Montu - Inquiry into the Impact of the regulatory framework for cannabis in New South Wales - Response to questions on Notice

Question 1

The Hon. JOHN RUDDICK: Mr McCrone, about the Tasmanian thing, you were saying that the prescription is an automatic defence. I'm all for liberalisation. Is impairment a factor in Tasmania or is it just that the prescription gets you off?

MATTHEW McCRONE: My understanding is that it's just the prescription. But it may be—and we could take this on notice, perhaps—that the requirements in order to get the permission through the Tasmanian Department of Health and Human Services are ones where the doctor actually has to make an assessment of the patient as to whether they're fit to drive or not. I don't know. But it could be that there is some sort of assessment done at that stage.

The Road Safety Alcohol and Drugs Act 1970 allows for prescribed medicine use if the medicine was obtained and administered in accordance with the Poisons Act of 1971.

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Question 2

The CHAIR: You talked at the beginning in your introductory remarks about the 70,000 prescriptions or patients in New South Wales that your organisation is aware of or has carriage of. You must have some sort of indication of what cooling effect the roadside drug testing laws have had on accessibility. Can you quantify it? How many people do you think would be availing themselves of this medicine if they weren't worried about losing their licence, especially in the regions, or they weren't getting that advice from their GPs? Are there potentially hundreds of thousands more people who could benefit from this legal = medicine?

EDWARD STRONG: It's always difficult to speak to an exact number in that sense. What I can tell you is that I have personally—and I know many within our organisation have—spoken to patients who have said they might have tried medicinal cannabis once and found it to be particularly beneficial. They might have been on it for a longer period of time and they might have had their own experiences with it but they've had to stop or they have not been able to explore that pathway in treatment because of the roadside drug testing arrangements. I think it is particularly onerous on New South Wales to make sure that patients in New South Wales who could benefit from a treatment, who are potentially going through severe PTSD or are suffering from chronic pain, don't have a treatment option removed from them because a blood test would show that they were, potentially, several days or weeks ago, impaired.

MATTHEW McCRONE: Chair, we periodically do patient surveys with patients who choose to volunteer to opt in. We have done patient surveys in the past about driving and the impact of the driving laws on their life generally but also on their decisions of when to take the medicinal cannabis and when not to. I'll see if we can get some data for you on that that's specific to our New South Wales patients.

The CHAIR: That would be very much appreciated, Mr McCrone.

Our June 2023 National Patient Survey asked patients questions relating to driving. Of the more than 6000 respondents, 99% supported change to THC driving laws, 91% of patients worry they'll lose their licence, and alarmingly, 86% reported worse symptoms because they don't take their prescribed medicinal cannabis due to a need to drive. Furthermore in March 2024, over 11,000 NSW citizens signed a petition to the NSW Legislative Council calling for changes to the Road Transport Act 2013 to make it no longer an offence for an unimpaired driver to have detectable THC in their blood or oral fluid, provided they have taken their medication as prescribed.

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Question 3

The Hon. CAMERON MURPHY: I want to come back to this issue around Tasmania. When I had a look at section 6A of the Road Safety (Alcohol and Drugs) Act in Tasmania, it seems to be a complete defence as long as you're taking it in a way that's been prescribed under the Poisons Act.
MATTHEW McCRONE: Yes, in accordance with the Poisons Act.
The Hon. CAMERON MURPHY: It doesn't really engage at all with the issue of impairment. Is there a model somewhere else that you can point to that may provide a better way of dealing with the issue of impairment?
EDWARD STRONG: We might have to take that on notice and come back to you.
The Hon. CAMERON MURPHY: Yes, take it on notice and come back to the Committee on if you can see some other jurisdiction that has a model that deals with impairment, other than just a complete defence in the way that Tasmania does.

While the experiences from other jurisdictions, particularly from the United States of America, vary significantly, they can generally be categorised into four broad models:

1. Zero tolerance law: Prohibits driving with any amount of THC and/or its metabolites in the body. (Used in 12 US states and equivalent to Current NSW Law)

2. Per se law: Prohibits driving with a detectable amount of THC in the body that exceeds the legal limit, such as 5ng/ml (Used in 5 US states)

3. Under the influence: Prohibits a driver from being under the influence of or affected by THC (Used in 32 US states as well as 5 US territories)

4. Permissible inference law: Applies if THC is identified in a driver's blood in quantities of 5ng/ml or higher. If so, it is permissible to assume that the driver was under the influence. (Used in Colorado only)

Further information is available for the Committee via the below linked brief developed by the National Conference of State Legislatures:
https://www.ncsl.org/transportation/drugged-driving-marijuana-impaired-driving

