotion of medications governed by the Medicines Australia Code of Conduct and the Medicines New Zealand Code of Practice [44,45]. The promotion of unapproved medicinal products is illegal, and should be reported to the TGA or Medsafe. Unlike prescription medications, advertising MC products directly to consumers is now illegal in New Zealand [46], however vertically integrated telehealth providers routinely advertise on social media in both countries [47].
- MC products are expensive as they are not subsidised by governments. The cost is prohibitive for many individuals, resulting in them, or their carer, turning to illicit sources of cannabis. [36]

Recommendations

- RANZCP does not support the use of MC for any mental health condition. Should this be unavoidable, a cautious, safety-first approach should be taken once, noting the absence of clinical evidence, the potential for harm and the need for informed consent.
- MC should not be accessed unless at least two TGA/Medsafe approved medications for an

indication have been unsuccessfully trialled, with doses trialled and outcomes recorded in the patient's Medical Record.

- MC should not be prescribed for anxiety unless the patient had at least one course of Cognitive Behavioural Therapy (CBT) and other treatment options have been exhausted.
- Clinical evidence for any product containing >12% THC is lacking, and access to higher potency products should be restricted to long-term tolerant users as part of a dose-tapering plan.
- Use of MC in paediatric patients should only occur under the direct supervision of a medical practitioner with appropriate training and expertise, such as a Paediatrician or Child & Adolescent Psychiatrist with documented individual HREC approval.

RANZCP therefore recommends that psychiatrists consider the following:

- The clinical use of MC, particularly for psychiatric disorders, should only occur in a clinical trial setting designed to test the efficacy and safety of the long-term use of MC products. Clinical trials must conform to the Declaration of Helsinki [48], and as such include oversight by institutional research or clinical ethics committees with careful monitoring, compliant data handling and transparent reporting of outcomes.

  Psychiatrists who are considering the clinical use of MC outside of a research trial should:

  - Confirm MC is appropriate only after other treatments have failed.
  - Ensure the patient can give informed consent.
  - Clearly explain & document MC's unapproved status, lack of clinical evidence and risks.
  - Consult with peers, ideally including a Specialist with MC experience.
  - Assess medico-legal risks and follow local laws for medicine access.
  - Recognise co-morbidity complexities, risk of drug/drug interactions and unknown contraindications due to limited clinical research into MC.
  - Base decisions on evidence, clinical indicators, and ensure prescribed products are manufactured to the highest medicinal standards.
  - Regularly review treatment progress and monitor for misuse using real-time monitoring tools where possible.
  - Avoid formulations for inhalation.
  - Seek institutional or advisory committee review when possible and ethics committees where appropriate.
  - Contribute outcomes data to registries and publish findings to address evidence gaps.

  Where MC products are being prescribed 'off-label', see RANZCP's guidance on off-label prescribing for further information [49].

Research and Education

- Legislation to enable the use of MC should be backed up by an ongoing commitment to fund high quality research. In Australia, research is largely being funded through philanthropy and the growing number of private companies with an interest in producing MC products for commercial profit [36]. In New Zealand, whilst the Medicinal Cannabis Scheme intends to monitor prescriptions and any adverse effects experienced will be monitored, there is no coordinated approach to research.
- A priority is to ensure that only high-quality MC products are made available, and to evaluate them thoroughly in large, appropriately powered RCTs. There is a need for comprehensive real-time monitoring systems and tracking of individual and service-level outcomes associated with MC. The increasing acceptance of cannabis as a medical treatment, facilitated by the availability of medical cannabis (MC), may have societal implications. This is particularly relevant for young individuals, whose developing brains may be susceptible to adverse effects from MC, including impacts on cognition, mood, and an increased risk of psychosis [28,36].

- Impartial education for medical practitioners should be made available. Training must ensure potential prescribers are aware of the absence of clinical evidence for use in mental disorders, and to understand that MC should only be a treatment of last resort for specific conditions in rare circumstances after stringent criteria are satisfied. [50]
- Public education further needs to reinforce the distinction between MC products and illicit forms of cannabis, as well as between the different types of MC products available for use. It is important that any public education clearly articulates the absence of clinical data for MC, especially in mental health conditions, and the clear risk of significant harm.

