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

MEMBERS

Trung Luu – Chair
Ryan Batchelor – Deputy Chair
Michael Galea
Renee Heath
Joe McCracken
Rachel Payne
Aiv Puglielli
Lee Tarlamis

PARTICIPATING MEMBERS

Melina Bath
John Berger
Georgie Crozier
Moira Deeming
David Ettershank
Wendy Lovell
Sarah Mansfield
Richard Welch

WITNESSES

Jan Kronberg, National President, and

Dr Karen Broadley, Executive Member and Researcher, Drug Advisory Council of Australia.

The CHAIR: We are recommencing the Inquiry into Workplace Drug Testing in Victoria. Thank you. In this last session we will have the Drug Advisory Council of Australia with us. Joining us are Jan Kronberg and Karen Broadley. Ladies, before we continue I just want to read this information regarding the evidence you are providing to us today.

All evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and further subject to the provisions of the Legislative Council standing orders. Therefore the information provided during this 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 things, those comments may not be protected by this privilege. Any deliberate 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. The transcript will also be made public and posted on the committee website.

Again, thank you for coming in and waiting around for this last session. I know you made a submission. Could you just please state your full name and the organisation you are representing, just for the record.

Jan KRONBERG: Thank you, Chair. My name is Janice Susan Kronberg, and my role is that of National President of the Drug Advisory Council of Australia Ltd.

Karen BROADLEY: Karen Broadley. I am an Executive Member of DACA, the Drug Advisory Council of Australia.

The CHAIR: Thank you. Quickly I will just introduce you to the committee. I am Trung Luu, the Chair. The Deputy Chair is Mr Ryan Batchelor. We have Mr David Ettershank and Dr Sarah Mansfield. Also, on Zoom, we have Dr Renee Heath.

I know you have provided a submission already. I just want to invite you, I guess, to make a quick opening statement before we open to the panel for questions.

Jan KRONBERG: Thank you very much, Chair. Well, between Karen and me, I am going to speak first. On behalf of the Drug Advisory Council of Australia Ltd, which is now a registered charity, and as its National President, we appreciate this opportunity for us to appear as witnesses today. During my eight years as a member of the Legislative Council I first served on the joint Law Reform Committee, and when we were in government I chaired both the joint Outer Suburban/Interface Services and Development Committee and the joint education committee, and so I can continue to draw upon much of this real-world learning for today.

My erudite colleague Dr Karen Broadley, with us today, has her PhD in child protection. Dr Broadley will draw upon her 20-year career on the front line of child protection, youth justice and academic research.

This proposed legislation causes us great concern, and tragically we see that often the elite dismiss and denigrate opinions that are not in line with their own. We say that one needs to face up to the issues faced by nations that have already legalised cannabis. One could say it is to look into the belly of the beast and be afraid, very afraid.

Now, of relevance today is last month's article published in the United States Association for the Study of Pain *Journal of Pain*, volume 25, number 4, April 2024, pages 833 to 842, headed 'Cannabidiol (CBD) products for pain: ineffective, expensive, and with potential harms'. And on page 838 we find the heading, 'Is pharmaceutical-grade CBD safe?' Cannabis and cannabis-based medicines have come under scrutiny regarding road and workplace safety. In 2018 the Occupational and Environmental Medical Association of Canada endorsed a position statement on the implications of cannabis use for safety-sensitive work, which commenced:

> … until definitive evidence is available, it is not advisable to operate motor vehicles …

or perform 'safety-sensitive tasks' for at least '24 hours following cannabis consumption'.

Cannabis consumption is associated with a more than doubling of the risk of motor vehicle collisions and is also associated with a range of other serious harms. A recent cross-sectional study in Canada reported an almost 500 per cent increase in emergency department visits involving road traffic injuries associated with cannabis following legalisation. So, ladies and gentlemen, here we are today sandwiched between the reported facts on the ground in North America just last month and the simple rebranding exercise brought about by Keith Stroup, who headed up NORML in 1979. Pamela McColl reveals on page 34 – and I am displaying this book for the purposes of Hansard, *The Pied Pipers of Pot: Protecting Youth from the Marijuana Industry*; I am quoting verbatim – in a presentation to Emory University that year, Keith Stroup said:

> We will use the medical marijuana argument as a red herring on the road to full legalisation.

