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SELECT COMMITTEE ON ELECTRONIC CIGARETTES AND PERSONAL VAPORISERS (VAPING)

Public Briefing Transcript

9.00 am, Monday 17 April 2023

Litchfield Room, Parliament House, Darwin

Members: Mr Brent Potter MLA, Chair, Member for Fannie Bay
Mrs Jo Hersey MLA, Member for Katherine
Mr Dheran Young MLA, Deputy Chair, Member for Daly

Witnesses: **Department of Education**
Saeed Amin: Deputy Chief Executive Regional Services

Department of Health
Samuel Keitaanpaa: Director, Medicines and Poisons
David Scholz: Director, Legal Services and Information and Privacy

ELECTRONIC CIGARETTES AND PERSONAL VAPORISERS
Department of Education

Mr CHAIR: On behalf of the committee, I welcome everyone to the public briefing into electronic cigarettes and personal vaporisers.

I welcome to the table to give evidence to the committee from the Department of Education, Saeed Amin, Deputy Chief Executive Regional Services. Thank you for coming before the committee. We appreciate you taking the time to speak with the committee and look forward to hearing from you today. The Member for Goyder, Kezia Purick, is not sick, but her house has COVID, so she will not be joining us.

This is a formal proceeding of the committee, and the protection of parliamentary privilege and the obligation not to mislead the committee applies. This is a public briefing being webcast through the Assembly's website. A transcript will be made for the use of the committee and may be put on the committee's website.

If, at any time during the briefing, you are concerned that what you will say should not be made public, you may ask the committee to go into a closed session and take your evidence in private. We can do that if we need to.

Could you please state your name and the capacity in which you are appearing before us?

Mr AMIN: Saeed Amin, Deputy Chief Executive Regional Services, Department of Education, Northern Territory.

Mr CHAIR: Would you like to make an opening statement? We can go from there, if that is easier.

Mr AMIN: I would be happy to answer any questions, Brent. We have put forward a submission, so I am happy to just take questions for any points of clarification.

Mr CHAIR: The first one I have, more generally as a parent with kids at high school, with Darwin High in my electorate—it seems to be the talk of the town for many of the teachers, and we are getting significant correspondence. What is the trend we are seeing, more generally?

Mr AMIN: I do not think there is any doubt that, anecdotally, vaping has gone up. It is obviously an issue in society and, therefore, that is coming to schools. Anecdotally, I wouldn't say it's an issue in schools, but there is no question that there has been an increase in vaping in schools.

Mr CHAIR: Is there a policy position from the department, though, going forward about how we will manage vaporisers that each individual school then enacts? I know when

we were talking to one of the schools in the electorate that was looking at some of the measures they would take, just in the toilets alone, as a policy position.

Mr AMIN: It is certainly broad measures in terms of vaping. It is absolutely not tolerated in schools; it is considered a drug, just like smoking and alcohol, et cetera. My understanding would be that every school, student and teacher understands that.

How we manage that, of course, then becomes contextually driven. It is probably more of an issue in urban than bush. We do not get too much feedback from bush schools; it is probably an issue in urban. It is probably an issue in high schools and middle schools rather than primary schools, in that sense—that slightly older group.

We have a double-pronged management of things like this, both from a health perspective, as well as a discipline perspective. Schools take all those precautions—extra people on duty. Toilets, of course, are a place where our students will congregate and manage to do all that kind of stuff, so there are extra sensors and people around toilets, et cetera. All of those things are in place.

Then there is the health perspective in terms of making sure the students are educated fully about the potential dangers of vaping.

Mr YOUNG: I was wondering if you have any data that shows young people between the age of between 13 and 18, for example—that age group we are seeing vaping happening …

Mr AMIN: Dheran, we do not have any specific data. It is something we are now going to have a look at. We have suspension data that does not classify vaping. We just have suspension data that classifies fighting or drug use, et cetera. We are now looking at going back and reclassifying that information. It is not easy, because they are just broad codes. We can print off the suspension data and look at each individual case. Obviously, it is a little more time consuming, but it is something we are considering.

The difficulty with vaping, of course, is it is just one more—I am certainly not demeaning it. There is alcohol, cigarettes, vaping—it is this, that, et cetera. It becomes really difficult to start to categorise all those from a broad policy. However, it is something we are considering.

Mr CHAIR: That is probably a good point I was going to ask that—was there a category for smoking?

Mr AMIN: Yes, it is the same category. I think there are seven or eight categories in the suspension policy, and one of them is just ‘drugs’. We list all those, both licit and illicit drugs, in that space.

Mr CHAIR: I note that at the start you said there is a submission. You probably saw the look on my face, 'There is a submission?' We have not received a copy of it. If there is anything in that submission you have in front of you—and I am happy to get one after this.

We pretend that we do not know your submission, because we do not. It would be good for you to talk us through that.

Mr AMIN: Sure. Obviously, as a department, we are committed to assisting schools to implement sequential age and contextually relevant educational policies. As I said to Dheran, we do not hold specific data on vaping. However, observational and anecdotal data advice from schools supports the statement in the 2022 ANU report that youth use of electronic cigarettes and vaping has gone up. It is an issue in Australia; we certainly see that in schools.

