LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Traralgon — 28 January 2014

Members

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Witnesses

Mr Peter Wearne, Director of Services, Youth Support + Advocacy Service (YSAS).

Ms Christine May, Manager Latrobe Valley, Youth Support + Advocacy Service (YSAS).

The CHAIR—We recommence the public hearing and welcome Peter Wearne, director of services for Youth Support and Advocacy Service, known as YSAS, and Christine May. You are part of YSAS as well?

Ms MAY—I am the manager of the Latrobe Valley site.

The CHAIR—Welcome.

Ms MAY—Thank you.

The CHAIR—My name is Simon Ramsay. I am the member for Western Victoria and the chair of this committee. I know you know what the inquiry is about, so I will not go through the detail of the inquiry, but I do need to read you the conditions under which you are presenting here. Then you are most welcome to make a contribution to this hearing.

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 at parliamentary committees?

Mr WEARNE—Yes, we have.

The CHAIR—You have? 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 will provide a proof version of the *Hansard* transcript at the earliest opportunity so you can correct it as appropriate. Thank you. We look forwarding to hearing from you.

Mr WEARNE—Thank you for the opportunity to present. When Sandy rang last week and said there was an opening, that was fantastic. I am here today with Christine. Christine has been our manager in the Latrobe Valley for, what, nearly nine years now?

Ms MAY—Nine years, yes.

Mr WEARNE—Prior to that she worked as an outreach AOD worker for us. Christine is also a long-term resident in this region and has a wealth of experience in social welfare and human service delivery in this area.

YSAS has had a team operating in the Latrobe Valley for 15 years. We were established when YSAS was established to deliver youth AOD services to vulnerable young people within this community. It is important to say that, although the drug patterns have changed, young people in terms of their main characteristics and backgrounds really have not. So we see the same types of young people coming through our service all the time. It is just that their drug usage has changed and varied.

For instance, 15 years ago the drug we were talking about was heroin, even in the Latrobe Valley, and we have had periods where inhalant use has been really out of control in terms of young people's presentations and behaviours, and more recently methamphetamine is a drug that young people in our cohort that we provide a service to have started presenting with. What I might do is get Christine to explain who our cohort is and what we are seeing from a local perspective.

Ms MAY—Historically and currently we see young people who are below social par. They have left school at a very early age, so they have no education. They come from

dysfunctional families who also present as substance users, so it's cross-generational. So the young person is brought up in that family and therefore it is normal behaviour.

We work in the Latrobe Valley. In the Latrobe Valley we have twice the state average of family violence. Thirty years ago I was working in a women's refuge. We had twice the state average then and we still do now. So the young people that we are seeing are victims of family violence. Their substance use starts at a very early age, via mum or dad, who either give them alcohol or cannabis or give them a fit and assist them in injecting. Because they are doing it in a family atmosphere, it is seen as being correct and appropriate.

So we are working with those young people who, by the time we see them, are drowning in apathy. They have no self-esteem. They basically think they are nothing in the world and, because they have been told they are nothing in the word, they suffer an enormous amount of violence and also abuse. They are sexually abused and are just basically dragged up. They are the young people that we work with every day.

Mr WEARNE—When we look at our data, we see that over 90 per cent of the young people that are referred to us or that we find through the court system have no employment; are not attending education, training or any sort of formalised activity in their life; over 60 per cent have engagement with the youth justice and criminal justice systems; they have tenuous housing; they have tenuous prospects for their future. The greatest concern that we see is that drugs and drug usage becomes, as Chris said, a normative part of their everyday life and a normative part of the way that they process the world.

Typically in our service the two drugs that are constantly appearing as regular and daily use are alcohol and cannabis, so our population of young people tend to not limit themselves to one type of drug. That, I would say, is fairly typical of adolescents and young people generally. So high rates of alcohol and cannabis use, but in terms of methamphetamine presentation, over the last three years we have seen a tripling of the numbers of young people in the Latrobe Valley that are now nominating methamphetamine as either their primary drug of concern or their secondary or tertiary drug of concern. So the typical pattern of use that we see is that young people might not use methamphetamine every day but they are certainly using it on a weekly basis.

Ms MAY—Yes, and they are bingeing.

Mr WEARNE—Yes, and that is really important to note. So they will use the drug and they will use it determinedly and persistently over a short period of time. One of the things that Chris and I were talking about not long ago was that one of the attractions of the drug for this cohort is that it provides the illusion of optimism and hope. It makes you temporarily feel better.

