T R A N S C R I P T

LEGISLATIVE COUNCIL LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into the use of cannabis in Victoria

Beechworth – 28 April 2021

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WITNESSES

Leigh Rhode, Chief Executive Officer, and

Maryanne Donnellan, Program Manager AOD, Gateway Health

The CHAIR: Thank you both very much for coming today. I'll declare open the Standing Committee on Legal and Social Issues, public hearing for the inquiry into the use of cannabis in Victoria. I know it goes without saying, but mobile phones, check, that is right. If I could start by respectfully acknowledging the Aboriginal peoples, the traditional custodians of this land where we are meeting on today and pay my respects to their ancestors, elders and families, and obviously we welcome any elders or community members who are here to impart their knowledge today.

I think we are all very well aware that whenever we talk about justice issues or issues around drug issues, but certainly justice issues, our Aboriginal brothers and sisters are always more greatly impacted by this and the evidence we received to date has shown that.

So welcome Maryanne and Leigh, thank you so much for making the time. All evidence taken at this hearing is protected by parliamentary privilege. And that is provided under our Constitution Act but also under the provision of the legislative counsel standing orders. Therefore, any information you provide to us today is protected by law.

However, if you were to repeat those comments outside, you may not have the same protection. Any deliberately false evidence or misleading of the committee may be considered a contempt to parliament. As you can see this is all being recorded, and you will receive a transcript of today's hearing and I'll encourage you to have a look at it. Ultimately that transcript will form part of our report and it will also go up onto our website. please do have a look and just make sure we haven't misheard or misrepresented you in any way.

We'd love it if you could make some opening remarks, I see that you may have some slides for us as well which is great. And then we will open it up for a committee discussion and questions. Thank you.

MS RHODE: Thanks Fiona and thank you panel members for the opportunity of speaking to you today. Glad you chose Beechworth as the venue for the hearing, it is very convenient for us so thank you for welcoming us here today. Just, I thought to start with, just to give you a bit of a background to date (indistinct).

The CHAIR: Yes, great.

MS RHODE: We are a large regional community health service covering, I think it is about eight - nine (indistinct) local government areas, particularly if you include Albury. We do operate in a cross-border environment. Albury Wodonga Health Service is one of our key partners that we work with, but our reach extends right across this beautiful region of the north-east, as far as Mansfield, Benalla, Indigo, Towong, which recently has experienced the bushfires and still recuperating from that traumatic experience, Wangaratta and Wodonga cities as well – quite a vast region. Not flat country like where I originate from in Shepparton – it is hills and valleys and it is great to so many challenges in region accessed to a fairly dispersed population. But we have centres based in Wangaratta and Wodonga and a smaller post in Myrtleford. Gateway Health offers a really wide range of community-based services, from healthy and healthy bubs programs to support healthy start to life in our younger citizens, right through to our aged care assessment services and supporting people to live independently at home, and pretty much everything else in between.

It is bed-based healthcare. That is what we do, over vast territory, very significant counselling and mental health type programs and a very large drug and alcohol program. Maryanne heads up our drug and alcohol services, and pretty much the broad spectrum of drug and alcohol treatment services. There is currently a residential rehabilitation facility being built in Wangaratta, that we are very excited about.

But we will be delivering to this community some much needed service in this region. Maryanne and her team have a fairly vast experience of drug and alcohol services and some of the issues in the region – and she will speak in more detail about some of those things – but probably just to talk briefly about the main things and of the topics that the Inquiry's looking into. Probably the main things that we would comment on would be around the health education campaigns and programs, and the access to mental health and social impacts and those broader impacts.

We are not really just talking about drug and alcohol, because I would say to you of all the clients that we see across all our programs, many of them will be experiencing or impacted by drug and alcohol issues as well. Not just those clients that are using our drug and alcohol treatment and support services. So it is a universal issue, all our staff (indistinct). We operate from a harm minimisation perspective. Abstinence is not what we promote. Just so we are clear about that from the sort of a starting point. Probably, the best thing to do now would be just sort of hand over and walk through the PowerPoint and for Maryanne to talk you through some of those topics.

