REPORT ON PROCEEDINGS BEFORE

STANDING COMMITTEE ON LAW AND JUSTICE

ROAD TRANSPORT AMENDMENT (MEDICINAL CANNABIS-EXEMPTIONS FROM OFFENCES) BILL 2021

CORRECTED

At Jubilee Room, Parliament House, Sydney, on Thursday 16 June 2022

The Committee met at 9:45.

PRESENT

The Hon. Chris Rath (Chair)

The Hon. Lou Amato
The Hon. Greg Donnelly (Deputy Chair)
Ms Cate Faehrmann
The Hon. Rose Jackson
The Hon. Rod Roberts

* Please note:
[inaudible] is used when audio words cannot be deciphered.
[audio malfunction] is used when words are lost due to a technical malfunction.
[disorder] is used when members or witnesses speak over one another.

The CHAIR: Welcome to the Standing Committee on Law and Justice inquiry into the Road Transport Amendment (Medicinal Cannabis—Exemptions from Offences) Bill 2021. I acknowledge the Gadigal people of the Eora nation, who are the traditional custodians of the land on which we are meeting today. I pay respect to Elders past, present and emerging, and celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of New South Wales. I also acknowledge and pay my respects to any Aboriginal and Torres Strait Islander people joining us today.

Today, in the first and only hearing of this inquiry, we will be hearing from a number of stakeholders with an important perspective to share on the bill, including cannabis researchers, representatives of medical cannabis users, road safety experts, advocates for prevention and legal organisations. We will conclude with evidence from the New South Wales Government. I thank everyone for making the time to give evidence to this important inquiry. While we have many witnesses with us in person, some will be appearing via videoconference today. I ask for everyone's patience through any technical difficulties we may encounter. If participants lose their internet connection and are disconnected from the hearing they are asked to rejoin the hearing by using the same link as provided by the Committee secretariat.

Before we commence I will make some brief comments about procedures. Today's hearing is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcast guidelines, media representatives are reminded that they must take responsibility for what they publish about the Committee's proceedings. While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the hearing. Therefore, I urge witnesses to be careful about comments they may make to the media or to others after they complete their evidence. Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard, it is important that witnesses focus on the issues raised by the inquiry terms of reference and avoid naming individuals unnecessarily.

All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. If witnesses are unable to answer a question today and want more time to respond they can take a question on notice. Written answers to questions taken on notice are to be provided within 21 days. If witnesses wish to hand up documents they should do so through the Committee staff. For those participating in today's hearing via videoconference, I ask that everyone state their name when they begin speaking, to speak directly into the microphone and to mute their microphones when they are not speaking. To aid the audibility of this hearing I remind both Committee members and witnesses to speak into the microphones. Finally, I ask that everyone turn their mobile phones to silent for the duration of the hearing.

Dr JOEL WREN, President, Society of Cannabis Clinicians, Australian Chapter, before the Committee via videoconference, affirmed and examined

Dr THOMAS ARKELL, Research Fellow, Swinburne University of Technology, affirmed and examined

Dr DANIELLE McCARTNEY, Research Fellow, Lambert Initiative for Cannabinoid Therapeutics, University of Sydney, affirmed and examined

Professor IAIN MCGREGOR, Academic Director, Lambert Initiative for Cannabinoid Therapeutics, University of Sydney, affirmed and examined

The CHAIR: Thank you all for joining us today. Would any of you like to make a short opening statement? Those statements should take no more than a couple of minutes. Dr Wren, would you like to go first?

JOEL WREN: Yes, thank you. As stated, my name is Dr Joel Wren. I currently work as a GP in southern Adelaide, though I also work as a telehealth clinician, servicing patients Australia-wide. I thank the Committee for the opportunity to provide a clinical insight into this issue. I am here to advocate on behalf of the thousands of patients in New South Wales accessing medicinal cannabis products legally and to show that the current punitive approach to detection only of THC is nothing short of discrimination. Every clinical decision holds so many variables, such as primary indication for intervention, concomitant medications, living arrangements, living capacity and kidney function, just to name a few. Impairment is an important social consideration. I counsel patients about psychotropic effects of opioid analgesics, antidepressants, hypnotics and anxiolytics. I advise them to avoid using machinery, including motor vehicles, if they feel impaired. As a legitimate emerging therapy, medicinal cannabis and the driving laws that surround its use need to be consistent with other prescription therapies currently available. By way of questions being asked, I implore the members to reconsider replacing medicinal cannabis with other current medications prescribed widely on a daily basis, such as benzodiazepines or opioids, and it will quickly become apparent just how archaic these laws actually are.

The CHAIR: Professor McGregor, do you have an opening statement?

IAIN McGREGOR: Yes, I do. Thank you very much. I represent the three of us in this opening statement. We are all by biomedical researchers with a strong interest in medicinal cannabis. That extends into running clinical trials with medicinal cannabis products, and developing the medicinal cannabis products of the future in our drug discovery paradigm but also doing a lot of policy work and outreach work for patients in the community. I'm very proud of the effort, particularly of my colleagues here, who have done some of the best international studies recently on the issue of cannabis and driving. The reason that the Lambert initiative is interested in this area is because we hear from patients all the time in our outreach work what an issue this is for them. This is, in many ways, the number one difficulty that medicinal cannabis patients face. This problem is not going away because we're anticipating to have maybe 300,000 medicinal cannabis patients in Australia by the year 2025.

Our own work and the work of our colleagues internationally shows that the crash risk with cannabis does go up, but it's a very small amount and relatively tiny compared to other drugs where you are allowed to drive, particularly opioids and benzodiazepines, as Joel mentions. So there is a bit of a double standard at play that concerns us. I think we can use our science in a very wise and informed way to develop a much more refined policy around medicinal cannabis and driving. I would invite you to explore the evidence with us this morning and examine what that refined policy might look like.

The CHAIR: Dr McCartney and Dr Arkell, you're fine with that opening statement?

THOMAS ARKELL: Yes.

The CHAIR: We will start now with some questions from the Committee members.

Ms CATE FAEHRMANN: Thank you all for appearing today and for the very important work that you all do. I might start with Dr Wren. You suggested that if there was a replacement of medicinal cannabis with opioids, we would quickly see how archaic these laws are. I think that is along the lines of what you said. Could you explain to the Committee a little more why replacing medicinal cannabis with opioids is a bad idea, in your opinion?

JOEL WREN: I think that the crash risk with medicinal cannabis, as has already been pointed out, is wildly overblown. The issue is that we are widely prescribing these medications every single day to many, many Australians. We're telling them, "It is okay to wait a while if you're feeling bad", that some people do metabolise these medications differently. With medicinal cannabis it's just a flat-out refusal—absolutely not. It doesn't matter about any sort of impairment. It's just based on presence. From what I see, it severely restricts the access to

legitimate medicinal cannabis products, which has been repeatedly highlighted in multiple inquiries—including a Federal Senate inquiry, I believe, from about 2019.

Ms CATE FAEHRMANN: Thank you. I might just take a step back with maybe the researchers from the Lambert institute and potentially just assume a level of knowledge about the benefits of medicinal cannabis for people with lots of different ailments—maybe do not assume there is a particular level of knowledge just in terms of this response, if that might help. Professor McGregor, you said you hear from patients. You work with many patients who have medicinal cannabis. You hear from them the difficulties they face. Firstly, what type of ailments? What type of people is medicinal cannabis helping? Let's just start there and then I'll get onto a question about the difficulties they face.

IAIN McGREGOR: Yes. Well, we've crunched the numbers on that quite recently and published a paper on the first five years of medicinal cannabis availability in Australia. We went down to a granular level of detail in terms of the conditions being treated. About 60 per cent of the prescriptions are for people with various forms of chronic pain—so that would be back pain, neck pain, arthritis, fibromyalgia, and so on and so forth. So that's by far the largest category in terms of conditions being treated. Then we see anxiety, and certainly the trends are upwards for the treatment of anxiety with medicinal cannabis products.

And there is an important technical point here that some of you are probably aware of and that is the difference between a THC base and a CBD-based medication. About a quarter of the prescriptions going out at the moment in Australia are for what we might call CBD-dominant products. CBD is a component of the cannabis plant that doesn't intoxicate whatsoever, but it seems to have strong anticonvulsant effects in epilepsy and also there's emerging evidence for a range of mental health conditions that it has quite dramatic beneficial effects, and we're doing a lot of work on that. So a really important point—and this is from Danielle McCartney's work here—is that CBD does not impair driving. Danielle published a paper on that just last week, which went viral all around the world, and Thomas Arkell has also published on that with vaporised CBD.

You could say that with a quarter of the prescriptions there is no concern around driving whatsoever because these are CBD-dominant prescriptions and the current drug-testing regimes used by the police in New South Wales don't get a false positive with CBD either. Danielle has also shown that in another very useful, practical study. So the concern is mostly around the 75 per cent of prescriptions that are for THC. They're for chronic pain, for anxiety, increasingly insomnia as well. A range of sleep conditions are being treated with THC medications. That's also very relevant to driving because these are typically taken at night so there's an important question, which we've answered in a recent study, which is: If you take THC by night, are you okay to drive in the morning? The answer there was resoundingly yes in a paper that we haven't published yet.

So, yes, a wide range of conditions. There's more than 130 conditions that are currently being treated with medicinal cannabis products, more than 250,000 prescriptions, more than 4,000 prescribing doctors and the trends are all ever upwards. So this has become a mainstream medicine and that exaggerates even further the need to deal with the driving issue.

Ms CATE FAEHRMANN: Can I just check on that? The conditions, is there something as well about in the laws governing the prescribing of medicinal cannabis that other medications, medicines, have to have been tried first or aren't effective or don't work. Is that correct in New South Wales?

IAIN McGREGOR: Yes. Generally, that's the TGA guidance.

Ms CATE FAEHRMANN: Right.

IAIN McGREGOR: Our clinician colleague here could probably speak better to that. Joel, is that the yardstick that you apply?

Ms CATE FAEHRMANN: Yes. Dr Wren?

JOEL WREN: Under the current legislative framework, because almost all of these medications are unapproved, unregistered medicines, applications must be made to the TGA to state that conventional therapies have been trialled and have either been discontinued because of adverse effects and intolerability or just being ineffective—initially, that must be trialled before then seeking approval for medicinal cannabis use.

The Hon. LOU AMATO: Professor, the patients using the THC, I presume, what percentage of those are cancer patients, particularly end of term in palliative care? Is that increasing?

IAIN McGREGOR: Yes. All of the conditions are increasing and treatment of cancer symptoms is certainly in the top 10 of the list. We did an interesting clinical trial. We were part of a trial at the Lifehouse here in Sydney, where patients that were receiving chemotherapy—and experiencing nausea and vomiting—that was resistant to normal medications used for nausea and vomiting were given a THC-containing medication to see

whether that would give them some relief from the nausea, which is very common in people getting chemotherapy. That showed a highly significant and beneficial effect of the cannabinoid medication. Recruitment in that study was actually very difficult because of the driving restriction. These patients were told, "Sorry, you're not allowed to drive for the duration, for the several weeks of that trial." We estimated about 50 per cent of patients or potential recruits to the trial walked away for that reason.

The Hon. LOU AMATO: I had a close friend who has passed away since, but the only thing that helped him, particularly the feeling of nausea, was medicinal marijuana. But, again, he couldn't drive. He said, "I feel fine to drive. There's nothing there, but even if I'm outside that area I can still get picked up and pinned."

IAIN McGREGOR: Yes, that's right. I was talking to Phil Donato, who some of you may know—a member of the Senate here, I believe, and the member for Orange. We had a chat with an oncologist based at Orange who likes to prescribe medicinal cannabis to his cancer patients and runs clinical trials out there as well. The story was basically the same, that there are many patients who would love to be trialling medicinal cannabis for their cancer-related symptoms who were unable to. This is a particularly acute problem in rural and regional New South Wales, where not driving is really an option. It's just something you have to be able to do.

The Hon. LOU AMATO: So the THC level, how long does it stay in your system for you to be picked up?

IAIN McGREGOR: I should refer this one to Tom Arkell.

The Hon. LOU AMATO: Is there a standard?

IAIN McGREGOR: He's done the study with the police drug testing.

The Hon. LOU AMATO: With alcohol, we know what the alcohol range is—roughly how long—but what about the THC?

THOMAS ARKELL: It depends what you're measuring it in. In oral fluid, which is obviously what roadside drug testing uses, it's highly variable. For a lot of people it can be gone within a couple of hours. I've been running a study over the last year with patients down in Victoria and I've seen that some people are still testing positive the following morning, so somewhere between 10 and 12 hours after they would have last used a dose of whatever product it is that they've been prescribed. It can vary a huge amount. It's very hard to say exactly how long it stays around in your system for, particularly in—

The Hon. LOU AMATO: Alcohol is the same. It's different for different people as well.

THOMAS ARKELL: Yes, but because it's eliminated from the body at a constant rate, there's a pretty good relationship between the amount of alcohol you consumed and how much you have in your system. First of all, that's why BAC limits work very well; and, secondly, why we can use breathalysers widely. It is because we know that relationship between how much you've had and how much is in your system is very reliable.

The Hon. ROSE JACKSON: Dr Arkell, in the New South Wales Government's submission to this inquiry—I'm not sure whether you've seen that. Yes? Excellent. It states, "Presence of an illicit drug in oral fluid is reflective of recent drug use." I suppose what you're suggesting is that statement is not entirely true or is slightly misleading. It may be reflective of recent drug use but it may also be reflective of drug use of some time past. Is that correct?

THOMAS ARKELL: That's right, it tends to indicate recent use. The reason for that is because when you have THC in your oral fluid that is simply a coating of your mouth from when you've actually consumed a cannabis product. If you inhale it, that vapour is coating your mouth. If you were to take an oil and you drop it under your tongue, that's also coating your mouth, and that's what's being picked up when you look for THC in oral fluid. If you look for it in blood, that's sort of reflecting circulation in the body, so it lasts for a bit longer. In urine, it can last for months in some cases. Oral fluid has the shortest window of detection because it's simply reflecting what's actually stuck in your mouth.

The Hon. ROSE JACKSON: The Government is using that line. It is making that statement to suggest that people who are testing positive at roadside mandatory drug testing have all used THC recently, and that is what is being picked up. But you're suggesting that that just isn't accurate—that people are testing positive at mandatory roadside drug testing who have not recently used THC.

THOMAS ARKELL: It's very possible that THC can be present in your oral fluid for longer than you're impaired for. It's also possible that it's present in your oral fluid and you're not impaired at all. That's not the case for everyone; it may be for some people that it does reflect recent drug use and it does reflect impairment. But it's not a reliable indicator of impairment.

The Hon. ROSE JACKSON: Professor McGregor, you cited research that you had done, and your submission talks about research on which you'd collaborated with international colleagues, in relation to the crash risk of people who have consumed THC. The Government's submission suggests that evidence cited by Monash University finds that THC can increase crash risk by around 50 per cent. I wondered if you might address that. The Government's submission is that it is very dangerous to drive after you have consumed THC and therefore this very punitive, zero-tolerance, presence-based blanket rule is appropriate. That is the sort of evidence that they are citing, so I wondered if you might respond to that based on the research that Lambert has done.

IAIN McGREGOR: I must say we were quite disappointed with the New South Wales Government submission—even though it cited a couple of our papers, which was nice. But I think the interpretation thereof was a little bit off, and there were some logical inconsistencies in that submission. We also have reservations about the recent work of Monash University Accident Research Centre [MUARC], as well. I know Danielle has been running a ruler over their latest studies and there are legitimate concerns there.

The crash risk data are complex. These are large epidemiological studies. It's very hard to get a highly accurate and refined methodology that will give you an exact number in terms of the enhanced crash risk with cannabis, but the best controlled studies are telling us that what we call the odds ratio is about 1.1 to 1.4 if you are acutely intoxicated with cannabis. In other words, it's an increased crash risk of 10 per cent to 40 per cent. That is about the same as .04 or .05 blood alcohol concentration, and it's significantly less than you would see with opioids, benzodiazepines or sedating antidepressant drugs that are very widely prescribed. That puts that risk in perspective.

The other really important point to make there is that if you're a regular user of cannabis, a daily user, then your driving impairment seems much reduced. You develop tolerance to impairment with driving. One of our assumptions—and this is yet to be studied in a proper clinical trial; there are basically no good-quality clinical trials that have been done with medicinal cannabis users and driving—would be that the crash risk may indeed be minimal, if not negligible, in people who are using cannabis for medical—

The Hon. ROSE JACKSON: Because they are using it regularly every night, as you say, to manage pain.

IAIN McGREGOR: But also if you're alleviating a medical condition, be it insomnia or pain or spasticity if you have MS, then these are conditions that will impair your driving anyway. If you take a medication that relieves your pain, relieves your insomnia, relieves your spasticity, then that may actually improve your driving. We've got a shameless pitch in our submission for a study that we'd love to do on cannabis and driving.

The Hon. ROSE JACKSON: That was my next question—the AMBER trial. Can you give us a little bit more information about what your pitch is? This is the opportunity to make it to the New South Wales Government about supporting that. Because cannabis has been an illicit substance, it has been very difficult to do a lot of research involving it. What does this particular trial look like and what would you be interested to see from the New South Wales Government in support of that?

IAIN McGREGOR: We've certainly made a mark internationally in terms of our driving research. Tom did a world-leading study using actual on-road driving in the Netherlands where people vaporised cannabis and went for a 100-kilometre drive in a specially instrumented Volkswagen so we could get a very refined picture, and maybe Tom will speak to that in a little while. We've also done a lot of work with driving simulators. To resolve this legislative problem, if you like—and it's certainly a major practical problem for patients—what we really need to do is gather data, and that is to take a whole bunch of patients, say about 150, who are initiating medicinal cannabis for the treatment of, say, chronic pain. We will give half of them the actual cannabis that they want and the other half a placebo, and this will probably be an oral oil, and then we'll track their driving performance over the first 12 weeks that they take their medication.

We can do that one of two ways. We can do that in a driving simulator. They come into our labs and we look at their driving, say, every week or every couple of weeks and see how they're going, and the simulators are very good quality and correlate very well with on-road driving. Or we may use a gadget that Tom has been telling me about where we can put this in their actual cars and measure their driving ability over time. There we have it; it's a very simple trial. We just look at their driving when they initiate a THC-based medicine and we have a run and we look at them at baseline and then when they go to the meds, be it cannabis or placebo. Then we've answered the question: Is their driving impaired by that medication or isn't it? Our strong belief is that if there is an impairment, it will probably be in the first week of treatment and that it will abate over time and then by week 12 they'll be driving just as well as they did without their cannabis-based medication.

But you're running across the passion of scientists. This is how we answer these questions, not with political arguments but by gathering data, and we'd love to do that study. Unfortunately, the Lambert initiative is

well funded from our philanthropists but clinical trials are expensive and we never have enough money to run all the clinical trials that we'd like to. We'd love to join with the Government actually in running this trial if there were a possibility to do so. Maybe there's a little bit of money sloshing around at the end of the financial year in NSW Health.

The CHAIR: In terms of measuring impairment versus measuring a historical or past presence, what methods do you have to do that in terms of when the police breathalyse motorists? Obviously there's a difference between what you were saying, Dr Arkell, about people who may have previously used cannabis but aren't currently under the influence. How do you actually measure impairment?

THOMAS ARKELL: Shall I take this?

IAIN McGREGOR: Danielle, you've written a book on cannabis impairment recently.

DANIELLE McCARTNEY: In out studies, we have a few different ways. As Iain has already referred to, we use our driving simulators and we have computerised cognitive function tests and a few sort of high-tech gadgets like that. Obviously, not all of that is as practical at the roadside. So we do need to be looking at alternative technologies, I think, that can be used effectively in that setting. There are a few different options that are being researched, I guess, at the moment. We've done a little bit of work using computerised apps. For example, you can put a fairly simple cognitive function task on someone's phone or similar sort of device and measure their impairment within the test that we have been using; it takes about two minutes. It's quite quick, and they're in the process of validating something like that at the moment.

Ms CATE FAEHRMANN: What's the name for that, again?

DANIELLE McCARTNEY: The DRUID task.

Ms CATE FAEHRMANN: Thank you.

DANIELLE McCARTNEY: That's the one that we've been using; I believe that there are others. There is also research going on looking at using all kinds of different technologies. There is some eye-tracking sort of work going on—I think that's something that's going on in Tom's lab—looking at how you can measure people's eye movement, behaviour and things like that in order to ascertain impairment. Beyond that, there are of course the field sobriety tests and things like that, which are still widely used internationally, in order to identify people who are not safe to drive. There are a lot of options. There is a lot of work going on in this space. There is a lot of room for improvement.

The CHAIR: Obviously that all sounds incredibly interesting and lots of very important technology seems to be developed. But with regard to being able to roll it out to police officers in terms of detection, it seems like it might be difficult to do that at this current time, compared to a breath test, which is easy and already being done for alcohol consumption. Is there anything that could be rolled out easily and practically tomorrow to measure impairment as opposed to a previous presence, if I can put it that way?

DANIELLE McCARTNEY: At this stage, I think we're still looking at field sobriety tests. It's still widely used, the old walk-and-turn and things like that. I believe things like that are used in the US and Canada to detect impairment.

IAIN McGREGOR: One very simple task that has been shown at least in one study—and we'd like to do some work on this—is something extremely simple. That is, "Can you stand on one leg and close your eyes?", which sounds a little bit flippant, but there is at least one study that suggests that's very difficult to do when you are acutely intoxicated.

Ms CATE FAEHRMANN: Sorry, can you repeat what it was? I was just distracted for three seconds. What was it?

IAIN McGREGOR: Part of the normal field sobriety testing on the roadside in the US are things like, "Walk this straight line." That doesn't work well with cannabis—people seem to be able to walk the straight line quite well. But if you ask them to stand on one leg and close their eyes and remain upright, that seems to be quite challenging. Tom, is that your understanding?

