

OHSa Mini Symposium

WHS implications of medicinal cannabis

Matt Butterworth Lead WHS Consultant, Epigroup





Our Vision

To be the most valued
Australian brand at the
forefront of creating
safer and healthier
workplaces.



WHS Consulting



Recruitment & Placements



WHS Advisory



Digital Training



Overview

Information presented is general in nature and not considered legal advice.

01

What is medicinal cannabis?

02

Current legislative framework

03

Types of medicinal cannabis products

04

Safety critical roles

05

WHS risk management

06

Frequently asked questions



PART ONE

What is medicinal cannabis?



A broad range of pharmaceutical cannabis preparations intended for therapeutic use.

- Tablets, oils, tinctures, extracts and dried flower for inhalation.
- Must be prescribed by a doctor to treat symptoms of a medical condition, or side effects of medical treatment.



TWO ACTIVE INGREDIENTS

Discussion generally centres on two cannabinoids: **delta-9-tetrahydrocannabinol (THC)** and **cannabidiol (CBD)**. Both are produced to varying degrees in different strains and ratios.



THC and CBD

Structurally very similar, but with different effects on the brain.

THC

Delta-9-tetrahydrocannabinol

Psychoactive. Produces the 'high' and carries the impairment risk that WHS decisions turn on.

CBD

Cannabidiol

Not psychoactive. Does not produce a 'high' but can cause fatigue and drowsiness.

Access by prescription was legalised in 2016 and is regulated by the TGA.

- Only **two** medicinal cannabis medicines have ever been registered on the ARTG.
- All other products prescribed are ‘unapproved’, accessed through the Special Access Scheme or Authorised Prescriber pathway.

Sativex (nabiximols)

Approved for relief of moderate to severe and resistant spasticity in multiple sclerosis. Note – not available on the PBS

Epidyolex (CBD)

Approved for control of seizures associated with Lennox-Gastaut or Dravet Dravet syndrome, for patients aged 2 years and above. PBS listed since 2021



PART TWO

CURRENT LEGISLATIVE FRAMEWORK





WA and Commonwealth legislation creates a permit permit system for accessing, prescribing and manufacturing cannabis for medicinal and scientific scientific purposes.

WESTERN AUSTRALIA

**Medicines and Poisons Act 2014
2014**

Provides the framework regulating medicines and poisons in WA.

COMMONWEALTH

Therapeutic Goods Act 1989

Governs scheduling, product registration, access pathways and quality standards for all medicines in Australia, including medicinal cannabis.

WESTERN AUSTRALIA

WHS Act 2020

Protects the health, safety and welfare of workers in WA workplaces, and of other people who might be affected by the work.



Five categories under the Special Access Scheme

Categories are set by CBD as a proportion of total cannabinoid content. THC risk rises as you move down the table.

CATEGORY	CBD RANGE	THC / OTHER CANNABINOID RANGE
Category 1	≥ 98%	≤ 2%
Category 2	≥ 60% but < 98%	THC and other cannabinoids make up the remainder
Category 3	< 60% but ≥ 40%	THC and other cannabinoids make up the remainder
Category 4	CBD makes up the remainder	≥ 60% but < 98%
Category 5	≤ 2% CBD	≥ 98%



Prescribing has shifted toward the highest-THC highest-THC products.

The 2016 market was dominated by oral liquids. It is now dominated by dried flower and inhaled products in Category 5 — the group where CBD is 2% or less of total cannabinoid content.

~50%

of all SAS Category B* applications were for Category 5 products as at 31 July 2025.

* Australian pathway used by registered health practitioners to request prior approval from the Therapeutic Goods Administration (TGA) to supply an unapproved therapeutic good for a single patient

250k+

Prescription application approvals for Category 5 dried flower and inhaled products between 2022 and December 2024.

75%

of Category 5 approvals are for chronic pain (42.4%) or anxiety (32.8%) — conditions common across the workforce.

Prescription rates in Australia

~1 million

Australians estimated to be using medicinal cannabis, with over 300,000 in NSW alone and monthly dispensing there almost doubling in doubling in twelve months.

- First available through the SAS in 2015; approvals reached around 10,000 per month by 2021 and have grown steadily since.
- Fastest growing group remains 18 to 30-year-olds. Male and female ratio is fairly even.
- Assume a portion of your workforce holds a prescription, whether or not it has not it has been disclosed.



S MacPhail et al., 'Medicinal cannabis prescribing in Australia: an analysis of trends over the first five years', *Frontiers in Pharmacology*, 2022. Scale figures: NSW Government ministerial release, June release, June 2026.



