**REPORT ON PROCEEDINGS BEFORE**

# LEGISLATIVE ASSEMBLY COMMITTEE ON LAW AND SAFETY

## E-CIGARETTE REGULATION AND COMPLIANCE IN NEW SOUTH WALES

**At Macquarie Room, Parliament House, Sydney, on Friday 12 April 2024**

**The Committee met at 9:30.**

**PRESENT**

Mr Edmond Atalla (Chair)

Mr Hugh McDermott (Deputy Chair)
Mr Tri Vo

**PRESENT VIA VIDEOCONFERENCE**

Mr Philip Donato

**The CHAIR:** I thank everyone for coming to the second hearing date of the e-cigarette inquiry. Before we start, I acknowledge the Gadigal people, the traditional custodians of the lands on which we meet here at Parliament. I also pay my respects to Elders of the Eora nation, past and present and emerging, and I extend that respect to any other Aboriginal and Torres Strait Islander people who are either present here or are viewing the proceedings online. Welcome to the second public hearing of the Legislative Assembly Committee on Law and Safety. I am Edmond Atalla, Committee Chair. We have an apology from Mr Paul Toole, the member for Bathurst. We thank the witnesses who are appearing before the Committee today and the many stakeholders who have made written submissions. We appreciate your input into this inquiry. I now declare the hearing open.

**Professor ROWENA IVERS**, Academic Leader, Community Based Health Education and Chair of Phase 3, The Royal Australian College of General Practitioners NSW&ACT, before the Committee via videoconference, affirmed and examined

**The CHAIR:** Thank you for appearing before the Committee today to give evidence. Please note that the Committee staff will be taking photos and videos during the hearing. The photos and videos may be used on the New South Wales Legislative Assembly social media pages. Please inform the Committee staff if you object to having photos and videos taken. Can you please confirm that you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

**ROWENA IVERS:** Yes, I confirm that.

**The CHAIR:** Do you have any questions about the information?

**ROWENA IVERS:** No.

**The CHAIR:** Would you like to make a short opening statement before we begin questions?

**ROWENA IVERS:** I'm here today on behalf of the Royal Australian College of General Practitioners, and I would like to thank the Committee for the opportunity to give evidence at this hearing. I'm sorry I couldn't be there in person; we've got medical student exams in one of our rural locations today. The RACGP is Australia's largest professional general practice organisation. We have 40,000 members working in or towards a specialty career in general practice. The RACGP NSW&ACT faculty actively supports and advocates for GPs working in this State. I am here today as a member of the RACGP special interest group in addiction medicine and a member of the RACGP NSW&ACT faculty council to represent the views of the college. I am also a member of the National Expert Advisory Committee on Tobacco, so I've worked in the tobacco field for over 25 years. In fact, I did my PhD on it, including—certainly in this area.

As GPs we provide holistic, whole-of-person care that encompasses both physical and mental health. As GPs we have a unique insight into the use and management of addiction medicines and also experience the damage to health that can be caused by the unregulated use of e-cigarettes. In clinical practice we see this. It would be every week that I am dealing with people dealing with nicotine addiction and looking at ways to regulate that, and we certainly see the effects of e-cigarettes. The inquiry represents a really significant opportunity to improve upon existing e-cigarette regulation in order to reduce potential harms associated with the use of e-cigarettes. The college looks forward to working with the Committee on this matter.

I will probably go into the New South Wales 2022 tobacco Act and thinking about the further changes that could be made to that, basically, to align with the new proposed Commonwealth legislation. We know that e-cigarettes—there's been a wave of uptake of use, especially, concerningly, in our young people. The main things that, as a college, we would like to see is that—really, we think we would like to see that tobacco packaging and labelling rules must also encompass e-cigarettes so that the consumers are aware of the risks of those. I guess, in our context, we think of e-cigarettes as a therapeutic good that might be useful for smoking cessation, so we believe they should have a clear warning about that.

Division 2 of the legislation must really clearly incorporate the sale of e-cigarettes into the discussion of retailing tobacco-containing products. Nicotine-containing products is basically what e-cigarettes are, so that includes including them in prohibitions and also licensing. Division 4 should include the seizure of e-cigarettes where breaches occur, because, of course, it is about enforcement of the legislation as well. Of course, we know that we have Commonwealth legislation, and we know we have State legislation as well. There's got to be synchronised enforcement of e-cigarette regulation between the Commonwealth and also New South Wales agency and the police. It's really important to improve that coordination. They are my main points on the legislation.

As GPs, we certainly are worried. We're very worried about the effect of nicotine vaping products. As a GP expert in this area, we have been working with Emily Banks who wrote the big systematic review of the effectiveness of nicotine vaping products. We have also looked at international evidence—the Cochrane review. Basically, one of the roles of the college is to write the national guidelines on smoking or nicotine cessation—looking at updating that guide so it can help health practitioners. We have gone through a lot of that evidence in very deep detail, and basically what we know is that we really don't know the long-term effects of nicotine vaping products. There is no research of a long lead time. We know a lot of health effects have a 20-year lead time but can have very serious and life-threatening effects. We don't know.

We do know that there are immediate risks including poisoning, including in adolescents but more worryingly in young children who find vapes lying around. There's been an increase in calls to the poisons line

and increased presentations to health settings. We see this in our patients—increased acute nicotine toxicity. Some of the devices that are being used to deliver nicotine actually deliver up to 700 per cent of what you would get through smoking. So young people are becoming addicted to nicotine much faster than they would and at higher doses without realising how much nicotine they're actually taking in. And, of course, injuries—burns and lung injury, and certainly some of the stories we have heard from the US about EVALI. Dental disease is the other clinical outcome we are seeing more recently.

Some of my colleagues at the University of Wollongong have done work on what constitutes the liquid inside the vapes from confiscated vapes, and what we know is that there is a range of products. We don't even know where they're manufactured a lot of the time. We know that there are products in them—heavy metals, carbonyls, volatile organic compounds. Some of the flavourings are actually carcinogenic, with a range of carcinogenic substances within those, depending on the novelty flavour that you prefer. Basically, there's a real lack of uniformity in the vaping devices available and the nicotine vaping products, which really means that it's hard for users to judge their contents. It's hard for prescribers to know what they're prescribing. We do know, by the same token—and I think GPs have come to the middle ground.

We really looked at the evidence very closely from across the world and we know that for smoking cessation there are studies that show that e-cigarettes—when delivered with health advice, say, by a doctor and at a specific dose relatively low compared to some of the doses people have been able to buy in the past and then monitored along with that support from a health professional—can be useful for some people in giving up smoking. In our analysis of the data, we judged it and we think that it was a pragmatic approach to leave them to be available. But we know that there are lots of other parts of that smoking cessation journey. There is strong advice from health professionals, the use of the Quitline and the use of the other pharmacotherapies, like nicotine replacement therapy, bupropion and varenicline. They are all appropriate treatments for smoking cessation.

For some people, where those had failed, vaping had more success than nicotine replacement. But that is weighed up with the fact that we don't know about the long-term effects. We like to see the evidence of no harm. Obviously, our young people are the main people we worry about. I see young people vaping in my local area outside schools and outside sporting grounds and running out of class to vape. In our clinical practice, we certainly are concerned about young people and the effect that it may have on their health because we really don't know. The marketing is also really targeted at young people. It is brightly coloured, with novelty flavours that appeal to youth and adults. It's very cynically targeted at those young people. A New South Wales Population Health Survey found in 2021 that actually e-cigarette use was highest in people aged 16 to 24.

**The CHAIR:** Many of the submissions that we have received state that e-cigarettes are not an effective way for smoking cessation and are a gateway for traditional tobacco cigarettes. What's your view? You're saying that, if it's done effectively, it can be a tool for smoking cessation, but that's not the feedback we're getting from many of the submissions we've received. I'm interested to hear your views on that.

**ROWENA IVERS:** We looked at a lot of evidence from around the world and we would say that there are some studies that show it can—again, it's in a therapeutic setting; it's not unregulated use. It's combined with targeted advice from a health professional and it's combined with monitoring from a health professional to give that support. It's weaning down and being able to prescribe a specific dose that can be weaned down over time, like we do for other medications. We are saying that it's not banning it; it's making it available for those people who find it useful to give up smoking. There is actually little advice about giving up vaping. The research is emerging in that area. But, again, it can play a small role and I guess we would say it's a third line. Looking at the evidence, we think that it's reasonable to have it presented in a therapeutic setting.

**Dr HUGH McDERMOTT:** I want to continue with that answer of yours, Doctor. On your website it cites research regarding e-cigarettes in the United Kingdom and how the increase in e-cigarettes has led to a decrease in combustible tobacco use. We have evidence here in Australia along those lines, where in fact e-cigarettes have gone up as far as use goes. But has tobacco dropped, in your experience?

**ROWENA IVERS:** I think it's about the availability. What we would like to see is that every town has GPs and pharmacists to make it available locally.

**Dr HUGH McDERMOTT:** Sorry, Doctor, that wasn't my question. My question was that the evidence on your website cites that the UK increase in e-cigarettes has led to a decrease in combustible tobacco use. Do we have any evidence in Australia that the same thing is happening or has happened?

**ROWENA IVERS:** We are lucky that from our strong smoking programs in Australia our smoking rates have been lower than a lot of other countries. We know that it varies in young people. Certainly, some of the research is showing that they can be a gateway to smoking for some young people and that it may be a preferential increase in some young people in smoking.

**Dr HUGH McDERMOTT:** That answers my question. I have a couple more questions. Your submission also states that there are potential medico-legal risks for prescribers as a result of the uncertainties associated with vape use. Do you anticipate that there could be a reluctance on the part of doctors to prescribe nicotine vapes for smoking cessation or do you think that they will embrace it?

**ROWENA IVERS:** Again, our college plays a role in producing guidelines that are available for free nationally that will be very considered and evidence based as far as we can. We have a big panel that's contributed to that advice and they're available to all clinicians. They're used by a range of clinicians—non-GP specialists, nursing faculties and a range of clinicians. I think it is about certainly upskilling clinicians to be able to feel that that is an option. I think there are some doctors who are very confident in prescribing them and recommending them. Again, it's about giving advice about the use of e-cigarettes in the context of all the other things that are available to quit smoking as well.

I suspect some clinicians may be cautious but, again, it's something that any GP can do. It's something that with the SAS C process is reasonably straightforward. GPs are very used to prescribing and accessing other websites to do a form or to get authority or apply for extra approval. It's fairly straightforward. Always there will be some people who will be cautious. There will be other people who are quite comfortable with it. We have a role in training people to support that.

**Dr HUGH McDERMOTT:** My concern, Doctor, is that people are coming off cigarettes or any type of tobacco or way they're taking it in, and you're suggesting putting them onto e-cigarettes where, in your own words, we don't have any type of long-term knowledge of what the long-term effects are. We don't have that research. We don't know what we're giving. It's as if they're giving up one poison to be given perhaps an equally bad or the same amount of poison again—from tobacco to e-cigarettes. That concerns me. Do you have a comment?

**ROWENA IVERS:** In the short term, we think it's lower risk than a smoked cigarette, but we don't know the long-term effects. A lot of the studies that we have looked at are bringing people a short-term course of eight to 12 weeks. Again, part of the advantage of having a health professional involved is you can monitor the dose, you can calculate how much nicotine people are getting, you can reduce it over the time and really support the person through that process.

**Dr HUGH McDERMOTT:** We have seen in evidence in this hearing what is in a number of these products—acids and formaldehyde, like I think you mentioned, and chemicals and all kinds of things. It's like they're smoking meth, almost. It concerns me a great deal. We will have to quite seriously regulate the e-cigarettes that doctors are prescribing as well.

**ROWENA IVERS:** Yes. Obviously, it's not registered by the TGA. Our advice is really that GPs and other doctors are able to talk about products that are not—I guess, we would do shared decision-making and a very close and, for us, very well-documented discussion about the risks and the benefits and all the other options, which include all the other well-researched quit smoking options. We have to explain it to that person, and that is something that we as clinicians like to document very closely so that that person is aware of that risk. But, in many cases, having an e-cigarette in the short term is likely to be lower risk than having a smoked cigarette.

**Dr HUGH McDERMOTT:** But can you really say that, if you haven't got the research? If you don't have the evidence, how can you say that?

**ROWENA IVERS:** In the short term, there is evidence of that short-term effect on smoking. But, again, we don't have the 20- to 30-year evidence.

**Mr PHILIP DONATO:** Thank you, Professor, for your evidence so far. I hope you can see and hear me okay.

**ROWENA IVERS:** Yes.

**Mr PHILIP DONATO:** That's good. I was interested in some of the evidence that you've given, and I will ask you some questions specifically in relation to the statement you made on some of the research that has been conducted on some of the vapes or e-cigarettes that have been seized by some of your colleagues at the University of Wollongong. You said potentially up to a 700 per cent increase of nicotine as opposed to what is contained in cigarettes. Is that right? Did I hear that correctly?

**ROWENA IVERS:** That was not from their research. But we know that, without realising, I think because it's very hard in some of the products for people to know how much nicotine they're taking in, they quite quickly can escalate to very high doses of nicotine. We see that clinically—I guess the smoking withdrawal scales that we use. All of a sudden in the last couple of years, with people vaping, we have seen there are some that are having signs of severe nicotine addiction—getting up at two o'clock in the morning, getting up at three o'clock in

the morning, kids running out of classrooms because of their addiction—which we haven't seen for a while. People have not been smoking that much. So clear signs of nicotine addiction.

**Mr PHILIP DONATO:** I think in your evidence you indicated some of the other chemicals that have been found. This inquiry has heard from other witnesses in relation to some of those chemicals. We heard of things like arsenic, weed killer, metals, formaldehyde. They're pretty nasty chemicals, right?

**ROWENA IVERS:** Yes. They're also contained in cigarettes as well.

**Mr PHILIP DONATO:** We've heard there can be up to 200 chemicals in these vapes or cigarettes. Would that be consistent with your understanding?

**ROWENA IVERS:** Yes. It ranges. There are so many products, each of them with their own ingredients.

**Mr PHILIP DONATO:** Would it be fair to say that in the absence of longer term research, the evidence would seem to suggest that these vapes are potentially probably more harmful than normal, conventional cigarettes? Would you agree?

**ROWENA IVERS:** In the short term, they—again, cigarettes contain a lot of other ingredients as well. As GPs, we would love to see a safe product that had gone through TGA, was produced in pharmacy, was produced in a reputable place, had been trialled over 20 years. It is not available. That is what we would love to see. We are always cautious and we always would be advising people about the safest option. In our guidelines, we do actually recommend some of the other options far first. Certainly advice, nicotine-replacement therapy—all the other options.

**Mr PHILIP DONATO:** Do you believe, then, that the use of vapes or e-cigarettes is a more effective form of cessation of conventional smoking as opposed to patches, for example, or nicotine gum?

**ROWENA IVERS:** Again, we come into the evidence. We look at it—I guess we look at pragmatic and measured approaches. When we looked at some of the studies, they had better quit rates than nicotine replacement therapy, for example. But the balance was that we didn't have the long-term effects of their other effects, so we just don't know. In the end, we know the long-term effects of those other options, and things like advice obviously also play a very big part of the whole interaction. The issue about unregulated vapes is that people just bought them wherever they got them from and they didn't receive any of that targeted personal advice. We would normally have that conversation with them about their family, how they feel about their smoking—thinking about the risks of that on their health, whether it's their emphysema or their risk of lung cancer. It's a very personal conversation. The benefit of being able to provide this in a health setting is that we can have those other conversations and we know that that is part of the package.

**Mr PHILIP DONATO:** Finally, do you think that the public health messaging in relation to vapes and e-cigarettes needs to be improved? Do the general community and especially younger people need to be made aware of the harmful impacts of these vapes and e-cigarettes?

**ROWENA IVERS:** Yes, exactly. My doctorate work is in this area. Any time a health promotion campaign—it's often a combination of legislation, health information, but clinical training and clinical interventions as well. They need to be combined. Health education is never enough by itself. It doesn't really work. School education is not really effective.

**Mr TRI VO:** Thank you, Professor Ivers, for coming to the hearing today. I understand that the Royal Australian College of General Practitioners plays a very big part in all this, especially when it represents over 40,000 members. What do you think needs to happen for the prescription model to work more effectively?

**ROWENA IVERS:** Of course, the Commonwealth is introducing legislation and there are the new regulations around that from March. It means that as doctors we can write a prescription for that. As a prescription, like antibiotics, it's available in most towns if there's a pharmacy. It's a process that we're used to. There's a form that we do for it online. It does mean our college has already done some training. Professor Nick Zwar, who has learned a lot about work in this area, has already been doing some training. Our team has been working very hard on these evidence-based guidelines—again, available online to everyone across the country—about how to use them: the practical day-to-day things about what health professionals can do to support people with giving up their nicotine addiction. There's always room for more research. We work with the most current research that we can find.

At the State level, you play a role as well. It's about that collaboration between the Commonwealth and the States. Obviously, the adjustments to your legislation, especially about the supply of nicotine, the licensing of premises basically to keep it in line with other tobacco products, but also the role of police and environmental health agencies in enforcing e-cigarette regulation, all play a really, really critical role. The Commonwealth also

has a role to play in enforcement at the importation level. But certainly at the State level, that role of police and environmental health. I've worked very closely with police and environmental health officers over the years and it is about upskilling those agencies as well. But I think it's something that is quite pragmatic. I think it can change. Again, it's about the outcomes for our young people.

**Mr TRI VO:** I have a follow-up question. What training and resources are being offered to general practitioners to help them understand when to consider prescribing an e-cigarette and how to counsel patients trying to quit smoking?

**ROWENA IVERS:** I've been involved in training medical students and general practitioners for 30 years. As part of our training, at all levels of training, we train them in smoking cessation and nicotine cessation. And now we've made a national evidence-based guideline, which has been led by Professor Nick Zwar. It is actually available online—google it, if you feel like it. A lot of other health professionals use that as well. Our college also runs training webinars, and so there has been some training in vaping specifically run through our college, and we are planning more. So, yes, it's basically ongoing support for our colleagues.

**Mr TRI VO:** Do you anticipate a surge in demand for prescription vapes under the new system?

**ROWENA IVERS:** Talking to members of the community already, I think that people are able to access themselves nicotine replacement therapy over the counter in supermarkets and pharmacies. But I think that certainly people have come to me for advice and I think there will be people—if the enforcement is in place and it's not available outside your school or on the way to university when you're walking past it, those kinds of enforcement measures play a really important role because that availability is one of the key things that makes people access it. Obviously the Commonwealth has a role in stopping importation. But I think certainly some people will present to health professionals for assistance, and we're there to help.

**Mr TRI VO:** Since you're a professional, what's the nicotine effect in the short term on a person and the long-term effect?

**ROWENA IVERS:** We used to say every cigarette is doing you damage and actually every suck on a vape does some damage. Basically it's the nicotine. With the vape, you don't obviously get some of the other ingredients but, again, we don't know the ingredients of vapes. But certainly the effect on blood pressure, pulse is immediate. Again, the kind of mid-term levels that we're seeing are escalating addiction to nicotine, insomnia because it makes people more alert. Again, people are seeing dental problems as well. And certainly the poisonings of young babies who access e-cigarettes is very real and seen in children's hospitals and the poisonings line. I think that the long-term effects, we don't know. Obviously, in the States it's different carrier fluid. There have been what we call EVALI—young people ending up in intensive care related to vaping. I believe there have been hospitalisations in Australia—rare but, again, it's the long-term effects that we just don't know about.

**Mr TRI VO:** With this prescription model—and the Royal Australian College of General Practitioners is a very important organisation in all this—what role do you think the Royal Australian College of General Practitioners plays in the long term?

**ROWENA IVERS:** We've got an ongoing role in providing support and training for our colleagues. We make the main national guidelines on smoking and nicotine cessation. We do, obviously, training at all levels. Again, we are supporting the health of the community. We have a very strong role in prevention.

**The CHAIR:** Thank you, Professor, for appearing before the Committee today. You will be provided with a copy of the transcript of today's proceedings for corrections. The Committee staff will also email any questions taken on notice from today and any supplementary questions from the Committee.

