T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Workplace Drug Testing in Victoria

Melbourne – Wednesday 22 May 2024

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WITNESSES

Professor Kate Seear *(via videoconference)*, and

Dr Sean Mulcahy *(via videoconference)*, La Trobe University; and

John Ryan, Chief Executive Officer, and

Rhys Cohen, Policy Officer, Penington Institute.

The CHAIR: Welcome back to the Inquiry into Workplace Drug Testing in Victoria. Joining us this session we have got members from the Penington Institute Mr Rhys Cohen and Mr John Ryan. Joining us on Zoom from La Trobe University we have got Professor Kate Seear and Sean Mulcahy. Thank you so much for taking the time to turn up on Zoom and come in today, gentlemen and Professor. Before we do continue, I will just quickly read this information regarding the evidence you are providing us today.

All evidence taken is protected by parliamentary privilege as provided by the *Constitution Act 1975* and further by the provisions of the Legislative Council 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 with a proof version of the transcript following the hearing. The transcript will ultimately be made public and posted on the committee's website.

Before we proceed, I would just like to quickly introduce the committee to you. I am Trung Luu, the Chair, and my Deputy Chair is Mr Ryan Batchelor. We have also got Ms Rachel Payne, Mr David Ettershank, Dr Sarah Mansfield, and we have got Dr Renee Heath and Mr Lee Tarlamis on Zoom as well.

Could I please ask you to state your full name and the organisation you are with – we might start with those on Zoom first – just for the record. Professor.

Kate SEEAR: Thank you. My name is Kate Seear, and I am with La Trobe University.

The CHAIR: Thank you. Sean.

Sean MULCAHY: My name is Sean Mulcahy, and I am also with La Trobe University.

The CHAIR: Thank you. John.

John RYAN: John Ryan, Penington Institute.

Rhys COHEN: And Rhys Cohen, Penington Institute.

The CHAIR: Thank you, gentlemen. Thank you. I know you have made a submission, but before we put it to the committee for questions I will allow you all to give an opening statement. Would you like to start from La Trobe University, Professor?

Kate SEEAR: Yes, thanks. Sean and I do have a few words we want to say by way of opening. First of all, thank you very much to all of you for the opportunity to be here today. I am sorry we are both not able to be there in person. I just want to underscore a few issues that we highlighted in our written submission, particularly as the committee will be aware that statutory workplace drug-testing regimes only cover specific industries like law enforcement and transportation. For other workplaces there are no governing laws on reasons for testing, the use of results, methods, the consequences for refusal or privacy protections. There is limited legislation that exists to safeguard employee privacy, and as other researchers have noted, who I will quote here:

> While … traditional sources of law have provided some normative framework for WDT practice, they are insufficient to ensure that WDT respect employee privacy while achieving … legitimate goals.

In our submission we highlighted the importance of considering the relationship between drug testing and stigma and discrimination, including because various state, national and international strategies and guidelines now emphasise the need to eradicate drug-related stigma and discrimination. We suggested that workplace drug testing can risk generating stigma and discrimination in a range of ways, including through insufficient privacy protections; undignified testing methods lacking safeguards; broad, imprecise testing powers with excessive discretion; stereotypical assumptions about people who use drugs; and inadequate training on stigma and discrimination. Workplaces should carefully consider the limitations of testing regimes, including the lack of impairment correlation and a risk of inaccuracies and potential unintended consequences.

The consensus is that workplace drug testing should be part of a comprehensive program with appropriate safeguards and clear policies developed through employee consultation. In our submission we talk about recommendations from the National Centre for Education and Training on Addiction, which recommend that programs focus on counselling over punitive outcomes, target safety-sensitive roles, allow employee input and appeals processes, and incorporate education and training. In our submission – I will not go through our various recommendations – we emphasise key elements for workplace drug testing, including that there should be qualified personnel, secure sample-handling processes, grievance processes to challenge outcomes and safeguards for intrusive testing and the like. Overall, we believe that policies should address privacy; follow statutory guidance, regulator advice and case law on areas like non-discrimination; and incorporate impairment-based testing wherever possible. I will hand over to Sean.

The CHAIR: Thank you, Professor.

