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 – Tuesday 21 May 2024

In camera hearing

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Ryan Batchelor – Deputy Chair
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Wendy Lovell
Sarah Mansfield
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WITNESSES

Adam Jacka, National Legal Officer, and

Mark Richards, State Secretary, Mining and Energy Union;

Tony Piccolo, Assistant State Secretary, Australian Manufacturing Workers' Union; and

Stephanie Thuesen, Projects and Political Liaison Officer, Health and Community Services Union.

The CHAIR: Welcome back to the Inquiry into Workplace Drug Testing in Victoria. Joining us for this last session we have got members from the Mining and Energy Union, Mr Mark Richards and Mr Adam Jacka. Also joining us are, from the Australian Manufacturing Workers' Union, Mr Tony Piccolo and, from the Health and Community Services Union, Ms Stephanie Thuesen. Welcome and thank you very much for attending.

Before I continue I just want to introduce myself – Trung Luu, the Chair – the Deputy Chair Mr Ryan Batchelor, Mr David Ettershank, Ms Rachel Payne, Dr Sarah Mansfield and Mr Richard Welch. And joining us also, as I am speaking, is Dr Renee Heath, on Zoom.

Before we continue I will read this information to you. Regarding the evidence you are providing for us today, all evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and further subject to the provision of the Legislative Council standing orders. Therefore the information you provide during this hearing is protected by law. You are protected against any actions 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 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 website.

Also joining us on Zoom is Mr Lee Tarlamis.

Just for the record's purpose, could you please state your full name and the organisation you represent here today.

Mark RICHARDS: Mark Richards. I am the Mining and Energy Union representative, State Secretary.

Adam JACKA: I am Adam Jacka. I am a National Legal Officer at the Mining and Energy Union national office.

Tony PICCOLO: Tony Piccolo, Assistant State Secretary, AMWU.

Stephanie THUESEN: Stephanie Thuesen, Health and Community Services Union, Projects and Political Liaison.

The CHAIR: Again, thank you so much for joining us today, giving us your submissions and giving time to give us your insights in relation to this matter, the inquiry. I know you made submissions, but I will open it up to the floor for a brief opening statement from each one of you before we open it up to the committee to ask questions. Would you like to start?

Adam JACKA: I will start for the Mining and Energy Union. Firstly, we thank the committee for the opportunity to contribute evidence to the inquiry. In Victoria the Mining and Energy Union primarily represents workers in the Latrobe Valley's brown coal mining and power sector as well as across various parts of the state's mining and energy industries.

Employers rightly have an obligation to ensure a safe workplace for others. Our members work in dangerous settings operating heavy machinery and vehicles and working long shifts, so we are very aware of the safety issues that may arise from that. However, and arising from our submission, our experience has been that employers' social attitudes towards medically prescribed cannabis are out of step with the growing mainstream medical acceptance of medical cannabis, particularly medically prescribed cannabis. Consequently, the MEU

members who have been prescribed medical cannabis by their medical practitioner have been disproportionately targeted by employers.

As a legal officer for the union I have represented a number of members who have faced unfair treatment due to their use of medically prescribed cannabis despite following all the protocols and drug and alcohol policies implemented at their workplace. The same approach has not been taken by employers in the workplace – for example, when managing employees who are prescribed medications, such as benzodiazepines and opioids, that can also cause impairment and should be treated equally when assessing an impairment.

Our submission to the committee highlights three case studies where workers prescribed medical cannabis have been treated unfairly by employers, including being subject to levels of testing beyond what is usually required by the workplace drug and alcohol policy, being stood down and prevented from attending for work. Some of those conditions include anxiety, insomnia and acute pain. In each case example the employer either directly or indirectly stated that if the employee continued to take medically prescribed cannabis their employment was at risk. The other detriment that these employees suffered was that they were required to deplete their leave balances and go on to unpaid leave while they were effectively weaning off the medically prescribed cannabis to go across to some other sort of prescribed medication. They were led to fear for their jobs and had to cease taking the most appropriate medication for themselves due to the insistence of their employer. These experiences caused anxiety for the workers and exacerbated their medical conditions.

We found that these employer actions are driven by a misunderstanding of the use of medically prescribed cannabis, in particular the fact that impairment can be managed appropriately to enable safe attendance at work, just like with any other prescription medication. Employer misunderstanding has been especially pronounced with regard to prescription medical cannabis in the form of CBD, which is a non-intoxicating cannabinoid with therapeutic benefits and value. The TGA has scheduled products involving lower doses of CBD as pharmacist-only medicine, so we are talking about things like – you can get analgesics, you get all sorts of things across the counter through a pharmacist. So that is where the situation is with CBD and the classification by the TGA. We consider that state and national OH&S laws and guidance must be kept pace with, including the increase in prescriptions of medical cannabis, to prevent future instances of unfair treatment by employers.

Our submission also deals with the possibility of amending the disability discrimination laws to clarify 'course of medication or treatment' as a protected attribute. For the Mining and Energy Union this is an emerging policy concern. I look forward to assisting the committee with any questions emerging from our written submission.

The CHAIR: Thank you, Adam. Tony or Stephanie.

Tony PICCOLO: Thank you. I also appreciate the opportunity to discuss medical drug testing within workplaces. The AMWU looks after 60,000 members across the country, and our membership consists of tradespeople right through to lab technicians through to lower skilled workers on a production line. Our members traditionally have heavy jobs and long shifts. The newspaper sector goes 24 hours, seven days a week. Quite often they are an older workforce. Our average member is 45 years or 55 years old, and we are a male-dominated industry.

Impairment is not something that has been around for a short amount of time. This has been something that workers have dealt with probably since the industrial age and probably prior to it. However, we have seen in the last two decades, probably the last 10 to 15 years in particular, that companies have changed tack and have used drug-testing policies for a number of reasons but I would argue to target older workers to get them out of the factory with little to no recourse or compensation. Some drug and alcohol policies require 'one strike and you're out'. We note that rather than a drug and alcohol testing regime, it should be around impairment, because being fatigued is proved to be as dangerous as if not more than 0.05. However, there is no testing regime for such things.

It is also important to note that people have self-medicated for a long time, and you now look at the rise of things like opioids and stimulants such as methamphetamine. If you are carrying a shoulder injury to get through a 12-hour shift, that is usually how people start on the slippery slope – to get through their shift they take a little bit of a hit.

You have got your mental health, your physical health and then you have got your recreational usage as well. We see this in professional sports, where everybody is well aware that cannabis stays in the system as a traceable product for some amount of time, whereas methamphetamine, cocaine, MDMA, GBH – the list goes on, and I could name a few; I should not say that – after 24 or 30 hours are out of your system, and people are well aware of that. So we are pushing people away from something that has been medically proved and has some sound medical research that deals with mental health and physical health as well as recreational health into something that is far, far harder.

We would like to see changes, if any are made, on a number of levels: support offered to workers that have issues and some understanding on how and when somebody is actually on a drug, but more importantly, some real strategies around impairment, around identifying impairment, around options to deal with impairment. We had a member in WA. A company brought out drug testing. We had an understanding with that company that they would offer these things, and we got reports back that the company had sacked two of these workers. So we rang them up and said, 'Well you promised not to sack anybody – what the hell?' And they said, 'Well, when we had the meeting, the first guy turned up in his slippers and pyjamas and said, "I've been smoking weed for 30 years, and if you think I'm going to give it up for my job, well, you're wrong."' Now, initially I thought, 'Wow, who would throw away their job for a bit of weed?' But if you flip it, it means he worked there safely without incident while smoking weed. He was a productive member of society while smoking cannabis – to sound a bit more sensible – and that is what you have actually got to look at here. The Canadian model looks at justifiable and demonstrable impairment, and that is when there is testing.

I was saying to my friends the other day – I started work in a factory when I was 18 years old, and I remember going out on a Friday night all night, let us say drinking and having a good time. And I rocked up – my shift started at 6 am in the morning. I probably had not been asleep for very long and probably should not have driven to work that day, I am not going to lie. My colleagues pulled me aside and said, 'Picco, what are you doing?' And I said, 'Oh, I had a great night last night. You should have seen this person I was talking to – pretty cute.' And they said, 'Well, mate, come with me.' They opened up the first-aid room and put me to bed for a couple of hours. Now, when my boss came in and they were informed, he said, 'We've all been there, haven't we?' and then on the Monday morning he pulled me into a meeting and said, 'Tony, that's not acceptable. Not only did you put yourself at risk, but luckily the guys pulled you up, because you could have put somebody else at risk, right?' And these are the types of interventions that workers and management need to be informed of, educated on and the changes made. I will probably leave my opening statement there.

