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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WITNESS

Robert Taylor, Manager, Policy and Engagement, Alcohol and Drug Foundation.

The CHAIR: I declare open the Legislative Council Legal and Social Issues Committee's public hearing for the Inquiry into Workplace Drug Testing in Victoria. Please ensure your mobile phone has been switched to silent and that background noise is minimised.

Before I continue I would like to acknowledge the traditional custodians of the land on which we gather today and pay my respects to their elders past, present and emerging. I particularly welcome any elders or community members who are here to impart their knowledge of this issue to the committee.

I would like to welcome our first witness, Mr Robert Taylor, from the Alcohol and Drug Foundation. Welcome, Robert. Thank you very much for your time. Before we continue I just want to introduce the committee to you. I am Trung Luu; I am the Chair of the committee. The Deputy Chair is Mr Ryan Batchelor. Also here are Ms Rachel Payne, Mr David Ettershank and Dr Sarah Mansfield. On Zoom I believe we also have Dr Renee Heath and Mr Lee Tarlamis. Again I say thank you so much for handing in your submission and presenting to this panel.

Regarding the evidence you are giving to us today, I would like to read this to you. 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's standing orders. Therefore the information you provide 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 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 a proof version of the transcript following the hearing. The transcript will ultimately be made public and posted on the committee's website. Just for the Hansard record, could you state your full name and the organisation you are appearing on behalf of, please.

Robert TAYLOR: I am Robert Taylor. I am the Policy and Engagement Manager at the Alcohol and Drug Foundation.

The CHAIR: Thank you, Robert. Thank you for your submission. Before I open up to the panel to ask questions I would like to invite you to give an opening statement. Please feel free.

Robert TAYLOR: Thank you, Chair, and thank you, committee, for inviting us today and for this inquiry. It is an important topic, and we are very happy to contribute. I would also like to begin by acknowledging the traditional custodians of the land and pay my respect to elders past, present and emerging.

I will say up-front, as we noted in our submission, we are not experts on workplace law, so that is something we will not be able to talk to with great detail. But I suppose we are here representing the perspectives of the evidence base within the drug and alcohol sector and particularly the importance of a health-based response to personal drug use, including prescribed medications. I will talk to a couple points just in terms of framing, and then I am happy to take questions and respond to the best of my ability.

As the committee heard yesterday, this is a very complex issue, but fundamentally alcohol and other drug use should be treated as a health issue. It is a health issue and should be treated as such, and we see the poor outcomes that result from punitive and criminalised approaches to drug use throughout the community. We also acknowledge the need for employers and employees to create safe workplaces, particularly where high-risk tasks or roles are being undertaken, but we know that approaching alcohol and other drug use, prescribed or unprescribed, from a punitive, stigmatising and often criminalise perspective can exacerbate harm.

There are a variety of prescribed medications that can affect someone's performance in a workplace that are not generally tested for currently. Careful thought therefore needs to go into designing an approach to workplace law that is not discriminatory against people who are prescribed medicinal cannabis. We know that individuals who test positive for medicinal cannabis may not be impaired, while there are other impairing prescribed medications that are not tested for and plenty of other impairing factors – like fatigue, distraction et cetera – that are not being tested for either. What we are really keen to see is a consistent approach to impairment across the

board and one that is not based on stigma towards particular substances. A regulatory approach that balances the requirements for a safe workplace with an individual's rights to use prescribed medications for health conditions is required for all possible medications.

We would also like to draw attention to the effects of stigma. This is a really big concern for the Alcohol and Drug Foundation. We know that stigma has a really serious effect on individuals' health outcomes. It can affect someone's willingness to seek support when needed. It can influence someone's willingness to disclose whether they are experiencing a health condition. We know the stigma towards mental health conditions and stigma towards the use of particular medications are topical here, obviously medicinal cannabis but others too, like psychiatric medications, antidepressants and so on, and that stigma can prevent the open and honest conversations that we would feel are necessary to support safe workplaces. So it is really important that through this process privacy, confidentiality and the dignity of individual employees are front of mind – that if there are any procedures that involve employees disclosing their medications, privacy is really up there.

Finally, the workplace drug testing, when it does occur, should occur within a broader health-based approach within the workplace. This includes appropriate evidence-based, non-stigmatising education for staff and employers about the effects of different substances and how these might affect an individual. Empowering people with information can help them make better decisions, which can prevent risky use of alcohol and other drugs. Creating a safe environment and creating a non-stigmatising environment will do a lot to prevent harm from occurring.

