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

Melbourne—Tuesday, 1 June 2021

(via videoconference)

MEMBERS

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Mr Tim Quilty
Dr Samantha Ratnam
Ms Harriet Shing
Mr Lee Tarlamis
Ms Sheena Watt

WITNESSES

Mr Justin McDonnell, Executive Director, Student Wellbeing, Health and Engagement Division, School Education Programs and Support, Department of Education and Training;

Mr Matthew Hercus, Executive Director, Mental Health and AOD System Operations and Commissioning, Mental Health Division, Department of Health; and

Mr Diab Harb, Executive Director, Justice System Reform, Department of Justice and Community Safety.

The CHAIR: Good morning, everyone. I declare open the Legislative Council Legal and Social Issues Committee's public hearing for the Inquiry into the Use of Cannabis in Victoria.

I would like to begin this hearing by respectfully acknowledging the Aboriginal peoples, the traditional custodians of the various lands that we are gathered on today, and pay my respects to their ancestors, elders and families. I particularly want to welcome any elders or community members who are here to impart their knowledge or who are indeed watching this broadcast and these proceedings, and I would like to welcome any members of the public who are watching this live broadcast. I hope you are all getting through your lockdown.

Now I would like to introduce the committee members. I am Fiona Patten, the Chair of the committee. With me I have my Deputy Chair, Tien Kieu; Ms Kaushaliya Vaghela; Ms Tania Maxwell; Ms Georgie Crozier; and Dr Catherine Cumming. We also in the background have our committee staff, our Hansard team and our IT team.

As I am sure many of you would already know, all evidence taken is protected by parliamentary privilege, and that is as provided by the Victorian *Constitution Act 1975* but also the standing orders of the Legislative Council. This means that any information you provide during the hearing is protected by law. You are protected against any action for what you say during this hearing, but if you were to go elsewhere and repeat the same things, you may not have the same protection. Any deliberately false evidence or misleading of the committee may be considered a contempt of Parliament.

As I mentioned, we have a Hansard team listening to your every word. Again, we very much appreciate you coming here today. The transcript will eventually go on to the committee's website and will form part of the report, so I would really encourage you to check the transcript when you receive it and make sure that we have not misheard or misrepresented anything that you have said today.

I am very pleased to introduce the witnesses that we have today and who will all be making some opening remarks for us. This is our Victorian government panel, so this is to hear about the whole-of-government policies on the use of cannabis in Victoria. With us today we have Justin McDonnell, who is the Executive Director of Student Wellbeing, Health and Engagement in School Education Programs and Support with the Department of Education and Training. We also have Matthew Hercus, who is the Executive Director of Mental Health and Alcohol and Other Drugs System Operations and Commissioning in the Mental Health Division of the Department of Health. Lastly, we are joined by Diab Harb, who is the Executive Director of Justice System Reform within the Department of Justice and Community Safety.

Justin, if you would like to start making some opening remarks, then we will go straight to Matthew and Diab after that. Over to you.

Mr McDONNELL: Thank you, Chair, and thank you very much, members, for having us here today. I would like to, on behalf of the Department of Education and Training, also acknowledge the traditional owners of the lands on which each of us is meeting, pay our respects to elders past, present and emerging and recognise Aboriginal colleagues who are with us here today.

As the Chair said, my role is as Executive Director of Student Wellbeing, Health and Engagement, and that role covers responsibility for policies and programs that relate to student wellbeing and I think particularly for this hearing programs and policies that relate to student mental health and alcohol and other drugs. So today I thought I would give a brief opening statement that covers our approach to drug education and really then hand over to my colleagues in the other departments from there.

School-based drug education plays a very important role in reducing drug-related harm. It helps to build the knowledge and skills for students to make responsible, healthy and safe choices. Our approach is grounded in five key elements. One is drug education being an explicit focus area in the Victorian curriculum. The second is we provide a range of resources to support teachers to deliver that curriculum to a high standard. We also have, as the department of education, a clear policy on alcohol and other drugs that covers schools' obligations in relation to drug education, prevention but also response and support for students who may be using drugs. We also have funded drug education programs. The fifth element is a range of other health and wellbeing programs and support that wrap around student mental health and wellbeing. The model for all of this is based on research and uses evidence-based practice with leading experts in the field. In line with the whole-of-government approach, harm minimisation is central to our drug education approach. It aims to reduce the risks associated with drug use and promote healthier alternative behaviours from young people.

The curriculum—as I mentioned, there is an explicit focus area on drugs in the health and physical education part of the curriculum, so that is a requirement of teachers across the state. The curriculum focuses on supporting students to understand drugs in terms of the health impacts, also the legal impacts and status of drugs, but also to grapple with the social pressures that can wrap around drug use, particularly at the younger ages, and also very much focuses on how students can seek help and build the social and emotional learning so that they can navigate those social pressures.

We define as a department and put advice out to schools what are some of the key features of good practice drug education. They include that it includes content that is relevant to young people's lives and experiences and in doing that that it contains activities that really engage students in problem-solving and critical thinking. We ask that it has content that is tailored for age and commences in primary school. So the curriculum about alcohol and drugs starts at primary school, obviously with content that is tailored for younger ages and then builds and becomes more explicit about illegal drug use in later primary years and senior school.

We also ask that drug education is part of a broader curriculum context, so it is part of the health and physical education curriculum—it is framed in terms of understanding of health and positive health—and also that it is linked to social and emotional learning. In particular there is a part of the curriculum called the personal and social capability, so it is really in the context of students understanding how to recognise their own feelings and pressures and particularly to seek help and see that as a positive thing to do. We also encourage a whole-of-school approach, and by that we mean that it is not just a focus in the classroom but drug education proactively engages parents so that parents have a good understanding of what is being taught in the classroom and can reinforce messages and that the approach is responsive to the cultural and social context of the school community as well. Finally, we encourage that schools engage drug and alcohol programs and expertise as appropriate, so to have a good grounding of knowledge with teachers and in the curriculum but recognising there is expertise that sits outside schools as well.

Some of the key resources that we produce for schools—we have a range of drug education resources on our key curriculum support website. It is called the FUSE resource library. In particular the main resource that the department has commissioned and published ourselves is a resource called Get Ready, and that includes a suite of teaching and learning activities on alcohol and drugs. It has got guides for teachers, activities for students. It has also got some videos and other resources that students can access. So that is the main resource that we have commissioned, but the FUSE website has a range of other resources that have been published by other parties as well that we recommend to schools. We also have guidance that supports schools to have those conversations with parents about how to talk about drug education. We have a range of other resources that support wellbeing responses to possible instances of drug use as well.

