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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WITNESSES

Patrick Cook, Director and Chair, and

Scott Osborne, Treasurer, Workplace Drug Testing Australasia; and

Dr Phil Tynan, National Toxicologist *(via teleconference)*, Safework Health.

The CHAIR: Welcome back to the Inquiry into Workplace Drug Testing in Victoria. Joining us for this session are Mr Patrick Cook and Mr Scott Osborne from Workplace Drug Testing Australasia. Welcome, gentlemen, and thank you for your time. And we have got someone on Zoom as well – Dr Phil Tynan, National Toxicologist. Welcome, Doctor.

Before continuing I just want to read this information to you, gentlemen. 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 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.

Could you please state your full name and the workplace you are representing today for the record.

Patrick COOK: Patrick Cook. I am Director and Chair of Workplace Drug Testing Australasia.

The CHAIR: Welcome, Mr Cook.

Scott OSBORNE: I am Scott Osborne. I am Director and Chair of Workplace Drug Testing Australasia. Sorry, did I say Chair? I meant Treasurer.

The CHAIR: Welcome, gentlemen. Thank you. We will get to Dr Phil Tynan as soon as his technical issue has been sorted out. Would you gentlemen like to make an opening statement, please.

Patrick COOK: Yes, please.

The CHAIR: Thank you.

Patrick COOK: On behalf of members of Workplace Drug Testing Australasia we thank you for your invitation to present to the committee. WDTA is committed to professional standards of testing in Australia and New Zealand as well as advancing the field through advocacy, education and conducting testing at the highest standards of integrity, accuracy and fairness. Our association represents more than 75 per cent of the industry, including testing organisations, product suppliers and consultants.

WDTA see workplace drug testing as one tool for ensuring the safety of a workplace. The basis of workplace safety is that an employer must provide a safe work environment for employees, and employees must attend their workplace capable of performing their work functions. Safety systems around drug and alcohol testing are well established in Australia and New Zealand. Many businesses have mature and well-developed programs designed to keep their businesses and workers safe and compliant within the well-established Australian and New Zealand standards for testing. These Australian and New Zealand standards cover technical aspects of testing, including ensuring a fair and consistent process, privacy of the person being tested and accurate and effective testing. In addition to these standards there is an auditing and accreditation regime conducted by the National Association of Testing Authorities, NATA. This ensures compliance with the standards. In Australia workplace drug testing as a safety system is well established and well managed when it is performed by a professional, accredited testing organisation – such as our members.

WDTA firmly believes that the robust process that is already in place covers all prescribed and non-prescribed medications that may impact safety. Medicinal cannabis should be treated as any other substance that, even if

taken legitimately, might impact on the safety of a workplace. The use of medicinal cannabis cannot be ignored, because of potential physiological effects that might impact safety. Therefore, if identified, employers must be obligated to investigate the potential effect on safety and take appropriate steps to ensure the safety of the workplace.

We have offered in our submission mechanisms for ensuring that donor workers who are tested with concentrations of various medications, including medicinal cannabis, are properly managed through referral to medical review and a genuine search for a design of an appropriate and safe work system of work. WDTA advocates that workplace drug testing should be conducted by professional organisations that are independent to the workplace, that are suitably qualified and accredited, such as members of our association. We thank you again for your invitation, and we would be delighted to assist with any further questions from the committee. Thank you, Chair.

The CHAIR: Thank you, Mr Cook. Mr Osborne, have you got any comments at all?

Scott OSBORNE: No.

The CHAIR: Dr Phil Tynan, can you hear us now? I think you have just joined us again. Okay, that is all right. We will continue.

Thank you, gentlemen, for the submission. The workplace drug testing – do you actually test and analyse the drugs at all? Or you do not – you just do policies?

Scott OSBORNE: No. We are an association of testing groups as well as suppliers and consultants.

The CHAIR: Okay. From your expertise – and I think there a few people on your panel doing the work – with medicinal cannabis, THC and CBD, can you actually analyse the percentage or proportion of THC in the drugs? Is that possible?

Patrick COOK: I would like to have Dr Phil Tynan answer that question, to be honest. We test for the presence of THC in the drug, not for CBD. CBD by itself is not actually found by our testing regimes, so it is the THC component of the medicinal cannabis that is tested and seen and analysed.

The CHAIR: You can analyse the percentage of tests, so in the substance?