Because the drug works on neurotransmitters dopamine and serotonin, which are the pleasure and wellbeing neurotransmitters that give you that sense of feeling good and good about yourself—because the drug works on those systems—when young people take the drug they instantly feel—and I say 'feel'—better. The long-term use of the drug actually has the opposite effect. You do not feel any better. In fact, you feel considerably worse, because it is a depleting drug. It is a drug that drains away your serotonin and dopamine to a point where you have chronic depression and where the ability to process normal environmental stimulation becomes quite distorted, so we see paranoia, we see anger, we see disengagement.

So actually the drug in the medium to long term works against the original reason why the young people take the drug. Of course explaining this to young people—'If you go down the path of using this drug you're actually going to feel worse, you're not going to feel better'—has to be contextualised within their life of what they perceive as being really a hopeless situation for themselves.

Within that context, methamphetamine has thrived. We can say that the supply of methamphetamine, especially in regional Victoria—the Latrobe Valley in particular—has obviously grown in the last two to three years. There is obviously more of the drug available. The police probably would have spoken to you about the ability to manufacture the drug. It is not

rocket science to make the drug. It is a relatively easy drug to manufacture and, therefore, source and the price of the drug across the whole of Victoria, including regional Victoria, has come down more and more. So we are seeing a dropping of the price of the drug rather than an increase in the price of the drug, again making it more accessible and more attractive to people on limited incomes or limited resources.

Ms MAY—We are also seeing a different cohort, because we are seeing young tradesmen that are affected by it. Really young tradesmen used to either, firstly, go to the pub or, secondly, use ecstasy, but now they are using methamphetamine and they are losing everything. The families that we are coming in contact with now are what we might call middle-class families who do not have the faintest idea what to do with their young people and basically are saying to us, 'Look, just put him into detox or put him into rehab and make him get better.' So we have a lot of education with those parents to assist them to understand that we do not have the wand that makes them feel better.

Mr SCHEFFER—What is the back story behind those kids then? You sketched out the back story of the other kids. What is the back story there?

Mr WEARNE—I think the back story is that the drug is so prevalent in social circumstances. We were at a public forum that was held in Warragul, and there were people there from sporting associations and sporting clubs talking about how methamphetamine—and I have had this experience in Melbourne too—has been introduced into what we call normal party or normal social circumstances and people have started using the drug there. They have also started using the drug in terms of their vocation, because the drug has a stimulation effect. It allows you to overcome tiredness and maybe work a bit harder, feel a bit better about going to work. You do not get the hangover in the morning that you do from alcohol, which I think I can remember is quite detrimental to your desire to get up and do a full day's work.

In some ways it has sort of been a subtle spread of the drug, and we see this across our services through Victoria, where the net is wide, but we also have seen where some young people seem to be able to have the recovery capital to say, 'Look, I'm just going to walk away from that drug use,' because it is not a drug like alcohol or heroin that you neuroadapt to and you get a physical dependence on. You certainly get a psychological and behavioural dependence on the drug and you do chase that feeling of invincibility and feeling good and great about the world and high energy levels, but in terms of a small part of that new cohort, they get into trouble very quickly. They often lose their employment, they lose accommodation and they lose connection with family.

Ms MAY—And mum and dad have bought them a car because they are doing very well with their job, and their cars have gone on deals because they had to pay their dealer. We had that recently with a young person from Warragul, who was in so much debt that—his parents had bought him a $35,000 car and he gave it to his dealer because his debt had run up. We have also had situations where young people have been playing football and their coach has given them a point for a really good game, so it is really outside our usual cohort.

Mr SOUTHWICK—Sorry, can you repeat that.

Mr WEARNE—They have been rewarded with drugs for playing well.

Mr SOUTHWICK—By a coach?

Mr WEARNE—By a coach, yes.

Ms MAY—Yes, by a coach of a football club, just in the outer regions here. It is also now cross-generational. It is seen in the industries around the area and the adult sporting clubs, so it is really becoming a communal drug.

Mr WEARNE—I think there is a lot of evidence—and I am sure others would have presented today, whether they be police or other services—where at one level you see a great increase in the presentation of the drug used socially. The fallout from that is that there will be people who start using that drug socially where that drug use will get out of control for them, they

will not be able to control that use, for all sorts of pre-existing reasons and features within their own lives. Where one person can walk away from a drug, some other people find it very hard to walk away from that drug.

