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—Thursday, 25 March 2021

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WITNESS

Dr Shalini Arunogiri, Chair, RANZCP Faculty of Addiction Psychiatry, Royal Australian and New Zealand College of Psychiatrists, Victorian Branch.

The CHAIR: Thank you, everyone. Welcome back. This is the Standing Committee on Legal and Social Issues public hearing into the use of cannabis in Victoria. We are very pleased to have Dr Shalini Arunogiri from the Royal Australian and New Zealand College of Psychiatrists come to present to us today. I would like to introduce you to our committee. To my far left we have Sheena Watt; we have Kaushaliya Vaghela and David Limbrick; we have Professor Tien Kieu; and Georgie Crozier will be joining us in just a moment.

Just to let you know, all evidence taken at this hearing is protected by parliamentary privilege. That is provided under our *Constitution Act* but also under the standing orders of the Legislative Council. This means that any information that you provide during the hearing is protected by law; however, any comment repeated outside the hearing may not be protected, and any deliberately false evidence or misleading of the committee could be considered a contempt of Parliament.

As you can see, this is being recorded by Hansard. You will receive a transcript in a couple of days, at the end of this. I would like to welcome you to make some opening remarks, and then we will open it up to a committee discussion. Thanks again.

Dr ARUNOGIRI: Thank you very much, and thank you for the opportunity. I would just like to start by an acknowledgement of country. The college of psychiatrists acknowledges the traditional owners of the land on which we meet today and pays respect to elders past, present and future.

A little bit about our college, the Royal Australian and New Zealand College of Psychiatrists—I am very pleased to have this opportunity to speak with you today: we are a membership organisation and we represent psychiatrists and people training to be psychiatrists across Australia and New Zealand. It is a college that prepares doctors to be specialists in the field of psychiatry. We support and enhance clinical practice, advocate for people affected my mental illness and advise government on mental health care. The RANZCP is the peak body representing psychiatrists, and we are also binational, so we have strong ties with the Asia-Pacific region as well. The college of psychiatrists Vic branch, who I am here to represent today, has over 1600 members, including more than 1200 qualified psychiatrists as well as 400 members in training.

Today we really welcome the opportunity to provide evidence at this public hearing for the Inquiry into the Use of Cannabis in Victoria. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey of recovery. Psychiatrists have a key role in the coordination and provision of preventive, early intervention and treatment approaches for those who present with problematic cannabis use specifically. The college's Victorian branch would like to put forward the following key findings in relation to our broader submission regarding the mental health and social impacts of cannabis use on people who use cannabis and also their families and their carers.

Recreational cannabis use, as we all know, is common in Australia. For a small subset of cannabis users cannabis use itself may be a precipitating or maintaining factor for a range of mental health problems, specifically psychosis. Cannabis use has been linked to psychotic disorders, as you may have heard already today, with the frequency of use and the high-potency cannabis use elevating that risk. Individuals who use cannabis to relieve symptoms of mental illness—there is a whole range of different mental health problems that may cause this—can be particularly problematic, especially when treatment access is difficult or unavailable. There are physical and mental health impacts of problematic cannabis use, especially for young people and adolescents, and this is a specific part of our submission as well that we would like to speak more broadly on.

Public health strategies should focus on delaying the age of cannabis use to protect young people and adolescents during the critical period of neurodevelopment. There needs to be greater availability and accessibility of mental health support for young people so that they can access support for mental health concerns rather than engaging in self-medication. It is essential public health messaging on cannabis use is destigmatising in order to encourage people to come forward for treatment. Again, this is a really important part of our submission that we would like to highlight.

Punishments for possession and use of cannabis are not commensurate with the level of harm experienced at a population level, with the mental health effects of punitive harms and punitive measures needing to be weighed against the risk relating to cannabis use. The mental and physical health of the community must be the priority when we consider criminal activity relating to cannabis. There is a need for a greater number of addiction specialists, and specifically addiction psychiatrists in this case, who can support and treat individuals with a cannabis use disorder and related mental health problems. We have just included some references in the back of the statement, but I am happy to now take some broader questions.

The CHAIR: Thank you so much, Doctor. I very much appreciate this. Many of us have got your full submission in front of us as well, or on our screens. I will start the questioning. I will ask the Deputy Chair, Dr Tien Kieu, to start the questions.