As with most of the initiatives by the pro-drug lobbyists, we see an illusion of responsibility, but it is always darkly cloaked with a tone of reasonableness and an action imperative. It is my sincere wish that members of this committee will recognise these sinister siren songs for what they are. Frankly, legalising something harmful never removes the harm, and frankly, this is the same as putting lipstick on a pig. It is still a pig. It changes the legal consequences usually for those who promote, produce or in other ways profit financially from the legalised substance. There is little to no regard for the negative impact on individuals or society. So, ladies and gentlemen, this proposition is clearly a Trojan horse that has been steadily built up since 1979 but with more muscle being added every year. I say, 'Oh, what a tangled web we weave when we set out to deceive.' This is a gift to the committee, because I am going to quote our founding patron Elaine Walters OAM, and she offers us this today: 'An unexciting truth can easily be eclipsed by a thrilling falsehood.' We attribute that to Aldous Huxley. Karen Broadley.

The CHAIR: Thank you. Karen.

Karen BROADLEY: Thank you, Chair. This is our submission. We did a submission to the inquiry.

The CHAIR: We have all got that submission. Just any opening statement that you have got.

Karen BROADLEY: Great. I will just make a couple of points, really – three or four points about the submission, just to clarify a couple of things. Our basic message is that if employees have recently used cannabis, either hours ago or days ago, this will result in a heightened risk of accidents and other adverse events, risking the health and safety of employers, co-workers and the public. One of the few points I just want to make is that we make the point that medicinal cannabis should be treated differently to other prescription medications. 'Other prescription medications' is a big bag. There are thousands of other medications. Whilst we recognise that some of those other medications – prescribed opioids, valium, sleeping tablets – might be concerning, that is a different question, and if we are concerned about some of those, obviously we need to do some sort of inquiry or investigation or ask some questions about that. We use this terminology because this was the term used in the terms of reference, but it is a bit difficult to compare cannabis with other medications when there are so many of them, like antibiotics, anti-inflammatories – so many.

The second point I would make is that our main concern – and we heard the previous witness talk about safety-sensitive environments – obviously is more about some environments, some workplaces, more than others, and our recommendation is that employers should be able to develop their own drug and alcohol policy depending upon their environment, depending upon their workplace and depending upon the risks that are associated with their workplace and their work activities.

Another quick point is that we draw from systematic reviews – recent systematic reviews – as much as possible. We are concerned about people and experts – so-called experts – when they give evidence, if they draw on old single studies, like a 2009 single study, 15 years old. We see that happen. We have made a very concerted effort not to cherrypick an old study that might confirm our point of view. We think it is very important to find recent systematic reviews. A systematic review is when the authors go through a systematic, unbiased process to find evidence and studies and then review those studies. We found a systematic review, a recent one from 2023. This reports on the findings of that systematic review, and it found sedation to be a concern and nausea, vomiting, dizziness and euphoria.

Then in our human rights section in our submission we just talk about the fact that, yes, we are concerned about it. We do not want to discriminate against people in the workplace, but there is also the human right to life and

the human right to safety, and according to the Victorian charter of human rights, the right to life and the right to safety are non-derogable rights. They are rights that cannot be suspended or limited in any way. Sometimes, like, for example, during those COVID times – we all remember lockdowns and our human rights – our human rights to freedom of association and freedom of movement, those things, are suspended for the sake of the right to life. So we believe that drug and alcohol testing and workplace testing should continue as they are according to people's – when I say people's, I mean organisations', businesses' – workplace policies, and certainly we heard from the last witness talking about education for workplaces. That is very important, but they still need to be empowered to assess and then manage their own risks. Thank you.

The CHAIR: Thank you, Karen. Thank you, Jan. I will quickly throw a question at you in relation to your submission. In your submission you mentioned that DACA strongly advocate for investment in drug rehab services across the nation and to provide greater support to the grieving families of those who are affected by drugs. You also argue that medicinal cannabis should be treated differently to prescribed medications. When you say that, what about prescribed medicinal cannabis? At the moment we do have prescribed CBD or cannabis which has some THC, which I will go to, but what is your position on that in relation to the rest of prescribed medications across the board?

Karen BROADLEY: Well, it needs to be treated differently to other prescribed medications. If cannabis is prescribed, it needs to be treated differently to other prescribed medications, primarily for the reason – and we say this in our submission on page 5 near the top, the third dot point – that there is no globally accepted definition of impairment associated with medicinal cannabis and no agreement on how to measure its occurrence. If that were to change, then we would certainly be talking about that, but that would matter. That would be a big deal if that was to change. But I think for us – for me, and I think for us – that is the sticking point, that there is no globally accepted definition of impairment. We cannot measure impairment. Impairment does not equal a positive test. There is just too much we do not know.