Scott OSBORNE: The devices we use onsite are purely a screening device. They get a dichotomous result above a particular concentration, which is set to the Australian standard. The levels that we are testing for onsite are above 15 nanograms per millimetre, for example, for oral fluid. The whole point there is we are simply identifying the presence of a drug above a particular concentration. From there, if we have identified above that, then it gets referred to an analytical laboratory, which then provides more of a qualitative result, so numbers and also some commentary underneath.

The CHAIR: I just want to know: what is the timeframe to get results back after they have tested positive for THC, to get the actual percentage in the result?

Patrick COOK: Again, that is sort of a toxicology question. We have got experience, I guess, but we cannot answer as a toxicologist. It depends what type of sample you take. If you were taking an oral fluid sample, you have got a detection period for THC specifically, let us say, of between 4 hours to 14 hours, something like that. But if it is a urine sample that you have taken, then you have got a longer window of detection.

Scott OSBORNE: From my perspective – I also run a testing organisation – it is 14 or maybe 24 hours; 24 is pretty far out, so the far end of the extreme. I thought your question might have been more about how long before we get a result back from a laboratory. Generally speaking, Australia-wide we are talking around about three days. It can go as far as five days if you are talking a very remote area. In a metropolitan area, typically we are getting a result back within probably a day and a half to two days from the analytical laboratory.

Patrick COOK: Sorry, it was turnaround time – my apologies.

The CHAIR: Also, Patrick, you mentioned medicinal cannabis. You said there is an impairment – having effects that are similar to other drugs. Could you just expand on that in relation to the impairment from medicinal cannabis?

Patrick COOK: Again, that is big. If we talk about Workplace Drug Testing Australasia, which is what we are here for, that is sort of slightly outside of our wheelhouse, let us say. But to expand a little bit, we are not testing for impairment; we are detecting the presence of THC, so in medicinal cannabis, for instance.

The CHAIR: Which we treat the same as other drugs.

Patrick COOK: Correct. We have a process involved in the testing regime. So we, as a testing organisation, do a screen. If that screen produces what we call a non-negative result – in other words, it is not truly a negative – we then refer that sample on to a laboratory for detecting the analytical component of that, to give a firm positive to that sample.

The CHAIR: Thank you.

Scott OSBORNE: So that turnaround time period does mean that the worker is generally stood down during that period unless there were other arrangements in place for a safe work method while that was occurring, but that is purely as a make-safe provision until we can get a proper analytical result back.

Patrick COOK: That comes back to the individual workplace policy, of how the employer organisation has developed their policy.

The CHAIR: Okay. Thank you. Ryan, do you want to –

Ryan BATCHELOR: Yes, thanks. Mr Cook, Mr Osborne, thanks so much. How widespread is the use of workplace drug testing and where is it most common on an industry-by-industry basis?

Patrick COOK: I might let Scott answer that question.

Scott OSBORNE: I was hoping to leave it to Patrick. That is a big unknown at this point. As an association we are looking to actually do a survey of our members and then try and extrapolate what is happening in the industry. In my other role we test about 400 different organisations, and that ranges from places as innocuous as a retail music shop all the way through to rail and that kind of testing under the ONRSR, Office of the National Rail Safety Regulator – those sorts of guidelines. So it is a really broad shop. Often they will contact us because they have identified a white crystal substance in a bag behind the stack of timber down the back, so they will ask us to test on that basis going forward and then set up a random program to ensure that it is prevented in the workplace. At this point it is a fairly difficult question to answer.

Ryan BATCHELOR: That gets to our next question about how it gets started or initiated. Why do employers come to you? Is it because they are in an industry that has a set of standards or a degree of regulation that says that they need to do this, or is it because they have had an accident in the workplace where they suspect someone has been under the influence of alcohol or other drugs or they have found some substances they would like –

Patrick COOK: It is both.

Scott OSBORNE: In short, all of the above.

Ryan BATCHELOR: All the above.

Patrick COOK: It is definitely both. The way it gets implemented is in terms of developing a policy first. We as a professional organisation just do not come in on the say-so of 'Hey, I want you to test my workers.'

Ryan BATCHELOR: Do you require organisations to have a policy before you test?

Patrick COOK: We request, we do not require. We have to request: 'Do you have a workplace policy in place first around this?' – because that is an important part. We found over the years – and I have been in this industry for a few years now – that following the workplace policy should involve the employees as well as the

employers developing that policy and then an educational process through the workplace to implement that policy before testing even begins.

