REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 1 – PREMIER AND FINANCE

INQUIRY INTO THE IMPACT OF THE REGULATORY FRAMEWORK FOR CANNABIS IN NEW SOUTH WALES

CORRECTED

At Macquarie Room, Parliament House, Sydney, on Wednesday 2 April 2025

The Committee met at 9:15.

PRESENT

The Hon. Jeremy Buckingham (Chair)

The Hon. Robert Borsak (Deputy Chair)
The Hon. Susan Carter
Ms Cate Faehrmann
The Hon. Dr Sarah Kaine
The Hon. Stephen Lawrence
The Hon. Cameron Murphy

CORRECTED

The CHAIR: Welcome to the fifth hearing of the Portfolio Committee No. 1 – Premier and Finance inquiry into the impact of the regulatory framework for cannabis in New South Wales. I acknowledge the Gadigal people of the Eora nation, the traditional custodians of the lands on which we are meeting today. I pay my respects to Elders past and present, 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 respect to any Aboriginal and Torres Strait Islander people joining us today. My name is Jeremy Buckingham, and I am the Chair of the Committee.

I ask everyone in the room to please turn their mobile phones to silent. Parliamentary privilege applies to witnesses in relation to the evidence they give today. However, it does not apply to what witnesses say outside of the hearing. I urge witnesses to be careful about making comments to the media or to others after completing their evidence. In addition, the Legislative Council has adopted rules to provide procedural fairness for inquiry participants. I encourage Committee members and witnesses to be mindful of these procedures.

CORRECTED

Professor JENNIFER MARTIN, Clinical Pharmacology Chair, NSW Health State Formulary, Clinical Excellence Commission, affirmed and examined

Mr BRUCE BATTYE, Director, Pharmaceutical Operations, Pharmaceutical Services Unit, Ministry of Health, sworn and examined

Dr SANTIAGO VAZQUEZ, Operations Director, Forensic and Environmental Toxicology, NSW Health Pathology, Forensic and Analytical Science Service, sworn and examined

The CHAIR: Good morning, everyone, and welcome. Thank you for making the time to give evidence. Would any of you like to make an opening statement, or do you have any introductory remarks?

JENNIFER MARTIN: I'd like to open with a very simple statement about the complexity of this plant, cannabis, and the drug product that we actually get from this plant. There are issues around whether this is a plant versus a drug, and some of the issues around the way we extract it and provide it to patients are quite different to how we use other drugs. There is some real complexity around the analytical aspects of measurement of the drugs in the body for this drug, but the analyte that we're measuring is the same, whether it's medically prescribed or recreational. There's some complexity around the regulatory pathway for prescription of what's called a TGO 93 product, which is a product that has been approved on a very baseline set of conditions, such as how much of the heavy metals would be able to be tolerated in a human, such as how much pesticide or microbe on the plant is tolerated, versus an actual registered therapeutic on the ARTG.

We do have two medical cannabis products that are listed on the ARTG. It's a complicated drug because it has a number of drug interactions, and those interactions are particularly with drugs that people who take cannabis take. You can see that by looking at the TGA website. Almost all or a significant proportion of those scripts are written for people with chronic pain and anxiety, and those conditions are often co-prescribed a number of drugs, such as opioids, antidepressants and other therapies which interact not just with the behaviour of the cannabis product in the body, but also the effect on the brain of having multiple drugs that actually affect the same organ. It's an area where there's a lot of contaminants and additives. A person who takes these products regularly might actually not know how the products they're taking from time to time are comparable.

I think there's an issue with replicability. That's why the ARTG-listed products are actually much easier for us in terms of using them from a clinical perspective, particularly if they're only TGO 93 approved. They might differ in batch and in time, even a script that a patient has in their cupboard. The products may well be different over the period of usage for that particular patient. There may be a difference between the amount of acid or drug or metabolite that's actually in a patient's batch. We actually don't know much about what that might look like for an individual product at a point in time or a particular patient.

The last point I wanted to make is that, as physicians and in health, we really focus on the safety of that person and the person that we're prescribing that product for. However, some of the safety that we have around the use of drugs, generally, we don't necessarily have for the cannabis products. That is because this particular drug can only can be prescribed by doctors who are not the patient's usual doctor, who may not be interacting with that patient's mental health team, with the other doctors that the patient sees for their other conditions. When that patient gets side effects from a prescribed TGO 93 product, the person that prescribed—or often it's actually not a person and this person has been able to obtain it over the web and not interacted necessarily with a doctor.

As practitioners, we can't actually find the person or a person that's responsible for the script and to know why that drug was prescribed. The person themselves often feels unwell. Because they may not have told their GP that they're actually sourcing this product outside, they don't necessarily want to go to the GP. If I or my colleagues get a call like that, we actually advise the patient to come to hospital if they're not feeling well. We wanted to really make the point that this product is complex to use and there are much greater effects on the person and the health system than a standard prescription of a standard drug.

The Hon. SUSAN CARTER: Thank you all for being here today. I will start with you, perhaps, Professor Martin. If I understand what you just said—and, forgive me, I'm not a scientist—there is a more complex issue if we were to regulate cannabis because of drug interactions and because people would be taking, commonly, a number of different drugs. What are the consequences of those drug interactions? I'm thinking with everyday activities, with ability to work, with ability to drive a car and that type of thing.

JENNIFER MARTIN: There are two types of interactions that we're seeing quite commonly. Firstly, some of the cannabis products stop the breakdown of normal drugs in the body. Drugs are broken down in the liver or in other organs—this particular one in the liver. But the cannabis products can stop the breakdown systems in the liver. That means that other drugs that are usually broken down in the liver, like antidepressants, their levels become very high and the side effects of those antidepressants are much more prevalent. Some of those

antidepressants might have a side effect of being sedated, for example. In addition, those drugs all work on the brain and so there's an additive effect on some of those side effects, such as confusion, sedation or sleepiness.

The Hon. SUSAN CARTER: If somebody was on, let's say, cholesterol medication or blood pressure medication and they were prescribed cannabis, would the cannabis interact and stop the effectiveness of the blood pressure drugs, for example?

JENNIFER MARTIN: It's more likely to lead to higher levels of those drugs. You might get more of an antihypertensive effect or more of a cholesterol-lowering effect. Those classes of drugs are typically broken down in the body usually by different pathways. But the antidepressant drugs and some of the opioids are the ones we're most concerned about because they are dependent on systems in the liver that break down drugs into inactive compounds.

The Hon. SUSAN CARTER: Did I understand you to say that there are two types of medicinal cannabis that are subject to more regulation and therefore higher reliability in terms of what is actually contained in the product, and that that would be the desired framework if cannabis was to be more freely available in the community?

JENNIFER MARTIN: From a health perspective, we prefer drugs to be listed on the ARTG, because that's the list of drugs that our regulator has ensured have proper manufacturing work done—that the batches are the same between the batches and that we actually have safety data, not just for a population, but across all the populations that are likely to be using the drug. They also have efficacy data, particularly information on different doses and different responses. All of that information has to be provided for the TGA to say, "This drug is safe and effective for Australians." We do have two cannabis products that have met that threshold. One is for some types of paediatric epilepsy and another is for spasticity in multiple sclerosis. The rest of the products to be prescribed under the Special Access Scheme are approved by what's called a TGO order, which is a minimum base of safety. It's not about efficacy. You basically have to meet these thresholds for how much heavy metal, microbe or pesticide is in your product before it's deemed appropriate to be available.

The Hon. SUSAN CARTER: If I can maybe translate that in a way that I can understand, the TGO standard is a food safety thing—making sure that there are no contaminants in milk, for example—whereas an ARTG standard is about being able to, with some degree of certainty, understand side effects, drug interactions and clinical safety for a person.

JENNIFER MARTIN: Yes, it's a much higher regulatory level. With the TGO order—and I know you've got a TGA specialist coming later—it's not that there are no heavy metals in it. It's basically saying, "This is the acceptable level for heavy metals, including arsenic and cadmium et cetera, that would be tolerable under this order."

The Hon. SUSAN CARTER: Can you give us some information about the potential effects associated with regular use of cannabis on driving, for example?

JENNIFER MARTIN: There's a lot of literature out there. I'm not going to go through all the literature today, but certainly it's well known that THC, which is one of the two main components that we've seen in a lot of the products that are available in Australia, does affect your reaction time, your ability to respond to external stimulus and your coordination et cetera. The cannabidiol appears to have less effect on that, and I think there's certainly been quite a difference in the regulation that's been applied in New South Wales around safety to drive with cannabidiol versus THC. However, cannabidiol does make you sleepy. People do use it to help them sleep. Certainly for a doctor talking to a patient about using cannabidiol, even though it might not be necessarily as illegal, it's still often recommended that people taking cannabidiol shouldn't drive because it actually might make them feel sleepy, particularly if they're taking other medications or if they're in some other way affected by a medical condition that might make their ability to drive less safe.

The Hon. SUSAN CARTER: Are there any studies which have demonstrated any causal links between cannabis legalisation and increased rates of mental health disorders such as psychosis or schizophrenia?

JENNIFER MARTIN: I think I'll take that on notice. There are certainly a lot of anecdotal reports from practitioners in the area that they feel they've seen more of this—that there have been more ED presentations. Another college, the College of Psychiatrists, have actually been in the media talking about the increased psychosis from the recent increase in availability of cannabis products. But in terms of the actual details, I would have to get back to you on notice.

The Hon. SUSAN CARTER: If you could take that on notice, I'd be very grateful. Mr Battye, perhaps I could ask you about challenges in regulating the quality and potency of cannabis products, because I think

Professor Martin outlined the different challenges with that. If it were to be regulated, can it be done? What would we need to do to ensure standardisation?

BRUCE BATTYE: NSW Health does not regulate the quality of the products. That's a TGA area. The TGA's jurisdiction is the quality of the products. Those which meet the standards of safety, quality and efficacy, they're the ones that they assess which end up on the Australian Register of Therapeutic Goods. What Professor Martin was referring to there was TGO 93. Again, that's a therapeutic goods order administered by the TGA and, in that case, they're not assessed for quality, safety and efficacy by the TGA. What they look at is contaminants and things like mould and that sort of thing, and that's about it.

The Hon. SUSAN CARTER: How do the regulatory frameworks interact? For example, if New South Wales was to legalise cannabis but other States had not, and we're relying on the TGA for those standards, how do those frameworks interact?

BRUCE BATTYE: The TGA regulates the product; that's all they do. When it comes to supply through the whole supply chain, whether it's from a wholesaler to pharmacy, dispensing, prescribing, labelling, storage and all those sorts of things, they're all under State and Territory regulation. That's the cut-off. That's where the line is. TGA regulates product and, in the case of non-ARTG products, the access to the product and getting through the border. But once it gets to the distribution or the supply chain, that's a State and Territory regulation, in all States and Territories.

The Hon. SUSAN CARTER: Given that medicinal cannabis is already legal, do you foresee any regulatory challenges in differentiating medicinal from recreational products, if legalisation were to occur?

BRUCE BATTYE: Are you asking me?

The Hon. SUSAN CARTER: Yes.

BRUCE BATTYE: Our area is really just the medicinal cannabis. TGA has another role, and that is the scheduling of medicines and poisons. Back in 2016 a delegate of the TGA made the decision to put medicinal cannabis into schedule 8 of the poisons schedule. Following on from that, all States and Territories then regulate that product as a schedule 8 product. Schedule 8 products are:

> Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.

That's the definition that they apply. As a regulator in New South Wales, what we're looking at is the licensing of wholesalers for schedule 8 medicines, the supply to pharmacies and the prescribing by medical practitioners or nurse practitioners. That's our remit.

The Hon. SUSAN CARTER: In terms of the prescribing—perhaps a question to the whole panel—the issue that Professor Martin flagged that the person prescribing the medicinal cannabis may not be the regular treating doctor, how does that come about? Why have we got different people prescribing medicinal cannabis, rather than the person who is responsible for monitoring the whole of the person's health?

BRUCE BATTYE: I'll go first. What's happened is, since medicinal cannabis could become available, from 2017 onwards, there has been the growth of third-party telehealth clinics springing up all over Australia, and the reality is that a lot of this medicinal cannabis is actually being prescribed via this telehealth model. That telehealth model is operated by third parties, generally. They employ doctors or nurse practitioners as their prescribers. They could be located in the Northern Territory or South Australia; they could be anywhere. The patients see these clinics—there's hundreds of them online—and they go directly to those clinics to get one product only, which is medicinal cannabis. Those clinics are set up not to provide whole-of-health care for the patient but to supply one product only, whereas the same patient may very well have a GP who they see for their blood pressure, asthma or what have you.

The Hon. SUSAN CARTER: But given the risks of drug interactions that we've heard, should there be more regulation around these one-off prescription factories that you've just described?

BRUCE BATTYE: Yes, there probably does need to be. But, unfortunately, if you look at the legislation that applies, they're outside our reach. Our jurisdiction is over the medical practitioners—the nurse practitioners, the pharmacists, the nurses. Anyone can open up a clinic. Quite often, even in the suburbs, your GP might be operating out of a clinic which is owned by a company who could be anyone.

The Hon. SUSAN CARTER: Did you have a comment, Professor Martin?

JENNIFER MARTIN: I was going to say that, from a physician's perspective, managing people that come in with, for example, psychosis—I know I don't have the numbers to give you—for example, there is some thought that for people that have dementia, sometimes their children think that their sleep will be improved by

prescribing a cannabis product. The GP may not want to prescribe that for the patient because they may know, for example, that earlier in life they did have a psychotic episode with recreational cannabis or that they've got all these other medical reasons that they don't want to prescribe cannabis. It is possible to then still be able to go outside the normal care model and get cannabis.

When the patient comes to hospital, the family often doesn't want the GP to know that their relative has been prescribed cannabis. It's actually quite difficult and complicated from a medical practitioner perspective. We like transparency, good discussion and data collection between people looking after a person. We think that's how you get the best health. But those communication systems are built up between the GP and their specialists and the community providers in the hospital. When someone else comes in and prescribes something else that's a one-off, for a start that person may not know all of their history, and certainly the other doctors may not know that this person has been given a cannabis product. It makes the care quite difficult and quite challenging. I was referring before to psychiatrists. They've actually been quite public in talking about this and the presentations that they're seeing. So I think it's a concern from a health perspective.

The Hon. SUSAN CARTER: It sounds as if the way in which medicinal cannabis is currently being prescribed and made available compounds health risks for patients.

JENNIFER MARTIN: From my perspective and my colleagues', we would say that it is making it very difficult to manage that patient's care.

The Hon. SUSAN CARTER: Are there any suggestions you have for how that could be addressed?

JENNIFER MARTIN: I see one of the issues being that although doctors can prescribe, we tend not to because the evidence isn't actually all that helpful, particularly in a comparative setting. We do have ARTG-listed products that we know work for sleep and we know they might work for other conditions. We have a lot of safety data and a lot of usage data across different populations, so we feel very comfortable with using those drugs. We don't feel comfortable with using a drug that doesn't have that efficacy data, even if it might be something the patient is requesting. If they feel they would like to try something else, other plant material, and we have psychedelics and other therapies, people certainly like to try those things to see if that will make them feel better. But it's certainly not something that a medical practitioner may feel warrants a prescription, based on the lack of efficacy and the concerns around safety, so they'll go elsewhere to get what they need.

The Hon. SUSAN CARTER: Dr Vazquez, what are the current capabilities and limitations of forensic toxicology in detecting cannabis impairment, especially in the context of road safety or operating machinery at work?

SANTIAGO VAZQUEZ: It's really difficult from a lab perspective to determine whether someone's impaired or not. From a lab perspective, what we're doing is we're objectively measuring concentrations of THC, whether that be in oral fluid, blood or urine, and potentially other matrices, depending on the situation. But we don't really comment as a lab on the level of impairment. We provide those data to the police pharmacology unit, and they make that assessment on the basis of the drug we see. For example, it might be THC, but there might be other drugs on board as well. So they look at the totality of the situation and see if there are drugs that have a summative effect or an additive effect and they cause impairment.

The Hon. SUSAN CARTER: For alcohol, it's .05 to .08. Is there a similar scale for THC impairment?

SANTIAGO VAZQUEZ: No, not that I'm aware of, although internationally there are various cut-offs that may be used for the level of the drug in blood, for example. It has to be in blood because that is indicative of something that is circulating in the body and may have that pharmacological effect. In some countries it is around two nanograms per mil. In other countries it is five nanograms per mil. But there is no literature that I have seen that says you can have a threshold level of .05 that is indicative of impairment.

The Hon. SUSAN CARTER: Is THC impairment similar to alcohol impairment in that we are told two standard drinks for women, three standard drinks for men? Does body size and gender affect THC impairment?

SANTIAGO VAZQUEZ: That's an area that's outside of my area of expertise. I am not a pharmacologist. There are a lot of factors that need to be considered: weight, metabolism, frequency of use, amount or level of dose given and concentration in that particular preparation. It's possibly a question best answered by Professor Martin.

The Hon. SUSAN CARTER: I am happy for anybody to jump in on these questions.

JENNIFER MARTIN: We're talking about blood measurements. We do have a reasonable understanding of the relationship between how much is in the blood and how the brain is affected. But you are correct that short-term use versus long-term use can actually affect that relationship. That's because the drug distributes round

all of the fat in the body. If you have used it long term, that relationship actually becomes less clear. The other issue that we have is if people lose weight, for example, and the drug has been stored in the fat, then we might see a release of that into the blood as well, and impairment.

We know that happens when someone has had an anaesthetic. They might be quite good after an anaesthetic, but then the very fatty drug, which is the same as the cannabis drug, then leaches out of the brain or other fat deposits into the blood, and people then feel quite sleepy. That is why there is often a period of not operating machinery or not driving a car after you've been exposed to any drug that can actually sit in a lipid store for a period of time. You actually don't have a clear knowledge of the half-life or the time taken to clear that drug from the body.

The Hon. SUSAN CARTER: In terms of the time taken to clear the drug from the body, I am thinking about THC impairment. We have got a rough understanding of how long you should wait after you've been drinking before you should drive without risk of being an impaired driver on the road. Do we have that data for THC?

JENNIFER MARTIN: We do have that data for the general population having a certain amount at a certain time. The problem we've got is that we don't really know how much will be in the body for some of the TGO 93 approved products. They're not standardised products. Again, as I said earlier, you might be taking a different amount of the drug by the time you're getting to the end of your bottle of the drug. I think it's that complexity that makes this drug very, very difficult to use clinically and why, as practitioners, we prefer to use the ARTG product. We know how that drug responds. We know the relationship between the dose and the effect on the body and how long it takes to clear that drug from the body.

The CHAIR: Professor, you just said you do have the data in that regard?

JENNIFER MARTIN: For those ARTG products?

The CHAIR: No, you were saying, society-wide, we do know how long it does take for your body to clear the drug?

JENNIFER MARTIN: That's correct—for a population, but not for an individual. That would depend on what other drugs they have been taking, whether they are taking other drugs that might prevent the breakdown of the products and whether there have been additives added to some of the TGO products that patients are taking. That is where the complexity is, not with the ARTG products. We know how to use those very well.

The CHAIR: Yes, but in terms of the data with the non-ARTG, could you provide that on notice?

JENNIFER MARTIN: Sure.

The CHAIR: I might just jump in and ask a couple of questions. What oversight does the New South Wales PSU unit have regarding doctors who decide to prescribe medicinal cannabis?

BRUCE BATTYE: In New South Wales we receive a lot of intelligence notifications that come to us—around about 2,000-odd a year—which includes also lost and stolen drugs as well. Quite often we get that intelligence from other prescribers, pharmacists and sometimes from patients as well. We have that sort of information. We also have SafeScript NSW. SafeScript NSW is a monitoring system which is available to medical practitioners, nurse practitioners and pharmacists to look into what the patient has had prescribed for them from the monitored medicines list, which includes all the schedule 8 drugs. It doesn't include all schedule 4 drugs, but it includes some schedule 4 appendix D drugs as well. By monitoring SafeScript NSW, we can actually pick up a lot of aberrant prescribing, excessive prescribing, dangerous prescribing—that sort of thing.

The CHAIR: How many medical practitioners in New South Wales are prescribing medicinal cannabis?

BRUCE BATTYE: I don't know the answer to that.

The CHAIR: So it's not compulsory for a doctor to inform NSW Health that they've decided to prescribe a particular medicine or medicinal cannabis?

BRUCE BATTYE: No.

The CHAIR: So we don't know how much medicinal cannabis practitioners are—

BRUCE BATTYE: If I could just explain a little bit further, to assist the Committee, what we do see is we see what's actually dispensed. The reason for that is that every schedule 8 drug in New South Wales and other drugs on the monitored medicines list automatically go into SafeScript NSW. With a prescriber in New South Wales, whether they wish to take up SafeScript and enrol in the SafeScript NSW program, that's up to them. It's not compulsory for them in New South Wales. But what we do see is we see what's coming out at the pharmacy

end, which includes not only those who are prescribing in New South Wales but, using the telehealth model, they could be prescribing for patients in other jurisdictions and we wouldn't know about that. We pick up those which are dispensed in New South Wales, and we can relate that to the prescribers in New South Wales or the prescribers interstate as well.

The CHAIR: So, in that way, you do know who's prescribing medicinal cannabis.

BRUCE BATTYE: For those—

The CHAIR: That are on the SafeScript.

BRUCE BATTYE: That's right, that we pick up on the database—correct.

The CHAIR: How many people are outside that framework, in your opinion?