In terms of our policy, as I mentioned, the department has an alcohol and other drugs policy that applies to all government schools in the state, and that requires schools to provide all students with alcohol and drug education using the curriculum, to take that whole-of-school approach that I mentioned, but in dealing with instances of drug use the policy does also outline our broader approach, which is to not permit student possession, consumption or selling of alcohol on school premises or at camps or excursions but to take appropriate action, including contacting police, if a student is found in possession of or selling or under the influence of drugs. So that is the response in terms of the rules, but wrapped around that to ensure that students have access to immediate and ongoing support for substance abuse issues—and I will talk more about some of the wellbeing programs we have—and really to make every effort to retain students in the education system if

they are in that situation, so recognising drug use may be an indicator of vulnerability in many instances and the connection with education being a vital factor for young people.

In terms of the programs, there are two in particular that government funds that have quite a clear focus on drugs. The department of education funds the Life Education Victoria program. People will be familiar with the program, possibly including through Healthy Harold, the mascot that is well known to young people across the state. Life Education has a student health focus but has particular modules focused on drugs, including at the younger primary years a module called Mind Your Medicine, which is introducing young people to the concept of medicines and the influence they can have on health and the body and making wise decisions around using those, and then in the upper primary years a module called Decisions, which includes a focus on illicit drugs, and it covers things like the classification of drugs, the effects of drugs on the body, analysing health messages in the media, influences on decision-making and strategies to stay safe.

The other program that the Department of Health funds is the Healthy Schools achievement program. That program provides a framework to help schools bring together a whole-of-school approach to health and wellbeing. That has seven key areas, and one of those is tobacco, alcohol and other drugs. That is available to all schools out there. The Cancer Council helped develop that one.

So, Chair, the final thing I wanted to mention was the broader health and wellbeing support that we have in place, and as I said, often drug use can be linked to other issues in students' lives. In this we cover the spectrum of prevention and early intervention and response. At prevention and social and emotional learning, as I said, it is embedded in the curriculum, but in recent years we have particularly included a strong emphasis on materials and training that support social and emotional learning and seeking help. So the resilience, rights and respectful relationships teaching materials, in addition to having a focus on gender equality under Respectful Relationships, have our most contemporary advice around social and emotional learning and help seeking.

To support student health we have a number of programs. Across secondary and primary we have the school nursing program, which is available to all government schools, which is trained nurses that work with schools on prevention and response. We have the Doctors in Secondary Schools program for 100 secondary schools in disadvantaged areas, and that really is reducing barriers to accessing primary health care. Noting that some of the previous witnesses to this committee have talked a lot about physical health and physical activity, last year we launched the Active Schools program, which provides a range of support and grants to schools to help boost sporting activity, extracurricular activity and active travel to and from school.

In terms of student mental health, in secondary school every government secondary school will be funded to have a mental health practitioner by the end of this year, and I have seen in some of the previous discussions with witnesses that has featured. Those mental health practitioners really provide that support at the school ground, can cover the school's health promotion activities and also provide that really early intervention for students so that they can access support very close to where they are every day. In addition to that we have a dedicated partnership with Headspace. So beyond the regular access that young people in Victoria can have to Headspace services, we have a dedicated contract to make sure there are no barriers to access, and that includes a telephone counselling line as well. And just in last week's budget the Acting Premier also announced a new initiative to respond to the royal commission into mental health, which is $217.8 million for mental health reform, including a $200 million School Mental Health Fund, which was recommended by the royal commission. That will be guided by an evidenced-based menu of programs to recommend to schools.

Finally, we have some programs particularly focused on our most vulnerable students. So the Navigator program provides wraparound support for students aged 12 to 17, and the trigger for students getting support through Navigator is their level of absence and disengagement from school. It is a very intensive service, so it is intensive case management. We fund community service organisations to really work with students to address a range of issues that will be barriers to them reconnecting with education, and alcohol and drug use and referrals to services are certainly a feature of that work.

I had also mentioned the Lookout program—

The CHAIR: Sorry, Justin, I am just conscious of time.

Mr McDONNELL: Sorry, Chair.

The CHAIR: Yes, if you would just like to wrap up, that would be fantastic.

Mr McDONNELL: I will wrap up there. I will in fact leave it right there. Thank you, I appreciate that. I will hand to Matthew.

The CHAIR: Lovely. I am sure there will be lots of questions to take on.

Mr McDONNELL: Thank you.

The CHAIR: Thank you. If I could welcome Matthew from the Department of Health.

Mr HERCUS: Thank you, Chair, and thank you, Justin, for your instructive comments. I would like to also, on behalf of the Department of Health, acknowledge that we meet on the lands of traditional owners and we acknowledge the elders past and present of the Aboriginal communities of the state of Victoria and indeed of Australia. We acknowledge that sovereignty also has never been ceded.

Thank you to the committee for the time to be part of this important conversation and to also acknowledge the previous hearings and submissions, which have also spoken at length about some of the lived experiences of persons and community members who have interest in this topic and who have experience to bring to bear. So we thank the committee for the time and the opportunity.

The Department of Health, in terms of a brief background, was established on 1 February 2021 as the result of a decision to separate the former Department of Health and Human Services into the Department of Families, Fairness and Housing and the Department of Health. The health department—the Department of Health—plays a pivotal role in the Victorian health system, being responsible for working with service providers, peak bodies and the community to shape the health system via policy development and the commissioning of services to meet the health needs of Victorians.

The Department of Health is committed to reducing the harm caused by alcohol and other drugs. A health-led approach to substance use is adopted, with a focus on supporting Victorians to minimise harm and maximise health, social and emotional wellbeing. To achieve these goals, services are commissioned to support people to access treatment and reduce the negative consequences associated with alcohol and other drug use. In 2021–22 the Victorian government will provide $330.2 million for alcohol and other drugs services. This funding will go towards a range of programs and initiatives. Core drug and alcohol services include counselling; withdrawal, both non-residential and residential; rehabilitation, both non-residential and residential; care and recovery coordination; pharmacotherapy; and specialist harm reduction services. Population-specific services are also a key part of the system, including youth, Aboriginal and forensic services. We work with our partners at the Alcohol and Drug Foundation, and VicHealth is focused on prevention initiatives.

