

Insight Newsletter AUGUST/SEPTEMBER 2003

Insight is a six weekly newsletter for **Family Drug Support** distributed to subscribers.

Contributions to Insight do not necessarily reflect the opinions of Family Drug Support or its Committee.

August - September 2003

Drug Action Week Family Forum & Expo

A Volunteer's Perspective

The venue for the Family Forum and Expo was great. The atmosphere was safe and calm, unexpected in the confines of an RSL Club•unexpected for me at least. Thank you to the management and staff of Burwood RSL for their generous support of our fast growing FDS. The organisation of the day, so obviously efficient, was appreciated by all, thanks mainly to Bruna, who has taken the worry of this type from the shoulders of Tony and Sandra.

What a fabulous opportunity to gather information from the impressive people who know their associations and the needs they are meeting with an awareness and caring that is so prevalent in this area of community, help and service.

The responses by the expert speakers to the parent panel produced very mixed feelings in me. I was most impressed with Alexandra Hodgekiss (Presbyterian Ladies College Public Speaking Team Captain), her plea for education ringing alarm bells in my head and hopefully in many others. For so long, no information, let alone education, was available.

For me, FDS five years ago was the beginning of my education and information on how to cope with illegal drug use in the family, although my introduction to this was in excess of 20 years ago through a family member using illegal drugs. I feel that nothing much has changed in all those years with regards to parental education in drug awareness. Are we so complacent that we feel we don't need to know? Are we afraid of this type of knowledge, in case we have to use it? Or, do we only want to know if drugs are affecting our lives? (That was me many years ago). Are we not acknowledging that drugs are here to stay? Like alcohol and cigarettes, drugs are available to anyone with the money to buy them, regardless of age, gender or laws.

The shame and stigma attached to drug use is still the biggest barrier to people seeking drug education. When this judging of peoples' choices is removed, education would go ahead and safety procedures put in place for safer drug use, not a road everyone wants to travel. From many years of parenting and grand parenting plus five years on the FDS telephone lines; really listening to peoples' needs, I have come to learn that education and information are very necessary priorities for all the community. If we are going to continue saving lives and preventing accidents through drug abuse, let's acknowledge drug use and prevent drug abuse.

The Ashfield Youth Theatre had it exactly right, so why aren't we listening? New ground, new thinking, please acknowledge our kids' needs, help them to make some better choices. Alexandra Hodgekiss knows that honest education is the way.

The beautiful parents who so unconditionally share theirs and their children's experiences so that we can all learn from them have my heartfelt thanks and total admiration.

Within FDS and on the telephone lines, this sharing of experiences not only helps alleviate heartaches galore, it enriches us all and strengthens resolves to try to change things for the better. The stories told on the day were heartbreaking and encouraging, sad and happy, ugly and beautiful. Illegal and legal drug abuse teaches all involved how complex every individual case is, how desperate we parents become in the search for information and knowledge to help us understand the complexities of personality, health issues and legalities facing the drug user and their families and even prison•issues which were so poignantly told by Judy in her son's story. Thanks Judy, you're a star.

During his speech, the Reverend Bill Crews touched on adversity. We know we grow in adversity depending on how we deal with situations and circumstances, but adversity comes in all shapes and sizes and, with current attitudes and laws, drugs in families is a very hard place to be. Therefore we, as parents who try to support our beloved children who succumb to the multi-billion dollar drug industry, know how we have grown in adversity.

I really want to say the day was a fantastic success, information and support for one an all, my bag of info was full, thanks a million Sandra, Tony, Bruna and Rose. One of my reasons for attending the Forum was to make contact with old and trusted friends, what an opportunity to grow and nurture myself and others, but alas time flies on these occasions and feeling disoriented at the fleeting and rushed words with these dear people involved with FDS, my disappointment at not actuating my real feelings was a let down. But I now look forward to Mulgoa, so watch out dear friends, I want to chat, chat and chat. *MF*

Insights Out

I am writing this on the balcony at Shellharbour. Sandra and I are having a Saturday break after talking at three forums here yesterday.

It's been a busy week of travelling and talking, with meetings at Coffs Harbour, Grafton, Casino, Lismore and the South Coast•and at the time of writing this, I am preparing for a trip to Hobart for four days. A lot of the talks I do are organised and sponsored by Community Drug Action Teams (CDAT). This is a great initiative to get local communities addressing local drug issues. CDAT teams operate in most areas of NSW and several of them have FDS members on board. Anyone (in NSW) interested in joining a CDAT please ring our office on (02) 9798 0001 and we will put you in touch with your local team.