PART THREE

Safety critical roles and and impairment

In WA it is unlawful to drive with with **any detectable level of THC** in a person's system.

Detection is by oral fluid or blood testing. The offence applies even where the THC was lawfully prescribed, taken as directed, and is no longer sufficiently active to affect driving capacity.

By contrast, a person may drive lawfully on other prescribed medications — including opioids, stimulants and sedatives — provided they have proper control of the vehicle. There is little evidence justifying the differential treatment.

A positive THC test is not a valid biomarker of impairment.

No BAC equivalent

There is no method of quickly testing a person's level of THC in the way blood alcohol concentration is tested.

Long detection window

Trace levels may be detectable for days or weeks after consumption, long after any risk of impairment has passed.

Individual variation

Impairment depends on dose, route of administration, metabolism, tolerance, drug interactions and comorbidities.



Where a zero tolerance position may be required

HIGH RISK WORK

Roles where there is a high risk of danger — operating operating plant and mobile equipment, working at height, height, confined spaces, driving.

SAFETY DECISION-MAKING

Roles where safety decisions are made — including including financial controllers and management positions, positions, not just frontline operators.

Medicinal cannabis v recreational marijuana

MacCallum (2022) found recreational users have an increased risk of impairment and adverse effects compared with medicinal with medicinal cannabis patients. Patients are likely to be less impaired because they:

Different goal

Use cannabis to manage symptoms rather than to 'get high'.

Different product

Use products higher in CBD and lower in THC — though note the market shift on slide 10.

Different dosing

Have consistent, standardised dosing schedules and increased tolerance to psychoactive effects.

There is no single concentration concentration at which THC impairs everyone.

Cannabis does not affect all individuals in the same way. Sex, age, body weight, weight, tolerance and route of administration all change the result — vaporisation, for example, can lead to higher THC levels and greater impairment than impairment than smoking.

MacCallum (2022) sets out factors that may increase or decrease the risk of impairment. They are the practical basis for a fitness-for-work conversation.

Factors affecting the likelihood of impairment

↓ May decrease likelihood likelihood

- Using the product for a specific medical condition
- Monitored by a medical professional
- Stabilised on the current dose for more than 2 weeks
- Product purchased from a regulated and tested third party
- Lower dose THC product prescribed (< 10 mg THC per day)
- Taking the product at the same time each day

↑ May increase likelihood

- Recently started the medication, or still stabilising the dosage
- Not monitored by a medical professional
- Uses other medications that may be impairing
- Consumption of alcohol in conjunction with medicinal cannabis
- Higher dose THC product prescribed (> 40 mg THC per day)



Use these factors in consultation, not in isolation.

Consider them in discussion with the worker and, with consent, their treating doctor. Three situations typically trigger the conversation:

01

A worker presents with symptoms of impairment

02

A worker fails a drug and alcohol test

03

A worker discloses that they hold a prescription



PART FOUR

LEGISLATIVE REFORM REFORM





Where reform stands across Australia

The zero-detection rule is no longer the national default. That matters for national employers running one policy across multiple states.

multiple states.

NSW Government ministerial releases, 4 and 25 June 2026; Road Transport Amendment (Medical Cannabis and Driving Offences) Bill 2026 (NSW); published state-by-state summaries, 2026. Confirm current status before relying on this table.

JURISDICTION	STATUS	DETAIL
WA	No defence passed	Strict THC detection offence remains. WA Government has established a Medicinal Cannabis and Safe Driving Working Group. Review completed – findings TBC
Tasmania	Defence in place	Prescribed patients may drive with THC present provided they are not impaired.
Victoria	Reform passed	Courts have discretion not to cancel a licence where there was a valid prescription and no impairment. Driving trial reports mid-2026.
NSW	Bill introduced	Registration with Transport for NSW, valid prescription and an education program; no further action where laboratory THC is below 50 ng/ml.
SA	Recommended	Parliamentary committee recommended a change to the Road Traffic Act; not yet passed.
Qld, NT, ACT	Strict	A prescription is not a defence to a THC detection offence.

Treat medicinal cannabis like other prescribed medications that may impair.

Under the model being discussed, it would not be an offence to drive with THC detectable in bodily fluids provided:

01

The medication has been prescribed and is used in accordance with the prescription

02

The driver is not impaired

03

The medication is not used in conjunction with alcohol

Supported by medical bodies and by the Senate's inquiry report into current barriers to patient access to medicinal cannabis, tabled March 2020. March 2020.



