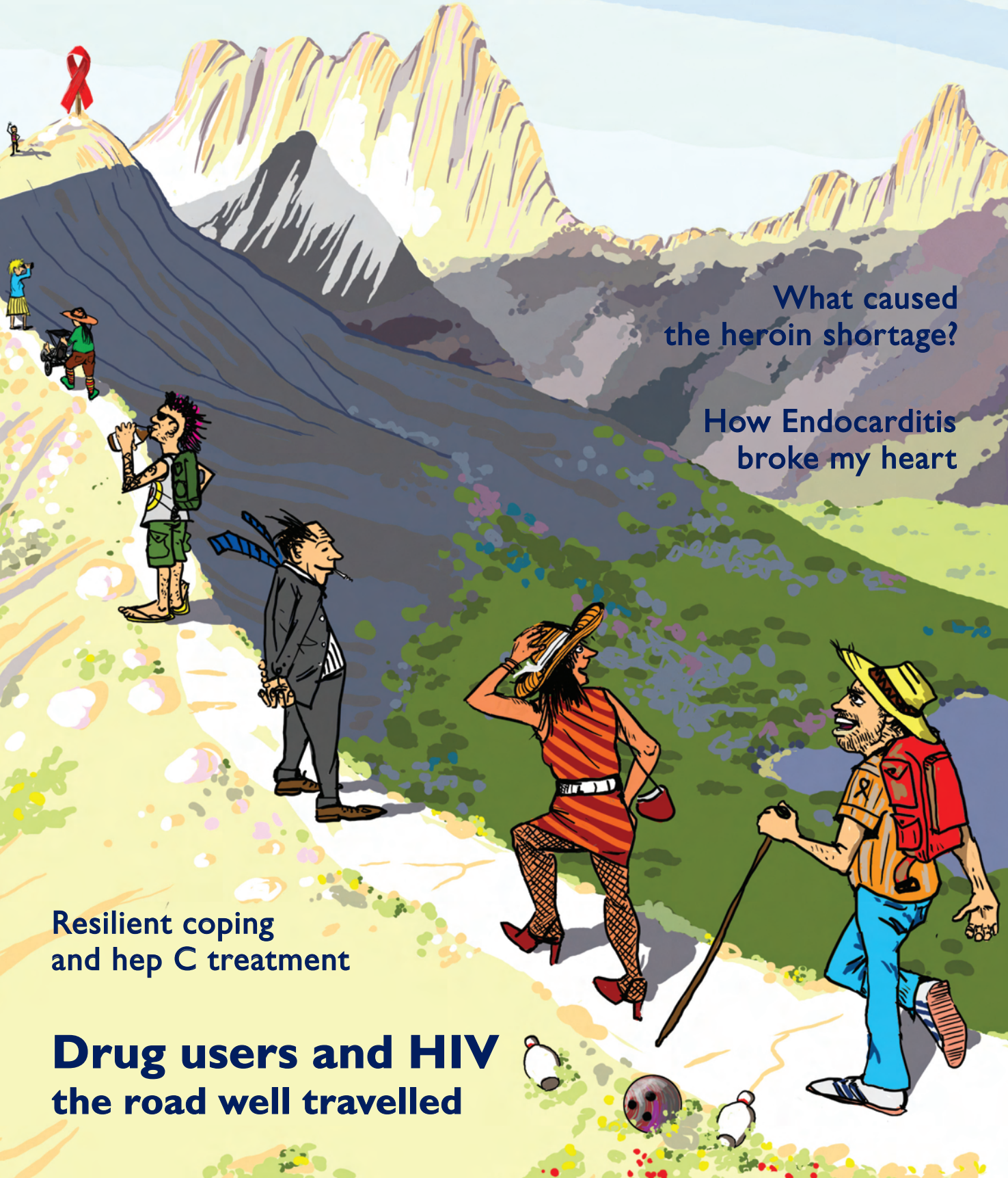
USER'S NEWS

Published by the NSW Users and AIDS Association

Issue No. 55 Summer 2008



What caused the heroin shortage?

How Endocarditis broke my heart

Resilient coping and hep C treatment

Drug users and HIV
the road well travelled

Tell your mates — hep C is preventable.

To find out more about safer using visit nuaa.org.au

USER'S NEWS #55

PO Box 278
Darlinghurst NSW 1300

p (02) 8354 7300 or
1800 644 413 (toll free)
f (02) 8354 7350

e usersnews@nuaa.org.au

Editor	Gideon Warhaft
Cover	Tony Sawrey
Illustrators	Bodine, Ursula Dyson, Rose Ertler, Tony Sawrey, Glenn Smith
Layout	Elisabeth Bischofer

ISSN #1440-4753.

Follow the Money

editorial

In December 1933 the 18th Amendment to the United States constitution was repealed, signalling the end of Prohibition and making alcohol legal once again. Although not the only reason, the Stock Market Crash of 1929 and the Great Depression that followed played no small part in Prohibition's fall. Almost overnight America's appetite for expensive moral adventurism evaporated as millions of people found they had more pressing concerns — such as feeding themselves or finding work.

Now, almost 80 years later, America — and the world — is in the midst of an economic crisis most commentators consider to be the worst since the 1929 Crash. The banking system is in meltdown, billions of dollars have been wiped from the world's stock markets and the US has more debt than at any time in its history. Some commentators claim that the US is actually going broke. And as the election of Barack Obama to the US presidency attests, America seems once again to be turning its back on empty ideology and moral platitudes and is instead looking for real answers to its bloated list of problems. So if there was ever a time when the War on Drugs might be exposed to some real scrutiny, then that time is now, particularly as this economic downturn is looking more and more entrenched.

The annual cost of drug prohibition to the US is estimated to be between $US100-150 billion, including federal money spent directly on drug control, state and local law enforcement, and the cost of imprisoning people. If you include lost taxes, extra welfare, the costs of crime, the costs of related (but avoidable) illnesses and the impact of the drug war on US foreign policies in countries such as Afghanistan, then some say that the figure jumps to over $US400 billion! Every year!

The logic of all this spending is supposed to be its deterrence value — that some Americans who might use drugs will be persuaded otherwise. But as US attorney Dick Minzner, writing in the Albuquerque Journal notes: "If, absent prohibition, the United States would have an additional one million drug addicts, we are spending $100,000 every year, year after year, on each of these potential addicts to keep them from harming themselves. If present policy deters five million potential addicts, we are spending $20,000 annually on behalf of each of them. Either of these numbers represents a collective decision by our political system that protecting each of these people from drug dependency is extremely important, perhaps more important than the welfare of many Iraq war veterans, social security retirees, children born into poverty or promising college students."

Or, as Gary S. Becker and Kevin M. Murphy, both professors of economics at the University of Chicago Graduate School of Business, argue, the War on Drugs is not only unsuccessful but is a very expensive method of cutting consumption. A far more efficient method would be to legalise drug use and tax consumption. If the size of the US market for illicit drugs is $US60 billion annually, and $US45 billion of that is the cost imposed by law enforcement, then by regulating and taxing drugs so that they retain their current market costs, rather than the government having to fork out $US45 billion it could instead collect $US45 billion. "Even if the government wastes the money collected, this would represent an improvement of $US45 billion," the authors note.

What to do with all that extra money? Well, aside from propping up banks and paying off a multi-trillion dollar deficit, America might, for example, want to repair a few of its 590,750 bridges that are "structurally deficient or functionally obsolete" according to a recent report by the American Society of Civil Engineers (if you've ever driven across the US, as I did a few years ago, you realise very quickly that its infrastructure is falling apart). The report states that it will take "$US9.4 billion a year for 20 years to eliminate all bridge deficiencies" (and that's before we get to airports, electricity grids and levies). If the government ended the War on Drugs, the savings could see those same bridges fixed in just two years.

Of course, we shouldn't get too ahead of ourselves. The War on Drugs is very entrenched in US culture and there are many who have a vested interest in ensuring it continues. But if a broke America is forced to bring in the receivers in for a good, hard look at what bang for buck the country is getting from its dwindling reserves, I wouldn't want to be the War on Drugs. Sometimes a perfect storm is required to force a change. Who knows if that change is around the corner? **— Gideon Warhaft**

AFP Commissioner Says Supply Reduction Not Working

Australian Federal Police (AFP) commissioner, Mick Keelty, has stated that authorities and law makers need to stop "quoting statistics and feeling good about ourselves that we're doing a good job" in tackling drug issues.

Speaking at a Australian National Council on Drugs discussion on justice issues for drug use, Keelty said that it was now time to address demand and harm minimisation as supply reduction wasn't working.

Keelty cited the volumes of seized drugs as an indicator of how ineffective current strategies are. "We've seized 195 kilograms of cocaine, which equates to 195,000 street hits; 4.4 tonnes or 15 million doses of ecstasy; 27 kilograms or 270,000 hits of crystal methamphetamine, or ice; and 1.7 tonnes of precursor chemical pseudoephedrine. They're enormous seizures. I remember years ago being excited about a multi-kilo seizure. But these seizures are beyond belief."

"It can't be just as simple as saying no to drugs. It has to be more important work in drug education," Keelty said.

Keelty's comments came as a shock to many, given the AFP's close association with the War on Drugs.

Paul Dillon, from Drug and Alcohol Research and Training Australia, believes Keelty would never have made these remarks under the Howard government. The Howard government's War on Drugs focused on making arrests and publicising them as widely as possible.

Keelty joins a growing line of police chiefs, particularly in the United States, who are publicly questioning both the bias towards supply reduction over other drug strategies and the War on Drugs generally.

Australians Support Cannabis Trials

Only a few months ago, Alex Wodak, director of Drug and Alcohol at Sydney's St Vincent's Hospital, copped a media hiding for suggesting cannabis should be sold at post offices. Now it seems many Australians are behind him. Results from the 2007 National Drug and Alcohol Household Survey show that 70 percent of the 23,000 respondents would support legalising cannabis for medical reasons. The results also show that over 50 per cent supported the Medically Supervised Injecting Centre, and 65 per cent supported needle and syringe programs.

Source: The Australian

ACT Heroin Trials Supported by Locals

The 2007 National Drug and Alcohol Household Survey indicates that 38 percent of ACT residents back a trial of prescribed heroin and would support the medicinal use of marijuana as well as supervised injecting rooms. The ACT had been considering a prescribed heroin trial for several years but the trial was thwarted by the Howard government.

Source: Canberra Times

Missing Heroin "a Time Bomb"

Media reports of illicit drug use in Victoria are suggesting there is a state-wide drug crisis that is a "social time bomb". A study looking at key police lock ups in Victoria found half of the detainees at a police lockup in Footscray were heroin users, with three quarters of the detainees testing positive to illicit drugs. A youth worker in the area has said Melbourne was "awash with heroin.... we haven't seen so much on the streets since the 1990s.... it's returned with a vengeance."

Meanwhile, reports from the United Nations say officials are scratching their heads wondering where all the heroin has gone. They have calculated that the

amount of heroin being produced each year is not matching up to demand. The rate of heroin production has been almost twice the level of global demand. The numbers aren't adding up, they don't know where the heroin is disappearing to, and the situation is "a time bomb for public health and global security." Maybe they should look in Victoria.

Sources: BBC News, Herald Sun

United Kingdom looks to Scrap Drug Classification

The UK Drug Policy Commission has acknowledged what many of us have known for some time, that classifying drugs according to a scale of danger has no effect on people's use of them. The UK presently classes drugs on a scale from A to C, with 'A' being the most dangerous and 'C' the least. The purpose of the scale has been partly to generate fear of drugs amongst potential users.

The main drug they are looking to reclassify is ecstacy, which is presently a class A drug. Ecstacy is popular amongst recreational users — five per cent of youth between 16 and 24 in the UK reported using the drug in the last year. A decision on the changes will be made in the next year.

Source: The Telegraph, London

Columbian Drug Barons Take a Dip

In a creative new approach to drug smuggling, Columbia's drug trade has developed the 'narco sub'. The narco sub is a semi-submersible vessel that has the ability to evade radar and sonar, barely breaking the ocean surface as it travels.

The US department of Homeland Security has said the subs are now accounting for a third of the cocaine trafficking between Latin America and the US, with each craft capable of carrying nine tonnes of cocaine.

The US Coast Guard has had a real fight trying to get its hands on the subs. In one incident, Coast Guard crew were left clinging for their lives on the exhaust pipes of the vessel, 560 kilometres off the coast of Guatemala.

The subs are being built deep in the jungles of Columbia and launched off the countries' pacific coast, which is renowned as a smuggler's dream with its many secretive coves and thick forest.

Source: The Telegraph, London

Drug Using Tools Used by Ancient South American Tribes Discovered

For many people the idea that drugs have been used for thousands of years has been assumed without much evidence. Although there have been written accounts of drug use, even within the Bible, little hard evidence has been found. Recently, however, researchers working on the Caribbean island of Carriacou have discovered ceramic equipment that they believe was used to prepare hallucinogenic drugs for sniffing.

Ceramic bowls and tubes for inhaling fumes or powders have been dated between 100 BC and 400 BC, and were believed to be used by nomadic tribes in South America.

Archaeologists believe that humans were extracting hallucinogenic drugs from mescal beans and peyote cacti as far back as 5,000 years ago. They believe the drugs were used to induce spiritual or trance like states as part of the tribes' religious beliefs.

Source: The Telegraph, London

NSPs in Prison

I would like to address the needle and syringe program (NSP) within our prison system. There are new jails being built all over the place; I myself have addressed the ACT Assembly on the pros and cons of a needle and syringe program within their jail at Hume. I also spoke about the condom handout and a tattoo shop. I didn't just dribble at the mouth; I produced facts from overseas where NSPs are in place in other jails.* It seems our government will not take a stand against hep B, hep C or HIV/AIDS. Hep C can spread like wild fire in jail (and so too could HIV) and the government doesn't give a fuck. Maybe they will when one of their kids catches one of those diseases.

The Aboriginal community seems to have a high rate of blood-borne diseases such as hep C. Why is this so? A large number of Aboriginal men and women are in jail, mostly for drug offences. This so-called War on Drugs is lost and the sooner governments come to terms with this the sooner we can come up with different approaches. Jail is not the solution. We need money spent on rehabs and detoxes. Jail is just a breeding ground for diseases and a place to train young crims to become better crims.

Surely someone can come up with a better idea. Once you're in the criminal system you have a good chance of losing your children to the Department of Community Services (DoCS). All I can see is this making the trouble worse. It should be left to the Aboriginal community to sort our problems out, not all this money spent on consultations. What a waste of money. Money spent on consultations could be spent on rehab, detox, councillors or helping people find employment. It seems that governments don't have the balls to stand up and put these measures in place to protect inmates (and the community when inmates are finally released).

Now how young is a kid when he or she gets in contact with the drug culture? Within lower income Aboriginal societies children can come into contact with pot at the age of seven or eight. Then there are the hippy kids — I used to buy pot off these kids when I was young ($25 an ounce!). I believe once a child knows about drugs it is time to teach him or her about the dangers of them. Middle class people think different. They think their kid doesn't touch drugs (Ha! Ha!). If drug advocacy was taught in schools I believe we would have less hassle with our kids and the law.

Most drugs should be legalised — not all drugs, but the soft ones to start with. Some of these drugs have medicinal values, so they can't be all bad. And then there's the problem of police involvement with drugs. I started travelling around about 1978. I've seen all sorts of things — police bashings, things I push to the back of my head to forget. I'm Aboriginal, so I've copped my fair share of bashing. Anyone who believes there are no crooked police came down in the last shower.

Well people, safe using, keep those eyes out for the cops and stay alive.

Snake

**Countries with needle and syringe programs in prisons include Switzerland, Germany, Spain, Moldova, Kyrgyzstan, Belarus, Luxembourg, Armenia, Ukraine, United Kingdom (Scotland) and — yes — Iran!*

Letters to the Editor

mail PO Box 278
Darlinghurst NSW 1300
fax (02) 8354 7350
e-mail usersnews@nuaa.org.au

Transitioning to Injecting
what's it all about?

For many years, dealing with HIV and hepatitis C amongst people who inject drugs has been a challenge for public health professionals and policy makers in Australia and overseas. Despite successes in controlling HIV within the drug using community through projects like needle and syringe programs, the rates of hepatitis C continue to be worrying both for people who inject drugs and for governments and policy makers.

In looking for new ways to overcome this problem, researchers and policy makers began to look more closely at the culture of injecting. They began thinking about ways and means to take control of injecting drug use itself as it occurred to them that turning people away from injecting or discouraging people from injecting in the first place would be a good way to control hepatitis C.

Transitioning to injecting has become an important point of interest. Looking at ways to stop people injecting, by moving them to another route of administration such as sniffing or smoking, could significantly reduce HIV and hepatitis C infections.

So, with these ideas starting to be used to develop new campaigns in Australia, we need to consider the problems and issues that could result from these campaigns for people who use drugs.

What is a transitioning to injecting campaign?

Transitioning to injecting campaigns have, essentially, two distinct messages:

1. Prevention of initiation to injection

Preventing drug users from starting to inject by deterring them from wanting to try it and by promoting other forms of administration like smoking or sniffing.

2. Reverse transition

A transition away from an injecting to a non-injecting route of administration. This method is often based on returning users to a non-injecting form of administration they used previously.

What is the research saying?

Many of the papers written on transitioning to injecting acknowledge that this is a new area of work and that there is little specific research or evaluation regarding its long term success.

