PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into Vaping and Tobacco Controls

Shepparton – Monday 15 April 2024

MEMBERS

Sarah Connolly – Chair

Nicholas McGowan – Deputy Chair

Michael Galea

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Lauren Kathage

Bev McArthur

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Aiv Puglielli

Meng Heang Tak

WITNESSES

Lee Coller, Manager, Health Planning and Prevention, and

Dr William Cross, Acting Clinical Director, Goulburn Valley Public Health Unit; and

Trish Quibell, Chief Executive Officer, and

Debbie McDonald, Manager, Alcohol and Other Drugs, Primary Care Connect.

The CHAIR: I declare open this hearing of the Public Accounts and Estimates Committee's Inquiry into Vaping and Tobacco Controls. If you have not turned your mobile to silent, please do so now.

All evidence taken by the committee today is protected by parliamentary privilege. However, comments repeated outside of this hearing may not be protected by this privilege.

Witnesses will be provided with a proof version of the transcript to check, and verified transcripts, presentations and handouts will be placed on the committee's website.

I would like to welcome Lee, Will, Trish and Debbie. Thank you very much for taking the time this afternoon to come and speak to us. I will invite you to make an opening statement, but if you want to keep it really brief because committee members are really interested in this inquiry. We have lots of questions, so we really want to save time for questions – a bit of Q and A at the end. Who would like to start?

William CROSS: I am happy to start. Firstly, thanks for inviting us to this hearing. My name is Dr William Cross. I am a public health physician. I work at the Goulburn Valley local public health unit, which is an organisation within Goulburn Valley Health, which is the hospital here.

Just noting that we have been asked to respond to a few key points – and we have done our best to do that – I think the first point that we would like to point out is that population-level data on the distribution and the impacts of vaping is sorely lacking at this time, which is understandable, but we would like to note that we would really support any programs that would continue to collect this data in line with other similar data which has been collected as a really important tool within tobacco control regulation. That is important for the whole state but also for us locally for us to be able to most effectively target our programs.

I would just like to note a few points as well. The emerging evidence suggests that medically supervised use of regulated e-cigarettes may be effective for some people in the cessation of traditional cigarette use but that that this evidence is not conclusive. But based on this we will be basing a lot of the points of our testimony and the responses to questions on that best evidence that we have at this moment. We would also note that the harms of e-cigarettes are as yet incompletely understood but that emerging evidence indicates that these harms are real and include potentiation of nicotine addiction, acute lung injury and exposure to carcinogenic substances, which I am sure you have heard a lot about already.

I would also like to just make the key point that throughout a lot of the references we would say that consumption of no nicotine is always preferable, but based on this evidence there might be a hierarchy of what would be preferable consumption of nicotine potentially. We would consider e-cigarettes at this moment potentially being preferable to tobacco use, particularly when they are used under medical supervision. We would also consider that regulated products are likely to be less harmful than unregulated products, as the latter can give an undisclosed amount of nicotine and may also contain a broader range of potentially harmful chemicals.

Based on all the above, we are really supportive at the present time of a policy approach that strikes a balance between decreasing access to and consumption of unregulated e-cigarette devices, particularly amongst non-smokers and young people, while maintaining access to regulated e-cigarette products as a means to support reduction in and cessation of cigarette consumption in current smokers. We know that lessons from tobacco control over the past 50 years have indicated that approaches to decrease consumption in Australia and abroad are based on effective supply-side and demand-side interventions within the markets. Some demand-side considerations that we would like to have within the e-cigarette market are a supportive investment in educational materials and programs on the potential harms posed by nicotine and other chemicals in

unregulated e-cigarette products, and we also support that any educational materials be developed to serve the diversity of languages and cultures of Victoria's First Nations and migrant populations. This is particularly important in regional settings where there still is a diversity of cultures, but these might not be supported by large communities so misinformation can often gain a stronger foothold. There may also be less capacity in local cessation and AOD services to service the broad range of communities that we see in cities such as Shepparton.

In terms of supply side considerations, we note that currently unregulated e-cigarette products are, anecdotally, broadly available across retailers across all of regional Victoria. Let us say anecdotally; I have not checked myself, but you certainly see them around and they are certainly available on the High Street of Shepparton. We acknowledge that where enforcement on restrictions and sales and advertising falls to local government, regional councils may face challenges as a result of relatively small workforces covering large geographical areas, so we would like this to be considered. We would support the consultations to take place with the diversity of councils around the resourcing requirements to effectively limit points of sale of unregulated e-cigarette products across all of Victoria.