Visual presentation

MS DONNELLAN: Yes. I am the manager of the AOD programs at Gateway Health and as Leigh said we cover the Ovens Murray area which isn't a huge area of Victoria, it is about 10 per cent of the state. We do that in total with around 20 EFT, just to give you an idea of what EFT staff support we have for that. We do operate under a harmony philosophy with a recovery orientated approach for our programs and that is with the Victorian State framework, that we utilise.

We always look to understand the person and what's happening for that person, because it is not just what might be alluded to; it is not just substance use that we see. We often see forms of self-medication to manage severe trauma, distress, mental illness and emotional and physical pain. The mental illness will come up throughout what we are talking about today. The majority of the people we work with have co-occurring AOD and mental health issues.

We often talk in the sectors about what comes first, the AOD, the substance use, or the mental health issues. We support the (indistinct) people who use cannabis and other drugs including alcohol from the criminal justice system, and we do not support the sale or the use of synthetic cannabis. We have seen some significant issues in the behaviours that are demonstrated with synthetic cannabis and the impacts on people's mental health, as opposed to the traditionally grown cannabis, yes.

Just to add to that, I guess we have a really broad range of services from assessment, (indistinct), recovery, youth, withdrawal, opioid replacement programs, family drug support, the NSP, the high risk of overdose. There are about 13 streams within our AOD area. Some of the impacts of cannabis use that we see, particularly around people who are incarcerated for substance related criminal activity, are often put on a pathway to continue to promote association activity and escalating drug use.

A criminal record – we see that impacting on people, in other areas, such as their education, their (indistinct) opportunities, but also it obviously can result in social isolation, more stigma discrimination and increased mental health issues for them. We do quite a bit of forensic work, so people coming through the justice system, both with young people and with our adult cohort as well. The next slide is what we hear from our clients. We often hear about self-medication due to a history of trauma, abuse, or mental illness, particularly mental illness.

We often hear about, and also observe, judgment and stigma from the health and other professionals in our community, leading to more fear and shame, and that can be a real barrier to accessing treatment as well. There is an incredible ease of cannabis for people. They can get that substance, or other drugs, quicker than they can get into treatment, whether it is over the net or from their local dealer.

We hear about manipulation by criminal elements – particularly from our young people – about how they move from being a consumer to actually dealing or supplying and how they are manipulated into that. In our adult cohort of people, we hear about how they were introduced to drugs and how they were brought into that lifestyle. And we – in our real reasons, there is a real lack of early intervention options and specialised services for people, particularly when you are talking about dual diagnosis and co-referring AOD. Supporting the staff to be educated and upskills is really crucial, and particularly with young people – managing that co-occurring mental health AOD, it is something that we really advocate for. Just in terms of talking about our criminal and our young people, we do know that the latest research around brain development for young people is it does not stop growing until about 25. The last parts that are developing are their reasoning and their ability to assess risk and right from wrong.

If you are looking at young people coming into our justice system, their exposure to other criminal elements, and then the continued association with that, is huge, and our justice system making cannabis criminalised is about stopping the supply and deterring people from use. We are not seeing that happening. The majority of people that are arrested for having cannabis are the consumers, the people that are using it. It 'is not the

suppliers. I do not think it is achieving what we hope or what we would like to see. The next slide is what I was talking about. We do see young people using cannabis to treat symptoms of emerging mental health. We have the Headspace service, which is not only mental health but education, it is like a social AOD.

We see our young people doing this all the time, and the ability to access appropriate mental health treatment is often – they are masking the symptoms, but they cannot access the appropriate services.

MS RHODE: This is probably one of my greatest concerns, having previously worked in youth sector. That masking of underlying symptoms, whether that is from a mental illness or trauma exposure, needs a deferred treatment support. They are not just accessing the support they need when they need it for the right things. The only way they are getting help is when the drug problem becomes worse, and often a bit later than it should be.