Dr KIEU: Thank you very much for being here today. There was a royal commission in Victoria into mental health issues in general. I believe that you submitted. Did you mention about the necessity for particular consultations and help with cannabis use, particularly in the youth cohort?

Dr ARUNOGIRI: Yes. Just to make sure I clarify that question: specifically in relation to mental health of youth in relation to cannabis?

Dr KIEU: Yes.

Dr ARUNOGIRI: In our broader submission we speak about different periods of risk in terms of the effects of cannabis on neurodevelopment and in terms of harm in terms of mental health. What we know is, as we all have heard from several other people as well, the studies and research into the relationship between cannabis and then a whole range of mental health harms—that includes depression, anxiety and psychosis—is fraught with a whole range of research-related challenges. Many of these research studies have been conducted on population level statistics and epidemiological studies rather than necessarily being able to look at a prospective link between substance use and harms and also wanting to disaggregate the impacts of punitive measures such as criminalisation, for instance, on those harms as well as disaggregating polysubstance abuse from those harms—the challenges in being able to, for instance, draw out use of other substances which often go along with cannabis use, including tobacco and alcohol. So having said all of that and with that caveat around the research, I think we have really conclusive kind of evidence that delaying the age of onset of cannabis use is a positive thing. It actually reduces the risk of a whole range of harms but definitely the mental health harms. For instance, if people are initiating below the age of 12, we know that that is significantly high risk in terms of actually transitioning to becoming dependent on cannabis itself but also actually developing a whole range of other harms. We also know that high potency, which is another separate topic, I suppose, is also associated with a high risk of harms.

Dr KIEU: For the younger people there are many issues, and a lot of education would be required not just for cannabis in particular but also for alcohol use, for example, which could severely impact their development intellectually and also their mental health. So is there any evidence that the psychiatric help for younger people, or education for young people, in alcohol has been effective and whether it would be translated or not into the cannabis damage?

Dr ARUNOGIRI: In our broader submission we mentioned a couple of population-level education campaigns that can be really helpful, and this is thinking about nuancing strategies around education for the demographic that we are trying to reach. So I think it is important when we think about children who are at school versus adolescents as they get to grow older that we actually have the right kind of targeted strategies that are evidence based and also not alarmist or sensationalist. It is important that they are factually accurate, and also it is important that those strategies are couched within a whole range of other sorts of health promotion strategies—for instance, looking after mental health and actually being able to come forward and seek help when someone identifies they have got a health problem.

There are a whole range of Australian things that are actually quite world leaders in that space in terms of education strategies. I think we have mentioned Positive Choices as being one of them, and that comes out of the University of Sydney Matilda Centre, which has been really both implemented widely but also heavily evaluated, which is really positive, and evaluated in an Australian context, an Australian school context. So that is important, I think, because we know that translates well to our climate. The other two that I will mention are Climate Schools, which again comes out of the Matilda Centre but specifically around mental health promotion

in the school setting; then the third one is a program called Making the Link, which is actually funded by the NHMRC and was a pilot and now has gone into a whole range of different programs. It is again school based and really focuses on empowering the child or the adolescent, depending on when it is, to be able to actually critically think about some of these questions—to be able to give them the skills to be able to have health literacy.

I think we have heard from many people around the capacity to engage in issues around social media or accessing information on the internet, so it is really important that when we have these education and promotion strategies we are equipping the young person to be able to have a lens that they can hold up information to and assess it themselves—is this accurate, is this not?—and to be able to identify when they have got problems how they can actually step forward and ask for help and that they can also rely on their own friends and their own sort of circle of individuals to be able to engage in help seeking.

So none of these programs are cannabis-specific, but as you point out, there is a whole range of substance use that individuals need to be able to be equipped to manage as they get older, and all of these strategies are translated to cannabis issues.

Dr KIEU: Yes, maybe just a very quick one?

The CHAIR: Very quickly, Tien.

Dr KIEU: The Victorian government has initiated recently a program to have more mental health specialists that can help at the school level. What do you think about that program in terms of the cannabis context?

