JUST SAY NO! TO THE WAR ON DRUGS!
This edition of Junkmail also has several articles on drug law reform including Leah McLeod’s article entitled “What Did You Do in the War, Mummy? Thoughts on Drug Law Reform” which looks in depth at the harms of the “war” and what she thinks may be the answer to this problem.

There are also articles on peer based naloxone distribution programs (will we ever get them here?) and naltrexone implants. And, also can you believe it? Retractable syringes have reared their ugly little heads again. We provide an update on this development.

Once again, I hope you find this edition of Junkmail an interesting and empowering read. I also welcome feedback or suggestions you have on issues you think we should cover in future editions. So, why not drop us a line? We’d love to hear from you.

I’ll finish up by thanking all the dedicated and inspiring people who have contributed to this and past editions of Junkmail, and make a special mention of our graphic designer who has now produced 13 of the last 14 editions of Junkmail, the very talented John Carey. Thanks for all your great work John.

Happy reading everyone. Sam Liebelt.
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The proportion of older Australians being treated for heroin addiction is growing

THE TIMES
JUNE 22ND 2011

The number of Australians receiving treatment for dependence on opioids such as heroin is on the rise and the proportion of older clients is also increasing, according an Australian Institute of Health and Welfare report.

“There was a rise of just over 2,600 clients between 2009 and 2010 which is consistent with the growth of pharmacotherapy treatment we have seen in recent years,” said Amber Jefferson of the AIHW’s Drug Surveys and Services Unit.

“Since 2006, there has been a shift towards older clients receiving treatment, with the proportion of clients aged 30 years and over rising from 72 per cent to 82 per cent and the proportion of clients aged under 30 falling in 2010.”

Meanwhile, a UK report recommends that everyone over the age of 65 be screened for drug and alcohol misuse by their GP to help to treat a growing generation of “invisible addicts”.

While illegal drug use is not common among the over-65s, the report says, increasing use in the 40-something age group means that it will become a serious issue.

Ilan Crome, professor of addiction psychiatry said: “A lack of awareness means that GPs and other healthcare professionals often overlook or discount the signs when someone has a problem.”

Australian illegal drugs among world’s most expensive

MICHAEL DUFFY
THE AGE
17TH JUNE 2011

In June 2011 the Parliamentary Joint Committee on Law Enforcement reported that there is an: “extreme difference between Australian and international drug prices. This difference is likely to make Australia an extremely lucrative target for drug smuggling syndicates.”

For heroin the wholesale price for a kilogram in Britain was typically $US29,569, in America $US71,200, and in Australia a whopping $US221,304.

For ecstasy the wholesale price for 1000 tablets was $US10,000 in the US, $US6468 in Britain, and up to $US25,344 in Australia.

The committee’s report is titled: “The Adequacy of Aviation and Maritime Security Measures to Combat Serious and Organised Crime”. It concludes that security must be improved because there is “significant evidence of infiltration of the aviation and maritime sectors by organised criminal networks”, which “poses a very real threat to Australia”.

Some interesting information was provided in submissions to the inquiry, especially from the Australian Crime Commission. Two things at random:

The annual consumption of cocaine in Sydney and Melbourne is estimated as 3000 kilograms. (Multiply that by say $200,000 - see above - and you get a $600 million industry, at the wholesale level.)

More than 20 criminal networks are involved in the Australian fishing industry, which is vulnerable because fishermen have been under severe financial pressure as their industry declines. Despite the lack of detection, the ACC believes fishing boats and other small craft such as yachts play an important role in drug importation into this country. It expects to see increasing cases of large quantities of drugs dropped off at sea from ships – in some cases weighed down so they rest on the ocean floor - and collected by smaller craft.

Another submission, largely ignored by the committee, was from Lorraine Beyer, a highly experienced researcher of the heroin market. She claims the most important people working in heroin importation remain largely untouched by law enforcement, because they distance themselves from the handling and transportation of drugs. The “successes” by police and customs tend to involve arrests at the “bottom worker role level” of importation. Partly due to this, there is “no evidence showing that current counteraction is working well.”
Drug-using prisoners overwhelmingly support a needle-and-syringe program at Canberra’s jail, according to a harm minimisation group.

Canberra Alliance for Harm Minimisation and Advocacy represents territory drug users and injectors, including those who are incarcerated.

Alliance Manager Nicole Wiggins said her group had interviewed hundreds of former prisoners in focus groups over the past few years, and overwhelmingly found them to support a prison-based needle disposal and exchange program.

The ACT Government has asked Public Health Association of Australia Chief Executive Michael Moore to identify the obstacles involved in getting a needle-and-syringe program up in Canberra.

Mr Moore is due to report to the Government next month, but the plan has been bitterly opposed by the union representing custodial officers at the jail, the Community and Public Sector Union, and the Liberal Party.

On Tuesday The Canberra Times reported that a submission to the inquiry by the ACT Magistrates Court Prisoners Aid counsellor Bill Aldcroft, showed zero support for the proposal among former prisoners.

But Ms Wiggins said the two harm-minimisation bodies were in direct contact with those people who stood to benefit most from an exchange program.

She had conducted focus groups with current and ex-prisoners, specifically addressing the issue of a needle-and-syringe program in the Alexander Maconochie Centre for Mr Moore’s review and most supported the concept.

Drug users could soon be caught out by their own excrement thanks to ground-breaking research techniques being developed and studied by universities in Tasmania and Queensland.

Site-specific waste water analysis is a relatively new science that involves testing sewage to produce an accurate picture of the types and quantities of drugs used by people in a certain area.

Testing waste water from prisons will form a major part of the study, said the lead researcher, Jeremy Prichard, from the University of Tasmania. He predicts the method may be adopted at nightclubs, music festivals and private residences, too.

“Potentially, we could develop a very accurate map of levels of drug use within a particular setting,” he said.

Preliminary data from sewage treatment plants in Queensland municipalities revealed much higher than expected levels of cocaine, “equivalent to amphetamine-type substances”, although the results are yet to be peer-reviewed.

The method could spread to large-scale music events or be used by agencies to gather intelligence in cases of drug consumption or manufacturing.
There are more indigenous young people in jail than at any time since the Royal Commission Into Aboriginal Deaths In Custody 20 years ago.

A parliamentary committee has labelled the situation a “national disgrace” and a failure of all governments.

The committee found the detention rate for indigenous juveniles was 397 per 100,000, which is 28 times higher than the rate for non-indigenous juveniles at 14 per 100,000. Indigenous juveniles account for 59 per cent of the total juvenile population in jail.

The imprisonment rate in the adult indigenous community was just as dire, with a 55 per cent increase in men in prison in the past decade and a 47 per cent rise of women in custody.

The committee has made more than 40 recommendations across every policy area of government to urgently address the issue, saying it was a concern that so little had changed, given increased funding.

“This is a national tragedy, and questions must be raised as to why the situation has worsened so dramatically after the sweeping reforms recommended by the royal commission.”

The royal commission’s report, handed down in April 1991, made 339 recommendations focusing on ways to stop Aborigines going to prison in the first place. The committee found federal, territory and state governments had failed to address the chronic disadvantage in indigenous communities and a lack of co-ordination had not helped the situation. “This is a shameful state of affairs.”

“We must act now before we lose another generation to the criminal justice system,” Mr Gooda said. “Importantly, this report recognises that many of these issues are made worse by a lack of government co-ordination and engagement with Aboriginal and Torres Strait Islander peoples.”

Singapore: drug laws and the death penalty

BY PALASH R. GHOSH
INTERNATIONAL
BUSINESS TIMES
JUNE 22ND 2011

Singapore, one of the world’s most dynamic, energetic and powerful economic engines and financial hubs, is widely admired and envied.

However, the wealthy city-state has a dark underside.

Singapore, like much of Southeast Asia, has very draconian laws, particularly with respect to drug trafficking – for which, a conviction often leads to the death penalty.

For example, any adult (aged 18 or above) convicted of trafficking (or possession for the purpose of trafficking) at least 15 grams of heroin, 30 grams of cocaine or 500 grams of cannabis, faces mandatory execution.

Amnesty International, which has long criticized Singapore for its harsh and unyielding form of criminal justice, estimates that at least 400 people have been executed in the island since 1991, mostly on drug-related convictions.

Thus, given its small population (about 5-million), Singapore has one of the world’s highest rates of executions per capita.

“Death sentences continued to be mandatorily imposed in Singapore, mostly for drug-related offences and mainly against foreign nationals,” Amnesty once said.

Moreover, Singapore has defended its drug policies. During the 2009 session of the UN Human Rights Council, the government said in a statement: “We strongly disagree that States should refrain from using the death penalty in relation to drug-related offenses. The death penalty has deterred major drug syndicates from establishing themselves in Singapore.”

At present, there has been much media focus on Yong Vui Kong, a young Malaysian man who was sentenced to death for drug trafficking in Singapore. Yong has exhausted all appeals and now faces a hanging, despite pleas from his own government.

Australian drug arrest stats reach decade high

BY MARIS BECK AND NICK MCKENZIE
THE CANBERRA TIMES
28TH JUNE, 2011

The number of Australians arrested for drug-related crimes and the numbers of secret speed laboratories detected by police are at a decade high.

But while police are making more arrests, with 85,252 Australians arrested for drugs in 2009-10, the amount of drugs they seized last financial year is 41 per cent less than the year before.
The 2009-10 Australian Crime Commission data to be published today leaves open the possibility that overall drug supply and demand remain largely unaffected by law enforcement.

More people were arrested for heroin use but fewer for heroin production. Slightly more cannabis consumers were arrested, while cannabis provider arrests were flat.

The report also suggests that vast amounts of illicit drugs continue to flow freely over the nation’s borders, a point highlighted last week by a joint parliamentary committee which called for an overhaul of policing of Australia’s ports.

