



**LEGISLATIVE ASSEMBLY FOR THE
AUSTRALIAN CAPITAL TERRITORY**

**STANDING COMMITTEE ON TRANSPORT AND
CITY SERVICES**

**(Reference: [Inquiry into the Road Transport \(Alcohol and Drugs\)
Amendment Bill 2026](#))**

Members:

**MR P CAIN (Chair)
MR A BRADDOCK (Deputy Chair)
MS Y BERRY
MS L CASTLEY**

PROOF TRANSCRIPT OF EVIDENCE

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**Acting secretary to the committee:
Mr A Walker (Ph: 620 50199)**

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents, including requests for clarification of the transcript of evidence, relevant to this inquiry that have been authorised for publication by the committee may be obtained from the Legislative Assembly website.

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Amended 20 May 2013

The committee met at 9.20 am.

PATTEN, MS FIONA, Chief Executive Officer, Medicinal Cannabis Council Australia

THE CHAIR: Good morning, and welcome to the public hearing of the Standing Committee on Transport and City Services for its inquiry into the Road Transport (Alcohol and Drugs) Amendment Bill 2026. Today, we will hear from the Medicinal Cannabis Council Australia, the Royal Australian College of General Practitioners, drug and alcohol harm minimisation organisations, Dr Michael White, and the ACT government.

The committee wishes to acknowledge the traditional custodians of the lands we are meeting on, the Ngunnawal people. We wish to acknowledge and respect their continuing culture and the contribution they make to the life of the city and this region. We would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people who may be attending today's event.

This hearing is a legal proceeding of the Assembly and has the same standing as proceedings of the Assembly itself. Therefore, today's evidence attracts parliamentary privilege. The giving of false or misleading evidence is a serious matter and may be regarded as contempt of the Assembly.

This hearing is being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be useful if witnesses used these words, "I will take that question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript.

We welcome our first witness, from Medicinal Cannabis Council Australia. Please note that, as a witness, you are protected by parliamentary privilege and bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

We have just over 20 minutes in this session. Do you mind if we go straight to questions?

Ms Patten: No problem.

THE CHAIR: If we have time at the end, we can let you wrap it up.

Ms Patten: I have a couple of comments about the ACT government submission.

THE CHAIR: You may well be able to go to that during questioning. You are, obviously, in favour of the change that is being proposed by the bill. For the record, I note that Mr Braddock, the deputy chair, has sponsored this as a private member, but he is here in his committee capacity and there are no issues otherwise.

Thank you for the update that New South Wales has passed its legislation to recognise the defence of cannabis in the system of a driver that is prescribed, as long as there is

no impairment. I have a very broad question. Let us focus on someone who is taking cannabis for a medical reason, under supervision and under prescription. Given the effect of THC on an individual, how is that person then in a position to judge? What guidance are they being given to say, “I’m okay to drive now”? I do get the point that it is like anything that an individual can be experiencing. “Is it a good time for me to drive?” “No, I’m about to go to sleep, so I won’t.” Is there anything in particular for those users of THC?

Ms Patten: The nub of this is that medicinal cannabis patients who take their medicine as prescribed must receive correct and good medical advice about when they are impaired and when they are not. We know that an awful lot, if not most, medicinal cannabis patients take their medicine at night-time. We know sleep deprivation is one of the main symptoms for which people are prescribed cannabis medicine. For them, they are sleep deprived. When they are sleep deprived, they are actually impaired to drive.

In that case, they take their cannabis at night-time and they have a good night’s sleep. They know that, seven hours later, they are not impaired. In fact, they are quite the opposite. They have had a good night’s sleep and they are quite alert. They can then drive more safely than when they were not using medicinal cannabis. Unfortunately, currently, they are prohibited from driving, even though they had it overnight.

Most doctors and all the medicinal cannabis clinicians that we have today will provide very detailed information to their patients. As part of the development of this legislation and as part of the implementation of it, we should certainly be creating clinical guidance for prescribers and for pharmacists, but we should also be providing really good clinical guidance for patients about this.

If you look at the research that was done in Victoria, they were testing the ability of medicinal cannabis patients. The patients took their medicine as prescribed, undertook a series of tests at two hours, four hours and, I think, eight hours. To be honest, even at two hours, or almost directly after, there was a modest level of impairment; but, after four to eight hours, there was really no indication of driving impairment.

We know that most medicinal cannabis patients have been on opioids, benzodiazepines or other significantly impairing medications, so they understand: if you are not feeling well, do not drive. But I agree, and I think the RACGP—in fact, most of the submissions—said that, as part of the implementation, we need an education program.

MS CASTLEY: I think you talked about safe use, and what is required. In talking about the practitioners that prescribe medicinal cannabis, there are online prescribers as well.

Ms Patten: Yes. Again, this goes to the implementation of this legislation. How is the ACT going to respond to or deal with interstate prescriptions? This is not required within the legislation, but it is required for the implementation. The bill, quite clearly, just says that you have a prescription that is from a TGA approved—I cannot remember the exact words. I think that is adequate. You might want to talk about interstate prescriptions. Yes, under those things, any doctor prescribing to an ACT patient should be providing the education and the information.

I know that, as a peak body, we provide guidance about this through our clinical working groups to all medicinal practitioners. If you are getting online any medication that might be impairing, the same should apply, and that guidance should be provided. Then you have the extra touchpoint of the pharmacy.

MR BRADDOCK: Going to your experience as a Victorian legislator, was there any evidence of their legislation leading to either increased or decreased road safety, as a result of its passage?

Ms Patten: No, not at all. It is a very modest piece of legislation, and I would not say that it is particularly satisfying. The Victorian legislation, in a nutshell, provides that, if a medicinal cannabis patient is pulled over, the magistrate now has the discretion to choose not to cancel their licence. Until that time, it was black and white: the licence had to be cancelled. However, the magistrate must take into consideration that the patient had a current prescription, and that the patient was not impaired at the time of the offence.

In 100 per cent of the cases that have been brought before a magistrate with medicinal cannabis patients, no impairment has been found, and every single one of those patients has maintained their licence. There was no indication that medicinal cannabis patients were driving impaired, at the time of being stopped.

I would like to add that Australia is the only country that does this. Australia is the only country that has prohibited medicinal cannabis patients from driving. I mentioned in my submission that the international safe driving guidelines clearly stipulate that you should not put a blanket prohibition on patients. You can put some conditions on them like, “Don’t drive for four hours,” or as prescribed by your doctor. In Victoria, it is proving that medicinal cannabis patients are careful. They are driving their kids to school; they are not going to put family at risk.

MR BRADDOCK: Also, comparing the Victorian legislation to that of Tasmania and New South Wales, which have passed this bill, do you have thoughts in terms of what are the strengths or weaknesses of any of those models, and which would be the best for the ACT?

Ms Patten: The ACT legislation probably most closely mirrors the Tasmanian legislation, in that it recognises that medicinal cannabis should be recognised the same as any other prescription medication, and that medicinal cannabis patients should not be discriminated against because of the medicine they are taking.

Tasmania is probably a better case study, because driving with medicinal cannabis has never been illegal there. The legislation was broad enough that it captured medicinal cannabis when it became legal 10 years ago. They have not seen an increase in road accidents or road fatalities in Tasmania because of the availability of medicinal cannabis. I do not know whether your secretariat has had an opportunity to reach out, but the Tasmania Police have also been quite open and vocal about this. In Victoria, we certainly heard from them that it was nothing—nothing happened.

THE CHAIR: Have Tasmania Police come out with statements saying—

Ms Patten: Yes, I believe they have. I am happy to take that question on notice.

MR BRADDOCK: Please.

THE CHAIR: Yes, if you are happy to provide what they have said.

Ms Patten: Yes. I have not read it recently, but I know there has been one.

THE CHAIR: Are you aware of whether the police initially opposed the relevant bill? It is okay if you do not know.

Ms Patten: Chair, it was not even a matter of opposing it, because the Tasmanian legislation was broad, in that it said that it was a defence to a drug-driving charge that the patient was taking a prescribed medicine. It did not carve out THC. It meant that, if a patient tested positive for an amphetamine, if they showed that they were taking an ADHD medication or another medication, there was no offence. That section of their legislation extended to medicinal cannabis patients.

MS CASTLEY: You talked about the safe use.

Ms Patten: Yes.

MS CASTLEY: Also, still on impairment, how can a person consuming medicinal cannabis, or others who might be present, distinguish whether they are impaired? I think you said there was that two-hour, four-hour—

Ms Patten: Yes.

MS CASTLEY: I have never used cannabis in any way, shape or form, so I do not understand. Someone might have a prescription and use it incorrectly, by taking it in the morning, or whatever the problem is. For instance, someone might get a prescription and decide to grow their own plant, and do it that way, which, obviously, is incorrect. How will the police be able to tell what is going on?

Ms Patten: Ms Castley, I think you raise really important and crucial questions around this. This bill, obviously, is not directed at a person who is growing a plant at home and self-medicating. This bill is only directed at patients who have a prescription from their doctor which has then been dispensed by their pharmacist. At those two touchpoints, they are provided with guidance and advice. If, say, they are taking a broad-spectrum medicine—it might be half-CBD, half-THC—the THC might be very low, but it will show up in a drug test. It probably will have a minimum impairment. But the doctor that has prescribed that, the approved prescriber, will be able to provide that advice to patients.

I have had serious surgery and I have taken opioids. I know that I cannot drive. I was a medicinal cannabis patient. I am not now, but I was; and I can tell you that I would know. This goes back to the education element of it, and I think it goes back to a point I wanted to make about the ACT government submission, which raised this.

MS CASTLEY: Yes, that was going to be my next question.

Ms Patten: They stated that that evidence came from the Lambert initiative. The Lambert initiative is very supportive of driving reform. I noted that they had not put in a submission to this inquiry, but I would note that they would be very supportive of this reform, as they were in Victoria, Tasmania and New South Wales.

