T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Workplace Drug Testing in Victoria

Melbourne – Wednesday 22 May 2024

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WITNESSES

Nathan Davis, Executive Director and Co-Founder *(via videoconference)*, MedReleaf Australia; and

Matthew McCrone, Government Relations Manager, Montu.

The CHAIR: Welcome back to the Inquiry into Workplace Drug Testing in Victoria. Joining us for this session we have got Nathan Davis from MedReleaf Australia on Zoom, and also joining us in person is Matthew McCrone, Government Relations Manager for Montu. Gentlemen, thank you very much for making the time, making submissions and giving evidence today. I will quickly read some information regarding the evidence you are providing to us today before we continue.

All evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and further subject to provisions of the Legislative Council standing orders. Therefore the information you provide during the hearing is protected by law. You are protected against any action for what you say during this hearing, but if you go elsewhere and repeat the same thing, those comments may not be protected by this privilege. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

All evidence is being recorded. You will be provided with a proof version of the transcript following the hearing, and transcripts will ultimately be made public and posted on the committee website.

Again, thank you for coming in. Could you please state your full name and the organisation you are representing, just for the record.

Matthew McCRONE: My name is Matthew McCrone, and I am here representing Montu.

The CHAIR: Thank you, Matthew. Nathan.

Nathan DAVIS: I am Nathan Davis, representing MedReleaf Australia. Sorry I could not be there in person.

The CHAIR: Thank you, Nathan. I will just quickly introduce the committee to you: I am Trung Luu, the Chair; the Deputy Chair is Mr Ryan Batchelor; Ms Rachel Payne; Mr David Ettershank; Dr Sarah Mansfield; and Dr Renee Heath is on Zoom with us as well. I know you gentlemen have made submissions. I will open it up for an opening statement before we proceed to open the panel for questions. Matthew?

Nathan DAVIS: Go for it, Matt. In person is first. You are up.

Matthew McCRONE: Thank you. I would like to start by acknowledging the traditional owners of the land on which we meet, the Wurundjeri people of the Kulin nation. I pay respect to elders past, present and emerging.

My name is Matthew McCrone. I am the Government Relations Manager for Montu, which is Australia's largest medicinal cannabis company and indeed the largest medicinal cannabis company outside of North America. I am also government and industry lead for the newly formed industry association Cannabis Council Australia, of which Montu is a founding member.

I would like to start by thanking you for the invitation and time here today to contribute to this inquiry on behalf of the medicinal cannabis industry in Australia. My background is as a pharmacist, with 23 years working in senior positions for both Australian and Victorian governments. I was a senior pharmacist at the Therapeutic Goods Administration, which is Australia's federal medicines regulator. I was the chief medicines regulator here in Victoria. I led the taskforce in Victoria to legalise medicinal cannabis back in 2015, and I also led the implementation of SafeScript here in Victoria. I am fortunate, I suppose, that I have worked across the health regulatory space and I understand where all the moving parts fit a little bit better than most.

For the committee's information, Montu, which was established in 2019, has several areas in which it operates. We have our patient clinic, Alternaleaf, which is an end-to-end online platform that connects patients with highly trained nurses and doctors. The clinic is trusted by more than 150,000 Australians, 20,000 of whom are Victorians. Given that only about 5 per cent of GPs across Australia are willing or able to prescribe medicinal cannabis to eligible patients, Montu also has developed Saged, which is an online training platform for

clinicians. We also have our distribution company, Leafio, which supplies pharmacies with more than 500 medicinal cannabis products across various ranges.

On to the specific issues of this inquiry, current workplace drug-testing laws across the country test for presence of drugs, not impairment. Given the reason workplace drug-testing frameworks exist is to ensure that workers in safety-critical roles are not impaired in their job, testing for presence, rather than impairment, is not warranted. Said more straightforwardly, the zero tolerance laws are discriminatory, they are outdated and they are unsupported by science.