Commission chief executive John Lawler told Fairfax yesterday, “The reality is that illicit drugs are getting into Australia undetected.”

Mexico is still the primary reported source country for cocaine arriving in Australia, but Peru is increasing in prominence.

Mr Lawler said it was hard to draw simple conclusions from the report, but stressed that it underlined the need to continue focusing not only on supply and demand reduction but also on “harm reduction.”

Harm reduction strategies, such as the provision of sterile needles or other public health programs, aim to minimise the effect of drugs on people, families and communities.

Mr Lawler said that the preparedness of some Australians to pay a premium price for drugs meant overseas suppliers would continue to target the domestic market.

“We are a very affluent, wealthy society and we are a society that clearly has an appetite for illicit drugs. That causes huge damage to the community, not only in the context of the cost of law enforcement and border protection but... the cost and impact on the health system.”

Call off the global drug war
BY JIMMY CARTER
THE NEW YORK TIMES
16TH JUNE 2011

In an extraordinary new initiative announced earlier this month, the Global Commission on Drug Policy has made some courageous and profoundly important recommendations in a report on how to bring more effective control over the illicit drug trade. The commission includes the former presidents or prime ministers of five countries, a former Secretary General of the United Nations, human rights leaders, and business and government leaders, including Richard Branson, George P. Shultz and Paul A. Volcker.

The report describes the total failure of the present global anti-drug effort, and in particular America’s “war on drugs,” which was declared 40 years ago today. It notes that the global consumption of opiates has increased 34.5 percent, cocaine 27 percent and cannabis 8.5 percent from 1998 to 2008. Its primary recommendations are to substitute treatment for imprisonment for people who use drugs but do no harm to others, and to concentrate more coordinated international effort on combating violent criminal organizations rather than nonviolent, low-level offenders.

These recommendations are compatible with United States drug policy from three decades ago. In a message to Congress in 1977, I said the country should decriminalize the possession of less than an ounce of marijuana, with a full program of treatment for addicts. I also cautioned against filling our prisons with young people who were no threat to society, and summarized by saying: “Penalties against possession of a drug should not be more damaging to an individual than the use of the drug itself.”

These ideas were widely accepted at the time. But in the 1980’s President Ronald Reagan and Congress began to shift from balanced drug policies, including the treatment and rehabilitation of addicts, toward futile efforts to control drug imports from foreign countries.

This approach entailed an enormous expenditure of resources and the dependence on police and military forces to reduce the foreign cultivation of marijuana, coca and opium poppy and the production of cocaine and heroin. One result has been a terrible escalation in drug-related violence, corruption and gross violations of human rights in a growing number of Latin American countries.

To help such men remain valuable members of society, and to make drug policies more humane and more effective, the American government should support and enact the reforms laid out by the Global Commission on Drug Policy.

Jimmy Carter, the 39th President, is the founder of the Carter Center and the winner of the 2002 Nobel Peace Prize.

To read the full opinion piece visit http://www.nytimes.com/2011/06/17/opinion/17carter.html?_r=2
The ACT is currently moving towards being the first Australia’s jurisdiction to introduce a take home or peer administration of naloxone program. Although at this stage there hasn’t been any funding or other commitments made which would guarantee this program happening, the progress that has been made is extremely positive, so much so that we at CAHMA are confident that this will happen sooner (this year?) rather than later.

Most heroin users would know of naloxone by its brand name Narcan with many having had first-hand experience, either being given it personally or witnessing someone else being given it by ambulance officers in the advent of an overdose. People’s experience with naloxone varies considerably depending on which part of the country you are in. In the ACT for example, naloxone administration by ambulance officers has incorporated an approach which is compassionate and understanding where small amounts are given to bring people around gradually and gently. This small dose is repeated if there is no reaction from the first shot with subsequent smaller shots given until the person responds. Although it should be noted that evidence from international
programs has shown that additional shots of naloxone are the exception rather than the rule. In some places the almost exact opposite happens where the person is immediately given a large dose which wakes them up very suddenly and abruptly and can leave them feeling sick from being in instant withdrawal. This is where naloxone horror stories come from.

The approach used in the ACT helps promote and encourage drug users to ring an ambulance when someone drops rather than the harsh approach where people wake up feeling like crap, which doesn’t help to promote calling an ambulance and gives naloxone a bad name. In a recent conversation about naloxone with an ACT Ambulance officer, he equated the administration of large doses with being fast asleep and someone throwing ice cold water in your face and therefore recognising that most people in this situation would wake up pissed off and not appreciative of the help they have just received.

He also commented on the difficulty experienced in educating some officers moving from other states who unfortunately felt that drug users didn’t deserve patience and understanding and should just be given a large dose to bring them around immediately so they could then move onto the next more ‘deserving’ person. This smaller dose, and subsequent shots if required, is the approach being promoted for the ACT program. It really wouldn’t help with selling the program if drug users had an particularly unpleasant or even painful experience. Some may feel that people should just be appreciative regardless and instant withdrawal is preferable to death, which of course it is. But since we can save lives without having to put people through an extremely unpleasant experience then this is the preferable option.

A very simple solution in managing overdoses and saving lives is to give drug users the tools, i.e. take home naloxone, to manage an overdose themselves. This has been happening around the world for many years and even in the usually conservative and harsh ‘tough on drugs’ environment of the United States there are around 155 programs operating with these US programs dispensing 53,339 naloxone kits with 10,194 overdose reversals reported1. That’s a lot of people who are still alive thanks to quick action being able to be taken by their peers to save them.

Around the world there are numerous programs, that have been operating for many years, and all of these have shown very positive results and without adverse events2. Amongst the concerns raised about naloxone programs is that opioid injectors will use larger amounts of drugs if they know naloxone is available to save their lives. This hasn’t happened with international programs and most heroin and opioid users would agree that using larger amounts with the risk of being given naloxone is not a desirable option.

CAHMA has developed a proposal for a peer administration of naloxone program that would involve peer educators providing overdose training to heroin and other opioid injectors, their families, friends and health professionals, or as this group is now being collectively called; Potential Overdose Witnesses.

On completion of this training, participants will be given their own take home naloxone. The CAHMA proposal received widespread support and has resulted in the formation of an expert advisory committee; ENAACT or Enhancing Naloxone Availability in the ACT, that is working toward progressing the aim of wider availability of naloxone. This group has representatives from a range of stakeholder that include general practitioners, researchers, pharmacists, ambulance officers, ACT Health, ATODA (ACT AOD peak body), drug user organisation reps (CAHMA) and drug users.

ENAACT is working towards developing a detailed plan of implementation, operation and evaluation of an ACT program and is exploring issues such as legal implications, specific details of training, strategies to work with the current shortage of naloxone (yes, strange but true) addressing any safety concerns, details around evaluation and importantly gaining funding.

For the first two years we are looking at training 200 potential overdose witnesses who on completion of the training would be given take home naloxone. Three priority populations will be targeted for the program, these being: Indigenous opioid injectors, recently released prisoners and other opioid injectors. These priority populations have been identified through a large body of evidence showing elevated risk of overdose death for these groups.

The training program will cover a comprehensive range of topics that include:

- Routes of administration and dosing guidelines for naloxone;
- Risk factors and prevention of overdose;
- Signs and symptoms for the early recognition of opiate overdose;
- Prevention of choking and aspiration in the unconscious patient;
- Techniques for rescue breathing;
- BBV risk and universal precautions;
- Protocols for follow up care; and
- Protocols for replacement doses.
One important point on this proposal is that it would be a program and not a trial as there is already ample overseas evidence into the efficacy of such programs deeming a trial unnecessary. Of course the program would include a comprehensive evaluation component that will seek to answer two research questions:

1. Can naloxone be used appropriately in a non-medical setting; and

2. Does naloxone administration result in successful reversal of overdose.

Although the answers to these may seem very obvious, especially with the plethora of international evidence, gathering Australian evidence is very important to assist in gaining support for expanding and increasing other Australian initiatives.

This program, if and when it happens (our optimistic view is yes it will happen) will be an Australian first contributing to saving lives and importantly sending a stronger message that drug users lives are worth saving and that as a community, drug users are able to look after ourselves if only given the opportunity. Of all the interventions that are considered controversial or particularly progressive it is really very safe with very little room for negative outcomes.

Naloxone has no value in the drug market other than as an overdose reversal drug therefore it’s administration to someone not intoxicated with opioids causes no harm or reaction. As a pure opioid antagonist its only pharmacological effect is the reversal of opioids therefore it is extremely safe if ingested by children or if given to a person who isn’t under the influence of opioids. It’s very cheap, around $12 a dose and is administered by injection into muscle, a task any heroin injector could do with their eyes closed (not recommended). This really raises the question of why we haven’t already got such programs?

At the moment it is a “watch this space” situation. CAHMA is very keen, ready, willing and able to get this program happening. We believe it brings us a step closer to other harm reduction initiatives such as heroin programs and/or NSP in prison by showing the general community that care and compassion, and evidence based approaches, are desirable options when dealing with illicit drug use. Sending the right messages that drug users lives are important, that the government does care about the drug using community and when given the opportunity drug users are able to be proactive players in reducing drug related harms and increasing their well being.

This has been demonstrated with needle and syringe programs, where given the necessary tools we have worked together as a community to reduce and prevent the spread of hepatitis C and HIV. So being given take home naloxone we will as a community reduce the number of overdoses resulting in the death of our children, brothers, sisters, mothers, fathers, friends and neighbours.

Opioid overdose is a major cause of preventable death among heroin and other opioid users. Death from overdose rarely occurs within minutes of use and in fact typically occurs many minutes or even up to an hour or more, after use. In many cases other people are present at the overdose. This means there is plenty of time and opportunity for those present to intervene and save a person’s life. Naloxone has been used routinely for decades in emergency treatment of opioid overdose by ambulance officers and by staff in hospital emergency rooms. Now it is the time to expand access and make this drug widely available to drug using peers and other potential overdose witnesses. The life saved by this intervention could be someone you love, your family member, your friend or even yours!