We have reviewed all our policies and guidelines for management. The Drugs in School policy now includes a section on vaping, et cetera. We have also worked very closely with the NT Department of Health to develop effective resources and materials that will support schools. We have actually sought permission from WA Department of Education—they have some extensive resources in this space—for the department to adapt the WA vaping teacher resource and the WA schools anti-vaping toolkit. They have granted us that permission, so we will do that.

The owners of the embedded educational video of Cancer Council WA have also granted permission to re-record their videos, adapting the context for an NT audience. Additionally, NT Health has secured a licence agreement with New South Wales Health to rebrand their toolkit and materials, et cetera, for use in the NT. They are on the New South Wales website at the moment.

We have developed the vaping teacher classroom resource to align with the NT curriculum. That work is currently under way by our teaching and learning services—developing NT-specific fact sheets for teachers, parents and young people on the harms associated with vaping; and a social media campaign that will be rolled out this upcoming term into the rest of this year. There is a bit happening in that space.

Then of course, schools—as you said earlier, Brent—are employing a number of strategies including installation of a number of vaping sensors in toilet blocks; very strong messaging to students that vaping is not tolerated, as is all drug use is not tolerated; and increased teacher supervision, encouraging students also to report to teachers on duty. Our teacher/student surveys show that students are quite happy to report vaping, which is a good thing. The number one issue for students is always toilets, so we need to do some work around toilets.

Mr CHAIR: That is exactly the message I have from both parents and teachers—that it happens in the toilets and then there is a varying degree of what the school thinks is

appropriate to do in there and what parents think. As you said, it is another problem drug in the way it is treated, even though we probably find later that the kids are not using a nicotine variance of that. It is still good to treat is like that, though.

The question I had, to follow up—the vaping teacher package you are talking about being developed. What is the time line for that delivery?

Mr AMIN: I will have to get back to you on that one, Brent. We would sooner put it into a submission once we—my apologies, I thought we had submitted this.

Mr CHAIR: That is okay.

Mr AMIN: It is being worked through at the moment with teaching and learning services, both from New South Wales and NT. We will, obviously, have to adapt that. We have made it a priority. I imagine that if it is not this term, it will certainly be the second half of this year.

Mr CHAIR: Is there anything nationally that the federal government—I know they have done a bunch of parliamentary inquiries and committees into this. Is there anything from the national education point of view that they are looking at a national package on vaporisers?

Mr AMIN: I cannot confirm either way. I know the CEs of their departments meet. I am sure it would be something they would be discussing from a broader perspective.

Mr YOUNG: You were saying there was an increase, anecdotally, in vaporising. From what you can see, would you say the same for smoking, or a decrease in smoking, amongst students, then translating across …

Mr AMIN: I could not say, Dheran. Maybe it is something that Health could give you some facts on. I could not say. Smoking, I think, largely has been managed in schools. It is an age-old problem, but I could not speak confidently whether it is more or less.

Mr CHAIR: I probably know the answer but I will ask anyway—in terms of surveying students, separate to vapour, in general, what are you doing in terms of student surveys within Department of Ed, and is there a way that we can incorporate that into it? Or is it already being incorporated?

Mr AMIN: Yes, there is an annual survey that is sent out to students, teachers and parents, so that is done annually by every school, and we aim for a 30% or more participation rate, which is considered as a reasonable participation rate. That is done every year. We collect that data, and it covers a whole range of questions and scenarios that we then have a look at and implement strategies back in there.

We ask students for their views on schooling, and that is where the number one issue for students is toilets, et cetera. We ask them about their relationship with the teachers. We ask teachers about their relationship with students and involve parents in that survey.

It is a fairly in-depth survey that then goes back to each school. Each school's survey results are broken down, and we also regionalise the results as well as NT results. That is a fairly comprehensive survey which we then take action on.

Mr CHAIR: A follow on question—I am guessing you would not know if there is a specific part related to vaporising and smoking?

Mr AMIN: There is nothing specific about vaporising but it is something we can consider. There are some specific questions about safety at school, how kids feel safe at school, what kind of relationships they have with their teachers so they feel confident in being able to pass that information on to teachers, et cetera—some general questions in that space, but nothing specific on vaping.

Mr CHAIR: Do you have any questions, Jo?

MS HERSEY: No, you have asked what I was going to ask. Thank you.

Mr CHAIR: I completely understand—no issues not having the submission. You will obviously get that as soon as we can and go through it, and if we have any follow-on from that, we can come back.

Is there anything else you would like to say in closing or any other points you want to discuss now?

Mr AMIN: I would just like to say that schools are doing a great job in that area. It is obviously a significant issue now—vaping in our society. As we know, issue coming to schools—I think schools are managing that really well at the time. Sure, there are going to be incidents that are going to erupt as there always are, but overall our schools are doing a pretty good job in that space.

Mr CHAIR: I tend to agree that schools—I have that same point—treat it like drug and work through it. If there is anything more we can do, this is why the committee is here to see what we can help with—but I completely agree.

If we can get that submission sooner than later, that would be fantastic.

Mr AMIN: Will do.

Mr CHAIR: Thanks very much for coming. It was pretty short and sharp but we will have more questions when we get the submission we can take before the committee. Thank you.