To this end, as an example, the ADF has collaborated with stakeholders in industry, including Hope Assistance Local Tradies, who are a suicide prevention group for people in trades, to develop a website called Trade Facts. This is a website that has evidence-based information and is specifically co-designed with this group. It has been promoted by HALT at TAFEs to up and coming tradespeople and on worksites around the state, like the West Gate Tunnel and others. That is an example from our perspective of what a health-based approach looks like. Whatever does come out of this inquiry should include a holistic look at how to create safe and healthy workplaces and prevent and minimise harm and not just trying to act after harm has occurred. I am quite happy to take questions.

The CHAIR: Thank you, Robert. Thanks for the brief outline. I will quickly open up, and then I will open it to the committee for questions. Just feel free. I know you mentioned medicinal cannabis for treatment and people do use that now. I just wondered about your understanding of medicinal cannabis itself. We heard so far that there are compounds within medicinal cannabis. There is the CBD, which is the cannabidiol oil, and also the tetrahydrocannabinol, which is THC. I just wondered about the ADF perspective in relation to the percentage of THC in medicines and what is allowed, what is not allowed and what is recommended or is okay for a person to be prescribed.

Robert TAYLOR: I would – sorry – probably not be able to give you a strong answer in terms of specifics around percentages within an individual compound, within an individual kind of prescription or medicinal product. I think that is a little bit outside our expertise. I think that falls into a bit more of a scientific or biomedical space. But I guess in broad terms, as I am sure you have heard, we understand that THC is generally understood to be the more impairing of the psychoactive compounds, or the most commonly understood to be impairing within the spectrum of compounds within cannabis, and that CBD is generally understood to not have a particularly strong psychoactive effect, if any.

The CHAIR: Yes. That is what we have heard so far. We have also heard that people have been safely using CBD with less than 2 per cent of THC, or nil at all. We heard that yesterday. I was wondering: does the ADF support that? What sort of position does the ADF have on CBD with a minimal percentage of THC, or does it not really stand either way?

Robert TAYLOR: I think we would, on that, defer to the TGA, who have done the scheduling work around the medicinal cannabis substances. I believe, if I am getting it right, those CBD products that are less than 2 per cent are schedule 3, rather than schedule 4.

The CHAIR: Sometimes people buy over the counter, which has higher THC. Would the ADF still support that as well, or not?

Robert TAYLOR: In terms of it being used in the workplace?

The CHAIR: Yes. That is what we are inquiring here. We are not looking into recreation but for the workplace.

Robert TAYLOR: I think ultimately it is going to depend on the individual role, the individual person and their specific circumstance, and that is why we are advocating for a health-based response within the workplace that it is holistic, that it is ideally open and confidential and that provides an opportunity for employers and employees to have conversations about safety.

The CHAIR: So the ADF is open to it, depending on the conditions of the workplace?

Robert TAYLOR: I could not give a firm answer either way, just given the huge range of variability that could come up.

The CHAIR: Okay. Thank you. That is all I have. Deputy Chair.

Ryan BATCHELOR: Thanks very much, Chair. Mr Taylor, thanks so much for coming in. One of the things that has come up – particularly we had a day of evidence yesterday. One of the matters that came up quite a lot was one of the consequences – and your submission describes it in more sophisticated and in scientific terms, but forgive me – of the lingering effects of THC in the system, basically, that it remains detectable for a longer period of time. This means that we had evidence that some people are, to avoid the consequences of detection from workplace drug testing, more inclined to use other drugs, whether they are opioid based or methamphetamine and the like. From a harm minimisation and addiction perspective, do you think that is the right kind of setting?

Robert TAYLOR: I think that is a good question. Thank you. It speaks to what we see often when we see punitive or criminalised approaches to substance use in the community. This is something that we see quite often, that when there are punitive approaches taken, people engage in behaviours to try and avoid those punitive responses, and often those behaviours can be as a result more harmful. In the case you are describing, someone wants to avoid THC detection and uses a drug that might be shorter acting but might have other consequences for that individual. It may be more harmful, it may not be, but we do see this, and that is one of the reasons we really support, again, a health-based response that does not approach things from a perspective where someone feels like if there is a detection, that is it, they are going to lose their job instantly, because that encourages behaviours where people are trying to get around things.

