USER'S NEWS

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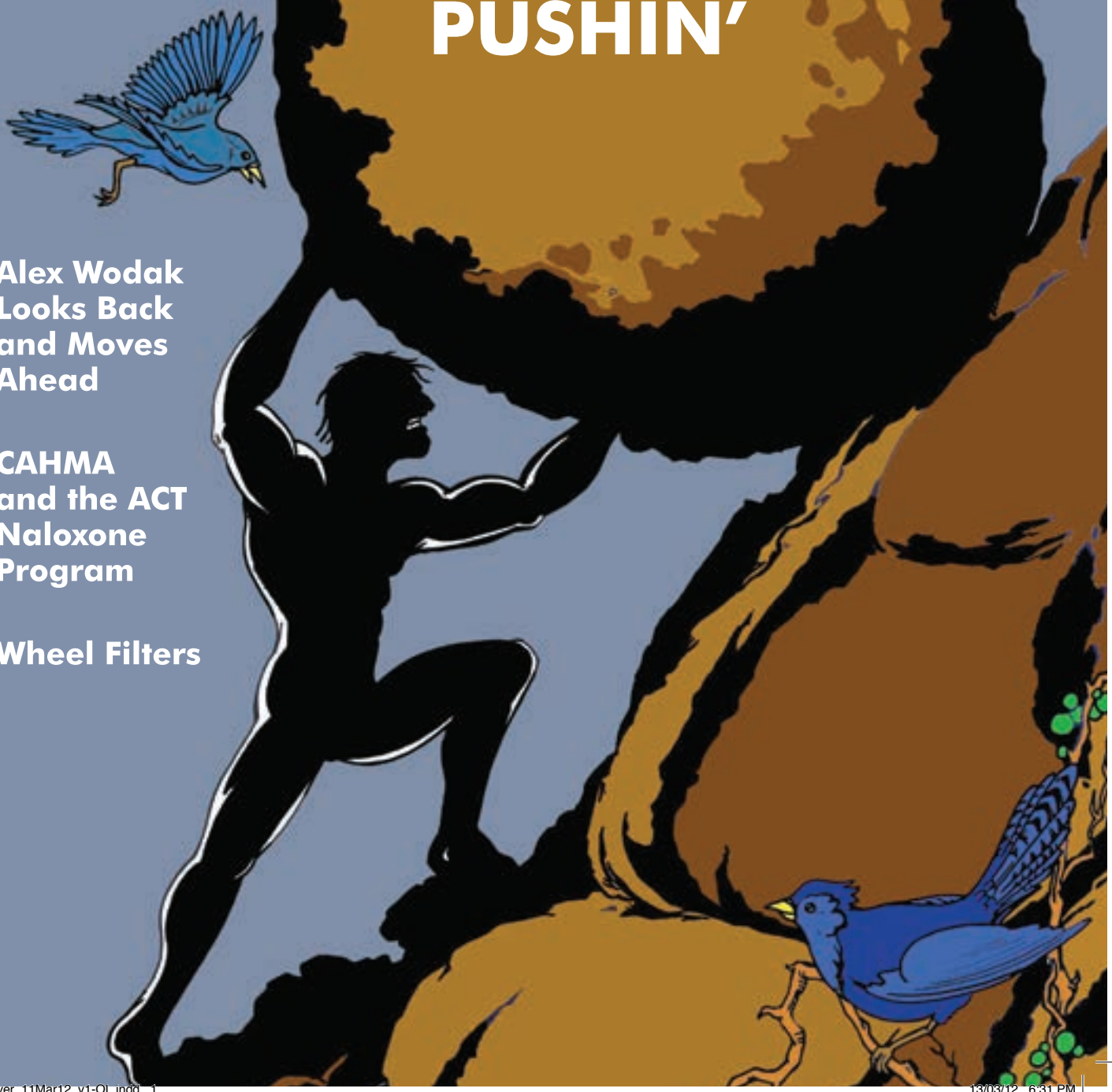
KEEP ON PUSHIN'



Alex Wodak Looks Back and Moves Ahead

CAHMA and the ACT Naloxone Program

Wheel Filters

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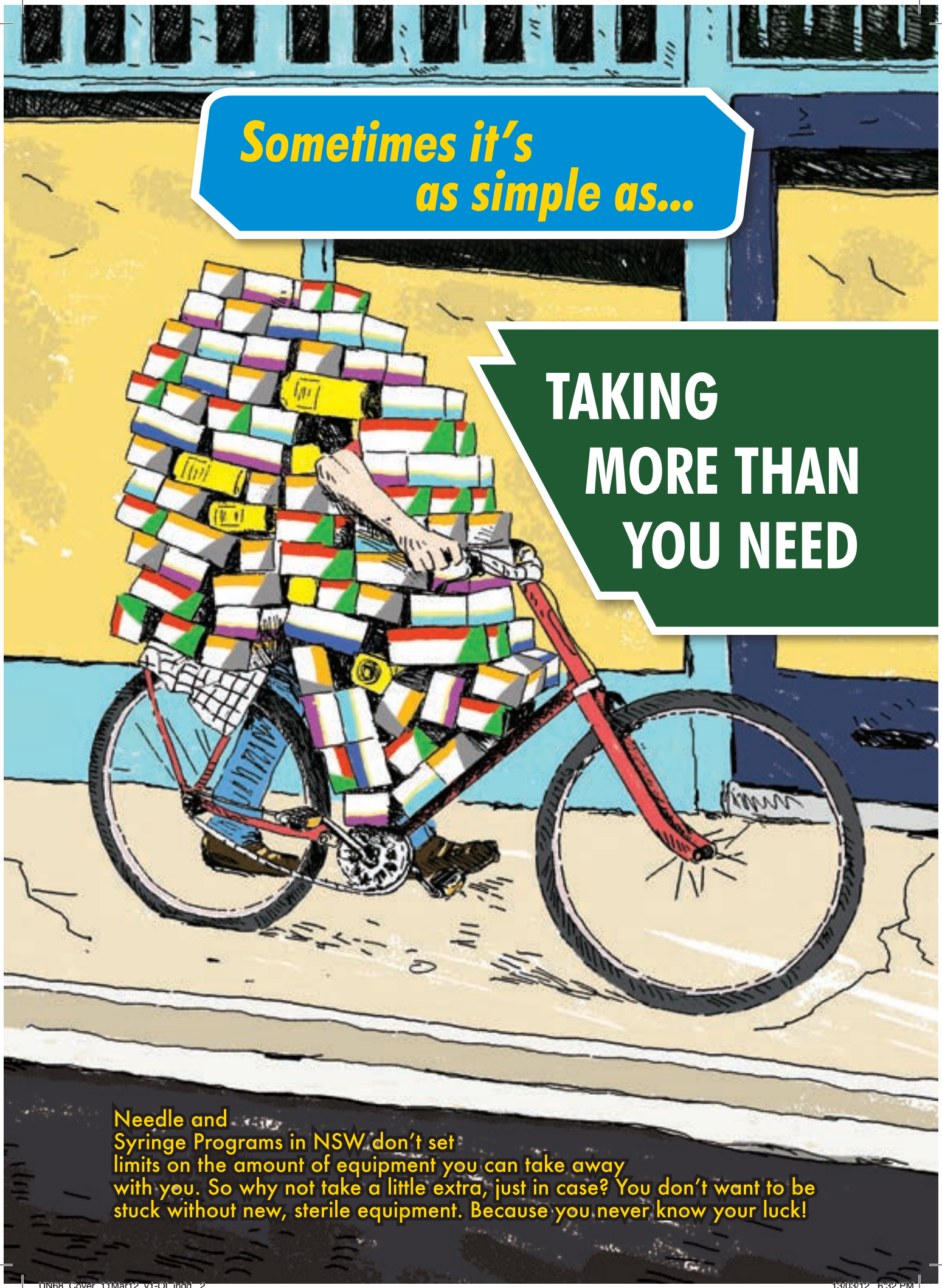

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USER'S NEWS #68

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There's no "I" in "team", but there's a You in user activism

editorial

To begin: an apology. As you see, this is not the Aboriginal edition that was promised last year. As we started preparing the edition, it quickly became clear that a great deal more groundwork was required to bring it to press. The last thing we want to publish is a token gesture to the Aboriginal community. The more people I meet in the community, the more I realise how important their involvement and ideas are to our organisation and to this magazine.

We remain committed to producing an edition for and about Aboriginal people this year. I encourage all of you to contact us at NUAA to have your say, to raise issues of concern, to tell your stories. We'll keep you posted.

— ● —

Either by accident or by zeitgeist, you'll notice a number of different contributors talking about how individual members of our community can and should express themselves to effect change.

We've endured years of apparent stasis in Australian drug law reform. Whilst other countries take the lessons of research and implement programs that save lives, improve living standards and, vitally for the "bottom line" in these economically rocky times, reduce costs, we in Australia have had to look at past glories and wonder how we can jump the groove.

In researching an article, one of our contributors came across the expression "activist fatigue" from one of her interviewees. This is where advocates for change become tired, fed up and disconsolate after banging on the doors of authority without any apparent result.

Now, however, is the time for people who use drugs to raise their voices higher than ever. Federally, a minority Government, despite media reports of dysfunction and stagnation, has provided an opportunity to move ahead in many reforms that required practicality over ideology. The Government's current stoush with Big Tobacco over packaging is an instance where Australia's hypocrisy over drugs is starting to be addressed.

The push toward changing drug policy, however incremental, is gaining momentum across the country. Meanwhile, state programs face funding freezes despite a growing demand for services. In this context, the need for new ideas, new voices, new grass-roots involvement is crucial for service providers, legislators and administrators to get the message and change drug policy in NSW and around the country.

This means you.

You will read about a number of areas where the voices of users need to be heard, and a number of ways that we can make them heard.

Do you face regular, frequent discrimination when dealing with your service providers, like clinics or treatment dispensers? Talk to your friends and peers and see if they agree. If so, it's not just your problem – it's a system problem that needs to be fixed.

Are materials and services like pharmacotherapy treatment, pill filters, naloxone, clean equipment simply not available to you where you live? Are you angry or frustrated about it? Then speak up: these materials can save lives and your lack of access to them is a human rights issue.

Of course, not everyone has the opportunity or confidence to "out" themselves as someone who uses drugs illicitly. People in smaller communities such as rural towns and metropolitan outskirts risk even greater stigma if they raise their voices. If you feel this way, why not write into *User's News* and express yourself, even anonymously? The magazine you hold in your hands is published to voice your issues, your concerns, your stories.

The most important thing to remember is that you can be an agent in your own change. You have experiences, knowledge and opinions that are valuable.

As a user advocacy organisation, we are here to help you raise your voice as a human being, a citizen, an individual deserving of respect. The first step starts with you.

Mathew Bates

National Crackdown on "Doctor Shopping"

Federal Minister for Health Tanya Plibersek has announced the roll-out of a national prescription database to monitor the dispensing of Schedule 8 medicines (described as "drugs of addiction").

In a February press release, Minister Plibersek said "while controlled drugs such as oxycodone, morphine and codeine play an important clinical role in managing pain, abuse of these drugs can cause enormous harm and is a growing problem in the community."

The database is designed to detect people "suspected, for example, of trafficking in painkillers, forging prescriptions and 'doctor-shopping.'"

The program, estimated to cost $5 million, will be made available to general practitioners, pharmacists and a limited number of health authorities. It will record the dosage, date and location of all patients' Schedule 8 prescriptions from the date of its roll-out in July this year.

"'Opting-in' to this program is not a choice for consumers," said Sam Liebelt, AIVL's BBV and STI Program Officer. "All data will be recorded. It means that patients risk being singled out as suspected diverters or "doctor-shoppers" of opioids without any evidence except being back for a script sooner than is expected.

"Pharmacists and GPs who may not be the regular service providers of patients will be making decisions about patients' pain management without a proper history. We may see a lot of people with good access to pain management assistance having their access cut back with no consideration to changes in their pain situation," said Liebelt.

AIVL has received evidence that some Tasmanian GPs are too scared to prescribe certain medicines (including Xanax, a non-Schedule 8 benzodiazopine that is included in the Tasmanian monitoring system), as they think it may put them under scrutiny.

"The database is a way of alerting pharmacists to a potential problem," said Minister Plibersek's Media Advisor Simon Crittle. "It's not necessarily a be-all and end-all. Obviously, pharmacists can contact GPs if there is any question about a script."

Hep C Vaccine in Trials

Biotech company Okairos has commenced a mid-stage study of a new hepatitis C vaccine.

The stage I/II study, funded by the U.S. National Institutes of Health, is a double blinded, randomized, placebo-controlled trial with 350 participants.

Unlike most vaccines which stimulate antibody production, the new gene-based vaccine is designed to stimulate T cells, the white blood cells that help the body fight diseases.

According to the World Health Organisation, as many as 170 million people worldwide are affected by hep C. In Australia, around 224,000 people live with chronic hep C (2010 statistics), and nearly 10,000 new infections occur each year. Around 89 percent of new infections occur through sharing injecting equipment.

In a report issued in February by the US Centers for Disease Control and Prevention, American fatalities from hep C have outnumbered HIV-related deaths since 2007.

20 percent of patients with early-stage hep C spontaneously clear the virus and avoid advancing to the chronic phase. Researchers have found these patients tend to have a strong response in the blood's T cells.

The race for a marketable hep C vaccine is one of the most competitive biotech enterprises today, with researchers at the University of Alberta, Oxford University, and biotech company Profectus Biosciences all developing vaccines that are at or close to clinical trial stage.

Sources: Bloomberg, BBC, Vancouver Sun

NSW "Kronic" Inquiry

The NSW Parliament's Legislative Assembly Committee on Legal Affairs has called for submissions from the public to an inquiry on the use of synthetic drugs, especially synthetic cannabinoids.

In a press release, the Committee stated it was "particularly concerned about whether current drug laws adequately cover synthetic cannabinoid products."

Committee Chair Dominic Perrottet MP said "We're hoping to have input from legal and law enforcement representatives, drug experts, NGOs, health groups,

and the broader community to acquire ideas on how we can strengthen current laws."

The NSW Government banned the sale of existing synthetic cannabinoids in July last year, but faces ongoing legislative catch-up as manufacturers find new chemical compounds not covered by existing legislation. Other Australian states banned sales around the same time, but new compounds were available for legal sale in Western Australia only a month after the bans were put in place.

The deadline for submissions to the inquiry is Thursday 5 April 2012.

Heroin More Cost-Effective than Methadone

The Canadian Medical Association has published a study from researchers at the University of British Columbia and Providence Health Care, contending that medically prescribed heroin is more cost-effective for treating long-term users than methadone maintenance.

According to the study, users prescribed heroin stayed in treatment longer, relapsed less, were less likely to commit crime and cost the health system less than those on methadone.*

Source: Postmedia News

Myanmar Cracks Down on Opium Production

Following its steps towards openness and democratic reform, the Myanmarese government has stepped up a campaign to eradicate the country's opium production.

Myanmar is currently the world's second largest producer of illicit opium after Afghanistan, producing an estimated 610 tonnes last year, according to the United Nations Office on Drugs and Crime (UNODC).

Since September, over 20,000 hectares of poppy fields have been destroyed, preventing up to 30 tonnes of heroin from global distribution.

"Every year the international community spends millions of dollars (on anti-narcotics initiatives) in countries like Afghanistan and Colombia, and the outcome is not satisfactory," said Sit Aye, senior legal advisor to Myanmarese President Thein Sein. "Here, with international assistance, we guarantee to wipe out the opium problem by 2014."

UNODC regards the 2014 target as unrealistic, as it estimates opium cultivation will grow by about ten percent over the next year, regardless of the eradication program.

Source: Reuters

Caught and Bowled

Hair sampling will be used to test Australia's élite cricketers for illicit drug use. The Australian Cricketers' Association and Cricket Australia agreed in March on a trial of hair sampling from July.

"We have agreed to trial hair testing for a 12-month period and will review it before we make any decisions for the future," said ACA CEO Paul Marsh said.

Drug detection using hair follicles can trace use of illicit substances back three months, compared with a maximum of five days for saliva or urine samples.

The AFL implemented hair follicle testing four years ago after growing concern of players' "party culture." Since then, it is believed that between eight and ten of the AFL's 700 players have tested positive to illicit drugs.

Source: Fox Sports

Diplomatic Baggie

In January, a 16kg consignment of cocaine was accidentally delivered to the United Nations headquarters in New York, shortly after being lost by Mexican traffickers.

Two bags with fake UN insignia were shipped through the delivery company DHL from Mexico. The bags set off a security alert when they were delivered. They contained 14 hollowed-out hardcover books, each containing cocaine.

NYPD Deputy Commissioner Paul Browne described the bags as "obvious fakes," which were quickly intercepted by security staff on delivery. "The working theory now is that possibly it was never meant to have left Mexico at all. Somebody in Mexico is probably in trouble now having let a significant amount of cocaine out of their possession," he added.

The mis-delivered shipment had a street value of about $2 million.

Source: AFP

* *See opinion piece on page 7*

ON A MISSION TO ACCOMPLISH THE IMPOSSIBLE

I'm a 39 year-old woman who's been grappling with drug use since the age of 14 and spent many years incarcerated as a result of my drug use.

I was released on bail in June. I then took myself off my 15mg methadone prescription and entered a detox facility of complete abstinence at Herbert Street Clinic, Royal North Shore Hospital.

I've unfortunately been placed back in custody for breach of parole, a robbery I had bail on and fresh criminal matters.

I've tried to apply to be re-assessed for the methadone program for harm minimisation purposes. Denying placement of inmates on this program is not only detrimental to their well-being but defeats the purpose of the program altogether.

I realise now I made a huge error of judgement by taking myself off methadone as I've been using illicit substances in custody and have suffered withdrawal symptoms from opiates on three occasions since my arrest.

A lack of Alcohol & Drug counsellors and programs has also resulted in my inability to address any long-standing drug use.

Records of my past in custody clearly shows I've regularly participated in illegal use of substances which has been in detriment to my health. I've contracted other genotypes of hep C in custody. Whilst staff may see methadone as only a Band-Aid solution, it does prevent me from utilising illicit substances in prison and also at liberty. I also have some mental health issues: post-traumatic stress, anxiety and depression. I'm not receiving any treatment or pharmacotherapy medication whatsoever.

Being placed on methadone or Suboxone is essential for me to deal with my continued drug use and mental health issues. I'm suffering from the adverse effects of these illnesses again after recently losing custody of my 18 month-old daughter until the age of 18.

I'm due to be sentenced in the District Court for robbery and have been informed by my legal team that I'll receive a lengthy parole period. Therefore placing me on a stable dosage would also prove fruitful for the prospects of parole.

I've recently been seen by the public health nurse in order to undergo hep C treatment, however due to my long-standing drug problem Justice Health isn't willing to offer me the opportunity to commence Interferon treatment unless I am monitored on the methadone program.