With regard to the treatment system, the Victorian government has a statewide intake model and area-based entry points into the alcohol and other drugs system. DirectLine, via telephone or via a website, provides 24-hour, seven-day counselling, information and referral support. Across the state service access can be facilitated by individuals directly contacting a local intake provider. People seeking treatment may also be referred to intake services from a range of other health and human services providers, including general practitioners. Following intake, a person is referred for a comprehensive biopsychosocial assessment, after which referrals then occur to the services that meet their needs as identified in the core services previously referenced. Individuals can also be referred to services that they may need outside the drug and alcohol system; for example, mental health and family violence support services. Access to targeted youth and Aboriginal drug and alcohol services is available through direct self-referral to those providers.

The department also funds the delivery of a range of alcohol and other drug treatment interventions for people involved in the criminal justice system. The Australian Community Support Organisation, ACSO, deliver intake assessment and treatment planning for clients in contact with the justice system. People involved in the justice system are able to access the full range of community-based alcohol and other drug treatment services, including the core services of counselling, withdrawal, care and recovery coordination, rehabilitation and youth- and Aboriginal-specific services. In addition, there are a range of forensic-specific alcohol and other drug treatment programs that address alcohol and other drug use in relation to offending behaviour.

Alcohol and other drug treatment helps not only address the substance use and offending behaviour but also reduces rates of recidivism and contributes to a safer community. Released in 2018, the forensic alcohol and other drug treatment service delivery model, in conjunction with the Department of Justice and Community Safety, provides a new targeted criminogenic alcohol and other drug treatment model as well as a range of critical service system enhancements. Harm reduction may include support to cease, reduce or manage current use while minimising harm and is a key component of the treatment system. We also know there are enduring harms relating to stigma and discrimination relating to substance use and that stigma and discrimination are barriers to help seeking education in preventable harms.

Specifically on cannabis use, submissions and previous hearings have covered the population prevalence of cannabis use as well as key risks, such as the age of onset and heavy use. Advice on these facets has been provided to the committee by nationally and internationally recognised experts in substance use research and treatment, policy and delivery, or both. We know that while many Victorians who use licit, such as alcohol, or illicit drugs, including cannabis, opiates and amphetamines, do not experience serious harms, a proportion do. Of those that seek treatment in Victoria, cannabis is the third most prevalent drug of concern reported behind alcohol, which is the most prevalent, and secondly amphetamines. From 2010 to 2020 cannabis was reported as the principal drug of concern for 19 per cent of unique clients presenting to the Victorian alcohol and other drug treatment system. Cannabis-related emergency department presentations also increased from 2008–09 to 2017–18.

The department resources the Alcohol and Drug Foundation to provide information services about drugs such as cannabis. Information is available to help young people, schools and parents prevent and delay alcohol and drug uptake. The *National Drug Strategy Household Survey 2019* informed that of those who use cannabis, 2.9 per cent are deemed to be at risk of harm, including dependency, and whilst I understand there have been no deaths in Australia directly attributed to natural cannabis toxicity, cannabis intoxication and use can be associated with accidental injury, suicide and deaths from natural causes. Synthetic cannabis, however—a novel psychoactive substance—has been found by the Victorian coroner to have contributed to up to 12 fatal overdoses across 2017–19.

The relationship between cannabis use and mental health is complex. Previous hearings have also engaged experts in research policy and treatment demands on this issue. With regard to the 2019 national drug household strategy survey, 29.3 per cent of people over 18 who had used cannabis in the previous month self-reported having a mental ill health issue. Of those that had used cannabis in the previous month, 42.7 per cent reported very high psychological distress. In the Victorian mental health system, 19 per cent of registered clients have substance use noted as a comorbidity and 6 per cent of clients report substance use disorder as a principal diagnosis, which is permissible under the framework of diagnosis in the system.

The final report of the Royal Commission into Victoria's Mental Health System recommended improving outcomes for people living mental illness and substance use or addiction. The royal commission's recommendation will target and significantly improve access to mental health services where and when people need them, including providing more locally accessible treatment, care and support to people living with mental illness and substance use or addiction. Recommendations of the royal commission that are being implemented include a new statewide specialist service for people living with mental illness and substance use or addiction, increasing the number of addiction medicine specialists, ensuring that at least one emergency department in each region is suitable for mental health and drug and alcohol treatment, improving system capability across new local and area mental health and wellbeing services. These reforms will see better supports available for people who may use cannabis to alleviate psychological distress or mental health challenges.

With regard to medicinal cannabis, while problematic cannabis use has been linked to a range of detrimental effects, there is also evidence to support medicinal use of cannabis as a treatment for a variety of mental health conditions. In Australia 'medical cannabis' refers to a range of quality-assured pharmaceutical cannabis preparations intended for therapeutic use. Medicinal cannabis products have been legally available in Victoria since 2016 following state and commonwealth legislative changes that have made these products available via prescription from a doctor. Victorians can access medicinal cannabis for a range of conditions, including chronic pain not linked to cancer, multiple sclerosis and the effects of cancer and cancer treatment, as well as for the treatment of epilepsy in younger people.

In closing, Chair, in summary, there are a range of specialist AOD supports in place. However, we know that there are still waitlists for some treatment types in some areas. Recent investment has focused on improving access to treatment and harm reduction services and providing services to people closer to where they live. The Royal Commission into Victoria's Mental Health System will also support more formally integrated access to services for people who may be experiencing both psychological distress or mental illness as well as substance use or addiction. In the implementation of the royal commission's recommendations and looking at long-term sustainability of the specialist drug and alcohol treatment system, the department will be reviewing and undertaking statewide and regional planning, assessing demand and reviewing key enablers of both systems, such as funding models. In this way, the department is looking to improve access and support for both substance use, addiction and mental health concerns, including ensuring appropriate access to integrated care. Thank you.

The CHAIR: Thanks very much, Matthew. Welcome, Diab Harb from the department of justice.

Mr HARB: Thank you, Chair, and also thank you to my colleagues. Can I begin on behalf of the department by acknowledging the traditional owners of the lands on which we are each meeting, paying my respects to elders past, present and emerging and recognising Aboriginal and Torres Strait Islander colleagues here today.

Thank you for inviting the Department of Justice and Community Safety to contribute to today's panel. Firstly, the Department of Justice and Community Safety leads the development and delivery of justice and community safety policy and services in Victoria. The department manages the development and implementation of a range of laws, regulations and policy and ensures that all elements of the justice and community safety system are working effectively and efficiently. To do this we obviously work across a various range of stakeholders and government bodies, including Court Services Victoria, Victoria Police and other departments to ensure a cohesive and connected system response. The department strives to achieve safer and more resilient communities, a trusted justice and community safety system with easy access to justice and safety systems and services, and a fair and accessible justice system.