Dr ARUNOGIRI: I think in terms of cannabis and I think also, then, in terms of other substance use and literacy as well, I think what is really important is we know—certainly in the royal commission this was pointed out in the report—that literacy amongst health professionals in terms of substance use itself is not universal. So all mental health professionals are not capable or equipped or have the knowledge or training to, first of all, know about substance use but also know about what is the most appropriate help-seeking in terms of substance use, and that is a much broader problem—that I think is associated with a whole range of other strategies—to address. But I guess what is important here for young people who might be seeing a counsellor in a school setting or a mental health professional in a school setting is that that individual is the right individual to speak to about their cannabis use problems, and this highlights the need for these sorts of programs to work in concert with education and training programs that are addressing AOD or alcohol and drug use workforce strategies as well.

Dr KIEU: Thank you.

The CHAIR: Kaushaliya Vaghela.

Ms VAGHELA: Thanks, Chair. And thanks, Dr Arunogiri, for your submission, for your time and for the presentation today. We have heard people saying it should be legalised—the use of cannabis—and, no, it should not be legalised, and in terms of one of the recommendations or the messages that you have in your submission, it is the physical and mental health effects of the use of cannabis. Before we decide on whether it should be legalised or not, do you think we should wait for data—statistics—specifically on cannabis and young people, to know what sort of impact it is having on mental health and physical health, and then they end up in the prison system? Do you think we have enough of that to go either way, to decide on the use of cannabis?

Dr ARUNOGIRI: Yes. That is a good question. It is a big question. In terms of legalisation I think we are all aware in terms of that spectrum, that continuum between current state versus someone, and complete legalisation and decriminalisation, too, where that sits along that continuum of strategies that can be applied. I think much of the data and literature that we draw from historically have been in spaces where none of those strategies have been taken in place, so again it is quite challenging to look at historical data and disaggregate the harms that might have come from criminal prosecution or imprisonment or recidivism—all of those harms that come along with that. But in terms of do we have enough data, I think—you know, as a researcher we always want more data—there comes a point when you need to make decisions. And I think in terms of looking at decriminalisation—in particular if we look at the middle level of that spectrum—we have got lots of examples to be able to draw from. The college of psychiatrists is very clear in recognising the harms that come from criminal punishment and criminal sanctions, particularly when they are associated with low levels of use and

they are associated with minimal other criminal engagement—that those harms actually can be quite substantial. If we take it down to an individual level, any incarceration will then impact on capacity to engage in employment, capacity to access housing in some cases, capacity to have a whole different trajectory in terms of your livelihood. And that is particularly important for younger people, so that is a long-lasting harm that sits with them for the rest of their lives. I think in terms of other harms we also need to think about mothers and in terms of families, and criminal sanctions on one side but also child protection concerns that can come into play in relation to cannabis use. And so here again we have a whole range of other harms that might not necessarily be associated with the use, per se, but the harms that come from being identified as someone who uses.

So it is about thinking about the levels of harm that are associated with those punishments: are they commensurate with the harms that we think are associated with the drug, and also are they effective in deterring ongoing use of the drug? I think we have got a large amount of information that suggests that probably the situation we have at the moment is that is unlikely to be the case, that it is unlikely to, first, deter ongoing use but it is also unlikely to actually benefit the individual's mental health and the community's mental health more broadly. So I think we have got enough data there.

In terms of young people and whether we have got enough data around young people's long-term harm associated with use, I think we have certainly heard from lots of people in the submissions to the inquiry about other places in the world that are testing different approaches to this. Increasing data is coming from those approaches that gives lots of opportunities to study different ways to look at this. But I think in terms of long-term harms, we do not have a tremendous amount of examples of extreme legalisation on one end of the spectrum that has been aggregated over, say, 30 or 40 years, so we do not have that life span perspective on harms. I think that also will take some time—to be able to aggregate that data.

Ms VAGHELA: Just a quick one from what Dr Kieu was saying and prior to that. What we hear repeatedly is of course and we understand that a preventative approach works and that educating youth from an early age, stopping them using cannabis or delaying when they start using helps. Dr Kieu mentioned about the psychologists in schools. Do you think if some sort of educational awareness was brought into the school curriculum, specifically about cannabis and also other drugs and maybe alcohol, that that would work? Maybe from that, then we could get data. Because if we do not have data for young people, do you think that is going to work? How successful can that be?