Tetrahydrocannabinol, more commonly known as THC, which is the psychoactive component in cannabis, can stay in your system for weeks after use. Having THC in your system does not mean you are impaired. In fact the psychoactive effects of THC can last for only a few hours. This means that someone who has been prescribed medicinal cannabis and is unimpaired by the medicine could be penalised or even lose their job, having taken their medication days or even weeks prior to a workplace drug test. Workplace drug-testing regimes therefore raise an important human rights issue because they potentially allow workers to be penalised who are not impaired while at work. For the most part there is not even a requirement to establish whether or not a worker was impaired by the drug or to establish the presence of the substance over a specific threshold, as is the case by comparison with blood alcohol concentrations.

Medicinal cannabis is typically taken every day. There is research that has found that medicinal cannabis, and I am quoting from Tom Arkell's research, which I am guessing has come up often in this inquiry:

> … medical cannabis may have minimal acute impact on cognitive function when prescribed and used as directed…

So these characteristics have led some to question whether workplace drug-testing regimes are proportionate or justifiable. Legislation in this area should consider the unintended consequences of mandatory and universal workplace drug-testing programs, including positive drug tests that are not linked to impairment as well as the possibility of inaccurate results.

Montu's written submission to the inquiry outlines several points of consideration around this complex issue, including the appropriateness of universal application of workplace drug-testing regimes, the need for legislation to protect workers' privacy, the need for more nuanced evidence-based testing frameworks and how treating medicinal cannabis differently to other types of prescription medication promotes stigma and discrimination of those employees taking a legally prescribed medication.

In conclusion, while Montu supports the current legal requirements for workplace strategies to protect employees in safety-critical roles, we are of the view that currently both the scope of substances in workplace screening and the approach of testing for mere presence rather than impairment are discriminatory and need to be updated. This means potentially expanding the scope of testing to other prescription medicines which impair cognition and developing separate tests which measure cognitive impairment. We have also put forward what a best practice workplace screening model might or would include with due process and natural justice at its core. In conclusion, I would like to again thank the committee for bringing to attention this very important issue of how medicinal cannabis is dealt with in workplace drug-testing arrangements. It is a significant issue for many of our patients, and the committee's work here has a focus on important principles of fairness and justice.

The CHAIR: Thank you, Matthew. Nathan, would you like to make an opening statement before we open for questions?

Nathan DAVIS: Yes, thank you very much, Chairperson. Chairperson and members of the committee, thank you for the opportunity to address the workplace testing inquiry today. I am here on behalf of MedReleaf Australia, a leading medical cannabis provider in Australia and New Zealand, to discuss critical issues concerning the treatment of cannabis patients and their need for fair and evidence-based policies.

We are licensed by the Australian Office of Drug Control, part of the TGA, to cultivate, manufacture and distribute medical cannabis. Our mission is to enhance the health of Australian patients guided by extensive research and development in pharmaceutical health care. Further to the submission into this matter that we have provided, I will focus on two key points: the critical role that doctors play in managing a medical cannabis patient's treatment and the necessity to prevent discrimination against patients who use medical cannabis.

Firstly, the role of doctors in managing medical cannabis treatment: medical cannabis, like any prescribed medication, is administered under the careful supervision of a healthcare professional. Victoria was among the first of the states to endorse the legal use, as Matt mentioned, recognising its potential benefits for patient care. This trust in medical professionals should extend to all aspects of policy, including driving and workplace drug testing.

It is essential to understand the presence of THC in a patient's system does not equate to impairment. Research does show that low levels of THC, particularly in regular medical cannabis patients, do not correlate to an increased risk of accidents or workplace injury. These findings emphasise the importance of evaluating impairment-based scientific evidence rather than mere THC presence.