The CHAIR: Yes.

MS DONNELLAN: And then you see in your residential rehabs, people that have detoxed or withdrawn, then the mental health issues come out, and the residential staff and the residents are managing the mental health issues that are coming out. In our adult service, what we see is that alcohol is the main substance that people seek treatment for. Forty per cent of the people that come to us are seeking treatment for alcohol.

Cannabis is the third, so followed by methamphetamine, then cannabis. That is reflective around the state figures as well. Then it is the legal drug, that people come. We see that daily cannabis is linked to underlying mental health concerns. So not the occasional user, but the consistent, using very regularly. We see it for self-medicating and masking symptoms of anxiety, depression, ADHD and PTSD and paradoxically increasing the very symptoms that they are trying to mask as well.

And it leads to all those other things of anxiety, low motivation, disorganised, difficulty falling asleep, staying asleep, low sense of self-worth, relationship issues and inability to connect. We see, which we've touched on already, the lack of alternative treatment for the non-acute, yet debilitating mental illness. We do have acute services that are quite stretched – are very stretched, particularly in regional areas.

But for that level, where they class them as non-acute, yet they have the mental illness, and it is quite impacting on them, we do not have the services to treat that. And they fall into AOD services to do that. And we are not equipped to do it.

This is a little bit about what we had hope to see in terms of outcomes and I do not think this is new. I had a look at the drug inquiry back in 2018 and some of the things that we have highlighted were highlighted back then – about increased treatment, about diversion, about quality.

Family drug support is a big one that is particularly under resourced. When you look at the importance of families, when someone is a substance user, it is incredibly important to their recovery. They are often the person that is holding them together, the first person that supports them. In our area, for example, we have a two-day-a-week family drug support worker for the whole of the Oven Murray area. That is it. That is all we have got. That is particularly important to us: the diversion programs, the treatment services, early intervention options, available. We get - and I know VADA did a submission to the inquiry and they highlighted - all of our services are funded for post stress: once people are well-established in their use. It is not the early intervention that we are funded for, I think in our youth program we might have half a day where they say we can use that for capacity building. It never happens, because we just do not have enough workers to meet the need as it is, let alone to work in the capacity or education aspects of it. That is something we'd like to see raised – I spoke about it already – the trauma informed and dual diagnosis education and resources of professionals across the services, including health, education, justice, community services, that interact with the young people. We are talking about co-designed programs here.

We are talking about involving the young people that have that lived experience as well. I do not think we, as service providers, can create something that is going to be worthwhile without involving other people. We talked about dual diagnosis with AOD mental health workers, and that is more holistic in working with people – education for children, young people, parents, teachers and families, and that is that co-design as well involving people in that.

Families know their circumstances better than anyone else. People who use substances know their life and their challenges and why they're doing it better than anyone else. It is really important to include those people.

The CHAIR: I know that is one of the key things that you have got on the list of your things you are enquiring about. Can I just say, I think that is great, but I'd like to see it strengthened; that that same sort of education needs to be provided for all health sector employees, frankly, because that is a point of opportunistic early intervention – if you're asking the right questions and are aware of what the right pathways might be for that person, to prevent escalation of an issue.

I am really encouraging the consideration of that broader campaign for general health sector and any staff at any level, in any kind of setting, perhaps housing or youth sector, that is working with young people in particular, so that they're aware, that they know what the facts are, that they know what addiction looks like.

There are degrees. Some substances are more addictive than others and there are patterns of use. We can use alcohol, for example, quite responsibly and it is okay, but when does it become problematic use? I think there's a lot we could do better in that space.