Ryan BATCHELOR: Noting that you cannot comment on the cases, that is the sort of thing that would make sense to you as a drug and alcohol expert, that people would substitute based on a fear of detection?

Robert TAYLOR: It is something that could potentially happen. There is a lot of complex evidence around what drives people to use one substance over another, and it is not necessarily a clear relationship. But it is not impossible.

Ryan BATCHELOR: One of the other issues that has come up a lot in the evidence is that some prescription drugs can have on impairing affect, particularly opioids – we had a range of evidence around that – but that much of the workplace drug testing or the policies that sit around workplace drug testing often accept those consequences because they are based on prescriptions. But the issue is, particularly for medicinal cannabis, that it appears that they do not. Do you have any view on the inconsistency between those two approaches?

Robert TAYLOR: Yes, absolutely. That is something we think is an enormous issue. We feel the same way about driving. I know this is not the driving inquiry, but it is a similar thing, where we only test for some substances. We know opiates can be unbelievably impairing, prescribed or unprescribed, as can benzodiazepines, as can psychiatric medications, as can fatigue, as I said earlier. I know there are studies that say having a poor sleep can be the equivalent level of impairment to having X blood alcohol content.

Ryan BATCHELOR: So 'Don't have young children' is the message for people in the workplace.

Robert TAYLOR: Something like that. In fact there is a study that shows having a few children in the back of the car is equivalent to having point-something blood alcohol content. So impairment is really complicated. It speaks to how the kind of zero-tolerance punitive response – you know, detection equals bad equals 'you're

out' – to, in this case, medicinal cannabis in the workplace we do not think is really health-based. We would really like to see that approached differently.

Ryan BATCHELOR: Based on your understanding and knowledge of the testing systems or the testing capability that we have available to us for those industries where it is appropriate or where circumstances give rise to employers feeling the need to undertake workplace drug testing, how sophisticated do you think, or do you understand, the testing systems and regime to be?

Robert TAYLOR: That is not something I can, unfortunately, speak to.

Ryan BATCHELOR: Okay. No worries. I might leave it there.

The CHAIR: Rachel.

Rachel PAYNE: Thank you. Thank you, Mr Taylor, for coming and presenting today. What we have been hearing through the inquiry is that workplace drug testing is implied to create a safer work environment, but what we are hearing from those that do workplace drug testing is that it provides a definitive result of a positive or a negative but it does not really go into further detail about impairment, which you have discussed. Talking to some of the other experts in this space, they talk about other measures first and foremost, and I note that in your submission you talk about some of these pragmatic solutions that may be more practical in the workplace setting, particularly around reducing harm. Would you like to talk us through some of the examples that you have discussed in your submission, noting that there may be a better approach rather than a drug test as a black-and-white sort of solution – rather, a holistic approach?

Robert TAYLOR: I think probably the best way to frame it is that I think everybody ultimately – I know, working in the illicit drug space, there is a lot of disagreement about how to get there, but I think everyone has the same focus, which is that everybody wants to minimise harm, and I think that is true of this too. We are really concerned with how we can minimise harm in the workplace; that includes harm to employees as well as incidents and so on. To do that, we would recommend that there is really a suite of health-based responses, and a really core part of that is ensuring that an employer has an evidence base, thorough drug and alcohol policy – one that is not based on stigma towards particular medications or particular drug types – and that there is, as I mentioned in my opening statement, adequate information.

Often people are unaware – and this is something that we learned through the Trade Facts process that I described – and people have a poor understanding of substances. One of the key things that that process told us was that people in the trades who might have used a substance do not know how long it stays in their system. I think if you give people the benefit of the doubt and assume that most people actually do want to do the right thing and do want to be safe in the workplace, information can be a really strong way of empowering them to do so. So it is ensuring, as I said, that there is a strong policy, that information is provided to employees and employers, ensuring that people have access to support and information when needed – whether that is referrals to treatment if they need it or whether it is simply about providing information – and, as I said earlier, that confidentiality is really respected. Unfortunately, stigma does exist, and unfortunately stigma does impact on an individual's willingness to disclose their use of medications and the conditions that they face. So ensuring that confidentiality is maintained is very key too.

Rachel PAYNE: Excellent. Talking of education, you mentioned Trade Facts. Do you want to talk to us about the uptake of that program and what the response has been?