Secondly, discrimination against medical cannabis patients: the current laws in Victoria can discriminate against patients who use medical cannabis. These laws often do not differentiate between a recreational user and a medically supervised patient. This results in unfair penalties for patients adhering to their prescribed treatments. Such discrimination is unjust and unsupported by scientific data. Evidence indicates that medical cannabis, when used under a doctor's guidance, is no less safe than any other medication being prescribed. Policies must provide and ensure that they do not disproportionately impact medical cannabis patients, respecting their rights to their treatment. Doctors should also not be placed in a position that sees a patient return to using medication that is not as optimal a treatment as medical cannabis is, but this is due to legislation, sadly.

I just want to point out that Tasmania's model for medical cannabis in relation to driving is a good one. Tasmania provides a valuable model by treating medical cannabis like other scheduled medications. The titration of dose is managed by the healthcare professional, and this approach ensures the patient's safety and fair treatment and upholds natural justice, as Matt mentioned. Adopting a similar model in Victoria could provide consistency and fairness for medical cannabis patients, we believe. Particularly some findings from Canada and our experience with medical cannabis being legal there illustrate that the actual impact of cannabis on road safety, for instance, is minimal compared to alcohol or other impairing drugs, and we know these, such as benzodiazepines and opiates. Policies should reflect this reality, ensuring fairness for medical cannabis patients.

In conclusion, MedReleaf Australia urges you and the committee to consider the critical role of doctors in managing medical cannabis treatment; there are more than 15,000 doctors prescribing medical cannabis in Australia currently. Victoria's pioneering stance on legalising medical cannabis should extend to fair, evidence-based workplace drug-testing policies. Thanks for your attention today. We are available for further discussion and other information if required.

The CHAIR: Thank you, Matt, and thank you, Nathan, for your opening statements. I will quickly ask a question, and then I will open it up to the panel. I definitely appreciate your presentation and definitely in relation to medicinal cannabis in relation to the health sector. I am sure that will benefit people in relation to their health issues and in relation to their medications, but this inquiry is looking into the risks and workplace testing. So I will firstly go to you, Matt. You mentioned in your submission – but before I do that, you mentioned 'penalise'. I just want to ask you, when you mentioned 'penalise', and we had a witness just prior to you mention high-risk employment, is removing a person who is positive from their task – not losing their job, just removing them because they test positive, removing them from the task they are actually doing at the moment when they test positive – and then discussing in relation to how it occurred and stuff and trying to seek support for them, under your definition, penalising or not?

Matthew McCRONE: It is if they are not impaired, because what the testing regimes currently look for is presence – presence of a substance, which can be in your body for weeks. Simply because you have got a substance present in your body does not mean you are not capable of performing a task.

The CHAIR: All right. I just wanted to clarify what you were saying about influence. To just go on, you mentioned that Montu has produced over 500 products which help the health sector. How many of those products have no THC? Or in the range of those 500 products, is there any product that has no THC in it at all?

Matthew McCRONE: Well, I would have to take that under advisement, but from previous lives lived, when I was running the taskforce, CBD is an incredibly difficult substance to isolate, so even with highly,

highly, highly concentrated CBD products, there still is trace THC in them, unless they are synthetic CBD, which is rare.

The CHAIR: Are you telling me it cannot be done or that it is very costly?

Matthew McCRONE: It is very costly.

The CHAIR: And can it be done or not?

Matthew McCRONE: It would probably be synthetic rather than plant-derived, and I think that misses a more germane issue: CBD is not the only cannabinoid that actually has therapeutic effect. Moreover, it is not just the cannabinoids, it is the presence of terpenes as well and the collective what they call entourage effect of all of those substances at once. But to say 'We'll just take the THC out of all the products and we're fine' kind of misses the point of the therapeutic nature of medicinal cannabis.

The CHAIR: So in all the testing, are they testing for THC or testing for all the other stuff as well? When you say, 'We do testing', does it record THC or does it record all that stuff you just mentioned?

Matthew McCRONE: Testing tests for THC as a surrogate of presence of cannabis.

The CHAIR: Okay. So my question again is – and you can take it on notice: how many of those 500 products have no THC from Montu? You can take it on notice.