The submission is wrong. They said that the study “revealed all users underestimated the extent to which THC impairs their driving”. In fact, that study did not find that at all. The study found that most cannabis users in the ACT appeared to have realistic beliefs about their impairment.

This does not differentiate between someone who grows a plant on their patio or someone who has a prescription as well. If you say that the majority of cannabis users in the ACT understand when they are impaired and when they are not, and you add the mitigating element of medical advice and pharmacy advice on top of that, I think you can really mitigate those risks. Again, I go back to the fact that they never said that all users underestimated the extent of the THC. In fact, the study said that the vast majority of users do not underestimate.

THE CHAIR: If impairment is the test, would the council support any user of cannabis—recreational or otherwise—who is not impaired, and it is in their system, not being found guilty of an offence if they are driving?

Ms Patten: It is hypothetical. With the Medicinal Cannabis Council, the name is in the brand. We are not about adult use. As I was mentioning to Ms Castley, how we can mitigate risk is through that patient advice, that doctor relationship and that pharmacy relationship. A medicinal cannabis patient is being treated with a substance. This goes also to the ACT government submission and another error they have made in it. They know what they are getting. They know what is on the packet. With the pastille or the oil that they are taking, they know what it is. The same cannot be said for someone who has grown it in their backyard.

MR BRADDOCK: You mentioned that there was another error in the government submission.

Ms Patten: Yes. This really got my back up. It said:

For products not approved by the TGA, the amount of THC contained in a medicinal cannabis product may vary between batches. In practical terms, this means that a person cannot rely on experience to predict the effects of a medicinal cannabis product.

That is not true. Yes, when the plant is grown, there may be differences in the batches, but this is a plant. This is a medicine that is regulated by TGO 93, by GMP practices. It is regulated in almost exactly the same way as any other medicine, except that it is not an approved medicine. However, when it goes through that process, the batch is tested. When it goes through the manufacturing, the manufacturing is tested. And when it goes into the medicine jar, what it is tested for before it goes into the jar is what is on the label.

If you have been prescribed, say, a 10:10, a 10 CBD, 10 THC medicine, there might be different batches, but, absolutely, it would be a serious criminal offence for a pharmacist in the ACT to provide a medicine that was not exactly what it said on the label. I think that was a really misleading statement in the ACT government submission, saying that that was not the case and that there were variations in batches. Variations in batches do not mean a variation in the medicine that is given to a patient.

MR BRADDOCK: Are you aware of scientific research about the comparative risk between THC use versus opioids, benzos or other distractions or rogue behaviour?

Ms Patten: Again, I thought this was one of the most curious statements that the government submission made, when they said:

In the context of driver impairment, the risk posed by opioids is lower than that posed by THC.

How could anyone really think that opioids, and the impairing effect that opioids have, are less dangerous than THC? I think there was a secondary submission from Dr White. I would reiterate that, and I would say that he has provided ample evidence to show that this is just not the case, and that, if we are looking at cause of death across the spectrum of impairing medications or impairing products, alcohol is at the top, followed probably by opioids, and with cannabis coming down at a very low third.

If you were to look at cause of deaths—and this is looking at recreational users as well as medicinal users—they would say that, for every 30 cause of death by opioids, there are six cause of death by cannabis. And that does not take in the mitigating circumstances of a medicinally prescribed product, with all the safety elements that sit around that. Dr White will probably speak to that in his evidence.

MR BRADDOCK: To test a different witness's evidence, because they will not be coming along today, the Alcohol, Tobacco and Other Drug Association said that THC consumption is 20 to 40 per cent higher risk. They said that, to put this in perspective, interacting with a passenger was 40 per cent higher, listening to a radio was 90 per cent, a blood alcohol concentration of .05 is 100 per cent, and texting whilst driving is 510 per cent. Does that sound about right to you?

Ms Patten: It does. If I speak from my personal experience, yes, sometimes I just have to drive quietly. I thought the RACGP, in their submission, made a very good point on that, in that they said that the effects of THC on driving are generally modest and similar to the effect of low-dose alcohol. I think that is where we should be looking at THC in this debate and in this inquiry. By all means, I think that people must not be driving when they are impaired, whether that is from alcohol, sleep deprivation, listening to the radio too loudly, texting or using their medicine. But there are ways that we can ensure that patients can drive safely, the same as we do for other prescription medication.

THE CHAIR: Would the council support zero tolerance for alcohol offences, as an example?

Ms Patten: I do not think it is necessary. Certainly, when you look at that, I think the ACT does have “cocktail” driving offences. When you look at the evidence, it is not

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there, to say that there is an exponential effect of alcohol plus THC. However, many medicinal patients would say that, if that was the price they had to pay to be able to drive and use the medicine that is helping to improve their lives, they would be willing to make it.

THE CHAIR: We will have to wrap up now. I would like to thank you for your attendance today. If you have taken any questions on notice—I think you volunteered—

Ms Patten: I think there was one, on Tasmania Police.

THE CHAIR: Thank you. Please provide your answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. We will have a short break while we change witnesses.

Hearing suspended from 9.45 to 10.05 am.

COHEN, MR RHYS, Senior Police Officer, Penington Institute

PETTY, DR JAMES, Senior Policy Officer, Alcohol and Drug Foundation

THE CHAIR: We now welcome witnesses from the Alcohol and Drug Foundation and the Penington Institute. Please note that, as witnesses, you are protected by parliamentary privilege and bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. I will lead into questions. Are you comfortable that people who are prescribed THC are given sufficient guidance as to self-assessing their level of impairment to drive?

Dr Petty: Sorry, was that: am I comfortable that they are currently given enough guidance?

THE CHAIR: Yes.

Dr Petty: I would say that I am probably not comfortable that they are given sufficient guidance. I think there are challenges in the practices of prescribing medicinal cannabis at the moment that are currently being explored by the TGA and which the states and territories have, I suppose, limited capacity to intervene upon. There is Australian research—certainly not nationally representative—where one Australian study that found approximately three per cent of medicinal cannabis patients were provided guidance around driving by their prescribing clinician and fewer than one per cent were provided guidance by their dispensing pharmacist.

So I would say I am not comfortable that people are currently provided enough guidance, but I am certainly confident and comfortable with the idea that people can be effectively provided sufficient guidance to help them take their medication in a safe way.

THE CHAIR: Do you think that the bill should not be enacted until those measures are completely and comprehensively in place?

Dr Petty: No, I would not say that. The ADF would support the bill in its current form and would think that that work can be undertaken concurrently, rather than needing to achieve a certain level of guidance provided in order to then pass the bill.

Mr Cohen: I broadly agree with James's assessment. However, it has been my personal experience that patients who are prescribed medicinal cannabis are often told, "You cannot drive while taking this." Whether that patient experiences that communication as guidance or a blanket instruction that is not particularly helpful or constructive is unclear to me. As James pointed to, it would be a completely normal and, I would assume, expected part of any reform of this nature that the community and relevant stakeholders are brought up to speed on the implications of the reforms and how they can safely navigate them. I think some of the lack of education and guidance from governments, in particular, on this issue is due to how apparently complex or overly complicated some governments in Australia are currently making this issue when the solution is, I think, relatively straightforward and simple and is reflected in the current language of the bill that is proposed.

THE CHAIR: What gaps are there at the moment in the guidance and what are the challenges? What do you think is flawed or a challenge, as you said, in the prescription regime?

Dr Petty: I think the challenge in the prescription regime is that our current settings are not fit for purpose. They are a special access scheme that is not designed to be the primary means through which people access a medicine. They are supposed to be used in exceptional circumstances, but, for a variety of reasons they have become the primary channel of access for literally hundreds of thousands of people to access the medication. Because those schemes are used to access medications that are not traditionally available in Australia or are not listed on the Register of Therapeutic Goods, it can be light on in terms of regulations, and then we have seen the medicinal cannabis industry, or perhaps some sections of the medicinal cannabis industry, move in and perhaps exploit some of those looser regulations compared to, say, a medication that is on the ARTG.

As I said, the TGA are undertaking an inquiry at the moment around how to reform this area and develop a more fit-for-purpose system for accessing medicinal cannabis products in Australia. As well as AHPRA, they are also undertaking some education activities. I agree with Rhys somewhat in that it perhaps should not be a complex piece of work, but it nonetheless is, and those prescribing challenges are not going to be resolved in the next couple of years. Rhys, do you have anything more to add to that?

Mr Cohen: No; I broadly share your perspective on that, James. However, relevant to this meeting today, although those challenges with the overall medicinal cannabis access framework do exist and deserve scrutiny and are being worked on by various regulatory agencies, the role that driving safety or driving law reform plays in that framework, I think, is slightly tangential. However, it has been really encouraging to see regulatory organisations such as AHPRA really step up in recent months and years to provide more explicit and clear guidance to the healthcare professionals that they regulate about, “Okay, we have been doing medicinal cannabis for a while. Actually, this is what ethical conduct looks like. This is what appropriate conduct looks like. This is what we are concerned about. This is what we are looking into,” and actually proactively providing some quite useful and specific guidance on what people can do to make sure that they are performing their duties correctly.

I think the challenge when it comes to driving law reform is that in most jurisdictions in Australia the law says you cannot do it, and that is the end of the conversation. So there is no opportunity for similar organisations to come out with nuanced or supportive contextual information or guidance that might help people navigate the situation more safely, because the law says that they cannot do it. So, in the absence of law reform, opportunities for meaningful engagement and education on this issue are constrained.