MS DONNELLAN: Yes, agreed, yes. We would encourage the education and positive role modelling for parents and families – what are they learning at home. Alcohol is a really good example. What do we teach our kids about alcohol and how to consume it? So that role modelling is really important. We talk about that play space, positive and community led prevention partnerships, and campaigns to reduce stigma and encourage help seeking behaviour. I think stigma and discrimination is a big one that people that use experience and that reduces their ability to come and seek help.

MS RHODE: Can I comment on that in particular in rural regions, where sometimes there's been media campaigns that talk about, Wangaratta went through a hard spell a while ago when it was seen as the ice capital of Victoria. And the press about that really was not helpful to a whole community to be stigmatised in that way. And it really does deter help seeking behaviour.

I do think that is something that is worth paying a great more attention to, what the media role is and how you might sort of make facts known about things like regional Victoria – what was that thing you said before Fiona, -- the sort of the waste water analysis, tells us there's higher, more prevalent use in regional Victoria than there is metropolitan.

So how do you kind of make those facts known? It is one thing to raise the need and initiate hey regional Victoria – hey all of Victoria! We need to understand this – it is a problem – without stigmatising communities. I have seen that sort of similar stuff before with Hume region. One year it was highlighted as having the highest alcohol sales of any region, per capita, of anywhere else in Victoria. Those sort of campaigns and how the media approaches these issues needs to be carefully thought through.

MS DONNELLAN: Just to highlight the work that was done with the local drug action team in Wangaratta to counteract some of that media and to work with the media to really look at stigma and why people use substances was huge – but the LDAT, the funding intermittent with that, you have to keep reapplying. That is a community-based response with services coming together. And that is not happening at the moment for that LDAT so, which is really unfortunate.

MS RHODE: It is not on our list, but we will support models like their local drug action teams, they've actually had significant impact around this region anyway so — —

MS DONNELLAN: Yes (indistinct) Wodonga to Alpine, a Wangaratta one, they've had some great outcomes, in what they've done.

The CHAIR: Yes, they're a very good model for being on the ground and working with the needs of the community that will be different (indistinct).

MS RHODE: That is right. And their ability to influence locally.

MS DONNELLAN: Yes. We work hard at the consultation with the VADA paper so I support their submission to the inquiry, and a lot of their recommendations are very similar to what we've - we've put forward as well.

The CHAIR: Yes, all right.

MS DONNELLAN: Yes. Yes.

The CHAIR: Thank you. Thanks Maryanne, thanks Leigh. We'll open up questions. I'll start with Tien and then I am going to go to Tania, just to give you all notice, then Kaushaliya, then Georgie, then Sheena, then David.

MS DONNELLAN: Yes.

Dr KIEU: Thank you very much for you appearing today (indistinct) and into this very important issue and thank you so much for the support and services you have been doing in this - not this region, it is very wide-ranging. I'd like to focus a little bit more on the younger people. In the number of clients, of people who come to seek help from you, how many in percentage terms, will be younger people, below, say 29, 25 and what is the success rate you think that you have been able to offer. Another component of my question is, you also mentioned of the lack of specialised services and so the lack of early intervention options, and so could you spell out what, exactly they are so that we could be informed, thank you.

MS DONNELLAN: In terms of the age of the people that we work with. the stats from 18/19 to 19/20, kind of show that it is around the 80 mark in young people that we (indistinct) for both of those years. The majority who we see is the 30-39 age. To say that, I do not think that is reflective of the need. We have an EFT for youth outreach workers which is 2.4 for our whole region, for the Ovens Murray. We have a lot of other services that pick up or support young people with AOD issues. For example, Headspace, they do not come into those stats.

Dr KIEU: Yes, okay.

MS DONNELLAN: That is just purely the AOD treatment strengths that are funded by the state government. Headspace is a separate funding stream through the Commonwealth and yes. So that doesn't pick up what they would see, in terms of AOD for young people. And it doesn't pick up for example, the triple P, so the young people's home - young people living out of home. A lot of those workers deal with mental health, AOD issues and we wouldn't see those kids, in our services.

Dr KIEU: Yes.

