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 *(via videoconference)*

Professor Iain McGregor, Academic Director, and

Dr Danielle McCartney, Research Fellow, Lambert Initiative for Cannabinoid Therapeutics, University of Sydney; and

Dr Katinka van de Ven, Principal Consultant, 360Edge.

The CHAIR: Welcome back to the Inquiry into Workplace Drug Testing in Victoria. Thank you so much. We have got two groups joining us for this session: the Lambert Initiative for Cannabinoid Therapeutics and 360Edge. We have Professor Iain McGregor, Dr Danielle McCartney and Dr Katinka van de Ven – if I have pronounced that right.

Katinka van de VEN: That was perfect.

The CHAIR: Thank you so much for joining us. Before I continue I will just read some information regarding the evidence you are going to present to us today.

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

Again, thank you, Professor and doctors. Just a quick introduction of the committee before we proceed: my name is Trung Luu. I am the Chair. My Deputy Chair is Mr Ryan Batchelor, with Ms Rachel Payne, Mr David Ettershank and Dr Sarah Mansfield, and we have got Dr Renee Heath joining us on Zoom as well – you heard the noise before.

I know both groups have made a submission, but I will open it up for each of you to make an opening statement before I open it up to the committee to ask questions. So if you would like to start, Professor, we will go with you.

Iain McGREGOR: Okay. Thank you very much for the opportunity to give evidence today –

The CHAIR: Sorry, Professor, to interrupt you. Could you state your full name and the organisation you are representing just for the record's purpose? Thank you.

Iain McGREGOR: Yes. My name is Professor Iain McGregor, and I am the Academic Director of the Lambert Initiative for Cannabinoid Therapeutics at the University of Sydney. Thank you for the opportunity to give evidence today and for the opportunity to make a submission. The Lambert Initiative is a philanthropically funded research centre that examines the medical potential, the therapeutic potential, of cannabis and related molecules, cannabinoids, from the cannabis plant. We do a lot of very basic research into chemistry and pharmacology. We also run a lot of clinical trials with cannabis-based medicines, and we also liaise a lot with patients within the community who use medicinal cannabis products and the doctors that prescribe these products to patients. One of the things that we have learned along the way is that there is a great deal of concern around the issue of impairment. That concern comes from doctors who are prescribing this product, it comes from employers who have employees who are using medicinal cannabis products and it comes from patients themselves, who are often concerned that they may well be impaired in the workplace or when driving a motor vehicle.

We readily identified several years ago that the issue of cannabis-based impairment in the workplace and on the road was a key concern for everyone around medicinal cannabis, and we therefore launched a lot of research into this area. My colleague Danielle McCartney, who is with us today, has led a lot of that research on behalf

of the Lambert Initiative, and also the group at Swinburne University, with Dr Thomas Arkell, who was previously with the Lambert Initiative, has led this research too. We have also engaged quite a lot with industry both in Australia and overseas, and I have given a lot of medicolegal expert witness advice around impairment in the workplace. This has been a major concern in Canada, where I have given evidence particularly in the transportation industry. For example, the Toronto Transit Commission had a major arbitration case around the rights of their employees to use cannabis-based medicines in the workplace, and more recently we have engaged with unions in Western Australia and New South Wales who are in the situation where their employees appear to be discriminated against or risk dismissal or have actually been dismissed as a result of legitimate cannabis-based medicine prescriptions that they have been taking, often after declaring to their employer that they are actually using these medicines.

So we perceive a conundrum at the moment. The industry, both in Australia and overseas, is a little bit uncertain about how to manage this issue, and of course we have a massive escalation of the numbers of people who are legitimately using cannabis-based medicines, not just in Australia but overseas. Scientists love a conundrum – I mean, we get paid to solve these problems. We cannot promise a solution, but we certainly have quite a refined viewpoint of the science underlying cannabis-based impairment, and we like to think that we are world leaders in this area at the moment.

The CHAIR: Thank you. Dr Katinka, would you like to make an opening statement?