BRUCE BATTYE: I wouldn't know. I suspect there would be some, but I wouldn't know the number.

The CHAIR: And those doctors are prescribing all kinds of different medicines. Why don't we have a compulsory system so that we know who's prescribing what?

BRUCE BATTYE: The decision with SafeScript NSW was to make it non-mandatory for prescribers. At the time it was introduced, my recollection is that COVID was still an issue for prescribers and also for pharmacists. I remember at the same time we also had a lot of floods in northern New South Wales. When SafeScript NSW was launched, that was in the background of the thinking—that these people who we rely upon to provide medicines, our doctors and our pharmacists, were already under a lot of stress in the circumstances.

The CHAIR: But we're not in COVID now, so why wouldn't we have a compulsory system so that we can assess if there's safe prescribing of all medicines?

BRUCE BATTYE: For all medicines?

The CHAIR: Well, say schedule 8 medicines.

BRUCE BATTYE: Schedule 8 medicines, yes. That's a policy decision that the Government would have to make, and I can only speak to the way it is at the present time. I might add that in some other jurisdictions where it is mandatory for prescribers to use a prescription monitoring system, there have been issues of compliance. For example, some specialists, they hardly ever prescribe. A cardiologist, for example, might be writing out the odd script here and now, and for those people, that means they'd have to take up the software and go into all of that. There's that consideration, which other jurisdictions have found has been an issue from time to time.

The CHAIR: Professor, you said that there's anecdotal evidence that people are presenting at EDs with psychosis or negative interactions with other drugs. How come we're not collecting that data, and what sort of numbers are we talking about here? Is it massive? Medicinal cannabis prescriptions have increased across New South Wales into the hundreds of thousands of patients. What sort of numbers are we looking at?

JENNIFER MARTIN: I can't give you an exact answer on the numbers. Certainly, through some work done by the ABC, psychiatrists have been very public about the number of presentations with psychosis, but I can get that that number to you. I think for many, particularly in the public health system, it's a matter of dealing with the patient who's unwell in front of you and dealing with those issues. There certainly have been concerns in the emergency department over people presenting with something called hyperemesis, which is vomiting that can't be stopped, and that's from the high-potency THC. These are often young people that sit in the emergency department, often for up to 24 hours, taking a bed because they need to be there, because they're sick and they can't take any fluids down.

A number of medications, including off-label medications, we may have to use to actually control that vomiting. As a pharmacologist, I do get called about some of those—for example, even the use of a derivative of a capsicum called capsaicin to actually rub on the abdomen to stop people vomiting. These are things that we might have seen irregularly in the past from people that had an addiction issue with cannabis, but we're now certainly anecdotally seeing across the board, not just young people presenting with such—I mean, these are really high-potency products, the TGO 93; some of them are greater than 98 per cent THC. It's quite different to some of the recreational use that might have been seen 20 years ago. I think we're seeing high-potency products, and we're seeing presentations with psychosis and hyperemesis—

The CHAIR: What do you mean when you said "across the board"?

JENNIFER MARTIN: In multiple different specialities. I guess I'm speaking as a physician, not a surgeon or a psychiatrist. A lot of these problems are from medicines that used to come into just general medicine

or geriatrics, but now these other practitioners in the ED and in mental health are seeing additional presentations with safety concerns around the use of some of these therapies. In particular, from a pharmacology perspective, I know that these are very high-potency medicines. Perhaps my colleague Bruce might like to speak on that fact of the potency, but it's quite different to, say, 10 or 15 years ago when, as a practitioner, you would see people that did smoke recreationally a few joints or cones, and they would come in with a particular presentation. This is on another level. These are people that we cannot control their vomiting because of high-potency THC.

The CHAIR: How many people are we talking about? There are hundreds of thousands. Are we talking about this being dozens and dozens of people a day? What sort of numbers?

JENNIFER MARTIN: I can't give you those numbers, but I will take that on notice. Certainly there has been an increase, and practitioners are talking about this. There are people that have written manuscripts about this issue, and certainly it was enough for the psychiatrists to talk to the media about the concerns they had with managing these products in the hospital setting.

The CHAIR: When there are red flags about prescribing patterns in New South Wales, especially with telehealth, how does the PSU deal with that? What are the red flags? What are you seeing in terms of practices that may cause you concern, and how do you respond?

BRUCE BATTYE: If I go back and give a little bit of context, Mr Chair, 2023 is when we realised through SafeScript—SafeScript NSW, I should explain, was rolled out across New South Wales throughout the whole of New South Wales in May 2022. During 2023 we noticed for the first time what appeared to us to be excessive volumes of schedule 8 medicinal cannabis products. I should clarify what I actually said before about scheduling with the TGA. At the time there was also a CBD product. Cannabidiol is actually schedule 4 but only at 98 per cent. It's very specific and there are some non-ARTG CBD products which are allowed also to be prescribed in Australia. What we actually picked up is what appeared to us quite excessive prescribing. The things we're looking at are actually the volumes going through being dispensed at particular pharmacies.

We also noticed that some of the patients were getting various opioids, psychostimulants, antidepressants, antipsychotics, benzodiazepines simultaneously. We noticed that some of the patients were also currently on the Opioid Treatment Program in New South Wales, so they're also getting methadone. That would generally be a different doctor. Some of the examples I can give you, a patient was prescribed 75 different medicinal cannabis medicines. We found over an 8½ month period a medical practitioner issued medicinal cannabis prescriptions which enabled a patient to receive 2,392 medicinal cannabis medicines at a cost of $348,000. Another example, again, over an 8½ month period we saw a medical practitioner who had issued medicinal cannabis prescriptions to a couple who were residing at the same address in New South Wales, and that couple received 3,590 units of medicinal cannabis at a cost of about $519,000. That was all dispensed at the one pharmacy.

The CHAIR: What tools do you have in your regulatory toolbox to deal with that? What's the response when you see something like that happen?

BRUCE BATTYE: What happens is we analyse that sort of data and then from that we have to decide on how we're going to address that. An investigation plan would be drawn up. The first point of call would be the pharmacy who is dispensing all that and we get all the data out of there. We look at the prescriptions. We also look at their storage at the same time. From there, we'll work out who the prescribers are and we'll address each of the prescribers. As I said, some of them are from interstate. Some of them are outside of our reach. Initially most of them that we were looking at were outside of our reach interstate.

The CHAIR: If they are outside of your reach, is there anything you can do about it?

BRUCE BATTYE: Yes. What we actually have done is—we can't investigate them. They're registered; their main place of practice is in another jurisdiction, so we refer them to AHPRA, the Australian Health Practitioner Regulation Agency. That's the process we go through with that.

The CHAIR: Is it symptomatic of a problem that the prescribing has across the board? Or is that an anomaly, an aberration? Do you think it's a problem across the cannabis prescribing regime generally?

BRUCE BATTYE: There is a lot of concern about the prescribing of medicinal cannabis. As I said to you, we started off having a look in 2023. In early 2024, AHPRA actually convened a meeting in Melbourne, which included AHPRA themselves, the Medical Board of Australia, the Pharmacy Board of Australia, TGA and all the State and Territory regulators.

The CHAIR: When did you say that was?

BRUCE BATTYE: That was February 2024. At that meeting there were presentations by Victoria Health. They had a PowerPoint presentation on the investigations that they'd undertaken. It showed exactly the same

things we were seeing. TGA, AHPRA—they all had presentations, and everyone expressed that they're all seeing the same sort of evidence that I'm talking about Australia-wide. Coming out of that meeting, there was a communiqué issued at the end of February from all the participants which said, "We've got to work together. We've got a problem here." So this is not a small-time issue; it's something that is apparent across Australia. All the regulators at different levels all recognise that this is an issue.

The CHAIR: What have you done subsequent to that?

BRUCE BATTYE: In New South Wales we then commenced further investigations—virtually the whole of 2024. As a result of that, we counselled some nurse practitioners and pharmacists, but then we also took regulatory action against some nurse practitioners, medical practitioners and pharmacists.

The CHAIR: Do you think it's possible that the problem with the medicinal cannabis prescription regime is that some patients are accessing it for adult use as recreational cannabis?

BRUCE BATTYE: Based upon, as I just explained, the couple of examples I gave you, I would think it was almost impossible for those people to be utilising the amount of medicinal cannabis that they were receiving, so the assumption is that they must be on-supplying to other people. The other—

The CHAIR: On-supplying is one issue, but is it possible that people are accessing medicinal cannabis, saying, "I've got back pain or anxiety" when they're really just looking for recreational cannabis?

BRUCE BATTYE: I think that is possible for sure, yes. I haven't seen any papers. I think the Australian Institute of Health and Welfare recently did a survey of users of cannabis, but I couldn't comment on that.

The Hon. STEPHEN LAWRENCE: Thanks to all the witnesses for coming along. It's really appreciated and helpful. Professor Martin, are you able to tell us, compared to other areas of research, how developed is the research on this interaction between cannabis and other medications? Is it an under-researched area or is it pretty well understood?

JENNIFER MARTIN: It's actually very well understood by the international pharmacology community. There are publications in American, European, British as well as Australian journals. It's well known and well understood. We did set up a statewide service to support practitioners using medicinal cannabis when the regulations changed because we knew that there would be patients who wanted their doctors to prescribe that. That was certainly in the evidence or the information and the guidance that we gave to practitioners. We have written documentation as well. It's on the NSW Health website. We provided that to practitioners who were prescribing it for the first time, to ensure that we could enable them to do it as safely as possible.

The Hon. STEPHEN LAWRENCE: Is it important that people accessing medicinal cannabis through these doctors get advice on the interactions with other medications?

JENNIFER MARTIN: Absolutely. And that was back to my original comment on the fact that the GP is the person who manages the patient's holistic care. They do send them out to odd subspecialists or specialists here and there, but the problem is that the GP is the font of all knowledge in terms of knowing what the patient has, what's happened to them in the past and the other drugs that they're on. So whenever that doctor will start a medication, they'll be checking for interactions and asking the patient to drop the dose of another therapy, for example. Following on, again, from that, the toxicity of drugs is often well known by a patient's GP, so they'll know that, when they've used something in the past that hasn't worked, they won't use it again. Once you break that communication up, and that model of care, then you lose that safety check for patients.

Coming back to the toxicity reporting—which I think you asked me, Chair, initially—a lot of that data is now not reported because practitioners are so comfortable, when they see a patient with psychosis who's been on THC, that it's not something that we would necessarily report to the TGA. I would but not everybody would because they're aware that these are common and everybody knows it's an adverse event with these therapies. That's common to all other drugs too. When they're first out, everybody reports everything because they don't know. Now it's just knowing that these drugs have these side effects so it's not, like, very interesting or novel news anymore. It's just a known thing.

The Hon. STEPHEN LAWRENCE: There's evidence before us already in the inquiry that millions of people are accessing cannabis through the illicit market, and there's evidence before us that there's very greatly varying strengths of cannabis in the illicit market. Should we be concerned about the fact that presumably those millions of people are not getting medical advice about interactions, because they're accessing the drug through the illicit market?

JENNIFER MARTIN: That's correct. Experience suggests that those people are actually also taking lots of other medications because they have things like chronic pain or other mental health disorders or issues, for

example, and they're seeking help for those. So, you're right, this is the reason why this medication needs to be much better looked after. If we put the patient first at the centre of where the information is, then I think that's much better for people's care. Another concerning thing that we see sometimes in presentations is people getting medicinal cannabis and they're also taking another product that they've received, sometimes at a market or a public place. They're taking the two therapies together and they're quite happy to tell you this. They might say, "Well, I took the medical product or even the ARTG product twice a day as prescribed," but they weren't getting enough relief so then they started taking other illicit cannabis as well, and now they've got these side effects. That becomes quite a complicated problem to manage.

The Hon. STEPHEN LAWRENCE: This issue of side effects, it's not just an issue for people taking cannabis as a medication, is it? It can be equally an issue for people that are using it recreationally who might be on other medication.

JENNIFER MARTIN: Yes, that's correct. Coming back to the numbers, we've seen people coming into hospital from recreational use in the past. It just appears that we're seeing so many more people coming in now with cannabis toxicity, often taking the prescribed product. I'm not aware of whether all of those people are also taking illicit product, but certainly I've been looking after people that have taken both. They're quite happy to tell you what they're taking and why they're taking it, but it just feels that there's a lack of overall management of that patient's health.

The Hon. STEPHEN LAWRENCE: What do you think is the best regulatory model to make sure that everyone consuming cannabis has access to advice? Whether they, obviously, choose to follow it is a different thing, but what is the best model for ensuring that everyone that is accessing cannabis has access to advice about the interactions with other medication?

JENNIFER MARTIN: There should be one person managing their care. In some jurisdictions it's a community health worker, particularly in regional parts of Australia. It may not actually be a general practitioner, but somebody that manages all of the health information for that particular patient and is their go-to person. In metro centres, obviously, it's a general practitioner, but it should be that person who is their family doctor, who manages that, because the hospital physicians and other physicians and psychiatrists have a good relationship with those general practitioners. These are models of care that have been built up over many years, and we have good communication. So if we are looking at models of care, that historical way of managing and communicating does need to be looked at as well. Certainly I would be pushing for a model where we can simplify communications and the patient, if possible, actually has control of their own data and knows which doctor and who's doing what.

The Hon. STEPHEN LAWRENCE: It's a relatively serious criminal offence in New South Wales to possess or even use cannabis. Do you think that's an obstacle to people generally, or maybe young people—there's obviously all sorts of different people out there—being frank with their doctor about their cannabis use or being frank with a pharmacist about it, those being the people that they might often be able to get advice from about these things?

JENNIFER MARTIN: I haven't seen that. People have always been very open in the hospital. I guess it's a trusting relationship with a health practitioner. But, as I mentioned earlier, sometimes if a family has accessed a product for a family member and that family member has got sick, we have been asking whether or not the other doctors on the team are aware of this. There's certainly been a concern around not giving that information back. It's hard to know whether that's a concern because it's illicit or whether it's a concern because the person has done something outside what their family doctor has been trying to help them with for a number of years.

The Hon. STEPHEN LAWRENCE: You can well imagine, though, for example, young people not wanting to tell their family doctor that they're smoking cannabis. You might have young people seeing doctors with their parents, for example. Do you think that the existence of a criminal offence of this nature obstructs people getting access to advice?

JENNIFER MARTIN: Not in my experience, but I don't look after people that are young enough to go to the doctor with their parents. I've always found that patients are quite happy to tell medical practitioners a lot of information: In fact, often tell us more than we were looking for. There's a whole duty of care and responsibility around what we do with that information, but certainly I think that people understand the confidentiality and the fact that that information is used to treat that patient in the best way possible.

The Hon. STEPHEN LAWRENCE: You don't think there's an issue about people getting access to prescription medication in circumstances where they haven't told their doctor that they're using cannabis but in fact they are?

JENNIFER MARTIN: I think that's a different issue than the illicit police kind of concern. Some people, particularly if they have a long relationship with their GP and the GP is unwilling to prescribe it because they

don't think it will help them and might cause some harm—we certainly have had patients that have told us they haven't told their GP for that reason.

The Hon. STEPHEN LAWRENCE: When I was a young person I became aware of this phrase, "Beer then grass, you're on your arse. Grass then beer, you're in the clear." It was a kind of rule-of-thumb understanding that young people had about how to manage the interaction between alcohol and cannabis. I was wondering if you could just speak to that?

JENNIFER MARTIN: Co-consumption of any medication, such as alcohol or cannabis, is not helpful for health. You don't know whether you're going to be the small percentage that will respond in a bad way. If you're talking about young people, everyone knows young people and their cohort that did very badly with a lot of alcohol or got very sick after smoking a joint, so I think there's always that concern of not knowing where a person might be on that spectrum. There may be something in that, but there are always people that get very sick from that combination. From a health perspective, that shouldn't be encouraged.

The Hon. STEPHEN LAWRENCE: For sure. Obviously it's a very serious issue in respect of motor vehicle accidents, and this interaction between alcohol and THC seems to come up a lot. To what extent does the criminalisation of cannabis interfere with public health messaging, with messaging in schools and different places? Are we actually not educating our young people enough about these matters because it remains a crime?

JENNIFER MARTIN: I can't answer that one, but I can certainly take that on notice. I'm not sure if anyone else on the panel can speak to that. Certainly from a health model we don't talk about the police aspect of it. We just talk about keeping healthy and understanding medications and making sure you're getting proper help for an addiction issue, particularly for young people who've had an addiction issue, whether it's cannabis or alcohol or many others, that's affecting their mental health or their ability to hold down a job. We do know that cannabis does have that effect on the brain. It does reduce your motivation. It also makes it difficult if you're in a job where you have to drive or operate machinery. These things do have an effect on young people and we really encourage people to get that help. But you've touched on another area which I also can't really comment on, which is access for young people to get help from an addiction expert, or from a mental health facility.

The Hon. STEPHEN LAWRENCE: The Royal College of Psychiatrists came along at one of our earlier hearings and gave evidence very strongly in support of decriminalisation of cannabis. Is that an issue that any of you would express a view upon?

JENNIFER MARTIN: I can express a view on the health aspects. That's certainly more a political point, I guess. From a health perspective, things that help people get the treatment that they need I think would be very well supported. If there's a link between those two, the health aspects would be incredibly supported. But, again, if it's not a criminal offence, you still have to be able to provide the health care and education and support for those people, whether it's criminal or not. I really encourage a focus on the health aspect.

The Hon. STEPHEN LAWRENCE: Any comment from you two gentlemen on that?

BRUCE BATTYE: Not from myself.

The Hon. STEPHEN LAWRENCE: Feel free to stay out of it. In terms of these very high THC content medications, is there any evidence that they're being used for non-medical purposes? Are they somehow increasing the access of the general community to these very high THC products? You've talked about people reporting to hospital sick. Are they people who have been using it as prescribed to them, or are they people that are somehow getting access to it through that legal system?

JENNIFER MARTIN: The first part is that sometimes, because these don't come from a normal standard pharmacy with all the pharmacy supports on it, they come from a distributor that comes through Australia Post and dropped at their house with some instructions on them about how to use the drug, the people do get a bit confused about how to actually take it. It might have some labelling on it about how much is in there, and people may feel that if they're not getting a response from that amount, they might just double it or triple it. It's certainly been a concern that we don't have the usual pharmacy support that, as doctors, we would like to have when someone gets a drug prescribed for them. I can comment on that; I couldn't comment on the other aspects. Can any of the team talk to that?

BRUCE BATTYE: Just one thing. I don't know how relevant it is, but the TGA has currently allowed 754 medicinal cannabis products to be accessed in Australia. They have them in five different categories. Category 1 is CBD 98 per cent, and that's the schedule 4 product. Category 2 is CBD dominant. Category 3 is a balanced CBD/THC product. Category 4 is a THC dominant product. When they say THC dominant, they mean between 60 per cent and 98 per cent THC. Category 5 is THC equal or greater than 98 per cent. What's interesting is of those 754 products, 513 of them are for the category 5, THC equal or greater than 98 per cent. It seems that

the market is definitely for where the highest possible THC is. I don't know—I can't link that to illicit use, but it indicates where the demand is.

The CHAIR: Those products would be like oils or distillates. They wouldn't be flowers, would they?

BRUCE BATTYE: Yes, they are.

The CHAIR: They are flowers?

BRUCE BATTYE: The category 5, 98 per cent. The growth in dried plant material is increasing, and the TGA actually mentioned that back in February 2024. I suspect that since then, because we're seeing it at our end very commonly, those sorts of products are being prescribed.

The CHAIR: Is that 98 per cent the ratio between THC to CBD, or 98 per cent of the product is THC?

BRUCE BATTYE: That's 98 per cent THC.

The CHAIR: But there's no flower on the market that is 98 per cent THC.

BRUCE BATTYE: I'm just telling you what the TGA has allowed with their product.

The CHAIR: I think the highest level of THC you can get in the market is about 30 per cent.

BRUCE BATTYE: I don't know—which market?

The CHAIR: If it was 98 per cent THC, it would just be a resin.

BRUCE BATTYE: The reality is there is dried plant material which is in category 5, 98 per cent THC.

The CHAIR: All right. Well, we'll take that as given. The time for questions has passed. We very much appreciate the work you do. We appreciate you coming along and giving your evidence today. It will greatly help the inquiry. There were some very important questions taken on notice. The secretariat will be in contact with you in due course for answers in that regard.

(The witnesses withdrew.)

(Short adjournment)

Ms EDWINA VANDINE, Assistant Secretary, Office of Drug Control, before the Committee via videoconference, affirmed and examined

Professor ROBYN LANGHAM, Chief Medical Adviser, Therapeutic Goods Administration, before the Committee via videoconference, sworn and examined

The CHAIR: Good morning to our witnesses, Professor Langham and Ms Vandine. Thank you for your attendance and participating in this hearing into the regulatory framework for cannabis. Thank you very much for making the time to give evidence. Do you have an opening statement to make?

ROBYN LANGHAM: I do. I'd like to start by the Therapeutic Goods Administration thanking the Committee for the opportunity to appear before the inquiry into the impact of the regulatory framework for cannabis in New South Wales, and thank you for the opportunity to provide a brief opening statement. I wish to acknowledge that I'm on the lands of the Wurundjeri people and I pay my respects to their Elders past, present and emerging. I also extend that acknowledgement to any other members of the First Nations community with us today. I will note that the Federal Government is now operating in accordance with the guidance on caretaker conventions, pending the outcome of the 2025 Federal election.