Ryan BATCHELOR: It sort of gets to one of the other questions I was going to ask, which is: when you provide reports back or guidance back to employers about what you have found, do you draw the distinction between your ability to detect the presence of a substance versus not being able to give guidance as to whether that presence has led to any sort of impairment? Do you provide that to employers, or do you put the obligation on them to know that and have that knowledge themselves?

Patrick COOK: No. We test for the presence, so in all of our systems we are testing for the presence of a drug.

Ryan BATCHELOR: I understand what your testing does. When you communicate back, what do you say that you can and cannot do?

Patrick COOK: Do you want to try and answer that?

Scott OSBORNE: The laboratory reports as they come back are pretty prescriptive in what they have to say. They comply with the standards, so there are certain things they are required to say. Generally speaking, from there, in my role as group GM for a testing organisation, I get asked, 'So what's that mean?' and it is always going to be along the lines of, 'This is an indicator that there are drugs present. Now this is a HR matter for a conversation with the worker about, "When did they take the drug?"' There is a whole range of questions along a very broad set of subjects there. When I do policy review, which I do a substantial amount of for a lot of organisations, that is the number one thing I am nailing – this is not just a closed process now. We have got this result; now we need to understand what is going on. Is the worker safe? What are they being treated for, if it is appropriate to ask that question? They might volunteer. Then it is a case of – let us move away from medicinal cannabis – 'Okay, you're taking a strong opiate or opioid for really bad back pain. We don't want you to go back into work into a place where you are likely to further injure that. Let's figure out a way to manufacture some duties here that are not going to further exacerbate that back pain until such time as this is all resolved.' So there is a much bigger conversation. There is a testing question and then there is a 'What do we do with that result?' question.

Patrick COOK: Management – and that is part of the medical review officer role as well.

The CHAIR: Thank you. David.

David ETTERSHANK: Thanks, Chair. Can I just be clear – WTA is the advocacy body or the peak body for the people who sell goods or services in the drug-testing industry. Is that correct?

Scott OSBORNE: Yes, and we are fundamentally focused on improving the professionalism and the standards.

David ETTERSHANK: Sure. So when you say in your submission that you recommend strongly that it should be mandatory that there is drug testing in all workplaces, there is kind of a pretty strong self-interest there, isn't there?

Scott OSBORNE: Totally. I would say that that is a fair characterisation. However, we are in this industry because we believe that this is an important safety system.

David ETTERSHANK: Okay. Can I go to your submission where you say, and I am just picking up on some questions from Mr Batchelor before:

> Workplace AOD testing is not and has never been about detecting "impairment" rather, it serves as a risk mitigation tool providing an objective measure to reinforce an employer's AOD testing policy …

If we are all agreed that you cannot test for impairment and impairment is the source of risk, how on earth can the presence of THC be an objective measure?

Scott OSBORNE: It is an objective measure of the presence of a drug.

David ETTERSHANK: That is all it is. It actually has nothing to do with impairment.

Scott OSBORNE: You cannot draw a direct line, but it is an indicator that there is further investigation required.

David ETTERSHANK: Right. I notice you have a very – how do I call it – conservative view of latency, because we have obviously got a lot of people, including from Swinburne and from Sydney University, who all say that in fact, and the police themselves say, flow-testing results – sorry, swabs – can detect THC more than a week after it has been consumed.

Scott OSBORNE: Oral fluid.

David ETTERSHANK: Yes, on oral fluid. Do you dispute that?

Scott OSBORNE: I am not qualified to answer that. I do not agree, but I am not qualified in that specific field.

David ETTERSHANK: Well, we have multiple submissions that say exactly that and also that there is a 20 per cent false positive and 20 per cent false negative associated with a standard flow test.

Scott OSBORNE: Hence the need for an analysis in a laboratory.

David ETTERSHANK: Right. Okay. Do your members actually sell anything that measures impairment rather than just the presence of drugs?

Scott OSBORNE: No, we do not.

David ETTERSHANK: Right. So, it is just a black hole really?

Scott OSBORNE: There is no scientifically reliable way, as far as I am aware within the scope of my skills and abilities, to test for impairment in a blanket sense.

David ETTERSHANK: Okay. So, things like Druid or Canntest are not on your radar.