Obviously it's imperative for me to commence this program for many reasons, including harm minimisation, hep C treatment and addressing my continuing drug use.

The main objective for me is to have the ability to rectify any long-standing health issues prior to my release to ensure I'll lead a longer, healthier, drug-free life.

Apparently Justice Health staff are of the opinion that there's no heroin in prison. This is absolutely ludicrous as we all know there are many illicit substances obtainable in all NSW jails. I'm living proof of that and I have sold my soul for them on many recent occasions.

I've been informed by Justice Health that unless I were pregnant or HIV positive, I had little or no home of commencing any program which entails dispensing the government-controlled substance (methadone) any time soon. I've contacted the Health Care Complaints Commission and completed the form they sent me. I've also put a letter in writing to the Chief Executive of Justice Health. I've written to the local MP in Parramatta, Dr Geoffrey Lee. My next step is the prisoner's rights group, Justice Action.

I am a stubborn little bitch who doesn't give up that easily, although I can't help but feel I've drawn the short straw.

If I don't receive the outcome I expect soon then at the very least I deserve a prize for my goddamn efforts.

If anyone has any other angles or avenues I haven't already exhausted, please write into User's News and voice your opinion.

Any assistance would be appreciated, as there are many inmates throughout NSW's prisons in the same predicament as me.

Jem

Pirates of Prescriptions

I'm writing to you guys so that we can bring this issue to anybody interested. Basically I believe that the chemists are gouging people on Suboxone.

Let's say that they have a good case to charge people on methadone $7 a day. That's what we get charged in a remote area. I agree that a community pharmacy may have to consider dosing people on methadone as it is slightly more difficult than a script for Physeptone. 20 10mg tablets of Physeptone currently carry a PBS price of $16.32 and a price to the consumer (RRP) of $20.36. That's a mark-up of roughly 20%. Referring to the NSW guidelines to the supply of methadone under the Pharmacotherapy Drug Treatment Programs, section 1:10, any charges or fees are a matter for the pharmacist and the clientele. In other words, the NSW Government supplies methadone at no cost to the pharmacist and the cost to the client is for dispensing only. So the comparison therefore is $4 per script for Physeptone and $7 per dose for methadone, just to dispense.

Let's also remember this is quite often to people on Newstart Allowance, people trying to normalise their lives, trying to change their lifestyles, to do something positive. Even their take-aways on the weekend get charged at that rate, almost $50 per week, not including travel costs to and from the pharmacy, or the time taken – a big factor in today's world, especially for workers. Throw in a couple of kids and you'd be thinking of selling your weekend doses to get by!

So now to the point of this letter: the unreasonable charge for clients on Suboxone. My friend works and has the authority to pick up once a month, but due to the gouging of his community pharmacy he can't afford the $196.00 in a lump sum. He has a dependant wife and two children, he also keeps and eye on his aging mother who lives alone 500 km away, travelling down to her as often as he can afford. This guy tries hard to keep everything together. I would like to know how his pharmacy justifies this kind of overcharging. There is no measuring; it is exactly the same as dispensing any medication except on one day, the customer is required to take a dose at the chemist. To be reasonable: $7 to oversee this dose and maybe $10 to dispense the rest of the packet. That works out at $17 per month, rather than the $196 being charged. Let me also point out that in remote areas we don't have the luxury of "choice"; we only have one pharmacy in our town and the hospital will only dispense daily, which is a ridiculous waste of emergency unit resources. I've exhausted any local support, which just don't seem to care about being fair and/or logical. I know of a pharmacy that charges $10 a month, but it's an hour's drive away and there's no public transport.

Could someone please look into this? It's really demoralising to escape the drug dealers' power to charge what they like, only to be treated the same way by so-called community chemists. No wonder so many of us need to escape.

Concerned

Letters to the Editor

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A CALL TO ARMS

Why aren't we discussing heroin-assisted treatments here in Australia when the success of such treatment is now proven?

Maybe I'm a dreamer, but I truly hope that, within my lifetime, Australia will implement heroin-assisted treatment programs which will allow us to be part of the society which has hitherto rejected and denigrated us. Even if we "fail" to abstain from our drug of choice, we can be valuable, contributing members of our communities, families, and society.

Countries such as Switzerland, the Netherlands, Germany, the United Kingdom and Denmark already have heroin programs in operation; trials have been carried out in Belgium and even the current conservative Canadian government is looking at prescribing hydromorphone (brand name Dilaudid), a semi-synthetic opioid that when injected acts similarly to heroin, in order to treat eligible hardcore long-term users. Progressive Portugal leads the way, having decriminalised personal use of all drugs since 2001. Naysayers feared this would lead to more young people trying drugs. In fact, the opposite is true: rates of new Portuguese drug users have dropped significantly over the decade.

In the UK, heroin has been available on prescription since the 1920s, albeit rather haphazardly delivered. In 2002, only 448 of an estimated 200,000 opioid-dependent people received prescribed heroin. Since then, the National Treatment Agency developed new clinical guidelines, informed by a group of experts comprising researchers, clinicians, policy advisers and, importantly, service users. This expert group recommended that injectable heroin/methadone be prescribed for the minority of patients who don't respond well to oral methadone maintenance (about 10 percent of the opiate injecting community). To be eligible for this treatment of last resort, patients need to demonstrate a history of over three years' heroin dependence (regular daily injecting), and have failed to improve following at least six months of methadone treatment. A decade on, some long-term users are able to inject their drug of choice under medical supervision in specialised clinics.

In Denmark, since the implementation of prescription heroin in March 2009, hundreds of refractory (treatment–resistant) users can attend one of five clinics to receive two heroin doses daily, free on the health system. The aim of the program is health improvement, allowing them to live a more stable life, without breaking the law. An overwhelming majority of Danes voted in favour the policy, even far–right political groups.

Results even at this relatively early stage show that the initiatives have demonstrably reduced crime and illicit drug use. Dutch studies have concluded that, despite the higher cost of prescribing heroin (or co-prescribing heroin and methadone) to users rather than oral methadone alone, the savings to society in terms of crime reduction (especially property crime), lower policing and court costs, and savings in medical costs add up to nearly €13,000 (around $16,000) per patient treated per year.

Professor John Strang, head of the National Addiction Centre at London's Maudsley Hospital, told the Independent newspaper that, following six months in treatment, crimes committed by participants were reduced from an average of 40 per month to only six. A third of participants ceased using street heroin; the rest reduced from daily use to just four to five times on average per month. These results are typical of data arising from research undertaken in those laudably progressive countries. They give credence to the validity of heroin-based treatment for long-term users who have not succeeded with existing treatment options.

The results of the North American Opiate Medication Initiative, a Canadian study, have just been released. Using mathematical modelling to compare treatment outcomes, the study found that treatment using diacetylmorphine (medicinal heroin) is likely to cost less overall than methadone treatment, and to be more effective for chronically dependant opiate users for whom methadone has not been helpful. In addition, people in treatment with diacetylmorphine were far more likely to stay in treatment (DUH!) and less likely to relapse to using street drugs, while enjoying a better quality of life and health, committing far fewer crimes and living longer. Surely these results constitute a sound argument for consideration in this country.

A CALL TO ARMS (cont.)

This is a highly pertinent issue to me. I am in that category of "problematic", intractable opiate users. I first injected heroin at 17. I don't know if I'd have taken that step if I could have foreseen the troubles it would bring into my life. Had I been able to learn, for example, meditation techniques to change the way I felt inside, I might have found them preferable to using an illicit and expensive drug which is deeply stigmatised and attaches to the user fear and suspicion from others. I haven't used continuously, but my habits (heroin use being a "chronic relapsing condition") have gone on for longer each time, involved higher quantities, have been more entrenched and harder to stop.

Although buprenorphine maintenance worked for me for several years, I now find it incredibly difficult to accept a substitute. I have an analogy for bupe treatment: I see each dose I take as a brick in a wall that I gradually build between heroin and me. Some years ago I had built quite a solid wall by using bupe, but a tragedy in my life acted as a wrecking ball and brought the wall crashing down. I feel ill-equipped to rebuild it. Although I've made considerable efforts to lay the groundwork for recovery, I just can't seem to put that first layer of bricks in place. I find it almost impossible to take my prescribed dose in the proper manner (I'm a compulsive diverter!) as I know it will render a shot of gear useless. Ultimately I feel this mode of treatment is inappropriate and a waste of time and money, because I don't want a substitute. It is a mystery to me why an issue of such importance to the thousands of us suffering daily from desperation, discrimination and despair is not even on the agenda for consideration by our government, when it would clearly change so many lives for the better.

I have discussed this issue with many people: doctors (my GP and my bupe-prescribing doctor), my former dealer, fellow NUAA members, and anyone else who'd talk to me about it. Most people are open to it, and not just the users! They see the benefits primarily as the inevitable reduction in crime, mainly in property theft – let's face it, who is going to break into a house, risking incarceration, if they don't have to? They also see the benefits of marginalised people being able to participate in life, community, employment, family, and society. Any of us with compassion for our fellow human would love to see these social improvements.

We all have talents and cultural interests that could be developed if we were freed from the daily grind of maintaining a habit illegally. A friend of mine has been on methadone for decades, yet is not considered "stable" by doctors as he still uses illicit gear out of a necessity and desire that can't be quenched otherwise. We agree we'd jump at the chance of a legal dose of heroin. We'd happily pay even double the cost of privately dosed bupe or 'done. Although still a ball and chain, it'd be a much more attractive option.

Frustratingly, doctors have attempted to disabuse me of the notion that heroin-assisted treatment could be possible in this country any time soon. My GP said, basically, "Forget it!" How disappointing. He went on: "If you saw the types of people with the power to make these decisions, you'd understand why it isn't on the agenda. These are ultra–conservatives with a vested interest in maintaining the status quo – irrespective of the lifestyle benefits for the participants. They don't care how much it is needed, or for the well-being or otherwise of those who do. They care only for what will gain the votes to keep them in power." Our needs are just not vote winners.

How can we change Australian public perception on this? Can we get past straight society's "ick factor" when it comes to injecting? If we were to organise and lobby those politicians claiming to have an interest in harm minimisation and health alternatives, could we not challenge this atmosphere of "NO!"? Why shouldn't we be heard, when the evidence in favour of treatment with heroin is so compelling? I really want to know what YOU think! Write or email User's News and give your opinion. I declare this debate open!

Erin Burroughs

Excuse Me, Driver

It was Easter 1998. I was 24 and driving home from Cabramatta. I certainly didn't go to Cabra in those days for noodle soup. I'd been working, performing in a children's theatre show and thought I deserved a special treat, it being Easter after all.

I've always been a little bit impatient when it comes to gratification, so of course I had to have a taste before leaving Smackramatta. Impatience and greed often go hand in hand. I was a greedy little pig and had overdone it just a bit, leaving me very stoned. So I waited for a little while before heading west on the M4 for the Blue Mountains, where I lived. Hey, I was 24 and bullet-proof.

I was driving pretty slowly along the freeway. I would have argued carefully. Every other car on the freeway was overtaking me. That is, every car except the patrol car that had fallen in behind me and turned on its disco lights.

"Damn it!"

I pulled over to side of the road and waited to be greeted by the constabulary. I always have to remind myself how much the police hate it if you get out of the car when you've been pulled over. I'm inevitably filled with the misguided notion to leap out of my seat and start proclaiming my innocence or explaining myself to them.

"Is there any reason why you're averaging about 50 kilometres an hour in a 110 zone?," asked the burly, forty-something officer who was now at my window. "Your driving seems to be a little erratic."

"Evening, officer. Happy Easter," I grinned sheepishly. I noted there was an exit to the freeway just on top of the hill in front of me. Gathering my story and some courage together, I blurted "I'm a performer and I've been working all weekend, doing kids' shows, and I'm really exhausted. I've gotta admit after the last show this afternoon a few of us did share a joint but that was hours ago. I haven't been drinking, I'm just tired and almost home. I'm stopping at a friend's place tonight just up the hill there near the next exit. It's five minutes away, if that."

He passed me a breathalyser. I blew into the machine and he looked disapprovingly when the test came up negative. Thankfully, it was dark and I've been blessed with brown eyes so I don't always look too notably pinned.

The officer drew a deep breath and narrowed his gaze. "Look, I don't know what your real story is and I don't want to know, son. You just count yourself lucky it's Easter and we've got a lot of other idiots out there to deal with. Now I'll tell you what you're going to do. You're going to lock this car up and you're going to walk to that service station at the top of the hill and you're going to call your mate, or anyone to come and pick you up and you're going home. You're gonna come back and get your vehicle tomorrow afternoon. If this car moves before tomorrow afternoon, I'm gonna come and find you and we will blood test you. Now lock your car up and get on your way."

"Thank you, officer," I said sombrely. "Can I just get my guitar out of the boot please? It's worth about as much as my car."

"All right. Anything else?"

"No sir. Thank you."

With that I opened the boot and took out my guitar case which, along with my guitar, contained the rest of my stash and fits. I proceeded to walk up the hill to the service station at the exit, called my friend and had a very happy Easter.

I hope you do too. Be careful on the roads, and not too slow on the freeway.

Sean

Illustration: Tony Sawrey

User's Story

Taking the Reins

I knew I needed help when my dog started looking at me, as if to say "I don't wanna know you. There's something wrong with you." That freaked me out.

I was introduced to ice when I was doing sex work. A client gave it to me one night and I thought it was just bullshit. Then I was still awake 20 hours later going, "Fuck, how irritating!" I didn't really think anything of it until I had to work on long shifts and started using it again.

Before I knew it, I couldn't actually function without ice. The comedown from it was so intense and so severe, and so painful – emotionally, mentally and physically. It's like the worst depression you've ever felt in your life. I'd be angry. I'd cry a lot. I couldn't do anything, couldn't talk to anyone. I felt like my body was moving through water; just to walk was hard. I got into a vicious cycle of doing this for about a year, then I went to rehab.

God I hated rehab.

I'd been in therapy since I was about 12. At a certain point, I felt like I was just entertaining them. And they gave me nothing back. It was the same with rehab, I wanted something to snap and to change, and it didn't. It was all so twee and so dated. Put a chair in the middle of the room and yell at your dad. And you don't get a tick until you cry. "Poor you! Awful, isn't it? Now here's 150 mg of revolting antidepressant, and you'll be right now."

I was sent out into the world, a raw egg full of chemicals that were fucking with my brain, giving me zaps all the time, making me feel very isolated, disconnected from society and other people.

For financial reasons I fell back into working again. One night a client said, "Here, have a line of coke." After the line I went, "That wasn't fucking coke!" Of course he knew it wasn't. And it all started again.

I got involved with a hard-core user. He'd been shooting base for about ten years then base and ice for five. He got me into injecting ice. I loved it; it was better than it had been the last time. Injecting was a massive step to take. There was a part of me that was like a 12 year-old going, "Whoa! This is naughty!" You have to acknowledge those parts of you, you know. Now, instead of doing that, I ride my bike really fast downhill. That's where I get my thrills. It's better than winding up in hospital from a psychotic breakdown.

I was really lost. I was trying to get my own business off the ground, but I was in a vicious circle of not believing in myself enough to let go of the sex working and needing the drugs to get through the sex working. It was a constant juggling act.

Illustration: Bodine

Eventually, I said to my boyfriend, "Enough! I can't do this again and I'm not going back to rehab. So let's get off it."

I wanted to do it myself. I took the reins and made a do-it-yourself home rehab booklet for us. I looked into all the things we had to do in order to detox at home, to get through it. It was an exercise I did to make it real for me, I guess. I became an amateur nutritionist and kept researching and researching. I made lists of foods that are high in enzymes and amino acids like tryptophan to help serotonin levels and support you when you're coming down. The fact that exercise, even though you don't wanna do it, is one of the most important things to keep you going, to lift you up and get the endorphins flowing. I've still got the booklet; it's about two inches thick.

After days of research on the internet, I came across an out-patient stimulant therapy program, a trial using pharmacology to support getting clean from ice. And I thought, "Bingo! That's me." I'll never forget the day of making the appointment. I was in the car park of some supermarket, waiting for my dealer who was fucking me around, on the phone to this woman who was interviewing me, to tick off the boxes to see if I was eligible. And I was. She said, "Right. We need to get you in as soon as possible." I said, "Actually, my dealer's not turned up today so can I see you tomorrow?" I expected it all to happen, you know, stamp, stamp, stamp. But it was an eight-week process. I was terrified the doctor was gonna say no. And he almost did. My counsellor asked me, "What would you have said if he did?" I said, "I would have chased him down the hallway, clung onto his ankles and been dragged along the carpet, screaming, 'No, you've got to help me! This is my last chance!'"

My boyfriend wasn't really on board. He was in love with me and he wanted to do whatever I said. So he thought, "If it's gonna work for you, I'll give it a go." But I had the benefit of years of therapy. I know who I am. He had been avoiding life for so long that the idea of being clean and learning how to deal with life in his skin for the first time ever was terrifying for him. He lived a life where everything was compartmentalised. Nothing was connected. And it all caught up with him. When he died seven months ago, two of his closest friends of 15 years had never even heard of each other. It was just weird.

The program made my drug use my own responsibility. It gave me a sense that I'm in control; I'm not handing my power over to anyone else and asking them to fix everything for me. I know that I have to get myself to the clinic every single day, which I've done now for almost two years. I don't even think anything of it anymore.

The program has given me my life back. It's incredible that in one year I now have a fully sustainable business. My job doesn't stop. I built up a business from nothing into something that is incredible and doing great things.

I'm glad that I've been where I've been and seen what I've seen, but I'm also glad to be out of it. And I'm very, very grateful. I'm really lucky because I can still experience joy and have a sense of humour, I can still appreciate beauty. A lot of people fuck up their levels so much that the chemical imbalance does not allow for any joy. I mean, I've been trying to kill my brain cells forever. I can't believe I can still speak, let alone put a sentence together.

For those of you who feel like you're trapped, I can tell you there is a way. Do some research like I did. You have to look at your life, look at your heart, your relationships, your financial state, your possible future and think, "do I really wanna keep doing this?" If not, go on the internet. There's so much information.

And be gentle on yourself. You're gonna use again. Every user knows that. But you've got to not think that's the end of the world. That attitude sends you back to square one. I guess I've been to the bottom and I've run the whole gamut of human emotions. That helps me be a lot more perceptive and understanding and it's also given me a great motivation and focus. I just don't have time for bullshit any more.

Georgia

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I Had a Dream

This story is about the death of my beloved soul mate Peter, father to our two beautiful kids. Before then, our lives had consisted of a happy, love-filled, great fun-filled days. After seeing many friends succumb to that evil hep C, I considered Pete to be "one of the lucky ones". He fell ill on a Thursday and died on the following Sunday. None of the drawn-out horror I have seen others go through. He was 42.