THOMAS ARKELL: Yes. The only other thing I suppose I would add to that is that some people find that very hard anyway.

IAIN McGREGOR: Yes, exactly.

The Hon. LOU AMATO: I was going to say.

Ms CATE FAEHRMANN: Can I just say on this—have you finished?

THOMAS ARKELL: I would say particularly in older people—where your balance tends to get worse, particularly if you have hip or knee problems—if we are talking about a 75-year-old who is using THC for chronic pain, it may be that they can't balance anyway. There are some, I suppose, limitations in terms of—while it appears to be sensitive, more sensitive than some of those other tests, it is true for some people that their balance is probably going to be bad enough anyway that whether they've had THC or not is probably not making much of a difference.

IAIN McGREGOR: You need a baseline. I think that's the problem with these functional measures of intoxication, that everyone starts at a different level. So, to see whether someone is impaired, you need to know what they look like when they're not intoxicated. As Tom points out, it's a big difference between a young, fit, 18- year-old athlete versus a 75-year-old with severe arthritis.

The CHAIR: The problem is that if you were to remove the standard breath test or saliva test and not replace it with anything, then you could have a situation where it could become quite unsafe if you are not measuring it in some other way. There has to be some sort of alternative to just removing the standard breath test used by police officers. Would you not agree?

IAIN McGREGOR: I think the intent of the legislation is an exemption for patients; it's not to remove oral fluid testing entirely. That's a different argument. I would say that other jurisdictions—we mention this in our reports—seem to be able to manage these exemptions without much of a problem. I know the New South Wales Government's submission seemed to find it incredibly difficult, the mechanics of an exemption, which I found rather strange. Surely it's just as simple as ascertaining from the person's physician that they have a legitimate prescription.

The CHAIR: I understand that in terms of the exemption for patients. But, with impairment, it can still be the case for patients as well.

IAIN McGREGOR: That's right.

The CHAIR: So how you would measure that is the difficult—

IAIN McGREGOR: In Canada it's erratic driving. The highway patrol see you weaving from side to side, as they would for other intoxicating medications or alcohol. Let me emphasise that THC intoxication is a really hot area of research. There are people, for example, working with virtual reality goggles to try and develop roadside tests where in 30 seconds you can tell whether someone's impaired. But cannabis impairment is very subtle, and that is the problem. Alcohol is very easy in comparison. Same goes with police trying to identify whether someone's intoxicated with cannabis. They are actually very poor at that. There are studies of that. Even in trained experts, they don't get it right very often. There is a subtlety there. Whoever comes up with the roadside functional test will be probably very famous and very wealthy, I imagine.

The Hon. LOU AMATO: Dr Wren, in your submission you mention about Mothers Against Drunk Driving and Health Canada, and their advice that individuals should wait four to six hours after using medicinal cannabis before driving. Is that the law in Canada? How does that work over there?

JOEL WREN: For specifics on the actual law and the legislation?

The Hon. LOU AMATO: Yes. Are there specific laws or is it only because Health Canada is advising it?

JOEL WREN: I'm not too sure, to be honest. I would have to take that on notice to actually get the specific wording of it. It would just be from a clinical advice perspective. That's what we have been talking to patients about: the duration of the possible impairment, which can actually relate to the formulation and how they're actually consuming these products as well. Because that period of impairment can vary between an inhaled product and an oral liquid as well.

The Hon. LOU AMATO: Thank you, Dr Wren. Does anyone else know any more?

IAIN McGREGOR: Danielle, again, wrote the book on duration of impairment. You would be familiar with the Canadian system.

The Hon. LOU AMATO: Doctor, have anything you'd like to add to it?

DANIELLE McCARTNEY: Yes. We conducted a big review of all of the available evidence around THC-induced impairment, looking at THC's effects on cognitive function and driving performance and all kinds of things like that. We, essentially, extracted all the data from the papers that existed, crunched the numbers, ran some modelling and looked at the various different factors that have just been spoken to that might influence the duration of impairment. I think, most importantly, we found that the dose of THC consumed and the route of

administration were important determinants of how long THC-induced impairment persisted, with higher doses causing longer lasting impairment and oral THC causing longer lasting impairment than inhaled THC.

What we found overall was that THC-induced impairment typically lasted anywhere between three and up to sometimes 10 hours, depending on those two factors. Of course, patients typically probably consume lower doses of THC in order to try and avoid intoxication and things like that, so they might be towards the lower end of that range. But, yes, we do have some good data to inform how long people should be waiting following cannabis use before driving now.

IAIN McGREGOR: The answer is five, isn't it?

DANIELLE McCARTNEY: Well, five, yes, but it's a bit of a range. We would say five would be a good general recommendation.

The Hon. LOU AMATO: Five hours is the general amount.

The Hon. GREG DONNELLY: Thank you all for coming along today. Professor, I will direct my question to you but it might be shared across the panel. I am looking at your submission on page 8 underneath the table. The table contains some useful information in other jurisdictions, particularly overseas. The first paragraph underneath says, "A nuanced approach might also require patients to not drive during the first few days." The next paragraph in the second last line says, "Might provide an additional layer" and then the last paragraph in the last line says, "Might be maintained." So there are some qualifying words there. I am just wondering, in terms of listing what might be some qualifiers or conditions around what's being looked at, is that what you see as the three that are the most important or the exhaustive list of what might need to be considered or are they just matters that, through your research, jump off the page and inform your thinking?

IAIN McGREGOR: These are the areas where we have a margin of uncertainty. Certainly, if you are adopting a safety-first approach, which I think we would all agree with, within reason, I guess the ultimate safety-first approach is that no-one drives ever. But how do you manage the risk in terms of risk management? I would say that advising not to drive during the first few days would be a reasonable public health message and safety message to give to patients. Again, going back to tolerance to the impairing effects of THC, we would expect any impairment to be biggest when people first use the drug. That would be something that the AMBER trial, if we were to run that clinical trial, could actually show for sure what the trajectory of impairment was over time in patients, initiating a THC-based medicine.

Also, again, with Danielle's work suggesting that—and not just Danielle's work; other recent work from the University of California San Diego has suggested this three to four hours as being the peak time where you will see cognitive and driving impairment. Another good safety-first message would be that if you take particularly a moderate to high dose of a THC-based medicine then wait three or four hours before you drive. That would be a sensible thing to do. We do know that THC can exacerbate alcohol-induced impairment. You might want to give some thought to how to best manage that. Perhaps the combination of a high concentration of THC and oral fluid together with a positive breath test would be something that is seen as more hazardous than either of these things alone.

The Hon. GREG DONNELLY: The first paragraph on page 8 is about requiring patients not to drive during the first few days of using a THC-based product and the second paragraph is about the mandatory time limit of no driving for three hours. What is the distinction between those two? Is the first one dealing with if you are commencing the treatment for the first time?

IAIN McGREGOR: Yes, that's right. The first one is dealing with drug tolerance. It's much like alcohol. If you've never had a drink in your life, a glass of wine will have a much bigger effect than someone who is a daily drinker. You're trying to allow people to become accustomed to the unusual feeling and impairment that THC can produce when they're initiating THC as a medicine. Whereas the second one, we know that even in people who are tolerant to THC, there can still be some impairment in their driving in the first few hours after use. The second one manages that. Even though you may be tolerant to THC, it may be wise, if you're taking a moderate to large dose, to wait two or three hours before you drive to enhance the overall safety.

The Hon. GREG DONNELLY: In your opening statement, Professor McGregor, you talked about the crash risk going up. But you said that, on the evidence, it appeared to be only marginally, as I understand your opening statement. Later on—I think it was yourself, but I stand to be corrected—there was a reference to between a 10 per cent and 40 per cent increase in the possibility of having a motor accident. I'm trying to reconcile those two explanations.

IAIN McGREGOR: Maybe the yardstick against alcohol is informative. If you were to look at a blood alcohol concentration of .049, where you're perfectly good to drive under current legislation—unless you're a

commercial driver or a P or L driver—you will be more impaired than if you have had cannabis. So we already tolerate a margin of impairment with alcohol and other drugs. It's a modest level of increased crash risk and one that we tolerate with alcohol. We also tolerate other prescription drugs that have a much greater crash risk. If you have a blood alcohol reading of .12, I think your crash risk is something like 20 to 200 times greater, so a 0.4 increase is very small by comparison to both prescription drugs and higher doses of alcohol.

The Hon. GREG DONNELLY: But 40 per cent is quite a high percentage, if that's the figure that's—

IAIN McGREGOR: If you look at 2,000 per cent with a blood alcohol concentration of .08, 40 per cent is quite small in terms of percentage increase. I take your point, and that is that no-one is arguing that crash risk doesn't go up with THC. But compared to other things that we tolerate, that enhanced crash risk is considerably smaller.

The Hon. ROD ROBERTS: Thank you all for your attendance today. I might direct my questions to you, Professor McGregor. THC affects individuals differently, as do all types of drugs, whether they be illicit or prescription. That's correct, isn't it?

IAIN McGREGOR: Yes.

The Hon. ROD ROBERTS: I take that point. Have you ever heard of the hierarchy of risk control? Are you familiar with that?

IAIN McGREGOR: No, I'm not, actually.

The Hon. ROD ROBERTS: If you're not, we'll leave that. Let's take you to your statement just recently. In your opening statement, you said the risk level of a crash goes up. Then, in answer to my colleague Mr Donnelly, you have said anywhere between 10 per cent and 40 per cent. Monash University says 50 per cent. You dispute that, but we're not here to split hairs. There is an increase in risk, though. Do we agree?

IAIN McGREGOR: That's what the evidence—

The Hon. ROD ROBERTS: Where that sits, we don't know. But there's an increase in risk.

IAIN McGREGOR: Yes.

The Hon. ROD ROBERTS: In that case, do you think it's appropriate for a Parliament to legislate or endorse a change in legislation that would allow for an increased risk of motor vehicle accidents, no matter whether it's 10 per cent, 40 per cent or 50 per cent? Do you think it's appropriate that we should change legislation that increases the risk?

IAIN McGREGOR: I have a couple of points, and I might throw this over to my colleagues as well, once I've quickly said something. We don't actually know, in the case of patients—as I've noted already—whether the risk goes up or not. Other legislatures around the world seem to be able to manage that risk and provide the exemption that is being sought with this amendment. Until we run a trial like the AMBER study we won't know whether that impairment is really—

The Hon. ROD ROBERTS: Can I rudely interrupt you? I apologise, but I want to hone in on this. We don't know at the moment, were your exact words?

IAIN McGREGOR: In the case of patients, we do not know whether crash risk is increased or not.

The Hon. ROD ROBERTS: Thank you. Please continue. I apologise for my interruption.

IAIN McGREGOR: I feel like I'm hogging the floor a little bit. Tom, would you like to say anything about this one—and maybe Joel, as well?

THOMAS ARKELL: In some sense, this comes back to civil liberties. The real comparison we should be making is to other medicines that patients already do take and drive under the influence of. That's really what we're talking about here. We are talking about patients. We are not talking about people who are using cannabis recreationally; that's a completely different question. As Professor McGregor has already said, we know that if you've got opioids in your system—even antidepressants, in the first few weeks of treatment particularly, can produce driving impairment; or benzodiazepines, which you may be using for anxiety, something like Valium. We have a lot of other cases already where we know that these drugs do impair driving but we trust that patients will make responsible decisions around whether they're okay to drive or not. I think what this is doing is bringing medicinal cannabis into line with those, I suppose, rules or guidelines that we currently already have for other prescription drugs.

The Hon. ROD ROBERTS: You can either agree or disagree to this proposition: You are suggesting benzodiazepines, opiates and all these other sorts of drugs over here impair your driving—which they do, I agree

with you entirely—but what you're saying is, "Well, perhaps we should just add another one on because these are already happening." It that basically what you're saying?

THOMAS ARKELL: I think if we're talking about medicines then we should treat all medicines equally.

The Hon. ROD ROBERTS: Fine. That's all I have, Chair. Thank you.

Ms CATE FAEHRMANN: Dr Wren, in terms of today's hearing you might be the only GP that is before the Committee who prescribes medicinal cannabis. I was hoping you could just give us a few examples of patients that you have seen with conditions where other prescription drugs didn't alleviate their condition, and how medicinal cannabis has worked for them. Do you have examples of that, firstly?

JOEL WREN: I certainly have hundreds, if not thousands, of examples. This is a really important point. When we're talking about THC-containing medicines, that is slightly different to THC-based medications in terms of the proportion of cannabinoid content as well. As I counsel patients, there are hundreds of products available between high levels of CBD with small amounts of THC—which research has shown that the entourage effect and hypothesis of a whole plant medicine rather than isolates can have an increased therapeutic benefit—compared to what we would refer to as balanced products—equal parts CBD and THC together—compared to half levels of THC as well. Further to that point, clinically and pharmacologically, CBD is what is called a negative allosteric modulator. By combining them together, CBD can actually reduce levels of impairment from THC as well.

I will give a couple of really textbook examples of providing medicines that do contain THC. I've seen plenty of middle-aged people between their 30s and 40s who have high levels of anxiety and have tried conventional SSRIs—selective serotonin reuptake inhibitors. That can impact their sexual function, which will obviously in turn affect their quality of life. They would cycle through a couple of SSRIs and potentially an SNRI as well—serotonin norepinephrine reuptake inhibitor. A really common tetracyclic antidepressant, Mirtazapine, can cause a lot of sedation, especially morning sedation and grogginess on the way to work, causing impairment. Potentially for patients in that scenario I would be prescribing something like a 1:25 oil, which is usually 25 milligrams per millilitre of CBD—understanding a dose of up to 1,500 milligrams of CBD has been tolerated safely in humans. But it is that one milligram per millilitre of THC, it is that presence in the first place, that completely makes it illegal for them to then drive to work. So they are forced to essentially sit with their anxiety.

Another example would be older people suffering from degenerative joint conditions and osteoarthritis, chronic pain, to the point that it affects their sleep. For example, a patient like that, a really common scenario is something like a 10-10 oil, which obviously has a substantially higher THC component. So 10 milligrams per millilitre of THC and CBD. They might be taking anywhere between five to 10 milligrams of THC in the evening to assist with their pain but also to assist with their sleep as well. In current guidelines, previously updated at the end of 2021, oral dosing of THC generally can be well tolerated in patients up to around 40 milligrams of THC per day.

Ms CATE FAEHRMANN: If this law passed and we did get changes in New South Wales where people who are prescribed medicinal cannabis were able to drive—similar to other prescription drugs like Endone and schedule 8 drugs—as a doctor, how would you advise them? I assume with your patients it would not be blanket advice. But how would that change in terms of how you prescribe? I assume at the moment you would just say, "You can't drive with THC in your system, this is the rule". How would that change? How would you approach it?

JOEL WREN: It would be discussing the current medications that they are taking as well and any potential risk of interaction both in a synergistic manner and in psychotropic medications. The combination of a CNS depressant plus THC on top compared to interactions of hepatic metabolism, which can be possible especially with antidepressants and antipsychotics. It is understanding that most people start with dosing of a night time, of an evening, to develop tolerance to the effects of the medication. And also potentially to start on the weekend where they are not going to be driving and if there are any side effects they can take note of them without needing to go to their job or anything like that.

Another huge part of prescribing medicinal cannabis that is not necessarily recognised is pharmacovigilance is greatly improving—even in the last couple of years. Between My Health Record and SafeScript NSW, there is QScript in Queensland and ScriptCheckSA, we can in real time monitor other prescription medication and see is this patient displaying drug-seeking behaviour. We can regulate their usage through minimum dispensing intervals from pharmacies and with a reduced, if any, use of repeats as well, just to actually ascertain what the clinical effects will be before advising them to continue the medication.

The CHAIR: We do have to wrap up, we are running out of time. We could have one final question.

The Hon. ROSE JACKSON: I just wanted to ask, in a way leading on from my colleague Mr Roberts' questions, if we are to be consistent here one option is obviously to treat all medicines the same—so medicinal cannabis along with the other prescription medicines. The other option is to move all of the prescription medicines into the current section 111 so that presence of any legal or illicit drug is illegal. If we were going to do that and be honest about impairment risk, we would have to move to a zero blood alcohol limit as well. If the State wanted to consistently treat the potential for impairment we would either have to say we will have a consistent prescription medicine regime or the presence of any drug, illicit or legal, and any blood alcohol level would be unacceptable. If we are being honest that is what would have to be put forward, wouldn't it?

IAIN McGREGOR: That would give you the level playing field. There's an additional aspect to this, just very briefly, that's worth considering and that is evidence from overseas—and to a certain extent in Australia—that when people initiate medicinal cannabis for a medical condition, their use of other drugs tends to fall away. So if you're a chronic pain patient—

The Hon. ROSE JACKSON: That's right. You're replacing opiates and benzodiazepines with cannabis.

IAIN McGREGOR: You're actually replacing opioids, benzodiazepines and sedating antidepressants with medicinal cannabis. Although I'm not exactly sure of the theory, if we're looking at the hierarchy of risk, then you're actually improving road safety if you get someone off an opioid, which is more impairing than medicinal cannabis, or get them off Valium, which again is more impairing than cannabis is.

The Hon. ROSE JACKSON: Yes, that's right. As you say, you either accept some risk—in which case you treat that consistently—or the State would have to make the case to the public that we are not going to accept any presence of any alcohol or any substance, legal or illegal, in the system. That's the only way. If we're aiming for a level playing field, that's the only way to achieve that.

IAIN McGREGOR: Exactly right. Just one very last thing I'd like to say is that back in 2015 Mike Baird together with Kerry Chant announced funding for some pioneering clinical trials in medicinal cannabis. This was a tremendous development which we applauded at the time. This was around about the time that the Lambert initiative started. That included the chemotherapy-induced nausea and vomiting trial that I referred to earlier. I'd like to see this continue into this area. I think the current State Government does have a proactive side to the issue, as was illustrated back in 2015. I think they could do it again by running the world-leading definitive trial on medicinal cannabis and driving. That would be a tremendous achievement.

The CHAIR: Thank you so much. We've run out of time, unfortunately. Thank you so much for your evidence today. If there is anything further you think the Committee should be aware of, please feel free to submit it along with any questions on notice. I think that there was only one question on notice. The Committee has resolved that answers to questions taken on notice be returned within 21 days. The secretariat will contact you in relation to questions you have taken on notice. Thank you so much for joining today.

(The witnesses withdrew.)

Ms LUCY HASLAM, Co-Founder and Director, United in Compassion Ltd, before the Committee via videoconference, affirmed and examined

Mr SCOTT FORD, Private Individual, before the Committee via videoconference, affirmed and examined

Ms GAIL HESTER, Founding Member, Medicinal Cannabis Users Association of Australia, before the Committee via videoconference, affirmed and examined

Ms DEB LYNCH, President, Medicinal Cannabis Users Association of Australia, before the Committee via videoconference, sworn and examined

The CHAIR: Could I ask the witnesses: Would you like to start by making a short statement and could the statements be no more than a couple of minutes? Ms Haslam, do you have a short statement you'd like to provide to us?

LUCY HASLAM: I don't have anything prepared per se, but I would just like to say that I think medical cannabis patients have been discriminated against in every possible way since it was legalised back in 2016 and before that for many, many decades because of the war on drugs. We're constantly told that there's not enough evidence for cannabis, yet there seems to be not enough evidence that drivers are impaired just by the mere presence of THC. So, at the moment, this is just another case of discrimination against the actual use of medical cannabis for genuine purposes. I welcome the inquiry and hope that this is rectified.

The CHAIR: Thank you. Mr Ford, do you have an opening statement?

SCOTT FORD: I do. Good morning and thank you for inviting me to speak at this inquiry. I regularly use medicinal cannabis to manage chronic pain. I am a military veteran and have had pain issues for around 10 years now. My injuries have significantly limited my capacity to work so, to keep myself productive, I run a small beef cattle farm. I was a long-term prescribed opioid user. My dosages just kept going up and the opioid medications became more and more ineffective over time. My pain specialist had advised me on several occasions that I had to get myself off the opioids. In the end, my wife, who is a nurse, pointed out to me I was becoming more and more vague and not really being myself. I had to change my approach to managing my pain and the solution I found was medicinal cannabis.

Now, as a prescribed cannabis user, I have found the medication is extremely effective for managing my conditions and is also safer than the previously tried opioid medications. My cannabis dosage has been determined in conjunction with my pain specialist. I experience no intoxicating or ill effects when taking it as prescribed. The downside is that I can no longer legally drive in New South Wales. This has put me in a very difficult position. I live in a rural area and being able to drive is crucial. If I can't drive, I must be completely dependent on others to go anywhere. At the moment, when I need to drive somewhere, I go early and delay having my morning dose until I return home. By doing this, there is no chance that I'm impaired since I've not medicated for more than 12 hours. However, I would still fail an RBT as I would have detectable amounts of THC in my system. I would be guilty of the offence of driving with an illegal substance in my system, even though that substance has been obtained and used legally. As such, I'm fully prepared to explain myself to a magistrate, if the need arises.

I would strongly urge the inquiry to support this bill so that users of medicinal cannabis can be acknowledged as genuine users of legal medications and not be treated as criminals. I am more than happy to answer any questions you may have. Thank you.

The CHAIR: Thank you. Ms Hester?

GAIL HESTER: Deb is actually going to read our opening statement, so I'm at a bit of a loss here as to what to say. But, vaguely, I could probably just read the draft that we did.

The CHAIR: We have Ms Lynch, who's just joined us.

GAIL HESTER: Oh, beautiful. I'll leave it to her then, yes please.

The CHAIR: Great. Ms Lynch, can you hear us? I'm just checking with the Committee staff. Hold on one moment.

GAIL HESTER: Deb is here now by the looks.

The CHAIR: Ms Lynch, can you hear us?

DEB LYNCH: Yes. Can you hear me?