Patrick COOK: The Druid in Europe – the driver system? Yes of course it is on our –

David ETTERSHANK: Well, it is not a driver tester; I mean, it is actually used in industry. Primarily it is used in industry.

Patrick COOK: When you say Druid, do you mean the Druid program that was done in the USA?

David ETTERSHANK: Correct. I am not talking about the wood-loving priests, no. You do not have any view on that? I guess I am looking at the logic in your submission and it basically seems to me you are saying that someone not guilty of impairment if they have got no THC traces in their blood. Otherwise you have to assume that they need to be the subject of further investigation and such like, which seems to me fundamentally discriminatory.

Scott OSBORNE: When we develop policy with clients we say to them, 'This is one tool.' If you are still concerned about impairment for that person – so even if the test is negative, they have come on your radar for a particular reason. If we are talking upon suspicion or post-incident testing and that sort of thing, they have come on your radar for some reason. You now need to either assess their ability, or is there something else going on here? Do we need to be looking at their safety in the workplace in a general sense because they have come on your radar? Why did they come on your radar?

David ETTERSHANK: Because they may have had traces of THC in their system.

Scott OSBORNE: Okay, so that might be as part of a random program. But generally speaking if you are talking upon suspicion or after an incident, they have come on your radar because of the incident, or they have come on your radar because of a suspicion that there is something going on there – because someone has come to you and actually said, 'Hey, look, this person is acting erratically, out of character behaviours.' I train in this particular area –

David ETTERSHANK: Are you saying there should be mandatory drug testing?

Scott OSBORNE: Sorry?

David ETTERSHANK: You are saying in your advocacy, in your paper, that there should be mandatory testing in all workplaces?

Scott OSBORNE: Yes, absolutely. Random testing, that is right. But what I am saying is if they –

David ETTERSHANK: Okay, come on. Well, I mean – sorry, Chair, I have used my time. I think I made my point.

The CHAIR: Thank you, David. That is all right. We have had a bit of a technical issue with Dr Phil Tynan. Dr Tynan, would you like to make an opening statement?

Phil TYNAN: As I said, I would like to express my appreciation for the opportunity to address this august body on the topic of medicinal cannabis. I am Dr Phil Tynan, the national chief toxicologist for Safework Health, Australia's largest private workplace laboratory drug and analytical service and collection agency. I am a retired chemical pathologist with over 30 years experience in the field.

I was just going to note that the clinical role of medicinal cannabis is not fully clarified. Evidence supports its use in treating chronic non-cancer and neuropathic pain, MS-related spasticity and chemotherapy-induced nausea and vomiting. Some possible but short-term utility does exist with dealing with sleep deprivation due to chronic pain, obstructive sleep apnoea and fibromyalgia. As with any medicine, there are obviously trade-offs – benefits versus side effects. The important thing is to realise that cannabis-associated impairment is real. In fact on-road driving studies show that cannabis impairment from low-dose cannabis is roughly equivalent to a BAC of about .02 – it can be higher with higher doses – or the equivalent of, if you like, one night's sleep deprivation or the hangover that we get from a 10-plus milligram overnight dose of Valium.

Carnide et al in 2023found that cannabis use during or just prior to work was associated with an almost twofold increased risk of experiencing workplace injury. Arnold in 2020 showed us that THC in medicinal-cannabis-equivalent doses causes significant impairments up to about 4 to 6 hours post dose. Eadie et al in 2021 showed that the neurocognitive impairment from medicinal cannabis mostly clears after about 4 hours or so, dependent on the duration and intensity, which is dependent on the dose. Unfortunately, they only address chronic non-cancer pain and spasticity, so we do not know whether this really applies for anxiety, depression or insomnia.

We should also note that unfortunately at the moment there are no guidelines for medicinal cannabis dosing – in other words, how much people should be taking. But from the data it appears a worker taking medicinal cannabis of category 2 or higher – in other words, greater than 2 per cent THC-to-CBD ratio – probably should refrain from use at work and ideally abstain for up to 8 hours prior to work, but for category 1 preparations, which are essentially nearly pure CBD oils, then there is no requirement for any restriction at all because, unlike THC, CBD cannabidiol has no substantial impairment.

An important thing is that drug testing is a critical factor in managing workplace drug use. I mean, Oslon and Koski in 2003 showed that there is a statistically significant link between the frequency of drug testing and dropping drug use rates and workplace injury costs. Miller, Zaloshnja and Spicer in 2007 showed that for every dollar we invest in workplace alcohol and drug prevention we save $26 in workplace accident expenses.