MS DONNELLAN: Same for the schooling system. A lot of them are picked up by maybe the welfare services, or by youth services, like Junction, and we wouldn't see them in our AOD streams.

MS RHODE: So, do you think that is a reflection probably more of our ability to meet the need and what supply we have available to us, rather than actual potential need. What we'd like to be able to do more strongly is provide consultancy services to those - some of those other frontline programs, so that they have access to local expertise. And we do have some of that secondary consultation that we provide to other services as well. Probably - but by the time those young people are getting to our service, it is probably past the point of the intervention.

Dr KIEU: A bit too late by then, yes, yes.

MS RHODE: Yes, unfortunately, yes.

Dr KIEU: Thank you.

MS DONNELLAN: So when you talk about the youth outreach program, those workers are working with the really disengaged, disengaged with other services, with the school, the high (indistinct) young people.

The CHAIR: Yes.

MS DONNELLAN: Definitely not the early intervention, early stage.

The CHAIR: Yes.

MS DONNELLAN: As to the second part of your question, about what we'd like to see. Unfortunately, (Indistinct) wasn't here, and she's the Headspace manager, so she could've spoken a bit more about that. But I

think we've alluded to it, that non-acute mental health support and that dual diagnosis work, with young people. The majority of the people we see have mental health issues, and they're just not at that acute level, that, say (indistinct) or mental health, community health we pick up. But there's still others — —

MS RHODE: (Indistinct) distress or distress, there may be some life circumstance that really troubles them that they've not got the coping skills to deal with. They haven't learnt some of those good coping skills and problem-solving skills and stress management techniques and skills that as grown-ups we'd probably have more time to develop those skills. In those early years, if they've not had exposure, if they've not had two stressors and learnt how to cope with them, depending on what their peer networks are like, depending on what their family and other personal support networks are like. The use of alcohol, or the use of cannabis to relieve the pain that they may be experiencing. It might be a loss of someone, it might be loss of a pet, it might be a failure at school, they might be seemingly simple things to us as grown-ups, but in a young person's life experience, quite tragic and make them feel alone and sleepless and you know, all these signs of depression and anxiety, if untreated, not supported — —

MS DONNELLAN: And on the other side the more severe trauma on the family violence or the families that are separated or abused, so there's, yeah, both of those prospects.

The CHAIR: Tania.

MS MAXWELL: Thank you Chair. And it is lovely to see Maryanne and Leigh here today to present to us. Thank you very much for that presentation. It was extremely informative.

Maryanne you spoke about co-occurring, co-morbidity, dual diagnosis, and early intervention, which goes hand in hand with our primary prevention. We know that in rural and regional areas, there is a significant lack of resources to accommodate and address all of those things that you mentioned. In a perfect world, what would you see as being required through an early intervention process – whether it be, your own personal resourcing through Gateway Health, or being extended onto other organisations that you can work with?

MS RHODE: I can comment. I think (indistinct) was involved several years ago in a fantastic program, and it might seem unrelated, but it is the process that I think we can learn lessons from, and that was strengthening hospital responses to family violence program.

Dr KIEU: Yeah.

MS RHODE: So, it worked with (indistinct) Health Services that traditionally wouldn't have seen themselves as having a role at all in family violence – that was up to the family violence sector. But what it did was encouraging support, rather than force, leadership in those hospital settings to raise their own awareness of the issues and provide internal leadership to facilitate this sort of program. Which led to development of some protocols, it led to training of staff at the frontline, it led to you know, 'how do you respond?'

Because what they knew, was that staff were afraid to ask the questions, to (indistinct) enquire about experiences of family violence, to even ask simple things like, 'Are you feeling safe to go home now?' after this visit that they've had. Because they might have been afraid of 'well what do I do, if the answer to that is, "No, I do not feel safe." What do I do?' So the work was really empowering, training, educating the frontline workers in how to ask the right questions and then resourcing and supporting them with the referral pathways, the tools and the connections to be able to do something about it, if they identified that this was a problem.