My opening statement is quite straightforward. It's really just to note that the role of the Therapeutic Goods Administration within the Department of Health and Aged Care relating to medicinal cannabis is limited to three things. One is to enable the access to unapproved medicinal cannabis products under the Special Access Scheme and the Authorised Prescribers Scheme, the other is to oversee quality requirements for medicinal cannabis products imported or supplied in Australia through the Therapeutic Goods Order 93, and the last is actions to address unlawful advertising of medicinal cannabis products. I thank you for your time and I welcome any questions the Committee may have.

EDWINA VANDINE: I have a very brief opening statement to allow the Committee sufficient time for questions. The Office of Drug Control, ODC, thanks the Committee for the opportunity to appear before the inquiry into the impact of the regulatory framework for cannabis in New South Wales and to provide an opening statement. I first wish to acknowledge the Ngunnawal people as the traditional custodians of the land from which I'm joining you today. I recognise any other people or families with connections to the land of the ACT and the region. I wish to acknowledge and respect their continuing culture. The ODC, within the Department of Health and Aged Care's Health Products Regulation Group, regulates and provides advice on the import, export and manufacture of controlled substances, as well as the cultivation, production and manufacture of cannabis for medicinal or scientific purposes to support Australia's obligations under international conventions. As Robyn said, I note that the Government is now operating in accordance with the *Guidance on Caretaker Conventions*, pending the outcome of the 2025 Federal election. I thank you for your time and welcome any questions from the Committee.

The Hon. SUSAN CARTER: Thank you both for being here and making your time available. Ms Vandine, I'll start with you. I'm just trying to work out the environment—the State regulation and Commonwealth regulation and how they sit together. What impact could cannabis legalisation in New South Wales have on any international drug control treaties to which Australia may be a signatory?

EDWINA VANDINE: Australia is a signatory to the Single Convention on Narcotic Drugs 1961. The United Nations Commission on Narcotic Drugs is the principal policymaking body of the United Nations on drug-related matters. They have the oversight of not only that convention but a few other conventions, such as for psychotropic substances as well. The Office of Drug Control is the national competent authority in line with the convention. These conventions aim to ensure the availability of controlled narcotic drugs and psychotropic substances for medical and scientific purposes, so they understand that there is a need for these drugs for alleviating chronic conditions and pain in society as well.

Their intention is also to prevent the diversion of controlled substances into the illicit channels. Under the single convention, cannabis is listed as a schedule 1 substance. Those are substances that are considered to have a serious risk for abuse. As the national competent authority under that convention, we are the Federal authority responsible for regulating the import, export and manufacture of controlled drugs to ensure access to essential medications. As I stated before, we're also responsible for regulating medicinal cannabis cultivation and production, so the domestic side of it as well. Principally, we are to prevent the diversion of narcotic drugs, and we also have reporting obligations to the International Narcotics Control Board.

The Hon. SUSAN CARTER: That explains the framework. If New South Wales legalised cannabis, what impact would that have on Australia's Federal and international obligations? What role would the Commonwealth

have? For example, you've just described a role in preventing diversion of regulated medicinal cannabis into recreational purposes. What role would you therefore need to play? How do the two systems talk to each other?

EDWINA VANDINE: Our responsibility is to ensure that cannabis is only allowed for medicinal or scientific purposes. As a signatory to the convention, it doesn't support the legalisation of recreational cannabis.

The Hon. SUSAN CARTER: With Australia as a signatory to a convention, arguably this then becomes a matter of Commonwealth legal competence rather than State legal competence.

EDWINA VANDINE: Correct.

The Hon. SUSAN CARTER: Are you aware of any unintended negative consequences in jurisdictions that have legalised cannabis, especially with regard to the spreading of illicit drug markets?

EDWINA VANDINE: The INCB, the International Narcotics Control Board, is aware of and does have concerns about certain jurisdictions, particularly the commercialisation or cultivation of cannabis for non-medicinal purposes. They do hold concerns that that is not aligned with the convention.

The Hon. SUSAN CARTER: Professor Langham, we have medicinal use of cannabis in New South Wales, and that's been legalised on an evidence base. If we move to legalise recreational use of cannabis, is it the same evidence base? Are there different issues in understanding the evidence base of medicinal cannabis and recreational cannabis and therefore understanding the risk profiles of each?

ROBYN LANGHAM: Thank you for your question. Perhaps, in clarifying the first statement, medicinal cannabis is made available. Of the many hundreds of products, only two of them are registered on the ARTG, so only two of them have gone through that process of evidence base, as you were saying. That's two products. One is called Epidiolex and the other is called Sativex. They're absolutely just indicated for either a rare form of paediatric epilepsy or for spasms in multiple sclerosis. Apart from those two products, the rest have not undergone a process of approval by an evidence base, so they are considered what we would call in Australia unregistered or unapproved products. The TGA's role here is really to provide the access scheme and not to have any role in determining whether these products are safe or efficacious, with the exception of our role in the TGO 93—the order looking at quality. The decision to make that access available was a decision of government. I guess that's just clarifying the first part of your question. You'll have to repeat the second question for me.

The Hon. SUSAN CARTER: You've answered it, in a sense, because we understand that there are risks associated with anything that we take or use. There are studied risks in relation to TGA-approved products, but there would be other forms of cannabis that would be used recreationally. I'm just trying to get an understanding of where the evidence base is for the risk profile associated with those recreational products that are not TGA approved.

ROBYN LANGHAM: As I mentioned, the vast majority of medicinal cannabis that's available and accessed in Australia is not evidenced, as it has not gone through an evidence process. When you're talking about legalisation, broadly, of all cannabis products, I guess the best evidence we have is the experience of international jurisdictions who've gone through that process. One of the best available experiences is that of Canada, who have noticed, since legalisation, that cannabis use is higher. I think their quoted figures are something like around 22 to 25 per cent of Canadians over the age of 15 are using cannabis on a POINT study basis. They've also noticed that, although their cannabis-related drug offences dropped and more Canadians were obtaining their cannabis legally, there were some effects in terms of safety and hospitalisation data. I don't have that data with me. I can certainly take that on notice and provide that to you later, in terms of the after-effects, if you like, in jurisdictions that have moved to broad decriminalisation.

The Hon. SUSAN CARTER: If you could do that, I'd be very grateful.

ROBYN LANGHAM: Happy to.

The Hon. SUSAN CARTER: If cannabis were to be legalised in New South Wales, are there mechanisms and is the TGA involved to stop the diversion of medicinal cannabis for recreational purposes?

ROBYN LANGHAM: The role of prescribing medicinal cannabis—the decisions around who does prescribe—rests with the practitioner here. The TGA does not make any decisions, as I've said, bar these two minor products—not minor products but two products that are used in the minority of cases. The TGA only oversees the access program. Decisions about prescribing, about suitability, about potential side effects and about understanding the current evidence for their use, all of that rests with the prescribing clinician. That is, by and large, registered medical practitioners but, in some States, that also extends to nurse practitioners. In terms of our legal basis for being able to affect diversion, again, that would probably be a question for the legal team of the TGA and I would have to take that one on notice for you.

The Hon. SUSAN CARTER: If you could, I'd be grateful. Thank you very much.

The CHAIR: There have been two products approved by the TGA that you referred to: Sativex, and the name of the other one escapes me.

ROBYN LANGHAM: Epidiolex.

The CHAIR: Are there any others that are in the process of being approved?

ROBYN LANGHAM: The process of approval requires a sponsor to submit a dossier to the TGA that demonstrates safety, efficacy and quality. Those two products have been presented to the TGA by those specific relevant sponsors. There have been no others that have presented, and none that I'm aware of that are currently in the process of doing so. So we have close to 1,000 products that are being prescribed in Australia that have not been presented to the TGA for registration.

The CHAIR: Why is that? Because my understanding is that those first two products were approved relatively early on. Why are there no other products going through that process?

ROBYN LANGHAM: That's really a question for the sponsors, for the developers of these medicines. The TGA does not have a proactive role in trying to find products that may or may not be suitable for registration. Our legislated role is to be the regulator and to have products sent to us by process of application.

The CHAIR: Is it a lengthy process? Is it an expensive process?

ROBYN LANGHAM: We are a cost-recovered organisation. Sponsors need to pay a fee for application for registration. We have legislated time frames by which we need to be able to turn around an application. We have other pathways which are available for priority or provisional approval as well. If the particular condition that's being treated is of such an urgency, those time frames can be shortened.

The CHAIR: We've heard evidence that many hundreds of products have been approved under the Special Access Scheme—700 or so. In terms of quality control, how is that done? Is there an initial assessment? I assume there's an initial assessment of the quality of a product, but is there an ongoing assessment? Are these products audited routinely?

ROBYN LANGHAM: Your initial statement was that there are over 700 products currently approved under the SAS. We don't approve the products; we approve the practitioners to prescribe the product. They apply to us for approval to access. The process of ensuring that aspects of the Therapeutic Goods Order 93—in mid-2023 there were a couple of aspects to it. One is that there are requirements for manufacturing known as good medical practice, which is a licensing process. All manufacturers, both in Australia and external, attest and must adhere to the requirements of that licensing. The TGA has certainly assisted many sponsors and manufacturers transitioning to those new requirements, working closely with industry associations and responding. We perform inspections of the manufacturing sites rather than do an audit, if you like, of the products that come to hand.

The CHAIR: But internationally you're relying an attestation from those manufacturers that they're according with GMP, but you can't do an audit of—

ROBYN LANGHAM: We do international inspections, as well, of overseas medicinal cannabis manufacturing sites. In some cases, those overseas manufacturing sites have achieved a licence and have ongoing inspections by the local regulatory jurisdiction, depending on which country they're in. We've performed, I think, eight inspections of overseas medicinal cannabis manufacturing sites: three in Canada, two in the US, two in Colombia, one in Lesotho. The certificates are issued on the basis of those inspections as evidence of GMP compliance for the purpose of TGO 93.

The CHAIR: I have a question for Ms Vandine and the Office of Drug Control. In terms of the Office of Drug Control, we have heard concerns from domestic manufacturers that imports may be leading to an oversupply in Australia that may disadvantage local producers. Does the ODC monitor the balance of supply and demand when it comes to the domestic consumption and supply of medicinal cannabis?

EDWINA VANDINE: At the moment, we don't have any data to suggest that there is an oversupply of medicinal cannabis in Australia. What we are seeing is that demand has been increasing. We have a permit process for our applicants—for our domestic cultivators, producers and manufacturers. We have approved what could be a sufficient amount for those permit holders to be able to produce to meet the demand. What we have been seeing historically is that what has been approved and what they have actually done doesn't come to almost 50 per cent of what's been approved. At this point in time, the data doesn't suggest that there is enough being cultivated in Australia to meet the demand. As you talked about, we also import medicinal cannabis. The Office of Drug Control is responsible for administering the import and export licences and permits. If the Government decided to prevent the import, it could have a significant effect on supply in Australia as well. There could be a risk, if there was an

environmental disaster or any other natural disaster, that it could impact the Australian cultivators and producers. That would have a big impact on patient access to it as well. If we were to prevent the imports, it could reduce the competitive market. There could be flow-on effects to the cost as well. If there is a big impact to the cost, it does mean that the patients may then turn to illicit sources.

The CHAIR: What proportion of the market is being supplied by imports? Has it changed over time?

EDWINA VANDINE: I have data from 2023. We are still consolidating the 2024 data. In 2023, 37 per cent was from Australia, 51 per cent was from Canada and below 3 per cent was from other sources.

The CHAIR: It is interesting about the amount coming in from Canada. In terms of the various licensing regimes, could you just explain the difference between the regulatory pathway for someone who is looking to obtain an import licence compared with someone who is looking to become a domestic manufacturer and supplier?

EDWINA VANDINE: An application can be made to import medicinal cannabis from another country that is a signatory to the convention. For the reasons why someone might be importing, as part of the application, they have to indicate whether it is for the special access scheme or clinical trials. We do a quick police check and so forth. They would also be required to either have a medicinal cannabis licence or permit under the Narcotic Drugs Act or hold a State-relevant licence to be able to import. On the domestic side, we administer the licences and permits for cultivation, production and manufacturing. As part of that, they also have to indicate what their supply pathway is after that process. The first step is that they have to be able to obtain a licence, but that doesn't actually authorise them to start cultivating, producing and manufacturing. We look at whether they're a fit and proper person to be able to hold a licence. That then gives them the knowledge that, once they've got that licence, they can actually start investing and building their facilities as well. When it comes time that they wish to start the actual activity, they apply for a permit, and that permit is then valid for 12 months.

The CHAIR: Do importers have to license a facility as well? Do the distributors of the cannabis and the handlers in the logistics chain all have to be licensed as a processing facility, in terms of importation?

EDWINA VANDINE: From where they're exporting from, they have to meet their obligations in that country, and that will be governed by the convention as well. The country from which it's been exported has to meet the requirements of the convention. Often they'll incur any of the fees at that point. Once it's imported, once it's cleared the border, it then moves into the State and Territory regulations.

The CHAIR: And so the ODC has no role in regulating or licensing facilities or logistics across the country?

EDWINA VANDINE: No, but I'll correct if that is incorrect.

The CHAIR: How many cultivators and producers have been licensed and are operational in Australia, and potentially New South Wales, at the moment?

EDWINA VANDINE: We have 82 licence holders; that was at 28 February 2025. However, not all of them will hold a permit, so we actually have 29 entities hold a cultivation and production permit, and 10 hold a manufacture permit as well.

The CHAIR: How many of those are in New South Wales? Could you take that on notice?

EDWINA VANDINE: We'll take that on notice, thank you. Sorry, to your question on how many are in New South Wales, as of 28 February—these are permit holders—there are four that hold a cultivation and production permit, and there are two that hold a manufacture permit.

The CHAIR: How do regulators coordinate between the Federal and State levels? Is there a round table that you go through? What entity, if any, looks at the interaction of State and Federal regulation in this area, and reforms et cetera or issues as they emerge?

EDWINA VANDINE: We do meet regularly with the State and Territory departments, both law enforcement as well as the health and primary industry departments.

The CHAIR: What about the TGA?

ROBYN LANGHAM: Sorry, the TGA in the sense of—

The CHAIR: How do you coordinate the regulation? Is there a framework for you to discuss issues that are emerging in this space with relevant State agencies?

ROBYN LANGHAM: Yes, we have regular meetings with stakeholders. This is a very complex area, as I'm sure you can understand, of the regulation of this system, given that we're responsible for regulating the product, AHPRA is responsible for regulating the clinicians, and the States and jurisdictions have their own roles

as well. So in the last 12 months I think we've had two broad stakeholder meetings to talk about specific issues in this space.

The CHAIR: What are some of the issues that have been coming up? We've heard some issues about prescriber practices. What are some of the issues that have been on the agenda?

ROBYN LANGHAM: From a TGA perspective?

The CHAIR: Yes.

ROBYN LANGHAM: I'm not really sure I'm able to comment, given our caretaker convention at the moment—apologies.

The Hon. STEPHEN LAWRENCE: Thanks, witnesses, for your attendance. Ms Vandine, just a couple of questions for you, firstly. Am I right in thinking that the 1961 convention is the main international instrument that obligates Australia to criminalise cannabis?

EDWINA VANDINE: The Criminal Code in Australia, that makes it—at a Federal level, there's an offence for the possession. The convention is also open to other measures as well, not just criminalisation. There is a large focus on education, also measures for decriminalisation and depenalisation for personal use as well as possession, but not for the cultivation of cannabis or the commercialisation.

The Hon. STEPHEN LAWRENCE: So your understanding of the international law position is that there's no prohibition in the instruments that Australia is bound by on decriminalisation broadly?

EDWINA VANDINE: That they're bound by it?

The Hon. STEPHEN LAWRENCE: There's no problem in terms of our international law obligations with decriminalisation of small-quantity possession, for example.

EDWINA VANDINE: They've made it clear in their report that they are open to measures of decriminalisation and depenalisation. That's in their 2022 report.

The Hon. STEPHEN LAWRENCE: And they're certainly open to diversion of users from the criminal justice system?

EDWINA VANDINE: Of personal use?

The Hon. STEPHEN LAWRENCE: Yes.

EDWINA VANDINE: Yes.

The Hon. STEPHEN LAWRENCE: The ACT has decriminalised, as I understand it, the possession of small quantities of cannabis. Are you on top of how that decriminalisation interacts with the Federal Criminal Code offence of possession?

EDWINA VANDINE: The Criminal Code covers it federally. Under the Federal law, there is still that offence for possession, whereas under the ACT, they have decriminalised possession of small quantities. The concern that is held, though, is that it also decriminalises cultivation.

The Hon. STEPHEN LAWRENCE: Around the time of the passage of the ACT law, there was some discussion about—I think it might be section 313.1 of the Federal Criminal Code that creates a defence to Commonwealth liability where conduct is justified or excused by or under a law. There was some political level discussions where the then ACT Attorney-General said that they believed that that would create a defence to any Federal prosecution, and the then Commonwealth Attorney-General, Christian Porter, had a different view, and he said that he would expect the AFP to continue enforcing Federal law in the ACT. Has that discussion, to your knowledge, gone anywhere in terms of whether 313.1 of the Federal Criminal Code is considered to provide a defence to a possession because of the ACT law?

EDWINA VANDINE: This might be more of a question for the Attorneys-General.

The Hon. STEPHEN LAWRENCE: To your knowledge, since the ACT decriminalised, acting under the Federal law, has the AFP sought to commence criminal proceedings against anyone for small-quantity possession?

EDWINA VANDINE: Sorry, I won't be able to answer that question.

The Hon. STEPHEN LAWRENCE: In terms of some evidence you gave earlier to Ms Carter, she asked you about legislative competence of State and Federal parliaments. I think you agreed to the suggestion that, because of the international legal obligations, that decriminalisation or legalisation would be a matter within the

competence of the Federal Parliament, rather than State or Territory parliaments. I think I've fairly summarised that. I want to ask you a couple of questions arising from that. In giving that answer, you weren't suggesting that, as a matter of Australian domestic law, it wouldn't be open to State or Territory parliaments to decriminalise or legalise, were you?

EDWINA VANDINE: At the Federal level, if the Federal Government was to legalise or decriminalise, that would be a matter for the Federal Government.

The Hon. STEPHEN LAWRENCE: Sure, but you weren't suggesting, for example, that what the ACT did is somehow not within the competence of the Territory Parliament?

EDWINA VANDINE: That would be another legal matter for the Attorneys-General.

The Hon. STEPHEN LAWRENCE: You weren't suggesting that it's somehow outside of the power of either State, Territory or Federal parliaments to legislate inconsistently with international law, were you?

EDWINA VANDINE: If a State or Territory were to legalise cannabis for recreational purposes, a breach of the convention does have an impact as well. We could be prevented from importing, which would impact access for patients as well.

The Hon. STEPHEN LAWRENCE: Let's say there was decriminalisation of small quantity possession, which you've said isn't inconsistent with the relevant conventions. How would that sit with any risk to importation?

EDWINA VANDINE: It may be okay. We'd have ongoing conversations as well with the International Narcotics Control Board.

The Hon. STEPHEN LAWRENCE: It wouldn't necessarily lead to revocation of those liberties under the convention?

EDWINA VANDINE: There would be conversations but, yes, there's no definitive answer, until we would have those conversations. We'd have to see what the proposals are as well to be able to make a definitive answer.

The Hon. STEPHEN LAWRENCE: To your knowledge, has the Federal Government sought to use their power under the self-government Act to disallow the ACT decriminalisation laws?

EDWINA VANDINE: Sorry, it's another question for the Attorneys-General.

The Hon. STEPHEN LAWRENCE: What's the mechanism, to your knowledge, under these narcotics conventions and the like to vary the conventions, so to change, for example, the prohibition on cultivation for recreational purposes and things like that?

EDWINA VANDINE: It would need to be taken to the convention and then agreed by all.

The CHAIR: How many approvals has the TGA made for access to medicines? Do you track that? Essentially how many doctors and their patients have been approved for access to medicinal cannabis?

ROBYN LANGHAM: We can't really provide accurate numbers of the number of patients because one patient could be associated with multiple authorised prescriber approvals from the same prescriber or multiple single approvals for different products. The majority of our approvals indicate that, when we combine chronic pain and anxiety, we have around 600,000 approvals. But then that may not necessarily reflect the number of patients. Our authorised prescriber process gives us six-monthly details and doesn't contain any patient details so we can't understand whether those are duplications. Equally, we don't hold any prescription data.

The CHAIR: Just a question to the Office of Drug Control, what is the quantum of cannabis being approved and used as medicinal cannabis in Australia in total? How many tonnes are we importing? How many tonnes are we producing in Australia?

EDWINA VANDINE: The amount that was imported—are you okay with just 2023? I've got 2021, 2022 and 2023.

The CHAIR: Yes, that's fine.

EDWINA VANDINE: In 2023, 42 tonnes were imported. We also exported just over two tonnes. The amount that was produced in Australia was just over 26 tonnes. That's of dried flower.

Ms CATE FAEHRMANN: I've got a question for the TGA: Whose responsibility is it to develop clinical guidelines for clinicians for medicinal cannabis? Is that the TGA's responsibility or does it sit with another group?