There are some people we know that just cannot drink—one drink is way too many; they cannot even have one drink—whereas we know other people that have one glass of beer or wine a night and are perfectly able to control that use. We see the same type of pattern with methamphetamine. The concept that this is an instantly addictive drug is a misnomer. I think it clouds the issue, where there is a significant group of people within our community that are using this drug on a regular basis, it is really destroying a great part of their life in terms of breaking down family relationships, ending employment, seeing them get into all sorts of debt, but more importantly they are now liaising with criminal elements within the community. Drug dealers are not people who you really want to start building strong personal relationships with in your life.

Mr SOUTHWICK—Just so I am clear on this, the actual use amongst the youth is more in a social setting like, say, marijuana tended to be, where people would get together in a group.

Mr WEARNE—That is right.

Ms MAY—They do.

Mr SOUTHWICK—And share together.

Mr WEARNE—Yes.

Ms MAY—They do, yes.

Mr SOUTHWICK—And it is very much a social thing to do.

Ms MAY—Yes.

Mr WEARNE—Absolutely.

Mr SOUTHWICK—So it is not 'I get my point and go off in a corner.'

Mr WEARNE—No.

Ms MAY—No.

Mr SOUTHWICK—They all sit around and smoke or do whatever they do.

Ms MAY—Yes. A young woman spoke to me the other day about her recent use and it was that they had purchased five points between 10 of them and it lasted four days.

Mr WEARNE—A point is a 10th of a gram. The drug is normally sold as what they call a rock, which is a gram, and then it is divided up into points. There are 10 points to a rock and the points can vary in price from $50 to $100, depending on where you live and who you know and what you buy, and the quality can vary too in terms of the manufacturing process, because these drugs are not made under pharmaceutically clinical conditions, let's say. They are made in caravans—police would have told you about that—in incredibly unhygienic and dangerous situations, but there is a lot of money to be made.

The component chemicals of the drug are not that expensive and not that hard to source. Anyone can go to the internet and find out how to manufacture methamphetamine. It is all over the place on the internet, so how to do this is not a secret, and that is why you see a prevalence of small, what are euphemistically called laboratories springing up across regional and metropolitan Melbourne. If you have got enough people with a bit of biology and chemistry in their background, they can manufacture the drug in not too difficult a fashion.

Ms MAY—We had another instance where a young woman was referred to us. Her father had created a lab in their home, and he had actually died. It had blown up and he blew his face off.

The young woman was referred to us a few months later and I asked her the question, 'How can we assist you?' and she said, 'You can't assist me.' She said, 'It's all right now. I've figured out what he did wrong and I won't make that same mistake.' She was 17.

Mr WEARNE—The other side of it for some young people is the attraction of being able to be involved, when you are coming from an economically, socially and emotionally compromised background. The ability to sell drugs is a fast way, it would seem, of guaranteeing some sort of financial gain and so selling drugs becomes an economy of its own.

The CHAIR—To feed the habit, though, or to—

Mr WEARNE—A bit of both. You get your drugs cheap and you can also make money on the side. If you have got no income or you have got very little income and no prospect of work, it also has the false allure of cheap and easy money. With our main cohort of young people, we looked at our figures this afternoon to make sure they were current. From the point last year to the point this year, we have seen a 50 per cent increase in the number of young people coming through our service who are claiming methamphetamine as part of their drug-using profile. That is only in 12 months. In some cases we are seeing methamphetamine challenging alcohol or cannabis as being the more dominant of the drug presentations, so there is no doubt that this has been on the increase and there is no doubt that for some reason—because of its availability, I would say; ease of manufacturing—it is actually very available like other drugs have not been.

The CHAIR—And attractive.

Mr WEARNE—Yes, and attractive, because of again, I think, the point that you made before: drugs in a social setting, where some people seem to be able to take them or leave them, use them for a night and then not use them again for three or four weeks. That has in itself issues, but the people who find that they cannot do without the drug and are constantly chasing that feeling are the people that really get into trouble with the drug, because they cannot revisit it.

Mr SCHEFFER—Can we just come back to that point about addiction that you mentioned before.

Mr WEARNE—Yes.

Mr SCHEFFER—You talked about an addition for alcohol, which is physiological. Do you remember saying that?