**(The witness withdrew.)**

**Dr CELINE KELSO**, Mass Spectrometry Facility Manager, School of Chemistry and Molecular Bioscience, University of Wollongong, affirmed and examined

**Dr JODY MOLLER**, Senior Lecturer, School of Chemistry and Molecular Bioscience, University of Wollongong, affirmed and examined

**The CHAIR:** I welcome our next witnesses, Dr Celine Kelso and Dr Jody Moller. Thank you for appearing before the Committee today to give evidence. Please note that the Committee staff will be taking photos and videos during the hearing. The photos and videos may be used on the New South Wales Legislative Assembly social media pages. Please inform the Committee staff if you object to having photos or videos taken. Can you please confirm that you have both been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

**JODY MOLLER:** Yes, I can confirm that.

**CELINE KELSO:** Same here.

**The CHAIR:** Do you have any questions about this information?

**JODY MOLLER:** No.

**CELINE KELSO:** No.

**The CHAIR:** Would either or both of you like to make a short opening statement before we begin questions?

**JODY MOLLER:** Just to give you some context on who we are and what we've been doing, we've been working in e-cigarette research since 2019 and basically we are both chemists. We specifically look at content. So any questions you've got to do with what is in an e-cigarette and what the chemical content is and what the potential harms from that are are the sorts of questions that we're really well able to answer. Since 2019 what we've really seen is a shift from freebase nicotine over to nicotine salts, which has allowed the concentration of nicotine in e-cigarettes to increase significantly.

We've also seen that shift from bottles of e-liquid across to largely now, particularly amongst young people, the use of disposable devices. Also, when we're thinking about e-cigarette content, we really need to think about what the intended content is in an e-cigarette. Someone mentioned before 200 compounds in an e-cigarette. There are actually very, very few compounds in an e-cigarette. We do have some additional ones that get formed during the vaporisation process. But generally 200 compounds is actually is not very many for something that you're inhaling.

Tobacco smoke, in contrast, has thousands of chemicals in it. So it's actually a lot easier for us to identify what is actually in there, because we can pull all of the pieces apart. We have the propylene glycol and vegetable glycerine, which are the carrier fluids or the solvents that are what form the cloud. We have nicotine and then we have a small collection of flavouring liquids in each of the e-cigarettes. That's the intended content, but we then also have some of the unintended content, which is where the potential harm lies—things like banned substances that shouldn't be in there at all, so contaminants and other things, heavy metals in some cases from degradation of heating coils, and then we also have some of the ingredients reacting with each other to make new compounds, which have potential harm as well. I guess we sort of need to separate those two, really importantly.

The only other thing I really want to say as part of this brief intro is to highlight some of our recent findings for things that we've been doing recently. We've been focusing really on disposable e-cigarettes over the last year and a half. What we found is that nicotine is in all of them, regardless of what it says on the packaging, whether it says that it's nicotine-free, whether it doesn't mention nicotine at all. About 98 per cent of the samples we've analysed recently contain nicotine regardless of what the packaging said. Young people are primarily using disposable e-cigarettes; they're not using refillable devices. They're only using these disposable devices. Banned or dangerous compounds were found in about 4 per cent of the products that we analysed. Once again, this is specifically in those disposable devices.

Just in response to the previous person, I'd just like to add as well that while we don't know long-term harms—that is absolutely true—we can be very confident, because what we do know is what the content is of the e-cigarette compared to what the content is in cigarette smoke, that these are not as harmful as cigarette smoke. We know that things like formaldehyde and acetaldehyde, which are 100 per cent present in e-cigarettes, are at least 20-fold lower in e-cigarettes than they are in cigarette smoke. They're both present. They are carcinogenic, absolutely, but they're present at lower concentrations. Even the metals that we find off the coil, while they're present and they are absolutely dangerous, they're not present at the same concentrations they are in cigarette

smoke. So it has to always be a comparison between those different things. E-cigarettes are absolutely not good for you but they definitely are better for you than smoking. Anything you want to add?

**CELINE KELSO:** No, I think you covered pretty much everything, so I'm just happy to go to questions.

**The CHAIR:** In your opinion, and both or either can answer, what actions can the New South Wales Government take to support the implementation of the Australian Government reforms that are currently being debated in the Federal Parliament?

**CELINE KELSO:** At the moment, we've seen that the supply or the access of the devices is mainly from illegal avenues. I guess having a much more available supply via allowed routes like pharmacies—which at the moment it's quite difficult to put your hands on—will allow to shift people towards the legal way, which is simply just hard to get at the moment as well.

**The CHAIR:** So you're supporting the banning of importation of these devices?

**CELINE KELSO:** We definitely are supporting the banning of the disposables, not only on the environmental issues that are linked to that—batteries, disposable resources, pollution—but as well in the fact that if you want to curb the access to the young people. We know the young people are mainly using disposables. Preventing access to those specific devices while allowing other users—ex-smokers, for example—to access vaping products as they would need would be the pathway we think is most appropriate.

**The CHAIR:** We understand the Federal Government is moving towards plain packaging, limiting the flavours to two flavours and restricting it to prescription only. What are your views on those proposed changes by the Federal Government?

**JODY MOLLER:** I guess with the flavours in particular, we do have some concerns over the idea that they would be limiting these to only tobacco and mint flavourings. The reasoning behind that is there is no chemical molecule that constitutes tobacco flavour. When I do a chemical analysis, you can't say to me, "Does this only contain tobacco flavour?" because there is no actual chemical that is tobacco flavour. When we analyse a tobacco-flavoured e-cigarette, every single one of them is different, and most of them contain exactly the same flavouring molecules as what we get in an ice cream or strawberry flavour. They contain a lot of the sweet flavouring molecules—things like ethyl maltol—and they sometimes also contain some of the cooling agents and things that we see in our other e-cigarettes. Because it can't be defined, how do you then enforce what is tobacco flavour and what is not? Our concern there is you can call it tobacco flavour, but does that mean that it actually tastes like tobacco? I don't know what level that would be enforced.

Potentially putting limits on the maximum concentration of specific flavouring molecules, yes, absolutely that would work from an enforcement point of view. But just blanketly saying "only tobacco" and "only mint"—obviously that's only going to be products that are coming through the legal pathway that are going to be limited to those—that's not going to be touching any of the products that are coming through the black market, so we're still going to be seeing the flavours available there. Additionally, we already have what's called a flavour concentrate. They're additional strong flavours that people can mix in themselves. If you're filling up your e-cigarette, you can just add flavour in yourself anyway, so potentially that also isn't going to impede people from going down that pathway. But what you are doing is introducing potential risk, as someone who is adding their own flavour could add too much and have a really high concentration that potentially could be dangerous or cause them harm.

**The CHAIR:** You're the experts in the analysis of the chemicals that go into vaping cigarettes. What's the most toxic chemical that you are aware of that's going into the vapes?

**CELINE KELSO:** In terms of what we know about the chemicals that are going in there, we know they're safe to eat. They exist in products that you consume in everyday life like biscuits, yoghurts, lollies—you name it. But we don't have much information as to what happens to your respiratory tract when you inhale those compounds after they've been heated up. We know that some of those flavours will decompose and create some other chemicals—formaldehyde, for example, and others—which are born from the degradation of those flavours. But, in terms of the flavour itself, we don't know what happens to your lungs when you inhale them at high dosage as they could be present in the e-cigarette vapour.

**The CHAIR:** Do you want to add to that?

**JODY MOLLER:** I was just going to add, in terms of what we've actually seen recently, probably the most harmful thing we've seen was ethylene glycol, which is antifreeze. That was specifically in a set of disposable e-cigarettes that we analysed recently that were confiscated off school-age children from a New South Wales high school. The teachers confiscated them, they sent them to our labs and we analysed those. That was the first identification of that compound in an e-cigarette in Australia.

**The CHAIR:** The reason for that compound?

**JODY MOLLER:** We think it's a contaminant in the production of the propylene glycol, which is the main constituent of the solvent. So our concern there is, once again, this is what happens when we push products into a black illicit market: We start to see products in there that are not intended.

**Dr HUGH McDERMOTT:** Thank you for your submission and for being here today. This is day two of the public hearings and your evidence and some of the things you've said and recommended are quite the opposite of what has been said on day one by pretty much all the parties, including parties in their submissions. You're nodding your head, so you're aware of that. I'm going to challenge some of the things you've put because I'd like to hear your views.

Before I get to those questions, you made a comment or a statement that vapes are better than smoking. I find that hard to believe when we've heard, like you've just said there, about some of the chemical products that are actually being mixed into vaping products: the coils, which we believe basically dissolve as you're smoking them, and the oils and others. I am quite incredulous that you could say that. To me it's just one poison or another poison. Some of the properties which are seen to be in the vapes are—it's a bit like mixing up meth and then making that. I mean, I'm very surprised by that. Could you justify how you could say that when there's not long-term effects that we're aware of? We have no evidence to say what will happen in 30 years to people who take it. Short term—well, even that. I look at regulated tobacco and the purity of it, if you want use that word, compared to say chop, which we see a lot of coming into New South Wales. And then we see millions of vapes in the last few months, prior to the regulation of the Federal Parliament coming in, being imported into this country from China. I can't see how one could be better than the other. Can you make a comment on that?

**CELINE KELSO:** I'll start first. When you want to compare the two, you have to compare, first of all, the same level of exposure. If you are a light smoker and a light vaper, the amount of chemicals that are entering your system in the same quantities—so light versus light—would be much less if you are vaping than if you are smoking. It's the same thing if you are a heavy smoker versus a heavy vaper. You have to compare how much you would do one versus how much you would do the other, and comparing at equivalent levels. Then you would have less exposure to toxic chemicals when you would be vaping against when you would be smoking. Now, if you are a light smoker but suddenly vape three bottles of vapes a day, then certainly you will have more chemicals entering your system.

**Dr HUGH McDERMOTT:** That's the evidence we've got so far in this hearing: That if you move from cigarettes to vapes, you vape a great deal more, and the fact that what you're taking in is a lot more nicotine and a lot more other chemicals than a simple cigarette. You may smoke 10 cigarettes a day, but once you start vaping you're vaping a lot more than the equivalent of 10 cigarettes. By what you've just said, you're taking a lot more chemicals already if you're doing that.

**CELINE KELSO:** It will depend on the vaper themself. If the person is a heavy vaper, for sure; I'm not contesting the fact that you will uptake more chemicals. But if your aim is to quit smoking by vaping about the same equivalent in controlled doses of nicotine, then you will vape the same amount and therefore have, in those cases, less chemicals entering your system. So it's all comparison of the—

**Dr HUGH McDERMOTT:** So it's one for one. What we are seeing in the evidence is that people aren't taking it one for one; they're taking it one for 20 or a lot more.

**JODY MOLLER:** Yes. I just wanted to add, we know in toxicology the dose makes the poison. What we know for a fact is that the carcinogenic compounds that are present in tobacco smoke—that is, the things that cause the cancer and the other things that we know smoking causes—are present in vapes at lower concentrations and by manyfold lower. And not if you vaped 20 times more than you would smoke, we are talking hundreds of fold difference between the levels of these contaminants. So yes, absolutely, I am not saying vaping is good for you by any stretch of the imagination, but it is a scale.

**Dr HUGH McDERMOTT:** You say that, but a cigarette hasn't got metal coils.

**JODY MOLLER:** But there are metals in tobacco. Arsenic is in tobacco. There are all these metals that are present in the coils. Let's be honest, the dangerous metals that we're seeing are largely present in the disposable style e-cigarettes which we have recommended should not be allowed. Disposables are where we're seeing the dangerous compounds like ethylene glycol and the high levels of metals.

**Dr HUGH McDERMOTT:** When you say stop importation, are you just talking about disposables? Nothing is produced here; it's all imported.

**JODY MOLLER:** The only thing we would like to see definitely banned in Australia is the use of disposable e-cigarettes.

**Dr HUGH McDERMOTT:** You were saying at the very beginning you're making recommendations which are different to everybody else's. One of them is that you believe in putting in place the regulation of e-cigarettes in line with other tobacco products rather than a total ban. Why?

**JODY MOLLER:** Our concern around that is what we saw in response to the 2021 changes to the e-cigarette regulations. In October 2021 we saw the last major regulatory change. What we saw was the market shift within two months to remove the word "nicotine" from their packaging to allow them to go through a loophole to sell them over the counter. Our concern is that the market is going to shift quickly again to find a way to continue selling. We mentioned in our submission that we have already seen watches that are a vape. We have seen drink bottles that are a vape. We've seen iPhone covers that are a vape. I've even seen a Ventolin puffer—looks exactly like a Ventolin puffer. That one was a cannabis vape, not a nicotine vape, but it's completely indistinguishable.

I believe that the market will shift again and what we will see is stealth products coming in, and they will still be coming into Australia. Young people will be utilising them. Effectively, that pushes it deeper into a black market, and I am concerned that that means there are more contaminants and more dangerous compounds getting into these products. We have already seen the introduction of some of these banned substances in the last 18 months. We don't want to see dangerous products in e-cigarettes in Australia at all, whether they're on the black market or elsewhere. If we have a regulated system, we can have much greater control over what is actually in e-cigarettes.

**Dr HUGH McDERMOTT:** Regulating the actual e-cigarette and the quality, just like we do with tobacco in an attempt to undermine the black market and organised crime.

**JODY MOLLER:** Correct. We can get quality control on what is available in them—exactly that.

**Dr HUGH McDERMOTT:** You mentioned cooling agents WS23. What is that? Can you explain what it is and what its effect is?

**CELINE KELSO:** A cooling agent, as we categorise in there, is a compound that, when you inhale it, gives your mouth a cold feeling without the taste of mint. The morning brush for your teeth—and then you inhale and that cool feeling that you get in the mouth is created by some of those compounds. They are odourless and tasteless, but they have that potential of giving that cooling feeling when you inhale. Those are classified as coolant compounds, and we have found two types of those compounds present in e-cigarettes. Those have been used to date in mint toothpastes and lollies. They are safe to eat. They go through your stomach and get digested before they enter your body, but we have no evidence as to how toxic they are when they get through your lungs.

**Dr HUGH McDERMOTT:** So you are concerned about what will happen?

**CELINE KELSO:** Yes.

**Mr TRI VO:** Thank you, Dr Jody Moller and Dr Celine Kelso, for coming to the hearing today. The beauty of this hearing is we have different views, and that is the best because while hearing all of your evidence and expertise, hopefully this Parliament will come to make better legislation on this. It's quite important. I hear that you've said e-cigarettes are not as harmful as tobacco because we know what is in them. Or at least most of the substances' maximum is 200 compounds, and flavours do not contain extra compounds, poison or harmful substances. Do you think we should have more than just two flavours?

**JODY MOLLER:** Like I said earlier, I think the issue really around the two flavours is that it's not two flavour molecules. A mint e-cigarette now doesn't just have menthol in it. It has menthol, sweeteners, cooling agents and other things.

**CELINE KELSO:** It's probably like four.

**JODY MOLLER:** Even though it's got mint on the label, it isn't just a single flavouring molecule. Tobacco has even greater variation. There's no specific set of molecules that are in a tobacco-flavoured product. My concern is over limiting to tobacco. What you will end up with is, potentially, a sweet tobacco, a cool tobacco, a wild tobacco—who knows what it ends up becoming—and each of those are actually strawberry with tobacco or something else with tobacco. As long as it's got tobacco on the label, does that get through the regulations? It's really about focusing down on specific chemical components instead of broad names of things.

Let's be honest, at the moment, particularly through the illicit market, we see products that don't even have a flavour associated with them. There was one called "assault" and one called "blitz". We would rather see a limitation on making sure that at least the flavour name is associated with an actual flavour than pursuing the tobacco and mint restrictions. We know that a lot of ex-smokers do use flavours. The vast majority of them do not vape tobacco and mint flavour. Fruit is the number one flavour option for ex-smokers in addition to young people.

**Mr TRI VO:** So you support more regulations because you think e-cigarettes are not as harmful as tobacco, but you support more regulations. What are the important actions for the New South Wales Government to take to support the implementation of the Australian Government's reforms? What are your recommendations or what suggestions do you have?

**JODY MOLLER:** I think enforcement would be the biggest one. At the moment the biggest problem is that we've got a regulation that says that e-cigarettes that contain nicotine cannot be sold over the counter, but in reality that is not happening. We are seeing thousands of e-cigarettes being sold over the counter through tobacconists and other places every single day, and that largely comes down to—we've done work with the enforcement teams through NSW Health. There are just not enough people to do all the enforcement that's required because so many places are selling these products.

And then, obviously, also making sure that there is deterrence for the people that are caught doing the wrong thing. We need to make sure that if someone is selling a product illegally over the counter there is actually a significant penalty for that to deter them from continuing to sell that product. In our local area where we are, in the suburb just where I live, there have been two American candy stores open in the past three months. Both of them sell tobacco products, including vape products, over the counter. We are also recently seeing an increase in nicotine pouches as well, and that's obviously an additional concern because young people can use those incredibly stealthily in the classroom if necessary.

**Dr HUGH McDERMOTT:** Does the American candy store sell candy and things for children as well?

**JODY MOLLER:** Yes.

**CELINE KELSO:** Yes.

**Dr HUGH McDERMOTT:** So it has children's products like lollies and it does vapes as well?

**JODY MOLLER:** Correct. That particular one that's opened at Bulli is directly across the road from a primary school. There's been no enforcement to look at that.

**Mr PHILIP DONATO:** Good morning, doctors, and thank you for joining us today. Dr Moller, in that last point you were taking about enforcement or lack of proper enforcement. Health inspectors and/or police are essentially the enforcement agencies that generally investigate a lot of these types of issues or inspect these premises. But you clearly say that there are not enough resources from either of those agencies to appropriately target the number of premises that are popping up all over the place to address this. Is that right? You just nodded your head. Do you agree with that?

**JODY MOLLER:** Yes, I think that is definitely true. The other difficult part has been that, with the current regulation that has been in place—and this is changing, potentially, when the new laws get through Federal Parliament—a nicotine-free e-cigarette was legally allowed to be sold over the counter to anyone over 18 but a nicotine-containing e-cigarette required a prescription. That meant that stores were just removing the word "nicotine" and selling them over the counter. In order to prove that it contained nicotine, it had to actually go to a chemical lab and get analysed. That obviously is a lengthy process and it takes time; you can't walk in there, see an e-cigarette and realise that that needs to be seized. Potentially, with an improvement in the Federal regulation around these, that will allow that process to become easier because all e-cigarettes will then fall under the same umbrella. Hopefully that will assist with enforcement.

**Mr PHILIP DONATO:** Finally, essentially a lot of the issues you said in relation to items that you're searching for or examining—seized items or seized vapes or e-cigarettes—the overwhelming majority are disposable types. Is that right?

**CELINE KELSO:** Yes, over 90 per cent.

**Mr PHILIP DONATO:** I'm not a smoker or a vaper but, as of my understanding, conventional cigarettes have filters in them. Are you aware of that?

**JODY MOLLER:** Yes.

**Mr PHILIP DONATO:** Do you know whether these vapes have filters in them at all?

**CELINE KELSO:** No.

**JODY MOLLER:** No, but the aerosol that is produced from an e-cigarette is actually a suspension of tiny droplets of propylene glycol and vegetable glycerine, so there is no particulate matter. It's not smoke. When you burn a normal cigarette, what you are producing is actually solid particles that are in the form of smoke. What is filtering out is some of the tar and some of those solid particles. An e-cigarette is an aerosol; it's not smoke, so it doesn't require a filter.

**Mr PHILIP DONATO:** But there is no filter in the overwhelming majority of these disposable vapes that you're saying to filter any of the contents of that vape into your lungs, is there?

**JODY MOLLER:** No, because it's not particulate. It wouldn't be captured on a filter anyway. It would pass through the filter.

**The CHAIR:** That concludes the questions. Thank you, doctors, for appearing before the Committee today. You will be provided with a copy of the transcript of today's proceedings for corrections. The Committee staff will also email any questions taken on notice from today and any supplementary questions from the Committee. Thank you both for your attendance. The Committee will have a 15-minute break. We will come back at 10.45 a.m.

**(The witnesses withdrew.)**

**(Short adjournment)**

**Dr COLIN MENDELSOHN**, Founding Chairman, Australian Tobacco Harm Reduction Association, affirmed and examined

**The CHAIR:** I welcome our next witness. Thank you for appearing before the Committee today to give evidence. Please note that the Committee staff will be taking photos and videos during the hearing. The photos and videos may be used on the New South Wales Legislative Assembly social media pages. Please inform the Committee staff if you object to having photos or videos taken. Can you please confirm that you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

**COLIN MENDELSOHN:** I have.

**The CHAIR:** Do you have any questions about this information?

**COLIN MENDELSOHN:** No.

**The CHAIR:** Would you like to make an opening statement before we go to questions?

**COLIN MENDELSOHN:** I have no current position. I'm a former founding chairman of the Australian Tobacco Harm Reduction Association, a former conjoint associate professor at the University of New South Wales and a former member of the committee that develops the Royal Australian College of General Practitioners' smoking cessation guidelines, amongst other things. Australia's policy on vaping is driven by valid concerns about harm to young people, but we need to balance the small harms to young people against the substantial benefits of vaping in reducing death and disease from smoking. Modelling studies consistently show that vaping has a positive effect on public health overall, and regulation should reflect that.