Sean MULCAHY: Thank you. Despite the recommendations from the National Centre for Education and Training on Addiction that workplace drug testing should target safety-sensitive roles, it is clear from the evidence before you that it has been expanded to everything from retail music shops to rail. Indeed you heard that testing companies are advocating for mandatory testing in all workplaces because of assumed risks arising from people who use alcohol and other drugs, or AOD, making decisions. Yet our industrial frameworks are not up to date with current drug laws, and as a result, testing can lead to punitive responses such as termination, forced leave, targeting of older workers and influencing workers to forgo medication. As other submitters have acknowledged, AOD is not a major contributor to workplace injury as compared to road trauma, and there is not sufficient evidence that testing reduces workplace injury, except to some degree in the transportation sector.

Under the *Occupational Health and Safety Act*, or OH&S Act, there is no express mandate or prohibition on workplace drug testing. The Act is silent on this and, in our view, inadequately addresses the issue. This means that there is not clarity on what kinds of tests can be used – whether these be buccal swabs, urine, breath, blood, hair or oral fluid – and also on what grounds workers can be tested. In the absence of this legislative guidance, WorkSafe's 2017 guide for developing a workplace alcohol and other drugs policy stipulates that alcohol and other drugs in the workplace should be assessed in the same ways as other occupational health and safety issues and also acknowledges that a positive drug test is not always directly related to impairment. But it does not include this in its tips for setting out a workplace AOD policy, and the guide also perpetuates problematic language that stigmatises people who use AOD and their colleagues. We are pleased that WorkSafe has agreed to revise this guide, and we believe it should include a more prescriptive and stigma-sensitive framework for workplace AOD policies. What is crucial is that the OH&S regulations stipulate that a person is only adversely affected if their judgement or capacity is impaired. But as WorkSafe acknowledged, assessing impairment is a real challenge for drugs as compared to alcohol and most testing companies only test for presence with no clear cut-offs for impairment.

Furthermore, we believe that issues relating to privacy and confidentiality of workers are sometimes not properly considered by testing companies or workplaces even though testing may be intrusive and raises confidentiality and privacy issues. Sometimes testing is commenced if drugs are found in the workplace based on a problematic assumption that the mere presence of drugs may cause impairment. Concerningly, some submitters discussed workers needing to declare drug use and said it would be an issue if this was not disclosed. However, Fair Work Australia has held that workers should not have to disclose personal information about prescription medication unless and until they have returned a confirmed positive test or they have a reason to believe they are suffering or may suffer side effects. We would be concerned if other workplaces tried to introduce mandatory notifications given the very real chances of stigma and discrimination that would follow.

Finally, we agree with VEOHRC's submission that section 7 of the *Equal Opportunity Act* should be amended to clarify that where a person uses prescription medication or requires treatment for a disability that is a characteristic that a person with a disability generally has, but we have identified some issues with the definition of disability, which we could address in a supplementary submission if the committee would be so minded. Thank you.

The CHAIR: Thank you, Sean. John?

John RYAN: Thank you very much, Chair. I am John Ryan, the CEO of Penington Institute. I am very privileged to be here today, so thank you very much for the invitation. These are definitely very difficult issues, and I do not have any envy for your position trying to work your way through them. I have just this morning, because of Penington Institute's role in relation to International Overdose Awareness Day, been speaking with the CDC in Atlanta, Georgia, about the changing dynamics in the American drug market, which includes obviously drugs that we do not have in our system yet, particularly fentanyl. They are struggling in a much more dire set of circumstances than we are in Australia, but the thing that strikes me is that we are all on a learning journey in relation to these issues. It was not long ago that we really did optimistically believe that we could eradicate these problems. What we have come to learn is that we need to better manage these problems. I think from a Penington Institute perspective that is focusing on community safety and health.

In relation to these substances, particularly cannabis, we have got this challenge of changed circumstances. Now we have got prescribed cannabis, which if you ask the patients who have received relief from their prescribed cannabis is an amazingly positive story very often. That does not mean that our regulatory and cultural approach to these issues has really caught up with the emerging evidence in relation to these substances nor I think in our understanding of their benefits and how we should amend our systems to accommodate improved understanding. We do really have I think a positive and a negative in relation to these substances. There is no better example I think than in relation to opioids. I would not want to deny somebody in pain access to opioid pain relief. On the other hand, we do know that from Australia's Annual Overdose Report that medicinal opioids are significantly implicated in the overdose toll, which does exceed the road toll. So we do have very significant challenges, and we have got a lot of, I think, fear and anxiety that has developed over the years in relation to substance use matters, which is sometimes driven by misunderstanding and sometimes deliberately exaggerated in terms of negative consequences.