The CHAIR: Yes, we can. Do you wish to make an opening statement?

DEB LYNCH: I do. Good morning and thank you for the opportunity to speak today. Medicinal Cannabis Users Association of Australian [MCUA] is a patient-based incorporated association that has been advocating for cannabis to be legalised for medicinal purposes for all who need it since 2014. But when the law changed in 2016, instead of access to cannabis for medicinal purposes for everyone, we got legal access only for those who can afford it. Approximately one million Australians are using cannabis daily but to date only 200,000 approvals have been processed by the TGA. The exorbitant costs force far too many low-income earners to self supply. They are further disadvantaged by the drug driving laws and they will continue to face the prospective loss of licence simply for wanting a better quality of life. MCUA hopes that some kind of scheme such as the proposed Cancard can be put in place to even up the playing field for those who cannot afford the legal pathway for medicinal use if this bill becomes law.

We agree that this bill is a much-needed initiative, though we worry it will meet the same fate of a similar effort in Victoria last year. That Victorian working group commissioned a study which found no justification for medical cannabis driving bans. It also concluded that Australia was out of step with all other countries that have prescription-only medicinal cannabis, which have policies that allow patients to drive when not impaired. Huge amounts of valid scientific research have been done. Sydney University pooled data of no less than 28 publications. This is consistent with many other local and international studies and opinions held over the last decade or more. No accurate device is available to measure impairment or safety risk. A 2019 study found that the Australian public are being tested with what amounts to faulty equipment. As well as false positives and negatives, the accuracy and sensitivity of two devices fell below the levels recommended by the European Union authorities. Yet no moves have been made to introduce a more accurate testing system or any kind of impairment or sobriety test has been employed.

When science-based evidence and professional opinion is so conclusive, the public begins to question why the lawmakers are not listening. Statistics show that the current laws have had little to no impact on decreasing the road toll and these expensive tests are increased year after year despite their failures. One has to question the validity and benefit of the regime and its impact on society. Cannabis is a legitimate medical treatment and must be treated like any other prescribed medicine, where the patient is the judge of whether or not they are impacted and are safe to drive. When I was lab tested in New South Wales last year, I was extremely fortunate in that I was represented by a solicitor pro bono and already had TGA approval documents and doctors' reports to submit to the court. I had obtained these expensive documents with the help of donations from our community to assist with an ongoing court case in Queensland.

The high cost to obtain evidence for defence and to seek legal assistance is another issue of grave concern to us. TGA approval via the doctor cost me another $450. My case in the New South Wales courts resulted in no conviction, no penalty and no loss of licence. Like too many others I can't afford to get the $1,920 per month prescription filled and I am forced to depend on self supply. Patients taking a recognised treatment should not have to go through the expense or level of stress to enable them to keep the right to drive that any other patient taking prescribed medication enjoys. From MCUA involvement with the cannabis community, we see that some patient drivers are being treated with discretion. In some courts patients like myself are not being penalised. Some magistrates appear to see the need for this kind of change to the law. It is our hope that this inquiry will bring about change to ensure all patients get a fair deal when it comes to drug driving. Thank you.

Ms CATE FAEHRMANN: Thank you all for appearing today, and also for having the courage to speak out and to advocate in the various ways that you have, over many years for some of you. I want to start with Mr Ford. Again, thank you for making your submission and being willing to appear today, which is sometimes a courageous thing to do. I have spoken with a number of veterans who have had quite astounding benefits from taking medicinal cannabis, whether that's just CBD or CBD-THC in whatever forms, after having tried different drugs for many years, particularly to deal with post-traumatic stress disorder. I understand that there are even support groups for veterans around the benefits of medicinal cannabis. If you're happy to, would you like to just talk to us a bit more about the reasons you're on medicinal cannabis and how it has helped you? Are there other drugs that didn't help? Do you also know of people in a similar situation to you?

SCOTT FORD: I'll speak for myself. I had used a whole gamut of different pain medications to try to manage my arthritis pain and back pain and everything. Over a long period of time, the conventional medications just lose their efficacy on the body. I've found that since I switched over to medicinal cannabis—and I'm using an oil that's a 50-50 mix—I've gone off all opiates. I just use some Panadol Osteo each day, and that's all I've needed to use. I've actually dropped off my antidepressants, because my overall mood and health have improved a lot. I do know of many other veterans who use medicinal cannabis. It just seems to be a very therapeutic medication and, as far as I've seen, there's been no downsides to its use. Does that sort of cover what you're after?

Ms CATE FAEHRMANN: Yes, thank you, that's great. You have said that you have to think about when you drive and not take the medication that's for pain relief. For example, you were saying you try to get things out of the way in the morning. Is that right?

SCOTT FORD: Yes. The only reason I'll skip my medication in the morning is if I've got to go and drive my car, and that's only to reduce the detectable limit in my saliva. If I'm going to go out and use the chainsaw, if I'm going to use the bobcat, if I've got to go and use the tractor, slash or work on hills, it's not a problem because no-one's going to drug-check me on my own property. The thing is, I've noticed when I started trialling medicinal cannabis that I've found it was quite obvious when you can feel a level of impairment come on, as things sort of start to slow down. For myself, things slow down. I can feel—"Okay, well, hang on. I'm not quite right here." It's quite easy to say, "Well, okay. I won't do anything that I shouldn't do." It's just being a responsible adult. But when it comes to driving the car, I don't want that THC in my saliva because I'm guilty of an offence, even though I don't see it as an offence.

Ms CATE FAEHRMANN: Ms Hester or Ms Lynch or Ms Haslam, in terms of representing medicinal cannabis users, are there stories of medicinal cannabis replacing a cocktail of drugs, which can have severe impacts on people's quality of life plus their ability to function? I might go to you first, Ms Haslam. Do you care to comment on that?

LUCY HASLAM: I can say that that's something that I come across all the time. We recently held an Australian Medicinal Cannabis Symposium only about four weeks ago and there were many people there who relayed that story of being able to basically use cannabis as an exit drug to opiates and benzodiazepines, and many other very harmful drugs. On Sunday I received an email. If I can read it out, it's a good example of the kind of email that I get quite regularly. It said, "Hi Lucy, my name is TT. I am from Inverell, New South Wales. I've been trying for years to find something or somewhere that can help me. As I came across an article about your cause or fight for medical marijuana in New South Wales, I'm wondering if there's any way I could get some help from you. I'm 24 years old and a father of two with a new baby on the way. I use cannabis as a pain relief for my chronic degenerative spine and for my depression and anxiety. I recently found myself in trouble with the police and have to go to court for having a prohibited drug in the system while using medical cannabis behind the wheel of a motor vehicle. I have previously been prescribed other drugs for my problems but they either don't work or they turn you into someone you're not. It makes you feel like a zombie. I don't get anything done through the day. I can't play with my kids or anything and I don't want that to be my life. Please can you help me in any way?"

That type of email is very common and very regular. I meet many veterans like Scott who use cannabis to exit all the very dangerous and addictive drugs that they've been put on over many years, which haven't actually met their needs but then they find this incredible relief from cannabis. It's something I feel very strongly about and I think that this is just so necessary. We really should be basing what we're doing on scientific evidence and on equality, and there is no sign of equality in this debate.

Ms CATE FAEHRMANN: Ms Hester, did you want to comment on that as well?

GAIL HESTER: I think Deb wants to take that one.

The CHAIR: I think you are on mute.

DEB LYNCH: Sorry. I agree with everything Lucy said. We have so many people who say exactly the same thing. We also have had people who have been roadside tested. There's one man in particular I'm thinking of. He had his six-year-old daughter with him. They were off to go fishing. He was on the way there, and they were actually taken back to the police station and both of them were put in a holding cell. These are the sorts of incidents that are going on in the community.

The Hon. ROSE JACKSON: To follow on from that, Ms Haslam, you said in your submission that the issue of driving laws is one of the major barriers. Can you elaborate on that? I think some people might see all of the issues in relation to access to medicinal cannabis and think, "God, this driving thing isn't such a big deal." How important the issue is might seem a little bit obscure to people at first blush. Can you elaborate a little bit on why the issue of driving laws is actually such a major barrier?

LUCY HASLAM: For any Australian, we just assume that we have the right to drive. When you put that in the context of using medication, we have the right to use medication that meets our needs. Those two things don't meet in the middle in Australia, sadly. It's not based on scientific reasons; it's based on really unjust law. Back in 2020 we fought for and won the right to a Federal Senate inquiry into the barriers to patient access. For every cannabis patient—bar children, pretty well—driving is an issue that they have to consider. People are even afraid to drive with CBD in their system only because there's such a lack of education and awareness about it. So it's impacting many people and, as Scott said, particularly in rural and remote communities where there's a lack of public transport. This is your access to help there that you're not allowed to maintain. It's very much impacting

probably more than people realise, unless they're in that situation. Emails such as that that I got from that young man, they're just so commonplace. I think if the truth were known, there would be every hand up of patients using medical cannabis that this is a concern for them. Some of the outcomes are very dire when you are charged. It can be the loss of your right to work because we all need our vehicle to access our employment. It's a very big issue.

The Hon. ROSE JACKSON: Mr Ford, you talked about your experiences on prescription medication, such as opiates and benzos, and prescription cannabis. Are you aware of individuals who are resisting moving off their prescription opiates and benzos because it is legal to drive with them in their system? Is that something that is keeping people on medication that they don't really want to be on, for all of the issues that you've raised, because under the present regime the presence of those drugs in their system isn't disqualification from driving?

SCOTT FORD: Yes, 100 per cent. I know a lot of people who haven't switched to medicinal cannabis. They've tried and they found it effective, but if they're still working, they have to have their car. Up here in the Northern Rivers, we get slammed with RBTs. They will come up here and they will just swamp the area. All of a sudden you can't go to work. You get picked up; you don't have a driver's licence. People don't want that problem. They want to be able to maintain their driving ability without worrying about being criminalised. The people that I know of who have been trying the cannabis have found it effective for themselves, the same as I have.

It was a big decision for me to go, "Well, all right, I'm going to drive. I don't care. Take me in front of the magistrate." I was going downhill on the Palexia and OxyContin that I was using. My wife said I was getting really vague. I realised what I was doing wasn't safe, using those other medications. Now I've gone on the cannabis. I know what I'm doing is safe and I can tell when I'm okay. Other people that I speak to who have used it and do use it have the same things. It's just they're too scared to go and get it prescribed. You can't drive with it because as soon as you get pulled up, you're done. You have to go and face the magistrate, and it's just not practical. The law is a remnant from the war on drugs that you're charged with having an illegal substance in your system that is prescribed legally to you. It's just time this was changed.

The Hon. ROSE JACKSON: I want to ask Ms Lynch and Ms Hester about the Cancard that was mentioned in your submission. Ms Lynch, you talked about your experiences with judicial discretion in relation to your charge. This is, I suppose, just another example at the police level, providing police with information about people's health conditions and the reason that they're using cannabis medicinally and therapeutically, the card providing an opportunity for police to exercise discretion, and the success, in a way, of that regime in the UK. I wonder if you could just talk a little bit more about how that has successfully worked and how you think such a regime might be able to be rolled out in Australia.

DEB LYNCH: The Cancard—Gail actually literally stumbled on that. We got into contact with the ladies in the UK who have set that up. Basically, it's run by a not-for-profit association. There's, I believe, a £30 fee associated with the card, and £20 of that goes to a proper ID-checking platform in the United States so that each person who applies for one of these cards is the person who is prescribed. In the UK, they have conditions. Our privacy laws wouldn't allow that. But there are ways around that, in that we could get recommendations from doctors or letters to say that this patient does qualify for a medical cannabis prescription in order to fulfil that part.

The second part of the card is that these lasses liaised with the police over there. They haven't had a change in legislation. But it's been a change in standard operating procedures. I believe 98 per cent of all people who are stopped by the police now—if they have this card, the police are walking away and just leaving them. For those 2 per cent who are still prosecuted, there'll be a 24-hour call centre attached to the card, with access to immediate legal advice. That's basically like an amnesty card for those who can qualify for medicinal cannabis but, like myself, can't afford—my prescription is more than my fortnightly pension. I can't afford to go the legal route. I am like so many other thousands and thousands of people in that same situation.

The Hon. ROSE JACKSON: Just to follow up on that, Ms Lynch, presumably, there is this particular issue of people who are on low incomes, who can't afford a legal medicinal cannabis prescription, who are most likely to be very negatively impacted by losing their licence.

DEB LYNCH: Exactly. These people, for the most part, are not well. So they need to attend medical appointments. They need so many different things. Personally, I have physio twice a week. If I lost my licence, I would have to rely on someone else getting me to all of those appointments. There are so many people who are unwell who use cannabis and who are in the lower income group. When you think that there's a million people using cannabis daily and only 200,000 TGA approvals, that shows you—I'm lost for words—the ratio of how many people are using illicitly.

Ms CATE FAEHRMANN: Ms Haslam, I might just throw to you again. It is interesting that you were at the medicinal cannabis symposium just one month ago because you may have some more stories for us. You're also from regional New South Wales. I wonder if you could just explain to the Committee how this particularly

impacts on people from regional and rural New South Wales because of lack of transport options and other things. Would you care to comment on that?

LUCY HASLAM: A few years ago, I did quite a bit of work with the New South Wales War Widows' Guild and the Country Women's Association. They were very supportive of trying to make some changes in this regard because they appreciate that, for anybody who lives rurally, a licence is a lifeblood. I've heard of parents that need to drive their children to a remote place to catch the school bus. If that person lost that capacity, what happens to that child's access to school?

Having a driver licence is just essential to everything in the country. It is essential to how you get your groceries or how you get supplies for your property. You just can't do without it. I do agree with the girls and with Scott that a lot of people have to make that real decision: Do I risk it or do I forgo the treatment that is best suited to me? That's a terrible choice that I don't think any Australian should have to make. If they're not impaired and they feel fit to drive, they should be able to drive in the same way that a patient being prescribed morphine is able to make that decision and drive.

Ms CATE FAEHRMANN: I think the previous witness Dr Joel Wren made the point as well that millions of Australians are taking drugs legally—and some illegally, but let's stick to legally—to deal with all of their conditions on the advice of their doctor. You are old enough to drive and to get a driver licence, and there is also the responsibility that individuals take to keep themselves safe behind the wheel and to abide by what the doctor tells them. Ultimately that is what people are doing every single day with the drugs that they are already being prescribed—whether or not it's cannabis.

LUCY HASLAM: Absolutely, 100 per cent. You can argue that patients that are well controlled and have their pain, tremors or spasms managed are actually better drivers if they're medicated adequately on cannabis. We have to really determine whether the rules and regulations as they stand are about raising revenue or keeping the road safe. If it's the safety issue, then I think you need to look to studies that have been done around the world that have determined that there is not a negative impact on road crashes. It is not a safety issue. I just think it is really a very outdated system that is really, as Scott mentioned, linked to the law on drugs and linked to the determination not to change. Really what it has to be about—it has to come back to the fact that it's discriminating against legal patients who have the right to choose the medication of their choice.

The Hon. GREG DONNELLY: Thank you all for joining us today. Mr Ford, the question about impairment and the comments you made about your sense of knowing when you are impaired and when you are not in terms of medical cannabis. Could you expand on that so we understand a bit more clearly what you mean about knowing whether you are impaired or not?

SCOTT FORD: When I first started trialling medicinal cannabis and we had to work out a dosage that was going to work for me—we started low and we gradually built up—what I found was that once I started to feel the effect of the cannabis I had an uplifting effect in my body. That was the first thing that I felt. After that I thought, "Hang on, maybe everything is not as it should be." It is not unpleasant but you can tell that there is a little bit going on. You can tell within yourself after that feeling comes on. The first time I get that uplift and everything I think, "Yes, okay," and then I start to feel a little bit more like, "Hang on, maybe I'm not quite right."

So then I go, "Hang on. That was the dosage for me that I didn't want to go beyond."

With taking the oils and getting up to the two millilitres that I take, that's been really effective, and I don't have any of that effect where I notice that things aren't quite right. I did at times have a higher dosage, trying to find out where we were, but it's really obvious. If I compare that to drinking alcohol, you can have one beer, you'll have two beers and you'll think, "I'm all right." You get onto your third beer, and you might still think and feel like you're okay, but the action in the brain with alcohol and with cannabis is very different. The best way to put it is you will detect in yourself a change. It's not bad; it's just you'll feel a change. At that point, I think that is when my impairment is beginning—beyond that point. I don't get to that point with my general dosage of my cannabis.

The Hon. GREG DONNELLY: Just expanding on that a bit further, if we could. You indicated there that when you commenced the regime of the medical cannabis there was a starting off at a lower dose as you and your clinician were working towards a sense of what was the right level. Has that been stable? In other words, that sense of being impaired was at the start, but are you saying that's stable now or that it still fluctuates?

SCOTT FORD: It's still stable for me. My medication for—I started with six millilitres daily of the oil. I have now reduced the oil down to just four millilitres. I have two millilitres in the morning and two millilitres at night. I find that it's been stable, and it's been like that for probably close to a year now of being on that dosage with no changes. I haven't had that impairment feeling come on. It has worked really well.

The Hon. GREG DONNELLY: For you, the issue was at the commencement of establishing—

SCOTT FORD: The issues that I found when I felt the highs, as such, and maybe a bit of incoordination, was just with trying to find that right dosage for me at the start. You do that with your doctor. You just discuss how it's affecting you. If you want to function properly, you don't want to be high because it's going to affect how you live your life. Is it active or not? If you get high, you just sort of end up a bit more of a lounge lizard. I don't want to do that. I prefer to be an active individual.

Ms CATE FAEHRMANN: Can I get Ms Haslam's view on that as well? She speaks for a lot of other users. That was Mr Ford's opinion, but just to see—Ms Haslam, is that the case with other patients?

The Hon. GREG DONNELLY: Just on the matter of impairment.

Ms CATE FAEHRMANN: Yes, that's what it is.

LUCY HASLAM: I think Scott is spot-on. I've been around this situation enough now, and around international and Australian experts, and the old adage of start low and go slow is very much how cannabis is prescribed by doctors. It's very much about patients titrating their dose until they get to the point where they find that sweet spot where they get maximum relief but they're not impaired. I think there are very few medical cannabis patients who would take more than is required to get a therapeutic dose. Largely, when you think about the cost factor, patients are struggling to afford it as it is, so they're only going to take what is absolutely necessary. I think impairment in that early stage when you're trying to find the dose, that's quite usual with any medication. I don't think that medical cannabis would be any different in that regard. It is certainly not the overall goal to get high. It's very different with medical patients. The overall goal is to find that therapeutic sweet spot where their condition is managed and there is no high—

The Hon. GREG DONNELLY: Just on the definition of—

The CHAIR: This is the last one, Greg, if that's okay.

The Hon. GREG DONNELLY: No, that's fine.

The CHAIR: We have run out of time, unfortunately. If there is anything further that you think the Committee should be aware of, please feel free to submit that. Committee members might have additional questions that will be sent through to you. I don't think there were any questions taken on notice in that round. Thank you so much for joining us today. We'll be in touch regarding the next steps.

(The witnesses withdrew.)

(Short adjournment)

Mr MICHAEL TIMMS, Deputy Chair, Australasian College of Road Safety, NSW Chapter, sworn and examined

Dr MICHAEL WHITE, Adjunct Senior Fellow, School of Psychology, University of Adelaide, and Member, Australasian College of Road Safety, before the Committee via videoconference, affirmed and examined

The CHAIR: We will get started with our next group of witnesses. I note that Dr White is not online yet. While we wait for Dr White, Mr Timms, do you have an opening statement you would like to give to the Committee?

MICHAEL TIMMS: The Australasian College of Road Safety is the region's peak membership association for road safety with a vision of eliminating death and serious injuries on the road. ACRS has State chapters that organise local events and consider jurisdictional matters. Parliament is aware of the contributions made by the New South Wales chapter to recent inquiries. The issues being considered today are not unique to New South Wales. At present, ACRS is yet to develop a national position regarding medicinal cannabis. The ACRS New South Wales submission confines itself to the inquiry's terms of reference: The wording contained in the draft bill. Should the bill ultimately become law, we seek that it be clarified so the exemption applies only to the holders of a current Australian driver licence. Only the holders of an Australian driver licence are required to obtain medical fitness to drive clearance.

The CHAIR: Thank you. While we wait to connect with Dr White, we might start with some questions. The Hon. Greg Donnelly has the call.

The Hon. GREG DONNELLY: Mr Timms, thank you for coming in today. If you wish to take this on notice you are welcome to do so, but in your opening statement you referred to the fact that the Australasian College of Road Safety has not at this stage formulated a position. In regard to the matter we are dealing with in this inquiry, is that a matter that is being examined or considered at the moment?

MICHAEL TIMMS: I think it was Professor McGregor this morning who said that this issue is not going away. Certainly it is something that nationally we need to consider. We are a national organisation. It is not appropriate for us as a State chapter to form separate positions. We have an extensive database of previous conference and journal submissions available on our website. Both of those happen to be peer and non-reviewed. In my preparation for my appearance, I searched that database for previous work on this topic of medicinal cannabis. That search thus far has yielded no results. Obviously we would have liked to have had something to come back to and assist the Committee with, but I note that previous witnesses today, in discussion around some current and possible emerging research projects—and I would, on behalf of the college, invite those researchers in due course to submit papers to future Australasian College of Road Safety events, as we do believe that the submission and peer review process would assist both the college and other authorities.

The Hon. GREG DONNELLY: I take you to your submission, specifically towards the bottom of the first page. The second last paragraph, before the final paragraph, which is a quote from a publication, states:

> ACRS notes that *Assessing Fitness to Drive*, a joint Austroads-National Transport Commission document—

Is that a document that is created with yourselves? I am just trying to understand the co-authors of that document.

