LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Melbourne – 31 March 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
Legal Research Officer: Mr P. Johnston

Witnesses

Professor M. Wakefield, Centre for Behavioural Research in Cancer, Cancer Council Victoria

The CHAIR —Welcome.

Prof. WAKEFIELD—Thank you.

The CHAIR—Sorry we are running a bit late. I did my best, didn't I, Mr Scheffer, to try and curtail a presentation? I am going to have to apologise for two of my committee members, who have commitments at 4 o'clock. There is no disrespect if they walk out, because it is on *Hansard* and the deputy chair and myself will stay here till the end of the time allotted.

You have agreed to present at this public hearing, to provide evidence to an inquiry which this committee is undertaking into the supply and use of methamphetamines in Victoria, particularly ice. I understand Sandy Cook, the executive officer, has provided you with some background material in relation to your area of expertise. I notice you are from the Centre for Behavioural Research in Cancer from the Cancer Council of Victoria.

Prof. WAKEFIELD—That is correct.

The CHAIR—You are here this afternoon to provide the committee with additional evidence in relation to drugs and the relationship, I assume, to the work that you do.

Prof. WAKEFIELD—Yes. As I understand it, I am here to provide some information on mass media campaigns in relation to how they might be used in this area that you are working in.

The CHAIR—That is true.

Prof. WAKEFIELD—I am definitely not an expert in methamphetamines. I know very little about it, but I do have a very deep background in mass communication on public health issues, especially tobacco control. I have worked for about 30 years in that area.

The CHAIR—It has worked very well, I might add, because I am a reformed smoker.

Prof. WAKEFIELD—Yes, we have been very successful in reducing tobacco use across Australia and in other parts of the world as well—also in skin cancer prevention, with our SunSmart campaign, pap testing and so forth.

The CHAIR—I have to read you the conditions under which you are presenting.

Prof. WAKEFIELD—Sure.

The CHAIR—Anything you say that goes on *Hansard*, you are then protected and so are we. Welcome to the public hearing of the 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 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. WAKEFIELD—Yes, I have.

The CHAIR—It is also important to note that any action which seeks to impede or hinder a witness or threaten a witness for the evidence they would give or have given may constitute and be punishable as contempt of parliament. We are recording the evidence and we will provide a proof version of the *Hansard* transcript at the earliest opportunity so you can correct it as appropriate. Thank you again for your time this afternoon, professor.

Prof. WAKEFIELD—You are welcome. What I thought I would do in this session is kind of leverage from a review of mass media campaigns to change health behaviour that I led, which was a commissioned review, for the Lancet Medical Journal and was published in 2010 across a whole range of different health behaviours.

What we ended up doing was distilling some lessons for public health campaigns, and I thought it would be helpful just to go through, by way of introduction, some of the issues that I think you are trying to grapple with, as I understand it, in the letter to me, where you make some comments on the utility of public health campaigns for methamphetamine use and so forth, and what they should look like if at all they should occur.

Basically, in this review we conducted a kind of review of reviews, because our brief was very wide. It was a whole range of different public health behaviours and so we ended up reviewing over 400 studies from the paper. These are the kinds of topics that we looked at in terms of substance use, heart disease prevention, diet and physical activity, birth rate reduction and HIV prevention, cancer screening and so forth, child survival, and other various health topic areas, so it was extremely broad.

Before we look at the outcomes of the review, it is important I think to define what we mean by 'mass media campaigns'. Mass media campaigns are mass by definition. They create and place messages on media that reach large audiences. Typically, exposure is passive, so people get exposed while they are consuming media, so if you are watching television, an ad interrupts your viewing and that is how you get exposure, and even with the growth of new technology, television is still very much the way to reach the whole population, surprisingly. Campaigns can be short- or long-lived. They can stand alone or, ideally, they can be part of a system and they can be linked to clinical services or other products and so forth and be part of a more comprehensive approach.

I might go through how mass media campaigns work to change population health behaviour. Most people think that pathway No. 1, which goes through the middle of this slide, is the only way through which campaigns work to change behaviour: that someone sees an ad on TV and is prompted to think about what the message is and goes ahead to change their behaviour. That certainly does happen if the message is a good one and exposure is high enough, but pathway No. 2 is really important as well.