Mr AMIN: Sure. Thank you.

The committee suspended.

Department of Health

Mr CHAIR: Before we get into it I am going to run through the obligatory things that I have to give you to let you know that we are being recorded and live.

On behalf of the committee, I welcome everyone to this public briefing on electronic cigarettes and personal vaporisers. I welcome to the table to give evidence to the committee from the Department of Health, Samuel Keitaanpaa, Director of Medicines and Poisons; and David Scholz, Director of Clinical Policy and Planning.

Thank you for coming before the committee. We appreciate you taking the time to speak to us and look forward to hearing from you today. This is a formal proceeding of the committee, and the protection of parliamentary privilege and the obligation not to mislead the committee applies. This is a public briefing and is being webcast through the Assembly's website—and the cameras are above me. A transcript will be made for the use of the committee and may be put on the committee's website.

If at any time during the briefing you are concerned that you will be saying something not to be made public, you may ask the committee to go into a closed session and take your evidence in private. Could you each state your name and the capacity in which you are appearing before the committee?

Mr SCHOLZ: David Scholz, Director of Clinical Policy and Planning with the Mental Health AOD Branch in the Department of Health.

Mr KEITAANPAA: Samuel Keitaanpaa, Director of Medicines and Poisons. We are the regulatory unit for nicotine products, as they are medicines.

Mr CHAIR: Thanks for coming along, gentlemen. Is there an opening statement that you would like to read from, or opening comments?

Mr KEITAANPAA: Yes. Noticing the committee's terms of reference, the Department of Health would like to make an opening statement, particularly just to inform the committee of the way that we see the issue and the predominant concerns, because this is a very

complex topic area, particularly when it comes to identifiable risk and the regulation of products as a concept across Australia.

First of all, the department recognises the immense risk of vaping products. The information portrays a picture of potential unknown risks and benefits, but it is unequivocally that there are risks of these products as they are poisons and that anything with risk must then have risk mitigation strategies with it.

The second component is some of the terms of reference regulatory models. For the committee's benefit it is worth consideration of regulation as a concept compared to enforcement. Regulation tends to imply working with willing participants in a model. We regulate liquor licences, pharmacists and health professionals through the acts as opposed to enforcement of illicit product sales or illegal activity. I believe that throughout the proceedings that you will see there will be a large discussion of the illegal sale of NVPs. While regulation is a concept of that—enforcement of laws and that approach can be seen very differently.

Mr CHAIR: Do you have anything to add to that?

Mr SCHOLZ: Yes, to add to that, as my colleague has mentioned it is beyond doubt that vaping is not safe and not without risk. That is clearly established. That particularly applies to young people. The constituents of vapes are highly variable. There are many chemicals in the product. We do not have a full understanding of their constituents and the way they behave when heated on a metal coil. We know that, almost invariably, they contain nicotine at high concentrations. We know that nicotine has a dangerous impact on the developing brain in youths and adolescents and, to some degree, adults. The human brain may not develop fully until about 25 in females and up to 35 for males. There is a substantial window of harm. We would like to make that clear.

Its use as a harm reduction measure should only be by people who are unwilling or unable to give up smoking by any other means. There are proven nicotine replacement therapies on the market, whereas vapes are not considered a proven nicotine replacement therapy. There are substantial concerns expressed by the Australian Medical Association, the World Health Organisation and the US Surgeon General. There are strong, yes, concerns about their suitability as an NRT at this stage.

Research indicates there is also a gateway effect and that people who are otherwise non-smokers are up to three times more likely to take up smoking as a result of vaping. That is thought to be linked to nicotine addiction.

The other area is in the public policy space—the use of e-cigarettes as a tobacco replacement is highly contested. You will see lots of arguments for and against. There is uncertainty at this point.

Lastly, it is good to recognise that vaping sales are highly lucrative, so there are large profits to be made and people will do what they can to protect commercial interests. It is a lucrative industry.

They are the key points to start off with.

Mr CHAIR: Fantastic. I have some questions. We will generally have some questions from reading a bunch of the other national and other jurisdictional committee reports. Then I have some questions in relation to your opening statement. I will do that first, if that is okay, and then we can get into more general stuff.

The one I had that caught my eye the most—I was under the impression you have two types of vaporisers. There are those that contain nicotine and those that do not contain nicotine. Correct me if I am wrong, but you were saying that the ones that do not contain nicotine, in some instances actually do; they are just falsely advertised—not advertised but marked incorrectly. Can you explain that a bit more?

Mr KEITAANPAA: Sure. What we found from local evidence and also from interstate colleagues and from the Therapeutic Goods Administration is there are a range of products, say, pre-2020, which did not contain nicotine, and of which people were subsequently adding nicotine liquid to them. That is where we ended up with the rescheduling of nicotine under the Poisons Act nationally in about 2020.

Since then, there are essentially two products—ones that contain nicotine and others that do not. The latter seems to be phased out of existence because most people have moved towards a different model where they are prefilled with nicotine.

Of those that contain nicotine, they may or may not be labelled as containing nicotine. That is where a lot of the problems that are encountered from a regulatory and enforcement and public policy space because the product is unknown. We do not know what is actually in there, because many of the products we see, particularly in the Northern Territory, are produced and destined for other countries such as the United States, where they may not need to include that on the label. Indeed, what we are finding here and in other jurisdictions is products that say they do not contain nicotine, but they do or products that say nothing but contain nicotine.