CORRECTED

ROBYN LANGHAM: The TGA has no legislative capacity to give clinical guidance or clinical advice, as we are the regulators of products only. When the Federal Government made a decision to establish or to make available medicinal cannabis under the Special Access Scheme and Authorised Prescriber pathway, there was some work done back in 2017 on an evidence base surrounding a certain number of conditions. I think it's fair to say that that was 2017 and now it's 2025 and there have been some changes made to those guidelines to make them contemporaneous, certainly for the patient-facing process. But really the clinicians who are prescribing them would look not only to the existing TGA documents that are there but also externally to the college of GPs. The Royal Australian College of General Practitioners have a document on their website. There are also some other international documents that are available. But the responsibility for clinical guidance does not sit with the TGA.

Ms CATE FAEHRMANN: If there's a specific opioid that's marketed by a global pharmaceutical company, for example, that the TGA has—what's the word for it?

ROBYN LANGHAM: Registered, approved.

Ms CATE FAEHRMANN: Thank you—approved. That pharmaceutical company would provide, I assume, very comprehensive guidelines for clinicians. We have hundreds of prescribers who apply for the Special Access Scheme and hundreds of products, but they don't necessarily have that level of clinical guidelines that are provided within—there does seem to be a gap there where the global pharmaceutical companies have the resources and the incentive, if you like, to provide that. Is it not necessarily the role of the RACGP to do that for everything? Is there a gap there that you can see?

ROBYN LANGHAM: According to our legislation, it is the responsibility of the clinician to be able to be across the research, the evidence and the suitability of that drug for the patient. Without a drug being presented for registration, and without all of that relevant data demonstrating safety, efficacy and quality, the TGA is not able to do that. Absolutely under our legislation, it's the responsibility of the clinician.

The CHAIR: Thank you. We very much appreciate your attendance and the evidence you've given today. It will greatly inform the inquiry. I think there might have been one or two questions taken on notice. If there were, the secretariat will be in contact with you in due course. Thank you very much for the work you do.

(The witnesses withdrew.)

Dr TERESA NICOLETTI, Chair, Australian Medicinal Cannabis Association, affirmed and examined

The CHAIR: Good morning, Dr Nicoletti. Would you like to make an opening statement?

TERESA NICOLETTI: I am a partner at Mills Oakley Lawyers. I'd first like to give you a brief summary about AMCA, the Australian Medicinal Cannabis Association, and then a brief snapshot of AMCA's position in relation to this inquiry, which I'm sure will prompt many questions from you. Firstly, I co-founded AMCA in 2020 with Lucy Haslam, who, I'm sure you know, is probably the most highly regarded advocate in the medicinal cannabis sector for her pioneering work, which I think actually led to the legalisation of medicinal cannabis. We saw a need for an association that considered the interests of all stakeholders. We also have another association, the Medicinal Cannabis Industry Association, which is more focused on industry, but we felt that the stakeholder interests needed to include clinicians, other healthcare practitioners like pharmacists and also, of course, patients.

AMCA is not for profit. It's registered with ASIC and ACNC, and it also has DGR status. We exist for and only through the generous support of our membership, so we have a range of fees to enable individuals at all levels to become members. We just have enough funding to survive so that we can do the work that we need to do to facilitate the industry. We have a board of directors, and our focuses include supporting veterans, changing the drug-driving laws, making medicinal cannabis more affordable to patients and creating a more even playing field within the industry for domestic and imported products. We have more than 500 members so we're by far the biggest association.

If I can turn to a brief position statement, as the largest membership association in the medicinal cannabis industry, we recognise that the landscape for cannabis use in Australia is evolving. In addition to the legalisation of cannabis for medicinal purposes in 2016, cannabis use in more recent years, particularly with the ACT legislation, has been shaped by the legalisation of cannabis for personal adult use. This, perhaps, represented the first shift in Australia's change in cannabis policy and now there are further proposals in Victoria and New South Wales to follow similar pathways to legalisation for personal use in those States.

From the perspective of AMCA and the medicinal cannabis industry more broadly, what we would like the Committee to appreciate is that the legalisation for personal use needs to be distinguished from the use of cannabis for medicinal purposes. AMCA's primary concern is to ensure that any steps that are taken towards broader legalisation of cannabis for recreational purposes ensure the viability of the medicinal cannabis industry, which many Australian stakeholders have invested very heavily in. One thing we do acknowledge, however, is that the legalisation of cannabis for adult personal use in the ACT appears to have, ironically, played a role in reducing stigma towards cannabis generally and increasing public awareness about cannabis as a substance, and it has perhaps led to broader acceptance of cannabis's potential benefits.

Ironically, this shift in perception may have actually assisted the medicinal cannabis industry as more members of the public and healthcare professionals become more comfortable with its use. However, I have to add that the limited proposed use of cannabis for adult personal use is very different from some of the models in other jurisdictions, which include much broader recreational use for retail sale and setting up of different markets for cannabis use. I think the medicinal cannabis industry would have a lot more to say if a proposal was put forward to legalise cannabis more broadly than what is proposed by the New South Wales bill. The legalisation of cannabis for personal use does present some challenges.

First and foremost, legalising adult personal use on the one hand while maintaining road traffic laws that prescribe strict liability offences for the mere detection of THC in body fluids while driving is not good overall policy. It is decriminalisation on the one hand, but criminalisation on the other hand by allowing that criminal offence to be maintained. The issue of impairment is still very poorly understood and still has not been addressed, but while those laws remain the legalisation of personal adult use may inadvertently lead to a rise in drug-related offences for THC in body fluids.

Secondly, the legalisation of adult personal use can lead to confusion between medicinal and recreational use. Our concern is that it can lead to self-medication based on a misconception that cannabis is cannabis when there are hundreds and hundreds of different strains of cannabis that have different effects and different potential benefits and risks. Self-medication may lead to poor health outcomes. This is where we think that education of both the public and healthcare providers on the distinct and regulated nature of medicinal cannabis is very important. The public's understanding of the need for safe, tailored treatment plans, using high-quality products of known composition overseen by medical professionals, remains central to the ongoing success of the medicinal cannabis industry in Australia.

AMCA does acknowledge that there is an increasing momentum towards legalisation for recreational purposes and is not opposed to the passing of the New South Wales bill. However, we emphasise that proper

education and public health messaging needs to distinguish recreational use of cannabis from medicinal cannabis so that the two frameworks can operate harmoniously and the benefits of the controlled more evidence-based approach to medicinal cannabis treatment and the current mechanisms that ensure that patients are receiving high-quality products from a regulated framework are not undermined by recreational use.

The Hon. SUSAN CARTER: Thank you, Dr Nicoletti, for being here. It was very interesting, I thought, your analysis of the framework, should legalisation or decriminalisation occur, and not conflating medicinal use with recreational use. I think you pointed to education and public health messaging. Are you aware of any jurisdictions where that public health messaging has successfully been able to differentiate between medicinal cannabis and recreational cannabis?

TERESA NICOLETTI: I am not aware. The frameworks internationally have either been based on retail models that treat recreational cannabis like a consumer product. My view is that the Australian regulatory framework is probably the most focused on treating medicinal cannabis as a pharmaceutical, rather than a more broad perception in other markets that it has health benefits.

The Hon. SUSAN CARTER: You raise, quite rightly, the issue of impairment, especially with respect to driving. We had evidence this morning that we don't really have the alcohol comparator of .05, or whatever. Are you aware of any framework or any research or any testing that's available so that we can test for cannabis impairment in driving in the same way we test for alcohol impairment?

TERESA NICOLETTI: The issue with cannabis, as I understand it, is that each person responds differently to cannabis. One person may be impaired, whereas another person taking the same quantity of cannabis containing THC may not be impaired. The other issue is around tolerance. As a person becomes more accustomed to using medicinal cannabis, they become more tolerant of it and less impaired. Whilst there has been research, the research has demonstrated that the issue of impairment is not of such concern as legislators have made it out to be in the same way as alcohol is impairing. So I don't have the answer for you. One thing I do recognise most importantly is we cannot continue with a situation where we have legalised medicinal cannabis for medicinal use and are sanctioning individuals who are legally taking it for that purpose simply because they need to drive for whatever purpose, particularly for work.

The Hon. SUSAN CARTER: But aren't there other drugs that are prescribed medicinally that preclude driving because of the side effects of those drugs?

TERESA NICOLETTI: There are many drugs that could be potentially impairing. In relation to those drugs, other than morphine under our State legislation, for which there is an excuse if someone has a medical prescription, there are many other drugs—not just morphine but other opioids, benzodiazepines and some of the antipsychotics—which are quite impairing. Those drugs contain information in their product information or consumer medicines information that states that a patient should not be driving or should take caution when driving or operating machinery. But there are no prohibitions, as such. I can't see why the same cannot be held for medicinal cannabis.

The Hon. SUSAN CARTER: Are you arguing that even though persons could be impaired while driving, it should be a matter for them to decide whether they drive and what risk they might pose to other road users?

TERESA NICOLETTI: Yes, in the same way as is the case for many other medicines that are impairing, or potentially impairing.

The Hon. SUSAN CARTER: But doesn't the logical extension of that argument mean that we would lift restrictions on alcohol and say to people, "You choose whether you are impaired and will endanger other users of the road"?

TERESA NICOLETTI: Yes, you could run that argument. But the evidence of alcohol is that levels above .05 have consistently shown impairment, and that is a reasonable benchmark. The same cannot be said for medicinal cannabis.

The Hon. SUSAN CARTER: Is the absence of as yet to be ascertained reasonable benchmark evidence that people driving under the influence of cannabis do not have impaired reaction times or other impairments that make them potentially dangerous to other users of the road?

TERESA NICOLETTI: The evidence has consistently come back that the level of impairment in many cases is not similar to alcohol. I don't have an answer for you.

The Hon. SUSAN CARTER: Are you able to provide on notice any evidence you have about the relationship between cannabis and impaired driving?

TERESA NICOLETTI: Yes, I can do that.

The Hon. SUSAN CARTER: From a medical perspective, what are the risks of conflating medicinal cannabis use with recreational use?

TERESA NICOLETTI: As I said before, the problem of muddying the waters with the two is individuals adopting a perception that if they can grow up to six plants of cannabis in their homes, they can treat their medical conditions. The issue with medicinal cannabis is there are so many chemovars that have a different composition. There are hundreds and hundreds of different chemovars, which have hundreds of different cannabinoids, hundreds of different flavonoids, terpenes and isoflavones—that makes one medicinal cannabis plant compositionally very different from another.

There is a lot of research that shows that certain strains or chemovars of medicinal cannabis may be very beneficial, for example, in the treatment of epilepsy, whereas other strains will have no effect whatsoever in treating those conditions. Our concern is that there needs to be sufficient education to understand the difference between recreational use and to understand the need to seek medical advice if a person, a member of the public, does have a medical condition that they feel could be treated with medicinal cannabis. One thing we don't want to see is patients assuming that cannabis per se will be a panacea for all conditions.

The Hon. SUSAN CARTER: Are you aware of any research that has been done about people using medicinal cannabis and then also using cannabis recreationally and what the interactions between the two different types of cannabis have been?

TERESA NICOLETTI: I'm not aware of any research.

Ms CATE FAEHRMANN: I just wanted to pick up on the drug driving questions. For example, if someone was taking, as prescribed by their doctor for severe pain, Endone or TRAMAL, for example—I think Endone is still schedule 8. Say they took it, and say a few hours later they drove, they were a bit drowsy and they got pulled over in terms of drug driving. One of the issues here—and the difference, isn't it, between medicinal cannabis users who are potentially using it for the same pain, maybe—is that, firstly, the police aren't testing for those drugs.

TERESA NICOLETTI: Correct.

Ms CATE FAEHRMANN: So even though those people are maybe slightly more impaired, it might not be coming up for the police, but they're a bit wonky and they're still behind the wheel. But that's a legally prescribed drug. That's correct? For Hansard's sake, you nodded.

TERESA NICOLETTI: Yes, that is correct.

Ms CATE FAEHRMANN: And for medicinal cannabis users, they're advised by their clinicians around when to drive and when not to drive. Doctors do that for most drugs. Is that correct as well?

TERESA NICOLETTI: Correct.

Ms CATE FAEHRMANN: What you're arguing for medicinal cannabis users is really the same application of the law, now that medicinal cannabis is legal, to any other drug.

TERESA NICOLETTI: Correct.

Ms CATE FAEHRMANN: It's different to alcohol because it's a medicine.

TERESA NICOLETTI: Yes. You raise an interesting point as well: There may be patients who are taking drugs like Endone and also taking medicinal cannabis. They may be tested on the roadside and there may be a detection of THC, but what's unknown here is what is causing the impairment, if they are impaired—whether it is actually the medicinal cannabis causing impairment or actually the Endone causing impairment. There's a disparity here that is really unfair in the context of patients who are legitimately being treated for a medical condition with medically prescribed medicinal cannabis. You're right, medical practitioners will advise patients who are taking morphine, oxycodone—which is Endone—TRAMAL or any other impairing drug not to drive or to take caution. But, ultimately, patients may need to do that for their work reasons.

Ms CATE FAEHRMANN: What's your understanding, therefore, of the difference, for example, between Tasmania and the rest of the country? Tasmania is obviously the only jurisdiction where they have an exemption. Is it your understanding, on what you've researched, that that has had any difference in terms of the drug driving or road statistics?

TERESA NICOLETTI: I don't know the difference it has made. But the point I made earlier was that allowing adult personal use does run the risk of seeing more roadside offences if you suddenly have households feeling comfortable to grow medicinal cannabis and then not be fully aware of the consequences if they then drive.

Ms CATE FAEHRMANN: Yes, that has to be sorted out.

TERESA NICOLETTI: It does need to be sorted out. But, at the very least, there needs to be strong public messaging around what recreational use means and the potential consequences.

The CHAIR: Since medicinal cannabis was legalised nationally, has it been popular with patients? What growth have we seen, and for what particular conditions are we seeing the growth, if there is any?

TERESA NICOLETTI: I wouldn't use the word "popular". I think there has been a strong uptake of medicinal cannabis mainly in terms of conditions like chronic pain and anxiety, which have seen increasing numbers of patients taking it. Some of the positive stories around the use of medicinal cannabis have been that patients have been able to reduce their reliance on other medications. The increase that we have seen really aligns with practitioners becoming more comfortable with medicinal cannabis. There has been some movement in price so that medicinal cannabis is more affordable, as supply and demand forces have led to a decrease in price over the years that we've seen legalisation. But also there have been a lot of medicinal cannabis clinics that have been established in recent years that have really facilitated access to medicinal cannabis. They were initially set up because there is a large proportion of the GP community who were uncomfortable about prescribing medicinal cannabis themselves—medicinal cannabis clinics established so that patients were able to go to an alternative medical practitioner to prescribe medicinal cannabis. I think that has seen the biggest increases in more recent years.

The CHAIR: In terms of medical practitioners who are now prescribing, are there more and more GPs or nurse practitioners who are now more comfortable? Is there a growth in the numbers of practitioners or has that remained relatively stable?

TERESA NICOLETTI: I don't see the general GP community really increasing their prescribing of medicinal cannabis. To some extent, they haven't had to address whether to prescribe it themselves because these medicinal cannabis clinics have addressed that issue. In some respects, I would have liked to see the GP community being more comfortable to prescribe because they have the relationship with their patients and they understand the patient's full medical history. The medicinal cannabis clinics were a separate avenue for patients to obtain access to medicinal cannabis, and there wasn't always that relationship between the medicinal cannabis prescriber and the patient's usual GP. But we are trying to address that to encourage best practice, which would be that there is a shared relationship between the medical practitioner who prescribes medicinal cannabis and the patient's usual GP.

The CHAIR: What about quality control? We've heard evidence that there is an inconsistency in the supply and some uncertainty about the potency. In terms of THC, I've seen reports and I think we've heard evidence that there are some issues around some of the regulation of imported product for quality. Do you have any reflections on those issues?

TERESA NICOLETTI: Yes. AMCA has received a number of reports or information, from either members or other stakeholders within the industry, that have raised concerns about quality—more about imported product than product derived from domestic cultivators, producers and manufacturers. All suppliers of medicinal cannabis need to comply with therapeutic goods order 93, as Professor Langham stated. Whether that is happening, though, is another question. In relation to some of the reports that AMCA has received, we're of the view that it isn't happening in all circumstances—that is, suppliers aren't ensuring compliance with TGO 93 in all circumstances. The only way to try and address that would be for—and the TGA is not going to like my saying this, but I feel that there should be some quality checking of products that are being imported and also of domestic product, because that would then create more of an impetus for companies to ensure that they do comply.

The CHAIR: We have also heard some evidence today and previously that, I think it was put to us, there were anecdotal reports of misuse—I would put it like that—of cannabis or adverse outcomes and an uptick in people presenting with a range of cannabis misuse disorders or associated with cannabis use psychosis or nausea. Is that something that AMCA has heard? How would you respond to that?

TERESA NICOLETTI: Yes, we have heard it. But one of the things AMCA has asked for is evidence. You may be aware that the AMA recently implored the Government to consider restrictions on medicinal cannabis use on the basis that patients were presenting to emergency departments with a range of concerns, such as psychosis. One thing we have asked for repeatedly is evidence that this is happening. It's all very well to write a letter saying, "Individuals and members of the public are flooding the emergency department," but we would like to see that evidence. The information that we've obtained is that there doesn't seem to be any evidence of additional cases coming to emergency departments that relate to psychosis or other adverse effects of cannabis.

But the thing that has not been considered is: What is the denominator here? If you do have 100 cases of psychosis across Australia in emergency departments, what is that as a percentage of how many patients are

actually taking medicinal cannabis? If you have a million patients taking medicinal cannabis and there are 100 cases of adverse effects, then that's a very low number based on the number of patients using. Secondly, we don't have any evidence as to whether their psychosis was causally related to medicinal cannabis—that is, was cannabis the only medication they were taking? That would tend to support a causal relationship. Were they taking multiple other medications such as morphine, oxycodone or benzodiazepines? We don't have that information either. AMCA has asked for this information and AMCA would welcome the opportunity to work with the AMA and any other representative bodies if there is actual evidence that this is occurring. We would be the first to step in line and say, "How do we address it?"

The CHAIR: An increasing number of jurisdictions, both in Australia and overseas, have travelled down the pathway of liberalising cannabis laws when it comes to medicinal cannabis, that then has moved into a liberalisation of adult-use cannabis laws. So if we look to the United States, Canada, Germany and other jurisdictions, what countries are doing it well, in your opinion? What are some of the jurisdictions we can look to that have managed that staged approach to cannabis deregulation, decriminalisation or depenalisation, legalisation—or however you want to put it—well, in your opinion?

TERESA NICOLETTI: I think Canada has a regulated model where there is some control over the quality of medicinal cannabis and accessing it through dispensaries. When you say "doing it well", there are various models, but the Canadian model I think perhaps aligns reasonably closely with a medicinal cannabis type model because it does have a regulated model which requires suppliers of medicinal cannabis to be licensed and for cannabis to be accessed through licensed dispensaries as well. At the moment, what is being proposed in New South Wales is a very—if I can say—low level legalisation for recreational purposes. The overseas models are not really relevant to what's being proposed here because they're more retail models which have tax revenues. It's not really the right conversation to be having in terms of what New South Wales is proposing to do. But, certainly, if there was to be a conversation about broader recreational use in that retail-type model, then I think we'd have a lot more to say about it.

The Hon. CAMERON MURPHY: I just want to go back to this issue about the roadside drug testing, Dr Nicoletti. The issue is that the roadside drug tests just detect the presence of THC; isn't that correct?

TERESA NICOLETTI: Correct.

The Hon. CAMERON MURPHY: They don't actually have anything to do with the level that might result in impairment. There's no way for that test to test impairment, is there?

TERESA NICOLETTI: Correct.

The Hon. CAMERON MURPHY: So, really, your complaint is that cannabis users are being unfairly targeted in that they're just using their medicine in the way that's been prescribed by a medical professional, yet this test picks up the presence of that THC in their system.

TERESA NICOLETTI: It's not really unfairly targeted; it's a hangover of the legislation pre-legalisation, and it hasn't been addressed. It should have been addressed, in my view, when medicinal cannabis was legalised. But there seems to be resistance to actually changing the road traffic laws, although Victoria has stepped up and allowed discretion in the context of a person that has a medicinal cannabis prescription. That should at least be followed in New South Wales.

The Hon. CAMERON MURPHY: Because there's still an offence, of course, for driving while impaired.

TERESA NICOLETTI: It's a strict liability offence and it's an automatic disqualification of licence. There's no discretion under the legislation, even if a patient has a legal script.

The Hon. CAMERON MURPHY: If that was to be removed, there's still an offence for driving while impaired that police could rely on in circumstances where somebody is impaired.

TERESA NICOLETTI: You're correct in stating that it's the mere detection that is a strict liability offence, even if it's in nanomolars in body fluid and even if the person doesn't have any evidence of impairment. There's no accepted quantitation of how much THC will actually cause impairment.

The Hon. CAMERON MURPHY: Because everybody reacts differently, you can't have a standard like we do for alcohol, where we do know that the more you consume, the more impaired you become. We have standards. Previously you could have two beers in the first hour and one every hour afterwards and stay under .05. There's no real way to do that with cannabis, certainly at the moment.

TERESA NICOLETTI: Correct.

The Hon. STEPHEN LAWRENCE: Just on that driving issue, the offence you're talking about, of driving with the presence of certain drugs in oral fluid, blood or urine, that's in section 111 of the Road Transport Act. It applies when a prescribed illicit drug is detected. The only drugs in the definition in that Act of prescribed illicit drug are THC, methylamphetamine, ecstasy and cocaine; is that right?

TERESA NICOLETTI: Correct, yes.

The Hon. STEPHEN LAWRENCE: So prescription drugs like valium and benzos are not in that definition, correct?