Dr Petty: Yes; and I might just add that what the bill proposes is to treat medicinal cannabis the same way that the ACT currently treats other medications that can potentially impair driving ability, like opioids and benzodiazepines. From a public health and regulatory perspective, we actually accept a degree of risk in relation to those medicines. We do not test for them in roadside testing. But there are, I suppose, regulatory measures attached to those, such as warning labels on those medications that

say, “Do not drive or operate heavy machinery while using this medication.” Again, because medicinal cannabis products are accessed through those special access schemes, there is a lower regulatory floor attached to those. So those warnings are not included on medicinal cannabis products, whereas they are on opioids and benzodiazepines. But we actually do accept a degree of risk around opioids and benzodiazepines and driving. I would say that the goal here is not to achieve a point at which medicinal cannabis poses zero risk to driving, but rather an acceptable risk in line with the risk we accept with other medications.

THE CHAIR: Thank you.

MR BRADDOCK: My question ties back into the education that happens between the medical professional and the patient. A previous witness discussed interstate prescribers versus local prescribers. If we were to tighten the bill to include local prescribers to ensure that educational step happened, would that address your concerns?

Mr Cohen: I do not think so, only because we know that it is very common for people who are prescribed medical cannabis to be prescribed medical cannabis by a practitioner who is not in the state that they live in. If you were to restrict eligibility for this scheme, for this law reform, only to patients who live in the ACT and have been prescribed medicinal cannabis by a physician who operates within the ACT, I do not think you would substantially address the issue at hand. I do not know off the top of my head how many medical cannabis prescribers there are in the ACT, but I would assume they are fairly limited. There are also, I am sure, plenty of people who live in New South Wales or other jurisdictions who pass through or visit the ACT. You might create an unnecessarily complex and insufficiently effective scheme if you went down that route. Did I understand correctly what you were inferring?

MR BRADDOCK: Yes, you understood correctly. What would be the effective policy response? Would it include, for example, putting those stickers, like we do on opioids and other medications, onto THC products? Are there other steps we need to take to make sure that that educational element happens?

Mr Cohen: I would, in an ideal world, imagine that educational efforts would involve not just ACT Health and the relevant authorities at the territory level but also the TGA and relevant authorities at the federal level. This is not a challenge or a policy issue unique to the ACT. I am sure federal counterparts are acutely aware of that and would likely be, I hope, up for supporting broader community education—which is really quite severely needed and notably lacking overall for medicinal cannabis, not just with this issue. But, for that to happen, of course, you would need to have a policy or a reform that requires people to have a nuanced understanding or a more thorough understanding of or appreciation for the risk posed by medicinal cannabis as opposed to a policy that says you cannot do it.

MR BRADDOCK: Thank you.

MS CASTLEY: I am happy to hear from both of you on this one. How can an individual—or others who might be present with a person who takes medicinal cannabis—assess their own impairment before driving? How can police make assessments at roadside stops?

Mr Cohen: Do you want to take this one, James?

Dr Petty: Sure. I think it is a really complex area. Some available evidence points to two things. One is that people's ability to assess their own level of impairment on a case-by-case basis is limited or mixed. The evidence does not point to people being consistently or very strongly being capable of assessing their impairment. But what the evidence does point to is that medicinal cannabis users tend to be very, very careful about their medicinal cannabis use and driving. So, rather than trying to assess their level of impairment on a case-by-case basis or a day-by-day basis, what they tend to do is take steps that do not require that individual assessment. For example, if they need to drive, they will get that driving out of the way first before taking their medicinal cannabis product; if they live with someone they will ask them, or a friend or a neighbour to drive them if they have recently taken a medicinal cannabis product; or they will take their medicinal cannabis product and delay the need to drive.

The evidence around that self-assessment of impairment is not very strong, but I would not want to see a situation the only thing they are relying on is a self-assessment of their own level of impairment. What we want is to really strengthen and support guidance and education around medicinal cannabis use, impairment and driving, and really encourage those risk mitigation strategies that are currently very, very widely undertaken by people who use medicinal cannabis. I suppose the risk of the current system is that, where someone, even if they have undertaken all of those risk mitigation strategies, is pulled over and detected with THC in their saliva and then they lose their licence or get fined, that really undermines those risk mitigation strategies because, if they are going to lose their licence and get fined regardless of undertaking them, that really disincentivises that. I will throw over to Rhys.

Mr Cohen: I agree completely, James. I will make two points. James mentioned prescriptions for opioids, sedatives and benzodiazepines—and I think close to one in five Australian adults are currently prescribed an antidepressant. I am not a scientist, but I believe that all of these drugs have a similar impairment profile to most ways of consuming medicinal cannabis. The way in which people assess themselves as to whether they are fit to drive with those drugs is based on the advice they get from their doctor, the warnings they receive, the self-assessment and just using common sense. By and large, these are responsible adults we are talking about. The volume of those drugs that are currently being prescribed across Australia are, in orders of magnitude, greater than any possible future levels of medicinal cannabis prescribing, and we are not concerned about that, by and large. It is not a topic of discussion or debate in parliaments.

The other thing is that often a comparison is made between cannabis and alcohol. These are very different drugs for so many reasons, including how they change people's perception of risk. The evidence, to my understanding, shows that, when people drink alcohol, they overestimate their capability and they become overconfident in a really risky and harmful way. But, actually, with people who use cannabis, the opposite tends to be more often the case—that they feel more impaired than they actually are sometimes and are even less inclined to drive than they otherwise would be. So we need to keep that in mind as well.

MR BRADDOCK: Mr Cohen, you mentioned how a group of drugs has a similar impairment risk profile to medicinal cannabis. Would you be able to provide to the committee on notice any studies that point to that?

Mr Cohen: Yes, absolutely.

MR BRADDOCK: Thank you.

THE CHAIR: I would like to drill down a bit. You mentioned how there is need for reform of the prescription regime. Could you give us the detail? As much as you understand the current ACT prescription regime, what are the challenges that might raise concerns about the bill's passage?

Dr Petty: I am not sure I understand the question, in terms of the ACT's prescription regime, because the prescription regime is national. As Rhys said, there may be medicinal cannabis prescribers in the ACT, but people often engage with a prescriber interstate. My understanding is that Victoria and Queensland account for about 70 per cent of all prescribers. I am not sure I can describe the ACT's prescription regime.

THE CHAIR: That is okay. At the national level, then, what are the challenges and what needs to be clarified or improved?

Dr Petty: I will say a bit, but it is a very long topic that we could discuss for a very long time. The challenges are significant. As I said, the current prescription regime is designed to be for special access and designed for, generally, quite specific conditions. For example, one wing of the prescription regime is designed for palliative care. One of the others is designed for medical practitioners who are working in a very specific area. They apply for authorisation to prescribe medicinal cannabis for specific conditions or a group of conditions.

One problem is that the medications are not listed on the ARTG. They are assessed to a basic safety standard but not to the safety standard that medications that are on the ARTG are assessed to. They are not assessed for efficacy, they are not assessed for indications—what they are indicated to treat versus what they are not indicated to treat—and limited guidance is provided to the prescribers around prescribing practices. I am really struggling to summarise all the challenges with the current regime.

THE CHAIR: That is okay. We might jump to Mr Cohen in that case.

Mr Cohen: James is right: we could be here all day to get into the guts of it. At a high level, regarding where the current problems come from, for many decades in Australia there has been significant and enduring demand for and use of cannabis for medical purposes by Australians, in the absence of law reform. That is why we are here today. Lots of Australians already use cannabis for medical purposes and the government felt it would be better to provide access to lawful, regulated products under doctor supervision than to continue to allow sick people to use unregulated products bought from the illicit market. So it is about significant unmet demand plus law reform.

The main handbrake has been how many doctors, physicians and healthcare practitioners are interested in, educated about and willing to consider medicinal

cannabis for their patients. When medical cannabis was legalised, the significant wave of unmet demand met a very narrow legal channel, and that incentivised the creation of the cannabis-only specialist telehealth clinics. People who were trying to get access to medicinal cannabis lawfully and appropriately could basically only go to an online telehealth clinic in Queensland for a significant part of the scheme. We are talking about the last 10 years. That created a path dependency, where it became normal and accepted for medicinal cannabis to be accessed through these vertically-integrated telehealth cannabis clinics. An industry grew that was structured around that approach. So there has been limited incentive for the cannabis industry, governments or other relevant stakeholders to expand the number of independent healthcare practitioners who are educated about, interested in and willing to consider prescribing medicinal cannabis.

The long-term solution to many of the problems faced by the medicinal cannabis sector in Australia is to democratise or spread out the access pathways available to patients so that they can just go to the GP they normally see and have a reasonable conversation about medicinal cannabis and whether that might be appropriate for them. That will allow a lot more better outcomes for patients, better conversations between doctors and their patients, better community knowledge and better health outcomes overall.

Dr Petty: There are also swings and roundabouts with these cannabis-only telehealth clinics. You basically cannot attend without getting a prescription for cannabis. It would be very difficult to make an appointment with one of these clinics and leave without a prescription. Other perverse outcomes include the fact that there are often stronger products. Higher concentration THC products are actually cheaper than lower THC and/or mixed products. A product with a fairly high amount of THC in it is actually cheaper than, say, a CBD-led product. I have heard from a colleague at the TGA that there are medical practitioners reporting that their patients cannot actually afford to move to a lower THC product.

On the other hand, you hear incredible stories about veterans in particular and some other people who have had long-term mental health problems, long-term AOD problems and long-term chronic pain problems, where medicinal cannabis has really changed their life, and there are good practitioners out there that people are having really meaningful conversations with. So it is a kind of swings and roundabouts situation. I do not want to come across as all doom and gloom about it. It is very mixed.

MR BRADDOCK: The ACT is an island in New South Wales, and New South Wales have just passed their bill. Do you have an assessment of how this bill compares to the models in New South Wales, Victoria or Tasmania, in terms of its effectiveness in enabling people to drive safely without impairment whilst utilising the substance?