References

1 Building Capacity in Overdose Prevention Symposium: Increasing community access to naloxone to prevent opioid overdose deaths: lessons for Australia held at the National Conference of the Australasian Professional Society on Alcohol and Other Drugs (APSAD) 2010; 1 December 2010; Canberra.


A few weeks later, one of Lillian’s friends who had been with her when she died – we’ll call her Carmen – came upon a training that was taking place on a street corner. As it turned out, a group of outreach workers from the local syringe exchange program were teaching people about the proper way to respond to a heroin overdose, so she joined in. After only a brief visit with the physician in the group, Carmen was handed a kit with two doses of naloxone, the antidote to heroin overdose, and she knew how to use it.

Just one month later Carmen’s husband was released from prison, where he had neither used heroin nor received methadone. Shortly after returning home, he began using heroin again.

Carmen found him – he was unconscious and turning blue. Then, she remembered her naloxone kit and this time, she was able to save a life.

Grassroots Public Health

In the United States (and in much of the world) anyone at risk of an overdose can receive a prescription for naloxone, however that prescription doesn’t always allow the recipient to administer his or her own naloxone to someone else who may be dying. Nevertheless, this did not stop the development of community-based naloxone distribution programs to drug users. The Chicago Recovery Alliance (CRA), a syringe exchange program in Chicago was the first to distribute naloxone in 1997, with services later ramped up in 2000. Dan Bigg, CRA’s Director, explains that “it was not out of brilliance but out of necessity.” CRA was losing so many exchange participants...
to overdose that they did not wait for legal approval – they just started distribution of naloxone. Various other states and cities followed CRA’s lead through pilot projects, legislation and underground programs. In New York City, harm reduction advocates observed these developments and started their own pilot project. Soon thereafter, the Injection Drug Users Health Alliance (IDUHA) – a coalition of needle syringe programs – successfully lobbied the New York City Council for dedicated funding to provide overdose prevention education and to distribute naloxone throughout the City. For several years leading up to this point, legislation had been proposed in New York to allow for the distribution of naloxone but none had passed. I believe that the rapidly developing programs throughout the City and nationwide pushed this legislation ahead. Just as underground syringe exchange had pushed New York State to legalize syringe exchange, it was time to once again push the envelope with another life saving initiative.

In 2005 the Harm Reduction Coalition hired a physician to develop the program and to actually prescribe naloxone at the IDUHA syringe exchange programs and thus the project began in earnest. At the same time, allies at the New York State Department of Health (NYSDOH) were working to build broader support. Overdose prevention strategies that included naloxone distribution were presented to Medical Societies and to the Offices of Alcohol and Substance Abuse Services with success in gaining support.

**Legislation**

In 2005 legislation passed that would take effect in 2006 allowing for non-medical individuals to carry and use naloxone as first aid under the condition that they have been trained by and received the naloxone from an authorized prescriber (in the US physicians are not the only medical personnel able to prescribe medications). This legislation was important because it allowed the person who had been trained as an overdose responder and received naloxone freedom from liability. The NYSDOH AIDS Institute was given charge over the program as the Institute has been overseeing harm reduction services since 1992. The NYSDOH agreed to purchase intramuscular naloxone while the New York City Department of Health agreed to purchase intranasal naloxone. (Remember the United States is one of few countries with no national health insurance so this support is a phenomenal asset to the program!).

**Expansion**

This legislation allowed overdose prevention to expand from the needle syringe programs to a wider array of programs serving opioid users including drug treatment programs, homeless shelters, HIV service providers, and, we hope, eventually to jails and prisons. Both the Offices of Alcohol and Substance Abuse Services and the New York Society of Addiction Medicine have promoted the initiative.

“...This legislation allowed overdose prevention to expand from the needle syringe programs to a wider array of programs...”

At the time of this writing there are over 60 programs registered to provide overdose prevention with naloxone across New York State. That said - it hasn’t been easy. The kits, as well as technical assistance to implement the program, are free and there are sample policies and procedures and a training curriculum available; however, service agencies have many obligations and funds are scarce. Even when there is great enthusiasm to implement an overdose prevention program, there is no new funding so it is easy for required programs to get stalled before starting up.

**The Training**

The overdose prevention and response training can be done in as little as 5-10 minutes, or it can be part of a longer group session that may discuss overdose experiences and losses that so many users have had.

The basic components of the training include:

- **Risk factors for overdose:**
  - Mixing drugs - especially mixing other sedatives but even mixing stimulants such as cocaine seem to increase the risk of death.
  - Reduced tolerance - using after a period of abstinence such as while incarcerated or in drug treatment.
  - Using alone - this doesn’t increase the risk of overdose however it does increase the risk of dying if overdose occurs.
- **Overdose recognition**
- **Actions**
  - Call Emergency services - even if naloxone is administered it is still
important to call emergency services

- Rescue breathing - sometimes we use a dummy in the training to demonstrate.
- Naloxone administration - each trainee gets a hands-on demonstration using the kit.

**Challenges (and some solutions)**

Naloxone is, by US federal regulation, a prescription medication, thus under NYS law each person trained must have a face to face encounter with a physician (or other authorized prescriber) in order to receive a kit. As licensed prescribers are expensive to hire and tend to stay in their offices, this requirement is limiting in many settings. Several localities, for example the state of Massachusetts, have addressed this barrier by allowing for “standing orders” wherein a certified nonmedical trainer is authorized by a physician to dispense naloxone.

Some physicians fear liability in the case of a medication being used on someone for whom it was not prescribed. In response to this concern, recent legislation in some states, for example Connecticut, also provides protection for the prescriber.

“...He remembered that his naloxone kit was in his car he retrieved the kit, and revived his friend...”

A further note on the issue of liability: a lawyer named Scott Burris has noted that at some point in the near future, when we have more data on the vast number of lives saved by community based naloxone distribution, the question of liability will no longer lie with the physician or program who does provide naloxone – but rather with those that do not. Although Burris is a strong advocate for harm reduction, it is notable that this thought has been raised in far more conservative, abstinence based programs as well.

Another challenge is that some drug treatment programs have expressed the concern that distribution of naloxone “sends the wrong message” – for example that it suggests that their patients will relapse. Well, aside from the pragmatic fact that many people do use again after treatment, we also remind these programs that a drug user can’t prevent his or her own overdose with naloxone, but rather it is a tool to save others. Training a person in treatment to use naloxone “sends the message” that s/he is trusted and equipped to save a life – a powerful statement to someone who has entered treatment because they no longer feel in control of their own life.

**Where We Are Now: A national overview**

As of August 2010 there are 163 providers of community-based naloxone ranging from underground programs to those coordinated by state health departments. The programs have distributed over 50,000 naloxone kits and over 10,000 overdoses have been reversed. Of course not all identified overdoses would have resulted in death, but even if just one in 10 would have, it would suggest that at least 1,000 deaths have been prevented. Furthermore, even nonfatal overdoses can result in prolonged hospitalization and loss of function due to lack of oxygen to the brain. Timely administration of naloxone restores respiration, so it is highly likely that these programs have also prevented hospitalizations and preserved the long-term health of many overdose victims.

**Saving Lives**

A physician at one of the first 28-day drug rehabilitation programs to adopt naloxone distribution has been especially enthusiastic about the program. In most settings, medical staff only prescribe the naloxone while non-medical staff take on the more time-consuming work of providing the training. However, this physician has chosen to offer a weekly group on overdose prevention himself. Within the first few weeks of implementing the program, a new patient said - “oh the blue bag [referring to the naloxone kit], a friend used that on me 2 weeks ago, so I survived to get here.” More recently the doctor saw a returning patient, George who had also received naloxone training. George explained that after receiving the training he was using heroin with a companion who overdosed. He remembered that his naloxone kit was in his car he retrieved the kit, and revived his friend. Although his friend was angry about losing his high and hasn’t spoken to George since, George is deeply gratified to have saved a life and has since re-entered treatment. The physician is also gratified and has been a great role model for other drug treatment programs implementing naloxone distribution.
**Definition:** Retractable syringe: /ˌrɪtræktəbəl ˈsɜːrɪndʒ/ n. 1. injecting instrument marketed as the answer to unsafe disposal/community disposal/thousands of syringes which litter Australia’s beaches and footpaths. Also claimed as the answer to sharing and re-use of syringes. 2. See also ‘the answer to everything’…

**Reality:** Studies show that less than 1% of syringes dispensed are disposed of unsafely. The majority of retractable syringes require the user to manually engage the mechanism to allow retraction to occur. Users have been known to disengage the retraction mechanism. Additionally, as the retraction is manually engaged, users can choose to not engage and subsequently re-use or share.

**Problem:** Retracting a syringe outside of the body/vein can cause blood splatter. **Solution:** Let’s tell users to retract (engage retraction mechanism) while still in the body. Outcome: unless you know that retraction has occurred users might believe that the needle tip was still in the body. Retraction of the needle tip can be jarring—sufficient to cause scarring, tearing and vein damage.

Some quotes from a small sample of recent users in relation to retractable syringes range from those unhappy with the devise: “didn’t jack back and the spring popped out”, “all my blood splattered everywhere”, “shit goes everywhere” and “needle fell off”, to the slightly more positive responses; “have friends who have to keep jacking them back…. think they’re great”, “took them back to the pharmacy” and “liked it, missus didn’t”.

**Potted History of Retractable Syringes:** the last time these were mentioned in this magazine was over 5 years ago when it was reported that the pilots (there’s always a pilot – just never sufficient aeroplanes) were stopped by the then Howard Government (maybe they’re air-traffic control) due to concerns with (among other things) blood splatter and the associated risk of blood borne virus (BBV) transmission.