Just a final point: in regard to maintaining access of regulated e-cigarette products as a support to decrease cigarette consumption in current smokers, taken from a regional perspective we know that strategies to support effective smoking cessation are particularly important for regional areas where smoking rates are higher than in metropolitan areas in general. There is evidence that medically supervised use of regulated e-cigarette products may be an effective strategy to support smoking cessation for some people. We are generally supportive of the prescription model of access to regulated e-cigarettes to maintain use as a method to support smoking cessation based on the current evidence at this time. We note that there will be challenges with the primary health workforce in regional areas to support this model, with generally lower workforces, longer wait times and higher billing rates, including lower rates of bulk-billing. This means that people in regional areas will generally face higher financial and other barriers to accessing regulated e-cigarette products. This is particularly concerning given the generally higher smoking rates and lower socio-economic status that we often see in many regional areas compared with metropolitan areas. So we would like this to be considered.

We would also note that there is a higher relative cost of regulated e-cigarette products compared to unregulated e-cigarette products at this present time and addressing this difference will be important to address cost barriers for the safer products, those being the regulated products. Equitable access to regulated products will also hopefully reduce demand for unregulated products, and this will in turn reduce the incentive for traders to participate in unlawful selling of e-cigarettes, in theory. That is the conclusion of my opening statement. Thank you.

The CHAIR: Thanks, Will.

William CROSS: Lee, did you have anything you wanted to add?

Lee COLLER: I was just going to reiterate. I am the Manager of Health Planning and Prevention at the public health unit, and so I work in mainly secondary and primary prevention activities related to any chronic diseases. Our role is to support people to make lifestyle and behavioural changes to enhance their health outcomes. Reiterating Dr Cross's testimony: the evidence of high smoking prevalence for low socio-economic and regional populations compared to the metro populations contributes to health inequalities. It is really important that we have a whole-of-community approach to ensure that if we are promoting educational materials or whatever it might be that we will refer to on that demand side, they are developed to serve those communities and the diversity of languages and cultures of Victoria's First Nations and multicultural populations as well. From a public health perspective, our objective is smoking and vaping cessation at every opportunity, and it will take a whole-of-community approach to do that.

The CHAIR: Thanks, Lee. Trish or Debbie, is there anything you would like to say before we kick off with questions?

Trish QUIBELL: Probably just that I will give a bit of a summary of where we sit in all of this just to give context to the committee members. Primary Care Connect is one the 24 registered independent community health services, so we sit outside of the public health services. We run a range of programs across the Goulburn area that cover the LGAs of Greater Shepparton, Mitchell, Moira and Murrindindi, so we cover a fairly wide

geographic area not only for our alcohol and other drugs programs but we run family support programs – where a family member has a drug issue – as well alongside our family violence, financial counselling, gamblers help, health promotion and allied health services. We tend to look for services that often collaborate or coordinate well together, recognising that community members often come in with multiple and complex needs and that if we can offer them more than one service within our four walls, then that is of benefit to them to assist them to live their best lives moving forward.

Today Debbie and I were looking to actually contain our comments predominantly to young people, and I note you had the education department members in here earlier on. We have a youth AOD program that operates in partnership with six of the local secondary colleges. The reason we are predominantly speaking to youth today is that of the adult – over-18 – population that come in and access our AOD services we do not see anyone coming through recognising or identifying vaping as an issue they want to address. In fact their philosophy predominantly is that if they are giving up something else – so a harder drug – vaping or cigarettes are the ones they want to hold on to; they do not feel as though they can give up everything. But if they give up the harder stuff, they do not recognise vaping or tobacco as a concern for them at the current time.

Our youth outreach program operates both in schools doing group work but also doing individual work. I think of the young people that we see, 45 per cent actually do not consider vaping to be a primary drug of concern. They have often already been smoking or using cannabis, so they do not see it as a major issue for them in any way. Only 25 per cent of our referrals are actually self-referred; the other 75 per cent are actually coming through directly from the school for one-to-one sessions to provide education and harm reduction due to being caught vaping at school. I think the challenge there for us is to ensure that it does not become a punitive measure, because that then will severely constrain the impact that we can have when working with young people – if it is seen as a punitive, disciplinary response to come through from secondary schools. Fifty-five per cent of the students that work one on one with our staff members often are saying to us that they are ceasing the use of vapes. We do not know of any longitudinal data on that at the moment, so it is just self-reporting.