Robert TAYLOR: Yes, it has been really well received, actually. It is a great piece of work. As I described, we were approached and this was identified to us as a piece of need within a particular cohort. Something the ADF does, backed with funding from the Victorian government, is provide information services, so this is part of that remit. Part of providing information is providing it to cohorts who are at more risk, and we know, for example, young men are at higher risk of drug harm. This was about us providing information in the right manner, to the right cohort, at the right time and in the right fashion. That is something we believe very strongly in – having targeted approaches. So that information is on a website, it is very accessible and the information is presented in a way that is accessible; it is not buried in complex sentences. Very interestingly, one of the key questions that we got a lot was, 'How long do things affect me – how long will this be in my system?' That may reflect higher use amongst that cohort, but I think it also reflects that people genuinely do want to do the right thing and do not want to be in a position where they are being unsafe.

Rachel PAYNE: So the questioning via that learning portal or that education was around 'How much will this affect me?' but also 'How long will it be in my system?' and whether it is causing impairment.

Robert TAYLOR: Yes.

Rachel PAYNE: Okay. Thank you.

The CHAIR: Okay. Thank you, Rachel.

Rachel PAYNE: Thank you, Chair.

The CHAIR: Dr Mansfield.

Sarah MANSFIELD: Thank you. Thanks for appearing today. We heard yesterday various views about the role of workplace testing that went from 'Everyone should be tested in every workplace' to views about whether testing is something that is justified in many circumstances at all. As far as you are aware, what role does workplace drug testing have? Does it have a role? What is the evidence for it?

Robert TAYLOR: We at the ADF work from a primary prevention perspective; that is where most of our work happens. I think there are pretty strong parallels here and in the workplace too. Ultimately, I think there are ways to create healthy environments and healthy workforces where the likelihood of someone impaired – acutely impaired, particularly – on the job site is much lower. I think we would point first of all to working upstream and seeing what we have in place in a workplace at a macro level – I will not go into employment law and stuff; it is not my space – and if we have the protective factors in place for individuals and communities that are going to ensure that we have got people who are healthy and who are coming into work bringing, hopefully, their healthy best self, and when they are not, that they are able to speak to someone because their workplace has the right settings for them to do that in a way that is confidential, supportive and open. Then it may be the case in very specific industries with tasks that are particularly safety-sensitive that it is part of that setting system, but we would say that it should not be the only gate.

But you know, again comparing it to something like drug driving or drink driving, we would argue you need to work upstream of that. You need to ensure that people have transport options to get home from places and you need to ensure that people are aware of the effects of different substances when they are driving, that there are opportunities to prevent and reduce the risk of harm in the first place and that these punitive deterrence factors, which we know are not necessarily always effective, are only at the very end and a small part of a larger process.

Sarah MANSFIELD: What could be the impact if you were not to do some of that upstream work and had testing as your primary tool or if you were leaning on that as a safety measure in a workplace?

Robert TAYLOR: I think you can probably draw a parallel with the way that we see illicit drugs being policed in the community, which is that, by and large, the majority of people using illicit drugs do not come into contact with law enforcement, so law enforcement has very little deterrent value. The evidence bears that out; there is very little deterrent effect from policing of drug use. Then those individuals who are detected and do face consequences face disproportionate consequences for being detected – for being unlucky enough, in a sense, to be detected. And we know that – again looking at it from a prevention perspective, which is where the ADF comes from – employment is a really strong protective factor. We know that about employment, meaningful activities, sense of purpose, identity and so on. When someone instantly loses employment as a result of a zero-tolerance approach – that may be appropriate in certain settings; I am not saying either way – we know that is potentially a huge exacerbation of risk factors for that individual, if they are in a place where they are at risk of harm. So yes, that would be my response.

Sarah MANSFIELD: Yes. And with respect to medicinal cannabis – the conversation has sort of touched on a broad range of alcohol and other drugs, but medicinal cannabis is a legal, prescribed medication. Or it is often prescribed; it is becoming available over the counter, and that is creating its own, I guess, challenges in this space. But we have heard stories through this inquiry, through the submissions, of individuals who have had a punitive approach applied because THC has been detected as a result of them taking medicinal cannabis – prescribed medication. What is your view on how well our workplaces are set up to deal with this issue?

