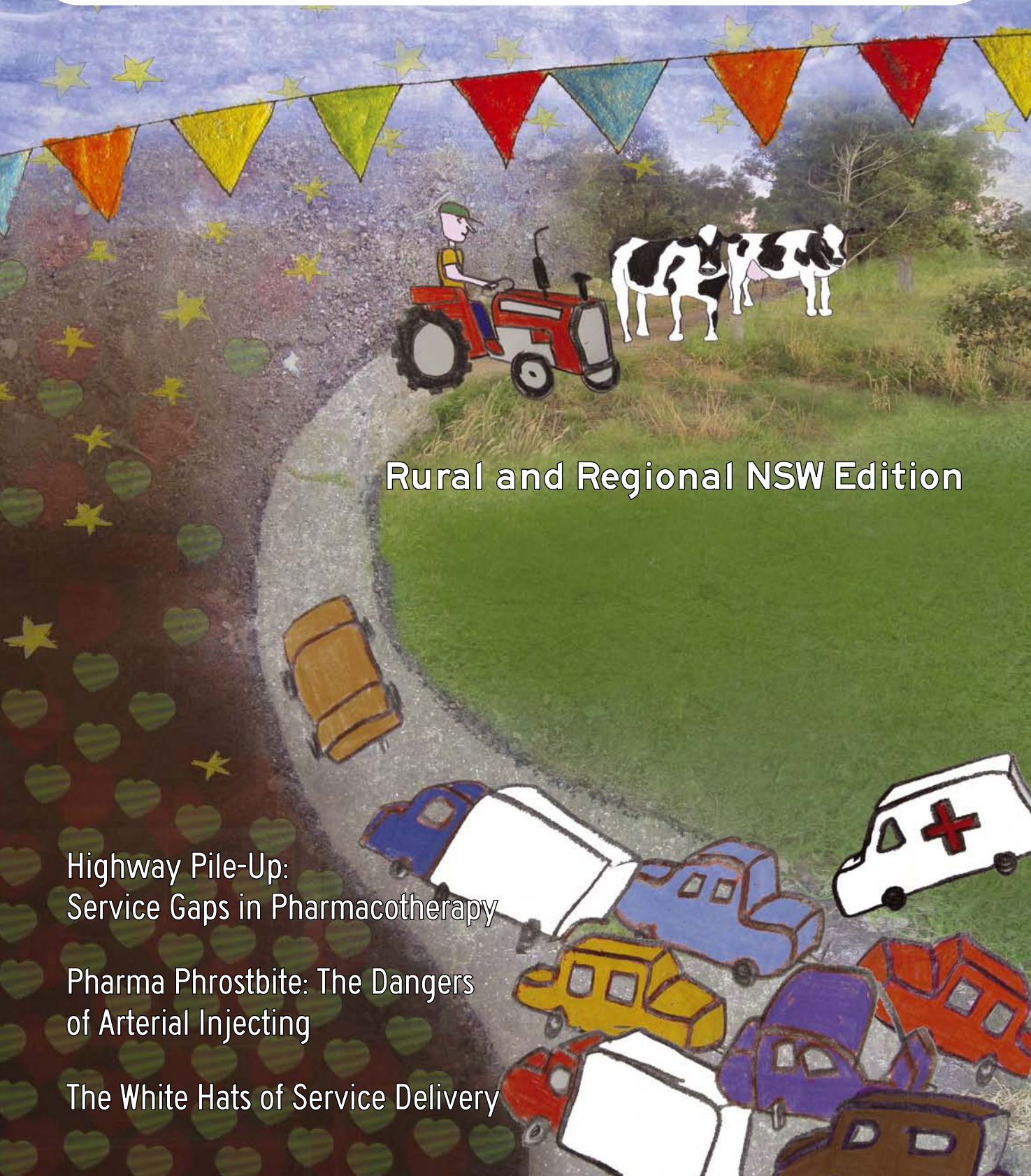
User's News

Published by the NSW Users and AIDS Association

Issue No. 66 Spring 2011



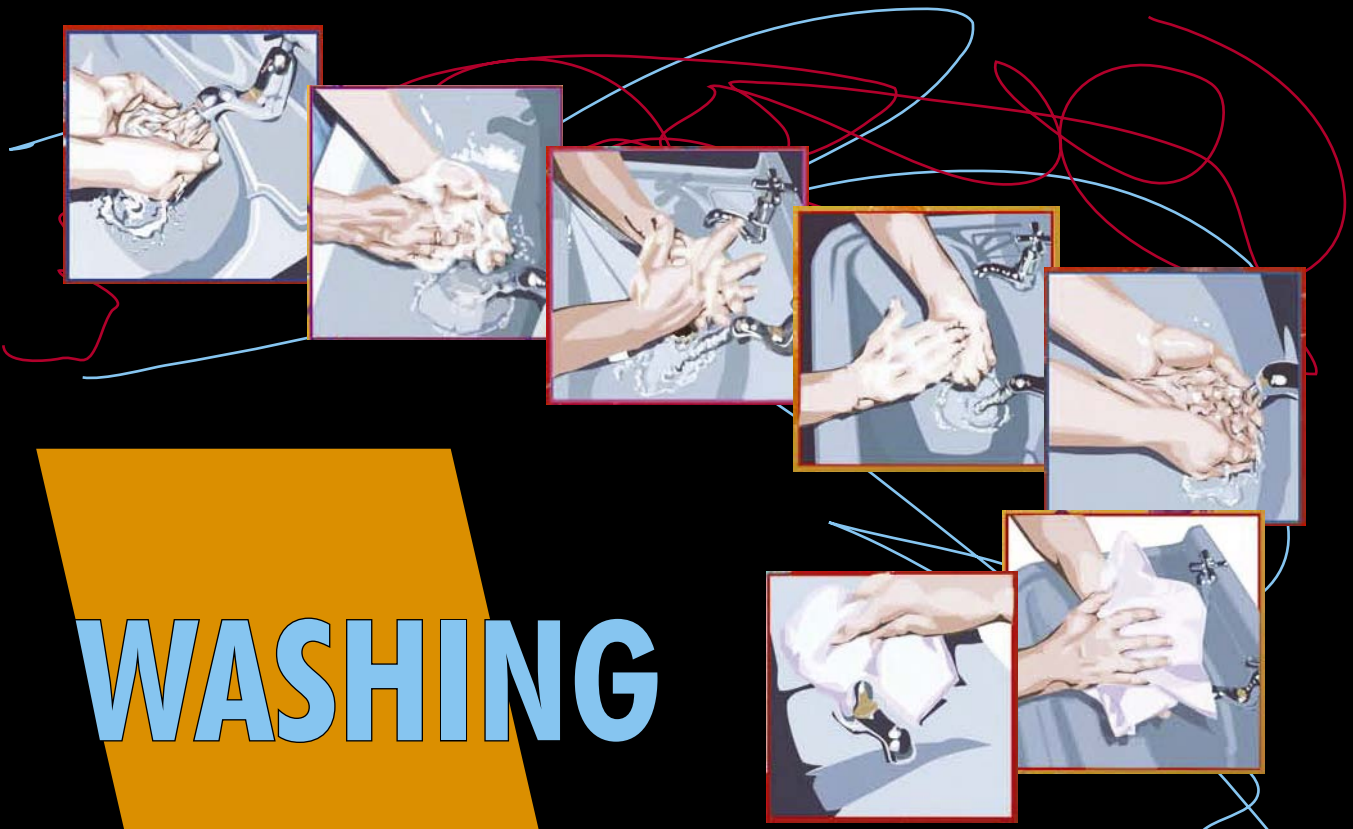
Rural and Regional NSW Edition

Highway Pile-Up:
Service Gaps in Pharmacotherapy

Pharma Phrostbite: The Dangers of Arterial Injecting

The White Hats of Service Delivery

Sometimes it's as simple as...



WASHING YOUR HANDS

Your hands may look clean but bacteria and blood-borne viruses like hep C can live in the tiniest bits of blood and dirt – bits you can't even see.

Getting into the habit of washing your hands before and after injecting is one of the best things you can do to prevent getting a dirty hit.

Based on an AIVL resource

USER'S NEWS #66

PO Box 1069
Surry Hills NSW 2010

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

e usersnews@nuaa.org.au

Editor Mathew Bates

Cover Rose Ertler

Illustrators Bodine, Ursula Dyson, Tony Sawrey, Glenn Smith, Caroline Zilinsky

Going Up the Country

editorial

Many crucial matters in rural and regional New South Wales have been raised in the course of this edition's production.

A worrying trend is the apparent increase in people who inject pharmaceuticals accidentally hitting an artery and causing severe health damage. This is a risk for anyone who has vein damage, of course, but the difficulties that injectors of pharmaceuticals face in obtaining filters and accessing proper harm reduction information means they're especially at risk.

If you shoot pills, I urge you to read the stories from people in your community.

The fact that so many people outside major centres are injecting pharmaceuticals is in itself important. Many of our rural and regional contributors have spoken of being forced to explore pills by the scarcity, poor quality and cruelly high prices of illicit drugs in their area. The situation may be changing, which of course provides its own set of challenges. So much rumour surrounds the murky matter of supply that it's hard to know what to believe. Once again, our writers provide their own perspectives.

The most important issue that has come across the *User's News* desk this quarter is a long-standing problem in a system that is now at crisis point: providing pharmacotherapy treatment to the people who want to access it.

As you will read in the following pages, the current system has taken its toll on many people, on both sides of the consulting desk.

We are in a period of significant change in our state. These changes must be seen as an opportunity for us to start again. We can't afford to let the hard work so many of us have done to help people come to nothing. But we must also learn and adapt.

Right now, too many people are being let down by a system that seems to have its hands tied. No one I've spoken to for this edition is motivated by anything other than compassion, but all of them are held back by too many barriers.

New initiatives to attract private practitioners must be introduced. The quota system of pharmacies must be properly revisited to address both capacity and efficiency. Programs must be made affordable to everyone in the state who wants to access them. We need to redefine what we mean by a "structured program" for people coming out of prison. The people who access pharmacotherapy treatment must take an active role in shaping how it's delivered. We must fight the stigma that surrounds the issue at every turn.

You'll find many views about how to do all this inside.

Whatever happens, we require reform of how pharmacotherapy is delivered to people in NSW. It will save lives; it will save money; it will honour the often thankless work that some good people put into the program, people who are asked every day to test the limits of their endurance. And for those of us who want to access pharmacotherapy, it will show that we are not treated with contempt.

In the lead-up to the state election, then Opposition Leader Barry O'Farrell pledged $10 million to the improvement of drug treatment services, including an expansion to pharmacotherapy access. As the State Government continues to implement its reforms, including State Budget funding for a third Drug Court, we all look forward to this important policy being put into action.

I thank all of you who contributed to this issue. I hope you feel we've done your struggles and successes some justice.

Mathew Bates

National Drug Strategy Household Survey Reveals Rise in Illicit Drug Use

The Australian Institute of Health and Welfare, the Federal Government's agency for health and welfare statistics, released its 2010 National Drug Strategy Household Survey in July.

The Survey, which canvassed over 26,000 people aged 12 years or over, found that the number of people who had used illicit drugs in the survey period rose to 14.7%, compared to 13.4% of people surveyed in the 2007 Survey.

The Survey showed a drop in rates of teenage drinking, and a continuing downward trend in tobacco use amongst people aged 14 years and over.

Source: Herald Sun, AIHW

US Drug Deaths Outnumber Traffic Fatalities

Drug deaths now outnumber traffic fatalities in the United States as a result of an increase in prescription narcotic overdoses.

Drugs as a cause of death in 2009 accounted for at least 37,485 fatalities, according to preliminary data from the U.S. Centers for Disease Control and Prevention.

The death toll has doubled in the last decade, claiming a life every 14 minutes. By contrast, traffic accidents have been dropping for decades because of huge investments in auto safety.

This is the first time that drugs have accounted for more fatalities than traffic accidents since the government started tracking drug-induced deaths in 1979.

Source: Los Angeles Times

In Vietnam, Rehab Means Torture

According to Human Rights Watch investigators, Vietnamese drug rehabilitation centres, funded in part by the Australian government, detain and hold tens of thousands of people who use drugs against their will, in some instances for years.

The centres, set up supposedly to treat people who use drugs, are little more than forced labour camps where detainees work six days a week processing cashews, sewing garments or manufacturing other items, according to a report from the organisation.

The report says detainees who refuse to work are subjected to punishment or torture that includes electric shock treatment and weeks of isolation.

Source: SMH

Surprise, Surprise: Pharmacotherapy Helps to Keep People Out of Jail

A study from the National Drug and Alcohol Research Centre (NDARC) of heroin-dependent inmates in NSW found that 84 per cent were back behind bars within two years of release, compared to the average return rate for all NSW prisoners of 45 per cent.

However, recidivism dropped by one fifth if inmates left jail on opioid substitution therapy and continued treatment in the community. Staying on a community methadone program also reduced former inmates' death rates by about 40 per cent.

Researchers based their findings on a study of 375 inmates who had used heroin over a decade.

Lead researcher Kate Dolan stated that the prison methadone program should probably be doubled in scope to accommodate the current shortage of pharmacotherapy

Source: AAP

Queensland Joins the Call for Safe Injecting Centres

Following the stalemate in Victoria over a medically supervised injecting centre, Queensland community groups have called for a safe injecting room to be put back on the agenda for Brisbane's Fortitude Valley area.

QUIVAA president Danielle Coade said "We're in a situation where [users] can go to needle exchanges to get

drug equipment but they can't use it in a legal way. It's a Catch 22 situation."

A spokesperson for Health Minister Geoff Wilson said medically supervised injecting centres were not on the Queensland Government's agenda.

Source: Courier Mail

Problem Gambling: Mo' Problems

A news study has uncovered evidence that criminal networks are recruiting problem gamblers into the drug trade.

A study of the parole records of drug offenders in Sydney's south-west has revealed nearly three-quarters of them blame problem gambling for their crimes.

The investigation by the ABC's News Online Investigative Unit found criminal networks actively recruit problem gamblers playing poker machines at pubs and clubs, to traffic heroin and cultivate cannabis.

Over 600 drug offenders with a Vietnamese background were surveyed. 72 per cent said they were enticed into the drug trade to pay their gambling debts.

Source: ABC

Standen Delivered: Top Cop Behind Bars

Former NSW Crime Commission Assistant Director Mark Standed has been found guilty of attempting to import 300 kg of the speed precursor pseudoephedrine.

Standen's conviction has prompted the NSW Government to announce a special commission of inquiry into the Crime Commission.

The five-month trial also led to Standen's conviction of conspiring to pervert the course of justice.

Source: ABC

Playing Our Part: Users Help in the Search for Hep C Vaccine

A team of Australian researchers from UNSW, the University of WA and Murdoch University have enlisted the help of people who inject drugs in their search for a vaccine against hepatitis C.

The researchers, led by UNSW's Professor Andrew Lloyd, have identified two "bottlenecks" or "Achilles' heels" that people infected with the virus have in common, one at the point of transmission, the other occurring in the body three months afterward. These events may lead to an effective vaccine against the virus.

For the first time in the history of hep C study, researchers were able to obtain blood samples only weeks after the participants became infected.

Meanwhile, French scientists are independently developing an experimental hep C vaccine that has been tested successfully on mice and monkeys, showing a strong response from the test subjects' immune systems. A spokesperson for French company Epixis, which holds the commercial rights for the vaccine, was hopeful that human trials may commence as early as next year.

Sources: The Australian, Reuters

Krokodil: Russia's New Deadly High

Desomorphine, a synthetic opiate manufactured with stolen headache tablets, is poisoning the users of Russia. Nicknamed "krokodil" because of its skin-decaying side effects, desomorphine is cheap and deadly.

Russia has up to two million people who inject heroin, according to unofficial estimates. Due to successful police crackdowns on imports of Afghan skag, up to 100,000 users in Russia may have resorted to using the cheaper, highly addictive desomorphine.

Source: The Independent

A Warning

This is an open letter to all the men who read *User's News*. October marks the second anniversary of the death of my partner from prostate cancer.

Michael was 54 when he died. When the doctors first diagnosed cancer, they gave him ten years. But it was much more aggressive than any of us expected and he lasted about 18 months.

When Michael died, his daughter seemed to handle it well – too well. After about six months she quit her job; if she'd stayed she might well have been sacked. She became agoraphobic. She's only now starting to pick up the pieces. Michael's death was just so awful for his mother; she lost Michael's father in an accidental OD years before. So sad.

I was so annoyed when Michael first told me. He'd had trouble going to the toilet for a long time. The doctor said if he had come in when he first had trouble, it would have been spotted. I asked him why he didn't go and he said "oh, I thought the trouble pissing was just age."

But I believe the real reason he didn't go was he didn't want a digital examination. In other words, he simply didn't want the doctor putting a finger up his arse. The doctor would've known straight away he had prostate trouble. Michael left it too long and he died.

So guys, no one likes a finger up the arse. But hey, if it's going to save your life, isn't it worth it?

Guys, if you're having problems taking a piss, go and see your doctor. It honestly could save your life. Don't put your family and friends through the horrors of watching a loved one slowly die.

Take care, guys. This one's up to you. Make the right decision.

Linda

Note to Contributors

Over the past three months we've received submissions and follow-up letters from people in prison.

Unfortunately, some of these letters do not have a MIN quoted.

We know you're human beings, not numbers. However, if you are in prison and don't include your MIN when you write to us, **we can't get in touch with you.**

We apologise to any of you who is yet to receive payment from us due to missing MINs. We have tried to contact you by other means, but without success.