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Question 4

The Hon. CAMERON MURPHY: So, in your view, you would need to distinguish between occupations, rather than dealing with the question of impairment?
EDWARD STRONG: I think you also have to come back to impairment. We in no way think that you should be impaired and working but, particularly for those occupations that are higher risk, you do need to be having a deeper look. For those occupations that are a lower risk, if you are not impaired, there should be no concern with your ability to do your work.
MATTHEW McCRONE: To take it further, it's aviation, it's police, it's commercial passenger vehicles and it's boats. Anyone who is in those industries, there's no question that—
The Hon. CAMERON MURPHY: Any industry could be dangerous, couldn't it, depending on what your particular role is or the type of work you're tasked to do? You could be a police accountant, where you may be no risk to anyone if you have THC in your system or if you're slightly impaired, versus a frontline officer about to effect an arrest. It's a completely different situation but same occupation, isn't it?
MATTHEW McCRONE: Agreed. But these are statutory. What we're referring to is where there are already statutory requirements for those industries. Beyond those ones where there are statutory requirements, we would say that there needs to be a testing regime that is best practice. I can give you the details of this on notice. NCETA at the University of Adelaide developed, some years ago, what a best practice model of drug testing looks like.
The Hon. CAMERON MURPHY: If you could provide that, that'd be great.

The National Centre for Education and Training on Addiction (NCETA) at Flinders University has demonstrated that workplace drug testing offers limited or no improvement to workplace safety. NECTA has also demonstrated that employees may also be reluctant to report near misses, and minor accidents and injuries due to fear of a workplace drug test.

NECTA has developed guidance on best practice workplace drug testing. NECTA notes:
Testing may have a limited role in improving workplace safety. However, for testing to have any impact, programs need to be based on 'best practice'. Best practice programs are based on principles of quality practice, and are accepted and endorsed by employees.

Best practice testing programs need to:

- *be justifiable*
- *be designed to address an identified risk*
- *adopt policies that are procedurally fair*
- *result in counselling, treatment, and rehabilitation rather than punitive outcomes*
- *target safety-sensitive rather than non-safety-sensitive work roles*
- *allow for employee input into the development and implementation of the program*
- *allow for a right of appeal*
- *adequately disseminate associated policy and procedures*
- *incorporate appropriate education and training.*

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(Pidd, K, Roche, AM. (2011). Workplace drug testing: Evidence and issues. National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide) Available at: https://nceta.flinders.edu.au/application/files/2115/0646/7809/EN454_NCETA_2011.pdf#:~:text=Evidence%20is%20inconclusive%20regarding%20the,or%20no%20effect%20at%20all.

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Question 5

The CHAIR: Mr McCrone, is there any research you could point to that Swinburne or the Lambert Initiative have done in this area? Could you take that on notice and provide us with any research on a similar comparable scheme where doctors or a researcher may be saying don't drive after four or six hours or until the morning?
MATTHEW McCRONE: Yes. What Swinburne has done to date has actually been with a driving simulator. They are patients who have brought their own medicine and have self-declared about their level of impairment before or after their medicine. What is yet to take place at Swinburne—and everyone is looking to this as being the answer for everything—is patients being enrolled and then actually getting in a real car and driving on a closed road. It seems the results of that trial will not be available until late 2026.
The CHAIR: We'll see about that. We're running a little bit over time.
The Hon. CAMERON MURPHY: If I can just ask also if you're aware, as part of that question that you're taking on notice, whether other jurisdictions have adopted that type of yardstick or have evidence of it. It's a problem everywhere in the world where people drive and have cannabis. Maybe you're aware of some other jurisdiction that has come to grips with it.
The CHAIR: If you could take that on notice, we'd appreciate that.
MATTHEW McCRONE: Yes.

When considering the use of a ‘yardstick’ it is important to note that its purpose would be to assist people in easily assessing if they are safe to drive or work after taking medicinal cannabis that was lawfully prescribed by their treating physician.

There is clear precedent from other medicines that cause impairment including antihistamines, sleeping pills, muscle relaxants, and cold and allergy products. With these medicines, patients are informed they can not drive by their doctor, the pharmacist, and a clear label on the medicines packaging. This is considered sufficient and it is only in medicinal cannabis where a patient is subject to testing intended for alleged criminals.

In relation to the concept of a ‘yardstick’ it is vital to remember it is used to inform recreational drinkers of the risk of driving shortly after consuming alcohol, it is not a medical process. Furthermore, it is not appropriate for public safety messaging to direct a patient to change the dosage of a medicine prescribed by a doctor.

Noting the above, there is no 'yardstick' that might compare an impairing dose of THC in the same way that there is an established view of a certain number of alcoholic drinks per hour these patients are undergoing a treatment. This is because alcohol is unique in its linear correlation between dose and impairment level.This linear correlation is why having a certain number of drinks per hour works for alcohol.

As such linear correlations do not exist for other substances, including THC, the idea of a 'yardstick', or an amount per hour, does not work for medicinal cannabis.