Mr WEARNE—Yes.

Mr SCHEFFER—And an addiction for ice or methamphetamines which is, could I say, attitudinal? I am just trying to separate that out.

Mr WEARNE—Technically we talk about neuroadaptation. There is no neuroadaptation for methamphetamine in the human body like there is for heroin or alcohol, where there is an actual physical withdrawal because of the nature of the drugs. For instance, when you take heroin your body stops producing endorphins, so when you stop taking heroin you have a physical response because your body has to start that mechanism up to produce those endorphins. Alcohol is a little bit more complicated and would take too long to explain, but there is real danger in withdrawal from alcohol, and there is a lot of pain and suffering in withdrawal from an opiate.

You do not get that with methamphetamine. What you get is a lot of anxiety, you get disrupted sleep patterns, you get all those sorts of things, but that is because the neurotransmitter balance of dopamine, norepinephrine and serotonin are starting to level themselves out again, and we think the recovery in terms of getting your body back to the normal levels of those neurotransmitters takes between a month and two months, depending on the person, over sustained use. Therefore, as a drug, the greatest risk of harm is if you have a pre-existing heart condition, a pre-existing propensity towards stroke or heart failure, or if you have an underlying mental health condition that has not been diagnosed.

This drug is extremely dangerous for you, and I repeat, there have been incidents in regional Victoria where people have died of a heart attack. I can think of one young man up Shepparton way that died of a heart attack and they found out he had meth in his system. He had a pre-existing heart condition. He was using methamphetamine as a performance enhancer while playing football, which it is; it is a performance-enhancing drug. It is banned in the Olympics. You cannot use any form of amphetamine in the Olympics or the AFL or cricket or anything like that. He did not know about his undiagnosed heart condition and that placed him at great risk.

In the sense of the profile of the drug use and the recovery time, it is a depleting drug. It really depletes you physically and emotionally. It depletes you emotionally because it depletes all the neurotransmitters that provide you with emotional and psychological homeostasis and balance.

Mr CARROLL—On that point, I do not think that message is out there that it is a depleting drug that actually does the reverse long term: depletes the serotonin and dopamine levels.

Mr WEARNE—No. That is right.

Mr CARROLL—People take it because it actually increases them and they feel fantastic.

Mr WEARNE—Yes.

Mr CARROLL—So when you say this is a depleting drug, I do not think we have had much evidence on that to the committee. Is this just common knowledge?

Mr WEARNE—Common knowledge. If you were to google 'neuroscience' and 'methamphetamine', all this information would be there. It is well researched. This is where the 'addiction' label becomes really problematic. There is no doubt that people habitually using this drug become attracted to its effects. They chase the effect. They will never get the effects by sustained use, but what they will get is unwanted psychological and physical distress. That is the truth. What you see with long-term use is, 'I find it hard,' 'I get paranoid,' 'I get deluded,' 'I can't process good information.' In some cases people even experience, hear and see things that don't exist, because their whole ability to perceive reality has been compromised by the use of the drug.

There are very few overdose deaths of the drug in terms of taking too much heroin and your central nervous system just stops functioning, you stop breathing and you die. It is not a drug like that, but there are dangers around pre-existing conditions—around pre-existing psychological and physical conditions—that can exacerbate those conditions and cause harm and death with those conditions. So it is a complicated drug. Unfortunately, when people are using it seemingly unproblematically these issues might not arise, but they will arise for some people.

Mr SCHEFFER—Spell out the trajectory of that 'seemingly unproblematically'. That has a time limit on it?

Mr WEARNE—No. I can refer to the most famous methamphetamine user in Australia, Ben Cousins. Ben Cousins took methamphetamine regularly. He played in a premiership team taking methamphetamine regularly. He never took it on match day. He took it recreationally and socially. While he had a training regime and a testing regime that meant that he had to be very cautious about the drug use, he was never detected and it seemed to have no effect on him. But once he stopped playing football, you see the pictures of him, seemingly deranged—or off season, getting out of that car along the highway and running through a swamp to get away from the police at a drug testing and alcohol breathalysing station. The stories are legend about what Ben was like in the nightclub scene anecdotally.

What you see there is a trajectory, 'While it's under control I'll use the drug and I seem to have all these other things that help me control it,' but the moment those things fell away that afforded some protection and he started using the drug habitually, then you saw the Ben Cousins that we were used to seeing the police arrest and chase down. So that would be the good contrast.