The CHAIR: Also we heard that the so-called impairment or cognitive effects are mainly caused by THC. What is your view in relation to CBD without THC in it or a very minimal amount or traces of THC which have no result in testing? Prescribed cannabis such as CBD oil which has no THC in it or so minute an amount that when you are testing it does not show up, what is your view on those ones?

Karen BROADLEY: Can I just read out one other study, just very quickly, which I actually found last night? Jan and I were talking about this last night, about CBD, and I quite quickly found a study. It was published in 2022, so quite recently. It is a systematic review. It is called *Adverse Effects of Oral Cannabidiol: An Updated Systematic Review of Randomized Controlled Trials*. When it comes to a hierarchy of evidence, this is right up the top of the hierarchy of evidence. It is a systematic review of randomised controlled trials, published recently. It is a review of 12 studies, and in there it says – and I will quote this; I just wrote it on my phone last night:

> The results showed that CBD had mild and moderate adverse effects in most studies, the most common being drowsiness, sedation, fatigue, dizziness, headache, diarrhea, nausea, decreased appetite, and abdominal discomfort.

Now, those first few, I think, particularly in some work environments, would be concerning – being drowsy, sedated and fatigued and dizziness. So I think even with CBD there are concerns. Some people have concerns; not everyone has concerns. There is a lack of consensus, yes? It would be good to have some consensus, but there are very, very diverse opinions about these issues.

The CHAIR: I only ask because you mentioned perhaps medicines being treated differently. I am just wondering about your stand, or opposition, in relation to CBD. Some submissions have said that there are no impairments, effects, from it when there is no THC, or a trace of THC, in it.

Karen BROADLEY: Yes. I can send you that article, if you like.

The CHAIR: Yes, that would be good.

Jan KRONBERG: Chair, I am just wondering: would I be able to amplify that point?

The CHAIR: Yes, over to you.

Jan KRONBERG: Thank you. I am actually just holding this up. It has been a worked-over document in the last 24 hours, but if it is of value we could table an electronic copy of this.

The CHAIR: Yes.

Jan KRONBERG: I will not give you this grubby one. It is a really important – I feel that it is a breakthrough – set of findings as published by the US Association for the Study of Pain. The heading is 'Cannabidiol (CBD) products for pain: ineffective, expensive, and with potential harms'. I would just like to preface what I am going to read into the record with this comment. We need to go to really core things when we are talking about the prescribing of medicinal cannabis. If that has been found and reported on in this respected medical journal in the United States last month – I do not think you could get things much more current than that – we should be questioning why medicinal cannabis is being brought to bear for people who have pain. I personally suffer from complex regional pain syndrome from six orthopaedic surgeries and I still have a limp from a major injury, and so I accessed a lot of typical pain relief medications: opioids, Lyrica, things like that – anti-inflammatories. And I do not take any of that now. Why? Because other things have come in – physiotherapy, exercise, weight reduction – and therefore I am not committing to a lifetime outlook of needing to take medicinal cannabis. So my question is: if people feel they need to take medicinal cannabis, what is their outlook for taking it? Are they taking it for a day, a week, a month, a year, a decade – until their grandchildren arrive? How long do they want to be suspended by this? Because they know that eventually – and we know – there is a ratcheting up of the THC content in it, because we know that this is the stalking horse for further legalisation programs. We have tabled the evidence of that. That is a fact. There will be people here who will not like to hear that information, but we cannot change history. That has occurred. That is on the record consistently – through the 70s, the 80s and the 90s – in print media and on television, and it is accessible.

Our concern is: why are we looking at saying you must have medical cannabis – you must have it – and you must look to engineer everything around society to have that? We have to commend scientists, the people looking for different forms of medicine and pain relief. I am a chronic pain sufferer myself, and I feel quite passionately about why people would be looking at just one course of pain relief. It is not about pain relief anymore; we know that other things are being brought in. It is becoming tantamount to why people would recreationally be using cannabis. They would be using cannabis to relieve tension, to face up to the next day, to confront a family dispute – a whole range of reasons why people need something to ameliorate their feelings. People drink alcohol for the same purposes. I am really pleased to have had the opportunity to make that point. I think it is really important, because if we are talking about testing in the workplace, we are saying that if you are found to be taking medicinal cannabis, then you might lose your job or you will be impeding progress through the phases of your career, right? We have to look at it from 'What's the need?' What is the need?