What we currently have with vaping in Australia is prohibition, and drug prohibitions are rarely successful. Vaping is so harshly restricted in Australia that over 90 per cent of users don't comply with the current regulations. This has predictably created a thriving and dangerous black market controlled by criminal gangs, with serious escalating violence. The vast majority of products are unregulated and have no quality control. We have made it easier, not harder, for young people to access these products. Perhaps most importantly, we have reduced legal access for smokers who need these products to quit.

History has shown that enforcement and border control efforts have minimal effect on the long-term supply of drugs. I don't think there is any question about that; we know the war on drugs has failed. The only significant way to reduce the black market is to replace it with a legal and regulated one. The New South Wales Parliament must decide whether to continue the failed regulatory model to continue criminal supply of these products or to take control and regulate the market. That, I think, is the key message to this Committee. The best way forward is to make vapes available as adult consumer products from licensed retail outlets, with strict age verification, like cigarettes and alcohol. This will bring Australia in line with other western countries, it will reduce youth access, it will enable legal access for the smokers who need it and it will reduce the black market.

**The CHAIR:** Dr Mendelsohn, I need to bring to your attention that you have been named by a previous witness giving evidence. The witness said:

> Dr Colin Mendelsohn in his submission, the former chairperson of ATHRA, has suggested that we set aside areas where young people can vape at school. If that's not tantamount to "we have a problem", I don't know what is.

How would you like to respond to that comment?

**COLIN MENDELSOHN:** I think we all have to accept that what we're doing at the moment isn't working. We're constantly told that we have huge behavioural problems at schools where kids suffering from nicotine withdrawal and unable to concentrate. What we are doing isn't working. What I am suggesting is a pragmatic, compassionate approach that recognises that we have a problem. I am suggesting a practical solution to that problem: that for young people who are nicotine-dependent, who have the permission of their parents, and who have nicotine withdrawals, that they be allowed to vape in an agreed area in schools so that they can get through the day and they don't disrupt the class, as a compassionate solution for them. I think we'd rather not be in this situation, but we are. This is about harm reduction. This is about accepting the situation as it is and finding a practical solution. I would rather kids didn't smoke or vape, but I'm being pragmatic.

**The CHAIR:** Shouldn't those kids be seeking medical advice, rather than just freely be allowed to—

**COLIN MENDELSOHN:** This is not about freely allowing vaping. This is about accepting that some kids are addicted and will continue to vape no matter what we do. We want to minimise the harm to them and the harm to their classroom. We would rather kids didn't vape—in the perfect world, we would rather they didn't vape. But I have to say that vaping is one of the least harmful risk behaviours that kids indulge in. I would much rather

my children or grandchildren vaped than smoked, binge-drunk, drink drove, used illicit drugs or engaged in sexual violence or suicide behaviour. Kids are exposed to much greater risks than vaping. I think we have got this out of perspective, to be honest.

**The CHAIR:** The inquiry has received many submissions that argue that e-cigarettes are a pathway to normal cigarettes—that vaping is really just another pathway to get people addicted to nicotine, and then after a while they'll just move on to normal cigarettes. What are your views on that?

**COLIN MENDELSOHN:** I think that has been debunked. We heard the same scare story with marijuana: that kids would progress to dangerous drugs. Of course, it didn't happen, and we're not seeing that with vaping. What is happening with vaping is that vaping overall is diverting people away from smoking. It's actually a gateway out of smoking. As vaping rates go up in populations—and we see this in most countries—smoking rates accelerate downwards. Vapes and cigarettes are substitutes. If you're a kid who is vaping a mango-flavoured vape which is a tenth the price of smoking, why would you progress to stinky cigarettes that are much more expensive, that make you cough and are much less enjoyable? We are not seeing that progression. What we understand is, yes, kids who vape are more likely later to be smokers. But there is no evidence that vaping causes them to take up smoking if they otherwise wouldn't have.

A much more plausible explanation is that kids who try vaping are just more likely to be risk-takers. We know they're more like to smoke, to drink and to use drugs. That doesn't mean vaping causes you to drink or to take drugs. Nor does it cause you to vape. It is just that these kids have common risk factors—genetic, social and environmental—that make them more likely to smoke anyway. There is no evidence of causation. In the real world we're seeing that as vaping rates go up, smoking rates are falling. I think that's the bottom line. I think the evidence is very clear now. Yes, some kids may have progressed to smoking who might not have, but far more kids are progressing away from smoking and being diverted from smoking. There are smokers who are switching to vaping as well—who are switching away from smoking—and that is a good thing.

**Dr HUGH McDERMOTT:** As has already been said by the Chair, your evidence is at odds with everybody else, to be honest, in a number of ways.

**COLIN MENDELSOHN:** In Australia, that's true. That's true in Australia.

**Dr HUGH McDERMOTT:** Not just in Australia—let's be honest—but also other places as well. We haven't just been looking at Australia in this inquiry. So let's just look at that. We've been told there is a health crisis, that it's the same type of health crisis that we had some decades ago with people smoking cigarettes, which we have then fought, and through government policy and other ways we have changed and lowered the intake of tobacco products. But now we are facing a new generation. You made a comment that the impact of e-cigarettes is only a small harm to young people. You said that in your submission as well. That is, once again, opposite to what everyone else is saying.

**COLIN MENDELSOHN:** Of course.

**Dr HUGH McDERMOTT:** You've said that nicotine is especially beneficial for young people with ADHD, improving attention and brain function; we have been given evidence to the opposite of that, especially from a number of young people who have spoken to us. One in particular said she didn't do it because she was a risk-taker; she was quite the opposite and that it was the social environment. You've also put to us this morning that we should have a special area for kids who are caught on vaping, which could be argued, I would say, would just increase the amount of people vaping because now those children have their own little area to go off and go in, even if they are addicted. I am just challenging your things and I would like to hear your comments back. It greatly concerns me that someone with your expertise could say these things when other people have been saying the complete opposite.

**COLIN MENDELSOHN:** Absolutely. I think it is important to say I'm strongly evidence-based. I make a study of the literature and I'm very aware of what is in the peer-reviewed scientific literature and overseas experience. That is my agenda. My agenda is to stabilise and improve public health. To answer some of the questions: Is vaping a health crisis? Absolutely not. It is perceived and promoted as a health crisis. What is a health crisis is that 20,000 Australians are dying every year from smoking. That is a health crisis. No-one has ever died from vaping nicotine. We have heard about EVALI this morning, but that's—

**Dr HUGH McDERMOTT:** Isn't that just because we don't have the long-term effects?

**COLIN MENDELSOHN:** We've had 20 years. If there was going to be some concern, after 20 years we would have some clear evidence. In terms of long-term harm, I have to say I think that is a bit of a furphy. We never insist on long-term proof of harm in any new treatment that we introduce. We introduced COVID vaccines after three months. We weren't concerned about, "Oh, but what about in 30 years' time? We might find there's

some problem." We thought, "No, the risk of delaying this is much greater than the potential risk of introducing it." That is how we make medical decisions. To say that we don't have long-term harm, therefore we shouldn't use it, ignores the fact that 20,000 people are dying every year in Australia—eight million globally every year. We have got to consider that in our long-term assessment.

Just on the point that you made earlier with about if e-cigarettes are actually safer than smoking, there is no question that e-cigarettes are dramatically safer than smoking. From the scientific research we know that there are over 7,000 chemicals in smoke, mostly in high doses. There are generally less than 200 chemicals in vapes. They are mostly less than 5 per cent. Almost all are less than 1 per cent of what they are in smoke. We know that the poisons in vapers after they've switched from smoking drop dramatically. We know that when people switch from smoking, their asthma improves, their COPD improves, their blood pressure improves, their lung function improves and they have fewer respiratory issues. There are a whole range of health benefits.

**Dr HUGH McDERMOTT:** I am sorry to interrupt you, but I'm just trying to explore this. I'm not having a go at you. I put to you that you are talking about people taking e-cigarettes that are perhaps regulated; perhaps we know what the product is. The millions of vapes that are coming in from China at the moment—record highs up until this month. We don't know what's in them. We're told all kinds of chemicals. It's like trying to say—I'll equate it to other drugs—there are certain levels of chemicals et cetera in methamphetamine compared to a well-mixed bag of cocaine. You know what I mean? I'm looking at the product itself.

**COLIN MENDELSOHN:** I know what you mean. I think that Dr Jody Moller answered that question. There are very small differences. She pointed out that, yes, there are cooling agents, 3 per cent or 4 per cent had banned chemicals in them, there were higher levels of metals, but there's not a lot of difference. The fact is that they are vastly safer than cigarette smoking. Of course, what I'm here to say is that we need to stop this black market. We're not going to stop it by enforcement and policing. We're only going to stop it by changing to a legal, regulated model. I'm very against the black market. It's doing a lot of harm. But we can't just stop it by the methods that are being suggested.

**Dr HUGH McDERMOTT:** Can I just explore the black market briefly? I know you're not law enforcement. Who runs the black market into this country? It's mostly from China; is that correct?

**COLIN MENDELSOHN:** No, it's mostly controlled by criminal networks—mostly Middle Eastern gangs supported by outlaw motorcycle groups. They employ young people as dealers. They have young people who perform some of their crimes, carjacking and the actual firebombings for them.

**Dr HUGH McDERMOTT:** But that's organised crime; I'm talking about e-cigarettes.

**COLIN MENDELSOHN:** That's run by organised crime. The health Minister said that the profits from organised crime are being used for sex trafficking, drug trafficking and other illegal offences.

**Dr HUGH McDERMOTT:** Yes, I understand that. But what I'm asking you is that we know that e-cigarettes that are coming into this country are imported—disposables et cetera—predominantly from China.

**COLIN MENDELSOHN:** Yes, that's right.

**Dr HUGH McDERMOTT:** Millions of the products a month. But that isn't coming into organised crime, is it?

**COLIN MENDELSOHN:** Yes, it is. It's being imported by organised crime groups.

**Dr HUGH McDERMOTT:** As well as shops and other organisations?

**COLIN MENDELSOHN:** Mostly the shops buy them through organised crime groups. Some do import directly. But the vast majority are imported by organised crime groups who have a network of distributors who visit shops and try to arrange for them to sell their products.

**Dr HUGH McDERMOTT:** And you have evidence of that?

**COLIN MENDELSOHN:** That's well-known.

**Dr HUGH McDERMOTT:** Well, no, I worked organised crime for many years so it's not so well known. We are putting things in evidence here in this hearing. I put this question to you again: Do you have evidence, have you seen evidence of this network you're talking about for e-cigarettes?

**COLIN MENDELSOHN:** I've spoken to a criminologist from Melbourne, Dr James Martin, who assures me that the organised crime groups who import tobacco products have now pivoted to e-cigarettes. They are importing these products through their networks and I've read that from other sources as well. But to answer some of the other questions, are vapes a small harm for young people? Yes, they are. The main concern is nicotine

dependence. Prior two largest national surveys recently, the ASSAD and the National Drug Strategy Household Survey, about 3 per cent to 5 per cent of 14- to 17-year-olds have said they may be addicted to these products. That's in their words from the drug strategy. That's the main concern. Nicotine dependence is a concern but it's not a serious medical issue. Vapes are not as addictive as smokes. If kids stop vaping, they'll get over that in a couple of weeks. It'll do them no harm.

Other serious effects, there's very little evidence of that. There's no evidence that vaping causes serious functionally important respiratory problems. There's no evidence it triggers asthma. It doesn't cause seizures—normal vaping—in spite of what we keep hearing. It doesn't cause spontaneous pneumothorax. It doesn't cause serious lung disease. There are no serious harms that I'm aware of in the medical literature in young people. Yes, they may get short-term cough, wheeze. That's not good. It's transient. I think there's a lot of moral panic about the harm to young people. But the facts from the scientific literature do not support that being a serious concern. I have to say that, of all the people who vape in Australia, teenagers are less than 5 per cent of the total. We need to look at the balance of that in determining our policy to vaping. Are we going to make a policy that's causing a small amount of harm to a small number of people? To what extent do we need to consider the needs of the 95 per cent of people who vape who are at immediate and substantial risk from smoking, which otherwise many of them would be doing?

**Mr PHILIP DONATO:** I want to ask you some questions in relation to some of the evidence that you've given thus far. You said in your opening address that vaping is so harshly regulated in this State. But we've heard evidence that, in fact, you can buy vapes in basically any sort of convenience store. You can buy them from tobacco shops, service stations, lolly shops, online. You can buy through social media platforms. You'd have to agree it's hardly a regulated industry.

**COLIN MENDELSOHN:** That's exactly not—the opposite to that. What you're talking about is black market illegal products are available everywhere. That's the problem. That's what I'm arguing we need to do something about. The legal regulated market is less than 10 per cent of the total. It's because we're so strictly regulating it that people aren't using the legal market. We heard from Professor Ivers this morning that GPs will just step up and supply these products. It's not going to happen. I've taught thousands of GPs about smoking. I can tell you that—and there have been a couple of studies recently that have questioned GPs. There have been peer reviewed studies questioning Australian GPs about vaping. They found that the GPs are not informed about vaping.

They say, "We don't know about it. We don't know how to write scripts. We're sceptical about it. We're not even sure why they're asking us to do this. We have medico-legal concerns. You're asking us to prescribe a drug that's not approved." GPs are very reluctant to take this issue up. I've spoken to a lot of GPs about that. Pharmacists are very unwilling to dispense vapes and very few have a significant stock. Patients say, "Why should I go to the doctor and the pharmacist, spend my time, all that inconvenience, and have to go to the pharmacy to buy products that I don't like that are restricted in flavour and nicotine?" I can tell you that the pharmacy model is not going to work.

**Mr PHILIP DONATO:** The terms of reference for this Committee are broadly around the effects this has on young people, its availability and prevalence amongst young people. Most of those young people aren't going to doctors and getting prescriptions for e-cigarettes. They're purchasing them—like I said—disposables on social media. We've heard evidence that you can purchase it on TikTok and Snapchat and those platforms or other stores. I want to challenge you and ask you some questions in relation to what you said about the harmful impacts or there's been no serious health consequences—I'm paraphrasing you here—and it's older people vaping. You would agree with me that there have been young people hospitalised. We've heard in this inquiry that people have been taken to hospital. Do you agree with that?

**COLIN MENDELSOHN:** What does that mean, though? That means that they've gone to the emergency—

**Mr PHILIP DONATO:** Hospitalised—young people taken to hospital.

**COLIN MENDELSOHN:** Well, I'd like to see the evidence for that. I think a lot of what has happened is that kids use these high-nicotine products that are available through the black market. They get nauseous. They get dizzy from too much nicotine. They're not smokers. They pass out. They're taken to the hospital. I've not seen any evidence of any serious harm.

**Mr PHILIP DONATO:** We've heard a lot of these illegal vapes are comprised of extremely high levels of nicotine; you would agree with that?

**COLIN MENDELSOHN:** Yes.

**Mr PHILIP DONATO:** And nicotine is a highly addictive drug; you'd agree with that?

**COLIN MENDELSOHN:** Depends on the way it's given. So if you give it in a patch, it's not.

**Mr PHILIP DONATO:** We're talking about the high levels of nicotine. What's been consistent across this inquiry is that these vapes comprise high levels of nicotine, not much higher than what you would ordinarily get in commercial cigarettes that you would purchase. Do you agree with that?

**COLIN MENDELSOHN:** I think the black market products are very high in nicotine. That's one of the problems with this black market. They provide unnecessarily high concentrations of nicotine and that's why we need to eliminate the black market.

**Mr PHILIP DONATO:** We've heard evidence that anxiety, depression, impacts to respiratory—lungs, teeth, gums. All those types of things are some of the side effects from these vapes. Do you agree with that?

**COLIN MENDELSOHN:** I think there's very good evidence now that nicotine relieves anxiety, it relieves depression. It improves cognition, memory, alertness. It's pleasurable, and it helps a whole range of medical conditions. If people are addicted to nicotine and they stop it, they will get withdrawal. That lasts 10 to 14 days and, yes, during those times people will have some anxiety as a result.

**Mr PHILIP DONATO:** You're disputing then, are you, these harmful impacts that others have told the inquiry about? You're saying these e-cigarettes or vape cores, especially the illegal ones that you purchase in these premises or locations, actually can be quite beneficial. Is that your evidence?

**COLIN MENDELSOHN:** All I'm saying is that there are positive benefits from nicotine. That's one of the reasons people smoke. They smoke to relax, they smoke to help them concentrate, and they smoke because they enjoy it. I'm saying that some of the kids who use these products will experience some of those positive benefits. I'm also saying that I don't think kids should smoke or vape, but that's why they're choosing to use these products.

**Mr PHILIP DONATO:** Surely the harmful impacts that these vapes are having outweigh those positive impacts that you say. Wouldn't you agree?

**COLIN MENDELSOHN:** I would strongly disagree with that. I wrote an article recently that argues that the overall impact to young people, for their public health, is beneficial from vaping. Now, I'm not encouraging kids to smoke or vape. But when you look at the evidence, the fact that smoking rates amongst kids are falling faster than ever as vaping rates go up, to me, far outweighs any harm, and I think the harms are fairly small. I think most vaping by young people is experimental and short term. It's a pattern which isn't associated with any serious harms. The benefit of not smoking—smoking is deadly. Smoking kills two out of three long-term people. We only have to stop a small number of people smoking to see a substantial benefit. As I said, I'm yet to see any serious harms in young people from vaping.

**Mr PHILIP DONATO:** But you'd agree with me that we haven't had a lot of time in relation to vaping. It's only been a fairly recent thing that young people have been taking up—only in the last couple of years. It hasn't had years and years of research or data or analysis to be relied upon like cigarettes, has it?

**COLIN MENDELSOHN:** I think you'd agree that any new drug that we release on the market doesn't have long-term data. I think in the case of vaping, we have to compare the potential risks—and there may well be problems we find in the future—against the known harms of smoking. We know that two out of three smokers will die if they continue to smoke, and I think there is some urgency to get vaping out there. Vaping is by far the most popular quitting aid in Australia. In spite of what was said earlier at this hearing, it's by far the most effective quitting aid. It is more effective, without doctor support, than any other treatment. That's why, in Australia and other countries, we're seeing an effect from vaping in smoking rates.

There was a study done in Australia published in *Addiction* about three years ago which found that, as vaping rates were going up, the smoking rates and quitting rates were significantly higher. There was an important study done a couple of years ago, a modelling study, that looked at the Australian population and modelled the effect of introducing vaping, allowing for the harms from vaping, the benefits from vaping and the harms to children. They found hundreds of thousands of lives would be saved and quality of life years preserved if vaping had been allowed to be regulated like it is, for example, in the US. But I think we can do a lot better than that.

**Dr HUGH McDERMOTT:** Can I just add a supplementary question to that. Isn't it just giving up one addiction for another?

**COLIN MENDELSOHN:** No, it's not. What it's giving up is a deadly addiction that kills two out of three users, that takes ten years of life on average for people—it kills eight million people in the world every year—and replacing it with a harm-reduction alternative: a much safer alternative that won't kill people, that gives

them a tiny fraction of the chemicals but keeps them off the deadly option. That's harm reduction. It's replacing a deadly option with a much safer alternative. No, we're not stopping nicotine, but we're stopping people from dying. This is for people who can't otherwise quit, so it's just harm reduction.

**Mr TRI VO:** Thank you, Dr Colin Mendelsohn for coming here today, being part of the hearing and for all the information. I realise you've been in the industry of tobacco harm reduction for over 40 years. Although we may not always agree, I thank you for coming to give a different view on this and for being such a respectful, calm witness. Your submission states that nicotine is especially beneficial for young people with ADHD, attention deficit hyperactivity disorder, improving attention and brain function—that's on page 10. This appears to be at odds with evidence cited by many other stakeholders who claim nicotine is harmful to a developing brain. Why is your position different?

**COLIN MENDELSOHN:** I think it's well accepted now that people with ADHD are much more likely to smoke. The reason is that nicotine is a stimulant and stimulants are the treatment for ADHD. I have had many patients who've told me that once they found smoking their ADHD improved. They can't stop because when they go back onto it, they get the ADHD again. If vaping was harmful to the adolescent brain, we would expect now to see millions of adults who smoked as young people with brain damage. There's no epidemiological evidence for that. In people who have smoked, they've followed them up and looked at them as adults. They smoked as youth, and as adults there's been no difference in IQ, no difference in educational achievement, no difference in cognitive function—in different studies—compared to people who didn't smoke as young people.

If smoking has no effect, how can vaping have an effect? The evidence for vaping harming the adolescent brain is based on large doses—of chronic use—of nicotine in animal studies. The general consensus is that that cannot be extrapolated to humans. There is no evidence in humans. Like most animal studies, that's perhaps a signal, but there is no evidence that that can be extrapolated to humans. I think it's purely speculative, for the evidence doesn't support it.