Matthew McCRONE: I will, but I would say to you tentatively that it would be zero that would have absolutely zero, because another point to raise is that THC itself is –

Nathan DAVIS: Can I –

Matthew McCRONE: Yes. Sorry, Nathan; you go.

Nathan DAVIS: I might be able to assist there. There is some information provided by the TGA in relation to the categories that are prescribed for doctors, and this relates to the amount of THC that is in those compounds. Ultimately, probably close to 98 per cent of the products available on the Australian market do contain traces of THC. Now, some of these amounts of THC are almost undetectable, as Matt was saying. However, we almost have to label them on the product because it is almost like 'May contain a trace of nuts'. But this is where we are in relation to that. There are products that are CBD-isolate, but they are very few, and when we look at THC and CBD, they are very different compounds in what they are doing in relation to their effect on the patient – just to assist there.

The CHAIR: Thank you. That also leads to my next question. I just want to get a perspective, because you are the two major large companies producing medicinal cannabis, as to what you are producing and what service you are providing for the health sector.

Nathan DAVIS: Certainly. Ninety-eight per cent of MedReleaf Australia's products contain some trace elements of THC, and those forms of products can be orally administered, like a soft gel. They can be inhaled via an inhalation route. So it depends on the treatment that the patient is under. Now, the patient is also under the management and care of a doctor through these processes. I want to highlight just two things. The majority of prescriptions being prescribed in Australia relate to three major patient health outcomes: pain, sleep and mental health. When we consider that as the subset of your workforce, there are a lot of patients that are already being treated via these medications. I just wanted to highlight that.

The CHAIR: Thank you. My last question is on THC as well. You have done a lot of research, and actually, Nathan, you mentioned that research into THC shows a very low level of impairment. When you say a low level of THC shows impairment, what is the low level from your research that you refer to?

Nathan DAVIS: There are two. I will take this on notice for clarification if required, but I believe Canada is under .2 of a nanogram in the blood, and the USA is under .5. In relation to how you test that on any roadside, workplace or anything, that is another question. So there are those. There are also some findings by the RACGP in relation to this. They published some information in the journal back in 2018 which can be provided post this if needed.

Matthew McCRONE: Chair, if I can add to that, it is almost an accident of history that alcohol was the first thing that we developed testing for, because alcohol has a very specific linear correlation between its blood concentration and its impairment effect. Very few other substances have such a linear correlation. So to even look at 'Let's look at what a blood level might be that's a reasonable blood level that probably isn't impairment' – there is not a linear correlation like there is with alcohol.

The CHAIR: Just the last question before I pass on to –

Nathan DAVIS: Again, it is a presence. That is correct. It is a presence only.

The CHAIR: Okay. Just in regard to how long the test is on your person and how long it has been there, with THC, from your position and understanding, does it cause impairment? From your research and from your understanding, does THC cause impairment or not?

Nathan DAVIS: I was going to say in relation to the doctors that are prescribing it, the response that we get and what we see and through the findings that we provided, medical cannabis under the treatment of a doctor is no less safe than any other prescribed medication. No, we do not.

The CHAIR: Okay.

Matthew McCRONE: I would say you cannot make a general statement like that. In general, patients who are prescribed medicinal cannabis are taking it chronically. They are taking it every day, and the way the body actually processes cannabis when it is taken chronically is very different to a patient who is taking it for the first time who is naive. It depends on so many circumstances, but at the very least I would say that if there is impairment, impairment would only be for the first few hours after a dose.

The CHAIR: Thank you. Ryan.

Ryan BATCHELOR: It may be a broad question, but it is kind of helpful to be fundamental for the inquiry: do you have an understanding about the prevalence of medicinal cannabis use in Victoria?

Matthew McCRONE: Montu has 20,000 patients, so we definitely can tell you that. Broader than that, outside of our own patient numbers –

Ryan BATCHELOR: Even from a peak? You mentioned you started a peak.