I am old enough to remember when drug testing was the new black, so to speak. I can remember 15-odd years ago how much drug-testing companies were claiming that they would have cut-through solutions to these issues if only workplaces would implement more drug testing. Obviously, notwithstanding the commercial imperative that those companies had, unfortunately the results have been much more patchy, and I am aware of a number of business leaders who have walked back from their commitment to drug testing because of the lack of effective results compared to the cost. So it is a difficult area. I have had the pleasure of reading a number of the submissions that have been provided to the committee, and I can therefore attest to how difficult your challenge is. But in relation to, more particularly, medicinal cannabis, it is worth remembering that while it was once illegal in its entirety it is now benefiting tens of thousands – in fact many more Australians than I would have predicted five years ago.

That rubs up against some of the protections that we have understood to be important in relation to particularly the *Equal Opportunity Act*. One of the opportunities I think is to better understand disability and particularly to better understand how we should be treating people who are under medical supervision and who have been prescribed medication according to a clinician's best judgement. Whilst it is true that there are some players in the medicinal cannabis industry that – what is the word – go close to the edge or indeed over the edge of inappropriate behaviour, inappropriate prescribing, inappropriate marketing et cetera. That is true across systems. There are always bad apples in any system, and we have had many, many experiences now of poor prescribing of substances. I do not think it is therefore a logical conclusion to make a sweeping generalisation that medicinal cannabis is an illegitimate form of medicine. Some people make that jump. It is an exaggeration. It is actually an effective medical intervention. That is why so many doctors are prescribing it and so many patients are benefiting from it.

When it comes to workplace drug testing one of the challenges in a fast-moving environment in relation to these issues is that some of our legislative frameworks are not contemporary and appropriate for current circumstances. I think that applies actually to what was mentioned by the previous witness, which was in

relation to the *Equal Opportunity Act*. I think there is a very cogent argument to make amendments to the *Equal Opportunity Act* to protect people who are being prescribed medical substances even if they are psychoactive substances. There are other protections in the Act to balance workplace health and safety priorities. But fundamentally we have a situation now where we have people who are prescribed medication and they are at risk of losing their employment and are at risk of absolute destruction of their livelihood because they are putting their health and the advice and recommendations of their doctor first. They are therefore discriminated against in the workplace, because I think mostly of the hangover that we have from when cannabis was purely illicit and the medicinal benefits were not understood or in fact legal.

We are now in the situation where we have medicinal cannabis as a legitimate treatment intervention, but we do not have protections for those people. I think in that sense amendments to section 7 of the *Equal Opportunity Act* are a logical modernisation to protect people in the community who are obviously already vulnerable because they are undertaking medical treatment for their disability. They should be protected. I think that is a clear and simple intervention that the Parliament could make to protect people in the Victorian community.

The CHAIR: Thank you, John. Rhys, would you like to make any comments?

Rhys COHEN: Thanks, Chair, for the opportunity. Just very briefly, I have been working in the medicinal cannabis space for about eight years or so, and I remember back in 2015 and 2016, when we were counting the number of patients who were getting access on a single hand, then two hands, the extensive hurdles that those often quite desperately sick people and their families needed to go through to get access to medicinal cannabis in what was at the time a really confronting political and social environment with very unclear regulatory structures and patient access processes. For many of them it was extremely traumatising and remains so, and that is still true for many of these people who are getting access.

As someone who has been paying very close attention to this issue for such a long time, I am obviously very heartened by the considerable growth from a negligible base that we have seen in terms of how many Australians are being able to access these medicines under clinical supervision, which I think is a good thing, but I would emphasise that it is not a done deal yet. I personally still speak to many people all the time who are unable to find a healthcare professional who is prepared to consider medicinal cannabis as a treatment option, despite it being appropriate for that patient or despite that patient feeling that it would be appropriate for them. Plenty of patients or people that I have been speaking to over the years who said that they had taken medicinal cannabis found it to be effective for treating their medical condition and then chose to cease taking it because of the real or perceived risk to their employment. I think that real or perceived risk is an important point, which I am sure many people have touched on in their submissions and their testimonies so far. It is clear to me from reading the submissions to this inquiry that there is significant ambiguity and uncertainty with regard to what kind of policies may or may not be in place and how they may or may not be enforced in this workplace or that workplace, and I cannot imagine how much more labyrinthine and risky it would seem to an everyday person who has not spent their whole life thinking about these issues. I think we need to keep patient access and the experiences of people who are treating their medical conditions front of mind.