Lying in my prison cell in 1984, due for release, I thought "How on earth can I stay out for good?" The scenario I came up with was one I'd avoided since I started on the gear: to find a partner. Believe me, I set my standards high – real high!

I'd known Pete since the late 70s. He was a nice guy who admitted he always held a flame for me – but so did others. I had seen too many friends treated badly by blokes. Besides, I was too busy trying to keep one habit going, let alone two. So I stayed one out and played by the unwritten rules the scene dictated.

After leaving Bathurst Jail I stayed with my parents to finalise a compo claim. Two weeks later, $14 grand. I was out of there. Another three weeks on, I was sitting in a pub with no money as my parents talked me into putting it into a fixed-term account. I was waiting for some good luck to come my way.

Two guys walked in; one I had briefly run with a while back, the other I couldn't place. They sat down with me and after some chatter I finally recognised the second guy. The last time I saw Pete he had a huge habit and looked like a wet greyhound. If he had a single white tooth, he'd have had a full set of snooker balls. After a three-and-a-half year lag-on for stick-ups, he'd got his bricklaying ticket and looked, to say the least, hot. Pete made it clear he had gear on him – always a pre-emptive thinker.

Fate was an amazing factor in all of this, like in everything we do, I guess. Off we went to Liverpool station to have a shot – later we jokingly called it "my pseudo engagement ring." Pete and I were Liverpool locals, yet he was staying with my first cousin (can you see fate at work?) and I was at Coogee. Once on the train we both nodded off, only to waken as the train pulled out and I caught sight of half a station sign: "-field." Fuck, we were

Illustration: Tony Sawrey

I Had a Dream (cont.)

at Ashfield and we hadn't had a chance to catch up. If I'd had some cash, we could have gone to a motel in Liverpool. I did have $150, but I owed it to my cousin.

Fuck it, I thought.

We jumped off the train to find the "-field" I saw was Fairfield!

That night was brilliant. I knew at once he was the one. He even asked me to marry him. Years earlier, Pete had told my brother in Parra Jail, "I reckon if I got K alone for 20 minutes, I would have her for the rest of my life." And so he did. He passed all the tests I subliminally laid out for him.

Our lives rolled on until I got pinched. I was terrified I was going back inside until fate stepped in. Methadone was available to us and after a month I was pregnant. We were overjoyed. Even with the form I had, I managed to get a bond. The 'done was heaven-sent, not only for us but for thousands of people in Sydney's western suburbs in the 1980s.

We thrived as we had time to do all the things that using prevented. After a "sweet struggle", we secured our own house and had two adored and planned kids, a boy and a girl. We went on picnics, took holidays, we even went once to the Melbourne Cup. We had two cars and a home chock-full of love. These were the halcyon days, the best days of my life.

In 1993 we both had liver function tests. Mine was fine; Pete's was not. After consultation with a doctor at Westmead Hospital, Pete was given five years to live.

Denial set in. Pete continued laying bricks and was active in our son's soccer team. We hired a 26-foot scow and had an unreal four days on the Hawkesbury River – hardly the actions of a dying man. Denial can soothe the inevitable. Pete never complained: that is, until one day he spoke the words that had never left his lips before: "Bub, I feel sick." Three days later, he was gone.

I was crushed. I became something I never wanted to be: a single mother. Family and friends rallied around and gave him a fitting send-off, one he so deserved. I believe you can tell the goodness of a man by the number of people who take the time to pay their respects. That day was standing room only.

My world spiralled down at an amazing speed. Being diabetic, I couldn't drink. The smack scene I once knew was no more. I found that benzos numbed the pain. Lucky for me the kids were thriving. My son was twelve, our baby was ten and I was 38. I should have been an actor: I was able to put on a front of coping really well. In truth, most of me died with Pete.

I managed to lose my 40s. Of course there were good days and even weeks, however few and far between. Depression replaced the monkey on my back. I lost all confidence. What a nightmare. Without Pete, the house fell down around us. By this time the kids were teenagers and allowed to have parties. Our place became "the House of Fun" but things for me were so sad. No hope was on the horizon.

One night I had a dream, such a beautiful dream: we had a beautiful brick house, I was nearly off the 'done, most of all I had peace of mind and was happy. When I woke up, the cold truth of reality set in. I thought "Yeah, that's all it will ever be, just a dream."

So here I am today. I live with my son in a lovely brick house. My daughter is married to another wonderful man and they have a five month-old son together. My lad smokes pot, but none of my family takes anything else. I'm on 3½ mg of 'done. The best thing is I'm so very happy.

The other night, after listening to a riff my son made up on his acoustic guitar and feeling a little high, I opened the lounge room door. Seeing how great it looked, I was transported back to that dream. I realised I had peace, control and, at last, contentment.

So, my friends, no matter how far out of reach some things seem, no matter that the road is long and hard, somehow, some way dreams can come true. Mine did; I truly hope yours do too.

Carpe Diem

The Consequentialist:
an Interview with Alex Wodak

On the 29th of February, after nearly 30 years in the position, Dr Alex Wodak stepped down as Director of St Vincent's Hospital Alcohol and Drug Service.

Dr Wodak's achievements will be well known to regular readers of this magazine. One of the instigators of Australia's first needle and syringe program and its first medically supervised injecting centre, he was also a key player in NUAA's establishment. He helped found the National Drug and Alcohol Research Centre, and served as President of the International Harm Reduction Association for nine years.

Whilst continuing his clinical work for the next few months at St Vincent's, he plans to concentrate his energies on drug law reform work as President of the Australian Drug Law Reform Foundation. A fortnight prior to his stepping down as Direcotr, Dr Wodak took time out from a busy day of consultations to sit down and chat with User's News.

User's News: **You came to St Vincent's Hospital as a man of medicine, but through your position you've become probably the most visible advocate for drug law reform in Australia. How do you feel about that?**

Alex Wodak: The drug policy framework is a travesty. We have a way of approaching drugs as a community in Australia and around the world which doesn't work. That used to be very controversial: it's becoming much less controversial as more and more people realise it. It's very hard to change it from inside politics because politicians are rewarded by advocating for things that don't work and are punished for advocating for things that do work. So the change must happen from outside politics.

By a quirk of fate, I happened to end up working at an ecclesiastical hospital, which means that it is not part of the Department of Health: it's like an NGO. Members of staff can't be sacked by the Minister for Health; they can only be sacked by the board, by the chairman of the board or his/her delegate. That gave me a freedom to speak publicly which my counterparts in other hospitals don't have. And I've used that freedom to advocate for drug law reform. Sometimes not entirely happily as far as the hospital and beyond thought, but I've tried to be responsible. It's difficult but the alternative was even worse – not speaking at all. Over time, the argument's been won and the debate is substantially over. Few people doubt that prohibition doesn't work. And I think the political élite have known that for a long time. I don't just think that: there's evidence that the political élite have known it for a long time.

UN: **I saw you last year in a public debate, arguing that all drugs should be legalised. You and former NSW Director of Public Prosecutions Nicholas Cowdery presented solid evidence and there seemed to so little persuasive evidence from the opposition. Yet the shortage of evidence doesn't sway the resolve of people who have fixed attitudes against drug law reform.**

AW: When you sit down and analyse this debate, you realise that it's not really a debate at all. Advocates for drug law reform or harm reduction are consequentialists; they argue that the wisdom of a particular policy is based on summing-up the benefits and the negatives. If the benefits outweigh the negatives then we do it; if the negatives outweigh the benefits then we don't do it. It's very simple.

The opposition are arguing not on the basis of facts – they're arguing on the basis of righteousness. "This is ordained, this is not ordained. These people are recommending we do something that is not ordained, therefore it is evil." That's why these debates are so unsatisfactory. They are a debate between one side that believes that evidence is everything and another side that believes that evidence is nothing. It's two very different philosophical frameworks. It took me a long time to figure that out.

UN: How do we break through that?

AW: Well, people are being persuaded. Attitudes are shifting in the direction of harm reduction and drug

The Consequentialist:
an Interview with Alex Wodak
(cont.)

reform. If you look at the National Drug Strategy Household Survey for 2004, 2007, 2009, and you look at support for a needle and syringe program, it went up from something like 64 percent to 67 to 69 percent. 52 percent of all Australians now support medically-supervised injecting centres without any concerted campaign in favour of them. If you look at the Gallup poll in the United States from 1969 to 2011 on the question "Do you support the legalisation of marijuana?" you see that in 1969, 84 percent opposed the legalisation of marijuana. By 2011, only 46 percent opposed legalisation. So there is a clear move. I mean we, we now have, in 2009, the UN Secretary General supporting the decriminalisation of drugs.

It's gonna take some time but it is clear that support for drug law reform is growing and support for prohibition is declining. And what's happened in Mexico and Central American countries in recent years is accelerating that trend. Now we've got serving presidents and prime ministers advocating market mechanisms for drugs. President Santos in Colombia and President Melena of Guatemala are now calling for legalisation of drugs. And for good reason: global drug prohibition has been implemented to the hilt in Mexico and Central America, and it's proved impossibly costly. 50,000 Mexicans have died since December 2006, caught in the crossfire, killed by the army, or killed by traffickers.

That's only the beginning of Mexico's travails. It's absolutely appalling. I was in Mexico last week, and the suffering is just unbelievable. There's been a breakdown in law and order. You don't know whether you're gonna get home tonight. You might be kidnapped. Mexico is close to a failed state. And things are even worse in Honduras and Guatemala, which have borders with Mexico. Why did all this happen? Because the drugs that used to go through the Caribbean can no longer: the Americans managed to stop that. Now they go through Mexico. And after 9/11, the Americans increased homeland security operations on the sub-border, which has reduced the competition between the cartels, and the price differential between heroin, cocaine and cannabis on the Mexican and US sides of the border has increased. Abraham Lincoln said that if you want to destroy a bad law, you should implement it to the full.

UN: **There are some important issues that are gaining traction, such as NUAA's push for consumer involvement in how NSW pharmacotherapy is dispensed, CAHMA's peer naloxone program, the ongoing push for NSPs in prisons. Do you see these individual issues as the way to push ahead for drug user activism? Or do you think activists should keep their eyes on the bigger picture of decriminalisation?**

AW: There's no simple answer. I think some issues are much easier than others to argue for. As you know, I was involved in the establishment of NUAA and it's always been clear to me it's been very necessary. Every other branch of medicine has a strong consumer group. Diabetes has it, mental health has it, coeliac disease has it. Why the hell shouldn't alcohol and drugs have it? That's at one level. On the other hand, if we're ever gonna make progress in the policy area of drug reform and human, it's clear that there also has to be a strong user movement – whatever you want to call it. If my colleagues and I had a stronger consumer movement that was beating us up, beating the government up, beating the community up about the crappy services that are provided, the services and funding would improve.

The easiest question of all to argue for is medicinal cannabis. The figures on that from the National Drug Strategy Household Survey indicate 69 percent of the Australian population support medicinal cannabis and 75 percent would support a trial of medicinal cannabis. I think it is outrageously wrong that in 2012 somebody dying of cancer or AIDS, or what have you... if he or she believes that cannabis is going to ease their last few weeks or months, let 'em have it. I can't see a single rational argument to deprive a person with a serious, terminal, painful, horrible end to their life from something

The Consequentialist:
an Interview with Alex Wodak
(cont.)

that compassionately could give them some comfort and peace. I have to tell you I feel so emotional and passionate about medicinal cannabis that even if medicinal cannabis were to set back prohibition for 20 years, I'd still be in favour of it. As it happens, I don't think medicinal use of cannabis will harm drug law reform at all: I think it will only help the arguments for drug law reform.

We have massively over-invested in the law enforcement side and under-invested in the health and social interventions where we get the real benefits. Once you make the decision that this is basically a health and social problem, everything else follows. Then budgets get realigned. We allow medicinal cannabis because it's primarily a health issue. And we make sure that that's not a fabric for something else. And one-by-one the issues become obvious. We have heroin-assisted treatment. We don't give that to everybody as a first-line treatment – it shouldn't be a first-line treatment – but we reserve it for people, a small minority who are severely dependent and don't respond to any other treatment. We run methadone programs so that they are accessible, attractive, based on science, run humanely and compassionately – very different from how we have to run them these days. And likewise we have substitution treatment programs for wherever there's enough scientific evidence to allow them.

We used to be very progressive and enlightened in Australia compared to other countries but we've stayed still and the rest of the world has moved on. It's high time that we also moved on in Australia. We still only have one injecting centre in the whole country. We don't have a single prisoner in Australia who gets sterile injection equipment. We tried hard to get heroin-assisted treatment almost 15 years ago; it was stopped. And since that was stopped, seven trials have been carried out in six countries all of which have been incredibly positive. So it's pretty depressing, really. Even the United States is way ahead of us in terms of cannabis. You have to ask yourself: why does a rich, enlightened, tolerant, accepting country like Australia allow an area like this to remain a backwater?

UN: **You've seen an extraordinary amount of change and I guess an extraordinary amount of stasis too. What part of your work at St Vincent's do you feel most proud of?**

AW: I've enjoyed all the different things I've done. I've done a wide variety of different things. I've enormously enjoyed clinical work with people but that can be frustrating. I've enjoyed work with doctors who have alcohol and drug problems. That's also got its frustrations. I've enjoyed the policy work, which is very much like the clinical work. In clinical work, you're dealing with people who, who can't function in an area of their life that's important to them – alcohol and drugs – and, in the policy work, you're dealing with communities that can't function with an important part of their policy, which is the alcohol and drug part. The similarities just leap out at you. But it's all been enjoyable.

I've enjoyed building institutions with other people, including NUAA, the Australian Society for HIV Medicine, the National Drug and Alcohol Research Centre, the Medically Supervised Injecting Centre. I've been very lucky and privileged to do a lot of travel, especially to third-world countries. That's really been a great privilege because I've seen more or less what we've seen here in Australia, except that the people I saw in developing countries are often really struggling, who go into empty libraries and centres where people have nothing. I've learnt a lot from that. So I've been very lucky to have these opportunities. And in the middle of it all there was the gale-force wind of the HIV epidemic blowing in, and that forced people to be much more realistic than they would have been otherwise. I've had a great time and I've had terrific support from St Vincent's Hospital, terrific support from colleagues all over the world and in Australia. I can't say that there's any one thing that I've enjoyed more than any other thing. It hasn't been easy, but it's all been a terrific variety.

NOW OPEN FOR SERVICE

Kirketon Road Centre's new public health service in Kings Cross!

The removalists have left, all boxes are unpacked and clients are already attending the new premises for Kirketon Road Centre's (KRC's) satellite facility 'Clinic 180', located at 180 Victoria Street, Potts Point.

The new premises have consolidated staff from KRC's satellite needle syringe program facility at K2 (formerly at 38 Darlinghurst Road, Kings Cross) and staff formerly located in office space at 140 William Street, Woolloomooloo. However KRC's headquarters – where a comprehensive range of primary health care services and methadone treatment are provided – will remain at its current location above the Darlinghurst Fire Station.

The new premises were needed due to the building and maintenance issues at K2. They also provide an important opportunity to better meet the often complex needs of club-based sex workers who do not access more traditional medical services during normal business hours.

Nurse-led clinics will operate from two clinical consultation rooms on the ground floor of the new premises and provide a range of services on a drop-in and appointment basis from 1.30 – 9pm Monday to Friday.

These services include:

- general health assessment
- STI, HIV and hepatitis testing and treatment
- hep B vaccination
- women's health checks
- first aid and wound dressings
- social welfare assistance and crisis counselling
- drug and alcohol assessment, counselling and referral to drug treatment and rehabilitation
- injecting equipment, condoms and advice.

Clinic 180's needle syringe program will operate from 1.30pm to 9pm, 7 days a week.

The second and third storeys of the new premises will accommodate KRC's outreach and health promotion team as well as the Inner City Youth-At-Risk and Aboriginal project staff.

Throughout last year, KRC held public community consultation meetings to inform members of the local community of KRC's Development Application to the City of Sydney, providing them with an opportunity to inform its Plan of Management for this site.

KRC anticipates that like K2 and KRC, Clinic 180 will have minimal impact on neighbouring residents and businesses, but has agreed for this to be evaluated after 12 months' operation.

How to save a life:
Nicole Wiggins on CAHMA's peer Naloxone program

In December last year, ACT Chief Minister Katy Gallagher announced the launch of a training program to respond to opioid overdoses. 200 Canberran peer participants will be trained over two years in overdose management, including administering the opioid antagonist naloxone. Participants will be prescribed naloxone as part of the program.
The program has been developed by the Canberra Alliance for Harm Minimisation (CAHMA), the Alcohol Tobacco and Other Drug Association (ATODA) and the Expanding Naloxone Availability in the ACT Committee (ENAACT).
The program's first training module commenced in March. Shortly before the program's commencement, CAHMA's manager Nicole Wiggins spoke to User's News.

User's News: **How does the trial work?**

Nicole Wiggins: It's not a trial. It's a peer distribution program. I say that because naloxone does not need to be trialled. It's really tested. We know it works. We know it doesn't have side-effects. But we have independent researchers evaluating its implementation.

Potentially, the program could involve more than 200 people because people can bring a family or friend along to do the training. But if they're not a user, they wouldn't get a script of Naloxone. We're only doing 200 scripts of Naloxone.

UN: **How does the recruitment process for the program work?**

NW: We've been approached by people who are interested because it's had lots of publicity and it's taken so long for us to get this happening. For the first few programs, we've got people queued up, really keen to do it.

But we do have a recruitment strategy, because we also have two priority populations for the program: indigenous people who inject opioids, and recently released prisoners who inject. I don't know that they're going to be the majority of participants, given the small indigenous population in Canberra. Also, we're having problems getting into the jail at the moment. Hopefully, in future, we'll be doing the training actually out at the prison. Then, when people are released, they'll have already done the training and their release pack will include naloxone.
And we're working with the Winnunga Nimmityjah Aboriginal Medical Service as well to recruit indigenous opioid injectors. We will be recruiting through our clients, through a needle and syringe program, and through the methadone program down here. We're working with other alcohol and drug agencies to recruit people. And CAHMA has an indigenous peer program, so we will also recruit people through that.

UN: **Is opioid overdose of concern to people who don't inject? Are there instances where non-injected opioid use can lead to a potentially fatal situation?**

NW: It definitely can but injectors are 14 times more likely to overdose than non-injectors, according to research. So injecting is an independent risk factor for overdose but absolutely you don't have to inject to overdose. Any amount of opioids in your system that your body can't handle, particularly in combination with different depressant drugs, can lead to overdose. So people don't necessarily have to be opioid injectors to do the training and get Naloxone.