Dr ARUNOGIRI: I think we have to think about the environment which this is being introduced into, knowing that our young people generally are aware cannabis is not very difficult to access anyway. In our community we know that cannabis is relatively widely available. It is readily accessible despite being illegal, and we know that most people who use it regularly said that they have no problems accessing it. That is on a whole spectrum, I think. In terms of that context and then thinking about how we introduce effective education and prevention strategies, I think it is about keeping that in mind, that that is the context which we are introducing that into, and being able to have accurate, factually based harm reduction strategies as well—for instance, individuals being able to understand, if they use, what they can do if these particular things happen. How do you seek help if you have any problems with use? How do you look after your friends if they are using? We know that overall young people are able to engage with this information very effectively. The evaluations, for instance, are pointing back to Positive Choices and Making the Link. We know that individuals can actually significantly improve their literacy around these substances through those programs. I think that there is quite a lot of data there to support that.

The CHAIR: Great. Thank you. David Limbrick.

Mr LIMBRICK: Thank you, Chair. And thank you, Dr Arunogiri, for appearing today. Your submission highlighted a harm which we have not really spoken a lot about but I think is a very serious issue. One of the harms from cannabis is the fact that many people mix it with tobacco and smoke it. One of the things that I have read about, which has happened with legalisation in the United States, is the usage of non-smokable forms of cannabis such as vaporisers and things like this. What are your views on legalisation as a way to avoid the harm from mixing it with tobacco and also smoking cannabis—for reducing harm? Do you think that this is something that is underappreciated?

Dr ARUNOGIRI: It is an interesting perspective, I guess, in terms of the sanctions around it. I think our perspective in terms of tobacco use with cannabis is not a uniquely Australian practice, but it is a very high use Australian practice. Many people in Australia smoking cannabis would spin it with tobacco. I think that the

harms associated with that are underappreciated in the sense that individuals seeking tobacco cessation are often a different group than individuals who are seeking cannabis cessation. When we actually look at cannabis cessation, there is not a whole lot of emphasis on helping that person also quit smoking tobacco as part of that process. I am aware of studies that have looked at, say for instance, pregnancy or neonatal outcomes as well. We know that again with tobacco mixed in with cannabis there are potential risks associated with the cannabis itself, but in fact the risks associated with the tobacco in that environment are significant as well and underappreciated. In terms of thinking of all the different options in terms of legislation, I think thinking about ways to minimise the use of tobacco and educate again about the risks of tobacco are important.

In terms of whether tobacco-free formulations of cannabis might be something to look at, I suppose it is kind of about thinking also what the formulations might look like. Are they palatable, acceptable? I do not think those studies have necessarily been done and certainly have not been done in the Australian context. I think it is important that we get more understanding of people who currently use: what would their perspectives be and why do they actually use tobacco with cannabis?

Could that still be replaced by a tobacco-free substitute in order to kind of understand would this be an acceptable, feasible strategy and what the outcomes are of that.

Mr LIMBRICK: Thank you.

The CHAIR: Georgie Crozier.

Ms CROZIER: Thank you very much. And thank you for being before us this morning and for providing the evidence that you have. I am very interested in both the physical and mental health impacts of cannabis use, especially with young people. We have heard an array of evidence this morning in relation to what is happening in international jurisdictions where this issue has been probably dealt with for longer. I was interested in your comment about not a lot of data is out there. In saying that, we heard this morning that there are world-renowned medical journalists that are reporting on this issue all the time and there are strong links between the potency, the use and very adverse health outcomes, both in a physical sense—neurodevelopment, pregnancy outcomes—but also mental health—depression, anxiety and psychosis. Here in Australia there have been studies. I know that in 2000 the Australian National Survey of Mental Health and Wellbeing did a study on this. That was 21 years ago. They were talking about the adverse impacts of increased use of cannabis. I am interested in your comments about we do not have enough data yet. What are you looking for to really have some proper evidence to suggest that this is not harmful, that what is currently being put out in medical journals, both here and internationally, is perhaps a contrary view to some of the statements of others and the evidence that you have provided?

Dr ARUNOGIRI: First of all, I think to go back to the statement about not enough data, I think perhaps I will expand on that a little more to kind of explain where there are areas where there are not enough data, because there are certainly lots of areas where, as you said, there is tonnes of data. This is certainly not a new drug. It has been around for a very long time and used very widely in Australia for a very long time, so we certainly have lots of population-level data in terms of levels of use, in terms of population-level harms and also of population-level appreciation of lack of harm too. So, for instance, to draw back to a number of consensus and priority statements both in the UK and Australia recently that have looked at addiction professionals and mental health professionals and ranking drugs in terms of ranking drugs in relation to harm, cannabis here rates very low among the risks of harms. Usually alcohol and tobacco are rated the highest in terms of actual risk of harms in terms of physical and mental health harms.