Matthew McCRONE: Yes, we have really only got our own numbers. Maybe Nathan can add to our numbers.

Nathan DAVIS: The TGA has some special access data that can be provided in relation to that. Currently Victoria is the fastest growing state in relation to the uptake via prescribers that we see. Patients have been accessing it, obviously, from the very start in 2017. We do see thousands of patients being dispensed medical cannabis by pharmacies around the state. Those numbers can be provided, but they are in the thousands.

Ryan BATCHELOR: Okay. Anything that would help us sort of ground the scale and rate of growth would be useful for the report, I think.

Matthew McCRONE: Sure. We will take that on notice. But Nathan is right – the dashboard that the TGA has is updated I think monthly.

Ryan BATCHELOR: Okay. That will be useful.

Nathan DAVIS: I can share a link back to the organisation committee in relation to the SAS dashboard, if Matt cannot do that there in person. No worries.

Ryan BATCHELOR: That would be great. My next question was going to go to the question about what medical advice is generally given on the likelihood or the length of likely impairment following ingestion of medicinal cannabis products. You mentioned that doctors probably cannot make a general statement. As a supplier, what advice do you give doctors?

Matthew McCRONE: Well, we do not. The medical practitioner is the one that actually has the –

Ryan BATCHELOR: So do you give any guidance to prescribers about different products' strength and impact?

Matthew McCRONE: If I could answer it this way: THC is the one. It is the cannabinoid that can have psychoactive effect. People are moving away from 'cognitive impairment' and referring more to its psychoactive effect. Certainly the higher the THC component, the higher the likelihood of the initial psychoactive effect. Beyond that – I mean, impairment is such a nebulous term. Besides the fact that it is not even measured for impairment in workplace drug testing –

Ryan BATCHELOR: Agreed. But we have had the analogy drawn to other forms of medication where warnings are given about the length of time that people should not drive or use heavy machinery following consumption. Do you have a similar construct of warning that you provide at a product level?

Matthew McCRONE: We do not for products. I do not think it would be appropriate in supplying products to actually be advising medical practitioners, but what I will say is medical practitioners universally advise their patients about cognitive impairment, whether they are increasing their dose of methadone, whether they are being prescribed an antipsychotic for the first time. It is grist for the mill for a medical practitioner to be advising a patient about the possibility of cognitive impairment with a prescription medicine, and also the pharmacists – I mean, I will call one for the team. Pharmacists are very, very able to counsel patients on side effects generally but specifically about impairment. I have not worked in clinical practice for a very long time, but generally you would say to a patient, 'You just need to see where you are. You need to see how you go, and be careful.' For advice beyond that, more specific advice, really depends on so many factors; you cannot generalise.

Ryan BATCHELOR: And that is what is in the training you provide?

Matthew McCRONE: As to what is in the Saged portal, again, I would have to take that on advisement, but that portal was actually written by clinicians for clinicians, so we can look at their specific advice there.

Ryan BATCHELOR: That would be great. That would be really helpful.

The CHAIR: Nathan, do you want to answer that question from the Deputy Chair too, please?

Nathan DAVIS: Yes. Just in relation to the question around what doctors are providing, unfortunately doctors are at a crossroads where they legally have to provide the update to the patient that, 'I'm letting you know that you're now taking medical cannabis as a patient and it is recorded on my system there.' They are doing that for protection, purely for the fact that they are disclosing to the patient that today's laws have not yet caught up with where the science is.

I just want to talk about what gets provided to the patient when they are picking up their prescription. It is not dissimilar to any other medication, and it is labelled appropriately by the pharmacist. If you are getting your benzodiazepine, which is your Valium, and you are taking it for your sleep, it is getting labelled with an L1 label. That L1 label says, 'It may effect drowsiness. Do not take'. That is there as a blanket statement. Now, we are still finding out that patients are being safely titrated, and doctors are reporting back to us in large numbers that their patients are actually better and safely titrated under their care than if they were on their previous medication or not taking their medication at all. So the doctors are informing their patients that the laws of today have not yet caught up when they start their treatment.