MICHAEL TIMMS: Austroads is basically the association of all State and Territory transport associations. The NTC, the National Transport Commission, has oversight of the development of a range of new and emerging policies and technologies. For example, NTC is heavily involved in connected and autonomous vehicles. That is the sort of space that they operate in. That publication is a guide for physicians as to how they should manage patients as they come to them. Obviously the holders of a driver licence and for those of us in the manner of ourselves may need to have that clearance or others also, like myself, are managing parents that have to go through that process. That is the policy that they need to assess fitness to drive in a consistent framework nationally.

The Hon. GREG DONNELLY: Part of this inquiry, in terms of considering the issue before us, is the discussion around the matter of driving impairment or what might be an impairment that impacts on a person's ability to drive. I take your comment that the organisation has not formulated a position at the moment. I am not pressing you further on that. Generally speaking on the matter of driver impairment, are you able to make some reflections about what it is? Is it something that is able to be measured and quantified or is it more elusive? Are you able to talk a little bit about driver impairment?

MICHAEL TIMMS: It certainly depends on what we are talking about. If you look at the issue of driver fatigue and tiredness, that can be quite subjective. Alcohol is measured through scientific instruments and governments throughout the world have adopted what they call per se requirements. New South Wales, for the

bulk of motorists, is .05. A driver in excess of .05, we are not necessarily saying that driver is impaired, but you are saying that on the bulk of the evidence to hand researchers, academics and governments have concluded that .05 is about the maximum trade-off between safety and mobility that they are prepared to allow. When you look at other drugs—be they illicit drugs or prescription medication—things again start to become a little bit more grey, as I think the researchers this morning testified to.

The CHAIR: Dr White, do you have an opening statement you wish to provide to the hearing?

MICHAEL WHITE: Yes, I do. A couple of things about myself. I am a 76-year-old person and have been retired for about seven years. I have worked as a secondary school teacher, university teacher in psychology and a public servant. I was employed by the South Australian public service for about 25 years where my main roles were to manage road safety and workplace health and safety research grant programs. I have been interested in drugs and driving for a long time. About 25 years ago I was the South Australian government representative on the national Austroads Drugs and Driving Working Group. I have co-authored five peer reviewed journal articles on drugs and driving. Since retiring I have maintained an interest in research on the road safety consequences of using cannabis. I now regularly distribute news briefings on cannabis use and driving to about 600 researchers and policy advisers around the world. Would you like me to briefly describe my two submissions?

The CHAIR: Yes, please.

MICHAEL WHITE: Okay. Submission No. 49a summarises the findings of two literature reviews that I have co-authored. The epidemiological review found that the prior use of cannabis increases the risk of crashing by about 40 per cent. However, if study biases are taken into account, it seems that cannabis has no overall effect on the risk of crashing. My second review was an impairment review, and it concluded that impairments from the use of cannabis are difficult to detect. They are often not found, especially for regular users of cannabis, and when they are found, they are relatively weak. The review observed that impairments that are statistically significant, found in the laboratory, can nevertheless be trivial in the context of road safety.

I will now briefly describe submission No. 49—my other submission. In 2013 a researcher from the Monash University Accident Research Centre, known as MUARC, conducted an evaluation of Victoria's roadside drug testing program and concluded that the program had been very successful. In submission No. 49 I provide a critique of that evaluation where I argue that the evaluation is invalid. Since then, the MUARC researchers have conducted a second enthusiastic evaluation of roadside drug testing in Victoria, and I believe that the second evaluation is also deeply flawed. So I guess what I am saying is I don't think there is any evidence that roadside drug testing works in Australia. That's it from me.

The CHAIR: We will continue with questions. If I is difficult for you to hear us, let us know and I will repeat the question. I ask Committee members to speak as clearly and loudly as possible. Ms Faehrmann?

Ms CATE FAEHRMANN: Dr White, could you try and explain to the Committee as simply as you can why you have said that the evaluation both times by the Monash University Accident Research Centre into the success of roadside drug testing is "deeply flawed" in your words?

MICHAEL WHITE: Yes. The first evaluation, I think, was conducted by Cameron in 2013. As part of their second evaluation, the MUARC researchers themselves now say that that one's invalid—perhaps not in exactly those words. But they have now discarded it, and they have said it was based on—I used the words "cherrypicked data". In a webinar they used a similar term, which I can't quite remember, but it was something like "adventitiously selected data". So they have acknowledged that the data they based it on was unrepresentative, and they are no longer actually supporting their own first evaluation. So it comes down to the second evaluation. I make a number of points about it in my review of it, the first one being that it's unreplicated. A good practice in epidemiology is to develop a model and then just see if it can be replicated against other data. If it can't be replicated, it might have just been idiosyncratic. It might have just been a description of the data you happen to have, with its quirks in it. So they've applied it without replicating it to validate it. Now, if they'd tried to replicate their first model they'd have failed, and they acknowledge that now—that it was not replicatable; it was a dud model. You'd think that having acknowledged that their first model was not replicatable they'd try to replicate their second model, but they haven't. They developed it on one set of data, which may be idiosyncratic, and they've applied it and said it's remarkably successful—the roadside drug testing is remarkably successful.

My second point against it is that it flies in the face of reality. Their evaluation claims that the increases in roadside drug testing reduce the prevalence of drugs in road crashes, but if you look at the 15 years or so of data that is available to them, exactly the opposite happens. Over those 15 years, as roadside drug testing has increased, so have the prevalences of THC and methamphetamine in road crash victims—injured people. So it fails the pub test. I have three other objections. Would you like me to go through those?

Ms CATE FAEHRMANN: You would need to do it fairly quickly. This is important, though, because it's one of the main research areas, so yes.

MICHAEL WHITE: Okay. I am having a little trouble hearing, Cate, but I took that to be a yes.

The CHAIR: Yes, very briefly, if you could. Recount the story.

MICHAEL WHITE: Yes. The next one is that the variable it uses to predict methamphetamine crashes is a very odd variable. One thing it says is that the only thing that matters is the hit rate: How many people you find through roadside drug testing that have actually got the drug in them. Now you can increase the hit rate by simply doing away with the general deterrence of booze bus cum drug buses and just have car based intelligence based. Even if you greatly reduced the number of tests you did but just made sure you targeted people who you knew were drug users, you'd get a remarkable hit rate and they say that you could do away with almost all of your enforcement and still have remarkable success. So they've sort of thrown out general deterrence and I think there's logical problems with that.

I'm not convinced that the data they've based their model on is good data. It's what's called time series data and with time series data a whole lot of things co-vary and it's very difficult to know what causes what because, over time, as one thing changes, another thing changes for reasons are not often evident.

My fifth point is that it makes unsupportable and self-serving assumptions in its application to crash reduction. Now, it makes a number of such assumptions. It's hard to tell because they hide their assumptions; they're not easy to find. But one of them is the assumption that prevalence equals causation, that if the drug is found in 100 people—the prevalence is 100 people have got it in them, say, cannabis—then, in 100 crashed people, the cannabis caused the crash in all hundred people, and that's just nonsense. To begin with, a lot of people have cannabis in them but they're the innocent victims of crashes. If they were T-boned at an intersection by a drunk driver going through a red light but they had cannabis in them, this analysis assumes that they were responsible for their injury. MUARC researchers know this. They're being sneaky here. They know full well that most cannabis-positive injuries are not actually caused by the cannabis. They're caused by other factors.

There are a couple of other assumptions which it's a bit hard to know if they make or not, but I think they make the assumption also that, if alcohol and cannabis are involved in the crash, then the cannabis caused the crash. Now, in most cases where alcohol and cannabis are both involved—you know, a person has used both alcohol and cannabis—it'll be the alcohol that caused the crash. So they've made some assumptions that exaggerate the apparent benefits from the program.

The Hon. ROSE JACKSON: I just have a couple of questions, Mr Timms. You mentioned earlier that, for example, when you were doing a review of the studies that you had on your database, there wasn't anything there that was able to assist you. So presumably you would be a supporter of the Government ensuring that there is more research done about the relationship between dangerous driving and those taking medicinal cannabis. Is that something that you would be a supporter of?

MICHAEL TIMMS: Yes. We had a look for, as I said, the research. We're very much a research-driven organisation. We have our annual conference every year and at that conference we have dozens of people come along and present PhD papers where they test certain hypotheses. Certainly, a project of this type of nature would be welcome. I suppose, even just going back a step, it appears to me that it's obviously a legitimate concern of people who have patients who are prescribed medicinal cannabis. I caught the end of the previous session, but obviously they hold a concern—an apprehension—that, should they be subjected to a roadside drug test, they'd prove positive. I don't even think there's been work to actually prove under what circumstances that occurs. We really are in search of knowledge in this whole space.

The Hon. ROSE JACKSON: Yes, there was evidence from researchers on the first panel of witnesses that we heard that they had similarly struggled to gather a lot of useful research and had put forward proposals in relation to the Government partnering with them to undertake further research. I'm just clarifying that that is something that you think would be a useful contribution.

MICHAEL TIMMS: Certainly. Again, I reiterate my opening statement. The College of Road Safety would welcome that type of research and we'd like the opportunity to review it.

The Hon. ROSE JACKSON: Excellent. In your submission and in response to my colleague's questions you referred to the—I want to get the terminology right—assessing fitness to drive work. Who did it? I'm just looking up your submission. It was Austroads and the NTC. Looking at that document, that is a very long document. It's an almost 200-page document that provides guidance to medical practitioners who are working with patients in assessing their fitness to drive. I appreciate you do not have a specific position in relation to medicinal cannabis, but one of the concerns people would have if we did remove an automatic zero tolerance

disqualification to the presence of THC is that people who are prescribed cannabis by their doctors would potentially be driving when they shouldn't be doing that. What are your reflections generally on how much work has gone into providing guidance for doctors in general who are prescribing medications to patients?

It is not a flippant thing, is it? It is a very detailed, comprehensive engagement with doctors who are prescribing all kinds of medication to people who hold driver licences.

MICHAEL TIMMS: It's a very serious topic and, obviously, these fitness to drive standards apply across the country. In the submissions that I've read, the relationship between patient and doctor is critical in this whole process, and ensuring that doctors have full visibility of the range of medications that patients are on. The Boxing Day crash in 2017 comes to mind. Obviously, medicinal cannabis was not a factor in that particular crash; I'll be perfectly clear. But the Coroner in summation said that no single doctor had a clear view of what the driver who was attributed as being at fault—as to that particular person's history of presentations at hospital or what that person was being prescribed. It is very important that we get the doctor-patient relationship right.

The Hon. LOU AMATO: That was one on methadone, wasn't it? Was it methadone he was using?

MICHAEL TIMMS: And a range of other drugs.

The Hon. ROD ROBERTS: Dr White, does the presence of THC in somebody increase the chances of them being involved in a motor vehicle accident if they are to drive a vehicle? Is there an increased risk factor?

MICHAEL WHITE: I guess the acceptable answer from the epidemiological research—and this seems to be the answer that is mentioned in a number of the submissions, including, I think, the Government's submission—is that most of the evidence points to about a 40 per cent increase in the risk of crashing. In my literature review of the crash information, the White and Burns literature review, we come up with much the same conclusion. We agree so far that THC-positive drivers seem to have a 40 per cent increase in the risk of crashing. That would be the conventional answer. However, in my literature review, I go one step further and say perhaps some of the studies suffer from biases of various sorts. We identified a range of possible biases and scored the studies for biases. We concluded that when you take the biases into account, it's possible that cannabis makes no increase to the risk of crashing.

The Hon. ROD ROBERTS: Thank you, Dr White. I will just rudely interrupt you there, because we are on the clock and I want my other colleagues to have their chance. Did you listen to any of the evidence earlier this morning, particularly the evidence presented by Professor McGregor from the University of Sydney?

MICHAEL WHITE: No, I haven't been listening to it. But I've read Iain McGregor's submission, and it looks to be an excellent submission to me.

The Hon. ROD ROBERTS: Yes, certainly. But Professor McGregor in evidence here this morning—albeit he is probably a proponent of this bill, if I could suggest that—says that there is an increased risk of motor vehicle crashes of anywhere from 10 per cent to 40 per cent and not that it has no effect at all, as you are suggesting.

MICHAEL WHITE: Yes, and I acknowledge that that is the commonly accepted view—40 per cent—from the literature. That is the view from about three, perhaps, recent literature reviews, including my own, unless you go the one step further and try to work out if some of those studies were affected by study biases. I agree with Iain McGregor that the normally accepted view would be 40 per cent.

The Hon. ROD ROBERTS: Alright, fine. That's all I have doctor. Thank you very much.

The Hon. ROSE JACKSON: To follow up on that, in that literature review are you able to provide any clarity on whether any of the research relates specifically to the risk of a crash for medicinal cannabis patients who are regular users of a prescribed medication in consultation with their doctor? I guess what I'm saying is that we know there is a difference between someone who is a regular user of medicinal cannabis taking that substance in consultation with a doctor and, say, a young bloke who's stoned off his brain. Those two individuals are different but they both potentially have THC in their system. Does any of the research go into those differences and specifically look at medicinal cannabis patients taking a substance legally in consultation with their doctor?

MICHAEL WHITE: Not that I'm aware of. Our crash study—our epidemiological review study—doesn't look at that. None of the papers I'm aware of on cannabis and crashing have tried to work out where the cannabis came from, whether it was taken medicinally or recreationally. My understanding would be that medical users would be taking it regularly—and often the findings on regular users is that they're not as impaired or probably not impaired at all—and they'd be taking it I think in doses that would be less likely to be impairing. I think just from common sense, one would suspect that the crash rate for medical users would be less. But having looked at hundreds of papers on drugs and crashing, I'm not actually aware of any that looked specifically at medical users of cannabis. Is it possible for me to say one more thing about the 40 per cent increase in crash rate?

The CHAIR: Sure.

Ms CATE FAEHRMANN: Yes, please.

MICHAEL WHITE: The important thing to note is that even if it is the commonly accepted 40 per cent rather than perhaps the 0 per cent that I suspect it is, that is very low. Alcohol at 0.05—the legal level—doubles your risk of crashing. That is 100 per cent. Cannabis at 40 per cent versus legal levels of alcohol is a lot less. If you look at other things, the use of a motorbike increases the risk of crashing 30-fold. That is 3,000 per cent. I think sometimes the focus is on the wrong things. If you look at all of the road safety problems, including other drugs—benzodiazepines, opioids et cetera—cannabis is way down at the bottom of the list as far as crash risk goes, and that's if you accept the 40 per cent and not my 0 per cent. If you accept my 0 per cent then there's no risk at all. I think the crash risk from cannabis needs to be put into context. It is a very small risk compared with almost any other cause of concern to road safety people.

Ms CATE FAEHRMANN: That was very useful, thank you, Dr White. Can I ask a quick question to Mr Timms to follow up on that, based on what Dr White has said? Mr Timms, is there something that outlines those risks in a chart or a scale in the way that Dr White has suggested in terms of the various risks, for example, of taking prescription drugs or alcohol at a certain level? Is there research that has shown that?

MICHAEL TIMMS: We would have to take that on notice.

Ms CATE FAEHRMANN: I just thought you might know. That's fine.

The Hon. GREG DONNELLY: I'm struggling to reconcile, Doctor, the matter of the 10 per cent to 40 per cent figure and what has been said by other witnesses today. I'm not suggesting anything, but we're having comments, for example—this was from Professor McGregor earlier today—that the crash risk goes up but only marginally. That was in his opening statement. Then later on in his evidence, he referred to the 10 per cent to 40 per cent figure, which we've been discussing in this evidence we're hearing now. In your comments a few minutes ago on this 10 per cent to 40 per cent, you seem to be repeating the 40 per cent more than the 10 per cent. I don't know whether that's because this research you're referring to is giving some emphasis to the 40 per cent compared to the 10 per cent.

You might appreciate it's a bit of a challenge for us who aren't experts in this area to discern exactly what the actual position is. I'm not reflecting on you, but you're overlaying your evidence now with some further comments around bias, which I have to say Professor McGregor didn't comment on and nor, indeed, have any of the other witnesses today. Various witnesses have also said that there needs to be far more research done—"far more research", that's my phrase that I'm using—to really try to understand what's going on here. Perhaps that's more of a statement than a question, but you can see how there's a bit of a struggle here to understand what the actual position is—at least for me, anyway.

MICHAEL WHITE: Yes. My advice would be to consider that the most recent literature reviews of a particular type called metanalyses come up with about a 40 per cent increase in the risk of crashing. The individual studies that they summarise have a wide range of risks. But when you do a thing called a metanalysis and put all of those individual studies into the one—

The Hon. GREG DONNELLY: Piece of research, yes.

MICHAEL WHITE: —conclusion, it comes out at about 40 per cent. That's what I concluded, and that's what I think other major recent metanalyses have concluded. I think it is safe to say that the best evidence, without taking study biases into account, is that the crash risk is 40 per cent. My analysis is a little bit radical, in that nobody else has tried to take study biases in the way that Burns and I have done it. Probably, for practical purposes, until my work is accepted in the literature—it's only just been published—it is probably best to stick to the 40 per cent. If you consider that cannabis increases your risk of 40 per cent, I think that's probably the conservative and sensible approach to take. Then it's a matter of getting that 40 per cent into perspective. It's a lot less than alcohol at 0.05 BAC. It's a lot less than travelling five kilometres over the speed limit in a 60-kilometre zone, which doubles your crash risk. So, 40 per cent is less than half of the doubled crash risk. It is way down at the bottom of the list. It's a lot less than accepted crash risks for benzodiazepine, methamphetamine and other medical drugs, opioids.

The Hon. LOU AMATO: Mr Timms, in relation to your research, you also get research from overseas when you're making evaluations to make recommendations?

MICHAEL TIMMS: We have connections with researchers throughout the world. We monitor conferences and proceedings globally.

The Hon. LOU AMATO: Have you seen any recommendations or research from overseas or other jurisdictions?

MICHAEL TIMMS: I think part of the challenge that this Committee has is that patients who are prescribed cannabis as a medicine by their treating doctor have different motivations for using cannabis than other drug users. I think that's part of the challenge. I think that's one of the reasons why we have been fairly limited in our commentary so far. We don't particularly want to be drawn into broader issues, other than—one has to be very careful, when dealing with road safety, not to undermine what we call the pillars of road safety. It's certainly quite a challenge that you have got in front of you.

The Hon. GREG DONNELLY: What are the pillars?

MICHAEL TIMMS: The pillars of road safety, I suppose, probably going back to the start of the century, road safety experts started to move away more from the "blame the driver" perspective in all cases. Certainly there are cases where the road users are at blame, but we have started looking more at what they call the pillars: safe speeds, making sure that people are travelling at a safe speed; making sure that the roads are appropriate and the roads aren't setting people up to fail; making sure that vehicles are equipped with modern safety features and also making sure that people are using restraints; making sure that people have the level of education about road safety such as that doctor-patient relationship and making sure that they're not impaired—be it alcohol or fatigue or drugs.

One failure in the system can lead to a catastrophic result. For example, in one of the submissions, somebody talked about financial difficulties that a lot of patients are suffering. People who suffer from financial hardship tend to drive older vehicles, which don't have the modern safety features. If those people then live in remote areas, their travel speeds are likely to be higher. So, if there is a crash, the crash is more likely to be severe. Then we have to look at trying to medevac them to major trauma centres. That golden hour of treatment starts to—the clock starts to run down. That starts to give you an example of the spaghetti strands, as it were. You might think that you're talking about one area, but there can be other aspects of road safety that are affected.

The CHAIR: Mr Timms and Dr White, thank you so much for attending this hearing today. We have, unfortunately, run out of time. The Committee has resolved that answers to questions taken on notice be returned within 21 days. The secretariat will contact you in relation to the questions you have taken on notice. Committee members may also have additional questions, which will also be sent through.

(The witnesses withdrew.)

Mr GARY CHRISTIAN, Research Director, Drug Free Australia, before the Committee via videoconference, sworn and examined

Mr SHANE VARCOE, Executive Director, Dalgarno Institute, before the Committee via videoconference, affirmed and examined

The CHAIR: Mr Christian, do you have an opening statement to share with us today?

GARY CHRISTIAN: Yes. I'll be very quick and keep it to 2½ minutes. Australia prides itself on following only evidence-based drug policies. I will repeat that: Australia prides itself on following only evidence-based drug policies. On this question of cannabis-impaired driving, what assertions should be immediately cast aside for lack of genuine evidence? The sheer bulk of submissions to this inquiry, as I read them, rely on "Medical cannabis works for me." That is what they were saying. That is their reason. But we all know that it is totally irrelevant because hundreds of thousands of Australians would attest that alcohol is very effective in drowning their worries or anxieties. Drunk driving does damage to others and that is the issue, not personal effectiveness. Observational studies are the arbiter and nothing else.

I see it argued that other countries are doing this. But for every country that is doing it, there are 190 that aren't. And then, did they decide on the emotional "it works for me" argument? That has to be asked. It has great appeal to the public, but legislators should be more diligent. It's also argued that morphine should be used as precedent in New South Wales, but most everywhere else doesn't do it. There is little parity between cannabis and the broad continuum presented by mild codeine use on one side and high powerful morphine on the other. What science should we rely on? Some 62 per cent of Australians use medical cannabis for chronic pain. That is the bulk of people looking for an exemption, of course. Observational studies of 110,000 medical cannabis patients showed that cannabis reduces chronic pain by 30 per cent, making it only ever useful as an adjunct to other drugs, like morphine. It is ineffective when used alone.

We have given you evidence in writing that cannabis used with other drugs has additive and even synergistic effects on driving. Most of the genuine cases amongst those 62 per cent using cannabis for chronic pain are using two drugs—not just cannabis, but cannabis and morphine. Both impair driving, creating far greater dangers to the public than the use of single drugs alone. So 62 per cent should be the end of this matter, shouldn't it? Even if the bulk of that 62 per cent are pretending to suffer chronic pain and are using it as a ruse to illegally use cannabis recreationally, they are not genuine medical cannabis patients. Laws should never be made in favour of such recreational users. That is the end of my statement.