Katinka van de VEN: Yes: also just to state that I am Katinka van de Ven, and I am a Principal Consultant at 360Edge. Actually, you know, it is really interesting how societal views of alcohol use during work hours has changed. I actually remember my dad told me – he was a psychiatrist with the Dutch military – that during the time when he was staged in Germany it was really normal to drink a glass of wine during lunch, something actually which you know in most workplaces is not tolerated anymore, which is a good thing. The question here today is whether drug testing is the way forward for dealing with workers who use alcohol or drugs.

I would like to thank the Council for providing 360Edge with the opportunity to speak about workplace drug testing in Victoria. 360Edge is Australia's leading specialist alcohol and other drugs consultancy, with workplace testing being a particular area of expertise.

We know that 67 per cent of people who use illicit drugs are employed. Most, however, only do it a couple of times a year and do not use drugs at risky levels that would interfere with their ability to carry out work duties. There are also an increasing number of people who use prescribed cannabinoids, stimulants and opioids for a wide range of medical conditions. Between 2020 and 2024 over 480,000 applications to access medicinal cannabis were approved. Regardless of being illicit or medicinal, no workplace drug testing is available to detect intoxication or impairment other than alcohol breathalyser tests, which have been mentioned by many people today and yesterday. They also cannot detect when a worker has used drugs, how much they used or the frequency with which they are using them. Someone can return a positive test for cannabis that they used weeks before taking the test, long after the potential impairment effects of cannabis have worn off. And as a meta regression analysis from the Lambert Initiative actually shows, people using medicinal cannabis are able to perform work duties after 8 hours of consuming it. Most people will still return a positive test after 8 hours, though. The link between drug test results and impairment is weak, and I am factoring in all the workplace risks. It is clear that drug tests are actually not a useful tool to mitigate workplace health and safety risks.

There are actually a range of workplace environmental personal risk factors that can impact workplace health and safety – for example, heat or poor equipment maintenance or mental health issues. So drug testing exposes workers to risks of being discriminated against solely for using drugs when there are a range of other factors that contribute to risk of workplace injury. There is very limited high-quality evidence that workplace drug testing deters workers from using drugs or reduces alcohol- and drug-related workplace injuries. Workplace drug testing can even result in unintended negative consequences, including workers modifying their drug-taking behaviours to avoid detection and being less likely to report minor accidents and near misses to avoid a test.

There is no valid rationale to support workplace drug testing in workers whose potential alcohol and drug use presents no risk to workplace health and safety. The only exception where drug testing is warranted is for entry to high-risk work sites to protect workers from serious harm – for example, people working in mining who have to operate heavy machinery. But the problem is that now workplaces in Victoria may respond differently

to test results, and responses to positive test results for cannabis when the worker has had a prescription are also really diverse, ranging from being referred to counselling to instant dismissal. The lack of regulation around this places many workers at risk of being sanctioned for taking a prescribed medication without any evidence of impairment. Someone who has had a mental health incident and who also poses a risk to safety would not be sanctioned but would, for example, be sent home to focus on their recovery. So if the purpose of alcohol and drug testing is health and safety, sanctions are not the way to go for people who test positive.

In every workplace a health approach needs to be front and centre. A health approach towards drug use, whether the use is illicit or prescribed, can both improve safety of workplaces and also provide support for those using illicit and prescribed medications. Workplaces that do have a drug-testing regime need to be based on best practice principles. This includes undertaking comprehensive risk assessments, including workplace risks, and influencing use, such as a workplace culture. A positive test should not result in dismissal and instead result in support. Procedures must be carried out fairly and consistently, and testing should be restricted to the least intrusive methods available. This approach is also in line with a general move by governments away from sanctions for drug use and towards a health approach – for example, through diversion to treatment rather than arrest. So a shift in the way prescribed and illicit drugs are dealt with in the workplace towards a more health-based approach would be in line with the approach to drugs in the community and community expectations.

To sum up, drug testing cannot determine impairment and presents a risk of discrimination. There is a wide range of workplace environmental and personal risk factors that can impact workplace health and safety, and a health approach needs to be front and centre.