Ryan BATCHELOR: I just want to pick you up on that. That it is not a question about whether the law has caught up, it is a question about whether there is any medical advice about likelihood of impairment. They are two very separate questions.

Nathan DAVIS: The doctor goes through their usual healthcare practices of optimal minimal dose and their quality use of medicines in relation to prescribing cannabis or any other medication, so I would have to say that no, they have every discussion with their patient around this treatment and what it may mean for them.

Matthew McCRONE: Nathan made reference to label 1, which is definitely in pharmacists' swim lane. That is actually for drowsiness, which is different to cognitive impairment. I mean, they can intersect, but they are not synonymous. In a previous life, when I worked at TGA, there was an ongoing battle, with

manufacturers just saying 'Label 1 needs to be applied to our medicine purely from a risk management point of view,' so that they could say, 'If the patient is taking the medicine and we have a warning that it may cause drowsiness and then they wrap their car around a tree, we have no liability because we have actually warned them of drowsiness.' There is a real disconnect between advice on prescription medicines broadly around whether they cause cognitive impairment and whether that is actually established by research. The challenge has ever been thus, and it is not just specific to medicinal cannabis.

The CHAIR: Rachel.

Rachel PAYNE: Thank you, Chair. And thank you to Nathan and Matthew for appearing before us today. What has come up quite a lot throughout this inquiry is that drug testing is there because there is not a real understanding as to whether patients are actually consuming their medicinal cannabis appropriately. So I guess I want to question both of you as providers working closely with doctors that are prescribing doctors: is there any concern that patients are using their medication not as desired or inappropriately? Is this something that has been flagged?

Nathan DAVIS: In terms of that, the patient is regularly screened with their doctor. They are not given a large – 'I'll see you in six or eight months.' They are managed on a regular basis with their patient. They are given proper, appropriate intervals when they are managing that and the titration period within that, because everyone's endocannabinoid system is different. This is the difference that we have to understand. We are all fighting that titration level. So the doctor is in regular control of that, not dissimilar to any other medication that you could be taking more or less of. Now, it is managed appropriately. I do not think we are seeing any difference if it is related to cannabis or another patient or not.

Rachel PAYNE: It seems, just from what you are reporting, that the treating doctor treats each patient on a case-by-case basis and that may even be more of a risk-averse approach than if it was a different type of medication, whether that be based on what they are prescribed, their modes of consumption or rates of consumption. All of that information would be provided by that doctor to the patient.

Matthew McCRONE: That is right. And there is follow-up. Patients are not just seen by a doctor, and it is 'Goodbye. Have a good life.' As to when they are coming back for repeat prescriptions, that would be an indicator of whether or not the patient has actually taken the medication beyond the prescribed dosage range, and there would be a conversation around that if there was.

Rachel PAYNE: Okay. You mentioned Canada and some of the examples that have happened there. Looking at best practice to ensure that due process and natural justice, do you think that there has been a resistance to the idea of medicinal cannabis being legally prescribed as a medication in Australia in comparison to what you have seen in other jurisdictions?

Nathan DAVIS: Australia right now is the largest jurisdiction for medical cannabis outside of North America. I am very clear about this. We have one of the largest and one of the most robust systems for medical cannabis in the world. We are a beacon. The TGA and our state health departments need to be commended for what they have done in relation to patient outcome and access. Yes, there is a massive uptake in relation to doctors exploring this as a treatment alternative to others that have been unsuccessful.

Matthew McCRONE: My answer is probably a little bit different to Nathan's. I refer back to the Victorian Law Reform Commission's report that special commissioner Ian Freckelton wrote and the intention of that, which is where the recommendations came from that built the legal framework for medicinal cannabis in Victoria. It was always intended that it was going to be embedded into normal general practice – that you could go to your GP, get a repeat for your blood pressure tablet and get a repeat for your medicinal cannabis medication while you were there. That unfortunately is not what has unfolded in lived experience. There is reticence still in general practice for GPs to prescribe, so we do not have a lot of GPs prescribing. Key organisations like the RACGP and the AMA are kind of turning around a little bit on their position, on their views, on medicinal cannabis. All of that adds to the stigma and the complication that medicinal cannabis patients suffer.