Summary

- There is currently insufficient evidence to support the use of MC in the treatment of any mental disorders. Further research is required to ascertain the potential risks and benefits of the targeted use of MC. High-quality studies directly examining the effect of MC on treating mental disorders are needed. There is a role for psychiatrists in contributing to this research, as well as supporting other medical colleagues in providing advice on potential risks in using MC for other medical conditions. RANZCP supports legislation that facilitates the research and appropriate regulation of MC products. These products should follow the same approval process as other new pharmaceuticals to ensure these standards are met before they are accessible.
- As the evidence for the use of MC continues to evolve, this memorandum will be reviewed and revised.

Further Reading

TGA Medicinal Cannabis Hub Accessed 29 June 2026

NZ Ministry of Health Medicinal Cannabis Information Accessed 29 June 2026

Royal College of Psychiatrists (UK). Position Statement on cannabis-based medicinal products. November 2019. Accessed 29 June 2026

AHPRA Guidance on Medicinal Cannabis Prescribing Accessed 29 June 2026

Pharmacy Board of Australia Medicinal Cannabis Supply Guidelines Accessed 29 June 2026

Federal Drug Administration Regulation of Cannabis Accessed 29 June 2026

Health Canada Medicinal Use of Cannabis Accessed 29 June 2026

References

1. SAS-B Approvals [Internet]. Available from: https://dashboard-data.health.gov.au/single/?appid=1066afbe-2b37-427d-8c47-2caa5082cccc&sheet=088f611b-10de-4d72-be68-ccf8d12c54e9&select=clearall
2. Special Access Scheme (SAS): Guidance for health practitioners accessing unapproved therapeutic goods [Internet]. Therapeutic Goods Administration (TGA). 2024. Available from: https://www.tga.gov.au/resources/guidance/special-access-scheme-sas-guidance-health-practitioners-accessing-unapproved-therapeutic-goods
3. Information for health professionals about medicinal cannabis [Internet]. Ministry of Health NZ. 2024. Available from: https://www.health.govt.nz/regulation-legislation/medicinal-cannabis/information-for-health-professionals