TERESA NICOLETTI: That's correct.

The Hon. STEPHEN LAWRENCE: Are you able to give us your thoughts on how much of the cannabis being prescribed through the medicinal cannabis scheme is actually being consumed for recreational purposes?

TERESA NICOLETTI: That's a very good question, and it's a very vexed question, because one of the concerns of AMCA, with the rapid increase in prescribing of medicinal cannabis, is whether it has set up a quasi-recreational scheme. I don't have any hard evidence of it. I don't have any numbers to talk to you about, but there is definitely that concern.

The Hon. STEPHEN LAWRENCE: How do you think full decriminalisation and/or legalisation of recreational use would impact the medicinal cannabis industry?

TERESA NICOLETTI: In the levels that the proposed New South Wales bill is proposing, which is six plants per household, I don't know that it will make much difference at all to the medicinal cannabis sector. Certainly broader legalisation would.

The Hon. STEPHEN LAWRENCE: In what way, do you think?

TERESA NICOLETTI: Increasing supply and increasing the ability to access.

The Hon. STEPHEN LAWRENCE: So people would be less likely to seek to access cannabis through the medicinal scheme if there was a full legalisation scheme, do you mean?

TERESA NICOLETTI: Possibly. It depends on what sort of regulated supply we have. It would ultimately depend on quality as well.

The Hon. STEPHEN LAWRENCE: Let's say we had a scheme where anyone who is an adult was able to go to a pharmacist, for example, and access cannabis without having to provide a prescription or proof of a medical condition. What impact do you think that would have on the medicinal cannabis industry?

TERESA NICOLETTI: Again it depends on what the supply chain looks like. Who's going to manufacture and supply that medicinal or non-medicinal cannabis? If the medical cannabis industry pivoted and supplied that product, then it may just be a shift and not actually impact the industry but, if there was wider access, it may actually decimate the medicinal cannabis industry.

The Hon. STEPHEN LAWRENCE: Does your organisation have a position on full legalisation?

TERESA NICOLETTI: Yes. We're opposed to full legalisation because we think it's a public health concern more than anything. That is because medicinal cannabis is not an easy product to understand because there are hundreds of chemovars. Our view is that the public shouldn't be self-medicating with cannabis, because they have no idea of the composition of their product.

The Hon. STEPHEN LAWRENCE: Is your organisation a membership organisation?

TERESA NICOLETTI: Yes, it is.

The Hon. STEPHEN LAWRENCE: So your members' industry could be severely adversely affected by legalisation.

TERESA NICOLETTI: Again it depends on what that legalisation looks like.

The Hon. STEPHEN LAWRENCE: Yes, what form.

TERESA NICOLETTI: Again I'm talking about broad legalisation.

The Hon. STEPHEN LAWRENCE: Is that part of the context in which your organisation has reached that position to oppose full legalisation?

TERESA NICOLETTI: Yes, correct.

Ms CATE FAEHRMANN: Can I ask a clarifying question in terms of full legalisation compared to a particular regulated market where some cannabis is available outside the medicinal cannabis scheme? Is there somewhere there that you support? When you say full legalisation, is it everything other than a medicinal cannabis scheme, or is there a well-regulated market where people can still buy cannabis recreationally without a script and where they know more in terms of what they're receiving? Is there some middle ground or not?

TERESA NICOLETTI: I don't think there is, because we have a world-class medicinal cannabis scheme that very carefully categorises products according to their composition and has a very strict standard of quality. Knowledge of those products is what is making the medicinal cannabis scheme work here, which is the reason why so many patients are getting benefit from medicinal cannabis. Once you introduce broad legalisation for recreational use, I cannot see in the longer term why the public would even bother going to a prescriber to seek prescribed medicinal cannabis. They might adopt the self-medication pathway instead and decide for themselves that they will opt for a recreational product that might be cheaper.

Ms CATE FAEHRMANN: What's your view in terms of how many clinicians, for example, are prescribing medical cannabis that are prescribing other things and patients are going to see their GPS or health professionals with, for example, anxiety or pain. They'll continue to do that because they've got anxiety or pain and they want to speak to a health professional. Isn't there surely still a significant number of people that will continue to see a health professional who will continue to prescribe medicinal cannabis, as opposed to everybody going to the recreational—

TERESA NICOLETTI: Perhaps.

Ms CATE FAEHRMANN: Sorry, just on this, in other countries' jurisdictions, has there been a very demonstrative slip away from people seeing their clinicians, for example, to get prescribed medicinal cannabis?

TERESA NICOLETTI: Those models didn't really follow the same structure as Australia. Our framework has now been in place for nine years, and it is a well-understood framework with very strict regulatory standards. No other market has really followed that. It's followed more of a decriminalisation or recreational pathway, so it's very difficult to align our framework with any other jurisdiction for that reason. On the issues you raise, yes, certainly there will be patients who, notwithstanding legalisation for recreational use broadly, may continue to see their medical practitioner to continue to be prescribed medicinal cannabis. But one of the biggest barriers to access at the moment is cost. If a patient can access a recreational product for much less cost than a highly regulated product to try and treat their condition, they may do that. That's one of the main reasons we're not supportive of a broadly recreational program.

Ms CATE FAEHRMANN: I have one last question, Chair, about cost. What are the association's recommendations as to some of the easiest things that can be done to reduce those costs? Because we hear from many people who simply can't access medicinal cannabis because of the very exorbitant cost. What are the association's recommendations there for us?

TERESA NICOLETTI: It's an invidious position that the industry is in. One of the things I often say is that you can't have your cake and eat it too. The regulatory framework we have in Australia is unique because we've essentially provided for broad access to what are unapproved therapeutic goods that haven't gone through the normal regulatory framework of being assessed by the TGA for quality, safety and efficacy. One of the requirements for reimbursement, which would make medicinal cannabis more affordable, is for products to be registered in the ARTG. If we want subsidisation, under the current legislation the only way to do that is to obtain registration in the ARTG, which would then allow an application to be made to the Pharmaceutical Benefits Advisory Committee for reimbursement. In the absence of the ability to do that, because the legislation is fixed, the only other opportunities are normal supply and demand forces. As supply increases, it's regulated with demand. The prices may fall or otherwise look to potentially private health insurers that may provide some subsidy for medicinal cannabis.

The CHAIR: Doctor, why hasn't anyone done that from the medicinal cannabis industry for THC for pain?

TERESA NICOLETTI: Done what, sorry?

The CHAIR: Have it registered under ARTG?

TERESA NICOLETTI: I can tell you why: The registration process is quite onerous. Professor Langham referred to a dossier that is required to be submitted. Medicinal cannabis is a schedule 8 medicine in the main. CBD is schedule 4. In any event, they're prescription medicines. The dossiers that are required to be submitted need to establish quality, safety and efficacy. Quality can be established. That includes the manufacturing process and the demonstration of quality through a range of production batches. It is the safety and efficacy that is the

problem. The only way to establish safety and efficacy sufficiently to support registration is through clinical trials. Clinical trials are very expensive. We are talking millions of dollars to generate the data required to support registration. That is the main barrier to the medicinal cannabis industry investing in generating data to support registration. If you are a company operating in this sector and the Government has created a regulatory framework that allows commercial supply—de-facto commercial supply, even though it's through the Special Access Scheme or the Authorised Prescriber Scheme—why would you then invest in generating clinical trials? They can effectively continue to supply the product to hundreds of thousands of patients.

The CHAIR: Because you might want to establish its efficacy.

TERESA NICOLETTI: The efficacy for the chronic pain that you are talking about in particular has been established through real-world data from the number of patients who are deriving benefit for that indication. But that isn't sufficient to support registration approval, because registration approval needs controlled clinical trials that regulate the inclusion and exclusion and do not have any confounders. The consensus in the industry is probably that there is sufficient anecdotal evidence of what medicinal cannabis is useful for and clinicians will continue to prescribe on that basis. The focus of industry—and I don't say this in a negative way; it's the reality—is the commerciality of its products, not whether patients can afford them. Patients are continuing to go to their doctors and have medicinal cannabis prescribed. That is leading to a viable industry.

The CHAIR: Thank you, Dr Nicoletti. The time in this section has passed. We very much appreciate you making the time to come give evidence today. It has been of enormous value to us and the inquiry. Thank you very much.

(The witness withdrew.)

Mr ALEC ZAMMIT, Cannabis Advocate, affirmed and examined

The CHAIR: Good afternoon, Mr Zammit. Thank you very much for taking the time to give evidence today at this hearing. Do you have an opening statement you would like to make?

ALEC ZAMMIT: Yes, just a very brief one to give some context on where I'm going to be speaking from. I'm 31 years old and, as I mentioned, a publicist by trade. I am a home owner and a business owner employing staff. I have been a resident of New South Wales my whole life. I have over 10 years of lived experience with and around both illicit and medicinal cannabis. I am a prescribed patient, although I have not been required to use my medication for some time now, and I do not currently consume the medication. With this said, I still maintain my ability to access it, should my needs change in the future.

The Hon. SUSAN CARTER: Thank you, Mr Zammit, for being here. When you say you're an advocate for cannabis, just so I understand your position, is it for medicinal cannabis or for complete legalisation of all cannabis? What's the position you're advocating for?

ALEC ZAMMIT: For all of it. I do see a place for medicinal and for an adult-use market where you could purchase it without a prescription. I started advocating for it prior to medicinal cannabis being available in Australia. I was running and operating businesses and contributing to society in a positive manner, in my own opinion. I didn't like that I was being considered a criminal for my choice to consume cannabis at the time, so, yes, I started advocating for it. Since then, we've had medicinal. I think it's a great system that we have. There definitely are some flaws within the current system, even, and we definitely haven't gone far enough. Something where you can walk into a retail store and purchase it is a lot more in line with where I see—

The Hon. SUSAN CARTER: Was your personal cannabis use self-medication for medicinal purposes, or recreational, or both?

ALEC ZAMMIT: I don't quite see a difference between recreational, which I can get into a bit later. I feel that everyone consuming cannabis has underlying medical reasons to do so, even if they don't identify that themselves; they may think they're consuming it recreationally. I definitely was self-medicating, and now I'm prescribed it.

The Hon. SUSAN CARTER: I don't know whether you're aware of this: We've heard some evidence this morning, in particular, about concerns about conflating medicinal and recreational use, because of the particular profile of certain types of medical cannabis products to treat particular types of medical conditions. Do you share those concerns, or do you think all cannabis should be seen as interchangeable?

ALEC ZAMMIT: I think all cannabis is interchangeable. You might have a stronger potency of a certain type of product. You can just consume less of it. If you have a lower potency, you can consume more of it. For the most part, and for everyone I know who consumes, it's quite easy for them to regulate their own use in a manner that works for them. By separating adult use and medicinal use, we're going to free up the medical professionals' time to be able to focus on the people who do actually need the help. We can redirect funds that are being spent on fighting the crimes that will no longer be crimes into education and harm reduction facilities so that if people do become dependent on it, they have other outlets to go to, which is already required at the moment. But I think it would definitely be beneficial to free up those medical professionals' times and weed out the ones who are just in it for a quick buck and not really providing the medical guidance that some people might be looking for.

The Hon. SUSAN CARTER: You indicated that you were advocating for legalisation or increased access for adult use. Bearing in mind our experiences with underage drinking and underage smoking, if cannabis was to be a fully legal product in New South Wales, how do we prevent underage cannabis use?

ALEC ZAMMIT: I think the same way that we do with cigarettes or alcohol. I think that as the stigma around cannabis is changing, it's actually becoming less appealing to kids. I think a percentage of the appeal was the fact that it was illegal and maybe something that they were doing that was naughty.

The Hon. SUSAN CARTER: Have you got any data or any research that supports your claim that there's reduced youth use of cannabis in New South Wales?

ALEC ZAMMIT: That's just my own personal perception—is that the appeal to buy from children is potentially lower. I speak with my own nieces and nephews and family that I know that are of a younger demographic and there just is no appeal to it, which I know that when I was younger, it was everywhere and it didn't seem to really be causing much issues for the kids around me that were smoking. I personally started consuming it at a young age and I don't feel that that negatively impacted me.

The Hon. SUSAN CARTER: You acknowledge that we have a problem with underage drinking. If we do exactly the same with cannabis, we're likely to have a problem with underage cannabis use, aren't we?

ALEC ZAMMIT: I'm not acknowledging that we have a problem with underage drinking. I'm saying that we could potentially treat it in the same way and try to prevent underage abuse of the product in a similar way.

The Hon. SUSAN CARTER: Have you got any research which demonstrates that we don't have a problem with those under 18 drinking in New South Wales?

ALEC ZAMMIT: No, I'm not saying we don't. I'm just saying that I'm not saying that we do.

The Hon. SUSAN CARTER: We've discussed a lot the issue of driving while impaired. There are a range of substances which can cause impairment. It's commonly accepted that cannabis is one of those substances. If cannabis is legalised, how do we go about regulating driving? Is there a safe level like alcohol? What's your understanding of that issue?

ALEC ZAMMIT: No. I agree with what Dr Nicoletti, who was on before me, said about most of it. One thing I do want to point out, though, is no-one that is advocating for the driving legislation to be fixed—at least even for medicinal cannabis, whether we talk about non-medicinal cannabis as well. But no-one is asking for the legislation about driving whilst impaired to be removed. That will always be maintained. That is applicable to if you're driving while drowsy just because you're sleep deprived or because you've been consuming other prescription medication like Endone. That will always be there. At least on the medicinal side of things, it will bring it in line with all other prescription medications.

We have that case study in Tasmania. Tasmania has had medicinal cannabis available to them for the same amount of time as mainland Australia and as we have here. The way that their laws are constructed, they have always had that defence available to them that—if they were a medical patient, they had a defence to the charge of driving with THC present in your system. They obviously can still be charged for driving whilst impaired if impairment was observed or if an incident had occurred, and we haven't seen any detrimental effects to their road toll.

The Hon. SUSAN CARTER: You're suggesting that, rather than a blood measurement, we should be looking for an impairment test like the old "walk the straight line with your finger on your nose"—that type of test?

ALEC ZAMMIT: Potentially that or even just if impairment is observed. Currently how do we police if someone hasn't slept in many days because they've been stuck on long hours at work or haven't been able to sleep for whatever reason and they're now driving whilst impaired? We have that legislation there. The police are trained in how to identify those, I imagine, especially highway patrol. They can just apply it in the same manner as they would for any other medication.

The Hon. SUSAN CARTER: Without any objective criteria, are we then relying on individuals to be able to assess themselves whether or not they feel impaired when they get behind the wheel of a car?

ALEC ZAMMIT: It would be the same as all other medications, so I guess that would be the case.

The Hon. SUSAN CARTER: But with alcohol we have objective guidelines, so people will go, "I've had two drinks. I won't be driving." Where is the objective criteria that helps adult cannabis users self-regulate cannabis use and driving?

ALEC ZAMMIT: All consumers that I know are rather responsible and can determine if they're impaired to do so and wouldn't get behind the wheel. I don't think it is in a similar basket to alcohol in terms of those benchmarks not being set. My response would be similar to what Dr Nicoletti said previously.

The Hon. SUSAN CARTER: If I understand you correctly, you're arguing that cannabis users are more responsible drivers and road users than alcohol users.

ALEC ZAMMIT: Not necessarily. I'm not comparing the two. I'm just saying that—

The Hon. SUSAN CARTER: Sorry, I understood that's exactly what you were just doing.

ALEC ZAMMIT: No, not comparing the two. I'd say they're responsible. Just like consumers of all the other prescription medications that can cause drowsiness, they're capable of making an informed decision on whether they'll be safe to get behind a motor vehicle.

The CHAIR: Mr Zammit, do you think it's the case that there are some people out there who are getting a prescription to access medicinal cannabis because they're avoiding criminality? They want to get a prescription

so that they don't have to buy from the black market. They're adult-use recreational users, but they're getting it from the medicinal cannabis prescription pathway because they're concerned about being prosecuted for cannabis cultivation, possession and use.

ALEC ZAMMIT: Getting a prescription will not relieve you from any criminality in terms of cultivation unless you're in the ACT, in which case a prescription becomes irrelevant. In terms of possession and use, when I assess their situation and why they're consuming, everyone I know who consumes—which is a very large number of people—they all have underlying medical reasons for their consumption. I don't really know anyone who consumes in a recreational manner. Some—

The CHAIR: So it's like an intersection of both: There's a convergence of a recreational and relaxation sort of thing, but it's also got a medical element as well.

ALEC ZAMMIT: Medical benefits, yes. And a lot of those people are consuming from the black market still; they're not under a prescription.

The CHAIR: In your experience as a resident of Western Sydney, is cannabis use pervasive? Is it normal in society? Most people have done it. Is it just part of the fabric of society in Western Sydney?

ALEC ZAMMIT: Yes, definitely. And I think that's true for beyond Western Sydney. I think that's true for a lot of areas and places I visit, out to the northern suburbs and the eastern suburbs. Cannabis seems to be very prominent throughout all socio-economic classes and all walks of life.

The CHAIR: And I'm not asking you to name anyone, but it's readily available. The policing hasn't really restricted its availability.

ALEC ZAMMIT: No, not at all. It hasn't been restricted at all. It is readily available throughout Australia, from my own experience.

The CHAIR: Have you ever experienced or heard of people talking of a decline in availability from the black market because of policing or a particular event that has meant there has been a drought of illicit cannabis?

ALEC ZAMMIT: No. I guess maybe COVID and the stay-at-home laws may have made things slightly more difficult, but I don't believe that there has really been any major impact from policing of cannabis specifically that's restricted the flow or ability for anyone to obtain it.

The CHAIR: Do you think that people who use medicinal cannabis, or an intersection between medicinal cannabis and recreational cannabis, can lead productive lives, contributing to their family, workplace and society?

ALEC ZAMMIT: A hundred per cent. I purchased a home whilst I was a consumer. I employ people and operate my company. I currently don't consume, so I'm capable of making that decision of when it is helping me and when it isn't helping me. I feel like a lot of consumers are in the same boat as me, and they're being unfairly victimised by the current legislation.

The CHAIR: And when you say that, you mean the roadside drug testing laws?

ALEC ZAMMIT: That is a big factor of it, but also just the possession—the fact that they're forced to go down an expensive medical route and potentially not even able to grow their own. I think home grow retail sales and the driving laws are all elements that could be fixed.

The CHAIR: Do you think that the price point for medicinal cannabis—the process you've got to go through—could force people back into the illicit market?

ALEC ZAMMIT: Yes. The problem you've got with it—the way it currently is in the illicit market, you have people who are in it just for quantity over quality and just looking to make a buck. Then you've basically got the same thing over on the medicinal side of things. Because of such poor and such strict advertising restrictions placed upon the medical industry, they can't advertise to people that are already consuming black market cannabis that they offer it, they have it available and the type of service that they can offer. So you're stuck with a bit of a process where you have to shop around with doctors to find someone ready to provide the suitable guidance that you need.

You may pay a higher consultation fee and see a doctor that's just ready to write your script and send you on your way and doesn't necessarily want to go through a long process of actually discussing your needs and providing suitable guidance for your consumption. Or you might find one that goes over the top and does do that. You may pay a low consultation fee and be forced to take certain types of medication which is at a higher price, where you could have something of similar potency or slightly different at a lower price which is still perfectly acceptable for your need. You just adjust the dosage you're taking, for example.

The CHAIR: That's a really interesting point. So you think that the restrictions on advertising in terms of medicinal cannabis is limiting the amount of knowledge or understanding people have about the services that a practitioner may provide—and the consultation—but also the medicine that they may be prescribing?

ALEC ZAMMIT: Yes, the availability of the medicine—a hundred per cent. The advertising laws and rules are restricting education being provided. It has relied upon people who don't have an industry interest in the situation to provide that education, whereas if the people who were the ones actually prescribing it and making the money off it and things like that, they could be a lot more forthcoming and provide that education there. I still meet a lot of black market consumers who didn't know that medicinal cannabis was available to them. Some of those people have a barrier of entry due to the costs. Others, once they find out it's available to them, head on and do it the right way and go through the proper process and obtain it that way.

The Hon. STEPHEN LAWRENCE: Thanks for coming along, Mr Zammit. It's much appreciated. I recently watched your interview on the new podcast *Into the Weeds* that's hosted by the Chair, Jeremy Buckingham.

The CHAIR: Available on iTunes, Spotify and YouTube.

The Hon. STEPHEN LAWRENCE: Available on iTunes, I just heard, and YouTube. I want to ask you a few questions arising from it, because I did find it really interesting. I remember that you talked about growing up in Western Sydney. I want to ask you, arising from that, what, to your observation, were some of the harmful effects of the criminalisation of cannabis, particularly on your peer group, when you were growing up in Western Sydney?

ALEC ZAMMIT: I personally was lucky I didn't receive any—I've never been charged or really had any negative interactions with authorities in relation to cannabis, apart from recently, as a prescribed patient, with two instances of driving offences, or it being detected in my system. When growing up and purchasing from the illicit market, I never really had an issue. Some of my peers haven't been so lucky, and I do attribute it just down to luck. If you do fall foul of the law, especially if you aren't well presented or from a higher socio-economic class, or potentially, for example, if you're Aboriginal, there's a much higher chance that you will be prosecuted for possession of a small quantity, for example. You then get stuck in a loop. Having that conviction on your record will limit your opportunity to gain good employment and that could force you on to further criminality and other means of obtaining income because the law has restricted your ability to assimilate into normal society.