UN: **What are the statistics on fatal overdoses in the ACT?**

NW: They vary between one and ten in any given year. So we are emphasising that we're not necessarily expecting to have an impact on overdose deaths at a population level, particularly not in these early stages, because it's just sort of, there's so many like contributing factors and we're not, we're only, given that, you know, 200 Naloxone scripts to a, you know, I think the, the population of opioid injectors in the ACT is projected at, I don't know, something like four or 5,000. But we are hoping that if the program is picked up in Sydney, Melbourne and Adelaide, then it will have an impact on overdose deaths at a population level.

How to save a life:
Nicole Wiggins on CAHMA's peer Naloxone program (cont.)

UN: **Have you been able to use the work of existing overseas naloxone programs to build CAHMA's program model?**

NW: Sure. There's the Chicago Recovery Alliance and New York's Harm Reduction Coalition. We've looked at a lot of their training material. The difference is that the drug scheduling is different in the US so it can be prescribed for people who are not opioid users. So they're a bit more free with their prescribing over there. And Chicago's been doing it for almost ten years, so they now do things like five-minute street corner training – some of the medical people here were a bit horrified when they heard that.

UN: **What issues around Australian legislation and policing have to be addressed in order make this program work?**

NW: Naloxone is a Schedule 4 drug which is prescription only. And any prescription scheduled drug can be administered by a third party to the person to whom it's prescribed. As long as it's administered to the person who the prescription's for, in the way that the prescription indicates, anyone can administer it.

But because it's a new program, we're sticking strictly to the idea that the written prescription's only to be used on you for you. We're just hoping that lots of people do the training, that lots of people will, in the end, have their own Naloxone script anyway.

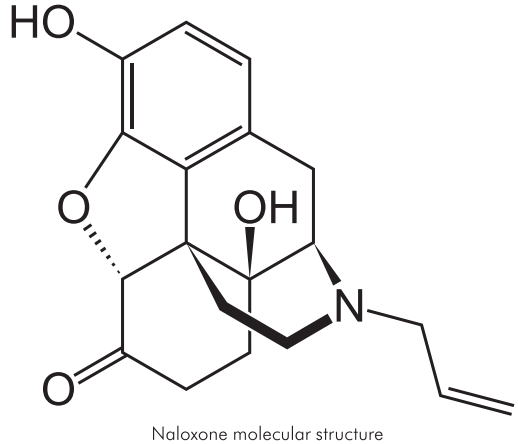
UN: **So you're imagining in the future that naloxone will just be a part of, you know, the medicine cabinet for pretty much every person who injects opioids?**

NW: Absolutely. And it is in other places. In the US, it's around five or six dollars a vial. There's often discussion around changing it to a Schedule 3 drug in Australia [a "behind-the-counter" pharmacy-only medicine], which apparently is a really long, involved, national process. But we may as well like start heading down that road if we can and start applying to the Therapeutic Goods Administration.

UN: **It's interesting that just, given the particular political and social nature of the two territories in Australia (NT and ACT), they often serve as, for want of a better term, guinea pigs for these kinds of programs.**

NW: I think so, and I think Canberra's an ideal place because it is fairly small. The independent researchers will do follow-up interviews with people when they use Naloxone and come back for a replacement dose. And they'll hold follow-up interviews at three and six months after the training to see what people have remembered around it. And to see what impact it has on the small population, especially this very small using population. You know, has anyone heard about this program? Does anyone know what it is?

I think the program will be great, not just for what it is in itself, this potentially life-saving drug, but for what it means in terms of policy shift. The last big thing that happened in Australia was a decade ago with MSIC. Before that it was needle and syringe programs 25 years ago. Once upon a time we were leading the way and then we slowed down big-time. So I feel a bit optimistic that maybe it indicates a policy shift and that we can move in other positive directions.



Naloxone molecular structure

THE ACTIVATE STUDY

Enhancing Hepatitis C treatment for People Actively Using Injecting Drugs

In Australia, hepatitis C is a major health problem among people who use drugs. Among every 100 people who have ever injected drugs in their lives, 70 people will have been exposed to hep C virus and 50 people will develop ongoing hep C infection. After 20-30 years of having hep C, people may develop serious long-term problems including scarring of the liver (cirrhosis), liver cancer and death due to liver disease. This is a big problem among people over 40 years of age. It means that one out of every two people who have ever injected drugs may have problems because of hep C, especially people infected with hep C in the 1970s, 1980s or 1990s.

The good news is that there is a cure for hep C! The treatment has two parts. The first part is called pegylated interferon and you take this once a week as an injection. Interferon is actually a protein that your body produces naturally to fight off infections. When you have the flu virus, the reason you feel bad is not because of the virus itself, but actually because of the natural interferon that your body makes. Unfortunately, this also means that when you take the interferon, you also sometimes feel like you have the flu! The second part to hep C treatment is called ribavirin. You take this as pills twice a day. The combination of pegylated interferon and ribavirin is used together to cure hep C.

There are three main types of hep C virus in Australia. These different types are called "genotypes". The main types are genotype 1, genotype 2 and genotype 3. Understanding your genotype is very important because some types of hep C are easier to treat than others. The most difficult to treat is genotype 1, while genotypes 2 and 3 are easier to treat. This means that standard treatment for genotypes 2 and 3 is shorter (only 6 months as compared to 12 months for genotype 1). Also, four out of every five people with genotypes 2/3 will have a cure following 6 months of treatment! In people with hep C genotype 1, half of them will have a cure with 12 months of treatment.

Among people who inject drugs, it is very important to treat hep C. A number of studies have shown that people who use drugs can respond very well to treatment. Also, guidelines throughout the world suggest that people who use drugs should be treated for hep C.

Fortunately, there is a study that will be starting in March 2012 called the ACTIVATE study. This is a study which will examine whether shortening treatment for hep C is feasible, safe and effective for people who are currently injecting drugs and who are responding well to treatment early on. The purpose is to investigate whether hep C treatment can be shortened from the standard 24 weeks (standard duration) to 12 weeks (shortened duration) if a patient has a rapid response to the treatment. A rapid response is where there is no hep C virus detectable in the blood after four weeks of treatment. The study will examine this in people who are infected with hep C genotype 2 or 3 and have injected drugs recently (injecting drug use in the previous 12 weeks).

The study is part of an international collaborative study sponsored by the University of New South Wales in Sydney, Australia and is being funded by Merck Sharpe and Dohme. The study will involve a total of 100 patients from Australia, Canada, Belgium, France, Norway, Switzerland, United Kingdom, Germany and Finland. In Australia, the clinics involved will be in Sydney (St. Vincent's and Nepean Hospitals), Newcastle (Hunter Pharmacotherapy), Melbourne (the Alfred Hospital) and Adelaide (the Royal Adelaide Hospital).

If you are interested in participating in this study, please contact the ACTIVATE Project Coordinator, John Morrison, at activate@kirby.unsw.edu.au. John will put you in contact with a suitable site so you can discuss with a doctor whether you would be suitable for this study.

Jason Grebely and Gregory Dore
Viral Hepatitis Clinical Research Program
The Kirby Institute for infection and immunity in society
University of New South Wales

ACTIVATE
A Collaborative Trial in Injectors of Individualized Treatment for Genotype 2/3

ICE: How to Use and Stay Healthy

I decided to write an article about crystal methamphetamine, as there are many pre-conceived misconceptions that many in the community at large only get to hear or read about. The fact is that while ice can have a dramatic negative impact on some people's lives, there are just as many people in the community who do use and are able to lead normal lives.

I am an occasional user (three to four times a year) and it has taken many years of struggling with drugs to bring me to this point. A major part of my time is spent as an NSP worker. It goes without saying that during my many hours spent working with people who use, I see and hear stories of lives in chaos and full of despair but I'm also in a position where I see that there are a large number of people who use ice and lead balanced lives.

For me ice is not a substance of necessity, as in "I can't live without it," but rather a substance of choice: "I choose to have some." It hasn't always been this way for me. Ice is one of the more potent substances that are available and therefore really must be treated accordingly with respect.

Like many people, there were times in my life when I blamed the drug but for me I realised that there were many reasons why I continued using and it was only when I started to reduce that my life started to change for the better.

I've found that it comes down to the decisions we make. With every choice, there are consequences. The outcome can be good or bad, depending on the choices we make and the options open to us at the time.

Ice can be unforgiving, especially if you are new and inexperienced, where we tend to act a little more impulsively with little regard to consequence. Some people are obviously struggling with their usage and present with many complex issues.

I've not been one to say to myself "I will never use again". That just seems to set you up for failure in my view. I have the occasional "tickle" and feel absolutely no guilt about it. I'm not saying that this is for everyone. For non-users, this stance might seem appalling but the fact is, I'm not directing this article at them. This is for all those who are

Illustration: Sasanki Tenakoon

ICE: How to Use and Stay Healthy (cont.)

thinking about using and those who are using, to try and safeguard you from the pitfalls that are associated with using ice.

The one piece of advice I continually offer people who are struggling comes from my own experience: Reduce, Reduce, Reduce! I have found it is the most successful way to take a step back from what is going on and to see things a bit more clearly. Then we can make decisions on where we want to be, what we want our use to be and indeed if we still wish to use. I believe this philosophy can also apply to all drugs available in the community.

Most of us know the various ways on administering ice into the system. The two most obvious ways are through injecting and smoking but there is also snorting, which can cause irritation to the nasal passages, drinking or wrapping the ice in a cigarette paper and swallowing and, finally, shafting (up the bum). This can be done by either wrapping it in cigarette paper and inserting it rectally, or by douching it using a tipless barrel. The second method is easier, as long as you use lube. The drawback with this method is that it can act as a laxative, so that can be a bit of a waste. Another potential problem from shafting is that it can cause irritation to the delicate membranes in the rectum. I don't think I need to go into too much more detail about shafting as I'm certain you all get the general idea.

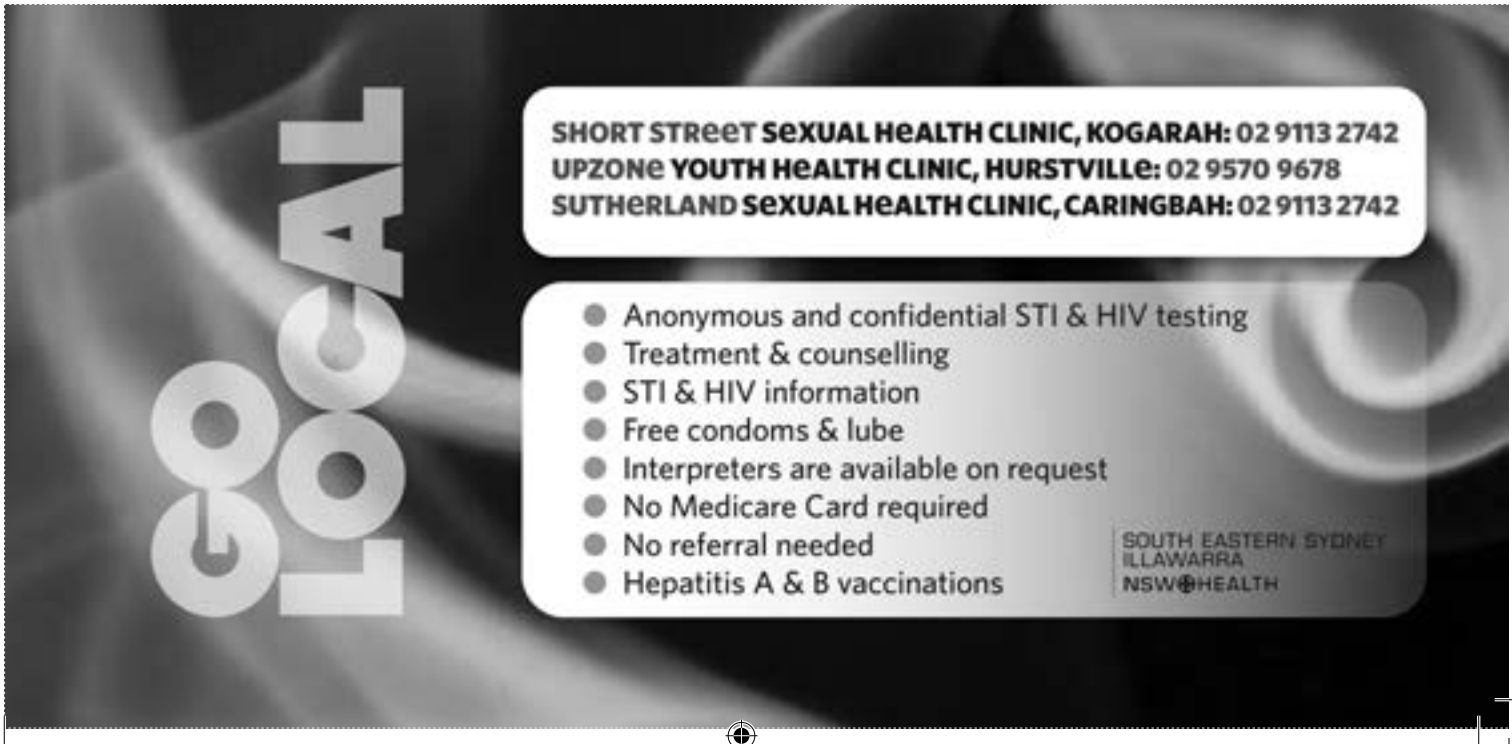
Physiologically, the overall affects of ice are ultimately the same whichever way you take it (although some people will no doubt disagree with this view). However, the differing ways of taking it will allow the substance to be absorbed at varying rates and in varying amounts, making the experience different depending on how you choose to take it.

Smoking ice will have the most immediate effect, followed by injecting, which is almost as instantaneous as smoking. With smoking, you can regulate more readily the amount that you put into your system. The downside of using this method is that it can cause irreversible lung damage. There is some evidence that smoking can exacerbate a degenerative gum disease caused through having a dry mouth due to dehydration and reduced blood flow.

While injecting ice seems to be one of the most common ways of getting it into your system, problems can arise from this method such as damage to your veins and the possibility of sharing – which naturally increases the risk of BBVs such as hep C and HIV.

The moral of this short story is: you can have your cake and eat it too. Just be aware that ice can be a cruel master if taken for granted.

John




ANOTHER EXCITING DAY IN THE LIFE OF YOUR FRIENDLY NEIGHBOURHOOD METH DEALER!!
..EXACTLY.. HE CAN'T BE ACCUSING ANYONE OF...
CRASH!
SORRY YOU'RE BREAKING UP... CALL YOU BACK
HEY TONES? CAN YOU GIVE ME A LIFT?
LOOK, MEET HIM ON THE CORNER..
HEY TONES, CAN YOU LEND ME $400?
HI, MEET HER ON THE CORNER...
ZEEM!!
RE-HAB CLINIC
LOOK, IM GOING TO BE OUT OF TOWN. CALL DAVE.
YEAH, THAT DAVE...
A WEEK LATER.
RE-HAB CLINIC
I'LL BE BACK TODAY. RELAX I'LL CALL YOU WHEN I KNOW
YEAH, OK, WAIT WHERE YOU ARE. I GOTTA GET CHANGED
YEP, I'VE GOT YOU ON SPEAKER. WELL, HE WOULD SAY THAT HE HASN'T SLEPT SINCE HE GOT OUT OF PRISON.
SNORE
FRACKLE
CHIRK
HELLO? YES, SAME PLACE.. GOTTA GO. WHAT? YES, SHE'S ON THE CORNER, BYE.

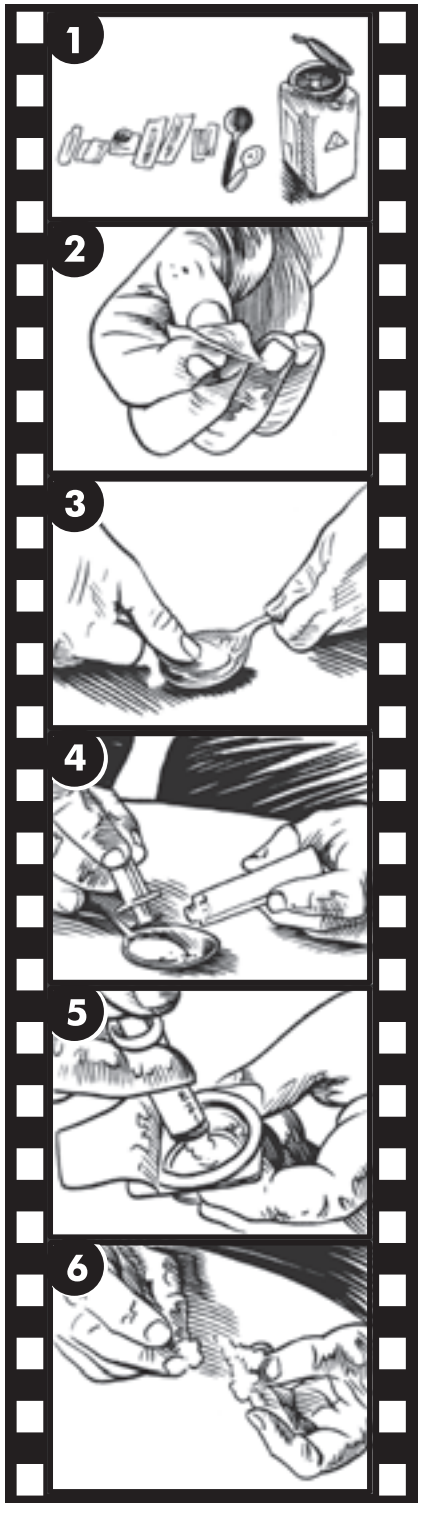

CASHIES
LOANS
AND BUMPS SAID, "GIMME THE FUCKIN TAZER" THATS RIGHT, A TAZER!
INSTA CASH
NATH
CASHIES
LOANS
UH HUH, UH HUH YEP, UH HUH, UH HUH, ERR... NO..
SURE, COME HERE THEN. DON'T WORRY, I'LL TELL HER.
RUFF RUFF
SO ANY-WAY, THE GUY HAD AN AXE, YEAH, HE WAS PSYCHO
RUFF RUFF
SURE, SURE, OK, LEMME GO HOME FIRST
HI BUMPS? YEP, THEY'VE BEEN HERE. UH HUH, CAN YOU? OK, I'LL FIND OUT.
FUCKED CUNT
TAXI!
HELLO? SURE. GO WAIT ON THE CORNER.
HI JOHNNY? YEAH, I'M GOOD... HEY, I'M COMING UP, YOU AROUND?
TAXI
TAXI
EXACTLY, THEY DONT KNOW I KNOW YOU
HOWS CHERIE?
YEAH, ME TOO LOOKING FORWARD TO IT. BYE.
THE END.

Tony Sawrey

Using Wheel Filters for Pills

Crushing and injecting pharmaceutical opioid tablets like oxycodone and hydromorphone can be a risky procedure, sometimes leading to lung problems, vein damage, necrosis of fingers and toes ("pharma frostbite"), heart problems and even death.