But if we kind of come back to the areas where there is not enough data, this is where it becomes quite difficult, I think, in the mental health space in particular. Because the harms that we are looking at—depression, anxiety, psychosis—we can measure these on a population level, look at the prevalence, for instance, of schizophrenia or depressive disorders, but then to be able to draw a link between that and cannabis use on a population level becomes quite challenging because we have to kind of tease out, for instance, a whole range of other confounding factors that might occur with cannabis. Also kind of thinking about how we have to look at individuals in a longitudinal or prospective way. So rather than just looking at an association between the fact that someone has used cannabis and that they have depression, trying to understand what the risks are in terms of causation—does the cannabis itself cause the harm?

I take your point in terms of there have been many studies in reputable journals. There are many, many studies also conferring the opposite kind of conclusion and again in reputable medical journals. So what is necessary I think is to be able to look at specific studies and actually interpret them with the lens of what is applicable to, first of all, the Australian context, what is also applicable here and we think about specific harms. We have got some references in here, but we can also forward some other references in relation to depression and anxiety in particular which have highlighted depression on a population level. The most recent large-scale studies have actually found very modest, if any, association with depression and cannabis on a population level.

In terms of anxiety, less so. Psychosis is the one risk that we think that there is something there in terms of there being an association, particularly for individuals who are at high risk and here we mean there might be some familial or genetic factors that might be promoting that risk.

Ms CROZIER: You said that cannabis has been used in this country for a long time, and I think we all understand that, but the evidence that was presented today was it is a different form of cannabis now. It comes in different forms, the THC levels are far more potent, they are far more complex and far more dangerous. That is what I am interested in because of exactly these issues that these medical journals and these experts are saying and the profound effects that that is having on the some of those local communities, which is probably a little bit different in this country but I do not know that.

Dr ARUNOGIRI: In terms of high potency, it is a really good point, because I think it certainly has changed in terms of the availability of different types of cannabis, and you will have seen several different types this morning. What we know is often drawn from international literature as well in terms of different types, and the climate here is a little different, but we have not as comprehensive kind of information on the different types and different potencies here in Australia. I think also the landscape is quite diverse, so there will be also low-potency THC and high CBD formulations in the community. There will also be other pockets with really high-potency, high-THC formulations. And so we do not necessarily currently have comprehensive data to support what the prevalence of very high potency formulations here are. In Europe there are a number of studies actually starting to map this and tap the fact that there are very high potency pockets in particular countries, and so I think that is a definite risk that needs to be looked at.

Ms CROZIER: Which countries is that in? Have you got that data?

Dr ARUNOGIRI: In Scandinavia there have been pockets where there have been, and also in the Netherlands there have been some studies. In the UK too there are some groups looking at specifically high-potency formulations that have been quite high risk.

Ms CROZIER: Thank you.

Dr ARUNOGIRI: So I think in in any sort of context where we are looking at, you know, be it regulation or legalisation as well, that needs to be really considered in terms of the availability of high-potency formulations—what can be done about that in being able to look at that.

Ms CROZIER: Thank you.

The CHAIR: Sheena Watt.

Ms WATT: Hi. Thank you for your presentation today. I had a different question to my colleagues, which was around your recommendation around workforce needs for addiction specialists, and I note in your submission that there was a lot to that. I just wonder if I can give you an opportunity to talk more to that, because I am keen to understand what are the real workforce needs in this area.

Dr ARUNOGIRI: Absolutely. I think this is a timely opportunity to talk about that in the context of the royal commission as well, and again this is quite a parallel discussion. I think the Deputy Chair mentioned before about the placement of professionals in schools. These are all sort of availability of opportunities for both young people and the general community to access discussions around the links between mental health and drug and alcohol use and come forward when they identify a need for treatment. So I think it is really important that that is part of the landscape of what is being discussed.