**Current Day:** So why are we belabouring the issue? “They’re Here!” Recently retractable syringes have been popping up in a number of Queensland’s pharmacies with a smaller number found in Victoria. While they can sometimes be appropriate for use in clinical settings, retractable syringes and illicit injecting drug use occurs in a very different context.

A number of national and state based organisations have been working (tirelessly I might add) to address the issue on a variety of levels: working with the TGA, ministerial group, education for users, focus groups, survey of users, worker questionnaires, etc. All with a view to having the issues of BBV transmission risk and vein damage raised in relation to retractable syringes and more importantly, proper Australian Standards lodged for the use of retractable syringes, for both now and in the future. I for one do not want to go through this process again in five years’ time.

You can help, if you’ve been in contact with a retractable syringe, have your say, complete the online survey at: [http://aivl.org.au/#p=294](http://aivl.org.au/#p=294)

To see the difference between retractable and standard syringes visit AIVL’s website at: [http://aivl.org.au/#p=238](http://aivl.org.au/#p=238)
Last week, an old friend of mine made the morning news. I dressed for work before images of her attending court for defrauding the Victorian bush fire appeal. In her 50s now, this smart, funny, attractive woman with loads of life force and lots going for her is about to start her third custodial sentence.

The news report was keen to tell viewers that it was a relationship with heroin that was behind the theft — labelled worse than robbing the poor-box — and hard to tell which was more ‘un-Australian’, crime or the drug use.

What did you do in the war, Mummy?

Thoughts on drug law reform ... By Leah Mcleod
It only needed a five line script over the image of my friend entering the courthouse to push home the accepted wisdom that heroin only ever leads to trouble. Heroin has been personified with a Force 10 ability to change people; it attracts criminals and nice girls alike, and makes them indistinguishable in the prison yard.

Prohibition has been marketed as the intuitive solution to saving people from themselves for around 100 years now. A money pit of a failed policy, prohibition has been responsible for most of the chaos, ruining incalculable lives all around the world.

Regardless of how people come to habitual drug-taking, by route of fun pushed hard or life management, it is mostly not the glory ride to hell that the middle class media finds titillating. Prohibition forces a slow isolation for most, a marginalisation that starts out quiet, that pulls to the side each time you have to hide what you are, each time you have to break the rules to make your life work and each time the consequences catch up with you. 'Til you don't respect the rules of the society that spurns you. 'Til there you are, fiddling while Victoria burns or up a Queensland creek without a paddle, detached from social conscience and fighting for your life.

And we are fighting for survival. We are in a war, the “War on Drugs” that the US President Richard Nixon declared at a press conference on June 17, 1971, when he named drug abuse(rs) as “public enemy number one”. Nixon gave a national organisation and swollen drug squads the task of subverting the poor and the black with the born-again crime: drug use as an act against society. Nixon found that prohibition is political viagra, and a succession of incompetent politicians has championed the policy, along with a tough on crime agenda, each time they feel threatened.

These drug laws have hardly done the job the public is hoodwinked into thinking it does. Since Nixon got on the job, the purity of street drugs has increased, to make them more compact and easier to smuggle. The price has decreased to garner more customers, and drugs have become easier to get, even for kids. (And yet the profit margin remains stellar; it is estimated that a seizure rate of 60-80% is needed to put a successful trafficker out of business). Production is up. The truth is that drug use has increased, not decreased under prohibition. And here we go: Prisons are burgeoning. Corruption is entrenched.

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There is no quality control so there are overdoses in one part of town and baby laxative next door. And the trillions of dollars generated don't end up in the hands of farmers, mules, or users, or runners, or even user-dealers. Prohibition only serves the very powerful: mafia-like organisations, triads, corrupt governments. Prohibition funds wars and inhumanity.

Something else prohibition does quite nicely is keep the stereotype of the druggie and junkie alive and in a brain near you...”

There is no denying this must be redressed. By any key performance indicator, law enforcement has failed to meet its targets of reduction in drug use. Remember the UN’s slogan “a drug free world by 2008 – we can do it!”? The billions of dollars spent on supply reduction have clearly been wasted, while other funding yields much better results. For example, for every $1 spent on methadone, $7 is saved from other parts of the public purse, yet it is estimated that as many as 33.5 million users worldwide would like to be on a substitution program but can't get access.

Fortunately, all around the world there are loads of current and former doctors, judges, police, professors and politicians from all parties including presidents and prime ministers, who agree that we need to open up drug laws and policies to a “green fields” approach. This would mean tearing down everything we’ve already got, looking at the evidence and including all stakeholders in building new laws and policies that will actually do the job everyone agrees needs to be done.

One of the strongest arguments denying drug law reform sits in the universally
held idea that prohibition protects society from the dangers of drugs and therefore anything less than a total ban would invite entropy of epic proportions. This fear is not borne out in evidence. Forays into decriminalisation have not been accompanied by spikes in drug use. Portugal has shown a very slight increase in casual drug use but a decrease in problematic drug use. A look at cannabis markets in Amsterdam (decriminalized) vs San Francisco (criminalized) found very similar profiles in each group of users in terms of age, frequency of use and career use.

Our ABC TV’s Hungry Beast funded a survey to complement their interview with Norm Stamper, when he came to Australia in 2009 representing Law Enforcement Against Prohibition (LEAP). Among other things, Australians were asked what they thought would happen if illegal drugs were decriminalized. Only 3% of people said they would personally use drugs more often; however, 62% said they thought others would. And for the virgins, when asked whether they would try drugs at all, 5% said they personally would, but 66% thought others would. It seems that everyone thinks they can be trusted with drugs, but no one else can.

In fact, an end to prohibition could see greater regulation than now. Like the alcohol and tobacco industries, we could see buyer restrictions such as age limits, mandatory safety and health warnings, price control through taxation and compulsory use monitoring to promote moderate use (à la the Northern Territory alcohol register for Indigenous people).

There are a number of models of drug law reform that have been put up for discussion by various organisations. UK drug law reform organisation Transform (the group responsible for the “NICE People Take Drugs” campaign) produced a document in 2009 called “Blueprint for Regulation” which looks at the pros and cons of five options from open market to prescription, pharmacy sales, licensed sales and licensed premises. It considers how production, availability and products could be controlled, how vendors and users could be monitored, whether different drugs should be treated differently.

It is time for users to decide where we stand. It’s no secret that I would love to slip into a discreet and stylish shop and, leaning girlishly against the display counter, order a gram of Burmese white from an attentive assistant. I have friends who see a crisp pharma-

emporium, sun-kissed firm-calved attendants, gleaming glass and stainless steel; but my taste runs more towards the gothic. Velvet screened privacy booths, twelve armed candelabra for those who like to cook, take-home packs beribboned and sealed with stamped wax. If this is drug law reform, I’ll take the buy-one-get-one-free pack.

For me, the open market is the gold standard. Anything less is compromise. I know this for sure: in any other market, a regular customer would be king. However, even the broadest thinking reformist knows that an open, free market for all drugs is not politically viable in the short-term, even with a swag of conservative economists on our side.

But, just like harm reduction’s “never let the best be the enemy of the good”, we need to focus on what might be workable. When Ethan Nadelmann from US organisation Drug Policy Alliance was in Australia last year, he spoke a lot about the “sweet spot”, that policy point somewhere between an open market and prohibition that will find general acceptability by all stakeholders. We users need to find just where we sit in that continuum. What we will accept, what is good enough, what we can support.

I would suggest that a good starting point is to see all drug consumption decriminalised. We need to have restored our personal rights so that police must apply for individual warrants to search our bodies or cars or premises: no dogs, no “just cause”. We need to be able to use safely, free of blood borne viruses with reliable hardware and supervised vein care. We need to also decriminalise drug supply and bring it into the mainstream so we can get some regulation – so we know what we are buying and can choose the level of purity or product fusion that we want.

We need to be paying a reasonable cost; in the case of heroin and cocaine this would be commensurate to a plant based medication that is well out of copyright. We need to be able to identify as users without being harassed, imprisoned or forced into treatment. And we need to be able to get treatment on request if we so choose.

Underpinning the model likely to garner most appeal is a policy and funding shift from the justice agenda to health. The billions of dollars spent ruining the lives of users have to be dispersed in a better way, no doubt. However, a shift to a health agenda may mean agreeing to commit even further to pathologising our drug use and relying on doctors to make decisions about our lives. Whether we want to get on board a policy that has as its foundation the belief that career drug use is a “health problem”, a disability, some kind of flaw, is something we as users need to seriously think about. What good if we gain a world and lose our souls? Since the dawn of time, people have been taking mind and mood altering substances to enhance their lives, but
drug use has only been medicalised since psychiatry weighed in at the end of the 1800’s. Only today I read a journal article that started “Addiction is a debilitating psychiatric disorder…” It is this idea of drug dependency as a disease that was ultimately responsible for the onset of prohibition in the first place, in the US in the 1910’s. No matter that centuries of drug use underpin contemporary civilization, cultivating magnificent adventures in science, technics, medicine, art, literature, politics, spirituality and love.

As a kid, I remember seeing an episode of a popular TV show that depicted a deaf couple who had a deaf child. They were given a medical opportunity for the child to hear, but deliberated on the basis that they were part of deaf culture and they didn’t see deafness as a disability. At the time I thought they were idiots, but I get it now. While being a user is hard work, frustrating, exhausting and often disappointing, it is central to my identity and self-perception. While I like the control over my drug-taking that methadone gives me in the current market, I don’t want to be “cured”. I want to be accepted. I would much prefer to be able to use heroin everyday than be on methadone, to be able to buy my product from a licensed shop for a reasonable price and without prejudice, than be on a medical program.