**Mr TRI VO:** What do you think needs to happen for the prescription model to work effectively?

**COLIN MENDELSOHN:** The prescription model won't work effectively. The prescription model has been rejected by the doctors, rejected by the pharmacists, rejected by the patients—the users. The only way to regulate these products, I believe, is to replace the black market with a tightly regulated adult consumer product where people can buy from licensed retail outlets, like cigarettes. If you have a licence to sell these products and you sell to a child, you lose your licence or you have a huge fine. This is the way they do it in other western countries.

In New Zealand they do not have a significant black market. Why would you? You can walk into a dairy, as they call them, or a vape shop and get a legal, regulated product quite easily. You don't have to find the local dealer to provide these products for you, so there's no need for a black market and these products are regulated. They're approved for safety and quality. They're kept away from kids. There will always be some kids who'll get them but that's inevitable. Kids are mostly getting products through the black market now. I think most of that will cease over time.

**The CHAIR:** Thank you, Doctor, for appearing before the Committee today. You will be provided with a copy of the transcript of today's proceedings for corrections. The Committee staff will also email any questions taken on notice from today and any supplementary questions from the Committee. Thank you for your attendance.

**(The witness withdrew.)**

**Professor NICOLE LEE**, Chief Executive Officer, 360Edge, before the Committee via videoconference, affirmed and examined

**The CHAIR:** Thank you for appearing before the Committee today to give evidence. Please note that the Committee staff will be taking photos and videos during the hearing. The photos and videos may be used for social media purposes on the New South Wales Legislative Assembly social media pages. Please inform the Committee staff if you object to having photos or videos taken. Can you please confirm you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

**NICOLE LEE:** Yes.

**The CHAIR:** Do you have any questions about this information?

**NICOLE LEE:** No, I don't.

**The CHAIR:** Would you like to make a short opening statement before we begin questions?

**NICOLE LEE:** Thank you, first, for the opportunity to appear today. As you know, tobacco is the leading cause of death and disease in Australia—that's the leading cause—but the risk from tobacco is not from nicotine. What makes cigarettes so dangerous are the naturally occurring chemicals in tobacco leaves and the chemicals that cigarette companies add to it for various reasons. That's why e-cigarettes and vaping is significantly less harmful than tobacco cigarettes—because they don't contain all of those dangerous chemicals from tobacco. Research estimates that vaping has less than 5 per cent of the harm of smoking and less than 1 per cent of the cancer risk.

There is also very good evidence that e-cigarettes help people quit or reduce smoking, and countries that have increased the availability of e-cigarettes have shown significant declines in smoking. Even in Australia, the latest data shows us that there is a large reduction in smoking—the largest we have seen in decades, in fact—as vaping has increased in the last few years. So, overall, e-cigarettes pose a relatively small risk for a very large public health gain in reduction in smoking. Most people who use vapes would buy them legally if they could, but the current models of availability, particularly the prescription-only model, have restricted access so much that 90 per cent of adults who use vaping products buy them illegally. The limited legal access to vapes has created a black market, and, on the black market, products are unregulated, they are not tested for safety or quality, and they can be easily accessed by teens.

Reducing access and increasing enforcement in the face of something that is in high demand is not an effective approach to reducing the black market. We have already learnt this lesson from illicit drugs, and many governments are starting to regulate these drugs properly through decriminalisation, diversion and legalisation for personal use. On the one hand, non-prescription vaping products are being criminalised; on the other, more harmful tobacco cigarettes carry no penalty. So we actually risk people going back to cigarette smoking, and that means we might see increases in cancer and other harms as a result in the future. We definitely don't want teens recreational vaping, but the best way to reduce access by teens is to increase access for adult smokers so they don't have to go to the black market. Finally, vaping, in principle, should be treated as a health issue and not a criminal justice issue.

**The CHAIR:** In your submission it states that punitive approaches to vaping in schools are not beneficial in achieving behaviour changes, so how do we discourage the uptake of vaping and support young people with nicotine dependencies?

**NICOLE LEE:** If kids have nicotine dependence already, the best option for them is treatment and support. In terms of prevention, we know that scare tactics and punitive measures don't work for anything. They don't work for alcohol, illicit drugs or vaping. The best option is to provide good and early education and clear guidelines in schools in terms of the use of e-cigarettes and the consequences for that. We know that things like suspending or excluding children from school when they've used alcohol, illicit drugs, e-cigarettes or anything else actually increases their risk rather than reduces it. Overall, take a more educational approach. We know that when you give kids good information—legitimate information that is factual—they tend to make much better decisions about drugs, generally.

**The CHAIR:** Do you support schools that confiscate vapes without punitive action being taken?

**NICOLE LEE:** Yes. I think that one of the reasonable measures that schools can take is having a policy that vaping is not okay on school premises. Like many other things, they may confiscate them if they find them, without the punishment element to it.

**The CHAIR:** What can schools do to support students who they have identified as nicotine-dependent? Just confiscating the vapes by itself is not going to help that student, even if there is repetitive confiscation. What is your view on the role schools can play in helping that student?

**NICOLE LEE:** I'll just reiterate your point that if someone is already nicotine-dependent, just confiscating the equipment is not going to do anything. One thing to remember is that by far the majority of teens who try vapes only use them once or twice, and then they don't use them again. Even those who use regularly don't use for very long, and they don't use very frequently. There is a very small percentage who would be considered so dependent that they couldn't quit on their own. We need to be sure that those teens who are using vapes are not existing smokers or pre-smokers, because even though they are teens, if they're smokers, it is still safer for them to be vaping than smoking. If they are just recreational vapers, we have good brief interventions and good treatment options that are also applied to cigarette smoking—similar to cigarette smoking—that can be applied, and I think treatment generally for adults and for teens is the best way to reduce demands.

**The CHAIR:** We have heard prior evidence that peer pressure plays a large role in terms of young people taking up vaping. We've heard that friends pressure particular students into trying the vape, and then they get addicted with the nicotine and so forth. What's your advice for schools—if you can give that advice—on how to deal with the peer pressure aspect?

**NICOLE LEE:** I think this is why education right across the school is important—and very early, in an age-appropriate way. Because fads spread through teens—all sorts of fads. So the education is really important. Early education is really important and age-appropriate education is really important. Just remembering again that we shouldn't panic if kids have tried vapes a couple of times, because by far the majority of them have never used one, and even those who try them don't use them very frequently. I think we need some universal education across the school and then some targeted intervention, if we know that they've used vapes.

**Dr HUGH McDERMOTT:** Thank you, Doctor, for being with us today. As I've already said to people who have presented prior to yourself on this second day of the hearing, we are hearing evidence which is quite at odds at times with what the hearing said the other day. I am sure you are aware of that. It has been touched on by the Chair that your submission says that punitive approaches to vaping in schools are not beneficial in achieving behavioural change. We have heard evidence from a 16-year-old who became addicted to vapes at 11. I put that to her and she said the opposite. She said that, amongst her peers, having a punitive approach and having a week suspension actually helps them to stop and refocus. It's the opposite of what you've said. I am just wondering, with your statement on page 3, what evidence have you used and where have you got that from?

**NICOLE LEE:** We have a lot of research. One thing to say is that individuals may have different experiences, but we need to take a more bird's-eye view and look at the impact overall of different measures. We have a lot of consistent research on alcohol and other drugs—pharmaceuticals and illicit drugs—that chose those punitive measures, like fear tactics and scare tactics, and those kinds of approaches are not effective. Good, factual information and education that's age appropriate is the most effective way to address all sorts of drug use—alcohol, pharmaceutical, tobacco and vaping—across the board. There will always be some people that don't respond to that but, overall, that is the best approach to catch as many people in the education as we can.

**Dr HUGH McDERMOTT:** I don't disagree with what you've put; I just put to you the opposite view. What is the avenue, then—they're caught vaping, you take the product off them and you then send them to medical practitioners to start counselling? What process would you follow?

**NICOLE LEE:** I think that's all very individual. One of the first things would be an assessment from a health professional. That would be a reasonable next step. I think parents play an important role. They are at the moment very confused about the communication that they should be making to their teens as well, so not just education for the teens but also for the teachers and for the parents is really important. If someone is dependent and wants to quit, then an assessment from a health professional is a good first step—a GP, for example, or a drug and alcohol professional or a quit facilitator.

**Dr HUGH McDERMOTT:** Page 5 of your submission states:

> … strengthening restrictions on the availability of e-cigarette products is unlikely to improve this situation.

Can you expand on that?

**NICOLE LEE:** Yes. We know from decades and decades of attempting to manage a whole range of other drugs that, if there's a substance that people want, restricting it, criminalising it and making it hard to get doesn't stop them from using it, all that happens is that they go to the black market and a huge black market develops. The problem for me with the black market is that it actually makes it much easier for teens to access than if they were legally available for adults.

**Dr HUGH McDERMOTT:** When we've put this to teens in evidence here, they've said that they really thought smoking was disgusting. They thought cigarettes and butts were filthy; however, they really liked vapes. In a way, with having access to the black market or other ways, giving them access or them using vapes—they wouldn't be using anything and they wouldn't be smoking at all, I put to you, if it wasn't for vapes. I don't know what you were like at school, but what we saw when I was in school was that we would sit in the toilets with cigarettes like these kids do with vapes. There would be none of that. My concern is that, no matter what we do, if those vapes are available and we have restricted it—when I was a teenager and when I was underage, we could still get cigarettes easily enough. It would be the same with vapes. It's not going to stop the black market. It's not going to stop unscrupulous retailers still selling the cigarettes or having older people buy it for them; it just means that they will be taking vapes instead of cigarettes. I put that to you.

**NICOLE LEE:** That's one possible logical outcome, but we don't know that that would be the case. We have a really good legislative framework for tobacco cigarettes that could be applied to vaping products. That legislative framework has significantly reduced adult smoking and access by teens. The problem with that argument, which is very logical, is that what happens with the black market is that it's actually easier for teens to access. As soon as we start to control and regulate the market and give access to adults, then no adults are going to be buying on the black market and the bottom falls out of it and so there is not that much around for teens to access. As you alluded to, when I was at school as well we weren't meant to be smoking but there were many people who did try cigarettes, and there will always be some people who will find a way. What we are trying to do is take a more public health view. Regulating properly is the best way to reduce access for the bulk of teens who are just trying it because it's there.

**Dr HUGH McDERMOTT:** You would regulate it like cigarettes. Does that mean plain packaging as well?

**NICOLE LEE:** All of that.

**Dr HUGH McDERMOTT:** Banning ads and all those things?

**NICOLE LEE:** Absolutely. We know that all of those things are effective that we've applied to cigarettes. And then the other option that might be more palatable to some people is to make therapeutic access much easier. At the moment, you have to go to your GP, which is expensive. GPs are under pressure and overworked and it's really hard to get in to see your GP. It's much easier and cheaper to go buy it on the black market. If that process was also made more available to adults, the black market would be significantly reduced as well.

**Dr HUGH McDERMOTT:** Do you think there will be a reluctance by GPs to prescribe medical nicotine in this way?

**NICOLE LEE:** Currently, we know there is significant reluctance among GPs to prescribe. They are getting a lot of conflicting information about the safety of e-cigarettes and about who should be prescribed them and so many of them are very reluctant to prescribe. If we are going to go down that prescription route, it needs to be much easier to access.

**Dr HUGH McDERMOTT:** Would it make sense to expand nicotine supply in this way to pharmacists as well? You've seen it with, say, the flu injection and things like that and now pharmacists take those things on. Or does there need to be a doctor involved—I know they are both doctors—rather than just a pharmacist? Do you know what I mean?

**NICOLE LEE:** My personal view is that a pharmacy option is worth looking at. I remember when we first had nicotine replacement therapy—gum and patches and all of that kind of stuff—and we went through the same process. It was a very long time ago now, maybe 30 or 40 years ago—I'm not sure. Initially you had to go to your doctor to get it and then we realised that that wasn't working very well and so it shifted into the pharmacy realm, where there was some supervision by a medical health professional but it was much easier to access.

**Mr TRI VO:** Thank you, Professor Nicole Lee, for coming and giving evidence today. Thank you for providing us another view. It's good for us to hear you, and probably make better and more accurate legislation. Your submission states that the overall public health benefits of e-cigarettes are likely to be considerably greater than potential harm. That's on page 3. Why do you believe this to be the case?

**NICOLE LEE:** Primarily because the main harm from vaping and from e-cigarettes is dependence on nicotine—assuming that there is a regulated supply. At the moment, when you buy on the black market, you don't know what's in it and there could be all sorts of contaminants and things. But if we were to regulate properly and manufacture it properly, and people got just the nicotine without all of the other crap in there that is in the unregulated market, then we know that there are not the dangerous chemicals that are present in cigarettes, and

the main risk is dependence on nicotine. Dependence on nicotine is a pretty benign thing—95 per cent of cigarette smokers are dependent on nicotine and it doesn't have the same harms as some other drugs like, say, methamphetamine. If someone is dependent on that, there's a whole lot of other social, mental health and physical health harms associated with that. With vaping and nicotine e-cigarettes, really the main issue is the nicotine itself. We don't get the risk of cancer, we don't get the risk of heart problems—all of those kinds of things.

**Mr TRI VO:** What needs to happen for the prescription model to work more effectively?

**NICOLE LEE:** The number one thing is to ensure much easier access for adult smokers. Any way we can improve access for adult smokers—they would absolutely buy legally if they could. And then that means that they're not buying in the black market, they're not supporting illegal production—and that will significantly reduce, and also significantly reduce access for kids. The number one thing is to improve access to e-cigarettes and vaping for adult smokers at least.

**Mr PHILIP DONATO:** Thank you, Professor, for your evidence. I want to ask you a few questions about some of the things you have said today. You said earlier in your evidence that e-cigarette use is generally, especially amongst young people, experimental and transient. That was in reference, I suppose, to young people.

**NICOLE LEE:** Yes.

**Mr PHILIP DONATO:** Is part of your idea, in relation to reform or legislation around e-cigarettes or vaping, that it should only be for adults, it shouldn't be children—or people under the age of 18 shouldn't be able to access it? Is that your view?

**NICOLE LEE:** In general, yes, that would be my view. The only exception is for teens who are already smoking and who are already dependent on smoking. Switching to vaping for them would be much safer.

**Mr PHILIP DONATO:** You said, and your evidence was, that kids would generally try vaping but may only use it infrequently. It might be something they try with their friends, their peers, a few times, but then not partake in it to any degree of permanency. Is that what you meant by that?

**NICOLE LEE:** Yes, that's correct. We already know, if you put all the data together from different sources, somewhere between two-thirds and three-quarters of young people have never, ever had a vape—never tried it once. That is the first thing to keep in mind. About 20 per cent of young people have used at least once in the last 12 months, but the majority of those have used just a handful of times. Most of them try it once or twice and then don't bother with it again. I don't know if you've used a vape, but it's not that good. It's pretty disgusting and it is a bit like smoking. And then there's a small percentage of people—about 5 to 7 per cent—who are regular users who are at high risk of becoming dependent on it.

**Mr PHILIP DONATO:** We've heard evidence during the course of this inquiry about the level of how addictive nicotine is. Obviously, that's the risk: that young people who choose to vape or get led down the path of vaping with their friends or peers may, in fact, become dependent on it because of the nicotine issues. Obviously that has health implications as well. I'm assuming you agree with that, for the purpose of the transcript?

**NICOLE LEE:** The biggest risk for people who vape is nicotine dependence but, as I said, nicotine dependence in itself is a fairly benign dependence when you consider all the other possible effects of drugs.

**Mr PHILIP DONATO:** I don't know about completely benign.

**NICOLE LEE:** Not completely—I don't mean completely benign, but relatively benign. The biggest risk from tobacco smoking is not the nicotine itself. The nicotine just keeps people coming back for more. Then all of the dangerous chemicals in it—they are just getting more and more of those dangerous chemicals, and that is not the case with nicotine vapes.

**Mr PHILIP DONATO:** Dangerous chemicals have been found in nicotine vapes as well. Would you agree?

**NICOLE LEE:** Yes, this is the kind of tricky thing. Currently, nicotine vapes are illegal. They're unregulated and, therefore, nobody knows what is in them and all sorts of contaminants can be put into them without any controls. But what I'm suggesting is that we move to a much more regulated market, in which case people will know exactly what is in it, we can restrict any dangerous chemicals in it, and then the biggest risk is just the nicotine dependence. And for people who are already smoking, they're already dependent on nicotine.

**The CHAIR:** Thank you, Professor, for appearing before the Committee today. You will be provided with a copy of the transcript of today's proceedings for corrections. The Committee staff will also email any questions taken on notice from today and any supplementary questions from the Committee.

**(The witness withdrew.)**

**Associate Professor RAGLAN MADDOX**, Senior Research Fellow, Tobacco Free Program, National Centre for Aboriginal and Torres Strait Islander Wellbeing Research, affirmed and examined

**The CHAIR:** I welcome our next witness, Associate Professor Raglan Maddox. Thank you for appearing before the Committee today to give evidence. Please note that the Committee staff will be taking photos and videos during the hearing. The photos and videos may be used on the New South Wales Legislative Assembly social media pages. Please inform the Committee staff if you object to having photos and videos taken. Can you please confirm that you've been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

**RAGLAN MADDOX:** I confirm that I've received those documents.

**The CHAIR:** Do you have any questions about this information?

**RAGLAN MADDOX:** No further questions.

**The CHAIR:** Would you like to make a short opening statement before we begin questions?

**RAGLAN MADDOX:** Yes. I'll also begin just by confirming that I don't receive any vested interest money. I don't receive any money from the tobacco industry or the vaping industry, consistent with article 5.3 of the World Health Organization Framework Convention on Tobacco Control. I also acknowledge and pay my respects to the traditional owners of the land on which we're meeting, the Gadigal people of the Eora nation, their Elders past and present but also acknowledge the youth and young people because they're going to be the leaders taking our cultures, values, beliefs forward into the future. I acknowledge and respect those young people that have come to this Committee and shared their truth and their stories.

On that note, I also acknowledge that health is not actually just the absence of disease; health is much broader than that. We're talking about social, physical, mental, spiritual health and wellbeing, not just of the individual but the community—the health of the environment. So I think it's really important that, when we're looking at things like our youth and our young people—the future generations to come—we leave Australia and New South Wales in a place that fosters the health and wellbeing of our people. I wanted to acknowledge that this is a harm-generating product. We have talked about that. You've heard about that over the last period. We've heard about that this morning. We've heard about the evidence around short-term harms. If we know there are short-term harms, we can be guaranteed that there are going to be long-term harms. Evidence suggests that inhaling an aerosol of any kind is—a general rule of thumb is it's not great for us. It's not great for our health and wellbeing. I think communities have been saying that for a while now, so I wanted to acknowledge the work of this Committee in taking this step.

As you know, and as written in my document, my submission, there are disproportionately high rates of tobacco use among Aboriginal and Torres Strait Islander people for a whole range of complex reasons, including being paid in rations of tobacco as part of the colonial process. But we do know that 70 per cent of Aboriginal and Torres Strait Islander people want to quit smoking, and 75 per cent wish they never took it up. This speaks to the environment in which we live, where it's been socialised and available on every street corner. But the majority of people quit cold turkey and the majority of people want to quit. With the right supports, with the right infrastructure around communities, we know that people will be smoke- and nicotine-free. I just wanted to acknowledge and celebrate that work in reducing tobacco use but also look forward to the outcomes from this Committee in supporting youth and young people from not taking up e-cigarettes.

**The CHAIR:** Thank you so much for those opening remarks. You just stated that the vast majority of Aboriginal and Torres Strait Islander people who smoke want to quit and you've indicated a figure of 70 per cent and 75 per cent indicated that they wished they had never started. As a government, what, in your opinion, can we do to support those wishes of our Indigenous people in relation to smoking cessation?

**RAGLAN MADDOX:** I think there's a range of things. Many years ago I started in this sort of—in tobacco control about 2007 and I remember communities saying, "Stop selling it to us. I go to the Aboriginal medical service. I go to the GP. I call the Quitline, but I know that I can buy this product 24/7 at numerous stores." So if I'm trying to give this up and it's a highly addictive product—as we've heard—why is it available at every street corner? We've known for over 70 years about the harms of tobacco, but it's still available as an everyday consumer product, which normalises that behaviour. It normalises that. As a society, we tend to minimise the role of addiction, the challenges with addiction. We know how hard it is. As a result, those 20,000-odd Australians that die every year—I think just under 7,000 in New South Wales. It becomes a part of our everyday reality that we know people that will have tobacco-related illness and also tobacco-related deaths.

We know that 37 per cent of Aboriginal and Torres Strait Islander people pass away due to tobacco use, 50 per cent over the age of 45. In terms of passing on traditions, cultures, languages, the work across New South Wales, the work of land councils across here and celebrating and acknowledging the oldest living culture around the world is exceptional, but we have an opportunity to reduce retail outlet availability as well as those personal services, supporting things like the Quitline, GPs to provide cessation supports and other things. But we know communities want to quit and we just need to get around and support them to be nicotine-free.