In terms of addiction specialty capacity, Victoria really lags behind the other states in terms of the capacity to address addiction, both within the treatment sector, so the addiction alcohol and drug sector, as well as within

the broader mental health sector. From other reports—this is information that I am happy again to provide after today if there is interest—there is a consultancy report that specifically maps the addiction specialty workforce in Victoria in relation to other states as well, and it again draws on some modelling that has been done in New South Wales, the DAS model, trying to estimate how much professional capacity is necessary to be able to treat burden within that state. And for Victoria, in comparison, say, to New South Wales, we really lag behind in terms of numbers of professionals. In total across the state I think we have about 25 EFT, so that is 25 full-time specialty positions. That is not 25 specialists. Half of those are people in training, so trainee registrars and doctors. If we actually look at somewhere in the realm of about 15 EFT in total, across the whole of the state, and again there is a rural, regional and metropolitan divide there. Even if you are square in the middle of East Melbourne, you would still struggle to be able to find an addiction specialist. So this is again one of those areas where even the metropolitan region does not have much capacity. Succession planning is another issue that has been brought up with addiction specialty, with a significant proportion planning to retire in the next five to 10 years, and then not increasing kind of space for new professionals coming in.

So based on those modelling statistics I think the thinking is that we would need somewhere in the region of about 70 more specialty physicians to be able to be actually funded and have capacity to have that, and in the initial estimate that I told you in terms of 25, that includes the private mental health sector too. So that actually did not include just the public mental health sector, so it is quite woeful in comparison to many of the other specialties.

The importance of this is when we identify someone who has potential harms associated with cannabis use with any other substances, there are also physical and mental health harms that go alongside.

People who have problematic cannabis use may also have a whole range of other complex psychosocial comorbidities and mental health comorbidities, including, for instance, psychosis, which is a severe mental illness that requires tertiary mental health capacity to address it. So within that specialty there is really a lack of capacity to be able to address that at the moment. In order to skill up and be able to train enough professionals, I think it really requires quite a significant kind of commitment and capacity to invest in this space. Again, I am happy to forward the report.

Ms WATT: Thank you.

The CHAIR: Are you good?

Ms WATT: Yes, I am good, thank you. And I would not mind that follow-up.

The CHAIR: Okay. I will go to you, David, then I will come back to me if you have got a quick one.

Mr LIMBRICK: Okay. Thank you, Chair. I have one further question. We have heard a number of times how important it is to delay when adolescents start using substances, whether it is alcohol or other drugs, and we have also heard about how important education is as part of that. I was wondering if you could maybe provide some insight on what sort of education strategies or campaigns do not work.

Dr ARUNOGIRI: Yes. I think bringing it back to some of the things we talked about in our submission, they are about what has evidence and what does work. I think in terms of what has evidence that it does not work, we can look again to some of the things that have been tried in the US over the last two or three decades. I think things that have messaging around 'Just say no'—we know categorically that that does not work. We also know that strategies that are not based in evidence or fact also do not work, particularly now when adolescents and children can easily access accurate information via the internet or asking a friend. So I think it does not hold anymore to be able to say, 'This is going to cause you significant harm' if it is not. I think the harms need to be actually clearly articulated, and articulated in a fashion that is understandable and approachable for young people.

In terms of other things that do not work, I think having a prohibitionist approach with that messaging also has not been particularly successful in the past. I think where there is no capacity for harm reduction, that can be problematic too. If we think of a substance, particularly in the context of, say, alcohol or cannabis, where we know that it is part of the landscape of things that the individual might be accessing or seeing—they might have friends or people in the community who use it—I think being able to give individuals a harm-reduction lens through which they can actually approach the issue can be really helpful.

Mr LIMBRICK: Thank you so much.

The CHAIR: Thank you. We have been talking considerably about that subset of people who are harmed by it and the difficulty in correlation and causation. I would certainly suggest if there is a child as young as 12 using cannabis, there is probably a whole range of other issues in that child's life that is leading to that use. But I note in your submission you actually go into this a little bit to say that there is a subset of individuals that have an increased risk for use disorder relating to their cannabis use and a much larger subset that does not have a high level of risk. Do you know the percentages there?

Dr ARUNOGIRI: Yes. So broadly speaking—I think we have got this in our submission—it is about one in five who have a risk of having a cannabis use disorder. But again, keeping in mind that high-potency risk that we talked about, with high-potency use that can go up. Risk is also associated with early use and high-frequency use, so when we are talking about that child of 12, certainly high frequencies of daily use as compared to, you know, past month use are in a completely different stratosphere in terms of that risk. And I think the other things that we have referenced there are people who have a history of trauma. Childhood trauma significantly increases that risk of a use disorder as well.