The CHAIR: Thanks, Tony. Stephanie.

Stephanie THUESEN: Thank you. Thank you very much for the privilege of appearing today on behalf of the Health and Community Services Union. We are the number two branch of the Health Services Union in Victoria and across the country, and we have the great privilege of representing the disability workforce, the drug and alcohol workforce and the mental health workforce. I hope today some of our commentary provides a unique perspective both in terms of how this issue affects our workers but also how inaction in other workforces and across the community negatively impacts our members.

The first thing I would say – and it is something our branch secretary Paul Healey says quite often – is that any failure in social policy always becomes the problem of mental health, and certainly on this issue in terms of workplace drug testing it does not discriminate. I think it is important to outline some of the non-negotiable facts that face my members at the moment when it comes to workplace drug testing. On average it takes Australians 20 years to seek assistance with addiction to drugs, alcohol or gambling. They do not put their hand up because of fear, shame and stigma. When we consider something like the introduction of medicinal cannabis, which we emphatically support, something that we are acutely aware of from our perspective is that to get to a place where workers are comfortable and feel safe enough to collaborate with their union and with the manager to come up with reasonable adjustments, which has been demonstrated really fantastically in the Canadian model, we know that we have a lot of work to do, because the reality is compassionate health-led responses to anything to do with drugs, alcohol or gambling are simply not present in the industrial relations landscape in Victoria. We know that this is really imperative, and we know that it is really urgent. At the moment our current policy settings when it comes to drugs, alcohol and gambling are costing the country over $80 billion. The highest losses come from workplace productivity, about 38 per cent, and for us we know that that is simply not good enough when it comes to working people who need an answer but also when it comes to our mental health workforce, who often are on the front line of having to pick up the pieces.

I think too that something that has become more and more prevalent in our role at the Health and Community Services Union is that more union officials, more union leaders and certainly more bosses are reaching out to our union to have confidential conversations about workers who potentially might be grappling with risky substance misuse. On the whole it is very difficult for us to provide answers that will ensure that those workers stay employed. I must say that every boss that has ever reached out to HACSU to have this conversation with us on the down low has been supportive of that worker and has wanted them to stay employed, but at the moment they are not able to have that conversation.

In getting ready for this submission we have done a lot of research and had a lot of conversations with drug and alcohol providers, with people who provide therapeutic rehabilitation, those who provide outreach and those who are on the frontline in inpatient units. Certainly what has become abundantly clear to us is that there is a severe need for generalised alcohol, drugs and gambling awareness training across a plethora of sectors. That needs to be standardised, and that needs to be linked in with the *Occupational Health and Safety Act* and the relevant compliance codes that go with it because, unfortunately, as that is not mandated, what we find is that education levels vary across workforces. Tony mentioned it before that we are starting to hear more and more now that working-class people are opting to use harder substances in place of medicinal cannabis or black-market cannabis because they are aware that it does not stay in their system for as long. For us, we find that very problematic. It is sort of like when you look at the entirety of the drug and alcohol system in Victoria, the way the policy settings are structured at the moment, we actually condemn working-class people to become far more unwell before they are able to access the public system. Unfortunately, we are finding that working-class people are going down the same route when it comes to medicinal cannabis and using other substances.

Look, I will finish by saying that for us, we have got a royal commission sitting there, we have got recommendation 16 called 'Establishing mentally healthy workplaces'. We detail a lot of the interventions we would like to see in our submission, particularly the introduction of recovery-ready workplaces, regulated workplace drug and alcohol testing and, most importantly, a health-led response to drugs, alcohol and gambling in the workplace because as I said, unless that is embedded as a cornerstone of industrial relations in Victoria, we will not be able to get to the place where people are confident and comfortable in putting their hand up, collaborating with their unions and employers to come up with reasonable adjustments when they are using medicinal cannabis.

The CHAIR: Thank you, Stephanie. Thank you. Yes, Mark.

Mark RICHARDS: If I may, I have not heard anything from my blue-collar colleagues, I guess, that I would disagree with. What I would say is – just so it is not missed – our industry is a potentially dangerous industry. We believe in impairment but unfortunately that has not been something that has been looked at too hard. There are some systems where they can use a screen-based system and the computer allocates exactly their responses over many times, so they can utilise that. But I would say we are very safety conscious, to the point that we put our drug and alcohol testing policies into our enterprise bargaining agreements, at Hazelwood for example, and at Loy Yang power station. That was to ensure that every worker understood what was expected of them and what the process was, to make sure that when and if something comes up, it was addressed.

We have found that, as the health group was saying down there, quite often we will be approached by companies that do not want to highlight someone publicly saying, 'How do we keep this employee? What can we do?' Unfortunately we have to come up with solutions and that might be time off without pay because there is no proper process to help that process be encouraged so both parties get back to work, shall we say. I would probably just leave it at that.

The CHAIR: Thank you. Thank you very much for giving us an insight in relation to different perspectives from different industries. I will start. If I could just quickly ask Adam, you mentioned prescribed medicinal cannabis has to be part of it, does that include self-medicated as well?

Adam JACKA: Our submission does not go into self-medicated.

The CHAIR: Just prescribed. Okay.

Adam JACKA: We only deal with medically prescribed cannabis for good reason. As we have highlighted in the opening statement and in our submission, we say that there should be policy settings and procedures in

the workplace that deal with that on the same level as, as I mentioned, other medically prescribed medicines that are used to treat different conditions for different people. Things like opioids and benzodiazepines not only can cause impairment, they all come with warnings. You can get simple medication that comes with – like Phenergan, for example, which is an antihistamine and causes drowsiness. I know because I am allergic to bees, so I have it. I have had it before getting an injection, and it knocks you out. That is just at a pharmacy; you can get that over the counter. But there should be a policy setting or a procedure that deals with medically prescribed cannabis in the same way that other prescribed medicines are.

The CHAIR: Thank you. I will go over to Tony. Now, with occupational health and safety, it is incumbent on the employer to provide a healthy and safe workplace. At the moment, is there any formula or any formal screening to prevent incidents from happening if a person is under any influence?

Tony PICCOLO: I guess that relates back to my point I was trying to make earlier: because policy and government have been devoid in this area in reality, other than saying they must provide a safe workplace, companies and unions have come up with their own means and ways, and some workplaces do not have the same strength or power, in a power differential, to work that out. Some are merely ticking a box; others are saying, 'Well, if you prang the forklift or hurt someone or hurt yourself, then we test you as a way to mitigate our exposure to a WorkCover claim.' But without onsite training for workers, who stand side by side with their workmates every day, then are we really interested in protecting people's health and safety or are we merely doing it out of etiquette and to mitigate exposure to a common-law claim? Let us be honest about that. I gave you an example earlier about myself, personally, where I came in under the weather and my workmates pulled me up because they knew me and they said, 'Not great today.'

I think it is important to talk about medical cannabis as well in relation to self-medication. You asked the question of my colleague here, and I want to add further insight, remembering medically prescribed cannabis has been around since 2016, 2015. Plenty of people were having to find their own ways to medicate themselves prior. Going to a doctor and getting a conscription can be quite embarrassing, and if you have already, for the last 10 or 15 years, found your own means and ways and it is pretty easy, it might become your friend. It does not matter why you continue to choose that way. At the end of the day it is the same substance; one comes in a packet and one comes in a bottle. It is the same result, and at the end of the day, whether it is fatigue, whether it is – I lost a child last year, and there were days when I probably should not have come to work, and my workmates said, 'Go home.' So impairment can come in all shapes, sizes and forms and in reality has the same effect. I remember driving to places and do not remember getting in the car. Now that is as bad as having too much Phenergan, or as bad as – it is a thing, right?