The CHAIR: All right. If you want to table that, I will pass it on. We have got some time for the committee to ask some quick questions as well. I think Ryan wanted to go first.

Ryan BATCHELOR: Thanks, Chair. Ms Kronberg and Ms Broadley, do you think that it should be legal to prescribe cannabis for medicinal purposes in Victoria?

Jan KRONBERG: It is legal, so we have to accept that that is a fact.

Ryan BATCHELOR: But do you believe that it should be legal?

Jan KRONBERG: No.

Ryan BATCHELOR: Do you support the law's existence?

Jan KRONBERG: No. I am uncomfortable with that.

Ryan BATCHELOR: Do you believe that people who are prescribed opioid-based medications should be permitted to work?

Jan KRONBERG: Yes, but there are going to be limitations to what occupations they have.

Ryan BATCHELOR: So you believe that there should be limitations on the employment of people who are prescribed opioid-based medication?

Jan KRONBERG: Okay, that is a curly angle you put in there, Mr Batchelor.

Ryan BATCHELOR: Just a question.

Jan KRONBERG: No, no. It comes back to the hierarchy of human rights.

Karen BROADLEY: But it also speaks to those other medications. We did not look into those other medications, because there are so many of them; there are a thousand of them. There could be opioids, there could be different types of sleeping tablets and valium – there are all sorts of things. The question in the terms of reference is not great, in my humble opinion. The question is about treating prescription medicinal cannabis as compared to other prescription medications, when you are comparing one medication, albeit there are many types of cannabis, with a thousand or more others. Do you know I am saying?

Ryan BATCHELOR: Not really, but that is okay.

Karen BROADLEY: Well, it is beyond what I have researched and what we know in detail to really be able to answer to opioids. It is a different question. If people have concerns about that, then investigate those concerns, look into those concerns. And if there are concerns, we do not want to add to those concerns by bringing cannabis into that mix as well – medicinal cannabis. They are two very different things. Sorry to interrupt.

The CHAIR: I think what the Deputy Chair meant to say is about the impairment or the effects of certain drugs which are across the board. Cannabis has been brought to our attention quite regularly with weekly news at the moment. We understand opioids have certain side effects and some impairment. We are just trying to establish that, because cannabis, as has been put forward, and THC has some sort of impairment – some say it does not. We are just trying to get your view in relation to how opioid impairment compares to cannabis impairment. Should we treat them differently if the impairment is the same? Whether you take opioids or cannabis, the impairment is the same. If you are on a site, risks will happen. It does not matter what you have taken, the outcome is the same. We are trying to establish what is your view in relation to opioid impairment compared to cannabis impairment. Why should cannabis be treated differently to opioids?

Karen BROADLEY: It does need to be treated differently in that you cannot actually test impairment in cannabis, whereas you can in opioids. That is my understanding. A positive test for opioids actually equates to impairment. It does not with cannabis.

The CHAIR: David.

David ETTERSHANK: I do not know where to start. Can I just get your point of departure here, or launching pad or whatever. You are saying to the committee that – you are quoting Keith Stroup from 1979, who is basically saying that medicinal cannabis is a conspiracy to legalise cannabis more generally. Is that correct?

Jan KRONBERG: Yes.

David ETTERSHANK: Therefore you should not have medicinal cannabis.

Jan KRONBERG: We just see it as a stalking horse for the full legalisation, which we oppose. We have to highlight that.

David ETTERSHANK: We have heard, for example, that there were about a million medicinal cannabis scripts provided by doctors to patients last year. You are saying that is not appropriate?

Jan KRONBERG: I just want to read something to you.

David ETTERSHANK: No, no – could you please just answer the question?

Jan KRONBERG: I would like to read it, augmenting my answer, if I may –

David ETTERSHANK: Please. Knock yourself out.

Jan KRONBERG: because I am going to go to the heart of your question.

David ETTERSHANK: Okay.

Jan KRONBERG: One of the problems we feel – it is quite possible that there has not been enough investment and energy to support the fact that medicinal cannabis is out there. Look, every day I hear a larger number of users. About a fortnight ago it was 300 and yesterday it was 800 and you are saying a million – 100,000, rather.

David ETTERSHANK: There were over a million prescriptions that went through the TGA last year.

Jan KRONBERG: Well, thank you for that. I appreciate that clarification. And that is a terrifying amount, because there is so much of this that could have THC embedded in it, as you know.

David ETTERSHANK: No, this is THC medicine we are talking about, and CBD medicine.

Jan KRONBERG: Yes. Are you talking about CBD or CBD and THC? Which one are you talking about?