Robert TAYLOR: I think that my sense would be: not particularly well – that is the feeling. We might have said as much in the submission, but I feel like medicinal cannabis has forced a lot of thinking around issues that have actually been latent for quite some time. This is not just about medicinal cannabis, this is about impairment. This is about the way we treat illicit drugs or prescribed medications and psychoactive medications, and it is a large issue. Medicinal cannabis stands out for a few reasons, because we know that the presence lasts so much longer than impairment and I think as well because of the stigma towards cannabis use because it is criminalised otherwise, particularly criminalised. I think it has acted as this kind of lightning rod, maybe appropriately, to an issue that has been latently sitting there.

Sarah MANSFIELD: Thank you.

Robert TAYLOR: Thanks.

The CHAIR: David.

David ETTERSHANK: Thank you, Chair. Thank you for your presentations – really appreciated. I guess I would like to move on to some of the sort of practical applications of this. Perhaps if we start with the issue you raised about stigma and a person's right to be able to work in an environment free of stigma and suchlike. It is not in your submission, but I am wondering if the foundation has a view on the applicability of the discrimination Act and particularly the definition of disability as it applies in this context.

Robert TAYLOR: Yes. I am afraid – sorry – that is just a little beyond our expertise. So no. Apologies.

David ETTERSHANK: Okay. That is a swing and a miss. In terms of the practicalities of implementing a health-based approach at a workplace level, and thinking particularly in terms of you are talking to lawmakers or hopefully shaping that legal process, are there specific changes you would like to see to the regulatory framework in terms of the application of an appropriate drug and alcohol policy at a workplace level?

Robert TAYLOR: That is an interesting question, and I am trying to think off the top of my head whether there is anything I could give you in concrete terms that aligns with our existing positions. A lot of our work does focus more on the criminalisation of personal use within the community more broadly. I think it is worth saying, you know, we support the decriminalisation of all personal use and possession of illicit drugs. We know that criminalisation is a key driver of stigma, if not the key driver of stigma. I think that is very clear in the way that medicinal cannabis is particularly singled out as a particularly controversial medication when other medications that are more impairing that are not criminalised in the same way as cannabis are not stigmatised in the same way. But beyond that, to specific workplace regulations, I am sorry.

David ETTERSHANK: Okay. Would you be happy to take that – in fact probably both of my last two swings – as a question on notice?

Robert TAYLOR: Yes.

David ETTERSHANK: Okay. That would be great. Thank you.

Robert TAYLOR: We will do what we can.

David ETTERSHANK: All right. In terms of the importance of education – and again this links back to prevention – outside of the workplace setting or in the context of preparing people for work and for re-entering work, would you have some thoughts on what is currently provided by way of that education and what is missing?

Robert TAYLOR: Do you mean in terms of someone going through, say, a workers comp process returning to work?

David ETTERSHANK: That might be one, or it might just be new work entrants. I am just wondering about the foundation's thoughts about to what degree people are actually educated about some of these issues before they get to the workplace.

Robert TAYLOR: I think that is a great point. I think overall we would say that what you might call drug literacy in the community is not as high as it could be. Unfortunately, again, stigma has really influenced the

way in which drugs are spoken about in the community, particularly in school settings. We have done a little bit of a review of the research around drug education in schools, and often it looks like they will bring in someone who is kind of 'I used X drug, and look what happened'. It will be a once-off session, and it will be designed to scare the kids. It will be a typical 'just say no' thing. The evidence tells us quite clearly that does not work and in fact in some cases can even exacerbate issues. It can make drug use look dangerous, interesting – all the things that children or young people are drawn to. Instead we have always advocated for evidence-based, non-stigmatising information to be provided to the right cohorts – as I said earlier, to the right cohorts in the right manner at the right time, so having targeted education, particularly to high-risk groups. The Trade Facts project is a really strong example of that, where we have a particularly high-risk group, and we have worked with that group to design something that is meaningful to them. So we would probably say that having information that is couched in the right terms for those cohorts is really important.

David ETTERSHANK: Thanks, Rob. I will not try to open another one just at this stage, Chair – it is 10 seconds to go. I might come back if there is time.

The CHAIR: Okay. Lee, are you online?

Lee TARLAMIS: Thank you, Chair. My questions have been asked, so I am happy to cede my time to others who still have some questions remaining.

The CHAIR: Okay. Thank you. Dr Heath.

Renee HEATH: Thank you so much. Thanks for your presentation. I just have a couple of questions – and they might be similar, so it could be, as Mr Ettershank would say, a swing and a miss. What is a good example of some upstream work that you have seen in the area of workplace drug and alcohol practices?