I thought it would be worth stepping the committee just quickly through the main ways that the department intersects with the committee's terms of reference. Predominantly the department's involvement generally occurs following an interaction with Victoria Police and, for example, across three broad areas of interactions. Firstly, within the context of roadside drug testing, obviously the forensic analysis that flows from that will confirm the presence of drugs in randomly tested drivers, drivers injured in road accidents or drivers suspected of being drug impaired, so this test will obviously form the basis of further action in that context. There may be instances following a crime where testing and analysis is used to identify the presence of illicit substances from perpetrators, and that is the second element. Thirdly, it is in relation to possession of an illicit substance, and depending on the quantities involved there, that would obviously determine where to from there. I think the committee is hearing from Victoria Police later today as well, particularly in the context of action following possession.

The department focuses on supporting efforts to reduce the harm associated with drug use and criminal offending, and this includes a range of justice-related programs that aim to address the underlying causes of offending, leading to a reduction in reoffending and increased community safety. The department of justice has successfully implemented a range of programs and service responses that assist people with drug and alcohol issues at different points in the justice system, including pre-charge via diversion programs, pre-sentence through things like the court integrated services program, and in custodial and post-sentence contexts. It is important to note though that much of the department's response is not specific to an individual substance but rather provided across the spectrum of drugs and alcohol. The department works closely, as Matt mentioned, with the Department of Health as well, and other stakeholders, to ensure that people in the justice system get support to manage their substance use and that these people are diverted away from the justice system where possible.

Just quickly, it is worth going through a couple of the different efforts that this includes. So the criminal justice diversion program offers an opportunity for offenders with relatively low level offending to avoid a criminal record through diversion and aims to reduce the likelihood of reoffending. Participation in the program can include alcohol and other drug treatment and counselling. The Drug Court model is an alternative sentencing option, aiming to divert offenders with a history of offending and drug and alcohol use away from further contact with the justice system—again, similarly reducing the likelihood of reoffending. The Drug Court

operates at the Melbourne Magistrates Court and is being extended to Shepparton and Ballarat and also into the County Court. The court integrated services program's bail and pre-trial support program includes, amongst other supports, access to drug and alcohol supports for offenders. The program is available for offenders engaged in the Magistrates Court of Victoria and, more recently, the County Court of Victoria. A subset of that is the court integrated services program's remand and outreach program. It is similar to the court integrated services program but supports people being held on remand to address issues that have prevented a grant of bail, including alcohol and other drug support.

Cannabis use is also addressed as part of the broad health stream of the alcohol and other drug programs that are available to individuals managed by Corrections Victoria and youth justice. Prisoners with a history of alcohol and/or drug use are offered a comprehensive suite of treatment options. So that can include participation in the identified drug user program, which aims to educate users about the risks of alcohol and other drug use and motivate them towards ceasing use. There are short duration health-focused programs which aim to reduce the harms of AOD use, as well as intensive long-term group treatment programs aiming to break the nexus between AOD use and offending—again, focused on reducing reoffending.

In closing, obviously you can tell by many of the interventions that the focus of the department is to support vulnerable people in the justice system and reduce the instances of reoffending. Our aim is to do this through working together across the system to build a safer and fairer and stronger Victoria as part of the department's vision. Thank you, Chair.

The CHAIR: Thank you, Diab, and thank you to the three of you. We will now move into committee time, and we have got about 45–50 minutes to ask questions. I will start. I would just like to start with you, Justin. You mentioned the vast range of programs that have been embedded into schools and are embedded into the curriculum. I am just wondering what evaluation is done of those programs. Is there a study that looks at drug or alcohol use amongst students once they leave school? How are those programs evaluated?

Mr McDONNELL: Thank you, Chair. Each program that I listed tends to be evaluated itself. So certainly all of the ones that I mentioned that have been funded in recent years all have evaluation built in. So, for example, Respectful Relationships, mental health practitioners or newer programs that have evaluations running on them have produced some evaluation reports so far and then continue along. I think it is fair to say with the broader health and wellbeing ones, the explicit evaluation of their outcomes in relation to drug use, there are not any that I can think of in the broader program ones that make that specific link. Life Education Victoria, as I said, is one of the more specific ones focused on drugs. Because that has been funded for a long time, it has been, I think, a number of years since its last evaluation.

But I think the mental health royal commission and that new fund that I mentioned do place a large emphasis on evidence. The royal commission recognised there are a lot of good programs in place funded both by government but also by providers out there that may be non-government providers. But what would be most useful for schools is to really organise those based on the evidence and what works and for us just to look at our school readiness funding model for kindergartens. In recent years we have had a menu that we have run our programs through—an evidence filter. So we are doing the design work on that now. The royal commission in making the schools recommendation did not have an explicit focus on drugs, but we know that was a broader big theme of the royal commission report. But I think, as I said, evaluations for wellbeing programs—we have got evidence of their impact on wellbeing. There is probably not so much specific to drug use, but we have got an opportunity through the royal commission and the new fund, I think.

The CHAIR: Okay. I think just making note of some of Matthew's statistics, cannabis in particular is a very popular product, and the largest cohort are people pretty much straight after they leave school—it is that 18- to 25-year-old group. So I would be really interested if there was any evaluation that tracked students having been through programs, whether it is life education—but I might ask if there was anything that you saw, if you could send that to us on notice, Justin.

Mr McDONNELL: Happy to, Chair.

The CHAIR: Thank you. Diab, obviously the justice system is the pointy end of this. You talked about a couple of things—the diversion programs. I have no doubt one of my other colleagues will ask more about this,

but I actually just wondered whether there were any figures on the cost of cannabis to our justice system, whether that is through arrests, through the court systems, through the prisons—is there a way to quantify that?