David ETTERSHANK: As the committee has heard, it is actually very hard to remove all THC traces from CBD.

Jan KRONBERG: I am glad to hear that admission.

David ETTERSHANK: You are actually the first people who have come in through all the submissions we have got that have said that CBD should be banned. So you are on –

Jan KRONBERG: If I may just correct that point, I have read evidence in from an article by a respected organisation of last month –

David ETTERSHANK: No, no, I am talking in terms of the submissions that have been received by this committee.

Jan KRONBERG: I am sorry, I cannot account for the submissions of other people.

David ETTERSHANK: Okay. So they are wrong and you are right?

Jan KRONBERG: Quite possibly.

David ETTERSHANK: So you are saying CBD is not effective for pain relief. You understand that most people that take CBD for inflammation and stress? And can I ask, whether that is right or wrong, why should that make it illegal?

Jan KRONBERG: Because it is part of a program – as a stalking horse, a Trojan horse, galloping horses – to actually legalise cannabis in a full-body form. We have so much evidence where it has been legalised and the reversal occurring in the United States, the chagrin that the Canadian government has looked at it in review, and –

David ETTERSHANK: Well, when you say 'chagrin' in Canada, let us just go to that one. You are obviously right up to date on this stuff. You have obviously seen, then, the review that was released two weeks ago or three weeks ago, which was the legislative review of –

Jan KRONBERG: Yes. I have it here.

David ETTERSHANK: Oh. That is a very slimline version, but interesting.

Jan KRONBERG: Well, I have brought in enough to refer to today.

David ETTERSHANK: That actually did not find what you are saying, did it – that Canadian review, the statutory review?

Jan KRONBERG: I would like to read a passage. It centres on the point you are making. It is recommendation 45, and I think this is really important, because if we are going to push through this – and perhaps the numbers are there for this legislation to pass and to be –

David ETTERSHANK: Sorry. You actually said that before. What legislation are you talking about?

Jan KRONBERG: The workplace regulations. If we are –

David ETTERSHANK: So that we are all on the same page – I think that would be appropriate, Chair – the legislation you are talking about –

Jan KRONBERG: The legislation that follows from these inquiries. That is the purpose of it, surely.

David ETTERSHANK: Well, not into cannabis. This is an inquiry into workplace drug testing, and up until now all of the focus has been actually on – really I think primarily on – the question of how you deal with impairment at the workplace. So contrary to what you have said before about all the other drugs and cannabis, we are actually focused – cannabis is obviously high profile, but we are actually addressing it in broader questions of impairment.

Jan KRONBERG: It is a very worrying substance, and the people who have become addicted to it have used it as a gateway drug. For societies that have been affected by it, it is a very serious question. We firmly believe that we are on the right side of history and that people will change their point of view. I would like to refer to recommendation 45, which has been referred to by David Ettershank –

David ETTERSHANK: That is me.

Jan KRONBERG: and it is the *Legislative Review of the Cannabis Act: Final Report of the Expert Panel* dated Friday 26 March 2024, and it is from the Canadian government. There are a number of passages in it that are pertinent, but we do not have time.

What I would like to say is that if we are going to forge ahead with this, everybody – doctors, nurses, hospital administrators, actuaries, people who write insurance for public liability, the whole panoply of entities and people who will be swept in through these processes going ahead – needs to understand that there is actually a lag in the learning of the people who are prescribing this. There is a missing link; there is a hole you could drive a train through. This is what recommendation 45 says:

> … Health Canada, in partnership with provinces, territories, patients and health care professionals, should support the development and dissemination of national clinical guidance documents related to cannabis for medical purposes to increase the knowledge and understanding of health care professionals.

I am going to interrupt my quote to say cannabis has been legalised in Canada since 2018, so this is six years on. This is an expert review. These are the things they did not think about when they launched into this.

David ETTERSHANK: Well, actually this is a review that was conducted because it was written into that Act when it was passed in Canada in 2017. Chair, I might leave it there –

Jan KRONBERG: It is not an episodic review, but I would like to finish my quote if I may, Chair.

David ETTERSHANK: I will finish my questioning there, but perhaps we can pick up some of this stuff when we do our visit to Roswell and Area 52. Thank you.

Jan KRONBERG: Okay, I will continue my quote for the purposes of Hansard. I am sorry to make it difficult for you.

> These documents should cover issues such as: indications for which there is a sufficient evidence base of effectiveness, how to monitor patients, and how to track and report adverse reactions.