The day that Ben Cousins got up and had the premiership cup with Chris Judd, no-one could have picked that he was a methamphetamine user, but I will bet London to a brick that he had been

regularly using that drug all that season. In fact, he admitted that, but he was careful about when he used. He avoided testing, because it only stays in the system for a certain period of time. He never used it on match day, so when he was match day tested, what, 17 or 18 times, no trace was found. So it metabolised out of his system. He was not under the influence when he played, blah blah blah.

So you see the sort of profile. So when people use the drug in a controlled way—this is an illicit drug that is manufactured by criminal organisations. You can buy pure methamphetamine under different market names—it is prescribed for certain conditions by drug manufacturing companies—but that is not the methamphetamine we are talking about here. This is not made under clinically supervised or laboratory stringent circumstances.

The CHAIR—In that sporting sense, I understand steroids are used for muscle building and physical capacity. Methamphetamine is really just pure mental—

Mr WEARNE—No, it has a physical side to it, where it releases norepinephrine. Norepinephrine is your fight or flight neurotransmitter.

The CHAIR—But it does not enhance the physical—

Mr WEARNE—For that period of time that the drug is effective in your system—if you were to take methamphetamine at half time in a grand final, you would experience a sudden burst of energy at some stage in the last half of the game of football that would be sustained for up to an hour, an hour and a half.

The CHAIR—But is that mental energy rather than physical—

Mr WEARNE—No, that is physiological, because norepinephrine helps with stimulating muscle activity and stimulating your ability to physically exert yourself, which is why vocationally the drug is sometimes used in work settings, so building sites where there is heavy labour being done. Do you see what I am saying? That is why it is banned as a drug. If it only had a psychological effect, it would not be banned in the Olympics or banned in professional sport. It is a performance enhancing drug at a physiological level, because it releases copious amounts of these neurotransmitters into your system. That is why young people when they take it can dance a lot. It enhances their sexual performance. When you think about young people and what is attractive to them and what turns them on, this drug—it is very much like cocaine. It almost works identically to the way cocaine works on the body.

Mr SOUTHWICK—How do you fight it?

Mr WEARNE—How do you fight it?

Mr SOUTHWICK—You have given us every reason for a young person—

Mr WEARNE—I think it goes back to what was said by Ben. I think there are a lot of misnomers about the drug and I think one of the dangers of the drug is that, when people walk around and say, 'You have it once and you're instantly addicted,' is not helpful, because the first person that has the drug and is not instantly addicted knows that is a lie. So do not exaggerate the harm. There are harms enough in this drug without exaggerating them.

The first thing is, tell the truth about the drug. I think we need a comprehensive education program within the school system that talks about the effects of drugs, the long-term harms, the immediate harms, the dangers, without exaggeration. I think you have to really work in the law enforcement area on supply. It is a very easy drug to manufacture. It is a very corrupting drug. There is a lot of money being made out of methamphetamine, which means a lot of cash is available. That is always a problem with drugs—no different to heroin, no different to any other illicit drug. It comes with a whole lot of money attached to it that can do all sorts of corrupting things within the community, and you would be as aware of that as I am.

I think the truth; work on supply reduction; have really good processes of making sure that, where groups are known or suspected of manufacturing the drug, there is a really clear response to that. I think the next thing is for the populations that we see—we call these kids at YSAS the kids that really believe they have no hope. We need to do something about meaningful activity and good education programs, not just around drug use. I mean about vocational education. Latrobe Valley for years has had poor employment opportunities for young people, and the further down the socio-economic order you are the harder it is to get work. We need to do something about that.

One of the responses that Chris has been talking about for years in the Valley, which we hope to enact in the next 18 months, is a community garden project that will lead to a social enterprise, which will see herbs and all sorts of things grown that can be sold into the local community to actually give young people somewhere they can come; work with people together; have meaningful activity.

Ms MAY—The reality of that is that the kids do not fit into mainstream education. They have not been there since they were eight or 10, so they are never going to be educated enough. They can be linked into training through Centrelink, but that training does not afford them a job. It just keeps them off the books for a little while. If we had a social enterprise like a community garden, then we would be teaching them the infrastructure of life without them being in the classroom. So everything that they need to succeed—the adding, the subtracting, social interaction—is all there. That is what we are hoping for for these young people, because if we do not, then there is no answer.

