The role of prevention and public health strategies in responding to ATS use

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Preventing/delaying uptake

- What do we do about the known predictors of hazardous use
  - Poor family functioning/disruption/ breakdown/connection and/or parental neglect
  - Childhood problems such as ADHD/CD
  - Mental health problems
  - Perceptions of drug use:
    - subjective and objective availability
  - Poor connectedness
  - Social disadvantage
  - Low social, cultural, psychological and economic capital

Reducing risk for those who use

- Low perception of risk or low influence of identified risk
  - Limited knowledge of risks
  - Self-serving optimism
  - Acceptable collateral damage in the pursuit of pleasure
- Perception of being distinct from other drug users
  - Implications for interventions?
- Broad range of using contexts, for example:
  - Long distance drivers
  - Shift workers/hospitality industry
  - Aboriginal and Torres Strait Islander communities
  - Late night revellers
  - Sex industry workers

Prevention

- Prevention consists of
  - …measures that prevent or delay the onset of drug use as well as measures that protect against risk and reduce harm associated with drug supply and use (Loxley et al 2004)
    - Delaying onset of use important because drug use and heavy drug use in the early years associated with a range of harms and higher risk of a range of problems later in life (such as continued drug use, criminal involvement, poor educational outcomes, mental health problems)

Prevention

- Commonly used structure has three levels:
  - primary prevention (e.g., preventing uptake);
  - secondary prevention (e.g., reducing uptake of **risky** ATS use, such as preventing the transition from oral to injecting use); and,
  - tertiary prevention (e.g., reducing behaviours or practices that lead to significant social and/or individual harms, such as reducing the risk of overdose).

Prevention

- Alternative structure offered by the US Institute of Medicine (1994). Three levels:
  - universal prevention (targeting whole populations);
  - selective prevention (targeting specific groups who have above average risk); and,
  - indicated prevention (targeting individuals with emerging problems).

Prevention

- Evident no single approach to prevention and need to consider diverse approaches and strategies targeting distinct issues, contexts, behaviours and/or populations.
  - Effective prevention in relation to ATS use is likely to include a range of strategies, from universal approaches that aim to prevent the uptake of ATS use, to more targeted programs aimed at those who are currently using.

Prevention

- Most universal drug prevention programs addressed more prevalent drugs (alcohol, tobacco and cannabis) rarely attending specifically to ATS use
  - S*ome* ATS specific interventions, usually delivered in recreational settings, mostly communicating information via the internet or in print materials, but there is no real evidence supporting their effectiveness (EMCDDA 2010).

Prevention

- Range of ATS harm reduction strategies such as provision of NSPs, chill-out rooms and pill-testing facilities -some evidence about the impact of such approaches.
  - overall lack of evidence results in neglect of prevention and public health activity. e.g. in recent WHO technical brief on principles of prevention and treatment of ATS, all nine principles addressed treatment, while none specicially highlighted prevention activity (WHO 2011).

Mass Media Campaigns

- Universal prevention strategies, usually designed to raise awareness, provide information and sometimes to provide a rationale for a policy position or support other strategies (e.g., a mass media campaign might be used to raise awareness of RBT).
  - aims are diverse, from:
    - attempts to ensure that the community is informed about particular interventions (e.g., RBT)
    - warnings about risks of drug use and/or.
    - advice about where to get help.

Mass Media Campaigns

- More likely to be effective when they:
  - are well resourced and enduring;
  - target clearly defined audience;
  - have basis in marketing strategies that effectively target, communicate with, and have relevance for and credibility with the desired audience;
  - provide a credible message to which the audience is frequently exposed; and,
  - where there is evidence of impact, it suggests that mass media campaigns might best be conceived as one component of a multifaceted approach.

Mass Media Campaigns

- Many illicit drug campaigns criticised because expensive/lack a strong evidence base - rarely adequately evaluated or appear to have little direct impact on drug use/related harm (e.g., EMCDDA 2010)
  - Are they generally ineffective or is the poor outcome because they do not adhere to quality practice?
  - Unintended consequences?
    - Messages that do not sit well with an individual's experience (e.g., implying that ecstasy use often leads to death may not be credible and undermine confidence in other messages or strategies).
    - Contribute to norms about use?
    - Contribute to stigma and marginalisation?