That is the hole, ladies and gentlemen – Canada six years down the line. Thank God for the review. I hope this nation can learn from the Canadian experience.

The CHAIR: If you would like to submit that for us. Dr Mansfield, would you like to ask a quick question before we finish this off, please.

Sarah MANSFIELD: Sure. I am not entirely clear why medicinal cannabis is so different to other prescribed medications. I want to understand why it has to be treated so differently. You have mentioned that a number of times, that it should be considered quite separately to other prescribed medications.

Jan KRONBERG: It is still cannabis. That is the simple answer. It is still cannabis, and cannabis is illegal. They have strapped on a very convenient prefix. In marketing it is called rebranding. Do you understand what I am saying? It is a rebranding exercise. There is nothing different.

Karen BROADLEY: Can I just add that cannabis causes impairment, whereas obviously antibiotics do not. Cannabis causes impairment, and like I said before, reading out from that systematic review, there is no universally agreed way of testing that impairment. So cannabis stays in the system beyond the acute phase into the residual phase. It can be days, weeks depending on a person's usage –

Sarah MANSFIELD: As can a whole range of other prescribed medications.

Karen BROADLEY: Yes, absolutely. So in terms of testing then, testing tells us that a person has used. It does not tell us when they used, and it does not tell us, importantly, about impairment, whereas with a roadside alcohol test .05 is an established measure of impairment. Now, of course it might vary a little bit from person to person depending on your weight, your size – are you a big drinker or do you hardly ever have a drink? There is a little bit of variation, but there is actually an agreed-upon approach that .05 is the point at which we are concerned about a person's reaction time, their processing speed, their alertness. That is the point. With cannabis, if there was some agreed cut-off – I remember working years ago in child protection and the struggles we had when we would get a parent to do a drug screen and cannabis showed. We did not know exactly what it was telling us because it can stay in the system for so long. That is the difference between cannabis and, say, opioids or alcohol – not that I am condoning alcohol; it is not a prescribed medication. But that is the difference between cannabis and opioids.

Sarah MANSFIELD: Okay. There are a whole range of other medications. We had someone appear earlier who listed a whole host of other medications that can cause significant impairment – more so than cannabis – that are prescription medications. They are not tested for. But you are saying we have a good way of testing for impairment for those medications. Is that correct?

Karen BROADLEY: That is my understanding from reading the research. I am not a scientist. I am not in medicine.

Sarah MANSFIELD: Okay. Do you know what tests we use to test for impairment for those prescription medications?

Karen BROADLEY: No, because I am not a scientist. I am not a medical person. I am quoting from the evidence, and there is evidence, like I said, from this systematic review last year talking about how the impairments and the workplace safety issues that can arise out of medicinal cannabis are numerous.

Sarah MANSFIELD: Was it just looking at medicinal cannabis or was it looking at cannabis?

Karen BROADLEY: No, it was just looking at medicinal cannabis. The systematic review of 31 studies looked at those 31 studies where medicinal cannabis was prescribed and what the adverse effects were, and these were the adverse effects. So then they applied that. It was in the journal of occupational health and safety – something like that. I can send you the research paper.

Sarah MANSFIELD: Very happy for you to.

The CHAIR: Yes, if you could table that, that would be good. Thank you.

Karen BROADLEY: Yes, absolutely, I can do that. If there was a journal article like that about opioids or about valium – and there might be; I have not looked, to be honest. I did not look at all of those other medications or any of those other medications. When we did this we focused on cannabis, because that is in the terms of reference. That is listed as one of the key terms – 'prescription medicinal cannabis' – so that is what we focused on. We did not focus on any of those other medications, because there are so many of them. But I would fully accept that there might be other medications that might also be concerning – fully accept that. And if that is the case, then we need to look into it for the point of worker safety – absolutely.

Sarah MANSFIELD: Thanks.

The CHAIR: Thank you, Dr Mansfield. Thank you very much for your submission and evidence today. Definitely include the submission which relates to the workplace drug testing, whether it is cannabis or other substances. That is what we will refer to. We will definitely look at your evidence after you submit that, and we will look into those relating to the testing part. As a committee we look forward to submitting recommendations based on some of the evidence you have provided as well. But again, thank you for coming in and giving your submission and also your –

Jan KRONBERG: Would you like me to send you an electronic version?

The CHAIR: If you could, please.

Karen BROADLEY: Chair, where do we send them to? We will find out.

The CHAIR: The secretariat will forward it. Thank you.

Committee adjourned.