The CHAIR: Thank you very much. I am mindful of time. I might just keep it to 4 minutes each. I will go first. Professor, I will throw my first question at you. You recommended guidelines in relation to implementing workplace testing, and you mentioned a lot about stigma, confidentiality, job loss and the need for a health approach. Have you looked at any model which used drug testing in the workplace which had a positive result, which ticked all the boxes in relation to stigma, confidentiality regarding information and a health approach and which assisted those who tested positive? Have you come across any at all?

Kate SEEAR: Thank you, Chair. I suppose the way I would answer the question would be to say that what I think you need, which from memory we have not found – and we detailed a number of examples in our submission of legislation that allows workplace drug testing – is a comprehensive approach that does a number of things at once, including legislation that sets out exactly how workplace drug testing is to unfold in a way that affords protections to employees, that has safeguards and that does not allow for excessive discretion or discriminatory targeting of employees and the like. I think there are gaps in a number of the Acts that we set out. In our submission we talk about the broad-based corruption legislation, policing legislation, commercial passenger vehicle legislation, and in all of those Acts there are gaps, I think. The short answer to your question is no, not in the Victorian context at least; there is nothing that I can point to that is absolutely perfect, especially because of the risk of stigma.

The CHAIR: I will just follow up. Is there any model across the world, in any organisation across the world, that you have come across or that you are aware of?

Kate SEEAR: I would have to take that question on notice I think, because I have not done a careful global analysis.

The CHAIR: Just in Australia, have you looked at the ADF model of drug testing and alcohol testing?

Kate SEEAR: Sorry, Chair, could you repeat that question for us?

The CHAIR: Have you touched base with or looked into the ADF – Australian Defence Force – model in drug and alcohol testing regarding their soldiers?

Kate SEEAR: I do not think we have at the moment.

The CHAIR: Okay.

Kate SEEAR: I am looking at Sean to see if we have looked at it, but I do not think we have it for this.

The CHAIR: No. It would be good, if you do look at that, to see what your opinion is in relation to their model in relation to confidentialities and stigma and the way they rehab their soldiers. If you could take that as a question on notice, just your opinions and your findings on that.

Kate SEEAR: Thanks, Chair. Yes.

The CHAIR: Thank you. I will just quickly throw a question to you, John. You mentioned across the workplace they have been asking for workplace testing and cost is a big factor. I was just wanting to ask in relation to medicinal cannabis, which is prescribed, not the other stuff. In different states I know there is a less stigma because of the history of cannabis usage. Where do you sit in relation to the impairment of medicinal cannabis? Should we look at prescription and medicinal cannabis as an overall, or should we just look at those which have a low percentage of THC?

John RYAN: Chair, it is not my prerogative, but if I may, I think the defence force policy in relation to drug testing is really interesting. I think there are going to be developments in relation to that based on my reading of the media and the recent tragic death of a paratrooper in relation to whether or not people tested positive and were then not available for work. One of the big productivity impacts of testing people not for impairment but for presence is that they are then removed from their productive work role unnecessarily. In terms of a model that I have seen that is interesting, the doctors' health program actually I think is very interesting in terms of how they very carefully manage and drug test doctors who have ended up with drug problems. But they throw a huge amount of resources at it, and most systems would not be able to afford that kind of care. It does show, though, that if we care about people who have run into a drug dependence problem, we can actually treat our way out of those problems. Now, sorry, having taken the prerogative, I have now forgotten exactly the specifics of your question.

The CHAIR: It was just a question in relation to medicinal cannabis – the prescribed one, not the recreational one. Due to the evidence we have got in relation to the impairment of THC, should we consider medicinal cannabis overall with high THC or just look at those with low percentage of THC or none at all?

John RYAN: Yes, I think the idea of none at all. I mean, what we are not testing for is actually impairment; what we are testing for is presence. I think if we get out of our minds this idea that we can test through drug testing for THC and as a result of that be able to judge an impairment – I think that is a logical error. The challenge is actually getting away from the idea that just because somebody tests positive for cannabis, they are therefore impaired. I think the evidence for that is non-existent because of the long time that it takes for cannabis to clear from our system. I think the *Equal Opportunity Act* provides a good framing for these issues, particularly in relation to when testing should be applied and how that should be implemented. I think that is a reasonable way of working, which is to really protect first and foremost the health of the individual who is under medical care but also acknowledge that that has safety impacts in the workplace. I think that balance is already covered off in the *Equal Opportunity Act*.