We have only had one young person identify as Aboriginal coming through the program in the first six months of this financial year, but as Dr Cross and Lee mentioned, there is a specific issue in, I think, the Shepparton area around CALD communities. As much as we are not seeing CALD communities come through in this space at the moment, we also know that they are being caught vaping at school but they are refusing to attend any services. I think there is some significant education that needs to go hand in hand in that space.

I think the problem we have got is that it is the cool thing. It is the fad at the moment. It looks cool, and I will let Deb speak a little bit more to some of the comments that we are getting back in that space to anecdotalise it.

Debbie McDONALD: We are seeing a big increase in vape pens, rather than those kinds of vapes that you have there. The vape pens are bought very easily online. I checked out one of the main sites online, which likes to promote them, with the watermelon one being advertised as ‘Giving you the feeling of devouring fresh slices of watermelon by the pool.’ That is one of the marketing strategies. They do state that the juice in the vape pen is different sweet beverages that are found every day in the common sweets that you might buy at the supermarket. So that is what youth are seeing first. They are not seeing that there are any other chemicals in there that could cause them issues: ‘It is fine – it is the same as sweets.’ They are also very well presented with different colours and patterns, and I just found out last week you can actually have your vape pen personalised as well, if you would like to have your name popped on it, when you are doing your order. So I think the youth are seeing that as cool and something different: ‘I’ve got something different to the next person.’

Purchasing vapes online – from our youth we are being told that it is very easy to purchase online. You just need to copy Mum or Dad’s debit card just once and you have got the details. They then deal with that once Mum and Dad realise that it is on the bank statement, but also they are getting older siblings to purchase all of that. I have tried five different sites in the past week, which asked me if I am 18; it does not ask me for proof that I am over 18, I just click, ‘Yes, I’m 18,’ and I am in there. Most of them are purchasing them, like I say, from older siblings or friends, taking money from their parents’ wallets. They are prepared to deal with those consequences if it means that they can get their vapes.

We have recently been told that within three of our local high schools – the youth word is that there are 15 dealers who are well known that the youth are now going to to purchase their vapes off at school. They are running their own little happy market. One disturbing report that we have just heard recently, a youth purchased

a vape pen – he had never vaped before, but it was the cool thing to do – from somebody from school. We think that that vape pen juice was laced, spiked – something else has been put in there to increase the consequences. That youth reported that for an hour he had no idea where he was, he could not speak. He ended up needing medical assistance but was too scared to go and ask the school, because he knew what he had done. Thankfully he will never vape again, but that is coming in more and more – we are seeing that the juice in the vapes is actually being changed, and we do not know what is in them. It is hard enough to find out what the information is in the first place.

The CHAIR: That is really interesting.

Debbie McDONALD: So, yes, it is very concerning. Our youth outreach sessions, our one-on-one sessions, include how to recognise addiction, recognising their triggers and their reasons for vaping. We work towards goals and reducing or ceasing use, and relapse prevention as well.

The CHAIR: Okay, thank you. I am going to throw to Aiv for the first round of questions.

Aiv PUGLIELLI: Thank you all for coming in today and for your contributions individually. I will try and be quick. We have heard earlier, just in the previous session, with regard to the education space this risk with the proposed legislation that is coming forward where it is going to be harder and harder to access vaping products for people who are addicted to nicotine, young people particularly in the school environment. There is a risk of withdrawals for these students who are not able to access prescription or other kinds of replacement therapies that would mitigate those effects. I might send these questions down the line – it just helps with time – starting with Lee. Do you foresee a scenario where teenagers or young people who are addicted to nicotine and currently vape might actually find it easier to switch to smoking rather than finding a GP who is willing to take them on as a patient and prescribe them nicotine as a teenager?

William CROSS: I think it is absolutely possible that that could happen. I think that the probability of that increases proportionally to how difficult it is to access GPs, and we know that there is a strong correlation with that in regional areas. I think it probably depends on a number of factors. I do believe personally that there is probably a bit of a barrier between vaping and smoking itself, but I think there is certainly some initial evidence that they can act as a gateway, if you will, to people taking on traditional tobacco consumption.

Trish QUIBELL: Probably similarly to Will, I think there would be some barriers. I think potentially cost would be one of those barriers, and I think in order for a young person to get before the GP to start with they have to have a parent that is going to recognise the issues and the risks here and be prepared to talk to their parents about that. While we still have this marketing of fresh, juicy watermelon slices or sumptuous strawberries and things like that, it diminishes that ability for parents to have an impact, I think, or to actually market how much nicotine is in them – 'Well, it can't possibly be that bad for me, because it tastes like strawberries.' I think that smell and the different flavours often mask it as vaping because potentially some parents are not as aware of the indicators of vaping as opposed to smoking, which comes with the smell and the odour and whatnot attached to it, whereas some of the vaping does not at the moment. None of the young people we are seeing – correct me if I am wrong, Deb – were using prescription vapes. They are all using the unprescribed, under the counter vapes and they are incredibly easy to get. We have had notification where young people have told staff that 'I can get it at this shop, but if the police have been sniffing around, they'll tell me to come back later on in the week.' I think that is going to be a really hard market now that it is established and known. How do we get into that and stop that?