School based programs

- School programs are popular but most have little evidence - evidence strongest for those targetting higher prevalence legal drugs, such as alcohol and tobacco, rather than illegal drugs, including ATS
- Most programs not drug specific – that is, for example, they aim to prevent any illegal drug use, as opposed to, say, focusing on cannabis or amphetamine use alone
- Most have narrow focus, for example designed to prevent the uptake of drug use - very few programs address those who are exposed to risk from their own drug use or the drug use of others (e.g. peers or adults).

School based programs

- More effective programs do not rely on passive information exchange or a singular focus on skills related to preventing drug use (e.g., drug refusal skills), but are based on more elemental personal self-management and social skills, and ensuring school connectedness through social and academic competence (e.g.,Midford and Munro 2006).

School based programs

- Effective programs well-resourced and ongoing rather than short-term, and connected to other initiatives across the school and in the broader community, rather than delivered in isolation
  - if drug use influenced by availability, environmental and individual risk factors outside the influence of the education system, it is unlikely that a few hours of drug education will be sufficient antidote.
  - what about children who are disconnected from the school system (e.g., frequent truants; those who have been suspended or expelled)

School based programs

- Guyll et al (2011) assessed Iowa Strengthening Families Program (7 sessions involving an adolescents and parents, focusing on parenting skills, parent-child relationships and adolescent skills) and Life Skills Training Program (15-session school based intervention with adolescents only, focusing on attitudes, norms, information and drug resistance/refusal skills).
- Evidence of program costs, prevalence of methamphetamine use and potential costs of methamphetamine use to employers, they noted that the relatively low cost programs could yield a net, modest, benefit to the community and employers.

Peer Based Interventions

- Evidence that perceptions about the prevalence and nature of drug use amongst peers is associated with personal drug use.
  - those who perceive that the majority of their peers are drug users, or heavy users, are more likely to use themselves. Many young people overestimate whether or not and how much their peers use
  - challenge norms about peer drug use might be an appropriate target of interventions but little research.

Peer Based Interventions

- Information about drug use comes from many sources, including peers
    - most knowledge about using drugs is almost exclusively derived from other drug users. (Moore 1992)
- Suggests that prevention should incorporate peer education approaches.
- Who are the peers?
    - In preventing use might be non drug using peers, whilst those who have experience of use for those who are currently using

Workplace Interventions

- Increasing evidence about ATS use association with work, including risks of working under the influence of drugs, and drug ‘hangover’ effects (such as fatigue) and impact on absenteeism (e.g. NCETA 2006; Pidd et al. 2011). Concerns include:
    - tiredness at the onset of the working week;
    - irritability, agitation or mood swings;
    - difficulty concentrating and reduced performance;
    - mental health and physical health problems.

Workplace interventions

- Some organisations/occupations have higher prevalence ATS use – long distance drivers
- Evidence of tolerance of use and low discouragement of use within some transport companies – detection of ATS in 23% of truck drivers compared to 4.1% of all drivers involved in road traffic crashes (Drummond et al)
- Unfortunately, little evidence about effective ATS interventions in the workplace

Preventing and reducing problems for current users

- Again – no single domain – using WHO catergories could target
  - mode of administration (e.g., swallowing, inhaling, smoking, injecting);
  - harms to others; and,
  - the effects of, and harms arising from intoxication, regular use and dependence.

Preventing and reducing problems for current users

- Developmental effects (e.g., use during pregnancy);
- Personal safety (e.g., injury to self and/or others);
- Social wellbeing (e.g., impact on relationships; financial issues);
- Physical health effects (e.g., cardio-vascular risk; sleep disorders; nutritional deficiencies; blood borne virus transmission); and,
- Mental health (e.g., anxiety; depression; psychosis).

Preventing and reducing problems for current users

- Responses in these domains have included
  - reducing risks of drug adulterants;
  - raising awareness of the harms and negative consequences of use in particular contexts (e.g. impaired driving or work performance);
  - managing sleep and nutritional disorders;
  - avoiding, managing and reducing adverse mental health outcomes;
  - reducing sexual risk taking;
  - preventing harm to other people (e.g. friends, family; children).