The CHAIR: Mr Varcoe, would you like to deliver an opening statement?

SHANE VARCOE: Certainly. Thank you for the opportunity, senators and the Committee. Thank you for the opportunity to present here with you today. The Dalgarno Institute is one of Australia's longest standing not-for-profit public health education charities and, as part of our multifaceted service to the Australian community, we also are the overseers of the People Against Drink/Drug Driving initiative, which commenced in the eighties. Concerns, practical wisdom and best practice—from the outset, we reiterate our concerns outlined in the submission that a vote for medicine framework has been, albeit inadvertently, permitted to undermine best-practice clinical protocols of the TGA. The lack of fully vetted clinical trials on efficacy and side effects of the new offerings of medical marijuana in the market is concerning.

To amend our original submission, the only cannabis-based medicines that are properly pharmaceutically vetted are Epidyolex and Sativex. Any product touting therapeutic capacity must be fully vetted, commencing with exhaustive clinical trials and then a thoroughly regulated and relentlessly scrutinised deployment. In this context, we are concerned that the new vote for medicine framework is creating both present and future public health and safety liabilities. Cannabis driving does not have to be one of them. THC formulations and various THC derivatives, including THC that is isomerized or converted from CBD, must also be considered in these deliberations on the issue. These derivatives are also being made almost three times stronger by the acetylation process. THC and all of its derivatives are what get people high.

THC is a psychotropic toxin that may or may not just cause drowsiness, but we know, from a growing body of research, it is a contributor to psychotic breaks and various manifestations and is now the frontrunner for substances that can transition a psychotic episode into a chronic psychotic disorder. We contend that exempting these formulations from drug-driving breaches is a serious public safety issue. Finally, recently published peer reviewed research, which has only just been released and the reason why it has been tabled here earlier, must also be weighed in these deliberations. The paper, *Effects of cannabis on visual function and self-perceived visual quality*, reveals the following: Cannabis consumption has a negative effect on both visual function and driving

performance. We have found significant correlations between certain visual and driving performance parameters, particularly regarding driving stability.

Thus our results highlight the importance of parameters such as visual acuity, contrast sensitivity and stereoacuity, which play a key role in maintaining the vehicle in the lane they are driving in properly. Moreover, our results suggest a lack of awareness of the risks associated with cannabis use in driving, given that a considerable proportion of participants have driven after using cannabis. There is therefore still a considerable need for awareness raising and information campaigns aimed at the general public, as well as for research that provides adequate insights into how the drug affects both short- and long-term vision and the ability to drive safely. Thank you.

The CHAIR: Thank you, Mr Varcoe. Could I also ask you to table the journal article that you made reference to in your opening statement? The Committee staff will circulate that to members.

SHANE VARCOE: That was submitted about half an hour or 45 minutes ago.

The CHAIR: Thank you. Questions from Committee members?

Ms CATE FAEHRMANN: I will kick off. This is probably a question to both of you because I think you've both done it in your submissions. Is there a reason why, when you refer to medicinal cannabis throughout your submissions, you put the word medicinal in quotes? Is it that you're disputing the medicinal effects of cannabis entirely?

GARY CHRISTIAN: I might address that one. It is fairly well known that cannabis—and I've already cited that—is not effective for chronic pain. That is established with 110,000 patients in a review done by Australians, as published in *PAIN*. There is a considerable number of people who are using this as a ruse. The reason that we know that is because we know the profile of people with chronic pain. It is usually ladies who are around 80 and men who are in their 70s. When you look at the people who are signing up for chronic pain in America, where we have good data, the average age is age 32, and it is 70 per cent men. The two profiles do not match chronic pain. We know that there is a considerable amount of ruse being used so that people can use medical cannabis as a way to have recreational use but make it legal for that reason.

SHANE VARCOE: If I may, Senator?

Ms CATE FAEHRMANN: Yes, please.

SHANE VARCOE: Just further to those remarks, again, nomenclature matters. I think in the current conversations around this often hijacked platform we are seeing a misuse of titles and names. As I read in my opening statement, there are two pharmaceutically graded medical cannabis offerings in the marketplace that have been fully vetted, and we have no problem with those. In fact, Sativex is one of the brand names it is known as. It has been on the market for nearly 30 years. Again, it is fully vetted, with all the understandings of its potential benefits and its harms and side effects.

With Epidyolex, GW Pharma, the responsible pharmaceutical, spent I think nearly 13 years and $1.3 billion dollars researching this properly. It didn't just concoct it in a farm in Colorado, call it Charlotte's Web and say, "It's medical because it makes me feel better." The offerings that have not been fully vetted through the clinical trial process—which should be watchdogged by TGA, not hijacked by this vote for medicine framework—should make very clear what is medicinal and what is just named "medicinal", hence the parentheses.

Ms CATE FAEHRMANN: Mr Varcoe, you also state that this bill will give a free pass to recreational users. However, the bill specifies that a user must have taken the drug in accordance with medical advice and only creates an exemption to section 111 of the Act, relating to the presence of THC, not section 112 of the Act, relating to impairment. The bill obviously says that someone who is noticeably impaired is not charged. Why do you say that this would give a free pass to recreational users, particularly because they need to have been a medicinal cannabis user?

SHANE VARCOE: Again, it depends on which derivation of cannabis has been used. Of those two medications that are properly, fully vetted, one is for Dravet syndrome epilepsy. One would imagine that a person suffering with that kind of shocking condition wouldn't be driving anyway. Sativex is used regarding spasticity. Some of these formulations can be used with end-stage cancer patients who are having difficulty with chemotherapy as an appetite stimulant. None of those patients should be driving. When it comes to THC in the system, determining where that THC came from—and if one has a pass for driving with THC they just say, "Oh, I've got a medical certification for this. Here's my prescription. I'm just using it according to that." The THC is in their system and the THC is an impairment. As I've just read through the latest research, they don't even realise they're impaired.

We've been involved with People Against Drink/Drug Driving for a long, long time. The anecdotal evidence around those who can maintain a capable driving ability with a blood alcohol content of 2.5 is unacceptable in our culture, even though they say they can do that and demonstrate it by doing it on the road. We have got to be concerned that we don't enable this kind of back door to be created. By simply leaving cannabis in its current place we are not going to have the problem of people driving with THC in their system. It is as simple as that.

GARY CHRISTIAN: I might just add that if you are a doctor who is prescribing cannabis you cannot prove that the pain is real. That is why it is used as a ruse. If you take PTSD, there is no objective way of being able to establish certain conditions. Those ones are targeted by recreational users who want to use medicinal cannabis as their ruse.

Ms CATE FAEHRMANN: I am done.

The Hon. ROSE JACKSON: Can I ask either organisation. Do you support a blood alcohol limit of 0.00 for driving? Is that the position that you have in relation to alcohol—that the law should be that you cannot consume any alcohol and drive?

SHANE VARCOE: I will jump in on that one, Gary. We have certainly advocated for that for a long time. In fact, we pushed for—because in Europe there are places that have already instituted that—being long-term advocates for zero tolerance when it comes to drinking and driving. There was debate held about—forgive me if I'm not completely accurate on this, Committee—about 10 or 11 years ago that .02 would be a better option for the simple purpose that it enables a person to go out for a night-time economy and have one glass of alcohol only with a meal and still be under that .02 limit. We also know that at that .02 there is still liabilities to the driving capacity. So we certainly advocate for zero alcohol use in driving, absolutely. We do not have a problem with that.

The Hon. ROSE JACKSON: Thank you, Mr Varcoe.

GARY CHRISTIAN: From the Drug Free Australia point of view, there is a difference between alcohol and cannabis which we sent in amongst the 30 documents that you have referenced in our submission. They have different actions; they work differently.

The Hon. ROSE JACKSON: It is completely acceptable to you that people would drive with a blood alcohol limit of .05, the current legal limit, but you have a zero tolerance to THC?

GARY CHRISTIAN: I think I'm closer to Shane's position. What I am just pointing out is that there is a difference. There is a relationship between dose and alcohol impairment, and that is not true of cannabis. They work differently.

The Hon. ROSE JACKSON: Again, to both of you: What about people taking legal prescription medications such as benzodiazepines and other opiates? Do you also support an absolute blanket zero tolerance to the presence of those drugs? Obviously they are currently excluded and people are able to legally have them in their system, so long as they are taking them consistent with their prescription and in consultation with a medical practitioner. That is currently legal. Your position presumably is that it should be illegal, Mr Christian?

GARY CHRISTIAN: Yes, we do have concerns about drugs and driving. If you look at the New South Wales report—I can't share my screen, maybe I could—if you have a look at the New South Wales report on drugs which are involved in accidents, benzos are very much implicated. I think there needs to be a tougher position on certain of those medications.

SHANE VARCOE: Just to—sorry, Gary.

GARY CHRISTIAN: That's what I had to say.

SHANE VARCOE: It concerns again different dynamics, both idiosyncratic responses to substances and their nature. Opioids commonly create drowsiness, which is obviously a concern for anyone driving under the influence of a drowsy causing substance. All these medications, I believe, from what I have seen both anecdotally and in my prescription viewing, that those who are prescribed these drugs are told not to drive or operate vehicles. That should be upheld, I think. Remember, as I said before, THC—not necessarily CBD, although CBD can be converted into THC derivatives—is a psychotropic toxin. It has a different impact on the psychobiology of the taker of that substance. That is not just about drowsiness. It can be all sorts of manifestations. Again, it is idiosyncratic, I understand that. We now know that cannabis—I will say it again—in the high-end use of THC is now the frontrunner of transitioning from a psychotic episode to a permanent psychotic disorder. That is in the literature. That is concerning. Any legislation that promotes the use of that kind of substance when in

charge of a vehicle is very concerning. We see vehicles weaponised by alcohol all the time. Why would we add another potential substance to that regime and cause that public safety issue. That's a concern we have.

The Hon. ROSE JACKSON: Obviously, as Mr Christian said, we know that people who are legally taking benzodiazepines and other prescription medication can be impaired. They are currently not caught by the section of the Road Transport Act that we're dealing with. They can be subject to the DUI offences in another section, but they are currently completely exempt, even though there may be traces of those medications in their system that could be operating in exactly the same way. How do you reconcile that inconsistency?

SHANE VARCOE: I thought I just did. Sorry, I didn't make myself clear enough. There's drowsiness and psychotropic intoxication and there's the psychoaffective dynamic of THC, which is different to other substances. Now this is a concern. THC—particularly high-end THC—consumption does create this problem. We're not talking just drowsiness. Again, we shouldn't be operating vehicles when we're drowsy or our faculties aren't at full measure. I don't have a problem with that. People do drive and they shouldn't. They do drive. But when it comes to a psychotropic toxin like THC—not cannabis derivatives like CBD, but THC—we're talking about a different manifestation and a different impediment. I think that's where the debate gets a little bit skewed. So just lumping them all together and saying, "Oh well, I can drive drowsy." But can you drive safe?

The Hon. ROSE JACKSON: Presumably someone who was in that state that you have described would obviously be subject to the DUI provisions in section 112. If you're driving in that state, you're clearly under the influence of a substance that you shouldn't be, just in the same way as if you're driving while you're zonked out on benzos. That is all illegal under section 112 of the Road Transport Act. Section 111 has got nothing to do with whether you're in a psychotropic state or whether you're a zonked zombie. It's only related to the mere presence of a substance in your system.

GARY CHRISTIAN: As we've said, there is a difference between these substances, and THC works in a different way to, say, alcohol. So here we're particularly talking about THC and an amendment for an exemption, or whatever. The point that we've made is that the bulk of people are going to be using—62 per cent use it for chronic pain. A whole other group use it for PTSD. You're going to have more than one drug.

The Hon. ROSE JACKSON: In relation to that, your concerns about people falsifying PTSD, chronic pain and other mental illnesses in relation to access to medicinal cannabis—again, putting aside the fact that that's relatively offensive to a number of the military veterans who have provided submissions to us, that is potentially the case in relation to other prescription medications as well, which they can legally get access to and legally drive. Again, specifically in relation to your concern about people falsifying mental illness, falsifying PTSD or falsifying chronic pain, if that were genuinely a concern, they were able to do that to access to opiates and benzos and then drive legally. Why is that not of more concern to you?

GARY CHRISTIAN: Yes, we are concerned. If they are going to impair their driving performance, we obviously have a concern.

SHANE VARCOE: The other concern here is that we are still looking for the pharmaceutically rated, clinically proven, non-anecdata, medical, cannabis-based pharmaceuticals for PTSD, for example. They are still not in the marketplace. We've got this new mechanism that's anecdata that now drives a lot of the assumptions. We can provide a lot of literature around the negative impacts that cannabis has on PTSD and the amplification views as well. So there's a lot of evidence on the other side of that coin. But, again, it's the nature of the psychosis potential of this substance that is different to the other ones. That's the biggest concern. The use and misuse of this, regardless of whether it's for recreational purposes or not, is concerning when one is behind the wheel of a car or driving a work vehicle or a piece of equipment or plant in a work situation. It's concerning.

The Hon. ROSE JACKSON: Obviously, the same would apply to alcohol but I do appreciate, Mr Varcoe, that you have a very consistent position on that. I actually respect that you have that. I will pass to my colleague for more questions.

The Hon. GREG DONNELLY: Thank you, gentlemen, for agreeing to appear today. One matter that has been exercising my mind is trying to define with some specificity the matter of impairment.

SHANE VARCOE: Yes.

The Hon. GREG DONNELLY: The term is used in a sense of having some certainty around what it means. In some of the evidence that has been provided today, it has been suggested that it is almost obvious what impairment is and that people will be guided by that sense of knowing what it is—in other words, they know when they are impaired and that will be the brake that will stop them from getting behind the wheel when there are impaired. But I'm just wondering whether the evidence—and this does not have to specifically refer to medical cannabis—but the ability for people to understand when they are impaired and them making that critical decision

not to get behind the wheel. I invite you to just reflect on this issue of impairment, the ability to be clear about what it is and people exercising that judgement about not getting behind a wheel of a vehicle when they are impaired.

GARY CHRISTIAN: Can I just speak to that one? In our submission No. 26, the medical journal studies and data that we sent you addresses that. People don't have a correct understanding of their impairment. That's even with alcohol and with cannabis—both of them.

SHANE VARCOE: It's become such a subjective criterion that one of the reasons that we introduced a blood alcohol limit—and we know the history of this particular framework quite well because it's part of our stable—and it took a long, long time to get BAC into the marketplace. It was a long fight; hence, we are very concerned about any mechanism that's going to let that standard slip because we were seeing credible issues around road tolls because people believed that they can drive a car when they are drunk. And, as I said, there was an incident—and, again, let's throw an anecdotal scenario into the mix here seeing they're popular in the current context—there was a Roman Catholic priest in Griffith who was picked up driving a car. He was meandering a little bit, just a little bit, and a little slower than normal. He had a blood alcohol reading of 5.0. He was clinically dead but he believed because he was a chronic alcoholic—basically suffering with Wernicke's disorder and Korsakoff syndrome, which are both quite debilitating—that he could drive. He actually got in the car and believed he was perfectly fine.

When you add THC—there again alcohol has its own issues with the brain chemistry but when you add any psychotropic toxin, that has the potential to create psychotic episodes, this is a concern. This is a distorted reality not just a sense of confidence or drowsiness, but a distorted reality. And, as I read in my opening statement, we now know that these drivers don't understand that they're vision is impaired. They don't believe it. They don't understand it. And that's the new research: They don't get it. So when they say, "I'm fine. I've just taken my medicine. According to some of the data out there, if I've waited"—let's say—"12 hours since I've had my THC"—or even seven hours, or I think one study said five should be okay—"it should be okay." So if I've had my THC medicine, I wait five hours and then drive I should be okay. But according to this new study, people don't understand the visual impact that's been given to them. Now, when you can't understand it visually, then you've got a serious problem when you're behind the wheel of any vehicle.

The Hon. GREG DONNELLY: We heard earlier today witnesses from the Lambert Initiative. They've provided a detailed submission, which is quite helpful. But I'm just inviting you to comment on this, because I'm wondering whether there's a time line that you might be able to place on this or some thinking around what it would take to identify something. It's on page 3 of their submission. I don't want to be appearing to reflect on people who have come before the inquiry or provided evidence to the inquiry about the therapeutic effect of medicinal cannabis, but in the Lambert submission towards the bottom of page 3—I won't read the full paragraph—it says:

> THC products have demonstrated efficacy in treating a number of debilitating conditions …

It goes on to talk about those. But, interestingly, it concludes the paragraph by saying:

> However, the quality of this evidence is still questionable with more high quality clinical trials required to confirm these effects …

I was just somewhat unsure about what they're actually saying. In one sense they're acknowledging that there is some effect that appears for some people to have—a way in which it may well ameliorate pain and other effects of perhaps a condition they may be experiencing. But really it's qualifying at the end by saying there needs to be—well, they used the words "still questionable", which seems to be a pretty strong statement made by an organisation like the Lambert Initiative. Can you comment about this issue?

GARY CHRISTIAN: Back in 2017 the National Institutes of Health, which is probably the premier health research body in the United States, looked into all of the different journal studies for various medical conditions. It actually rates—it gives us some idea as to whether the data is reasonably conclusive or totally inconclusive or fair to middling. They make those judgments on a condition-by-condition basis. I think that would be the place to turn, to be honest. I think it was 34 researchers, many of them pro-cannabis, who were on that committee that did that massive review.

SHANE VARCOE: One of the interesting realities of the emerging space we're in when it comes to clinical trials—there's been a new term that's emerged in the last 12 to 18 months called "anecdata". It's a wonderful little concoction between "anecdote" and "data". What we do is we throw it in the mix and we add passionate pathos to a series of personal stories that—as we saw with Charlotte's Web in the US when they were feeding this concoction to Dravet syndrome epilepsy kids, who were not at that stage diagnosed. They said their fitting stopped: "Look, it's magical. It's wonderful." When you see a fitting child, it's awful. It is just awful and you want it to stop. But the short- or long-term harms of that substance on that child have still not been clinically

verified or validated. That's one of the reasons why your studies talk about and use anecdata, which concerns me, as Gary has intimated.

We are looking at hard clinical trial evidence. GW Pharma, again, did the right thing. They come up with Epidiolex, which is their legal, pharmaceutical form of Charlotte's Web, if you like. Mind you, what's interesting to note is, as a formulation for Dravet syndrome epilepsy, which is a very small window—and it's an awful condition. I understand why people are desperate to have it. At least symptoms abated. It is now a fourth-line treatment only and it has a 25 per cent efficacy. That is a fully vetted, clinically trialled cannabis-based medicine. Now, our concerns are, as I said—well, Lambert is actually stating publicly that we need more trials. Cannabis was touted to be the new miracle drug since 1970. In the 1990s it was pushed as the new medical marijuana.

We've had 30 years of trials, 30 years of stories, and we still come out with a product that does not do what it claims to do. It's supposed to be a panacea of all ills. Its placebo effect is breathtaking, and we've asked that organisers and researchers focus on the placebo effect of cannabis. You don't have to ingest THC or CBD to get the impact if you could harness that scientific phenomenon. Our concern is, and with Lambert, we need to have proper, clinically trialled researches. But again, if you put a vote for medicine framework in, you get this. We don't have to have clinical trials; we just have stories, and then we just go, "We've got to change the rules." That's a real concern.

The Hon. ROSE JACKSON: Just to follow up on that, Mr Varcoe, one of the things that Lambert also talked about was what they call their AMBER trial. I think you are in agreement with them that more research is useful.

SHANE VARCOE: Absolutely.

The Hon. ROSE JACKSON: They talked about trying to come up with a comprehensive way to specifically measure the driving impairment impact for medicinal cannabis patients and wanting to partner with the Government on that. Is that something that you would be supportive of?

SHANE VARCOE: Of course. Like any drug, we need to make sure that we understand it. Getting back to the previous witnesses' comments about impairment, we need to establish a baseline. We've done it with alcohol; we call it .05. Personally, I'd like to see it, as is done in some Scandinavian countries, down to .00. It would be great. But with this, we need to establish a clear evidence base—again, across a broad section, because then you're going to be dealing with various idiosyncratic responses in people. You've got to make sure there's a vast array of clinical trials done on vast demographics to ensure that we come up with the best definition of impairment before we release or unleash this pass to drive a vehicle under THC influence.

GARY CHRISTIAN: And we all love research. What they're wanting to do, that's well and good. What they're not addressing is the point that we have made that 62 per cent of medicinal cannabis users are there for chronic pain. It is two drugs which are generally going to be used, both of them debilitating of driving. Is that going to be addressed? That's going to be a very important consideration.

The Hon. ROSE JACKSON: This question is to you, Mr Varcoe, but either can comment. One of the things that they talked about is that it will always be difficult to measure THC impairment in the same way that we measure alcohol. Particularly in a roadside testing model, you're not taking everyone off to get a blood test all the time. It will always be difficult to find a test that genuinely measures THC impairment in the same way as it does with blood alcohol. The use of field sobriety tests is one way to try to measure the impairment of someone. Is that something that you think could play a role, where we try to develop a comprehensive framework that allows police in a roadside setting to try to test someone's impairment? Do you think that could be useful?

GARY CHRISTIAN: I think the dangers are too high. As we've pointed out a number of times, the bulk of your users are using it for something that requires multiple drugs. I think it just makes the question that you've asked moot.

The Hon. ROSE JACKSON: In a way, actually, it tries to address that. If someone is taking THC along with high-dose codeine or morphine or something else, and that is interacting in their system in a way that is impairing them such that they should not be driving a vehicle, some kind of sobriety test or roadside test that bears that out would potentially allow you to identify people committing an offence and people who are not in any way impaired. I am just positing it as a potential solution.