PART FIVE

WHS Risk Management Management

A PCBU has a primary duty of care to ensure the health and safety of workers while at work.

This includes, so far as is reasonably practicable, the provision and maintenance of a work environment without risks to health and safety, and of safe systems of work.

The risks from workers taking medicinal cannabis can be managed along the same lines as prescription medication that can cause impairment at work. Consider the risks to the worker, to other workers, and to other people in the workplace.

Appropriate actions for a PCBU

01

Develop policy and procedures on procedures on managing the use of medicinal cannabis in the workplace

02

Consult with workers, health and safety representatives and committees

03

Identify roles and tasks where impairment may present a risk, including safety critical work

04

Provide a process for workers to confidentially notify management

05

Provide an assessment process including medical advice on fitness for work

06

Conduct a risk assessment and modify work tasks where required

07

Run an education and awareness program for workers, supervisors and management

Then review it.

Cut-offs, products and the law are all moving.

A workable approach to workplace drug testing

Deal with medicinal cannabis products in the same manner as other potentially impairing medications.

- 01 Employees disclose any relevant medications before undertaking a drug test.
- 02 Employees provide a medical certificate or filled prescription within 48 hours of a positive result.
- 03 If results are consistent with the stated medication and no signs of impairment are present, the result is deemed negative for disciplinary purposes.
- 04 If a prescription raises reasonable questions about fitness for work, the employer may require a fitness for work assessment with an occupational physician.
- 05 The employer may also ask the employee to supply written advice from their doctor.

The prescription drug driving laws are effectively the default position, pushing employers toward zero tolerance — despite THC blood levels not correlating directly with impairment.

That is the practical problem this session leaves you with. Until the law shifts, the defensible middle ground is a documented, consistently applied fitness-for-work process.

Four principles for the policy itself

Reference standards, not cut-offs

Cite the current standards generally — AS/NZS 4760:2019 (oral fluid) and AS/NZS 4308:2023 (urine) — because cut-offs and testing requirements change over time.

Same as any prescription medication

Medicinal cannabis should be treated the same way as any other other prescription medication, such as painkillers.

Respect the right to privacy

A worker is not required to declare their medications. Encourage workers to come forward and work together rather than compelling disclosure.

Emphasise minimising harm

Favour harm minimisation over zero tolerance, since the policy must be must be applied equally across all employees.



PART SIX

Frequently asked questions

This commentary is primarily from a WHS perspective. Consider it in conjunction with your internal HR internal HR policies and practices.



If a GP provides a letter and the worker then then misuses the medication, isn't regularly regularly tested, and is later involved in an incident while affected — where does does liability sit? With the worker, the employer or the GP?

RESPONSE

A duty of care implies all these parties share some responsibility for the worker's designation as fit for work. The expectation is that the reviewing Medical Officer's opinion will be paramount — so if the GP says the worker is fit, the primary responsibility lies with the MO.

If the worker abuses the prescribed dosage and shows clear evidence of impairment, the workplace must assume primary responsibility for not intervening and instituting testing on suspicion or for cause.

Is there a way to determine if the medication is being misused — a level level above which the result must be misuse? Can you differentiate prescribed prescribed dosage from misuse?

RESPONSE

There are methods of determining whether a confirmed drug drug test result is in line with expected levels. The determination determination can be complex and requires additional information on the donor — age, sex, height, weight — plus plus dosage, frequency of use and time since last dose.

Urine THC levels can be used as a rule-out assay: the level either is or is not consistent with the stated dosage.



Could it be considered discrimination not to employ people with a medicinal cannabis prescription?

RESPONSE

Yes. It is possible that it may be considered if the deciding factor in the decision was their medicinal cannabis prescription.

Anchor any decision to the inherent requirements of the role and a documented fitness-for-work assessment.

Five things to take away

- 01 Assume some of your workforce holds a prescription, and that most of it is high-THC product.
- 02 A positive THC result is not proof of impairment, and zero detection is no longer the national norm.
- 03 Define your safety critical roles before you define your response.
- 04 Treat medicinal cannabis as you treat any other potentially impairing prescription medication.
- 05 Reference standards, not cut-off numbers, and review the policy as the law moves.

THANK YOU FOR JOINING US

Epigroup works with businesses on policy development, safety critical role definition and fitness-for-work processes.

GET IN TOUCH

Matt Butterworth Lead WHS Consultant, Epigroup

Matt.butterworth@epigroup.com.au

epigroup.com.au