I do not think there is a market for people who are searching for non-nicotine vapes that we are currently seeing in the Northern Territory. Most people are seeking them because they contain nicotine; that is what they are seeking. They understand that the products contain that, whether they say they do or not.

Mr CHAIR: Do you have any questions? Are you happy to keep going? No, we will keep going down that path. They would not, obviously, advertise that they have nicotine in them because it is a controlled item or a poisons item. They would not be advertising if it was not there, and it was not the intent to do that.

At the moment—I want to get this right because of the way I interpret it—nicotine can be prescribed for those who are transitioning from smoking, but generally speaking it is illegal, for a lot of intents and purposes, without a script. Is that the best way to describe that?

Mr KEITAANPAA: Correct. Nicotine exists in the Poisons Standard, which then means there is a regulatory model that goes with it. For example, water is not classified as a poison but nicotine is. It exists in schedules. Unscheduled means it can be available in supermarkets, for the purpose of smoking cessation. That is your gums, lozenges, patches with established efficacy and safety portfolios. Over the years, the delegate for the TGA has said, 'These are safe to be accessible by anyone'.

At higher concentrations, without confirming what the product is or about linking it to smoking cessation, it exists in Schedule 4, which means that you can only be in possession of it with a prescription issued by a doctor and done through a pharmacy. That is how each state and territory adapts that law. On a federal level, it does not actually quite classify that; it says it should have controlled access—every state and territory means doctor prescribes, pharmacy dispenses.

It also exists in Schedule 7, which means it is essentially an industrial chemical. However, when they changed the scheduling in 2020, they amended it to say that it is any nicotine for human use. Where it would exist in Schedule 7 is if you are using it in an industrial application or for mass production of something. The minute it is intended to go into a human body, it is Schedule 4, which means it should only be available on prescription and dispensed by a pharmacy. There are legislative offences if you act outside of that.

Mr CHAIR: What is the uptake rate we are seeing from pharmacies and GPs in prescriptions in those pharmacies that offer that service to fill the script up here?

Mr SCHOLZ: A recent study by the Victorian Cancer Council indicated that about 9% of the survey group were getting a prescribed product. The other 91% were getting it through what are effectively illegal channels.

Mr KEITAANPAA: We will note that medicines and poisons regulates the pharmacy sector in the Northern Territory, so we routinely inspect them, deal with them and have close relationships with them. We ask whether they stock vaping products for sale with a prescription. Several of them have done, but most of it is market driven. If they are not seeing prescriptions, pharmacies will not necessarily supply. We do not believe there is any fundamental barrier to pharmacies stocking and supplying it by prescription. They are happy to do so if there is a public need for it.

Mr CHAIR: I guessing in that instance it comes to a GP actually determining that would be path that individual would take. Do we have any data on what NT GPs are doing in that space and the numbers they are referring?

Mr SCHOLZ: We do not have any specific data, but anecdotal evidence suggests the uptake is very low.

Mr CHAIR: Has there been a shift in young people, do you think, going to it? You said you see it as gateway, for lack of better term. Has there been a shift, do you think, to vaporisers to start with? Then, where is the empirical data to say they are transitioning, as a gateway? That is the first I have heard of it, and that is concerning if that is the case, that they are then transitioning to—I am guessing—tobacco products more generally. Where is that coming from?

Mr SCHOLZ: The transition or the gateway effect—there have been a number of studies, the most recent by the Australian National University which did a meta-analysis of a range of existing research and confirmed that finding. It is from national and international research rather than—there is very little NT-specific data.

Mr YOUNG: I think it has been answered, but I will put it on the record anyway. The World Health Organisation cautioned against the introduction of e-cigarettes in countries with low smoking rates. You have stated there is no real data to back that up. Have we seen a significant decrease in smoking rates since the introduction of e-cigarettes—with the legalisation of e-cigarettes in Australia?

Mr SCHOLZ: The overall consumption of traditional tobacco products has been on a long-term decline; nationally it currently stands at 10.7%. There has been a trend towards lower and lower tobacco consumption, and that trend is expected to continue.

Mr YOUNG: Is the trend expected to continue because of e-cigarettes? Or if you were to remove e-cigarettes and nicotine patches, would you see that?

Mr SCHOLZ: The trend has been occurring well before the introduction of e-cigarettes, and it will be interesting to see, as e-cigarettes now have become so widely available, what the data does in future.

Mr CHAIR: Are any studies currently being undertaken? We have the data now for smoking—we understand the long-term side effects and the morbidities that come with it. Is there anyone looking at predictive models from studies now—it is time that we need—when we have to go through this to figure it out, but is anyone doing predictive models and what that is going to look like in the future around health issues and what those health issues will be?

Mr SCHOLZ: There are not any Australian studies that I am aware of apart from the general impact of e-cigarettes on the community. Given the very strong growth in e-

cigarettes I would expect there will be a lot more research applications to study this—that people are applying for National Health and Medical Research Council funding to undertake further studies.