The CHAIR: Thank you, Katinka. Dr Danielle McCartney, would you like to make your opening statement, or are you happy to go straight to questions?

Danielle McCARTNEY: I am happy to go straight to questioning. I think Iain covered our submission and the Lambert Initiative really well.

The CHAIR: Thank you very much. I will direct my first question to the professor, if I could, Professor. With this inquiry we are basically trying to establish a safe workplace, a workplace that gets employees rights and employers requirements on occupational health and safety. In your submission you mention that for THC-induced impairment, from your research on that, evidence shows that patients showing medicinal cannabis likely pose a safety risk. Can you expand in relation to the amount of THC in medicinal cannabis which causes the impairment, because we have a lot of issues with the term 'impairment' being thrown around in various submissions.

Iain McGREGOR: Yes, thank you. It is a tricky question that you have posed. The traditional approach in my field of psychopharmacology is to get people into the laboratory – and Danielle is a leading person in the world for doing this kind of research – where we can administer THC or CBD or other cannabinoids, and then there is a whole bunch of different cognitive and what we call psychomotor tests, things like balancing, reaction time, the ability to recall digits or phrases, a whole lot of specialised tests that are variously sensitive to the effects of THC. Some are more sensitive than others, but basically we have had a cottage industry in psychology and psychopharmacology of doing dozens of different trials around the impairing effects of cannabis and its main psychoactive ingredient THC on these tests. Danielle is the world leader, and I might actually defer to her, and she can tell you what she found out when she reviewed basically every study that had ever been done on different types of impairment – so maybe over to you, Danielle.

Danielle McCARTNEY: Thanks, Iain. As Iain has already explained, in these studies we typically bring people in a lab and can administer a whole range of different types of tasks. When we conducted a review of those studies, I think we identified 80 since 2020 that had administered THC or cannabis in some form or another and then went on to conduct some form of assessment of impairment. We sort of brought all that data together, extracted it from all the different papers and attempted to determine, as you say, how impaired someone was following a given intake of cannabis or THC.

We ended up breaking the data down into two main routes of administration. So we had our inhaled cannabis studies and our oral THC administration and we found that both tended to elicit similar amounts of impairment, if that is what you would say. We quantified impairment in a metric called Hedges' g, which I will not delve into too much but suffice to say the magnitude of impairment we were seeing was considered moderate on that

scale with oral and inhaled THC. Then what we were interested in was the effect of dose and also time following cannabis or THC administration on that magnitude of impairment. When we ran all the analyses, firstly, we tended to find that impairment from inhaled THC or cannabis tended to subside comfortably within 8 hours, often less if the dose was less, and comfortably within 10 hours of oral THC depending on the dose as well. I am a little bit lost in what the question was now.

Iain McGREGOR: It was generally around impairment. The three things that stuck in my mind were that, first of all, if you take an oral THC medicine, like a cannabis oil containing THC, it is a different time course of impairment. It creeps up quite slowly. You get peak impairment, say, at about 2 hours, whereas with inhaled cannabis you are impaired within 5 minutes. Then the inhaled cannabis tends to wear off more quickly, whereas the oral THC creeps up more slowly and lasts a bit longer. The dose is an important determinant as well, so with higher doses you are impaired for longer. Probably the most important thing that came out of this huge analysis that Danielle did was that it is very much dependent upon how experienced you are as a cannabis user. So it is actually very difficult to show impairment in people who are daily regular users of cannabis. Nearly all of the laboratory studies, for whatever reason, have been done on occasional cannabis users, often uni students who have a bit of cannabis once a month or once every couple of months. So if you are in that category, then you are likely to be much more impaired because you have no tolerance towards THC. These were the three determinants: the route of administration – oil versus smoke – the dose of THC that you have taken and whether you are a routine user. The last point is really important for medical users, which is your main interest of this inquiry. It is actually really quite hard, when people are currently using cannabis every day and often to alleviate a medical condition such as chronic pain or insomnia, to show any sort of impairment when they are using THC-based products in the manner that their prescribing physician has instructed them to use such products.