4. Australian Health Practitioner Regulation Agency - Medicinal cannabis prescribing [Internet]. 2023. Available from: https://www.ahpra.gov.au/Resources/Medicinal-cannabis-prescribing.aspx
5. Geoffrion L. Dangers of Marijuana: Long-Term Effects on the Brain and Body [Internet]. American Addiction Centers. 2024. Available from: https://americanaddictioncenters.org/marijuana-rehab/long-term-effects
6. Dellazizzo L, Potvin S, Athanassiou M, Dumais A. Violence and Cannabis Use: A Focused Review of a Forgotten Aspect in the Era of Liberalizing Cannabis. Frontiers in Psychiatry. 2020 Sep 16;11.
7. Guidance for the use of medicinal cannabis in Australia: Overview [Internet]. Therapeutic Goods Administration (TGA). 2025. Available from: https://www.tga.gov.au/products/unapproved-therapeutic-goods/medicinal-cannabis-hub/medicinal-cannabis-guidance-documents/guidance-use-medicinal-cannabis-australia-overview
8. Lintzeris N, Mills L, Abelev SV, Suraev A, Arnold JC, McGregor IS. Medical cannabis use in Australia: consumer experiences from the online cannabis as medicine survey 2020 (CAMS-20). Harm Reduction Journal. 2022 Jul 30;19(1).
9. About the Medicinal Cannabis Scheme [Internet]. Ministry of Health NZ. Available from: https://www.health.govt.nz/our-work/regulation-health-and-disability-system/medicinal-cannabis-agency/about-medicinal-cannabis-scheme
10. Wilson J, Dobson O, Langcake A, Mishra P, Bryant Z, Leung J, et al. The efficacy and safety of cannabinoids for the treatment of mental disorders and substance use disorders: a systematic review and meta-analysis. The Lancet Psychiatry [Internet]. 2026 Mar; Available from: https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(26)00015-5/fulltext
11. de Carvalho Reis R, Almeida KJ, da Silva Lopes L, de Melo Mendes CM, Bor-Seng-Shu E. Efficacy and adverse event profile of cannabidiol and medicinal cannabis for treatment-resistant epilepsy: Systematic review and meta-analysis. Epilepsy & Behavior. 2020 Jan;102:106635.
12. Rice LJ, Cannon L, Dadlani N, Mei M, Einfeld SL, Efron D, et al. Efficacy of cannabinoids in neurodevelopmental and neuropsychiatric disorders among children and adolescents: a systematic review. European Child & Adolescent Psychiatry. 2023 Mar 3;
13. Silva EA da, Medeiros WMB, Torro N, Sousa JMM de, Almeida IBCM de, Costa FB da, et al. Cannabis and cannabinoid use in autism spectrum disorder: a systematic review. Trends in Psychiatry and Psychotherapy [Internet]. 2021 May 21;44. Available from: https://www.scielo.br/j/trends/a/LBmJK6d8bqr5jVK6fp3CHXt/
14. Purcell C, Davis A, Moolman N, Taylor SM. Reduction of Benzodiazepine Use in Patients Prescribed Medical Cannabis. Cannabis and Cannabinoid Research. 2019 Jan 23;
15. Bhagavan C, Kung S, Doppen M, John M, Vakalalabure I, Oldfield K, et al. Cannabinoids in the Treatment of Insomnia Disorder: A Systematic Review and Meta-Analysis. CNS Drugs. 2020 Nov 26;34(12):1217–28.
16. Professional documents - ANZCA [Internet]. ANZCA. 2026 [cited 2026 Jun 29]. Available from: https://www.anzca.edu.au/resources/professional-documents/standards-(1)/pm10-2019-statement-on-medicinal-cannabis.pdf
17. Medicinal Cannabis Agency - Information for health professionals [Internet]. Ministry of Health NZ. Available from: https://www.health.govt.nz/our-work/regulation-health-and-disability-system/medicinal-cannabis-agency/medicinal-cannabis-agency-information-health-professionals
18. Medicinal cannabis: Access pathways and patient access data [Internet]. Therapeutic Goods Administration (TGA). 2022. Available from: https://www.tga.gov.au/products/unapproved-therapeutic-goods/medicinal-cannabis-hub/medicinal-cannabis-access-pathways-and-patient-access-data
19. Darabseh MZ, Selfe J, Morse CI, Degens H. Is vaping better than smoking for cardiorespiratory and muscle function? Multidisciplinary Respiratory Medicine [Internet]. 2020 Jul 3;15(1). Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7348661/
20. Stewart BW, Marshall H, Bonevski B, Griffin HJ, Hopkins AM, Itchins M, et al. The carcinogenicity of e-cigarettes: a qualitative risk assessment. Carcinogenesis [Internet]. 2025 Dec 26;47(1). Available from: https://academic.oup.com/carcin/article-abstract/47/1/bgag015/8555982?redirectedFrom=fulltext
21. Rychert M, Wilkins C. NEW ZEALAND MEDICAL JOURNAL TE A RA TIK A O T E HAUOR A H APO RI [Internet]. [cited 2026 Jun 29]. Available from: https://digital.mas.co.nz/hubfs/NZMJv137i1604_18Oct2024.pdf?hsLang=en-nz