Mr KEITAANPAA: If I may—we also see from the pharmaceutical sector that any time they want to register a product in Australia for sale at a Schedule 4 level they require safety data as well as efficacy data. There is currently one pharmaceutical company producing goods and bringing them into Australia. It is theoretical that if that market was expanding that there would be more research into those areas as well. As David has mentioned, I do not believe that there are any NT studies around the safety, nor in Australia, looking at the safety of this as a poison, as nicotine, that is established.

The delivery device and the other elements are also incredibly variable because it is an unregulated product, so it is very hard to compare what you are actually looking at. What we know from the 2020 Senate review on it, I think Dr Boland mentioned it, was around the fact the science is still roughly out and it is very hard to predict long-term effects. Again, from Health's point of view, if there is ambiguity about potential health risks then that has to be considered, because there is a difference between being unsafe and not proven safe. From a pharmacy poison point of view, things must be proven safe, not considered to be unsafe.

Mr CHAIR: It is made pretty clear in that report when they are talking throughout society and the Lung Foundation says their last quote:

… the burden of proof that it is not harmful falls on those wanting to progress the issue.

I can understand the position from the medical point of view, and obviously there is a counter to that. Do you have any questions, Jo?

Mrs HERSEY: No, Dheran just asked it.

Mr CHAIR: We understand alcohol in young kids and FASD. How does nicotine—is there any link between young kids, pre-natal and the use of nicotine? As you said, you are concerned about the development of young adults and the use of nicotine. Can you run that through for us a bit more so we get a better understanding of that?

Mr SCHOLZ: Sure. Nicotine is widely understood to have impact on brain development. That is reinforced by recent studies which show the increase in the rates of common mental illnesses in people who vape. An American Heart Foundation study recently showed a 50% increase against the controlled group in anxiety levels and 100% in depression. It has a quite marked effect on neurological status.

Mr CHAIR: What was that number for depression?

Mr SCHOLZ: A hundred per cent, in approximate terms.

Mr CHAIR: When they are exposed to nicotine, is there an age …

Mr SCHOLZ: This was studying the 18 to 24 cohort.

Mr KEITAANPAA: If we look at it in a comparative product sense from a risk point of view, you are comparing vaping against, say, other forms of, let us call it, only nicotine which would be NRT products, which, as I have mentioned before, can be available at any supermarket, because they are tailored at people who are already smoking. The risk benefit between smoking and not is incredibly clear—as I think you were raising.

The other argument is vaping versus nothing. That is essentially where a lot of the health concern comes from and where many of the sort of potential benefits of it that are raised can be counted against the risks, because against smoking—we know what smoking has done, but the actual comparative thing from a risk point of view is nicotine replacement therapy which undergoes significant trials to get listed, is proven and comes to Australia in regulated channels. That is the access mechanism that has served for the last 15 years.

Mr CHAIR: They are concerning stats for the 18 to 24-year old cohort, nonetheless. The first inquiry term for this is around the use and trends of young people. With the Department of Education, although it was fairly quick, it was evident that it is an emerging issue for them. They are treating it no different to any other illegal substance that they would have on the school ground, and that data is concerning.

We understand, for example, other illegal substances and drugs that people take and what is used in those—what are we seeing inside these non-nicotine substances that people use unknowingly? What are the sorts of products we are seeing inside there that they are using?

Mr KEITAANPAA: Do you mean specifically illicit products or potential adulterants?

Mr CHAIR: You said that some of them will advertise that they do not have nicotine or will not say they have nicotine. Is there anything else in there that is inside the—it is not just water; it is obviously a fluid. It is a consistency—having seen it. I was saying before to the committee, I have tried it once pre-2020—I am curious—what is in these pieces?

Mr KEITAANPAA: What we know from TGA analysis of products is looking at whether they contain nicotine, the concentration if it was what they determine to be on the packaging and then if there was the presence of any other adulterants. Of the product that the TGA tested they have continuously shown none of the other banned ingredients—that was various products known to actually cause lung injuries, vitamin E acetate for example. Several other volatile substances if super-heated can cause harm.

In the testing of the products that we know is occurring those do not appear to be evident, which grew with what we would expect, because many of these products are no longer

being home mixed. They are an industrial product meant for retail settings in other countries, so they are produced in accordance with that. Nevertheless, the products themselves do not state what they have, and because it is in an unregulated access model the end consumer has no idea what they are actually purchasing. You are going off the goodwill of what it says on the product and what someone says to you when they get it from behind the counter.

Mr SCHOLZ: To add to that, research shows that internationally they have been found to contain a wide range of compounds. They generally have glycol carrier; they have a number of flavourants and while some of those flavourants will have approval for use as an oral product, we do not know whether that is safe when you heat them against a metal coil and what the health impacts will be—that is unknown.

The metal coils are often heavy metals and there are micro-fine particles …

Mr CHAIR: Hold on one second—I remind those in the audience that it is a public hearing. We need to refrain from any commentary in the background please. Please continue.

Mr SCHOLZ: There are a range of micro-fine particles that can cause respiratory damage. There can be a variety of organic solvents and other products. The mix is highly variable and has been found around the world to contain a range of different products.