Preventing and reducing problems for current users

- Be aware of the subjective interpretation of harm and costs – what is of concern to one consumer is acceptable collateral damage in the pursuit of pleasure for another (Peters et al 2008)
- Peters et al - lifestyle change had more impact on use than concern about adverse outcomes

Preventing and reducing impact on others

- Manufacture, distribution and consumption can affect people other than those directly involved
  - BBV
    - interventions should not just target consumers but also family and other significant people such as offspring, (Colfax et al 2010; McGlade and colleagues 2009)
  - First responders, family members and the broad community can be exposed to risks associated with the manufacture of ATS

Sexual risk taking and injecting

- Connection between ATS use, sexual experience and risk taking
  - … for some young people drug use is an integral part of their ‘strategic approach to sex’. … to enhance and prolong sexual pleasure, reduce inhibitions and contribute to increased risk taking, including unprotected sex, having more sexual partners and engaging in longer sexual episodes (Colfax et al. 2010).

Sexual risk taking and injecting drug use

The separate and combined issues of sexual risk taking and injecting behaviour suggest that these should be specific targets of interventions among ATS users.

Sexual risk taking and injecting drug use

- Not everyone will want to forgo the perceived pleasures - to illustrate
  - Morgenstern et al (2009) reported on a RCT to reduce ‘club drug use’ (including methamphetamine and cocaine use) and to reduce HIV risk-taking among men who have sex with men.
  - The intervention was effective at reducing drug use only among those who were at-risk to mildly dependent users – not dependent users. Less clear-cut impact on sexual risk taking

The need for multifaceted responses

- Degenhardt et al. 2010 concluded no single strategy could possibly address all the potential issues of concern (e.g. mental health and physical health; risk taking behaviour; etc.).
- Diverse contexts and diverse range of consumers means need multifaceted approaches.

The need for multifaceted responses

- Victorian Inquiry (Drugs and Crime Prevention Committee (2004) recommended responses such as:
  - peer-based strategies to prevent uptake of use and provide harm reduction information and assistance at events;
  - youth media to communicate information and advice to young people;
  - communicating information and advice to young people, parents, club owners, licensees, people working in the entertainment industry, and school staff;
  - information specifically targeting the needs of parents/carers/families;
  - information specifically targeting professionals who respond to ATS; and
  - developing interventions tailored to meet the needs of specific populations such as Aboriginal and Torres Strait Islander people, or high-risk groups such as people in the gay community.

Interventions tailored to different contexts and settings of use

- Duff et al (2007) recommended prevention effort should:
  - Be sensitive to relevant cultural and contextual differences;
  - Involve more extensive and meaningful peer-to-peer components;
  - Emphasise the more ‘ordinary’ risks, such as social embarrassment, harm to relationships, comedown;
  - Retain an abstinence focus for school-aged prevention strategies;
  - Strategies to strengthen and improve communication between young people and their parents;
  - Make use of information networks of most relevance to young people;
  - Develop context-specific ecstasy-related drugs (ERD) prevention materials (e.g., in bars and clubs, rural settings etc) tailored to particular sexual and cultural communities; and,
  - Tailor specific materials for young and novice members of clubbing and rave communities.

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- Despite some significant improvements
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- Despite some significant improvements
  - Still limited systems of response to “managing intoxication and madness at midnight”
    - Most people in need end up in lock ups or ED
    - Need safe environments for those intoxicated by or withdrawing from ATS (e.g. those who are agitated but not psychotic who nevertheless need care – currently many such individuals are managed by police and/or emergency departments)
    - Need to continue to enhance clear pathways of care, develop and/or disseminate assessment, referral and treatment protocols
  - Enhance treatment engagement and retention – Many do not enter and/or remain in treatment

Treatment: where might we do better?

- More assertive outreach and target interventions at issue, in time and place of relevance to client
- Role of peers used more effectively
- Communication strategies hampered by limited focus on some risks, overstate other risks
- Provide more focus on role of families
- Recognise where we have had success

Conclusion

- Limited **specific** evidence that can guide effective prevention and public health responses to ATS related problems but …
- Need to be guided by what we know about what contributes to preventing/delaying onset of use and factors that reduce problems for existing consumers – including “what matters to/concerns consumers”
- Recognise, for some, the strong link to sexual risk taking
- Invest in broad based prevention strategies to enhance connectedness, respond to needs of vulnerable families and communities and, in times of limited budgets, invest in evidence based approaches
- Develop multifaceted responses in broad range of contexts

Shameless self promotion