Most of the studies focus on detailed analysis of the social networks of people who inject drugs, trying to figure out why and how people start injecting in the first place.

The key areas being discussed are how programs can identify and target 'at risk' groups, meaning people believed to be highly likely to start injecting; how to understand the social factors affecting why people want to start injecting; and looking at the availability and types of drugs people are using when they start to inject.

What are some examples of campaigns around the world?

Most of the existing transitioning to injecting campaigns have been run in the UK and Europe.

One example is the 'Break the Cycle' program in London. The Break the Cycle campaign is an example of a preventive campaign trying to stop people injecting before they start. The campaign's aim is to target people who are already injecting and to create or enforce negative opinions on initiating others to injecting. The messages used include, for instance, warnings that they may be charged with manslaughter if they help someone with their first injection and that person dies from an overdose. The idea of the campaign is that by creating fear around helping someone initiate injecting, it will make them less likely to pass injecting techniques on to others.

Another campaign was the 'chasing' campaign, also in London. This campaign is an example of a reverse transition intervention, aimed at moving people back to the forms of drug administration when they started using, such as smoking or sniffing. This campaign worked in London as many of the users were already smokers and chasers. Smoking heroin in the UK is far more common

than in Australia because the majority of heroin is brown, which is easier to smoke than the white heroin commonly found in Australia.

What are the issues in starting transitioning to injecting campaigns in Australia?

One main concern for introducing transitioning to injecting campaigns in Australia is our drug using culture, which is very different to the UK and Europe where the interventions have been trialled. Australia has a strong culture of injecting drug use, particularly for heroin users. Campaigns focused on moving heroin users to smoking or sniffing would be unlikely to work in a country like Australia where there are very practical reasons, particularly the type of heroin used, why the injecting culture is so strong.

Another significant error in these campaigns is the belief that if you make users afraid of initiating others to inject it will result in less people starting to inject. Much of the research conducted around why people start injecting suggests that it is because they are curious and they have a desire to experience the intense euphoria of injecting.

All the research shows that starting to inject drugs is based on a user's own desire to inject, sometimes influenced by the people around them, but mainly driven by their own curiosity. At the end of the day it is something many people actively look for and it is not something that happens by accident. It is the people who have no injecting experience who are responsible for instigating first injections. They are the ones making the decision, and then asking for help, to inject.

In our needle and syringe programs peer education is an important tool. These transitioning campaigns are asking our peer educators to stop educating about injecting. By focussing on trying to stop people passing on injecting techniques we are overlooking people's own desires to start injecting in the first place. More importantly we are ignoring the more urgent need for safer using messages targeted at new injectors.

A final concern is looking at how these campaigns feed into existing Australian drug policy. When research started looking at transitioning to injecting campaigns, the conversation was framed in the context of harm reduction. Harm reduction is the framework in which Australia's health promotion programs for people who inject drugs are developed. The guiding principle of harm reduction is to help people who use drugs to do so in ways that are less harmful to themselves and to others. It is not about making judgements on how they use, or their decision to use in the first place.

Transitioning to injecting research stemmed from debates on blood-borne virus transmission, specifically hepatitis C, amongst people who inject drugs, then identifying the processes of injecting as a key factor in the spread of hepatitis C, and finally looking for ways to stop people injecting. The conversations stopped being about harm reduction and became focused on exploring methods of control of individual drug using behaviour.

Campaigns aimed at preventing harm to people who use drugs need to be about health promotion and healthy living and supportive of individual freedom of choice. The examples of these transitioning campaigns pay no respect to an individuals' desires to inject, particularly regarding the heightened pleasure people associate with injecting, the broader historical culture of injecting drug use, or the basic chemical properties of drugs used in Australia.

If transitioning to injecting campaigns are to be considered in Australia, the many problems and issues around the social and cultural factors surrounding injecting drug use need to be fully considered.

Erin Halligan
Erin is NUAA's Policy and Campaigns Coordinator

Back in Prison Again!

My name is Carlos and I'm back in prison again after lasting just three and a half weeks out in the streets of Sydney. I had just finished doing two years for drug related offences because of my past heroin addiction. This is about my ninth time in prison for crimes like breaking into houses, and stealing people's treasured and sentimental items like rare jewelry which may have been handed down through the generations. I recently found out that one item I had stolen was a pearl diamond ring that was 90 years old and probably worth $5,000 today. I sold it for a lousy $200 just to feed my filthy habit. These are things that I have done so many times I've lost count, but I can tell you that there have been countless victims.

This isn't something that I'm proud of; on the contrary I am sickened to my core. I feel a lot of shame for the terrible things I have done over the years. I have hurt so many people in the process. I'm only one person and I have created so much damage and so many victims. Every day there are lots of people committing crimes, doing break and enters, and stealing precious and treasured items from their victims. All these victims, all this pain and misery, just to feed our addictions!

For around nine months before I was to be released I had asked the prison authorities for the help I needed to be able to rehabilitate myself so I would no longer use drugs and commit crimes. What I needed upon my release to remain drug free and be a productive member of the community were stable accommodation and supportive people around me. What I received were excuses such as that the government had cut funding for this and that or they didn't have the staff to be able to help me enough, or there wasn't enough places of accommodation for me to go to or enough money in the budget for better or more programs.

I became so frustrated by this before I was released from prison and I am hardly alone — guys and girls from all over the prison system are being released straight out of prison with a few hundred dollars from Centrelink and forced to fend for themselves with little or no support or accommodation. These are people who often have severe problems on top of their drug problems, that need to be dealt with before and after they are released back into society.

For all the people who want to stop using drugs, gain employment and have a healthy, normal, stable future, this will only happen if there is more accommodation, programs and support upon their release from prison. Otherwise people will continue to get released, become overwhelmed and stressed out, lose hope and give up, and go back to the only thing they know to deal with their problems — the merry-go-round of drugs, crime and prison until the next time they are released.

I know this from my own experience. I have been on this merry-go-round for about 16 years and I've only started to want to change the way my life is headed. About five years ago I made the decision that I would start looking for a job, have a place of my own, start a family and be drug and crime free. But I found it very hard when I got out of prison due to the lack of services and support. I always got kicked out on to the streets with a fistful of money and told good luck — don't come back! This last time I was released I had tried to get the support I needed so I would have a smooth transition upon release, but I got nothing.

I honestly think that the system owes it to society to make sure inmates leave prison in a better state than when they got there, if not for the prisoner's sake then at

least for the community's! They owe it to society to help people who go to prison come out a better person and not ten times worse than when they went in!

I feel that there is no way that the fight against drugs and crime will ever be won unless politicians get real instead of playing into people's fears, emotions and prejudices and the lock 'em up, give 'em nothing attitude! I know from personal experience that it will never, ever work and it only hurts the community in the long run.

Yes, we do suffer whilst we are in prison, but all that happens is that we harbour a grudge towards everyone around us and in turn all we want to do is use drugs to block out the pain and stress or just keep up the cycle of 'I'll pay you all back!' by committing crimes. Imagine if, say, ten people are released from jail every day and at least five or six of those go back to drugs and crime. That's a hell of a lot of new victims who will suffer from a lot of heartache, pain and stress.

So even if the cops lock up 30 people a day, out of that 30 only ten to 15 will go to jail for a period of six months to five years. They will still be released when their time is up and you'd think the system would be accountable to society to make sure they do not come out worse than when they went in.

I can honestly say from my experience that there is no benefit from being locked up. I have become worse from the trauma caused by over-zealous prison officers with spiteful and sometimes sadistic natures. A system that is more worried about money and budgets instead of setting up more support for inmates before and after their release and that only instills a sense of helplessness and that we are not worthy or capable of leading a productive life, is going to do nothing to reduce crime. It just makes it harder for inmates to break their cycle.

We are told that once you do your time you are able to get on with your life but it's a lot harder than people think! All we ask for is more compassion, sympathy and help instead of being told that we deserve to suffer and pay. Yes, we get locked up for our crimes, but once we have done our time and paid our dues we should be able to move on and get the help that we need so we don't continue to use drugs and break the law.

The media doesn't help. Most of the time I see lots of negativity about people in prison, not anything about what is really happening in our prisons. Doesn't the community deserve to know the truth about how the government penny pinches from prisoner rehabilitation budgets and pre-post support programs? At the end of the day it affects all of the community.

The media portrays prisoners as though everybody who gets locked up is serving long terms when the truth is that the majority is only doing five years or less and mostly due to drug offences like petty thefts, break and enters, car thefts and use of drugs and so on. If only society really knew the truth.

I believe that the War on Drugs will never be won until the government and media start reporting the truth and drugs are legalised.

I also believe that if drugs are legalised it will dramatically reduce crime, making many jobs redundant as there will be less need for lawyers, prison guards, police and other jobs that relate to drug-dependent people. Sometimes I think this is the real reason why so little changes. Imagine how many people would be out of work if there was less crime and less people going before the prison system and courts. People should really have a good think about the truth.

Carlos

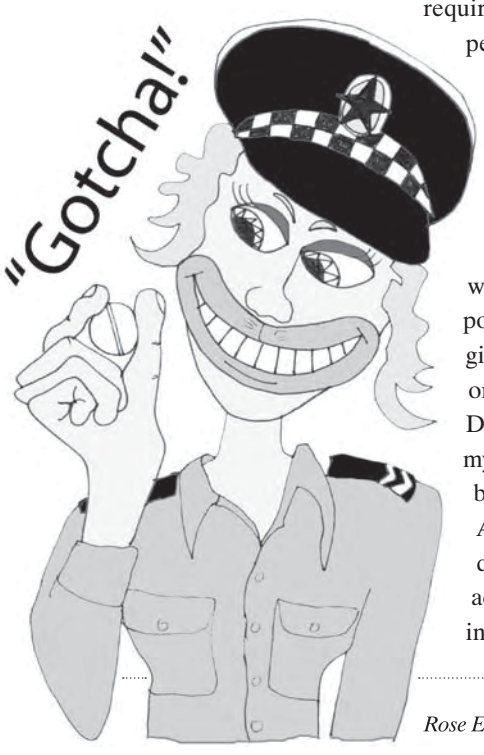
A Dopey Justice

Whoa Nelly!!! Stop the bus!!! I may get a little bit behind sometimes but I definitely was not prepared for one particular low point due to my drug use. Here I was with a full blown heroin habit and living life in the clutches of its power.

After a while it became harder to fund my habit so I started selling the green stuff which became a very profitable little venture. If I didn't have any demons to feed I would probably be able to buy my own little Private Idaho by now. And as usual, I got too complacent and had a million people pulling up outside my house at all times of the day and night.

The inevitable raids began and I started feeling a little bit special when the cops started greeting me by my first name. Soon the court was getting sick of seeing me and I was a cigarette paper away from going to the Big House. Time to stop everything, I told myself. I went cold turkey (yet again) and I'm sure I cried out to my non existent God a few times. When I was about half way through this traumatic ordeal, my very sympathetic friend (and drug buddy) gave me half his precious Valiums to ease some of the fidgets.

So there I was, being a good citizen, doing what was required of me by the people in the funny wigs and BANG!! Another bust!! I had given up dealing, I had given up hammer (reluctantly), I was reporting to the police every week and giving urine samples on demand. WHAT DO THEY WANT? my still mixed up brain was asking. Apparently the busts don't stop at the exact time you stop being naughty.



Rose Ertler

I did tell the familiar faces tearing my house apart that they were wasting their time, but then one young rookie came practically skipping out of my room with a smile on her face like the Cheshire Cat. She was dangling my Valiums in the faces of her cohorts and I could almost hear her thoughts out loud: "Look what I found boss, look what I found." Boss man originally thought they were ecstasy tablets and when I explained they were plain old Valiums his face lit up brighter than the Queen Street Mall Christmas tree. Aha! Gotcha! Possessing a dangerous drug without a prescription! I was still quite sick and little tears started to collect in the corners of my eyes as they stowed the dangerous narcotic into their little evidence bag.

Off I trundled to court again and got fined $350 for daring to try to get myself straight with the help of something that might allow me to sleep an hour a week. To top that off I had to reappear for probation and got fined another $250 for breaching my conditions. It was a rude shock as in my circle anyone who had Valium, Normison, Xanax or any other comfort maker would share them around if anyone was hanging out or just needed a good damn sleep.

Yes, I accepted my fate. Yes, I know we are not supposed to take other people's medicine. Yes, I will get my own medication in the future. But my biggest whinge is that not three weeks later a certain show on television set in the customs area of an airport showed a man being allowed to walk through and go on his merry way with three boxes of sleeping tablets that were written out to somebody else. I was aghast! I was found with 16 tablets. Sixteen!!! And fined a bucket load of cash! Where is the justice? I was mortified!

Anyway, I stayed off the heroin for ten months, went on a bender for a month, and have successfully stayed away from my poison of choice for four months this time.

To all those out there struggling to give up their drugs, keep your chin up, there is light at the end of the tunnel. I have caught a glimpse of it and will chase it until it is glaring!

Sandy

Pal — a Perspective on the Cross

Ten years ago I came to know a person called Pal, who seemed to be this indestructible man who was part and parcel of the Kings Cross area. He was always dishevelled and pushed around a Coles shopping trolley with all sorts of rubbish that he had collected from garbage bins in the area. He was always polite and seemed to know most of the people who ran businesses in the area.

One fine Saturday in September, I was informed that Pal had been found dead that morning in Green Park, opposite to St Vincent's Hospital. I heard that he was in the hospital earlier and he had discharged himself, taken a turn and died alone. I felt very sad hearing this news.

Sad, not just because of the manner in which he died, but also because there were so many people and agencies that had tried so hard to assist him, from finding accommodation to just trying to stabilise his life and finding services more suited to his condition.

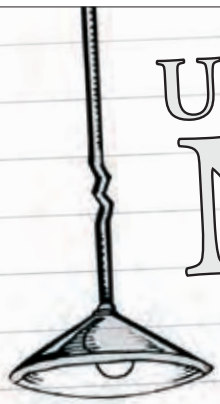
Pal was a chronic drug user and everyday he plied through garbage bags trying to wash the dregs from used syringes and plastic bags to get a hit. On occasions when he could afford it, he would score a real hit. He was well known to the drug and alcohol services in the area. He was particularly well known to the needle clean up guy who picked up the discarded fits Pal had found rummaging through the garbage. Although Pal's behaviour posed a major health risk to himself, many agencies around the Cross put up with it hoping that he would get better and change his behaviour.

Many questions need to be asked in regards to Pal. One thing is for sure, Pal's was a very complicated case for the various departments trying to assist him. My personal feeling is that it would have been better, perhaps, if just one case worker worked with him long term instead of a different face for each different problem.

Many agencies tried to help Pal. In the end they could not save him. No one is at fault. Pal was loved and respected by all who came into contact with him. May now he rest in peace.

We Love You Pal.

Mojo



USER'S NEWS №56

Have you got a story for User's News?

We bet you do!

So pick up your pen, pencil, quill or keyboard and start writing today.

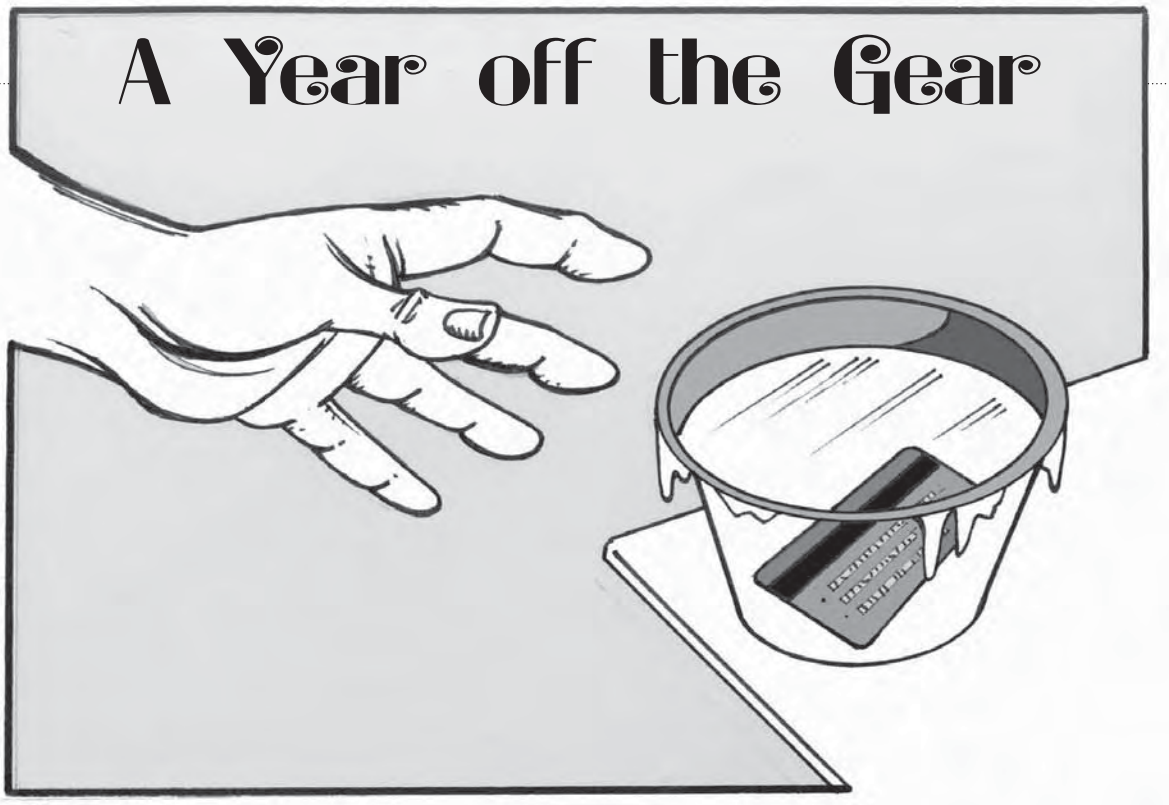
And remember:
we pay 13 cents per published word!