Please don't give up. If you believe you are due payment, please get in touch with us again – but make sure you include your MIN.

Letters to the Editor

mail	PO Box 1069 Surry Hills NSW 2010
fax	(02) 8354 7350
e-mail	usersnews@nuaa.org.au

Obituary

The Man from the Health Department

Owen Westcott 1946 – 2011

"Is it at all possible to NOT talk about the needle and syringe program in this car?"

These were the desperate words uttered by my 13 year-old son, trapped as he was in with his stepfather and me in the middle of New Zealand. Put a NUAA worker and Owen Westcott together and this is what you got. Owen loved the needle and syringe program as much as any drug user did; after three weeks driving around the South Island with us, my boy could quote policy like an analyst at the Health Department.

Owen was the manager of the Health Department's Harm Minimisation Unit until 2008, and had in his care the organization I worked for, NUAA. He was a champion for the NSP and prepared briefings for several Health Ministers. If there was a terrifying event in the paper that threatened to close down the MSIC or an outlet for syringes, it was going to be Owen's job to defend it. He loved it. Making an argument was his great strength and he made watertight and evidence-based ones that also made economic sense. He was never afraid to fight for the program; never afraid to shake his head and say "no" either, if a promotion or article had potential to threaten the status quo. He used to say he had one belief: "that there should be a Needle and Syringe Program".

I first met Owen in the 1980s. The Newtown Needle Exchange delivered, and so through a quirk of fate he became my outreach person and my best mate's boss. I will never forget the vans parked up in Reiby Street in Enmore or on the Block at Redfern and the amazement I felt at being welcomed in to have a full range of equipment offered. Ringing for a delivery was a far cry from sidling up to the pharmacy counter and hoping for the best. This kind of thing made avoiding blood borne viruses very easy. Owen held that time so dear. The people he worked with – Miles Rooke, Sean Davies, Anne Marie Weatherall (now Apanski) – he still thought of them as his team twenty years later. He had his young family, two kids, Matt and Andrea. I think it was one of the happiest times of his life.

Owen's Health career started in laboratories, after he completed his Bachelor of Science at Macquarie Uni. He did his first work in immunology and used to joke that he was experimenting on me. (I have an immune disease.) His mind was nimble and his way of assessing a problem thorough. The concrete parameters and measurements of science suited him and I think that the NSP and drug user politics at the NUAA Board of Governance combined that precision and love of evidence with his equal love of social justice and individual freedom.

Let's not forget he was a young man in the sixties. He had a "hippie" period, though he hated that word, which saw him working during his twenties in a saw mill as the tailer-out (the guy who holds the wood to the saw). He left that job – as he told it – when a moment's inattention sent a chunk of hardwood screaming towards the miller at high velocity. Before his Science degree there was time at Sydney Uni and a BA. Owen worked as an English teacher at a well-to-do Catholic residential college in Sydney. He taught classes using Beatles records and rode his Harley to work. His favourite poet was Andrew Marvell. He taught English at Tech too until he decided to retrain. He had a genius for reinvention, and was not the "suit man" he seemed.

The thing about Owen was he was brave. He believed deeply in justice and was prepared to break the law to get it. He had been to jail. He had a scar on his mouth and chin from being punched out in Coonamble during the desegregation efforts associated with the Freedom Rides. It was badly stitched up by the town doctor and even after forty years you could see it. His lawyer was the young Michael Kirby and they were still in touch years later. You can read about it in Ken Buckley's book *Offensive and Obscene: A Civil Liberties Casebook* if you want to.

The earliest photo I have of him involved in a protest is sitting in a store window, playing a guitar on a hunger strike as an 18 year-old, to promote the then-new Freedom from Hunger campaign. He was one of Robert Askin's "bastards", laying down on front of US President Johnson's car during the Vietnam protests, prompting the line attributed to Premier Askin, "Run the bastards over". Owen joked that he was the Forrest Gump of Australian History, so often did he pop up at these events.

So this was the person who moved from outreach at REPIDU in Newtown and Redfern into the Health Department in 1997, where he took responsibility for the state's needle and syringe program, the hepatitis and HIV responses, and of course the Medically Supervised Injecting Centre. I think he was made for the job. He shared so much with users that many blokes in suits do not and he translated it at the big tables, in the meetings that counted.

Owen worked for nearly twelve years as the boss of the NSP and I re-met him through my NUAA job. I nearly jumped out of my shoes the first time I went to a meeting at the Department of Health to find the Newtown Needle Exchange guy on the other side of the table.

After he stepped back from his job as Manager we became a couple and he moved to Newcastle into a part-time job with Hunter New England Area Health, plunging back into the hurly-burly with users up here. It was our joke that his move to Newcastle was a return home – when I researched his family it turned out they were from Cessnock. I drove him out there. He was thrilled to find a Westcott Street there; after that he called Newcastle the "ancestral lands".

Leaving the bureaucracy was bittersweet for Owen but he relished his freedom to be an activist once again, campaigning for an issue close to his heart: the reintroduction of butterflies to the needle and syringe program.

There are a number of people in Newie who have Owen to thank for buying their butterflies. He had both run a service that supplied them and written the brief in 1991 that banned them. It never sat well with him. He knew their removal was politically motivated and it bothered him enough to want to set it right.

He joined me and my successor on outreach, joined the Board of NUAA and got to know many users. People respected his experience. There could be few people with this breadth of knowledge and experience in NSP and users knew that you don't normally run into them in the housing commission flats at Hamilton South. He was happy to tell people the ins and outs of how the government worked or the best way to get your complaint heard. He was generous with his time and took everyone as he found them. Owen was never a snob.

He campaigned on butterflies up to the day of his death. As ever, he went carefully through the evidence before making his argument.

While in the Department he penned this limerick:

Dark thoughts of the ten-ml syringe
On the minister's dreams did impinge.
For the sake of election he would risk mass infection;
His conscience gave barely a twinge.

Owen felt it was better to be at the table and make your voice heard, even if you sometimes had to do things you disagreed with. He believed in honesty and evidence. He died working on something he believed passionately. And that, my friends, was Owen Westcott all over.

Kerri Shying is a former employee of NUAA

You are invited to the event of the year!



REDFERN PARK
(Redfern Town Hall if raining)

1 November 2011
International Drug Users Day

from 11:00am

NUAA is making the most of International Drug Users Day and will launch two important documents:

Strategic Plan 2012 - 2014

Reconciliation Action Plan

Come along and meet your community, have some lunch and celebrate NUAA's achievements while acknowledging International Drug Users Day.

- *Meet the Chair of the International Network of People who Use Drugs*
- *Browse the stalls of services that NUAA works with*
- *Have a go at painting and be part of NUAA's community arts project*
- *Listen to some great music and entertainment*
- *Meet NUAA's staff and Board of Governance*
- *Most of all come and have fun!*

Bring your friends and family

SEE YOU THERE!

nuaa
NSW USERS & AIDS ASSOCIATION INC

Images of Redfern Park: City of Sydney, freeaussiestock.com

Knocked Up or Locked Up

There is a critical shortage of pharmacotherapy prescribers in many rural areas, such as where I live. My town has a pharmacotherapy clinic located at the base hospital. Until about two years ago the clinic had one full-time doctor who, although he treated you with less dignity than was ideal, was available to put clients on a program at the adjacent clinic. Since his departure, the hospital has been unable to find a replacement and has had several doctors acting as locums, treating current patients whenever they can manage to travel up from their regular practices. Due to the vast workload, these locums can't see the current pharmacotherapy patients as often as is dictated in the pharmacotherapy guidelines (every three months). Far worse, they're taking on no new clients. There is currently no waiting list even to enter the program. To add to these ridiculous limitations, there is a single private prescriber in town who charges exorbitant fees (around $300 with only $50 back from Medicare) to put a new client on a program. This price is far beyond the means of a Centrelink-supported person, especially if they are paying private rental. This has lead to many people, including ourselves, being unable to access pharmacotherapy programs.

Not enough doctors, it seems, are willing to take on the pharmacotherapy clinic as a job. Last year I was approached by a prescribing doctor in a nearby catchment zone, asking me to write a letter for him to take to the next quarterly prescriber review for the issue to be dealt with. I wrote about the situation, citing the health problems in the area and the toll on the wider community from the desperate measures that some people were driven to. The result was a pledge to have the job filled by Christmas 2010, even if it meant offering increased incentives to the accepting doctor. Nine months later, nothing has changed! We are still without a replacement and the community is still suffering.

I have found the situation to be very frustrating. I set a plan to reduce and exit the methadone program while the old doctor was still at the clinic. I reduced from over a hundred milligrams a day to 2.5 milligrams over the period of just over a year. I saw the doctor once at the beginning, once when I was half-way down and once at the end. I was given no help whatsoever during the entire period. When I reached 2.5mg I was told that I either had to jump off the program now or double my dose! The reason given for this was that the clinic lacked the equipment to measure out such a small amount of methadone. They certainly didn't appreciate it when I went in the next day with a fresh 1ml barrel and told them that I would show them how to measure out a small quantity if they needed help!

By now the pressure of being set up to fail by the clinic got to me. I ended up jumping off the program after writing a strongly worded letter of complaint to the clinic's manager. As withdrawal racked my body, my willpower, so good for over a year, deserted me and I started to use pharmaceutical opiates. Twelve months later and over the methadone withdrawal, I had a nice neat habit once again tucked under my belt.

I then realised I could not get back on a program. I tried a number of GPs, all with the same negative result. I then marched up to the intake nurse at the hospital's drug and alcohol section. She told me that there was no waiting list and no private prescriber who she could recommend. I then said that I had tried almost every GP in town, to which she replied:

"If you find one, can you please let me know?"

This was a little too much. Wasn't it her job to find this sort of thing out? However I continued contacting the rest of the GPs, all with the same negative result. It was often difficult even to get past the receptionist or "gatekeeper". As soon as you mention methadone or pharmacotherapy, the temperature seems to drop until it hits frost. It would have been better to say nothing to the receptionist and wait until I was face-to-face with the GP before bringing pharmacotherapy up. A lot more time and effort making appointments, but I may have had a better chance. The best I could manage was to find a GP who was willing to prescribe a detox kit (a single, short-term script of Valium, Catapres and a few other drugs).

Knocked Up or Locked Up (cont.)

The inability of people to access pharmacotherapy programs in town has led to the euphemistic phrase "just get locked up or knocked up". Going to jail or becoming pregnant are two of the only ways to enter a pharmacotherapy program. While trying to access a program one morning (without success) a peer came to me with the answer:

"It's easy, man. You just go and hold up a convenience store, stay there until the police arrive, hand back all of the stuff you stole and get taken off to remand. Then you get on the program, explain to the judge why you did it so that you get a light sentence, do your time and then bingo, you're on the program! Too easy!"

Although this sounds like a joke, it's a pretty sick one. This peer was 100% serious. These are the lengths some people are willing to go through to be prescribed. This is the damage occurring within the underlying community.

The situation in my area also puts GPs in a very difficult position. Many doctors will prescribe detox kits to make it easier for you and as a way around the pressure of being asked to help with an opiate dependent person. Every doctor by law is able to prescribe pharmacotherapy treatment for up to five patients, but due to the vast amount of paperwork and general lack of incentive, very few are willing to do so. When I asked my private GP to do this she physically recoiled, stating that there was no way she was dealing with "that place", meaning the public clinic! This shows the obvious need for the clinic to reform in order for it to fulfil its health responsibilities. In order to get around all these problems, a few GPs actually break the law and prescribe opiates such as Kapanol or oxycodone, not for pain management but as a maintenance program. Although this is a kind gesture made in the spirit of harm minimisation, it puts these doctors at significant professional risk and can also cause additional harm to the client, as these drugs are easily abused and difficult for users to remain stable on.

The situation in my town is not unique. In fact it appears that we are getting a better go than many other rural areas. It is disgraceful that in Newcastle not even released prisoners have access to the program that they were on while inside. Being released from jail is rough enough, without the excruciating pressure of being unable to access your medication! It seems that the only option for people in Newcastle who want to access a program is to travel to Sydney every day to pick up your dose! I talked to a Sydney doctor about this problem. She commented that although the situation is far from ideal, there is actually a benefit to this long (three hours each way) commute. It seems that sitting on a train is good for you. Patients whom she has dealt with have benefited from the commute because it sets a fairly strict routine and therefore helps that person's stability. Tough luck if you have work or family commitments, let alone a life, I guess. The situation appears to be bad throughout rural NSW with a shortage of doctors in most towns. One centre in the Northern Tablelands was once seen as having very little access to pharmacotherapy because it only had one private bulk-billing GP and one expensive pharmacy. These days that seems luxurious!

We seriously must be missing something here. In Australia it is a basic human right to seek treatment for opiate dependence. In keeping with World Health Organisation recommendations, drug dependence should treated as a health issue, not a form of criminality. Rural towns have always been notoriously difficult to find help in, but when clients from Newcastle have to travel to Sydney, when access in regional centres is restricted to a single private GP, there is obviously a systemic problem which warrants grave and immediate attention. I write this in the hope that someone out there has at their disposal the right communication networks and contacts to make meaningful change to help solve this situation. Until this problem is resolved, rural communities will have to deal with desperate, sick people on top of their already full plates.

Anonymous

How Ya Gonna Keep 'Em Down on the Farm After They've Seen Paree?

Eleven years ago I did a geographical, moving from Sydney to the NSW mid north coast. Two differences in their respective dope scenes were immediately apparent. Firstly there is very little smack up here. The vast majority of opiate use is pharmaceuticals, oxycodone being the most easily obtained. The second major difference is the difficulty in accessing clean equipment and a lack of knowledge about harm reduction practices in the injecting community. This vacuum causes highly dangerous injecting behaviour.

I live halfway between two regional centres. Whilst we are inside a major regional health catchment, the reality is that we do not have easy or efficient access to the services available in either centre. In the ever-tightening world of health funding it is all too easy to overlook the needs of areas such as mine. The general feeling amongst users here is that the agencies simply can't be bothered. An exception to this is the staff of the NSP at the regional hospital, who do a valiant job of distributing both equipment and information, but the odds are stacked too heavily against them for their impact to be anything more than superficial.

The use of wheel filters is virtually zero, even by people who are well versed in harm reduction. To get a wheel filter usually involves a round trip of over 100km, and a lot further the outlying areas where many of the IDU population live. One hospital a further 50km away has a machine, but it is regularly out of supplies; besides, most users are reluctant to use it as its location is exposed and users are worried about being outed. As a direct result of the lack of access to wheel filters and the information on the dangers of not using them, a large proportion of local users have very poor veins. This leads them to inject in dangerous sites such as the groin or neck.

But the shortage of wheel filters is the least of the dangers faced by the injecting population here. Statistics show that the NSW north coast has amongst the highest Hep C infection rates in the state.* Makes sense really – we have a disproportionately high number of users and a disproportionately low number of services available to those users. The re-use and sharing of syringes is the norm here and blood awareness is negligible.

So why is access to services in our neck of the woods so difficult? Apart from the obvious difficulties inherent in the distances involved, anonymity is extremely important to all drug users (especially in the current climate where government agencies can equate drug use with child abuse and take your children from you). And anonymity is very hard to maintain in the small communities where we live. This is particularly the case for the Aboriginal community. The vast majority of Aboriginal people who use are very reluctant to access health services; they know that doing so will become common knowledge within their community almost immediately.

Add the fact that many of the local using population have been jailed for short periods and you begin to see the time bomb ticking away in our area. Evidence says that many users continue to use while they're incarcerated, increasing the odds of their contracting a blood borne virus.

Australia has spent tens of millions of dollars to combat HIV infection amongst the injecting drug using community. Its world-leading success is a badge of honour that governments and agencies should wear with pride. But unless something is done quickly to address service shortages in the mid north coast, all this great work may have been in vain.

An innovative approach is needed. The only chance to get the necessary harm reduction information and equipment out to rural users is to use peer networks over health professionals. Users' anonymity is, as I said, paramount. Only by using peer networks will rural users feel comfortable enough to come forward and access the service. Let's face it – the majority of distribution of both information and injecting equipment already occurs via peers. But under the current system not only is this not recognised and applauded, it is actually illegal!

So will the government and its agencies get it together in time and implement a peer-based system? Or will they sit back, thinking it's all too hard, until we see more users testing positive to hep C and HIV and hear a chorus of voices complaining about the enormous strain their treatment will put on an already over-taxed health system?

Olf

This article is dedicated to my brother user TR. RIP

*Hepatitis C notifications between 2005 and 2007 showed a crude rate of 84.2 persons per 100,000 population, compared with the NSW statewide rate of 63.5 persons per 100,000 population. http://www.health.nsw.gov.au/publichealth/chorep/com/com_hepcnot_ahs.asp

The "Shoot Clean" Garden Team
A PeerLink Participant Story

I had dropped into my local NSP one day, not long after my life partner Robbie had lost his battle with hep C. Cirrhosis had taken its course and liver cancer was the consequence.

As the NSP was one of the places he and I visited to pick up our supplies, chat to the workers and meet with our community, it wasn't long before my mind started drifting back to happier times we had shared during our using years together. How ironic that here I was, mourning the loss of my love, in a place surrounded by posters, information and tools aimed to educate users of the dangers of sharing needles and harm reduction advice openly displayed. All of these simple and inexpensive measures weren't around in the late '70s, back when opiate users had to go underground for fear of exposure to an equally uneducated audience of the day.

Whoever said "ignorance is bliss" obviously wasn't a heroin user!