Mr HARB: That is a good question, Chair. Unfortunately we do not have any information on what it does cost the justice system, and we have not modelled that ourselves. We do have statistics that talk to the proportion of drug offences that are related to cannabis: 30 per cent of drug-dealing and trafficking offences are cannabis related, and 45 per cent of drug use and possession offences are cannabis related. So we are talking for drug use and possession about 11 789 out of 32 926. Cannabis offending made up about 2.3 per cent of all offences recorded in the year ending December 2020. There are some studies from other bodies that have looked at this. There is a 2020 National Drug Research Institute report into the social costs of cannabis use in Australia. Unfortunately we cannot comment on or have not reviewed the efficacy of those estimates, so I just point that out as being something that the committee may wish to look at. Then there are further statistics. The Sentencing Advisory Council releases trends on minor drug offences sentenced in the Magistrates Court. Interestingly, your question to Justin then—the findings of their work looking at illicit drugs sentenced in the Magistrates Court from 1 July 2007 to 30 June 2017, so over a 10-year period: of the 23 000 cannabis-only offences considered by the report, 25 per cent of offenders were under 25 years old and 29 per cent were over 40 years. So that was the predominant coverage of the statistics there.

The CHAIR: Yes, thanks, Diab. We did look at that, and young people are, looking at those statistics, demographically over-represented there. A number of the submissions that we have received and the evidence that we have received have been recommending some form of regulation of cannabis—maybe some very modest regulation but anything from something that looks like the ACT model through to something more like New Zealand. What strikes me is how that would play into our commonwealth legislation. I am wondering if you have any thoughts on, if Victoria was to take a role to regulate the sale and use of cannabis, how might that touch on any federal legislation. I know it is a question that is probably bigger than for today.

Mr HARB: Yes. Unfortunately, Chair, I might have do take that one on notice. I am not sure I can answer that one.

The CHAIR: Yes. Look, if there were any thoughts and if your department did have any thoughts on that, it would be interesting. Certainly we have heard that it is possible for a state to regulate. However, given that we have got federal drug laws as well as state, I was interested in the interaction. I will move to Deputy Chair Tien Kieu. Then we will go to Tania, Kaushaliya, Georgie and Catherine. Tien.

Dr KIEU: Thank you, Chair. Thank you, panel, for your presence here today and presenting on a lot of aspects, from diversion to education and particularly mental health, with the funding from the government for mental health and with the royal commission into mental health. I would like to ask a question about the specialist or the mental health practitioner recruitment in order to meet the demand in schools, particularly for regional schools and also for multicultural and Aboriginal communities**,** because it is not just the language but also the culture, the faiths and also some other aspects. Do we have enough practitioners to satisfy the demand in schools to help there? This may be directed to Justin or Matthew, thank you.

Mr McDONNELL: Thanks, Dr Kieu. It is a very relevant question for anyone in the field of allied health. The supply is a real challenge, including in rural and regional areas, and the mental health royal commission really called that out. I think in terms of the currently funded program of mental health practitioners in secondary schools, the initiative is on track to have all schools with a practitioner by the end of the year, which has actually brought the rollout forward from the original 2022 deadline. That was in recognition of the particular need that schools have been expressing. In terms of the supply, the program is on track, but certainly it is a really big effort of the department and of schools to be attracting qualified professionals to that. We do find in the field of education that there is a bit of a calling, so a lot of people really do, particularly in that allied health space, love the idea of working with young people and working in schools, particularly perhaps if they have been in the mental health sector and think they can have a really beneficial impact to address those issues early. So there is a particular calling in people who love the school and young people environment, which I think works a bit in our favour.

But I think going forward it is one that will definitely be a continued challenge. The royal commission asked, and the Department of Health will lead this to develop a workforce strategy, so Matt may wish to touch on that. But that will certainly look across the board at allied health, and we will be absolutely part of that as the

department of education to make sure that we are making sure that the needs of schools and their allied health professionals are met but also that we are not robbing Peter to pay Paul with the mental health system, which will obviously need to hugely expand.

I think, Dr Kieu, the other element—this mental health fund that I mentioned—is another avenue beyond the current funding for mental health practitioners for schools to engage additional support. The Deputy Premier talked about allied health being absolutely an option for schools that need it there, but I think the broader work that we will need to do is to articulate to schools, particularly through this menu that I talked about, the range of support that can help students. That may not be a psychologist being necessary at all schools, for example. It can really be some people doing great work in the prevention space, and they do not necessarily need to have those full allied health qualifications. In fact their education qualifications are really important in that. Schools will be able to engage professionals themselves, but that menu will also have external programs that, as I said, meet a good evidence bar. There will be great existing programs out there that we can put on that menu and connect schools with as well. So there are a few levers that we have got to address the issue, but certainly it will be one of our key challenges and things we will be bearing in mind for the next few years.

Mr HERCUS: Dr Kieu, thank you for the question. I am happy to chime in here. Justin has created the introductory comment for me to talk about workforce, which is key and pivotal to the implementation of the raft of reforms the royal commission has put in front of us. So Justin is right, workforce strategy is due for completion by the end of this year, 2021, at least to commence that task of thinking about and getting energy and focus on the idea of increasing the mental health workforce and all of its capabilities.

Specific to your question, though, about younger people and in schools, I think what the royal commission helpfully called out as well was it is not either a schools program or a mental health and drug and alcohol system program; it is actually joining them together, which is one of the fundamental approaches required here. The royal commission has recommended our current system of area child and adolescent mental health services reshaping and reforming be much more designated and focused as a specialist level and a brand-new service type called local integrated child and youth services. So as we are reforming through education we are also reforming the system outside education to enable more seamless referral between education mental health practitioners and local providers and area specialist providers.

Specifically to your questions about the CALD community and Aboriginal communities, the royal commission has focused at length on the Aboriginal community, with the interim report from the royal commission recommending Aboriginal social and emotional wellbeing program expansion across the state of Victoria, and that has been further endorsed through the final report—a centre of excellence in Aboriginal social and emotional wellbeing and further expanding the options and the culturally appropriate safe approaches. With CALD communities we understand the royal commission has surfaced what we have known for too long, that CALD and diverse communities do have a challenge in understanding the mental health system and navigating the mental health system, so therefore the royal commission made recommendations to build and enable a diverse community mental health and wellbeing framework to enable and resource community-based organisations and peak bodies to create some resources to help navigation and support. And it has also further endorsed through the budget the better mental health program for young asylum seekers and refugees, so certainly very much in frame for improving access and pathways.

Dr KIEU: Thank you.

The CHAIR: Thank you. Tania.

Ms MAXWELL: Thank you, Chair. And thank you so much for your presentation today. I am just wondering, Justin, in particular you spoke about the plethora of programs and initiatives that are being implemented into our schools at both the primary and secondary level. What I am curious about is: what are the drivers behind requiring this expansion of initiatives and what is the relationship for these new initiatives being implemented in relation to cannabis use?