Robert TAYLOR: That is a good question. Thank you. When we talk about prevention we try to approach prevention from a systemic perspective. That means working at multiple levels, so working at an individual level around how we can ensure that individuals have the right protective factors in place or their risk factors minimised, ensuring that communities around individuals are strong and also that the regulatory settings are right. There are these different levels that we can work at in prevention. In terms of working upstream in the workplace, that might be everything from ensuring that young people coming through education are being provided with the right education about the potential impacts of impairment, whatever the causes may be, their rights, their obligations and so on in that regard. So that is information provision. There are broader social factors that go to general community wellbeing, like ensuring that you have a healthy workforce, but that goes to much broader social determinants of health. And then I think some of the questions that you are here to answer as a committee in terms of the regulatory settings are important in helping minimise and prevent harm.

Renee HEATH: Thank you. And more downstream, have you seen an example of where testing in terms of either drug testing or impairment testing has worked well and has been implemented in a supportive way in a workplace?

Robert TAYLOR: I am sorry, I am probably not familiar enough with the space to point to specific examples. It may be the case that it is, but sorry, I could not talk to it specifically.

Renee HEATH: That is okay. You have spoken quite a bit about stigma and how often, when we talk about drugs, it is stigmatised. How should we be talking about drugs?

Robert TAYLOR: There is actually quite a parallel, if you are thinking about drug education in schools, for example, with the change in the way that we talk about sex education in school. Where it has previously been quite a taboo, stigmatised topic, now the curriculum is designed in a way that is meant to provide age-appropriate information about a topic that is relevant to all people in the right ways at the right time. We would say, similarly, we should talk about drugs in a way that is non-stigmatising, that is evidence-based and that is generally neutral. On our website –

Renee HEATH: Sorry, because I am not in that space, what is an example of that, if that is all right? I understand the big picture – that we do not want it to be stigmatising – but what is an example of talking about a specific drug to a specific age group?

Robert TAYLOR: A great example is recently we gave evidence to Parliament around the vaping inquiry. Young people, for example, find that they are told constantly that vaping is bad, that it is going to hurt your lungs, it is going to hurt your brain and all these things, and they are constantly being told all the negatives. When they are out experiencing potentially positive effects of vaping – fitting in, having fun and so on – it can be really discordant; it does not resonate. That is just an example for you. Speaking about the positive effects that some people might perceive around a substance is an important way of talking about things in an evidence-based way.

Renee HEATH: Is talking about the positive effects of drugs, though, normalising it in an unhealthy way?

Robert TAYLOR: I understand the question, but in our perspective, no. In fact we find almost the opposite. It is when information provided does not resonate with people that people see it and think, 'This isn't true. My friends have used X drug and haven't had terrible things happen to them, despite what this person is telling me.' They do not engage at all. Whereas if they are presented with information that says 'Hey, someone might use this because of these particular reasons. There are these effects, though, and this is what you should think about if you want to be safe', that can be much more engaging.

Renee HEATH: Yes. Do you think drug use is healthy?

Robert TAYLOR: I think there are risks to lots of different behaviours. We would say there is no level of use of anything that is not risky, alcohol included.

Renee HEATH: So you would see drug use as no different to alcohol use?

Robert TAYLOR: Yes, in the sense that they are psychoactive substances.

Renee HEATH: Okay. All right. Thank you. I am just seeing if I have got any others.

The CHAIR: Do you want us to come back to you?

Renee HEATH: Oh, yes, sorry. Am I still within my time?

The CHAIR: I think your time is up. We might come back to you if we have got more time.

Ryan BATCHELOR: Just one. Mr Taylor, your submission talks a bit about testing and impairment testing generally. Because it is sort of relevant to where this committee is considering matters, how effective are current tests for impairment, and how far do we need to go, do you think, before we get something that is usable?

Robert TAYLOR: In terms of general impairment beyond the presence of, this is the question: how do we test for impairment in a very broad sense and beyond simply the presence of particular drugs in the bloodstream? To that I think the answer is unfortunately a long way off. I know some cars these days track your eyes to see if you are falling asleep, but I think in terms of a technological silver bullet, it is not something that is on the horizon, which is why I think we cannot look to testing as a silver bullet in general. I think it needs to be an upstream process where we are working to create healthier environments in the first place to minimise the risk, and that testing for impairment or presence is kind of a last step in a process if it needs to be in place.