So, that is an example of a way of identifying a window of early intervention. I would see an early intervention program. If you think about young people for example, what are the sectors and areas that they're exposed to, so obviously the school environment is one of them, but things like housing services, youth housing and support programs, any health program, any health service really is an opportunity for that first point of identifying that there may be an issue and an opportunity for early intervention.

So, as a process if there's a sort of universal blanket process that is about asking the right questions and creating the right pathways, then any sector, whether that is police or anywhere a young person, or even an adult, is connected to – the family violence sector also.

MS MAXWELL: I have actually suggested that we should be looking at some of the youth organisations in rural areas, whether it be homelessness, or whatever it may be, because they do and can pay a role.

MS RHODE: Well whoever has the connections, Tania, yes, I think that is right. And that is the new sectors and the housing sector, organisations like (indistinct) in this region. We've already had rural pathways from them, like Maryanne said, but our capacity is limited, so they are picking up some of that work.

MS MAXWELL: Yes.

MS RHODE: And having a systematic approach to it would be really helpful and naming it, that this is what it is. And we all sign onto this — an accord if you like. Yes.

The CHAIR: Yes, I know. Thank you. Kaushaliya.

MS VAGHELA: Thanks Chair. Thanks Leigh and Maryanne for your submissions and for your time today. Your presentation had quite a few interesting points, and mentioning that, my question is one of the points that was mentioned in the presentation was, at times the consumers of cannabis becomes themselves either the dealers or the suppliers of cannabis. How common is that? Do you have any data, or percentagewise?

MS DONNELLAN: It is really, I guess what the staff tell me or report (indistinct) about that. And about some of the things that young people report to them about who approaches them and how they get into the use of it. And you know, a sample entitlement to use and then asked to supply. So that is kind of the information we hear from the young people, but there's no data. We wouldn't have the capacity to look at that.

MS VAGHELA: And the other part of the question is that you also mentioned about the users using cannabis to self-medicate, say, for example, for anxiety and paradoxically that itself is causing anxiety and other issues that were listed in that presentation. Again, how common is that? Do we have any evidence or research data that we can see, and is it being regular users or heavy users? Where do we see that?

MS RHODE: It's in the nature of the (indistinct) self isn't it, to watch how it interacts with (indistinct) the brain.

MS DONNELLAN: Yes, I think the data behind how many of the people that seek treatment from us that also have a mental health illness supports that. And what staff tell me about them self-medicating and then the flow on, issues or consequences of that, so not sleeping and not - so there are some measurements that we take, or some screenings that we do that show that particular stuff happening. But yes, I haven't got any data to bring to you today about that.

MS VAGHELA: Yes.

MS DONNELLAN: So, I guess what the staff report to me and then what we see in terms of our recording about the co-occurring.

MS RHODE: It was (indistinct) dependency issues and part of that anxiety can often be about continued supply and that demand for continued supply. That can also lead to that manipulation to then become involved in dealing, not just supply for your own use. It is a trade-off isn't it? 'I'll keep you supplied with the cannabis you want, if you do this for me'.

MS DONNELLAN: And I think there is a gap there in us being able to evaluate or analyse our data. But the state has done quite a bit of work in trying to improve the data with the transition to the VADC. That being complicated with certain things, but we do not have the resources to really look at our data and start to analyse it, so we can prove certain things. To evaluate it would be a great step in understanding what's going on in our communities.

MS RHODE: I mean that is your last point about assessing the impacts. And I am not sure to what extent the sort of research – we haven't really been involved in any particular research studies on any of those topics to date, but we'd certainly be (indistinct) to be. If there was opportunity there, I think it would be worthwhile.

MS DONNELLAN: Yes, absolutely.

The CHAIR: Georgie.