I have always known that the "old timers" of our using community had it tough, and too many have died as a consequence, but the sadness of it all overwhelmed me on that particular day. As a result, I came up with a simple idea; not only to create a space to visit and reflect on our friends who have lost their hep C battles, but more importantly to create a space to use as a positive inspiration to new or younger users when visiting the NSP.

I realised I could plant a small garden. This was the birth of our "Shoot Clean" Garden Team.

The plan was practical and low-budget. With help from fellow PeerLink participants and NSP workers, we planted pretty plants, created some garden art and formed a backdrop by cutting heart shapes out of disused corrugated iron. I painted the hearts red, symbolising passion.

Bright, colourful flags now fly proudly to announce "we are here to stay", openly offering guidance to all.

As a PeerLinker and a methadone client, I say that the Garden of Remembrance is a tribute to past and present users, and an exercise in showing the strength of our solidarity.

We are mighty and many. Long may we reign.
Peace and pleasure to all.

Doodie

PeerLink is a project of NUAA's Community Programs Team. The project aims to educate and support peer educators to share harm reduction information with their community.

Illustration: Bodine

IT'S A LONG WAY TO DUBBO
WHEN YOU WANT A DOSE OF BUPE!

Back in 2003, during the eight years I spent on buprenorphine, I wanted to go and live in the bush. I was on a stable dose, and having no desire to jump off, I intended to continue my pharmacotherapy despite the big geographical change. Whilst staying with my girlfriend in Mudgee, I had found a wonderful studio to rent in nearby Gulgong. My mum had bought twenty-five acres in the area, and I hoped to create a small business with my art work, design and illustrations. The place was suitable for a gallery and shop, and my head buzzed with ideas. It was a large shed built by an artist in pioneer style, with a gabled roof and lovely brick floor, set in a lush garden with fruit trees and even a cubby house. I fell in love with the place at first sight. Sadly my vision was not to be, as the owners put it on the market just a month after I moved in, and the uncertainty of that – the agents bringing potential buyers into "my" studio, saying "You could use this for anything, really..." – as well as other life-changing events, brought my best-laid plans undone. I ended up moving out under a cloud of debt, feeling like an utter failure. Oh well, there were some good times there before it all went pear-shaped.

I'd been attending a clinic in Sydney with no particular dramas. In those days there was just Subutex – Suboxone wasn't yet available. You could have takeaways once in a blue moon, but otherwise the only takeaways were what you could "divert" or buy on the black market, and that's how I managed shorter trips prior to my big move. (If I ever start another band, I'm calling it "The Diverters"!) The clinic staff looked into how I could access bupe dosing in the Mudgee/Gulgong area. I couldn't believe it when told that the nearest dosing point was in Dubbo – over 120 km away, with no direct public transport!

The public clinic was at Dubbo Base Hospital, and it opened for about three and a half minutes each morning (I'm exaggerating, but not much!) so that was out, but a pharmacy on the main drag did dosing for eight dollars a pop.

The first time I went, my mother agreed to drive, so we made a trip of it, Dubbo being the biggest regional centre and a good place to visit. I discovered some great op shops! There are also some nice old pubs serving counter lunches. I presented myself at the pharmacy and Mum went off to buy a sack of chook pellets. But she made it clear she wouldn't be prepared to do this often, and fair enough I guess. So I looked at other ways of getting there. The next time, I got a lift with my auntie to a turnoff 50 km north of Mudgee where the Newcastle/Dubbo coach stopped. Even the concession fare was pretty dear. That afternoon, I missed the coach back, so found a room at a big pub in the centre of town. It was a Saturday, so that night I discovered Dubbo's nightlife. I met some really nice people, not that I remember many – except for the young bloke who came up to me on the dance floor and yelled in my ear "Ya wanna fuck?!" I also met a horsebreaker – you wouldn't find one of them in Surry Hills! The next day I figured it made more sense to stay another night and get my next dose, thereby saving on travelling. I found a cheaper hotel to stay in – an Irish pub, rooms above only $25 a night. I liked that pub, it had character AND characters. They've since renovated it beyond all recognition. The barman I got talking to (who also wanted to fuck me – these country blokes must be sex-starved!) told me it was haunted. Doors that he had closed opened themselves, lights mysteriously played up. I didn't see anything myself, but I didn't get much sleep either! At least I'd found somewhere to stay when I was stuck.

Once I was able to get a lift with Mudgee's Community Transport scheme. I felt guilty using a service meant for "proper" people with serious medical problems, so I only went with them when someone else was going anyway, such as when one elderly man had day surgery at Dubbo Base Hospital. The drivers are volunteers and on this occasion I found the man driving to be an obnoxious prick. On the way he boasted about shooting kangaroos from his verandah. I really didn't want to reveal to him why I had to go; what my medicine was for. Of course I didn't have to say a damn thing, but strangely, I felt obliged to explain myself, and had to then cop his bigoted views on drug users.

I made about ten journeys to Dubbo in all, and mostly I hitched. I found it the most pleasurable way to travel,

IT'S A LONG WAY TO DUBBO (CONT.)

if unpredictable. Touch wood, but I've never gotten into any serious trouble whilst hitching in country NSW. There's no way I'd hitch on the north coast again though; a young woman from a community I knew went missing near Coffs Harbour, has never been found. I use my intuition about people but maybe I've just been lucky – if I'd been chopped up and left dismembered in the bush, I wouldn't be writing this, obviously. The only thing for me that was a bit off was that, hitching back to Gulgong once, I was picked up by a fellow and his dopey gronk of a mate, then ended up seeing the mate around in Gulgong forever after, and had to put up with his unsavoury remarks and leering at my tits. Many men seem to think that a woman travelling on her own is fair game.

I find with hitching that you really get to know an area and its people. I always walk along while trying to thumb a ride, rather than stand in one spot. I think this embeds in your subconscious that you are travelling, albeit slowly, and also tells the drivers that you aren't just passively awaiting a free ride! Of course if it's boiling hot, it makes sense to stay in the shade. Sometimes I would find interesting things along the road side; I called it "road combing".

I was hitching the day I spontaneously bought a gorgeous electric/acoustic guitar from Country Buy & Trade that we christened the Dubbo Special. Choosing the idiot's route out of town, I found that it was miles to the edge of Dubbo. Crossing through a roundabout in front of a line of cars, my foot snagged in my trouser leg, and I went flying. Luckily the first driver saw my mishap and halted. My new guitar wasn't in a case, but I managed to save it from serious injury by falling onto my knee instead of the hand holding the guitar. The Dubbo Special survived with only a tiny nick – but my knee was another story! Be careful crossing at roundabouts, folks!

Whilst all this went on, I enquired about dosing locally. I rang all the local pharmacies and found one that dispensed methadone. The pharmacist there had done the buprenorphine course, but had not yet applied for the certification to dispense it. All he had to do fax off the paperwork and wait for approval, so I lobbied him (read: hassled him repeatedly!) to do so. Anyway, at five bucks a dose it was worth his while. Boy was I glad at the news I could get dosed in little old Mudgee!

There were still challenges in accessing pharmacotherapy in a country town – especially anonymity – but at least I could catch the school bus into Mudgee, use community transport, or hitch easily. Furthermore, I have the satisfying knowledge that if anyone else requires bupe there, they can get it because I helped to make it possible.

Erin Burroughs

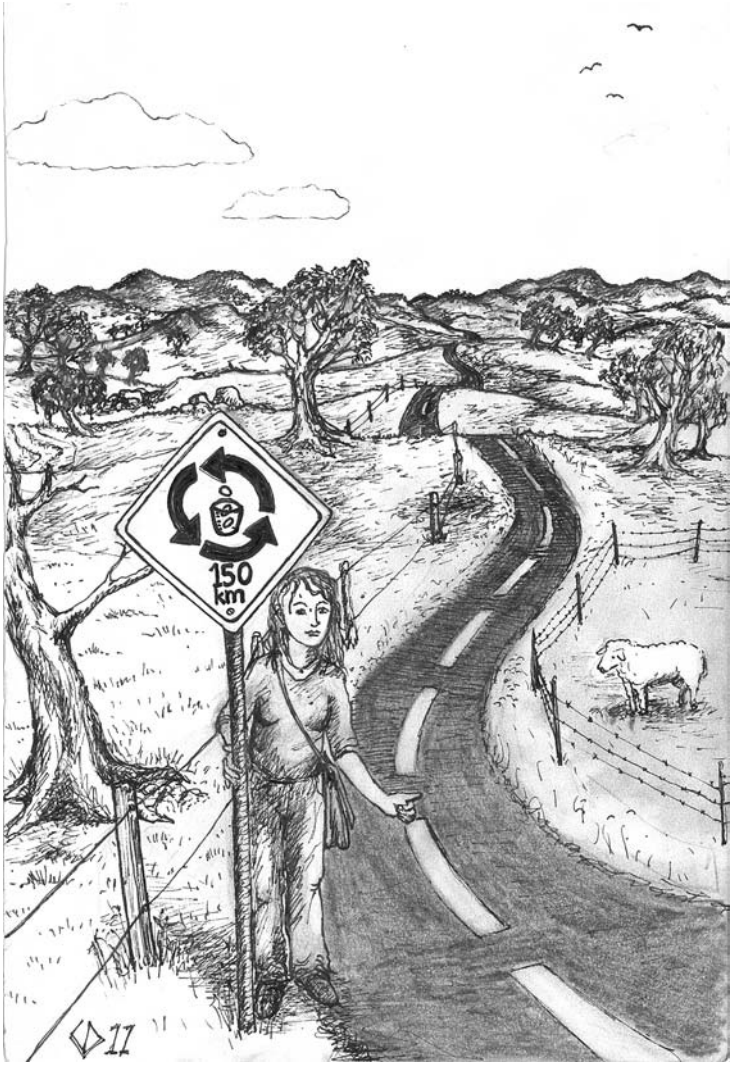


Illustration: Ursula Dyson

Solutions to Saturation

Pharmacotherapy in Newcastle

Donna McKinnis is a pharmacist who works at two pharmacies in Newcastle and runs dispensing of pharmacotherapy treatment for a large number of patients. In September, the Sydney Morning Herald *ran an article on Donna and on James, a pharmacotherapy treatment client who could not access treatment in his home of Newcastle and had to travel to Sydney every day for three years.*

The article followed an open letter to numerous State Government deparmtents, where Donna told more of James' story and bravely proposed that Justice Health transfer the pharmacotherapy scripts of Newcastle-based people formerly under its care to her pharmacies. She spoke to Mathew Bates just before the Herald *article was published.*

Donna McKinnis: It appears that the biggest problem we have here in Newcastle is doctors. Justice Health has a backlog of people who they can't send off to private practitioners, which would be the ideal situation. When I was looking at the books of the pharmacies where I work, both of which have methadone programs, they've both got nearly full books. Most of the time we're working off a full list. And if you look at who the doctors are, 75% or 80% of them are from public clinics. They can't find a doctor in General Practice Land to see them.

If you're pregnant, if you've done some harm to yourself, you have severe psychiatric problems, or you have a car accident or something of that nature, they will then treat you. But if you just happen to need it, or you just happen to be released from jail? No.

We've just released people from jail, for God's sake, and they've been on the methadone while they're there. Then we don't continue that treatment. What do they think is going to happen to these people? It's outrageously offensive.

So my proposal is this: Give them to us. We will dose them for a while until we can find them a GP and get them set up. They don't have to do anything except give us the patients' script. We will dose them. They get a script from Justice Health that is valid for one month. We can strictly speaking use that as their script.

But right now we can't get that information. They won't give it to a community pharmacy. I've been told by Justice Health that they have to be released into a specific structured program because they've come from a structured environment. Now we know that the most dangerous part of inmates' release is that first month afterwards because that's when they're at greatest risk of going back to using drugs. They may end up using more than they should and die. So a specific structured program? That's fine.

Just explain to me: just what structured program you'll release James into? It's idiotic to say that you're going to release people out of prison into a structured program when you know damn well there isn't one there.

Would they would rather not give people any dose, than give a dose to a community pharmacy that's not going to cost them a cent? Maybe they don't get enough services at a pharmacy, but they get more than having no structured program at all.

User's News: **Because they insist that it has to go to a prescriber?**

D McK: That's the stupid thing. I know cases where patients were referred to clinics, and were then getting dosed on that script for up to twelve months before they'd see a doctor. Doctors at the clinic would rewrite the scripts, but they wouldn't actually be seeing the patient, they'd just say "okay, we're going to keep it on that dose, we're not going to change anything, we're not going to assess them. We're just going to keep them going on that dose."

UN: Do your clients know of other people who want to access pharmacotherapy but can't?

This morning, we had 50 patients. One of them told me he often gets approached by people after he's been here to buy his take-away doses. They'll do anything for him.

Solutions to Saturation (cont.)

They'll offer to punch up someone for him. They've been released from jail and they've got nothing. They're desperate. Can you believe that? It just gets worse and worse the more I find out about it.

***UN:* Why won't private GPs see people wanting to access pharmacotherapy?**

D McK: They don't like the methadone program, they don't want the bother. But it doesn't have to be like that. You pick who you send to GPs. If it's about snobbery, as stupid as that stigma is, we can still select patients to go into GP Land who are going to fit into that environment. They're are plenty of people stabilised who are working, don't have other health issues, present well. But apparently you can't get the GPs to take them. Why aren't they at a general practice?

I wouldn't ask any doctor to take on 50, the maximum they can have. Maybe the guys working in the clinic might have to, but In GP land, I haven't heard of a doctor taking 50. I think that's an enormous burden.

Another way through the system might be a clinic set up whereby a doctor sees his/her pharmacotherapy patients at a particular clinic, set up for the purpose, but not in the general practices. They don't have to deal with all the paperwork, because you've got services around the clinic doing that. Setting something like that up might possibly be easier than sending them to a general practice. I don't know. But you can't afford to leave people in the lurch. It costs our community too much. If you don't like the idea of people taking drugs, then support the program. If you don't support the program, what do you think is going to happen? They're going to go back to drug use, some of them are going to go back to theft, they're going to go back to jail. And that's costly. I think the costs are $10 a day in the community, $250 a day in jail.
It just stumps me.

There's still not enough of an awareness of how bad things get in the wider community. To me, that's the easiest sell. I talk to people who say "Oh, I don't like those methadone people.". Well, I tell them that if people are on the methadone program, they're off all their drugs, for heaven's sake. When you point that out to them they say, "Oh yeah! I hadn't thought of that, yeah!"

For three years, James had to travel down to Sydney every day for dosing. That's outrageous. You can't have a job if you have to do that, and that further isolates you from other members of the community, makes it harder to be this "fine, upstanding member of the community" that everyone wants you to be. Surely we can do better than that.

It isn't that difficult, it isn't expensive. We know what works. Don't ask people to keep doing the same job over and over and over and then burn out.
It's time to spread the load.

You Get What You Give

an interview with Frank McLeod

Dr Frank McLeod, as CEO of the NSW Prison Medical Service, was one of the figures responsible for introducing methadone programs into our state's prisons. He personally administered treatment to inmates in the 1980s. After the Service was restructured into Justice Health, Dr McLeod decided on a sea change and found his way to Nowra. He spoke with Mathew Bates about the state of pharmacotherapy treatment on the NSW south coast.

***User's News*: Can you describe the work you do?**

Frank McLeod: I'm a semi-retired in private practice. I have my own rooms in Nowra. I see about 170 patients on the opioid replacement program with methadone and buprenorphine. I have patients from Dapto in the north down to Ulladulla, about an hour south of Nowra. And some from Wollongong. They make their own choice to do that rather than go to the public clinic.

***UN*: That's a pretty big catchment area.**

FMcL: There's an absolute deficiency of prescribers on the south coast. Apart from the public prescriber, who I don't think sees as many as I do (although I can't be sure of that), there's no one until Bateman's Bay, which is two hours down the coast. And there's one doctor I know of in Dapto who's doing a significant bit, but we're not thick on the ground, that's for sure.

***UN*: What are your memories of the Prison Medical Service?**

FMcL: I look back on those five years with a great deal of pride. I think a lot was accomplished, in particular the introduction of methadone as an anti HIV strategy. Also the 3+3+3 needle sterilisation campaign, which I think was a good move. I think my tenure there was a time when the attitude of the health service did a significant turnaround and treated inmates with a great deal more respect.

When I went into private practice, I certainly didn't meet any ill feelings from prisoners I'd met in jail. I still have patients that I knew quite well in prison. I treated tattoos on two women yesterday. I knew both of them at Mulawa in the late 80s.

***UN*: Your private practice included helping people get onto and continue opioid substitution. Why did you decide to continue administering pharmacotherapy?**

FMcL: From a straight-out professional point of view, I knew it was a niche market. I knew I was comfortable with it and I thought I was quite effective. I knew a lot of other practitioners who were neither effective nor comfortable.

I'm qualified as a specialist physician, so I started using some rooms in a couple of private clinics in Sydney. Then my wife and I decided ten years ago to come down the coast.

***UN*: What's your approach to pharmacotherapy?**

FMcL: I work on the philosophy that I will not knock back someone hot off the streets. I won't necessarily accept all transfers. But I won't knock back anyone who's got a hot habit.

The thing I probably enjoy most about this sort of work is just talking to people. That's a big thing. I think a lot of people looking for help are needing to find the compass, if you like, and you're just trying to help them get the needle steady.