Send your story to:
User's News, NUAA,
PO Box 278, Darlinghurst NSW 1300

Fax it to us on **(02) 8354 7350**
or **email** it to us at **usersnews@nuaa.org.au**

Don't forget to send us your contact information!

A Year off the Gear



Bodine

This time it was different. The quality of the heroin was okay but I just didn't like the stoned feeling anymore and wanted it gone as soon as possible. My mood and sense of wellbeing had been much better before I had the shot. I sometimes reckon that heroin only really works well when you're down to start with and that if you feel really good in a day to day sense then it's less likely to be appealing and therefore to seduce you into addiction. Now that I felt good enough in my own skin the heroin just felt like a nasty imposter creeping round my body. That was what my last shot was like and although I can't be sure of what will happen in the future, I think it was my last shot ever.

It's now been a year since I had that shot and I thought I'd take the time to consider where I'm at and how something that was such a large part of my life for so many years now seems like something that happened to another person.

For the first five or so years I was a weekend user, but for ten years after that I used more or less every day. My habit didn't get big in terms of the size of the shot or the money spent, but was strong and insidious in the relentless monotony with which it ran my daily life. Often I'd feel like I was in control and just choosing to use. I'd wake in the morning thinking I wouldn't use that day (only because there was enough gear in me from the day before that I wasn't actually hanging) and by the afternoon would have changed my mind and decided to get on. It's amazing that days could go by like this and turn into decades, with the illusion of free will in choosing to use when in reality my whole routine was controlled by the ebb and flow of the opiates in my system.

It's hard to pinpoint how and why I stopped using when I did. I had tried so many times and so many things, from drinking poppy tea to spending years on methadone and buprenorphine. Not to mention the sleepless

weekends at my parents, the home detoxes, the scripts of Panadeine Forte, studying psychology, attending NA and AA meetings, travelling overseas, moving cities, going to church, literally freezing the keycard in a bowl of water in the freezer (someone at work said it worked for her friend with shopping issues), a two week outpatient rehab (it's true when they say not to attend with the friends you use with). It seems that while none of these methods worked for me in isolation, it is possible that the accumulated benefits, the best bits and pieces from each that stay with you, somehow contributed to me getting off heroin for good. Or perhaps I just had to try and fail so many times before I was really ready, each of these failures helping to make me a little less enamored with the thrills of using and a little more open to the realisation that if I wasn't using I would never have to try any of these treatments again.

NA was good in the sense of exposing me to people who didn't use anymore and who enjoyed their lives without drugs. There were times when I would be coming down and was out of money and having to face some miserable three day detox (until I got paid again) where I would feel so broken and empty. I felt like I was absolutely nothing without heroin in me, as if the heroin was the actual backbone of my body and the only thing that held me together, the only thing that gave me favourable qualities such as humour or the strength to face each day. Seeing these people who had come through the other side challenged that thinking and made me aware that perhaps I too could be strong without heroin.

Another factor that drove me from heroin was reaching middle age (which in my thinking is your mid thirties). I had more of a sense of time being limited and my life passing before it. I started thinking that I could keep using, which was no longer interesting or exciting, or I could get free of the gear and do a whole lot of different stuff in life. I reflected on my 15 years of using and realised that I had done it to death, there was no new learning to be had, and that something that had seemed exciting and romantic at first now seemed so boring and clichéd.

Strangely, I was also having relationship upheavals at the time. Usually, such emotional stress would have been an excuse to use even more, but this time my line of thinking was that I needed all my wits about me, that I needed to be as strong as possible to make the major life decisions required of me. I also reduced off buprenorphine, slowly but steadily, at the rate of 0.4 mgs per week, and heavily utilised the support of friends who had already shaken their addictions. This support was often via phone or email due to the geographic dispersement of my old peer group, but it was a great help. Continuing to work full time was important as it helped distract me from myself and helped make me tired so I could sleep at the end of the day. I did the basic things of walking each day, eating well and really seeking out and making time for the things I enjoyed doing that didn't involve drugs (such as horse riding, visiting friends and planning a lengthy overseas trip). I was also lucky to have a group of old friends who I had once used with but who had also come out the other side, most of them having not used for many years.

So what's it like being free from heroin after all those years and feeling cured in the sense of not using and not feeling at all interested in using, even when things go wrong and life seems a bit harsh? It's good! My stress threshold is much higher. I can afford to take longer holidays and enjoy life more. My attitude is positive and I feel more warmth and am more caring towards other people. I seem to have lost the junkie look that used to invite cops to search me in the street, and this contributes to a greater sense of freedom than I ever had with heroin. It seems that for me the best I could hope for on the gear was to go through life simply treading water. It feels like life off the gear is about moving forward and being happy and strong.

Becky

Interview

The Road Well Travelled

How drug users took on HIV

Julie Bates played a leading role in Australia's early response to HIV/AIDS and has spent the past three decades working to improve the legal and human rights of marginalised people, specifically sex workers, injecting drug users and people living with HIV/AIDS. Julie was a foundation member of ADIC (the AIDS Drug Information Collective, the forerunner to NUAA) and was the first coordinator of NUAA. Today, Julie heads up Urban Realists, which provides advice and support to the sex industry. In this interview with User's News *editor Gideon Warhaft, Julie talks about the early days of HIV in Australia, specifically its impact on injecting drug users.*

User's News: When did you first get involved in drug user issues? What year are we talking about?

Julie Bates: Way back in the early 1970s. At the time, I had a pretty successful career as a law clerk in one of Melbourne's preeminent criminal law firms. The illegality of the sex industry at the time and, of course of drugs, kept our firm very busy. As a law firm that was known for representing the 'goodies' against the 'baddies' the firm went on to represent complainants (the goodies) in the 1975 Parliamentary Inquiry into the Victorian Police Force, known as the *Beach Inquiry*. A number of our clients, including dealers and users, gave evidence to the Inquiry. One of my duties was to take their statements, which would then be presented to the Inquiry.

I had been raised to believe that the police were there to protect people, that they were honest and trustworthy. Suddenly this belief was being challenged. I was listening to people talking about having drugs and guns planted in their homes, even in the bedrooms of their children, about being bashed into submission and admitting to things they hadn't done and having those statements turn up as evidence against them.

It was later that I became aware of the need for advocacy for both drug users and sex workers in the health and social welfare areas, especially primary health care and methadone maintenance. All of this sharpened my sense of social justice and led me, along with others, on a path towards social and structural change that would really benefit people. And not just about the prevention of life threatening illnesses but also in a more general sense. Being
a member of several of the affected communities certainly helped.

UN: People assume that it was HIV that got users politically engaged to set up their own organisations and lobby for needle and syringe programs and so on. Is this true?

JB: It certainly upped the ante, but there was a growing number of disgruntled people unhappy with limited access to treatment and methadone programs, and with the stigma and discrimination which affected their daily lives. There was little or no respect, compassion or dignity towards drug users. Just getting regular access to new injecting equipment was fraught with difficulties.

At some point in the early '80s, the political became personal for some like myself and the personal became political for others like Alan Winchester, the inaugural President of NUAA. For Alan, who had been a social worker and had previously worked with homeless people living with mental illness, his passion for the marginalised was rekindled when he saw himself as one of them. Waiting at the end of a very long queue to get on a methadone program and then seemingly trading his dignity to stay on the program, his fight then became political as he fought for not only his own rights, but also for fair, equitable and non-judgmental treatment for anyone on a methadone program. What we did not see at the time but what was just around the corner and would change our lives forever, was HIV.

HIV was the catalyst that brought many people together and helped forge the necessary alliances that supported all of our initiatives. Members of other affected communities, sex workers and gay men, were already engaged in their own struggles for social justice and law reform and together we were able to strengthen our alliances with politicians, health care professionals, bureaucrats, social researchers and even the media.

Once HIV was added to the equation, the first two drug groups to emerge were known as Injector Services and ADIC [the AIDS Drug Information Collective]. Injector Services was made up of people primarily committed to an abstinence-based philosophy with the support of Narcotics Anonymous, while ADIC took a pragmatic approach to reducing harms and getting the "don't share" message out to users. ADIC's membership was comprised of users, social workers, nurses, policemen, nuns, sex workers, researchers, educators and the good doctor himself, Alex Wodak [then, as now, the Director of Drug and Alcohol at Sydney's St Vincent's Hospital]. Some of us were gay, straight, transgender or somewhere in between and on occasion described by media commentators as a "bunch of misfits, junkies, poofters and whores". Only a few of us, however, held the exalted position of identifying with all four categories! As disparate a group as we were, we all had one thing in common: the belief that injecting drug users deserved to be treated with dignity and compassion and had the right to accurate information, clean equipment and non-judgmental support that would help protect themselves from HIV.

UN: What was the availability of injecting equipment before that?

JB: There were no NSPs as we know them today, with primary and secondary outlets in a variety of community and health care settings. The only access to injecting equipment was through a small number of pharmacies, but you had to brace yourself for a hostile reception when going in to buy them. It was not illegal to buy needles and syringes but it was really frowned upon. There were only a few pharmacies that were in any way 'user friendly'.

Some of the dealers somehow managed to get boxes of syringes that seemed to come off the back of trucks. Without knowing it, street level dealers who were mostly users themselves were actually doing peer education of sorts by giving out, or in some cases selling, equipment along with the drugs.

This was before we'd even heard of HIV — it was all about reducing other damage caused by used equipment.

In those days people would have to sharpen their needles on matchboxes and glass, and clean them as best they could. People would store their equipment in places where others were unlikely to find them before the owner's next hit. Because of the limited supply, users often suffered from abscesses at the injecting sites, and some contracted endocarditis and other infections, all because of the need to reuse and share equipment so many times. So even before HIV was identified, users understood the need to not share injecting equipment, but their practices were determined by the lack of availability of new equipment.

I always laugh when I hear people say it's part of the ritual, that users like to share their injecting equipment. It just doesn't make sense. In fact, it's complete bullshit. Users don't want to share now, nor did they in the past — they only do it when there isn't any choice.

UN: It seems that when HIV was eventually identified there were three distinct groups: drug users, sex workers and gay men, and that these three groups worked very closely together. These days they work largely independently of one another. Why were they originally together and why was it important that they went their own way?

JB: Some of us naturally gravitated towards each other. I think this was because we shared the perception of being at the margins of society. Regardless of our sexual identity, employment in the sex industry or drug use we saw benefits in sharing our collective experience, knowledge and skills. Underlying this was the shared sense of personal and social calamity.

I also think in those days, and perhaps even still today, gay men who also injected drugs and maybe worked in the sex industry found it a whole lot more comfortable being around this broader group. Identifying as a drug user or sex worker within the gay community was often frowned upon. Segments of the gay community were not

The Road Well Travelled (continued)

kindly disposed towards their own kind who injected drugs or received payment for sex.

For gay men, of course, the laws had changed, and while their lifestyle was no longer criminalised, they still faced enormous obstacles in achieving equal rights. Aspects of the sex industry, and of course drug use, were still penalised, and everyone still suffered enormous stigma and discrimination. In the early days of the first NSPs you could be arrested on route to taking a used fit back to the exchange and the cops could — and did — analyse the contents. This was used as evidence in charging you with a drug related offence — being in possession of used injecting equipment. This law was finally repealed sometime in the mid '80s as it hindered HIV education and did nothing to take used syringes out of circulation.

Turning to the second part of your question, why it was important that the groups went their own way, it was not so much the importance of why we went our own way, which was largely a natural progression, but that in many ways we are still intrinsically tied together, if not always harmoniously. Over time there has been greater competition for HIV dollars and that early sense of foreboding and mutual support, particularly when our friends and colleagues were literally dying before our eyes, has disappeared thanks largely to anti-retroviral treatment.

UN: So rather than a strategic decision to get together, it was more a case of so much overlap?

JB: That's right, but this overlap was nothing new. Sex workers and gay men, for instance, had been involved in feminist politics and gay rights from the late 1960s and had linked arms in the first gay street protests that gave birth to Mardi Gras. An early Mardi Gras poster depicts a sex worker rights activist on roller skates beside Paul Young, who was one of the first gay men to publicly announce that he had HIV. In fact, Paul is famous, or in some quarters infamous, for his statement at the time with words to the effect: "I am a gay man, have been a junkie and whore, and I don't know how I got this bloody virus. But it doesn't really matter… what really matters is the care and treatment provided, and it's not in who you are but the safety or otherwise of what you do."

UN: Was it clearly known back then that you could contract HIV from sharing injecting equipment?

JB: When it was recognised that the Human Immunodeficiency Virus (HIV) caused AIDS it soon followed that the virus was transmitted by body fluids including blood and blood products. It was then immediately clear that transmission could occur via shared injecting equipment, although there had been speculation all along that this was the case. The trick was to get the message out to the thousands and thousands of people who injected, of whom only a fraction could be easily identified at methadone clinics or other health and welfare services. The evidence told us that the majority of people who injected drugs were occasional or one off users and were never going to be reached in those environments. They did not identify as people with a 'drug problem'.

In those days there was great debate about whether one should submit to being tested for HIV or not, particularly as there was no treatment. What was the point of knowing your antibody status when there was little or nothing you could do? Added to this was the stigma and discrimination one faced in both health care settings and society generally. We must not forget that AIDS was originally called GRIDS [Gay Related Immune Deficiency Syndrome] and there was even a theory that it was transmitted by gay men sniffing amyl nitrate. If HIV had first been identified in using communities, I am sure we would have seen an equally hideous acronym blaming users and their lifestyle for spreading AIDS. This would come later, of course, though without the acronym.

UN: Do you think that the needle and syringe program was the biggest single outcome to make HIV rates so low amongst injecting drug users?

JB: Undoubtedly, but peer education and user community development was no poor second cousin and ultimately a combination of many things was necessary to prevent

the spread of HIV. The introduction of the first NSPs required leadership from people in authority, such as Alex Wodak. In opening the first NSP, not only was Alex having to deal with breaking the law but also with his own staff at Rankin Court [a methadone clinic in inner Sydney]. They had an expectation that clients would stop using illicit drugs and return 'clean' urines in exchange for a continued place on the program. Alex's pragmatic harm reduction approach, of course, was new and scary to most even in the drug treatment field. They had relied on a 'us and them' approach and a strict formula for behaviour. This new-fangled harm reduction approach seemed to be at odds with their expectations. If you can imagine it, clients would go in through door C to get their dose of 'done, come out through door B and ring on door A to get their fits, all within ten metres of each other. It was clear to everyone, without the need for urinalysis, just who on the program was breaking the rules. But the biggest rule breaker of all, of course, was Alex, who knew the risks to users were too great and he could not stand idly by and let the virus move into the injecting drug using population without a fight. Alex understood that you can kick a drug habit, but not HIV, and based his HIV prevention practices on that simple understanding.

UN: Do you think that understanding came from all these alliances?

JB: Yes it did. I think it emboldened Alex particularly to continue to support the development of a user organisation because he was seeing people with lived experience and peer based knowledge who were courageous in their public presentations, acknowledging their own drug using history but having a lot more to offer. People such as Marion Watson and Jude Byrne, formidable individuals particularly at the speaker's podium at HIV Conferences. These women were frank and powerful in their self-disclosure and in so doing they helped to dismantle some of the myths surrounding drug use, and drug users, and helped forge user organisations and challenged the traditional AOD services and treatment regimes. Alex also saw people with using histories being capable of leadership, writing funding submissions, chairing and presenting at meetings and conferences.

The stereotypes around drug use and drug users were being dismantled with the evidence that users could be found in every environment, could come from every walk of life.

UN: How do you feel about your part in this and is there a danger of complacency in the future?

JB: I am proud to be part of Australia's early responses to HIV but I would rather it not have happened and that the 6,000 or so Australians who have died of AIDS related causes were still alive today. As the song goes, it has been a long and winding road, but I was far from alone on this journey. Having come from a legal background, I could see the injustices and the fact that if people were maintained in a 'us and them' holding pattern, users had more to lose than their dignity and freedoms — people's lives were literally on the line. Action needed to be taken, but we did not think how fabulous we were or how we were going to stop a plague. We just got on with it.

You see, we really did not know how bad it was going to get, the merciless suffering and loss we were going to witness and how many friends we were going to lose. We would be at a funeral grieving a lost friend or colleague one day and back at our desks the next; such was the urgency we all felt in the work we were doing. Not a lot of time for grieving. We learned from and supported each other, and provided a shoulder to cry on as we went. In that process, of course we finally got money out of the government to fund a user organisation, but let us never forget that out of the 6,000 people, mostly gay men, who have died of AIDS, a large number were our early foot soldiers in HIV prevention and care. They did not survive their own battle, but they paved the way to make the world a better place for others at risk of getting or already living with HIV.

User's Story

Happy Birthday, Dad!

It has been a long time since I have sat down and contemplated what the future holds for me.

Take for example my drugs, my cigarettes, and my attraction towards anything that society deems unacceptable and out of the ordinary.