Rachel PAYNE: Okay. Thank you.

The CHAIR: Thank you. Dr Mansfield.

Sarah MANSFIELD: Thank you. Thank you for appearing today. I was interested in your proposition around broadening workplace testing potentially. It highlights, I guess, a bigger point around a lot of the other medications that we do not screen for and our different treatment of them, and they are at least as, if not much more, impairing than medicinal cannabis would be.

Matthew McCRONE: Indeed.

Sarah MANSFIELD: I guess I would just be interested in exploring what that might look like if we were to expand testing and whether that is, even just from a technical point of view, possible. What would be the practical implications of that?

Matthew McCRONE: Okay. Well, not being a pathology scientist, I cannot say exactly, but certainly standards can be developed to screen for anything. Oxycodone was added to the standard not that long ago, so standards can be added. As to what needs to be added – and I did refer to this in our written submission – rather than manufacturers, look to clinicians and clinical experts. The Victorian Department of Health commissioned a report from Austin Health on all prescription medicines which cause harm including cognitive impairment, and I think that is the most exhaustive list out there as to potential prescription medicines which can cause impairment. These are not fringe medicines. Gabapentinoids are prescribed for chronic pain really, really broadly; Z-class drugs, zopiclone and zolpidem, for insomnia – and they cause daytime sedation – are probably the number one treatment for insomnia other than medicinal cannabis; antipsychotics; anti-inflammatories and first-generation antihistamines, which you do not even need a script for – you can just buy them from the pharmacy. So the idea that this list that exists in the Australian standard of substances is of the only substances that can potentially cause risk at work is not based on fact.

Sarah MANSFIELD: I guess in terms of what a workplace drug testing or AOD approach might look like, other than broadening that list to include all of the potential medications and substances that might cause impairment, do you have another approach that you suggest?

Matthew McCRONE: Yes. We certainly listed what best practice looks like – I can read from notes here and go through that – but it is mostly based on the NCETA review that they did in 2011 about best practice workplace drug-testing programs. It is all about natural justice and about not implementing testing until at least six weeks after a drug education program has been done through the workplace. I could go on, but I think the important thing is there are lots of substances out there that are prescribed by doctors which can cause impairment other than the ones that are already being tested for. So from a natural justice point of view, yes, that does need to be looked at, to expand that. But what that points to is the need for a reliable test for impairment becoming greater than ever. The Druid test was referred to, and that is the test that Arkell et al used in their published open-label trial for those patients taking medicinal cannabis that used a driving simulator. Indeed it is the same research team that will be doing the closed-road trial that was announced by the Premier earlier this week. So there are impairment tests, and they are being used already, so it is not that the technology or the idea of it does not exist.

Sarah MANSFIELD: So why do you think we do not use that test in a test for impairment?

Matthew McCRONE: As a prior regulator, I would say sometimes regulations do not move quickly enough, and I think that is all that is the case here.

The CHAIR: David, your turn.

David ETTERSHANK: Thanks, Chair. I have also got a curiosity that I share with Mr Batchelor. We have got all these massive numbers for scripts, and we have never been able to translate that into persons. I am wondering – maybe if we could start with you, Nathan: in terms of med relief, roughly how many patients would you have here in Victoria, do you reckon?

Nathan DAVIS: It is very difficult to answer that specifically as well because obviously we do not get that data on what has actually been dispensed. That is a very hard thing. We do see some of that information. In relation to the number of patients, are you wanting to know the size of the actual market that a patient is using or how many patients might be using a product? Because there could be a patient that is using one product once a month when they are having their anxiety but they have got THC in their system or it could be that patient who is dealing with their chronic pain who is using an oral dose in the morning and then an inhalation dose at

night, and they are using two products. So those numbers that you are actually seeing are probably more closely related to the Victorian health department. I do not have access to those specifically in relation to how many patients.