The current drug-testing regime and the legislative framework we have got are adequate to deal with this issue. Workplace drug testing is regulated, as we all know, by the current Australian drug-testing standards, which are AS 4308:2023 for urine and the sister standard AS 4760:2019 for oral fluid. Of course these standards ensure that the testing process is robust and the results are accurate and scientifically verifiable. The entire drug-testing process is overseen through a really stringent auditing process by our statutory accreditation authority, which of course is NATA, the National Association of Testing Authorities. Moreover, the fairness and robustness of workplace drug testing is ensured by the fact that we are subject to the rulings of the Fair Work Commission.

My point is that workplace drug testing should not and cannot be used to enforce legitimacy. The overriding concern we should have is the focus on potential impairment. Therefore test results should not be treated as unequivocal proof of impairment – they are not – but actually as red flags, this is for this drug, for potential impairment. Therefore in this context urine testing, although it is valuable for many other drugs, is unhelpful here because its detection window is three to five days for one-off use, which is clearly useless, whereas the

oral fluid detection window is a lot better. It is up to about 12 hours and very rarely extended to 16-plus hours. This better reflects impairment from cannabis usage, and therefore in many situations you can use random oral fluid testing to determine if the person is affected. In other words, if it is not detected, the worker is likely unaffected.

My closing point is that medicinal cannabis is not a unique product and should be treated legislatively and in the actual workplace with the same professional rigour as we routinely handle other potentially impairing medications, like also the opioid analgesics or benzodiazepine sedatives, which clearly have a similar workplace impact. Thank you.

The CHAIR: Thank you, Doctor. I am happy for you to stay on the phone, if you would like, if we cannot get you –

Phil TYNAN: Happy to.

The CHAIR: Dr Mansfield, would you like to continue?

Sarah MANSFIELD: Thank you, and thank you for appearing today. I might just continue on from where Mr Ettershank left off. I know that you both have separate submissions, but in your submission you indicated and you made quite a definitive statement that workplace testing does reduce injury risk. The evidence – and I think some of it was referred to just now – that you have relied on to make that statement was two studies. When you actually read the studies, they are particularly old studies. They were looking at interventions that were in the mid to late 90s in the US and both of them were in individual workplaces. And the methodology – there are some questions about the relationship between the intervention and the outcome. I was just wondering if you have any other more up-to-date evidence that demonstrates the role of workplace drug testing in preventing injury. No doubt there is a link between impairment and some of the effects of some substances in creating impairment and the safety risk. But the role of testing in preventing injury, do you have any strong evidence to support that?

Scott OSBORNE: The easy response is no. There are no current studies that I am aware of. I keep looking for some. Phil might have –. But as far as I am aware there are no current studies that have been done on this. It would be very good to see some studies in that area.

Sarah MANSFIELD: Okay.

Phil TYNAN: There was some work done in the Portuguese rail service in the last decade where they demonstrated that by imposing a stringent drug-testing policy among other factors they actually decreased the workplace accident rate. But the applicability to the general workplace is, I suppose, to some extent open to question.

Scott OSBORNE: Certainly there was a flurry of studies sort of in that 90s, early 2000s period that I think possibly here in Australia, particularly here in Victoria, related to the introduction of roadside drug testing. I think that was sort of the last big flurry of such studies, so yes.

Sarah MANSFIELD: Okay. So I guess I am just curious as to the conclusions you have drawn. You have made quite a strong statement that it does prevent workplace injuries. So I am just wondering how you can come to that conclusion given we do not have a strong evidence base to support that.

Phil TYNAN: I think we do have some evidence when dealing with drugs like methamphetamines and amphetamines; it is quite clear there are problems. If you look at the Quest data, there does appear to be a correlation with both frequency of testing and the drive to reduce workplace accidents, and this is the Quest drug-testing data from America, which is somewhat more recent. Apropos cannabis, again that is a more recent issue, and it is rather harder to determine, because again if you are relying on stuff like urine you really cannot tell whether the person has taken it recently or not, so urine should be excluded. When it is dealing with oral fluid, that certainly would give you some indication of recent effects. I think we can be pretty certain that with amphetamine-type stimulants there does appear to be a positive effect, ditto with cocaine. Just speaking as a clinician, we do actually tend to find, when we are dealing with individual cases as opposed to generic cases, that drug testing and the actual quantitative drug levels are very useful in assessing potential impairment at work. I mean, Sapolsky's work with opiates, for example – he demonstrated that with codeine, if you alter the

dosing by 50 per cent, you do in fact run a substantial impairment risk, at least for a couple of days until you get an adaptation effect. So I think we can quote data for the opiates and for amphetamines but not for cannabis and certainly not recently for Australia.