The Hon. STEPHEN LAWRENCE: So when you were growing up, did you have friends who were charged with possession of cannabis or supply of cannabis?

ALEC ZAMMIT: Yes, I know people who have been charged with both.

The Hon. STEPHEN LAWRENCE: Did you have friends who might be stopped and searched on the street on account of suspicion of possession of cannabis?

ALEC ZAMMIT: Yes, definitely. That has also happened to me. Whilst driving, there have been many occasions, since the driving with it present in my system was detected, where I was pulled over and searched. None of those occasions ever resulted in any offences.

The Hon. STEPHEN LAWRENCE: To your understanding, was that happening to you because your name had basically gone onto the database?

ALEC ZAMMIT: Yes, I believe so. And the number plate was entered into an automated recognition system, so once I changed the vehicle I was driving, I haven't had an issue since then.

The Hon. STEPHEN LAWRENCE: To your observation, these young people that you knew growing up, who were having those interactions with the criminal justice system, was that a positive or a negative experience for them in terms of how their lives then progressed?

ALEC ZAMMIT: It's definitely a negative experience. It can also be costly, both costing you money on legal representation, if you do choose to obtain that, and the limitations it then imposes on assimilating into society further—if we're talking at a school age, once you leave school and start seeking employment.

The Hon. STEPHEN LAWRENCE: Were some people more affected than others by those experiences? Say, people maybe from certain backgrounds were more affected, less resilient—any dynamic like that?

ALEC ZAMMIT: Yes, definitely so. I know people from very wealthy and affluent suburbs and I also know a lot of people in Western Sydney and further out west than where I am. It definitely seems that the lower socio-economic class and different minority groups or different racial backgrounds are targeted more heavily, yes.

The Hon. STEPHEN LAWRENCE: Something that concerns me about the current regulation of cannabis in terms of the medicinal scheme is that we're, in effect, creating a two-tier system: one system for people advantaged enough to get prescriptions where they're exempt from the criminal law irrespective of whether they're using it for recreational purposes or medicinal purposes, and then another tier system for those who maybe don't know about the medicinal scheme or don't have the means or wherewithal to access it, where they're subject to the full criminal law, which might impact on them differently, depending on who they are and their circumstances. Is that something that concerns you? If so, could you maybe expand on your thoughts on it?

ALEC ZAMMIT: Yes. I a hundred per cent agree it's something that's concerning. The cost is a big barrier to entry, and just knowledge and education around the topic and knowing it's availability is another example of some shortcomings that feed into that.

The Hon. STEPHEN LAWRENCE: When you were growing up, did you get any knowledge or instruction about the interaction between cannabis and other prescription drugs?

ALEC ZAMMIT: Not necessarily. I didn't really consume much other prescription drugs when growing up. From time to time throughout my youth, I was prescribed ADHD medicine, sleeping tablets. Cannabis was able to replace those in my later early adult life. Now, I don't consume any medication whatsoever.

The Hon. STEPHEN LAWRENCE: We took some evidence earlier in the inquiry from people on the medical side of things who were very concerned about the interaction between cannabis and prescription drugs and were making the point that people getting medicinal cannabis should get that advice from doctors and so forth. I asked a few questions about what's happening to the millions of people accessing it through the illicit market who might not be getting that advice at all and might not even be aware of it, and might be less likely to seek it out. I'm just wondering about when you were growing up and in the milieu that you were in, do you think those young people had access to advice about the interaction between prescription drugs and cannabis?

ALEC ZAMMIT: No. The stigma is changing. Along with the stigma changing, there's a lot more education available. Even on the illicit side of things you have a lot of knowledgeable people who aren't just looking to make a quick dollar. They're passionate about the plant and they're passionate about helping people—different people for different reasons as to what they're passionate about, what type of consumption. But I found that, even on the illicit side of things, there is a lot of support and a lot of knowledge and a lot of guidance as to what is a positive way to use it and how it should be used.

I think that, when looking at regulatory changes, it's important that we don't eliminate those people. A lot of people who are very passionate about the plant, have a lot of the lived experience and the knowledge about how it should be used, the best way to grow it and all those other things—a lot of those people would probably have a criminal record. We heard earlier the ODC does criminal police checks, for example, when issuing permits and licensing. That's potentially eliminating some of the best people in Australia that we have for the job. That's something that should be thought about and addressed when making these changes.

The Hon. STEPHEN LAWRENCE: Do you think that the existence of criminal offences for possession and cultivation creates obstacles to people getting the information that they need, particularly when they're young?

ALEC ZAMMIT: It definitely did in the past, yes. Now that the conversation is changing and the rest of the world is moving towards a legal market, that education is becoming more abundant. But the laws definitely do hinder that. Even in terms of the medicinal side of things, we have strict regulation around how the companies can advertise, and that's a big hindrance on education getting out there further.

The Hon. STEPHEN LAWRENCE: We've taken evidence from the Australian College of Psychiatrists. In summary, they said that if you're smoking cannabis daily and you're 15 or under, your risk of psychosis is much elevated. What do you think is the best way to stop young people in those age categories, and young people generally, from smoking cannabis or consuming cannabis?

ALEC ZAMMIT: I think education and having a legal, regulated market—as long as it's regulated in the right way—would reduce it. For example, by allowing retail stores to open, we're taking money out of organised crime, and that would start to subside. Most of the suppliers for cannabis would either be medicinal or legitimate business, and they're unlikely to provide it to children, just like you see with tobacconists and things like that. On that note, we don't want to do it in the wrong way. If we if we tax it too high, for example, we'll fall into the same mess that the tobacco industry has fallen into, and the vape industry, where you're just feeding it and handing the money straight to organised crime and encouraging that market, while facilitating it because they can sell from a retail store and it's all still illicit.

We need to make sure we really hit the nail on the head with how things are done in terms of providing licensing and permits that are required and how much tax we put on it. But I do think that taxing it is a positive

thing so that we can put more into education and harm reduction. It has a lot of medical benefits, but it's definitely not for everyone. If there are people presenting with psychosis from it, for example—I don't know of anyone who has had that happen to them, and I know of a lot of consumers—then we can divert some of the funds to those professionals who would be dealing with that.

The Hon. STEPHEN LAWRENCE: The other factor that we've taken some evidence on, in terms of eliminating a black market, is distribution—how it's sold and where it's sold, particularly. We've taken evidence that one way to eliminate the black market is to ensure access very broadly. You'd need to have distribution in small communities, in big communities, not just in particular suburbs et cetera. Have you got any thoughts on what the best retail model would be? I know that in parts of Canada it's a government-owned dispensary, and the government takes the responsibility of making sure the dispensaries are in lots of places. In other American States, for example, it's essentially a private enterprise and they can set up anywhere. Have you got any thoughts on that issue of access?

ALEC ZAMMIT: I think to some degree it should just be treated like any other herb or vegetable, really. You register a business, you pay tax on the relevant tax class for the product, and then you operate. As for further regulations, they can be implemented, such as not selling to someone under the age of 18. And then we have the businesses follow that legislation, and punishments implemented if they don't.

The CHAIR: Thank you very much, Mr Zammit, for your advocacy and for your evidence today. I very much appreciate the perspective you've brought to the hearing and to the inquiry generally.

ALEC ZAMMIT: No worries. Thanks for having me.

The Hon. STEPHEN LAWRENCE: I was wondering, Mr Zammit, could you tell us about your interesting activism in this space?

ALEC ZAMMIT: We run a campaign under the title "Who Are We Hurting?" That is a self-titled question to ask who is actually being affected by people that want to consume cannabis. In turn, that also relates to people cultivating and distributing it. So far, we can't really find the victim. The only victims seem to be from the legislation itself, not from anything to do with the actual plant outside of legislation.

The Hon. STEPHEN LAWRENCE: What other sorts of activism have you been involved in?

ALEC ZAMMIT: The types of activism we do are basically just peaceful public activations that don't impose on the day-to-day lives of people. As an example, we projected something onto the Sydney Opera House, which doesn't stop anyone from getting to work or living their day-to-day lives but also conveys the message that we do want change and the question of who are we hurting as cannabis consumers.

Ms CATE FAEHRMANN: Mr Zammit, I'd be keen for you to tell the Committee what you believe is a difference, for example, at a big street festival where it is predominantly alcohol and people are drinking alcohol compared to, for example, let's say MardiGrass Nimbin or a festival where people are largely consuming cannabis. What, from your experience, will be the difference in terms of interaction, the way people behave and behaviour particularly from men, let's say?

ALEC ZAMMIT: From my own experience attending festivals where there are bars scattered all around the place and the prominent substance of choice is alcohol, you tend to see a lot of fights and violence and unsavoury types. When I attend Nimbin MardiGrass, there's a large demographic of different types of people of different ages and different social backgrounds and everyone seems to be quite friendly and getting along with each other. You don't see any fights and it's just a much more pleasant experience all around.

Ms CATE FAEHRMANN: Cannabis generally doesn't make people want to get involved in street brawls?

ALEC ZAMMIT: Definitely not. If anything, it would help stop them.

The CHAIR: Thank you very much for those questions and that contribution. Mr Zammit, we really appreciate you coming along and giving your evidence and perspective to the inquiry. Thank you very much, mate. That draws to a close the morning or early afternoon session. We'll now break for lunch and return at 1.45 p.m. to hear from the Centre for Road Safety and the cops.

(The witness withdrew.)

(Luncheon adjournment)

Ms LOUISE HIGGINS-WHITTON, Director, Road Safety Policy, Transport for NSW, on former oath

Mr BERNARD CARLON, Chief, Centres for Road and Maritime Safety, Transport for NSW, on former oath

The CHAIR: Good afternoon, everybody. Welcome back to the inquiry into the impact of the regulatory framework for cannabis in New South Wales. Mr Carlon and Ms Higgins-Whitton, you do not need to be sworn because you have already been sworn before this Committee during this inquiry. Would you like to start by making a short statement?

BERNARD CARLON: Thank you for inviting us to appear again. I'd like to provide the Committee an update on our drug driving research and analysis since our last appearance. These steps are consistent with the New South Wales Government commitment to actively monitor this issue. Since December last year we have progressed and are now finalising a study into the knowledge, attitudes and behaviours of driving after taking drugs, which includes a survey of over 5,000 drivers. Transport understands that many users of prescribed cannabis medicine are using their medicines appropriately and are not risking drug driving. However, among those who reported using prescribed cannabis in our research, 54 per cent did not use it as prescribed. This includes the use for recreational purposes, at a higher dose, more frequently than prescribed, or using medically prescribed cannabis without their own prescription.

Among those who reported using prescribed cannabis who had their own prescription, nearly 40 per cent reported using illicit cannabis some, most or all of the time in addition to their prescription. Around four out of five said they were advised by a medical professional not to drive after using medically prescribed cannabis. Of those who had been advised not to drive, 45 per cent had driven within six hours of using medically prescribed cannabis, which may well be while they are impaired, noting medical advice that impairment typically lasts three to eight hours. This highlights one complexity of providing what may appear to be a simple solution for people taking medically prescribed cannabis while managing safety outcomes for all road users. Most of the published research on cannabis and driving has focused on recreational use, and has found around a 40 per cent increase in crash risk.

The crash risk from medical cannabis is less clear, but there is no scientific consensus on an acceptable THC level in blood that indicates the degree of impairment and crash risk, as there is for alcohol. There has been no change in this overall position since we last appeared before the Committee. We've also provided more information from our crash data to the Committee. We advise that there were 241 drivers or motorcycle riders with the presence of THC involved in fatal crashes between 2019 and 2023, and 120 of these—that is, half—had no other illicit drug present or illegal levels of alcohol. This means about 8 per cent of fatal crashes over this period involved a driver or rider with the presence of THC only, and no other illicit drugs or illegal levels of alcohol.

To supplement our own analysis, Transport has commenced procurement of an independent literature review into cannabis and driving, with specific focus on medically prescribed cannabis and approaches in other countries. We are regularly in contact with Victoria about their closed circuit track trial, interim legislation changes as well as point of prescription information, which was enhanced in March 2025. On that point of prescription information, we're liaising with Victoria to adopt that in New South Wales. Thank you for this opportunity to provide an update. We are pleased to take your questions.

The Hon. SUSAN CARTER: Thank you very much for being here. I apologise—I'm conscious that you've presented evidence before. I wasn't on the Committee at that stage, so if I'm asking you old questions, feel free to tell me you've already answered them and we can move on. If I understand you correctly, in the update you gave us, you said that most medical cannabis users were using the medication appropriately. Could you tell me what you mean by using it appropriately?

BERNARD CARLON: In the research, many of those prescribed cannabis users were using it according to their medical practitioner's advice. What we've clearly then discovered in that survey—

The Hon. SUSAN CARTER: But 54 per cent were not using it as prescribed?

BERNARD CARLON: —was that 54 per cent did not use it as prescribed.

The Hon. SUSAN CARTER: Did "using it appropriately" relate to driving afterwards or was that just using it as prescribed?

BERNARD CARLON: We would say "in accordance with the script" and that would be in accordance with any advice the medical practitioner had given them not to drive.

The Hon. SUSAN CARTER: Your understanding would be that a medical practitioner may say avoid driving for eight hours. Would that be your understanding?

BERNARD CARLON: The current health advice in New South Wales is not to drive whilst taking medicinal cannabis.

The Hon. SUSAN CARTER: Not to drive.

The Hon. STEPHEN LAWRENCE: At all?

BERNARD CARLON: That's my understanding of the current advice from NSW Health.

The Hon. STEPHEN LAWRENCE: Is that not during a period proximate to ingestion or just not at all—don't drive, ever?

BERNARD CARLON: My understanding is the health advice is not to drive.

The Hon. STEPHEN LAWRENCE: Through the period of the script?

BERNARD CARLON: Whilst you're on the prescribed—

The Hon. SUSAN CARTER: I believe there might be drugs, for example, with respect to epilepsy or something—are there other drugs that you're aware of, used medicinally, where the same advice would be given not to drive while you're taking this medication?

BERNARD CARLON: Again, it's probably a question more relevant for Health, but my understanding is that, yes, where medical practitioners are prescribing, there are occasions where they will say that you should not drive whilst taking this prescription.

The Hon. SUSAN CARTER: What strategies are currently in place to deter cannabis-impaired driving? Are these the same as those for alcohol-impaired driving or are they different?

BERNARD CARLON: New South Wales and most of the jurisdictions in Australia have adopted a mobile drug testing program, which is modelled on the drink drive program. That has been an RBT, which has been in place since the '80s and has seen a significant reduction in the number of people who drink drive and also those who have been killed in crashes involving drink driving. That system is a broadscale oral-fluid roadside testing program, which detects illicit drugs, including THC. In New South Wales the policy framework in our Road Safety Action Plan is to conduct 200,000 roadside drug tests. The evaluation of the Victorian scheme has indicated a significant positive road safety benefit in the roadside drug testing program. We do have the information on the specifics of the number of fatalities and serious injuries that they have demonstrated have been prevented as a result of that broadscale roadside drug testing program, which is modelled on the RBT program.

The Hon. SUSAN CARTER: If you could provide those on notice, I'd be very grateful.

BERNARD CARLON: Yes.

The Hon. SUSAN CARTER: The objective is 200,000 roadside drug tests. How are we tracking with getting up to that 200,000?

BERNARD CARLON: Indications are that New South Wales police last year actually delivered just over those 200,000 tests in New South Wales.

The Hon. SUSAN CARTER: Great. That's the annual target, is it?

BERNARD CARLON: Yes.

The Hon. SUSAN CARTER: Who collects the data on how many drug detections there are?

BERNARD CARLON: New South Wales police conduct the tests. Certainly we share that information and that data on the detection for that program as well. Around 50 per cent of the detections are THC detections. In my understanding, around a quarter of those are poly use, so we do get the detection of THC with the other drugs that are being tested for in the program. So, yes, THC alone—we also have the data on how many are just THC detections.

The Hon. SUSAN CARTER: If you could provide that on notice, that would be great. And the drug tests are also alcohol tests?

BERNARD CARLON: Yes, generally police would conduct an alcohol test as well. From our point of view, in terms of fatal crashes, we would see around 25 per cent of the detection of THC in fatal crashes includes alcohol, and it's around the same for methamphetamine. Around 25 per cent of those crashes would include both.

The Hon. SUSAN CARTER: There's been some discussion in evidence this morning about other prescription drugs that can affect driving ability. Do you have any information about how THC-based impairment risks compare with those of other prescription drugs that can affect driving ability?

BERNARD CARLON: I might make an initial statement and then hand to Louise for this one. What we do understand is that recreational use of cannabis is at significantly higher levels—the illicit use of cannabis is at significantly higher levels than the illicit use of other prescription drugs. As you would have heard from our Health members this morning, the regulatory regime and the approval process for those prescription drugs which have TGA approval have much more robust systems in the management of those drugs, whereas the Special Access Scheme for the currently more than, I think, 750 medicinal cannabis products doesn't go through that same degree of robust analysis by the TGA. I'll hand to Louise for more detail.

LOUISE HIGGINS-WHITTON: In relation to the crash risks that are associated with other prescription drugs, there are definitely and repeated research studies have found that there are elevated risks associated with misusing opiates, with misusing benzodiazepines and with mixing those substances, particularly with alcohol. That definitely elevates the risk of a crash or of a driver being culpable in the event of a crash, so there are certainly risks associated with those drugs. Those drugs can be enforced at the roadside where a driver is deemed to be under the influence under our current laws. That is distinct from the presence regime, but I just wanted to clarify that there is a way for prescription drugs to be enforced under our current law and that there are risks associated with those drugs too.

The Hon. SUSAN CARTER: Mr Carlon, I think you said—correctly—that there's probably more cannabis users than prescription drug users. Do we have any data about how many driving incidents were caused by the presence of THC, compared to opioids or benzodiazepines?

BERNARD CARLON: Again I might get Louise to respond.

LOUISE HIGGINS-WHITTON: I think not in the same way. We don't currently have an aggregated number that indicates where we see particularly benzodiazepines or opiates in the drugs. The data is there, but it does require us to have a framework to look at it. Benzodiazepines is a class of drug and there are various drugs that fall under that regime. There are some complications because some benzodiazepines—or opiates for that matter—can even be administered to someone after a crash and it can sometimes be caught up within the post-crash data that we have. In terms of pulling out those numbers, it is a more complex task in terms of identifying the substances themselves and then identifying how and why they were present, and then looking at the levels of those to see whether they were associated with the crash. We don't have nice clean aggregated numbers around those substances.

BERNARD CARLON: Just to clarify, I was referring to the national household survey on drug use, where 11 per cent of people had reported taking cannabis in the 2022-23 year, whereas the illicit use of pain relievers and opioids for non-medical purposes was 2.2 per cent. That had reduced since 2026, when it was at 3.6 per cent.

The CHAIR: Sorry to jump in—do we have the numbers for non-illicit use of opioids?

BERNARD CARLON: No, sorry, I don't have those here in front of me.

The CHAIR: That was for the illicit use of opioids, not prescription opioids?

BERNARD CARLON: Yes, that's correct.

The Hon. SUSAN CARTER: If I understand you correctly, a target of 200,000 roadside drug tests is acting as a deterrent on driving after cannabis use. If there was to be a regulatory change where we might perhaps see more people using cannabis—some from of legalisation or decriminalisation—what extra resources do you anticipate would need to de deployed to keep our roads safe?

BERNARD CARLON: There is modelling work that has been done around the levels of roadside drug testing by Monash University and the optimal road safety benefits from different levels of screening testing. Certainly, in that context, we would need to do the work to determine what sort of risks or additional risks there are. That said—and, again, Louise can confirm—the research on legalisation in other jurisdictions has indicated a slight increase in road crashes and road trauma when that has been implemented in other jurisdictions internationally. We would look to that research in order to make that sort of assessment, I would imagine.

The Hon. SUSAN CARTER: Do we collect data on road crashes by police district or geographic area, or just the whole of New South Wales?

BERNARD CARLON: The data that is collected from crash reporting, which is reported to us by New South Wales police, is geolocated at every site. That data is aggregated. It is provided to local government

based on the local government boundaries. It goes right down to publishing those crashes on our website at the street level. All that is publicly available, as well as being available in open data.

The Hon. SUSAN CARTER: I am aware that at an estimates hearing the Commissioner of the NSW Police Force expressed a concern about the southern command and anticipated additional crashes after the liberalisation of the ACT drug laws. I wonder if we have any data that indicates that that fear was actually made out?

BERNARD CARLON: Not to my knowledge.

The CHAIR: I have a couple of questions. If the national household drug survey is showing that 4 per cent of people are using illicit opiates annually and opiates generally can be a significant issue in terms of impairment and road safety—whether illicit or prescribed—why do we not test for opiates at RDTs?

BERNARD CARLON: Just to clarify, it was 2.2 per cent. Certainly, those drugs are tested for in terms of impairment for driving under the influence. I suppose there is a historical context—

The CHAIR: But they are not tested for at roadside drug tests, which is a swab?

BERNARD CARLON: No, they are not.

The CHAIR: So they are tested for in terms of impairment?

BERNARD CARLON: Absolutely.

The CHAIR: If a police officer believes you're impaired, they can—

BERNARD CARLON: Arrest you for the purposes of that—

The CHAIR: And then a blood test.

BERNARD CARLON: Yes, and that offence is the equivalent of a high-range drink driving offence.

The CHAIR: Exactly. At a roadside test, how do they establish if you are impaired on opiates?