The CHAIR: Yes. So to clarify your answer, basically the THC is not an issue. We should not treat it as an issue, regardless of the percentage or whatever the traces are, with the prescribed one, not the recreational. Is that correct?

John RYAN: I think the problem is that the presence of THC as a positive test result is not evidence of impairment.

The CHAIR: Not impairment. But we should not consider the level at all.

John RYAN: Yes.

The CHAIR: Thank you. Deputy Chair.

Ryan BATCHELOR: Related to that, do you think there can be harm from impairment in the workplace due to the use of prescription medication, including medicinal cannabis? And I suppose related to that, who do you think is best placed to identify and respond to that harm?

John RYAN: Yes, in answer to your question directly, absolutely these substances can be impairing. Benzodiazepines, for example – anti-anxiety medications or sleeping tablets – also have a very long half-life and can be very impairing, and so can opioid pain relief. I have had that experience myself when driving after a surgical procedure, having not been told that I should not have been driving with a high dose of opioids. We focus so much in the community conversation about the impairing effects of cannabis, but I think some of the other medicinal products that people are being prescribed are also impairing. In terms of who is most responsible, I am afraid to say that it is the Parliament of Victoria who is responsible for providing the legislative framework. In the end –

Ryan BATCHELOR: But assessing risk – do you think it is the Parliament?

John RYAN: Yes. The job for Parliament I think is to create the framework that is fair, reasonable and protects individual patients but also protects their colleagues and the general public. At the implementation level I think it is reasonable that business owners take responsibility for that, but as has already been described, at the moment it is a wild west approach and I think we do need improved safeguards.

Ryan BATCHELOR: Excellent segue into my next question, which is: who do you think has the best examples of regulatory practice or codes of practice for workplace drug testing at the moment? Do any of our colleagues from La Trobe want to tell us who is doing it well or what makes a good regulatory approach?

Kate SEEAR: I am happy to jump in. I know this is a similar question to that of the Chair's, which I have taken on notice, and I will provide some further information on some of those models. But I think in answer to your question of 'What makes for a good regulatory approach?' it is an approach that first and foremost is grounded in a public policy rationale – that is that there is a connection between the reason for testing and the industry within which testing is taking place and public policy considerations, such as safety. As John Ryan was just explaining, I could not agree more about those concerns around testing for presence rather than testing for impairment. That is a good example of a situation where there would be no, in my view, sound public policy rationale for testing somebody for the mere presence of a drug that might not be impairing, let alone in an industry where safety, for instance, is not a consideration or not a central concern. That to me is the sort of foremost consideration: what is the public policy rationale for testing? And then: what kind of testing are we going with in light of consideration of the industry or field within which the employee sits? And then –

Ryan BATCHELOR: Sorry, just on that point, do you think therefore that we need an overarching approach or an industry-by-industry approach if the Parliament needs to make a decision about these sorts of things?

Kate SEEAR: Yes. I think an overarching approach, but there have to be clear guidelines and policies to direct businesses then in terms of the operationalisation of those policies. We talk a little bit about that in our submission – the kind of glaring omissions and gaps in certain industries that do not seem to have those kinds of protections in place.

Sean MULCAHY: Just to build on that, if I can draw your attention to page 2 of our submission. In that we point out that in 2005 the Victorian Law Reform Commission published a report into workplace privacy, and

that report recommended the creation of workplace privacy legislation and mandatory codes of practice about the taking of bodily samples from workers or prospective workers for the purposes of AOD testing and would address a number of matters. It has been some time since that 2005 report. New South Wales introduced legislation that same year on this particular topic, and perhaps it might be prudent for the committee and the Parliament to consider that report in light of the issues that have been raised during this inquiry.

Ryan BATCHELOR: All good. Thanks, Chair.

The CHAIR: Rachel.

Rachel PAYNE: Thank you, Chair. Thank you to you all for coming in today and presenting. Yesterday we heard from some of the unions and associations that represent workers, and in particular we heard of case studies where medicinal cannabis patients had disclosed that they are patients. In one instance they had a supervisor actually say to them, 'It would be easier if you were just back on your opiate-based medication.' John, I note that you mentioned earlier around benzodiazepines and the impact that they can have on impairment. But considering in those case studies that we heard from, when they had a medicinal cannabis test or even a disclosure of using medicinal cannabis, they were instantly stood down for review. In comparison, if they were to use other medications, including opiate-based medications, they had a medical defence. Is this workplace policy about creating a safe work environment, or is it that there are laws that are not currently adequate to protect medicinal cannabis patients? I am opening it up to the floor.

