LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria

Melbourne — 3 February 2014

Members

Mr B. Carroll
Mr T. McCurdy
Mr S. Ramsay
Mr J. Scheffer
Mr D. Southwick

Chair: Mr S. Ramsay
Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook
Senior Legal Research Officer: Mr P. Johnston
Committee Administrative Officer: Ms K Martinow

Witnesses

Professor R. Midford, Professor of Health in Education, School of Education, Charles Darwin University.

The CHAIR — Good morning, Richard. We are looking forward to your contribution to this inquiry. As you know, we are conducting an inquiry into the supply and use of methamphetamines in Victoria, particularly ice given a significant increase within regional areas of use and distribution of this drug. I see from your background that we are going to have some discussion in relation to drug education in schools, which is very pertinent given that we are looking at a number of possible recommendations for early intervention in the school system. We look forward to your evidence this morning.

Prof. MIDFORD — Sure.

The CHAIR — Welcome to the public hearing of Law Reform, Drugs and Crime Prevention Committee. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. It is important that you note that any comments you make outside the hearing, including effective repetition of what you have said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Prof. MIDFORD — No, I have not.

The CHAIR — It went with the original documentation. You were provided with a copy, so hopefully that will cover off any problems that might arise.

Prof. MIDFORD — Sure. I am happy to proceed.

The CHAIR — It is also important to note that any action which seeks to impede or hinder a witness or threaten a witness or the evidence they would give or have given may constitute and be punished for contempt of Parliament. Hansard staff are recording the evidence, and we will provide a proof version of the transcript at the earliest opportunity so you can correct it as appropriate.

Prof. MIDFORD — Thank you.

The CHAIR — What we have done in the past is allow a few brief opening statements and then allowed the committee to ask questions, both of that verbal submission and also obviously about other issues around the inquiry we are conducting. I know for the record that you are a professor of health and education in the school of education at Charles Darwin University. Interestingly enough for me, Richard, you worked at Edith Cowan University in Perth, where my son is presently doing a course.

Prof. MIDFORD — That is handy.

The CHAIR — I am very familiar with that university. I understand you are going to be talking particularly around your work with drug education in Victorian schools.

Prof. MIDFORD — Yes. Would you like me to make a statement about the work I have done in recent years in Victorian schools?

The CHAIR — Please. We have allocated time until 11.45, but because of the technical problems we will allow more time. We do have other witnesses presenting straight after you, so we will have to try to it keep fairly tight.

Prof. MIDFORD — I will make a very brief statement, if that would suit, just to give you a bit of an understanding of what I based my evidence on.

The CHAIR — Thank you.

Prof. MIDFORD — As I said, over the last five or six years I have worked in collaboration with the University of Melbourne and Oxford Brookes University in the UK with the Department of Education and Early Childhood Development in Victoria on a program which was called

DEVS — Drug Education in Victorian Schools. It was a study that started off as a pilot with three schools. We then got an ARC linkage grant and extended the trial to 21 schools across Victoria. It was a harm minimisation-focused drug education project in the sense that objectives are measurable. It is very much about harmful consumption and harms associated with alcohol use. We have finished the trial now. The main study finished the year before last, and we are still writing up results.

It was a program that targeted all drugs, both licit and illicit, so we targeted alcohol, tobacco, cannabis and other illicit drugs. We found that in terms of alcohol and tobacco we did not reduce uptake — we did not stop people from using — but we found that we reduced consumption. We reduced harmful or risky consumption — that is, consumption of five or more standard drinks per occasion — and we reduced associated harm. The same was the case with smoking. We did not reduce uptake, but we reduced the amount that people smoked, and we reduced the harms associated with smoking.
What I would say in regard to illicit drugs apart from cannabis is that we virtually recorded no responses in terms of illicit drug use, and what responses we did record tended to be around ecstasy use. I can provide more information than that if you wish.

The CHAIR — Thank you. Are there any other statements you want to make?

Prof. MIDFORD — No, that covers my background in drug education. In terms of methamphetamine use, my experience in that area is very much related to gathering data about usage and harm in schools, and as I said, the findings from the Victorian study were that self-reported methamphetamine use was negligible.

The CHAIR — Right. If you are happy, we might just tease some responses out of you. I will lead, and then I will open it up to the committee. Part of the work we are doing in relation to this inquiry is trying to provide some recommendations that will deal with early intervention — that is, trying to make people aware of the consequences of taking methamphetamines particularly. In the school system it was suggested to us that we need quite early intervention — in years 7 and 8. I am just wondering, given what you said about the work you have already done in relation to drug education in Victorian schools — I think you indicated that there was negligible response to illicit drugs — and information coming to this committee in relation to other programs where there has been in fact not a reduction in consumption but an increase, particularly in relation to drugs, can you maybe just provide a response to that? What do you see as a beneficial recommendation in relation to early intervention in drug education in schools?

Prof. MIDFORD — Drug education is quite controversial in that most of the research comes out of America; about 75 per cent of published research is American. They tend to have as their goals abstinence or delayed onset, and their programs in terms of those objectives have not been very successful, so drug education does not have a good reputation. What we tend to do in Australia, and not just in the DEVS program but generally — programs in Australia tend to focus on reducing harm and then measure outcomes in terms of reduced harm rather than reduced use.