BERNARD CARLON: It would be the manner of driving that they observed and any other physical characteristics of the individual in the vehicle. There are police procedures which, clearly, they would be better to respond to. Within the law, the manner of driving and the appearance of the individual that indicate some level of impairment provide them the opportunity to conduct a sobriety assessment.

The CHAIR: But, again, why do we not test for illicit opiates in RDTs?

BERNARD CARLON: Again, I'd say because it has come from a history of being a regulated drug, a medicinal drug. From our observations in the road trauma data, the two significant drugs that appear in the road trauma data are THC and methamphetamine, and—

The CHAIR: Sorry, amphetamines?

BERNARD CARLON: Yes.

The CHAIR: And alcohol, though, as well.

BERNARD CARLON: Louise might like to add.

LOUISE HIGGINS-WHITTON: If I can just add, as I highlighted, we currently haven't looked in depth in terms of aggregating the impact and the prevalence of, say, benzodiazepines in our trauma as well as opiates. It's an area that we've identified as needing further work, because raw data does sit there and there is a need for us to do further analysis of that piece. We are looking at providing a framework for looking at those drug classes that would enable us to then better understand the extent to which opioids and benzos are actually contributing to the trauma problem, which may then justify some reform in that space in a different approach other than the DUI approach, which has applied for a long time.

The CHAIR: You said there were 240 fatalities, I think you said, and 120 where cannabis was present in a post-mortem, to some extent, and there was no other illicit drug. Of those 120, how many had some form of prescription drug?

LOUISE HIGGINS-WHITTON: There will be some. We have not distinguished out whether some of those drivers, aside from those illicit drugs, may have had a prescription drug either at a therapeutic level or a misuse level.

The CHAIR: How come we don't have that data?

LOUISE HIGGINS-WHITTON: That's because we haven't got that framework for distinguishing out whether that drug was there for a therapeutic or a non-therapeutic reason. These samples come generally from when a person is injured in a crash. They're taken in a hospital environment where, if the person is alive at the point, a range of pharmaceutical drugs may have been administered as part of their treatment, noting that that patient care is the priority before the samples are taken for the purposes of our Act.

The CHAIR: But we were talking about fatalities. People who are dead aren't getting medicine.

LOUISE HIGGINS-WHITTON: These are drivers and riders involved in fatal crashes. Some of them will have died, that's right, so their samples will not have anything, obviously, administered post their death. Others are people that are still alive.

The CHAIR: So these figures would capture people who weren't at fault in an accident?

LOUISE HIGGINS-WHITTON: That is true. They may, yes, because it's all drivers and riders involved in fatal crashes.

Ms CATE FAEHRMANN: Let's say opioids. For example, somebody is involved—and this is relevant because we're looking at a bill that's coming before the Parliament that's going to extend the testing for illegal drugs for people who were in accidents that caused grievous bodily harm, not just fatalities. So I think it's quite relevant to consider in that way. When people get tested, say, in a fatality, does the quantity of the drug—for example, they have a super high level of certain type of opioid in their system, in their blood, compared to a little trace of an opioid that they may have taken according to prescription 15 hours ago, because they understand oxycodone, for example, can stay in your system. I've got it here from anything for up to 20 hours, but it can also turn up in drug tests up to 90 days, according to some things that I'm seeing. Is that tested, firstly, for example, for someone who could have a tiny little trace of THC in their system or they could have much more?

LOUISE HIGGINS-WHITTON: Yes. It does provide a concentration. There are analytical cut-off levels that our colleagues at Health can talk about—but are there to ensure that we can have certainty that the drug is there and is at that level. But it can find low levels of all drugs, be they licit or illicit.

Ms CATE FAEHRMANN: Who determines, if it just goes to a court, the determination around the level? Because we see the stories about somebody having a very high blood alcohol level, for example, and we all go, "Wow, that is very impacted by alcohol." What are the cut-offs? What's the determination? For example, again, a particular level of opioids where somebody could say, "Gee, that is really impacting them"—do we have those levels for any of the prescription drugs, for example? Who does that determination?

LOUISE HIGGINS-WHITTON: There are no levels established within the law. However, once there's a fatality and the blood sample is analysed at our NSW FASS health lab, the results of that analysis go through to a pharmacologist at New South Wales police for consideration of whether any charges should be laid. In any person's sample, you might have a mix of substances at various levels and a clinical determination is made as to whether those particular substances—because you could have many substances in a person's blood—are there in a level that's consistent with a clinical or a prescribed dosage or they may be there in a much higher level than that. That is a clinical investigation and look at that blood level and the mix of drugs. Because one particular drug concentration may not indicate impairment on its own but, if it's there with three or four other drugs or with alcohol, it may be that, based on that expert evidence, it's enough to indicate impairment.

Ms CATE FAEHRMANN: In terms of the statistics that you collect in relation to drugs and driving and the data that you provide, at this point when you're gathering data around fatalities, is it just the illegal drugs that you have in terms of data? Or do you have "This person was found in a fatality with opioids in their system", and that is collated and reported as well?

LOUISE HIGGINS-WHITTON: Those substances will be listed there in the sample record that comes across to Transport.

Ms CATE FAEHRMANN: Any trace—listed publicly in terms of the report?

LOUISE HIGGINS-WHITTON: Not publicly. It comes across—it's held in confidential information that we have in our drug database. We have protocols around who can access that particular personal information that we hold.

Ms CATE FAEHRMANN: In terms of the reporting that Transport for NSW and the road safety centre do in terms of the impacts of drugs and drug driving and fatalities, the drugs that are reported—alcohol clearly is a drug. The other drugs are currently illegal, even though medicinal cannabis is legal. They are the drugs that are tested for. Is that correct?

LOUISE HIGGINS-WHITTON: In addition to others as well. They're the ones that we report on because we have a framework around those for prescribed illicit drugs.

Ms CATE FAEHRMANN: That's the key question I'm asking—the reporting.

LOUISE HIGGINS-WHITTON: We don't report on the others.

Ms CATE FAEHRMANN: You're testing for others, for example, benzos or other things, but they're not in the drugs and fatalities, drug driving—that's not reported.

LOUISE HIGGINS-WHITTON: That's right—not systematically.

Ms CATE FAEHRMANN: Even though what is being reported is partly a legal prescribed drug.

BERNARD CARLON: We can't differentiate the THC records—

Ms CATE FAEHRMANN: I'm aware of that.

BERNARD CARLON: —from recreational use and medicinal cannabis. That's not possible either.

The CHAIR: How do you differentiate between opiates, between a legal—like unprescribed benzos and prescribed benzos. Because you can buy benzos on the black market. You can buy heroin. How do you differentiate when it comes to opiates and benzos in your reporting?

BERNARD CARLON: Again, the pharmacologist is making an assessment of the information that comes from blood tests that actually collate all drugs that are being tested for. They prepare that in terms of evidence for an offence. As Louise has pointed out—and she might want to just re-cover this—because of the complexities of the administration of drugs in that post-crash period, we haven't done the analysis of separating out those particular drugs at this point.

The CHAIR: I have one more question, which is about the Road Transport Legislation Amendment (Post-Crash Drug and Alcohol Testing) Bill. There's an absolute liability. If you're on any form of THC whatsoever, either prescribed or not, you should never be on the road. That's the current situation. With the post-crash drug and alcohol testing regime that's proposed, if there's a serious crash where there's grievous bodily harm involved, there will be mandatory drug testing of everyone who's involved in that. Therefore, if someone was in an accident with grievous bodily harm and they weren't at fault, if they have trace levels of THC in their system, they are in serious trouble, aren't they? They've committed an offence. They should not have been on the road and could be culpable.

BERNARD CARLON: Just to canvass the use of the word "trace levels"—

The CHAIR: Or any level.

BERNARD CARLON: —the laboratory, I understand, has a cut-off level that it applies in the detection of all drugs in that context—again, a matter for FASS from NSW Health. But, yes, a presence offence would be able to be detected if THC was present in the blood.

The CHAIR: So potentially we're just about to expand the class of people who may be subject to the testing, and therefore medicinal cannabis patients who may have had medicinal cannabis a week before, but it turns up in their blood in an accident—not at fault—committing an offence.

Ms CATE FAEHRMANN: Including cyclists.

LOUISE HIGGINS-WHITTON: Just to clarify, in relation to cyclists, the presence offence that we have doesn't apply. There is no risk of the proposed reform—which would extend those post-crash fatal provisions to cyclists—applying in that context. The presence offence doesn't apply. Just to provide a little bit more clarity, the bill that has been introduced would extend the provisions that we already have for post-fatal crashes—mandatory testing—to cases of crashes involving serious harm consistent with grievous bodily harm. It does not affect any of the offences under the Act. It doesn't change the offences. So, yes, it's an offence to have THC present in your system, and it will remain so. This may provide another way that drivers could be identified with having THC in the system, and that offence could apply.

However, we have had a closer look at our fatal data—because obviously this is something that already occurs—and the charges that proceed against a driver after they've been involved in a fatal crash. I think it's important to highlight, when we talk about fault and not fault, that within our crash data we don't attribute fault or responsibility for a crash. That's something that's established through police investigations, charges and then the court processes. But we do identify a key vehicle in a crash. This is generally the vehicle that initiates the movement that results in the crash. It's not a direct indicator of fault, but it's a good proxy, in our experience. In some cases, detailed police investigations can find that other parties in the crash that aren't the key vehicle also

did something that contributed to the crash occurring, so it's not a perfect measure, but we have been able to further look at the charges that have resulted from fatal crashes in New South Wales.

You can get an indication of how frequently drug presence is pursued as a charge. That does indicate that the drug presence offences represent a small proportion of the offences following a fatal crash. They're typically in combination with another serious offence and involve the key vehicle controller. Over the five year period, 2019 to 2023, there were 238 drivers who, obviously, were not killed. They were convicted of at least one offence as a result of a fatal crash, and that was a total of 452 offences. So 99 per cent of the offences following a crash are associated with this key vehicle driver—a not-at-fault driver, generally. And 71 per cent of the offences for a key vehicle controller relate to serious offences involving death or serious injury, so not necessarily the presence offence. That includes dangerous driving resulting in death or GBH or negligent driving resulting in death or GBH.

Of the 238 drivers that were convicted with offences following a fatal crash, 38 were convicted of an illicit drug presence offence. That's over a five-year period. Most of the drivers were considered the key vehicle and had concurrent convictions for more serious driving offences relating to the incident. Drilling down further into those 38 drivers, 24 in our analysis had an illicit drug presence offence with THC present, which is around 10 per cent of the 238 drivers, and that THC may have been present with another prescribed illicit drug. In summary, while the law does apply and, in the event of a fatal crash, a driver who uses prescribed cannabis may be convicted of an offence, our data indicates that it's not currently a common occurrence.

The CHAIR: Thank you. I'm mindful I've taken up your time, Mr Murphy.

The Hon. CAMERON MURPHY: Thanks, Chair. Mr Carlon, earlier you spoke of roadside drug testing as a deterrent and described it as a success. How do you say it's successful? What are you basing that on?

BERNARD CARLON: Most jurisdictions operate a very similar program. Victoria's roadside drug testing program is similar to New South Wales. An evaluation of the Victorian random drug testing program independently conducted by Monash University Accident Research Centre found the system of the broad-based roadside drug testing, directly comparable to the New South Wales approach, had had a positive impact on road safety. Specifically, their report found the expansion in roadside drug testing in Victoria, from 42,000 to 100,000 in 2015 to 2017, has saved more than 30 lives and almost 80 serious injuries on that State's roads every year, and the further increases in roadside drug testing—

The Hon. CAMERON MURPHY: Why do you say that's happened?

BERNARD CARLON: They've done the analysis of the preventative effect of the roadside drug testing program—

The Hon. CAMERON MURPHY: So you're saying people—

BERNARD CARLON: —the same way that we've evaluated RBT over the years in terms of the reduction in trauma.

The Hon. CAMERON MURPHY: Yes, that's what I was going to ask about because it's quite clear from the evidence that the more alcohol you have in your system, the more impaired you're going to be. The evidence in relation to cannabis is quite different to that, where the roadside drug test is picking up potentially trace amounts that may not have anything to do with impairment or safety. We heard evidence earlier today from Mr Zammit, who described it, if my memory's correct, as a lottery effectively, where people are following the advice from their medical practitioner about how to use the cannabis that they've been prescribed. Some people are being picked up and prosecuted because they happen to come across an officer who administers a roadside drug test, whereas others aren't. He described it as more of a lottery, but not something that was changing behaviour.

BERNARD CARLON: Clearly this research indicates that it has and has had an impact on trauma. Just to clarify, the roadside drug testing program is scientifically calibrated in order to detect recent use of THC. There's a significant body of evidence that THC actually increases your crash risk by 40 per cent.

The Hon. CAMERON MURPHY: Sorry, when you say it's calibrated to detect recent use of THC, what do you mean by that?

BERNARD CARLON: It's an oral-fluid wipe. THC is retained in oral fluid.

The Hon. CAMERON MURPHY: I know how that works, but a doctor may say to somebody, "Don't drive for the next six or eight hours." They may drive, say, 10 hours later and still have trace amounts of cannabis picked up by that test.

BERNARD CARLON: They're unlikely to be detected by the oral-fluid device that's used in New South Wales because it has a cut-off threshold which only detects recent use. By far the majority of people would be detected within that eight-hour window.

The Hon. CAMERON MURPHY: The majority of people?

BERNARD CARLON: By far.

The Hon. CAMERON MURPHY: But not everybody. There'll still be people who will have been using their medicinally prescribed cannabis, according to the instructions of their doctor, that will still be picked up, won't there?

LOUISE HIGGINS-WHITTON: A lot of the research of what we know about how THC is eliminated from oral fluid—we definitely see after use a very significant spike in the THC levels and then quite a rapid drop-off in the oral fluid. We do know that those peaks are associated with close after the drug has been used. Most of that research comes from clinical studies that have been done of people using a recreational drug, but there has been some research that's looked at what happens to oral-fluid levels after prescribed cannabis medicine has been used. Swinburne university did a study only last year, I believe, which looked at this. It does show that you have the same pattern of a peak after use and then a rapid drop-off.

Some of those levels, the peak is lower than what you'd get for recreational use being consistent with the THC level, for some patients, not being as high. Within participants that were part of that study that looked specifically what happens for a person with a prescription, there was significant variation. It was a semi-naturalistic study. Participants were taking what they'd been prescribed. Those who were prescribed higher dosages presumably may have been those participants who had higher levels for a longer period.

The Hon. CAMERON MURPHY: You're still going to pick up people who are using it in accordance with their instructions.

LOUISE HIGGINS-WHITTON: That's right. However, most drivers in that study had dropped well below a detection level by six hours post-use. We can provide that study to the Committee, if you want to have a look.

The Hon. CAMERON MURPHY: If you can, that would be useful.

BERNARD CARLON: They wouldn't have been detected in a roadside drug test.

The CHAIR: If someone is taking medicinal cannabis in the capsule form, there's no way that they can be detected in an RDT.

LOUISE HIGGINS-WHITTON: I couldn't comment on that. I know there have been studies where they've looked at different forms of cannabis and how that affects the levels that you see after use.

The CHAIR: But if the cannabis doesn't appear in your oral fluid, it's just in your blood—if you take a capsule that you then ingest, then it's absorbed in your gut and then into your blood—you're not going to test positive in an RDT.

LOUISE HIGGINS-WHITTON: I couldn't confirm that because pharmacology is not our area of expertise, but I can say that it would be—

The CHAIR: It's not pharmacology; it's the test itself. Unless the THC ends up on your tongue, that's the only way it's going to be tested.

LOUISE HIGGINS-WHITTON: If there's contamination of the oral cavity with the THC, then there'd be a risk.

The CHAIR: Therefore, if there's not—because when you have a capsule, the capsule itself isn't THC. You ingest it and then you absorb it in your gut. If you decide to take your medicine in the capsule form, you wouldn't test positive to an RDT. Is that a possibility?

LOUISE HIGGINS-WHITTON: I expect it is a possibility, based on science.

BERNARD CARLON: The roadside drug testing program is measuring the THC in oral fluid.

The Hon. STEPHEN LAWRENCE: Mr Carlon, I think you said that over a four-year period the drivers involved in fatalities just with THC was 8 per cent. Is that right?

BERNARD CARLON: Correct, yes.

The Hon. STEPHEN LAWRENCE: I'm not sure what the right word is, but if you break that down for factors like age and gender, and then consider use of cannabis across the community, to what extent does that 8 per cent figure—and I suppose the other figures where there's a mixture of THC and something else—speak to an elevated risk from cannabis? I'm just thinking about a scenario where you might have 8 per cent but you might have something like that across the community that are smoking cannabis, and so it just turns up in the accident stats without necessarily of itself indicating an elevated risk.

BERNARD CARLON: What we would say is that in those cases the testing clearly is determined by the timing at which the bloods were taken in the test. It's clear that in many of those cases they're at a level that would affect your driving skills. I'm not sure exactly what your question is.

The Hon. STEPHEN LAWRENCE: I'll put it a different way. If you assume that there's a bias towards young men in the fatality stats, for example—which I think there would be; there would certainly be a bias to men—are you able to say to what extent that bias has an impact on these figures? If you randomly sampled 100 young men walking down the street, I wonder what percentage would have THC in their system. That's relevant in considering the significance of these statistics. Has that been disaggregated, if that's the right word?

BERNARD CARLON: We do have the data on the age and distribution of the fatalities in this area as well. Whilst, yes, there's an overrepresentation of males and also younger drivers, it is distributed across broad age ranges as well. Certainly the rationale for the programs that we have in place is actually in relation to the impairing effects of the use of THC. The reason why we're focused on programs to manage and reduce the occurrence where people take THC and then drive within a short period of time after their consumption is that the body of evidence is fairly clear that that's an impairing period for driving after you've consumed THC.

The Hon. STEPHEN LAWRENCE: I have one more question, and you might want to take it on notice because there's not a lot of time. In terms of the amount of fatalities where benzos or opioids of a prescription type are found in bloods, I remember reading Institute of Criminology stats and various stats from different sources that seemed to reflect that those two prescription drugs were—if you combine them—certainly turning up at a higher rate than cannabis. Can you take that on notice and give us some information about how often they're turning up in fatalities blood samples? I think you said, Mr Carlin, that there's more cannabis use going on than prescription drug use, for example.

BERNARD CARLON: Illicit use, yes.

The Hon. STEPHEN LAWRENCE: But if I'm correct in my recall of those stats, which is that if you put them together, they actually turn up in more fatalities than cannabis, then I'm interested in what that says about this link between accident and use.

BERNARD CARLON: Yes, absolutely, we can have a look at that data.

LOUISE HIGGINS-WHITTON: We can have a look at what we can provide. As I mentioned, at the moment we don't have a framework for looking at those substances. There are obviously a lot of drugs that can fall within that benzos class. Some of them, a person may have taken their particular medication and it may appear in a fairly low and therapeutic level. I think it might depend on the study. If the study is just looking for the presence of benzodiazepines, then you may find that they are present there in a level that's consistent with prescribed use across the community of those particular types of drugs, to some extent. There would probably also be misuse.

The Hon. STEPHEN LAWRENCE: I don't think so, on the stats I remember. I remember stats like somewhere between 15 per cent and 20 per cent of fatalities had either one of those two. That would seem higher than general use in the community, I would have thought.

LOUISE HIGGINS-WHITTON: The challenge for us is that without diving in and doing a detailed look at those cases, we won't necessarily know, without that advice from a pharmacologist, whether it was there in a level that's consistent with a therapeutic use, where you wouldn't expect there to be impairment if there was a stabilised dosage and a period of adjustment after, say, a prescription change or something like that.

The Hon. STEPHEN LAWRENCE: But if you're relying just on the statistics to compare the two then you could say the same thing about cannabis, right? You won't know whether that was in the person's blood to a level that impairs, but it's still factored into the 8 per cent that you presented to us with.

LOUISE HIGGINS-WHITTON: That's true. We can look, and we have looked, at a very raw level, at the level of cannabis that's in all those drivers that are appearing in our fatal crash stats. I think it's fair to say we have provided some of this information on the record, actually, in response to a parliamentary question from the Chair. You do see in those stats that there are fairly high levels of cannabis—of THC, to be correct—in those

drivers. It's not necessarily only drivers with a small amount from use for a substantial period of time before. It's definitely there in an elevated level.

The CHAIR: I apologise; we ran over time. That has to draw an end to that round of questions. Thank you very much for coming to provide the inquiry and this hearing with evidence. It's very much appreciated and it's going to be of enormous use in our deliberations. If there were any questions on notice, the secretariat will be in contact in due course.

(The witnesses withdrew.)

Deputy Commissioner DAVID HUDSON, APM, Deputy Commissioner, Investigations and Counter Terrorism, NSW Police Force, before the Committee via videoconference, sworn and examined

The CHAIR: Thank you for joining us, Deputy Commissioner Hudson. Do you have any introductory remarks or an opening statement you would like to make?

DAVID HUDSON: No, I don't, sir.

The Hon. SUSAN CARTER: Good afternoon. Thank you for being here, Deputy Commissioner. We're contemplating in this Committee the legalisation of cannabis. How might that impact police procedures relating to search and seizure and what training would be necessary to adapt to any changes that we may recommend and Parliament may accept?