What is this in me, my hunger, this need for some warped type of absolution? Hey I miss you, Dad. HAPPY BIRTHDAY. Wish you were here so that I could share this occasion with you.

Maybe I would have been somewhere else, maybe a different person, who knows, can't go back now can we?

I've been using drugs on and off (mainly on) for almost 15 years now. Makes me older than some, maybe not wiser.

I straddle between two different lives —
my Monday to Friday (socially acceptable) job,
and my pay day. Thursday onwards drug fucked,
as much as possible, as often as possible.
Brothels frequented, other dimensions.

The two lives are so entwined, yet so vastly different that sometimes I struggle to define who I am.

Bupe maintenance helps a bit, but not enough. It's far too easy to avoid, so much so that it sometimes becomes irrelevant; just a means of survival on hard up days. Shit, they give you tick once you've proven you're a good enough customer. Just like my dealers (and what's the difference, really?).

What works, what helps, what ends it all? I don't know. Kids, a family, a purpose, can't really relate to any of those yet. Wish I could, maybe it would make me into the person I want to be.

I love you Dad, I miss you, I wish you were here.

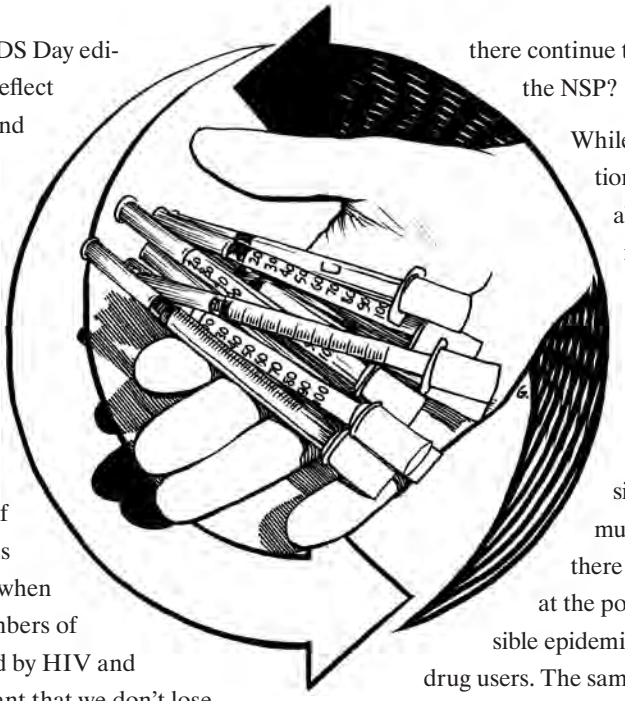
Your guidance would mean a lot.

M

Dedicated to my father who passed away from an HIV related illness on January 1st, 1991.

Illustration by Ursula Dyson

HIV/AIDS and the Future of the Needle and Syringe Program



It is timely, in this World AIDS Day edition of *User's News*, that we reflect on the significance of HIV and AIDS for the needle and syringe program (NSP) and how this may be relevant to the program's future.

Most of the time, in discussions about the NSP, and especially if those discussions involve people from states or territories other than NSW, the issue of principal concern is hepatitis C. This is hardly surprising when we consider the relative numbers of injecting drug users affected by HIV and hepatitis C. But it is important that we don't lose sight of the fact that it was AIDS, and the widespread fear created by AIDS, that directly led to the establishment of NSPs in all states and territories in the 1980s and 1990s.

This is important for at least three reasons. First, without HIV we probably wouldn't have an NSP at all. Second, there continues to be a serious risk of an epidemic of HIV among injecting drug users. And third, we need to recognise the profound changes which have occurred in the treatment of HIV infection.

This last point raises a serious question. The advent of effective treatment for HIV over the past ten years means that HIV is increasingly being seen, in the majority of cases, as a manageable chronic condition and no longer a terminal disease. However this is not yet widely understood in the general community. So if the NSP owes its existence to the community's fear of HIV and AIDS, what happens when this perception of HIV is dramatically altered by the advent of effective treatment? Will there continue to be political support for the NSP?

While there are some assumptions and simplifications in the above scenario, I believe it needs to be taken seriously when we consider the future of the NSP.

My own view on this is one of cautious optimism. I think that even if there is a significant reduction in community fear of HIV in general, there will still be concern, at least at the political level, about a possible epidemic of HIV among injecting drug users. The same arguments which apply at present will continue to be relevant, in particular the issue of secondary transmission to non drug using sexual partners and children. And the existence of effective HIV treatments may to a large extent be negated, in the political calculation, by a view that a significant proportion of injecting drug users will either not be able to adhere to rigorous treatment regimes, or not access treatment at all.

In this way, HIV is likely to continue to occupy a central place in the rationale for NSPs, even if there is a general reduction in fear of HIV.

However what this discussion also illustrates, I believe, is the importance of ensuring that there is a continued focus on HIV as the key public health issue in support of the NSP. For despite the seriousness of the hepatitis C epidemic, the huge number of people affected and the enormous harm it is causing, there are few signs that it has been taken seriously by politicians. I don't believe we will ever have an NSP based on hepatitis C alone.

For professional reasons, the author wishes to remain anonymous

Illustration by Glenn Smith

Confronting HIV and Drug Use in Indonesia

The number of HIV infections among injecting drug users in Indonesia is increasing. Between 2003 and 2004, reported cases rose from 146 to 1,183. Previous data from the Health Department of Indonesia indicate that the total number of HIV/AIDS cases recorded in Indonesia is over 8,000. About 50% of these cases stem from injecting drug use, more than any other high risk population.

The increasing number of HIV/AIDS cases among injecting drug users is a relatively new phenomenon. Initially, most HIV infections seemed to be transmitted through unsafe sexual practice. But over the last three to four years more and more cases of HIV transmission among drug users sharing equipment have been reported. If this trend continues it will trigger a second HIV/AIDS epidemic in Indonesia.

To tackle this problem the Indonesian National AIDS Commission (INAC) formulated the National HIV/AIDS Action Plan 2007 - 2010. One aspect of the plan is harm reduction among injecting drug users through behavior change intervention. But it's not clearly stated what kind of behavior change intervention will be used, whether stopping people from using drugs by rehabilitation, encouraging non-injecting methods of taking drugs or facilitating and educating drug users to inject more safely.

To formulate the best harm reduction strategy, INAC can learn from Australia, which has needle and syringe programs as a cornerstone of its harm reduction approach. These programs have enabled people to avoid sharing injecting equipment and have been hugely successful in containing the spread of HIV among people who inject drugs. NSPs provide a range of services that include the provision of injecting equipment, education and information on reducing drug use, referral to drug treatment, medical care and legal and social services.

In Australia, NSPs have been one of the major public health success stories. At the end of 2006, the cumulative number of HIV infections diagnosed in Australia was estimated to be 26,267, of which only 3.5% were attributed to injecting drug use. Indonesia still has far to go before it reaches Australia's level of success. People tend to ignore the problem of HIV infection and drug use. Injecting drug users are labeled as community waste in Indonesia. People think drug users do bad things, so they deserve bad things to happen to them. Some fanatical people view HIV/AIDS as a punishment from God to those who are considered to have low moral standards. This attitude is the biggest obstacle to reducing HIV infection among injecting drug users in Indonesia.

The common view in Indonesia is that NSPs are a means to legalise drug use, or at least to support people to use drugs. People think supplying injecting equipment is simply against the law and can't see it from any other perspective. The INAC plan, for example, is not supported by the Indonesian National Narcotic Bureau. They prefer to rely on supply reduction and law enforcement to reduce drug abuse.

To make NSPs acceptable in Indonesia people must change their perspective towards drug users first. People have to understand that injecting drug users need help, not punishment. They should be educated that NSPs have more advantages than disadvantages — not only in reducing the risk of HIV transmission, but also in saving money. In 1991, $10 million was spent on needle and syringe programs in Australia, which prevented an estimated 3,000 cases of HIV infection, saving at least $266 million in health care costs in that year alone.

If Indonesia could save health care costs from HIV/AIDS, the money could be used to overcome other problems such as avian influenza outbreaks. The health problems in Indonesia are very complicated, but the Indonesian government has very limited resources. To fund the Indonesian national HIV/AIDS response, the government cooperates with other countries and has established the Indonesian Partnership Fund for HIV (IPF). The IPF is managed by the United Nations Development Program and donors to the fund include AusAID and the Australian Development agency.

Indonesia requires a huge effort to overcome its increasing number of HIV infections. It's hard work, but not impossible, and Indonesia can learn from Australia's success in fighting HIV among injecting drug users.

Harry Wicaksana

Harry is a Balinese medical student, currently participating in the Australia-Indonesia Youth Exchange Program 2008. As part of that program, Harry spent three weeks at NUAA.

My Name is Flo-Rider

— that's the nick-name the inmates at Mulawa gave me.

I'm writing as I would like people to know more about the situation I'm in. I was released from prison in December 2007. I'd finished doing just under four years. When I was released I had good intentions of staying away from drugs and crime. All I wanted was to be a good mum — I've got a handsome little boy. For the first month things were really good. I was picking up my methadone dose on a regular basis and enjoying being a mother.

But after a little while I started getting really depressed and eventually I became suicidal. I was thinking about ways to end my life. I was thinking that because I thought everyone was against me and that they wanted to see me fail and end up back in jail. It was really hard — my family didn't trust me with my own son. They all thought that if he was in my care I'd go on the blink and hurt him. But that wasn't the case — all I wanted to do was get out of jail and be a good mother. I missed four years of watching my handsome little man grow up. All I wanted to do was be there for him, walk him to school, take him to the park, bathe him, cook for him, put him to bed — all the things a mother would do for her children. But I couldn't — my family would get in my way. They didn't trust me and I had to prove to them that I was capable of looking after my son.

It was hurting me bad. I was more and more suicidal as each day went by. Eventually I ended up getting back on drugs and I had to support my habit. Things were getting bad and I was getting really sloppy at doing crime. Every time I was out searching I didn't give a damn about leaving my DNA or fingerprints because all I wanted to do was come back to jail.

Eventually that happened. I'm sitting at Mulawa on aggravated break and enters and other serious charges. I'm sentenced on my parole and haven't been sentenced for all of my other charges. They've got me on anti-depressants and I'm actually a little happier than when I was out of prison. I've got a great cell mate — we take care of each other and when I start to feel depressed I speak to her and feel so much better. Yeah, I miss my son so much it hurts, but I know that he's safe, well looked after and he knows that I love him dearly.

So what I'm trying to say is that if any of you feel depressed or suicidal there are a lot of things out there and people can support you. I find it really helpful to talk about all of my problems and get everything off my chest. My time here at Mulawa has helped me deal with a lot of my problems but jail isn't the way to go.

Flo-Rider

Glenn Smith

Resilient Coping in Hepatitis C Treatment

making the most of your hard earned experience

It has been called 'ordinary magic'. It occurs in situations where people achieve a good outcome despite being faced with extreme hardship. This is resilient coping. In this article, Max Hopwood, a researcher from the National Centre in HIV Social Research, discusses findings from studies which highlight how people are usually very resourceful, drawing on their experience and expertise to help them get through often very difficult situations. To illustrate, he presents evidence of resilient coping during hepatitis C treatment among people who had acquired hepatitis C from injecting drugs.

Researchers have noted that some people who are exposed to a lot of risk, trauma, loss and hardship have an ability to cope well, deal with their problems and get on with life. These people are described as resilient. For a long time, resilience was seen as a personality trait that appeared to be unique to 'special' people; it was thought to be something that came from within, and you either had it or you didn't. Then, during the 1970s, findings of studies into childhood development suggested that resilience might be far more common and indeed ordinary than previously thought and was probably something that most people could work at developing. Children and adolescents growing up in disadvantaged circumstances in some ghettos of America's major cities were observed to be coping very well and indeed appeared surprisingly resourceful. Sure, not all kids were thriving in the poor conditions; many adopted destructive patterns of drug use which were modelled by their parents and peers. However the studies found the reason why some children could cope better than others had to do with protective factors in their social environment. These factors included things like having strong connections to competent and caring adults (often extended family members), but also having access to supportive community networks like youth groups and sporting or recreational organisations, and knowing how to access and use community services like shelters and youth services.

Perhaps this is not rocket science, but this research challenged the belief that resilience was solely a personality characteristic by highlighting the important role of social environment in influencing how well an individual copes with difficulty. Today, resilience is increasingly understood as something that almost any of us can develop from factors in our surroundings; it is ordinary and everywhere, but needs to be harnessed. Many people can improve their ability to cope with difficult circumstances by identifying and mobilising their forces; that is drawing together strength and support that come from their personal networks and local community. This revised notion of resilience was seen in the coping strategies used by people who have injected illicit drugs when they were undergoing treatment for hepatitis C.

In a study conducted during 2004 and 2005, I interviewed people who were receiving treatment for hepatitis C infection. Study participants who had acquired hepatitis C from injecting appeared to use different strategies to cope with the side effects of treatment than people who had medically acquired hepatitis C infection. For example, people who were former users accessed social and community services to gain support during treatment, whereas people with medically acquired infection tended to seek support from partners and immediate family.

People who had acquired hepatitis C from injecting sometimes had networks of supportive friends and peers, and many had prior experiences of counselling services which they tended to revisit during treatment. Some people with injecting-related hepatitis C in this study were members of support groups like NA and AA and this was where they said they learnt strategies that helped them cope with hepatitis C treatment side effects like anger and depression.

Finally, participants who had injected drew upon past experiences of hardship, like drug dependence, coming off heroin and methadone, living with symptoms of chronic illness, and dealing with depression in order to help them cope with the impacts of hepatitis C treatment. In short, it seemed like being an illicit drug user — and learning to cope with the associated marginalisation from mainstream society — had given people particular experiences, strategies, skills and knowledge which were useful for coping with adverse events during hepatitis C treatment.

For example, Kate, 38, said she had used heroin for many years. She had dealt with the aches and pains and skin

rashes from hepatitis C treatment by using alternative and complementary therapies which had worked for her while she was in withdrawal. She said of her experience:

"Yeah, I just think that [hepatitis C treatment] is a reality that you have to deal with. That's learned only through having been through heroin addiction and stuff like that… and even my friends would say that to me, before I started treatment 'You'll breeze through it! You've been through heroin addiction; it'll be a walk in the park'… And in a way I kind of agree… I do feel sorry for people who've never experienced… that level of discomfort in their lives. Yes, [hepatitis C treatment] would be tough for them. But I've kind of been through it before… just the rough knocks during my life too… because I'd been through withdrawals and all of that, so of course I could handle, you know, itchy skin or that physical side of things… because heroin addiction… and actually getting off methadone was worse."

While a heroin user, Kate had occasionally attended counselling services which she had found helpful. So during treatment Kate took advantage of having access to psychologists at her treating clinic and said that her long talks with the counsellor had helped her manage the depression that was a side-effect of her treatment. Kate also moved to a familiar area where she knew friends who could lend extra support, and she started regular swimming to get fit. According to Kate, these factors had helped her to cope when stopping her drug use and now the same strategies were helping her complete hepatitis C treatment.

Another example of people drawing on past difficulties to help cope during hepatitis C treatment comes from Gerry, 48, who said:

"Having lived with chronic pain for the whole of my adult life basically, I already had coping mechanisms to handle those things… I'm used to just not being able to get out of bed for two or three days in a row. That happens occasionally; I just live with it… I may be in a better position than some other people to cope with the [hepatitis C] treatment because I'm used to being in a debilitated state… that's not a good thing, but it's a fact. I guess the coping mechanisms were always there, from over a long period of time."

At the time of interview Gerry described treatment as tough going, however he was getting some support through his network of friends. He borrowed money to set himself up in a flat where he could live during his treatment, and like Kate he was applying simple health remedies he had previously used for chronic pain to help manage treatment side effects.

Similarly, Marsden, 50, said that during treatment he relied on community-based resources and services which he had accessed in previous periods of financial difficulty. These services included sponsored food vans that provided free meals to homeless and disadvantaged people. He also knitted hats and blankets which he bartered for goods at community markets (although sometimes he gave his work away for free in order to shore up good will among other users of the services). According to Marsden, these strategies and skills were important factors in coping with unemployment, depression and hepatitis C treatment.

There were other people in my study who reported similar ways of coping to Kate, Gerry and Marsden. Their past experiences of drug dependence and living on the edge of the mainstream had taught them coping strategies, which appeared to be working because they were all nearing the end of a long and challenging treatment.

The findings of this research suggest that resilient coping is about identifying and drawing on (i) the strategies and/or supports that have helped you to cope during previous difficult times, and (ii) using your personal networks, and the resources and services that are available in your local environment, to help you cope with the impacts of hepatitis C treatment. Even small improvements in people's situations can mean the difference between completing hepatitis C treatment, or giving up treatment before it's had time to work. Most people have access to some resources, whether it's among networks of friends, family or within their community, which they can draw on to help improve their situation. It's about identifying where your strengths are, mobilising your forces, and putting these resources and past experiences to good use.

Max Hopwood, PhD *National Centre in HIV Social Research, University of New South Wales*

long over due...
The world
PARALETIC OLYMPICS!!

Hi there and welcome to the highlights of day is of the PARALETIC OLYMPICS!

The games so far have been a non-stop feast of drug inhibited ACTION...

Todays events were no different, and to recap the highlights we go first to the track and field arena....

GOOOLD!
GOOOLD!