Dr Petty: Absolutely. The ADF has concerns about the New South Wales bill. Even though it is moving in the right direction and we certainly welcome reform in this area, how it is going to operate, in terms of a person having their licence suspended for a day, is fairly onerous. And there is the threshold that they are using. I am not a pharmacologist, but my understanding is that 50 nanograms of THC is a fairly low threshold that probably most medicinal cannabis users are going to exceed. The ADF certainly has some concerns about how effective it is going to be and that it might end up not providing the defence pathway it is intended to.

In Victoria, we are in a bit of an interstitial period. It is really positive that magistrates now have the power to dismiss charges when a person has a prescription, but it is still a fairly onerous system. The Victorian government are awaiting the outcomes of a few studies that are currently being undertaken to inform the development of their model. Currently, Tasmania probably has the best approach to THC impairment in the country, in that THC is listed as a medicine alongside opioids and benzodiazepines and is treated in line with those. I would say Tasmania currently has the most promising system.

MR BRADDOCK: You refer to the New South Wales threshold of 15 nanograms. Whilst it might capture the medicinal cannabis users, is that a reliable indicator of the level of impairment leading to road safety risk?

Dr Petty: No; not at all. Unfortunately, in contrast to alcohol, where blood concentration is a very reliable indicator of impairment, with cannabis there is absolutely no correlation between the level of concentration in blood or saliva and the level of impairment. I was reading a study the other day that assessed driving impairment with edible cannabis products—gummies—and they found high levels of impairment and very low levels of THC concentration in blood, below five nanograms per millilitre.

MR BRADDOCK: Thank you.

MS CASTLEY: What indicators would you like to see reported as part of ongoing monitoring and any evaluation of the reform? Are there outcomes that would suggest to us that the reform might not be working? What should we be looking at in the future?

Dr Petty: I would not be able to come up with an exhaustive list off the top of my head. I certainly think one would be monitoring the number of charges for cannabis intoxication—THC intoxication—while driving and also monitoring the number of people who are pulled over and their impairment is assessed but they are found to be capable of driving, or are non-impaired. I would also say the proportion of traffic casualties, serious injuries and/or fatalities, where cannabis is indicated and, in particular, where cannabis is the only indication—so not in the context of poly drug use and not in the context of cannabis and alcohol but where cannabis is the only indication—and, if possible, where that cannabis use has been part of a medicinal regime. That kind of data collection might be pie in the sky thinking, but, ideally, that is what we would be looking at.

MS CASTLEY: Thank you.

Mr Cohen: I would add to that: asking people who use medicinal cannabis about their experience of the reforms and whether they think they are working as intended. There was quite a lot of excellent qualitative research done by ACT Health in reviewing other recent drug law reforms that has been quite enlightening and helpful. I would hope to see something along those lines.

MS CASTLEY: Thank you. I am wondering about treatment commencement, dose changes and other circumstances where impairment risk might be higher, when you first start to take it and see how it goes. Do you think there are enough safeguards in this bill to handle that?

Mr Cohen: I would say it is not for this bill to be responsible for implementing or changing safeguards that are about clinical practice. This is about: given someone has been prescribed medicinal cannabis by a qualified healthcare practitioner, in accordance with the law, what then?

MS CASTLEY: Thanks.

THE CHAIR: We talked a bit about the prescription regime—the national approach and some concerns that you had. You did not take it on notice. It may well benefit the committee if you have a view about where the regime could be improved or what the risk points are if this bill is passed. That is an invitation. The committee has a report to write. Any further material lodged by any of our witnesses should be done very promptly to allow us to get onto our draft report. I will leave that in your hands. There is no compulsion, of course, regarding that.

Dr Petty: No worries. Rhys and I might have a conversation about that and we might submit something together.

THE CHAIR: Thank you. That would be very useful. On behalf of the committee, thank you for your attendance today. I do not believe any questions were taken on notice, apart from your offer to consider putting in a submission. Any questions on notice should be provided within five business days of receiving the uncorrected proof *Hansard*. Thank you.

Hearing suspended from 10.42 to 11.20 am.

WHITE, DR MICHAEL, private capacity

THE CHAIR: The committee welcomes Dr Michael White. Please note that, as a witness, you are protected by parliamentary privilege and bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. We will not have opening statements; we will go straight to questions. Something that was of interest to me in an earlier session was the national prescription scheme and whether that poses some challenges to the passage of the bill. Do you have any insights into the national prescription scheme and maybe some weak points in terms of passing this bill?

Dr White: No; I do not. My expertise is quite narrowly circumscribed. I am interested in the road safety side of cannabis and driving—whether cannabis is an impairing drug and how impairing, and whether it increases the risk of crashes and by how much. I am not particularly interested in the medicinal side of it—whether it works and what it works for—and I am not an expert on the details of legislation in various places. I know there are medical cannabis driving exemptions in New South Wales and Victoria. I do not know how effective they are. That is about all I know about the legislation side of it.

THE CHAIR: Thank you.

MR BRADDOCK: Dr White, you provided an additional submission which questioned some of the claims made by the ACT government in their submission. Most particularly, I am interested in the relative road safety risk of opioids versus THC. Can you please elaborate further on where you think the ACT government submission might be in error?

Dr White: They are just plain wrong. As far as I remember, they said opioids were more dangerous than cannabis. A major study was done. A consortium of university drug-harm researchers did a study—I should get that briefing out—on fatalities from opioids. They concluded that there were quite a few. My briefing says there are 30 fatalities a year on Australian roads due to opioids, and I can compare that with 135 from alcohol and six from cannabis. The opioid study involved a lot of assumptions. In fact, they said that it is really dependency on opioids—dependency and risky use—that kills hundreds of people from accidental opioid overdoses each year. Some of that infiltrates into the road safety arena and kills people on the roads. There was a certain amount of guesswork in that study, but it is probably the best we have for Australia, and the ACT government did not seem to be interested in it or aware of it.

Using a different method, a paper by Zahra et al—again drug-harm researchers—looked at all of the coroner files across Australia on the role of cannabis in road fatalities. They concluded that about six per year in Australia can probably be attributed to cannabis. So the best evidence that we have, and evidence is always questionable to some extent, is that opioids kill 30 Australians per year on the roads and cannabis kills six.

I do not think the ACT government even bothered to provide any references for stating that opioids were more dangerous than cannabis. I guess I have interpreted “dangerous” as “gets you into a fatal crash”. Perhaps they were thinking of something a bit different.

But, if you interpret “dangerous” as “gets you into a fatal crash”, I think the evidence is that opioids get you into a lot more fatal crashes than cannabis.

As far as cannabis goes, I have looked at a couple of coroner files where the coroner said cannabis killed a person, and I do not think it did. I was involved in a legal case for a woman who had not slept for 24 hours. She was weaving all over the road. She was THC positive and the coroner said that cannabis killed her. She obviously died from going to sleep at the wheel. Whether cannabis contributed to that, I do not know. That is the sort of case that would have been one of the six fatalities a year. There is guesswork all over the place, but I think the best guess is that opioids kill a lot more people on the roads than cannabis.

MR BRADDOCK: Dr White, I want to test another witness’s evidence. The Alcohol Tobacco and Other Drug Association referred to a study by Dingus et al, 2016—Guo and Lee—saying, basically, that the risk of listening to a radio was higher than the risk of THC consumption, in terms of road safety. Is that something that would accord with your appreciation of the evidence?

Dr White: I might have read that paper a long time ago. Distractions. The road toll has been going down for a long time and now, all of a sudden, it is not going down any longer; it is going up a bit. I think that what is getting in the way is mobile phones. Distractions of various sorts are becoming an even bigger cause of crashes. Was that about listening to the phone versus cannabis? That is probably about right.

MR BRADDOCK: This was that listening to the radio was an even higher risk than cannabis. Texting was a risk five times higher.

Dr White: I am not sure about that one.

MR BRADDOCK: Thank you, Dr White.

MS CASTLEY: Dr White, in your submission you talk about a trial model with additional safeguards. Can you talk a bit more about that—what that model would look like, who should participate and what the trial should look at measuring?

Dr White: Victoria did a trial when they introduced roadside drug testing. They did a bureaucratic evaluation of it and said it was working. Having said there should be a trial, it would be a bit difficult to know how to evaluate it. The ACT presumably has so few crashes and so few cannabis-related crashes that doing before and after numbers would probably not be feasible. It would be a process-level evaluation on how smoothly things operated. You could keep a bit of an eye on injury crashes.

In South Australia, for every injury crash where someone goes to hospital, they do good toxicology on them all. You would have to have that in place, and, if Canberra had good toxicology on all road crash victims, you could look at the toxicology before and after the trial. I am getting myself into a bit of a hole here. The trouble is that you could not tell from the toxicology if it was medicinal use. A trial would be hard to do and I think it would mostly have to be a process-level evaluation—whether the medical cannabis users were satisfied with the way the police dealt with them, or something like that. Sorry—I cannot deliver a definitive trial.

MS CASTLEY: No worries. Thank you.

THE CHAIR: A general approach to people being fit to drive is a self-assessment of their capacity—whether, to them, they are drowsy or have had too much alcohol. They may even be under the limit. We have heard that people who are prescribed THC are given guidance on assessing their capacity for various activities. Have you turned your mind to that guidance from the medical profession and whether it is adequate?

Dr White: I suspect that the guidance given by the AMA—I think they have written a paper on it—would be pretty conservative. I think that you would be pretty safe if you stuck to that. Four experiments have been published in Australia on impairment from appropriate medical use of cannabis. They measured impairment immediately after taking cannabis and found no impairment at all. There were cognitive tests in the laboratory and driving simulator tests. Two of the experiments were done in Swinburne and two were done at, I think, the Lambert Initiative. There is not much of a problem to be addressed.