John RYAN: Okay. Kate, do you want to? Well, thank you for the question. From a learning perspective, I think we are still learning, and I do not think we have quite caught up with medicinal cannabis. I think there is in fact quite a lot of ignorance about medicinal cannabis, and it gets treated most harshly by lots of people across the community compared to what we have got very used to, which is opioids and benzodiazepines and other medications. So I think it is actually a challenge from a legislative perspective to protect people who are vulnerable, aka people who are under medical care and treatment. But it is also a challenge to improve community understanding, and that is something that I think we have not done in relation to medicinal cannabis. We have not explained enough to the community the reasons why people are using medicinal cannabis, the benefits that it provides and indeed how to effectively operate in our community with medicinal cannabis. The community education piece has been almost zero.

Rachel PAYNE: Great. Thank you.

Kate SEEAR: Can I jump in and just add there to John's response? In our submission we raised some concerns about these issues as well, and we do make the observation that, I suppose, there are two things. One is that, as John has been describing, there is a legacy issue here in terms of cannabis historically being illegal and the legacy effects of that and its flow-on effects in terms of how medicinal cannabis is understood. But also we do make the observation that there is generally a low level of literacy around drug law and drug policy in Australia broadly, and I think that we see that in the example that you mention, given in evidence yesterday from some of those union members. In our submission, this is one of the reasons why we talk about the importance of ensuring that there are safeguards in workplace practice, so that there is not excessive discretion or a lack of guidance for individual workplaces and employers on how to operationalise their obligations when it comes to workplace drug testing, including because there may be a lack of understanding among those responsible for operationalising such policies that medicinal cannabis is legal and perfectly suitable and in many instances, as we have been discussing with the kinds of questions around presence versus impairment, that if you have a system that has too much discretion involved and does not have those protections, you do end up with these kinds of results that you have been describing. That in our view is very problematic and something that we hope the committee is able to address.

Rachel PAYNE: Thank you.

The CHAIR: David.

David ETTERSHANK: Dr Mansfield, do you want to –

The CHAIR: Okay. Dr Mansfield.

Sarah MANSFIELD: Thank you. Thank you for appearing today. I might just continue on that line of questioning. You pointed out a number of examples in your presentation and in your submission about where there is inconsistency, I guess, even across industries in how they test and their approach to AOD issues in the workplace. In order to resolve some of those inconsistencies, where do you think we should be looking from a legislative point of view? Where are the key areas we should be targeting as a starting point?

Kate SEEAR: Sean, did you want to say anything there?

Sean MULCAHY: I might just say that one of the key things that we have identified in our submission is that there is an inconsistent approach whereby some industries are quite regulated in terms of drug testing whereas other industries are not. The first key thing would be to have a consistent legislative approach across industries in line with the kind of recommendations that are set out in our submission and that of others. Then the second is to provide consistency across those industries that are currently regulated. So this is going to take some degree of law reform in addressing the inconsistencies in legislation but also providing an overall legislative framework that can underpin workplace drug testing in line with the recommendations of that 2005 VLRC report. Kate might have some more to add.

Kate SEEAR: Well, perhaps other than just to go back to the point that I made earlier about public policy rationale, which is I think where reform has to start. The sort of fundamental or foundational question really in my mind is: what is the public policy rationale for testing? And a framework should follow that allows for testing in instances of workplace and community safety first and foremost.

Sarah MANSFIELD: Thank you. I think that leads to a question we heard a bit about yesterday: there are different views on the role of testing in and of itself. There are some who believe that it should be done in every workplace for everyone and that it does lead to reduced injuries and adverse events in workplaces; there are others that contest that information. I guess from your perspective perhaps, Penington Institute, do you have a view on that?