MS CROZIER: Thank you very much Chair and thank you both very much for presenting to us and being very, very helpful for the committee to understand the issues that your communities face. I am very interested in following up on what Ms Vaghela has spoken about in terms of some of those issues. My concerns are about the linkages between cannabis and mental health and other health issues, and you've spoken about those and the circular sequence, if you like, and what comes first and how it all inter-relates.

You mentioned, Ms Rhode, about the neural pathways and potential damages to young people, especially while they're brains are developing. And I am interested in understanding a little bit more from your perspective and you've just mentioned you do not have the data, but really those concerns between those linkages, between the use of cannabis, leading to stronger drugs like amphetamines and other drugs – that might be alcohol abuse, leading to those issues, around how it is all linked, and whether you've got any observations that you could impart to the committee?

MS RHODE: Well, the fact that Maryanne mentioned a lot of the patterns of behaviour that we are seeing is that there's generally more than one drug involved. I think that tells you something as well. I think they're important questions that we need to understand better, because if there's going to be educational campaigns for young people, for other professionals, this is some of the kinds of information that you want to get right. So, for a lot of it, I would have thought that there's already some supportive science and scholarship around some of those issues. We are not actively involved in that kind of research, but it — —

MS CROZIER: I am interested in those comments. And we know that there are many thousands of medical journals that talk about the linkage of cannabis use with mental health. You're talking about those pressures that you've got up here with the lack of services to deal with those issues and it might be something that is small, that triggers, and then it leads to this use, so that education I think is very important.

MS RHODE: Yes.

MS CROZIER: But I am just wondering from your perspective as well, Maryanne, if you could comment? Do you see a linkage there in that multi-drug use that is in your community?

MS DONNELLAN: Yeah, absolutely, and like we said, we have virtually very limited opportunities to look at (indistinct) what we do, but what we observe is those linkages. What we see with young people coming in and then older people coming into our services, if that was (indistinct) so they get involved in say the criminal system, and their drug use increases or diversifies to a lot more drugs. We definitely see that happening. The mental health linkages, we see that every day, and the struggle to link them into appropriate mental health responses, we experience that every day with our clients.

MS CROZIER: Thank you.

MS RHODE: And the mental health (indistinct) would probably say the same thing.

MS WATT: Hello, thank you so very much for your presentation and contributions today. I am just having a look at the alcohol and other drugs strategic plan, that you guys have put together.

MS DONNELLAN: Catchment player. Catchment.

MS WATT: Catchment player, sorry. That Aboriginal threshold of clients, list cannabis as their primary drug of concern in that plan.

MS DONNELLAN: Yes.

MS WATT: At a higher rate than the general population. Is this still the case and how has this indeed changed over time? Do you have any reflection on that to share?

MS DONNELLAN: Yes, that is silver case. When we look at data about the Indigenous population that we work with, cannabis is the main drug that they seek treatment for. We work with about 12 to 14 per cent, depending on the year, of Indigenous require - so there is Aboriginal-specific AOD services in the community and I am unsure what their data is, but yes, that is the case.

MS RHODE: And I think that is an important distinction Maryanne, around the data. We can really only compare data to those who seek treatment, not necessarily the extent of use, they're not the same people, by a long shot.

MR LIMBRICK: Thank you Chair and thank you for appearing today. You touched on this a little bit in your presentation, but I am interested in how does the current cannabis prohibition regime affect your ability to deliver services and how does it affect the outcomes for your clients?

MS DONNELLAN: For me there's a real barrier for people seeking services with the stigma and the discrimination that comes along with it being criminalised. You do have your forensic clients that come through, they're mandated, so they'll have an order that tells them they have to come and seek AOD support. Obviously, we've had less positive impact working with someone who's mandated, who's not seeking treatment because they want to. There's a big difference in the outcome you'd have with someone voluntary as opposed to mandated.

MS RHODE: Yes. We mentioned those longer term concerns, about say possession and use and that once you have a record the impact that has then on your education retainment and your future career prospects, because it is on your record. And that is in part – like compare possession and use to supply and dealing in the significant impacts and consequences. It doesn't matter; it is still a blot on your record.