The CHAIR: Thank you, Professor. That is very insightful in relation to the study you did. I know the committee will have a lot more questions for you. I will quickly jump to Dr Katinka. You mentioned drug testing will have an adverse effect. You also mentioned about stress, fatigue – all of those do have some sort of mitigation strategy at the moment, if the employer wishes to implement them. But in relation to a high-risk work site – not all manufacturing, just a high-risk area – what do you suggest if you do not think work testing is a proper tool to eliminate the risk factor? What do you suggest those sectors should be doing to address the risk issue in relation to the employee, where there are prescribed or not prescribed medications?

Katinka van de VEN: Sorry, I am just trying to make sure that I understand the question. Are you asking me to think through when potentially testing is justified in certain areas?

The CHAIR: No, just in relation to the risks on a high-risk work site, you mentioned there are various factors related to stress, heat and fatigue. I am saying for those factors we have strategies to implement to address those if they are subject to those areas. But with drugs, at the moment drug testing is being used to identify who is at risk. If your submission is that drug testing is counterproductive, I am just asking: what is your recommendation for those sectors to be using, or what methods should they be doing?

Katinka van de VEN: Okay, I am sorry. Thank you for clarifying that. Just to confirm, drug testing in general is not very effective, and just as a quick side note, even in certain safety-sensitive areas where potentially drug testing could be justified it is still very important that that then comes with a very comprehensive alcohol and other drug policy. But having said that, what is really important is that alcohol and other drugs are actually not that different in relation to other factors like mental health and fatigue. Basically you need to think through this in the same sense as a fit-for-work policy, where you can outline all those different areas that potentially are a risk to health, safety and wellbeing and the performance of a worker, where actually drugs could be outlined as well as one of those things that can influence health risk and safety.

What is really important, though, is that drug testing seems a little bit as the easy way out, so in the sense that for workers it is an easy thing to do – we can implement the test and then we can see the presence of the drugs and then we can make steps based on that. But to be honest, there are a lot of workplace conditions that actually can influence these risks and even also increase the risk of people using a substance. So what is really important is that we actually look at those workplace conditions and the culture around that that could influence substance use as well. But that is of course very much harder, and it is probably also much more cost intensive to think through those kinds of mechanisms. As an example, someone yesterday within the inquiry mentioned that some people were making these 18-hour shifts for 20 days straight and there was a risk that potentially those people

were using substances just to get through their shifts. So what we need to do here is actually identify these risks and all those factors that potentially can impact the health and safety of the workplace and address that in a holistic way. So we need to understand, 'Okay, what kinds of pressures are people experiencing within the workplace? How are they contributing to an increased risk of use? How can all those factors also affect the health and safety of the workplace?' and then support those people to be able to function within the workplace, in which support always should be at the forefront.

Also one of the things that we probably should be focusing more on – because it was also mentioned, what the problem is – is that people are making these long shifts because they potentially have to pay these medical bills. If we are going to put steps in place to safeguard the health and safety of these workers and take hours away because we want to ensure that they are not too stressed or tired and that impacts their performance, that could also then potentially add financial stress to these people, so then you should probably be thinking about making sure that people get enough pay and they are fairly compensated. But these are much higher level things that we need to think about that are at the root of alcohol and other drugs. In general we need to think about policies and how to deal with this. Alcohol and other drugs is an area that can impact health and safety and performance.

The CHAIR: Even in a high-risk area where immediate action may cause fatal injuries to another person?

Katinka van de VEN: No. So I do think that for certain safety-sensitive industries there is potential – where there is a high risk of injuries, for example, with mining where people are using heavy machinery – there is justification, to use drug testing, but even that needs to be supported with a policy. And also what we need to do is really think through the unintended consequences. As I believe John from the Penington Institute also mentioned, 20 years ago when we looked at mining when they were testing for cannabis we saw actually a shift to people starting to use meth – because the detection window is less – which potentially is a more harmful substance than cannabis. So even where, potentially, testing is justified, we really need to be very careful as to, 'Okay, we need to think this through,' so people are not shifting, for example, to more harmful substances. And also what we see is that there is a risk that people will actually stop reporting minor incidents because they do not want to be tested. So even where testing is implemented we need to make sure that there is a very comprehensive policy where support is at the forefront for these people. So we sit down and we analyse what kinds of factors are influencing the performance of the workers, of which alcohol and other drugs is one thing, and we also need to think through 'Okay, so what is potentially causing alcohol and other drug use' or risky use 'within that worker' and address that holistically.