But on top of that, I want to go little bit further. The unions have had their say and do the best they can, but if members do not back in their union advice – and some members have more experience of doing that than others – some drug and alcohol policies require them to tell them what drug, any drug, they are on, prescribed by a doctor. Now, ask yourself why that might be. Your doctor tells you if you cannot drive a heavy vehicle; your doctor tells you if you should not drive. What is it really about then, when you go to make your WorkCover claim, is them being able to say, 'No, no, no – they've had a bad shoulder for 10 years, they've been on aspirin.' Because they want to go to that level, you know. Think about that for a second.

The CHAIR: Thank you. I will open it up to the floor. Ryan, thank you.

Ryan BATCHELOR: Thanks, Chair. Thanks, everyone, for coming in. We had evidence this morning from what I will loosely describe as the drug-testing industry representatives – people who conduct drug tests and their peak bodies. Obviously they were here telling us how wonderful their services are. It was clear that they can detect presence but not impairment, and they do not go to those issues, but clearly more and more workplaces are turning to them. I am wondering if you have evidence you would like to give to the committee about your views about how and where we should be dealing with employer-initiated requirements for drug testing and whether things like mandatory drug-testing requirements are appropriate and where and how we should be dealing with those things. Mark, did you want to –

Mark RICHARDS: I have had the unfortunate opportunity in that I have been dealing with the drug-testing labs for probably – I do not want to say four years, but it is somewhere around that period – and interacted with them probably 10 years ago. My partner was an authorised drug tester – she is not doing it anymore – for

Programmed skilled, for example, covering all of eastern Victoria in the past before she changed jobs. So I have got a fairly close understanding.

There came an opportunity a little while back when updating one of our drug-testing documents about the level they were testing for. My understanding from memory – it is going back a couple of years now – is that the old testing machines tested to a certain level. I cannot remember the figure; let us say 50 or 100 or whatever – it might have been 25. And the new ones are so sensitive they test down to, say, a quarter of that; it might be five or 10 – I really cannot remember the numbers, unfortunately. What that showed was that they were picking up stuff from a week before or even months before, depending on the use. That was THC, for example. The problem we had is that all the companies were saying, 'We're now going to drop the standard to this new level,' so someone could go overseas on a holiday, come back three weeks later and then lose their job potentially. It turns out that it was because all the new Australian Standards dropped, and there was no interaction with anyone, just with Australian Standards. So no-one knew about it until they said, 'These are the only machines we're going to make.' We managed to deal with one site and said, 'You'd better buy a couple of the old machines while they're still available,' because it was in the middle of an EBA, and that is how we have our drug policy. So that is an issue.

What I have just come across recently – and the name is a little bit confusing – is fingerprint drug testing. What it is – it looks like a COVID sample. You put your finger on it and put each fingerprint across it – it does not capture a fingerprint; they just call it that – and you get a result, and that result is based on impairment. It is the model they use in the UK. It takes away the need for urine tests. It tests pretty much all the drugs you are looking for. And they are going through the process now with Australian Standards of getting it certified, which is a very long process. I would probably say we support that sort of stuff, because it does talk about impairment. It has been used in the UK for probably a decade or more. So that is all I would add for that. It is very complicated because Australian Standards seem to be setting a target which has no connection with impairment, which is the key point that we are trying to save here.

Stephanie THUESEN: Our strong belief – and this might be controversial to say, but we say this after really examining the evidence of what has occurred in New South Wales whereby those construction unions up there have clauses in their agreements that say that no workplace drug testing of any kind can occur unless the employer has paid for general awareness training. Within that EBA they state which general awareness training has to be undertaken. I suppose for us, we are strong supporters of that, because without regulation in terms of education of workforces – and I hate to say it, but in our view it should include the public sector, which means the government would be up for that training if that were to roll out across public sector workforces, but it should happen anyway, let us be honest – there is no guarantee that the training that is occurring across workplaces is fit for purpose. It is our strong view that that training should be developed in partnership with public sector providers of drug and alcohol training, so I am thinking particularly Odyssey House, Windana – the reality is the public sector providers of drug and alcohol treatment in this state are fantastic – but also in partnership with lived and living experience providers like ADA, for example, who all came from the shop floor, all have lived experience and are all incredible examples of people who have gone back to work.

So for us the regulation should not just be applied to the actual testing regimens themselves. A lot of work should be done before that to ensure that education is rolling out across workforces, and we would also include being really up-front and being really frank about what impairment could occur with medicinal cannabis as well – going low, going slow.

Tony PICCOLO: If I could answer that, Canada legalised cannabis in 1999 and across many arbitrators and courts have come to an understanding on demonstrable justification on reasonable grounds or probable grounds. The other three – people in seriously dangerous industries were not even automatically justifiably tested. There were only three considerations for that too, and they are: there is reasonable cause to believe that employee was impaired while on duty; following a workplace incident, accident or near miss whose cause was not attributed to mechanical or other non-human failure and where there is a potential for significant harm; or upon returning to work after treatment for substance abuse. But picking up on Steph's point and on Mark's point, it is really easy to offload someone if they have got a problem. It is really hard to not give somebody an option or an answer to get fixed if they have a problem. To have a 'Surprise! I've jumped out of the bushes and I've caught you today' approach rather than a systematic, educational-based, evidence-based approach is a really haphazard way to do it. And then to only do it after a serious incident or accident or near miss prescribes people to get either lucky that they did not get seriously hurt or significantly hurt before we catch somebody.

But I am promising you that if somebody is under the influence, usually it is not just on one day. Having people trained in identifying telltale signs or cries for help is one thing that is really important, but there is no point asking for help if you have got nowhere to send people. And so if I say to you, 'I've got a problem,' you go, 'Well, mate, you've either got to go off on unpaid leave, drain your super, go get some private rehab or just try and do your best and I won't tell the boss because we don't want to you to lose your job.' You cannot fix one without fixing the other really.

Ryan BATCHELOR: Thanks. If I get time I am going to come back to the rehab question later.

The CHAIR: Yes, sure. David.

David ETTERSHANK: Thank you, Chair. Thank you, all, for your very, very thoughtful contributions. It has been fantastic. We had two really interesting poles-apart-type positions put to us today. One was from WorkSafe, where they drew the committee's attention to the fact that there are no express requirements, mandate or prohibition around workplace drug and alcohol testing policies. When asked, 'Is that your job,' they said no. When they were asked, 'Is it somebody else's job,' they said, 'It's not for us to say it's somebody else's job,' which is all very bureaucratic, but anyway. And then on the other hand, as Mr Batchelor referred to, we had the drug and alcohol industry merchants here, who were basically saying it should be mandatory in every workplace.

Ryan BATCHELOR: 'Test early, test often,' they said.

David ETTERSHANK: Mandatory – yes, that is right, that sort of thing. I guess I would be very interested in your thoughts as to if there was to be a more contemporary legislative or regulatory regime what that might look like and where it would be located in terms of legislation and suchlike, if that is possible.

Mark RICHARDS: I might just go to pre legislation. For those that are unaware, generally, as was mentioned, there is no requirement to have drug and alcohol testing onsite from an employee-type perspective. What we have done is been proactive as a union to say to all of our OH&S reps, which are usually our union members, 'You don't want to work with a colleague that might potentially put you at risk. We need a policy in place.' And we would have definitely high standards of what we want, which would be, as was mentioned by Tony, some process where they get a second or third chance and some process to help heal it. You would talk about the testing levels, and we can never get to impairment because we could not get the testing parts, but make sure that we had an opportunity for employees to – I would not say 'dob in a mate' because that is not what it is about; it is about some sort of intervention. And then we would put that to the OH&S committees. That is how we get them, because quite often when the company would propose something it was pretty draconian and all the OH&S people would just shut it down and not have it. I do think it needs some boundaries, and I think if you look at some of the unions that have put it forward, like ours and others, you would probably find that that would give you a bit of an idea of framework. I am sure, Tony has probably got more to add to that, or even Adam.

Adam JACKA: So just to clarify, are you saying WorkSafe have said it is not their role to have a drug-testing policy and where that would sit in the legislation?

David ETTERSHANK: The only document they have produced is the guide for developing a workplace AOD policy, which was produced in 2017 and has not been amended since then. In Victoria it virtually came in the same time as medicinal cannabis was legalised.

Adam JACKA: I do not think I can necessarily answer that question, because it has been an age-old position where the legislation, and it is in our submission, talks about the duty to eliminate risks to health and safety, and then what flows from that is that workplaces individually develop it. It might be the case that that guide which WorkSafe use to supplement legislation and even codes of practices probably needs an update, and that would be my suggestion. It should be brought up to the modern standards, so to speak, because of the things that we are talking about. That would be my suggestion.