There was the Lambert Initiative study—another study done on ACT medical users. Despite what was said in the ACT government report, the study by the Lambert Initiative concluded that users were pretty good at working out whether they were impaired and were pretty reluctant to drive if they did feel impaired. There is always some danger that you will either ignore your own assessment of impairment or that you will not be able to assess your own impairment, but the Lambert study seemed to think that was unlikely to be a big problem.

MR BRADDOCK: Dr White, there is a statement in your submission about the effects that cannabis has on reducing drivers' travelling speeds and the lengthening of headways. I am trying to understand: why does the use of THC potentially cause people to drive slower and give more space?

Dr White: I think they are a bit afraid. Cannabis can make you a bit cautious—perhaps paranoid in an extreme case. I think they are just being more cautious. They are saying, "I've taken this drug." Unlike alcohol, where you take it and you are the king of the road, you take cannabis and you have more idea that it might be affecting you, so you slow down a bit and you only accept larger gaps. Gap acceptance becomes more conservative.

MR BRADDOCK: Does this kick in at the level of impairment or even for people who are not impaired?

Dr White: I am not sure. I think people are being cautious about the possibility that they are impaired, and in some cases they will be impaired. In some of the driving simulator studies, they give quite high doses of cannabis, and people will be impaired and they will compensate for that by driving slower and leaving larger gaps.

MR BRADDOCK: So, in those studies which were based on driver simulations, the doses used were higher than what would be considered normal medicinal-level doses?

Dr White: Earlier studies tended to have lower doses. Later studies used moderate and

high doses. I think the best approach now is where studies say, “Do it the way you normally do it yourself.” They are called ad libitum studies, where you use the dose you would normally use. In the general findings I have come to about cannabis not being a terribly impairing drug, they take that range of studies into account. The ones I would be most impressed by are the ones that are ad libitum. They are the most real-world studies.

MR BRADDOCK: Dr White, is there anything you wish to say that we might not have asked?

Dr White: No. I had a little original blurb where I said that, as a scientist and taking a scientific approach, you have to be quantitative and you have to be comparative. You cannot just say, “Zero tolerance.” That is a prohibitionist approach. For example, when it comes to crash risk, there is a small additional risk, but you have to measure it and you have to compare it to other things—as Andrew was saying, with respect to distraction. But there are a lot of other comparisons you can make, such as: at the upper end of crash risk, cannabis is about half as bad as alcohol at 0.05, which is not a big crash risk, and it is about half as bad as going five kilometres over the limit in a 50-kilometre zone, which the police do not even bother to enforce.

When you are quantitative and comparative, the crash risk from cannabis is not as bad as being a 70-year-old. It is not as bad as a whole lot of other things. Andrew mentioned being a bit distracted by the radio. There is a whole range of things. It is important to see cannabis in that perspective. It is certainly a heck of a lot less dangerous on the roads than alcohol. We should not be afraid to be quantitative and comparative. That means that just saying things like the government report said—“Zero tolerance”—is too simple and unrealistic.

THE CHAIR: Dr White, thank you so much for your wrap-up, for your presence here as a witness and also for your submission. On behalf of the committee, thank you for your attendance today.

Dr White: Thank you very much.

THE CHAIR: If you have taken any questions on notice—I do not believe that was the case—they should be provided within five business days of receiving the uncorrected proof *Hansard*. Thank you.

Hearing suspended from 11.39 am to 1 pm.

CHEYNE, MS TARA, Attorney-General, Minister for City and Government Services, and Minister for Transport

PATERSON, DR MARISA, Minister for Health, Minister for Mental Health, Minister for Police, Fire and Emergency Services, and Minister for Gaming Reform

LEE, DEPUTY COMMISSIONER SCOTT, Chief Police Officer, ACT Policing

KENNEDY, COMMANDER JASON, Commander of Operations, ACT Policing

BROWN, SUPERINTENDENT ANTHONY, Acting Superintendent, ACT Policing

GREEN, MR BEN, Executive Group Manager, Policy, Planning and Built Environment, City and Environment Directorate

COX, MS KIRRA, Executive Branch Manager, Data Projects and Improvement, City and Environment Directorate

THE CHAIR: We welcome Ms Tara Cheyne MLA, Attorney-General; Dr Marisa Paterson MLA, the Minister for Police, Fire and Emergency Services and Minister for Health; and officials from both the City and Environment Directorate and ACT Policing.

Please note that as witnesses you are protected by parliamentary privilege and bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

We are just going to go straight into questions. I am going to start with a really obvious one, ministers. I am happy for each of you to speak. I am not sure if someone is taking the lead here. I note that your concluding statement is that you do not yet support a change but are open to seeing more evidence-based research to support any such change. Noting that New South Wales has recently passed the bill that was presented, could you explain why you would not go the same direction compared to New South Wales and Tasmania, who have had a regime for a while, and other states which seem to be moving in the same direction?

Ms Cheyne: Just to perhaps clarify for the record and for *Hansard*, our concluding remarks are that we have reviewed the weight of evidence currently available and we are generally of the view that we do not yet support a change to the presence-based offences for medicinal cannabis containing THC, but we note that there is still significant research underway. We look forward, of course, to receiving the committee's recommendation. It is not to say never, ever, and indeed the committee may have some very strong points to make, having heard all of the evidence, but based on the evidence available to us when we wrote the submission—and certainly what you will hear today—there are some concerns.

I think the way that the bill is drafted there are probably six main issues, if I could summarise, that I think we have a particular challenge with in the ACT. I will let ACT Policing explain how roadside impairment tests work, but I think there is no reliable roadside impairment test that determines impairment. I know that you have heard evidence about what impairment is or is not this morning, but ACT Policing can certainly give you their view—and that devices detect presence only. Lawful use at the roadside—hard to tell. Someone may lawfully have access to medicinal cannabis, but that does not mean that the cannabis that they have taken was for medicinal purposes or that it came from medicine rather than recreation. There is no way, as the bill is

currently drafted, for police to make that distinction.

There is the removing of section 20, which weakens preventative enforcement. Again, there is a gap where a person might not be meaningfully impaired or they may be meaningfully impaired but not obviously incapable of proper control of the vehicle. There is a lot of responsibility on drivers judging their own impairment. The alcohol and the THC exemption is a particular concern. Then there are some drafting and implementation concerns. Particularly section 47B makes it harder for police to direct someone not to drive without further evidence of impairment. Again, ACT Policing can speak to the resourcing ask.

The retrospective provision may operate more broadly than it is intended as it is currently drafted, and there is no differentiation between higher risk special drivers and people with a full licence, so people just starting out like learners and provisional drivers or some heavy vehicle drivers. Some of those issues are unique to the ACT, some of them are because of how this particular bill is drafted and some of them are implementation issues. That is a long answer to a short question, but I hope that gives you some direction of why our position is as stated in the submission.

Dr Paterson: I might add just a couple of things on top of that too. The government has a commitment to Vision Zero. In between 2019 and 2022 15 people died on our roads that had THC present in their systems. From a perspective of community messaging around zero tolerance to drugs and alcohol in your system, I think there runs a quite significant risk of mixed messaging to the community around that.

In relation to Mr Cain's question around New South Wales, there is their legislation, which is not what Mr Braddock's bill presents. The model from New South Wales is really a very significant impost on police resources and government resources to implement. It is a very complex scheme, so I think we would have real concerns there. There are a lot of points of potential issues with what New South Wales has progressed. I think from that perspective in terms of impost on police, we would be reluctant to go down that path as well.

THE CHAIR: I will open with a very broad one that gives you all the chance to ask, but I will just ask one supp. Apart from the resourcing concern that you have about the New South Wales approach, was there anything else about the New South Wales legislation that you would suggest just will not work here or you just cannot support policy wise?

Dr Paterson: Aside from the fact that people are dying on the roads with THC in their system.

Ms Cheyne: Complexity.

Dep Commissioner Lee: I will pass to Commander Kennedy, but we have spoken to New South Wales Police around how their system operates and some of the complexity with their system. Fundamentally, in terms of the legislation, without going over the issues that have already been touched on by the minister and the Attorney, there are certainly a couple of the issues from our perspective which go to the bill and I think go to, obviously, some of the challenges around people driving with medicinal cannabis or

other cannabis in their system. It goes to the issue, I think, fundamentally around the current evidence. The research does not provide a reliable, objective method to determine THC-related impairment or a safe THC threshold for driving. Certainly, our current roadside drug-testing regime and technologies are only able to detect the presence of THC. There is some additional complexity there with the New South Wales legislation and how they have determined the threshold, which we can touch on, but obviously that is a challenge for us at the moment in terms of our testing regime and the technology available to us.

Obviously, then there are some broader issues, which we can talk through, around the implications for policing, depending on where the legislation lands, that we can touch on. I might pass to Commander Kennedy, who has had some engagement with New South Wales Police in terms of some of the complexities around their regime.

Cmdr Kennedy: New South Wales's scheme applies a limit of 50 nanograms per millilitre, which has no real scientific basis as to whether that causes an impairment or not. It appears to be more related to the devices that they use and what the thresholds are for the devices. I guess that is the concern: there is no science behind why the 50 nanograms per millilitre has been chosen.

What it does require as well is that they have a scheme where the person who is prescribed medicinal cannabis has to register with the RTA and undertake a course of education. It is actually on their drivers licence, similar to wearing corrective lenses and the like. You haven't got police down on the roadside juggling prescriptions and trying to prove whether it is actually medicinal cannabis or not, and it requires two lick sticks from separate batches, so two samples. If they both come up positive, then they go to the laboratory to then determine whether they fall under or over the 50 nanograms per millilitre. In New South Wales, under the legislation, which is still to be enacted, if it falls below 50 nanograms, then there is no action taken. If it goes over the 50 nanograms, then I believe the person gets two opportunities in two years, and any more than that in two years, after the third, action is taken.