I am junkie, hear me roar. Out and owning it. I long to see a footballer or politician’s husband, on being caught with drugs, refuse to beg forgiveness. I am junkie, hear me roar. Out and owning it. I long to see a footballer or politician’s husband, on being caught with drugs, refuse to beg forgiveness. I feel we must back any chance to provoke sympathy and understanding change the laws in such a way that will be part of any hope for drug law reform in the next decade or two. A likely approach would put decisions in the hands of doctors, supported by the health department, much like the way methadone or oxycontin operates. Medicinal cannabis might be the first step. We might perhaps be offered some sort of heroin on prescription programme much as we were promised 20 years ago but on demand rather than for the small percentage of “stubborn” users originally targeted. Dexamphetamine on prescription might also be on offer.

Given that we already struggle with the methadone program and the processes around prescription opioids, this model does not guarantee the best outcomes for users. But it would be a propitious step forward. Our hopes for an open market model might lie in cannabis, given its wider use and general acceptability. Cannabis on demand, say in bottle shops or mimicking Amsterdam’s cafe system, would most likely be controlled by a public health approach, much like the current treatment of tobacco. This could set the precedent of a workable model for other drugs on demand down the track.

In the US, sixteen states now have medical cannabis. California’s Proposition 19 which put cannabis legalisation to the vote failed by only a slim margin (53.5% voted no, 46.5% voted yes). Portugal and the Netherlands have taken the lead on decriminalisation and seven countries have heroin on prescription. In 2009, UN Secretary-General Ban Ki-Moon made a public statement supporting decriminalization with a treatment twist. This year, US President Obama said that drug legalization was an “entirely legitimate topic for debate”. Drug law...
The launch of AIVL’s new online NSP Directory and Legal Guide.

The NSP Directory is the first Australian state and territory listing of NSP services. The listing provides information on the contact details, location and hours of operation. Users can use the link to Google maps which will make finding locations easier particularly for those that are travelling and/or who are unfamiliar with areas.

Those that are unfamiliar with NSP related laws will also find a link to the Legal Guide which contains state and territory legislation relating to NSPs, for example the carrying of syringes and syringe disposal. This Directory and Guide, the first of its kind in Australia, has been developed to be expanded and updated as services and legislation changes.

The Legal Guide is a reference to NSP and drug related laws for people who inject drugs across each state and territory in Australia. It provides access to information such as possession of needles & syringes and other paraphernalia, disposing of used equipment, rights relating to police questioning, illicit drugs and sex work, etc.

To access this new site visit: nspandlegal.aivl.org.au

reform is now a mainstream concept and it is time for users to take control of shaping our future.

Only when we have a free market will we be able to prove our case that most problems associated with drugs are caused by prohibition. In the meantime, we should support any measure that represents improvement in the lives of drug users around the world. If we focus on those things that connect us with the mainstream, rather than those that separate us, if human rights are the priority, then we can’t fail.

“...Only when we have a free market will we be able to prove our case that most problems associated with drugs are caused by prohibition...”
We all use drugs, but only some of us are labelled drug users

Articles about ‘drug use’ are a regular feature of newspapers in contemporary Australia. On the 23rd of October 2002 for instance, the Melbourne Herald Sun had an article titled “Cobain’s cruel return to drugs” while the Weekend Australian (26-27/1/02) had an article titled “plan to detain addicts.” Both these articles presented a picture of drug use we all recognise. Kurt Cobain the singer of Seattle band Nirvana we learn, had a “problem”: he was “hooked on drugs.” The writer describes Cobain “kicking” his “drug habit” only to “relapse”: “the tortured singer was back on the drug.” The second article concerns an initiative being considered by the Victorian Bracks’ government under which: “teenage drug addicts would be detained and forced to undergo rehabilitation.”

If you ask a person in the street what do they think about drug use, the conception above and the language used, is what you are likely to hear in response. Drug use is something done by “drug users” or “drug addicts”; they become “hooked” or “addicted” to dangerous “addictive” drugs, and live in a personal hell until they...
either die or go into treatment where they detoxify and are rehabilitated.

However, a careful reading of our newspapers will demonstrate that the term “drug” is also used in relation to an entirely different type of drug use, namely, “pharmaceutical” or “therapeutic” drug use. For instance: “drug treatments offer MS sufferers a new lease of life” in the Weekend Australian (13-14/9/03, p.3). With this type of drug use we are told about “sufferers” and the search for “more effective” drugs. We learn about how hard a sufferer’s life is and how the drug “improves [their] quality of life.” This type of drug use involves “patients” being given drugs by doctors to “treat” “disease” and “illness”. The drug use transforms a life of hell into one where the person is able to live life to the full.

Clearly these two forms of drug use appear to be mirror images of each other. One is said to cause suffering while the other is said to relieve suffering. However, they are not the only forms of drug use presented in our newspapers. There is also what is described as “drug cheating”: the use of “banned” drugs to enhance performance in a sporting contest. Then there is the occasional article on the use of drugs by “primitive people” for the purpose of communicating with the spirit world. (The Age, 28-3-02, p.8)

There are also two other forms of drug use which can be distinguished from the other four by how rarely the term “drug” is used. These are: herbal substance use, which is often contrasted favourably with “pharmaceutical drug” use, and, legal (nonmedical) substance use, involving the use of four substances that appear to stand alone, each considered unique in its own right: alcohol, tobacco, coffee and tea. All together it is possible to identify six dimensions of drug use:

- Illegal drug use;
- Medical or therapeutic drug use;
- Legal substance use (alcohol, tobacco, coffee and tea);
- Performance enhancement drug use;
- Spiritual or shamanistic drug use;
- Herbal substance use;

The argument I would like to put forward in this essay is that the first three listed form the key components of a symbolic drug classification system; symbolic because despite statements to the contrary, it is only in the smallest degree based upon pharmacology. All of these dimensions are presented to, and understood by, a majority of Australians to constitute fundamentally different and separate areas of social life.

If we can understand how these dimensions have been constructed, it is my contention that we will be able to deepen our shared understanding, not just of the nature and extent of drug use in Australian society, but also how the policy of legal drug prohibition that we have inherited is constructed. This in turn will assist those of us working towards drug policy and law reform to better understand the challenge we face. For what I believe is, that this classification structure that incorporates and separates all drug use is empowered by fears, not just of the risks and harms associated with drug use, but with more general fears of disorder, crime, chaos. The six dimensions identified above can best be grasped in diagrammatic form: See Diagram 1 above.
As the above diagram suggests, the key to the symbolic classification of drug use are two binary distinctions, one between medical and non-medical drug use, and the other between morally acceptable and morally unacceptable drug use. Figuring out where these two distinctions came from and how they became institutionalised in legislation and consciousness is a historical question. In his 1993 book from “Mr Sin To Mr Big”, Desmond Manderson traces the history of Australian drug legislation and early on he makes the observation that:

“... A hundred years ago, legislative structures and social attitudes relating to drugs were radically different from those now in place. Their use was left to individual choice, rather than being subject to strict medical control or even prohibited by law. The lines between medical and non-medical use, or between use and abuse, now so clear and bright, were indistinctly drawn. The addict was defined as neither diseased nor evil, and the label was not yet a way of pigeon-holing a whole person.” (1993: 10)

The precise steps by which the distinctions between medical and non-medical use, and between legal and illegal drugs, became solidified, are beyond the scope of this essay. What we can say is that between 1880 and 1910 both distinctions found acceptance and both became enshrined within federal and state laws. Further, this legislative classification took on a taken-for-granted-beyond-question status and included a belief that the distinctions were, and are, based upon empirically measurable pharmacological differences. What were perceived to be different dimensions of drug taking behaviour became understood as empirically measured classes of drugs.

The truth of this view is known by anyone who has tried to convince a confirmed prohibitionist that the reasons why certain drugs were legally prohibited, and others not, were political, racial and social rather than pharmacological. What has amazed many of us who do not accept the prohibitionist view, is how resistant this belief is in the essential dangerousness of certain drugs is, and how evidence and rational debate seems so powerless to affect a change. This is a question we need to answer if drug policy and law reform is to make progress.

One way of approaching this is to explore how the three major dimensions of drug use behaviour have taken on the status of pharmacological classes of drugs. This shift from behaviour to objects was, and is, mediated through the idea of identities: doctors, pharmacists and patients; publicans, retailers, drinkers and smokers; and drug dealers, drug users and drug addicts. The important thing to note is that the last three operate as what sociologists call ‘a primary label’. The first seven identities when applied, do not erase other aspects of the person, their character, talents and activities. The last three do.

We are used to talking about “theories of addiction” but what we often fail to recognise is that they are more accurately described as addiction theories of drug use, for what they do is explain the outcome of drug use. At its most simplistic it is a belief that drug use (read illegal and addictive) leads to, or causes, addiction. This belief is based upon what Craig Reinarman and Harry Levine have called ‘pharmacological determinism’. Pharmacological determinism, they write, is the belief that the effect and outcome of drug use is caused by the pharmacological properties of substances alone, independently of individual psychological differences or social context. [Reinarman and Levine, 1997: 8]

This belief provides the ballast and justification for perceiving the three dimensions of drug use behaviour as classes of drugs. For instance financial crime committed by heroin dependent people is understood as being caused exclusively by the pharmacological properties of heroin. If you think about it, we all apply this model to therapeutic or medical drug use: we expect them to work independently of individual personality, social class or cultural context. However we do not apply pharmacological determinism to the four legal (nonmedical) substances. With these four we apply a Zinbergian model, usually called the drug, set, setting model, which states that the outcome of drug use is always the result of an interaction between the drug’s chemistry, the individual’s psychological make up, experience and expectations, and, the social (and legal) context in which the drug use occurs.