Stephanie THUESEN: I would say we find that response extremely disappointing. We go into great detail in our submission about the very clear and key role that we believe WorkSafe and the *Occupational Health and Safety Act* as a piece of industrial might can assist with in this endeavour. In terms of the WorkSafe guidance

note – I want to get this word for word – when we put this submission together we noted that the foreword of the WorkSafe guidance note states:

> Employees unfit for work as a result of alcohol or other drug use put themselves and other people at the workplace at risk of harm. Co-workers may feel obliged to cover unsafe work practices or not report an affected employee due to loyalty or fear of consequence.

Certainly given that we now have the Royal Commission into Victoria's Mental Health System sitting there telling us we must establish mentally healthy workplaces, we find that sort of rhetoric deeply problematic and very unhelpful. What we would like to see is the introduction of alcohol, drug and gambling health and safety representative refresher training to get people on the job who are confident and comfortable having those conversations, because as Tony alluded to, it is one thing to put your hand up, which is extremely courageous, and say you have a problem or to disclose that you are using medicinal cannabis, but it is a whole other thing when you are the worker being disclosed to. You need to be confident and comfortable to know what to do, what to say and what the industrial framework is.

Tony PICCOLO: Do I keep going? I am always after the buzzer. Is that an issue? I do not know. It is not *Who Wants to Be a Millionaire* is it? Do I miss out on a prize? In relation to that question, I would say it definitely needs to sit somewhere in legislation, but there also needs to be a formation of – you have got health and safety reps; you almost need an impairment rep, so whether impairment is taught to the health and safety rep or whether it is taught across factories as a requirement across those. But there also needs to be the imperative that a company must support somebody through this. I mean, where is the community in terms of getting around a worker? This is a community issue.

As I said, not many people will choose impairment over their employment unless they actually have to. Not every time you smoke a joint at 6 pm after doing your job are you impaired at 8 am the next day. That is the true travesty of this, and there are not many companies, even if they wanted to, that have got options to get you help. They are forced with either stigmatising you, turning a blind eye or sacking you, and unfortunately the first two happen for a while until they sack you. Without any legislative guidelines, without any legislative framework, it gives companies the audacity to ask you to disclose if you are on Panadeine Forte, if you have taken Nurofen, if you have taken medication for gout. And some policies go so far as to say that if you get tested and you have not disclosed that you are on a drug which is legal and which is not for an impairment by nature, they can terminate your employment. So what is this actually about? Is it a fishing expedition to find reasons not to help you should you get injured or is it about mitigating a company's exposure to a common-law claim? I would argue that is what it is actually about, more than providing a workplace that is safe and so on.

The CHAIR: Thanks for that. Sarah.

Sarah MANSFIELD: Thank you, and thanks so much for appearing today. Tony and Stephanie, you both referenced the Canadian approach to these issues, and I would be curious to hear a bit more about what they do differently there that we can learn from.

Tony PICCOLO: First of all, they have that clear trigger point, which is a justifiable and demonstrable reason for testing, because you are obviously impaired or you are not on your game. And then in more dangerous occupations, it is either that first reason, justifiable and demonstrable, or it is after a serious near miss or injury within the workplace or you have returned after receiving treatment for such issues.

Sarah MANSFIELD: So it is not random or mandatory blanket testing, it is actually in response to a particular trigger that the testing is done?

Tony PICCOLO: Yes. You might smell alcohol on somebody, or in one of our case studies somebody got terminated for suspected drug use who was a diabetic. We got their job back because we proved they actually were not on drugs but they were needing their treatment so as a result were slurring their words and stumbling about and came across drunk, but they actually were not drunk. But that is an impairment thing, where if somebody had said, 'Hey mate, where's your insulin?' – and that gets back to that point.

Stephanie THUESEN: I think for us it is sort of strange to talk about these cases because it feels as if Victoria and indeed Australia are years behind in terms of how we deal with drugs, alcohol and gambling, philosophically, comparatively to places in Europe, America and Canada. But there was a key case, *Bird v Lafarge Canada*, where it was an unfair dismissal, essentially. The worker was found to be in breach,

but they were not in breach because they were using medicinal cannabis, they were in breach because they did not bother to tell their employer. Employers over there have in place industrial mechanisms where you can disclose, the unions support you disclosing and employers now have an imperative in Canada to provide reasonable adjustment. So this worker was not sacked for using medicinal cannabis, it was because they did not follow the industrial process already put in place to protect that worker. In a dream world that is exactly where we want to be: where workers, if they are to get stood down or in trouble, it is not for the use of medicine and it is not for accessing critical health care, it is for not following protocol. Hopefully, we as unions are going to be in a position where we can catch workers before that happens.

We know it is really important too because in our research we were really grateful to have a lot of conversations with our industrial comrades over in the United States and in Canada, and something that became abundantly clear to us and something they all said over and over and over again was that if they could do cannabis – whether it was med can or legalising recreational cannabis – differently, the thing they would have done first was get the industrial frameworks right and get the laws right, because unfortunately a lot of those states in the US and Canada find themselves in a place where cannabis has gotten way ahead of them and workplaces are still decades behind and employers do not know what to do. So with this legislation, while it is fascinating to watch over here to see more catching up, I can also understand that for employers and their industrial representatives it is really tricky and really complicated. Ideally, that is where we want to get to, but we are concerned that because of where we sit philosophically we might be a way off that yet.

Adam JACKA: Just one other comment in dealing with medically prescribed cannabis is that it should be treated the same as other prescription drugs and dealing with impairment, but there needs to be a balance between a therapeutic benefit to the employee and also risk in the workplace. You do not hear or see that in any procedures; there is no mention that there this that balance. So I think that is an important aspect.

Mark RICHARDS: Just a quick response to Dr Mansfield's question in regard to the random sampling, one of our original EBAs had random sampling. What the company would do is they would target the group that had the highest level of physical work to do and who used to do their shoulders. They would keep targeting that group for testing and eventually got rid of people. So what we did is we basically made sure that they could do that for a certain group two or three times. And after that they had to test the entire workforce, including management, which they were not real keen on, but we put that in the document. That then cleared it up. It became a small issue because they thought the cost was going to be expansive. What we did is we reduced the randomness. In other words, we sampled more people but only tested one in six. Everyone was getting an opportunity where they were dragged out and, 'Oh my God, I could be caught,' so they were being reminded that it was an issue. At that point too, once management gets involved, they are sharing the same responsibilities as a worker – just a bit of feedback for you.

Sarah MANSFIELD: Thank you.

Tony PICCOLO: We did do that, but as an industrial campaign to stop the testing, because the company realised how expensive it was going to be, so nobody got tested. So both work.

The CHAIR: Richard.

Richard WELCH: Thanks, Chairman. Thank you, gents and Stephanie, for coming in today. It is really interesting and refreshing to hear this perspective as well. But I had a question for you, Stephanie. You mentioned just right at the top that in New South Wales you have some EBAs where there is no testing without training. I am trying to frame it a little bit that if you are taking a prescribed medicine or you are indulging in recreational drug use, it is generally understood that it has the risk of impairment. What is the training doing that is not already a common understanding – do not work when you are impaired?

Stephanie THUESEN: Yes, absolutely. I think in the first instance there is a grave lack of education amongst workers about the negative impacts that drugs, alcohol and gambling can have, but there is also a grave misunderstanding that every single person who engages in drugs, alcohol and gambling is a junkie or does not care about their family or their employment. There are many people who self-medicate for a range of reasons. As part of that general awareness training we are really interested in making that critical connection between mental ill health and potentially risky substance misuse, with the acknowledgement that not everyone who uses an illicit substance is using it to self-medicate. That is of critical importance.

What we also want to stop are instances of workers who might say to their colleagues, 'If you use ice, it's out of your system quicker. If you don't like alcohol, just use ice, on the down low.' That sort of thing we definitely want to stop. Certainly, while there is an educational aspect of it, there is also a part of it that we are really hopeful normalises these conversations. I said at the top it takes an Australian 20 years to seek assistance with addiction – 20 years. One in five Australians will grapple with a risky substance misuse in their lifetime. What that is actually translating to is more and more impacts on the mental health workforce, because you are in a state where the public drug and alcohol system, while it is great and has got over 500 rehabilitation beds, is simply not enough. And while we have got WorkSafe and the OH&S Act, that does not adequately deal with these issues. You have got all these compounding factors happening.