Pills were manufactured to be swallowed, and any unintended use, like injection, carries risks. However, using a wheel filter can reduce these risks significantly. If you're going to inject, the following guide is our recommended method for using wheel filters.



1 What You Need

You will need: a wheel filter, sterile water, alcohol swabs, a soup spoon, a teaspoon or other small spoon, cotton wool, two 3ml or 5ml barrels with luer screw tops (one for mixing, one for injecting), one blunt (drawing up needle), at least one sharp (injecting needle).

2 Wash and Swab

Wash and dry your hands, then swab them with an alcohol swab. Once your hands have dried, swab your spoons. Place your pill between the leaves of a fresh alcohol swab. Gently rub away the pill coating (which is dangerous when injected). Most pills will change colour to white or off-white when the coating is removed. Some people use masking tape instead. The most important thing, though, is not to use your saliva to remove the coating.

3 Crush

Place the pill in the soup spoon. Use the back of the teaspoon to crush the tablet. Gently and carefully, press your thumb on the bowl of the teaspoon to grind in a gentle circular motion. Keep going until the pill is crushed to a very fine powder. The finer you crush, the easier the easier it is for the active drug to dissolve. Alternatively, many pharmacies (including some online sites) sell twist-action pill crushers. Prices start at around $10.

4 Mix

Add a few drops of sterile water into the spoon and stir carefully with the handle of the barrel plunger until you form a paste. Continue adding water slowly, stirring constantly, until you have a milky liquid with no large particles, thin enough to draw into your barrel. The recommended amount of sterile water is 3ml.Do not heat the mixture. (see sidebar)

5 Prime the filter

Open the packet containing the wheel filter, but keep the filter inside the packet. Don't touch the filter itself. Add 3 or 4 drops of sterile water in the central hole of the filter. This will lubricate the filter and make it easier to use.

6 Cotton wool

Pinch a small amount of cotton from the centre of the cotton wool. Roll it into a tight ball (the tighter, the better), about the size of your little fingernail. Place the ball in the spoon.

Our thanks to Sarah Hiley, Health Education Team Manager at MSIC for her input in the preparation of this article.

7 Draw up mix
Draw up the mix through the cotton wool into a new barrel. This coarse filter will remove the largest particles from the mix and make the wheel filter more effective.

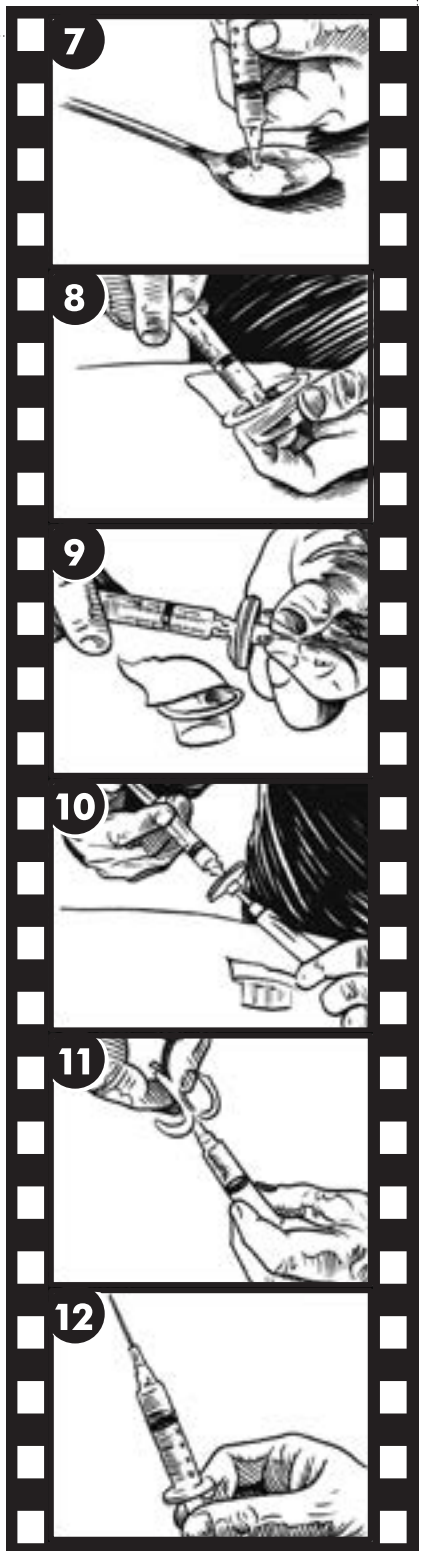
8 Attach filter
Screw the tip of the barrel onto the top of the filter. If the barrel has a slip-tip instead of a luer lock, push it into the top of the filter. But be careful: pressure build-up can force the tip off the filter and spray your mix everywhere.

9 Attach blunt
Remove the filter from its packet and attach a blunt (a drawing needle) to the bottom of the filter.

10 Filtering
Unwrap a new barrel and insert the blunt well inside it. Slowly push the plunger to run the mix through the filter into the second barrel. Some people draw up another ½ ml of water and flush through the filter; others flush air through the filter to force through the last of the mix.

11 Attach tip
Unpeel a sharp (an injecting needle) but don't remove it from the packet. Instead, pinch the packet and attach the sharp to the second barrel.

12 Finished fit
The mix in the barrel will be clear, but it will contain the active ingredient.



WHY NO HEAT?
Opioids like oxycodone dissolve in water without heating. But opioids make up only a fraction of what's in a pharmaceutical tablet. Tablets contain lots of different inactive ingredients like chalk (calcium carbonate), hypromellose and magnesium stearate. If you heat the mix, these ingredients can melt, become liquid and slip through the wheel filter. If you inject these substances, they will cool in your bloodstream, solidify and potentially cause permanent damage to your lungs, veins and extremities. If you're worried that you won't get enough of the dose out of filtering, let the mix stand covered for a few minutes before drawing up from the spoon.

DO I REALLY NEED 3 MLs OF WATER?
The more water you use, the better the opioid will dissolve into the mix, the more effective the filtration will be and the more of the opioid will end up in your shot.

I FILTERED A MIX ONCE, AND IT CAME OUT CLEAR. DOESN'T THAT MEAN I LOST MY DOSE IN THE FILTER?
No. Dissolved opioids can't be seen by the naked eye. If your mix is cloudy or has particles, you're not looking at a dose – you're looking at the harmful inactive ingredients listed above.

HOW OFTEN CAN I USE A WHEEL FILTER?
Wheel filters are designed for single use only.

WHAT IF I CAN'T GET A WHEEL FILTER?
Wheel filters are the safest available filtration devices in NSW. If you don't have access to wheel filters, many experts recommend using a cigarette filter (don't cut or tear off a filter from a tailor; you can buy packets of filters from a tobacconist). Make sure you use tightly balled cotton wool first to get rid of the larger particles, and try to touch the filter as little as possible. Cigarette filters are not as effective as wheel filters, but the more particles you remove from the mix, the more you reduce the risk of infection and damage to your body. Ask your NSP if they're able stock wheel filters. Bear in mind that many NSPs simply don't have the funding to provide them, as sterile injecting equipment is the priority for NSP budgets.

MY MIX IS GLUGGY. WHAT DO I DO?
Some pills, like MS Contin, contain a lot of microcellulose. The only way to deal with gluggy mixes is to add more water and repeat the coarse filtration with fresh cotton wool as you draw up. You may need a larger barrel and more water, and a coarser wheel filter (red). Microcellulose can easily get into your lungs and organs, causing severe damage over time, so be careful.

Illustrations: Glenn Smith

FILTERING FACT FROM MYTH with Raimondo Bruno

Dr Raimondo Bruno is a senior lecturer in the School of Psychology at the University of Tasmania. For over a decade, he has worked in research, evaluation and consultancy in the alcohol and drug sector. Among many projects which Bruno has undertaken is a series of studies into the harms associated with injecting pill-based pharmaceuticals.

Raimondo Bruno: I've sort of "grown up" running the Illicit Drug Reporting System in Tasmania. That's a study where we talk to 100 consumers a year. My background is in chemistry and psychology, and one of the things apparent to me amongst the people I was speaking with was that there were a lot of injection-related harms that seemed to be associated with pharmaceuticals they were injecting. We wanted to try and do something to assist them. That's where the idea for the studies came from.

To design the studies, we talked to local consumers about how they prepare the drugs that we've looked at for filtering and injection. We've replicated that in the lab to see how effective these different techniques have been.

User's News: **Sarah Hiley at MSIC told me that, when heroin was more prevalent on the streets than it is today, the average time between entering the centre and taking the shot was about five minutes. Now with so many users injecting prescription medicine, the average time is around half an hour.**

RB: The things people do to speed up preparation time can undermine some of the benefits of filtering. A lot of people heat their drugs to prepare them quicker. Some of the non-drug parts of the tablet, which give the drug sustained delivery, go into solution with heating. When they cool down in your body, they go back into solid form. So even if you do a good job of filtering them and the mix looks clear, they'll re-congeal in the body and have the potential to cause harm.

UN: **I note that the use of cigarette filters is covered in your studies. There is some concern that fibres from the filters might get into the mix.**

RB: That certainly is the case. The other trick with cigarette filters is you have to handle them a lot. In the process, you add bacteria and things like dead skin cells from your fingers into the mix. If you can do something that doesn't involve handling, it's better. That said, if you've got a choice between not filtering and using a cigarette filter, I would go the cigarette filter every time. Depending on how chalky the mix is, it'll get rid of between a third and two-thirds of particles. But you've gotta remember that there's hundreds of thousands of particles big enough to cause blockage in every injection. If you look at a mix that's gone through a cigarette filter, it's a lot easier to see through but it's still a bit cloudy. The smallest blood vessels in the body go down to about five microns but, in the lungs, they're typically around 300 microns. Basically, if your mix is cloudy at all then you've definitely got particles big enough to cause harm.

UN: **Some people believe that if the mix is cloudy, it means the active ingredient is in there. And if it's clear then all they're doing is shooting up water.**

RB: It's exactly the opposite. The active drug should dissolve. If you've got enough liquid, the active drug should dissolve perfectly. You get a beautiful, clear solution. Anything that's cloudy means it's not dissolved and it's likely to be contaminating material.

UN: **The effects of not filtering are not always immediately apparent. Problems in the body can accumulate over years of using. What are the warning signs?**

RB: If you're injecting into your arm, the first place that things are gonna start lodging in is the lungs. So you're gonna get constricted lung function. But many people who inject drugs also tend to smoke a lot. That also causes lung problems. So you might not be aware of which is which. The other thing is that some components of the drugs will be local irritants around the injection site. They might lead to inflammation in the veins or at the site, which can lead to abscesses. And bacteria from handling equipment and from non-sterile production can lead to local infections as well. If you're getting a lot of those things, it's a good sign that filtering, particularly with sterilising filters, would potentially be really beneficial, if you can afford them.

FAVOURITE DRUG: Choice or Accident?

I like to think that a conscious, well informed decision went into my specialising in using speed rather than gear or ice – although, to be honest, I'll pretty much do anything as long as you can shoot it up. And let me tell you I've shot up many things. If this story came with an advisory warning, right now you would be reading "please do not try this at home." Since it isn't, read away to your heart's content –and possibly your veins' detriment.

I chose speed a few years ago for many reasons. Ice had become ridiculously overpriced, especially after my dealer went to jail. The quality was shit, too. While I will do gear if it's offered, I don't do it regularly because of the body's natural tolerance for it and the huge withdrawals the body goes through when it doesn't receive it. With speed I can quit at any time with minimal withdrawal, apart from eating and sleeping a huge amount at first. I have quit many times, often because of lack of money or the need to keep a current partner happy.

Another reason I choose speed rather than gear is that when I first started injecting I was working in the sex industry. I wanted my drug to help me work better. Even when I occasionally used slow, I never used it at work. I wasn't comfortable working on slow as I didn't feel in control in the room with a client. Safety is of paramount importance to me. I kept it for a relaxing treat after a hard double shift.

My acquaintances who use gear have huge withdrawals; physiological, not just in your head as it can be when stopping amphetamines. I have seen so many girls coming off gear whilst at Mulawa that I made the decision not to make smack the drug for me. Although I didn't believe it at the time, I had minimal withdrawals from the small amount of gear I used on a semi-regular basis. The chick who scored for me saw I had been having cramps and diarrhoea. She said, "You are starting to hang out for it. Stop now, or you will be like me in no time at all and your life will be fucked!"

Before I started injecting I had spent 18 months clean after stopping a $1500-a-week ice habit cold turkey. Back then I smoked ice habitually for about three years. A decade ago, prices were reasonable and quality was good, especially as I bought in bulk.

After all those months clean, what made me inject? Let me be totally honest and say that I was clean but drinking heavily, mixing zolpidem (that notorious sleeping pill), and at times benzos. So was I clean or simply substituting one habit with another?

One day, I agreed to score for a good mate who was an injecting user. I said to her, "Okay, if you are going to start back injecting, you can give me a shot too." She hesitated but I was persistent. When she finally agreed, she told me not to try and do it on my own. To be honest, the first shot wasn't mind-blowing – probably because she was greedy and only gave me a small amount. Regardless, it was the beginning of my craving for the needle. It only took about two weeks to become my focus after that first shot. I never blame anyone else for my habit as it has always been my decision and I am a very strong willed, obstinate person. Once I want something there is no changing my mind.

No matter what your drug of choice is, do it safely. You only live once so make your life count. Don't let the stigma rule your life. We are still contributing members of society. Even though I haven't met most of you readers personally, you are all my friends. Happy and safe injecting to all (especially the girls at Mulawa – I miss you all).

Destini

Illustration: Bodine

Competition!

To mark the commencement of the ACT peer naloxone training program, we are running a competition open to all readers.

In 50 words or less, tell us: why should NSW have a peer naloxone program?

The most original or positive answer will win this fabulous T-shirt from redbubble.com!

Post, fax or email your entry to "Calm" c/o NUAA, PO Box 1069 Surry Hills 2010. Remember to include your name, address and your T-shirt size (S, M, L, XL, 2XL)

Entries close Friday 18 May 2012.
So get writing!

NEXT EDITION / USER'S NEWS #69

We want stories from young people!

The next edition of User's News will have a special section for and about younger people. If you're under 25 and have experiences you'd like to share around drug use, we want to hear your story. Submission deadline: Friday, 18th May 2012.

- Good times, bad times, scary or exciting times.
- Hassles from the law, hassles from parents, hassles from authorities.
- Experiences with your friends or relatives.
- Or any story you feel like telling related to drug use, getting clean, managing on methadone or bupe.

Remember, even if you're not under 25, we always want your stories. Send them in typed or handwritten, by post, fax or email. User's News pays 13 cents per published word if your story is selected.

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CAN'T GET NO SATISFACTION?

How to Make Your Complaints Count!

My favourite lesson about self-advocacy comes from the film Legally Blonde 2, when cute Reese Witherspoon gets snaps in the senate for a great extended metaphor around getting a bad haircut from a famous salon. She explains that by not communicating her wants and needs, by watching on silently as bad decisions were being made for her, she only had herself to blame. She punchlines: "I didn't participate in the process."

I love that scene. I love the advice more: it's your life, step up and shape it. Seize control! Take personal responsibility for getting good service.

Too often users feel powerless because we have so many agencies laying down so many rules for our behaviour. Everyone seems to think they can have an opinion about our lives (yes, Miranda Devine, I mean you). Being an active consumer starts simply by letting people know, calmly and directly, what we need and how we want to be treated. And if they don't listen, we get to tell someone who can help; we make a complaint.

There are four ways to complain effectively: anonymously in a service survey or to a service consumer representative; formally to the service at fault through their complaints process; formally to a specialist complaints body, like the Methadone Advice and Conciliation Service (MACS), the Health Care Complaints Commission (HCCC), the Anti-Discrimination Board and the Ombudsman; or through the political process – the right of all Australians. A consumer group like NUAA can help you tease out the issues and work out who to complain to.

When you complain in a constructive and effective way, you make things better not only for yourself, but for everyone else. You raise the bar for all of us.

A service will assume everything is okay unless we complain. In "real life", consumers vote with their feet. Unfortunately, it's not that easy for us, with few alternatives and long waiting lists. We can't walk, so we need to make it work better.

We often don't say anything because we assume a complaint is unwelcome, but this may not be the case. A service may need your evidence to discipline a staff member, hire more staff or change a process that isn't working. Our complaint can provide ammunition for change.

Alex Wodak once told me about the first customer satisfaction survey put in at Rankin Court pharmacotherapy clinic. At the time, the clinic was housed in a cramped, dirty old terrace that stank and leaked. Including a question on physical environment, Alex hoped to get evidence to pressure the hospital to move the unit to a better location. Except 80% of patients responded that the venue was just fine. They lost a chance to get a service improvement and sent a message that for users, horrible is good enough.

So if you're asked your opinion, don't hold back. Find out if your service has a consumer representative and who it is. If a service doesn't have a feedback route, complain about it until they do.

CAN'T GET NO SATISFACTION? How to Make Your Complaints Count! (cont.)

Most of the things people complain about relate to practice issues: the way a professional has behaved or the way rules have been interpreted. You deserve to be treated with respect and compassion. You deserve to be given the benefit of the doubt and not to be accused of wrongdoing without proof. You deserve to have your activities and details kept private. You deserve to be medicated if and when you need it, and not under- or over-dosed.

It is advisable to complain first to the service at fault; then, if you are not satisfied, go to a complaints body. The benefit of complaining to a complaints body is you get an objective opinion and can shine a spotlight on the issue by taking it to the attention of senior people in the field. Remember: "the personal is the political." In other words, if it is happening to you and you don't like it, the chances are it is a larger problem affecting other people.

Unfortunately, some things are just not fixable through a service's complaints process. If your chemist only offers methadone and you want Biodone, or your clinic has moved to Suboxone film and you want Subutex, maybe you have to change services. Likewise, you can't make a GP prescribe methadone or a chemist dose even though they can and should. Internal complaints services won't help here. But you can write a letter to the editor or go on A Current Affair. You can take up a petition, have a demonstration outside their business or get everyone to wear slogans on T-shirts saying "HIPPOCRATES WOULD ROLL IN HIS GRAVE!" You could even try suing the service. You can ask NUAA to take up those issues through their committee participation. Or you can write to Queen Elizabeth's public servants – our politicians – about it.

When something is wrong with the rules themselves, you need to complain to the rule makers. This sort of complaint needs to be kept personal and specific: talk about how the status quo makes life difficult for you and how changing it would make life better. Tell them that because they have spent the lion's share of money targeted for drug services on drug law enforcement, you were unable to access treatment when you needed it. Describe what happened in your life as a result. Say how your livelihood has been threatened due to ridiculous methadone takeaway rules. Talk about the overdose of a friend that could have been prevented through the provision of naloxone to peers.