22. Consultation: Reviewing the safety and regulatory oversight of unapproved medicinal cannabis products [Internet]. Available from: https://consultations.tga.gov.au/medicines-regulation-division/test-soms/user_uploads/final---consultation-paper---medicinal-cannabis-review---august-2025.pdf
23. Graham M, Assafa D, Kellner P, Ngo C, Tsering D, Delafosse V, et al. Potential health effects of higher potency (Australian Category 5) medicinal cannabis products [Internet]. Monash Addiction Research Centre (MARC). 2025 [cited 2026 Jun 29]. Available from: https://www.monash.edu/medicine/ehcs/marc/research/completed/potential-health-effects-of-higher-potency-australian-category-5-medicinal-cannabis-products
24. International Academy on the Science and Impact of Cannabis. IASIC Library [Internet]. Iasic1.org. 2025. Available from: https://iasic1.org/library/
25. Di Forti M, Marconi A, Carra E, Fraietta S, Trotta A, Bonomo M, et al. Proportion of patients in south London with first-episode psychosis attributable to use of high potency cannabis: a case-control study. The Lancet Psychiatry. 2015 Mar;2(3):233–8.
26. Di Forti M, Quattrone D, Freeman T, Tripoli G, Gayer-Anderson C, Quigley H. The contribution of cannabis use to variation in the incidence of psychotic disorder across europe (EU-GEI): A multicentre case-control study. The Lancet Psychiatry. 2019 May;6(5):427–36.
27. Galimberti M, Overstreet C, Gupta P, Beck S, Dao C, Deak JD, et al. The genetic relationship between cannabis use disorder, cannabis use and psychiatric disorders. Nature Mental Health. 2025 May 29;
28. Stuyt E. The Problem with the Current High Potency THC Marijuana from the Perspective of an Addiction Psychiatrist [Internet]. Nih.gov. 2024 [cited 2026 Jun 29]. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC6312155/#b21-ms115_p0482
29. Reece AS, Hulse GK. Epidemiological overview of multidimensional chromosomal and genome toxicity of cannabis exposure in congenital anomalies and cancer development. Scientific Reports [Internet]. 2021 Jul 6 [cited 2021 Oct 24];11(1):13892. Available from: https://www.nature.com/articles/s41598-021-93411-5#Abs1
30. Varner MW, Silver RM, Rowland Hogue CJ, Willinger M, Parker CB, Thorsten VR, et al. Association Between Stillbirth and Illicit Drug Use and Smoking During Pregnancy. Obstetrics & Gynecology. 2014 Jan;123(1):113–25.
31. Gunn JKL, Rosales CB, Center KE, Nuñez A, Gibson SJ, Christ C, et al. Prenatal exposure to cannabis and maternal and child health outcomes: a systematic review and meta-analysis. BMJ Open [Internet]. 2016 Apr;6(4):e009986. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4823436/
32. Alpár A, Di Marzo V, Harkany T. At the Tip of an Iceberg: Prenatal Marijuana and Its Possible Relation to Neuropsychiatric Outcome in the Offspring. Biological Psychiatry. 2016 Apr;79(7):e33–45.
33. Reece AS, Hulse GK. A geospatiotemporal and causal inference epidemiological exploration of substance and cannabinoid exposure as drivers of rising US pediatric cancer rates. BMC Cancer. 2021 Feb 25;21(1).
34. Hjorthøj C, Posselt CM, Nordentoft M. Development Over Time of the Population-Attributable Risk Fraction for Cannabis Use Disorder in Schizophrenia in Denmark. JAMA Psychiatry [Internet]. 2021 Sep 1 [cited 2021 Oct 29];78(9):1013–9. Available from: https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2782160?guestAccessKey=6d4e6058-7b5f-4e7a-997e-12d59f4a9522&utm_source=pocket_mylist
35. Mustonen A, Niemelä S, Nordström T, Murray GK, Mäki P, Jääskeläinen E, et al. Adolescent cannabis use, baseline prodromal symptoms and the risk of psychosis. The British Journal of Psychiatry [Internet]. 2018 Mar 4;212(4):227–33. Available from: https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/adolescent-cannabis-use-baseline-prodromal-symptoms-and-the-risk-of-psychosis/D5CAA12A5F424146DABB9C6A6AB4CB56
36. Castle DJ, Strauss N, Norman A, Bonomo Y. Medical Marijuana: The Australian Experience. Missouri Medicine [Internet]. 2019 Jul;116(4):270. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC6699817/