What we know is that more and more workers who perhaps if they were confident and comfortable and were safe and protected in putting their hand up earlier, if they had had general awareness training and if it was normalised on their worksites, maybe would not be ending up at the inpatient unit at the Alfred and by that point had lost their job and lost their house. You can see how it is a snowball effect. We know that when it comes to risky substance misuse, the biggest indicator is trauma. And you cannot be what you cannot see, so if we do not start normalising these conversations on worksites, logic prevails that workers simply will not talk about it.

Richard WELCH: Thanks, Stephanie.

Tony PICCOLO: If I could answer that – if people knew what people knew, there would not be any TAC ads. Education is an ongoing battle and an ongoing journey, and people migrate through parts of their life. But I think we are remiss if we think that impairment merely comes from drugs and alcohol. Impairment can be from fatigue; can be from stress; can be from a mental health disorder; can be from, you know, even financial concerns where your presenteeism is a thing. And if we think that by sticking somebody's tongue on a piece of plastic once every six weeks – hell, I do not care if it is every day. There are many other factors of impairment, and if we are not looking at that, then what are we actually looking to achieve here? Are we looking to provide a safe workplace for people, or are we looking to kick those that do not conform to our agreed set of values? I mean, alcohol kills more people in this country than any other drugs combined. It is the most dangerous drug, yet it is legal, so therefore nobody bats an eyelid when I say, 'I got shitfaced last night. It was a Friday, so I didn't have to work Saturday and I didn't drive my car, so that's okay.' I think that is the point that we are sort of missing here. Impairment comes in many shapes, many sizes, for many reasons and can be brought on from many different triggers. And I think that is where the training and the observance of people that you work with every day – you spend more time at work, or I do, sorry. I spend more time at work than I do with my loved ones, so they are probably going to pick it up way before my significant other or my mate that I am lucky to see once a month, do you know what I mean? And that is the point. That is where education comes in and that is where I would like to see change.

Richard WELCH: Everything you have said I agree with in essence, particularly early intervention in all these things, but I would think that that is a public health issue. With the training itself, what is the union's position of who should pay for that training, as a public health issue as opposed to an employer issue?

Tony PICCOLO: Who pays for the drug test?

Richard WELCH: Presumably the employer.

Tony PICCOLO: That is right. I do not care who pays for it. You know, I think that is a secondary thought. But obviously we are a union, and if you are happy to pay for a drug test to punish people, you should be happy to pay for an educational process which keeps your workers safe, which keeps your business more productive. As I said, presenteeism is a thing. There is a cost to the Victorian economy of billions of dollars where people turn up and stare at a wall all day or run their machine at half mast. I am sure we have all been there before, anyway.

Stephanie THUESEN: I guess in response to that I would point to our first comment, where we said that any failure in social policy becomes the problem of mental health. I suppose from our perspective we would say yes, there is definitely a role to play for public health, but there is also a role to play for WorkSafe, the occupational health and safety regimens and all of business. I mean, I do not think we can continue to make this

solely a public health issue whereby all of the responsibility falls to public health. I do not think that is reasonable, and I do not think it is right and fair in this economy to do so.

Certainly I think it would be very dependent on what sector you were talking about. I mean, if we look at the examples in New South Wales whereby the construction unions up there have the clauses in the agreement that say no workplace drug testing can occur without training, most of their agreements are with the likes of Mirvac or Lendlease or big sort of giants that are relevant to their sector, so my inclination would be to say the employers relevant to the particular sector that you are dealing with.

Adam JACKA: I think, just from what Tony said and what was just said then too, if there is this incumbent onus on employees to follow policies and not breach policies and that is the standard of the employer, then in terms of cost and dealing with that, there should be an onus on the employer to provide proper training and education that is also underpinned by supported training programs, not just some program that they designed themselves so they can tick off a box and go, 'Great, we've met our liability risk problems.'

Richard WELCH: Just to make sure you feel like you have had a proper grilling here – otherwise, it is just an echo chamber, right – employers might say, 'Well, okay, at what point do we have to take on the public health role when we're just trying to make sure we are running a business?' If you have got an answer to that, that is good.

Mark RICHARDS: Mr Welch, what I would say is that the companies I deal with, the large ones like AGL and EnergyAustralia and any others connected to them including the subcontractors, is they have a lot of training courses. They have a lot of boxes they have to tick for operation of plant and regular updates. One extra course, to be honest, is pretty minor, and they usually have these things that can be done in a pretty short term. It is not like we are talking about a day course; we are talking sometimes 30 minutes, or not even that.

Richard WELCH: But is that materially different to box ticking then?

Mark RICHARDS: No, but what I am saying is that it needs to be integrated at a legislative level, and then the companies always want to add something themselves anyway. What I am getting at is that if they are going to run a course and you have legislative boxes they need to tick, well, that is what is going to be ticked, and they will add a few extras in there for related stuff. So I do not think it is an issue. But I would go to a point that we mentioned – things such as fatigue. I can tell you I have pushed fatigue for many years, and I can I assure you that I quite often come across rosters that hit the fatigue limits, and there are processes – they kick into place – where the management will come and assess the individual with a face-to-face.

Richard WELCH: I totally agree with that, and you are spot on that there are all sorts of impairments. There is a risk, though, that you start conflating voluntary impairment, if you like, versus involuntary impairment. I think there should be in the nuance some distinction between the two so that we do not put all the worst-case scenarios of involuntary impairment with the other kinds of cases where people are recreationally doing that.

Mark RICHARDS: I would suggest the training costs are very minimal, to be honest.

Tony PICCOLO: Do you remember, Mr Welch, there was a saying when I was much younger that, 'You drink and drive and you make it home, you're a bloody legend?' Remember that?

Richard WELCH: Oh, yes.

Tony PICCOLO: You tell somebody who drunk-drove home – not many people at a barbecue would go, 'Well, done mate,' would they? They would not. They would just say, 'You're a bloody idiot,' and that is probably where that whole program came from. To tackle a problem, it has to have many facets. I guess the real question here is: what is the end of the means? Is the end of the means to limit my exposure and to kick workers out, or is it about providing a safe workplace? I guess if you look at the issue through different lenses, they it will give you a different answer. Let us face it, if I am a ma-and-pa employer and I have got six or seven people working with me and one of them is whizzing by on a forklift, then it is inherent that I want to keep not only my workers safe but myself and my partner safe, right?

Richard WELCH: No question.

Tony PICCOLO: No question. If you are an Amcor and you have got 3000 employees, you have got a similar thing, because you might be the one walking past that gets run over by a forklift too. That sort provides the space where, in the current legislative framework, if you have got a health and safety rep, which every Australian business can have, there is a requirement to get training off the job that the boss must pay for, and a refresher course every year. A smaller employer really does not usually have an HR department. It is usually one of the partners' jobs to do that stuff. You might find that they would actually prefer to sign up to a registered course, a one-day course or whatever length it goes, versus the large employers that usually say, 'Well, I can save a couple of bucks and do the tick box.' You are more likely to get a ticked box from a large employer than from a ma-and-pa employer, because they do not have the time nor the want to design this course.

For this side of the room, you have also got to have an answer if you have done all the impairment stuff, and I do not know whether I would call it voluntary versus involuntary –

Richard WELCH: For want of a better term.

Tony PICCOLO: Yes, I get you. Discretionary, maybe. No, uneducated. But if there is someone with a genuine problem that has been identified, then the next step of that equation or the next face of the dice needs to be – because it happens to union officials all the time, where workers or bosses ring us up and say, 'I've got this person, they're in trouble, I'm worried if I sack them they are going to kill themselves,' or, 'They're a great person, they've worked here for 30 years, I don't know what to do.' And then, neither do we, so bosses do not know what to do and we do not know what to do. We had an option to send someone to a rehab and could not get him detox for six weeks, so you cannot have one answer and not another answer – you get what I am saying. The problem in itself is pretty complex, but I think we need to refer back to impairment is the first hurdle, and then identifying strategies around that and having people that are equipped to recognise when somebody is impaired, for whatever reason – and be able to have a conversation. Because sometimes, just a conversation, you know what I mean: 'My mum died last night, I haven't slept.' 'Well, go home mate, have the rest of the day off.'