Complaint is a dish best served cold. Losing your temper and swearing at someone is going to turn you into the problem, even if you are totally justified. It's best to step back, think logically, and get it on paper. It is important your complaint be courteous and reasonable. As my mother used to say, you get more ants with honey than vinegar.

It is always better to complain in writing. It packs more of a wallop; it can't be ignored or misinterpreted. If writing is not your strong suit, enlist a friend or family member to help, or ask NUAA. Hospitals, prisons and government departments will usually have a form designed to help you and are required provide support for language, disability or learning issues. One of the few exceptions to the writing rule is MACS, set up to take methadone complaints over the phone.

For best results, name yourself. If you are complaining about a person, they will usually get to read your complaint so they can give their side of the story. Don't be scared. If you are being bullied or singled out by a professional, your best protection is to make a formal complaint. It is very hard for people to get away with bad behaviour when they are being monitored.

Most importantly, be clear about what you want out of your complaint. If you have been treated badly, an apology is nice, but what you really want is for it to never happen again to you or anyone else. You need them to activate a plan for change to improve the dodgy aspect of the service. For example, you might ask for staff to be trained in being fair and equitable – you could suggest NUAA run a training session on how to work with us.

It is in our best interest to get along with the services and professionals who are treating us. Services are not ideal and are often under-funded and short-staffed. Things like queuing and waiting are part and parcel of life, especially in a big city. People are definitely far from perfect and everyone can have a bad day. But ongoing and serious breaches of behaviour, and obvious and institutionalised discrimination need to be addressed.

You owe it to yourself and to your peers to help services improve their game. If you think it's about time for drug policy and law reform, tell your local member and the Minister concerned. Or here's a thought: write an opinion piece for User's News! You'd be amazed who reads it.

Leah McLeod

CHECKLIST! for Making a Formal Complaint

YOUR COMPLAINT NEEDS TO BE AS COMPLETE AND SPECIFIC AS YOU CAN MAKE IT.

1. **Get organised.** Buy a folder or envelope and keep everything related to your complaint, including your evidence, research, notes and responses.

2. **Make a rough copy first.** Start by making notes of everything that happened, then arrange it all in a logical way and write out a fresh version. Take out emotional language; you want it to read simply and straightforward. Use headings if it helps. Get someone to help you put it all together or check it over for you.

3. **Talk to witnesses.** See if they will write a statement for you and if theyare willing to speak to someone or appear at a hearing. The best way to get what you want, on time, is to write a draft statement for them to rewrite and/or sign.

4. **Include your name and contact details.** Anonymous complaints are not as powerful and sometimes are not addressed at all.

5. **Start with a short statement that summarises,** in a couple of sentences, what your complaint is, who it is against, when it happened.

6. **Tell what happened as clearly as you can.** You need to show that you have a genuine complaint. Include as much evidence and detail as possible. Include dates, times, places, names, conversations, statements from witnesses. Attach clearly labelled copies of any relevant documents, letters to and from the service, notes from your diary, appointment cards etc.

7. **Let them know how you were affected by what happened** – emotionally, physically, financially, in your relationships, job, housing etc.

8. **Explain why you felt what happened was wrong** or why the way you were treated was unfair and discriminatory.

9. **Tell them any steps you have taken to sort this out,** e.g. if you tried to reason with the person involved at the time, spoke to the manager etc. Again, include any letters and relate any conversations. Say why you weren't happy with how they dealt with it. Say if the problem occurred again, or if you were bullied as a result of complaining.

10. **Own up if you had any part in the incident and apologise if you responded disrespectfully to staff at the time.** Don't justify it, just say it.

11. **Say how you want the problem fixed.** Make sure that what you want is within the power of the organisation that you want it from. Be reasonable but as well as an apology, ask for real change – change in practice guidelines, training for staff etc.

12. **Get a response.** Ask for the complaint to be acknowledged in writing. Ask how your complaint will be advanced, who will address it and how long it will take.

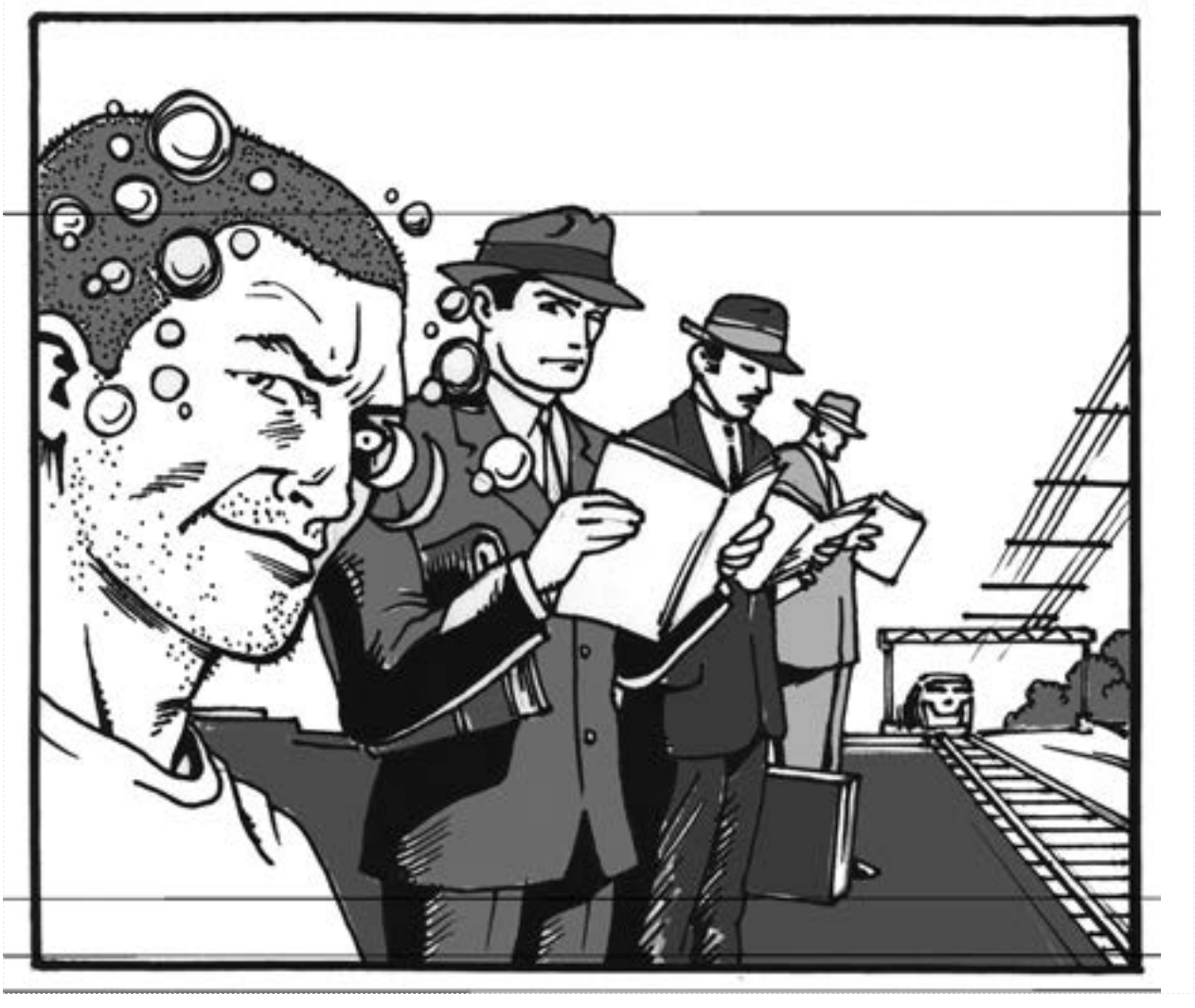
13. **Tell them what you will do if they don't resolve it at this level,** i.e. go to a higher authority, go to the media.

14. **Check it all before you send it off.** Use a spell check if you are using a computer, or get someone else to look over it. Make sure you include your address and phone number.

15. **Take a photocopy of your complaint and send the original.** Do the opposite for any letters and other inclusions, that is, keep the original and send photocopies. Keep any responses and add them to your folder.

User's Story

Not Waving, but...



I experimented with crystal methamphetamine for almost six years. Smoking eventually led to injection which, after numerous failed attempts, led to quitting. One of the symptoms I experienced during the withdrawal process from meth was hallucinations. My vivid imagination, fuelled by the substance, showed me many things that were often enjoyable, occasionally not so. This is one example.

"I'm late," I said to my wife. I kissed her on the cheek and closed the car door behind me. The rain hadn't stopped for days. I hurried for the entrance to Central Station.

The concrete umbrella built for all the 9-5's who dwell in the tunnels, like rats in the race to provide fuel for the economic fire that in the end, leaves nothing behind apart from a trail of burned memories turned to ash. I told myself that I was part of something bigger, but I didn't believe it. I waited impatiently on the platform. I felt almost as bad as I looked and wanted nothing more than to sit down and dread the moment when my arrival at work would commence my anxiety- and stress-filled day. I took a seat by the window and looked around vainly for a familiar face.

Illustration: Bodine

User's Story

Not Waving, but...

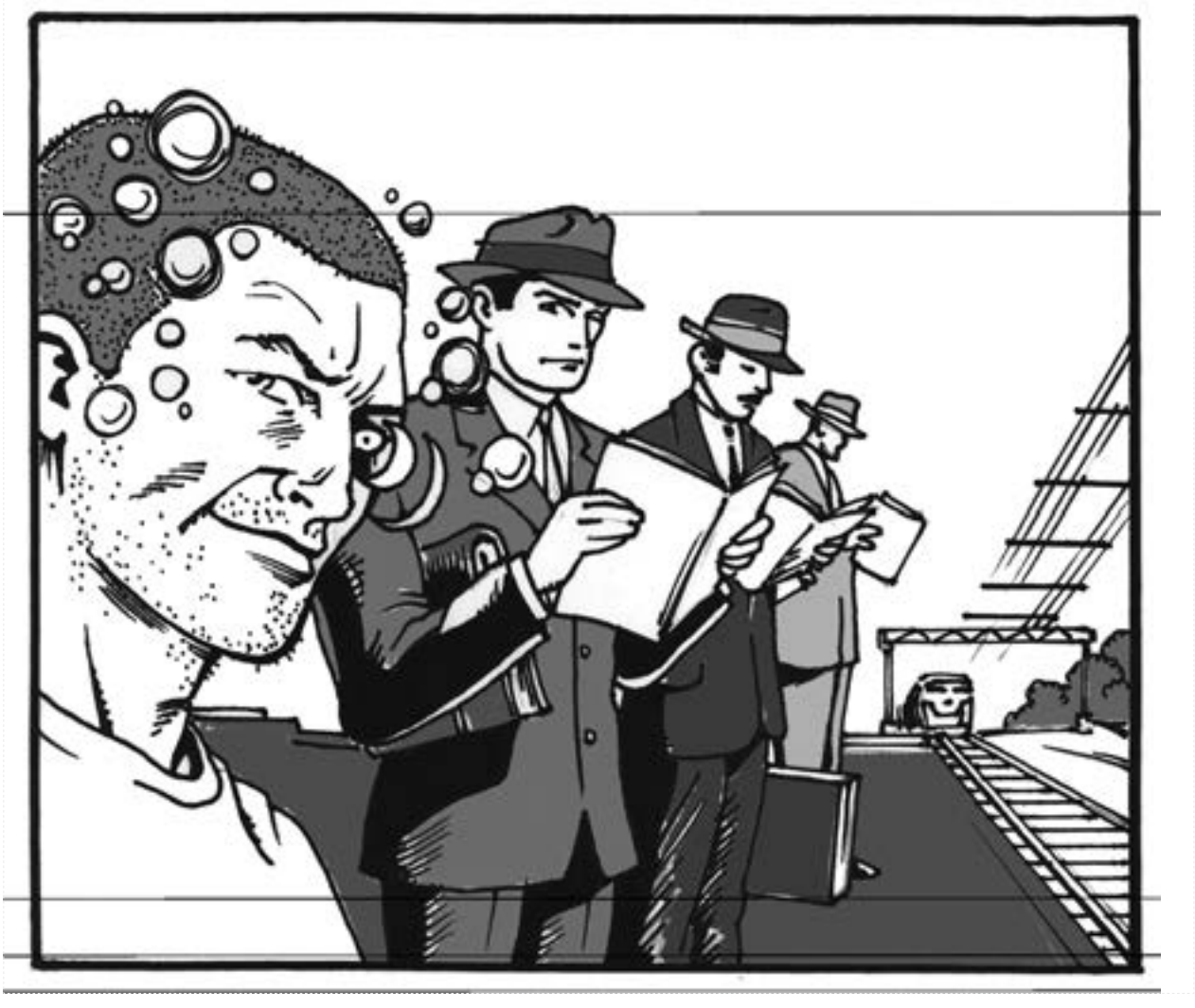


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Illustration: Bodine

Not Waving, but... (cont.)

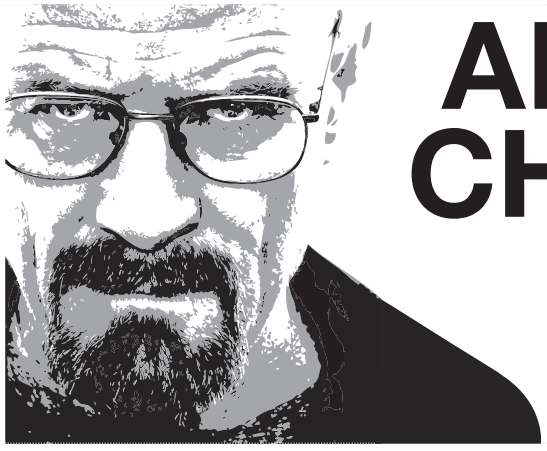
My clothes were filled with rain. When I moved my toes around inside my shoes it felt like they were swimming. I watched a man standing by the carriage door, holding his bicycle steady, wearing a matching outfit of top-to-bottom stretch fabric. I could not tell which direction his eyes were focussing from behind his sunglasses. I wondered if he was looking at me. "He is facing in my direction," I thought. "Oh no, he's probably looking right at me while I have been staring at him this whole time with this confused look on my face, but I can't look away now he'll think I'm rude, but why do I care? The guy is probably an idiot I mean who carries a bicycle on a train? Doesn't the whole concept seem a bit redundant to him?" The man smiled. I quickly looked down at the floor around my shoes, feeling embarrassed that I had thought all those things over nothing.

The train entered a tunnel and the lights in the carriage went out for a moment. I felt a slight panic but I looked at the other passengers' faces and none of them seemed to mind. Living in the city long enough allows people to get used to things not working. The lights flicked back on and I could have sworn there was a man sitting directly across from me. It occurred to me that rather than feeling slightly dryer I felt slightly wetter. I felt drops of water run down my wrists and down the side of my face. I slowly shifted my eyes to see whether the man sitting next to me noticed. He was wearing an expensive looking suit and was reading his paper. The lights went out again; not only was there no light but there was no sound. The lights came back on to reveal that water was now running down my ankle as a puddle formed on the floor beneath me. The angle of the carriage caused the puddle to shift towards the man's shiny black shoes. The puddle reached his shoe and he turned his head to share his expression of disgust. He folded his paper and stood up to make his way to another carriage before I had time to work up the courage to say sorry.

The water kept flowing. By this time it had covered most of the floor but looking around and seeing the lack of interest from the other passengers I wasn't so sure. The lights left us again. All I could feel was darkness and water. I began to shiver. The lights came back on and water was pouring out from my sleeves, my shoes and my collar. Water was running down my face from the top of my head, leaving barely enough room for my mouth to find air. The lights went out again and I felt myself floating. Like gravity had left me. The lights came on and the carriage was almost full of water. A woman sitting on the seat in the corner of the carriage was still reading her magazine even though it was falling to pieces in her hands. I tried to scream but the water covering my face only allowed a gurgle. Slowly, the water level reached the roof. I watched, submerged, as people's clothes and hair slowly danced around them as they sat completely unaware of their newly aquatic environment. I turned to see a transit officer swimming towards me. He connected both his index fingers and both his thumbs to make a rectangle. I reached for the ticket in my back pocket. Before I could place the ticket into his outstretched hand the carriage emptied itself. The water swirled around like a whirlpool and in an instant the transit officer and I hit the floor. I stood up and faced the officer and as he opened his mouth to speak I realised he was now looking down at me as the man in the expensive suit nudged me with his elbow. "Hey, ticket please," the officer demanded impatiently. As I reached up to hand over my ticket I looked past my dry sleeve at the man by the train door holding his bicycle steady. He was still smiling.

I kicked my habit a while back now. I am now in a habit of "not using." To continue to no longer use remains a goal of mine. All one can do is look back and appreciate not only the pleasant memories but also the unpleasant. Contrast is very important in life, it gives a person perspective. If life was everlasting bliss it would be ever so dull. Would it not?

Roscoe



Credit: Sony Pictures Television

ALL ABOUT CHEMISTRY

TV's Breaking Bad

Breaking Bad has been acclaimed for its writing, cinematography and exceptional cast. Created and produced by X Files co-producer Vince Gilligan, the US drama series has won six Emmy awards since its first episode debuted on January 20, 2008. It has since gone on to complete four seasons, and is currently in the process of being filmed for its fifth and final season. Unlike many television series, this show just keeps getting better and better.

So what's all the fuss about? Why do users and "straighties" love this show alike?

The world depicted in this drama is the world that America's international "War On Drugs" has created. Similar to the Prohibition era of the 1920s and early 1930s, the creation of illicit drugs by passing laws that prohibit their production and distribution let alone their consumption has led to a dog-eat-dog gangster mentality in the trade of proscribed drugs.

Far from reducing the trade in drugs, these laws have served to escalate prices at the same time as increasing their demand, thus turning it into a very lucrative industry indeed. Being on the wrong side of the law may make drugs more profitable, but lawlessness also means that the normal 'rules' of acceptable behaviour no longer need apply. Breaking Bad is an exploration of that world through the eyes of a novice who progressively breaks one rule after another until he becomes almost unrecognisable.

When asked what he meant by the term "breaking bad", Gilligan defined it as "to raise hell":

> *Jesse Pinkman: Nah, come on man. Some straight like you, giant stick up his ass at like what, sixty, he's just gonna break bad?*

Walter White (played by Bryan Cranston) is a high school chemistry teacher. He is struggling to maintain his enthusiasm because he feels that he's missed his chance to attain success in life. Then suddenly he's dealt a card by fate in the form of lung cancer. Walter doesn't smoke. This becomes another cause of resentment towards the "pious" way he's lived his life of no returns.

When he discovers that the very people he resents for stealing his chance at success are the ones that are going to pay for his treatment (thanks to a request from his wife), he decides to use his knowledge of chemistry to not only pay for his own cancer treatment, but also to provide for his wife Skyler (Anna Gunn) and his son with cerebral palsy, Walter jr, (played by R.J. Mitte, who has mild CP in real life). Gilligan stated that he wanted "to turn [Walter] from Mr Chips into Scarface."