The CHAIR: That is right. So it may be all of those compounding factors as well in that subset of cannabis users.

Dr ARUNOGIRI: That interact, yes.

The CHAIR: Thank you. Sorry, I had another question, but it has just slipped out of my mind. I will move to Sheena while I remember. Thank you.

Ms WATT: I will take a moment on that one, but I am interested. You have talked about the addiction specialists, and they are very much used at the tertiary sector. Is there a broader workforce need that you can speak to and expand on? I know that it might be beyond your college, but I think it would be helpful to know what other health professional shortages there are in this space that further exacerbate the needs of your professionals.

Dr ARUNOGIRI: I am happy to speak broadly about the issue again, and most of the modelling provided is specific to addiction specialists and addiction psychiatrists. But if we think about the health professionals that an individual is most likely to see first—and thinking about young people as well this also applies—often it is their general practitioner. It might be their primary care provider. It might also be a range of nurses that they might interact with in school settings or in other broader general healthcare settings. So this kind of comes back to, I guess, broader addiction education and training at those levels. We know from a whole range of other work that that can be quite variable across health professionals. There is a lack of addiction training in undergraduate curriculums and postgraduate curriculums across all health professional specialties, and so that impacts on the information that they take forward. It can also impact on perceptions and attitudes to drug use in general. For instance, the stigma that is associated with the use of any drugs that is held in the broader society can also impact on health professionals' views if they do not have commensurate training or education around those risks. So that stigma and perception can also have an impact.

I guess from a primary care perspective, I know a lot of work has been done in this space to improve general practitioners' capacity to engage around drugs and alcohol more broadly. It is not cannabis-specific, but it will have an impact as well.

Ms WATT: Thank you, Dr Arunogiri.

The CHAIR: Thank you. Dr Kieu.

Dr KIEU: Thank you very much. We have a few minutes left, so I have a question. First, it is interesting that you have been using the words 'delaying the onset of cannabis use' rather than 'minimising the use'. Is there some reason for that, and what is it? The other more substantial question is about what you think about the level of need for education and treatment in the CALD community, particularly maybe Aboriginal communities, and whether the training of a specialist would need to have some culturally sensitive element to that training?

Dr ARUNOGIRI: In response to the first part of the question, I think 'delaying the onset' is a term that is used frequently in the literature and the research around this space because they are comparing individuals along a spectrum of when they have initiated use. So, for instance, in a research study they might be comparing people who started using at 12 versus someone who started using at 25, and, say, trying to delay it longer—

Dr KIEU: So are we aiming for minimising and eliminating rather than delaying something as if it were inevitable?

Dr ARUNOGIRI: When taken outside that space, yes, exactly. So I think it is certainly not inevitable on a population level. I think taking it outside of our research study, what we are talking about is raising that age of potential initiation to a point that potential initiation, not inevitable initiation, is at a later stage. Coming back to the second part of that question, I think just to clarify that second part of the question, do you mind repeating the second part of your question?

Dr KIEU: The level of need for education and training and treatment for the community and the cultural element in the training of a specialist.

Dr ARUNOGIRI: I think that is crucially important. It is not something that we have unpacked particularly much in our submission, but again I am happy to provide more information on it. Our college has quite a comprehensive range of information around culturally appropriate strategies, both for Aboriginal and Torres Strait Islander communities, who I think have specific needs as well in this area, and then also thinking about CALD communities and migrant communities that might actually come from a variety of diverse backgrounds in relation to cannabis use as well.

I think in terms of Indigenous and Torres Strait Islander communities, what we are thinking about there is really that there are pockets where there are disproportionate harms associated with a whole range of things. That includes cannabis use, but I think it also significantly includes all of the harms that can come from cannabis punishments. So here I am talking about incarceration or repeated incarceration and also the child protection framework that comes along with that. I think that is a really important framework to keep in mind as well when engaging with people from particular backgrounds that may have been disproportionately affected by those harms too.

Dr KIEU: Thank you.

The CHAIR: I remembered what I was saying. Thank you, Dr Kieu, that was interesting. And thank you for committing to send that information. We were talking about the subset where that may lead on to mental health or other disorders, and it was one in five. It struck me that that is the national statistic for people who may experience mental health concerns. So I am just wondering: could we also say that one in five alcohol users may also lead to having a problematic use or a mental health concern relating back to that substance use?