Mark RICHARDS: Just to add to the cost conversation, a lot of our guys, some of them will tell us they spent $500,000 on employees – I think is probably closer to 150 K – to train them up, and obviously some of them have five to 10 years to get into positions where they are running the place. So you could theoretically say it is in the hundreds of thousands of dollars of training to get them there, from their skills perspective. I do not think a small cost in terms of making sure they can keep them there is an issue, to be honest.

The CHAIR: Thank you. Rachel.

Rachel PAYNE: Thank you, Chair. And thank you to everyone for appearing today. It seems as though random drug testing or drug testing in the workplace is becoming more common. Would you agree with that?

Mark RICHARDS: I think the push was some years ago. It has become standard for most of us unions to push it, so I would not say there has been a change. I think the difference is they are going away from what most people would perceive as impairment to just a tick-a-box for testing, from the standardised testers.

Adam JACKA: But from the industries that we represent, that has been policy for quite a long time now.

Rachel PAYNE: We will get into more detail with that.

Tony PICCOLO: In terms of my industry – well, the industries my union looks after; I do not own any industry, not yet – it was probably 10 years ago that it was a really strong fad, and it comes in waves of the new fad to bring it back in or where they not have got it over the line and we have got a union one to really push it back through.

Rachel PAYNE: I guess, just picking up on a few things that you have mentioned, which is someone whispering in the ear of, you know – meth is out of your system within 24, 48 hours compared to other drugs. Do you think there are some unintended consequences of having such firm policy positions of, your drug test is going to pick up X, Y, Z and those drugs we know are out of your system within 24 hours, so someone might be more inclined on a weekend to party with harder drugs comparative to potentially using cannabis,

recreationally, or even just accessing a medicinal cannabis prescription; would you say that is anecdotally something that you hearing?

Mark RICHARDS: I could give one example, and that is that some years ago there was a person that took what was legal at the time, I think it was synthetic marijuana, and they tested clear. But people working with them knew there was a problem and reported it, that is why the test was kicked off, and it came back clear. And that would be a case, potentially, along the lines of your question, because there is something they can take that harder than maybe some alcohol or something the weekend before or the week prior to work, the weekend starting prior to working Monday. I think that is a risk.

Adam JACKA: I am union, and I am not supporting employers, but I think there is a word that has been used a lot, which is impairment, and that should be the reason for testing. I do not pretend to be an expert, but all the expert reports that I have read – and there are reports that have been filed in this matter – is that there does need to be some sort of science behind what the thresholds are and how you do that. I think there is going to be a prescriptive nature to it, and the reason for that is, in some ways, because the employer then says, 'Well, look, this is the standard,' and everyone at least knows what the standard is. Now, probably the unions do not agree on what the standard might be and also there is the impairment and the other policy positions about that. I do not have the exact answer, but I think that is what underlies it, that then there is an apparent science to most of this, and that is why you have that.

Mark RICHARDS: I can assure you when this new testing model came out for the THC we had employers contact us saying, 'How do we deal with this? We're not interested in the lower level, but that's all we can buy for the replacement machine.' So even they know it is not realistic, but it is the only standard they have got because the Australian standards changed without any consultation.

Tony PICCOLO: But I think it is also important – and this comes back to impairment – to recognise that impairment is different to usage. If I had a puff of a joint of weed nowadays, you give me one puff of a joint and I am pretty cooked. If you rewind to when I was 20-odd and gave me 10 Hong Kongs, I was flying – I was having a great day. You know what I am saying, right? There is impairment and there is usage. It is just like an alcoholic. I remember there was a report about somebody driving a car, and they blew six times the legal limit. Somebody said, because it was a woman, 'Most men would have been dead,' but this person had built up a tolerance. This is where the impairment model around the hand–eye coordination type test – this is what makes it really complicated. I think, getting back to the synthetic stuff, there was a report from Canberra that a pill-testing thing had a product that was 20 times stronger than fentanyl.

Adam JACKA: Just on that, that is right. There should be impairment and understanding what that is, and also then you have the more scientific drug testing et cetera. There is an expert report I think by – he is quite a specialist in particular fields – Iain –

Mark RICHARDS: Take it on notice?

Adam JACKA: Professor McGregor and others. And there are toxicologists that say – just so you understand what we are saying – that if you go over drug threshold, that does not necessarily mean that you are impaired. It is indicative of recent use, which then you look at 'What is impairment?'

Rachel PAYNE: Like random drug testing would be more of a gotcha moment rather than 'This person looks like they are a bit wobbly; they're not making eye contact'.

Adam JACKA: Correct.

Rachel PAYNE: And I am assuming that is where you are referring to this Canadian model of 'This person appears to be impaired, and then I'll test for the drug'.

Tony PICCOLO: And if you think about that within a workplace, you know the community I was talking about, where I say, 'Hey, you don't look right. Are you okay?' as the first part of the conversation rather than, 'Hey, can you come with me to a room. I want you to blow in this bag and let me swipe your tongue.' Isn't that the kind of workplace and methodology that we want to see generally in the community?

Stephanie THUESEN: I note too in New South Wales if someone was to fail a drug test and it came back positive, that worker is stood down on pay, true, but in the first instance the health and safety representative is called, an alcohol and other drugs worker is called and the organiser is called simply for a conversation – just a conversation. It is very rare that people in New South Wales get the sack if they do come up positive on a drug test, because they have embedded a compassionate health-led response within that sector. We would say that certainly at the moment, if you look at the jobs and skills plan, we need 53,000 more healthcare workers in this state in the next three years, 27,000 more manufacturers, 16,000 more construction workers. This is not the time to be kicking working-class people to the curb and condemning them to losing their job and, as Tony pointed to before, many, many times withdrawing their superannuation on compassionate grounds to go to private rehabilitations, which for the most part are not regulated.

The CHAIR: Thank you. Lee, have you got any questions?

A member: Lee has gone.

The CHAIR: Or Dr Heath? All yours.

Renee HEATH: Yes, I am here. Just a couple of questions. First of all, thank you for your presentation. So maybe drug testing may not be as effective as other sorts of training – for instance, spotting the signs of impairment. Do you agree with that statement?

Stephanie THUESEN: I would say we need both, and –

Renee HEATH: Right. But it would be sort of a stepped approach: so first would be some sort of impairment test or training to spot the signs and then the second thing would be a follow-up drug test?

Mark RICHARDS: I would suggest that in general when someone is either reported or if there is a random test, that that would then require usually the tester themself, without the company's knowledge, to discuss their medication, their prescriptions, and they would make an assessment whether that level was there. In that conversation there is a little bit of leeway for that tester to make the opinion whether they have got impairment. That will sometimes, from what I am hearing, make the decision tip one way or the other whether they report to the company that it is a negative or similar or a positive. So it is not necessarily the measurement, it is the interaction they have with that person and the list of their stuff. Either way, they are connected. I would not pick one over the other personally.

Renee HEATH: Yes, right. So if we were to give a recommendation? Because this committee will provide recommendations to the government.

Mark RICHARDS: I would refer to the expert opinions of the reports, I would probably suggest.

Tony PICCOLO: I would say that for workplace leaders and workers in general as well as employers, to be fair, an educational program is rolled out on what impairment is, some of the triggers of impairment – and it is not just drugs and alcohol, there is a whole myriad of impairment – and that all impairment is just as dangerous to a degree as any other impairment. There are levels of impairment, a measurement of that level of impairment, and depending on the response – like if you go to a worker and you say, 'You're stumbling around. You look a bit under the weather,' and they go, 'No, I'm fine' – well then, a drug test would be in order because it is demonstrable and it is justifiable. It is called for. So the first step is an educational program for workers and employers, then an impairment developed test of whatever that nature is and then the third point is a set of tools that can be given to employers and workers on how they can refer different impairment. They might need to go to their GP and get a mental health plan, right?

Renee HEATH: And you think that all that should be the responsibility of the employer?

Tony PICCOLO: Well, providing a safe workplace is, isn't it? And if you are impaired because you are suffering from grief or trauma –

Mark RICHARDS: Fatigue.