In terms of the programs that have been carried out in Australia, there are three major ones in recent times: SHAHRP, Climate in New South Wales and the DEVS program in Victoria. They have found that drug education has been useful in reducing harm. Harm can be measured in a number of ways and should not exclude abstinence. Abstinence is a legitimate harm reduction strategy, but in some cases it is not going to be appropriate; people may have already started to use, and to try to say, 'Don't take up use', or, 'Don't use', is not going to be particularly effective as a drug education strategy. So what we try to do with harm minimisation is acknowledge that use takes place and give young people the skills and understanding to make better decisions so that they keep themselves safer. An example would be if you go to a party where there is going to be alcohol around, have a strategy for being able to get home safely or stay the night rather than risk getting home with a drunk driver or getting into trouble in other ways because of transport issues. That is the sort of approach we take.
What I would say with illicit drugs is that you have got to be very careful with what you tackle or how you tackle them, because if it is not on the radar for young people, you do not want to give them very prescriptive harm reduction strategies, like, 'If you use heroin, make sure you clean your needle', or that sort of thing because you may actually then give them the

confidence to do things which they would not necessarily do. With illicit drugs, in our drug education program we generally went for generic safety strategies about how you keep yourself safe in situations where illicit drugs are being offered — things like blood safety, not taking up things you do not know anything about, staying with friends and that sort of thing.
In terms of when to start drug education, we started in year 8. We focused very much on alcohol, and then we went into illicit drugs in year 9. We started at year 8 with alcohol because that is when use tends to rise, and with cannabis anyway it tends to rise a bit later on, so we tended to deal with it a bit later in the program. We did not deal extensively with other illicit drugs for the reasons I have already stated.

Mr CARROLL — Thank you for your presentation. Richard, you mentioned that with harm minimisation you basically deal with generic strategies. When you are dealing with a student, do you get to the stage where you have to go further than that and provide referrals?

Prof. MIDFORD — We had a train-the-trainer model in the sense that what we did was provide education — professional training — for teachers, and the teachers delivered the program. Part of the training was for them to recognise if an individual had a particular problem and for them to know what the appropriate referral protocols were. We were certainly not encouraging teachers to deal with it themselves but to recognise that something more was required than simply the education process and then to make appropriate referrals.

Mr CARROLL — You mentioned that it originally began as a pilot in 3 schools and then was extended to 21 schools.

Prof. MIDFORD — Yes.

Mr CARROLL — Where is the program now?

Prof. MIDFORD — The program as a research trial has finished. The materials are available on the Victorian education department website. My understanding is that the schools can choose can to use it if they wish, but that is a choice by individual schools.

Mr SOUTHWICK — I was just wondering if you could comment, Richard, on how you measure success. You spoke about the reduction in, particularly, smoking and alcohol. How is that measured?

Prof. MIDFORD — Let me focus on alcohol. We asked whether they drank, and then we asked, 'When you did drink, how often did you drink and how much did you drink?'. We got a measure of consumption by multiplying those two factors to get a sense of how much they drank in total over a 12-month period. We then looked at whether, when they drank, they drank in the risky range — i.e., five or more drinks usually, which is considered to be risky consumption by the Australian national guidelines. We also then asked a series of questions in terms of the harms they experienced. I cannot remember every single one, but the sorts of questions were, 'Have you ever not remembered after you have been drinking?', 'Have you even gotten into a fight when you have been drinking?', 'Have you ever gotten into trouble with police when you have drinking?', 'Has drinking ever stopped you from doing what you wanted to do?' — those sorts of questions. Then what we did was we asked, 'Ever; once or twice; three or four times; five or six times', and then we totalled those up in terms of the harms they experienced associated with their drinking.

Mr SCHEFFER — You talked at the beginning about, when the program was operating in the schools, licit and illicit drugs, and you mentioned the issue of needle management and how that could go in different directions in terms of how young people interpret that. With something like needle management, it is a danger in itself, but it is also problematic because it happens to be illegal. How did the program negotiate with the young people in schools about the legal framework — regulatory framework — that it operates in and then the safety? How was that transacted?

Prof. MIDFORD — As I said, we did not get into specifics like needle management. We just did not do that, for various reasons. We thought it was inappropriate for that age group. It was not relevant for that age group. We were very mindful that what we did not want to do was give

kids — students — harm reduction strategies which were not relevant to them at that age and which may have encouraged them or may have given them the confidence to try things which they would not have otherwise tried.

What we did in terms of illicit drugs is that we talked about illicit drugs and the effects of illicit drugs. We talked about the legalities. We talked about consequences. We just talked about keeping themselves safe in terms of not getting into trouble with the law and not getting into trouble in terms of health issues, but we did not get into specific, prescriptive harm reduction strategies, like, 'If you use, you should use this way to keep yourself safe'. We did not get into any advice on use at all.

Mr SCHEFFER — I appreciate that. I am sorry; I have misled you into thinking that I did not understand what you said the first time. I guess what I am driving at is: does the fact that a substance is illegal and that you talk about that in the school have a cautionary effect on the young people?