Mr WEARNE—So really we are looking at building up social, economic and personal recovery capital in these young people; things that they can look forward to, things that they can be connected to, things that they can find meaning in.

The biggest challenge is going to be the pervasiveness of illicit drugs across the whole of society. When you hear of a coach rewarding a player with a point of methamphetamine for a good game, you realise how far back we might be starting in some areas.

Mr McCURDY—But didn't they do that with alcohol years ago?

Mr WEARNE—Absolutely.

Ms MAY—Yes, they did.

Mr McCURDY—People would be looking at that and saying, 'We do it now, but years ago it would have been unacceptable too.'

Mr WEARNE—That is a fantastic point. Alcohol was legal years ago, though. We are talking about now the normalisation of an illicit substance. So I think that is another bridge. That is a different level it has gone to. One of the great ignorances I see in the community is how people talk about illicit drugs like it is always a very small group of people that are involved in the use and, 'You can always tell a drug user because they wear a certain type of clothing and they have certain tattoos and they come from a certain part of town or a certain part of the community.'

The truth of it is that illicit drug use for a couple of generations now socially is normalised. I could tell you stories of my own children going to nightclubs and telling me what they have seen, and they are all now in their late 20s and early 30s. This is not hidden in regional Victoria. This is in people's faces. I really think the police have a hard time in actually doing something about this normalisation, because it is beyond a legal response. It requires a really honest discussion. I would like to see another Pennington inquiry into drug use in Victoria. Obviously it will not be David, but it is now, what, nearly 20 years since the last Pennington report. I think it is about time we had another inquiry into drug use across the Victorian community. It brought in the best evidence and the best understanding of what works in terms of combating this, not just from Australia but from around the world. Give people a chance.

Give people a chance to really think about what this might look like if it were different, because at the moment we are not winning the hearts and minds of people around this issue. I think people

would be amazed to see how prevalent illicit drug use is. I have to say the characteristics of methamphetamine are like those they found with cocaine in America. This is our cocaine. We do not have a lot of cocaine in Australia. Only the very rich can use cocaine in Australia. Methamphetamine is our cocaine in the sense that its physiology and its impact on your feeling and wellbeing is so powerful for some folk. It is very hard to tell people not to do it. We have had some people who are very close in professional sports say that methamphetamine is often seen as a viable alternative because of the lack of weight gain or fitness compromise that it affords people while allowing them to get intoxicated. Alcohol is not a great drug for an athlete to take if they are worried about weight and fitness. With methamphetamine you put on no weight and you do not lose fitness by taking it but, as we said before, habitually taken it is not a good thing.

Ms MAY—When young people first come to our service and identify that their ice use may be a little bit out of control, and then we ask them what they do not like about the substance, they say, 'Nothing.' They cannot identify one thing they do not like about it.

Mr McCURDY—In their early stages of use?

Mr WEARNE—Yes, that is right. It is often the consequence of use over time. The other thing that you see is that once a person goes down the path—and this does not happen to every methamphetamine user, but people whose mental health is compromised by the drug, and that is a significant part of the cohort—they become unable to make really good decisions about their drug use because they are compromised with their mental health.

Mr McCURDY—So we need a multipronged attack. For example, threatening drug testing in the local football league is only going to drive the problem further underground because they will get like Ben Cousins and work out when they can take it and when they can get away with it.

Mr WEARNE—Yes.

Mr McCURDY—So that is not going to solve the problem.

Mr WEARNE—If we did not catch Ben Cousins with ASADA, and everybody turning up at all times of day or night to have a wee in a cup, good luck with—I do not want to name any football clubs but somewhere a long way away from here. How are you going to manage that? I think I presented to your committee on day one and I have been called now by half a dozen sporting clubs to come in and talk to their players about drug use, particularly methamphetamine, because they have become aware that it is so accepted within the social groups and social hierarchies of the clubs. There was a gentleman from the Drug Squad and we presented a forum and training on methamphetamine. I think he was their meth lab occ health and safety accreditor. He had to go in and say that it was okay to go in and dismantle the—and he was saying he was a regional person, grew up in regional Victoria. He was saying, anecdotally, that methamphetamine is present and growing, socially and within sporting clubs. That was over a year ago.

The CHAIR—Do you have any views, Peter, about the association between alcohol and sport, particularly in advertising?