MS DONNELLAN: And I think that is particularly noticeable. We are a sector that values lived experience and those people with lived experience. And often they've got a criminal record, and that is an issue when they come to us.

MS RHODE: Yes.

MS DONNELLAN: And the stigma and the shame associated with having to explain that or to talk about that is huge.

MR LIMBRICK: Yes. Thank you.

The CHAIR: Thanks David. Thank you. That sort of goes nicely into what I wanted to explore a little bit, which was around that stigma and discrimination; that notion that it is easier just to access cannabis than it is to probably go and talk to someone about cannabis use. Do you think that is largely because of the illegality of it, or is it also because of the misunderstanding, I suppose of cannabis use amongst doctors and amongst health professionals?

MS RHODE: (Indistinct). Well that is like a double standard isn't it?

The CHAIR: Yes.

MS RHODE: If you asked every adult in Australia how many had ever used alcohol and they were truthful, they'd be quite comfortable to tell you because it is legal. If you asked every adult in Australia had they ever used or were they still currently using cannabis on any occasion, they'd perhaps be a little less likely to tell you, while it remains an offence.

The CHAIR: Yes.

MS RHODE: And so on, and so on with all the others, you know, if you asked that question. I think it does. It makes it quite complex for people to express that they have an issue or a problem. And it may be that the problem they want to express is not so much the cannabis use, but the underlying issues about why they're not using it and that is to get to the heart of it. It does create a barrier in getting to the heart of what the issues are that are holding people back.

MS DONNELLAN: And I think there's an issue, or what we see is people that maybe using cannabis to mask other things and then have the other symptoms as a result of using cannabis. If they can't get access to appropriate services, they'll go to their GP. GPs are not necessarily equipped to manage this issue. I think there's a lot of stigma within the GP world about working with people who have substance issues and concerns about their behaviour. We see that really regularly. GPs really frustrated and unable or unwilling to work with the people that are our clients.

MS RHODE: We have seen, and it might seem unrelated, but through the bushfire experience and our role in follow-up bushfire case support, we've reached people in isolated parts of this region that we've never reached before, and they in fact, do not engage with anybody.

The CHAIR: Yes.

MS RHODE: Similarly, with the high-risk accommodation response to COVID. Part of our outreach work is engaging with vulnerable communities in specialist rehab caravan parks, disability houses people that do not necessarily again, have contact with the system, because it is a trust issue. If someone comes knocking on their door, the concern is it is the sheriff come to repossess something, or somebody delivering a notice about debt, or some other behaviours that they're chasing up. So the trust issues and the help seeking behaviour, it is a significant issue.

The CHAIR: Yes.

MS RHODE: And you know, people sometimes come to little regions to hide. They do.

The CHAIR: What a beautiful place to come.

MS RHODE: Yes, but (indistinct) if you're going to hide.

The CHAIR: That is right, totally understand. Unfortunately, we've run out of time because I think there was a lot more conversation that was emerging, but again thank you so much for your presentation and being so open with us. You will get a transcript of today. Just check we haven't misrepresented anything that you've said and thank you for sharing the slides as well. We'll have a look at those with interest.

MS RHODE: All right, well thank you and we will look forward to the outcomes of your learning and deliberations and recommendations at the end.

The CHAIR: Yes, thank you.

Dr KIEU: Thank you.

MS DONNELLAN: Thank you.

MS RHODE: (Indistinct) interesting project. Thank you.

MS MAXWELL: Leigh, is Gary Croton still — —

MS RHODE: Sorry?

MS MAXWELL: Is Gary Croton still working in the — —

MS RHODE: He's still in the region of the dual diagnosis work. He is really worth talking to.

MS DONNELLAN: He would be, yes.

MS RHODE: Yes. Yes.

The CHAIR: Yes, great, thanks Tania. Thank you.

Witnesses withdrew.