37. Solowij N. Psychotomimetic and Cognitive Effects of Cannabis Use in the General Population. In: The Complex Connection Between Cannabis and Schizophrenia [Internet]. 2018. Available from: https://doi.org/10.1016/B978-0-12-804791-0.00005-7
38. Hadland SE, Knight JR, Harris SK. Medical Marijuana. Journal of Developmental & Behavioral Pediatrics [Internet]. 2015;36(2):115–23. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4318349/
39. Schoeler T, Ferris J, Winstock AR. Rates and correlates of cannabis-associated psychotic symptoms in over 230,000 people who use cannabis. Translational Psychiatry. 2022 Sep 6;12(1).
40. Wang GS, Buttorff C, Wilks A, Schwam D, Tung G, Pacula RL. Impact of cannabis legalization on healthcare utilization for psychosis and schizophrenia in Colorado. International Journal of Drug Policy. 2022 Jun;104:103685.
41. Callaghan RC, Sanches M, Murray RM, Konefal S, Maloney-Hall B, Kish SJ. Associations Between Canada's Cannabis Legalization and Emergency Department Presentations for Transient Cannabis-Induced Psychosis and Schizophrenia Conditions: Ontario and Alberta, 2015–2019. The Canadian Journal of Psychiatry. 2022 Jan 12;67(8):070674372110706.
42. NDARC. Trends in drug-related hospitalisations in Australia, 2003-2023. UNSW Sites [Internet]. 2023; Available from: https://www.unsw.edu.au/research/ndarc/resources/trends-drug-related-hospitalisations-australia-2003-2023
43. Arlen MT, Patterson SJ, Page MK, Liu R, Caruana V, Wilson ET, et al. Cannabis vaping elicits transcriptomic and metabolomic changes involved in inflammatory, oxidative stress, and cancer pathways in human bronchial epithelial cells. American Journal of Physiology-Lung Cellular and Molecular Physiology. 2025 Jan 17;328(3):L478–96.
44. Medicines Australia Code of Conduct [Internet]. Available from: https://code.medicinesaustralia.com.au/wp-content/uploads/sites/68/2025/03/MA_Code-of-Conduct_Edition20_Edit_25032025.pdf
45. Medicines New Zealand: Code of Practice [Internet]. Medicinesnz.co.nz. 2019. Available from: https://www.medicinesnz.co.nz/our-industry/code-of-practice
46. Advertising Guidance: Medicinal Cannabis [Internet]. 2025 [cited 2026 Jun 29]. Available from: https://www.health.govt.nz/system/files/2025-07/advertising-guidance-medicinal-cannabis-july25.pdf
47. Google Search. Online Telehealth Medicinal Cannabis Instagram [Internet]. [cited 2026 Jun 29]. Available from: https://www.google.com.au/search?q=online%2Btelehealth%2Bmedicinal%2Bcannabis%2Binstagram
48. World Medical Association. WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Participants [Internet]. Wma.net. WMA - the World Medical Association-WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Participants; 2024. Available from: https://www.wma.net/policies-post/wma-declaration-of-helsinki/
49. Off-label prescribing in psychiatry | RANZCP [Internet]. RANZCP. 2023 [cited 2026 Jun 29]. Available from: https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/off-label-prescribing-in-psychiatry
50. RACGP - Use of medicinal cannabis products [Internet]. Racgp.org.au. 2018. Available from: https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/medical-cannabis

REVISION RECORD

Contact: Executive Director, Policy & Advocacy

Date	Version	Approver	Description
10/2018	1.0	2018/6 R22	New document
11/2020	2.0	B2020/16 R6	**Reviewed and Updated**

01/2021	2.1	EM01	**Updated**
03/2024	3.0	B2024/3 R24	**Reviewed and Updated**
07/2026	4.0	PPPC	**Reviewed and Updated**