Mr McDONNELL: Thanks, Ms Maxwell. I think the drivers for the support really reflect the way we organise the support. We take a tiered approach, so we really think about it in terms of the role of the education system across the whole student population—so all 650 000 students in the government school system—being to build the social and emotional learning, the positive understanding of health and health promotion, and really

that grounding in the classroom in relation to drugs, for example, to understand the health impacts and be able to make good choices. So there is a real relationship at that tier of—in order to be able to navigate in life students grappling with drugs and all the social issues around that—having a really good grounding of social and emotional literacy so they can kind of understand what they are thinking and feeling and particularly they can put their hand up and ask for help if they are feeling uncomfortable. They know how to do that, and they can have that resilience to resist that social pressure or work with their friends. So it is very much at that prevention tier. All of these things come together, and good prevention can be making good choices about anything, whether it is drugs, whether it is cannabis, whether it is other choices.

Probably where a fair bit of the activity has been added in recent years is in the early intervention tier, so really recognising the important role that schools can play in addressing issues earlier in life and really where students are. I think mental health practitioners is a really good example of that, where previously those kinds of professionals would have mainly sat outside the school system. There would be examples of schools that have those, but this is systemically an approach where they can all be on the same page and be linked into the broader health sector. Again, the issues that they were facing will be varied, but with alcohol and drugs, given the relationship that the royal commission talked about with mental health, there is typically a link. So any program that is focused on broader mental health will always have certainly a focus on alcohol. I guess I have mainly been talking about alcohol and other drugs, but Matt talked about the prevalence of cannabis. All of these things are important to build around the specifics of drugs because the context of it is so critical. As I said, we have had probably longer standing programs. So Life Education Victoria, the Get Ready education materials—they have been in place for quite some time and they have held well to have that specific focus. They get into more of the specifics about drugs and to more of the specifics about understanding cannabis.

Ms MAXWELL: I guess, Justin, I am quite curious about the models being implemented. What it sounds like is they were not actually born from the result of evaluations being completed on specific programs, and we know that in rural and regional areas it can be so difficult to resource staff and there are significant programs that are not evaluated. How do we continue to recognise and learn what are the needs of individual schools in rural and regional areas? Those programs are born from being evidence based, but if they are not evaluated at the completion of each program, how do we actually know that they are working, particularly if the intention is to drive down that recidivism rate? Part B of that is: what is the data that you have for the programs that have been implemented that support the reduction of those recidivism rates?

Mr McDONNELL: Thanks, Ms Maxwell. As I said in response to the Chair's first question, a number of those programs that I listed have evaluations, but probably the specific tying of the outcomes of those to drug use or reduced drug use may not have been specifically built into those evaluations. So there are evaluations there talking about their impact on wellbeing, but they are less explicit to be able to talk about the impact on drug use or recidivism.

Going forward, I think the royal commission did pick up on this point in that there is a lot that is good. They really did emphasise a lot of the good things that are in place through these programs and through work that schools are doing. But a fresh look at the evidence base—they called for that through, as I said, this evidence-based menu. So that is the task we now have, set by the royal commission, and that is set by the funding in the budget to set a bar for evidence, assess programs against that evidence, allow providers of programs to have a transparent look at what bars they would need to hit and then recommend those to schools. As I said, the template that the royal commission specifically asked for was school readiness funding in kindergartens, and we have got certainly information on the categories of evidence that providers need to meet to get on that menu.

Ms MAXWELL: Thank you.

The CHAIR: Thank you. Kaushaliya.

Ms VAGHELA: Thanks, Chair, and I would like to thank the team from various departments of the government today. I want to ask a question to Justin. Justin, alcohol and drug education is taught to all students in government schools. What happens in private schools? Are there any such educational programs in private schools, and if yes, then who oversees those programs?

Mr McDONNELL: Thanks, Ms Vaghela. So, as the department our primary levers or responsibilities are in relation to the government school system, so as the employer of principals the policy that I said applies to

government schools. But certainly the things that apply more broadly to the whole school system are the Victorian curriculum. So the Catholic sector in Victoria follows the Victorian curriculum and that explicit focus on alcohol and drugs that I mentioned there across that system. I am aware that for Catholic Education Victoria they have an alcohol and drug policy which has a lot of similarities with the department's one for government schools that I mentioned. They publish that and that is available. It literally steps out, as I said, what good practice education and prevention and response look like. The differences are that there is some tailoring and framing of the Catholic messaging, which has the Catholic messages, which we do not have in the government school system. In terms of the programs that the Catholic school system uses, they would be able to access that same FUSE website. That is open and available to anyone no matter which school sector they are in. Then I know that the Positive Choices website that the committee has heard about has that evidence-based range of resources for any school in Australia to access too.

I would say with the independent schools the relationship is a bit different. They do not sit under as much of an organising agency as government schools do for the department and Catholic schools do for the Catholic dioceses, but we understand that independent schools do draw quite a bit from, as I said, those resources that are available. In terms of the programs that they use, I think they would be varied. We would probably need to source that information through Independent Schools Victoria.

Ms VAGHELA: Thanks. The other question is—you mentioned a lot of programs and projects that are run in schools for educational and awareness purposes to prevent or maybe for early intervention, but we have heard today that there is still an increase in the use of cannabis—do you think these programs are working? And bluntly, is prohibition working on cannabis use? Is that working or not? Or if we, say, legalise cannabis use, then what will be the impacts of that?

Mr McDONNELL: Thank you. On the second question, I think in the education system we certainly talk about the law as it stands and try to make sure that is a feature of what students understand, but certainly the health impacts of it as well. As I said, it is all in the context of harm minimisation and it is a recognition that the content needs to be relevant for students. So a just-say-no approach, as many witnesses I have seen have said to the committee, is not realistic or feasible, but certainly we are clear about the law and the health impacts. I think in terms of changes to broader laws we would reflect current law in terms of what we talk to students about, but beyond that I probably would not comment too much on a proposed change in law.

In terms of your first question about 'Are the programs working?', as I said to Ms Maxwell, really I think in recent years we have boosted support at every tier. So at the prevention level we have tried to bring that really right together with the best evidence-based support in the classrooms for prevention. The early intervention and the more targeted support certainly happen in recognition of the need that we have been seeing, and what we see with mental health issues and, as I understand it, you know, those drug trends as well—some earlier signs too. I think it is not only to support students in the education system but, as Matt said, it is recognised that there is a far more integrated approach between education and the health sector these days as well. We know that doing more in the education system and doing more in primary school and doing more in early intervention is addressing demand and issues that are there but in the long term preventing the strain on the other services.