Tony PICCOLO: or fatigue, then it is their responsibility to identify that. I would say this to you: if somebody turns up because they are fatigued or from trauma or grief and you go, 'Well, I haven't got any other

answer other than, here – blow into this bag and lick this stick,' and they come back negative on all because they have not had drugs, are they any safer than they were 15 minutes ago? Is there an inherent risk to people's health and safety, including potentially your own? So therefore we need to be trained in identifying and having a suitable response to any form of impairment that is presented. Let us be honest here, employers have for the most part since the industrialisation of the system.

Mark RICHARDS: I understand the terms of reference here are around what I perceive as prescription medication, but I would say one of the big ones we run into with fatigue, for example, is when a company has a very large project that they are trying to squeeze into a short period of time. I can think of just months ago where the company had someone working, let us say, 12-hour days for 18 days straight without a day off, and they were longer than 12-hour days, I can assure you.

Renee HEATH: That is actually one thing I was going to ask, because somebody said that a lot of people will take drugs to get through a shift because they need a hit. I would say then: do not change the drug policy, change the work practices because that is just wrong, I think.

Mark RICHARDS: I know the individuals in this case, and I would suggest there was no drug taking, ever, in this circumstance. I can tell you that no-one knew they were working those hours because their roster was specifically removed from the general population to see. We became aware of it at the end of the situation when obviously the pay dockets went through; we were informed. So that, to me, is a fatigue issue. It could not be addressed by any random testing, I would suggest, unless every day when they came to work they went through, say, a 'follow the bouncing number' or 'follow the dots around', which is the only thing I would suggest.

Stephanie THUESEN: I think Mark raises a really good point too: they became aware of it at the end. I think that is the dominant feeling across the majority of the industrial sectors who have to grapple with this, which I would like to wager is everyone, whether it is dealing with the consequences of it or dealing with it in real time on a shop floor in a range of sectors. The reality is that because with compassionate health care – and when I say compassionate health care it is not just about drugs, alcohol and gambling; it is about mental health, it is about fatigue, it is about a range of issues to do with impairment – those conscious conversations are not being had on shop floors across the state. From the public to the private sector, union officials but also employers are finding out about potential issues far too late.

The other thing too is that when we talk about employers – and I think about the new federal laws that have come down saying that employers now have the onus to provide a safe workplace free of sexual assault – the onus now sits on employers. I of course emphatically agree with that, but I come from the mental health, disability and drug and alcohol sector, so I also know that there are a range of employers – good employers who want to do the right thing – who actually have not been supported to provide that because they have not been funded to do so, and without funding they cannot provide it. I would say there are a lot of employers who are in that boat as well, whether it is about funding but also whether it is about support, so any mechanisms we can have to link up employers, whether public or private, with the leaders in the sector – Odyssey House, Windana, Turning Point – to get educational programs together, whether it is checklists, industrial frameworks or working with each sector, we need to make accessible wherever we can, I think.

Tony PICCOLO: And if I can answer your question, people work because they have got bills to pay, and if there are overtime shifts and they are trying to get a new set of braces for their kid, they do those shifts. If there were not these financial pressures on workers, we would not have to mandate that they are only allowed to work 13 days straight, and then when you find them working 18 and 20 days straight they crack the shits at the union for enforcing the law. As a worker, particularly a man, gets older he has to admit to himself and his colleagues that his body cannot keep up with the strenuous job – for fear of losing their job because of the inherent requirements of the job. People get doctored out. Like, we are pretty naive if we do not realise that these are the pressures that working people face every day. Workers can get independently medically assessed – those who have done a knee 15 years ago and never had a day off for their knee – and get TPDed out because they may potentially cause a risk in the future. They have got two choices: to rock up to VCAT doing cartwheels saying, 'I'm fine,' with no guarantee, whereas if they lose, then they go to the TPD, and they go, 'Well, hang on. Over there you said you were fine, and now you're here saying your crippled. We won't give you any money.' That is simply the reality that we face every day. That is the carnage that we deal with every day, and that is the reality of the working world for a lot of people. So yes, people do take a hit sometimes.

Mark RICHARDS: One last one to close from me. Something just triggered a memory here. In terms of occupational health and safety, which generally we are talking about here, most reps will do a five-day course and an annual-type refresher. There is no requirement for anyone in management – at the coalface, shall we say, up to senior management – to do any sort of occupational health and safety course. So you will find that from the grassroots up to the senior manager they have no understanding of what the requirements are for OH&S, which is a really big issue here, because if we are talking about managing fatigue, they have had no training. That to me is something that probably should be linked back to WorkSafe – to make it mandatory to do at least a one-day course, if not two. That is where I will leave it.

The CHAIR: Thank you. Renee, are you done?

Renee HEATH: I actually did have one other question, but do I have time? There is no issue if I do not.

The CHAIR: Fire away. After you, I will pick up.

Renee HEATH: There were just a few things that were said that I thought were concerning and might point to a bigger issue. Stephanie, you said that a lot of employees sort of tap each other on the shoulder and say, for instance, 'Why don't you try ice? It will leave quicker.' How prevalent is this? How often is that happening?

Stephanie THUESEN: I would love to be able to adequately answer your question, but the reality is I cannot, and it points to a larger issue in that given our role being the union for mental health workers, and certainly our branch secretary being a former mental health nurse of 26 years and many mental health nurses and clinicians working at our union, what tends to happen is that employers from a range of sectors including our own but also more and more other unions, whether it is from a range of sectors, call and ask us for advice because these are the stories we get told. But also on the second point, when we go out, and we are routinely out with our mental health workers in inpatient units and community teams, when you go through for your members meeting and you talk about who is admitted at the moment, these are the stories we are hearing more and more and more: 'This patient –'

Renee HEATH: Sorry to interrupt, but I just want to know how often those complications would occur – once a day, twice a day?

Stephanie THUESEN: Multiple times a week, I would say.

Tony PICCOLO: You only have to talk to the general public when they talk about AFL testing regimes, and they say – like, everyone says it – 'Why wouldn't you just be able to do a bit of coke after the game and by the Monday it's out of your system?' Peptides – people know.

Mark RICHARDS: Whatever it takes.

Tony PICCOLO: Yes, people know out in the community. People know that weed is in your system for up to six weeks. People just know it.

Adam JACKA: So bringing it back to the terms of reference in terms of medically prescribed cannabis, just on this point, from our point of view it is anecdotal, but it is exactly what they are saying. Everyone takes – sorry, not everyone. I withdraw that. Recreational drugs are common in the community. They are there. But if you talk to people, and it is a drug of choice between cannabis, whether it is social, recreational or medically prescribed, and then a drug of choice, where it can be out of your system in a day and you can get to work and not risk your employment, that is the type of comment that we also hear. So the problem is there is the attitude to cannabis –

Tony PICCOLO: Punishment.

Adam JACKA: Yes, and the punishment as well in terms of the risk.

Renee HEATH: And how often – and that thing Stephanie said was about how often people will adapt work. I just cannot find where I wrote it down. They adjust the work because of impairment. Is that with medicinal cannabis, and how often does that happen?

Stephanie THUESEN: It does not happen at present, but it is what we would like to see happen. We would like to see reasonable adjustments to work. In an ideal world, I would have a disability worker, for example, working in supported independent living. I would call their organiser and say, 'Hey, I've got a bung shoulder and I've got a med can prescription. Can you come with me to talk to the HR manager and CEO?' 'Yep, no worries.' So in my ideal world, I would love to be able to sit there as an organiser. If I had access to some sort of worker-led drug and alcohol worker, I would love to pull in that knowledge and expertise as well, but I would love to be sitting there with the union, the AOD worker if necessary, the worker and the employer to come up with what reasonable adjustment looks like. For me, it is no different from when we have got workers who are returning to work after seeking the assistance and perhaps going to rehab. Oftentimes we will get a supported work plan that can be presented to the workplace if that workplace is open to those conversations. We have got reasonable adjustments laid out. We have got – I would hesitate to say consequences, but what do we do if someone is feeling a bit shaky? Who is our support person? It is those conversations we want to have happen.

Renee HEATH: But that is with general drug addiction, though, not with medicinal cannabis. Would you agree that with medicinal cannabis, we want to treat that without any stigma?