Drug law and policy reformers of course see no reason why this model does not apply to all non-medical drug use, whether illegal or legal, and even medical drug use if we think about it. The question is: why is there this belief that the Zinbergian model applies to legal (nonmedical) drugs while the pharmacological determination model applies to illegal drugs?

This is not a question I feel currently capable of
answering in any depth. ‘Ignorance’ is not the answer because even the presentation of evidence can often have no effect. It goes deeper. On the one hand we can say that all drug use is dangerous because to interact so directly with our internal chemistry is always unpredictable and risky. On the other hand we can observe how widespread the phenomenon of labelling drugs as too dangerous for nonmedical use has been.

The ancient romans were so concerned about the use of alcohol they banned woman from using it. The newly institutionalised christian church sought to prohibit the use of a psychoactive substance used by an ancient fertility cults in Rome around 186 CE. Islam rejected all intoxicants (in theory anyway) in the 7th century CE, and tobacco was prohibited in a variety of european countries between 1600 and 1700. The chinese tried to prohibit opium importation and use in 19th Century and the biggest social movement of the 19th Century in America, England and Australia, was the temperance movement, which sought, in complete contradiction to its name, to prohibit alcohol use. In summary, there has probably never been a time when nonmedical drug use has not been an emotionally charged and highly contested issue.

At the same time alcohol, cannabis, coca, peyote, tobacco, magic mushrooms and soma (whatever it was) were all used as religious sacraments and understood as gifts from, or the flesh of, gods. Just as importantly, distilled alcohol, tobacco, cannabis, opium and derivatives, coca and cocaine, amphetamine, benzodiazepines, mdma, lsd were all first used as therapeutic drugs.

These observations alert us to why the symbolic classes we have inherited are protected so fiercely. Firstly, because drug use has always been understood as an important social issue. Secondly, because religious institutions have always recognised the drugs we would call psychoactive, to be connected to gods (and devils). Thirdly, because the distinguishing pharmacological differences between good and bad, medical and nonmedical, drugs are so minor or nonexistent, the legal and symbolic distinctions are protected so fiercely.

When we understand that drug use is an ancient and important human technology, that it is intimately tied up with religious and spiritual values and practices, and that all drugs are capable of causing benefit and harm, it becomes clear that the challenges faced by drug law and policy reformers are far greater than simply presenting the “facts” and replacing ignorance with knowledge. Drug use is tied up with human consciousness and meaning. Further, drugs and their use have regularly been used as markers of, and explanations for, threats to social order. Therefore the question becomes not how to change ignorance into knowledge but how to challenge a centuries old ingrained use of drugs to manage fears on an individual and social level.

I shall conclude this essay by listing the implications of this approach to drug use for those committed to drug law and policy reform. Before I do though, I would like to stress that I see this approach as just a beginning. I do not present this approach, nor the suggestions below, as the model, but rather, hopefully, pointers to possible avenues.

- We have inherited a symbolic classification system that embraces all drugs and substances used by humans. The term ‘prohibition’ brackets out the majority of drug use in our society and fails to identify the intimate connection between drugs used for medical purposes and those (often the same ones) that are used for nonmedical purposes.

- This classification system is animated by two issues: a recognition that all drug use is risky, and, the need of all societies to protect themselves from chaos, disorder and harm.

- We all use drugs, but only some of us are labelled drug users. Thus, while arguing for the acceptance of the use of currently illegal drugs for nonmedical purposes, we also need to address the real extent and nature of drug use within our society, for currently, people who use illegal drugs are being scapegoated for something all australians do, but are in denial about.

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Once upon a time in a land far, far away... Nah! Just joking. I always wanted to start a story like that.

A few years ago I was doing a stretch as a guest of the Aussie government. 5 Years on the top with 3 on the bottom. I was a bit over 2 years into my stay and I'd finally been given a C2 security classification and had the chance to get moved to a really good prison with better facilities that was much closer to my kids. This was a big deal to me as I hadn't received many visits in all the time previous. For anybody who has done any time you would know how much this means to be able to see your family and for those of you who haven't I still think you can get the general idea. The feelings of separation and isolation are exaggerated and reinforced when you're missing the ones you care about so the idea of that changing even a little bit was very exciting. But if there was one thing I'd learned during this time was not to get my hopes up as they had a tendency to get crushed.

At this stage I was in Cessnock Gaol in lovely rural nsw. Cessnock was a working prison and you were expected to work from Monday to Friday in one of the prison industries and weekends were for visits. Shit! Those bloody weekends used to drag on and on. I had a pretty interesting job as a carpenter working on demountable classrooms. You know those classrooms you got at every school that would be brought in on the back of trucks in sections and set up for students to use when the school started to get overcrowded.

Well strange as it may seem the contract for the refurbishment and upkeep of those buildings was and is still held by Corrective Services Industries otherwise known as CSI.

But here's the interesting thing. During the Sydney Olympic Games it was our job at Cessnock Gaol to turn all those classrooms into portable living spaces for athletes attending the games. We turned them into bedrooms, bathrooms, kitchens and lounge rooms that were all shipped to the athlete's village at Homebush and put together down there by outside contractors.

A few of us suggested that it would be better if they, the screws that is, should just take us down to Homebush to put them together seen as though we were the experts on how they all went together and such...Strangely they wouldn't be in it..Don't know why... Ha-Ha.

At the end of the games they were all sent back up to be turned back into classrooms. During the build up to the start of the games it was all really hectic as we tried to keep up with the demand of the quota of buildings that needed to be finished and shipped daily that they started running double shifts in the workshop. Talk about earning good money over that period. I was on the top rate of gaol pay which was...Wait for it...$1.30 per hour. No shit $1.30. Yet I was still earning over $100 a week into my gaol account.

The average rate of pay in prison is between 0.60 To 0.90 Cents an
hour. Nothing like good old slave labour, hey? But anyway, I digress. My point is that with so much to keep us occupied during the week, there wasn't much time to sit around feeling sorry for ourselves except on weekends.

Sitting around watching all your mates get called for visits and even pricks that you wouldn't give the time of day were getting visits and the hours would just drag on. I actually used to look forward to getting locked in my cell on those days just to get them over and done with.

The only fun part was waiting for your mates to get back from visits and see if any of them were lucky enough to get a drop from there visitors so we could all get stoned that night when we were locked in. Although trying to find half decent fits to use was another nightmare that deserves its own telling at another time.

I met some really good people during my time, and yes plenty of arseholes too. But a couple of the guys and I became really close friends. There was Richie, a musical genius who also happened to have a pretty big heroin habit on the outside. Kiriaxos or Kiri to his friends who was a cocaine importer from Chile. Bruno and Michel were both from France and both had been picked up for drug importation charges.

All of us had met early on in our sentences and no matter where we got sent we managed to stay in touch with each other. We started playing music with each other on battered acoustic guitars in Cessnock and even put on a show for the prison with some borrowed electric guitars and a p.a. system brought in by the music teacher.

There was a crappy old drum set there as well in a back storeroom which we were able to bring back to life with some borrowed drum skins and a set of drumsticks made for us from some boys in the cabinet shop. They cost us a few tailor made ciggies I can tell you.

Our drummer was this huge guy from Papua New Guinea called Jeremias Ohello. No shit. Jerry had done 14 years so far at this stage for murder. The first 7 years he did was just about all in segregation in chains because he attacked and assaulted so many screws. It would be fair to say that he had a lot of respect from the inmates and I can safely say that having Jerry as my friend probably helped me out a few times.

Anyway Richie, Kiri, Bruno, Michel and I all made a pact that we would try our hardest to get classified to John Moroney Prison in Windsor as they had a kick arse music program with a recording studio. We all had to jump through some hoops to get there but with 8 months to go on my sentence I finally got to Windsor and I was the last one of our group to get there.

Meeting up with the boys when I got there is difficult to describe. I mean I was just so happy to see my friends again that I sort of didn’t mind that I was still in gaol; if that doesn't sound too weird. Windsor was definitely the easiest prison that I had been to and it was while at Windsor that I had the moment that I was talking about at the start of this tale.

All of us were by this stage on our C3 classification which allowed us to seek employment outside of the gaol on a work release program. I had been studying a fair bit during my incarceration and applied to do some coursework at the University of Western Sydney in music management.

This was approved by the powers that be, so I was promptly fitted with an electronic monitoring device around my ankle and was let out into the world to attend classes.

I was also receiving visits on a fortnightly basis from my kids and I could start to imagine a life outside of gaol in the not too distant future. All the other boys were either working or studying as well and we were all playing music together as much as we could. The next major step was being moved into the honour house which was a unit just outside of the main gates on the prison grounds.

We were all still subject to searches on return to the prison each day and fairly regular urinalysis to make sure we were all still behaving ourselves. We were, but we decided to have one evening of playing up just to break it up for us.

It was Richie's birthday coming up so we decided to have a private little party for ourselves. As we were all going out each day we needed to bring back supplies for our party over the period of a week and somehow get them into the unit without getting busted. Bruno and Michel worked in a large delicatessen so they handled getting the cheeses, salamis, fruits and other smallgoods. Kiri was in charge of procuring the party drugs we wished to take as he had the contraband mobile phone, and my job was to get the birthday cake and whatever else I deemed appropriate and could get in.

This turned out to be 2 bottles of a good red wine and the biggest baked cheese cake from

Continued on page 25
One Person’s Experience of Naltrexone Implants

I had been using on and off (mainly heroin, but also methamphetamine to a lesser degree) for quite a while and had managed to keep my use to a level where I could both afford it and go without it if I had to. As time passed gradually my use had gone from weekend use, to “long” weekend use (logically this included Thursdays and Mondays), then to “afternoon” use (again, I thought not a problem if I could restrict to arvos only), and after this to morning, lunch and dinner use... I found working full time I could keep this going for a while with my income, but obviously after a bit it was all I could afford i.e. no rent, bills, food etc. I knew I couldn’t maintain my habit for too much longer without losing my job, house etc. but I was also in an awkward situation with work as I thought coming out as an injecting drug user would also cost me my employment – or at the very least lead to unfavorable treatment by my employers in the drug and alcohol sector.