Pathway No. 2 basically alerts people to the fact that this is an issue that deserves public attention. It shapes their views about it. It also shapes the views of policymakers. It puts it as an agenda, I suppose, as a public issue, and it leads ultimately to policy discussion and ultimately to policy change and, through that pathway, mass media campaigns can lead to policy change and it is the policy change that drives health behaviour change, so it is kind of an indirect pathway.

Pathway No. 3 is that when people see mass media campaign messages it sets the agenda for discussion between them, so antismoking mass media campaigns typically provide great fodder for discussion between parents and children about tobacco, or for a kid to nag their parents to quit smoking, and that is quite helpful. It also changes the social norm and feelings about social acceptability of the behaviour. Because of that, it can also influence people who have never been exposed directly to the mass media campaign—the social network member there. For example, as a result of being exposed to a mass media campaign, people at work put together a stop smoking group and someone who has never been exposed to the mass media campaign decides to join the stop smoking group and ultimately goes on to quit smoking. It can have amplified effects, rather than just on people who are directly exposed to the campaign, and when you are talking about mass media campaigns it is really important to consider all those pathways. It is not just individuals who see the message and go on to then change their behaviour that is important.

Mr SOUTHWICK—What about where you have public relations/current affairs

driven off the back of a mass media campaign—like Derryn Hinch having a discussion on talkback—which decides to run an initiative to stick it on the back of cars to reduce the road toll?

Prof. WAKEFIELD—Yes. That is a more formalised media discussion that is prompted by the media campaign and it can amplify beneficial effects or it can cut off beneficial effects, depending on the frame and on the tone they want to take with that. It lost control of it at that point, but if you do your research well with your mass media campaign and you run your campaign well, you should be able to make sure that you bring the major commentators along with you to some extent. You will not be able to bring them all, because who would want to?

Mr SCHEFFER—What are the components of what you call a mass media campaign?

Prof. WAKEFIELD—I think what we are calling a mass media campaign in this review is typically paid, planned, educational messages in the media, where you would buy purposively on television in particular, which might be complemented by radio, cinema, online, whatever, but television leads the population penetration of messages still at this point in time.

Mr SCHEFFER—Taking up Mr Southwick's remark, using Derryn Hinch as an example, it really ends at that point? It is off and running at that point and you would hope that the discussion that the person like Mr Hinch would have through his program would be shaped by the public messaging rather than going in another direction?

Prof. WAKEFIELD—That is right, and as part of the planning of the whole media campaign, your media campaign planners would have prepared a fact sheet for people like Derryn Hinch or would have prepared some other material for them to help them think through the issues in advance.

Mr SCHEFFER—It does go into the mainstream. You said mainstream media, television pre-eminently, but it does have some communications out there as well?

Prof. WAKEFIELD—Correct. Good, well-resourced campaigns should try to do that. It is kind of responsible. If you are setting the agenda with paid sort of agenda-setting discussion material—

Mr SOUTHWICK—You need a communication strategy.

Prof. WAKEFIELD—you need to help people unpack it.

Mr SOUTHWICK—A communication strategy that has mass marketing in it, as well as some of the other things that you mentioned?

Prof. WAKEFIELD—That is right, yes. It is a planned kind of attack. It is formalised rather than reactive. It is proactive.

Mr SCHEFFER—You would measure its success by the discussion beyond the messaging that you had put out, how that discussion was more informed in the way that you think is useful?

Prof. WAKEFIELD—Yes, you could do that, definitely. That is what people want to see. Depending on the behaviour you are targeting, you can be a little more optimistic than that. Sometimes you can go straight to the behaviour that you are trying to target.

Mr SCHEFFER—When you are planning a campaign such as, for example, smoking, you would look at the behaviours of people who are using tobacco, as a start.

Prof. WAKEFIELD—Yes, you would.

Mr SCHEFFER—Then you would look at the behaviours of people around that person using tobacco, but would you also look at the kind of discussion around them?

Prof. WAKEFIELD—You would.

Mr SCHEFFER—You would look at media as well?

Prof. WAKEFIELD—You would. We will generally do that when we evaluate Quit campaigns and so forth, the sort of balance of the discussion in the media that goes on, and usually it is extremely good because we have really prepared well.