The show is filmed in Albuquerque, New Mexico. The scenes of illegal border crossings, with people crawling on hands and knees to avoid being spotted by the border patrols, are nothing less than mesmeric. The knowledge that these scenes are based on reality make them all the more compelling. What we call "people smugglers" they

ALL ABOUT CHEMISTRY : TV's Breaking Bad (cont.)

call "coyotes", and the number of illegal immigrants attempting to cross la linea puts our Australian politicians' beat-up about boat people to shame: tens of thousands every six months, with hundreds dying on the wayside every week.

Although the series revolves around drugs, there's not much actual drug use in Breaking Bad. What use there is, however, is seen – briefly but intimately – through the eyes of Jesse Pinkman, Walter's former student and the guy he teams up with to start his cooking career.

Jesse is an archetypal delinquent – a high school drop-out and petty meth dealer who has been rejected by his family and is trying to get by as best he can. When he and Walter first get together we glimpse the world of the small-time dealer: Jesse's friends, the "smurfs" who laboriously gather the pseudo-ephedrine needed from pharmacists far and wide, all users themselves; the drawn-out process of selling deals by the unit whilst partying all night with the music of It's such a good night to scooby-de-do-bee-do in the background – fun, but not very profitable, and more than a little risky.

In this way we are introduced to Jesse as a participant – a user – unlike Walt, who sticks to cooking and is always outside the drug-using experience, even as he is supplying it.

Breaking Bad is based around the fractious but indispensable relationship between Walter and Jesse. Jesse is the agent that triggers most of Walter's changes, both good and bad.

There's an amusing but sad scene in which Hank Schrader (Dean Norris), Walter's DEA brother-in-law, attempts to educate Walter jr as to the evils of drugs. He drives Walter jr to a car park in a red light district well known for its high proportion of crystal meth users to demonstrate the fallen state of the populace. He corners a prostitute and commences a degrading series of mostly rhetorical questions designed to highlight the shame of her situation. Her haunted, hollow eyes and rotten teeth correspond accurately to the many photographs depicting the physical degeneration caused by crystal meth on YouTube. The smugly arrogant attitude of Hank Schrader would be familiar to any drug user who has ever had to survive an encounter with the police. It is this attention to detail and accuracy that makes the show and its characters so believable.

Heroin use gets a brief – but intense – appearance as well. In fact, it is the only time that the modality of injection gets introduced to the script, for all the crystal meth use is done by snorting or free-basing. The image of Jesse floating up to the ceiling was a little overdone in my opinion, but given the difficulty of expressing feeling and sensation in a visual medium it can be forgiven.

The term Breaking Bad implies a sudden transformation, but what the series portrays so well is that the changes that lead to transformation are so incremental and gradual that it is only after their accumulation that someone is recognisably altered from their original state. It compellingly suggests that every decision in life is a moral decision: every act affects us and those around us, whether we notice or not.

Breaking Bad's use of symbols and motifs along with its far-from-shallow writing makes it stand out in both a visual and literary sense as one of a genre that dares to look at the darker side of life without preconceptions and the standard stereotypes that characterise more mainstream Hollywood fare. From Nurse Jackie to The Sopranos and Weeds, American television has entered a brave new world where the chief protagonist is morally ambiguous and the bottom line eschews easy answers. It is courageous and it is relevant. And it seems there are enough people intelligent and nuanced enough to form a viable audience for it.

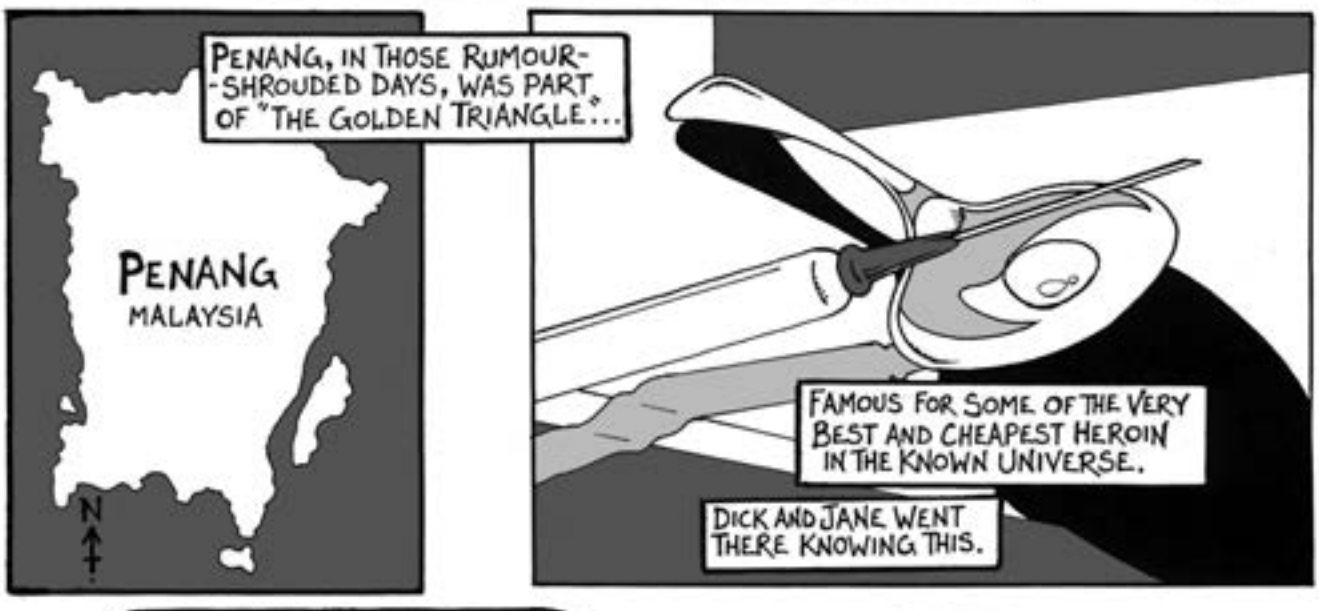
With the fifth season of Breaking Bad already well into pre-production this trend seems set to continue and even develop. And that can only mean more thought-provoking and thoroughly exciting viewing for intelligent audiences here in Australia and the world over.

Suzy

BASED ON A TRUE STORY...

The Name Game.

BY BEAUMONT JARDINE .COM




SEE DICK RUN.
SEE JANE RUN.
RUN RUN RUN.
TAXI
TAXI CABS ONLY
WE'RE HERE TO SEE SAM.
NO.
NO SAM HERE.
SO...NO SAM, HUH ?
YOU HERE TO SCORE ?
YES.
HEROIN ?
YES.
THEN I'M YOUR MAN !
SOON...
C'MON BABE - HURRY IT UP...
YEAH ?
PISS OFF !
IS IT O.K. TO COME BACK HERE ?
BUY SOME MORE ?
SURE IT IS !
SO WHAT'S YOUR NAME ?
SAM.
END.

User's Story

Laughing Stock

I started using speed with my brother and his girlfriend when I was 14. My grandmother had died. I was a pallbearer at her funeral. After the service, my brother asked me if I would like to try some. It was pretty incredible.

Three years later, on my 17th birthday, at 6:25pm (I was given a watch for my birthday), I had my first shot. Speed again, beige this time. It was so incredible; soy unreal. A year and a half later I started using heroin (and we know where that leads).

My heroin addiction habit lasted 17 years. Which reminds me of the time I scored some really, really, really good beige. I shot up under the bridge at Canley Vale, next to the needle tree. I was going to save half but I thought if the Jacks saw me in this state, they'd have a word with me and the game would be up. So up the Warwick Farm it went. I left my shooting equipment behind, remembered, and went back for them.

The next thing I knew, I woke up head-butting the train seat in front of me, whilst this attractive, dark-haired woman sitting next to me and half the train were pissing themselves over my drug-fucked state. Funny thing was that I was going to Granville, although I woke up sitting in the train at Liverpool. Either I got the wrong train or I travelled to the city and back.

To cut a long story short, I started on methadone. At the beginning I used it to help me at work. But now I'm seriously trying to get my life back on track, and if you're serious I believe it does help.

Jason

Illustration: Glenn Smith

Would you like to help with hepatitis C research?
You can if you have been recently infected with hep C

Research Study

Treatment of recently acquired hepatitis C virus infection (ATAHC II)

ATAHC II

The Kirby Institute (formerly the National Centre in HIV Epidemiology and Clinical Research) is running a hepatitis C study for patients who have acquired hepatitis C recently (in the last two years).

ATAHC II aims to explore the best treatment strategy for patients with recently acquired hepatitis C infection. You can choose to receive treatment or not if you decide to help.

There are clinics participating in the study in Sydney, Melbourne, Brisbane and Adelaide.

Contact Barbara Yeung at the Kirby Institute on 02 9385 0879
or byeung@kirby.unsw.edu.au for your nearest site or to find out more about the study.

This study has been approved by the St Vincent's Hospital Human Research Ethics Committee.

Doing BUSINESS

This happened years ago. Another miserable day in the Cross, overcast, raining on and off.

What's all the commotion near Les Girls? Some coppers had two dealers bailed up in the doorway. It was Dom and Steve. They strip-searched them right there. When the coppers left empty-handed, Dom saw me and called me over. I'd known Dom for a few months. I would run for him and get customers and after so many deals he'd give me one. He asked me if I still rented a room in the boarding house at the bottom of Macleay Street. "Yeah," I said.

"I'll make it worth your while if you let us use it to make up our deals." My room was dark, damp and half underground. The window opened at ground level. At least the coppers didn't know about it, and it was better than sleeping on the street.

Dom and Steve went to the bathroom. When they came out, they were laughing, saying how dumb the coppers were, as they each threw a ten-weight bag on the table.

After we all had a shot, Dom made up one of the bags into deals.

We went back up to the Cross. The coppers had warned the boys that if they saw them again today they'd be taken into the cells. This usually meant that they'd receive a flogging or even be sent up. Dom got me to do laps of the main street and check for anyone who wanted to score. I would tell them to go up a back street to find Dom. He sold out really quickly, so they made up deals from the other bag. After another shot, we returned to the Cross and sold out even faster than before. Dom and Steve were rapt at how smoothly everything went. We had a feed and they gave me $100 in cash.

After two weeks of helping Dom do his business, he told me I'd earned so much helping him that I had five grams that were mine. He said I could put in with him as partners. We could do heaps of business.

One Monday night as I sold my last deal, Steve drove up out of the blue as white as a ghost, asking me where

Illustration: Glenn Smith

Doing BUSINESS (cont.)

Dom was. We drove off to find him. Steve reached under his car seat, handed me a bag and told me to get out of the car; he and Dom had some business to take care of. There was half an ounce in the bag. I was to sell half; the rest was for me so I wouldn't be sick because they were going to be gone for a few days. As I got out of the car I gave Dom a hug and whispered "be careful." They were the last words I ever said to Dom.

The next day I made up what I had to, went up the Cross and sat around near the supermarket on a crate selling my deals. Before lunchtime I'd sold out, so I met Steve's sister Nicky and gave her the money. We had a coffee, then I invited her back to my motel room for a shot as I knew she used. We spent a stoned afternoon together. At six, she had to go and said she'd see me the next day and that she would bring some different dope her boyfriend was picking up in the morning. Because I still had cash from selling I went and scored of some Romanian guys nearby. I knew their gear was the same quality as I'd been selling, except they charged me an extra $150 for five weights. I went home, made the bag up into deals and went back up the Cross. I sold out so quickly, I didn't even get to my spot at the supermarket. I went back to the Romanians for another five-weight bag. They were surprised to see me so soon. One of them tried to talk me into selling for them. I played along and said "Yeah, if you give me the dope cheaper." They agreed to sell it to me for the same price I was paying Steve. I finally returned to my room, had a shot and passed out.

I awoke to someone bashing my door down. It was Nicky, sobbing, mascara stains down her cheeks. She walked straight over to the TV and turned it on. Still crying, she put her arms around my neck and said "they're dead." "Who?," I said. As if on cue, the TV came to life with breaking news: "Drug Deal Gone Wrong." There was a shot of a car smouldering. Then I saw a bumper sticker on the car. I'd put that sticker on. The newsreader said that there were two bodies, male, found in the car with gunshot wounds. The police received a tip-off but said they arrived too late. The names were withheld until their families were notified.

"What the hell were they doing in Melbourne?," I yelled at Nicky. "All their contacts were here!" Nicky finally told me that Steve found a heap of counterfeit money. He knew he couldn't scam his contacts here in Sydney, so he thought he could go down to Melbourne and scam them there. Obviously things went terribly wrong. The worst thing was that poor Dom went with Steve, trusting him to his death, not knowing the cash was fake.

Nicky pulled out a bag with a few weights and shouted me a shot. She asked me if I could go with her to see Dom's mum. We pulled up to the house just as the D's were leaving. I couldn't believe how young Dom's mum looked. She grabbed both of us and hugged us even though I didn't know her. I hugged her back and we all went inside. In the lounge room were 20 women, all dressed in black. An altar to Dom stood in the corner, with his photo and heaps of flowers everywhere. I felt out of place but the women made me feel welcome, even though we didn't speak each other's language. Dom's mum was sitting, rocking, holding his favourite shirt and a photo of him.

We heard that the Melbourne coppers believed Steve and Dom went to Melbourne to score, got ripped off and killed. They didn't know about the fake money.

We stayed for an hour then went to her parents' place. It was the same as Dom's except heaps more people showed up to pay their respects. Nicky found me and took me to Steve's room. She knew where Steve kept his stash. There was heaps there. I couldn't believe how greedy Steve had been. Nicky decided to start selling to me. I ended up selling both for her and for the Romanians.

Business was good.

J

HOW Did I Get Here?!

I started using drugs and alcohol at the age of 15 after a family member began sexually assaulting me. I was forever in search of a short, a cone – anything that would get me off my head. At the age of 18 I began working in a swingers' club and on the streets of Kings Cross, selling my body for money as my drug habit had become too expensive for me to afford off my Centrelink benefits. I had no self-respect and no reason for me to live. My live revolved around drugs. I did anything to obtain them.

When I was 16 I was diagnosed with pancreatitis from alcohol use. I was told if I kept binge drinking I would not make it to 18, so even to be alive at this point was nothing short of a miracle. I was in and out of abusive relationships until one day I met Keith.

Keith convinced me he loved me and got me off the drugs. I stayed clean for close to twelve months until he, too, began abusing me. Once again I used drugs and alcohol to block out the pain. He left me soon after, eight months pregnant with a $500-a-day habit. I quit drugs again soon after and my son was born. I stayed off everything whilst I breastfed.

Then I met Josh – a seemingly nice man who seemed to care about me. Until AGAIN he started abusing me – physically, sexually and emotionally – and once again I got caught in the drug cycle. I fell pregnant again and gave birth to my daughter on the 19th of May. She was taken into DoCS care soon after. Now I sit in my cell in jail questioning myself. My mind is racing as I question my choices and my life.

Jail makes you question every move you have made leading up to this moment. How did I end up here? Was it worth it? How could I be so selfish? I have left two beautiful children motherless, an amazing father daughterless, and for what? Drugs and alcohol? A good time? I regret so much of my short life. I am 21 years old and am facing a long lag-on. I hate being away from my two year-old son and my four month-old daughter more than anything. They are so young and I have already failed them. I have put drugs and alcohol before them and I feel sick to my stomach over it. I am so full of regret I wish I could turn back time and not have that one-too-many drink, that one-too-many cone, that resulted in me blacking out and waking up in Mulawa Correctional Centre.

My babies were taken into DoCS' care after my fiancé of four years bashed me and hospitalised me, resulting in a fractured eye socket and two fractured ribs. How did I handle this? I hit the drugs and alcohol, trying to block out the pain.

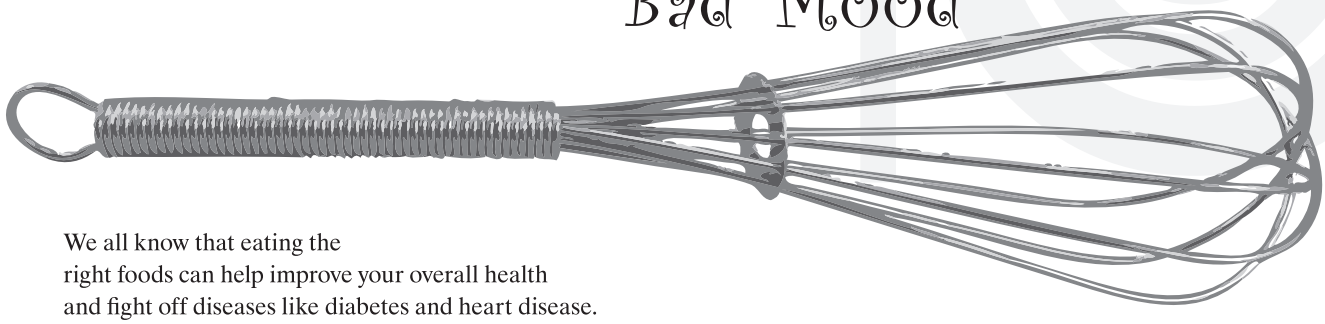
I am writing this today from my cell at Emu Plains Correctional Centre to ask all the girls on drugs and alcohol, trying to block out the pain: is it worth it? Is it worth losing your freedom and everyone you love?

I wish I had taken the time to stop, think and ask myself that question. I implore you all to do that: stop, think and ask, is it worth it?

Kearna

Illustration: Bodine

EATING GOOD FOOD to Fight a Bad Mood



We all know that eating the right foods can help improve your overall health and fight off diseases like diabetes and heart disease. There is new evidence that shows us that eating the right foods can help treat or even prevent depression and anxiety. The opposite is also true: eating the wrong foods can increase your chances of developing or maintaining a depressed or anxious state.

Eating a wide variety of foods from all the food groups is important. If you do this, you will get all the essential vitamins and minerals to keep your insides healthy.

Some tips on fighting a bad mood with good food are:

- Try to eat a wide variety of foods
- Increase your weekly dose of fish
- Limit alcohol if you're a heavy drinker
- Limit excessive sugar
- Avoid excessive caffeine

Variety

It is important to vary your intake from day to day. Try to include a variety of:

- Fruit:

Fresh, tinned, frozen... They're all good!

- Vegetables:

Frozen is as good as fresh

- Milk, Yoghurt & Cheese:

Aim to eat 2-3 times/day

- Bread, cereal, pasta & rice:

Wholegrain varieties help to stabilise mood!

- Meat, Fish, Chicken & Eggs:

Trim the skin from chicken and fat from meat

Eat more fish

Fish contains omega-3 fatty acids. These have been shown to improve symptoms of depression, improve brain functioning and development. The two most effective omega-3 fatty acids are EPA & DHA. They are found in cold sea water fish – tuna, salmon, mackerel and sardines.