The CHAIR: Thank you. Ryan.

Ryan BATCHELOR: Thanks, Chair. Thanks very much, everyone, for the evidence. Just going back to the studies, Professor McGregor. Clearly there is evidence that impairment occurs following the consumption of cannabis in some users but that the variables include methods and then length of impairment. The science is very good at telling us things. We have got to translate that into public policy questions and often, particularly at a rule-making, policymaking but even public-messaging level, we have to strip away complexity and get to simplicity so that we can effectively set messages. Do you think that things like time-based exclusion periods would be a better form of messaging – about when people should regard themselves to possibly be subject to impairment following consumption of cannabis products?

Iain McGREGOR: Yes, I think that is a very rational approach in terms of providing public health advice. We just did a survey up in Canberra, because it is legal to cultivate up there. We had more than 400 cannabis cultivators, and we asked them a whole range of questions. It was quite cool, because we actually grabbed some of the cannabis as well and checked the THC content and looked at pesticides, heavy metals and all sorts of stuff. The cannabis checked out pretty well, but what I am getting at is that it is interesting. Danielle did an analysis of the time they waited before they would drive a motor vehicle, and it was kind of binary. There were people that basically could not drive a motor vehicle for almost 8 hours after their cannabis use, and then there were others that would drive readily within 1 hour. So there was this bifurcation into what you might call a high-risk and an extremely risk-averse group. But I think we can use the work that Danielle has done to provide nuanced advice to cannabis users and say, 'If you're inhaling cannabis at this particular dose, then chances are within 4 or 5 hours you're probably good to drive, you're probably okay, but let's be ultra cautious and call that 8 or 10 hours. And if you're working on a mine site and you're prescribed a THC-based medicine, that's probably fine. What the evidence is telling us is that it is okay to use that by night to help through pain and help you sleep, but don't take it first thing in the morning before you attend work.' I think these are very

commonsense interventions that are evidence based and that could provide a much more nuanced public health message around medicinal cannabis use – and recreational cannabis use, for that matter.

Ryan BATCHELOR: Nuance is very helpful in individual circumstances, but we have got a public policy question that is hard to nuance down to that level. How do you think we land that plane at a place where we can have something that understands the science but also has a policy and public health messaging framework that has universal application?

Iain McGREGOR: I have been very much focused on safety steps for industries, and I think that is the key question. You know, if you are flying up to Sydney on Qantas and you know that the pilot of your 737 inhaled cannabis for their chronic pain 2 hours ago or the night before, how does that make you feel? That is the question I ask myself. I would say that when it comes to these highly safety-sensitive positions we want to ensure that there is a long interval between THC medicine administration and the performance of a safety-sensitive task. I think it is reasonable to expect that we have got broadbrush goals in terms of the amount of time that you should wait before performing driving, for example, but if you are working the blast site at a mine, driving a train with 500 people on it or flying a 737, maybe we could push it out that little bit further just to make sure. But my Qantas pilot, if he or she is using THC for insomnia or pain, I am quite comfortable with 12 hours – you know, if they used that at 8 pm last night and the flight is at 8 am, I am fine with that. There is nothing in the literature, and we have comprehensively reviewed that literature that suggests that there is a problem there.

As I say, in terms of broad policy, I am not quite sure how to do this, because you are going to capture non-medical use and young people who are maybe engaging in more risky behaviours. There is a big difference providing advice to an 18-year-old who is using a wad of cannabis for entertainment purposes versus a 60-year-old who is using it for their arthritis. So it may not be possible to capture all of these people in one sound bite with policy. I think the ones we really need to get right at the moment are the people working in safety-sensitive positions, and we have some ideas about how that might be done.