***UN*: Where do you see the biggest problem with the system right now?**

FMcL: From my perspective, it's not so much getting a prescriber, it's getting a dosing point. The public clinic is full to bursting. A lot of my patients start their methadone at pharmacies. Now that's not advisable, but it's a necessity. And the reasons are finances and travel. If you haven't got a car and you want to catch a bus, the round trip costs a substantial amount of time and money. Especially if you're hit with a daily pickup as you are in the first three months.

***UN*: What kinds of improvements or changes would you like to see in NSW's pharmacotherapy programs?**

FMcL: The thing I'd like to see is if a person wakes up one morning, hanging out and says "I want to get on treatment", they should be able to go on treatment that day. That would be a major step, but it's resource

You Get What You Give (cont.)

dependent and I don't know if it's ever going to occur. Motivation is fairly transient. It doesn't last a long time once the pain and hanging out start to kick in. If that desire isn't quickly dealt with, people often lose focus. I know I'm part of the problem that I only work two days a week. But people will ring up the day before and book an appointment, then not show. So it's a very transient thing and you've got to catch them when they're hot. That's the biggest thing.

The other thing is humanising it. I've read about it in your magazine and I've discussed it with others. It's an interesting thing. You get what you give. If you treat patients with respect and good humour, you get respect and good humour. That doesn't mean I get "Sir" or "Doctor" and they all stand up when I come in the room. There's some fairly florid language that happens in my room. But the communication is pretty good and I enjoy the two-way exchange. If you can have a supportive, personal relationship with your patient with a degree of empathy, I think that's good. I think actually being interested in the patients and liking what you're doing makes a difference.

***UN*: Many of the people we talk to who access pharmacotherapy treatment speak of poor treatment by pharmacy staff.**

FMcL: There's a huge variation in how pharmacists treat their patients. Some of them are absolute, unmitigated gold. You can almost see patients changing their wills to put the pharmacist's name in. They are supportive, they are flexible, they won't hesitate to ring a prescriber if there's an issue or if they want clarification.

It goes from that level to others who basically see pharmacotherapy as a cash cow. I'm not against people making a quid off it. That's fine. It's a service. It's associated with its own difficulties.

But I go back to my earlier statement: you get what you give. If your personal problems are such that you need to feel superior to someone else, you're going to put some of the methadonians down – if not by statement then by approach. That tends to get people going. One of the classics I hear about is precedence at the counter. A methadone patient will come in, waiting to be dosed. After that, a prescription will come in. The methadone client is asked to wait until all the scripts are done. I have regular complaints from my patients who say they're made to wait half an hour, three quarters of an hour for a dose. To my mind, that's the height of stupidity. If certain customers are not comfortable waiting, if you're concerned they might be disruptive or loud offensive or get angry easily, get 'em in, get 'em out, get 'em gone!

***UN*: Do you have any advice you think may be useful for people who want to get onto a pharmacotherapy program?**

FMcL: From what my patients tell me, the best way to work out where to go is to get on the grapevine. Talk to your fellow users or people who have just gotten into treatment. They'll give you some sort of assessment of the services available, how to access them, and they'll give you a pretty succinct picture of what they think of the person you're likely to meet.

I reckon it must be pretty hard for people to come up into my rooms on the first day. They don't know what to expect. They don't know how they're going to be greeted, they don't know how they're going to be treated, and they don't know how they're going to feel at the end of it. So many of them are nervous and often a bit strung out.

I think it takes a lot of guts to stick your head up and say "I can't handle this any more, I need some help." When you do that, you give the prescriber on the other side of the desk an enormous amount of power. You're saying to them, "I'm going to let you prescribe for me. And if you get the shits with me and have a hissy fit, if you decide in a rush of blood to the brain to throw me off the program, I'm in an awful state." Now does that happen often? I don't think it does. But the fact that the fear is there initially would be very off-putting, I imagine. I would hate to be across the desk from someone who's got that amount of control over my level of comfort.

Cheap and Nasty

Life in Tamworth is pretty laid back. But if you want to score street drugs here, you'd have to go somewhere else. There's been no heroin here for the last few years, and the stuff they call Ice here is terrible. It's not worth buying.

I started using drugs like most users do, as a recreational thing. I smoked weed and snorted speed. I was 14, living at home with both parents, pooling any money my friends could find to buy whatever drug we could buy on the weekend. Life was fun.

Then I left school and had a full time job in a factory – I didn't need to pool my money any more.

I discovered injecting at 16. I truly enjoyed the immediate effect of speed. Six years later I discovered heroin and soon realized that this was my drug of choice. When the heroin supply dried up here I managed to get on a methadone program and found that injecting methadone satisfied my needs, however I still needed to inject the occasional other drug.

Then someone offered me some dex.

When I was 18, I'd tried injecting dex. Someone I knew had a kid who was on it. He threw me a few tablets and I tried to bust it up in a spoon. But I mixed it wrong and didn't get anything out of it. At the time, the speed around here was still pretty good, so I didn't go back to it.

By the time I was 40, however, it had become a waste of time scoring speed. You'd spend $150 and get nothing out of it. So when another friend threw me a couple of tablets of dex and said "here, try these, they're as good as a half-weight of the stuff that gets around now", I gave it another go. He showed me how to bust them up in the syringe instead of the spoon, and it was a better stone for a third of the price. It was cheap, but as I found out, it was very nasty, too.

My mate didn't show me how to filter the pills. Looking back, I can't believe I was so stupid, because it's so basic.

For about 12 months, I continued busting dex, but I started noticing it was difficult to find a vein. I went to get a blood test for hep C and the nurse couldn't find a vein either. I'd get golf ball-sized lumps on my injecting sites from missed attempts. It didn't register with me, but the unfiltered dex was wrecking my veins. I managed to find a pharmacy in a town nearby that sold butterflies, which helped, but I often needed a mate to help me find a vein.

Illustration: Bodine

Cheap and Nasty (cont.)

Finally, at the age of 42, I injected into the crook of my arm. It hit an artery.

As soon as it happened, I knew I'd done something wrong. My right hand began to ache immediately. A few weeks before, I saw a mate do something similar. He went up the hospital and waited for three hours without being seen. So he went home and the pain dissipated over the next couple of days. I thought my problem would resolve itself the same way.

I was dropping three or four codeine tablets every few hours to try and get rid of the pain, but it got worse and worse. My whole forearm became rock-hard. After two days it became unbearable, so I reluctantly presented to the Emergency Department at the local hospital. They diagnosed that I had compartment syndrome. This required immediate surgery – my forearm had a cut about 35 centimetres long with four other incisions in my hand. I needed to stay ten days in hospital, six of those in Intensive Care. My fingers started turning black. The doctors warned me to prepare myself.

I've lost the pointer finger and ring finger on my right hand up to the first knuckle. The middle finger has lost its tip, and my thumb has just a little bit of knuckle left. The doctors told me if I'd left it for a few more hours, I would have lost the whole hand.

I can't believe the damage I've done. I can't blame my friends, but I don't know why they didn't show me how to filter pills. If people using for the first time were shown how to filter it, instead of just shaking it up in a fit, this wouldn't happen.

It's obvious why I did so much damage to myself. The sludge you get from filtering you wouldn't believe. If you don't filter, that sludge ends up in your bloodstream.

The worst thing is my friends still shoot pills without filtering. They don't see the danger in injecting pills. They even phoned me while I was in Intensive Care wanting to score!

A girl I know accidentally hit an artery near her thumb. I told her she was so lucky. Her boyfriend hobbled around for two or three weeks because he missed a vein in his leg. (I refuse to inject in my leg – I don't want to lose a foot.) Another mate of mine was in agony for days from doing it.

I've shown them how to filter. They've seen what's left of my hand, they've seen the 30 centimetre scar on my arm. They still don't do it. I don't get it.

Injecting dex has created a life-long disability for me – now I'm careful and use filters (wheel filters if they are available).

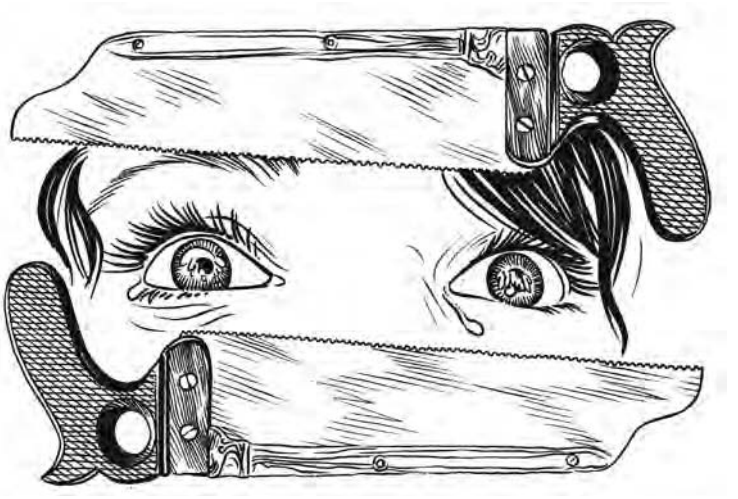
If you have to inject tablets, never, never use a pill that hasn't been filtered.

David

WIDE AWAKE

One day I was with friends and they decided to have a shot. They kept at me to join in. I said "no" numerous times, but eventually gave into temptation. Little was I to know an eight-week nightmare was about to begin.

I accidentally injected into my wrist, because I have bad veins. Halfway through I realised it didn't look quite right. The blood seemed light, frothy and a little milky. When I pulled out, a fine spray of blood started spurting out of the hole and I couldn't stop the flow. I still felt okay but after about ten minutes my wrist was screaming at me. I couldn't feel my fingers and I had the most excruciating, burning pain in my wrist. Pain like I have never felt.



We tried wrapping ice up to put on the site, but it seemed to make it worse. We then tried wrapping a hot tea towel around my wrist and that seemed to help the pain a little. A red mark had appeared and was starting to creep up my arm. My wrist was becoming swollen.

After an hour I knew it was hospital time. We drove there at high speed. I told the intake nurse I had just had a shot and that something was badly wrong. Eventually the doctors saw me. They admitted me and I was on drips and was closely monitored. The ends of my fingers slowly turned purple, then black.

I was told that three parts of my left hand, my thumb, index and ring fingers might have to be removed. After two weeks I was released, not knowing what was going to happen, only that my hand was in serious trouble. I had to go back the following day and ask for my antibiotics. I wasn't too impressed with this situation, as I could tell that my hand was getting worse. I went to see a private GP and it became obvious that I was going to lose my fingers. As the date for surgery approached, I could see the dead fingers starting to disconnect themselves through to the bone. It was scary as hell, but I tried to hold myself together. But it was only to get worse.

The surgery was brutal. I was told that for health reasons and due to the high dose of methadone I was on I was going to be awake throughout the amputation. When I saw the huge saw they were going to use, I felt sick. They had trouble anaesthetising me. I could still feel my fingers as they were getting ready. The anaesthetist tried again and eventually used a nerve blocker. My hand was put under a piece of blue plastic and the sawing began. I could hear the sound and was awake for the entire three-and-a-half hours of surgery.

I was released late that night with a script for paracetamol/codeine. The pain has been extreme and almost impossible to control. It became infected and when I had some of the stitches removed. It was excruciating. I am still in recovery, having the wound changed every three days or so. If I'm lucky, the nail will regrow on my ring finger.

I hope my story will help even one person from going through the nightmare I am still going through. I would do anything to turn back the clock, but at least I am alive and it's only the tips of my fingers missing, not my entire arm. It could have been worse than even all this. I was told that I could have had a heart attack or even a stroke.

Maria

Illustration: Glenn Smith

Risky Business

Accidental Arterial Injection and Its Consequences

Recently accidental arterial injection has caused a number of friends in our region to lose parts of their fingers. Others, because of the discrimination they receive at the hospital in this town, have not even had their hand seen to. As a result, their fingers are slowly becoming more and more damaged, risking both loss of fingertips and infection - in some cases, life-threatening infection. We want to offer a little information about the signs to look out for, why it is so risky and the potential consequences involved in arterial injection.

Arterial injection is when you hit an artery, not a vein. Blood in veins travel to the heart and arterial blood travels away from it. So any particles in your mix go straight to your limbs and bodily extremities when you inject into an artery. These particles get stuck in your capillaries (which are tiny blood vessels little bigger than the size of blood cells), cutting off your circulation. Eventually, lack of blood flow causes the tissue to die. The wrist, groin and neck are the most dangerous areas for accidental arterial injection, as veins and arteries are close to one another. Ankles are less dangerous, as the arteries and veins are further apart, but people who use larger needles may still run a risk.

Apart from the severe damage you could can do, arterial injection will not get you stoned. Instead of going to the brain receptors where they give you your buzz, opiates will react with the muscle tissue that the arteries are supplying. This causes swelling, redness and tissue damage. Eventually the opiates might find their way to the right receptors, but this could take hours if at all.

You don't always feel pain if you hit an artery, although some of our friends have found out this way. A better indicator is the pressure of the blood jacking into the syringe. Often the blood is a brighter red but this doesn't necessarily show up. Don't jack back, just withdraw straight away. Make sure you apply firm pressure to the injection site for two to three minutes.

If you do not notice anything unusual at this point, you will as you start to push the mix in – it will become very painful. This pain may be around the injection site or it may be further down the limb where the blood starts to get into the muscles (for example, if you've injected into an artery in your wrist, your hand may start to hurt and become swollen). One common problem is that arteries often lie underneath veins in your groin, neck and wrists. So you may hit your vein and then halfway through the injection you may slide a little deeper and hit the artery. No matter at what stage it is, at some point you will know that something is not right. Don't persevere – take the needle out and use another spot after applying pressure to the old site. Remember, even if you do manage to get it all in there you won't get your stone.

If you have injected into an artery (even just a little), you could potentially end up with swelling and redness around the area. After a period of some weeks the tips of the fingers may go from sore and inflamed, to black, just like frostbite. This seems to be the most common outcome of arterial injection, but in some cases it can cause strokes due to the particles in the mix.

So now that you know a little more about arterial injection, let's get serious. As users who inject progress through the years, they do damage to their veins. Eventually, they may come up against the sticky dilemma: do I risk injecting in my neck, wrist or groin? This is the essence of the problem. No-one in their right mind would volunteer to inject in these risky places; they only become an option when we are faced with the choice of abstinence or chancing it.

There are a few tips to be given here. Remember prevention is better than cure. Have a look at where the main veins in the body are and where they are closest to the arteries, find them on your body and pick your sites well. There are "risky" areas that should be avoided and safe regions with less risk involved.

Take care of your veins. Make sure your mix does not have any particles in it and is not milky (this milkyness is just lots of small particles). If it is, put it through a filter; ideally a wheel filter (or a cotton filter if you can't access a wheel filter). Remember to rotate your injecting sites. Hunt out a couple of sites on your arms that are easy to use and then move from site to site each time you inject.

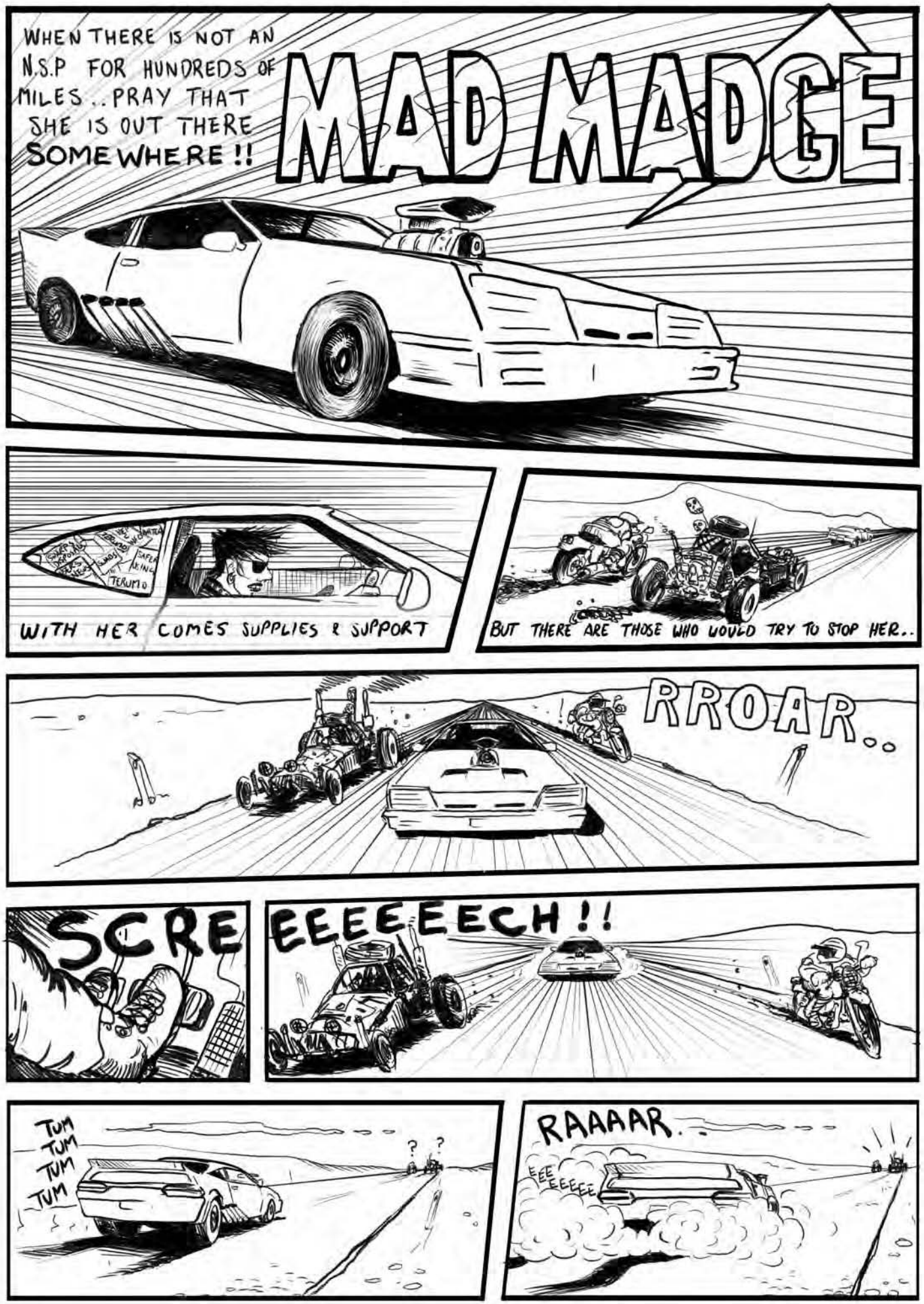
Don't forget that re-used fits are always blunt. Even a needle that's only been used once has been damaged by its use, so make sure you have a new, clean fit if you possibly can. Finer tips will also reduce damage and keep that vein going longer. Many users note that it is easier to find veins when they are warm, or have just exercised. Some people bring veins up by running their arms under warm water prior to injection. This seems to increase blood flow to the area, which enlarges their veins.

