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CSIRO STAFF ASSOCIATION

List of Issues with draft AOD Policy

- Generally, it is unclear what risk is being mitigated/managed here. While the removal of AOD use is elimination, any exception (corporate events) immediately says they will tolerate risk and then there are a host of equity issues that follow.

- There are important definitions missing including but not limited to: impairment, visitor, workplace, positive test result, staff etc. These may be elsewhere in which case a clear reference would be useful.

- Random, blanket, oral testing will not provide robust, valid information to improve risk assessment or mitigation across the workforce.

Starting with the text that appears on the intranet:

- There is no differentiation between AOD use and AOD impairment. They are not interchangeable.

- Applying the procedure to 'all CSIRO people, contractors and visitors' is unreasonable and seems pointless given the relevant risk is unclear.

- Some CSIRO staff as part of their research and jobs have contact and handle alcohol and other drugs. No clear distinction is provided on how the policy will or will not apply for these staff.

- Also - visitors? Are we posting this advice clearly and prominently and giving them the opportunity not to attend the site and under what authority are we collecting and storing their samples and data?

- There is no acknowledgement that disclosure of medications is a proxy disclosure of medical conditions and there is no obligation to disclose a medical condition (in this context)

- How will they record the use of medications without reference to the condition and how will these data be kept confidential?

- How does this procedure interact with travel and travel allowance procedures?

- Relying on unskilled judgement and suspicion is poor practice - to identify impairment and risk caused by impairment.

- For home-based work it appears that suspicion immediately becomes a misconduct issue - so this procedure is designed to obligate site attendance through fear?

- A non-negative result does not equate to impairment. When applying the standard it should be clear that this is not about impairment but an arbitrary quantity. This then complicates

judgement and suspicion because some people will appear impaired with little (or no) substance consumption while others will not be impaired regardless of quantity consumed.

- When a staff member discloses a potential AOD substance use issue to a manager/colleague testing is not an appropriate response. Asking if they are able to continue with their duties and an appropriate risk assessment is.

- The concept of having 'regular, informal, open and non-judgemental conversations about alcohol and drug use in your team' is weird and inappropriate. Having a competent grasp of risk assessment and psychosocial climate and discussing the issue of misuse accordingly would be more appropriate.

- Poppy seeds are a strange example to use when mouthwash and chocolate are more common, repeat causes for non-negative results.

- The language in general needs to be cleaned up. It varies between Drug use, dependency and substance use and impairment is actually the issue.

On to the procedure

- Clarity is needed on prohibiting use and impairment.

- Prescription medication doesn't need any more info than a valid prescription. Misuse or what it is for is not the business of this procedure.

- The requirement doesn't mention speaking to the person being suspected of being impaired - asking the question directly and kindly would be good practice. The current approach encouraged suspicion and dobbing. Also, no mention of making a donesafe report?

- Never refer to people 'suffering from substance dependence'. People experience substance misuse or dependency.

- The Privacy and confidentiality section contains nothing about how stored information will/can/cannot be used.

- The testing section doesn't mention visitors (visitors in general are treated inconsistently)

- There should be an indication of how much notice is given/required for people to attend testing and secure a support person.

- Any reference to aspects of testing 'deemed necessary' needs careful consideration - who is making the decision, based on what, ate they qualified, does the testing mitigate the risk identified etc.
- Post incident and near miss incidents section has no mention of donesafe so what is the link between the incident and testing in a reporting sense? How is the test triggered?

- A decision needs to be made on use of 'impairment' or 'under the influence' because they aren't interchangeable.

- Does this procedure apply to on-site hospitality venues with members of the public? Like visitors to cafe's?

- I would be interested what legal basis the organisation can undertake misconduct for substance use in 'non-prescribed purposes and misuses of prescribed dosages' especially for PRN medications including those used for anxiety.

- The appeals process should read 'permitted to resume work activities when they are able to produce confirmed negative result

- The roles and responsibilities should align with broader governance and compliance hierarchies.

- It's surprising to see a procedure with this sort of reach. It seems more sensible to risk associated with roles and tasks and to exclude visitors. Incidents and near misses should be clarified because discovering a bucket of old batteries is unlikely to trigger a test but then neither is a report of sexual harassment, so it is unclear what the risk being mitigated is.

- How does such a policy interact with jurisdictions, like ACT where the possession of small amounts of illicit drugs is decriminalised and we can use cannabis in our homes.

- Good AOD policy focuses on keeping people safe and includes clear communication of health and support, not differentiation between alcohol and 'drugs' and definitely does not require people to disclose their medical conditions to be kept on a record.