Mr HERCUS: I may, Ms Vaghela, pick up from Justin there. I think that is an excellent question and a good point that has been made in relation to the programs in schools in fact potentially driving some identification and some early pathways and early access, which is contributing to access to the service system. So it is not necessarily a bad thing potentially in relation to some of those numbers.

Ms VAGHELA: Thank you.

The CHAIR: Thank you. Georgie.

Ms CROZIER: Thank you very much, Chair, and thank you all for appearing before the inquiry this morning. I have got a number of questions, and because of the limited time that we are provided I am going to start to list those. You might need to take the questions on notice, but if there is time to answer them, I would appreciate that. To start with you, Mr McDonnell, you mentioned the clear policy on alcohol and other drugs within schools and talked about education, prevention and support. So my first question is: how many students does the department support who are using drugs or are affected by drugs and alcohol? I would like to know the answer to that. You also mentioned that the programs are tailored from an early age—it starts at primary

school—and the curriculum also has health and physical education. So how much time is dedicated to drug education and how much time is dedicated to physical education? I am interested in understanding those components. And you just mentioned a few minutes ago the mental health funding that is in addition to the current funding that has been announced. I am just wondering how much that is.

Then to you, Mr Hercus, if I could ask: you mentioned the number of people that have been having referrals to services. There is a 24-hour, seven-days-a-week counselling service. I am interested in the number of referrals to those services and how many people have been successfully rehabilitated. Does the department follow up with those individuals and how often? You also mentioned a very important point, I think, around synthetic cannabis and the number of fatal overdoses—12 fatal overdoses in recent years from synthetic cannabis. We have heard from a number of witnesses regarding this and how dangerous that can be and the toxicity which you spoke about. You said that 19 per cent that had registered with the mental health system had been using this drug or polydrug. I am interested in what that number of 19 per cent is—how many individuals that is. And you said in some cases there are waitlists in some areas. So where are those waitlists, and what are the numbers?

And then finally to you, Mr Harb—thank you so much. I am following on from Ms Maxwell's questions on the data, the justice related programs. You spoke about the reoffending and the success rates, but you do not single out single-use drugs, I think is what you said. So my question is: do most offenders through these programs have multiple drugs and not just use of cannabis? I am trying to understand how many of these offenders use cannabis, because this is around cannabis, this inquiry, so I am wondering about all of those questions. I am happy for you to start answering them, but I suspect we will run out of time, so if they could be taken on notice. Back to you, Chair.

The CHAIR: Yes, we are going to run out of time with that fairly expansive list of questions. I suspect some of them you are going to have to take on notice because of the data that is being requested. I think there have been questions directed to all three of you, so maybe if each of you could limit your responses to a couple of minutes and try and address as much as we can get through.

Ms CROZIER: Thank you.

Mr McDONNELL: Thanks, Chair, and thanks, Ms Crozier, for that. In terms of funding I have some detail here, but I am happy to take that on notice and do the count. I understand you are asking for the existing funding and how that relates to the new funding.

Ms CROZIER: You said 'beyond the current funding', so I was just wondering what that funding is, where it is and where it will be applied.

Mr McDONNELL: Yes, I can certainly give you the count of the existing programs that I mentioned and their funding and the new funding, which I was talking about as being 'beyond'. It is funding announced in last week's budget, so $217.8 million in new funding for schools mental health reform over the next four years.

Ms CROZIER: Thank you. That is all I really wanted to clarify.

Mr McDONNELL: Great.

Ms CROZIER: Thanks.

Mr McDONNELL: In terms of the number of students supported with drug incidents, I will take that on notice. We will just look at our data systems on that. And how much time for drug teaching in the curriculum and physical activity in the curriculum, we have certainly got the curriculum authority's standards on those, but I will come back to you to clearly articulate those and give you any information we have on how we know how many schools are delivering those particulars. I think that was the scope of the education questions.

Ms CROZIER: Yes, it was.

Mr McDONNELL: Thanks, Ms Crozier.

Ms CROZIER: Thank you.

Mr HERCUS: Through the Chair, Ms Crozier, I will just acknowledge and note I will take on notice the question about referrals to the system and the pathway and passage through the system—if we can follow-up. But as a general comment I note that of the 19 per cent of consumers present in Victoria that have cannabis as a primary drug of use on admission to AOD, 19 per cent is a reported completed episode of care for those on cannabis so there is some match there, I understand. I will take on notice the question about the numbers in the mental health system—

Ms CROZIER: Sorry, can I just ask: the 19 per cent, what is that figure? Is that—

Mr HERCUS: Indeed. I will take on notice the figure in terms of numbers.

Ms CROZIER: Okay. Thank you.

Mr HERCUS: Very useful. Similarly, I will take on notice the figure and data about the mental health system as well.

Just in terms of waitlists, it is important to note that waitlists in a numerate sense are important—the numbers of people waiting. It is also important to note that waitlist management is not a static approach, it is a dynamic approach where the service providers are constantly revising and reviewing the needs of people so that access to services is based upon need rather than time in the queue. It is important to note that the 100 new specialist drug and alcohol workers through the 2021 and 2022 budgets will really focus on targeting those on a waitlist or engaged or disengaged in treatment through the pandemic as well.

Ms CROZIER: Yes. But we have certainly got people on waitlists. I understand that some are more acute than others, but I do think we need to understand what those waitlists look like and where the issues are, because you said 'in some areas' so I think we would like to understand where those areas are if we could.

Mr HERCUS: Indeed.

Ms CROZIER: Thank you.

Mr HARB: Ms Crozier, from us, thank you for the question. Look, we will endeavour to consider where we can provide some more specific information on cannabis use, noting that there will be areas in which offences are not reported by drug type. But we will have a look and come back to you with the best information we can.

Ms CROZIER: I appreciate that. Thanks so much.

The CHAIR: Thank you. Dr Cumming.

Dr CUMMING: Thank you to the departments for the answers you have given so far. Mr Harb, Mr McDonnell and Mr Hercus from all three departments, in some of the answers that you have given to the committee you have actually referred to certain documents or policies, so I am wondering if you could make those available to this inquiry, especially—

The CHAIR: We have those.

Dr CUMMING: Mr Harb, the information that you were giving around the statistics in the justice department?

The CHAIR: Yes.