Probably that concern really is—even in regard to the testing of the sticks as well—that when it is placed into a vial, based on the THC being quite a sticky substance, it actually binds itself to the vial. They are saying you can potentially lose up to 40 per cent of the THC, so it may not be accurate testing of what is actually in the person's system at the time simply by way of the current testing. There are a lot of concerns around that current system as it exists.

Like I said, there is a lack of science to actually say that more than 50 nanograms per millilitre—simply because THC impairment, unfortunately, is not linear like alcohol, where we have got set standards, where at .05 we know this is what is going to be the impairment on the body and at .08, .15 and the like. THC does not operate in that way. It is not linear, so that is where we really require that evidence base to show what that impairment is. In the lack of that impairment, that is why we have got the presence offence, because we do know the THC does cause impairment in driving. It is really about a prevention piece more than anything else.

MR BRADDOCK: Minister Paterson, I believe the figure was 15 that you quoted—the people who had died. How many of those were actually in the scope of this bill in

terms of their actual taking of medicinal cannabis and no other substance?

Dr Paterson: No-one was because we do not have the laws currently to require a prescription.

MR BRADDOCK: We do have laws in terms of people who are taking prescription medicinal cannabis. Do we know out of those 15 people who died who had THC in their system whether that was taken for medicinal purposes or whether it was in combination with another illicit drug?

Dep Commissioner Lee: Mr Braddock, we are not aware of that. We do not have that information. We are happy to take it on notice to see if that is able to be provided. It may be, it may not be, but we are happy to take it on notice and come back to you.

MR BRADDOCK: How many had alcohol in their system that died over the same period as that figure?

Dep Commissioner Lee: Again, I will talk to my colleagues, but in terms of road fatalities over that period, we do not have that detail with us either today.

THE CHAIR: You will take that on notice?

Dep Commissioner Lee: Take that on notice, yes.

MR BRADDOCK: Just to clarify, because this morning some witnesses raised questions about some of the conclusions the ACT government had drawn from some of the scientific research, the first one was where the ACT government claims that a study revealed all users underestimated the extent to which THC impairs their driving, to which we received further evidence that the study actually concluded most cannabis users in the ACT appear to have realistic beliefs about how cannabis affects driving and do not appear to be driving whilst impaired. Can I just please try to correlate in terms of why we are receiving different information from the same academic studies—the conclusions drawn from the ACT and the other from various witnesses?

Dep Commissioner Lee: If I can, Mr Braddock, I might pass to our colleagues from CED in terms of the drafting of the submission, and we are happy to add to that if you wish.

Ms Cox: I think that is a slight misinterpretation, and potentially our submission was not as clear as it could have been. It was intended to say that both medicinal cannabis and recreational cannabis users both underestimate the level of impairment, not that everybody in the study did underestimate their impairment.

MR BRADDOCK: So to be clear, the ACT government now agrees that medicinal cannabis users do not underestimate their risk?

Ms Cox: Some do. Not all of those in the study did. Both medicinal and non-medicinal cannabis users do to some extent underestimate the level of impairment and risk.

MR BRADDOCK: The other one where there was a difference of opinions was the

risk posed by opioids is lower than that posed by THC. We have received evidence—it goes back to the original scientific evidence—that seems to indicate that opioids are about five times the risk of cannabis in terms of road safety. I am just trying to understand why we have a difference there as well.

Ms Cox: I think, again, this one is around prescription opioids, so something that is regulated we understand an impact from and we can predict a level of impairment, as compared to a drug that is largely unregulated, where the levels of impairment for each dose and different types can be absorbed differently. There is a different risk profile.

Dr Paterson: Opioids that are prescribed versus not.

Ms Cox: Yes.

MR BRADDOCK: But the bill is about prescribed medicinal cannabis, which is under a regulated TGA scheme. I am trying to understand why you are saying one is regulated, one is not.

Ms Cox: Most medicinal cannabis that is prescribed is not regulated under the TGA. Only one medicinal cannabis that contains THC is regulated under the TGA; the rest is unregulated.

Dr Paterson: Mr Braddock, I will add to that. There is recent research out from Monash University that basically says that there are more than a thousand medicinal cannabis products in Australia and only two have undergone pre-market evaluation. Ultimately the products that this research tested ranged from approximately 13 per cent to 88 per cent THC concentration, so ultimately consumers in Australia are not clear on what concentration of the drug they are actually taking even through prescribed medication. I guess that poses another layer of risk that even as an individual, whatever product you take, you actually do not necessarily know how much you are taking.

MR BRADDOCK: We received evidence this morning from the Medicinal Cannabis Council—I think that is the group—where they were saying they are regulated. They undergo thorough testing to make sure the dosage that is prescribed in the bottle is actually what is on the label, because we are talking about a TGA-regulated substance under this bill.

Dr Paterson: Prescribing. I would recommend talking to AHPRA and TGA and Monash University about it because I think they all have a lot to say around the concentrations of THC in these drugs, and they are not evaluated by the TGA. As I said, only two have undergone market evaluation out of the thousand products prescribed to Australians.

Ms Cox: Only one of those products contains THC. Of the two, only one of them actually contains THC.

MR BRADDOCK: A CBD product.

Ms Cox: A good amount of what is being prescribed is not a TGA-approved product and is therefore not regulated by the TGA.

MR BRADDOCK: I will come back to the opioids in terms of there are opioids being taken as prescribed but there are also opioids that are taken that are not prescribed. Is there still a case that THC is of a greater risk than opioids, as you claim? The studies seem to indicate it is actually the inverse and that opioids are the greater risk in terms of driver safety.

Ms Cox: As compared to prescribed opioids, THC is a greater risk. When we are talking about illicit drugs, we would not be able to tell because they are not regulated and we would not understand the risk profile.

MR BRADDOCK: How did you come to the conclusion that the risk posed by opioids is higher than THC?

Ms Cox: In terms of prescribed versus, again, THC not currently being regulated.

MR BRADDOCK: I have probably taken enough time.

THE CHAIR: We will come back.

MS CASTLEY: I would like to ask about the ability to get medicinal cannabis and how easy that is; how regulated that is. And have we seen any kind of increase over the last couple of years in people with prescriptions in the ACT?

Dr Paterson: I have had a recent meeting with APRA, and one of the concerns that they have raised is the significant level of prescribing of medicinal cannabis in Australia. They have seen dramatic increases over the past 10 years. I mean, they are very concerned about it. And I guess, the government's perspective is that ultimately there are potentially more people driving impaired on our roads, potentially. So, I guess that presents a concern and a challenge to our community. Whether Mr Braddock's bill is successful or not, I think there are potentially more people driving with substances in their system, on our roads.

MS CASTLEY: I mean, for me the whole problem has been how a police officer is going to assess impairment on the side of the road. It is pretty clear if someone is drunk. I imagine this is a little bit different. And I know you discussed it briefly, but can you just explain what it looks like when you pull someone over, and what your officers will be expected to go through?

Dep Commissioner Lee: I will pass to Commander Kennedy. I think the only thing I would add, Ms Castley, if I can: certainly, just drawing on the minister's point—and we can step through this data in a bit more detail if you wish—certainly, we have seen a significant increase, almost 100 per cent increase, in people driving on our roads who have been charged with drug driving offences. So, in 2024-25, it was 352 people were charged. In 2025-26, it was 700 people that have been charged in terms of drug driving.

That increased positive rate of our drug driving tests, that has also occurred with us undertaking less drug driving tests roadside. So, the positive rate increased by about 22.5 per cent, in terms of the rate of tests we conducted. So, in terms of the number of tests we conducted in 2024-25, it was around 9.3 per cent in terms of proportion of

persons tested, to charged. In 2025-26 that was 22.5 per cent of individuals who were tested were charged. So obviously, a significant increase in terms of the positive rate where we have found people are, unfortunately, driving impaired with drugs in their system on our roads. I will pass to Commander Kennedy who can step you through the process, if you like, and then I am happy to go into any more of that detail that might assist.

Cmdr Kennedy: I might refer to Superintendent Anthony Brown, who is the superintendent in charge of road policing.

Supt Brown: Yes, I look after all the members that lead this testing. Even though we have a lot of members across the ACT that are trained, but all of our road policing members are. So, the initial process would very much mimic what roadside alcohol testing is. We would stop the vehicle, or we would have a station set up where we would direct the driver in. We identify the driver, conduct a breath analysis for alcohol—a screening test—then we do the oral fluid analysis for drug testing.

In that case, we do the lick test, for want of a better term. We will do two of those, similar to what they do in New South Wales, which would indicate the presence of a drug. Again, similar to what we do with alcohol testing, we will give them a 20-minute observation period to ensure that that is—you know, if someone has had a beer in the last 10 minutes, we will let that clean out of their system so we get an accurate test. We do the same with drugs. They are taken back to the police station where we have a system that is designed to do an analysis and confirm that test.

One of those tests that we do with the lick test is place it into that machine and it will give us a confirmation, at the roadside or at the station. We then also send the second sample off to ACTGAL, who conduct that analysis, which will be prepared for court.

I think the new legislation will give us power to direct someone not to drive for 24 hours, but currently we can issue an immediate suspension notice, and that person will lose their right to drive immediately—or it will go to court through a summons process, and that will be determined later in court.

So that process, for us, we can determine—given any sort of indication at the side of the road when we are dealing with someone—if we suspect that they are under the influence of a drug or alcohol, then we can issue that test as well. So, it can be random or it can be more targeted.

Which would be—you know, if we were to walk down a path where we needed to do a sobriety test, that would rely very very heavily on the observations of the member at the time and then, you know, whether or not we are trained to do that, whether we can convince the court that our analysis is accurate or our observations are accurate.

MS CASTLEY: So, at the moment, if you do a breath test, you can just do a drug test at the same—? You can just say, “do both”?

Supt Brown: It can be random, yes.