Dr ARUNOGIRI: Coming back to the one in five, that was in relation to developing cannabis use disorder from using cannabis. For instance, individuals who might use cannabis are likely to actually develop dependence on it and this is about that high. The one-in-five statistic is obviously relevant for a whole range of different mental health harms. In relation to alcohol use, we know that we have got quite established evidence that is clear around alcohol causation in relation to depression, for instance, and that is stronger than we have for, say, cannabis in relation to depression. So that harm is very clear. I do not have the order specifically here in front of me, but for someone who is using alcohol every day, it would be higher than one in five if it was a daily use pattern. I think it is certainly relevant to kind of think about that in parallel.

The CHAIR: Great. If I could just seek some clarification on that. We heard from VAADA previously, and I think they used the household drugs survey where they found that 2.9 per cent of people who use cannabis were deemed to be at high risk of harm. In looking at that 2.9 per cent compared to that one in five, or that 20 per cent, what are the differences?

Dr ARUNOGIRI: I think first of all the national household survey is done on a population level and is done on a specific and much broader subset of individuals. I think the statistic that we will draw back from—and again, I am happy to provide the original study and references—specifically looked at, once you have initiated, the likelihood to transition. That transition factor is really interesting. But the transition from recreational use to disorder, that is quite different from, say, any use or use in the past 12 months in comparison to using in a fashion that is actually problematic and regular, particularly in terms of frequency. We know that that high

frequency has a significantly higher risk of a whole range of harms, and again drawing back to that idea of, for instance, any use in the past 12 months versus using every day—it is quite a different ballpark in terms of risk. So I think, again, that 2.9 per cent on a population level includes every harm. It includes the likelihood of dependence but also other mental health harms as well. And then here when we look at this statistic, this is about the likelihood of transition across if someone uses.

The CHAIR: Thanks for that clarification. We have got a couple—yes, last question.

Ms VAGHELA: Just a follow-on question from what the Chair asked earlier regarding the correlation and causation between the issue and the symptoms, because during the homelessness inquiry what we heard was: does a mental health issue cause homelessness or do people who become homeless then end up having mental health issues? It is the same thing again over here as well: using cannabis for recreational purposes and then becoming a problematic use, does that then cause mental health issues? Or does people, users, having mental health issues and other issues—the Chair mentioned a host of other issues, and you also mentioned about having some sort of trauma or whatever—cause this? In the submission there is reference to cannabis, but at times it is in correlation with other drugs and that. Once we know what it is, if we get that clear idea of what is causing what—it is like the chicken and egg. Do you have any further information? Or do you think we will be able to get that? Because that will give us a clear indication then.

Dr ARUNOGIRI: I think it is very challenging. I completely agree. This is fraught across the whole drug and alcohol space, being able to tease out use alone versus use correlating with a whole range of other confounding factors. I think trauma is a significant confounding factor. We know that regular use of drugs and alcohol is much higher in people who have had exposures to trauma in childhood or even later in life. And we know that rates of PTSD are very high in people who have regular use. So again, here is the chicken or egg. How is that correlated? I think in many cases, when you can follow people up prospectively through their life it is often the trauma or the difficulties, the challenges that arise first versus then the substance use as a form of self-medication. That is easy to do on an individual level. On a population level trying to understand that relationship is more challenging.

In terms of do we need to get more and more data specific to cannabis, I think in relation to enacting decision-making around this area we are also looking at it again not in a vacuum. There is this cannabis use but there is also use of all of these other drugs, and we I think can clearly highlight who are the individuals at highest risk here, because they are the individuals who normally use cannabis and use it at a high frequency but they are also individuals who have those other risks together. For instance, individuals—the example which I gave before of the 12-year-old who might be smoking—might have lots of other harms already there. So when we are thinking about who we want to assist in a high-risk space, I think it is pretty clear who those individuals might be from a whole range of disadvantage, social determinants of health and a whole range of other mental and health and psychosocial complexities. So I think the strategy to assist that individual will be probably different from the strategies to support the broader community, and I think that is where it has to be.

Ms VAGHELA: Thank you.

The CHAIR: Thank you so much. That was really informative, and I appreciate you also making the commitment to provide us with further information on top of your submission. Thank you, all. Thank you to everyone who is watching online. The committee will take a recess, and we will return at 1.30 pm. Thank you, everyone.

Witness withdrew.