SHANE VARCOE: Can I speak to that, Senator? It's a fair question. In the history of BAC in this country—and we have the records of this, having auspiced this for nearly 30 or 40 years—all those roadside sobriety tests were superseded by the BAC test. In fact, when it was created, Australia was one of the countries that fought hard against having it. In the police it was going to be a bit of a joke. But once they got it in, it had remarkable outcomes. My concern is that if we can create—through the research and going back to the previous

statements—research that develops a clear understanding of what impairment is under THC usage across a wide range then that can be an application that can be then used to bring about a sobriety test. For example—and, again, I'm being arbitrary here so don't quote this figure—let's say 0.03 grams of THC in the system is the impairment level. At the moment that's difficult to do because it's one of the issues.

If studies and research can bring that about, that would be as handy as 0.05. If finding that line cannot be done for whatever reason, then the impairment process is going to be very subjective. Again, as I said, we have an individual driving a vehicle at five, not 0.05, and being actually able to get in and start the car. This person's clinically dead. Again, our concern is the subjectivity of this and the roadside testing, and people can put their fingers on their nose and walk a straight line and they're fine to drive. We just read that will not test visual capacity. That will not test their impaired vision, and that's the concern we have.

The Hon. ROSE JACKSON: I understand your point, Mr Varcoe, about people's inability to self-assess their impairment. But that relates not only, as you said, to alcohol, for which we have a clear test, and to drugs like THC, opiates and benzos but also to things like tiredness and risky driving.

SHANE VARCOE: Of course.

The Hon. ROSE JACKSON: We allow people to get driver's licences and get behind the wheel of very dangerous machines that kill them and other people—being cars—and we say, "Don't do it when you're tired. Don't drive in a way that's dangerous or where you can't control the vehicle. Be extra careful when it's raining," and those kinds of things. We allow drivers of vehicles to make assessments about their own state in a range of circumstances, yet in this area we don't. We don't allow them any capacity to say, "I am completely fine to operate this vehicle." It's a blanket rule. I'm trying to tease out what the difference is between saying, "If you're sleepy don't drive," and "I wasn't feeling sleepy at all; I just swerved on the other side of the road."

GARY CHRISTIAN: On that logic we would go back to alcohol and say that a person who feels that he can hold his liquor, his own self-assessment should rule. I don't think there's any reason to go that track. The other thing is—I again refer to the medical journal study number 26 that we had within our written documentation, which says there's no real relationship between blood THC levels and an impairment. It differs. Everybody's metabolism differs—a bit like ecstasy. It's all over the shop. I don't think that's going to work for us.

SHANE VARCOE: Just on that—and, again, at the risk of calling a foul on that—that argument sounds a little bit like the argument I hear about sugar and cocaine. Sugar's bad for us and now we're at a place in some sectors where we stigmatise chocolate eaters to justify the use of cocaine. There's chalk and cheese between your faculties being undermined because you're tired—and, sure, you shouldn't drive; there's no argument there—and actually having a substance that does impair in your system and having taken that substance and know you've taken it. That's why we have the blood alcohol content. That's why it would be great to have a THC content and an opioid or benzo content and say, "We've now defined that if you have an opioid content of less than 0.0 grams, you're okay to drive a car, but if you haven't then we're going to fine you for driving under the influence of a substance." I have no problem with those mechanisms, but to detune those and devalue and derail the current mechanisms and undermine them, I think that is really concerning at the moment. That's why this process has to be very carefully managed. We do not want to go backwards after decades and decades of fighting to get road safety on a better track.

The CHAIR: We have unfortunately run out of time. Mr Christian and Mr Varcoe, thank you so much for joining us today. We'll be in touch regarding any supplementary questions or questions taken on notice. I think there were one or two maybe. We will also get back in touch with you if Committee members have any additional questions.

(The witnesses withdrew.)

(Luncheon adjournment)

Mr GREG BARNS, Spokesperson, Criminal Law Australian Lawyers Alliance, before the Committee via videoconference, sworn and examined

Mr NICHOLAS COWDERY, Member, Criminal Law Committee, New South Wales Bar Association, before the Committee via videoconference, affirmed and examined

Ms ROSE KHALILIZADEH, Member, Criminal Law Committee, New South Wales Bar Association, affirmed and examined

Ms OLIVIA IRVINE, Vice President, NSW Young Lawyers, before the Committee videoconference, affirmed and examined

Ms AMY FARRUGIA, Vice Chair, NSW Young Lawyers Criminal Law Sub-Committee, before the Committee via videoconference, sworn and examined

The CHAIR: I welcome our next witnesses. I also remind Committee members to identify themselves when asking questions in case people online can't see or know who they are. I will call for opening statements. Mr Barns, do you have an opening statement?

GREG BARNS: Very briefly, we have made a submission to the Committee. In essence, the experience of our members—including my own experience, although I don't do much of this sort of work now—is that drug-driving laws are inherently inequitable in many respects but particularly in relation to medical cannabis patients. I've given advice to South Australian MPs in relation to possible reform in the area. I have also read some decisions of former magistrate David Heilpern on this matter. Probably most importantly, I practise partly in Tasmania where, in fact, there is a defence—well, not so much a defence but an exemption, if you like—from drug-driving laws if a person has a prescribed drug that came from their medical practitioner or otherwise enforces legislation in Tasmania.

The CHAIR: Thank you. With the New South Wales Bar Association, is there one opening statement?

ROSE KHALILIZADEH: I will attend to that. The Bar Association has set out its position in the written submission to the Committee of 4 May 2022. In short, the Bar Association supports the enactment of legislation to amend the Road Transport Act to provide a defence for those who are legally prescribed cannabis from the offence of driving with a presence of a prohibited drug in their system—that is, legally prescribed THC. The Bar Association recognises that if currently THC is detected in a driver, they face significant fines—$2,200 for a first offence, $3,300 for a subsequent offence and also potential licence disqualification. If the matter proceeds by way of a court attendance notice, there are costs associated in the criminal justice system, including the allocation of court, prosecution and legal resources.

In essence, the Bar Association supports the introduction of a defence that is consistent with the current defence available in section 111 (5) of the Act, with respect to the presence of morphine—that is, that the accused would be required to prove, on the balance of probabilities, that the THC in the accused's system was as a result of lawfully consumed medicinal cannabis.

The CHAIR: The NSW Young Lawyers, is there one or two opening statements?

AMY FARRUGIA: We have one opening statement. In summary, the Criminal Sub-Committee is in favour of the proposed bill that we're here to discuss today. We see it as a sensible, logical extension of the existing exemption for medically prescribed morphine. We are of the view, though, that certain clarifications could be made to the bill to remove any potential ambiguity or any difficulties in the ultimate implementation of the bill. Then, finally, we have decided that we are not in favour of imposing any further limitations to the ability of the proposed exemption. That is our summary. We're prepared to assist.

The Hon. ROD ROBERTS: I might direct my question to you, Mr Barns, in the first instance. We're here to look into the provisions of the bill. I know it's presumptuous of me, but I assume you have a copy of the bill in front of you.

GREG BARNS: I have read the bill. I don't actually have a copy.

The Hon. ROD ROBERTS: I'm not going to take you to a specific line or anything. It's not a trap question. I look for your comment and perhaps yours too, Ms Khalilizadeh. I believe the bill is deficient in its silence in a number of areas. I'll explain that to you. Let's take it to the practicality of a random roadside drug test, where I get wheeled over by the police and they say, "You're subject to a random test." I do the saliva test and I return a positive to THC. The bill doesn't say what happens from there. It certainly makes an exemption similar to the morphine. Certainly, it puts the onus of proof back onto me, which is a reversal from the usual practice, as you know, of "He who asserts must prove", but doesn't say whether I need to prove it to the police there and then,

on the spot, or whether I need to appear before a magistrate or a court or some form of tribunal and prove it there and whether it's beyond reasonable doubt or whether it's on balance of probabilities et cetera.

My concerns come from this: If it is to prove it to the police on the spot, how do we do that? Is it the production of a doctor's certificate, perhaps, or a copy of the prescription itself? Taking that as the example, it's possible that that production of a doctor's certificate or the prescription could be a masking for the illicit use of cannabis. I may well have a prescription for medical cannabis. But, if I get stopped at the random test and I prove positive to cannabis, there's no proof that I haven't smoked a joint or pulled a bong or whatever expression you want to use, prior to driving the motor vehicle. So I have concerns about just providing it to the police on the spot.

If it was provided to the police on the spot and the police were to accept that this is medicinal cannabis, without being aware of the full circumstances, and the driver was then allowed to drive down the road and had an accident in which somebody sustained a serious injury—or fatality, even—would there then be some sort of vicarious liability on the police because they've got knowledge that this person has THC in their system but allowed them to drive? I'm looking for some comments from you folk as the experts in law, where you see some issues. Do you see any issues with the propositions I've just put forward?

GREG BARNS: I might be able to assist by telling you what happens in Tasmania. In our submission, we've set out the Tasmanian provisions. What the Tasmanian provision does—it doesn't reverse the onus. It doesn't make it an offence. It simply says a person who drives a motor vehicle while a prescribed, illicit drug is present in their blood or oral fluid is guilty of an offence. It then says that you don't commit that offence if the prescribed drug was obtained and administered in accordance with the Poisons Act 1971. The way it works in practice, as I understand it, is that people who are prescribed medicinal cannabis by their doctor will, generally speaking, have that prescription with them, for example, in their vehicle or on their person.

There have certainly been cases in Tasmania that I'm aware of where police have simply accepted that on the spot. Generally speaking, what police will do, because you don't automatically lose your licence because you've got THC in your system—it would only be if the driving was the issue, rather than the presence of the drug or the alcohol.

Sometimes what happens is that they will, in fact, indicate that you might receive a summons. People then get another letter from the doctor saying, "Look, Bill was prescribed this. He takes it in accordance with the prescription," and that is shown to the police and then the summons is either not issued or withdrawn. So it's a bit of a mixture in terms of when that is done. I might say that the Tasmanian provision is much broader, though. It's not confined to medicinal cannabis. It is, in fact, any drug that is prescribed or administered. I think it is now, just as aside, ketamine, MDMA and psilocybin and other drugs increasingly being used for PTSD. That is probably going to become something for me to look at. But for the moment that's the way the Tasmanian provision works. In essence, if you can show them that you have a script and it's a current script, then you are entitled not to be charged with that particular offence. Generally, you don't have to wait for it to go to court. You can do that because it is not, in fact, an offence; it is simply that you have not committed an offence.

When it comes to the issue of how does the doctor know—I think the question was: How do you know that the person has taken it in accordance with the prescription? Essentially, unless you've got a police officer standing with you while you take it or you are being monitored, you are never going to know that. But what we are talking about here, of course, are not cases where people are driving under the influence. What we are talking about is simply that they have got out of the car and done a lick test and they say, "You've got THC." It doesn't save you in Tasmania if, for example, it's erratic driving and the police pull you over. This provision won't save you. I hope that helps.

Ms CATE FAEHRMANN: Can I clarify what Mr Barns just said? In terms of how the laws are operating now in Tasmania, you were saying that if the police pull someone over it's an offence for impairment. You might have been driving erratically, or whatever, but it's not an offence in terms of traces. You were referring to Tasmanian in terms of the law now. Is that correct?

GREG BARNS: No, what I was saying was that if you are pulled over because your driving is erratic [inaudible]. The fact that you are on medicinal cannabis and you've got a prescription won't help you. The nature of your driving is the issue. This charge is simply the case where you get pulled over, do a random lick test, you've got THC, so you pull out of your vehicle your prescription and say, "Here's my prescription from my doctor." The police will, as I understand it, generally accept it. If they don't accept it at that point in time, they will accept it later. I might say that there has been a more liberal policy here when it comes to medicinal cannabis generally. For example, if people are found with cannabis in their household even if it's not medically prescribed and if it's just plants but they've got a letter from their doctor saying that they are using it for pain relief, there is a de facto policy for Tasmanian police not to charge people in those circumstances either.

NICHOLAS COWDERY: I thought as one of the Bar Association representatives I might comment on the initial question. The bill in its presently intended form, in practical terms, would result in a situation like this: somebody is pulled over, tested, they're positive for THC, the police would issue a court attendance notice and it would then be open to that person to put forward representations to the police establishing the defence or the exemption. If the police accept that, that is the end of the matter. If the police don't accept it and it goes to court, then the same sorts of defence or basis for exemption could be established in court by the person who has been charged. I think that is how it would work in practical terms.

ROSE KHALILIZADEH: If I could add to that? You might have seen in the New South Wales Bar Association's submission that the suggestion is made, or there is some encouragement, that there is consistency with the current subsection (5) defence. In the subsection (5) defence, there is an important reference to it being a defence that's proved to the court's satisfaction. In those circumstances, as Mr Cowdery has set out, if the police are not accepting of the evidence prior to the matter proceeding to court, it is entirely within the court's purview or discretion to accept or reject the evidence and accept or reject the defence. Also, it can be subject to challenge by police or the prosecution in that environment. There are checks and balances. It is not simply the raising of the defence and that's the end of it. It has to be within the court's satisfaction.

The Hon. ROD ROBERTS: But the bill in its current form does not take it far enough there, does it?

ROSE KHALILIZADEH: This has been set out in our written submission. At the moment, there is perhaps some need for some clarification about precisely how that might work in practice in terms of the onus of proof, where the defence lies and who needs to prove what if it does proceed to court.

The Hon. ROSE JACKSON: As we are discussing the current exemption in relation to morphine—and I think the Young Lawyers' submission also referred to their preferred position being that this exemption would operate in the same way as that exemption—you have set out how the law says that operates. How does it operate in reality? Have you had experiences in relation to the operation of that exemption? Can you give us some more information in relation to how often police accept that exemption when it is raised? How often does it proceed to court? How does that play out practically?

ROSE KHALILIZADEH: I don't know the precise statistics around how many matters proceed to court and how many are withdrawn in terms of the discretion of the police. I'm happy to take that as a question on notice and provide that information at a later stage in writing. In terms of the practicalities of how it would work—the reality of day-to-day prosecutions, in a similar way to what was set out by Mr Cowdery—if a matter was to proceed by way of a penalty notice, the person would have the opportunity to challenge that and raise that in court and, if the matter was to proceed by way of a court attendance notice, to raise the defence prior to hearing, potentially by way of representations to police, and then at the hearing. Again, I can't precisely say how many have proceeded to a full hearing within the courts in terms of the current section 111 (5) defence. It may be that the Young Lawyers have some further information about that, but I'm happy to provide that.

The Hon. ROSE JACKSON: That would be useful, if you were able to take it on notice. It is more, if you have any, what are your reflections on whether that is successfully operating in terms of clients that you may have dealt with in your—perhaps it is self-evident that you think it's successful, in a way, because you have suggested that be the way this exemption operates. I am interested about any reflections that people on this panel may have about the actual use of that and whether them and their clients found it easy to use—whether it was something that was very difficult or tricky to apply operationally or whether it was relatively straightforward?

ROSE KHALILIZADEH: I don't have any personal experience in the operation of that particular subsection in a criminal matter. I, of course, defer to anybody else in the session today who has had personal experience. Again, I'm happy to take the matter on notice if there is anyone from the New South Wales Bar Association who can reflect upon the difficulties or otherwise of navigating that. I apologise that I can't be of any further assistance on the practicalities of that, but there might be someone else who is able to comment on that.

The Hon. ROSE JACKSON: Has anyone else on the panel had any experience with the actual application of the current exemption in relation to morphine that they are able to offer?

AMY FARRUGIA: Unfortunately, I can't offer any personal experience. I can't speak for my Young Lawyers colleague though.

OLIVIA IRVINE: Likewise, I think we would have to take that on notice to see if, perhaps, the rest of the subcommittee had further anecdotal evidence.

The Hon. LOU AMATO: What is the difference between whether you get a penalty notice or whether you get a court attendance? My understanding is that if you get a penalty notice, you do not have a criminal record.

But if you have to go to court and you get found guilty, then you will have a criminal record. That's my understanding of it. Can you explain that to the Committee, please?

ROSE KHALILIZADEH: In terms of proceeding by way of a penalty notice and by way of a court attendance notice, I think that question is best answered by police, as I understand it to be a matter within the discretion of the police as to whether a matter proceeds by one way or the other. That is not a discretion where, as I understand it, that discretion needs to be justified in one way or the other, at least not publicly. Perhaps that is a matter best answered by police. In terms of the second part of your question as to whether it results in a criminal record or not, as I understand it, that is a relatively complicated definitional issue that arises from what one sees as a criminal record or as an entry on a criminal history that is not necessarily a criminal record.

Again, I am happy to take that question on notice and place something in writing. The New South Wales Bar Association has not reflected upon that in their current submission as to what the consequences might be and what that might mean, but that is as far as I can take it. I'm not sure if my colleague Mr Cowdery is able to say.

The Hon. LOU AMATO: I wonder if any of your colleagues might know why you would be given a penalty notice rather than a court appearance. Would any of your colleagues perhaps be able to answer that question?

NICHOLAS COWDERY: Some offences are able to be dealt with by way of penalty notice. For example, with a speeding ticket you can pay the penalty on the penalty notice, which disposes of the matter without a criminal record in the sense of a criminal conviction. But if you don't accept the penalty notice, you then go to court and fight it out on the merits of the case. If you are convicted and a conviction is formally entered, then you end up with a formal criminal record from the court.

The Hon. LOU AMATO: No, I understand that part. I was trying to work out why the police would issue an infringement notice to someone and not to another person. I could understand that if they were driving in a manner dangerous or so forth there would obviously be a court attendance. But if it was in relation to the same issue and they just had THC in their system, why would one person just get a penalty notice rather than someone else having a court attendance?

NICHOLAS COWDERY: I think, with respect, you would have to take that up with the police because it falls into—in part, at least—the area of police exercise of discretion.

The Hon. LOU AMATO: Yes, fair enough.

The CHAIR: We do have the Assistant Commissioner of the NSW Police Force appearing at three o'clock. You might be able to ask your question then, Lou.

The Hon. LOU AMATO: Thank you, Chair.

Ms CATE FAEHRMANN: Just following on from that question, I assume it partly has to do with—which is outlined in the New South Wales Bar Association's submission—the cost of the penalty, which is prohibitive for many people even if they are provided with that option. It is $2,200 for a first offence and $3,300 for a second offence, as well as licence disqualification of up to six months. Is that just to get that confirmed or else there is, of course, going to court? Is that correct? Mr Cowdery or Ms Khalilizadeh, do you know that?

ROSE KHALILIZADEH: Can I just make sure that I understand your question? Does your question relate to whether someone might challenge the fine and go to court on the basis of the challenging of the fine?

Ms CATE FAEHRMANN: Yes. For example, if they are pulled over and they have THC in their system, can the police, say, issue them with the fine of $2,200 and they might say, "Well, I can't afford that." The police might then say, "Well you're going to have to go to court then." Is that essentially the difference?

ROSE KHALILIZADEH: As I understand the operation of the legislation as it currently stands, there is the opportunity for a person who has been issued a penalty notice to challenge the quantum of the penalty notice by electing to have the matter heard by a court. But it would be dealt with in a different way to the way that we are discussing today, in terms of raising a defence and having a hearing. Generally, where matters are challenged in terms of a fine that has been imposed, it is a much quicker and more efficient process through the courts. That's what I can say, generally speaking, about it, not specifically about this offence; I am talking generally about road transport offences. I'm not sure if there is anything from Mr Cowdery in relation to that.

NICHOLAS COWDERY: I agree that there are two lines of challenge from the initial step. One is, in effect, an appeal against conviction, if I can apply that loose term to it. The other is an appeal against penalty. If the only issue is the quantum of penalty well, then, as my colleague says, the proceedings can be very much more economically conducted.

Ms CATE FAEHRMANN: Can I get your views—you have outlined it in all of your submissions but I think it is worth expanding upon the fact that, essentially, what we have before us is that our current drug-driving laws in New South Wales have not actually kept pace with changes in other laws that have made medicinal cannabis legal. Starting with you, Mr Cowdery, why does that really need to change? Why is that unjust?

NICHOLAS COWDERY: Expressing my own personal view and not the view of the Bar Association, I think the whole drug-driving law regime is misconceived. What we should be focusing our legislative attention on, if I may say so, is driving impairment. These laws very largely miss that. Having created that problem, what this bill is now trying to do is to mollify the effect of that strict provision by enabling people who are legitimately and for quite proper purposes ingesting THC, to be exempted from the otherwise harsh conditions that have been imposed by the original legislation. I think it is a small step in the right direction but that is really the best that can be said for it.

GREG BARNS: I might just add to that if I may. I will give you an example of exactly what Mr Cowdery is talking about. We were sitting in court in Hobart last year waiting for a matter and the man was before the court on a drug-driving charge. He is using cannabis but not on a scheme because it is difficult to get on a scheme—which, as you know, is another issue. He was using cannabis for pain relief. He was charged under section 6A of the Tasmanian Act with driving with an illicit drug in his blood. He could not avail himself of the exemption because it is not from a doctor. He did have a letter from his doctor that said, "He has been a patient of mine for a long time. He used to be addicted to Oxy. He has now finally beaten that addiction and uses cannabis. Whilst I cannot support that because of the law, it is working and he now has a job again", et cetera. I remember the magistrate just shaking her head and saying that this is where drug laws are so wrong. There was nothing untoward about his driving. All that the Tasmanian law does is, in a limited way, exactly what Mr Cowdery says. It is seeking to mollify the impact. But there are still many, many people out there who are caught by what is an unjust law because it does not, unlike drink driving, focus on impairment.