Mr KEITAANPAA: You would have come through it already, but the Therapeutic Goods Order 110 includes the list of those ingredients. However, as David was saying, you do not know in many of them because that order applies to bulk importation as a business, so it excludes personal access scheme. If people are actually importing products from any other country—we do not know—and that might be the subset that is present for some people in some areas. It is just unknown, and that is where a lot of that risk comes from.

Mr YOUNG: We know the risk of disease with passive smoking that comes with smoking cigarettes, is there any evidence to show the same when it comes to e-cigarettes?

Mr SCHOLZ: The evidence is still emerging. There are possible cardiac respiratory and carcinogenic effects, but further research is needed to determine the exact nature of that risk.

Mr CHAIR: That is where we find ourselves—if we knew what we now know about tobacco 30, 40, 50 years ago we would be having these committee meetings to get ahead of it, hence why we are having this committee meeting now. I appreciate that there is not going to be an answer for every question.

One of the ones Dheran, Jo and I were taking about before—how is this impacting the Indigenous population? They have exceptionally high rates of tobacco use throughout

the Northern Territory, and that comes with its own health issues. Are you seeing any trends in Indigenous communities with vaporisers? Is there a merit for it? I dare ask knowing that like we spoke before about the harm minimisation position, but I would be interested to hear your points and thoughts on that.

Mr KEITAANPAA: What our department has been asked is involving seizures that have occurred in Nhulunbuy, potentially through Alice Springs—are these products coming into there as well as the Katherine area. Noting the high Indigenous populations of those areas, I do not think it would be unreasonable to say that people are looking at that as a potential market. We know of at least one person that has attempted to inquire to be a nicotine vape wholesaler by essentially claiming themselves to be a pharmaceutical company. That was not approved. It says to us that people are looking at it as a market.

In terms of the benefits of it, I am not aware of any data to have a look at that. As we know with illicit substance use in our Aboriginal and Torres Strait Islander population it can be quite tricky to work out trends. From a pharmacy point of view, we do not have a lot of controlled narcotics moving into those areas because that is a heavily regulated space. How that would look for other products I do not think we know and I do not think we can predict, which adds to that risk portfolio of trying to plan for the unpredictable.

Mr CHAIR: How are we tracking in terms of reducing the number of young adults using tobacco in Indigenous communities? We seeing the good rates from 2016, with 12.2% nationally, down, as you said, to about 10. Where are we at in the Indigenous population to address that?

Mr SCHOLZ: Unfortunately, the Aboriginal and Torres Strait Islander smoking rate remains very high. It is approximately 50% in many remote communities, which is of concern. It has been a difficult to address – limited or impacted by other variables which are the social determinants of health. This works against achieving really good reductions as we have seen in the general population.

Mr KEITAANPAA: When we look at the legal mechanisms there are registered NVP products that you can get on a prescription; they are not covered through the PBS, but prescribers can prescribe them, pharmacies can supply them and patients can use them. There is a legal access mechanism where it can be effectively used as a smoking cessation aid. That access mechanism is not the current predominant one in the market.

Mr CHAIR: For the record, that starts with engaging the GP—a discussion with a GP.

Mr KEITAANPAA: Correct.

Mr YOUNG: Going back to the smoking rates in Indigenous communities—in this report it says that in 1991 to 2013 we saw a drop in smoking from 24% to 12.8% in the Australian population. Is there any data in that period for Indigenous communities in the Northern Territory?

Mr SCHOLZ: We have data that is collected through our Aboriginal health framework key performance indicators. The smoking rate is part of that data collection. And that is where …

Mr YOUNG: Sorry, what was that—Aboriginal health?

Mr SCHOLZ: The Aboriginal health framework key performance indicators.

Mr CHAIR: The UK is legalising and handing out government-funded and paid-for vaporisers. I can read everything I've read publically on it, but I am just curious if the department has a deeper dive on this and where the position and understanding sits of why they have got to this point. As Dheran said, when the World Health Organisation said, 'If you have a low uptake or continuation of tobacco use then introducing vaporisers is not going to see a massive reduction'—I am curious what you know about that from a departmental point of view and what are your thoughts.

Mr SCHOLZ: We are certainly aware of the swap to stop program that was recently announced in the UK. It is targeted at one million of the estimated five million smokers in the UK. It will be a targeted program. It is accompanied by a behavioural support program. That is a really important component of any quit campaign that you do not just try an NRT or other support—that it is bundled with a range of supports to give you the best chance of success.

We will be watching that with interest. Clearly, the UK has made a determination that even though there is a lot of uncertainties in terms of the long-term outcomes—we certainly know the harms of smoking, - and they have made a decision that they will try it, targeting approximately 20% of the adult smoking cohort.

Mr CHAIR: You mentioned the behaviour support program. What do we have in terms of the Territory? Do we have that in remote communities? You mentioned it is targeted with a behavioural support program. I am curious what we have in similarity here? Or do we not have one of similarity?

Mr SCHOLZ: It is available through Medicare. There are Medicare items to support quit attempts …

Mr CHAIR: That includes the patches and …

Mr SCHOLZ: Yes.

Mr CHAIR: Okay.

Mr SCHOLZ: It is part of that, and you can have psychological support sessions. You can have the broader clinical staff, the nurses and other allied health professionals supporting the client through the quit journey.