Debbie McDONALD: I think as well, talking youth, we are looking in our program at people from the 12-, 13-year-olds, not the 14-, 15-year-olds. A 13-year-old going to a GP and asking for a script like that – I doubt would happen, unless they were supported.

Aiv PUGLIELLI: Thank you. Sort of following on – and again I will go down the line – we see, for example with pharmacotherapy, concerns where there are GPs or medical practices that are not prescribing because there are stigmatised groups or there are cohorts who would be requiring those services. There are clinics that do not want to have them coming in, frankly. That is anecdotally what we hear. In your view, in the proposed federal model where you would only be able to access a nicotine vape via a GP prescription, do you think, in each of your respective views, that many or most GPs will prescribe vapes, particularly to young people?

Lee COLLER: I think we would have to take it on notice and ask the GPs really.

Aiv PUGLIELLI: Sure. That is all right.

Lee COLLER: With the research that has been done to date and the emerging concerns and whatnot, I do not know. There would be some GPs who would be making that stand around no nicotine.

William CROSS: I think it is entirely possible. As Lee was saying, I think that perhaps some representatives of general practice bodies might be better to talk to about that such as the primary health network in the regions. But we do see that generally in our region, like in any region, different GPs provide different services based on what they feel comfortable with, and that can sometimes, particularly in controversial areas, be based on personal beliefs as well. So we do see that in medicine everywhere.

Trish QUIBELL: I would agree completely. I think the college of general practice would have much better commentary on this. I worked for the Department of Education when they introduced the doctors in schools program, and there was the controversy around parental consent for doctors to prescribe things to students under the age of 16 as the mature-age minors concept. I would say you would probably get a similar pushback from GPs in terms of that concern about what might be the risk that they carry if they are actually prescribing that, which may have an impact on their ability or their willingness.

Aiv PUGLIELLI: Thank you.

Debbie McDONALD: Same for me.

Aiv PUGLIELLI: No worries. I will just ask one more, if that is okay, Chair.

The CHAIR: Yes, sure.

Aiv PUGLIELLI: Obviously that proposed federal model that we have just been referring to is where it is a GP-prescribed medication, effectively, or product. Will, you mentioned in your contribution the view that you are generally supportive of the prescription model that I have just spoken about. Just going down the line, would it be your view that potentially a pharmacy-only medicine option would be better than requiring that prescription?

Lee COLLER: No idea.

William CROSS: It is a difficult question to answer, and again, I do not think it is probably within the public health unit's area of expertise. On the current evidence it is stressed that it is medically supervised, so it is, as of yet, unknown whether or not that might be successful – if it was unsupervised, if it was pharmacy-only medicine, like a lot of the other nicotine replacement products are. I think it would also depend on the parameters, which I believe are still coming through, about what products exactly would be offered – whether it would just be the nicotine or whether there would be other appealing factors, as some people have noted, for younger people. I think that lack of medical supervision is probably quite concerning and would cause a lot of people to be concerned if it was just freely available through pharmacies only.

Aiv PUGLIELLI: When you are saying supervision, you mean the prescription and not the actual use of the substance, right?

William CROSS: It is the giving of a prescription, but it is the idea that they give one prescription, perhaps, for one vape or a vape and some repeats and then the patient will come back and consult with the doctor again. Presumably the doctor would then counsel the patient about how often they are using and how much nicotine they are getting, look at any other medications they are using and look for interactions, look for any adverse effects and counsel them on other non-replacement therapies such as CBT or otherwise that they might be able to pursue. I think that oversight has a lot. Pharmacists can do that up to a point, but I think the doctor–patient relationship is often different to the pharmacy–patient relationship.

Aiv PUGLIELLI: Thank you. Anything further?

Trish QUIBELL: I am a bit the same. I do not know that this is our area. This is certainly not our area of expertise to speak to, but I think given the fact that we are working predominantly with clients who are using

non-prescription and have no interest in going to see a GP for a prescription, there is a possibility that it may be the same as if it became a pharmacy-only one, because they would still look for that opportunity to find it elsewhere.