The benefits of fish are found in fresh, tinned, frozen and baked fish. Be careful when frying that you limit the oil to avoid excessive fat and choose olive oil.

Limit alcohol

The highs that you feel from alcohol are short-lived and the long lasting effects include headaches, dehydration, mood swings, anxiety and guilt. Alcohol can affect the chemistry of the brain and increase the risk of depression. To avoid long-term health (and possibly relationship) damage; you should only drink in moderation and have a few alcohol-free days per week.

Avoid the sugar/caffeine cycle

Sugar is hidden in many foods including soft drinks, lollies, chocolates and cakes. Sugar isn't essential in your diet because it doesn't provide any vitamins or minerals. Both sugar and caffeine (in coffee and "energy drinks") give you a quick burst of energy; followed by a very quick drop in blood sugar levels.

Low blood sugar levels can make you feel sluggish, tired, irritable, shaky and sometimes even depressed.

Don't fall into the cycle of having coffee followed by energy drinks to "wake you up." Fill up on fresh foods to avoid the cravings for sugar which has these nasty side effects!

Jessica Lewis
Dietitian, Nutrition Development Division
Albion Street Centre

Vegetable Frittata (Serves 4)

What you will need:
- Whisk
- Baking tray

Ingredients:
- Olive oil spray
- 1 tbs olive oil
- 500g frozen stir-fry vegetable mix, thawed
- 6 eggs
- ½ cup low fat milk
- Mixed salad leaves, to serve

Method:
Preheat oven to 180°C. Spray a 20cm (base measurement) square cake pan with oil. Line base and sides with non-stick baking paper, allowing the two long sides to overhang.
Heat oil in a large non-stick frying pan over medium-high heat. Stir-fry the vegetables for 3 minutes or until soft. Transfer to the prepared pan.
Use a whisk to whisk eggs and milk in a bowl until combined. Season with salt and pepper. Pour over the vegetables. Bake for 25-30 minutes or until set and light golden. Set aside for 10 minutes to cool slightly. Serve with salad leaves.

Fish tacos (serves 4)

What you will need:
- Oven
- A few bowls for ingredients
- Knife

Ingredients:
- 2 tomatoes, finely diced
- 1 avoacdo, finely diced
- 1/4 cup finely chopped fresh coriander leaves (optional)
- 1 tablespoon lemon juice
- 1 teaspoon Mexican chilli powder
- 1 garlic clove, crushed
- 2½ tablespoons olive oil
- 600g redfish fillets (swap for canned fish if you prefer)

For vegetarian option, use kidney beans or 4 bean mix
12 (135g packet) taco shells

Method:
Combine, tomato, avocado, 2 tablespoons coriander and half the lemon juice in a bowl. Season with salt and pepper. Cover and set aside.

Combine chilli powder, garlic, 2 tablespoons oil, remaining coriander and remaining lemon juice in a shallow ceramic dish. Add fish. Coat the seasoning on fish.
NB: If you're using tinned fish or beans, coat in the same seasoning.
Preheat oven to 180°C/160°C fan-forced. Line a large baking tray with baking paper. Warm taco shells according to packet directions.
Meanwhile, heat remaining oil in a large frying pan over medium heat. Cook onion for 4 to 6 minutes or until softened. Remove to a bowl. Cover to keep warm. Cook fish, in batches, for 2 to 3 minutes each side or until cooked through.
NB: If you're using tinned fish or beans, simply heat seasoned mixture in saucepan with oil and onion until warm.
Divide onion and fish between taco shells. Top with tomato mixture.

Mango and passionfruit smoothie (serves 1)

This is a great breakfast, a quick and healthy way to start your day! You can substitute the fruits for any of your favourites.

What you will need:
- Blender
- Ice
- Knife

Ingredients:
- 1 small mango, peeled (fresh, frozen or canned)
- ¾ cup skim milk
- ¼ cup low fat yoghurt
- 1 tsp honey
- ¼ cup crushed ice
- ½ -1 passionfruit

Method:
Cut the mango flesh away from the stone. Cut the mango into rough pieces and put into blender. Add the milk, yoghurt, ice and honey. Blend until smooth and then stir through the passionfuit. Serve immediately.

Variation:
Mixed berry smoothie:
Replace the mango with ¼ cup frozen raspberries & ¼ cup strawberries.

Help Lines

ACON – AIDS Council of NSW
1800 063 060
Sydney callers: 9206 2000
Health promotion. Based in the gay, lesbian, bisexual and transgender communities with a focus on HIV/AIDS.
Mon – Fri 10 am – 6 pm

ADIS – Alcohol & Drug Information Service
1800 422 599
Sydney callers: 9361 8000
General drug & alcohol advice, referrals & info. NSP locations and services etc. 24 hrs

CreditLine
1800 808 488
Financial advice and referral.

NSW Hepatitis Helpline
1800 803 990
www.hep.org.au
Mon – Fri 9am – 5pm
Info, support and referral to anyone affected. Call-backs and messages offered outside hours. Email questions answered.

HIV/AIDS Infoline
1800 451 600
Sydney callers: 9332 9700
Mon – Fri 8am – 6.30pm

Homeless Persons Info Centre
(02) 9265 9081 or (02) 9265 9087
Phone info & referral service for homeless or at-risk people.
Mon – Fri 9am – 5pm

Karitane Careline
1300 227 464
Sydney callers: 9794 2300
Parents info & counseling
Mon – Fri
www.karitane.com.au

Lifeline
13 11 14
Counseling & info on social support options. 24 hrs.

MACS – Methadone Advice & Conciliation Service
1800 642 428
Info, advice & referrals for people with concerns about methadone treatment. List of prescribers.
Mon – Fri 9.30am – 5pm

Multicultural HIV/AIDS & Hepatitis C Service
1800 108 098
Sydney callers: 9515 5030
Support & advocacy for people of non English speaking background living with HIV/AIDS, using bilingual/bicultural co-workers.

NSW Prisons HepC Helpline
Free call from inmate phone for info & support. Enter MIN number and PIN, press 2 for Common List Calls, then press 3 to connect.
Mon – Fri 9am – 5pm

St. Vincent De Paul Society
Head Office: 9560 8666
Accommodation, financial assistance, family support, food & clothing.
Mon – Fri 9am – 5pm

Salvo Care Line
1300 363 622
Sydney callers: 9331 6000
Welfare & counselling. 24hrs

SWOP – Sex Workers Outreach Project
1800 622 902
Sydney callers: 9206 2166
Health, legal, employment, safety, counseling & education for people working in the sex industry.

Self-help & Complaints

NA – Narcotics Anonymous
(02) 9519 6200
Peer support for those seeking a drug-free lifestyle.
24 hr number statewide.

CMA – Crystal Meth Anonymous
0439 714 143
Regular meetings around Sydney. Call for times and locations.
www.crystalmeth.org.au

SMART Recovery – Self-Management & Recovery Therapy
(02) 9361 8020
Self-help group working with cognitive behavioural therapy.

Family Drug Support Hotline
1300 368 186
Support for families of people with dependency. 24 hours

NAR-ANON
(02) 8004 1214
Support group for people affected by another's drug use. 24 hours

Women's Information & Referral Service
1800 817 227

Anti-Discrimination Board of NSW
1800 670 812
Sydney callers: 9268 5555
Mon – Fri 9am – 5pm

Health Care Complaints Commission
1800 043 159
Discrimination, privacy & breaches of confidentiality in the health sector.

NSW Ombudsman
1800 451 524
Sydney callers: 9286 1000
Investigates complaints against the decisions and actions of local government and NSW police.

Legal Services

CRC – Court Support Scheme
(02) 9288 8700
Available to assist people through the court process.

Disability Discrimination Legal Centre
(02) 9310 7722
Provides free legal advice, representation and assistance for problems involving discrimination against people with disabilities and their associates.

HIV/AIDS Legal Centre
(02) 9206 2060
Provides free legal advice to people living with or affected by HIV/AIDS.

Legal Aid Youth Hotline
1800 10 18 10
For under 18s. Criminal matters only. Open 9am – midnight on weekdays, 24 hours on weekends

Legal Aid Commission
(02) 9219 5000
May be able to provide free legal advice and representation. The Legal Aid Central office can also put you in contact with local branches.

The Shopfront Youth Legal Centre
(02) 9322 4808
Legal service for homeless and disadvantaged people under 25.

ASK! – Advice Service Knowledge
(02) 8383 6629
A free fortnightly legal service for Youth, run by the Ted Noffs Foundation (Randwick & South Sydney) in Partnership with TNF & Mallesons and Stephen Jaques Lawyers.

The Buttery, Bangalow
Ph: (02) 6687 1111

Medical Services

Aboriginal Medical Service, Redfern
(02) 9319 5823

Albion Street Centre, Surry Hills
1800 451 600 or (02) 9332 9600
Free testing for HIV / hep C & other. Medical care, nutritional info and psychological support for people living with HIV & hep C.

Haymarket Foundation Clinic, Darlinghurst
(02) 9331 1969
Walk-in homeless clinic at 165B Palmer St Darlinghurst. No Medicare card required.

Mission Australia, Surry Hills
(02) 9356 0600
Dentist, optometrist, chiropractor, mental health. Medicare card and income statement required.

KRC – Kirketon Road Centre, Kings Cross
(02) 9360 2766
For 'at risk' youth, sex workers, transgender and injecting drug users. Medical, counseling and social welfare service. Methadone & NSP from K1. No Medicare required.

MSIC – Medically Supervised Injecting Centre, Kings Cross
(02) 9360 1191
A safe supervised place to inject. 66 Darlinghurst Road, Kings Cross opposite train station.

South Court, Penrith
1800 354 589
Medical service, sexual health & nurses. Vaccinations, blood screens, safe injecting & general vein care. No Medicare required.

Youthblock, Camperdown
(02) 9114 4100
12 – 24 years. Medical and dental available. No Medicare required.

Treatment Centres

Detour House, Glebe
Ph: (02) 9660 4137
For women only. AoD service, crisis accommodation.

Fairfield Drug Health Service, Prairiewood
Ph: (02) 9616 8800

Gorman House Detox, Darlinghurst
Ph: (02) 9361 8080 / (02) 9361 8082

Hadleigh Lodge, Leura
Ph: (02) 4782 7392

Inpatient Treatment Unit, Ward 64, Concord Hospital
Ph: (02) 9767 8600

Jarrah House, Maroubra for women and children
Ph: (02) 9661 6555

Kathleen York House, Glebe for women with children
Ph: (02) 9660 5818

Kedesh House Rehabilitation Service, Berkeley
Ph: (02) 4271 2606

Kedesh Phoenix Rehabilitation Unit, Manly
Ph: (02) 4222 1800

Lakeview Non-Medical Detox Unit, Belmont
Ph: 4923 2060 or 1800 422 599

Lorna House, Wallsend
Ph: (02) 4921 1825
Appointment required

Langton Centre, Surry Hills
(Outpatient Service via Sydney Hospital selective process only)
Ph: (02) 9332 8777

Lyndon Withdrawal Unit, Orange
Ph: (02) 6362 5444

Miracle Haven Bridge Program, Morrisset
Ph: (02) 4973 1495 / (02) 4973 1644

Nepean Hospital, Penrith
Ph: (02) 4734 1333

O'Connor House, Wagga Wagga
Ph: (02) 6925 4744
Emergencies only: 1800 800 944

Odyssey House, Eagle Vale
Ph: (02) 9820 9999

Odyssey House, Minto
Referral: (02) 9603 2157

Orana Outpatient Withdrawal Management Service, Wollongong
Ph: (02) 4254 2700

Phoebe House, Arncliffe
Ph: (02) 9005 1570
Maintenance for women with children under 5 years

Riverlands Drug & Alcohol Centre, Lismore
Ph: (02) 6620 7608

Royal North Shore Hospital NSP and Clinic St Leonards
Ph: (02) 9462 9040

St George Opioid Treatment Service, Kogarah
Ph: (02) 9113 2055

St. John of God, Burwood
Ph: (02) 9715 9200 or 1300 656 273

St. John of God, North Richmond
Ph.: (02) 4570 6100 or 1800 808 339

The Salvation Army Bridge Program, Nowra
Ph: (02) 4422 4604 or 1300 363 622

South Pacific Private Hospital, Curl Curl
Ph: (02) 9905 3667

The Ted Noffs Foundation, Randwick
Ph: (02) 9305 6600 or 1800 151 045

The Ted Noffs Foundation, ACT
Ph: (02) 6123 2400

WHOS – We Help Ourselves
Ph: (02) 8572 7444

William Booth Institute, Surry Hills
Ph: (02) 9212 2322

Wollongong Crisis Centre, Berkeley
Ph: (02) 4272 3000

Ward 65, Concord Hospital
Ph: (02) 9767 8640

This list includes detoxes, rehabs and counselling services.
This is not a comprehensive list. Ring ADIS on (02) 9361 8000 for more.

Where to Get Fits

NSP Location	Daytime No	Alternative No
Albury	02 – 6058 1800	
Armidale	0427 851 011	
Auburn Community Health	02 – 8759 4000	0408 4445 753
Bankstown	02 – 9780 2777	
Ballina	02 – 6686 8977	0428 406 829
Bathurst	02 – 6330 5850	
Bega	02 – 6492 9620	02 – 6492 9125
Blacktown	02 – 9831 4037	1800 255 244
Bowral	02 – 4861 0282	
Byron Bay	02 – 6639 6635	
Camden	02 – 4634 3000	
Campbelltown MMU	02 – 4634 3000	
Canterbury (REPIDU)	02 – 9718 2636	
Caringbah	02 – 9522 1039	0411 404 907
Coffs Harbour	02 – 6656 7934	0408 661 723
Cooma	02 – 6455 3201	
Dubbo	02 – 6885 8999	
Goulburn S.East	02 – 4827 3913	02 4827 3111
Grafton	02 – 6640 2229	
Gosford Hospital	02 – 4320 2753	
Hornsby	02 – 9977 2666	0411 166 671
Ingleburn	02 – 8788 4200	
Armidale/Inverell	0427 851 011	
Katoomba / Blue Mountains	02 – 4782 2133	
Kempsey	02 – 6562 6066	
Kings Cross KRC	02 – 9360 2766	02 – 9357 1299
Lismore	02 – 6622 2222	0417 062 265
Lismore – Shades	02 – 6620 2980	
Liverpool	02 – 9616 4807	
Long Jetty	02 – 4336 7725	
Manly / Northern Beaches	02 – 9977 2666	0412 266 226
Merrylands	02 – 9682 9801	
Moree	0427 851 011	
Moruya	02 – 4474 1561	
Mt Druitt	02 – 9881 1334	

NSP Location	Daytime No	Alternative No
Murwillimbah/Tweed Valley	02 – 6670 9400	0417 062 265
Narellan	02 – 4640 3500	
Narooma	02 – 4476 2344	
Newcastle/Hunter	02 – 4016 4519	0438 928 719
New England North Regional Area (referral service)	0427 851 011	
Nimbin	02 – 6689 1500	
Nowra	02 – 4421 3111	
Orange	02 – 6392 8600	
Parramatta	02 – 9687 5326	
Penrith / St Marys	02 – 4734 3996	
Port Kembla	02 – 4275 1529	0411 408 726
Port Macquarie	02 – 6588 2750	
Queanbeyan	02 – 6298 9233	
Redfern Harm Minimisation Unit	02 – 9395 0400	
Rosemeadow	02 – 4633 4100	
St George	02 – 9113 2943	0412 479 201
St Leonards - Royal Nth Shore	02 – 9462 9040	
Surry Hills - Albion St Centre	02 – 9332 9600	
Surry Hills - ACON	02 – 9206 2052	
Surry Hills - NUAA	02 – 8354 7300	
Sydney CBD	02 – 9382 7440	
Tahmoor (Wollondilly)	02 – 4683 6000	
Tamworth	0427 851 011	
Taree	02 – 6592 9315	
Tumut	02 – 6947 0904	
Tweed Heads	07 – 5506 7556	
Wagga	02 – 6938 6411	
Windsor	02 – 4560 5714	
Woy Woy Hospital	02 – 4344 8472	
Wyong Hospital	02 – 4394 8472	
Wyong Community Centre	02 – 4356 9370	
Yass	02 – 6226 3833	1800 809 423
Young	02 – 6382 8888	

This is not a comprehensive list. If you can't contact the number above or don't know the nearest NSP in your area, ring ADIS on 02 – 9361 8000 or 1800 422 599. ADIS also has a state-wide list of chemists that provide fitpacks.

NSW USERS & AIDS ASSOCIATION INC

PO Box 1069 Surry Hills NSW 2010 Australia
345 Crown Street Surry Hills NSW 2010
t 02 8354 7300 or 1800 644 413 f 02 8354 7350
e nuaa@nuaa.org.au w www.nuaa.org.au
Monday - Friday 10:00 am - 5:30 pm
except Wednesday 2:00 - 5:30 pm

The New South Wales Users & AIDS Association (NUAA) is an independent, user-driven, community-based organisation funded by NSW Health. NUAA aims to advance the health, rights and dignity of people who use drugs illicitly; provide information, education, and support for drug users; promote the development of legislation and policies to improve drug users' social and economic well-being; and improve the quality and standards of services available to drug users.

NUAA relies on a strong & active membership - people who support the work & aims of the organisation. NUAA membership is free, confidential, and open to anyone interested in the issues affecting people who choose to use drugs illicitly. You can become a member of the association (receive voting rights, stand for election, and receive *User's News*) by sending a completed form (below) to NUAA. You can use the same form to be placed on the *User's News* mailing list. Copies of *User's News* are posted free of charge in a plain envelope.

To join NUAA - or just receive *User's News* - complete this form and post it to NUAA:

☐ **I am already a member of NUAA / on the mailing list, but am updating my details.**

☐ **I want to be a member of NUAA.**
I support NUAA's aims and objectives.

☐ **I do not want to be a member of NUAA. I want to receive *User's News* only.**

Inmates, please give MIN number:.....

Name: .....

Address:.....

City / Suburb:..... Postcode:.....

Phone:..... Mobile:.....

Email:.....

Mail Preferences:

☐ **I want to receive *User's News*.**
☐ **I want to be emailed NUAA's monthly newsletters.**
☐ **I want to receive news and information about NUAA events and activities.**
☐ **I do not want to receive any mail from NUAA.**

I am allowing NUAA to hold the above information until I want it changed or deleted.

Signature..... **Date:**.....

Personal Information Statement:

We collect this information to add you to our database and/or notify you of information and events relating to NUAA. We store this information either in hard copy or electronically or both. Access to your information is strictly limited to staff who need it to act on your behalf. Your information will not be passed on to any other organisation. You can access and correct your personal information by contacting our Privacy Officer on (02) 8354 7300 or freecall 1800 644 413.