AMY FARRUGIA: Could I perhaps follow Mr Barns, if that is okay? It makes a good segue to the Young Lawyers' submission. The Therapeutic Goods Administration now is offering guidance on the use of medicinal cannabis for epilepsy, MS, non-chronic cancer pain, people that are experiencing nausea as a result of chemo or are vomiting because of their cancer, and palliative care. Speaking I guess anecdotally, I am sure we all know at least someone who has experienced one of those conditions. With the law as it stands there is a chance that people who are using medicinal cannabis for those very just reasons could be unjustly captured. In our submission we also turned our mind to people who may be suffering from those health conditions and be prescribed medicinal cannabis and then also live in a rural or remote area. The burden of that conviction will be heavier on them. If they're to lose their licence or their ability to drive, they're going to be far more isolated than if the same thing happened to someone living an urban or a city area. So it becomes more onerous for these people.

Ms CATE FAEHRMANN: Just following up from that, could you just talk to the impacts on our court system and justice system of having THC listed under schedule 3 [11] of the Road Transport Act? It sounds like there are all these cases going before the courts that really should not be and would free up our judicial system. Maybe we will start with you, Ms Farrugia, if you're already there.

AMY FARRUGIA: I can't speak to exact numbers and percentages as to how much this would free up our court system. That's something I'd have to take on notice. But, as Mr Barns said, in that case that he experienced there was clearly someone there taking up the court's time and costing everyone money and time that didn't need to be there. I can't speak to the numbers of people that are coming and taking up the court's time, but it would be good if they weren't.

NICHOLAS COWDERY: Could I add to that? There is a gentleman by the name of David Heilpern who is a retired magistrate who sat as a magistrate at Lismore for many years. There is a whole series of judgements that he issued in that time in relation to the presence of THC driving cases that he dealt with. The Committee would be well advised to get hold of that bunch of judgements and have a look through and see the problems and the scope of the trauma, trouble and expense that everybody has had to go to because of these laws.

Ms CATE FAEHRMANN: He was invited to appear today but, unfortunately, he had to be in court and couldn't. But we will endeavour to do that, maybe.

The CHAIR: Absolutely.

The Hon. GREG DONNELLY: Thank you all for making yourselves available this afternoon. The matter of impairment that we've just made some comment on or some reflections on has been put before us in some of the evidence today and in some other submissions about understanding impairment in the context of being inebriated with alcohol. We obviously have a law around an amount that is deemed to be an impairing amount, and we know what the consequences are for driving on or above that limit. But with respect to the matter of illicit

substances, and if we use the case here, not distinguishing between medical and non-medical cannabis but just on the matter of cannabis in general, the issue of understanding accurately the matter of impairment is much more difficult. So I invite witnesses to pass some comments about the issue of trying to understand the matter of impairment and how that's able to be dealt with with a substance that is unlike alcohol, where there is a community acceptance around a limit relating to impairment.

GREG BARNS: We have done some work on this, and I've done work more broadly on it. I might be very brief on it. There is some work being done on this, Mr Donnelly. I think I'm right in saying that in Canada and in the United States, where cannabis is legal in a large number of States and is now legal in Canada across the nation, there is work being done on impairment levels. Because, in relation to drink driving, those laws came about as a result of a vast number of epidemiological studies that establish in a scientific way an impairment level. There is work being done including, I think, in the UK. I'm not across the work but there's certainly quite a lot of work being done. There's a man called Michael White, I think formerly of Adelaide University, who is now an emeritus professor and who is very well versed in this area. It might be worth the Committee contacting him.

The Hon. GREG DONNELLY: He provided facts and evidence earlier today. Thank you. That is quite apposite.

NICHOLAS COWDERY: If I could make a comment about that. The law cannot deal with absolutes, generally speaking—the criminal law. And what has been done with alcohol is to find a level that is acceptable to the community to be enforced. So almost any mind-altering substance is likely—and I'm not a medico, but is likely—to create some kind of impairment in the motor functions of the mind-hand coordination et cetera, et cetera, functions that we do, including in driving. So it's a question of drawing the line with what is going to be an acceptable limit of restriction. Medical evidence can probably give you this information, but the vice of the present drug-driving law is that it doesn't try to draw any kind of line. It just says that if you have any presence at all then, in brackets, you are deemed to be impaired, close brackets, and you have committed a criminal offence and there's just no logic, there's no reason, there's no rational basis for that.

The Hon. GREG DONNELLY: But can I just perhaps be the devil's advocate and say if we take that proposition as being a reasonable one, do you understand why legislators just might be a bit reserved if there is no consensus about an amount that goes to the question of impairment, moving from the current legislative provision?

NICHOLAS COWDERY: I would suggest that a consensus can be built by the evidence being broadcast and made known to the community and by appropriate consultation and debate about the issue. It was done with alcohol, as Greg Barns has said; it can be done with other things as well. This really comes down to being a matter of balance. You won't get absolutes enshrined in legislation. You have to balance competing interests all the time and strike the right balance that is going to be acceptable to the community and effective in keeping the community safe.

OLIVIA IRVINE: If I could add to that comment as well. Within our submission we commented on the difference between section 111 and section 112 and we've advised consideration around whether or not this would impact section 112 and we have also advised that, to the extent that it can be drafted such that it doesn't, that is ameliorated to some extent. Further, we have also provided a submission on the recommendation that we not get into the weeds of implementing further restrictions on this very limited scope exemption on the basis of time limit or waiting period simply because of this matter where we don't have a sort of general consensus on affectation.

The CHAIR: We probably have time for one last question, if there are any?

The Hon. ROSE JACKSON: I might ask a question, although I'm not sure, considering most of the panellists are from the criminal law division, it would necessarily be able to add anything. But I did want to just ask, the New South Wales Government in its submission to this inquiry drew attention to what it claimed were possible insurance implications for this change in that previously ineligible at-fault drivers, who are currently ineligible for CTP statutory benefits because they're in breach of the law, would become eligible, potentially, through the operation of this exemption and this may have some impact on insurance premiums. I just wondered if anyone were able to reflect on that. As I said, I think perhaps not because I know most of you are criminal lawyers, but there hasn't really been anyone else on any of the panels who might be able to reflect on that, so I thought I'd just ask if anyone did have any experience in relation to insurance law and the way that that might work.

GREG BARNS: I don't, but what I can say is that in Tasmania, where this provision has now been in law I think I'm right in saying about 15 years, I've never seen an article in the media and I'm not aware of any increase in premiums.

The Hon. ROSE JACKSON: That's useful. Thank you, Mr Barns.

The CHAIR: Great. Thank you to all the witnesses for attending and for your evidence today. The Committee has resolved that answers to questions taken on notice be returned within 21 days so the secretariat will contact you in relation to questions you have taken on notice. As well, Committee members may have additional questions that we may put to you. Thank you for coming today.

GREG BARNS: Thank you very much.

NICHOLAS COWDERY: Thank you.

OLIVIA IRVINE: Thank you.

ROSE KHALILIZADEH: Thank you.

(The witnesses withdrew.)

Mr BERNARD CARLON, Chief, Centre for Road Safety and Maritime Safety, Transport for NSW, sworn and examined

Mr PETER DUNPHY, Head of Transport Safety, Security and Emergency Management, Transport for NSW, affirmed and examined

Mr BRETT McFADDEN, Assistant Commissioner, Traffic and Highway Patrol Command, New South Wales Police, affirmed and examined

Professor JENNIFER MARTIN, Senior Staff Specialist - Internal Medicine and Clinical Pharmacology, John Hunter Hospital, Hunter New England Local Health District, affirmed and examined

Associate Professor BRIDIN MURNION, Senior Staff Specialist, Drug & Alcohol Services, Western Sydney Local Health District; Senior Staff Specialist, Clinical Pharmacology and Toxicology, St Vincent's Hospital Sydney, before the Committee via videoconference, affirmed and examined

The CHAIR: I welcome our next witnesses. Associate Professor Murnion, did you want to make an opening statement?

BRIDIN MURNION: I don't have an opening statement. Sorry, my understanding was that Transport were to do the opening statement.

The CHAIR: Just the one?

PETER DUNPHY: Just the one statement, Mr Chair. Good afternoon. I'm here from Transport for NSW with my colleagues from NSW Health and the NSW Police Force to answer any questions the Committee has about the New South Wales Government's submission. I start by briefly explaining relevant road safety offences. There's a two-tiered approach to drug driving. There's one offence for driving under the influence, which is the DUI offence. This offence applies to a driver who, when stopped by police, is visibly affected by a drug, and has higher penalties equivalent to the higher range drink driving. The one we're talking about today is the other offence to which the bill applies. It's for driving with the presence of one of four proscribed drugs, including THC. As roadside drug testing can be undertaken anywhere, anytime, it is designed to deter drivers who have recently used illicit drugs from driving.

We've seen how successful this has been for random breath testing, which commenced in 1982. In 1980, 389 people were killed in alcohol-related crashes in New South Wales, compared to 51 in 2020. But this change in public attitude does take time. Crash data in New South Wales shows that between 2016 and 2020, there were 253 fatal crashes involving drivers and riders with the presence of THC. This represents 16 per cent of all fatal crashes and approximates closely to one fatality every week. THC can affect cognitive and motor skills necessary for safe driving, such as attention, judgement, memory, vision and coordination. Medicinal cannabis patients are advised they should not drive while using a product that contains THC. Of course, CBD-only medicines would not be detected under roadside drug testing, and patients taking CBD-only medicines can lawfully drive as long as they are not impaired.

While it is true that much of the evidence for impairment impacts are from illicit THC use, there is still evidence that medicinal cannabis users can be impaired for a period of time. This can vary significantly due to differences in ingestion method, dosage, presence of other drugs or medicines and individual biology. It is therefore not possible to be certain of the effect of any dose of medicinal cannabis on an individual. Medicinal cannabis is not comparable to other drugs due to the large-scale use of recreational cannabis and the inability to distinguish between medicinal cannabis and recreational cannabis when analysing samples through our roadside testing.

I heard the evidence this morning and throughout the day; I know there are many people who would like to see the bill passed. As part of the 2026 Road Safety Action Plan, the New South Wales Government has committed to continuing monitoring drug-driving research and developments. Until there is clear evidence on the effects of medicinal cannabis on driving, the New South Wales Government will continue to take a cautious approach to changing policies and consider the safety of all road users. I must also highlight the practical challenges and implications of this bill, which I think have been discussed this morning. Firstly, there is no reliable way to distinguish at the roadside whether the source of THC detected is illicit or prescribed as medicinal, or whether the driver has used cannabis illicitly in addition to their prescription.

Secondly, to attempt to determine whether THC from cannabis was administered as prescribed by a doctor would require a blood sample to be taken by an authorised sample taker and would require expert pharmacology review. This is a much more invasive, uncertain and resource-intensive process for everyone involved. It would limit the ability to deliver the high volumes of roadside drug tests that serve to deter drug

driving, an approach that has community support and has been independently evaluated in Victoria as successful in saving lives. Alternatively, if we were to rely simply on a medical exemption certificate without actual verification, there is no way of knowing if the patient had taken the product as prescribed and without any other additional substances. This is just not workable. It is contrary to the wording of the bill and is too much of a risk for other road users.

A similar bill was introduced in Victoria in 2019. An expert working group was established to look at the risk of medicinal cannabis and options to implement the bill that would not be detrimental to road safety and would ensure the integrity of their roadside drug testing program. In 2021 the group produced a final report with no consensus and did not recommend progressing the bill. Finally, at this stage, in the face of the existing evidence and the practicalities involved, the New South Wales Government is not ready to allow an exemption for THC in medicinal cannabis users.

Ms CATE FAEHRMANN: Thank you for making a submission and for your opening statement. I want to go to some of the data that you have raised in both of those. You've raised the success of the random breath testing scheme in your submission and you said that it had seen alcohol-related fatalities drop from 389 people in 1980 to 51 in 2020. Is there similar data to suggest the same success in the mobile drug testing scheme?

PETER DUNPHY: Across the board in terms of reductions and through the road safety programs we've seen significant reductions in road fatalities over a period of time from the early twenties down to last year when we had the lowest level of road fatalities in almost 100 years. The general trend in all of the areas have certainly shown those decreases. But I might just refer to—

Ms CATE FAEHRMANN: But with the random breath testing scheme, that was specifically in relation to alcohol-related fatalities. The success has been that there was a drop from 389 to 51. Specifically in THC-related fatalities, have you got the same data?

PETER DUNPHY: We do have data in terms of the reduction in fatalities for drug offences. I might just refer to my colleague Mr Carlon to provide a little bit of further information about that.

BERNARD CARLON: In relation to that, the overall data indicates that there has been a decline but it's not significant. We can provide the data to the Committee. The key issue here in comparison with the roadside breath testing program and the 50 years of research and implementation of strategies for reducing drink driving related fatalities and serious injuries over those many decades is that general deterrent approach that's being used in terms of RBT and the specific deterrent approach. Then of course there is the penalty regime, which has been put in place, and then the changes over time that have been implemented as well, right through to the graduated licensing system where provisional drivers are actually now required to have zero BAC when they drive a vehicle. Similarly, this program has only been in place for a fifth of the time in terms of the reduction and the implementation. We have seen a significant increase—

Ms CATE FAEHRMANN: When you say a fifth, how many years is that?

BERNARD CARLON: It's more than a decade. We have seen a significant change in the demographics and the use of drugs throughout the community. We have increased over time from 30,000 tests in terms of the mobile drug-testing program to 100,000 tests to now 200,000 random tests.

Ms CATE FAEHRMANN: You say you're up to 200,000 tests. You also state in your submission:

> In numerical terms, this means that, of the 264 fatal crashes in NSW in 2020, THC was a factor in nearly 60 deaths.

How did you determine that THC was a factor in those 60 deaths?

BERNARD CARLON: That's the presence of THC in the driver's blood—in the controller's blood.

Ms CATE FAEHRMANN: The presence of THC in the driver's blood makes you draw the conclusion that THC was a factor in nearly 60 deaths? Are you serious? You can't be serious.

BERNARD CARLON: We know that THC has an impairment—

Ms CATE FAEHRMANN: Did you draw that conclusion?

The Hon. ROSE JACKSON: Presumably a bunch of them were women. Maybe that was a factor in their deaths.

The CHAIR: Order! We will have this in a question and answer format.

The Hon. ROSE JACKSON: Sorry.

Ms CATE FAEHRMANN: Did the Government draw that conclusion, or is it peer-reviewed research that has found THC was a factor in or caused nearly 60 deaths?

BERNARD CARLON: Well, a factor, yes. We know—

Ms CATE FAEHRMANN: Or do you mean it was just present in their system?

BERNARD CARLON: We know in our research—and it might be useful, actually, to refer to Professor Martin on this as well—about the impact in terms of THC in the blood.

JENNIFER MARTIN: I will clarify the difference between being a factor and the cause. We have this problem in medicine all the time where it's often done on probabilities and the whole environment, because people who have THC are often taking other medicines as well. So often it can be difficult to be certain what has done what. There is a difference between being 100 per cent sure on causality as opposed to being a factor that is known to contribute to people's impairment, which is known to contribute to death.

Ms CATE FAEHRMANN: Professor Martin, do you have the rough statistics in your head of how many people in New South Wales on any given day are taking cannabis, using it either medicinally or for recreational purposes?

JENNIFER MARTIN: I will give you those numbers in just a minute, but it reminded me to also add to that point of when you're talking about the reduction in deaths from THC, that we all have to remember that these drugs are a lot more available in 2022 and going forth than they were in 2020. We can see that from the TGA data, which shows just the number of prescriptions, so those that have gone through the SAS B. I think if we're looking at a reduction in numbers with THC, we also have to be aware that there's so much more availability and use in the community. In terms of the numbers, I have it in my notes. I will get back to you in one minute. I might hand over to my colleague Professor Bridin Murnion, who may have the numbers at her fingertips. Do you have the numbers for New South Wales, Bridin? It's the TGA data.

BRIDIN MURNION: The national statistics on recreational cannabis use varies, obviously, in different age groups. The 2019 National Drug Strategy Household Survey indicated that 25 per cent of people between the ages of 20 and 29 have used recreational cannabis in the previous year. I also have statistics on the use of medicinal cannabis. I don't think, Jenny, that you've had time to add those totals in your papers yet.

JENNIFER MARTIN: No. I will take that on notice, but we have those numbers.

PETER DUNPHY: I might be able to add that in the Government's submission we did refer to the percentage of users of cannabis in the community. I think it was 12 per cent of Victorians detected in autopsies or road deaths. THC is used recreationally by a large number of Victorians compared to other recreational drug users. I think what we identified in New South Wales is that the figures cited are similar for New South Wales: 11.4 per cent of people in New South Wales aged over 18 use cannabis illegally.

Ms CATE FAEHRMANN: That is in your submission. Are you aware that quite a few of those people who—everybody, actually—use cannabis will have traces of THC in their system sometimes hours, if not days, beyond when they're impaired in any way by that drug? I will ask you, Mr Dunphy. Are you aware of that?

PETER DUNPHY: Getting back to the point that you raised before about the behavioural factors from the Centre for Road Safety, we do report on—

Ms CATE FAEHRMANN: It's just a question about impairment or tracing. I'm not asking about impairment. It's a question of if you are aware that traces of THC can stay in a person's system well beyond when they are impaired.

BERNARD CARLON: I will address the oral fluid sampling that is done at the roadside, and I might then hand to Assistant Commissioner McFadden as well. Essentially, the device that we're using for oral fluid swipe in order to screen drivers on the side of the road does not detect traces of illicit drugs—in particular, THC. It only detects recent use. I'm also happy for our colleagues from Health to talk about the time frame in which oral fluid THC is detectable.

The Hon. ROSE JACKSON: You are aware, Mr Carlon, that we received contradictory evidence on that basis from the experts at the Lambert institute this morning? We asked them exactly the same question. They said it wasn't fair to say that oral swabbing only detects recent use. They just said that is not a statement that they felt comfortable making, based on their expert research.

BERNARD CARLON: Professor Martin might have—

JENNIFER MARTIN: Hopefully they can provide that evidence. It is correct that you can pick up in the blood, fluid and the urine the parent drug of the THC and the metabolites for a number of days. In urine,

14 days—maybe even longer—after someone's ingested some THC. In terms of the oral fluid, it's very unusual for chemicals in the blood to end up in the saliva—this particular drug. It's certainly possible, but there would be very, very small amounts detected in the oral saliva if it so happened that you had a high amount in the blood. It's usually the other way round.

The Hon. ROSE JACKSON: Thanks. I just want to clarify, this submission was authored by Transport for NSW? That was the lead agency in relation to the submission?

PETER DUNPHY: It's a government submission that was coordinated by Transport for NSW.

The Hon. ROSE JACKSON: NSW Health were consulted and approved this submission?

JENNIFER MARTIN: Yes. I didn't see the submission, but the evidence that I've given is from a pharmacological perspective about drugs moving from the blood into the oral fluid.

The Hon. ROSE JACKSON: Of course. I was referring in general, not the evidence that you just provided. NSW Health was consulted on and approved this submission?

JENNIFER MARTIN: I didn't see that submission before it was submitted. I have read it in preparation for giving my evidence today.

PETER DUNPHY: It's a whole-of-government submission.

The Hon. ROSE JACKSON: I'm aware of that.

BERNARD CARLON: NSW Health and police were consulted, yes.

The Hon. ROSE JACKSON: One of the things that you referred to, Mr Dunphy, was the paucity of evidence in a way, in relation to the impact of medicinal cannabis on driving, the issue being medicinal cannabis users are regular users who are not looking to get high. They are looking to relieve pain or other symptoms: nausea, vomiting, seizures—whatever it is. Again, the Lambert institute suggested that they would be very enthusiastic to partner with government on a study that looked specifically at that issue. Is that something that the Government is open to, as potentially a way to move forward on this?

PETER DUNPHY: Yes, absolutely. In the 2026 Road Safety Action Plan, certainly one of the priorities and one of the areas that we focused on is really looking at further research. We recognise that we want to be best practice. We want to make sure that whatever our control frameworks have, whatever advice we're giving in terms of road safety is world's best practice. We can only do that, really, through supporting good evidence base. We're very strongly supportive of the research. As everyone has discussed today, there are still gaps in the research. We would certainly appreciate and welcome further research in this area, to better understand the impacts and also to better target our approaches in terms of prevention and also the enforcement approaches.

The Hon. ROSE JACKSON: One of the issues that has been consistently raised is the different treatment of medicinally prescribed cannabis to other medicinally prescribed legal drugs—opiates and benzodiazepine, specifically. Can you give us your explanation as to why it is fair that someone who perhaps has transitioned from being addicted to OxyContin or other benzodiazepines, which is—I'm sure Health would agree—an extremely problematic position for someone to be in, has moved away from those kinds of addictions, to medicinal cannabis use, legally prescribed by their doctor? They are open to losing their licence because they have moved away from taking prescription benzos or opiates to taking prescription marijuana. In fact, we have heard evidence that people are avoiding that transition and remaining on drugs that they don't want to be on—it's making them feel like zombies—because of the driving prohibition relating to THC. Can you explain why you think that distinction is fair?

PETER DUNPHY: Firstly, we don't discriminate against any prescription drugs. The whole purpose of—

The Hon. ROSE JACKSON: But you do discriminate against prescription THC. It is treated differently.

PETER DUNPHY: In terms of the approach that we take, our focus isn't on what is a prescription drug. Our focus is on ensuring road safety and ensuring that people who are driving are not impaired in terms of the activities that they're doing.

JENNIFER MARTIN: Can I comment on that? In terms of the fairness, I'm not sure whether that's a discussion so much for us today because they're worried about patients, and about impairment and harming others from a health perspective. So the fairness, I can certainly see is an issue for others, but on a daily basis as a physician in the hospital I will have to take people's licences off them or tell them they can't drive because they've had a stroke or they are impaired in some other way, or there's a perception of impairment so we are waiting for

further testing. I understand that that is not fair and it is certainly perceived as not fair by that patient or their family sometimes. I think the fairness thing is slightly different to what we understand also from a health perspective.