Matthew McCRONE: What I would say is unfortunately the TGA numbers are not unique patients necessarily, they are instances of approval, and with authorised prescribers that is even more murky because, I am sure you know, once a prescriber becomes authorised as an authorised prescriber under the TGA framework, that is it; they report six-monthly. Our numbers are accurate because it is our clinic, so when we say 20,000 Victorians, they are active patients within the last six months.

David ETTERSHANK: Is there a way we can get some understanding in terms of being able to get – I mean, you have got obviously a huge sample there. Do you know what the average number of scripts per patient is?

Matthew McCRONE: We would have to come back to you on that.

David ETTERSHANK: Can I give that to both of you? I think the committee would be deeply appreciative of what data is out there, given the TGA cannot tell us this. What data is out there in terms of the total number of people on med can, and if you could, what is the average number of scripts per patient?

Matthew McCRONE: Yes.

David ETTERSHANK: That would be really useful information.

Thank you both for your really interesting points of view. We are hearing from lots and lots of witnesses about the need for consistency of treatment. From what you have already said, clearly you do not feel that that is the case. You also talk about, in your submission, coming up with drug screening for all types of medication. I guess there are two questions in my mind out of that: (1) is that actually practical and (2) if there is not a direct correlation between presence and impairment, is it worth it?

Matthew McCRONE: Again, from a previous life as a regulator, sometimes you have to step slowly rather than radically to keep everyone comfortable. Certainly we would say in the first instance, yes, there would need to be broader testing of presence for any prescription medicine that can cause impairment, but then if the presence comes up positive, an impairment test would need to be done. But moving forward there could be a future perfect world where it is just about testing for impairment, you know, cognitively of the worker, rather than actually caring about whether there are substances in their system or not.

David ETTERSHANK: Okay. If we take that as the Holy Grail, to actually have a great impairment test, is there a potential role, then, for there still being some sort of presence testing as well?

Matthew McCRONE: Again, I say in a future perfect world, no. But a lot of people would have to come a long way to be comfortable with that.

David ETTERSHANK: Yes. Okay. So it might be a bit of a safety net that the legislators might feel comfortable with if there was both.

Matthew McCRONE: Yes. That is right.

David ETTERSHANK: Nathan, did you want to add anything to that?

Nathan DAVIS: I do not have anything to add.

David ETTERSHANK: Okay. All right. Thank you very much.

Nathan DAVIS: Nothing specifically to that, no.

The CHAIR: Thank you. Thanks, David. Dr Heath, have you got any questions before I wrap this up?

Renee HEATH: No, thank you. Actually, maybe I do have one. I think it was Nathan who may have said that it does not cause cognitive impairment, but also I am hearing that it is used as a treatment for insomnia. That to me would say that it would at least put you to sleep, so how do you balance these two?

Nathan DAVIS: Again, it depends where the patient and the doctor – you are on an optimal minimal dose of that treatment. A patient would generally start on a CBD-dominant formula with little THC, and then you would manage that patient up either to a balanced or another appropriate medication. I guess in terms of the statement, the patient is being managed under the care of their doctor. The impairment piece needs to go back to the psychoactive discussion that Matt alluded to, because that psychoactive compound that is actually assisting that patient to sleep may not be causing them any impairment, regardless of the dose of that THC.

Renee HEATH: All right. Thank you so much. Just in the interest of time, any other questions I will provide on notice. Thank you.

Nathan DAVIS: No worries. Thank you.

The CHAIR: Thank you, Dr Heath.

Gentlemen, thank you so much for coming in and giving your submission. There have been a few questions on notice I think for both of you. Nathan, thanks so much for giving your submission. The information provided will definitely be taken into consideration when we form our recommendations as well.

Witnesses withdrew.