The CHAIR: Thanks, Deputy Chair. Rachel.

Rachel PAYNE: Thank you, Chair. And thank you to everyone for presenting for us today. I guess what is coming up here is the very distinctive impairment testing versus testing for presence, and I note that in the Lambert institute's submission you talk about opportunities for impairment testing and some of the things that you have reviewed, mainly being the Druid application. Do you mind talking us through, first of all, what that does test for and what capabilities that has, and is it possible that that could be used as an option for employers to monitor impairment?

Iain McGREGOR: We were asked in a recent case to come up with, 'Don't just tell us what the problem is; give us a solution.' I think it is very important in this space to come up with solutions. There is no definitive test of impairment, but Druid is quite good. It is a smartphone app. It takes about 2 minutes to administer these tests, one of which is a balance test. You are holding your phone in your hand and standing on one leg, and it measures your sway through the accelerometer in the phone. Another one is a visual–spatial tracking task where you have basically got to move your finger around, following a dot on the screen. These are tests that are sensitive to THC impairment, and they are quite useful inasmuch as you can get a baseline for someone. You administer that test a few times, and they show a fairly stable baseline. Then if you get intoxicated with alcohol, cannabis or some other intoxicant, their baseline will deviate quite markedly from that sober baseline that you have established. Now, this will never work for roadside drug testing with the police because you need the baseline for everyone in the entire population, which is completely unfeasible. But within, say, the mining industry or the transportation industry, it is quite feasible to actually take a baseline for employees in safety-sensitive tasks and then randomly test them every now and again to make sure that they are within plus or minus 10 per cent of that baseline. That was something that we came up with when we provided an expert report to do with an employee in the mining industry who had been fired for use of a medicinal cannabis product.

We also suggested that, although oral fluid tests are a little bit unpopular, one thing that oral fluid tests are quite good at is detecting whether you have smoked cannabis in last 1 or 2 hours, particularly if you get the cut-off quite high. If you are showing 25 or 50 nanograms per mil of THC in your oral fluid, it is actually quite hard to attribute that to cannabis that you smoked a month ago, last week or even yesterday. So some kind of judicious

combination of oral fluid testing with a very high cut-off – 25 or 50 nanograms per mil – plus something looking for deviation in a Druid test, which only takes about 2 minutes to administer, would be one possible approach to trying to detect impairment in medicinal cannabis users, so someone that had taken their product half an hour ago instead of 12 hours ago. That is probably the best that I can come up with at the moment. I would be interested to see what Danielle thinks, however.

Danielle McCARTNEY: I have very similar thoughts, Iain. I would agree the combination of some kind of biological test with some kind of functional test is probably the best that we have at the moment. Certainly blood and urine are not good biomarkers. That is not to say that oral fluid is a perfect biomarker either. If you take encapsulated THC, it is not going to show up on an oral fluid test, so there are certainly limitations to those drug tests as well. But when you compare to urine, which I think as already mentioned can show a positive test weeks afterwards, and blood, which is just not practical in the workplace and also can show a positive test well after use, oral fluid plus a functional test is probably the best that we are currently looking at, at least to my knowledge.

Rachel PAYNE: And just if I may clarify: would the Druid application measure impairment more broadly? So that could be whether you are affected by alcohol or other drugs or if you are tired, if you are distracted, if you are grieving? Would it monitor that?

Iain McGREGOR: Yes. There is published data on a number of different intoxicants. It is certainly good for alcohol and THC and benzodiazepines but maybe not so much for stimulants, because sometimes your reaction times can be improved and your attentional processes can be improved by a stimulant, so I am not going to vouch for it there. But the race is on to come up with better methods for assessing cannabis-induced intoxication. There are a number of labs around the world who are looking at this. Druid is probably the best that we have got at the moment, but I am always going to vote for ingenuity and innovation. I think within the next year or two we will be seeing probably a whole load of alternative things that may come along. They may involve eye movement; they may involve subtle changes in balance or fine motor control. We have a few ideas, but they are not ready for prime time yet.