Mr CHAIR: Do you have any questions you would like to ask?

Mrs HERSEY: No. That is very interesting.

Mr CHAIR: I think you have answered it but I will ask it again. I am getting to the point where—I will go back to Indigenous communities. The problem we have, like you said, is that it is not really going down, and you made the point about kids and nicotine. Do you think we are doing enough to address that particular portion of society and the transition to smoking and tobacco products? I will be honest—I am surprised that e-cigarettes have not made their way out to community because of the allure of the way it is targeted and marketed. Do you think enough is being done?

We spoke to Education, and they said there is more that can be done that they should be doing. From a health point of view is there more that we should be doing at the younger 18 to 24 group, knowing the significant rates of anxiety and depression. Mental health is a huge issue in Indigenous communities.

Mr SCHOLZ: As in many aspects of the health system we could always do more. The Commonwealth has focused the Tackling Indigenous Smoking program, funded by the Commonwealth, to the Aboriginal community-controlled health organisations, so there are Tackling Indigenous Smoking teams throughout the Territory in the large ACCHOs. Yes, more resources would always be better.

Mr KEITAANPAA: As a pharmacist the potential scoping of those questions are around, are these products able to reduce the rates of smoking and moving on? What we know from the data available on the use of pharmacotherapies in Aboriginal areas is that uptake is low for many reasons. One of which is not attending clinics and areas which is different to the efficacy of the product. We also know that medicines and smoking cessation aids are not the panacea. They work well but there is a lot more about the non-drug options. As pharmacists having this discussion nationally around scheduling around the benefits is why we do not see such a large market coming in because it is very hard to predict smoking cessation models using any particular drug, because it does not address the psychological components and everything else.

I would say, as a pharmacist, the idea of a vaping product being an effective cessation tool is only as effective as the counselling and support that goes on. We see that with NRTs. NRTs without support are not particularly fantastic. NRTs with support are immensely useful for people. It is about that engagement and support.

Mrs HERSEY: We were talking about smoking rates declining. I was saying to the guys before that there seems to be—and it is only anecdotal in what I see in the broader

community—an uptake of younger people smoking again. For example, I have three children, and two of them have chosen to smoke. I am not saying they do it all the time. I try to understand, with all the advertising and everything out there, why young people still choose to smoke. Do we have any data on those rates in more recent times?

Mr SCHOLZ: The overall trend is down in all cohorts. There is no strong indication that there is an increase in that younger cohort. What it may boil down to is we all have individual risk profiles and tolerances. For some people, trying something, even though it is potentially harmful, will be an option.

That is where those broader support programs are really quite important to help prevent people taking up harmful behaviours.

Mr CHAIR: I thought it was interesting that the RACMP said it thinks we should have an excise tax on it, less than tobacco products, to stop people transitioning to tobacco products. I did not think it was an issue that people transition necessarily to smoking. You made that point.

I am pretty comfortable you have answered most of the questions I had. We will have a submission from you later. As I said to the Department of Education representative, I am sure that will trigger further questions when we start to get the public submissions that do not come in until May. We will probably ask you to come back. I suspect we will because it is, at the moment, a vastly emerging area with, as you said, a dynamic set of views for most people, which is fair. We will get to the bottom of that.

We will very strictly stick to the terms of reference, because it is one of those areas where you can end up being taken down a path.

I have no further questions at this point, unless one of my colleagues has, which would be good. Keep going, absolutely.

Mr YOUNG: What I would like to see with the data before e-cigarettes came into effect, the smoking rates amongst young people between 13 and 18 and what the smoking rates are now with the introduction of e-cigarettes.

Mr CHAIR: You can add that into the submission.

Mr KEITAANPAA: Can we clarify? Are you speaking specifically for the NT population or for the Australian trend?

Mr YOUNG: It would be good to break down between the Australian population and the NT population. It is probably hard to get this data again to break it down, but remote Aboriginal communities and a split between urban and remote Aboriginal communities would be interesting.

Mr CHAIR: We have been talking, and our biggest concern is our youths getting onto this. In any way or shape—transition or not. There are adults already on it; I completely understand that. We do not know the long-term effects. Unfortunately it is the youths today—there will probably be that data set in 10, 15 to 20 years.

That is a fair point to ask for a submission. If you have time to do that, it would be fantastic.

Mr KEITAANPAA: That is in our opening statement. That is the Health perception as well—that youth uptake is one of our biggest concerns. Obviously, not having the information to make those decisions and the various public health campaigns that NT Health is currently getting ready to roll out includes strong messaging about the lack of knowledge and safety, and to empower children and adolescents to make more informed decisions about some of the risks they are taking on.

I note, too, that on comments about the change in smoking rates over the years, what has been continuously shown to be effective is public health messaging, plain packaging and taxation. None of those are possible when your access is purely through an illegal market. That is one of the fundamental barriers we have. If you cannot touch it, you cannot regulate it. That becomes very difficult to enforce. That is what we are seeing across Australia.

Mr CHAIR: That can be said for many things. There was one I have written on my notes and have not asked. Have there been any medical episodes that are documented that relate to vaporising? Is there anything—this person was a heavy vaper—I do not know if that is the term. Is there anything at the moment in the short term? There is a lot of either misinformation or correct information out there that is going through many channels that both sides of the argument is putting out. I am curious if any medical diagnoses from vaporising—that people were potentially using tobacco products ever and they have started using vaporisers.