Prof. MIDFORD — What we found is that the young people were very interested in illicit drugs. It is sort of like forbidden fruit, I guess. What we also found was that in terms of self-reports, self-reports were negligible, and their understanding and knowledge about illicit drugs, even cannabis, was very low. One of the questions that came up was that when we were talking about, 'Have you ever used cannabis? If you have used, how often have you used?' et cetera, what we found was that quite a few kids did not even know what cannabis was. We used the technical term rather than 'marijuana', and I think that is probably something we would not do again if we did the same sort of trial, because 'marijuana' is much more common usage. They just did not understand what cannabis was. We started at year 8, when they were turning 13. At that age their knowledge and exposure to illicit drugs is really minimal.

Mr SCHEFFER — And what about the older ones as you step up?

Prof. MIDFORD — The trial went for two years — year 8 and year 9 — and we followed it up again without an intervention in year 10 to see whether the effect is maintained without any further education. It went up a little bit, but still around 1 per cent said they used an illicit substance.

Mr SCHEFFER — My last bit on that, then: I presume you did tests and were confident that they were telling you the truth. What I am driving at is: does the fact that it is illegal prevent them from really talking about these drugs frankly?

Prof. MIDFORD — It could have. It is difficult for us to tell, but all the other research that we based ours on suggested that students are pretty honest in their responses. What other studies have done is that they have used what they called bogus drugs, or the bogus pipeline, and they said, 'Have you used various drugs?', including a couple of bogus ones. What they found was that there were very few respondents saying they had used a bogus drug. In terms of on-field response, I think we are on safe ground using the methodology that has been used in these sorts of studies for a long time.

Mr CARROLL — Richard, what approaches should schools and teachers take to drug use? I ask that in this context: is it best that a teacher is teaching drug education or, to get the message through to students, is it better to have a qualified drug counsellor talking to them? You have spoken about how you have dealt with a lot of students. Who is the best person to get the message through? Is it a teacher, or is it someone from outside the school environment who has a background in the industry? Do you have a view on that?

Prof. MIDFORD — Yes, I have a very strong view on that. The literature suggests that it should be the teachers. That does not preclude the teacher, in doing drug education, getting somebody in as part of the program, but what has happened in the past and is proving totally unsuccessful is that people are saying, 'Look, we need to do drug education. We'll get the local GP in or get somebody who's an ex-user to come in and tell people about how bad it is to use drugs'. That really is not a good strategy, particularly the ex-user strategy, because very often while the ex-user may say all the right things in terms of it being bad for their life, they often present as very

attractive role models in the sense that they may be good looking, they are articulate and they have come through the other end and do not seem to have had too much harm from it. What happens is that often the message the kids take away from it is, 'Look, these people used drugs and they came out okay. Therefore I can probably do the same thing'.

It is much better to have a teacher on the basis that the teacher knows the kids. If anything comes up and the teacher is somebody the students trust, they will follow that up with the teacher. The teacher is somebody who will follow those kids through and is available, whereas somebody from outside is a one-off hit. They may be really good at doing their presentation, but that follow-up and continuity is simply not there.

Mr CARROLL — Thanks, Richard. They are good points.

Mr SCHEFFER — Richard, you mentioned that drug education has a bit of bad press because of the way this was approached in the United States, where a lot of it seemed to be related to abstinence and so forth, and then you talked about Australia and Victoria having a different, harm minimisation and harm reduction approach and a lower use approach. Have you looked at research at all in, for example, Vietnam and Thailand? We had a witness previously who said that there had been quite a lot of good work going on in those jurisdictions. Do you have anything in relation to that?

Prof. MIDFORD — No, I do not. I would not say that I know that literature at all. I am not aware of any drug education in school programs that they use. I am aware of some of the harm reduction strategies they use with users, which have been quite successful, and I am aware that in the big ones that are talked about — programs in those countries — there is a completely different cultural context. I think it is a much more difficult context in which to put forth harm reduction and harm minimisation approaches because I think that the culture in those countries makes it much more difficult than it does in our country. I certainly do not think that what we do in Australia would translate easily into those countries.

The CHAIR — All right, Richard. Are there any other closing statements you would like to make to the committee before we finish up?

Prof. MIDFORD — No, not at all, really. All I would finish with is that I think that drug education is a really important component in prevention. It has a bad rap, and certainly a lot of people in academia who work in the drug area do not feel that it is a particularly effective strategy, but my sense is that it is an effective strategy if it is done properly. I think harm minimisation is the way to go, particularly with the more prevalent drugs, because if people are using, giving an abstinence message is not going to be particularly effective. The harm minimisation message about keeping oneself safe and being aware of how to negotiate and navigate the dangers of drug use will keep them safe. I feel that a skills-based, realistic, harm minimisation drug education program is probably the best thing you can do for kids of that age who are on the cusp of making decisions about drug use.

The CHAIR — Good. Thank you very much for your time this morning. I am glad we were able to make contact, apart from a few technical problems.

Prof. MIDFORD — Thank you for inviting me to give evidence.

Witness withdrew.