MS CASTLEY: Okay. And the waiting for 20 minutes, if they are visibly impaired,

would they wait? Like, is there a necessity—?

Supt Brown: Yes, it is still—well, I think it generally comes from the theory from alcohol, in that, if you have just had your last drink, your mouth alcohol analysis—your breath analysis—will be higher. So, we give it that 20 minutes to let it sort of settle, and make sure it is an accurate reading. And you know, we can do that. You can test having your first sip of beer and then comparing that 20 minutes later; it is a completely different result. So, we do that to make sure that, again, to make sure that no one is taking drugs in the middle of the time between when we first see them and we conduct that further analysis, so that we are showing that the impairment that was in place at the time of driving has not been increased by anything that has happened in-between.

MS CASTLEY: All right. I will think on that for a bit more. Thank you.

Supt Brown: Yes, is that all making sense?

MS CASTLEY: Yes, it really does. It does. We have just been told all day today that when you get that—you know, having it in your system, you could have had your medication that night, but it would still be in your system the next morning.

Supt Brown: Yes.

MS CASTLEY: And so, because it is in the system, you are not impaired; even though it is in your system, you could appear not impaired and that would not—

Supt Brown: Yes, absolutely.

MS CASTLEY: So, it is just a tough one.

Supt Brown: I think it very much mimics our alcohol testing, but also just to make sure that no-one has taken any drugs between. So, we need to make sure that we have them under observation before they go through further analysis.

MS CASTLEY: Yes, I understand. Thank you.

Cmdr Kennedy: Just on that, where there is that concern from, say, medicinal cannabis users that they took their prescribed medication the night before, and whether it will still be there, the actual test is more for recency. So, it is actually an oral fluid analysis. The THC itself, in the way it is used, will only show recent use in the oral fluid analysis. It is unlike a blood test, which will show the actual that has been ingested into the blood and the like.

MR BRADDOCK: Can you provide the evidence on which that is based?

Cmdr Kennedy: Yes, we can take that on notice.

MR BRADDOCK: Because a lot of the advocates have indicated that it could provide a positive saliva test for days.

Cmdr Kennedy: Yes, and it was certainly something, when we introduced roadside

drug testing, I think back in 2010, it was part of the education that we provided to magistrates as well. We knew that one of the things that would be potentially raised by drivers was people in the car, passive smoking and things like that. We can certainly take it on notice and produce that for you, to assist the committee.

MR BRADDOCK: Thank you. Superintendent, how does it currently work, in terms of where someone may be impaired from opioids or benzos, when you have a roadside encounter?

Supt Brown: At the moment, under the DUI legislation that we have with driving, it would rely on the observations of the police officer, but it can be confirmed through a blood test.

MR BRADDOCK: Thank you.

THE CHAIR: I will go back to my theme of other jurisdictions' actions. In Tasmania, we heard this morning from the Medicinal Cannabis Council of Australia—and feel free to counter this—that Tasmanian policing had not noticed any increase in THC-related fatalities or accidents after the passage of the legislation. Again, I am keen to know why, for example, the Tasmanian experience and example is not something that you are comfortable enough with replicating here.

Ms Cheyne: I think that witness said this morning, as you have flagged, that they have not experienced an increase in crashes or fatalities. However, I believe that same witness also took on notice the position of Tasmanian police. While I think that Tasmania might provide some useful comparative evidence, I do not think a raw claim about fatalities necessarily establishes causation or safety.

THE CHAIR: I am happy to check the *Hansard*, but I believe my question about the Tasmanian submission was: when the bill was first presented, did the Tasmanian police have a position that opposed it, or otherwise? Again, the comment Ms Patten made was that, since the passage of the legislation, policing have not observed any increase in THC-related fatalities or accidents.

Dr Paterson: Another way to frame that, though, is that you could arguably say the number of fatalities and accidents on our roads, currently, that have THC involved, whether alone or with other drugs, is unacceptable. If you were to argue that an increase, if the legislation comes in, is non-problematic, I think you could easily make the argument that, currently, where we stand in the ACT, the number of fatalities and accidents that do involve THC is very deeply troubling.

THE CHAIR: But, as was confirmed a bit earlier in the questioning, there is no way, at the moment, it seems, to report on what other factors were involved in that particular fatality.

Dr Paterson: Well, there is.

THE CHAIR: Whether there was solely THC or alcohol—

Dr Paterson: There is.

THE CHAIR: or other drugs, other factors; whether there was distraction from a phone or whatever.

Dr Paterson: There is, Mr Cain.

THE CHAIR: Is that clear on each of those deaths; that here are all of the elements that may well have contributed?

Dr Paterson: The coroner investigates those deaths.

Dep Commissioner Lee: Yes, Mr Cain, I think what I indicated was that we did not have that information with us at the moment. I will take that on notice. Obviously, if those deaths have been subject to a coronial, which they would have been—I would imagine all of them would have been—all we need to do is go through a manual process just to check the coronial findings on those matters, and see if there are indications from that coronial hearing that go to the question you have asked.

THE CHAIR: Absent the coronial findings, that is the only way you would know, is that the case?

Dr Paterson: That is the definitive.

THE CHAIR: What all the factors were that may well have contributed to a death?

Dr Paterson: That is what a coronial does.

THE CHAIR: There is no internal policing?

MS CASTLEY: Is there always a coronial inquest? In every death on the road, is there always one? That is just a blanket, so there will always be a test?

Dep Commissioner Lee: There will be a major crash investigation in relation to those fatalities. It will be a combination of our investigation and the coronial process. That is why we just need to do a manual review for each of those matters. I am not saying that information is not available; it is just that we will need to have a look at that.

THE CHAIR: Check it. I would be very interested in that.

MR BRADDOCK: Probably building on that one, anyway, I want to talk about the relative risk. We have received evidence from another submitter that said that, with THC consumption, the risk is less than or equal to interacting with a passenger. It is less than listening to a radio. I am wondering: why are we putting so much emphasis on a risk which has not been quantified—because we do not know exactly how many crashes have been due to medicinal cannabis—but we are not taking any action against these other, more risky behaviours?

Dep Commissioner Lee: What I would say to that, Mr Braddock, in terms of the impaired driving, is that it is a key contributor to the fatal five factors, in terms of road trauma around the country. Obviously, in terms of the illicit, or the substances that we

test for at the moment—THC, methamphetamine, cocaine and MDMA—the pure presence alone is taken to contribute to the impaired driving of an individual. That is the action that the police take, and that is the enforcement action that we take. Certainly, we know that that is a key factor, in terms of people's concentration levels, their reaction times, their ability to suitably control a motor vehicle to ensure that they are safe, their passengers are safe and other road users are safe.

Regarding how that then translates, obviously, we always say to people that we want you to concentrate on the road, minimise other distractions that you have in the motor vehicle. Obviously, touching your mobile phone is an offence. Those factors are always there. I do not think we would want to—if I could respectfully suggest to you—suggest that the mere presence of a substance for a person reduces the risk. Those are other risk factors that you have talked about. With trying to balance those or rate those, there are so many other complexities, including the amount of those illicit substances someone may have taken et cetera. There is a range of complexities, I think, that we need to take into account. Ultimately, our main focus must be on keeping every person on our road safe.

Dr Paterson: And driver distraction is one of the fatal five as well. It is very much up there in potentially leading to road fatalities or accidents.

MR BRADDOCK: I do not see a government campaign to stop people listening to the radio. So, why have we got zero tolerance—

Dr Paterson: I think they are quite different things, Mr Braddock.

MR BRADDOCK: on what is academically shown to be a lower risk activity, versus we are allowing this other one to go through?

Ms Cheyne: I think we can all appreciate, Mr Braddock, that the presence and detection of THC are not the same as impairment. There is a genuine objective being sought with this bill. The whole zero-tolerance, I think, is a mischaracterisation of our overall position. I think we do understand that there are plenty of people who have very legitimate reasons to take it. It may just be slightly in their system, but people's bodies absorb and react to THC in different ways. It is highly variable, especially when we have so many things on the market that are not regulated.

In the current environment, what tools we have available to test impairment are limited. They are basically limited, in our view, to presence or not—and with that further evidence about the oral fluid tests and recency. It is not zero-tolerance. I think we do understand that there are legitimate reasons, just like there are legitimate reasons for people to take opioids. But our way of testing that, at the moment, does not provide us with the certainty to remove, effectively, what is a preventive mechanism. Policing, please correct me if I said that wrong.

THE CHAIR: If the methods and the resources were available, would the government be supportive of the bill?

Dr Paterson: Yes, absolutely. Technology is coming a long way. We now test for cocaine in the ACT. With the drug testing that has evolved over the past decade, I think

that, absolutely, there is a technology answer to this. It is just that we are not there yet, I would say.

Ms Cheyne: I think that affirms our conclusion. Evidence is changing. There are new studies being done all the time. On the evidence that we have available—this is not so much about empirical evidence; it is about a lot of tested or rigorous studies—we are not there yet.

MR BRADDOCK: This is where we have the advocates presenting the same scientific studies and saying that the evidence is there. They are saying that THC users have a more risk-averse approach, as to whether they are impaired or not. They are saying that opioids are a far greater risk. I am trying to understand why there are two different views of the evidence here.

Ms Cox: Certainly, when we reviewed the evidence, we did quite a big literature review; we spoke to our colleagues in ACT Health and the ACT Chief Pharmacist to get their view—the consensus. While there are some studies that suggest that it may be safe to drive with certain amounts of THC in your system, the weight of the evidence currently leans towards it being an unresolved matter, in terms of threshold and impairment, in a way that is measurable.