The CHAIR—Do you think the government strategy of doing a step-by-step process of restricting smoking in public places is having the desired effect?

Prof. WAKEFIELD—Yes, I can tell you that it has. It is a very important driver of reduced smoking prevalence in Australia. It is such a shame we are a little bit behind here in Victoria in banning smoking in outdoor dining venues. That will happen at some point; it is a step-by-step process. But there is research that we have done, looking at changing monthly smoking prevalence over several decades. We know that laws have changed at different times in different states, so we can relate that to the acceleration of the rate of decline in the different states at different times, and it is quite notable. It is a very big driver of reduced smoking prevalence in adults, as is increased tobacco taxation and greater exposure to mass media campaigns. They are the big three for tobacco.

Mr SOUTHWICK—I am going to have to leave, I apologise, so can I just ask about your exec summary, and I know you will go through the details, but what have your findings been able to reveal in terms of the success of mass media?

Prof. WAKEFIELD—I think there are certain circumstances under which mass media campaigns do best. They have to be comprehensive. You cannot expect them to do all the work on their own, so you need to complement them.

Mr SOUTHWICK—Yes.

Prof. WAKEFIELD—They need to be part of a public health system, not a one-off campaign. Campaigns only work for a short time. They only really work while they are on air and a short time afterwards. They are not a once-and-for-all fix-it strategy. It is really like operating an ambulance service. You have to keep resourcing it all the time. For behaviours like smoking and other behaviours that have drivers that drive people back to the behaviour, you have to be there with a message that pushes them and supports them to do the right thing.

It is an ongoing investment that requires repeated cycles of messaging. For things like tackling overweight and obesity, we are looking at that issue. We have a lot of drivers pushing people towards having an unhealthy diet and not having enough physical activity and we need a lot of messaging to support people to do the right thing, to even up that balance in the messaging environment.

I think there are times when mass messaging is not the right thing to do, and I think methamphetamine use is an example of that. The reason is because, on a population basis, methamphetamine use is relatively uncommon. I realise it is a higher frequency in some population subgroups and it has terrible consequences for some individuals, but on a mass population basis it is extremely low-prevalence behaviour.

The risk of running a mass reach media campaign is that you are informing people this stuff is out there, you are drawing attention to the issue, you are making it a discussion item, when in

fact it probably was not in many children's eyes before. You can have boomerang effects, which I think is risky. I think this is a behaviour for which you should narrowcast, not broadcast. You could have education approaches for high-risk groups. You certainly would have at least an adequate school based program, which might be more kind of resilience training for kids in general, which would deal with a number of different drugs.

Mr SOUTHWICK—Would you say the same of marijuana?

Prof. WAKEFIELD—Yes, I think so. It is a higher prevalence behaviour but it is sort of a sliding scale, I suppose, isn't it, that sort of prevalence of use? Alcohol use is so much more common and so much more needy of a mass media approach, and we do not invest in that very well. Yes, it is horses for courses, I think. That is my bottom line.

Mr SOUTHWICK—Okay. I have to go.

Prof. WAKEFIELD—Okay.

Mr SOUTHWICK—Thank you very much.

The CHAIR—It is an interesting commentary you have just made then, because the media, we have found, has been running a campaign in relation to the prevalence and use of ice and in concert with that even the Department of Justice has been running public forums where people have been attending in their hundreds. Whether it is thirst for knowledge or whether it is because of the media—

Prof. WAKEFIELD—It does stoke the embers, yes.

The CHAIR—What you are talking to us about is critical to how we respond to what we have been hearing, because part of the recommendations is dealing with early intervention. Do we recommend an education program in schools to make children at even primary school level aware of the dangers of drugs, or are we creating a problem that does not exist and/or at what point do we do early intervention to not do the very things that you are talking about?

Prof. WAKEFIELD—Yes.

The CHAIR—We have talked about the Grim Reaper programs and other sort of quite significant shock therapy, I guess, in advertising or in messaging that, from what we understand, has not worked as successfully as they would have hoped. Perhaps you could provide some guidance about how you see we should respond to what the media is writing in relation to this crystal meth—

Prof. WAKEFIELD—I think that clearly what you are all coming up against or experiencing are a lot of people who have been personally affected. Their families are affected. They are very close to the issue and it is very motiving for them. They want to see a solution. That does not happen with other issues generically like tobacco or skin cancer prevention. It does not generate that kind of angst so much.