The CHAIR: David, do you want to add some questions you want to ask?

David ETTERSHANK: No, I am fine.

Rachel PAYNE: What we are hearing throughout this submission is that a patient is being prescribed medicinal cannabis – they have got a working agreement with their doctor as to how that prescription is fulfilled and how they take their medication – and then when they are disclosing it to their workplace, this is where they are finding a zero-tolerance approach. It may not even be through a test; it may even be just through disclosure. You mentioned in your submission that obviously there is an uptake in medicinal cannabis prescriptions. In my eyes that is because it works, and that is why people are accessing it. But in your experience with harm minimisation, are we also seeing this uptake because people are more inclined to access medicinal cannabis because they feel it is safer than other medications that they may have been previously accessing?

Robert TAYLOR: That is an interesting question. I do not know if I could speak to that from an evidence-based perspective, I am sorry. I just do not have that off the top of my mind. I could take it on notice if you like.

Rachel PAYNE: Do you want to just talk about what you have monitored with the uptake in medicinal cannabis prescriptions?

Robert TAYLOR: Sure. In general I think it is probably no surprise to the committee that the number of medicinal cannabis prescriptions has increased dramatically in the last five years. I think the curve looks like this, and it is only going up. I was looking at the stats yesterday, and what is quite interesting is we know the proportion of Australians who use cannabis for medicinal purposes is about 3 per cent of Australians who do so, and of that the proportion of those people who use cannabis for medicinal purposes and are accessing it via script has increased dramatically from our data point in 2019 to our most recent data point in 2022–23. Now we are seeing a really significant proportion – I think about a third – of people using cannabis for medicinal purposes accessing it via a script, so that is 1 per cent or maybe a little bit less of the population. It is quite a significant change, and it is important to note too that the number of people using cannabis overall in the population has not changed between those data points. This is more so a cohort who were already using for medicinal purposes and are now accessing it via a legitimate pathway.

Rachel PAYNE: Thank you.

The CHAIR: Dr Heath, we have time. Do you have some questions still?

Renee HEATH: I have remembered what my question was. Why do you think medical cannabis is stigmatised?

Robert TAYLOR: We generally see stigmatisation where drugs are criminalised, and even though medicinal cannabis is now available medicinally we are seeing still cannabis use more generally criminalised. So we see criminalisation as probably the key driver of stigma towards a particular substance and substance users. I would say it is probably softening, the stigma towards medicinal cannabis and cannabis, and is probably in terms of different drugs in the community not as strong as some of the stigma towards other substances, but we would say it is still there and still affecting people's outcomes.

Renee HEATH: Thank you. Thanks so much, Chair. They were all my questions.

The CHAIR: Anyone else?

David ETTERSHANK: I will just ask the question, Robert: are there any other issues that you would like to bring to the attention of the committee before we close up?

Robert TAYLOR: Thank you for that offer. Stigma was something I really did want to bring up, and I think we have spoken about that quite a bit, so I appreciate that.

The CHAIR: Rob, thank you so much for coming. I have got just one question. This is an inquiry on workplace testing, and I think we all heard in relation to the approach of the health aspect and I think we understand that. Just in relation to your alcohol and drug foundation's position in relation to prescription medications, including cannabis: should they be in the same category as illicit drugs and those who are using harder drugs and having issues? We understand that we need to have a health approach to them, but should all these people who are prescribed by doctors and are not addicted in any way but are actually trying to treat their own whatever disadvantage they have medical-wise or healthwise, should they be subject to the same as those who are under illicit drugs for whatever purpose – recreation – and are going through the rehab phase, which we should be supporting? Should these people who are already seeing doctors, who then go and prescribe, if they test positive be categorised the same, or should we just be putting them in a separate category and say 'You've been prescribed. You see a doctor and you are fine, even though you have tested positive'?

Robert TAYLOR: I think my response to that would be that ultimately, as I said before, I think everyone's concern is with minimising harm and creating, in this case, safe workplaces. And from that perspective, whether it is Valium that is prescribed or whether it is cannabis that is unprescribed, I think the question remains the same, which is: how do we create safety? So I think impairment should be treated the same within a workplace setting.

The CHAIR: Thank you very much for coming in and for your submission. Thank you, members.

Witness withdrew.