**Dr HUGH McDERMOTT:** You talked about availability there. It reminded me of how in certain States they've banned alcohol altogether in certain communities. Is that what you're talking about—doing things like that?

**RAGLAN MADDOX:** Yes and no. I think licensing is key. Where communities have gone dry and it's a community-driven approach, I think it works. The top-down approach doesn't necessarily work and has other implications. But we know at the moment—and I guess the privilege and honour I get to listen to communities' stories is they can't get their meds, they can't get bread, milk and those things 24/7, but they can buy smokes. They can get e-cigarettes. You've heard about e-cigarettes being sold at retail stores around the State. We know you can get them on Snapchat, Facebook. We can probably order some here. We know that people have been ordering them to schools, so that availability needs to change. The number of outlets where they're available needs to change for people to have an easier time quitting. We know that quitting is hard. But we can make it a little bit easier because, obviously, nicotine is highly addictive but if it's not available everywhere, it will make those quit attempts a little bit easier knowing that you don't have to walk past the person selling it to you.

I'll just share a story. I was just thinking as I was coming up, the first focus group I did back in 2007 down in Queanbeyan in the Eden-Monaro—the Venice of the Eden-Monaro. The discussion was, "I'm going to walk out of this medical service and I know that there are seven stores across the road there that will sell me tobacco. And I'm going to try and give up. If I was on crack or some other product and then you made me walk past my crack dealer to go to the medical service, I'm guaranteed to fail." How do we change that power balance, particularly when we know that people are taking up these products as youth and young people, children, and then having a lifelong addiction where they're trying to give up? But then we have a predatory industry obviously marketing and selling a product and profiting at the expense of Australians' health and wellbeing. So how do we shift that?

**Dr HUGH McDERMOTT:** How many people within the Indigenous community vape, do you think? What's the percentage? Do you have any idea?

**RAGLAN MADDOX:** We heard about the household survey and other things but, unfortunately, we know that that undercounts Aboriginal and Torres Strait Islander peoples. I think we sort of heard about a third of people. I think that's conservative. I think people have tried it, for sure. We've seen a real explosion since COVID. Public health and other places have been caught up with other everyday realities and the ability to keep on top of the retail sector of a multimillion-dollar industry is very hard. So I'm nervous about the next lots of national and—well, decent Aboriginal and Torres Strait Islander data to come out. We expect to roll out a survey at the end of this year, but I suspect it's just over a third of people.

**Dr HUGH McDERMOTT:** A significant amount. Is it throughout the community or is it mostly the young people? Is there a particular group? How is it spread?

**RAGLAN MADDOX:** I think definitely youth and young people. Social media's obviously been a useful vehicle for people to be targeted with. I will also just give a couple of anecdotes because I do get to travel around the State and hear stories. When we're sharing some of the national data—I work with big data generally but it's really important to get the context right. What young people have been telling us is that they don't know how to quit, and actually taking up smoking provides barriers to them where they can quit.

At the moment when they're vaping, it's not an uncommon story that communities across the State have told me that they can vape anywhere. They can vape in the cinema. They can vape at home. They can sleep with it under their pillow; they can wake up at 3.00 a.m. and just suck on it and then get their hit and away they go, whereas the reality is with smoking you can't do that. You can't sit up in bed and spark up your cigarette and smoke without implications, without your parents knowing, without other things happening.

I think that normalisation of it is one of those things we have to change. Actually, just when I'm talking about that, I will touch on the access point that I think we've heard about this morning and throughout this hearing—that it is available in every store, so why would you get a prescription? If it's easy just to go down to the convenience store and pick one up or walk across the street, which I'm sure we could probably do, and pick up a product, then why would I go to the doctor and increase those barriers for me? So just a couple of thoughts.

**Dr HUGH McDERMOTT:** Are you finding people in the Indigenous community are using vapes as a way of coming away from cigarettes or is it something different? Talk about who takes it up, but are they using it as a minimisation plan?

**RAGLAN MADDOX:** The vast majority, no. The vast majority of people are youth and young people that have never smoked.

**Dr HUGH McDERMOTT:** It's social, is it?

**RAGLAN MADDOX:** It's social. The messaging we're hearing from communities is "It can't be that bad for us because it is available everywhere. Everyone's doing it. We'll give it a go." Unfortunately, I know when we're doing focus groups and interviews we hear these stories where people are being misled to think that this is a product that will help people quit. I mentioned those barriers. I appreciate that everyone's quitting or switching experience might be different, but I've heard from countless people about the challenges they faced using this product and then realising that they can use it everywhere, that there are no social barriers to it. As a result, they start to suck on this thing a lot more than they would if they were smoking and then come to me asking for advice around "Now how do I get off the vape? I'm sucking on this vape constantly throughout the day 24/7, not just my waking hours."

How do we provide those supports, and how do we provide that structural support and also the social accountability? When I talk about social accountability, I'm talking about—we've done a great job in Australia, to some degree, around de-normalising tobacco. So you can't smoke in this Parliament. I'm sure we could've at one point. You can't smoke in the aeroplanes—all those sorts of things. Vaping isn't quite like that. I know we have vape-free legislation but the enforcement of that is challenging. The social enforcement of that is also challenging.

**Mr PHILIP DONATO:** Thank you, Associate Professor. Does the public health messaging need to be nuanced to target Aboriginal and Torres Strait Islander people to be more effective, do you think?

**RAGLAN MADDOX:** Yes, I think so. I think the reality is the implications are different. We know that the social determinants of health—those factors that put people at risk of tobacco use or vaping and other things—are different. We also know that the answers lie with communities. I've heard from communities over the last couple of years "How do we stop these vape stores popping up in our community? How do we stop them popping up throughout Western Sydney?" or wherever. I think engaging with those communities and hearing what they want and how they want it addressed is incredibly important to make sure that it's culturally safe—cultural safety is safety—but also that it resonates.

Similarly—we were talking about supports for youth and young people throughout today—youth and young people know what will help them quit smoking or quit vaping, noting that we've done a great job with de-normalising that. Not a lot of young people are calling the Quitline or going to see their GP to say, "I've got an addiction issue", so I think it's really important that they have a voice at the table in addressing those concerns so that they are used and used well so that they are effective and sustainable. That's exactly the same principle around Aboriginal and Torres Strait Islander communities.

**Mr PHILIP DONATO:** You said earlier in your evidence there was a disproportionate use of smoking or vaping amongst Indigenous communities. Why do you think that is the case?

**RAGLAN MADDOX:** How long have we got?

**Mr PHILIP DONATO:** About five minutes.

**Dr HUGH McDERMOTT:** It's all good.

**RAGLAN MADDOX:** I'll just go a quick context because I think it's important and we tend to gloss over it. Obviously, commercial tobacco was systematically embedded throughout Australia through the colonial process, particularly among Aboriginal and Torres Strait Islander people being paid in rations of flour, tea, sugar and tobacco. We also know that Aboriginal and Torres Strait Islander people were excluded from the cash economy and paid in those rations. We know they were excluded from the Euro-western academic education system. The civil rights movement in the '60s, '70s that saw the first Aboriginal and Torres Strait Islander people graduate from university and being able to go to university means that there is a significant difference in the way that people engage with Australian society.

We know that these are risk factors for tobacco use. We know that those risk factors for tobacco use, like income, education, stable housing, experiences of racism, are consistent with risk factors for vaping. We've got some research that we expect to come out, hopefully shortly, that highlights that they are consistent—those patterns of addiction and other things are consistent. The way our society works as a system means that there are

some areas for improvement, some gaps and some things that we need to address. That's, fundamentally, the challenge we're facing. Does that make sense?

**Mr PHILIP DONATO:** No worries.

**Mr TRI VO:** Thank you, Dr Raglan Maddox, for coming today and giving your evidence, especially with your wonderful work with the Aboriginal and Torres Strait Islander people. How can school-based learning about vaping be improved or delivered in a more culturally appropriate way, since you have a lot of experience working with young people and especially Aboriginal and Torres Strait Islander people?

**RAGLAN MADDOX:** It's a great question. I think we can probably learn some lessons from the Tackling Indigenous Smoking program that was implemented nationally around 2010—established in 2007, rolled out from 2010. Basically, it's locally driven processes to support communities to be nicotine free. Even around the table here, I'm sure we all know that your electorates are different. Eden-Monaro is different from Sydney and other places. How we engage with those schools and communities should differ according to that environment, but we can consistently roll out that information education, and try and understand the needs of communities.

The context at the moment is, regardless of where you live, there is retail availability and other things, so if we change that to de-normalise it, then the job of the schools, parents and teachers becomes a lot easier because there is that consistent messaging that this is a harmful product. At the moment we know teachers, parents, principals are reaching out because it's so pervasive and the messaging is complex, and the commercial environment undermines their ability to teach or to parent because it is normalised that there are people that are vaping everywhere. I think if we change that, then it becomes a lot easier for schools to say, "Here are the harms that we know about around vaping. Here are the short-term harms. We might not necessarily know about all of the harms but here's what we do know." I think that's a good starting place.

We probably have also learnt a lot of lessons from tobacco control more broadly. I will just touch on this briefly. We've known about the harms of tobacco for over 70 years. We had the US Surgeon General report come out in 1964. We know it causes cancers, cardiovascular disease, diabetes—you name it. There's health implications for it. So I just question how much more evidence do we need in that space. We can learn from that to make sure that we do things differently in this situation.

**Mr TRI VO:** One way of de-normalising smoking and vaping is to do with compliance and enforcement. Do you think we should penalise the suppliers, the users or both?

**RAGLAN MADDOX:** I don't want to go down the path of criminalising or penalising people with addiction issues. I think it's an unfair society if we sell this product and then penalise the people for using the product, who are dealing with a whole range of issues. I want to be very clear that I don't support that, but I do acknowledge that it's complex. I think we do need to enforce and create an environment that is conducive to health and needs to protect the health and wellbeing of all people, including Aboriginal and Torres Strait Islander people, young people and those generations that are going to walk this land after us while we've all disappeared. I think that retail environment needs to change. I think the predatory nature of it and the commercialisation of it is what's actually harming Australians.

**Mr TRI VO:** We need to support young people, especially Aboriginal and Torres Strait Islanders. Your submission states that more financial support is required to develop and deliver strategies and programs that support Indigenous people who are nicotine-addicted to quit vaping. That was on page 6. How should this investment be targeted?

**RAGLAN MADDOX:** Yes. Like I was saying, I think we've got a bit of a head start. We know that Aboriginal and Torres Strait Islander people live everywhere—that's my starting point—including in Sydney, but, also, there are discrete communities across the State. The answers do lie within. We've seen with the Tackling Indigenous Smoking program that, with appropriate investment and support, those communities can change the narrative that people have been talking about. Even the term "black market" is problematic; I guess we're talking about the illicit market. Just trying to think about the way that the industry is so predatory in attacking communities and Australians.

The communities that are being targeted know the answers to addressing those challenges. Sorry, that wasn't very clear. I think if we go back to that and we use the infrastructure that is already in place—we know there are a whole range of community controlled health services and land councils that are doing work very successfully to reduce tobacco use—there is no reason why that wouldn't be different to reduce vaping use in addition to the systems approach to reduce retail availability and other things. In summary, there is no silver bullet. We need a multi-pronged approach to reduce tobacco, vaping and other harmful products.

**Mr TRI VO:** What are the risks associated with passive vaping? What action would you like the New South Wales Government to take to ensure a high degree of compliance with smoke-free environment regulations?

**RAGLAN MADDOX:** Probably a couple of things. One is—we're talking about it here and our communities have talked about it—increased communication and awareness. We know that communication campaigns are incredibly successful in generating those discussions. We know at the moment that there's mixed messaging going out through our communities through a whole range of resources, including social media, that essentially, on one hand, is promoting the product. An example from today is we have heard very mixed messaging come out of the Committee so far. How do communities actually understand or differentiate that, especially when some people are differently resourced to promote their messages? Good, clear, consistent messaging and national, regional and local approaches to communicate clearly that we know that this product is harmful, and try to minimise second-hand vape exposure, similar to the way we've done it with commercial tobacco use.

**Mr TRI VO:** How can we ensure that the prescription-only model works properly for people trying to quit smoking, especially Aboriginal and Torres Strait Islander people?

**RAGLAN MADDOX:** It's a great question. There is a whole range of evidence-based pharmaceuticals that the RACGP and others already provide advice on. I think we know that Aboriginal community-controlled health services are doing a great job in supporting people to quit when they're coming in, but I think we can do better in terms of making those patches, NRT, emulators, the mist, and all of those sorts of products more accessible. Increased communications—we know that when we roll out communication campaigns about the harms of smoking that there are increased calls to Quitline and people go to the doctor. How do we provide that environment to support people to make a quit attempt but also have access to those evidence-based medicines to help them quit smoking is really important. We have a tobacco strategy that details some of those strategies. If we do all of that as well as change the retail environment so it isn't available so widely, we will see tremendous success, and we can bring down the smoking rates and vaping rates at a greater rate than we have seen to date.

**Dr HUGH McDERMOTT:** You talked about the predatory nature of the vaping and tobacco industry. Has the vaping industry targeted Indigenous communities? Has it targeted Indigenous people?

**RAGLAN MADDOX:** We know that big tobacco has sent out letters to Aboriginal medical services promoting their products.

**Dr HUGH McDERMOTT:** Do you mean their vaping products?

**RAGLAN MADDOX:** Yes, e-cigarette products. Obviously we see retail stores popping up in Indigenous communities. I don't think "encouraging" is the right word, but we had quite a big turnout. One of the interesting things around vaping is that when people ask us to talk about smoking, they want to know about vaping. We have had a number of community consultations where communities have just said, "How do we get rid of these vape stores? They just keep popping up. How come we have eight stores here with a population of 4,000 people?" I think we need to see that change.

**The CHAIR:** Thank you, Associate Professor, for appearing before the Committee today. You will be provided with a copy of the transcript of today's proceedings for any corrections. The Committee staff will also email any questions taken on notice from today and any supplementary questions from the Committee.

**(The witness withdrew.)**

**(Luncheon adjournment)**

**Mr MARTIN GRAHAM**, Deputy Secretary Teaching, Learning and Student Wellbeing, NSW Department of Education, affirmed and examined

**Ms MEGAN KELLY**, Executive Director Curriculum and Reform, NSW Department of Education, affirmed and examined

**The CHAIR:** I welcome our next witnesses. Thank you for appearing before the Committee today to give evidence. Please note that the Committee staff will be taking photos and videos during the hearing. The photos and videos may be used on the New South Wales Legislative Assembly social media pages. Please inform the Committee if you object to having photos and videos taken. Can you please confirm that you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

**MARTIN GRAHAM:** Yes, we both have.

**MEGAN KELLY:** Yes, we have.

**The CHAIR:** Do you have any questions relating to that information?

**MARTIN GRAHAM:** No.

**MEGAN KELLY:** No.

**The CHAIR:** Would either of you like to make a short opening statement before we begin questions?

**MARTIN GRAHAM:** I have a very short statement, if that's all right with the Committee. I will start by acknowledging that we are on Gadigal land today and I pay my respects to Elders past, present and emerging. Our area of the department oversees the Drugs in Schools policy as well as drug education through the curriculum. Ms Kelly chairs the department's drugs committee and is responsible for our actions in response to the vaping round table, which was hosted by the department in November 2023 as part of an election commitment by the Government to address the growing problem of vaping in primary schools and high schools. We know that vaping is having an impact on our students and members of our school communities. A significant issue raised by the community is how accessible those vapes are. We also know that vaping is a community issue, which will not be solved by schools alone.

Nicotine use and dependence through vaping impacts a student's ability to learn. It impacts their ability to pay attention and behave appropriately in our classrooms and schools. We know it also affects their mood and their memory. Given those impacts, the department has commenced work on cessation support for young people alongside our prevention work. We also provide our teachers and leaders with curriculum resources and training to educate our students about the harms of vaping, explain how vapes are marketed towards and target young people, and teach the skills they need to make healthy choices regarding vapes. We also work closely alongside our government partners, such as NSW Health, and non-government organisations, including Cancer Council NSW, and so we take a well-coordinated approach to the issue of vaping. We also support schools to communicate with parents and carers about the harms of vapes, their own school policies and ways to support their children in relation to vaping.

In collaboration with P&C Federation NSW, we delivered live webinars to increase community awareness of the harms of vaping and other practical advice for parents and carers. Specifically on the issue of vape detectors, at our vaping round table detectors were strongly discouraged by most participants. The evidence indicates that the systems deter vaping only when complemented with human interventions, including education and support for students to quit vaping, which are the things we are concentrating on. We believe the introduction by the Commonwealth of the reforms around vaping accessibility will go a long way to reducing access for our students and other members of the community. In conclusion, we are committed to working with our Commonwealth, State and non-government colleagues to eradicate vaping, support school communities and collectively help the health and wellbeing of our students.

**The CHAIR:** Ms Kelly, do you have anything further?

**MEGAN KELLY:** No, nothing further to that.

**The CHAIR:** First of all, is vaping education currently integrated into the primary and secondary school curriculum?

**MARTIN GRAHAM:** Certainly, issues of drug use and dependency and so on are integrated into the PDHPE syllabus. I might ask Ms Kelly to talk about how we do that.

**MEGAN KELLY:** It is done in an age-appropriate way, making sure that it's addressing those developmental understandings of students and building on those skills over time. And then additional resources and support are also being added to that—so curriculum resources, like teaching and learning materials, particularly around vaping—to support that curriculum focus that is already there.

**The CHAIR:** Do you feel that is making a difference?

**MEGAN KELLY:** It's a good question to ask. I think over time we will understand the full impact of those resources. I think it is definitely giving students the information that they need about recognising the dangers and understanding those dangers, as Mr Graham also mentioned, in terms of advertising, marketing and knowing that they are the target of that marketing and how to respond to peer pressure. It is the curriculum focus but it's also giving them those skills that they need to be able to manage the situations when they encounter them. It's a broad approach that we take.

**MARTIN GRAHAM:** It was only in 2007 that vapes were invented. I think we have been much faster onto this than onto some previous things. We have started with Health and so we are using exactly the same messaging and the same materials. New South Wales has got comprehensive packages, particularly around high schools, and the national Student Wellbeing Hub actually uses the New South Wales material. We have always got more to do and, particularly within schools, each individual community is different, but we think we have made a pretty good start to it.

**The CHAIR:** We have heard earlier evidence that, if students knew what chemicals are actually in the vapes, it might discourage them from continuing because they simply don't know. It's just a peer pressure thing that they have engaged in. Does your curriculum go into educating the students about not just drugs and smoking being hazards but actually why vaping should not be done because of these chemicals that they are inhaling? Does it go that far?

**MARTIN GRAHAM:** It certainly does. I might let Ms Kelly go to the detail. From my perspective, reading through our materials, I learn a lot about the chemical compounds. When you talk to kids in schools, they are way more educated on this than, I think, the rest of the community. They are able to talk about the acetate in them and they can talk about the different compounds, so I think we have been a bit quicker.

**MEGAN KELLY:** We have used the NSW Health campaign, which is called "Do you know what you're vaping?", to build some of our resources on. So, yes, we are absolutely helping our students to understand the contents of vapes and then the effect of it on their health.

**The CHAIR:** In relation to teachers, what professional development do teachers get to deliver vaping education modules?

**MEGAN KELLY:** There is quite a bit of professional learning that is available for teachers. We've got things that are online modules that they can work their way through, from understanding vaping and the knowledge that they need around what vapes are to how to teach those materials and then how to support students, importantly. For those students who are vaping, how do you then support those students to access the health support that they require? It is comprehensive. We have added to that recently this year. There is new professional learning available for our teachers.

**Dr HUGH McDERMOTT:** Thank you for coming in today. Your evidence is really important to us. The member for Mount Druitt and I were first contacted by principals of our schools five or so years ago. It's becoming a bigger and bigger problem. It has been put to us that it's a health crisis amongst youth in our schools. Would you agree with that?

**MARTIN GRAHAM:** I certainly think it's a rapidly growing health issue. I guess we will leave it to the health people to define it as a crisis. It is certainly a health issue that has been identified in all schools, and we are absolutely approaching it as a health response.

**Dr HUGH McDERMOTT:** Your response is a health response, not a disciplinary response.

**MARTIN GRAHAM:** It's absolutely a health response, which is important. If we take any kind of action, because there is a lot of vaping going on, the direction is not just about the education for why you shouldn't vape but also moving them on to cessation and helping them get off the vapes. That's a really important part of the health response.

**Dr HUGH McDERMOTT:** Can you talk me through the process? A group of students is socialising in the bathroom with vapes and they get caught. What then happens? Talk me through the whole process.