Mr WEARNE—I am a libertarian so I tend to think intervene only when absolutely necessary. I think we send really mixed messages to young people about intoxication. I really do. I spoke at a forum once after watching an Allan Border Medal night where they had 20 minutes of stories of how many cans Boonie drank on the plane between London and Tullamarine, and the record that he broke, and it was glorified. That is a really odd message. Kids get confused about what we are really saying about drugs, what we are really saying about alcohol. With so many of the people in the media and in so many public events, it is a cultural lubricant.

When Australia plays cricket, VB is the main, dominant badge on the chest of the players. You think, 'Are they playing for VB or are they playing for Australia?' In truth they are playing for both, aren't they? Because it is the sponsorship dollars that drive. I am not naive enough to think you can end that. We have done with tobacco; I think tobacco was easier. It is much harder with alcohol

and it is going to be much harder to send a message about responsible drinking when there is so much evidence that irresponsible drinking is lionised.

Mr McCURDY—Isn't that because there is no safe level of smoking?

Mr WEARNE—That is right.

Mr McCURDY—Whereas there is a safe level of alcohol.

Mr WEARNE—That is exactly right.

Mr McCURDY—It is when you step over that line.

Mr WEARNE—Yes, and that is the dilemma.

Mr McCURDY—That is what I was saying earlier today about is there a safe level of ice? No, because it just turns from one to the other to the other.

Mr WEARNE—Is there greater risk with use? Yes, there is. So if someone came to me and they said, 'I'm using methamphetamine every week,' and they did not want to give it up, I would say, 'Let's try only using it every fortnight. Let's start reducing the time between your use so your body and your mind have time to recover.' When you go through and explain to that person—and I have done this with young people myself; even in my dotage I have done this—56-year-old man talking to teenagers about drug use. There is a joke. I have explained to them how they feel and because I know the neuroscience and know the physiological impact of the drug, I know as much about how they are feeling when they take it as they know about how they feel when they take it, and I have never touched it. But I know what is going on for them and I know how attractive that can be.

I think there are messages there about reducing risk. There is no safe level for any drug use really. All drugs have their risks and we have seen that with alcohol in a different way to methamphetamine. One of the things we need to talk about is responsibility, giving people the ability to take more control and make better decisions about their lives. It gets back to better social, economic and cultural circumstances for kids.

Mr CARROLL—We are talking about the drug ice now, but what is the next drug?

Ms MAY—That is right.

Mr WEARNE—Fifteen years ago we were talking about heroin, then talking about ecstasy. We have been talking about this—

Ms MAY—We had it.

Mr WEARNE—You are working your way through all the sinful parts of human society that you could imagine. I do not know what is next but I will tell you what, there are chemists now, as we speak, thinking about designing a better drug because there is so much money to be made. That is the biggest problem. When you can make such ridiculous amounts of money for something that is so cheap to make, you are going to be in trouble. There is always money to be made. Like they say, in life you follow the money. If you follow the money, that will lead to the cause of the problem.

The CHAIR—I think about that every time I have a can of Coke.

Mr WEARNE—That is right.

The CHAIR—Pay $4.30 for 60 cents worth. Anyway, Peter, I think we are running out of time.

Mr WEARNE—That is okay.

Mr CARROLL—Do you have an opinion on a substitute, like a pharmacological—

Mr WEARNE—There is no pharmacotherapy relief for methamphetamine.

Mr CARROLL—But what if one was developed?

Mr WEARNE—I will say, from a neuroscience point of view, I do not know how you can do it because of the nature of the way the drug interacts with your system. The two pharmacotherapies we know about are methadone and other opioid replacements. They work because they actually have the same drug effect, in moderation, compared to the drug they are using. The big attraction of methadone is that it stops people going through withdrawal, which means they stop using. That is the big attraction, 'I don't have to go into withdrawal. I can come off slowly.' Methamphetamine is not that type of drug. I can be corrected but I would say get a neuroscientist and a pharmacologist in here and I doubt they could give you a drug. They have tried. The same drug, even in a pharmacological sense—the same activity—will have the same problems as methamphetamine itself. It will deplete your system.

The CHAIR—Peter, we are going to have to leave it.

Mr WEARNE—That is okay.

The CHAIR—Thank you very much, Peter, and also Christine, for your contribution this afternoon to this inquiry. I am sure we will hear more from you down the track, hopefully. I found it was very stimulating.

Witnesses withdrew.

Committee adjourned.