Aiv PUGLIELLI: Okay. Thank you. Nothing further.

The CHAIR: Thanks, Aiv. Lauren.

Lauren KATHAGE: Thank you, Chair. Thank you so much for joining us. We heard that you have got 25 per cent of people in your program who self-refer. Can you tell me a little bit about what a self-referrer looks like and why they might want to come to your program?

Debbie McDONALD: Again, it is because of the youth. Our youth outreach worker works very closely with the schools and does presentations on standardised drinks as well as a vaping program that she does to a whole class – she can do it to a whole school at once. From those we are getting connections from the youth who are sort of coming up to her on the side and going, 'Can I come and see you?' Obviously we have our intake and referral process where they can just get online and fill in a form and they will be referred to her or do an intake with one of our consumer care team. So it is somebody who has stepped forward and gone, 'I really want to make a change and I want to learn more. I don't necessarily have to tell my parents, and I don't have to tell anybody I'm coming. I can just do that referral and come and see somebody that I have met at the school and feel comfortable with.'

Lauren KATHAGE: Could it be that for these people, meeting with your staff through the program is the first sort of non-parent or non-school-type figure that they have had a discussion with?

Debbie McDONALD: Yes. It is about building that rapport with them and building that trust with them and them understanding that what they do tell us is private and confidential. But obviously if it is something that risks their health, other than vaping, we would be in touch with their parents. They can have that one-on-one conversation with the youth outreach worker and be able to get the information they need without feeling judged or pressured. We do harm minimisation and harm reduction rather than ceasing. We work towards that in the end but start with making sure they are using safely and minimising.

Lauren KATHAGE: Okay. Thank you. You were talking about CALD communities and said that they are refusing to attend the program. Did you mean that the parents are refusing to allow the children or the children are refusing to attend?

Debbie McDONALD: No, the children are refusing to attend. We feel that is a cultural thing – the shame and that they do not want to say that they are a part of that program or attend that program. The schools are making it mandatory, so it is hard for us to get that cohort to come.

Lauren KATHAGE: Okay.

Trish QUIBELL: I think it would also be very difficult for a lot of the young people from our multicultural communities to have that conversation. If their parents found out that they were attending a service, they would hold a much more different conversation with those parents than they would within our more predominant Anglo-Saxon communities, as we know that it would bring that shame not just between them in their social group but in their cultural group as well to have been sent to a service or to go to a service such as ours.

Lauren KATHAGE: Okay. Thank you. Some of the other barriers we have heard from the panel this afternoon, barriers to seeking help and accessing help, are around lower bulk-billing rates and the price differential between regulated and unregulated products. Are there any other barriers that you can share with us that are stopping people from seeking help or accessing help?

William CROSS: It can be a bit difficult to comment on that because we are the people – well, I think that our colleagues over here would be the people that would always see people once they have attempted to access help.

Trish QUIBELL: I think for young people it is the stigma, and I think it is going outside the social group or what they consider to be the social norm at the moment. If vaping has become a norm in their social sector and in their outings and their social engagements, then to no longer be doing that would be a whole great stigma, the

same as it probably was with smoking a generation ago. So to actually come into a service does take a high degree of motivation and a fair amount of guts for a young person to walk through the front door, which is why I think it is easier to engage with our worker actually in the school. I know you had the school nurses in here previously, with Mark Metcalf. They do an amazing job in this space as well because they are not the teacher. They have a great engagement with young people. So the ability to create those relationships with young people in environments where they are comfortable makes it much easier for them to come to a trusted adult who is not in that authoritarian position, whether that be a parent or a teacher or a sporting coach even or something. If they have got those other avenues where they can even just ask the vague question or maybe the non-judging question, that makes it much easier for them to have a conversation with that trusted adult.

In terms of the barriers for our adult clients, it is very much that by the time someone seeks out AOD services, they are often down the path of using drugs that are much more potent than smoking and vaping. So for them it is wanting to keep the smoking and the vaping because it is seen as the lesser evil when they are trying to get off harder drugs as well.

Debbie McDONALD: For most of our adult clients if they are vaping or smoking and possibly going into detox for cannabis or alcohol, most of the detox and rehab centres now are non-smoking, including vaping. So we are actually having adults saying, ‘I will not go to detox or rehab if I have to give that up as well as that, so just don’t bother sending me to detox – I just won’t go.’

Lauren KATHAGE: Thank you. And if there is anyone else.