Rachel PAYNE: Excellent. Thank you.

Danielle McCARTNEY: One group is doing portable brain imaging.

The CHAIR: Okay. Dr Sarah Mansfield? Thank you.

Sarah MANSFIELD: Thank you for appearing today. Katinka, I might start with you. We have heard from different submissions and witnesses at the hearings that there is a lack of consistency between different pieces of legislation, different bits of regulation, policies around workplace drug testing and perhaps the approach to alcohol and other drugs issues more broadly in workplaces. What has been your experience of that from your organisation's perspective? Is that something that is difficult to navigate for businesses?

Katinka van de VEN: Yes. It is something that is difficult to navigate, and although you can potentially have an overarching framework that provides guidelines around this, organisations will have to think through how that potentially would work in their organisation, because, especially, risks differ per organisation. So while there is a need for overarching guidelines, there also needs to be thinking through, for each organisation, how that would apply in their context.

Having said that, though, I feel that alcohol and other drugs is often something that is a bit scary for organisations, because it is so stigmatised, because it causes quickly a big response. But in a sense it is not really necessarily different when it comes to mental health. If people have mental health issues, which can also impact health and safety in the sense that people can become distracted, what is really important is that organisations, like supervisors and managers, have the ability to be able to recognise when a worker is not doing well and to sit down with that worker and in the same way you would also support someone who is using alcohol and other drugs and to create an environment where supervisors and managers can recognise signals like, 'Oh this person is not doing well. I need to sit down with this person and think about how we can support this person best.' So yes, you are right. There are a lot of different policies. I do think that we need some overarching guidance, but organisations will need to think through how that would work best in their situation.

Sarah MANSFIELD: Yes. Earlier we had some questions asking whether anyone had examples of organisations that do this really well. I do not know if you have seen that in your experience at all?

Katinka van de VEN: I heard that question, and I was thinking I need to look into this. So I will take that on notice, and I will get back to you about it to see if we can think of some workplaces that are a good example, because there is nothing that at the moment comes to mind. So if you do not mind, I will take that on notice as well.

Sarah MANSFIELD: Yes. That is fine. We also heard earlier that some businesses feel that workplace drug testing is something that they implement to limit their liability and exposure to risk, and in the absence of any other guidance around what to do they take a very cautious approach to a positive test result. It came up particularly in the context of THC. I would be interested in your views on that, given that workplaces are worried about, say, some accident or something that happens where they have had a positive THC test and have not taken a more punitive approach to responding to that and then being held liable for potentially having a worker who had detected THC in their system and was still working. Regardless of the question of impairment, they are worried about their exposure to risk. Do you have any thoughts about that?

Katinka van de VEN: Yes. I mean, I would say in these high-risk safety-sensitive industries there is something to say about where testing can play a role to navigate those kinds of risks. I will not go into detail because a lot of people have already discussed that issue that you are only testing for presence; it does not say anything about impairment, so how do you then deal with that issue? But I do think that in general for most workplaces you can navigate that risk without needing to do testing as long as you have an appropriate policy in place, because mental health can also cause – I keep coming back to that – a significant risk, but there is not something that we can test that says, 'Oh, you've tested positive for mental health issues, so we need to now sit down for this.' For most workplaces, if you have a clear policy in place that outlines the procedures around alcohol and other drugs as well, that should be then sufficient to navigate that risk.

Sarah MANSFIELD: Thank you.

The CHAIR: Thank you. David.

David ETTERSHANK: Thank you, Chair. Can I first of all just get a sense from Danielle and Iain – in your submission you pretty comprehensively critique both oral and urine samples and suchlike, and we are obviously at that point in the inquiry where we are keen to try and get answers. So can I just confirm what you are suggesting is that if there is a combination of oral testing and Druid-style testing, what we are covering with the oral is the presence but also possibly how recently it has been consumed, and then we are matching that with an impairment test via something like Druid that gives you a sort of balanced overview of the whole question. Is that a reasonable characterisation?