Nonetheless, it is pretty hard to run an intervention at a population level and expect to see a decline in substance use when it is already, at a population level, very low. That is quite unlikely. You are unlikely to be able to demonstrate any benefit of a mass reach campaign. You have to balance up—which you are obviously aware of—painting an issue as a problem for young people who have probably never heard of it and would never take up use of the substance anyway—

The CHAIR—This is an interesting—

Prof. WAKEFIELD—It is a conundrum.

The CHAIR—kind of reversal, in a way, because we have a lot of media stories—and we have collected them. There is lots and lots of stuff out there.

Prof. WAKEFIELD—Yes.

The CHAIR—Let's just say for the purpose of the discussion that not all of that is really useful, because it is ramping up the kind of awareness that you are talking about. It kind of puts the policy people—the government—in a position of saying, 'We want to dampen that down,' but you do not want to dampen it down to limit what the press writes about, because that is an issue for the media. It is kind of like a reverse intervention, and you do not do that by providing them with necessarily more information about the drug and what to say, or maybe you do in a subversive way.

I know I am a bit at sixes and sevens. What would you do? Would you get a forum with some journalists and say, 'Is this the most constructive way to communicate this?' How do you handle a thing like that, or do you just stay away from it?

Prof. WAKEFIELD—I think it is just accepting the fact—and it is hard to do—that it does not matter what you do, you are always going to have distraught parents who would have wished something different for their children as they aged into adulthood.

The CHAIR—Sure.

Prof. WAKEFIELD—You are not ever going to get rid of that, whatever you do. You need to have a comprehensive approach. There is no quick-fix solution. There are supply side interventions that need to be pursued and there are obviously some, I would say, demand side interventions that need to be pursued, and they are basic education. I probably would not go much beyond doing a sort of more generic school based program which is just responsible. I would not necessarily do it in primary school.

My centre coordinates the Australian secondary schools' survey of alcohol and other drugs and we do it every three years. 20,000 to 25,000 secondary school students complete the survey. We report on tobacco, alcohol and normal illicit drugs. With 12- to 17-year-olds it is really hard to find kids who have recently used methamphetamine. Obviously, as they get older there are more of them, but it is likely to be a very high-risk, select subgroup of kids.

I am quite impressed by some of the school based programs that are much more about resilience training for kids, social skills training, not just programs to sort of 'Say no to drugs'. I think they are too shallow. More the core skills of being an adult—respecting yourself, knowing what your values are and those sorts of things. I think there are some of those programs out there that could be fairly generic but very useful for not just methamphetamine use but have other benefits as well. You could frame it from that point of view and introduce them as they come into secondary school. That is what I would probably advise.

Mr SCHEFFER—Not to put words in your mouth, I take it from what you are saying that in this particular issue relating to a drug like methamphetamine that has, as far as we can gather, such low usage rates even though it is creeping up here and there, it may be best not to say anything about it at all, even in a targeted way.

Prof. WAKEFIELD—Clearly in terms of treatment you would.

Mr SCHEFFER—Sure, okay.

Prof. WAKEFIELD—There might be some subpopulations where it is the most prevalent: prisoner populations, whatever they are. You might have more of a proactive approach there. I think trying to be so upstream that you are messaging to very many to catch those few that may take it up, you need to narrow down as to who those people are going to be, and be at the point they are at. I do not know enough about the problem to know where

that would be. I assume it is a party type thing.

Mr SCHEFFER—If I can just take what the chair was referring to earlier on with the HIV-AIDS Grim Reaper approach, one of the issues that has been brought to our attention is the Montana Meth campaign, which you would probably have seen.

Prof. WAKEFIELD—I have read a few papers.

Mr SCHEFFER—Could you give us your thoughts on whether you think that kind of approach is useful?

Prof. WAKEFIELD—Because it was mass reach I do not think it was useful. I also think that people already have certain views about that kind of drug use and they are almost seeing effects. It is hard to improve further beyond where people already are now. Because of all the news coverage they are all kind of, 'Oh, yes, that's bad. You know, you shouldn't do that.' You are never going to improve more on that. The emotion evoking kind of messaging that was a feature of that campaign, which has been used in tobacco control as well—the graphic imagery, the personal stories and things like that—is a very powerful and effective communication method in general for high-prevalence behaviours. Human behaviour is not just guided by rational choice. It is very subject to emotion and it is very situationally dependent.