Lee COLLER: I was just going to add to that. On thinking about that I think there are two things. One is sometimes a barrier is that you do not even know that they are addicted or that it is an issue. I think VicHealth has taken the approach where they are giving information to families and parents on understanding vaping and the harms that are known to this point and the problems of addiction and where their child might be at and how they might be able to speak to them; you know, to have great conversations – as you said, talking to them about it as opposed to – and parents and kids may not even know that that is an issue. But I think the second thing that is interesting and what Primary Care Connect is sharing as an AOD specialist is that vaping and smoking are at the bottom, and it often will not be the thing that they are coming to get rid of or to cease. So I do not think there are a lot of services that focus on that area. I know for sure in this area there is some AOD but limited in regional areas.

Lauren KATHAGE: We have certainly heard from prior witnesses that in the cycle of addiction or change there are lots of happy users and not many people are recognising that they are – yes.

William CROSS: I think, much like with smoking, with vaping it is the chronic harms that often are more evident or more well researched as opposed to many other substances that have those acute harms, and often episodes of acute harm can be a good catalyst for individuals to change, whereas when it is chronic harm it is really more about knowledge of the chronic harm. That took a long time to really penetrate that throughout the entire population during anti-smoking campaigns, and I would imagine there would be a significant amount of people that do not wish to change because they do not see it as being harmful; they see it as being significantly less harmful than cigarettes. There is certainly a role for increased educational campaigns.

Lauren KATHAGE: Thank you. Thank you, Chair.

The CHAIR: Thank you, Lauren. Michael.

Michael GALEA: Thanks, Chair. Thanks for joining us today. I might start with you, Dr Cross. You spoke in your introductory remarks about the rates of nicotine in vapes. I am curious, have you seen any trends? Have vapes become stronger with their nicotine value over time?

William CROSS: I am probably not in a position to answer that. I am aware, and this is purely through third-party sources – I believe it is quite difficult to actually test for nicotine concentration, so it is not done routinely. But it seems like there has been some more testing, and it seems like there have been some wildly high concentrations of nicotine that have been reported in vaping products. I understand that it has become quite variable, though, and I think that is one of the dangers of lack of regulation.

Michael GALEA: Yes, and even if it is anecdotal, you are hearing more cases of extremely high nicotine ratings. Would that be the same for you, Ms McDonald?

Debbie McDONALD: Again, I do not know that we are in a position to answer on the nicotine level other than – like the doctor said, it is really hard with a vape to even know what chemical is in there, let alone the level of nicotine, because there are plenty of other chemicals in there. It is not listed on the outside of a vape, and it is not listed on the box.

Michael GALEA: Yes, and other dangerous chemicals that are not.

Debbie McDONALD: Yes.

Michael GALEA: You do not know what could be in there, yes. It is interesting.

Trish QUIBELL: I think there is a proportion of the community that probably still thinks that they do not have nicotine in them, and they think that they have stepped down from smoking to vapes because it is the healthier option.

Michael GALEA: Yes, and even without knowing what is in there, you could think 'It is harmless, it is just –'

Debbie McDONALD: 'It is harmless, but it is still going into my lungs, but that is okay because it is not nicotine.'

Michael GALEA: Yes. It is interesting. Dr Cross, I understand your remit covers quite a few council areas – Greater Shepparton being the heart, I guess, but others such as Moira and Strathbogie, I am assuming, as well. In terms of the compliance activity that councils do, we heard from Greater Shepparton this morning, but I am curious about some of those smaller councils that may not have the same resources. Are there any particular trends that you are seeing in those council areas where it has been tougher for councils to maintain compliance or to attempt compliance?

William CROSS: We have certainly spoken with a couple of those smaller councils, primarily in preparation for this hearing, because I think that is obviously a role that is under council jurisdiction, and we keep in close contact with our constituent councils within our catchment area. But certainly the smaller councils have raised that, and that is why I wanted to put that in my opening remarks, because I think that is a really important part of the whole control strategy. I think that the game is really going to change if there is an increase in looking at anti-point-of-sale campaigns that were run through local councils, just because of how broad we can see this problem being and how many retailers dotted across the region there are selling these and potentially how large the market is, as that is a real incentive for those people to continue to sell. They did flag that as a challenge. I think consultation and consideration of those challenges will be really important to ensure that that supply issue is equitably managed across all of Victoria.

Michael GALEA: Yes. Thank you. And I am noting of course the new reforms announced by the Premier about those regulations in terms of point of sale. Do you think that will support those smaller councils as well?

William CROSS: Sorry, I did not quite catch that.

Michael GALEA: Well, the new scheme around regulating point of sale for tobacco, will that assist those smaller councils, do you believe, in being able to undertake enforcement?