To the relay where a botched drug transfer left the american favorites well behind searching for the foil....

Next we go to the wresting. In the "Where's My Fucking Money?!" tag team event (lightweight division), the sensational German duo took the honors in convincing fashion!

Here is the awsome finishing replay

A sequence th
the partner ent
the crucial ti

The hundred meter dog paddle was won by the sensational "Darlinghurst Dart" with a record time of 15.36.251

PUF! PUF!
SPLATCH!
SPLATCH!

She attributed her sucess to a rigorous training program and diet regime

WHITE BREAD
5 steps to house

The world beating peformance vindicated by a completely saturated drug return...

Donor Information
Drugs Tested
Easy to read Results
Results Guide
Fill Line
Temperature Strip
OK!

Another
was th
Britis
in the
Balco

Looping into a disoriented back bend....

Opening out into a blind panic maneuver..

And completes the effort with a textbook back whacker...

To the marathon and a challenging course that tested the resolve of all the participants...

Afte
that
lead
to
hou

A desparate duel ensued which saw victory go the Kenyan as they crossed the finish line at the injection center...

BANK BANK!
LETTUS IN!!

Now to Gymnastics.. The talented Romanian wowed the judges with her finals routine

CLAP! CLAP!
YAY! HURRAH!

They try to make me go to rehab...

SWING!!

I said no, no, no..

GRIND!

Yes
I co
Kn

Finally. We wrap up our highlights with the injection final..

00:000

The crowd is hushed. the french woman is ready...

She's off!

SNATCH
TIE!
PRICKLE!
PRICKLE
INJECT!!
AHH!!

What a hit! A new world record!! 8.219 seconds!

YEAH! YEAH!
YEAH!

Sensation in the hundred meter shuffle when the Bulgarian winner was STRIPPED of his gold medal!

YAY!

YAY!

A random post-race drug test found no traces of any drug in his system..

Donor Information

Drugs Tested

Easy to read Results

Results Guide

Fill Line

Temperature Strip

FAIL!

The team officials plan to appeal the descision

I could have won it on drugs as well

CLIK! CLIK! CLIK!

PRESS CONFERANCE

...at saw
...er at
...me..

A deft parry and strike with the shopping bag laid the Pakistani out cold

A great win by all accounts..

To the pool now where there was amazing performances all round...

...highlight
...e stirling
...h showing
10 Meter
...ny Free Style.

In the slow motion you can see his genius at work...

Launching backwards he flails majestically...

Completing a half twist knee in mouth arc...

...r a tight start
...t saw no clear
...er on the way
...the dealers
...se...

WHEE!

YAY!

The Somalian broke away to a strong lead on the ten flights of stairs

CLASP!!

HUF!

PUF!

4 hours later, the tension showing, the kenyan inched ahead on the way to the A.T.M.

FAST CASH

BEEP! BEEP! BEEP!

At the final leg via the 7/11 to buy smokes, The leaders were challenged by the fast finishing mexican...

24 hrs

...lve been black but when
...me back, you'll know
...ow, know...

GRACEFULL SWEEP!!

I aint got the time & my daddy thinks Im fine...

DANGLE!!

He tried to make me go to re-hab..

SMASH!

I wont go, go, go...

BRAVO!

CLAP! CLAP!

HURRAH!

YAY!

thanx to amy winehouse

AND NOW THE NEWS.

Sensational Images as prehistoric monster neutralised during city rampage...

RARR

RAR!!

RAAR!

EEK HELP!

NOO!

ZEEM!

BOOM!

THE END

Tony Sawrey

How Endocarditis Broke my Heart

Bodine

Twenty four years ago my loving wife Sue and I were tossing up whether to head north or south from Coffs Harbour with our 12 month old son Bill for a two week sabbatical. We'd had a reasonable pot growing season and our heroin usage had burgeoned in line with the proceeds of our dope business. But enough was enough and we needed to stop. Our finances were reasonable so we decided to head north to the lovely surrounds of a palatial 15th floor room in one of the hotels on Coolangatta beach.

When we arrived we were ready for the two weeks of torture ahead. We knew that after a week or so things usually started looking up and we were young and healthy and knew there were worse things than hanging out. Sure enough, after the first week, things did start getting a bit easier to handle: the aches and pains receded, nightmares lessened, sleep increased and the thought of taking a walk along the beach with Bill actually looked somewhat enticing. For one of us anyway. Thank God Sue was coming good. As for me, the real illness was only just beginning.

On about the eighth or ninth night, a few hours after finally succumbing to total exhaustion and falling asleep, I awoke with the sheets and pillows soaked in sweat and with a chronic, thumping headache, the likes of which I'd never had before. Of course Sue woke up as well and was quite concerned because along with how I felt, I looked pale and sickly like a ghost. We figured I'd caught a 24 hour bug and that this was the final expulsion of poison, after which I'd start to come good. Eventually, after a cuppa, I got back to sleep. I woke in the morning feeling a bit better but as the day wore on and Sue was feeling better and better I was heading in the opposite direction. It didn't make sense but it was getting worrying.

That night we ordered Chinese takeaway. Wanting some fresh air I volunteered to go and pick it up. The

restaurant was across four lanes of heavy traffic throttling in both directions. Finally there was a small break in the traffic and as terrible as I felt I made a dash for it. WELL! Believe me when I say that as I ran every heavy step hitting the ground made my head feel like it was going to explode! I grabbed the food and with my head still feeling like it was going to blow up I tip-toed back across the road, not even looking at the traffic and not really caring if I got run over.

I sweated and vomited all night so in the morning Sue packed the car and started rally driving home to get to my doctor and the hospital before I died!

In five hours we made it back to Bellingen Hospital, just south of Coffs, where a bed and my doctor were waiting. Fortunately he knew our background and so he immediately began looking for illnesses which injecting drug users might be prone to. Luckily for me he was right on the ball and within the hour he'd diagnosed me with subacute bacterial endocarditis. In layman's terms, it's an infection in one of the four valves we have in our heart.

Without going into too much detail, a few weeks previously I'd used with a friend who, unbeknownst to me, had impetigo (otherwise known as school sores), an infection that can be caused by streptococcus bacterium. While I didn't use her syringe I did mix up in the same spoon after she'd used it. It appears that this bacterium got into my bloodstream and then infected my mitral heart valve. This heart valve is in the left side of the heart and, along with the other heart valves, controls which way blood flows.

The doctor instantly gave me huge amounts of antibiotics and transferred me to nearby Coffs Harbour Hospital. I was put on a drip of six grams of penicillin daily. This was a large dose that I was kept on for the eight weeks I stayed at the hospital. The next step was supposed to be replacement of the heart valve, but after many tests and what I believe to be intervention form the man upstairs, it turned out that the valve was not damaged enough to need replacing, although it was scarred from the infection and blood leaked every time it pumped!

A few years later I was taking some pot down to Melbourne to sell. A mate was coming with me and we'd decided to take a train down from Coffs as we thought this was the safest bet. We left at 10pm with the goods and enough hammer to make the 28 hour trip bearable. I wasn't feeling particularly well when we boarded and by the time we made Sydney I had deteriorated considerably. We had some errands in Sydney and it soon became clear that there was no way I could continue the train trip to Melbourne. (Don't forget those were the days of the old 'red rattlers' and they really did rattle your head.) So although it was riskier we decided to fly down instead and by 10.15am we were in a hotel in Melbourne.

I was really ill and going down by the minute. I had a mate coming over to pick up some pot and I took a bath in the meantime, leaving the door unlocked so my mate could get in.

I didn't hear my mate come in but when he saw me he was terrified at my condition. We were close to the main heart hospital in Melbourne (more luck) and I was just lucid enough to tell the triage nurse that I'd had a previous heart infection. These words, leaving my hotel room unlocked and flying instead of taking the train all contributed to saving my life! If I'd taken different decisions I certainly wouldn't be sitting here writing this. It's the closest I've ever come to death. Apparently my temperature was 41.2 degrees. At around 42 degrees, brain damage and other bad stuff can start occurring. The hospital staff started pumping me with antibiotics and for four days I was delirious.

Test results showed that I had another infection on my mitral valve. This time it was a bacterium called Staph aureus — sometimes known as golden staph. Three months worth of hospitalisation and antibiotics are usually needed to sort it out. Ten or 15 years before I got it, most people died from a golden staph infection. Staph aureus is actually really common and often present on our bodies. The problem is when it gets inside our bloodstream. There are many ways for this to happen, but if you inject regularly you need to be extra careful. I guess I wasn't careful enough and got infected three

How Endocarditis Broke my Heart (continued)

times! Although the infection is not always on the heart, the fact that this happened to me three times and I'm still alive and kicking is a miracle! A common ailment for people who've been affected is stroke. Luckily this hasn't got me yet either!

The reason I'm writing this is to let everyone know what can happen when injection goes wrong. But it does not take that much to avoid this ever happening to you. I was told when I was released the second time to swab, use new syringes, and use cold water. I would say in addition to use your own new spoon, or at least a swabbed one. I managed to survive three infections, but I was lucky!

Justin

Justin hits the nail on the head when he says that it does not take that much to avoid these infections. But it does take more work than you might think because you need to practice these safer using practices every time you use. The problem is that with endocarditis, like other infections, you don't know at the time of your shot that you've just infected yourself. The only thing you can do is to take precautions every time you use.

The precautions Justin refers to are:

1. Swab properly. This means using the swab by wiping in one direction, once only. If the injection site is really dirty, open another swab and do the same again. If you do 'scrub' back and forth at the site to clean it, make sure to then use a fresh swab and swab in one direction, once, just before injecting. The reason for this is that swabbing back and forth actually spreads bacteria back onto the site, whereas swabbing in one direction once swabs it away from the site.
2. Use new syringes. Most users try to use new equipment, but for some getting hold of it can be difficult. The reason it's so important is that microscopic bacteria can live in the syringes and even flushing out your own used ones is not totally safe. If you use large barrels, like 20mls, there is the problem of them costing money, but have a think about the few dollars of cost against the nastiness of endocarditis and if you can afford it, buy new ones for each shot. Most importantly, whenever you're in an NSP or pharmacy, make sure you stock up with more equipment you think you will need. Having too much is better than running out. Also try not to reuse butterflies (winged-infusion sets) as they are difficult to clean and can harbour all sorts of bacteria. They are not distributed through the needle and syringe programs in NSW but are available at some pharmacies.
3. Use cold, sterile water, not warm water in the mix. If you leave your mix sitting around for a while, remember that warm water helps bacteria breed. Sterile water from ampoules is always the best water to use. Boiled water cooled down in a clean, covered container is probably the best option if sterile water is not available. Ampoules are available at pharmacies and some NSPs.
4. Use your own swabbed spoon. Well, you just don't know where any other spoon else has been, or what has been in it. At least swab any spoon you use and remember that bacteria can't be seen and are all over the place.
5. Use a bacterial wheel filter. Justin didn't mention this but they weren't around in the days he was writing about. At NUAA we have blue wheel filters which filter out any bacteria. If you want to know about them call us on 1800 644 413.

The great thing about these precautions is that following them greatly lowers your risk of contracting or passing on viruses such as HIV or hep C as well. Although viruses are smaller than bacteria (and wheel filters won't filter them out), following safer injection guidelines can keep you safer from them as well.

Sione Crawford
Community Development Worker,
NUAA

Fate Gives you Two Choices

I can still hear the words now. They sound so familiar, but I couldn't understand them back then. "The choices you make now will determine the course of your future" the counsellor said. "Don't you understand that simple fact?"

Simple, moral boundaries tended to elude me and even when they didn't, my reckless 'don't give a fuck' attitude always pushed me over the line as surely as night followed day. You'd think you'd learn these lessons after a lifetime of ending up where you don't want to be, but sometimes fate and desire play tricks and the real issues in life blindside you whenever they feel like it.

I read a magnificent book that said fate gives us two choices, the one we should make and the one we do make. I remember my first such choice at about four years old, lighting the cigarette in the toilet at home, the consequences of which were swift as my father's hand descended towards my arse.

I remember making the poor choice for about the millionth time at 19 when the house I was robbing in desperate need of heroin was surrounded by the SWAT team and I decided that it made sense to try and rush the line to escape. The familiar feeling of losing control cushioned me as I was violently punched to the ground, my face held into the dirt with a monstrous police boot. The shotgun at my temple completed the overreaction of the police towards a derelict kid about as powerful as a cockroach.

There was no daylight after that for four days, until I was released back onto the street, to my chaotic existence as a broken soul, a sad thieving junkie who would do just about anything to absolve himself of the emotional bushfire that raged inside.

My dislocation from the community was almost complete as I hunted the streets, my infrared eyes seeing only money and drugs. I broke into houses and the first thing I did was look in the medicine cabinet. To me it didn't matter if the people were home or not — if they were home, I'd just have to be quieter. Eventually the community saw fit to remove me completely and I was given a lengthy jail term.

Those words the counsellor said came back to haunt me: "The choices you make now will determine the course of your future." For the first time I heard those words with clarity and I thought about my life. I had no education, no employment history, no friends, no aspirations and no skills of any sort to manage my life. I was a loser. The decision to leave school, the decision every day to take drugs, the decision to hang on the dole and do nothing, all the poor decisions I'd ever made had led me to this point.

It was from that moment of clarity that I decided to start making the choices I should have made.

I became employed in the prison library. I started and finished many educational courses. I attended drug and alcohol counselling sessions. My whole outlook towards life changed. I now felt positive and optimistic about the future. Good things started to happen to me. I was contacted by my family and have re-established a great and loving relationship with them. I have just begun a university degree and am making new choices everyday to continue on this explorative path I've encountered of hope, love, joy and life.

So the next time you hear the words, "The choices you make now will determine the course of your future", pay a closer attention. This is a statement that has changed my life. I know it can change yours.

Aaron

Illustration by Glenn Smith

What Caused Australia's

In early 2001, the availability of heroin in Australia decreased suddenly. Prices rose and purity fell. Heroin overdose deaths decreased from over a thousand a year during the last years of the heroin glut in the late 1990s to about 400 a year. These conditions have remained much the same until now.

National and international supporters of supply control claimed that the Australian heroin shortage was a triumph of drug law enforcement. In recent years, there has been increasing skepticism about the effectiveness of War on Drugs type policies. In the long-running debate about drug policy, staunch advocates of drug law enforcement have struggled to produce evidence that supply control has produced clear-cut and sustained reductions in the availability of illicit drugs (with a few exceptions, such as New Zealand), while the high costs and often severe collateral damage produced by supply control have been hard to deny. Unintended negative consequences include severe police corruption and the development of 'narco-states' where governments and drug traffickers in countries such as Afghanistan, Pakistan, Bolivia, Peru and Columbia are intertwined. In Mexico 6,000 police, army, government officials and civilians have been killed by the War on Drugs in the last two years.

Support for supply control may have peaked when the United Nations Office on Drugs and Crime (UNODC) attended the United Nations General Assembly Special Session on Drugs in 1998 using the slogan 'A Drug Free World: We Can Do It!'. At that meeting, it was agreed to review the effectiveness of drug policy in ten years. This review is now well underway and concludes at a meeting in Vienna in March 2009. In the same decade when the world was supposedly advancing to drug free status, global heroin production more than doubled while global cocaine production increased by 20%. The Australian heroin shortage is one of the few pieces of good news that the international drug law enforcement fraternity has been able to show for all the generous funding received.

The international drug trade is estimated by UNODC to have an annual turnover of $US322 billion. A confidential report commissioned by the Blair Cabinet in the UK in 2003 estimated that the profit of major drug traffickers in Afghanistan accounted for a staggering 26-58% of turnover. So this is a large and immensely lucrative industry. Drug traffickers have more funds available to defend their activities than drug law enforcement authorities have to attack them. If illicit drugs still find their way into prisons throughout the world, and they do, how could drug law enforcement authorities ever manage to restrict drug supplies in the community? If a kilogram of heroin is worth $US1,000 in source countries like Afghanistan or Burma, and can fetch two to three hundred times that price in destination cities like New York, Amsterdam or Sydney, how can customs, police and other drug law enforcement authorities ever manage to put a dent in the drug trade? How can drug law enforcement ever reduce the availability of drugs when all commodities must conform to the inexorable law of supply and demand?

Nevertheless, a number of researchers concluded that drug law enforcement was a major factor in the Australian heroin shortage. Professor Louisa Degenhardt and Professor Wayne Hall wrote (with colleagues) an influential paper from a study funded by the National Drug Law Enforcement Research Fund (NDLERF). Some would argue that the fact that studies funded by the pharmaceutical industry are much more likely to show that medications are effective and safe than studies funded by other sources should have been sufficient warning to avoid drug law enforcement funding. Others have argued that in the real world, alternative sources of funding are simply not available.

Degenhardt and Hall adopted the 'most plausible explanation' as their level of proof in this study. Harm reduction interventions, including needle and syringe programs, methadone maintenance treatment and heroin assisted treatment, are held to a much higher standard of proof in scientific research. But Degenhardt and Hall argued that they had no option but to adopt a lesser standard of proof in their (inevitably) retrospective study. Degenhardt and Hall also relied heavily on the uncorroborated opinion of anonymous drug law enforcement officials regarding the causes of Australia's heroin shortage.