John RYAN: I am sorry, but I am just reminded of one of the under-researched areas which are the consequences of drug consumption as a result of drug-testing regimes, and I think there is a lot of anecdotal evidence, particularly from Western Australia, that the increase in methamphetamine consumption was a direct result of cannabis testing. Because methamphetamine goes out of your system quickly, it is better to take methamphetamine on Friday and go to work Monday than take cannabis on Friday and go to work on Monday. The harm profile from methamphetamine is much worse than cannabis. We have seen in custodial settings in England where the preference is for synthetic cannabis to be consumed because it avoids drug-testing regimes. I think it has a distorting effect on the drug market, which can actually be more harmful to the community than not doing that testing, so I think it is a risky approach. In terms of the cost effectiveness of doing it right across the community, other than the amazing share price rocketing for those drug-testing companies, I do not see it as either practical or affordable, let alone it makes me very uncomfortable about what sort of draconian system we live in if that is how we are going to play. That is something that other countries might do that are not liberal democracies, but we are, thankfully.

The CHAIR: David.

David ETTERSHANK: Yes, thank you, Chair. Can I first of all just thank both organisations for your really thoughtful submissions and your presence here today – I will not go into presence puns. Could I perhaps just first of all ask the folks from La Trobe – first of all, can I take you up on your offer of supplementary information with regard to section 7 of the discrimination Act? But possibly to broaden that, I guess the question in my mind is: you raise a whole lot of really interesting and historical perspectives to this. I mean, I had no idea about the 2005 privacy element. My question is: firstly, you say that testing should cover all workplaces, or you need an approach to testing that covers all workplaces, but also that one size does not fit all. So I am wondering: how do you square the circle on that or what would that look like if it was given practical application?

Kate SEEAR: I might jump in here and make an initial comment just to make sure there is no confusion which dovetails off the back of the last question and John's response. To be clear, we are not suggesting or recommending testing in all workplaces – I just want to make sure that that is clear. And for some of the reasons that John suggests, as well as others, we would be in fact very much opposed to such a proposal.

What we are talking about in our submission is the need for overarching, consistent framework with consistent principles and practices and fundamental principles about how workplace drug testing should be approached. I am not a parliamentary draftsperson; although I have a little bit of experience in legislative drafting, it is very minor. There is a question in my mind about whether there is the need for an overarching workplace drug testing Act that instils various principles and then allows for the Act to be operationalised in individual workplaces where appropriate and where, for instance, the public policy rationale sits or matches. Beyond that, as I said, I am not sure if that is the best approach, but that might be one possibility – an overarching Act that contains those protections. Sean might have some additional thoughts on this as well.

Sean MULCAHY: No. I think you have summed that up well. Thanks, Kate.

David ETTERSHANK: Okay. If you do not have some sort of an instrument like that, presumably you are also going to be going into things like the *Privacy Act* and various other pieces of legislation. Perhaps I could ask you, given time, if you could just elaborate on that, without doing the drafting. I think we would certainly be interested in your thoughts on, if you like, the architecture and the application.

If I could just ask our friends from the Penington Institute a question about the setting of notional maximum blood levels for things like THC. I guess we have seen this in a number of countries where, if you like, they are fairly progressive, but they have still done it. I am wondering about your thoughts on whether or not there is a role for the setting of maximum blood levels for things like THC?

Rhys COHEN: I believe you are having representatives from the Lambert Initiative for Cannabinoid Therapeutics later today, and they are the best people to ask on this topic. But my very layperson understanding of the literature is that there is no clear correlation between blood level of THC metabolites and impairment despite attempts to find a correlative link.

David ETTERSHANK: So why do you think in those countries that have fairly sophisticated approaches they have chosen to do that?

Rhys COHEN: Well, it is not clear to me that those choices were made for scientific reasons.

David ETTERSHANK: Would you like to elaborate on that?

Rhys COHEN: I guess they were probably made for political reasons. The community expects to be protected from risks – many people believe that THC in particular poses a risk in some way, shape or form – and as politicians it is a delicate balancing act to implement sound policy while also reassuring people that you are implementing sound policy. Sometimes you make compromises.

David ETTERSHANK: So you see that as primarily a political trade-off?

Rhys COHEN: Based on my very limited layperson understanding of policy decisions made in a foreign country, yes.

David ETTERSHANK: Thank you.

The CHAIR: Thanks, David. Quickly, Dr Heath, have you got some questions?

Renee HEATH: No, I am okay. Thank you so very much for your presentation.

The CHAIR: Thank you so much, Professor, Sean and the Penington Institute for coming in, putting in your submissions and giving evidence. It is invaluable. Also, on those questions on notice, Professor, we will get all the information and we will put forward our recommendations as well. Thank you so much for coming in.

Witnesses withdrew.