The CHAIR: Thank you. Richard.

Richard WELCH: Thank you, Chair. Thank you, gentlemen. I just want to acknowledge that every industry needs an association. You do actually play an important role in the industry in keeping our workplaces safe, so please do not take offence to my questions as a result. As part of your advocacy, your correct advocacy, is part of those activities alerting parts of the industry that are not currently doing widespread testing to the dangers that they may incur and then extending testing into a wider range of industries?

Patrick COOK: Correct, yes. So that is one of the fundamentals of our advocacy: to try and get more and more businesses looking at doing workplace drug and alcohol testing but more importantly the broader aspect of safety in the workplace.

Richard WELCH: And that would include perhaps more white-collar-type industries as well.

Patrick COOK: Correct? Yes.

Richard WELCH: Looking at a heavy machinery industry, the cause and effect are very clear and tragic; in a white-collar industry, the worst is they push the wrong button on a spreadsheet. How do you reconcile the importance in that environment?

Patrick COOK: Do you want to do it?

Scott OSBORNE: Yes, I am happy to. So in general the sort of people who are in a white collar sort of perspective are often making decisions. I am not talking an accounting office, for example, but people who are administering in a high-risk industry, around high-voltage electricity or something like that, for example – the people who are in the white collar roles are still making decisions that can impact the safety of the worker. So you do not want them making those decisions if they are not in full possession of their –

Phil TYNAN: For me there is also the issue of codeine dependency, and this is what has provoked the TGA to change the regulations about over-the-counter codeine use. Codeine dependency is highest among white-collar, socially well-adjusted individuals, and the evidence is that you do get impairment of performance – not universally. So if it is a long-term usage, people often will adapt, especially if it is to mitigate the effects of chronic pain, but there certainly is evidence that you can have subpar performance even among white-collar workers who are misusing opiates for whatever reason, so I think that is a point.

The other point is that we must consider that in Australia we have quite a high, for example, death rate among miners, which is a bit atypical given our OECD ranking. One of the significant factors, apart from fatigue, is drug use, so I think we really should not underplay the importance of trying to control drug use, not preventing people from having fun on the weekend but actually ensuring that the workplace is maintained as a safe environment. The large fact of that is going to be workplace drug testing. Even if you are a white-collar worker, you can make major disasters by being affected, and quite unintentionally there can be problems with that. Opiates are a major issue, and I would suggest cannabis could be a factor as well.

Richard WELCH: I guess, as the follow-up to that – and again, particularly in heavy industries it is really not contestable to me – for white-collar industries, does the association have a view of where the employer and safety is one area of interest? Where does the association view civil liberties in terms of the right of the individual? If there is not a direct correlation between their impairment and their role and the potential for a creeping intrusion, as has been pointed out, you could be accused of having a vested interest in creeping that. Civil liberties are what I am interested in.

Patrick COOK: I guess one of the major parts of our association is that we have got to respect the individual's privacy and civil liberties and not be discriminatory against anybody in terms of what we are trying to advocate for.

Richard WELCH: Does that also include the right not to be tested?

Patrick COOK: Absolutely it includes that, but that should be then covered by a workplace policy. As in, what happens if I refuse to be tested? You cannot force somebody to be tested; that is not what we are advocating. But in the policy there should be some sort of section – 'Well, what do we do if an employee refuses a test?' And that should be prescriptive in their workplace policy.

Richard WELCH: As opposed to an implicit common-law entitlement not to be tested?

Scott OSBORNE: Yes. I do a heap of policy work, and in that regard it is always around that initial consultation, workforce-wide. I appreciate there is a power dynamic, but there still needs to be that consultation. And then there needs to be widespread publishing of the policy and procedures et cetera associated with that, followed by a strong education process prior to any sort of testing starting.