I’d thought about going onto a methadone or bupe program, but the main concern I had with that was having to pick up daily... both from people I knew and/or had worked with – I worried that it wouldn’t take long for word to get around and to lose my job as
a result. A close friend of mine at the time had previously had numerous Naltrexone Implants that suited her, she told me a bit about them and the rest I looked into myself on the internet. After this I managed to rationalize that it would be a chance for me to not use for 3-6mths after which I could start using again but just try and limit to the weekends (Hmmm!), I’d also be able to keep my job. While I knew a fair bit about the Implants and effects etc., I knew nothing about the archaic way they actually do the procedures to insert them and the general shitty treatment you get - I was probably naive about it all, and definitely underestimated how much not using/injecting would affect me.

When I initially called the clinic (where I live in Perth) to enquire more about the Naltrexone implants I was told that no information could be given to me over the phone and that I would have to make an appointment to discuss the implants. I made a few appointments and backed out and then ended up finally going to one, when I attended the appointment I was asked to give my history of drug use and mental health, I told them how much I was using but that I couldn’t maintain that habit...blah, blah, the usual.

The lady I saw was an absolute cretin; rude and condescending, she started telling me things like “your life is hopeless...you’re going no-where” and this continued. I remember arguing with her heaps, not because I had changed my mind but that she had such single minded warped views on drug use and more so drug users. After telling her where I worked and who I worked with she attacked my employers for the ‘perceived’ irresponsible stance they took on drug use and drug users (this being harm minimisation as opposed to abstinence only).

I was also told that given my working/educational background in the AOD (alcohol and other drugs) field I should have known better and was “incredibly stupid” for using illicit drugs.

I was then told in this appointment how much the Naltrexone implant would cost; $5,000, and was given an extremely brief explanation of the surgery process. I enquired as to what would happen if I needed to have the implant removed and was told that only if there was a very serious health problem would the implant be removed and this would have to be done by a hospital (I didn’t know then that in the majority of cases hospitals will refuse to remove implants, preferring you to get them removed where the initial surgery took place).

So many things pissed me off during the appointment; they never spoke of any other options for people other than abstinence...”

When I returned to the clinic three weeks later for the Naltrexone implant surgery I took two friends with me as I was told in my prior appointment that I would be unable to drive myself home after having the implant done (I was not told that I would need any other specific care other than this). I booked in and filled in a form with my personal details, bank details, and carers numbers, after this I was told that it was a very quick process whereby I would meet briefly with a nurse and then the doctor would commence with the implant surgery.

After about an hour’s time I was taken through to a nurse who asked me if I had used any drugs (specifically opiates) that morning, to which I replied ‘yes’ id had a large shot immediately before leaving to go to the clinic (who wouldn’t?). The nurse I spoke to stated that this would make the rapid detox a lot more unpleasant
than normal and then I was asked to sign consent to continue with the surgery (informed consent—hardly). After signing the consent form the attending nurse handed me a cup with a few pills—I wasn’t told what they were, but assumed they were benzos; I was completely fucked so didn’t really care.

When taken into surgery, the doctor was present, 2 work experience students, and a nurse; my friends were also allowed to be present. Immediately a very large tube with multiple drugs inside it was intravenously administered to me, however I was never at any time told what the specific contents were and had started to feel very drowsy due to the benzos the nurse had given to me prior to this. While my memory after this became a bit fuzzy I specifically remember the doctor repeatedly asking (and encouraging me) to change my mind and have more than 6 months worth of implants fitted. I repeatedly had to refuse, and had also asked my friend who was standing next to me to advocate on my behalf regarding this as I had heard from numerous people that this Dr had tried to talk patients into having more implants fitted whilst under surgery.

Immediately after the implant was fitted I was released into my friends care to be taken home. As very little of the after-effects of the rapid detox were explained to me I was pretty unprepared for how ill I would become nor the level of care I would need. When I left the surgery I couldn’t walk and it took both of my friends to carry me to the car, they had realised that due to how ill I was I would need full time care for the time being and called my parents (who were aware of me having the implant) to take me back to their house and detox.

While I accept that the Naltrexone implants work in the sense that you can’t use heroin with them active, there are massive drawbacks. Without being able to use I just craved gear constantly, I started to get really depressed and basically started injecting anything I could get my hands on—from heroin to speed and benzos...yay!, heaps better off now! The treatment methods were horrendous and glossed over by employees, I don’t think I could ever recommend anyone ever get one unless they were absolutely sure of the process and really wanted to stop using (i.e. were prepared to keep getting them!).

As the months passed by Id occasionally try some gear here and there just in case I’d lucked out and the implant stopped working, I never got that lucky but I was desperate to be able to use again. I found after about 5 months I could use but had to use a lot it just eventually wears off and you (well I did anyways) end up where you started, the inevitable happened and I ended up on bupe when it ran out anyways.

There’s not heaps of things I regret but obviously wouldn’t go there again. Whenever I have had the opportunity I’ve tried to warn people of the problems with implants (of which there are many!). I still think its mind blowing that there is so little regulation, and research around implants and more so clinical practices.

Sadly it seems under the guise of “helping” people doing ‘gods’ work, more and more money gets thrown at these people. In the meantime the majority of people on opiate substitution treatments pay a small fortune (money they don’t have) for medications that should be subsidized.

"...I was never at any time told what the specific contents were and had started to feel very drowsy due to the benzos the nurse had given to me...

"...When I left the surgery I couldn’t walk and it took both of my friends to carry me to the car..."
The launch of AIVL’s new online NSP Directory and Legal Guide. The NSP Directory is the first Australian state and territory listing of NSP services.

The listing provides information on the contact details, location and hours of operation. Users can use the link to Google maps which will make finding locations easier particularly for those that are travelling and/or who are unfamiliar with areas.

Those that are unfamiliar with NSP related laws will also find a link to the Legal Guide which contains state and territory legislation relating to NSPs, for example the carrying of syringes and syringe disposal. This Directory and Guide, the first of its kind in Australia, has been developed to be expanded and updated as services and legislation changes.

The Legal Guide is a reference to NSP and drug related laws for people who inject drugs across each state and territory in Australia. It provides access to information such as possession of needles & syringes and other paraphernalia, disposing of used equipment, rights relating to police questioning, illicit drugs and sex work, etc.

To access this new site visit: nspandlegal.aivl.org.au
Many ask, “Why all the fuss about Naltrexone Implants, they work for so many people — what’s wrong with having them as another treatment choice for people experiencing dependency on opiates?” Adversely, even more are asking; how can a treatment not approved for use in opiate dependency, without TGA approval and limited peer reviewed research (compared to other pharmacotherapies), be allowed to be used for over 10 years - with government funding no-less?

In this article we will scratch the surface and try to tease out some of the major issues surrounding Naltrexone implants, and put forth a balanced argument so that you can make up your own mind, rather than just following the hard line of ‘Naltrexone Implants are BAD or GOOD!!!!’

**What is Naltrexone?**

Naltrexone is an opioid antagonist, which works by blocking the effects of opiates at the opioid receptor site; it is also used in the treatment of alcohol dependence. Methadone is an opioid agonist which binds to the opioid receptor and causes an opiate effect like sedation, lowered respiratory rate, and reduced pupil size. While some opiate dependant people take methadone to stop them going through withdrawal, naltrexone is used to stop people from getting any effect, or high from opiates and therefore becoming dependant to it. If a dependant person wishes to utilise Naltrexone as a treatment, they must first be withdrawn off opiates, either through traditional detox, or more commonly rapid detox.

There are two types of naltrexone treatment available, one is in the form of a tablet taken daily, and the other more controversial type, is what is known as a Naltrexone Implant. Naltrexone Implants are tubes filled with Naltrexone then implanted under the skin around the pubic area. The difference between these two is that if a person on naltrexone tablets forgets, or just stops taking the tablets, they are then able to take an opiate (like heroin), and get an effect from it. However Naltrexone implants create a continuous release of Naltrexone into the blood stream for up to 6 months (or longer depending on how many you get implanted) therefore blocking any opiates from working.
Many people who have heard of Naltrexone implants as a treatment for opiate dependency find themselves sitting on one of two sides, they either consider them the golden bullet of opiate dependency treatment (better than methadone and buprenorphine) or they consider them an unethical, non-evidence based treatment that needs to be halted immediately until the proper processes are completed and the effectiveness of the implants independently studied and verified.

**Key Issues for and against Naltrexone implants?**

A key reason people support Naltrexone implants is that unlike traditional drug treatments such as methadone and buprenorphine, naltrexone implants don’t require people to visit a chemist, or self-administer a medication on a daily basis. People go and get the implant inserted, and for the next 6 months or so, are unable to get any effect from opiates. This removes the “choice” of the individual to drop out of treatment or to ‘use’ on top of treatment which some might do on methadone or bupe. Some might also believe they are also less conspicuous than daily dosing at a chemist or clinic so there’s less chance of being exposed as a ‘drug user’ to others including family members, friends, co-workers, and so on. It is also not uncommon for some people to repeatedly go back, every 6 months and have another implant inserted, or get more than one inserted at a time.

On the flipside of what seems like a great way to ensure people dependant on opiates comply with treatment, don’t use opiates and hopefully are able to begin living a life free from drug dependency, there is, as with most things, negative aspect to this treatment and the way it is currently administered in Australia. For example, It is universally recognised in the drug treatment field, that many people with a history of drug use relapse after a period of not using and as the naltrexone implant wears off, this leaves the person with a reduced tolerance to opiates, much less than when they were dependant and therefore at high risk of overdose and death. One study suggested that patients exiting naltrexone implant treatment at 6 months were 8 times more likely to overdose than your average street heroin user (that’s a staggering figure). This is in complete contrast to the other treatments for opiate dependency; methadone and buprenorphine which have been shown to protect people on these treatments from overdose.