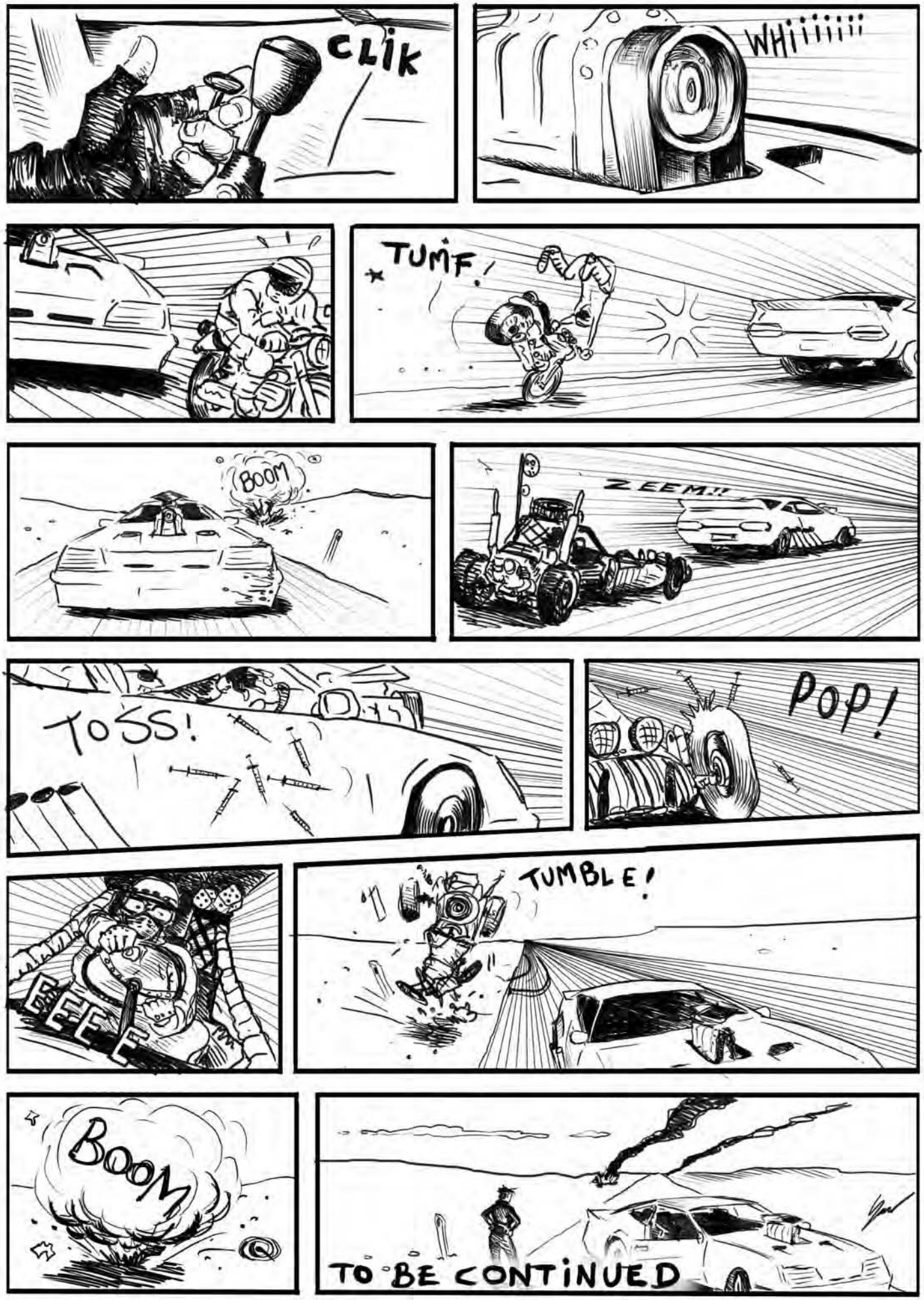
This is all very well for newbies, but what about us old-timers who have already done the damage? Well, there are no magic bullets, however if you get a map of the veins in the body and go looking for some you might be surprised and find a few you didn't even know were there. If they are staring you in the face, but you just can't seem to get them, try a smaller tip or going in from a different angle or side. Just the other day one of us was asked to do someone up in the neck because he "didn't have any veins left", but found a very nice vein on his arm to use instead.

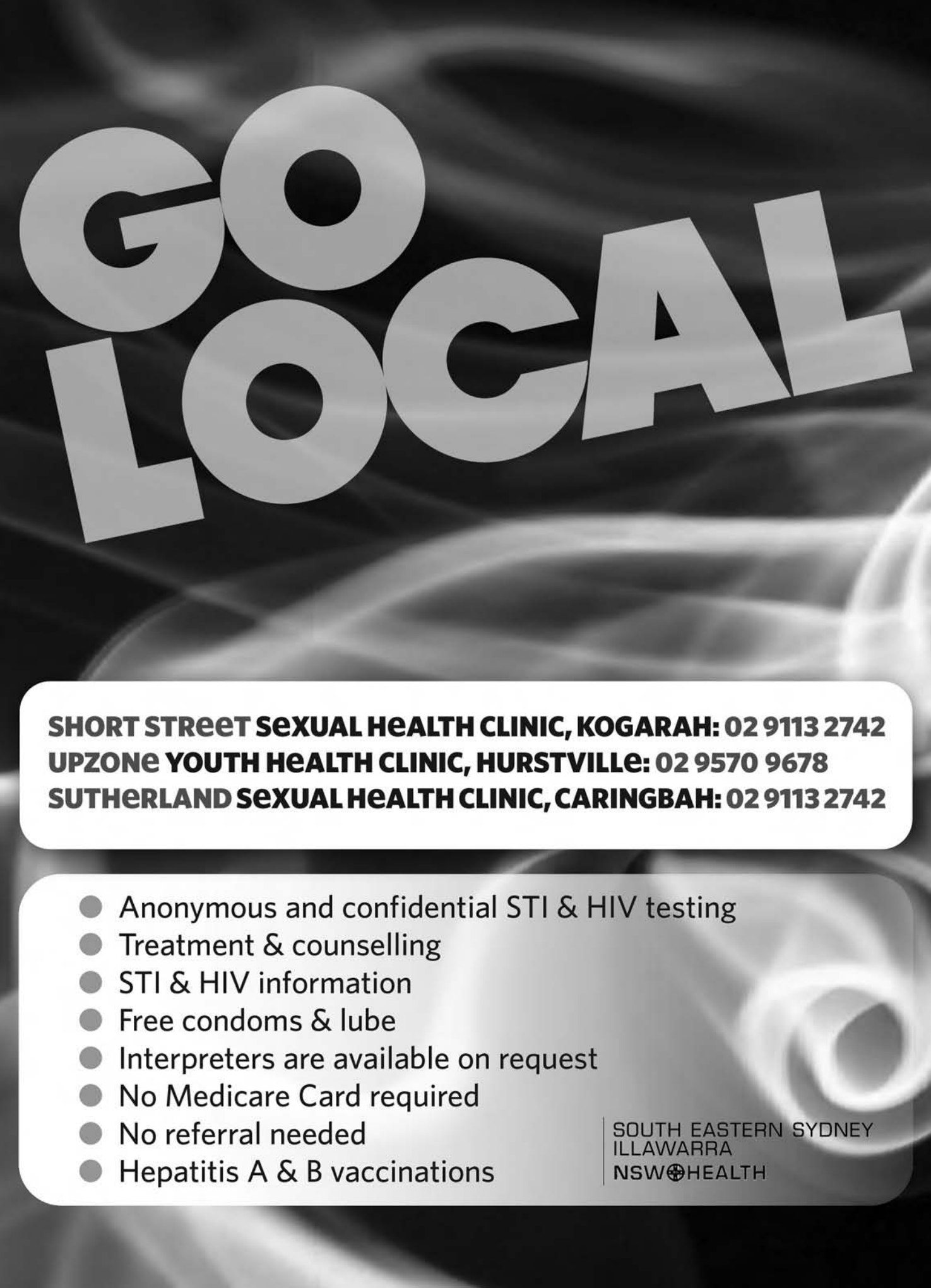
If all of this advice is of no use to you, then you are faced with a dilemma: Do you risk it? You can take all of the precaution in the world, but risky spots are still risky. There are no sure-fire solutions to bad veins. Is it time to think outside the box? Perhaps you could consider dropping, snorting, smoking or bunting. Yeah, we know what you are thinking, but this is not a sermon. We just want to tell you your options, and the consequences involved with each. It is for you to decide what the answer will be. Good luck.

C and C

Thanks to Zoe Potgieter, Clinical Nurse Consultant at St Vincent's Viral Hepatitis Clinic, for her technical advice in the preparation of this article.


WHEN THERE IS NOT AN N.S.P FOR HUNDREDS OF MILES.. PRAY THAT SHE IS OUT THERE SOMEWHERE !!
MAD MADGE
WITH HER COMES SUPPLIES & SUPPORT
BUT THERE ARE THOSE WHO WOULD TRY TO STOP HER..
RROAR..
SCRE
EEEEEECH !!
TUM TUM TUM TUM
RAAAAR..
EEE EEEEEE


CLIK
WHiiiiiii
TUMF!
BOOM
ZEEM!!
TOSS!
POP!
EEEE
TUMBLE!
BOOM
TO BE CONTINUED



SHORT STREET SEXUAL HEALTH CLINIC, KOGARAH: 02 9113 2742
UPZONE YOUTH HEALTH CLINIC, HURSTVILLE: 02 9570 9678
SUTHERLAND SEXUAL HEALTH CLINIC, CARINGBAH: 02 9113 2742

- Anonymous and confidential STI & HIV testing
- Treatment & counselling
- STI & HIV information
- Free condoms & lube
- Interpreters are available on request
- No Medicare Card required
- No referral needed
- Hepatitis A & B vaccinations

SOUTH EASTERN SYDNEY
ILLAWARRA
NSW HEALTH

The Journey of a HCV Peer Support Worker

One Sunday morning I was at my clinic getting dosed when I saw a job advertisement on the wall. NUAA wanted two peer support workers to contribute to a project to do with hepatitis C treatment. I was invited to an information session, where we were informed about a pilot project called ETHOS. I was one of the lucky two who got the job.

ETHOS stands for Enhancing Treatment for Hepatitis C in Opioid Substitution. It's a mouthful, but it's the name of an exciting research project run by the Kirby Institute. A number of sites across NSW are taking part in the ETHOS study, including NUAA. Our role in the study is to try out or "pilot" different models of peer support. We believe it is crucial that the community most affected by hepatitis C be strongly involved with all parts of hep C prevention and treatment work, and this project is involving us front-and-centre.

NUAA has over 21 years' work in harm reduction and the prevention of blood-borne viruses. The ETHOS project, however, is one of the first times that NUAA has worked at the hep C treatment end of the spectrum.

Pharmacotherapy in NSW is delivered very differently to the way that hep C treatment is delivered. It is often delivered in a harsh and judgemental manner, with punishment for not strictly following instructions.
NUAA feels that this punitive attitude clashes with the need for an honest and trusting relationship with health care workers when people undertake hep C treatment.

People who use drugs illicitly often hide the fact of their use in a pharmacotherapy clinic setting, because of the potential impact on their treatment. Often, clients can have their right to take-aways removed if the prescriber or dispenser becomes aware that they use. The problem is that hep C treatment workers sometimes need to know about their patients' illicit drug use. Clients can confuse hep C treatment workers with pharmacotherapy workers, especially if they work in the same clinic. They may think of their hep C outreach nurse as "part of the clinic", and may therefore find it difficult to keep up an honest relationship with the nurse if they believe their methadone or buprenorphine treatment may be affected.

NUAA ran a three-day training course for us peer support workers, covering a huge range of topics including ethics, confidentiality, the different strains of viral hepatitis, testing and treatment options. NUAA wanted peers from the clinic because we knew the people, the routine and the issues that peers might face. We understood the frustration many people who access pharmacotherapy feel. We'd seen aggression amongst clients and between clients and staff. We'd experienced the punitive nature of pharmacotherapy treatment: the bullet-proof glass and buzzing doors that felt like jail; the punishment for missing doses and for using illicitly. We knew that because of all this, clients didn't trust the staff. Not an ideal situation for setting up hep C treatment, where trust is vital.

So how to engage with people now we were peer support workers? We needed to think carefully about how to promote our new service. Everybody likes something for free, and people coming to pick up their dose often don't feel at their best. So we decided to offer clients some healthy, easily digestible snacks. We went with soft fruit, breakfast bars and small containers of fruit juice, as we realised many clients had dental problems.

When people entered the waiting room we greeted them and told them about the free snacks available once they'd been dosed. After dosing, clients came to the back of the room to see what goodies we had. We reintroduced ourselves as peer support workers, letting them know who we worked for and what we were doing. It was important that we stayed honest and open with people. We encouraged people to be open and honest with the liver wellness nurse and quickly reassured them that nothing they say to us will get back to the dosing staff or prescribing doctor, or impact in any way on their pharmacotherapy treatment.

After a couple of weeks we started to get a feel for the clinic and the clients. Initially the question we were asked the most was "What are you doing here?" It became my favourite question as there was a world of answers to it. By the third week, all the bad stories and myths about treatment were being thrown at us: "all your hair falls out", "it can feel like hanging out", "you have to have

The Journey (cont.)

chemotherapy". The hardest fear to change was the dreaded biopsy. People had trouble believing that there was now a non-invasive procedure available. We knew that we would have to do some solid groundwork to get people interested.

I noticed that the liver wellness nurse was becoming busier, that clients were spending more quality time with her, while we dealt with more general queries. About six weeks in, the clinic bought us a TV/DVD player so we could run some educational DVDs. We noticed a positive change to the clinic's atmosphere. People saw the clinic putting money into them, not just taking it every day for dosing. They were encouraged to participate in how they improved their own health. Sometimes a crowd of people stood around discussing the DVD, asking lots of questions. There seemed to be less anger at the clinic on the mornings we were there. Something was definitely happening.

People accessing pharmacotherapy face many barriers before they can engage in hep C treatment. Our role is to keep people linked into the program through this time. Besides referrals to the liver wellness nurse, we make loads of referrals to other services, like housing or the Salvos to get someone a fridge. Any time we can help out a client, it brings them a step closer to a point where they can think about their liver and hep C. The important thing is to help them make an informed decision for themselves about testing, treatment and improving their health.

We run monthly health promotions which have had enthusiastic participation from clients from the start. With the help of our liver wellness nurse, we brought in a nutritionist and ran a smoothie morning, handing out flyers with step-by-step recipe instructions. The nutritionist was able to come in on a fortnightly basis, which worked really well, as a lot of people from the clinic don't eat at all throughout the day. With the help of the nutritionist we were able to get vitamin and mineral supplement drinks to people who really needed it.

Clients have told us that they've learned a lot, not just about hepatitis C but also about how to live a healthier lifestyle. People who are still using have told us the information they learned had made them change the way they were using.

Others who had ruled out hep C treatment now saw it as a real option. One person attending the clinic made it perfectly clear at the outset that he wanted nothing to do with us. Weeks later, one Wednesday morning when it was quiet, he approached us and asked if he could be tested for hep C. Another guy in the same situation is now half-way through treatment. These moments are very exciting for me as a peer support worker. They make our work worthwhile.

We currently have 39 people in the ETHOS study. Four people are currently on treatment, and five have gone through treatment. We have run 46 clinic sessions over the past year. Only one or two sessions were missed due to illness. Within those sessions we provided 457 brief one-to-one sessions with people at the clinic.

The ETHOS project has taught us that the way that hepatitis C testing and treatment is offered to people must change. So must the way that pharmacotherapy clinic staff see and treat their clients.

The ETHOS project is a partnership. Unfortunately, most pharmacotherapy treatment is neither a partnership nor truly therapeutic. This is due largely to years of mistrust that has built up between pharmacotherapy clients and their service providers. Peer support and the involvement of the affected community is crucial to integrating hep C treatment into pharmacotherapy sites.

Our role, in partnership with clients, the clinic and the outreach nurse, has been to break down barriers and to rebuild trust. The project has been lucky to have service providers and nurses who recognise the importance of peer involvement and the importance of treating all clients as individuals. Without the support, trust and mutual respect of all our partners, this project would not have been as successful as it has been.