This month, I have been involved with several other individuals and organisations in an effort to save a valuable service•the Drug Intervention Service Cabramatta (DISC). This has been a beneficial and wide-ranging service, which has particularly helped marginalised groups in the area. It is being closed without much community consultation or communication. The fight to preserve DISC, and all the valuable services that it provided for Cabramatta, has been taken up by a broad number of individuals and non-government organisations, and we have formed a group called the `2166 Drug Services Coalition.'

Our highly successful Family Expo and Forum as part of Drug Action Week 2003 was due to the efforts of staff, volunteers and especially those family members who told their incredible personal stories.

The next major event on our calendar will be the Alcohol Summit at NSW Parliament House in the last week of August. We are inviting FDS members to an evening at Ashfield on Tuesday 12 August at 7pm to put together an FDS submission to this very important event. I have real issues regarding the targeting of teenagers by the liquor industry with the proliferation of soft drink flavoured but high alcohol drinks. Binge drinking by teenagers is one of the most common predictors of future problematic drug use and is on the increase thanks to these products. Please come along and be part of this discussion.

Our telephone service is taking more calls than ever. We now have two lines and need more volunteers. If you are available for the training on Saturday 16 August and Sunday 17 August, we would be very happy to have you on board.

Look forward to seeing many of you at Mulgoa. Until next time, take care.

TT

Drug Action Week • Family Forum & Expo

Bruna Paci

Drug Action Week is a national week of activities to raise awareness about alcohol and other drug issues and promote the achievement of those who work to reduce drug-related harm, sponsored by the Alcohol and Other Drugs Council of Australia (ADCA).

This year's Drug Action Week had a theme day for Family and Communities • a perfect opportunity for Family Drug Support to bring greater education and information to the community.

As a relatively new member to the team, organising the event appeared a daunting task to me. Despite Tony's constant assurances that everything would turn out fine, I endured endless sleepless nights worrying about the smallest details. I should have let Tony's confidence guide me.

The commitment, dedication and enthusiasm I encountered from every individual and organisation, professional and parent panel member whom I approached about being involved was encouraging to say the least. It proved to be yet another indication of the calibre of people with whom I have the greatest pleasure of working and associating.

Everyone from the staff at Burwood RSL Club to the volunteers who so generously provided the delectable goodies, to the speakers, and even the audience, were tremendous. Without all involved the event could not have come close to the being the success that it was.

The stalls and displays looked fantastic, with organisations and services represented including the likes of Justice Action, Youth Off The Streets, Alcohol and Drug Information Service (ADIS), The Langton Centre, The Australian Red Cross, Drug and Alcohol Multicultural Education Centre (DAMEC), Manly Drug Education and Counselling Centre (MDECC), Hepatitis C Council of NSW, Odyssey House, Parent Line, Club Speranza, Family and Friends for Drug Law Reform, Magistrates Early Referral Into Treatment (MERIT), Central Sydney Area Health Service (CSAHS), Ted Noffs Foundation, Holyoake, Blacktown Youth Group, Wesley Mission and Exodus Foundation.

Thank you to the wonderful parents, Laurel, Bob and Pam, Chrissy, Don, Lorrie, Patsy, Judy, Fay and Marion, who so generously and trustingly told their stories and shared their pain and triumphs, their insights and practical wisdom.

Our deep felt gratitude to the individuals on the professional panel, Brian McConnell, Dr Ray Seidler, Reverend Bill Crews, Dr James Bell, Clive Small, Barbara Adair, Fiona Santangelo, Gino Vumbaca, Alexandra Hodgekiss and the

exceptional skill of Bill Leak as MC, who so willingly gave of their time so that we may benefit from their expertise and were so enlightening.

And who could forget the brilliant performance by the talented Ashfield

Youth Theatre. Those young people certainly had a valuable message for us all•education and knowledge are essential if we are to make a difference at all.

How The Process Aids In Recovery

BOB Our journey with addiction began about 10 years ago. Our 17-year-old son initially became involved in drugs with a group of friends at a local climbing gym. His journey with addiction has led our family through some pretty rough patches and scrapes with the law. During this time our son has lived on the street for a period; lying cheating, dealing drugs; anything to support his addiction/his illness.

PAM We have been through the self recrimination, the hatred, the lying, and the stealing. At the moment our son is in remission, just like a cancer sufferer, an illness that we have learned to live with, with the help of Family Drug Support. Our son has been through numerous rehabilitation programs•but at the end of the day it is not only about his recovery, it is about our recovery also and the survival of our family as a cohesive and effective element in society.

BOB I went to FDS looking for the answers, the switch to throw to stop the madness.