Stephanie THUESEN: Absolutely.

Renee HEATH: Without it being 'You're on drugs'. They are taking a legitimate medication. So I am just finding that this conversation – I am trying to separate the bundling with illicit drug use. Wouldn't you just treat medicinal cannabis, a person with that, the same as you would treat anyone else that is going through a health thing?

Stephanie THUESEN: A hundred per cent, yes.

Renee HEATH: Okay.

Stephanie THUESEN: A hundred per cent yes, but I think – and I do not want to speak for my other colleagues here, but I think the reality that we face on all worksites is that is simply not the case for any drugs, alcohol and gambling, whether it is licit, illicit or whatever it might be. We do not live in a framework where that feels possible at the moment.

Tony PICCOLO: If I could supplement that answer, the terms of reference speak about drug testing in general, they ask about legislative framework in general and they also speak about roadside assistance. In terms of the direct question you just asked Stephanie, I would say that for the longest time, for impairment, there have been reasonable adjustments made, just like the story I told you about: when I was 18 years old they put me in a sickbed for 2 hours and I got up and did my job, and I worked there for another 10 years. Or just like when somebody says, 'I've got this thing, I'm on this opioid, it says I shouldn't be driving heavy machinery,' then a boss might say, 'Okay, you can work on SOP,' safe operating procedures. That is a reasonable medical adjustment. Now, I cannot answer in relation to medical cannabis because I am not an expert on the impairment that that ascribes, but I dare say a doctor would be – not I.

The CHAIR: Thank you, Renee. We are just running out of time. Just before – I think Ryan has one question – Mark, I just want to ask you: that impairment testing machine, can we get more detail, or can we get some back relation to that?

Mark RICHARDS: Queensland, I think, has had quite a lot of interaction with them. I have only read some of the documents. The simple thing I would say is they used to have one where, when you drove up to swipe into the gate there would be a screen there and a dot would pop up; you would have to touch it and you would chase the dot around the screen. That would be done every single day they drove in, as an example, on some sites. What that would do is they have got an algorithm that allows it to see if you come at a different time. There are certain allowances for if you are tired, but it will get to the point that if you do not get it right, it will let you know then that, okay, you had better be switched on and follow it right. And if it does not happen again on the second or third time, then you basically have to pull aside and talk to the person onsite that will decide, face to face, through their protocol whether to let you in. I think there were some other ones which relied on facial recognition, which were not that successful. Those are the only ones I have really read about.

The CHAIR: So the ones that are used in the UK at the moment – are they the same ones?

Mark RICHARDS: The ones in the UK – they are ones that look like a COVID test. It is fingerprint testing. They can be used for no matter what people are doing. Apparently, you cannot – because your fingers sweat, that is one that is very stable.

The CHAIR: Residue, yes. Do you have any information on that at all? We can get it on notice.

Mark RICHARDS: I do. The Victorian Trades Hall Council has put a submission, I believe; I thought it was to this inquiry, it might be a similar one. I think it is Ted, from memory.

David ETTERSHANK: Yes, it is. Ted Sussex, yes.

Mark RICHARDS: I gave him the documentation to follow it up. I believe it is going through trials to prove it now.

The CHAIR: Okay. Thank you. Just before I pass to Ryan for one question to ask you about rehab, I heard you mention all this awareness and all these lessons. I hear this all the time. I am not too sure if you know about mandatory training with the army – they do this every year and they go through all the process. So maybe have a look at that, because they actually go through all the gambling, drugs, stress, heat, self-awareness, identification. It is something that, when you mentioned it, did just trigger, because they train all the officers that way.

Mark RICHARDS: I think, unfortunately – Fitzgibbon's parachute, not his packing group but the other group was pulled up just recently about that too.

The CHAIR: That is actually a day's course, and they cover various different topics. It is mandatory training. They do that every year. Ryan.

Ryan BATCHELOR: Very briefly, you mentioned a couple of times what should happen next, identifying people with drug addiction problems through a testing regime. I think, Adam, you mentioned in your submission the kind of rehab services that we need to get. We probably do not have the time to go into detail now, but if you can provide us on notice your assessment of the current state and what options there are to improve drug rehabilitation services for workers, I think the committee would value any of that information.

Stephanie THUESEN: Fantastic. Can do.

Mark RICHARDS: Just on the fatigue question you asked, there was also another bit of software – there is numerous software – called FAID, F-A-I-D. That was fatigue, accident, incident something or other. You used to be able to download it for free and install it. Now, that was one where you put in your rosters and it made the assumption that the person would get say, 6 or 8 hours sleep – you would have to adjust that for the individual – and that would give you an equivalency of .05-type relations. That has been used, I believe, in court some many years ago, but I am not across the details recently.

The CHAIR: Thank you. David, do you want to ask a question on notice?

David ETTERSHANK: Yes. I think we are in that question-on-notice-type stage because it is obviously getting late in the day. There were a couple I would just like to respond to. Mr Jacka, you talked about the *Disability Discrimination Act* and the potential effect of that applying to medicinal cannabis. What if we just put a question on notice to you, if you could just elaborate on whether you think there should be reform or amendment to the discrimination Act to clarify its applicability to an industrial setting or workplace setting?

Adam JACKA: I will take that on notice.

David ETTERSHANK: Yes. That is what I am asking.

Adam JACKA: I think the Victorian discrimination commission has also made a submission and suggested some wording that I cannot tell you off the top of my head, but I will come back to you on that.

David ETTERSHANK: I think we would love to get an industrial perspective on that. You also referred to the submission from the Lambert Initiative with Professor McGregor. Heaven forbid I ask a group of union officials whether you would agree to something or not, so perhaps on a without prejudice basis: the Lambert

Initiative submission refers to the concept of 'cocktailing' both a swab-type test with a Druid-style test, so you have one that is for presence and one that tests for impairment, and unless you fail both then you fail none. I guess I would be interested in, again with –

Mark RICHARDS: On a without prejudice basis, I am not aware of the actual impairment side of the test, but I would say in general if an impairment process is in there and it passes the test, I would suggest that would be a better process than we have got at the moment.

David ETTERSHANK: I am going to put this as a question on notice, if that is possible, and we will just go from there. Ms Thuesen, the HACSU submission is fabulous, really comprehensive, so thank you for that. I am again putting this as a question on notice. You made a comment about getting laws and industrial frameworks right. I guess from a committee point of view, we would be interested in terms of the learnings you had from America and Canada. As lawmakers, we would be very interested in your thoughts as to specifically what you think this inquiry could be recommending based on those learnings. That would be fantastic. That will do. Thank you, Chair.

The CHAIR: Thank you. Rachel, do you have any questions on notice?

Rachel PAYNE: I was just actually wanting to talk about the employee examples that Adam had referred to and sorry –

Mark RICHARDS: Mark.

Rachel PAYNE: Thank you, Mark. Sorry, I should put my glasses on. Just quickly, all the employees that you referred to here had disclosed medicinal cannabis, and that meant that they were stood down and then investigated. If it was a different medication that they had disclosed, do you expect that there would be a different outcome?

Tony PICCOLO: Yes. Well, almost 100 per cent yes.

Rachel PAYNE: Right, so a medical defence is afforded to, say, an opioid-based medication for pain relief but not medicinal cannabis for pain relief?

Tony PICCOLO: The problem that we had experienced was that, just to start with, each one of these employees followed the policy and procedure to a tee and treated it as if it was prescription medication. Whereas I cannot exactly remember the other medications that they were on to treat this medical condition, but there was no issue with them coming to work having that prescription medication so long as they had a consult with a doctor, got it prescribed and followed whatever guidance came with that. So, for example, if it said 'this may cause drowsiness' or whatever that might mean, then the employee had an obligation, coming to the impairment point, to either say, 'Hey, I'm not feeling right,' or whatever. There was no problem with that prescription medication, but when it came to medically prescribed cannabis the blanket position is 'No, not at all,' despite them following the process.

Rachel PAYNE: Okay. Thank you.

The CHAIR: On that note I want to thank you so much all for coming in to impart your knowledge and your experience. You are representing a large cohort in different sectors. I understand the essential relation to heavy industry and various different types of manufacturing workers as well, so thank you so much for your insight. Those questions on notice that you will forward to us we will definitely take into consideration in relation to making recommendations.

Committee adjourned.