Mr KEITAANPAA: We do know it happens, yes, both in Australia and internationally. A lot of them are to do with unregulated products where people were adulterating it themselves, by vitamin E acetate, for example, to vaporise THC …

Mr CHAIR: What is that?

Mr KEITAANPAA: Vitamin E acetate is essentially just vitamin E oil. It is supposed to be inert. There were instances overseas where people were using that to refill cartridges and add THC in order to vaporise cannabis.

In terms of adding nicotine, there have been poisonings across Australia, particularly one episode in New South Wales with a child who drank straight nicotine and, unfortunately, was poisoned through that, which is the basis for the rescheduling and bringing in the TGOs. That was to try to close the loophole around open bottles of

nicotine. Nicotine, as a physical irritant, is extremely dangerous. If you touch it, it will, as a pure salt, be quite irritating to your skin, eyes and mouth ingestion, particularly in children.

Where we then move into these unregulated products, there are also concerns about super heating them, which then releases unknown substances. We are currently seeing in the market disposable vapes that are produced in a factory of a commercial setup. It is unknown; many of them may be mental health effects, which are hard to track. I am happy to take that on notice and have a look through the data that NT Health keeps with presentations.

Mr CHAIR: That would be good, yes. When you spoke about the mental health implications, that to me is a huge concern. We already have enough issues around mental health as it is and other factors that cause that through social media and the like. We need not to be contributing to that.

Mr SCHOLZ: There have been others documented relatively isolated, but we only see reports of the most critical ones. We will certainly go through our records and see if we can find any other record of adverse events locally.

The other thing that is different with an e-cigarette compared to conventional tobacco is potentially the number of doses available in a single product—up to 6,000 doses, which means the quantity of nicotine that can be ingested rapidly is much easier to do than with a conventional cigarette.

Mr CHAIR: I guess that does not necessarily put a financial impediment as well, with the cost and the taxation of tobacco products. I did not know that was …

Mr KEITAANPAA: If you look at high risk-taking behaviour where people are seeking some sort of effect of it, then it is potentially more palatable to inhale than cigarettes, meaning it is easier to take a higher dose deliberately or accidentally.

Mr SCHOLZ: Without flavouring, they would be much less popular with young people.

Mr CHAIR: That was the discussion we had prior to the public meeting. I could not understand if it was not flavoured or had nicotine, why the allure to it, unless it was marketed in a particular way. For no other reason, personally—and I am happy to be proven wrong, hence the public meetings to find that out—the flavouring and marketing is a particular target.

Mrs HERSEY: That is actually one thing that has come up in boarding schools—having children who have now finished in boarding schools, but been there. There have been a lot of children between 13 and 15 who have been caught vaping in schools. It has been a concern in boarding schools.

Mr KEITAANPAA: I will say the flavouring concept—for the committee's benefit—those topics are discussed at a national level. I will not comment now because I am not sure of the confidentiality of those discussions and which meetings they had. During the TGO submission to add flavourings, there were discussions about whether flavouring should be included—including public submissions from pharmacy peak bodies. The committee may be able to get that information from the Commonwealth. That discussion has been held about whether flavourings should be included in a regulatory model or not.

Mr CHAIR: How long ago was that?

Mr KEITAANPAA: On the spot, I would say within the last two to three years. It was fairly recently. The TGO came out in 2020, I think, around the same time they rescheduled. There would have been public submissions then about it because flavourings were a consideration, because we know oral NRT products, such as gum, are allowed to have mint and berry, so should vaping products have the same—that would be a consideration to whether you then outlaw flavourings or not. The current TGO does not outlaw flavourings.

Mr CHAIR: If I had a script and went to the pharmacy, I can get a flavoured nicotine for my vaporiser?

Mr KEITAANPAA: The difficult part there is the pharmacy would not have access to a flavoured product because what is available on the Australian market tends to be unflavoured, because they are the ones that are of a medical grade.

The other element as we have mentioned is the personal importation scheme, which is that you can currently purchase them from an online website purely based on the idea that you may or may not have a script, so those products are then sent to you from internationally. That is the same model used for performance-enhancing drugs and steroids in order to circumvent the laws involving the personal importation scheme.

Mr CHAIR: It is interesting when I read through the federal committee's report; they were saying that kids are not taking up tobacco chewing gum or patches because it is not seen as cool or socially appropriate, which is interesting in the way that it has been marketed. That comes back to that flavouring piece that you are deliberately doing it for a reason. Otherwise we would not be selling tobacco chewing gum in supermarkets where anyone could purchase it. I thought that was quite interesting. Thank you very much.

Do you have any other comments?

Mrs HERSEY: No, thanks.

Mr YOUNG: No.

Mr CHAIR: Thank you very much for coming before the committee. I am sure we will have you back after we get the public submissions in May. I am anticipating that we will get quite a strong representation from both sides of the argument, which is exactly what we need to come to decisions.

Thank you very much for coming in, gentlemen.

Mr KEITAANPAA: Thank you for your time.

Mr SCHOLZ: Thank you.

The committee concluded.