Stephen Musgrove is a Community Programs Worker at NUAA. This article is based on a speech delivered by Stephen at the Second International Symposium on Hepatitis Care in Substance Users, Brussels, Belgium.

City Dreams, Country Troubles

I remember my first trip to Sydney. I was in the family car with my parents, brother and sister. The buildings were so huge, towering up in the sky all around me. The intense feelings it invoked in me were fantastic. I was in awe of the sheer size of the city surrounding us in our tiny Kingswood station wagon. So small and insignificant in contrast to our surroundings. The moment that I saw the city around me, nothing else mattered in the world.

When I had children, I desperately wanted them to feel those same feelings in the same way. I achieved my goal earlier this year. I took my sons and one of my beautiful daughters to Luna Park. I can only guess if they felt anything like the emotions I experienced as a child. I'm sure they at least had a wonderful time and may even wish to take their own children there one day.

That trip had special significance to me in other ways too. For a large part of my adult life I seemed to feel like I could never achieve anything worthwhile.

I always seemed to be on the back foot, always making things hard for myself and for those around me. Life was a long and winding rollercoaster. I was constantly in trouble with the law, always chasing excitement in one way or another. Drink, drugs, car theft, break-and-enters. Only now have I realised that everything I did at that stage of my life ended badly. Someone was always getting hurt, emotionally, physically or financially. It never occurred to me that I was destroying my life, my future and my soul.

For years, I seemed to be stuck in that teenage mindset where I didn't really care about the future or what it might hold for me. Young people in my family were dying around me directly or indirectly from drug use and I still couldn't take the hint. I was on a road to nowhere. I just let it all go over my head. I didn't care about why bad things where happening all around me and just continued on my path of destruction and bad choices.

I didn't work for years, and spent a lot of time chasing drugs and finding any means to pay for them. Don't get me wrong. I was never the type to rob little old ladies or people who couldn't defend themselves. I tried to keep it to insured businesses and the like. Funny how they would always claim more was stolen than what really was. (That always made me feels like I was doing them a favour.)

It slowly dawned on me that every time that I stole or destroyed some stranger's car or property, something bad in turn would happen to me. Over the last few years I've tried to live without doing wrong to people. Now my life seems to flow a lot more evenly. Things just seem to work themselves out. The depression I lived with for years has left me. So has the need to live every day recklessly, without a care for anyone else in the world, without even a care for myself. I wish that there was some way of telling all those strangers I stole from that I am truly sorry for the things I have done in my selfish pursuit of what I perceived to be happiness.

I am now nearing my thirty-eighth birthday. I feel like my life now has promise, a future, perhaps even the chance that I may grow old and die a happy man. I still have plenty of cravings, and have to use something to take the edge off every weekend. (My job keeps me clean throughout the week, with drug testing and all that.)

Raising these children and helping to run this family gives me the drive I need to function, to hold down a job, and to give a shit about more than just myself. I know deep down in my heart that if I lost my family and my work in some tragic twist of events, I would really struggle.

As drug users, we all just need to keep our chins up and keep moving forward through the good and bad days. We are all human. Every day has a new story to tell.

Brett

Illustration: Glenn Smith

Introducing CREIDU

On behalf of the Burnet Institute I would like to introduce Australia's exciting new Centre for Research Excellence into Injecting Drug Use (CREIDU). With four years of federal funding from the National Health and Medical Research Council, the Centre involves a large collaboration of researchers, policy-makers and community-sector representatives working in the fields of alcohol and illicit drugs, blood-borne virus transmission, justice health, mental health, and policy research.

CREIDU's vision is to improve the health of people who inject drugs by generating new knowledge and translating it effectively into policy and practice. CREIDU will also build capacity in the sector through education and training for students, early-career researchers and community sector workers in areas relating to the health of people who inject drugs.

In July this year the Burnet Institute hosted the first annual Colloquium for CREIDU in Melbourne. This discussion group was designed to raise awareness of CREIDU and provided a great opportunity to showcase some of the latest research and to engage with key stakeholders in order to ensure that the work of CREIDU is relevant to their needs. With an interactive format and a fantastic mix of Australian and international speakers, the Colloquium drew together around 100 researchers, consumers, policy makers and practitioners from around the country.

We were delighted to have internationally renowned Professor Thomas Kerr, from the British Columbia Centre for Excellence in HIV/AIDS, open the Colloquium with a fascinating and inspiring keynote presentation on harm reduction in Vancouver, Canada. Professor Kerr described the response to injecting-related harm (including escalating rates of HIV infection and overdose mortality) in Vancouver's lower east side over the past ten years. He outlined the impact and benefits of increased access to sterile injecting equipment and interventions such as Vancouver's medically supervised injecting centre. He highlighted the important role that drug user activism and peer-driven interventions have played in the success of harm reduction programs in that city.

The Colloquium then covered four important and topical themes relating to injecting drug use: 1) emerging issues and new developments in hepatitis C; 2) links between injecting drug use and mental health; 3) improving response to overdose with peer-delivered naloxone programs; and 4) managing the injecting environment, including the issues of supervised injecting facilities and vending machines. This mixture of thought-provoking themes and engaging presenters ensured the day was filled with fascinating discussions and debates. A video of Professor Kerr's keynote and copies of the presentations will soon be available on our website.

The other fantastic news is the recent funding of a number of small seed projects through CREIDU. One project being supported by CREIDU in 2011 is Public Opinion and Drug Policy: engaging the "affected community", a collaboration between NUAA and the Drug Policy Modelling Program at NDARC. This project will explore the attitudes of people who inject drugs towards drug policy in Australia, with a view to enabling greater participation and consultation. Another project is the B-vax Project, an initiative to provide hepatitis B vaccinations to people who inject drugs in Melbourne through assertive outreach.

We're looking forward to an exciting, busy and productive few years where effective collaborations are formed. We will work to build capacity in the sector through education and training of researchers and consumer based organisations, and importantly, to see our research translated into policy and practice that improves the health of people who inject drugs.

CREIDU involves a number of collaborators from around the country, including the Burnet Institute, the National Drug and Alcohol Research Centre, the Kirby Institute, Turning Point Alcohol and Drug Centre, the National Drug Research Institute, the University of Queensland, the ACT Corrections Health Program, Hepatitis Victoria, Anex, and Harm Reduction Victoria. We are very grateful to many other organisations who have also contributed to the Centre's work, including NUAA, YSAS, Innerspace, the Yarra Drug Health Forum, and the Alcohol Tobacco and Other Drugs Association ACT.

Dr Rebecca Jenkinson is a Research Officer at the Burnet Institute's Centre for Population Health. For any questions about CREIDU, contact Dr Jenkinson at rebeccaj@burnet.edu.au

Mount Penang Graduate

When my parents were killed in a house fire I was made a ward of the state until I turned 18. I was kept in a series of boys' homes around NSW, mainly living with older boys who had been locked away for having committed various crimes. My crime was being an orphan.

I had to spend five years in youth detention centres unless I could be adopted out to a suitable home. As far as adoption went for me, I was considered too old; most adoption candidates are under ten. I wasn't keen on living with strangers anyhow. Two of my good mates were adopted out to "good homes"; one to a middle-class Christian family and the other to a wealthy Sydney eastern suburbs family.

At 18 I was released from the Mount Penang Training Centre for Boys at Gosford with $55 and a train ticket to Central station.

I don't know what they were thinking when they released me. I guess they must have guessed that I would have a life to resume and a place or family to go to. In reality I had nothing. No identification to get a job or Centrelink payments. No clothing other than what I was wearing and not very much to look forward to at all.

I remembered many of the boys at Mount Penang talking about Kings Cross. Once on the train to Central, looking hopelessly out the windows at the old buildings, I thought it would be a worthwhile option to go to up there. I was bound to run into someone I knew up there.

I got off the train at Central and asked a couple of old ladies to direct me where I could catch a train to Kings Cross.

I got off the train and walked the busy streets, freaking out at the world and how bizarre it seemed to me, a country boy checking out life in the big smoke. It was hours before I ran into one of my Mount Penang mates. He couldn't talk long because he had to go home for a family gathering, but he told me where I could find a whole heap of my other Mount Penang mates. He said some were sleeping at Central station, some in Hyde Park, while others could be found after dark working up at the Wall.

Society (in the form of the "system") doesn't look after young people coming out of the juvenile system. It often releases them with nothing, sending them out on the streets, often ill-equipped to deal with life in the real world, or to a non-existent life. I am curious how this is

Illustration: Ursula Dyson

Mount Penang Graduate (cont.)

able to occur. These young people are too young to vote and at least at that time very little advocacy was being done for them. I guess the powers that be simply assume that we have lives to continue and families to go home to. In an ideal world this may be the reality, but it's not true for everyone.

I went back to Hyde Park and while sitting on a bench eating a hamburger and hot chips I saw two of my Mount Penang mates. They had been sleeping in the park. With very little going for me, I teamed up with them and used the garden beds as my bed too.

I went to Centrelink to apply for whatever benefit I would have been eligible for. I was turned away because I had no identification and no bank account to receive payments. My application could not proceed in the absence of proof of identity.

My mates would ask people walking through the park for money much of the day. I joined them and was told to say "Hey, have you got a spare dollar, please?" to anyone who looked like they could afford to part with it. Initially this money was for food.

The hopelessness of our situation meant that we simply had to look out for each other. My two mates both received unemployment benefits but had been spending most of their money on heroin. While I never had much going for me I was, at that time, drug free.

One night, when the rain refused to stop and sleeping in the park was not a great option, we ventured into the Cross. As good an excuse as any. My mates scored some heroin and I guess in this hopeless situation I thought heroin couldn't hurt me. An overdose would be an advantage, not a deterrent. As I was injected, I thought "we're all equals now". From then on we robbed parking meters and broke into parked cars for small change.

Within a short time we were all heroin addicts. Some great people at the Salvation Army assisted me to get onto the Newstart allowance with Centrelink and housed the three of us in an inner city apartment. It wasn't anything too flash, but for us grateful recipients it was like paradise.

Just when things started to work out, after all the hardships we endured, we robbed an Oxford Street pharmacy for pills. Once the alarm sounded, the doors automatically secured themselves with bullet-proof glass. I tried kicking out the glass to no avail.

We spent that night in the MRRC at Silverwater Correctional Centre. We were on remand and we've since all contracted the hep C virus from using fits used by anybody and everybody else.

While on remand for armed robbery in company, sitting in jail here, I have been charged for being in possession of a syringe, stealing four syringes from the prison clinic and providing a positive urinalysis sample for Xanax and heroin.

This situation has brought significant undue attention to myself. My cell is constantly searched by prison officers and I am subjected to constant targeted urinalysis tests.

I have decided it is best for me to go on the methadone or buprenorphine program. I have made half a dozen referrals while "at risk" to no avail. In the meantime I am still sharing needles to inject heroin.

I cannot wait to get onto the methadone program.

P.

The Golden Armidale

I lived in Armidale between 2005 and 2009. The main drugs available in town at that time were amphetamines or pills such as oxycodone, morphine, methadone and bupe. I found it very hard to access equipment up there. You could get 1ml ten-packs from the hospital, which is fine if you were using speed, but the staff at hospital really looked down their noses at you if you asked for a fit pack. There were a couple of pharmacies in town that stocked 3ml barrels and assorted tips, but I found trying to get barrels and tips together was a major problem. I had to bullshit the pharmacists and tell them I was giving my horses steroid injections. That worked until they started questioning the fact that I was using a 27 gauge syringe with a half-inch tip for horses – too small for the job. I changed tack and told them that I had to give my grandmother injections for pain relief. They then questioned whether I was qualified to give her injections. Eventually they gave me 27 gauge syringes with one-inch tips just to make life that little bit harder.

As for wheel filters, no-one in Armidale seemed to have heard of them, pharmacists and users alike. I was mixing up for a mate one day after I had just come back from Sydney. I brought back a few wheel filters. My friend had never heard of them, so I used one to mix a 100mg morphine pill. When I was done mixing it, my friend thought I had ripped him off and given him straight water as the mix was clear. Most of the users up there were under the impression that the cloudier the mix, the stronger the shot. My friend was quite shocked at first; he didn't want to have it as he insisted it was straight water. But when he eventually put it away, he was quite impressed. He told me it was a lot better than he was expecting.

There is a fairly large drug using community in town who could use a service similar to what we have in larger cities, that not only provides the correct equipment you need for the particular drug that you are using but also proper advice. Advice around the safest possible ways on mixing up pills; around the dangers associated with injecting tablets such as bupe that may have been in people's mouths; around the risk in long-term use of injecting such pills without correct filtration.

As for accessing treatment for drug and alcohol dependence, there was one rehab centre in town. I went through the program once and was clean for nine months, but it was a real struggle and I relapsed. The rehab staff were very resistant toward accepting me again. In the end they declined my application, which left me with a choice of going on Subutex or methadone. I spoke with other members of my community who said they also had trouble getting into rehab. Staff seemed to prefer to take people from out of town, because they don't know anyone local to trigger a relapse. It doesn't leave people in town with a great deal of options besides methadone or Subutex.

There was one prescriber I knew of and two chemists in town that were owned by the one person. I found out that if you got on the wrong side of the chemist it made life a lot harder than it needed to be.

In the end, I found that I had to move back to Sydney in order to try and get my life back on track. Although I have not stayed 100% clean, I found I had a lot more choices here in Sydney than I did in the country. Part of my way of making my lifestyle better was getting some sort of routine back in my life. This included accessing a free bupe program and doing a couple of days' volunteer work at NUAA each week. This has really helped me escape the isolation that using tends to leave most of us in. Now I feel like I am part of a community again.

I believe that larger rural communities like Armidale could really benefit from peer-based organisations like NUAA, so that the using community can access both equipment and the correct information around the drugs they use.

Bob

Illustration: Tony Sawrey

For the Love of the Game

A one-stop-shop approach to treating people living with hepatitis in opiate substitution therapy

Dedicated to all of you – you know who you are.

There is an increasing need for satellite hepatitis clinics in Western Sydney, in the Blue Mountains and beyond. For many people who attend Opioid Substitution Treatment (OST) clinics, travelling to hospitals for appointments to see the doctors in the Gastroenterology and Hepatology clinics is not a possibility. A crucial reason for this is past bad experiences with health care providers. Stigma and discrimination are known barriers to accessing health care for many people on opioid substitution treatment.

Many people who would benefit from hepatitis treatment currently face heavy barriers to accessing health care in OST clinics due to their geographical location. Other factors can come into play too, including poor physical and/or mental health, domestic issues, ongoing drug use, relationship breakdowns, financial debt, criminal activity and unstable living conditions.

Nepean Hospital's hepatitis treatment staff know many clients who describe financial hardship as one of the most common reasons for not travelling to Penrith to have ongoing follow-up with the doctors at our Gastroenterology and Hepatology clinics. Many people are without a car or money for travel or living expenses, making it difficult to access the hepatitis clinics.

In order to address these issues, the Nepean Blue Mountains Local Health Network currently provides viral hepatitis services to the following OST clinics: the Gateway Clinic at Nepean Hospital, the Woodlands Clinic at Blue Mountains Hospital and the Lithgow Community Health Centre OST at Lithgow Hospital.

These services are in the form of a nurse-led clinic at these centres. The nurse-led clinic provides a direct and informal referral pathway for people who want more information about viral hepatitis. Most referrals are made through the case managers from the OST clinic. Some referrals come independently from advertising or by word-of-mouth.

This model of care offers a "one-stop-shop" for people living with hepatitis, a hassle-free approach to accessing health care in a pharmacotherapy setting. The satellite clinics aim to increase service accessibility to, and to decrease waiting times for, the Gastroenterology and Hepatology clinics in Nepean Hospital.

Each clinic has a specialist nurse on staff, qualified to provide a basic assessment for people living with hepatitis. The clinic model of care is based on approved medical protocols for ordering diagnostic tests and is compromised of a mix of nursing and medical reviews.

It takes care and compassion to support our clients through diagnostic tests and hepatitis C therapy on a case-by-case basis. The nurse/patient relationship is built on rapport and trust through continuity of care. We always encourage ongoing follow-up, but we make sure the client knows it's always their choice to come back. Building an informal yet professional relationship with the people we see in our clinics will ultimately result in better health outcomes for them.

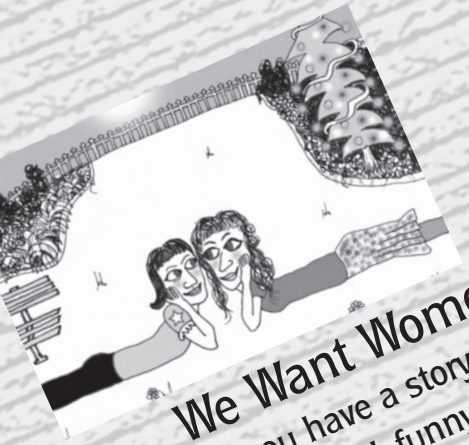
Our goal with the services is a holistic care approach, increasing health care accessibility and appropriate referral when needed. In the future, depending on appropriate funding, we may be able to engage a doctor whose role would be strictly to provide medical review for our clients.

I want to thank all the clients who have shared their opinions to help me write this article. My experiences in working with you all have only been good. I have met some amazing people along the way and it has always been a pleasure. I can honestly say that I love my job – and it's for the love of the game that I go to work every day.