**MARTIN GRAHAM:** The first part of the process is that it's now absolutely clear in the student behaviour code that vaping is absolutely not permitted in schools. You might think, "Why is that important?"

Often that behaviour code is put by schools perhaps in a diary or some other thing, or it's reinforced in assembly or it's in a newsletter right at the beginning of school term, so those expectations are clear. When the students are doing that, it's very clear that they are breaching the student behaviour code and that they are not meeting the expectations of the school. We give principals a lot of discretion because it will depend on how old the kids are, if they have done this a lot before and what the risks are. It's really around the risks. The principal will say, "What are the risks I'm managing here? Am I managing a group risk that will expand to other kids?"

**Dr HUGH McDERMOTT:** Can I stop you for a second? It is a risk model based on the policy of the department?

**MARTIN GRAHAM:** Yes. We are clear to principals. They do get discretion. But we have also been clear in our behaviour policy that vaping is something they should take seriously, and they can take action for it. If they have a particularly difficult situation and they need time to bring that under control—to bring in risk mitigation—that is the time at which you may consider something like a suspension. But there is no automatic "you vape, you're suspended". They might be the kids who need most to go to the counsellor, because they know they've been trying to get them off, and the parent's a bit—there are so many different circumstances. We give the principals the discretion to be able to put the risk management in place to minimise the risk of harm to other students or to staff.

**Dr HUGH McDERMOTT:** And that is it? They are not referred to counselling, they're not referred to—bring the parents in?

**MARTIN GRAHAM:** No, part of that—

**Dr HUGH McDERMOTT:** Tell me the process.

**MARTIN GRAHAM:** It is different for each school depending on what has happened, but the process could be they bring the parents in because it is a health issue. We speak to the parents about whether they need advice and support with getting the kids off the vapes. Often kids are vaping because of other underlying issues. We know anxiety, eating disorders, things like that are often closely related to that behaviour. We want to address that root cause. We are not a primary health provider. We do have counsellors in schools and so on, but they are not providing long, ongoing therapy. They might work with them. The other thing the principal might do is go, okay, we really need to hit those department vape resources. Let's get on the website and let's talk about what we're doing for—it might year 8 there's a particular issue in, and we might use the PDHPE class as a time to talk about that in year 8. They might go individual student, group, whole school depending on the circumstances. It is not a neat, simple thing, but it is, "What is the risk? Who is it to? What can I do about it"?

**Dr HUGH McDERMOTT:** Is it the same model if they were caught smoking cigarettes?

**MARTIN GRAHAM:** Yes.

**Dr HUGH McDERMOTT:** They're identical?

**MARTIN GRAHAM:** Absolutely the same—taking the same.

**Dr HUGH McDERMOTT:** It was put to us today in evidence that perhaps what you need to have within each school is a vaping area for those kids who are addicted to the nicotine. Would you agree with that?

**MARTIN GRAHAM:** No.

**Dr HUGH McDERMOTT:** Why not?

**MARTIN GRAHAM:** It was the same discussion that was had about cigarettes. We are very clear. Adults, children, contractors—there's no smoking and no vaping on any government school site. The same issues were discussed with smoking, and it's the same. If you start the grey zone of "we have a safe space", it just makes it too difficult for schools to manage that.

**Dr HUGH McDERMOTT:** To manage it?

**MARTIN GRAHAM:** Yes.

**Dr HUGH McDERMOTT:** But what about the welfare of the child?

**MARTIN GRAHAM:** We are concerned about the welfare of the child, but we believe there are ways of—we would rather have medical advice about how to manage that addiction than have them bringing the vapes onto the school grounds. But we know that is challenging.

**Dr HUGH McDERMOTT:** This discretion you give to the principal in the risk-based approach, which is obviously what you are doing. Do they then report to the Department of Education that they have found so many students that week? What is the process?

**MARTIN GRAHAM:** Most of the data is local but if there are incidents, we have an instant reporting system and that is all logged centrally and comes through to the department.

**Dr HUGH McDERMOTT:** You have a database of—not finding out incidents—

**MARTIN GRAHAM:** We have a database. I can't tell you it's got the fidelity of picking up every time someone has seen a vape. It might be reported as an illicit substance rather than particularly a vape. It is managed locally at the school level. But the reason we have all the resources is the health data is very clear. It is in every community. It is in every school. The material is available to schools. The principals know best whether they are having an outbreak in their school.

**Dr HUGH McDERMOTT:** Sorry, but you're really not answering what I am asking you. What I'm asking is what the whole process is. I have been spoken to ad nauseum by principals of different schools in Western Sydney about the problems they've got with vaping—and they have for many years. I am trying to ask what is the responsibility of the department. What do they do? Just saying, "Oh, it's back to the risk of the principal"—no. I want you tell me what happens, so I know.

**MARTIN GRAHAM:** In developing our new behaviour policy—the previous one didn't include vaping in it. We have listened to those principals and we have worked with them. We have made clear their authority. Some of them didn't know. "Am I allowed to do anything about it? I'm not allowed to do anything." The behaviour policy is now very clear. You can include vaping as a serious thing to deal with, and if you needed to suspend a student, you are entitled to do that under that policy. But it doesn't say that you have to, because of course the principals know their kids best.

**Dr HUGH McDERMOTT:** Which is fair enough. That makes a lot of sense.

**MARTIN GRAHAM:** The department's responsibility is also to provide that material—and we can provide you with the links. It is expert material with Health. I have educated myself a lot, just using our own department's materials. It is on us to give them the tools they need so their expert teachers can deliver that education. I think that's something the department definitely does. We are now doing it for Australia, because we're doing it quite effectively. School counselling and referral to health services for the cessation is the other really important thing. They're the things that we have been doing, and I think they're starting to be a lot more effective.

**Dr HUGH McDERMOTT:** If the Committee asks you for some data about how many reports are coming back to the department—how much one suburb is to another, or where the hotspots are—are you able to do that?

**MARTIN GRAHAM:** It would mainly be Health data that would do that.

**Dr HUGH McDERMOTT:** Health?

**MARTIN GRAHAM:** Yes. We have instant data, but it's this trade-off between how much admin burden for the principal, if we ask them to log every single little thing—but we certainly have enough of a sense that it is everywhere and we need to do something about it everywhere.

**Dr HUGH McDERMOTT:** I imagine—you didn't mention this—that you would seize the vapes or the cigarettes or whatever other drug gets caught.

**MARTIN GRAHAM:** Absolutely.

**Dr HUGH McDERMOTT:** You basically seize the vapes. Obviously, safe storing of these vapes is an issue. I have also heard all kinds of reports from schools in my electorate regarding fires and other things like that. What is the process of storage? What is the process regarding safety when they do seize these vapes?

**MARTIN GRAHAM:** Look, it is a challenge. I think it is a challenge like all kinds of e-waste, and it is, unfortunately, fairly localised how that's managed, because e-waste in particular is often managed through local councils and local refuse collection contracts and so on. We know it is not straightforward, but it is a similar problem to lithium batteries. We have lots of robots and things in schools now, where we have that kind of issue as well.

**Dr HUGH McDERMOTT:** Is there discretion within each school on how they dispose of it?

**MARTIN GRAHAM:** We can give them professional advice, but unfortunately it's not as simple as—the department doesn't have a statewide collection system for this stuff.

**Dr HUGH McDERMOTT:** That's the type of thing I'm asking.

**MARTIN GRAHAM:** No, we don't have a statewide collection system because it is localised. That's partly because the refuse system is localised in New South Wales.

**Dr HUGH McDERMOTT:** So the schools have to deal with it themselves, correct?

**MARTIN GRAHAM:** But with advice from the department. We can help.

**Dr HUGH McDERMOTT:** You wanted to say something?

**MEGAN KELLY:** I was just going to say that we would advise them to contact their local councils, essentially.

**Dr HUGH McDERMOTT:** And that is what they do.

**MARTIN GRAHAM:** There is a challenge.

**Mr TRI VO:** Thanks, Ms Megan Kelly and Mr Martin Graham, for coming here today. Your evidence can be very important. You are part of the Department of Education, and a lot of the users in this case are young people. A lot of them are in high school, so your evidence is very important. How prevalent is vaping in New South Wales schools? How is this detracting from teaching—from the teachers teaching and the students learning—and also to our young people, looking to the future?

**MARTIN GRAHAM:** I think the health data is about one in six, but we know that it's not consistently one in six across the State. Certainly, within a school, we know there will be whole classes who aren't vaping and then there are whole social groups who are. The students are probably clearest with us about how that works. When you speak to students, they know how that is happening. We know the effects of particularly the nicotine. They're not often marketed as having it, but we know that they do have it. The head spins and the other medical effects are real. At its most acute, it can distract from the class in that students will have medical episodes and might need to go to the sick bay or have some other assistance if they have trouble breathing. That's at its most extreme. That's not incredibly common but it certainly can happen.

Certainly they are not vaping in class, but we would be worried about any kind of absenteeism that was maybe driven by kids needing to vape elsewhere. That can also be an issue as well. We know that it is pervasive in communities, and as long as it is in communities, we're going to be dealing with it in schools. We don't want to see them—obviously, education is a fantastic place in that we have everybody and we know we've got them for these precious years. We can give them the tools, not just to deal with vaping, but to deal with whatever next comes along when they leave school. We think that is one of the reasons why we don't just tell them about vapes; we tell them all about peer pressure, marketing and all that stuff—how to resist it. Because then something else comes along that we haven't thought of yet, but they will be equipped to deal with it.

**Mr TRI VO:** You mentioned peer pressure. Are you aware of peer-led vaping prevention programs being trialled in New South Wales schools—for example, engaging older students to become vaping prevention advocates? What is your view of this approach?

**MARTIN GRAHAM:** We are very excited by those approaches. We've got an arrangement with Western Sydney Health where we are working to develop a professional learning package where year 10 students will be working to help inform their year 7—particularly as they are coming into secondary school—about vaping and so on. I was lucky enough to be in our building in Parramatta and I just happened to be walking past the room where we had Health and students from government and non-government schools, and they were helping to work with Health about what would be influential on kids. What is influential on their peers? What does social media, TikTok look like?

They were starting to develop that program together. I think that, particularly how quick vaping has taken off, a lot of the teachers—there were no vapes when they were in school. We are very excited by the peer thing. We still think, absolutely, the department of health, professors, proper evidence-based stuff is really important. But if we can build on that and use peer coaching as well, we think that's an addition to that model that will be very powerful. The kids themselves are really excited by it. That's what I mean. I think, compared to smoking, the students are way ahead of us on this one, which is really heartening.

**MEGAN KELLY:** In addition to that point, the way we deal with e-cigarettes is different to smoking in some ways. Student voice here is really important for us to understand what's going to work in this situation to be able to better address it because it is a different problem to solve. Cigarettes were seen as dirty and it was a bad

habit, whereas this is a bit—vaping is seen to be a bit cool. It is understanding what will it be that makes that difference, and how do we use our students to be able to influence that with their younger peers is an important piece of addressing this issue.

**Mr TRI VO:** We're talking about the peers here but, talking about the parents, how are schools supporting parents and carers to have informed conversations with their children about the risk of vaping?

**MARTIN GRAHAM:** Statewide we've done things like have webinars with the Federation of P&Cs, so they can bring parents in. We had Dr Kerry Chant. We also had a young person who'd recently given up vaping. It was really helpful to talk to parents about, well, what is it that would influence young people around that. Schools are obviously—particularly we knew during COVID people looked to their local school as a source of authority. So we provide schools with information for their newsletters and so on, so they can help educate the community about what they're doing in schools about vaping and it can help them talk to their kids.

**MEGAN KELLY:** Because it is important parents—it's a partnership between schools and parents, and in many instances parents aren't aware of the dangers themselves of vaping. They're learning along the way. They're looking out and they're asking for that support to be able to explain it to their children and to protect their children. We take very seriously that role in providing that education for our parents as much as we are for our students.

**Mr TRI VO:** Is it quite difficult to talk to the parents and the students? How do you approach the issue? Is it more like educational or information or awareness? Or is it there to help the child or punish the child? How do you approach situations like that?

**MARTIN GRAHAM:** It's informational, so they've got the same information that their kids have. The biggest question from parents was, "How do I start to talk to my kids about this?" It does differ, obviously, with the age and so on. One of the things we're aware of and really age sensitive is—one of the risks is, if you just start flooding everyone with vaping information in year 5, are we going to get uptake of vaping because we've suddenly started talking about it when the kids might not previously have been talking about it? We work with parents about when is an age-appropriate way to talk about it, what you might talk about, what's a non-threatening way to talk about it. Some of the advice we give on every issue is the classic talk about it in the car, when everyone is facing forward and you don't have to have the confronting looking into each other's eyes. Some of those are really simple techniques, but they're the powerful things that were shared during the P&C webinar.

**MEGAN KELLY:** And depending upon the context too, you might manage a conversation with a parent in a different way. If it's a student who is vaping, then you'd invite the parents in and have those conversations. I think it does depend upon the situation. There's that general support but then there's more targeted support as well when it's needed.

**Mr TRI VO:** A teacher friend of mine said vaping detectors in the toilets are not that useful. Do you think they're useful or are there more useful ways of detecting or supervising the children not to use vapes or e-cigarettes?

**MARTIN GRAHAM:** The strong feedback we had from the round table—and that was young people, principals, health professionals, everybody—was there's just not a magic solution. They might detect vaping but you also need to have adults going around and checking, which you need to have anyway. It kind of gave people a false sense of security—"I've done something about it"—but, in fact, it's kind of a really minor thing. We would never say no. If a principal had a really specific situation, they're absolutely welcome to do that and we'd help support them to do that.

But the other messaging was, of course, you'd just get them damaged, people flush them down the toilets. It just creates an extra layer of problem. The one that was brought to us by the young people and the health professionals was suddenly a trend to try to hold the smoke in your lungs to avoid the detector. That's just making things way worse. In the end, our advice was not a wide rollout of detectors. But if a school wants to use them and they have a really specific need and a place, or it might be a supervision issue, then we'll support them with that. So your teacher friend was absolutely spot-on.

**Mr PHILIP DONATO:** Are either of you aware if any vaping-related safety incidences have occurred at any of your schools, either kids being hospitalised or having to be treated by ambulance or any other injuries that have been sustained whilst they've been vaping at school?

**MARTIN GRAHAM:** I don't have specific incidences but I certainly know that it has happened. I don't have kids' names but I certainly have heard of incidents—I think particularly kids who are vulnerable, perhaps have asthma and so on. I guess there's always the question of, "Was it the vapes?", and so on. I don't have an exact clinical diagnosis.

**Mr PHILIP DONATO:** Are you able to take that on notice and provide a written response to this Committee, Mr Graham?

**MARTIN GRAHAM:** I can see what we've got on that. But, as I said, sometimes incident data won't exactly identify that, but I can certainly see what we've got.

**The CHAIR:** We don't need children's names, just the number of incidences.

**Mr PHILIP DONATO:** Surely there'd be a report at the school of an incident like that, wouldn't there?

**MARTIN GRAHAM:** Well, the question might be did they refer to it as a vaping incident? Was it something else? But we'll certainly look into that data.

**Mr PHILIP DONATO:** The vaping round table discussion that you said was held last year—what were the recommendations or findings that came from it?

**MEGAN KELLY:** There were quite a few recommendations that came out of that. Many of those actions were already underway. It's just ensuring that we're delivering on those. One of those recommendations was to bring the education and the resources and support down to a younger age group. We had been looking at high school students specifically—so bringing it down to our years 5 and 6 students. That work is underway. Development of a guide for our teachers—we've already got a whole lot of advice but are consolidating that into a guide that they can use. The additional professional learning has already gone live. Linking our resources and support to the latest health campaign—that work is underway.

**Mr PHILIP DONATO:** Are you able to provide this Committee in the next seven days with a copy of those recommendations?

**The CHAIR:** You can take that on notice.

**MEGAN KELLY:** Certainly. And they are published on our website. They're publicly available now, but we can, yes.

**MARTIN GRAHAM:** We can provide them.

**Dr HUGH McDERMOTT:** I have one last question. Obviously, there's been a lot of work dealing with tobacco but also with vaping from the department. You probably can't answer this, but if you can, how much educators' time or resources do you think are spent in each school dealing with this vape problem?

**MEGAN KELLY:** I think it would be very hard to quantify.

**MARTIN GRAHAM:** It would vary.

**Dr HUGH McDERMOTT:** It can be anecdotal. Just give me your opinion.

**MARTIN GRAHAM:** I couldn't quantify it. Some of it would be we've displaced concerns about cigarettes onto it, so not additional time, just a different concern. What we would say is what we're really passionate about—in providing all this support, we'd like to say there's been no time having to think, "What kind of resources am I going to need for this age group? How am I going do it?" We've provided them. We do know it takes time. We're passionate about reducing admin load for teachers, reducing the cognitive load for them. That's what we would say: We're trying to minimise any additional time. They're going to have PDHPE classes anyway. This kind of stuff is in the curriculum, but how do we give them the vape-specific element so they don't have to develop all that themselves? Sorry, I probably haven't answered your question.

**Dr HUGH McDERMOTT:** No, you kind of have because it's a fluid question.

**MEGAN KELLY:** It would be different for different roles in a school, too. If you're a head teacher welfare, then you might be spending a bit more time on it than a classroom teacher, for example, which is part of why it's hard to quantify because it looks different for different roles.

**The CHAIR:** Once again, thank you both for appearing before the Committee today. You will be provided with a copy of the transcript of today's proceedings for corrections. The Committee staff will also email any questions taken on notice from today and any supplementary questions from the Committee.

**(The witnesses withdrew.)**

**Ms GEMMA BRODERICK**, Acting Executive Director, Legal and Regulatory Services, and General Counsel, NSW Health, affirmed and examined

**Professor TRACEY O'BRIEN**, Chief Cancer Officer and Chief Executive Officer, Cancer Institute NSW, NSW Health, affirmed and examined

**Dr KERRY CHANT**, Chief Health Officer and Deputy Secretary, Population and Public Health, NSW Health, affirmed and examined

**Assistant Commissioner SCOTT COOK, APM**, Commander, State Intelligence Command, NSW Police Force, sworn and examined

**The CHAIR:** Thank you all for your attendance. I welcome our next witnesses. Thank you for appearing before the Committee today to give evidence. Please note that the Committee staff will be taking photos and videos during the hearing. The photos and videos may be used on the New South Wales Legislative Assembly social media pages. Please inform the Committee staff if you object to having photos and videos taken. Please confirm in turn if you've been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses.

**GEMMA BRODERICK:** Yes.

**TRACEY O'BRIEN:** Yes.

**KERRY CHANT:** Yes.

**SCOTT COOK:** Yes.

**The CHAIR:** Do any of you have questions about this information?

**SCOTT COOK:** No.

**GEMMA BRODERICK:** No.

**TRACEY O'BRIEN:** No.

**KERRY CHANT:** No.

**The CHAIR:** Do any of you have a short opening statement before we begin questions?

**TRACEY O'BRIEN:** I just want to say I am also a conjoint professor in paediatrics and child health at UNSW.

**KERRY CHANT:** NSW Health has not prepared a statement. We really wanted to allow the Committee to have the full time for questions.

**SCOTT COOK:** No, thank you.

**The CHAIR:** We'll move to questions from the Committee. According to recent media reports, NSW Health launched only 12 prosecutions for illegal vapes sold over 18 months. What's preventing NSW Health from securing more convictions?

**KERRY CHANT:** I would respond to that by saying that our regulatory activity has got a number of components. First of all, in a number of those cases we will have seized the product. One of the intents of our compliance activity is to remove product from sale. That in itself has an impact on the retailers. We also have the ability to initiate PIN offences. That's almost like an on-the-spot fine for some offences. In others, we lodge activity in terms of the formal legal processes. It does take time for us to lodge those cases. We work with our colleagues in legal services to ensure that the prosecutions are robust and support our officers to take them through the court system.

**The CHAIR:** We've heard earlier evidence today of a retailer set up in a candy shop near or opposite a school. I think it's been in the media, that particular retailer, yet no action's been taken in relation to that retailer.

**KERRY CHANT:** If the Committee would like to give me the details of that retailer, we would be happy to initiate compliance activity. We have a system where we receive intelligence from members of the public and from other sources. They have an ability to go to our website and complain. We use that intelligence. We'll obviously prioritise things that are concerning, particularly if there's concerns around sale of the product to minors, those types of issues. We would be very happy to follow up that premise. I would just like to ask all retailers to act responsibly at this time.

**The CHAIR:** What's the process for the public if the public identify a particular retailer selling to minors. Is there a process that the public can go through?

**KERRY CHANT:** If they go to our website, there is a link and they can make a complaint online. That's probably the most efficient and effective way for them to complain.