Here in Victoria I recently did one where they also put out an FAQ with the ability to ask questions anonymously and self-declare. There is a whole well-developed program. It needs to have all of those elements in place – testing is one element, and then what happens after that? Whenever I am doing policy review, I am always saying, 'You've got to refer out at the end into a more HR-type thing.' Separate the testing from what we do after that – they are two separate issues. We have got professionals who are well qualified and medical review officers involved where necessary, who are highly trained and part of the AMROA framework, so that that whole process is then properly managed in a non-discriminatory way.

I think where I see it really going wrong – and we do see this on occasion – is organisations that will get a screening result and then just terminate the person. In one case they refused to pay my bill because they went to Fair Work and lost of course, which was totally contrary to all of my advice and all of the support. So we are really focused on ensuring that. Testing is one element, but at the other end let us get the outcome to be the right outcome for that worker.

The CHAIR: Thank you. Just minding the time, Rachel, do you have some questions?

Rachel PAYNE: Thank you, Chair. I actually have quite a few questions, so if you are happy, I may put them to you on notice, if that is okay?

Patrick COOK: Sure.

Rachel PAYNE: I am just being mindful of the time. Thank you.

Scott OSBORNE: For sure.

Rachel PAYNE: Just going off what my colleague was talking about in relation to balancing workers rights with the issue of discrimination: you believe your model for medication use, including the medicinal use of cannabis, strikes that balance, and in your submission you talk quite a lot about testing procedures, but there was not a lot of reference to preventing discrimination. Can we talk a little bit about that discrepancy, just going off the back of what you were just talking of?

Scott OSBORNE: So we are testing organisations, by and large, and our predominant role is in essence to perform scientific testing and provide a result. It just so happens that within my organisation I do a lot of policy review and as part of that I get asked all sorts of questions, and actually I did do a separate submission. I get asked a lot of questions about these things, not in Workplace Drug Testing Australasia but in terms of my other organisation. From a Workplace Drug Testing Australasia perspective my submission is very much about the testing processes, but while wearing my other hat I am very focused on saying, 'Hey, keep them separate. These are two different issues.' One is finding out what is going on as much as you can within the limitations of technology and all the rest of it, and then having an adult conversation with your staff afterwards to figure out, okay, we have got this situation, what do we do from here? So my submission as part of the WDTA was limited to really largely testing.

Rachel PAYNE: And you would say that would be captured in, say, that policy framework and then it would become a matter then of referral for medical review, potentially with the HR officer within that employer's purview.

Patrick COOK: Correct.

Scott OSBORNE: Mostly within the policy review that I do it is very much around, 'Okay, here is a testing policy and procedure,' and I am not going to lie, a lot of clients then want to go straight to termination. They find something – terminate the person. Get rid of them, out of the organisation – it is easy. I am constantly working with them to educate them to say no, you have got a testing policy and procedure, hand it over to the professionals in the human resources element, who are then able to conduct an appropriate investigation. They are the professionals dealing with non-discrimination and all of those sorts of things. So that is very much the sort of the model I advocate for. As with anyone, when you are working with people who might be a small mum-and-dad type business, there is an education process. Even the data does not support termination for a first offence – offence in inverted commas – it actually indicates that that will actually raise the likelihood of somebody taking drugs. I do not know what the psychosocial things are behind that, but that is what the data shows. It is an American study, and it is probably 30 years old, but nevertheless that is the data. So from my perspective, dealing with testing is one issue, highly regulated under the National Association of Testing Authorities, but then you have also got legislation and case law and all the rest of it that kind of deals with the other end of it, which is discrimination and privacy and ensuring that you are not asking questions that you are not entitled to ask. So there are a whole range of things there. I am sorry I chewed up your time – apologies.

Rachel PAYNE: No, that is okay. I did have some questions for Dr Tynan, but if he is okay for me to put them on notice to him, that would be ideal.

The CHAIR: Yes. Lee and Dr Heath, would you mind putting your questions on notice, is that okay due to monitoring the time?

Lee TARLAMIS: That is fine.

The CHAIR: Dr Tynan and Patrick and Scott, thank you so much for coming in today. We will definitely put some questions on notice for you.

Patrick COOK: Okay, thank you.

The CHAIR: Regarding Dr Tynan, I would be happy for you to review the transcript of today, which will be provided to you, and if there is anything else you want to add, please do add on, and we will give you some questions on notice. Is that okay?

Phil TYNAN: Absolutely. Thank you.

The CHAIR: Thank you, Dr Tynan, and thank you, gentlemen, for coming in.

Witnesses withdrew.

In camera evidence follows.