I will say some words and I wonder if we can bring Bridin in at that point because I think there's a bit of a narrative around people having to take THC for a bit of pain here or taking THC for another indication. We need to remember that there's actually no evidence to support clinical use of any of the cannabinoids, apart from two small indications for cannabidiol, which is not the subject of today's discussion, for a rare form of paediatric seizure and for resistant multiple sclerosis. The patients that are getting prescribed on a script are able to access a special scheme through the TGA, which is not as a registered drug. It hasn't got the safety, quality or evidence data to support its listing but we are making it available for patient end-of-line therapy as a trial. Because it's end-of-line, these people are very sick and are often taking multiple medications. Therefore, they often should not be driving anyway. That's certainly the recommendation for many of our patients that do wish to take medical cannabis and drive. They're already on a number of medications and the cannabis is end-of-line therapy for these patients.

I think the fairness is an important thing to consider. Certainly for the safety of a patient's health and a quality practice for health, it's actually even unclear whether there's much support from the medical practitioners. I appreciate that you referred to the Lambert scientist twice but from medical practitioners generally and from our registration process there hasn't really been a lot of support for routine use of these compounds for the common medical conditions that you bring up, such as pain and insomnia. I just wondered if it might be helpful for my colleague who works more on the addiction perspective—I work more in general medicine—to discuss, if they are willing, about the patient group that we are talking about here that actually have access to THC and the fairness discussion.

BRIDIN MURNION: I might step back a bit and address one statement that was made by the Committee, which was about the use of cannabis to treat opioid addiction and dependence, which is probably what we would more call it. That is not recognised or evidence based or recommended within any New South Wales or Australian guideline. It is not a way to manage opioid dependence. Moreover, myself and colleagues from the Australian addiction research centre in Monash University recently published our second review of whether or not cannabinoids have a role in opioid-sparing. It is pretty clear with this meta-analysis of both animal and human data that we don't have any human data supporting that. That is very much in early scientific development. There is some animal data, but it's very specific animal data for very specific substances. So in terms of cannabinoids being used as management for opioid dependence or as opioid sparing, we don't have data to support that.

In terms of the use of cannabinoids in chronic pain in the database, supporting cannabinoids in chronic non-cancer pain—and I think you need to, when we talk about pain, differentiate between non-cancer pain and cancer pain. That is clinically what we do. We have different specialties dealing with them both. Clearly, there are different trajectories for both problems. The majority of people using medicinal cannabis in Australia, I believe, are doing so for chronic non-cancer pain. There is a paucity of data indicating benefit outside the situation of spasticity related to multiple sclerosis. There is some early data that there may benefit in other nerve pain-related conditions, but the data for the use of cannabinoids in chronic pain, specifically chronic lower back pain and fibromyalgia, which are the commonest pains, is very non-persuasive. It really doesn't suggest a role there. The best treatment that we would generally recommend for those conditions are exercise, weight loss and psychological intervention. We would also generally be steering away from long-term opioid use in that situation—in fact, increasingly so. Does that answer what you wanted to—

The Hon. ROSE JACKSON: It does. Although, I want to be clear that I didn't make up those comments in relation to people using cannabis and THC products to try to resolve their opioid—it is not as if I have just made that up. That was evidence that we have received from multiple witnesses to this Committee. I want to be clear on that.

BRIDIN MURNION: I appreciate that, but my recent meta-analysis since the stat review that was published in *Neuropsychopharmacology* about two months ago shows that, really, we have no robust data in humans that cannabinoids are opioid sparing in the sense that they help people reduce their opioid dose.

The CHAIR: I've got a couple of questions, just going back to the statistics that we were talking about before in terms of motor accidents that are related to cannabis use. Is it not the case that it would be impossible, or very difficult, to separate the motor accidents that are caused by cannabis impairment versus those that would just be as a result of people with a THC presence in their system? I assume you do not differentiate. I assume you do not because it would be very difficult, or near impossible, to differentiate.

BERNARD CARLON: There has been evidence earlier today around—I think there is binary discussion around the contributing factors to crashes. We do talk quite often around the speeding issue or the drink-driving issue or the illicit-drug issue. The reality of crashes is that they are multifactorial. There are a range of factors which come to bear. In these 259 drivers and motorcycle riders with the presence of cannabis in those 253 fatal crashes, 24 per cent also had illegal alcohol recorded, 13 per cent also had fatigue recorded and 55 per cent of them had speeding recorded. We do know in the analysis of those crashes where people actually have consumed cannabis that, in fact, they are more likely to involve alcohol and they are more likely to involve speeding because those behavioural factors are actually associated with that risk-taking behaviour. It is important to understand the road environment—I know that Michael Timms raised it this morning—the vehicle safety features and the road environment. There is a whole range of factors which cause the person who is in a crash to either die or be seriously injured.

There is agreement universally in the evidence that THC has an impairing effect on the ability to safely drive a vehicle. When combined with alcohol at any level, it actually is 40 times more likely to cause a crash involving serious injury or a fatality. That is the rationale for having a general deterrent program, an oral fluid and large-scale implementation of the detection of the presence of those drugs from recent use through an oral fluid system.

The CHAIR: I suppose, more accurately expressed, it would be "THC-related motor accidents" rather than "THC-caused motor accidents" because of the multifactorial nature of what you are talking about.

BERNARD CARLON: I think that we describe it as that it is present in the drivers and riders who were in control of those vehicles involved in the fatal crash, as were the speeding behaviours or a whole range of other factors as well. But the evidence, in the same way for drink driving—where for the last decade we have been telling people that, "If you are going to drink, don't drive"—is that every drink you have has some impact. We have set a legal framework around 0.05 for the general population but we have set zero for provisional drivers. In this instance, for these four illicit drugs, we have set, I suppose, a zero-tolerance approach to the presence of those drugs in an oral fluid screening program, which then gets validated by a secondary oral fluid sample being tested at a laboratory.

The CHAIR: I think it is important to measure those statistics because you might not be able to prove with 100 per cent certainty that those accidents were caused by THC, but nor could you prove with 100 per cent certainty that it was definitely not as a result of the THC. If you stop measuring that entirely, which may be a suggestion, then you wouldn't accurately be capturing that at all.

BERNARD CARLON: Yes. I think the key, when we look to the review of the legislation proposed in Victoria, is the need for additional research about the impact, from a risk perspective and road safety risk perspective, in relation to medicinal cannabis. There are gaps in our knowledge. There are different positions being put by different stakeholder groups as well.

PETER DUNPHY: To add to that, in terms of the way that we do report, we report on the behavioural factors. We know that certain behavioural factors can have an impact in terms of road crashes. You are right, the causative links are not always—you can't prove or disprove those. But what we do is try to unpack the data, as much as we can, to be able to identify those behavioural factors that we know can impact road fatalities and report on those across those different groups.

The CHAIR: It is sometimes very hard to prove causation. It could be just be very highly correlated rather than actually proving the causation on any accident.

PETER DUNPHY: That's right. But from a safety perspective you want to unpack, as much as you can, the information you've got around that particular incident. That's helpful, in terms of doing those safety assessments, to see whether there's anything more that can be done to prevent those fatalities.

BERNARD CARLON: I would just clarify that there is a significant body of evidence over the last 50 years in road safety research, and evidence that there are very specific results of particular behavioural factors causing crashes. There are very specific factors causing the level of either serious injury or death associated with the environment that those crashes happen within.

The Hon. GREG DONNELLY: Thank you all for coming along this afternoon and participating. I wonder if any of the witnesses have some insights into what happened in Victoria with the study they did down there and the consideration of the whole matter. Obviously it is referred to on page 8 of the submission, but does anyone have any particular knowledge of how it played out in Victoria?

Obviously, it was a contested area and it ended up in the way that it did. Is anyone who has an insight into Victoria able to comment?

PETER DUNPHY: I probably can't really comment on another jurisdiction's deliberations and how they landed on their outcomes. Generally I guess we can say, as I think you have experienced today, there is a lot of different divergent views and the research is incomplete. There is more research that needs to be done to further quantify issues. I guess we are working from a precautionary principle based on what we know around the evidence in terms of what behavioural factors are important in road crashes, and we do want to make sure that the work that we are doing is continuing to drive down the road fatality rate. I'm happy for my colleague Mr Carlon to add to this. I think it was very difficult to be able to rule out the knowledge of impairment and how much that translates to the road toll and to potential injuries, serious injuries and fatalities.

The Hon. GREG DONNELLY: I'll just take you to the final paragraph on page 8 of the submission. The first sentence says, "Laboratory tests and research studies show that the effects of THC on individuals vary more than with alcohol." Is part of the concern that with respect to THC there is a wider spectrum or a broader scope of understanding its impact on individuals compared to that of the consumption of alcohol?

PETER DUNPHY: I might ask my colleague Professor Martin to talk to that. I guess with alcohol it is something that is very clearly labelled in terms of the alcohol content in terms of consumption and use, and it has been more widely researched in terms of the intoxication levels and the impact. I'll hand over to my colleague.

JENNIFER MARTIN: I think that is a good point and it comes back to the earlier point that I made that there is evidence that you should prescribe or give people a trial of medicinal cannabis—people who are at the end of line of treatment—because these drugs are not registered, apart from the two that I mentioned. These are off-label indications for people for whom there is no other options and people are wanting to know whether this chemical might help them. They are usually people with cancer or at the end of life, they are people with other chronic diseases that have symptoms that distress them. These people vary depending on what disease or underlying condition they have, in terms of the amount of body fat even. If you are a big person with a lot of body fat you can store a lot of THC in that body fat that can leach out over time. If you are a thin cachectic person at the end of life you might get much more brain impairment from the same dose because you haven't really got a huge amount of distribution in the fat tissue.

What we are finding in the clinical trials that are running is that there is a significant variation in dose and the levels that we are getting. But, in addition, that relationship between the levels in the blood and impairment—in terms of how patients describe their sedation or their brain fogginess or their cognitive dysfunction—can vary significantly as well. It is so variable it has actually become quite difficult for us as clinicians to predict how someone is going to respond. So we usually start low, go slow. Just in relation to that, because these people are often on antidepressants and other pain medicines, they are frail and they have other diseases, they are already not driving. I think just that concern about the variability—because we cannot predict whether someone is impaired or not, we tell people not to drive if they are coming onto the clinical trial program or if they are being prescribed it.

The Hon. GREG DONNELLY: The issue of impairment obviously has featured a great deal over the course of today. I have asked this question before but I will bowl up again—about clarity around what impairment means. You have just referred to obviously discussions between a clinician and a patient and receiving feedback or comment from the patient and helping to elucidate the person's impairment or otherwise. How else is impairment understood, in terms of defining it?

JENNIFER MARTIN: I can talk from a medical perspective. My colleague might want to add in as well. It's a complex picture. There's no clean definition, but it usually involves the cognitive and/or a psychological and/or a physical and/or other features of impairment, which are measured objectively because it's very difficult when you're impaired to know you're impaired, just as if you're impaired because of a mental health issue. It speaks to our whole discussion around impairment and ability to consent for treatment. It's a very big discussion in the medico-legal area. But impairment is not usually how good you feel. A patient might say to you, "I drink this much but actually I'm not impaired." That's why we have these objective tests, to tell how impaired somebody is. But certainly from the cannabinoid perspective, depending on which cannabinoid you take, what other the drugs you're taking, what your disease and what your body shape is, your impairment may be more cognitive than physical or more psychological than physical. That's why it's such a complicated area, and people feel that it's so complicated that you can't be sure that a number or a cut-off figure in the blood would ensure comfort that you know that that person is or isn't impaired.

BRIDIN MURNION: I am so sorry, somebody has decided to drill a hole outside my window. If I can comment on assessing impairment, when we look at people who are using alcohol, they self-rate their impairment much, much lower than we would probably formally assess their impairment. So an individual's perception of impairment is much poorer than the objective analysis of impairment. In the sense of drug-related impairment, clinically for us, in the clinic, we may see someone—as I'm sure people have seen them on the street on a Friday

night, barely being able to stand up, and they're clearly very, very impaired. Lots of very subtle assessments, cognitive assessments and executive decision-making is quite difficult with complex tasks such as typing or writing a will or planning your day or going shopping. So it can be a fairly complex process of assessment in terms of impairment, but certainly with alcohol people underrate the [inaudible] compared to other measures.

BERNARD CARLON: We refer to the Victorian paper that was produced by the committee reviewing the legislation. I think it's useful that there's evidence on THC and road safety risk that shows that there's a global consensus that THC impairs key driving skills. That is supported by a host of psychometric, behavioural and on-road studies that have been published. In the document published by Victoria, there are appendices of all those research studies that demonstrate that THC causes risky driving behaviours such as lane weaving, inappropriate speed changes, following distance, reduction of reaction times, reduced capacity to divide attention and reduced vigilance. So there is a body of evidence that has been published over time in relation to recreational cannabis use. I think that the clear issue was that there is no significant body of evidence in the same vein with regard to medicinal cannabis, currently, because this body of evidence has been gathered over a significant period of time, and a lot of this new evidence for medicinal cannabis is emerging.

The Hon. LOU AMATO: Welcome everyone. Assistant Commissioner, I asked this question earlier to the Bar Association and they said it was a police discretion matter. Why would one person who has tested positive for THC be given a penalty notice and somebody else be given a notice to attend court?

BRETT McFADDEN: It's probably just helpful to understand the process generally. I think it's from about 2018 that there were some new measures where penalty notices were introduced to assist in streamlining the process—least invasive and detaining people. So there's an option for a penalty notice to be issued for a first offence for a positive indication of THC. The penalty is about $587, I think it is, which is consistent with a low range PCA infringement.

The Hon. LOU AMATO: That is a first offence and a six months loss of licence as well, isn't it?

BRETT McFADDEN: I'll take that on notice. But in terms of the penalty and the regime or where it sits compared to, say, alcohol, for our understanding. However, that's only for a first offence. So, if there are subsequent offences, that option is no longer available. However, on the first occasion, it's the environment—an appreciation of the circumstances in which that offence is identified. For example, it may be the first offence for a roadside drug test, but the particular individual may have an extensive traffic record. He may be a disqualified driver and may be subject to bail conditions for a whole range of other things. There may be factors in the wider investigation that actually involve—it might have been a domestic violence matter in play. There may be other things that come to the fore. They are the things that that original authority discretion is designed for, to say, "Well, let's look at the person and the circumstances in which we find them to give us options that are available to us." And for the safety of the individual or others concerned, it may be more appropriate that a court attendance notice is the appropriate mechanism to act on this particular offence because it's tied up with other matters, or there's antecedents that need to be considered, or the wider safety of the community. And so it's just merely a process of how it's looked at. I hope that assists.

The Hon. LOU AMATO: Thank you for clarifying that. If you just get a penalty notice, do you get a criminal record?

BRETT McFADDEN: If you receive a penalty notice and that notice is paid, there is no criminal record really associated with that. If you choose to take the matter to court—

The Hon. LOU AMATO: That changes.

BRETT McFADDEN: Certainly there is provision by magistrates to have no conviction recorded. It's merely you enter the justice system to have that sort of worked through, and it may be that at the end an outcome by a magistrate is that "I am satisfied", or not satisfied. If they're satisfied, the provision of no conviction can be available so it doesn't impede anything in the future.

Ms CATE FAEHRMANN: Is that subsequent times as well—just for clarity—the no conviction?

BRETT McFADDEN: Yes.

Ms CATE FAEHRMANN: Or if a magistrate is needing to—if a person comes before the court for a second or third time?

BRETT McFADDEN: So, if an infringement notice is given in the first instance and just, say, that is resolved in its own way, if the same individual experiences a second detention, there is no option to actually give an infringement notice. That goes to court, but you can't have a conviction recorded to you unless you've got a previous conviction in a court. So, it's an escalating cycle of there's an option for an infringement notice and there's

options to take the matter to court on the first occasion. So, really, in a pure instance, it wouldn't be until a third occasion that an individual would be susceptible to a conviction.

The Hon. ROSE JACKSON: Can I just ask a quick follow-up question? You may need to take this on notice. It's just in relation to a first offence only whether a penalty notice is issued or a court attendance notice is issued, how that is different for THC, methamphetamine, ecstasy and cocaine. Do you have that information?

BRETT McFADDEN: I can make some inquiries and get back to you before we close today. I will seek my assistance from the back.

The Hon. ROSE JACKSON: Potentially, you can take it on notice.

BRETT McFADDEN: I'm happy to take that on notice.

The Hon. ROSE JACKSON: I'm just interested in the percentages in relation to each of those different categories where a penalty notice is issued for a first offence or where a court attendance notice is issued.

BRETT McFADDEN: Okay. I'll take the question on notice, but in terms of some numbers that may assist generally: For our penalty notices—bear with me for a second.

The Hon. ROSE JACKSON: Perhaps Ms Faehrmann may ask another question.

Ms CATE FAEHRMANN: We have just got five minutes left. I just wanted to get some clarity from the NSW Health witnesses. Associate Professor Murnion, you were talking about the two legally—oh, where is it?

BRIDIN MURNION: Registered products?

Ms CATE FAEHRMANN: Yes, the ones that are through the ARTG. Can I just get clarity then? Is NSW Health trying to suggest that medicinal cannabis available through the Special Access Scheme is not as legal, if you like, or does not have as much standing as that available through the ARTG?

JENNIFER MARTIN: To me or to who?

Ms CATE FAEHRMANN: Professor Martin, we can start with you, if you like.

JENNIFER MARTIN: I'll steal your thunder, Bridin. So, the products are either registered with the ARTG or there are provisional pathways—I shouldn't use the word "provisional"—but there are Special Access Schemes where we can actually import drugs for our patients that aren't actually registered in Australia. So, there are two pathways: SAS B and a SAS A. The products that the prescribers are writing scripts for are all going through the SAS B, so they're not registered products. They do have to meet the TGO 93 standard, which is a very basic standard of making sure there are no aflatoxins and other chemicals in the cannabis products. So they go through a safety thing and they are TGO 93 approved.

Ms CATE FAEHRMANN: Is this a NSW Health opinion about the special access scheme in terms of medicinal cannabis in this State? Are you coming to this inquiry with a particular view about the special access scheme—that it is less legal, less safe, that people shouldn't be doing it and that GPs shouldn't be prescribing it? Because that's certainly the opinion that I have taken away from the evidence from NSW Health. Would you like to clarify?

JENNIFER MARTIN: It's not about legal, it's about a regulatory process that we have to ensure that our drugs are safe.

Ms CATE FAEHRMANN: Sure, but you know what this inquiry is about? This inquiry is about people who are taking legally prescribed medicinal cannabis. It doesn't matter which way they get it. It's legally prescribed. Whether it's from the special access scheme or whether it's from the one that you mentioned, it's the same though, isn't it, in terms of what we're arguing here today?

JENNIFER MARTIN: Not really, because when drugs are listed on the ARTG they have a body of efficacy and safety evidence. It's a much higher bar to get a drug listed on the ARTG. Because we don't have those products on the ARTG, we have another pathway to facilitate access for patients who need it through the SAS B. It would be great—

Ms CATE FAEHRMANN: Are you saying that NSW Health doesn't think the special access scheme should exist?

JENNIFER MARTIN: I haven't said that at all. The SAS pathway is a Commonwealth process. It's just part of our regulatory—

Ms CATE FAEHRMANN: I'm just wondering about the relevance. What we're inquiring into today is legally obtained medicinal cannabis. That's via the special access scheme as well.

JENNIFER MARTIN: Correct. The reference to that was to say that there isn't a body of evidence to support its use in clinical practice. So the only way that patients can access it legally at the moment is either through the SAS B or through clinical trials. That's what we're saying. But I think we have to be clear that it's not a drug that's widely used or widely accepted, or that there's evidence to support it in clinical use. It's a pathway for us to help our patients when we want to use it but haven't got—we haven't got a registered product. Does that make—

BRIDIN MURNION: If I might say as well, Jenny, that is a view shared by the TGA in most of their—on their website where they talk about cannabinoid products. They generally do recommend that people seeking cannabis products are involved in clinical trials and do acknowledge the paucity of data around many of the common indications. It's not about legality or illegality; it's about the evidence of efficacy and the role in treatment—

Ms CATE FAEHRMANN: The special access schemes did come in place. Just to be clear, there's a reason they came in place.

JENNIFER MARTIN: We use them for other drugs as well.

Ms CATE FAEHRMANN: Yes.

JENNIFER MARTIN: When there's no evidence yet for a particular drug—

Ms CATE FAEHRMANN: But they're needed.

JENNIFER MARTIN: —but as clinicians we're really struggling to give a cancer drug to a patient that's not available in Australia. We use the SAS pathway so that we can provide that to our patients, but we tell our patients they're not registered products and we don't have the efficacy data yet.

BRETT McFADDEN: Just to clarify, the point about the licence disqualification, it's three months, not six months. Just some data, in the period of 2020-21, there were 5,388 penalty notices issued and 4,561 court attendance notices. So there's a favour in terms of the penalty notice over a court attendance notice in terms of enforcement. I hope that assists with that inquiry.

The Hon. ROSE JACKSON: That was just for THC?

BRETT McFADDEN: No, that's for all drugs.

The Hon. GREG DONNELLY: On page 15 of the submission about the possible insurance implications, I'd like elucidation on that. There are three paragraphs there to make some comment. Is there anything you'd like to add to what's there? Or does that essentially reflect what—have you sought legal advice on this, or is this an opinion formulated by just thinking about the matter?

PETER DUNPHY: Thank you for the question. The submission was really identifying that there are obviously issues in the CTP insurance scheme that would need to be considered if there were changes, as with any changes that would impact part of the motor vehicle insurance scheme. Obviously that would need to be considered and factored into any future changes to SIRA's greenslip CTP insurance scheme.

The CHAIR: Thank you all for attending today and for your evidence. The Committee has resolved that answers to questions taken on notice be returned within 21 days. The secretariat will contact you in relation to the questions you have taken on notice. In addition to that, Committee members may have additional questions that could be submitted to you for our response as well. Thank you all for coming.

(The witnesses withdrew.)

The Committee adjourned at 16:01.