A critical part of their argument is that a heroin shortage occurred in Australia, but not in other countries also sup-

Heroin Shortage?

plied by heroin originating from Burma. The evidence for the assertion that other countries were not affected came from the opinion of two anonymous drug law enforcement officials. Degenhardt and Hall argue that evidence from Vancouver of declining provision of injecting equipment from needle and syringe programs, declining drug overdose deaths, and declining naloxone provision for heroin overdoses does not refute their notion that Australia's heroin shortage was unique because similar declines in Australia began much more abruptly and were far deeper.

Until recently, virtually all heroin reaching Australia originated from Burma. The UNODC and a section of the US State Department publish annual estimates of global and national production of illicit drugs. These sources claimed that heroin production in Burma decreased by 79-89% from 1996 to 2004. Why heroin production declined so steeply in Burma in those years is still debated. But Degenhardt and Hall reject declining heroin production in Burma as the 'least plausible explanation' because, they claim, Australia's heroin shortage was unique.

Much of the heroin reaching Australia passes through China before reaching this country. Heroin consumption in China increased so spectacularly in the 1990s that a reputable Australian intelligence analyst predicted in 1996 that a heroin shortage would commence in Australia within five years. While heroin production was decreasing in South-East Asia in the 1990s, amphetamine production was increasing rapidly. It is unclear whether these two trends are connected. But it is known that at least some of the syndicates responsible for trafficking heroin to Australia also trade in amphetamine. If the heroin shortage was produced largely by Australian drug law enforcement, why was amphetamine trafficking not also affected?

A critical part of the argument proposed by Degenhardt and Hall hangs on the question of whether or not Australia's heroin shortage was unique. Assessment of international illicit drug markets is complicated by the fact that drug traffickers in some parts of the world clearly have large stockpiles available — the virtual suppression of opium production in Afghanistan in 2001 produced barely detectable effects in the heroin markets of Western Europe.

In medicine, new interventions these days are regarded as ineffective and unsafe until proven otherwise. It is not possible to ever conduct the same sorts of rigorous trials of drug law enforcement that are possible for health and social interventions. But the dearth of evidence for drug law enforcement, in combination with the powerful arguments suggesting supply control effectiveness is likely to be limited, require supporters of drug law enforcement to come up with something which can justify the current international system.

The recent reduction in heroin supply in Australia is the most severe, longest lasting and best documented heroin shortage in the world. The fact that this heroin shortage cannot be confidently attributed, solely or largely, to improved domestic drug law enforcement significantly weakens the argument that both individual countries and the international system should rely on measures to cut drug supply. At best, domestic law enforcement may have made a small contribution to Australia's heroin shortage compared to several other factors. (The confidential report commissioned by the Blair Cabinet in the UK in 2003 also gave little credence to the notion that drug law enforcement was largely responsible for Australia's heroin shortage.)

Calls for new approaches to drug policy are coming thick and fast these days and have even been supported by Mr Mick Keelty, Commissioner of the Australian Federal Police, and Dr Antonio Maria Costa, Executive Director of UNODC. The newly elected President of the United States, Barack Obama, is also among those calling for more emphasis on health and social interventions. Law enforcement attracts the lion's share of government drug funding around the world, with health and social interventions for illicit drugs only receiving the small change. Australia's heroin shortage should not slow the development of a more balanced approach where funding for health and social interventions would be raised to the level enjoyed for decades by drug law enforcement.

Dr Alex Wodak
Director
Alcohol and Drug Service
St Vincent's Hospital, Sydney.

To 'Hab or to'Hab Not

D.I.Y. Detoxing

Well, here I am again. Waiting for a place in rehab. And barely two years after swearing blind that I'd never piss on demand under the scrutiny of a public servant again. But here I am, nevertheless. And this one depends on a D.I.Y. detox, requiring three cleans per week, until a bed becomes available.

I love to go up, down, sideways and round and round — preferably all at the same time. I dearly love my ganja, my gas, and my gin'n tonix, (usually in that order). I've had on-again off-again love/hate affairs with that charismatic and treacherous Dr Harry (although that's been history for ten years), and occasional one-night stands (technically one-night crashes) with benzos and other sleeping dragons. And I'm still in thrall to that most futile and least enjoyable of substances, nicotine, which imparts nothing except a compelling need to be needed.

And I've been doing it all for a long time now. Over 30 years. In that time you get to try pretty much everything, including giving things up. I gave things up all the time, sometimes even when they were readily available, and even when I could afford them, and sometimes for weeks at a time.

After Dr Harry moved in the other drugs got scared and moved out, and then I started giving up other things, like jobs, possessions, friends, and getting out of bed in the morning. Finally, I gave up real estate, specifically my house in Sydney, which was almost all mine and hardly any of the bank's. It was 1995 and time for a geographical. Oddly enough, it worked. My partner and I even stayed together as a couple, said goodbye to the doctor, and settled down on the Central Coast to a life of beers at the bowling club and walking the dog on the beach.

In-Patient Detoxing

I had already cold-turkeyed heroin (several times, for varying periods), and gone on, and jumped off, the 'done, before my first in-patient detox (which was for alcohol) back in 1997. I remember being appalled by the staff's suggestion that this extremely unpleasant week of shaking, sweating, humiliating group sessions and compulsory AA meetings should not be considered the end of my 'problem'. Quite the opposite, in fact. It was the start of my 'recovery'. I was henceforth to consider myself an addict for life, a person who not only could never drink again, but also could never take any other drug.

What did they mean? I'd stopped chucking, started eating and I could even write my name more clearly than a five year old again. In short, I was a functioning adult once more. And as for lumping alcohol in with my dearly beloved pot, well that was tantamount to heresy in my book. Dope had never caused me to lose a day's work, or fight with my boyfriend, or cuddle a toilet whilst heaving my guts up! They were totally different kettles of fish, and while I might concede that alcohol might not, in the long run, be my longneck of lager, there was no way I was throwing out the bong with the bottle!

It was here that I first heard the term 'rehab'. There was a great deal of pressure to continue my 'treatment' by going to one for a while — a 'while' being anywhere from a month to a year. A year! I protested that it was impossible to just give up my life — I had a job to return to! And I was acting as carer for my ex, who had an acquired brain injury from a bad OD the previous year. I couldn't just leave him to the tender mercies of Centrelink! No, I'd go to AA every day and I'd be fine, I assured them. I walked away, healthy and confident, and lasted 17 days.

Since then I've lost count of the number of in-patient detoxes I've done; they've become a bit of a walk in the park, though I admit I've never done one for opiates or anything nasty like that. Also, you've got to pick the right one.

Grand Plans

Yes, detoxing is usually pretty easy for me, especially if I'm broke. But my grand plans for a change of lifestyle never last. For years I put the responsibility for my using down to 'childhood trauma' and 'external influences' (i.e. my ex-partner. I never blamed him for my using, but just being with him made me want to use. It still does.)

So I made the move away and returned to my old job in Sydney. On my own. It was great for a while. I was determined not to fuck it up this time. Kept the beers to a minimum. No cones for eight months.

The Gods like a joke as much as the next person and I got an insurance payout of $30,000. Wow! It was like winning the lottery! Then a guy I had worked with for five years offered me a toke on a joint. Oh, fuck yes! Turned out he deals. Thank you, whoever, I was really missing this stuff. And then… "I can also get you nice gas", he said.

"You little ripper. I'm cashed up, bring me in a gram."

It was rocket fuel! I hadn't had any for about five years and totally reveled in staying up for days. I thought to myself, I'll just do it for two weeks, to lose some weight, and then I'll stop. Oh, yeah?

Two weeks later I knew. I knew I was going to lose my job, and then my house. I knew I wouldn't stop until the gear dried up, or my friend got busted, or I ran out of money. Most of all, I knew I couldn't blame anyone else for my choices, ever again, especially the one person who would, without question or hesitation, give me somewhere to live. Again.

I had a Grand Plan taking shape in my head. It was this: I decided to spend all the money, then 'asset-strip' myself of anything I had valuable left (so that I couldn't change my mind), and then go into a long-term rehab. If, at the end of a year, I came out and still couldn't wake up in the morning without feeling terrified of the day ahead of me, then I would kill myself. Easy.

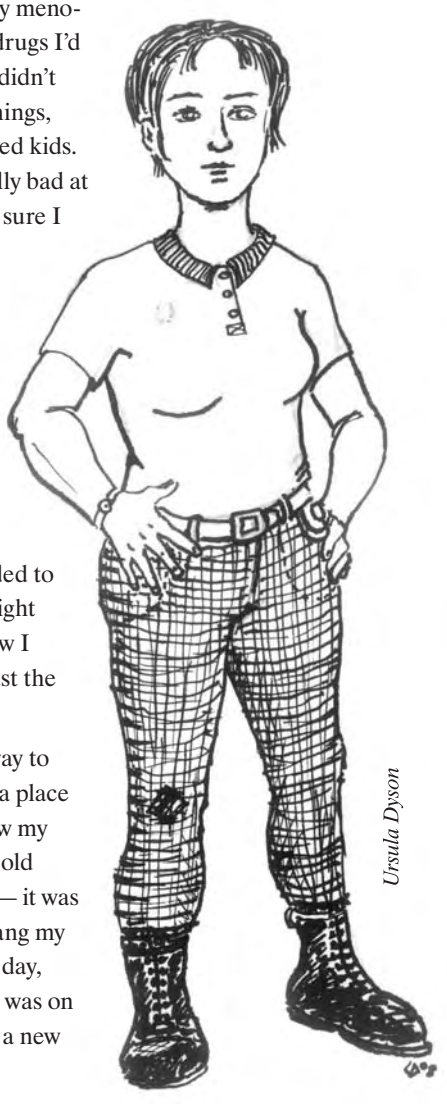
It took four months to spend most of that money. Before I lost my job I applied for an increase in my credit card limit, and spent that too. I already had two mobile contracts plus a landline, but I took out a two-year broadband contract as well. I knew I could never pay what I owed, but I thought I'd rather go down with a bang than a whimper.

By November 2004 I was back on the coast, crammed into my ex's tiny little flat, broke, depressed beyond daytime telly, but with my plan slowly becoming realty. Once a fortnight, on payday, we would drive down to Sydney for some gas, but apart from that we could only afford a few beers here and there.

I got myself a financial counsellor to put the wheels in motion and to put my debts on hold which I had heard you could do in my situation. I wrote long letters of explanation to my debtors, but the only acknowledgements I received were more demands. I threw them on the ever-increasing pile, exclaiming: "Get in the queue, you bastards." I even sold my car to the local car yard for half of its worth one day because we'd run out of ciggies.

Soon even our fortnightly trips to Sydney ended. We found a local dealer but the gear was not nearly as good.

I'd been pretty sick since getting back to the coast, and I put it down to the sudden withdrawal from large quantities of speed. My periods stopped. I was really angry and depressed all the time. The quack said it could be early menopause from all the drugs I'd taken for so long. I didn't mind, I hated the things, and had never wanted kids. I thought I'd be really bad at mothering, and I'm sure I was right.



Ursula Dyson

I started researching rehabs on the internet. I avoided anything to do with Gods of any kind, but it was nigh on impossible to avoid AA. I needed to get somewhere straight from detox or I knew I wouldn't make it past the first pub.

Soon I was on my way to detox, yet again, to a place where the staff knew my name. I ran into an old music buddy there — it was really quite fun. I rang my chosen rehab every day, and within a week I was on a train, heading for a new kind of hell.

To 'Hab or to'Hab Not (continued)

Rehab by Numbers

I knew straight away that I was not going to like this place. It had a depressing feel, and a one-size-fits-nobody approach which was specifically designed, I'm convinced, to break the spirit (though the powers that be denied it). Within three days I was packed and ready to walk out, hitch-hike back to the coast, broke or not. It took a lot of persuading to keep me there.

The best way to describe this gloomy institution is by comparing it to George Orwell's classic novel, *1984,* which nobody there had never heard of, let alone read. Not even the staff, made up largely of ex-users (I thought this would be a plus, but in many ways it was worse than a teenage student counsellor). They had the equivalent of 'Thought Police', 'Everything Not Compulsory Is Forbidden', 'The Anti-Sex League' and lots of shadowy 'Big Brothers' who turned up once a month for meetings. Every day someone came round with a sheet of paper to ask you how you were feeling. I once replied, "DoublePlusUnGood", but though nobody understood the reference, the instruction came down from on high not to use that term again.

Strangely, I found myself relaxing little by little into a state of surrender and took immense pleasure in the small things they couldn't take away, like singing subversive jazz songs about whisky and sex. Every time you broke a rule, you had to write an 'Awareness', and I enjoyed playing around with the words and politely insulting the shit out of the place as much as I could get away with. I would wake up at 4.00am, just to get some head time to myself, but it was hard because we had AA or NA every night till 10 or 11pm. Although I really hated it there, I was determined to see it through. After all, I'd left myself no escape route.

My Escape Route

One way of getting out for a bit was by asking to see a doctor, which I did straight away. Someone told me that if you went to the sexual health clinic you got out for a couple of hours, so I said I needed to have a PAP smear (which was true), and I was booked in for the following Friday. The nurse I saw was the first person who had spoken to me like a normal adult since I'd been in rehab. She was very nice, and we spent a long time documenting my history and so on. Then, finally came the PAP smear — never a pleasant test at the best of times, but I'd had a cyst there for a long time which always made it more painful. This time it was really bad, though, and the nurse seemed to be having trouble getting where she needed to be.

The following conversation is verbatim, to the best of my memory.

"I can't find your cervix", she said, with concern.

"I'm sure I've got one somewhere", I quipped. Then she said, "You know, I used to be a midwife. Are you sure you're not pregnant?"

"Oh, look, it's just not possible", I said, although with some doubt as I knew it was. *Just* possible. But I also knew that if I was pregnant, then I was *seven months pregnant!* It had been back in December when I first arrived back on the coast from Sydney. It was now the end of July!

She said, "I really think we'd better do a test. Are you okay with that?"

"I suppose so", I said. "Better to know, one way or another." And so 15 minutes later the test was done and she's going, "mm, mmm."

"Don't tell me," I said, "inconclusive?"

"Yeah, it is a bit", she said.

I asked if I could have a look, and it took only a glance. "That's not inconclusive! That's positive!"

"Yeah, I think it is."

That was when my jaw hit the ground. All I could say was, "Faaarrrrkkkk", over and over again, but inside, I was surprised to find myself quite … *tickled* is the only word that fits. I knew instantly that it was far too late to do anything about it; it was all out of my hands. I also knew that I wouldn't be able to stay at the rehab: they had no provision for babies, or even pregnant women past a certain point.

I had so many different feelings and thoughts swirling around that I didn't really know what to do so I went on gut instinct. Since I had felt happy, not scared, when I saw that positive sign, then it must the right time and I would give motherhood a go. If this didn't give me a reason to

get up in the morning then nothing would.

I instantly began worrying about Downs Syndrome, or some other malformation, caused by all the drugs. The chances were probably high. I'd have to wait for an ultrasound, which in this backwater could take two or three weeks. But she really pulled some local strings, that nurse, and I had the ultrasound the next week. It showed a perfectly normal, if small, boy, with an expected birth date of October 25th, just three days earlier than his dad's. (Two Scorpions, I thought, that's a lot to cope with.)

As soon as I got back to the rehab I informed the nicest of the staff that I was going, that afternoon. I was back on the coast three hours later, at square one, sort of, but with much bigger squares.

The Perks of Pregnancy

I rang all the numbers I had for Central Coast Health as soon as I could, and after a lot of red tape found myself back in my favourite detox, waiting for a place at Kamira Farm, the **only** long-term rehab in NSW which accommodates women with their children.* (Are you listening, Mr Reece? Mr Rudd? When I was last there it had capacity for eight women and their kids but that's now been doubled with their new facility. Wow! Sixteen women and their kids! That'll make a difference, eh? It's a disgrace!)

So by mid-September I found myself in a place that was so diametrically opposed to where I'd been that I couldn't even resent the urine tests. Oddly, both used the same label to describe themselves, namely 'therapeutic community', but that was where the similarity ended. Kamira's program covered more than just the symptom, i.e. substance abuse; it incorporated all sorts of issues, like assertiveness, domestic violence and parenting, and included weekly individual counselling. And not a whiff of testosterone anywhere.

And at 3am in mid October I woke the others up and the Night Plan (organised a week before) was put into action. One girl drove me and my wonderful 'support person' to Gosford Hospital, where at 8.01 on a Sunday morning my little Danny-boy, a miracle-baby if there ever was, came into the world. Not a scorpion at all, but a well-balanced little Libran. (Mmm, we'll see).

I stayed at the farm for another six weeks, until a rehab camping trip made it impossible for me to stay.

This Time

I always felt that I'd like to come back and finish the program because I thought it was a really good one, but why would anyone go to rehab if there was any other alternative? Up until recently I managed pretty well, especially considering we were homeless for almost a year, staying on people's couches and always moving. On top of this, before Daniel was finally diagnosed with coeliac disease at 18 months, I was virtually accused of starving him by a particularly nasty baby health nurse who was just itching to bring the Department of Community Services (DOCS) in.

Finally, I got us a small flat (no thanks to Department of Housing) up the coast again, and at the time I thought, "If I can't make it work this time, then I really am a complete waste of space."

Well, it's a year later, and I am a complete waste of space. Daniel is two and a half, and I now realise I should have called him Damien. I'm the same person I always have been, and my latest attempt to live like a 'normal' person, like all the rest, has failed.

So, that's why I'm on that list again. To finish the job. This time. And that's why I'm having such a hard time with this detox.