Jamieleigh Petersen is a Registered Nurse at the Centre for Addiction Medicine, Nepean Hospital

Next Edition *User's News* No. 67

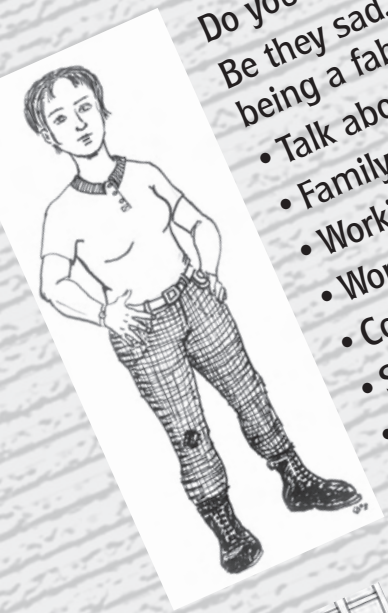
Women! This Issue Is for You!



We Want Women's Stories.

Do you have a story to tell that shows how wonderful women are? Be they sad, funny, political or spiritual, we want stories about being a fabulous woman who takes drugs.

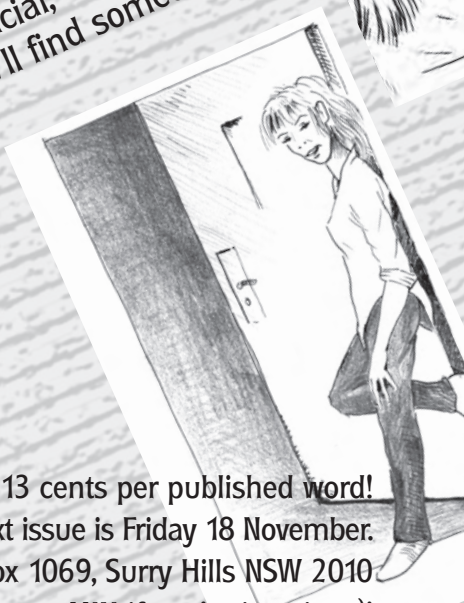
- Talk about your experiences negotiating life as a user
- Family and parenting, relationships and friendships
- Working, Using drugs, being in treatment
- Women in prison
- Coping with hep C, HIV, diabetes
- Sex, menopause
- or simply being a chick in the predominantly male world of drugs



PLUS - THE RETURN OF IDA!

READERS ASK EXPERTS ABOUT THE THINGS WE NEED TO KNOW!

Send in your questions - medical, lifestyle, harm reduction, child care, legal, financial, mental health - ask anything and we'll find someone to give you a sensible answer!



Remember, we pay 13 cents per published word!

The deadline for the next issue is Friday 18 November.

Send your stories to: *User's News* c/o NUAA, PO Box 1069, Surry Hills NSW 2010

Don't forget to include your contact information (including your MIN if you're in prison)!

(Please note that we usually publish stories using the first name of the contributor. If you wish to be published under another name, please say so in your submission.)

Poisons and Remedies
An Interview with Lisa Pryor

NUAA's Policy and Advocacy Co-ordinator Joe Kim caught up with author and journalist Lisa Pryor at the launch of her new book A Small Book About Drugs*, an even-handed mix of interviews, research and anecdotes that argues the War on Drugs has failed and honest, searching debate is needed to reform drug policy in Australia.*

User's News: **I was impressed by how your launch presented where the argument sits for drug law reform agencies. That the harm of criminalisation is the salient concern and the romanticism/glorification that reform advocates are accused of is unfair. Can you give me your thoughts as to why criminalisation does more harm than good?**

Lisa Pryor: It's really not so different from other controversial practices which have been legalised in recent decades, such as prostitution and abortion.
Neither of these practices was legalised because they were harmless – they were legalised because of the realisation that criminalisation didn't eradicate these activities, it simply made them happen in ways which were particularly harmful. Taking place underground without proper safety measures, providing a lucrative source of income for organised crime, enticing police into corruption, punishing victims as much as perpetrators.
The situation with drugs is very similar. You don't have to love drugs to think that drug laws should be reformed, just as you don't have to love prostitution and abortion to believe they should be legal.

UN: At the launch you spoke of most people moving on from their drug use in the third or fourth decade of life, or the need for people to move on if they are no longer enjoying the experience, which is borne out by statistics. But in my experience, the majority of people either change their drug use so that it is solely legal, like alcohol and caffeine, or they change the types and frequency of their illicit drug use. It could be argued that most people are drug-dependent for most of their life, that they require the use of drugs to live a fulfilling life. Can you comment on this?

LP: Statistically drug use, including alcohol use, does drop once people hit their thirties. I don't think drug taking is necessary to a fulfilling life, I think of addicts in recovery who find life more fulfilling once they stop taking drugs, people who never drank or took drugs for religious reasons, or all the women of childbearing age who go for years without being intoxicated because they are pregnant, breastfeeding or trying to conceive. But I agree that a lot of people moderate drug use with age rather than forgoing it altogether.

UN: **Given the evidence that has emerged over the last 50 years or so, why doesn't everyone just stop consuming caffeine, nicotine and alcohol, given that these are the drugs people seem most dependent upon? Many of these people expect abstinence from the "addicts" in our society, so why don't they lead by example?**

LP: While people have stopped consuming nicotine in large numbers, you're right: there aren't many signs that society is weaning itself off alcohol and caffeine. Those who drink alcohol and coffee could plausibly argue that there are known safe levels of alcohol and caffeine use and if they stick within these levels they are not doing themselves damage. The reality is that the way we commonly use alcohol is not within these safe levels. For a woman to drink safely she would never be able to have more than two large glasses of wine at a dinner party, never have more than two caprioskas at a party, never have a gin and tonic followed by a glass of wine followed by a dessert wine at a restaurant. Perhaps the reason why drinkers think differently about illicit drug use is that it makes them feel better about their drinking.

UN: **After two decades working or dealing with drug use, I've come tot the conclusion that the three most vexing drugs in Australian society are alcohol, nicotine and benzodiazepines [Valium, Serapax, Xanax *etc*.]. The first and third are the only major drugs that can cause death in withdrawal. All seem to interfere the most with humanity on both an individual and social level .**

LP: In an ideal world we would regulate drugs more or less strictly according to the level of harm they cause. Unfortunately drug regulation has not developed

so rationally and reflects historical accident more than anything. One of the dangers of the legal/illegal divide is the false assumption it seems to engender in those who favour alcohol and prescription pills. It must be safe or it wouldn't be legal. There is a quote I love from the Renaissance physician Paracelsus which points to the fact that you have to be careful about all substances: "Poison is in everything, and nothing is without poison. The dosage makes it either a poison or a remedy."

UN: **I have seen people injecting heroin over the medium- to long-term who are in better mental and physical health than people who've never touched a syringe in their life but have experience with other drugs.**

LP: I don't feel like I have enough detailed knowledge to comment but I suppose that heroin, for all its faults, not least the risk of sudden death, messes with the head less with the mind than drugs like ice. It may also have something to do with the fact that people who are still alive after 20 years of heroin dependence are bloody hardy individuals.

UN: **You write of the many creative minds who immerse themselves in drug use. Why do you think this is?**

LP: Perhaps creative people fear ordinariness, and try to escape it through both drug use and creative pursuits. Perhaps creativity and drug use are both ways to have adventures and explore new worlds. When I think of the particularly creative people I know, artists and writers, I would say most have enjoyed illicit drugs at some point in their lives. I'd also say the most successful ones have not used drugs as a creative tool. Anyone who has tried to create something while high on drugs knows it usually doesn't look or sound or read so well once the drugs wear off. It might not seem romantic but the commonest traits of people I know who have achieved a lot creatively are discipline, commitment and hard work.

UN: **Why do you think the topic of drugs brings in the lofty opinions of individuals who have little or no expertise in the area? We never see this with aeronautics or heart surgery or genetics. Why is ignorance so easily accepted in debates around drug use?**

LP: I guess most people have some experience of drug use in a way that they don't have experience of rocket ships or surgery or chromosomes. Many people see drugs as a moral issue rather than a health issue. Absolutely, there are questions of morality related to drug use, but it's impossible to have a meaningful moral position without at least trying to understand the science of addiction and the impact of addiction on a person's free will and ability to make choices.

UN: **You told the audience that you would feel safer if your young daughter were around a group of older men who had smoked pot or taken MDMA than around guys who had drunk too much alcohol or were on crystal meth. If your child showed interest in cannabis or ecstasy, how would you feel about taking it with them as a safety assurance?**

LP: My gut reaction is that I wouldn't. Absolutely not if she was high school age, probably not even after that. It's a boundary I would not want to cross. I don't want to intrude in her social life that much, or feel the need to be the boss of her experience. Maybe there are circumstances in which parents and adult children can make this work, but I think most children, even as adults, would probably prefer not to see their parents intoxicated.

UN: **What do you think would happen in Australia if alcohol, nicotine and caffeine were made illegal tomorrow, using the "success" of the War on Drugs as a justification?**

LP: It could never happen. There would be a revolt. There would also be powerful commercial interests which would throw money around lobbying against it regardless of whether there were health benefits. This is worth keeping in mind when it comes to decriminalising illicit drugs. We need to look at models which don't allow commercial interests in the future to lobby for the laws to develop in ways which are not in the public interest.

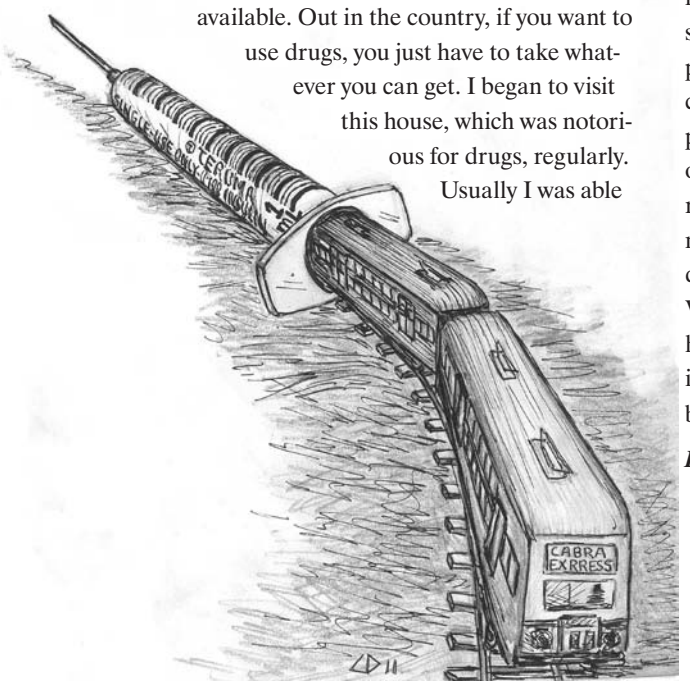

THE PLACE: DUNWICH WEST. . . N.S.W.
ALWAYS GREENER
THE TIME: TWENTY MINUTES AGO. . .
WEIRD CHANTING IS HEARD FROM THE ASKLEY FARM-HOUSE. . .
HERE'S ME. JACK. I'M ATTEMPTING TO RAISE A DEMON ~ USING A BOOK FROM THE PUBLIC LIBRARY. . .
I FAILED FOR DAYS: BUT EVENTUALLY. . .
MORTAL... WHAT IS IT YOU SEEK?
BE STILL! I COMMAND THEE ~ FOUL DEMON; -TO FURNISH FOR ME ~ A GREAT BOON! I WANT A BAG OF MARIJUANA. . .
...THAT WILL NEVER, EVER RUN OUT!!
SO.
USING THE PARLANCE OF THE DAY. . .
WHAT'S IN IT FOR ME?
...PUNY MORTAL.
HEY KIDS! DON'T TRY ANY OF THIS SHIT AT HOME!
GIFT ME WITH THE ETERNAL DOPE BAG - AND ALLOW ME TO USE IT - FOR 25 YEARS...
WWW.BEAUJARDINE.COM
KEWL!
THEN WE HAVE A DEAL!
...AND, AT THE END OF THAT TIME ~ YOU CAN FEAST UPON MY ETERNAL SOUL!
THE BIBLE SAYS: "HAVE NO TRUCK WITH THE UNCLEAN THING!"


Oh SHIT! IT WORKS!
A BAG OF GRASS THAT WILL NEVER RUN OUT!
HAR!!
I'M GOING TO BE RICH!
I UNDERSTAND THE DEAL HERE... - HE WILL WANT ME TO SIGN MY SOUL AWAY.
LUCKY I BROUGHT THE PEN FILLED WITH ROSE SCENTED HOLY WATER..!
CONTRACT
BLESSED
THE PLAN IS SIMPLE ~ I TOUCH MY PEN TO THE PARCHMENT... AND BYE-BYE BEASTLY DEMON!
SIZZLE SIZZLE!
EXORCISM.
ARGH!
NO!
I SEND THE STINKING BASTARD BACK TO HIS PERSONAL HELL-HOLE!
THIS LEAVES ME: SOUL INTACT, WITH THE SPOILS OF HOLY WAR!
?!!
BUT
AWW - NO! IT... IT'S MALE LEAF!
FUCK.
USELESS MALE LEAF!!
AWW... FUCK IT!
END.

The Cabra Express

It was a cold, miserable, rainy day. I woke feeling as if I'd gone ten rounds with Mike Tyson and caught pneumonia into the bargain. Luckily, I'd just got my dole check and was soon waiting, strung out and freezing, at Blackheath train station. It was 7am and the trip to Central was long and frustrating. When the train pulled into Katoomba, all the other junkies embarked. We were on the same mission: to get on. Some were heading for Cabramatta, others for Marrickville. I met a couple of guys from Orange who made the journey twice a week, and it turned out we were all going to score from the same dealer. They were the only smack dealers in their town, so a lot of people were depending on them. There were a few times when I had to travel all the way to Port Kembla, as my regular dealer had been busted.

I soon got tired of all the travelling and decided I had to find a more local source for my chemical of choice. The next time I was in Katoomba, I trawled the local cafés looking for skaggy types to enquire where I could find some H. I asked the first hippy I saw, "Hey, do you know where I could get some heroin?" He looked at his friend and replied "Sorry mate, I don't indulge." I continued to walk the streets, dodging tourists, families and straights, until a seedy looking bloke directed me to a nearby house. Lo and behold, every junkie in Katoomba was hanging out there. I scored four matchhead-sized caps. I couldn't get a quarter or a half, or anything of proper weight, because that was all that was available. Out in the country, if you want to use drugs, you just have to take whatever you can get. I began to visit this house, which was notorious for drugs, regularly. Usually I was able to score something there, but it was by no means a sure thing. Often they were out, or we had to wait until they could get a car so they could travel to Cabra.



One summer day, my girlfriend was giving me a lift to work and I decided to score on the way. I turned up and they didn't have anything. Everyone was hanging out. The dealer was trying to get a lift to Australia's Wonderland to meet his contact and score an eight-ball.
He had to do this several times a week. Usually a mate drove him, but the car was on the blink and he was ringing everyone he knew, trying to find someone who could give him a ride. The day was sweltering hot, and our tempers frayed. Eventually my girlfriend reluctantly agreed to drive down the highway to Sydney, on the condition the dealer gave her $50 cash for petrol. I was so late for work that I rang up and told them I was sick and couldn't make it. Well, it was kind of true... (Not long after this, I was discovered having a shot at work – I was sent home and when I phoned to ask if I still had a job, was told "No more shifts!")

It turned out to be a fun drive. We were all laughing and telling jokes on the way. We scored and drove back to Katoomba, arriving three hours after we left. Everyone at the house was very relieved, and thanked my girlfriend for driving us down. We all agreed that being a junkie in a country town made life difficult.

For many of us, heroin is an essential ingredient of our lives. If society as could just accept this and get over its squeamishness towards injecting, the benefits would be profound, not just for those who use drugs which are currently illicit. Millions of dollars now spent enforcing prohibition could be redirected to health, education, and other essential services. Police could focus on crimes like rape and domestic violence, and on making our communities safer. As this story shows, things are particularly difficult for users of illicit drugs who live outside the city. With a regulated heroin program, many people would have much more time and energy to pursue more meaningful goals and activities. Ending prohibition would benefit us all – no matter who we are or where we live.

Bucketman

Getting Our Heads Together in the Country, Man

It was the longest ten days of my life; I had just trekked for hours through the bush to escape my camping ground detox. It was the middle of the night and I sat alone at Parkes train station going over and over in my head how I got to be there.

A year ago I was living with my girlfriend Malina in a nice apartment on Macleay Street in the Cross. We were recreational users but we paid the rent on time, we both had good jobs, good furniture and a nice bed. We had a good, happy, normal relationship. Then we met a guy called Bob, who asked if he could use our apartment to make up his deals and reload. For that he would give us a cap a day. We gave him a key so he could come and go when we were not home.

Soon Malina lost her job because she was always sick. She looked an awful yellow colour and was very skinny because we couldn't afford to buy food – all our money was being spent on drugs.

I was still going to work but I needed way more than a half a cap a day. So I still split the cap we got off Bob with Malina in the morning, then I'd have sly shots on the side. I was using about a half gram of smack and coke a day. What I didn't know was that Malina was sleeping with Bob. When I came home from work she'd either say she was tired as she scratched her nose or she'd have a shot of coke and pick her face all night. She was also using more than she let on, too.

Then one day Bob just didn't show up. We rang his phone and it was switched off. We had no money and we were counting on Bob for tick so we sat there sweating for three days. One night we decided to end the cycle. We would go detox in the bush.

When Bob finally showed, he was cold and arrogant and wouldn't say where he'd been. I got the feeling that he'd lost interest in Malina now that she looked so crook. We also owed him thousands of dollars.