Dr CUMMING: Okay. So if there is anything that has not been given to the committee that you have referred to, could you please make that available? I guess that is my first question. Then my specific question is actually to the Department of Education and Training. I am wondering how you actually engage with the parents and families to ensure that children who have been identified as using cannabis have access to rehab and drug treatment programs and that their family has counselling, that their family has services and that their family has mental health services and wraparound services. I am wondering what department policies versus school policies are there to actually keep the parents and the families informed and involved when children are actually identified through our school system, because obviously there are a lot of children that just look tired but they may be under the influence of cannabis and they are not being identified at school and they are not

getting the help that is needed. So I am wondering how we are able to capture all those children who are at school at the moment looking tired but who are under the influence of drugs.

Mr McDONNELL: Thanks, Dr Cumming. In terms of our engagement with families, our policies are very much set in articulating what good practice drug education looks like. It is engagement with parents and carers to understand what drug education has been taught.

Dr CUMMING: Sorry, it is not just engagement but making sure that they are actually informed, rather than what I hear is occurring—that for children obviously under the influence, the school deals with it without informing the parents. The parents actually find out months or weeks later.

Mr McDONNELL: I think, Dr Cumming, I would say that our policies and our program approach would certainly be encouraging that link back to family, recognising, as I said, drug use is likely to be a symptom of broader issues that a child may be facing, and I think recognising the important role that schools can have to support the student but also addressing those root cause issues. I mean, one example at the more extreme end of issues that students may be facing is that Navigator program that I talked about, and that funds community—

Dr CUMMING: Justin, I am aware of that program, but I would like the actual specifics of, when they are identified in the schools, how parents and families are sure that they are being told immediately rather than the system thinking that they can deal with it. That is a really specific question to make sure that if it is the department's policy or if it is the school's policy that parents and their families are involved immediately, how the department of education or the school is actually identifying and wrapping around these services immediately. I am very pleased to hear that the Department of Health as well as the department of education have put more money into the school in the last 12 months due to COVID to actually identify children with mental illness and actually get in there and help children that have got learning disabilities. But we are talking about, hopefully, children that are under 18 in the school system being identified as using cannabis—because this is what the inquiry is about—and then acknowledging and making sure that those wraparound services are actually there for them. So I am almost glad that COVID has come along because we have actually now got money in schools for mental health as well as identifying children that have got learning disabilities. So if you are going to repeat what I already know from the departments and the media releases, that is not going to be very helpful. I would like to know what, on the ground, is actually happening.

Mr McDONNELL: Sorry, is that for me, Dr Cumming? I will give one quote from our policy, but I am happy to follow up if you need more information. The policy states that:

> Principals should notify parents or carers of a student's alcohol or other drug use as soon as practicable.

That is in our policy. So that is our statement to all schools and that is an expectation on government school principals. I appreciate the issue you are talking about is sometimes the difference between what a policy might say and what the reality on the ground is. That is probably what I would state on that, Dr Cumming.

Dr CUMMING: Yes. And also too, I guess, Justin, how the teachers are actually being trained to identify not just tired children but children under the influence of drugs and actually making sure they are getting care immediately on a school level, because I hear that there are a lot of children actually smoking on ground or around at lunchtime and therefore being under the influence and their parents are not aware, obviously, when they get home.

Mr McDONNELL: Yes, look, I think the education materials and the training that I referred to in the opening statement certainly do get into the nuances of drug use and recognising drug use, so it is fairly detailed information. Again, there can be possibly gaps between, you know, what the advice and the guidance say and the practice of schools when there are 1500 government schools across the state, but I do think our policy statements, the resources that we have, do encourage that really nuanced understanding. So, yes, look, I think we have got frameworks in place, as I said, if there is that gap between what we say and what happens. I think, again, as I mentioned in response to previous statements, what is working, what is the evaluation of what is working—the royal commission into mental health has set us that task to look across the board and set a bar for evidence and to make sure that the interventions that we have got in place are effective. So I think that is a key focus for the reform as well.

Dr CUMMING: I guess my other question follows from Ms Crozier, making sure that we have actually got the statistics of children that are on waiting lists to actually get drug and rehab services.

The CHAIR: Matthew, I saw you wanted to make a comment. Was that—

Mr HERCUS: Absolutely. I have written that down, Dr Cumming, as a question on notice. Critically though, Dr Cumming, the question about carers, families and engagement in treatment has also come out of the royal commission as reference to the integrated youth, child and family service. The family work is critical and pivotal to that and needs to be absolutely implemented to integrity and with fidelity to what the royal commission suggested for those reasons you articulate. Treatment of a young person, support of a young person, cannot occur without that network of support, being, in the case of some and a lot of young people, families or families as they define them to be in terms of support structures. So it is a really important question and we need to keep on that pathway.

Dr CUMMING: And I guess, Matthew, that the importance is actually making sure on the ground that people know that families need to be involved rather than the drug and alcohol services saying, 'No. These are teenagers. They have got rights and responsibilities and you step out of the room'—that it actually states that the parents need to be involved the whole time during the counselling and the like, so they understand and can identify—

The CHAIR: Thanks, Catherine. We will take that as a comment at the end. I very much appreciate that you have got a number of questions on notice, and again, we are grateful for your appearance today. We are grateful for you taking them on notice. I just have one final question that has been raised with us in numerous submissions, and it is around cannabis and driving. Certainly, as we pointed out, we now have medicinal cannabis that is legally available, but it would appear we have a system that tests for the presence rather than impairment. I know this has been an active question in the department of justice, and I was wondering if there were any updates on whether there is a move to an impairment test for cannabis as opposed to a mere presence test?

Dr CUMMING: Sorry, Ms Patten, is that also synthetic cannabis or just cannabis?

The CHAIR: No. Catherine. I will talk to you offline about synthetic cannabis, but it is a misnomer. It has got absolutely nothing to do with cannabis. They are completely different substances. They are just called that from a marketing perspective. But no, this is particularly to do with THC.

Mr HARB: Thanks, Chair. I might take that just briefly. I think probably it is a question best directed to Victoria Police in this context, in terms of drug presence versus impairment. It is probably something that they are best placed to answer.

The CHAIR: Okay. Thank you. Thank you again to you all. Thank you to the committee for making time this morning. We will certainly circulate a transcript to you in the next few days. As I mentioned, please have a look at it to make sure that we have represented you accurately. Ultimately those transcripts will form part of our report but also go up onto the committee's website. I look forward to seeing some of the responses to those questions on notice. We will call this hearing to a close. Thanks, everyone.

Mr McDONNELL: Thank you, Chair. Thanks all.

Committee adjourned.