William CROSS: I am not completely across all the points of those. I suppose what we are primarily concerned about is people unlawfully selling them or selling them under the counter, if you will, and understanding that as long as there is demand from children or young people in the short term – and in the short term there will be demand for these things even after it is unlawful to sell them, which is expected – in order to properly quash that out and make sure that that is being enforced appropriately to put the disincentives in there to stop the selling I think is likely to be a key point. Notwithstanding, though, the other factors and the fact that online access is equally simple. There are a lot of holes in the pocket, so to speak.

Michael GALEA: Indeed. Right. Thank you, all.

The CHAIR: Thanks, Michael. Mat.

Mathew HILAKARI: Thank you. I might actually continue on just where Michael left off. You mentioned about risking licences briefly, but I am probably taking you to a different point, which is if people were found to be selling vapes, would you be satisfied if their whole licence, which is part of a future regime, was cancelled for any tobacco salesperson?

William CROSS: I think that is probably a complicated question. I am sorry. I do not really want to give a wholesale answer there, because I think that there is always context around why people choose to do the things that they do. I think this new concept of tobacco licences is reasonably new in Victoria, as far as I understand it.

Mathew HILAKARI: Yes, in a broad sense – the definitions have not come through, and that legislation will be introduced in the second half of this year. I guess part of the inquiry that we are doing at the moment will to a degree inform some of those decisions, so this is maybe an opportunity to put some things on the record, so to speak.

William CROSS: I suppose I would say that with any licence it stands to reason that cessation of the licence because of repeated, intentional infractions would be a reasonable consideration, in addition to the other things that are normally put on.

Mathew HILAKARI: And I do note the large number of online sales that you were attempting to do. They have still got to get delivered at some point. Do you have a sense or an understanding of how they were getting delivered? Was it through regular mail, through Australia Post?

Debbie McDONALD: It is also extremely easy, yes, through Australia Post to get yourself a – not a private postbox, but now you can get your deposit box, where parcels can be put, in Benalla Road. Youth can do that just as easily as anybody else using their own date of birth – or other people's if need be. Once that is set up, you do not need a photo ID; you just have a key and you go and open it up.

Mathew HILAKARI: Do you have a sense of that happening at all?

Debbie McDONALD: Yes.

Mathew HILAKARI: Okay.

Debbie McDONALD: Partly because our youth are great.

Mathew HILAKARI: Because that is an expense.

Debbie McDONALD: They tell us what is going on, to a point, until we ask questions, and then they stop. But to a point, they tell us. They know exactly which wholesale outlets to go to on what days. Those wholesalers will say, 'Not today, but come back in a couple of days when there is an opportunity.' They know where to source it from – and online as well. One of our questions was: were you buying this online without Mum or Dad knowing? Surely when it hits the letterbox, they know. They go, 'We don't use our address.' I know of one who actually just picked an address as he was going past and realised it is an empty letterbox, so that is where his get delivered to. On the way to or from school, he opens up the letterbox and collects his mail from a place that nobody knows. But he is using their address.

Mathew HILAKARI: People are ingenious, aren't they?

Debbie McDONALD: They are not silly people. As with any substances, if somebody wants to get hold of the substance, they will find a way of getting hold of it.

Mathew HILAKARI: Thank you. I do note, and I take your point immediately, that vaping is not the highest order issue when they are coming to see you and talking about alcohol and other drugs, but you mentioned that I think 55 per cent of people had stopped vaping.

Trish QUIBELL: They self-report at the end of their one-to-one sessions. So we do not know whether there is any longitudinal outcome that mirrors that. We cannot obviously predict the impact of going back into the

social group and then at the next social function someone handing you something that tastes like a juicy watermelon by the poolside.

Mathew HILAKARI: I am glad you predicted what I was going to ask, so thank you. What were some of the steps that you were taking that were getting some of those good initial results?

Trish QUIBELL: I will let Deb answer that.

Debbie McDONALD: That would be our youth outreach worker doing the one-on-one sessions with them, and that can be over any length of time. So to start with, it is about building rapport and trust, without even discussing the vapes. But having easy-to-read documentation for them that she has developed on what triggers are, how you might feel in withdrawal, how you feel about peer pressure and, if you do stop, how you are going to feel. How are you going to cope when somebody does say, 'Go ahead and do it'? And there is ongoing support as well, so that even if they get to a point where they feel they no longer need her, they can call her back and go, 'I need to come back to you.' She can re-engage with them at any time. It is about not being judgemental and giving them a lecture; it is about, 'How do you want to do this? What are your goals? What goals are we going to get to and how are we going to get there?'