Another area of concern with naltrexone implants is that they are currently not registered, or approved for use in opiate treatment in Australia (or any other use for that matter) and have passed none of the standard government (TGA) and scientific requirements that are set up to protect health consumers in Australia.

These requirements generally ensure medical and health products that people use in Australia have rigorous scientific evidence to show they are effective, do what they are meant to do, and don’t aggravate any existing conditions. Even your basic insulin syringe is required to go through these processes before it can be supplied to diabetics in Australia, yet Naltrexone implants have yet to pass these requirements.

It is often argued that no other group in society would be allowed to utilise an un-registered medical product, yet for some reason, heroin and other opiate users are exempt from this requirement.

As you can see there are very complex issues at play when discussing the merits and ethics involved in the use of Naltrexone implants for opiate dependency. Stories and reports from the people that matter, drug users who have been through Naltrexone Implant treatment, are as varied as the views expressed by professionals.

While this article only provides a snapshot of what Naltrexone implants are and are not, and lays out some of the reasons for and against, it is in no way an exhaustive list of issues and does not in any way delve deep into this very complex and often heated area of debate amongst people in the drug and alcohol sector. I hope it does give you some insight into this yet to be approved treatment for opiate dependency; however I would urge anyone considering undergoing any treatment for opiate dependency to first speak with a representative from your state/territory based drug user group. They can provide you with an unbiased and educated run down of the various treatments available and help you in deciding what is best for you as an individual. No one treatment is suitable for everyone, and choice is important.

*Contacts for your nearest drug user group are on the back inside cover.*

There’s a story about how I stumbled across this book, wandering around the Hamra District of Beirut during the 2011 International Harm Reduction Conference. But that would be wasting time - I can’t wait to tell you about this fantastic book!

Basically, what you get with “500 Essential Cult Books” is a synopsis and review of 500 different ‘cult’ books, complete with cover illustrations. The covers alone make this book worth picking up. The authors waste little time explaining ‘cult’ and the rationale for their selections – a short intro and you’re into the main material. The book is broken up into ten chapters, or genres if you like. In addition to what are called ‘cult classics’, chapters include: sci-fi/fantasy; thrillers; rebellious voices; outcasts and loners; and sex, drugs & taboo busting in a chapter called ‘Walk On The Wild Side’. For each chapter a top ten is given, plus a range of additional books – the ‘best of the rest’ as they’re called. And it’s not all fiction either – “Barack Obama’s Dreams From My Father: A Story of Race” and “Inheritance as well as Adolf Hitler’s Mein Kampf” are both included in the “Real Lives” chapter.

I’m absolutely loving this book – the joy of remembering or re-discovering books I read and loved in my teens and early twenties – like Luke Rhinehart’s “The Diceman”, or Ray Bradbury’s “Fahrenheit 451”. So many books I’d happily read again (such as Joseph Heller’s “Catch 22” or the, for me timeless, “Candide” by Voltaire). There’s also the joy of being reminded of books (and authors) I always meant to read, but haven’t ever quite managed to, such as Ayn Rand’s “Atlas Shrugged”, William Powell’s “The Anarchist’s Cookbook” and the wonderful J. G. Ballard. Books I reckon I might just get my hands on. And then there are the books I’ve heard of, but never quite checked out, and of course a great many books I’ve never even heard of before.

The beauty of this book is in the format – the short synopses and reviews that jog the memory or pique your interest, along with at least one cover illustration for each book (and often two or more) are great. For the impatient, or merely curious, the reference section provides both a title index and an author index. As I’ve browsed the chapters, I’ve found myself counting how many ‘top tens’ I’ve read, and also thinking about whether the authors got it right or missed the mark.

But what makes a ‘cult’ book? According to McKinnon and Holland, a cult book must ‘speak’ to the reader in ways that transcend being “merely liked, or even loved” – they have to “inspire a fierce, unquestioning devotion”. Accordingly, “recommendability” and “covetousness” are also important ingredients in a cult book. And, cult books are often those texts that caught the imagination when you were young and have stayed with you forever, embedded as a kind of “emotional literary baggage you won’t ever lose and wouldn’t want to”. Well, that might be stretching it perhaps, but I think you get the point, and if you find any such books (as I did) in this collection, you’ll see what they’re getting at.

I just know, after 500 Essential Cult Books, I can’t wait to get my hands on another in the series, 500 “Essential Cult Movies”, by Jennifer Elms.

5 fits – full of the purest china white
(Dear Ed: sorry, I couldn’t help myself)
Everyone has their own list of favourite drug songs and here is my Top 50 (the ones that have come to mind at least). Music played a really important role when I was growing up and songs about drugs certainly piqued my interest. As the late comedian Bill Hicks said, without drugs your music collection would be “really fucking boring!!”

50. Marilyn Manson: “I Don’t Like the Drugs (But the Drugs Like Me)” (1999)


45. Elton John: “Rocket Man” (1972)

44. The Powder Monkeys: “Get the Girl Straight” (1997)

43. My Bloody Valentine: “Soon” (1990)

42. 13th Floor Elevators: “Roller Coaster” (1966)


40. Donovan: “Hurdy Gurdy Man” (1968)


48. The Rolling Stones: “Mothers Little Helper” (1966)

37. Funkadelic: “Maggot Brain” (1971)
36. Tim Hardin: “Red Balloon” (1967)
34. The Ramones: “I Wanna Be Sedated” (1980)
29. The Tubes: “White Punks on Dope” (1975)
15. The Only Ones: “Another Girl, Another Planet” (1978)
the Cheesecake Shop. I bought an extra half cheesecake to bribe the honour house screw with and he turned a blind eye to the fact I had this massive cheesecake box sticking out of my backpack. As the screw opened the main door for me to be admitted to the unit I had to put my backpack down on the ground as he handed me the box of cheesecake that I had just given him when quite clearly you could hear the wine bottles clink on the concrete.

There was this moment where everything just stopped as we looked at each other and I’m waiting for my world to come crashing down. Suddenly the screw says rather loudly “the weather sure has been a bitch today, you’d better get inside. Goodnight mr ________.” I couldn’t believe it and when the boys heard about it; neither could they.

That night we had a nice shot of gear with brand new equipment, a couple of glasses of red wine. A beautiful lamb cutlet stew made to a traditional french recipe and some luscious cheese and fruit to compliment the baked cheesecake for dessert.

We had all this while we were sitting looking out of bars towards civilisation. Good food, good friends and a feeling of satisfaction and I know just for that moment, just at that time, none of us wished to be anywhere else.

| 7. Jimi Hendrix Experience: “Purple Haze” (1967) |

| 5. Lou Reed: “Perfect Day” (1972) |
| 4. The Velvet Underground: “I’m Waiting for the Man” (1967) |
| 3. The Rolling Stones: “Sister Morphine” (1971) |
| 1. The Velvet Underground: “Heroin” (1967) |

continued from page 25
Would you like to help with Hepatitis C Research?

You can if you have been recently infected with Hep C

Research Study

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

The National Centre in HIV Epidemiology and Clinical Research (NCHECR) is running a hepatitis C study for patients who have acquired hepatitis C recently (in the last 2 years). ATAHC II aims to explore the best treatment strategy for patients with recently acquired hepatitis C infection. You can choose to receive treatment or not if you decide to help.

There are clinics participating in the study in Sydney, Melbourne, Brisbane & Adelaide. Contact Barbara Yeung at the national Centre in HIV Epidemiology and Clinical Research on 02- 9385 0879 or byeung@nchecr.unsw.edu.au of your nearest sites or to find out more about the study.

The study has been approved by the St Vincent’s Hospital Human Research Ethics Committee.
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<td>Australian Injecting &amp; Illicit Drug Users League</td>
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<td><strong>WASUA</strong></td>
<td>WA Substance Users Assoc.</td>
</tr>
<tr>
<td></td>
<td>519 Murray St</td>
</tr>
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<td></td>
<td>Perth</td>
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<td></td>
<td>WA 6000</td>
</tr>
<tr>
<td>POSTAL</td>
<td>PO Box 7083</td>
</tr>
<tr>
<td>PHONE</td>
<td>(08) 9321 2877</td>
</tr>
<tr>
<td>FAX</td>
<td>(08) 9321 4377</td>
</tr>
<tr>
<td>E-MAIL</td>
<td><a href="mailto:info@wasua.com.au">info@wasua.com.au</a></td>
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<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
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<tbody>
<tr>
<td><strong>NUAA</strong></td>
<td>NSW Users &amp; AIDS Assoc.</td>
</tr>
<tr>
<td></td>
<td>345 Crown St</td>
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<td></td>
<td>Surry Hills</td>
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<td>POSTAL</td>
<td>NSW 2010</td>
</tr>
<tr>
<td>PHONE</td>
<td>(02) 8354 7300</td>
</tr>
<tr>
<td>FAX</td>
<td>(02) 8354 7350</td>
</tr>
<tr>
<td>E-MAIL</td>
<td><a href="mailto:admin@nuaa.org.au">admin@nuaa.org.au</a></td>
</tr>
<tr>
<td>Web</td>
<td><a href="http://www.nuaa.org.au">www.nuaa.org.au</a></td>
</tr>
</tbody>
</table>
OUR C-CIETY

DRUG USERS AND PEOPLE ON ‘DONE OR BUPE’

ARE YOU ON OR THINKING ABOUT HEPATITIS C TREATMENT?

THEN THIS CONFIDENTIAL SITE IS FOR YOU

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