That day I went to work and my boss asked to see me at lunchtime. Just before I went to see him I went into the toilet, had a shot and passed out with the needle in my arm. My boss rang the ambos and the cops. I was escorted out.

Bob stopped giving us any freebies or tick and we had no money or jobs, so we hocked everything we owned and sold the rest of our stuff across the road at the local markets. We sold our bed, our clothes, everything. We kept our tent, two sleeping bags and some camping gear.

Malina picked a campsite at Goobang National Park. It would take about six hours by train and then we'd walk the rest of the way.

We made as many preparations as we thought we needed. We packed our fits, smack, Coke, cereal, milk and two-minute noodles into a backpack and set off at dawn. We took a train to Tomingley West station. By the time we arrived the sun was going down.

We walked for about an hour down a rural road to the campsite knowing that we had enough smack and coke to shoot up that night and the next day.

When we got to the campsite it was deserted. We soon realised we were fucked. We didn't have a torch so we had to shoot up in the dark. There was no running water and we'd only brought one bottle with us. There were no toilets, we had no toilet paper. We couldn't be bothered to pitch the tent in the dark so we waited 'til morning. As soon as it was light we had a shot of smack, put up the tent and settled in. I walked back to the train station to get some water and other supplies with the three dollars I had to my name. I took the rest of the drugs with me and left the fits with Malina so we'd both have to wait to have our last shot when I got back. All I managed to get was some water out of a tap in an old bottle.

I don't know how but I lost the smack somewhere. We had a huge fight when I got back. Malina thought I had snorted it but I hadn't. She made me strip and she searched me. Still no smack. So we shot up the last of the coke and it made us feel really sick. We walked

Getting Our Heads Together (cont.)

back and forth to the station looking for the smack but we didn't find it.

The next morning I was so sick, I couldn't move. Malina looked okay. I thought she had found the smack and used it but she said she hadn't. We decided to have some cereal but the milk was off. We couldn't even have the noodles 'cause we didn't have anything to boil the water with. So we just sat there feeling sick, hungry and miserable. We spent the whole day talking about how stupid it had been to come this far away to detox with no meds, no real food and no water. That night was so cold.

The next day I had uncontrollable diarrhoea and was dry retching. My eyes were watery and I couldn't stop yawning and sneezing. We were so desperate we pulled apart our bag and clothes looking for any trace of a rock of any sort of drug that we could ingest, we mixed up water in our old spoons and shot up the watery mix trying to get a hit.

By the fourth day we just lay there all cramped up smelling like death warmed up, we couldn't move even if we wanted to. We hadn't eaten any food, drunk any water or slept for over five days. The next few days just blurred into each other and I felt delirious thinking of ways to get some money so we could go get on. But I came up with nothing.

The only solution now was to wait four days until I got paid.

On the tenth day I woke up. Malina was gone. So was my ATM card.

Was I dreaming? I looked around for her, yelled out her name. Nothing. I got myself together to make the trek back to the train station and decided to leave everything at the camping ground. When I got to the station I found out that there wouldn't be another train 'til the next day. I tried to hitch back to Sydney but nobody would give me a lift. So I cut through a marked bush walk that was supposed to be a short cut back to Parkes but I got lost.

By the time I got back to Sydney I felt better but I still went and got on. I never saw Malina again. Years later, someone told me she OD'd.

Ralf

Illustration: Tony Sawrey

Reunions

The other day I ran into another old friend who like me had become drug dependent in the decade since we had last seen each other. Unfortunately these days, it's not an uncommon story when being reunited with friends.

I left my home town on the mid north coast of NSW straight after finishing high school. I recently returned after spending fifteen years or so around Melbourne and Sydney. The first few years after "fleeing the nest" for the big city were a blur of partying, drugs and alcohol. I also managed somehow to squeeze in a chef's apprenticeship.

Most of my friends experimented with drugs for a while. As time wore on they stopped and settled into "normal life". I went the other way. I pursued drugs with gusto and put anything I could get my hands on into my body. When I found opiates, it was like an epiphany – a defining moment in my life. I had found the perfect drug. Very soon my life revolved around heroin, morphine, doctor shopping and wheeling and dealing to maintain my lifestyle.

Within a couple of years the inevitable reality set in and the game wasn't so fun anymore. I was stuck on the junk merry-go-round and eventually got onto the methadone program. Then reality started to set in, rapidly and harshly. The things in life I had been avoiding with junk suddenly hit me all at once. The effect on my family and few remaining friends, the reputation I had earned for myself, my health – all these things and more I suddenly was forced to deal with.

Once I was stable on the program and sorted myself out enough to become an active member of society I decided to move back up the coast, hopefully to kick the methadone for good. I knew from rumours and the few people in town who still spoke to me that my arrival wasn't going to be a popular occasion, so I was prepared. I didn't get upset when people who had once been good friends crossed the street to avoid me or simply looked at me blankly and walked by. The rednecks shouting "fuckin' junkie!" at me from passing cars didn't bother me. I was expecting all these things. But there was something that I wasn't prepared for, something much sadder, something that hurt me much more.

One day, whilst waiting to be dosed in the public clinic, I recognised two faces in the waiting room. They were the faces of two women who I had gone to school with since kindergarten. They looked so sad and worn, the complete opposite of the happy, innocent girls I remembered from school. Seeing them hit me like a ton of bricks and made me wonder if that was how people saw me these days: sad, broken, just existing, not "living". It really struck home.

I got to talking with them and found that they had their own sad stories: kids taken away, broken families, all the stuff that too often goes with a junk habit. Then one of the girls rattled off a list of half a dozen others in our graduating year who were on the program or affected by drugs in a serious way. It broke my heart to look back and see those people as happy kids playing in a primary school playground without a care in the world, now shooting heroin or slaves to the 'done.

After the initial emotional reaction wore off I did the sums and realised that a relatively large percentage of graduates from my class were users, much larger than the national average. I still run into old classmates who have had struggles with drugs and or alcohol and I wonder just what it is that caused such a drug-addled generation to be. There are all the standard answers about small-town boredom, low socio-economic standing and so on, but I guess when it hits so close to home and becomes personal rather than just being a bunch of statistics on paper, the sadness is so much more profound.

I keep recovering and I know many others who are recovering too, which is great. But I really hope I don't have to keep having these painful reunions.

Luke

Illustration: Caroline Zilinsky

Going Bush

Choosing food for health in rural and remote areas

We need good food to stay healthy. But people who live in rural and remote Australia may have a tougher time putting healthy foods on the table. There is evidence that food prices are higher in rural and remote localities than in urban areas. The high cost and limited availability of healthy food may have negative nutrition and health consequences.

Rural grocery stores are relatively scarce. Much more common are convenience stores, which offer far fewer choices of fresh veggies and fruits. Under such conditions, it's far easier to find a bottle of Coke and a bag of chips than a bunch of fresh carrots.

Access to sufficient quality and quantities of food isn't always easy. People living outside town centres can have greater difficulties accessing transport to a supermarket due to limited public transport (especially if you don't have a car). So all shopping may be restricted to the local food outlets which can be more expensive.

Quick and cheap take-away foods may be tempting, but they often have added fats, sugar, salt and preservatives. On the other hand, cooking your own meal at home has many benefits. By making food at home, you get to control the ingredients and put in what's good for you! Healthy eating is a key building block to your good health.

Here are some practical suggestions for you to improve your own nutrition if you're living in country areas. These tips are also useful for anyone who has limited transport options to access food outlets.

Stocking a healthy food cupboard

Fresh food is great, but it's not always available, and is often expensive in many remote areas. Keeping a supply of different non-perishable foods can be very handy for your quick and healthy meals. Frozen and canned foods are good alternatives as their nutritional quality is very similar to fresh versions, with long shelf lives if stored properly.

You can also buy your items in bulk which will save you money. However don't forget to check the expiry dates and rotate them. Put the newest items in the back and the oldest in the front. Use these ones first.

Here's a list of "essential" pantry and freezer food:

- Dairy products: UHT or powdered milk, UHT custard
- Bread and cereals: breakfast cereals, rice, pasta, instant noodles, couscous, crispbreads, canned spaghetti
- Fruit and vegetables: tinned fruit in juice, frozen fruit or vegetables, canned vegetables (e.g. tinned tomatoes/asparagus/beetroot), canned legumes (e.g. chickpeas, brown lentils, red kidney beans)
- Tinned fish (e.g. tuna/sardines/salmon)
- Herbs and spices
- Canola oil or spray; olive oil
- Dried fruits, nuts and seeds

DIY and save: grow your own

Springtime is seedling time! Having a kitchen garden is a budget-friendly option for getting your year-round supply of colourful produce. All it costs is the price of a few packs of seeds, a bag of potting mix and some tender loving care. Growing your own veggies, herbs and fruits means you can have them fresh on hand to snip and pick whenever you need them.

Here is some info to help get you started.

Where?

You don't need a farm to grow your own food. Work with what you have got. It can be as simple as a few pots, clean food containers or tin cans if you don't have space for a garden. Just make sure there are a few holes in the bottom of the containers for drainage. If you're lucky enough to have a backyard, why not set up your own vegetable patch? An easier option to start is a raised bed or a no-dig garden in a sunny location in your yard or on the patio/verandah.

What to plant?

Start out with veggies that are easy to grow. These include herbs, beetroot, tomatoes, and salad greens like Red Oak lettuce. Different types of vegetables can be planted all year around. Most veggies that grow in a backyard will do well as container plants. Strawberries also can easily grow in a small, hanging container right on your balcony. Speak to your local garden centre for watering and feeding tips to get you going.

No room for a garden? New gardeners?

If you don't have room at home for a garden or simply just want to learn more about gardening, then why not join a community garden? As well as veggies, fruits and herbs, some community gardens also include bush food plants. Community gardens are a great way to get involved in gardening, to grow your own fresh produce, to learn from others and simply to have fun.

Below are a few simple recipes using ingredients from your own fresh produce and pantry.

Couscous and chickpea salad (Serves 4)

This super-quick salad can be served alongside a cooked piece of meat, or on its own for lunch.

Ingredients:

3/4 cup couscous
3/4 cup boiling water or stock
400g can chickpeas, drained
1/4 cup walnuts, toasted
2 tablespoons olive oil
2 cups of any salad greens from your garden
Juice and zest of 1 lemon

What you need:

Chopping board
Knife
Can opener
Bowl
Fork
Plate

What to do:

Mix couscous and lemon zest in a bowl. Pour the boiling water over the couscous. Cover the bowl with a plate and set aside for 5 minutes while you chop the other ingredients and open the can of chickpeas. Remember to rinse and drain the chickpeas to remove some of the salt.

Fluff the couscous with a fork. Add all the other ingredients, toss well to combine.

Parsley and basil pesto (Makes 1 ½-2 cups)

This works great as a dip or a pasta sauce.

Ingredients:

4 cups basil leaves
2 cups flat-leaf parsley leaves
2 cloves garlic
2 tablespoons pine nuts or walnuts
¼ cup grated parmesan
½ cup olive oil

What you need:

Blender
Screw-top jar or air-tight plastic container

What to do:

Place all ingredients except olive oil in a blender and process until smooth. If you have a stick blender, put the ingredients in a tall plastic container and blend. (Tall containers stop splattering!)

Add oil in a slow stream and mix into a smooth paste.

Season with freshly ground black pepper.

Pack into a jar and cover with a thin film of olive oil before sealing, and then refrigerate.

Lia Purnomo

If you would like more information on this or other nutrition issues please contact the Albion Street Nutrition Division for an appointment on 9332 9600, or at the clinic at 150-154 Albion Street, Surry Hills.

Help Lines

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

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

CreditLine
1800 808 488
Financial advice and referral.

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

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

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

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

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

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

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

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: 9206 2166
Health, legal, employment, safety, counseling & education for people working in the sex industry.

Self-help & Complaints

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

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

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

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

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

Women's Information & Referral Service
1800 817 227

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

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

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

Legal Services

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

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

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

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

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

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

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

The Buttery, Bangalow
Ph: (02) 6687 1111

Medical Services

Aboriginal Medical Service, Redfern
(02) 9319 5823

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

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

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

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

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

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

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

Treatment Centres

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

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

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

Hadleigh Lodge, Leura
Ph: (02) 4782 7392

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

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

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

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

Kedesh Phoenix Rehabilitation Unit, Manly
Ph: (02) 422 1800

Lakeview, Belmont
Ph: 4923 2060

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

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

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

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

Nepean Hospital, Penrith
Ph: (02) 4734 1333

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

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

Odyssey House, Minto
Referral: (02) 9603 2157

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Where to Get Fits

NSP Location	Daytime No	Alternative No
Albury	02 – 6058 1800	
Auburn Community Health	02 – 8759 4000	0408 4445 753
Bankstown	02 – 9780 2777	
Ballina	02 – 6686 8977	0428 406 829
Bathurst	02 – 6330 5850	
Bega	02 – 6492 9620	02 – 6492 9125
Blacktown	02 – 9831 4037	
Bowral	02 – 4861 0282	
Byron Bay	02 – 6639 6635	
Camden	02 – 4634 3000	
Campbelltown MMU	02 – 4634 3000	
Canterbury (REPIDU)	02 – 9718 2636	
Caringbah	02 – 9522 1039	0411 404 907
Coffs Harbour	02 – 6656 7934	0408 661 723
Cooma	02 – 6455 3201	
Dubbo	02 – 6885 8999	
Goulburn S.East	02 – 4827 3913	02 4827 3111
Grafton	02 – 6640 2229	
Gosford Hospital	02 – 4320 2753	
Hornsby	02 – 9977 2666	0411 166 671
Ingleburn	02 – 8788 4200	
Katoomba / Blue Mountains	02 – 4782 2133	
Kempsey	02 – 6562 6066	
Kings Cross KRC	02 – 9360 2766	02 – 9357 1299
Lismore	02 – 6622 2222	0417 062 265
Lismore – Shades	02 – 6620 2980	
Liverpool	02 – 9616 4807	
Long Jetty	02 – 4336 7725	
Manly / Northern Beaches	02 – 9977 2666	0412 266 226
Merrylands	02 – 9682 9801	
Moree	02 – 6757 0000	02 – 6757 0222
Moruya	02 – 4474 1561	
Mt Druitt	02 – 9881 1334	
Murwillimbah / Tweed Valley	02 – 6670 9400	0417 062 265

NSP Location	Daytime No	Alternative No
Narellan	02 – 4640 3500	
Narooma	02 – 4476 2344	
Newcastle / Hunter	02 – 4016 4519	0438 928 719
New England North Regional Area (referral service)	0427 851 011	
Nimbin	02 – 6689 1500	
Nowra	02 – 4421 3111	
Orange	02 – 6392 8600	
Parramatta	02 – 9687 5326	
Penrith / St Marys	02 – 4734 3996	
Port Kembla	02 – 4275 1529	0411 408 726
Port Macquarie	02 – 6588 2750	
Queanbeyan	02 – 6298 9233	
Redfern Harm Minimisation Unit	02 – 9395 0400	
Rosemeadow	02 – 4633 4100	
St George	02 – 9113 2943	0412 479 201
St Leonards - Royal Nth Shore	02 – 9462 90404	
Surry Hills - Albion St Centre	02 – 9332 9600	
Surry Hills - ACON	02 – 9206 2052	
Surry Hills - NUAA	02 – 8354 7300	
Sydney CBD	02 – 9382 7440	
Tahmoor (Wollondilly)	02 – 4683 6000	
Tamworth	02 – 6764 8080	0427 851 011
Taree	02 – 6592 9315	
Tumut	02 – 6947 0904	
Tweed Heads	07 – 5506 7556	
Wagga	02 – 6938 6411	
Windsor	02 – 4560 5714	
Woy Woy Hospital	02 – 4344 8472	
Wyong Hospital	02 – 4394 8472	
Wyong Community Centre	02 – 4356 9370	
Yass	02 – 6226 3833	1800 809 423
Young	02 – 6382 8888	

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

EMILY & SAM'S STORY

Emily and Sam didn't start using together. For both that happened years earlier. But their heroin use was the reason for their paths crossing a few years back when they were involved in the same research study. The support they've given each other ever since, both in treatment and in life, has changed everything.

"I guess it started with Sam helping me," remembers Emily of a time when she was suffering through the after-effects of an unsuccessful treatment. **"I was pretty sick and messed up. We were in regular contact through that, just as friends."**

But over time their relationship blossomed. **"We got married last year,"** Sam says smiling, **"And our first child is due in three months."** In what can be a daunting time for any young couple, Sam and Emily are full of optimism, built around the stability of a strong relationship and their successful treatment programs.

Neither is in any doubt of the other's influence. Deep and unconditional support has made all the difference. **"We've both had less understanding partners in the past,"** says Emily. **"It's good to be around someone who doesn't discriminate against you."** Sam agrees and adds, **"In the past, drugs were a sore point, something you just didn't talk about or deal with. We're open about the way we feel, it's a lot less complicated."**

Clearly, their relationship isn't without its challenges. **"You have to be careful not to be competitive in your treatment,"** Emily warns. **"But for us there's no pressure, to come off or reduce or anything like that. We understand each other... we're in a similar place."**

Everyone's story is different.
To know more about opiate dependency treatment options ask your healthcare provider for an Options Pack or visit **www.mytreatmentmychoice.com.au**

NSW USERS & AIDS ASSOCIATION INC

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

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

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

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

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

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

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

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

Name: .....

Address:.....

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

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

Email:.....

Mail Preferences:

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

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

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

Personal Information Statement:

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