Iain McGREGOR: I think so. We have some very good data from a number of different labs, not just ours, looking at the probability of giving, say, a 25-nanogram per mil THC oral fluid test at various time points after consumption of cannabis. Really, there is an ever diminishing likelihood once you get past 3 hours of reaching that level, so that tells us that if you are trying to capture someone who has very recently used cannabis, then that might be a feasible way of doing it. However, it does not at all correlate with impairment. You could actually be 50 nanograms per mil in your oral fluid and have smoked a considerable amount of cannabis in the past hour, but there is no guarantee that you are not fit for duty if you are a regular user. So that is when conjunction with a test of functional impairment might be quite useful: if you tick both boxes, then you probably should not be undertaking safety-sensitive tasks.

David ETTERSHANK: Okay, thank you. That is terrific. Can I just pick you up on that last term? We have heard lots of reference to 'high risk' and 'safety-sensitive'. Is there any sort of definitional set that says to us, 'Well, this industry or this vocation is safety-sensitive or high risk'? Are you cognisant of anything you can point the committee to that would give us some definitions in that regard?

Iain McGREGOR: I mean, you are getting to the area of occupational medicine, which is not my strong point, but there probably are definitions to be had in that particular area of medicine.

David ETTERSHANK: Could I ask you maybe to take that as a question on notice, Iain?

Iain McGREGOR: Yes, that is fine. I will mention that in the Canadian cases we locked horns with a number of specialists in occupational medicine who were extremely concerned at it. I know one real hallmark of conservatism in this space is where people are asking for a ban in safety-sensitive workplaces for people who are using CBD-only medications, and that was happening in one of the Canadian cases I was involved in and also in a mining industry case I was involved in in WA. That is really counter to all scientific knowledge. I mean, Danielle has done studies where she has given 1500 milligrams of CBD and done extensive tests on driving and cognitive function, and you just do not see any impairment whatsoever. So the extreme conservatism can move into areas that are really quite dark in terms of there being no evidence whatsoever for what these people are asserting. Their safety-sensitivity goes so far as to be preposterous, and it is very important to call that out, because it impacts people who are on these medicines.

David ETTERSHANK: Okay. I would like to give one more question, if I could, Chair. Thank you. Thank you, Iain. Katinka, can I ask you a question? You talked about the importance of testing, however done, occurring in an appropriate context of policies and procedures, and we have had a lot of evidence about the absence of appropriate policies and procedures and the fact that there is very little or nothing from WorkSafe or other authorities to guide employers. Is there a framework or some exemplars that you could provide to the committee about, if there was to be something put into guidelines or resource materials for employers, what that would – well, does it exist and can you point to it, or would you like to take it as a question on notice?

Katinka van de VEN: I will have to take it as a question on notice. A lot of our work is for internal purposes, so let me have a think about that and come back to you, because I agree that it would be very beneficial to have some frameworks that could guide us as well.

The CHAIR: That would be good. Thank you.

David ETTERSHANK: Thank you very much.

The CHAIR: Thank you, Doctor. I am mindful of time. Dr Heath, do you have any questions you want to put on notice, because we have got one more to go?

Renee HEATH: No, thank you. That has been extremely helpful.

The CHAIR: Thank you. Professor, doctors, it is like you said: Don't come in with a solution; come in with an answer. I think what you have said today is remarkable and will give us good insight in relation to various recommendations for what we will put forward later on. I just want to ask you: with your research and surveys et cetera that you have done regarding testing, would you be able to provide us with the data and research results, Professor or Danielle?

Iain McGREGOR: I did not hear the question. Danielle, would you like to take that one?

Danielle McCARTNEY: I believe the question was if we can provide data and things like that. We can certainly share published data and publications and things like that. There are some things – I cannot remember if we mentioned any unpublished data in that submission. I do not think that we have, although we have mentioned a couple of unpublished things right now today. We probably cannot share all of that information, but we can certainly share published things and maybe some bits and pieces from any unpublished things.

The CHAIR: Whatever you can – it will be much appreciated to have all the research you have done. Again, thank you so much for your time. I appreciate it.

Witnesses withdrew.