Social Research & Evaluation Pty Ltd
ACN 113 241 973; ABN 40 113 241 973
David McDonald, Director
Phone:
Mobile:
Facsimile:
Australia
Email:
www.socialresearch.com.au

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Ice Task Force

Dear Task Force members and Secretariat

Submission

Thank you for providing an opportunity to present a submission to the unfortunately named Ice Task Force. I say 'unfortunately named' because, as you know, we should not use street names for drugs in professional communications. Doing so can readily be seen as a way of promoting drug use: ice is cool, speed gives you a rush, ecstasy is fantastic, and so it goes on

I was pleased to be able to hear the brief presentation by Professor Richard Murray at this week's National Methamphetamine Symposium, although it was unfortunate that there was no opportunity for any engagement or discussion about the Task Force and its work. Perhaps that reflects the early stage of the process?

I left a number of suggestions about actions that the Ice Task Force might take with the conference organisers. We were all invited to record suggestions for actions and I presume that they will be passing on to you those that are relevant to the work of the Task Force.

At what point are we in the methamphetamine epidemic curve?
The members of the Task Force may find it useful to familiarise yourselves with what we know about the nature of epidemics of drug use and drug-related harm, based on communicable diseases epidemiology.[1] Typically, by the time politicians and the public become aware of a drug problem and decide to act, the epidemic is past its peak, i.e. the incidence of users, and probably the prevalence of harms, is falling.

The main thing to learn from the body of theory and empirical evidence on the trajectory of drug epidemics is that different interventions work best at different stages in the epidemic curve.[2]

Obviously there is no epidemic, in Australia, of methamphetamine use. Prevalence is low and steady.

If the Task Force determines (from the data) that we are at an early stage of an epidemic of shifting from powder methamphetamine to the crystalline form, then preventive programs could have

[1] Rothman, KJ 2012, Epidemiology: an introduction, 2nd edn, Oxford University Press, New York, N.Y.
[2] Perhaps the most accessible presentation of contemporary understanding about drug epidemics is Kleiman, MAR, Caulkins, JP & Hawken, A 2011, Drugs and drug policy: what everyone needs to know, Oxford University Press, Oxford, pp. 88-91.

prominence. If it determines, however, that we are past the peak of initiation to the crystalline form, then treatment and harm reduction should get most attention.

Of course, drug law enforcement (as it is usually done in Australia) has little to offer at any stage of the epidemic curve, as it fails to respond to the research evidence of what works, for whom, in what settings. This is perhaps best evidenced by the heavy focus of police efforts on arresting consumers at all stages in the epidemic curve, rather than being smart about at which point it is best are focused on consumers, and it which it is best to focus on providers.

Harm reduction

The anomaly of banning the sale of pipes used for smoking crystalline methamphetamine in most (but not all) jurisdictions, while heavily promoting the availability and use of sterile injecting equipment, including for the injecting of crystalline methamphetamine, should be obvious to the Task Force. It will be great if you can develop recommendations to remedy this: NIROA should be one of the central goals in methamphetamine policy. You may consider that the ACT's recently legislated approach of prohibiting the display for sale of implements intended for smoking drugs, but not prohibiting the actual sale (i.e. taking the same approach as we use with tobacco products) is a useful model.

The mass media

The Commonwealth Government's current media campaign about crystalline methamphetamine has been universally condemned. I imagine that members of the Task Force, and of the Secretariat in PM&C, cringe every time you see it and wonder if you really should be involved in this work. It is a real tragedy when politicians and their advisers care so little about people who use drugs, their families and carers, along with the people dedicated to assisting people who use drugs and who work in community treatment centres and other places. The current media campaign is factually wrong, demeaning and almost certainly counter-productive.

The Task Force may care to review the current Australian Press Council guidelines relating to media reportage of drugs: *Guideline: Drugs and drug addiction*. They are dated July 2001 and are badly out of date. It would be a great step forward if the Task Force is able to get these updated to reflect contemporary knowledge, particularly about what works and what is counter-productive in social marketing. It will also be a great step forward if you can make firm recommendations for guidelines about social marketing, pointing out what we know from the research evidence about the waste and potential counter-productivity of using the mass media to address low prevalence problems (such as MA use) in our society. Any such initiative should include, of course, social media.

Drug user organisations

Members of the Task Force are undoubtedly aware of the wonderful contributions that organisations of people who use drugs are making both in the preventive field and in facilitating treatment access for people experiencing drug-related problems. They are also increasingly being involved in policy forums as well.

It is a ridiculous anomaly that the Commonwealth Government continually calls on representatives of these user organisations to sit on policy committees and make contributions to policy activity, but consistently refuses to provide any such financial support for their activities. So far as I know, AIVL still derives almost all of its funding from the communicable diseases part of the Commonwealth Department of Health, rather than from the National Drug Strategy. It is not funded to contribute to drug policy.

The failure of most previous illicit drug strategies

Task Force members are undoubtedly aware that almost all of the previous single drug focused Strategies developed and promulgated under the NDS have largely not been implemented. This is been the case with the national illicit drug strategy, the heroin strategy, the ATS strategy, the cannabis strategy, and so we could go on. This is not surprising considering that their contents generally have to be the lowest common denominator in terms of what is acceptable to the various jurisdictions, and because we have no coherence with regard to the funding of national initiatives in this country. The strategies fail to indicate who will do what, when, using what resources, and with what performance indicators. While I have little confidence that the 'Ice Strategy' that will be produced following the Task Force's work will be any better, it will be wonderful if you can take into account what we know from Implementation Sciences[3] that will facilitate the actual implementation of a worthwhile strategy.

As you are undoubtedly aware, one of the main reasons that the NDS strategies, over the years, have largely failed, is that they focus on single drugs. This fails to acknowledge the realities of the social determinants of problematic drug use, the nature of drug markets and the realities of polydrug use. I wish I had some concrete suggestions to put to you on how to overcome this significant problem, but do not, considering your terms of reference and the approach being taken by politicians to people who use methamphetamine, treating them so disgracefully.

Thank you for providing an opportunity to present this submission.

David McDonald
Director

[3] E.g. Fixsen, DL, Naoom, SF, Blase, DA, Friedman, RM & Wallace, F 2005, Implementation research: a synthesis of the literature, FMHI Publication #231, University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network, Tampa, FL.