Mathew HILAKARI: I was interested: earlier one of our witnesses, a young person, talked about the shame that people in year 12 had around vaping. They were actually saying, 'This isn't something I'm necessarily proud of anymore,' and that it was lots of younger 12-,13-year-olds. Does anyone have any comments on that sort of change in attitude to vaping as people get older, from when they enter teenagehood to when they are entering adulthood?

Debbie McDONALD: I think it is partly maturity. As they get into year 12, they have a bit more of an understanding healthwise and might think, 'Well, it's not going to help me when I'm looking at a job in a sports arena,' or something like that. For the younger youth, the 12-, 13-year-olds, there is more of that peer pressure I think than anything else. It is cool to hang out in a gang of six or eight of you on the corner and vape to watch everybody's faces as they go by to go, 'Oh, how disgusting.'

Mathew HILAKARI: Is it accurate, though, from what you are picking up in the community, that there is that sort of up and then decline?

Debbie McDONALD: Definitely, yes, from our program.

Trish QUIBELL: It would be anecdotal at the moment.

Mathew HILAKARI: Of course, anecdotal. I was going to ask you, because you have mentioned baseline data and the lack of baseline data that exists: what would it mean to you in terms of your work to have that baseline data?

William CROSS: That is a good question. A part of what we do is develop, implement and evaluate programs that are really focused on local needs. We are often reliant on state-level data, but that can be cut down to a local level and can give us information about how we can best target some of our programs. So, for example, understanding knowledge, attitudes and beliefs of various different age groups of young people and other demographic factors might allow us to target our programs a bit more efficiently, and it might also give us a stepping-off point in bringing in our partners to understand the importance of certain things, particularly if we can demonstrate that certain groups are significantly disproportionately affected by these whole problems.

Mathew HILAKARI: Thank you.

Lee COLLER: I do know that VicHealth have done some research around the different age cohorts and what their attitudes are to vaping.

Mathew HILAKARI: I am going to ask VicHealth all about that.

Lee COLLER: I did read it, but I do not have the reference here. It is part of that education for parents to help them understand.

Trish QUIBELL: Could I add to that: I know that some of our community health colleagues at Gippsland Lakes Complete Health have been running a vaping program for grade 6 students in schools and doing a lot of education in that space about the difference between something that tastes like watermelon and actually is watermelon, which has been interesting. They presented it at the Alliance of Rural and Regional Community Health conference last year. They are getting some very interesting data and reports back from those young people in sort of primary school age groups before they get into secondary school, where there are different levels of availability, but trying to impact those belief systems much younger. One of the little girls made a comment such as 'Why would you want to suck in something that tastes like banana when you can actually have a banana?' which from a health promotion perspective is exactly what we want to hear. It is about how we target it at different levels in a very complex but very much a layered approach to intervention.

Mathew HILAKARI: I know our secretariat were listening intently then, but they might grab the details of your contact there to provide some of that information. That would be really helpful.

Trish QUIBELL: No worries.

Mathew HILAKARI: Thank you.

The CHAIR: Thanks, Mat. Heang.

Meng Heang TAK: Thank you, Chair, given the time that we have. I guess I would go back to Lauren's question but further on that in terms of barriers. In terms of those of an older age that want to get off with the nicotine replacement tools such as nicotine patches and gum and all of that, do we know how much that costs?

Debbie McDONALD: No, we could not give you figures.

Meng Heang TAK: Okay.

Trish QUIBELL: We would not have any idea, sorry, about how much that would cost. I think it would probably be very personal – like how many times someone tries it, whether they try multiple approaches to nicotine replacement before they hit on the one that works for them. I could not possibly – it would be a 'How long is a piece of string?'

Debbie McDONALD: And how much relapse prevention is also provided as a support so that once they do cease it, they do not go back again, because that increases the cost again.

Meng Heang TAK: Yes.

Debbie McDONALD: Cigarettes alone cost too much money now.

Meng Heang TAK: Okay. All right. That is fine. Thank you. Thank you, Chair.

The CHAIR: Thanks, Heang. On behalf of the committee, I want to say thank you very much for coming and talking to us this afternoon. It is always insightful to hear about the work that you do and the people that you are seeing. I really do think that some of the insights and experiences that you have shared today will help form what I hope will be a very good report with plenty of meaty findings and recommendations to the government on this topic.

The committee is going to follow up on any additional questions or questions taken on notice in writing, and responses are required within five working days of the committee's request. The committee is going to take a very short break before commencing the last session for this hearing. I declare this meeting adjourned.

Committee adjourned.