**The CHAIR:** Yes, but if going online is too difficult, is there a phone—

**KERRY CHANT:** There is actually a phone number as well. They can also ring their local public health unit which is a 1800 number. I'm happy to provide those details to the Committee and for the Committee to disseminate that.

**The CHAIR:** How could that information be given to the public? Remember the campaign about dobbing in a litterer? There's nothing available in that sphere of illegal retailers operating that people can use to dob in a retailer.

**KERRY CHANT:** We have put that in some of our social media posts and our media about how to make a complaint. But I take it on board that you're reflecting that we haven't done that adequately enough to reach the groups, so we'll take that on board and reflect on how we can get those complaints to the community and to the different segments of the community.

**The CHAIR:** Dr Chant, you are aware that the Federal Government is currently in the process of legislating in relation to implementing controls over vaping probably later this year. Who will be responsible for ensuring compliance of the retailers? Will it be the State Government's responsibility once the Federal legislation is in place?

**KERRY CHANT:** There are a number of regulators and so various entities will have a key role in different components. For instance, the Australian Border Force will be tasked with maintaining vigilance at the border and ensuring product does not breach those requirements. The Therapeutic Goods Administration is another regulator. They will also have a focus, and we are working closely with the Therapeutic Goods Administration. In terms of the retail setting, NSW Health would be the lead in doing that, but we do acknowledge that, from time to time, we do work in coordination with police and our other regulators in coordinated activity and really acknowledge the assistance police provide when the circumstances require that support.

**The CHAIR:** That is leading to my next question. When raids are to occur on a particular retailer and you have information about a particular retailer that is selling illegal vapes, is NSW Health the lead agency that does the raid or is it the police?

**KERRY CHANT:** NSW Health is the lead agency. We have information-sharing arrangements, which we are just consolidating through a memorandum of understanding to share particular intelligence that might highlight any risks associated with our regulatory activities. In the main, we would initiate that regulatory activity. What we also have done is coordinated action with the Therapeutic Goods Administration. There might be intelligence that the Therapeutic Goods Administration has that they might work in concert with us. Again, we look at the roles and responsibilities and we look at what we can contribute. We are very clear that there are a number of regulatory agencies that have a role in achieving a reduction in the use of vapes. Our officers are also focused on illicit tobacco. When they are going into vape shops, they are also focused on loose-leaf tobacco products, nicotine pouches, sale of single cigarettes, sale of cigarettes to minors and other offences in relation to tobacco. Overall, we are interested in supporting the community to reduce both tobacco and e-cigarette use.

**The CHAIR:** Assistant Commissioner, what role do you think the police have in relation to the enforcement of illegal vapes in retailers? Is it just the supporting agency to Health or do you have a specific role?

**SCOTT COOK:** No, we support Health. Health is the regulator. At the Commonwealth level, Border Force is responsible for the border, with AFP. We support those agencies. At a regulation level, it's the Therapeutic Goods Administration. We work with all of those partners to support them. Our primary interest in terms of any of this is relating to serious and organised crime matters where there could be some overlap with a particular retail outlet. Then we might provide an additional interest into that for other purposes. In terms of vaping and in terms of tobacco generally, we support the regulator, which is Health.

**The CHAIR:** Do you do your own intelligence or do you rely on the intelligence that Health is providing to you?

**SCOTT COOK:** Primarily, in terms of vaping, we would rely on the Therapeutic Goods Administration, Border Force and NSW Health in providing us with intelligence. Those frameworks are in place for that to occur. We would generally only be interested in that if we found some other criminality associated with it or some organised crime involvement in that. However, we also have a mechanism to provide those other agencies with

limited information as well, within the bounds of the law, to support what they may be doing in terms of their targeting and their approach to their issues.

**Dr HUGH McDERMOTT:** Thank you all very much for appearing today. It's nice to see some of you again that I know. I will start with Assistant Commissioner Cook. Talk to me about organised crime in New South Wales and the impact it has on the illicit market of e-cigarettes. How big is the market for them?

**SCOTT COOK:** At the moment, I don't know that it's very big at all. They've only just been prohibited at the Commonwealth level. I anticipate that, based on that action by the Commonwealth, in due course we will end up with some sort of illicit market. It appears that, any time there is prohibition and there is a demand, there is always an illicit market that is generated. The quantity and size of that market is unknown. It may not grow to be a big market if the demand side of the equation can be addressed properly. Organised crime is basically motivated by cash—money. If there is no demand for a particular product—in this case, e-cigarettes—then it's unlikely that that illicit market will grow too big. If there is strong demand and that demand is not arrested early on, then potentially it could increase to a substantial level. For other tobacco products which have had import restrictions for some time, there is already an illicit market around that. But, by comparison, it's nowhere near the prohibited drugs illicit markets.

**Dr HUGH McDERMOTT:** You are saying that organised crime really doesn't have much of a presence in the vaping industry at the moment and it's basically pretty legal?

**SCOTT COOK:** At this point in time.

**Dr HUGH McDERMOTT:** If children want to go and buy it, where do they buy it from?

**SCOTT COOK:** They can buy it from any tobacco retailer.

**KERRY CHANT:** Can I just correct that? I just want to make it clear that it's not lawful to sell nicotine-containing vapes in a retail setting and there are also prohibitions on the sale to young people.

**Dr HUGH McDERMOTT:** That doesn't stop—

**KERRY CHANT:** I understand that.

**Dr HUGH McDERMOTT:** We know that the marketing of these products is without the word "nicotine" on it and that there has been a complete change to focus on children, by the evidence that has come before us. We've been given evidence over the last few months that we have had record importation levels of e-cigarettes from China—millions and millions. In the last few weeks, it has been a record low. It dropped 93 per cent as we are now going towards regulation at a Federal level. Where do you think all those vapes are going? They are obviously going into storage somewhere. Assistant Commissioner, it's not going to organised crime?

**SCOTT COOK:** I think the Commonwealth approached this in a staged approach. They set a particular date for the seizing of importations and then they allowed a certain period of time for retailers to then onsell or sell legally to the ones that are legally able to sell those vapes. I think only on 1 March—and I am sure Dr Chant will correct me if I am wrong—was the point in time where that should have stopped. There may well be stockpiles of vapes still but, at this point in time, I think retailers would be taking quite a bit of a risk to be selling them, given that the Commonwealth has now prohibited those sales

**Dr HUGH McDERMOTT:** I remember some years ago, before I came into Parliament, I worked with a Federal police and a State-based taskforce on illegal tobacco. At that time, you could bring in a lot of tobacco—millions of dollars worth—and get next to no penalty for it. Do you know what the penalties are now if you do that with vapes or what it might be in the future with illegal vapes?

**SCOTT COOK:** My recollection of the Commonwealth legislation is seven years.

**Dr HUGH McDERMOTT:** So it has picked up. It's similar to what it is now with tobacco. I think they are about the same.

**SCOTT COOK:** I think that is correct. I think the Commonwealth would be best to provide you with that detail. But that is my understanding, yes.

**Dr HUGH McDERMOTT:** Dr Chant, I'll go across to you and the team from NSW Health. I have just talked about stockpiling millions of products. Is there any evidence or have you heard anything about where that stockpile is going to or where those millions of vapes are going to?

**KERRY CHANT:** I am aware that the regulators are aware of those issues. Obviously, some of the things that are in the public domain have been—earlier this year, with the blitz, the Therapeutic Goods Administration did announce that they targeted a number of warehouses and secured products. Clearly, that

looking for warehouses or other large places where stock may be held is part of the regulatory and compliance activity. But I don't have any other detail other than to note that there has been some focus on warehouses, wholesalers or storage facilities where they have failed to comply with the requirements under the Commonwealth legislation.

**Dr HUGH McDERMOTT:** If your inspectors from Health find a stockpile or they find illicit vapes, what is the process then? Do they seize it?

**KERRY CHANT:** They seize it.

**Dr HUGH McDERMOTT:** And it has to be taken away for testing?

**KERRY CHANT:** No. It depends on the circumstances. Where it contains nicotine or where they have reasonable suspicion—I will probably get the terminology legally wrong. My colleague Gemma can correct me. If they have a reasonable basis according to our Act, they can seize the product. In some circumstances—it might be tested in other circumstances—when we know that it contains nicotine, there is an opportunity for the retailer to provide contrary evidence in a period and then we get approval often from the retailers. Often the retailers will be approving for us to destroy that product immediately where it's clearly containing nicotine. We then dispose of that product using appropriate contractors and we then store it. We have secure storage facilities that comply with the appropriate regulatory requirements and then we will discard and destroy that product.

**Dr HUGH McDERMOTT:** How many employees in Health are doing this type of compliance work?

**KERRY CHANT:** We have a centralised core of inspectors. That is around sort of ten. I can give the Committee the exact numbers. We also have public health unit staff, particularly in our regions, that work alongside us, particularly on blitz activity. It is a matrix of both a centralised core of inspectors plus also our public health units in various districts and our regional public health units that work with us on compliance activity.

**Dr HUGH McDERMOTT:** Do they go and visit the retailers in vaping stores?

**KERRY CHANT:** That's right. We have a program of activity. Sometimes our inspectors from the centre will go out and complement the staff. We are very aware of the communication techniques across the suppliers—the retail premises. What we have tended do in terms of our modus operandi is to try to target concurrently in a geographical location so that people are not given pre-emptive warning and can secure the stock in an inaccessible way. We do try to do planned activity. We have a planned program of activity, and obviously when new intelligence comes in, we are able to deviate or respond to those needs. But we do have a planned program of work across the State.

**Dr HUGH McDERMOTT:** Is there a particular area of the State where a lot more of this work is being done because there is a greater demand or a greater problem?

**KERRY CHANT:** We do try to service the whole State. I'm also very pleased to say that there has been a lot of compliance activity done in our regional areas. I would say that we don't prioritise one area over another, but we do act on intelligence. When our partners such as Border Force or TGA have new evidence or new insights that we feel will yield a greater outcome, we can modify our program of work to take those opportunities for greater seizures and greater regulatory impact of our activities.

**Dr HUGH McDERMOTT:** Can you tell us of a particular area—say, in Sydney—that has that, or is it just across the State?

**KERRY CHANT:** We would have to say that it is not that difficult to get nicotine-containing vapes. This is a widespread issue. Until the Commonwealth legislation fully takes effect, our regulatory activity is just the tip of the iceberg. We are working very, very hard. We are seizing lots of products and we are acting with our regulatory partners. We are doing everything we can, but obviously the border restrictions will have an impact. Anecdotally—and I wouldn't want to oversell this, because it is the sense of our inspectors—it has had an impact already on the supply. But clearly the reforms, should they pass the Commonwealth Government's processes, will really cement—make compliance much easier, because basically retail premises will not be able to sell e-cigarettes.

**Dr HUGH McDERMOTT:** That was the segue to my next question. Evidence was put to us that when these Federal regulations come through, it will drive these products into a black market and increase the involvement of organised crime. Would you agree with that? Do you think that is what will happen?

**KERRY CHANT:** I would defer to the police who would know those criminal hazards better.

**SCOTT COOK:** In some respects or in some capacity, I think that is likely. That's the standard occurrence. When we create prohibition, it creates illicit markets to some degree. As I said earlier, how that will

play out in terms of e-cigarettes is, in my view, highly dependent on what we do about demand. If we address demand through education and other methods so there is not that drive for illegal vapes, then organised crime is not going to invest in the market. It is not going to make them money. I think that the jury is out on that, and I don't know which way it will go. If we do nothing about demand— then it would follow any other illicit commodity—I imagine that there would be a black market that develops as a result of that.

**Dr HUGH McDERMOTT:** We do a lot of work for tobacco and they still bring in millions of dollars of chop and other things, and it's used in shishas and all kinds of things. That demand is still there.

**SCOTT COOK:** Correct.

**Dr HUGH McDERMOTT:** Wouldn't you just equate that? This will be a similar type of problem we will have with vaping.

**SCOTT COOK:** I guess the open question is about who is using vapes. If it is predominantly children, where there is an opportunity to intervene before hitting the criminal justice system, we would encourage that as a method because that may well arrest the demand for vapes. In terms of other tobacco products, that ship has sailed. There is already a black market for those other tobacco products and it's high-yield, low-risk in terms of organised crime. It doesn't compare to the illicit drug black market, by comparison. I think it is a matter of perspective around these things. Given that vapes have only just been prohibited at the border, I don't think that we can foresee how that will end up. It will follow the same trajectory as other illicit commodities unless something is done about demand early.

**GEMMA BRODERICK:** The market at the moment is actually an illicit market, by and large, because nicotine-containing vapes are, in fact, illegal unless they are supplied by a medical pathway: by a medical practitioner or a nurse practitioner. The only legal vapes that should be sold in retail premises, in fact, should not have nicotine, but that is not necessarily what we are seeing. The market at the moment is, in fact, to a large degree, an illicit market.

**Dr HUGH McDERMOTT:** That's right. We have a large illicit market, as all the evidence keeps on showing to us.

**GEMMA BRODERICK:** That's correct.

**Dr HUGH McDERMOTT:** The million-dollar question is what have been the barriers to increase the amount of compliance enforcement. What can we recommend that this Government does to assist NSW Health to actually increase the amount of enforcement?

**KERRY CHANT:** The current landscape is such that basically there have been so many access points for this. The uptake of young people—the demand has been great. People are able to access it through various routes and that has driven economic gain from this product. To some extent, really, the Commonwealth legislation which will come into effect will make it very clear that retail premises will not be able to sell this product, which means that regulatory activity will be simplified. It is not a question of whether they know that the product contains nicotine; it will be clear that they are conducting unlawful activities. The regulatory process will be very streamlined, because at the moment we have to, in some circumstances, demonstrate an awareness of nicotine in the product to effect the prosecution.

I have written as Chief Health Officer to all of the retailers, telling them that they should not rely on any assertions that the product does not contain nicotine. I think it has been very clear in the media that, on the benefit of doubt, they should assume that the product they have been onselling contains nicotine. But the legal processes are that we have to prove those elements of the offence. Clearly the current regulatory environment isn't robust enough for us to achieve the compliance we need, and clearly we are looking forward to the Commonwealth's legislation, which will then move this to a prescription model.

**GEMMA BRODERICK:** The Commonwealth reforms, when they banned the import of vapes, also assists because they had the same problem in trying to differentiate between the non-nicotine vapes versus the nicotine vapes. So covering the field, in effect, in relation to importation, we would hope, would assist by at least making compliance easier and detection easier.

**Dr HUGH McDERMOTT:** This is my last question. We have asked the industry to be here. We've asked the vaping industry to appear. They have refused on a number of occasions—and clearly the tobacco industry. What engagement have you had? You have just said that you have just written to the retail industry. Do they openly engage with you on these issues? Or is it, like for us, being stonewalled?

**KERRY CHANT:** I would have to take on notice what engagement the teams have done in speaking to the retailer associations. All I can confirm to the Committee is that I have written on at least a couple of occasions to retailers, highlighting the issue directly to them.

**Mr PHILIP DONATO:** I know we've heard from Dr Chant before in evidence in relation to this matter. I heard the Chair in his question; I think it was to Ms Broderick. I just want to clarify something from her correctly. Was it 12 enforcements or prosecutions? Is that the number that I heard that the Chair asked in relation to proceedings that have been commenced for matters involving vapes or illegal e-cigarettes?

**GEMMA BRODERICK:** That was the number referred to by the Chair, but I think the actual figure that I have is—I think it's 40 defendants for both nicotine and e-cigarettes for 2023. It's more than 12, but that 40 defendants includes convictions in relation to both cigarettes and nicotine vapes.

**Mr PHILIP DONATO:** So they're people who have appeared before the court and have been convicted, is that right?

**GEMMA BRODERICK:** Yes.

**The CHAIR:** Just to clarify that number—45?

**GEMMA BRODERICK:** Forty defendants. It can differ how you count because, as I said, sometimes they're charged and convicted of both offences relating to nicotine and e-cigarettes. We can get you the formal figures on notice and we can get back to you on that.

**The CHAIR:** Yes, if you can take that on notice.

**Dr HUGH McDERMOTT:** Could you tell us what the penalty was as well when you come back to us?

**GEMMA BRODERICK:** Yes.

**Mr PHILIP DONATO:** Over what period of time are we talking about that those prosecutions—is that in a calendar year?

**GEMMA BRODERICK:** Yes, the calendar year for 2023.

**Mr PHILIP DONATO:** Do you know how many penalty infringement notices or PINs have been issued during that time?

**GEMMA BRODERICK:** I'll take that on notice as well and can get back to you on it. It'd be more than that, but I'll take that on notice.

**Mr PHILIP DONATO:** And cautions and confiscations? Do you have that information?

**GEMMA BRODERICK:** We can take that—

**KERRY CHANT:** I can provide the Committee the details of the confiscations. In 2023 NSW Health inspectors conducted over 3,000 inspections. We seized around 431,000 nicotine vapes and e-liquids with an estimated street value of $13.7 million and we seized more than 4.8 million cigarettes and 1,700 kilograms of other illegal tobacco products with an estimated street value of over $5.8 million.

**Mr PHILIP DONATO:** Sorry, Dr Chant, I missed the number. The sound was dropping in and out when I was listening to you answer some other questions. But in terms of the number of health inspectors that you have, you said there was a centralised core of inspectors. But how many are there across the State? Did I hear you say 12?

**KERRY CHANT:** Not across the State. Just in terms of not wanting to mislead you, there is a centralised team and I'll just get the updated numbers because we're just in the process of recruiting some additional staff for that team. I just want to give the Committee the correct number, but it is a small team centrally. Then we also work with our colleagues, environmental health officers located in our public health units that complement the regulatory teams that we use.

**The CHAIR:** The Minister recently announced 12 new inspectors.

**KERRY CHANT:** He announced additional inspectors for pharmaceutical services, as well as some additional tobacco. In addition to that we've also recently recruited—we're in the process of increasing further the number. But it is a small team that's working with its colleagues across the State to undertake the regulatory activity, but we're also working very close with the regulatory authorities such as the Therapeutic Goods Administration.

**Dr HUGH McDERMOTT:** So how big is this small team?

**KERRY CHANT:** I'd just have to check the numbers, but it's in the order of 10.

**Mr PHILIP DONATO:** To cover the whole State?

**KERRY CHANT:** No, that's the central core team and that team then will work with our colleagues in local health districts, environmental health officers and we will usually put together a mixed team that then does regulatory activity according to a program of work.

**Mr PHILIP DONATO:** Is it fair to say that those environmental health officers—is that one per LHD?

**KERRY CHANT:** It varies by local health district and a number of people can be authorised under the Act and assist in aspects of the regulatory work. In some districts it will be more than one environmental health officer that's involved in the activity.

**Mr PHILIP DONATO:** Obviously, in the country where I am, the tyranny of distance can often make it very hard for enforcement officers to get around their patch. It seems to me that you are grossly under-resourced. Would you agree with that?

**KERRY CHANT:** I think the compliance activity—I just want to acknowledge the teams working hard and acknowledge the rural teams. They're working very diligently to do as much as they can but at the moment the size of the problem is quite onerous.

**Dr HUGH McDERMOTT:** It is worth noting also that we have been given evidence by a number of people who have come before us who are very supportive of the work that they're doing and saying what a great job they are doing, but they've all said they're under-resourced.

**Mr PHILIP DONATO:** I'm not making any criticism, Dr Chant, and I don't expect you to say it, but it would appear, at least from my own opinion, that you guys, especially the inspectors, are grossly under-resourced to tackle the problem across New South Wales. I'll make that as a comment. I don't expect you to agree or disagree, but I think, based on the numbers that you've given us, that would appear evident. I want to ask some questions now of Assistant Commissioner Cook. Do the police need further powers or resources, whether search and seizure powers or other powers to—I appreciate Health is the main combat agency in relation to this, but do police also need additional powers, either search and seizure or other areas that could easier facilitate or help police do their job in relation to these issues?

**SCOTT COOK:** No, not at all. Police have sufficient powers for their purposes and their charter. I think perhaps, as I said earlier, looking at non-criminal approaches to this in the first instance is probably a preferable way to go. We notice that there's no actual licensing scheme in New South Wales for tobacco sellers and by that I mean actually having to hold a licence and maintain a licence and something that Health, for example, could take away if they weren't complying. That doesn't exist at this point in time. I think that's a challenge for Health. I think we would throw our weight behind some reform in accordance with Health needs so that they can undertake their role more effectively. In terms of policing, we have sufficient search and seizure powers. We can use Commonwealth powers. The Commonwealth legislation in regard to search and seizure we can use. So the police are not seeking any additional powers.

**Mr TRI VO:** Your evidence is very important because NSW Health and New South Wales police play a very important role in reducing the harm and usage of e-cigarettes. What research is NSW Health undertaking into the dangers of passive vaping?