Until those studies that are being referred to are peer-reviewed, until those results can be duplicated, and until there is a sufficient body of evidence, with the information that we have available now, the weight of that evidence sits more firmly with saying that nobody can agree that a certain percentage per millimetre of blood results in a certain level of impairment. That has not yet been broadly agreed. Until there is a sufficient body of evidence that says that, we cannot treat it in the same way that we treat alcohol. It leaves us in a position where we have your bill in front of us, or we have the status quo. The middle ground around what is a safe threshold, what is a safe level of THC to be able to drive, is not yet agreed.

On that basis, the more conservative and more consistent approach, with our Vision Zero and the ACT Road Safety Framework, which was released earlier this year, is to err on the side of caution, until that can be resolved. There is a lot of work going into resolving that question, nationally and internationally. There are a lot of people trying to work out what that safe threshold might be. In that case, you could have a very similar framework as for alcohol. Our assessment is that the weight of evidence is not yet agreed on.

MR BRADDOCK: With the ACT being an island in New South Wales, who have just made a decision to proceed with this, why have three other states, including New South Wales, gone ahead with this reform, but not the ACT?

Ms Cox: I cannot speak to why they would have passed it, but in terms of the relative risk and benefit, certainly, in the ACT, there is the issue of the resourcing that we would need in order to effectively manage. My ACT Policing colleagues have done a great job in outlining the steps that would be required. It is quite burdensome, for what we currently do not know is a safe outcome. As the City and Environment Directorate, we are not looking at this purely from a health perspective; we are looking at it from a road safety lens. From that lens, we have a safer option, which is to maintain the status quo.

Dep Commissioner Lee: Mr Braddock, going to your question on opioids, we can certainly provide you with some additional detail around our current testing regime, particularly for prescribed opioids, and particularly in terms of what we can and cannot test for; and, if we do believe that a person is impaired through the use of opioids, what the process is for that.

Cmdr Kennedy: Currently, with the roadside drug testing oral fluid analysis, it is limited to four drugs. It does not mean that we cannot test for other drugs, but that requires a person to have a blood test. If we do observe someone driving and it is quite clear that they may be, or would appear to be, driving under the influence, we do the roadside alcohol screening test. If it is negative, we then do the oral fluid analysis for the four prescribed drugs. If that comes back negative, and we honestly believe that this person is affected by a drug, we do have the power to take them into custody, take them up to the hospital, and subject them to a blood test, which would then show us what is in their system as a totality. We would then have the toxicologist provide evidence to say whether what was in their system at the time would make them incapable of having proper control of the vehicle. That is the evidence that we would glean to take that to court for a DUI offence.

Certainly, even following road crashes and the like, when people are transported to hospital, bloods are taken. At the same time ACTGAL analyses what is in their blood and, again, our toxicologists will provide us with advice as to whether or not what was in their system did have an impairment effect on them. We can test for those things, but it is in a different way, and probably a more significant way.

Dep Commissioner Lee: A significant way, and an intrusive way; that is right.

Cmdr Kennedy: An intrusive way.

Dep Commissioner Lee: Obviously, it would only be in those exceptional circumstances where the level of impairment, we believe, leads to that course of action. At the moment it is very much based on the presence, in terms of the drugs that we can test for.

MR BRADDOCK: You might need to take this on notice. Could you provide the number of tests undertaken and the number of positives from those tests? That would be appreciated.

Dep Commissioner Lee: Do you want all the ones where people—

MR BRADDOCK: No, the blood test results or records.

Dep Commissioner Lee: All blood tests? Yes.

THE CHAIR: Take that on notice; thank you.

MS CASTLEY: The government has concerns about the retrospective operation. Can someone talk to me about that?

Ms Cox: The current provision is quite broad, and we are not able to understand the impact on current matters that are under consideration. Additionally, ACT Policing will not have collected relevant information. If you apply this retrospectively, ACT Policing will not have asked a person who was found with cannabis in their system whether or not that was prescribed. There is an amount of work that would need to be done to work out what the circumstances were at the time. I think that is a relatively complicated thing for us to do.

Ms Cheyne: It does come down to, perhaps, the way that it has been drafted. We accept that the explanatory material indicates that the intention is to concern proceedings that are underway, but our submission is that the operative provision to give effect to that intent does not expressly combine it in that way; so, in the way that it is currently drafted, it might have a broader retrospectivity that could have some real consequences. We have asked the committee to look at that closely.

MR BRADDOCK: Ms Cox, I might come back to some earlier evidence you gave in terms of the definition of “obtained in accordance with the Medicines, Poisons and Therapeutic Goods Act 2008”. That seemed to form the basis of some of the evidence provided by the respective ministers, where it may not be as closely defined to include something that is provided by a prescribing medical professional and regulated under the TGA. This might be an unfair question for you, Ms Cox, but is that what the government is seeking? If it was defined in a way that is under those regulatory schemes, would that be a more acceptable version of the definition for the purposes of the bill?

Ms Cox: It certainly would allow a better analysis of the risk that the bill may pose. I have not considered the limitation of the provisions in the bill only to TGA-approved medications. We have not done that analysis. Certainly, it would allow more analysis to be done on the risk level, I think.

MR BRADDOCK: Understood; thank you.

MS CASTLEY: We have discussed unsafe driving behaviour and the actions that can be taken. Section 20, from my understanding, will be gone, but section 24 will remain in the bill. Does anyone have any technical detail about what that means?

Ms Cox: With section 24 being retained, this goes to the example that ACT Policing have given around when a person appears, to a police officer, to be under the influence of something. This is a penalty where it is not a screenable offence, so we do not have the testing.

MS CASTLEY: I wanted to make sure that I was clear in my understanding of that.

Ms Cheyne: There are the practical challenges. There is a person who is incapable of having proper control of their vehicle, but the practical challenges are that some of those physical signs might not be immediately obvious. You might not immediately notice that someone is not concentrating, or their reaction time or decision-making are marginally slower. That is hard to establish quickly.

MS CASTLEY: I am shocked by the reference to a thousand medications being

available, and only one being properly regulated. Do we know how many face-to-face clinics in the ACT can prescribe medicinal cannabis and what they are prescribing? How can we find that out?

Dr Paterson: I do not know that, but there is a lot of access to telehealth prescribers now. I think that has proliferated the number of prescriptions. There was some data in the submission around—

MS CASTLEY: I will go back over it.

Dr Paterson: the number of 56,000 prescribing events involving approximately 10,600 ACT patients between June 2024 and June 2026—a couple of years.

MS CASTLEY: We expect that a lot of that would be telehealth, so it is not your GP that you go and see every day and that has your medical history.

Dr Paterson: Yes.

Dep Commissioner Lee: Ms Castley, I want to come back to your question on section 24, in terms of the impairment component. From our perspective, we do have significant concerns, because the vast majority of our drug testing or roadside alcohol testing is purely for presence. In terms of section 24, it is something that is unusual for us, in terms of relying purely on an assessment of impairment, particularly when our officers are trying to do that at the roadside.

Certainly, from my perspective, attempting to put that onus onto a police officer at the roadside, where they make a decision based on impairment, particularly if there is a positive drug result, and particularly if we then, a short time later, end up with a fatal collision, puts an undue onus on that police officer, in terms of that decision process, while they are trying to deal with that at the roadside.

Notwithstanding that issue, if the bill was to introduce that requirement, from our perspective, the training and the resourcing would be significant for ACT Policing to implement that. Also, where there is a greater requirement for us to undertake additional impairment testing at the roadside, it would have a downstream impact, in my view, around our road safety, because it would mean we would be undertaking less roadside drug tests, because of the time during which our police officers would need to be dealing with a specific incident.

MS CASTLEY: With special drivers, what are the police concerns? Why are some considered special? The bill, obviously, does not carve them out; that is my understanding. How do we feel about that? We would be looking at P-platers, learner drivers, and drivers of heavy vehicles.

Dr Paterson: People who drive for work.

MS CASTLEY: That is right.

Ms Cheyne: Heavy vehicles is another.

MS CASTLEY: Heavy vehicles, yes. Could you talk about what impact that might have, if we are not carving out the special drivers from the bill?

Dep Commissioner Lee: Yes, of course. I will pass to Commander Kennedy and Superintendent Brown.

Cmdr Kennedy: The New South Wales system does not extend to P-platers or truck drivers and the like. They are actually carved out of that part of the legislation in New South Wales. People that are on their P-plates—a provisional or a probationary driver—are still learning to drive properly. That is why we have lower blood alcohol levels as well—.02, as opposed to a .05 drug alcohol limit. Where we have novice drivers, they are still learning to drive. To use alcohol as an example, there is a lower threshold for them. It used to be a zero blood alcohol level, but there was an acceptance that there are potentially cough medicines and the like that might pop them over zero. Being novices, you would have to carve them out.

MS CASTLEY: You think that this is significant enough that we should consider carving them out.

Cmdr Kennedy: Yes.

MR BRADDOCK: Going back to Deputy Commissioner Lee's comments about section 24, isn't that currently being applied, in terms of those other substances like opioids and benzos, in terms of monitoring for those, and making an evaluation by the police officer beside the road?

Dep Commissioner Lee: It is something that is used, Mr Braddock. The point we were trying to illustrate before is that, for the vast majority, it is purely based on presence. It will only be in a circumstance where the impairment is such that it gives our police officer grounds, where they believe that they have reasonable grounds, to undertake those more intrusive processes. It is fair to say that, for the vast majority, it is purely based on presence rather than impairment. That was purely the point that I was trying to identify for the committee.

MR BRADDOCK: Thanks for clarifying that.

THE CHAIR: On behalf of the committee, I would like to thank you for your attendance today. If you have taken any questions on notice, please provide your answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*.

On behalf of the committee, I would like to thank all our witnesses who have assisted the committee through their experience and knowledge. We also thank broadcasting and Hansard for their support, and our secretariat. If a member wishes to ask questions on notice, please upload them to the parliamentary portal as soon as possible, and no later than five business days from today. This hearing is now adjourned.

The committee adjourned at 1.54 pm.