Because it's the gateway to the rehab which has to be my last. Because I have no more rehabs left in me. Because I've given up so many substances, so many times, that I've given up giving up. Because if I come out the other end feeling the same as always, then I really will give up. Completely.

Because this time there's so much more to lose.

Alice

**There are other rehabs in NSW that accommodate women with children (such as Phoebe House and Jarrah House) but they are three to six month programs rather than the six to 12 month program offered by Kamira Farm.*

User's Story

Tripping Out in '78

I left home as soon as humanly possible. I had an unhealthy relationship with a brutally violent step-father and on the occasion of my 15th birthday I made my first bid for freedom. I secretly packed up my meagre belongings and headed off to a mates place. My beloved step-father sought me out, scaring the living shit out of my mates in the process. Things went much better for me a year later: all I received for my 16th birthday was a note telling me to leave my house keys and not to come back. They knew I wanted out.

I found Woolloomooloo Squats the same way that most run-a-ways did. In those days almost all of Sydney would shut down around 11pm, and the only place happening in the wee, small hours was Kings Cross. That got boring real fast, but if you hung around long enough you eventually ran into other kids, and it was through those kids that I found Woolloomooloo Squats. I was introduced to the 'Elders', who interviewed me and granted me my own room, rent free. I had known about this place for a while; I used to come here to score grass. I never thought that I would one day actually live there.

It was a wonderful group of people — people who really cared for each other. Singers, musos, kung-fu-ers, politically inclined types and most were users of one evil drug or another. The smell of marijuana in the air was way more prevalent in those days. But as you met and talked with different people you got this strange feeling that something undefined, yet urgent, was about to happen. Something that nobody wanted to talk about whenever the topic of drugs came up. I eventually managed to suss it out. Everyone was silently awaiting the arrival of a man named Bill. The acid dealer.

He came up from Melbourne, once in a while, and everyone was waiting for his visit. I had tried tripping already on a whole variety of inferior concoctions but had never had real acid: LSD 25. When Bill finally arrived, on his Harley Davidson Chopper, all this changed. He passed out cards of 100 trips each to the inter-squat dealers and eventually, through the famed and fabled trickle-down system, some of them came my way. I thought to swallow these little wonders right away but was stopped in my tracks by my girlfriend who exclaimed: "No! What are you doing? The chosen time is ten thirty tomorrow morning!"

I didn't understand until someone else explained it to me. These people were into 'communal tripping'. The deal was you bought your own dose. You waited until the chosen time, 10.30am Saturday, so that you knew there were many other people swallowing their trips at exactly the same time as you. Then you and your friends could run wild all over the city, doing whatever you wanted to, knowing that at anytime you could run into many, many other tripping people. Which we all did, constantly!

That day my girl and I decided to see *Star Wars*, which had just been released and was playing down at the Hoyts Centre.

We enjoyed the film as only kids on acid can, and on leaving we ran into a huge group of tripping squatters about to go into the next session. We walked up to Hyde Park and discovered another 30 tripping hippies! In unison, and singing all the way, the gang of us made our uncertain way down to the Botanic Gardens, where we found, to our utter shock and disbelief, another giant-arse group of intrepid trippers and their mates. Now some of these

guys I'd only seen, but had yet to really meet, while others were total strangers. But it made no difference at all; these people had all dropped acid at the same time as I had. They were all on the same level as I, on the same wave length. They all felt like family. Whether I knew them or not.

Some headed off towards the Opera House steps to sing and play guitars and the rest of us decided to try and stay hidden inside the Botanical Gardens while the gates were shut.

The sun provided a wonderful light-show as it set, the likes of which I'd never seen before. Right on cue the full moon ascended over the city centre and I remember quietly thanking God that I was alive to see all this. I felt both lucky and blessed. The words of an old Small Faces song comes to mind: *Itchycoo Park — It's all too beautiful.*

Days later I had learned just why everyone around the squat had spoken of the waiting for Bill's return. Now I was one of those waiting. It took many hard and boring months for him to show up again, but this time I knew why I shouldn't drop the acid right away! The next agreed upon time was Saturday, 12.30pm. And boy-oh-boy — was I ever ready!

As we approached the chosen date we were hearing that not only were Bill's trips selling well all over the city, but also way out into the suburbs. And there were many more people eagerly willing to 'time-trip' or 'date-trip' (people always want to label things with silly names). The whole phenomenon was mentioned more than a few times on Double J (the forerunner to Triple J). They called it 'communal experience' which is the most honest and accurate term I heard.

We went to see *Star Wars* again because we'd missed the very end the first time we saw it. But we missed it this time too and for the same silly reason: going outside for a cigarette and running into swarms of tripping hippies. This time the city seemed even more alive with young trippers. People from the outer suburbs were dropping their tickets and training it into the inner city to take part. It was nothing at all to pick a guy out of the crowd with a flushed face and a bemused expression and big, bowling-ball pupils. I would simply say, "Whoa! You must be as tripping as I am!", resulting in laughter all around.

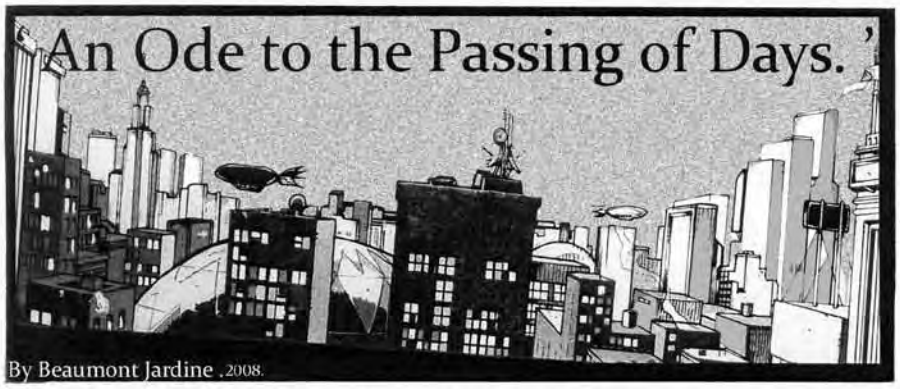
I lived at Wooloomooloo Squats for about two years and during this time I partook in four of those communal trips. I understand that there were another four that happened before I came. These were 'the best of times and the worst of times'. I had wanted a family and this one felt right at the time. Some folks freaked out, but there were always caring and compassionate types who knew what to do with those for whom it was all too much.

I don't take acid anymore. It seems to me to be a younger man's drug. And my poor, fucked-up physical frame would bitch loudly at me if I even considered it.

But I will always cherish even the tiniest details of that time. It was a better time, more hopeful, people shared their marijuana like nobody does anymore, people trusted each other, and life in general was easier for the committed hedonist. It was, quite simply, the good ol' daze!

Bodine

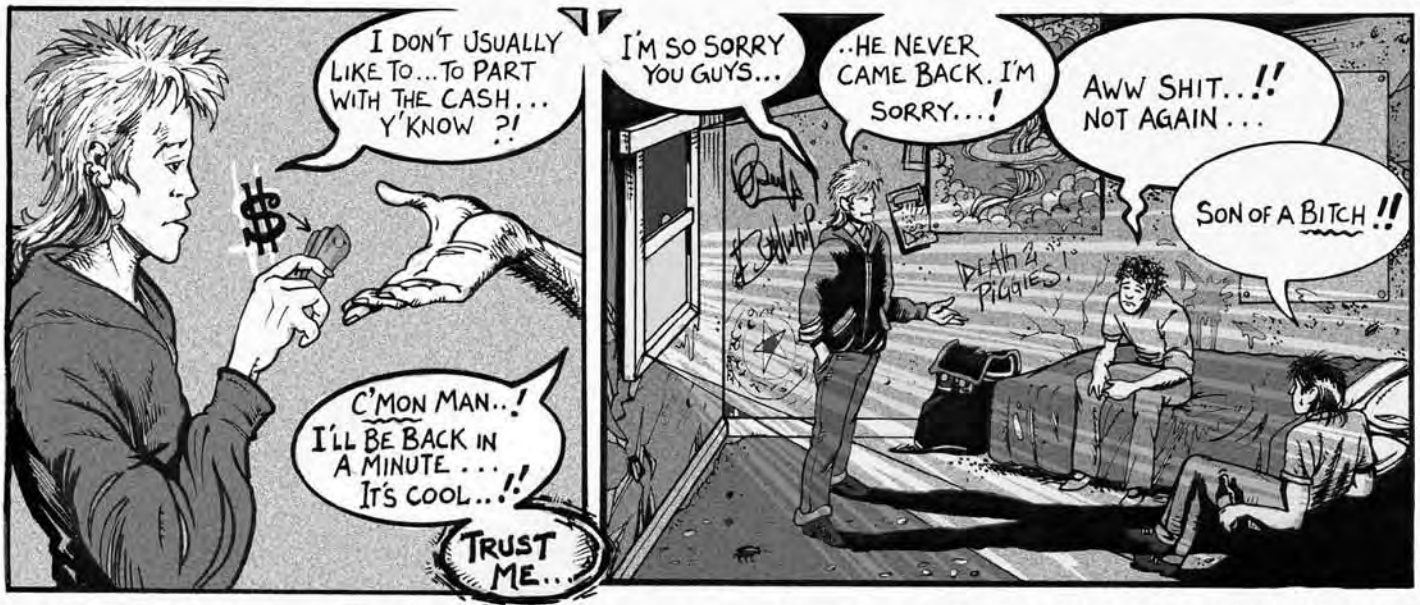
Illustration by Bodine



WAY BACK IN 1977, THE BUSINESS OF BUYING ILLEGAL DRUGS WAS WAY DIFFERENT~ BACK THEN, THE IDEA OF GROWING YOUR OWN CROP, UNDER U.V. LIGHTS, WAS THE STUFF OF SCIENCE FICTION..! I WAS 16; AND I LOOKED EVEN YOUNGER... I GOT RIPPED OFF. A WHOLE LOT!

I 1ST USED HEROIN BECAUSE GRASS WAS SO HARD TO GET.. I WAS OPEN SEASON TO ANY LOW-LIFE IN TOWN...

BUT HEROIN I COULD GET ANYWHERE!

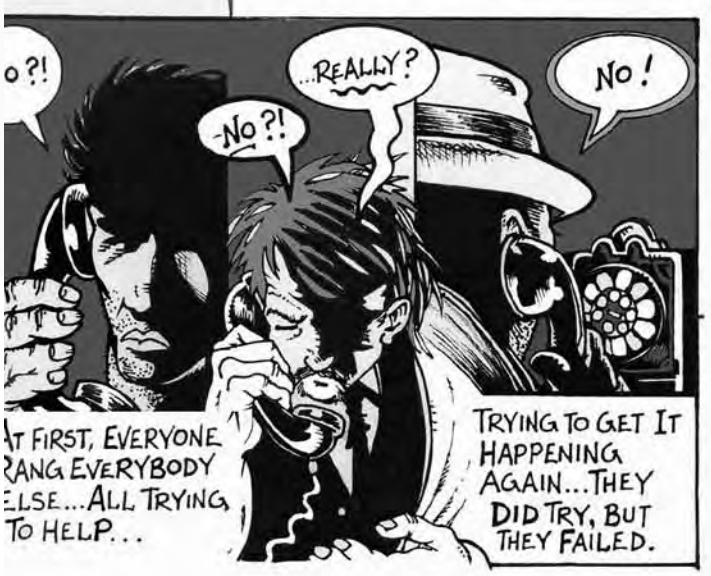


BUYING SMACK SUCKED. WHO MADE THESE RULES?! $350 FOR A 'WEIGHT' GRAM-BUT MOST PEOPLE I KNEW ONLY BOUGHT $30 'CAPS'...

ONE USUALLY NEEDED LEMON JUICE OR VINEGAR TO BREAK IT DOWN. WHITE POWDER WAS FROWNED UPON ~AS IT WAS SO EASY TO CUT... NEEDLES WERE AN ULTRA-HASSLE TO GET TOO. PEOPLE SHARPENED 'PICS' ON MATCHBOXES. SOME BOUGHT GLASS WORKS... THEY BECAME QUITE POPULAR. A MARK OF ESTEEM... KUDOS!

SOME PEOPLE CRUSHED UP MORPHINE OR METHADONE PILLS + SOLD IT OFF AS SMACK... (THIS WAS HUGE IN NEWCASTLE!) – IT WAS A LANDSCAPE WAY TOO SUSS FOR YOUR HUMBLE NARRATOR– SO I FOCUSSED UPON MARIJUANA SMOKING...

RD WAS OUT - AND MORE PEOPLE SHOWED EACH TIME... AND WHY THE FUCK NOT?!



AT FIRST, EVERYONE RANG EVERYBODY ELSE... ALL TRYING TO HELP...

TRYING TO GET IT HAPPENING AGAIN... THEY DID TRY, BUT THEY FAILED.

IT WAS A LOST CAUSE... NOW-A-DAYS I GET DOWN-RIGHT NOSTALGIC WHENEVER I PASS **THAT** UNI... IT WAS QUITE SIMPLY, 'THE GOOD OL' DAZE'... **TOODLES!!**

+THANKING YOU FOR YOUR RAPT ATTENTION. — Bo.

PeerLink — Users Connecting with Users

PeerLink is a project of NUAA's Community Mobilisation Team and aims to educate and support 'peer educators' to share harm reduction information through their networks. Last year sessions were held in Coffs Harbour and Lismore, and the local users, with support from NUAA, have undertaken a variety of activities since.

At Coffs Harbour, peers now regularly get together with the needle and syringe program workers every couple of months to go over key issues of concern. In addition, individual peers have been supported to attend and contribute to conferences and courses around the state. Next year the Coffs workers and peers are holding a peer educator's conference. Knowledge gained at these events is shared with their community.

The Lismore peer volunteers have also been very busy. Joe in Nimbin has been introducing people to the wonders of wheel filters, while the Lismore guys have been meeting fortnightly, doing peer education, planning events to publicise their group, recruiting new members and working closely with the local NSP and the AIDS Council of NSW (ACON), whose support has been invaluable.

NUAA will be running more of these projects in the near future which will involve recruiting users for a two-day peer education training session, and meeting with local service providers for a day to involve them in supporting the project.

Some of the peers in the North Coast Peer Support Team have combined to give a quick run-down of themselves and their group:

We are a group of users who, after participating in PeerLink, decided to get a team together on the North Coast. We aim to contribute a regional update for each quarterly issue of *User's News* to allow local drug users to have a voice around local issues. The team has a commitment to assisting local users with advocacy, complaints and by liaising with services.

By being non-discriminatory and non-judgmental in the way we work with peers we hope to set an example for local services and the wider community. Our group meets fortnightly. Gives us a call at ACON on (02) 6622 1555 and leave a message.

Hi, my name is Sue. I've been using drugs since I was 16, 28 years ago! A mother of five great kids aged 6-18, I've lived in the region for 15 years and have a commitment to helping the underdog. I was just voted onto the National Executive of the Australian Injecting and Illicit Drug User's League (AIVL) as Assistant Secretary. My aim is to raise the profile of regional NSW at this level.

Hi, I'm James. I'm 38 and I've used drugs since my early teens. I also have personal experience of the effects of domestic violence and sexual assault. I am presently on methadone. I am interested in growing organic food and passing on knowledge to provide healthier home grown food options for people living with hep C or HIV. I look forward to hearing from you.

Hello people, my name is Paul. I'm 40 and have been an injecting drug user for a number of years. I'm currently on methadone and am trying to stay focused and remain positive. Our group is here to inform people about blood-born viruses such as HIV and hepatitis C, and to encourage safer using techniques. I feel really positive about this group. I'm a happy person and enjoy playing guitar.

Hi, my name's Micha. I've been a long term user and am now on pharmacotherapy treatment but still have my struggles! My particular area of interest (among many) is helping people with body image issues, particularly young users. Having been a sex worker I also have great interest in supporting other sex workers in a confidential and caring manner.

In Lismore the group will be at the Barrow on World AIDS Day (December 1st). Seek us out as we would love to meet and chat with you! (You'll find us by our *User's News* T-shirts.)

Our group would like to give a big thanks to ACON Lismore, Lismore and Nimbin NSPs and the NUAA team.

User's News No. 55 • Summer 08 40

Society's Cure!

Society's cure for people like me

Is lock them away, where no-one can see

Where none can see them cry late at night

Just lock them away and not teach them what's right.

They surely won't help you, 'cause you are scum

They will just keep you hidden until your time's done

And then you'll be out the gate on your arse

They say corrective services I say what a farce.

Now just what has changed?

I'm now labeled a crim and by you I'm estranged

You say I'm no good, I can't get a job

But then you still wonder just why you get robbed.

To you I'm a nothing, a loser, a crim

I've entered a contest I just cannot win

And no matter what, you won't let me in

I bang on the doors of society's halls

I say please let me in, I'll live by your laws.

But it's far too late, you're not one of us

'cause jails are our sores, and you are the puss

And for this infection we don't have a cure

We'll just make more pain for you to endure.