At a point in time, if you can expose enough people to a message that kind of catches them in their gut so they do not just go, 'Oh yes, I know smoking is bad for me,' they feel the risk that they may be doing to themselves. That is a much more powerful driver of going ahead and doing something about that behaviour—an increasing urgency to do something about it. When you are in the grip of an addiction like smoking and it is an approach-avoidance type of thing, it gives much more punch to the avoidance type driver. For something like methamphetamine use, yes, people will be addicted to it and are obviously ravaged by it, but sometimes they are not going to be in a state of mind to even process that message.

Mr SCHEFFER—What the data is telling us is that it is around about two per cent in the population. The treatment centres are telling us there is an upward movement; we have heard in some areas alarming upward movement from a low base, but nonetheless I think everyone is saying there is a bit of a creep up. There is a kind of exponential sense in some quarters of the media that, 'If you don't watch it, it'll be an epidemic, so you better slow it down while it's just starting or we'll have all hell to pay.' Given that there is a fear of where we go next with it, people would not necessarily be responsive to what you were saying when you said, 'You couldn't do better than get it down to that level.' Sure, if you took cannabis, or indeed alcohol and tobacco, and said, 'Let's get it down to two per cent of the population,' people would think we were geniuses.

That is true but it is the trend that seems to be alarming people, and then the enormous power of the drug and the behaviour change during the time a person is subject to the influence of the substance. What would you say about the fear of the future?

Prof. WAKEFIELD—You could frame it as we are having a two-part approach. One part is we are focusing on young people who are extremely high risk as a pathway into this. It could be homeless, it could be whoever they are. I recommend you do that but you could also say we are having a more longer term sustainable approach to this as well and looking right back, as kids age into adolescence, and running a kind of resilience improvement program. There are lots of them around. They all have a lot of other benefits as well in terms of kids being a lot more resistant to lots of other undesirable influences too. You get a broader benefit. You would have to have a PR agency to know how to frame that properly. I am just a researcher but that is the kind of strategy I would use: one very high-risk approach and then one much more systemic approach that reaches all kids but treats it as 'This is another thing that you may come across' and puts it into perspective.

The CHAIR—Professor, we are nearly out of time. Do you want to make some closing remarks?

Prof. WAKEFIELD—I do not think so. I have been able to say what I felt that I should say.

Mr SCHEFFER—Through our brilliant questioning.

Prof. WAKEFIELD—Definitely!

The CHAIR—We have concentrated quite a lot on early intervention, particularly for the younger demographic, but the evidence suggests to us there is a whole range of demographics involved in the use of methamphetamines. Most of them do not come to the notice of the authorities—the housewife, the tradesman, the white collar worker, for a whole range of different reasons are using the drug, becoming addicted and seeking help through agencies or within the family support mechanisms. They are being dragged into a drug that they had not experienced before, particularly in regional areas and Indigenous populations. We are concerned for those communities. I know we have talked about a prevalence of two per cent but I think there are areas now where there has not been this quite significant prevalence that methamphetamine is now in regional areas, or areas that are traditionally marijuana, cocaine, perhaps not heroin.

I did not want you to leave thinking that maybe the picture has been overdramatised and overexaggerated by the media. It might well have been in part but the evidence does indicate that there has been an increase in areas that traditionally do not have significant drug problems. That is probably a fair summary. I guess we are really trying to understand how best to message that and reduce the incidence. Supply is all law enforcement stuff and we are dealing with that in another way. The education early intervention is an issue for us to try and work out how best to deal with it. Your contribution this afternoon, or your evidence, was very good. Thank you for that. It gave us a different perspective.

Prof. WAKEFIELD—Sometimes the best decision is not to do as much as you may do, but do something quite strategic. Then you have to sell it.

The CHAIR—Yes. Thank you very much.

Prof. WAKEFIELD—Thank you.

The CHAIR—I am closing this public hearing at 4.20 p.m.

Witness withdrew.

Committee adjourned.