DAVID HUDSON: Thank you for the question. I imagine it's what legalisation looks like. If it's totally legalised rather than being decriminalised, then we wouldn't be looking for it because it wouldn't be a crime. There are a variety of options available to your Committee to make recommendations, I would imagine. Training is something we constantly do. A variety of changes to legislation are constant. We continually update our staff as to procedures, especially in relation to searching and especially in relation to seizures if there's a legislative change. If there is a change, then our compliance with that, I would suggest, would not be an issue if there is an appropriate time for training to be delivered.

The Hon. SUSAN CARTER: Are you aware of other jurisdictions that have legalised cannabis and what impact, if any, that's had on the illicit trade in cannabis or organised crime?

DAVID HUDSON: I've had some experiences overseas, especially in the United States, where it's openly and freely available for purchase from shops in certain cities like New York, Las Vegas and San Francisco. For cannabis itself being decriminalised, there's a whole swathe of research that I read some time ago—and it is some time ago—that cannabis leads to other drugs. I think that's probably revealed in some of the drug testing that traffic and highway patrol do with detection of cannabis and a mixture of other drugs in an individual's system. The major cities of New York and Las Vegas have decriminalised cannabis. San Francisco has gone a bit further with other drugs and so did Portland in Oregon, which led to some quite horrific outcomes which have caused certainly Portland to reverse that decision and make it criminal again for drugs. But, specifically for cannabis, I'm not aware of impact on those jurisdictions. It's more the what is probably described as harder drugs that have had a major impact.

The Hon. SUSAN CARTER: Assistant Commissioner Glenn Weir from Victoria Police told the Victorian inquiry into the use of cannabis that studies from overseas show that legalisation has not eliminated black market supply or associated organised crime. Do you share those concerns or would you have a different view of the impact on the black market?

DAVID HUDSON: When any commodity is decriminalised—made legal—it becomes expensive in a legal framework as well. We've seen that in the tobacco trade. The illicit product is a lot cheaper than the valid legal product, so we've seen organised crime enter into that market. I've recently seen some evidence from one of our intelligence agencies that by next year illicit tobacco will be sold in higher quantities than legal tobacco in this country. Organised crime will take any opportunity—and we've seen that seeping into the tobacco trade—to make profit. If decriminalisation or legalisation of cannabis leads to opportunities for organised crime, they will certainly take it. That has been the evidence we've seen historically, that's the evidence we've seen overseas and that's the evidence we've seen here with tobacco, at the moment, and vapes. There will always be an opportunity for organised crime to take advantage of any loophole in any system. They will find it.

The Hon. SUSAN CARTER: We've had an extensive discussion this morning about driving while impaired by cannabis and some of the difficulties because we don't have the nice .05 or .08 like with alcohol. There were suggestions that what we should be testing for is impairment rather than the presence of THC. Does the New South Wales police have experience running impairment tests? What would an impairment test look like? Is it possible to do random impairment tests or would that have to be a post-crash test?

DAVID HUDSON: We don't have a lot of experience in impairment tests. We make observations for driving under the influence offences which are then presented to the court, but we're not experts in impairment. Significant training would be required to undertake that, if that ever came to fruition. The issue of THC and impairment—as you indicated, with alcohol it's quite a simple threshold, and alcohol over certain limits will impact individuals. THC will impact upon individuals differently, leading to a greater level of impairment. Frequent users won't be as impacted, I would suggest. Medicinal cannabis, at the moment, is not exempt either. We find people detected for cannabis at roadside tests who claim that they're using it for medicinal use. We have

fairly strong evidence from our clinical pharmacologist that if somebody is taking the levels of medicinal cannabis, then after six hours it won't reveal itself in a saliva test on the roadside.

It's quite evident to us that some people who are prescribed medicinal cannabis also use other drugs as well because it's cheaper—other forms of cannabis rather than just the medicinal cannabis that they are prescribed. It's a really problematic area when you consider the number of fatalities. I think it's sitting at about 16 per cent of fatal crashes involve positive blood tests for THC, which is a significant number, with a rising road toll. The road, traffic and highway patrol take their responsibilities very seriously, and not just with THC but with some other drugs that we detect as well. I think it's one in nine drivers that they pull over test positive.

The Hon. SUSAN CARTER: With respect to prosecutions for driving under the influence, how do you prove that? What are the evidentiary issues in a driving under the influence or an impaired driving prosecution?

DAVID HUDSON: Physical observations of a person's appearance. Under certain conditions, we can't charge with—when we don't get a reading for a drink driving offence, we have to go with observations. We look at being dishevelled, bloodshot eyes, slurring of speech, and unsteady on their feet—those types of indicators, which are then put before a court. The court makes its decision as to whether that individual was under the influence of something or not. On impairment, certainly, experienced drinkers and, I would suggest, experienced cannabis users would be able to—because I've seen this with experienced drinkers who ultimately might reveal a very high reading on the breath analysis machine but, to be perfectly honest, you'd have to really scrutinise them to actually realise they'd been drinking at all, but they have a very high content in their blood alcohol. It impacts upon people differently in relation to physical appearance, but what that impact is on their depth perception, their reaction time and everything else is really undetermined. Impairment might show in the physical signs. We might be able to detect physical signs of impairment, but what that does to the individual in relation to their ability to drive, I don't think that has been tested.

The Hon. SUSAN CARTER: We've had some evidence that, for example, medicinal cannabis users are responsible and could be responsible for deciding themselves if they were impaired. Is it your experience that people using alcohol and/or drugs are the best judges of their own ability to drive?

DAVID HUDSON: I think experience would show that they're probably the worst people to make a self-assessment of their sobriety, whether it be from alcohol or cannabis.

The CHAIR: Deputy Commissioner, cannabis has been prohibited and illegal in this State for nearly a century. Actually, we're up for 100 years this year. Has prohibition led to reduced rates of cannabis use, or are cannabis use rates pretty much static, especially over, say, the past few decades?

DAVID HUDSON: I don't think prohibition has reduced the level of consumption over the past hundred years, as you say, Sir. But if it was decriminalised or legalised then you wouldn't know what the level of consumption might be. It might be similar levels to smoking or whatever. I don't know.

The CHAIR: It's possible it could just stay the same. It's an illicit drug that's readily available and pretty cheap. Is it possible that use rates could stay the same?

DAVID HUDSON: I'd be guessing, sir. I'm not too sure what the experiences are overseas in relation to the usage rates where they've legalised cannabis. But I think there's a certain deterrent effect for a proportion of society who won't engage in cannabis taking because of it being illegal. I think that is a deterrent to a certain proportion of society.

The CHAIR: What cost is there to the NSW Police Force's budget of enforcing cannabis laws? Do you have a line item in your budget for the police who are out there detecting cannabis grows, arresting people, enforcing it and searching people? How much does it cost annually for the New South Wales police to enforce our current cannabis laws?

DAVID HUDSON: We don't have a particular line item in relation to commodities like that. We have a cannabis eradication team that sits within the Drug and Firearms Squad of State Crime Command. Their responsibility is to investigate major crops, whether they be hydroponic or in public parks. In the growing season up north they visit commands with a helicopter, identifying large-scale plantations of cannabis plants, sometimes unearthing over 10,000 plants in one crop; then they remove and destroy them to try and reduce that supply. They also look at hydroponic set-ups and target them as well. But that's just a particular unit of a squad at State crime that focuses specifically on cannabis.

The CHAIR: Could you take that on notice, the budget for just that unit? I think that would be interesting for the inquiry.

DAVID HUDSON: Yes, I certainly can.

The CHAIR: We've heard evidence from other sources and senior police that cannabis sometimes has been described as a startup business for organised crime. It's a relatively cheap and easy way to generate an illicit substance and an income. Are those major cannabis operations that you're investigating and eradicating usually associated with other forms of organised crime—other drugs, arms, human trafficking, that sort of thing?

DAVID HUDSON: As I said earlier, the criminals involved in organised crime will take any opportunity to make a profit. We've seen them move between different environments depending upon the profitability, whether it be cannabis, whether it be harder drugs or whether it be tobacco, where they can make the most profit for the least risk. Cannabis has certainly been seen as a precursor to potentially the supply of more serious drugs. Once an individual crosses that threshold of criminality, which at the lower levels cannabis supply and production might be considered as by some people in the community, it's not a long stretch to escalate for greater profitability within that environment, if the opportunities are there for those criminals.

We don't see organised crime, whether it be organised criminal networks or whether it be outlaw motorcycle gangs, focusing on one particular commodity generally. They will take any opportunity to make a profit, depending upon what opportunities present themselves to them. Cannabis at the moment is certainly one of those, as are other illicit drugs and illicit tobacco, and as are illicit vapes at the moment as well. We target criminal environments rather than commodities. We have a twofold process in relation to how we dismantle criminality. We have environmental targeting, looking at the group itself and taking any opportunity to charge them with an offence, or looking at the commodity and following those commodities themselves. In relation to cannabis and the work of the cannabis team at State Crime Command and the cannabis eradication program, they are very much focused on the commodity. In that, the organised crime elements are pulling the strings.

Ms CATE FAEHRMANN: Good afternoon, Deputy Commissioner. Why is it that so many people are still diverted or sent to court in terms of cannabis in New South Wales, despite us having the Cannabis Cautioning Scheme in place as well as, from last year, the Early Drug Diversion Initiative? Why is it that so many people are still going to court for cannabis possession and personal use?

DAVID HUDSON: It depends, I would suggest, on the circumstances of the detection by police. Obviously, the conditions of the Cannabis Cautioning Scheme were relaxed last February to align with the introduction of EDDI. There were certain preclusions prior to that in relation to the amounts. It doubled to, I think, 30 grams being allowed for a caution. Previously, the requirement was that if you had been convicted of a violence offence, a sexual offence or a serious drug offence, then you wouldn't be entitled to the Cannabis Cautioning Scheme. You had to consent to the Cannabis Cautioning Scheme. Those barriers to the use of the scheme were removed with the introduction of EDDI.

I go back to what I said before: It depends on the circumstances of an individual's detection by police. If they're being charged with a variety of offences, such as assault, break, enter and steal, and stealing a vehicle, and they have got cannabis in their possession, they will most likely be charged with the possession of that cannabis, even if it's a small amount, because it's in conjunction with a more serious offence—rather than charging them with the various offences and then giving them a caution for the cannabis possession. Some of the data is slightly skewed because when the statisticians look at it, they look at it as a single item. I think we need to look more broadly. I have spoken about State Intelligence Command in relation to this after the last budget estimates hearing in relation to EDDI and cannabis cautioning. We need to look at what other offences they were charged with at the time they were charged with the cannabis possession.

Ms CATE FAEHRMANN: I think with EDDI—I am trying to find the data, which I will have in a second—a significant proportion of the people caught with cannabis were still sent to court and didn't receive the option of that phone call. That goes to show that even with the diversion scheme, there are either too many requirements or too much discretion in terms of the police. It doesn't seem to be working there, even with EDDI. You just said it was relaxed a bit with the Cannabis Cautioning Scheme. But even with the Early Drug Diversion Initiative, it's still not working.

DAVID HUDSON: I think at the time EDDI was introduced, so that the cannabis cautioning aligned with it, it was the same set of criteria. The requirements of the Cannabis Cautioning Scheme were made more broad so more people could be captured by it, including the amounts being increased. Previously, prior to 24 February last year, when the Cannabis Cautioning Scheme was changed, if you had been convicted of a violence offence, a sexual offence or another drug offence previously, you were not entitled to a cannabis caution. Those restrictions have been removed. You would anticipate seeing an increased use of the Cannabis Cautioning Scheme. I don't have the statistics in front of me, but if that's not the case then I would suggest that possession of cannabis charges have been made in conjunction with the arrest of an individual for another offence as well. It would not be a police practice to charge with five or six break, enter and steal matters and then caution someone for the possession of

cannabis. You would charge them with that and put all charges before the court at the same time, to reflect their true criminality.

The Hon. STEPHEN LAWRENCE: Thank you very much, Deputy Commissioner, for your time. I just want to ask some questions about stop and search and cannabis and, I suppose, other drugs as well. Has anything significant changed in the last 10 or 15 years in terms of the way that the police use stop-and-search powers in respect of cannabis?

DAVID HUDSON: No, sir. Our powers come from LEPRA about our ability to have our reasonable suspicion in relation to someone and that threshold to search someone. If that reasonable suspicion is activated, then an individual can be searched, and then subject to whatever charges flow from what is found upon them, including cannabis.

The Hon. STEPHEN LAWRENCE: How common is it, in your experience—let's say across the State—for children to be stopped and searched solely on account of a suspicion of possession of a small quantity of drugs?

DAVID HUDSON: It would depend; I'm not aware of any data captured on that. I would suggest that it depends on the circumstances of where that individual was located. If they were coming out of a known drug supplies house, depending upon the individual officer's observations, that might cause a reasonable suspicion in their mind that they have the ability to search that individual. I don't think anywhere in the State of New South Wales do police on patrol go around looking specifically to search individuals for cannabis use, unless there are circumstances that would dictate that. As I said, the circumstances of the environment they're in, who they're with and observations made by police. If they see a transaction that would give them reasonable cause, they are entitled to search. But they don't patrol simply for the purpose of searching for cannabis.

The Hon. STEPHEN LAWRENCE: What about if young people are on suspect target management schemes or things of that nature? I know the names of those have changed over the years; I'm not sure what the current one is. Are cannabis laws used, then, to stop and search young people who might be suspected of being at a higher risk of engaging in other crimes?

DAVID HUDSON: The suspect target management plan has been discontinued. We don't utilise that process anymore, in relation to reducing crime. We now have a more holistic approach, which looks at crime within a particular area. It's called "prevention, disruption and response", PDR. A command will be required to, every month, have a PDR meeting, chaired by the commander of that command, look at the crime problems within that particular command and come up with solutions for that particular area, because they are specific to individual commands. All those documents are appropriately recorded. The commander is required to sign off on them.

At times, individuals will be known by that command to be committing crime. That can come from a variety of sources. It can come from a variety of informants within the community, or it can come from individuals' families, to be perfectly honest, that they are committing crime. If that's the case, then the reasonable cause or the reasonable suspicion of an officer working that command might be enlightened because of that knowledge, which may give them justification to search an individual who is in a potentially high-crime area, with the knowledge that they previously had and current intelligence of the crimes that had been committed in that area. And that could give them, as I said, reasonable suspicion to search someone.

The Hon. STEPHEN LAWRENCE: Back in 2013 in my previous job as a lawyer, I did a case for a 17-year-old boy in Broken Hill. He had an intellectual disability, he was an Aboriginal kid and there was an issue in his case about the lawfulness of a search. He'd been found guilty in the Children's Court of the possession of a small quantity of cannabis and there was an appeal where the lawfulness of the search that led to the seizure of that cannabis was the issue. There was evidence in the case by way of COPS events that showed that in the previous 2½ years he'd been searched 26 times by police on the street and no drugs were found on any of those 26 occasions. I'm just curious about your comment—about whether you think that's an unusual situation.

DAVID HUDSON: Every circumstance is different. We're now in an environment 12 years further on from that particular date. We don't have the Suspect Targeting Management Plan at the moment. We don't engage in that practice. I'm not too sure what the circumstances of that particular search were that found the cannabis. If I'd personally searched someone 26 times and failed to find anything, I would seriously doubt my ability to form a reasonable suspicion to search that individual again. But that's my personal perspective.

The Hon. STEPHEN LAWRENCE: I should say I don't think it was the same officer every time. It might have been, but I don't think it was.

DAVID HUDSON: But the circumstances of that individual, where they were frequenting, might have led to some of those searches. I'm not sure. As I said, the individual matters—if they were living or frequenting high-crime areas where offenders who were known to carry drugs were frequenting, then that might have led to—

the environment, as I said. As an organisation with State crime, certainly with environmental and commodity targeting, local commands target areas where crime is committed.

The Hon. STEPHEN LAWRENCE: The reason I raise it is it seems like, in terms of the public interest in searching people on account of the possession of cannabis to try to reduce that incidence of criminality occurring, if that was actually the purpose of those searches—that is, to find cannabis—it would seem like an extraordinary use of resources. It suggests to me that cannabis laws might be being used to pursue other police objectives in terms of other criminal offences that might be more serious. I was wondering if you think that is the case.

DAVID HUDSON: No, I don't. I'm unaware of—unless an individual who is a known cannabis supplier is being surveilled by police and we're pulling people over as they leave that premises to try and justify potentially a search warrant on those premises, I wouldn't suggest we would be ever targeting specifically for cannabis in an individual. Unless a drug dog—well, the drug dogs indicate drugs, not specifically cannabis. It's not a commodity that we specifically go searching for as a commodity on individuals. We look at it from the environment. We look at cannabis plantations. We look at hydroponic set-ups. We look at drug suppliers. We look at drug houses that supply cannabis, but most usually they supply other drugs as well. We don't specifically search individuals with one intent in mind of possession of cannabis, unless the individual is well known to be always carrying cannabis.

The Hon. STEPHEN LAWRENCE: You're saying that you don't think that general duties police officers search people solely on account of a reasonable suspicion of possession of cannabis, that they somehow shy away from that if they form the requisite suspicion, because they wouldn't consider that serious enough criminality. Is that what you're saying?

DAVID HUDSON: Unless the circumstances dictate that an individual might be carrying cannabis, the reasonable suspicion doesn't surround the commodity. On most occasions it surrounds the behaviour of the individual. My point is that I would be very surprised, unless the environment that the individual is in and the circumstances that they came under notice from police led police to specifically say that the person could be carrying cannabis. It would be more a general search looking for criminality, based on suspicions and the area that they are in, the behaviour of the individual, the people they are frequenting with and so on. That might lead to an individual officer's reasonable suspicion to search under LEPRA.

The Hon. STEPHEN LAWRENCE: In terms of black market issues—and you talked about tobacco—there is obviously a black market in tobacco. We have heard some evidence that that might be explained by the high taxation of tobacco. We also had some evidence from the Crime Commission to the effect that there is not a black market in alcohol, except maybe for certain types of alcohol in cultural communities. Generally speaking, in Australia, there is not a black market in alcohol, which tends to suggest that legalisation of all products doesn't always lead to a black market. In terms of cannabis, if legalisation was to be looked at, we've also had some evidence that the factors that might determine whether a black market does emerge would include the price of the cannabis and also how widespread its availability was. For example, if you couldn't access it in most of the State, then you're more likely to have a continuing black market. Apart from its provision and its price, can you think of any other factors that might go towards determining whether, in the context of a legalised cannabis market, you would continue to have a black market, such as you do for tobacco?

DAVID HUDSON: If you look at it specifically as a commodity—whether it is cannabis or any other commodity—organised crime involvement will come down to their ability to make a profit out of it. If there are opportunities for organised crime to make a profit out of cannabis if it is decriminalised or legalised, they will take advantage of that, as they have done with tobacco. Tobacco is driven largely by taxation and the price of legal cigarettes. That is not the case with vapes. Vapes have been prohibited. Organised crime are taking advantage of that total prohibition on vapes to get them into the country and sell them. Vapes are prohibited, and now we are talking about legalising cannabis. I am not too sure where that sits with society's expectations. I am not an expert on that. Certainly, opportunities for organised crime will be taken if they are available to them. If cannabis is decriminalised, I am not too sure what that would look like in New South Wales. I am not too sure what the price would be. I am not too sure how that would be regulated as it is in other countries to a certain degree still. I would be guessing as to what that would look like. But I will say that organised crime will take advantage of any opportunity to make a profit where they can.

The Hon. STEPHEN LAWRENCE: I have one more question, and then I think Dr Kaine has one. It always struck me as strange, as a criminal lawyer—noting that in your evidence you described cannabis as a less serious drug than other drugs—that there is the same maximum penalty for possession of, let's say, a very, very small quantity of cannabis as there is for possession of a much larger quantity of methamphetamine, for example. If it's not such a quantity that it becomes deemed supply, it has got the same maximum penalty of two years, irrespective of whether it's a small quantity of cannabis or a larger quantity of meth. It is the same for the supply

offence. It is the same maximum penalty for the supply of cannabis, whether deemed or otherwise, as it is for the supply of methamphetamine, unless you are getting into, obviously, commercial quantities or other aggravated quantities. Do you have any thoughts on that? It seems a bit odd for the maximum penalty to be the same for cannabis as it is for more serious drugs.

DAVID HUDSON: I haven't really turned my mind to it. Obviously cannabis has its own cautioning scheme and has had it since the year 2000, following the 1999 Drug Summit. The Early Diversion Drug Initiative commenced on the 29 February last year for other small quantities of drugs, so they're more or less replicated in that environment with health interventions available, or the ability of the individual to seek that rather than—under EDDI, certainly—go to court. Obviously with a Cannabis Cautioning Scheme, they get a caution but they are also entitled to health assistance if required, similar to EDDI.

In relation to the maximum penalties of the specific offences, ultimately, no matter what the penalty is in the statute, it's the discretion of the court as to what's awarded based on the circumstances. There may be circumstances where possession of an amount of cannabis is more serious than the possession of an amount of some other drugs, such as cocaine or MDMA or methamphetamine—I'm not sure—but that's for the court to determine. There are maximum penalties available based on the circumstances but the courts certainly take a wide amount of things into consideration before they issue a sentence.

The CHAIR: Dr Kaine?

The Hon. Dr SARAH KAINE: I think I might put mine as a supplementary.

The CHAIR: All right. Thank you very much, Deputy Commissioner. There were a couple of matters taken on notice. The secretariat will be in contact with you in due course to get an answer to those. Thank you very much for the work you do on behalf of the people of New South Wales, and for taking the time to appear at this hearing and assisting this inquiry. We appreciate it.

(The witness withdrew.)

The Committee adjourned at 15:15.