**KERRY CHANT:** In terms of the effects into passive vaping, we're not undertaking directed research but we're very much surveying the international literature on the passive effects of exposure to what we'd call second-hand vape. We're also reviewing the evidence just around particle exposure in general and looking at anything that can give us some guidance as to what those impacts would be. We obviously know that, in relation to tobacco, the information around second-hand smoke in terms of those impacts was a long time coming. But we are also looking at very much the basic research as well—so no specifically funded research. It's going to be generated in all sorts of different forms across the world. Did you want to add anything, Tracey?

**TRACEY O'BRIEN:** No, that covers it.

**Mr TRI VO:** What impact does vaping have—this is to NSW Health—on adolescent mental health?

**KERRY CHANT:** I've had the privilege to discuss this with a number of our colleagues in youth, and adolescent physicians. We are really concerned about the impact of nicotine on the developing brain. We're concerned around the fact that if someone is anxious or depressed or using it for any other reasons then it can actually exacerbate those conditions. You get this cycle where the young person is vaping to relieve stress but they become addicted to the nicotine. Then when they try to stop the nicotine, they actually get all the symptoms

of anxiety and feeling anxious. We actually think it's not an appropriate way for young people. We need to support young people's mental health and wellbeing and these products are really very counterproductive.

I've really been very chastened by the stories that young people have told us about how rapidly they become addicted and how surprised they are at how quickly they become addicted to it. It often takes maybe a health incident—in one case, someone was admitted to almost, I think, intensive care—or having something else to make them reflect on how the e-vaping has almost controlled their life or had this impact. It's often been that sort of "aha" moment. I've got to say that the young people that we've used in our campaigns or the young people who have come forward as advocates are very powerful in telling the story about how they would not recommend this to other young people. I've really been very privileged to hear young people really wanting to support other young people to not get addicted to vapes. Tracey, did you want to add to that?

**TRACEY O'BRIEN:** No, I just would echo that. The work that's been done by—Cancer Institute NSW takes responsibility for the social marketing, the behaviour change campaigns. A lot of formative research goes into that. We spend a lot of time with young people, hearing from young people—both vapers and non-vapers—around the harms that they're concerned about and what it is that's motivating them to quit so that we can share that information. The behaviour change campaign that is currently in market at the moment—the "Every vape is a hit to your health" campaign—is the voice of young people influencing other young people. It's incredibly powerful. As Kerry said, those stories are sobering. What is also sobering is that young people really do want to quit as well. All of the information in the campaign—evaluation, pre-concept and also post—is that they do want to quit. They want tools to quit. They understand how powerful the drug of nicotine is and how damaging that can be, as well as the other health harms that we've heard across the inquiry on people's health from vaping.

**Dr HUGH McDERMOTT:** How long has the campaign been going?

**TRACEY O'BRIEN:** There have been three phases to campaigns that have been run through the institute. This current campaign is phase three. This started in January of this year. It was launched in an event by the Deputy Premier and the Minister for Health. Dr Chant and I were there, as well as two passionate young advocates who appear on one of the campaigns. That campaign will run across this year. There are a number of features to the campaign. It runs through all of the social channels. It's directly targeted towards 14- to 24-year-olds. The only thing that you may see is stuff at a cinema, unless you're frequenting TikTok or other channels that young people—

**Dr HUGH McDERMOTT:** Yes, I've seen it on TikTok. It's very sad.

**TRACEY O'BRIEN:** It's also influencers involved in that campaign. It's very important to say that it's not just a public health campaign. It's then connected to tools and further information that point young people towards cessation tools as well. It's connected to websites and lots of information that's provided around the options for cessation for young people.

**Dr HUGH McDERMOTT:** When will you know how successful the campaign is? How are you doing that?

**TRACEY O'BRIEN:** There's a formal process to doing that. The last campaign, phase two of the campaign, ran through 2022 and 2023. That was what the "Do you know what you're vaping?" campaign was about. That was targeted towards 14- to 17-year-olds and looked to expose the truths around the harms of vaping and the contents of vapes, but also really looked towards empowering young people to quit vaping or not take up vaping as well—to address some of those social norms around vaping that we were seeing rapidly emerge for it to become a normalised behaviour.

That campaign has been evaluated. The evaluation hasn't been published yet, but I can share and am happy to provide some evidence to the Committee afterwards. That campaign reached the target audience, we know that, above the projected averages. Among the vapers who saw the campaign, 71 per cent indicated that they intended to try and quit from seeing the campaign. In those who don't vape, for over 90 per cent of them the campaign actually reinforced not vaping as well. There's a formal evaluation process and lots more questions from that. In the current campaign, we test the final campaign product. We test it in a pre-launch with a number of young people. That's being done with hundreds of young people, both Aboriginal and non-Aboriginal. We test that it's well understood and that it's likely to invoke behaviour change as well with that. That has tested very, very favourably as well.

**Mr TRI VO:** During the inquiry, especially today, we've heard that e-cigarettes and vapes are not as harmful as tobacco and also could be beneficial to some people—

**Dr HUGH McDERMOTT:** To youth, I think he said.

**Mr TRI VO:** What are your views?

**KERRY CHANT:** NSW Health's position—and that is a position shared by the Cancer Institute—is that it's the best situation to neither vape nor smoke. Both are harmful for health. The comparison is probably a little misleading because they're very different products. We're yet to know the full—we haven't had a sufficient follow-up for the long-term health effects of vapes, but we know from some of the basic science studies that they do cause irritation, scarring and things that are precursors to poor lung health in the longer term. We know about the other impacts that I've described on neurodevelopment and also on pregnancy. We certainly wouldn't describe them as a safe product, but we do recognise that we are open to the role of prescription in limited circumstances. But in terms of the hierarchy of evidence, the evidence is stronger for other methods of quitting, including other nicotine replacement therapies. Whilst it may be useful to consider this in the armoury for a clinician, it would be on a very case-by-case basis and in very specific circumstances where that benefit and risk is really weighed up carefully. It's not a product for which we would encourage ubiquitous use. Tracey, would you like to add?

**TRACEY O'BRIEN:** I can speak specifically to the risks of cancer. I think there was evidence this morning that the risk may be less, or there'd be no risk of cancer. What is clear is there is no definitive either population- or individual-based evidence that vaping causes cancer. I'd take caution to stopping at a full stop after that sentence, simply because we don't have the duration of time to be able to prove that. It took decades to prove that tobacco smoking caused cancer. It wasn't until the 1960s that we knew that tobacco smoking caused lung cancer. Several decades after that, we now know that 15 other cancers apart from lunch cancer are caused by tobacco smoking as well.

We do know that there are 200-odd chemicals contained within vapes. Many of those chemicals are known to cause cancer. I believe in some of the submissions—and this morning some evidence was given that the quantities of those chemicals are much less and therefore less likely to cause cancer. Again, I caution that, both as the Chief Cancer Officer but also as a paediatric cancer specialist, our understanding of cancer really has evolved with genetics and the biology of cancer. We know that cancer is almost like a fingerprint—each of us is unique. It's not necessarily a dose response; if you're exposed to X number of chemicals, you will develop cancer in X time. Some people may develop cancer much earlier than other people so it's not a straightforward equation from that point of view. I have concerns about the health impacts, in terms of cancer, of the products that are currently being exposed to young people.

**Mr TRI VO:** As access to vapes in retail settings becomes more restricted, are people likely to turn to tobacco or black market nicotine products, do you think?

**KERRY CHANT:** I suppose, in terms of our approach, we're very keen to manage illicit tobacco products as well as we know that the approach to tobacco, which is the plain packaging and taxation, are important barriers to entry. Part of our regulatory approach to actually reducing the harms of tobacco is to make sure we maintain a very strong vigilance in relation to loose-leaf tobacco, sales of single cigarettes and any other related products. It is about a combined approach because we want to reduce the harms of tobacco smoking in the population, and there is still much more work to be done there as well. We have made great inroads but we still have a lot of disparity in terms of smoking rates in some of our communities that we need to tackle, and we need to tackle the challenge of e-cigarettes as well.

**Mr TRI VO:** Could the proposed flavour restrictions deter—because I think they're restricted to just two flavours, tobacco and mint—

**The CHAIR:** That's the federally proposed legislation.

**Mr TRI VO:** Would this deter e-cigarette users from accessing therapeutic vapes through a prescription pathway in favour of the black market product, do you think?

**KERRY CHANT:** Personally, I see that if someone is wanting to cease tobacco, there really needs to be a strong bond and a therapeutic relationship with a primary care provider that supports them through that journey. The normal route would be a trial of a number of different strategies that suit the person—conventional and NRT—and then if there was an assessment of risk, these products would be used. I think in the context of a therapeutic approach, the use of mint or some other—having two choices—is probably inappropriate for that paradigm. I think it's too early to speculate but I see that the prescribing of e-cigarettes in a therapeutic pathway allows for the best outcomes for the patients. What we would like to see is cessation. We wouldn't want to see dual use, which is also a pattern in the data—showing that many people are maintaining a dual use of products.

Could I just also go back? The team have provided me with the fact that we've got 11 officers currently in the tobacco team in the ministry, so apologies to that one person I'd not counted. We have over 50 authorised inspectors in our local health district; they're the partners that we do work with. We're currently looking for an additional three contractor positions to boost us over this period and make sure that we have a full complement going ahead for the continued high level of compliance activity.

**The CHAIR:** Thank you for clarifying.

**Mr TRI VO:** I've got a few more questions for New South Wales police, if that's okay? Assistant Commissioner Scott Cook, how does regional and rural New South Wales compare with metropolitan areas in terms of the extent of illegal retail supply of e-cigarettes and tobacco? Are police in regional and rural communities sufficiently resourced to carry out enforcement actions against these businesses?

**SCOTT COOK:** The first point I'd make is that police are not required to carry out enforcement activity; that's the responsibility of Health. In those areas the police have been very conscious and very willing to assist Health. In fact, most of the enforcement activity undertaken by Health has been in those regional areas and police have supported those operations. It's not a great impost on police but it sometimes is difficult to arrange timings for police depending on other workloads. We've undertaken to Health to support them in their efforts. Wherever we can practically do that we will do that, and continue to do that.

**Mr TRI VO:** I'm not sure whether this question was asked before but how much money is organised crime making from illegal vapes, do you think?

**SCOTT COOK:** We don't know the answer to that question.

**The CHAIR:** If I can just jump in, the reason for that question is that we've had earlier evidence that suggested that all the imports that are coming in are done by organised crime and they're the ones that are selling those products to the retailers. He's saying the majority of vapes are controlled by organised crime, but your evidence is contrary to that.

**SCOTT COOK:** Yes, we would disagree with that. The vape market, up until recently, was supplied on a legal basis. In other countries where these vapes are coming from, they're all legal—that's legal; not illegal—so there's no need for an organised crime market to drive that into Australia. But recently, with the change, that may change as well, but we haven't seen that yet.

**Mr TRI VO:** Are the current penalties for illegal selling of e-liquids and e-cigarettes containing nicotine adequate? If not, how would you like to see them change?

**KERRY CHANT:** I think the Minister has flagged, consequent on the Commonwealth legislation once that finally passes through and we're clear on the parameters of that, that we'll certainly increase penalties significantly. We are looking at other minor modifications that the Minister's asked us to look at in terms of the penalties but also things like disposal costs and a range—so in responding to the Commonwealth legislation, we are taking a look over all our tobacco legislation and looking at if there are ways that we can streamline to facilitate the compliance.

**The CHAIR:** Do you foresee legislation changes once the Commonwealth has acted, in New South Wales?

**KERRY CHANT:** We foresee that there'll be a tidy up required. Gemma's probably the best person to talk to that.

**GEMMA BRODERICK:** It's something that we're considering. We'll need to see what happens with the Commonwealth legislation and how it passes. Then how best to actually implement it in New South Wales—whether or not we need some complementary legislation or whether or not we need to also increase generally regulatory provisions in order to assist with compliance and enforcement.

**Mr TRI VO:** I've got one last one to both NSW Health and police. What needs to happen for the prescription model to work effectively? What role do you see the New South Wales Government playing in ensuring compliance with that pathway?

**KERRY CHANT:** What we have a role in is providing evidence. We see that cessation therapy and overall preventative health care should be delivered primarily by primary care, so clearly partnering effectively with primary care to support increasing evidence-based knowledge of the use of smoking cessation and to make sure that they're aware of the different options for them and the different evidence base underpinning them. I've got to say we've been running a number of webinars with our RACGP colleagues. I think you attended one earlier this—

**TRACEY O'BRIEN:** Yes, on Monday.

**KERRY CHANT:** We've run a series of that. So we're supporting general practice to really know the evidence so that they can provide the best evidence to their patients. Then there is regulatory activity. We are also working closely with our pharmacist colleagues—we see that pharmacists are often a point of contact that community might ask—and working with pharmacy groups to ensure that there's a high level of knowledge of the

evidence and processes in the pharmacy sector. We will also, as part of the previous announcement of governments, be increasing our pharmaceutical regulatory activity because obviously as the product coming in is largely pharmaceutical in nature, we will want to make sure that that's not diverted.

Our pharmaceutical services area has a regulatory function in working with wholesalers and others to make sure that those controls are in place. Our focus at the moment is really education and support to those people that would be the prescribers and also working with the community to make sure that they understand the evidence base and know where to go to access help and support. Depending if the Commonwealth legislation comes into effect, we understand that we also will have an increased role in the pharmaceutical regulatory compliance area.

**TRACEY O'BRIEN:** If I could just add, the other parts of the education that we are working on are education modules for different touchpoints within the health system for opportunities to identify those that smoke or vape and connecting to vape services. We are also working at the institute to develop education programs for other youth workers outside of NSW Health who could benefit from that education as well.

**Mr TRI VO:** Assistant Commissioner, do you have anything else to say?

**SCOTT COOK:** I don't have anything to say beyond what I have previously said, and that is that I think a licensing scheme would be useful for the Government to consider. That places an onus on retailers and others—whether they are chemists or retailers or whoever it ends up being distributing these things—to do the right thing and not the wrong thing because there is some risk of them losing their business and their livelihood. I think keeping it within that civil space in terms of a civil penalty space is probably the first step, I would suggest. The last thing we want to see, as police, is the criminalisation of vaping, particularly for young people. It will bring them in contact with a criminal justice system they will never get out of. I would suggest treading very carefully around using the criminal justice system and I would perhaps focus as much as possible on the civil penalty system.

**GEMMA BRODERICK:** Once the Commonwealth reforms come in, the only people that will actually be able to sell any types of vapes will in fact be the pharmacists. They will have to either be supplied on prescription by a pharmacist or direct supply by a doctor or nurse practitioner. Pharmacists themselves all have to already be approved. There is a scheme. The Pharmacy Council of NSW actually approves all community pharmacies.

**The CHAIR:** And that will make it easier for enforcement because once that's in place—

**GEMMA BRODERICK:** That will be the legal pathway.

**The CHAIR:** —then any retailer, whether it's got nicotine or no nicotine, it's illegal.

**GEMMA BRODERICK:** Correct. They shouldn't be selling it.

**KERRY CHANT:** It's a very cut and dry offence, if they are selling it.

**Dr HUGH McDERMOTT:** Let's go back to compliance. With tobacco, if you are caught smoking in a restricted area or someone is selling tobacco and they haven't got a licence to do that, they can be fined by a health inspector—obviously the department of health. Correct?

**KERRY CHANT:** Yes.

**Dr HUGH McDERMOTT:** What about a council equivalent?

**KERRY CHANT:** I think there are two different offences you are talking about.

**Dr HUGH McDERMOTT:** There are.

**KERRY CHANT:** If you are looking at smoking in a smoke-free environment, I think, Gemma, we are the enforcers of the Smoke-free Environment Act?

**GEMMA BRODERICK:** Which also includes vaping. In the same places that you can't smoke, you can't vape.

**Dr HUGH McDERMOTT:** I understand that. Let's just stay with tobacco. I will explain why in a moment. If you are smoking a cigarette or a vape in a restricted area where you are not allowed to do that, who can fine that person?

**GEMMA BRODERICK:** NSW Health.

**Dr HUGH McDERMOTT:** Can a council inspector do it?

**GEMMA BRODERICK:** They sometimes, as I understand it, have their own by-laws and I think Transport might have its own regulation as well relating to smoking, say, on transport stops, so it can differ. But, generally speaking, it would be NSW Health.

**Dr HUGH McDERMOTT:** But there are some by-laws for council officers.

**GEMMA BRODERICK:** I understand, yes.

**Dr HUGH McDERMOTT:** What about New South Wales police?

**SCOTT COOK:** I think we have some capacity on trains and transport, but I'm not sure about the other particular places.

**Dr HUGH McDERMOTT:** So potentially for tobacco and some vapes they can be fined by all three groups. With the illicit sale of vapes—when it comes in, finally—who can actually seize those products? Is it just Health?

**GEMMA BRODERICK:** This is something that we will need to consider, if the Commonwealth legislation passes. The Commonwealth legislation is an amendment to their Therapeutic Goods Act. The States and Territories will need to work together with the Commonwealth about who is actually going to enforce it. You would generally expect that the Commonwealth would be enforcing more around the border and trying to stop the border and then the retail supply would come back to the States and Territories. But how that is actually going to work—it is in the TGA Act. I think we are looking and considering whether or not it is actually better to have some kind of complementary legislation within New South Wales legislation to ease enforcement. That will need to be considered. None of the Commonwealth legislation, though, relates to where people vape.

**Dr HUGH McDERMOTT:** That's fine. Let's go back to the retailers. At the moment, if you have an illicit product—a vape—you can be basically seized and fined by Health?

**GEMMA BRODERICK:** Yes.

**KERRY CHANT:** And police are also authorised.

**Dr HUGH McDERMOTT:** That's my next question. So police can do that as well? They can seize the product and issue a fine or court action?

**KERRY CHANT:** My understanding is that all police officers are authorised under the Poisons Act.

**GEMMA BRODERICK:** The Therapeutic Goods Act sets the general requirement. Nicotine is a schedule 4 substance. It can generally be only prescribed or supplied by a medical practitioner, a nurse practitioner or a pharmacist on prescription. For the enforcement of the Poisons and Therapeutic Goods Act, officers within NSW Health are authorised officers. New South Wales police are all authorised officers as well, although—and the police can correct me—they don't actually get involved. They would get involved in some of the medicines that are more illegal, like some of the steroid-type products and the like or peptides. They may have more involvement where there is more of an illicit market.

What would happen, though, if the Commonwealth legislation Act passes, is that it wouldn't be in our poisons legislation; it would be in the Commonwealth Therapeutic Goods Act. The intent, as I understand it, for the Commonwealth, is for them to authorise officers of the States and Territories to enforce the Commonwealth legislation and the Commonwealth TGA Act. That is one option. Another option that we are considering is whether or not it's actually better to think about putting something within our own framework, which is more readily understood, I think, by officers, to mirror the Commonwealth provisions.

**Dr HUGH McDERMOTT:** I know that you have given us the numbers of how many inspectors Health has and it amazes me the amount of work they have done with such small numbers; it's a real credit to them. Is it worth expanding the power so that the New South Wales police can also start doing more of this work and so they can do more seizures, rather than just supporting Health?

**SCOTT COOK:** Is that question to me?

**Dr HUGH McDERMOTT:** It can be.

**SCOTT COOK:** The NSW Police Force has significantly higher priorities than doing enforcement work for vapes. Notwithstanding that, we have sufficient powers, as I said earlier, to do seizures. Where there is that overlap with organised crime, the NSW Police Force definitely has an interest and, in those circumstances, would be available and would contribute and, in fact, in some circumstances, would lead efforts to curb unlawful supply. However, in terms of a regulatory approach to inspections or things like that, vaping would not be a priority for the police, given their other priorities.

**Dr HUGH McDERMOTT:** I understand you say it's not a priority, but that's not really your call. It will be what the Government suggests is a priority. I hear what you are saying, but you could go back to a lot of theories about what they should be focusing on. I accept what you have just said, but the priority should be what the community expects the priority should be. The fact that children as young as 11 are getting addicted because they are being sold vapes illegally and there is not enough enforcement about that needs to be seriously considered.

**SCOTT COOK:** I agree with that.

**Dr HUGH McDERMOTT:** I take it on board that other more heinous crimes need to be dealt with and there are maybe not enough police.

**SCOTT COOK:** To be fair, I think, if that is the Government's position, then Health should be resourced to do that properly.

**Dr HUGH McDERMOTT:** I don't disagree with you.

**The CHAIR:** Thank you all for your contributions today. It has been very informative. You will be provided with a copy of the transcript of today's proceedings for corrections. The Committee staff will also email you any supplementary questions that you might need to respond to. That concludes our public hearing for today. Thank you all once again for your attendance.

**(The witnesses withdrew.)**

**The Committee adjourned at 14:55.**