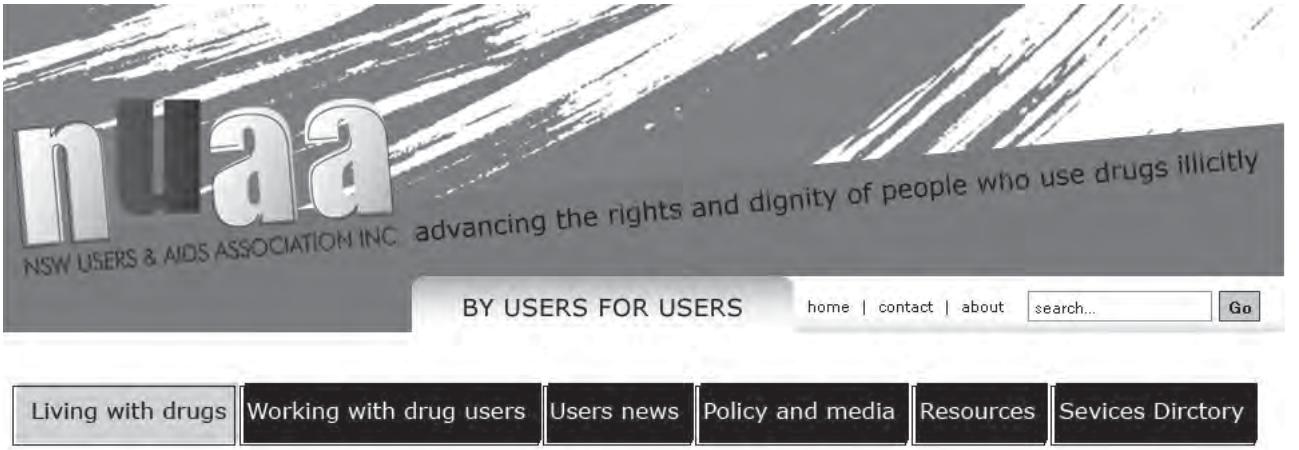
They lock you away, and take all your rights

From the end of your tunnels we'll steal all the lights

Take all the reasons why I'd want to change

AND THEN YOU HAVE THE HIDE TO CALL ME DERANGED.

The Axe



NUAA has just launched its new website!!

It's the same old address, but has updated information on everything from safer using to treatment. And you can still access User's News stories and articles, but with better searching ability when you're trying to find that favourite story.

You will also be able to leave your comments on almost every page on the site.

The new NUAA website also features:

- new resources section (with service providers able to update their own information)
- regular updates on what NUAA is up to
- newsfeed to keep you up-to-date on news affecting drug users.

So visit www.nuaa.org.au and tell us what you think!

What are your problems? with Ida Bigge-Hitte

Dear Ida

What's up with the Sydney Dental Hospital? They ripped half my teeth out and then told me I had to wait to get plates. They told me I had other holes in my teeth but by the time I'd get another appointment they'd be so rotten I'd have to have them ripped out as well, instead of filled. Is there anyway I can get my teeth fixed for free without having to wait 15 years for an appointment?

Hole in One

Dear Hole in One

Medicare to the rescue! People with a 'chronic illness' are now able to get their teeth fixed as part of the Medicare benefits scheme. Medicare will cover work done by a dentist, specialist dentist or dental prosthetist in private dental surgeries as long as it's not purely for cosmetic reasons. You do need to be a bit special to get it though…

To be eligible, you must have a 'chronic medical condition and complex care needs' and your oral health must be impacting on your general health.

Allow me to explain in human language. A chronic medical condition is one that you have had, or will likely last, for at least six months. Things like hep C, asthma or mental illness will have you covered.

'Complex care needs' means you are engaged with a multidisciplinary team, which includes your GP and two other health or care providers, for example a hep C clinic, counsellor, methadone clinic or mental health service.

Most dentists are able to provide this service under the Medicare dental items but some may choose not to treat patients using Medicare.

The process to get your teeth done is:

1. Go to your doctor and get him to write a care plan for you. He will then have to fill out an official referral form for you to take to your dentist. NUAA has put together Medicare Dental Packs which contains this referral form.
2. You need two referrals from other people in your 'multidisciplinary team' who are helping you with health issues. These referrals may come from your hep C clinic, counsellor, psychologist, prescriber, methadone clinic, etc.
3. Call your dentist and ask if they're willing to be paid through Medicare and bulk billing.
4. Ask your dentist if there is a gap you need to pay or if there are any extra hidden costs that Medicare won't cover. Your dentist is required to provide you with a written quote prior to commencing any work which should cover this.
5. Make an appointment with your dentist to have the work done.

So to the magic question of how much work will you be able to claim or get done? You can claim up to $4,250 in Medicare benefits in the first two years and another $4,250 in the two years after that if you still meet the eligibility criteria. In other words, you can have $4,250 worth of fillings, plates, crowns, and dentures, WHATEVER (as long as it's not purely for cosmetic reasons), in the first two years!

NUAA's dental pack contains an information booklet for you, an information booklet for your GP complete with referral forms, and an information booklet for your dentist. You can give the info packs directly to your doctor and dentist and it explains everything they need to know. If you'd like one, please call the ISR service at NUAA.

Summer Salads

Who said salads are boring? Modern salads make a delicious meal when boosted with extra protein foods and nourishing carbohydrates. Salads suit the summer season as they are cool, fresh, light and easy to prepare. In this edition of User's News we challenge you to make up your own salad and have provided five steps to make the best summer salads. Good luck!

1. Colour clash

A mixture of brightly coloured vegetables and salad leaves will provide a variety of nutrients, including antioxidants, vitamins and minerals. Some examples are:

Red and Orange	Green
Capsicum	Lettuce
Tomato	Cucumber
Carrot	Broccoli
Radish	Zucchini
Pumpkin	Cabbage
Sweet potato	Asparagus

2. Add protein

Turn your salad into a meal by adding grilled chicken, lean beef or fish. A salad that includes a small serve of protein will be more satisfying and give you energy to see you through the day. Excellent protein foods to add to your salad include:

- A can of lentils/chickpeas/beans
- One or 2 boiled eggs
- A piece of cheese or grated cheese
- A handful of nuts or seeds such as almonds, walnuts or sunflower seeds
- 1 small can of tuna
- Grilled or BBQ chicken (remember to remove the skin!)
- Lean bacon, grilled
- Grilled beef or lamb, sliced

3. Crank up the carbs

Throw in some nutritious carbohydrates like rice, chickpeas or sweet potato to give you an energy boost. Carbohydrates are essential for brain function and are a great source of fibre and vitamins. If your salad doesn't contain any carbohydrates, make sure you eat a couple of pieces of bread with your salad. Carbohydrates you can use include:

- Rice
- Pasta
- Bread
- Fried noodles
- Sweet potato
- Boiled or roast potato

4. Be creative!

Try adding less conventional ingredients to your salad like pumpkin seeds, apple, dried fruit, herbs… Almost anything can go into a salad; it's up to your imagination.

5. Dress to impress

The best dressings are often the simplest. Try a squeeze of a fresh lemon juice with olive oil over your salad to add both flavour and nutrition. Keep in mind that unsaturated oils like olive, canola and sunflower are good for heart health and can help maintain a healthy weight.

— Megan Gayford
Dietitian, Albion St Centre

If you would like to see a Dietitian (free of charge) please contact the Albion St Nutrition Division for an appointment on 93329600, or at the clinic at 150-154 Albion St Surry Hills.

Classic balsamic dressing

4 tablespoons of balsamic vinegar

4 tablespoons of olive oil

Shake together in a jar and store in the fridge. A clove of garlic, slightly smashed and left in the jar, will add to the flavour of this classic dressing.

Soy sesame sensation dressing

2 tablespoons of soy sauce

2 tablespoons of sesame oil

2 tablespoons of lemon juice

Shake together in a jar and use immediately or store in the fridge

Easy tuna salad for two

This salad is delicious, filling and a good balance of nutrients.

2 really big handfuls of mixed lettuce or baby spinach

½ red onion, sliced or diced

1 red capsicum, sliced

1 can of tuna, drained

1 tablespoon of capers

1 cup of cooked brown rice

2 tablespoons of olive oil

2 tablespoons of balsamic vinegar

Juice from 1 lemon

Add all ingredients in a bowl and using clean hands or tongs, mix gently. Eat immediately.

Apple and cheese salad for two

Try this salad for something different. An apple and cheese salad also makes a great picnic lunch with crusty bread.

2 really big handfuls of mixed lettuce or baby spinach

1 apple, sliced finely

100 g cheese (any cheese will work — if possible try parmesan/blue or feta)

2 tablespoons of walnuts

2 tablespoons of raisins or sultanas

2 tablespoons of olive oil

2 tablespoons of balsamic vinegar

Add all ingredients in a bowl and using clean hands or tongs, mix gently.

Eat immediately.

Crunchy Asian chicken salad for two

A perfect evening meal when the weather is hot and you feel like something light.

2 handfuls of mixed lettuce

1 handful of bean shoots

1 carrot, sliced into sticks

1 red capsicum, sliced

1 large chicken breast, cooked and cut into strips

1quantity of soy sesame dressing

Add all ingredients in a bowl and using clean hands or tongs, mix gently.

Eat immediately.

Help Lines

ACON –
AIDS Council of NSW
(Hep C Info Line)
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.

HepC Helpline
1800 803 990
Sydney callers: 9332 1599
Mon - Fri 9am - 5pm

HIV/AIDS Infoline
1800 451 600
Sydney callers: 9332 9700
Mon - Fri 8am - 6.30pm
Sat 10am - 6pm

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
1800 677 961
Sydney callers: 9794 1852
Parents info & counseling. 24hrs
www.swsahs.nsw.gov.au/karitane/

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

MACS –
Methadone Advice & Complaints 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.

Prison's 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 & counseling. 24hrs

SWOP –
Sex Workers Outreach Project
1800 622 902
Sydney callers: 9319 4866
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
0410 / 324 384
Regular meetings around Sydney. Call for times and locations.
www.crystalmeth.org

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

Family Drug Support Hotline
1300 368 186
Sydney callers: 9818 6166
Support for families of people with dependency. 24 hours

NAR-ANON
(02) 9418 8728
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
1800 063 060 or
(02) 9206 2060
Provides free legal advice to people living with or affected by HIV/AIDS.

Legal Aid Hotline
1800 10 18 10
For under 18s.
Open 9am - midnight during the week
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) 9360 1847
Legal service for homeless and disadvantaged young people.

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

Medical Services

Aboriginal Medical Service, Redfern
(02) 9319 5823

Albion Street Centre, Surry Hills
1 800 451 600 or (02) 9332 9600
Free testing for HIV / hepC & other. Medical care, nutritional info & psychological support for people living with HIV & hepC.

Campbell House, Surry Hills
(02) 9380 5055
GP, dentist, optometrist, chiropractor, mental health. Medicare card required.

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

KRC - Kirketon Road Centre, Kings Cross
(02) 9360 2766
For 'at risk' youth, sex workers, and injecting drug users. Medical, counseling and social welfare service. Methadone & NSP from K1.

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) 9516 2233
12 – 24 years. Medical and dental available etc. No Medicare required.

Treatment Centres

The Buttery, Bangalow
Ph: (02) 6687 1111

Corella Lodge, Prairiewood
Ph: (02) 9616 8800

Detour House, Glebe
Ph: (02) 9660 4137

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

Hadleigh Lodge, Leura
Ph: (02) 4782 7392

Herbert St Clinic, St Leonards
Ph: (02) 9926 7276

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

Jarrah House, Maroubra
Ph: (02) 9661 6555

Kathleen York House, Glebe
for women and girls
Ph: (02) 9660 5818

Kedesh House, Berkeley
Ph: (02) 4271 2606

Lakeview, Belmont
Ph: 4923 2060

Lorna House, Wallsend
Ph: (02) 4921 1825

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

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

Meridian Clinic, Kogarah
Ph: (02) 9350 2944

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

Nepean Hospital, Penrith
Ph: (02) 4734 1333

Northside Clinic, Greenwich
Ph: (02) 9433 3555

O'Connor House, Wagga Wagga
Ph: (02) 69254744

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

Orana House, Warrawong
Ph: (02) 4223 8155

Palm Court, Concord Hospital
Ph: (02) 9767 8640

Phoebe House, Banksia
Ph: (02) 9567 7302

Phoenix Unit, Manly
Ph: (02) 9976 4228

Riverlands Drug & Alcohol Centre, Lismore
Ph: (02) 6620 7612

St. John of God, Burwood
Ph: (02) 9747 5611 or 1300 656 273

St. John of God, North Richmond
Ph.: (02) 4588 5088 or 1800 808 339

The Salvation Army Bridge Program, Nowra
Ph: (02) 4422 4604

South Pacific Private Hospital, Curl Curl
Ph: 1800 063 332

The Sydney Clinic, Bronte
Ph: (02) 9389 8888

The Ted Noffs Foundation, Randwick
Ph: (02) 9310 0133 or 1800 151 045

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

The Ted Noffs Foundation, Coffs Harbour
Ph: (02) 6651 7177

The Ted Noffs Foundation, Dubbo
Ph: (02) 6887 3332

WHOS - We Help Ourselves, Redfern
Ph: (02) 9318 2980

WHOS - We Help Ourselves, Cessnock
Ph: (02) 4991 7000

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

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

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	
Auburn Community Health	02 - 9646 2233	0408 4445 753
Bankstown	02 - 9780 2777	
Ballina	02 - 6620 6105	0428 406 829
Bateman's Bay	02 - 4475 5162	
Bathurst	02 - 6330 5677	
Bega	02 - 6492 9620	02 - 6492 9125
Blacktown	02 - 9831 4037	1800 255 244
Bowral	02 - 4861 8000	
Broken Hill	08 - 8080 1556	08 - 8080 1333
Byron Bay	02 - 6639 6635	0428 - 406 829
Camden	02 - 4629 1082	
Campbelltown MMU	02 - 4634 4177	
Canterbury (Repidu)	02 - 9718 2636	
Coffs Harbour	02 - 6656 7934	02 - 6656 7000
Cooma	02 - 6455 3201	
Dubbo	02 - 6885 1700	
Goulburn S.East	02 - 4827 3913	
Grafton	02 - 6640 2229	
Gosford Hospital	02 - 4320 2753	
Hornsby	02 - 9858 7955	0411 166 671
Jindabyne	02 - 6457 2074	
Katoomba / Blue Mountains	02 - 4782 2133	
Kempsey	02 - 6562 6066	
Kings Cross KRC	02 - 9360 2766	02 - 9357 1299
Lismore	02 - 6622 2222	0417 489 516
Lismore - Shades	02 - 6620 2980	
Liverpool	02 - 8777 5219	
Long Jetty	02 - 4336 7760	
Manly / Northern Beaches	02 - 9977 2666	
Merrylands	02 - 9682 9801	
Moree	02 - 6757 0222	02 - 6757 3651
Moruya	02 - 4474 1561	

NSP Location	Daytime No	Alternative No
Mt Druitt	02 - 9881 1334	
Murwillimbah / Tweed Valley	02 - 6670 9400	0429 919 889
Narooma	02 - 4476 2344	
Newcastle / Hunter	02 - 4923 6056	0438 928 719
Nimbin	02 - 6689 1500	
Nowra	02 - 4424 6300	
Orange	02 - 6392 8600	
Parramatta	02 - 9687 5326	
Penrith / St Marys	1800 354 589	
Port Kembla	02 - 4275 1529	
Port Macquarie	02 - 6588 2750	
Queanbeyan	02 - 6298 9233	
Redfern (REPIDU)	02 - 9699 6188	0419 801 997
Ryde / Hornsby	02 - 9858 7955	0411 166 671
St George	02 - 9113 2943	0412 479 201
St Leonards - Herbert St Clinic	02 - 9926 7414	
Surry Hills - Albion St Centre	02 - 9332 1090	
Surry Hills - ACON	02 - 9206 2052	
Surry Hills - NUAA	02 - 8354 7300	
Sutherland	02 - 9522 1046	0411 404 907
Sydney CBD	02 - 9382 7440	
Tamworth	02 - 6766 2626	02 - 6767 7435
Taree	02 - 6592 9315	
Tumut	02 - 6947 1811	
Tweed Heads	07 - 5506 7556	
Wagga	02 - 6938 6411	
Windsor	02 - 4560 5714	
Wollongong	02 - 4275 1529	0411 408 726
Woy Woy Hospital	02 - 4344 8472	
Wyong Hospital	02 - 4394 8293	
Wyong Community Centre	02 - 4356 9370	
Yass	02 - 6226 3833	
Young	02 - 6382 1522	

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.

HIV IS STILL HERE
NSW WORLD AIDS DAY

20th Anniversary 1988 - 2008

December 1st

NUAA would like to acknowledge drug users across NSW who have worked together to prevent HIV in their communities.

NUAA would also like to acknowledge those drug users who have supported people living with HIV/AIDS, and to remember those who are sadly no longer with us.

World AIDS Day NSW
www.worldaidsdaynsw.org

nuaa
NSW USERS & AIDS ASSOCIATION INC

NSW USERS & AIDS ASSOCIATION INC

PO Box 278 Darlinghurst NSW 1300 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 10.30 am - 5.30 pm
except Wednesday 2.30 - 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

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

Name: .....

Address:.....

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

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

Email:.....

☐ **I want to be emailed NUAA's monthly newsletters.**

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

☐ **I want to be a member of NUAA *AND* I want *User's News*.**

I support NUAA's aims & objectives. I want to receive User's News and information on NUAA events and activites. I am allowing NUAA to hold this information until I want it changed or deleted. (If you want to be a member, but don't want User's News, tick here ☐ .)

☐ **I want *User's News ONLY*.**

I don't want to be a member, but I want to receive User's News and information on NUAA events and activities. I am allowing NUAA to hold this 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.