PAM Originally I went to GAMANON Meetings; Bob had tried these but found that they did not help him. We moved to Drummoyne three years ago and I started going to FDS Meetings. I am the rescuer and I rang around to find all of the information to assist our recovery and to hold the family together.

BOB As I learnt to stop looking for solutions and to listen to what was being said we have become more regular attendees at FDS meetings•for the last 18 months we have been to Burwood and more recently the Ashfield premises of FDS on most Monday nights when we have been in Sydney. The most important lesson that we have learnt is to let go of the problem. There is nothing that we can do to solve or stop our sons' addiction. It is his problem to address and to solve; all we can do is to provide him with a healthy, supportive environment in which to recover.

PAM We are strong advocates of FDS; we attend meetings regularly as we learn something new each night and it helps to reinforce the process that will aid our sons' recovery. It has taken years to get to this point but we love our

son and the time that we invest is an investment in his future and the future of our family. I have had to learn to love him for what he is, not what 'society' expects him to be.

BOB We cannot guarantee that our son will be drug free; there are few guarantees in life but we do know that we will continue to assist him in his struggle with his addiction. It does not stop us being frustrated and angry when he succumbs to his addiction and uses drugs but it has helped us to understand; it has educated us; FDS has taught us that 'busting' is a normal part of the process of recovery and we

can see that each time he has 'slipped' he has grown stronger from the experience and his drug free periods grow longer.

PAM We are members of a club to which nobody wants to belong; this experience has taken us places that we would never have expected to go; it has made us better people.

Out Of Solitude

When we honestly ask ourselves
which persons in our lives mean the most to us,
we often find that it is those who,
instead of giving much advice, solutions, or cures,
have chosen rather to share our pain
and touch our wounds with a gentle and tender hand.

The friend who can be silent with us
in a moment of despair or confusion.

Who can stay with us
in an hour of grief and bereavement.

Who can tolerate not-knowing, not curing, not healing
and face with us the reality of our powerlessness;

that is the friend who cares.

That Friend for us is FDS!

Henri Nouwen

Volunteer Profile

Heather Flanagan

My first experience with FDS was when I rang the telephone support line one night some five years ago. My son was using heroin, pills and anything else he could get his hands on. I was frantic and all I could see was death for my son and I needed to know how to stop it. I was the mum and I had to fix this! Whomever I spoke to that night was wonderful. It was so calming to talk to someone who understood how I felt. Not long after this I received my first FDS Insight and attached was a note from that volunteer wishing my son and I well. There was also a request for more volunteers and details of a training course to attend. I remember thinking this could help me to help my son. A purely selfish reason, I also thought at the time. I went along and did the course and met two wonderful people and numerous other good people who were all like me; who were there for the same reasons as I.

I am now that voice on the other end of the phone. I do a shift once or twice a month and I listen to other mums and dads, family members, friends and sometimes users themselves, all hoping I can give them some answers. Sometimes I can, but mostly I just listen and understand, just like that volunteer so long ago. I also get the opportunity to hear some great speakers, professionals in the alcohol and drug field and just ordinary people who like me just need to know what to do. And I have learned.

I have learnt that I cannot fix my son's addiction. He has to want to take the steps to do that himself.

I have learnt to listen and not give advice and not try to fix his problems.

I have learnt that our anger and threats and emotional blackmail only create added pressure for him.

I have learnt that things like negotiation, honesty, tolerance, acceptance, encouragement and talking calmly actually do work.

I have learnt that he will lie and manipulate, say and do whatever he has to in order to get what he needs.

I have learnt to let go. To not rescue him for he must accept the consequences of his actions and solve his own problems otherwise I am only contributing to his fear and weakness.

I have learnt to get on with my own life and not let his consume mine.

I have learnt that he may never be clean of all drugs and that he needs and loves his family and needs them to understand that.

I have learnt to have hope and believe that changes can happen and lives can be repaired.

I believe in harm minimisation and have learnt that if we, the family, can change ourselves and our prejudices and offer support, love and understanding we can be the best help of all.

I have learnt and heard and seen so much that sometimes it overwhelms me and I know that we are so, so much more lucky than some. But most of all I have learnt that there are no end of things in the heart. Thankyou FDS for your friendship, support and for everything I have learnt, for I know that without it my son and I could not have come this far.

Oh and one last thing, we volunteers who can make it get together once a year for a weekend away in the country and have some fun, catch up with old friends as well as make some new, learn some new stuff or just `veg' out and have a rest. See you there in August.

Simon's Mum

Sharp End Of Redfern Drug Use

Ruth Pollard, *Sydney Morning Herald* 28/11/02

The issue of illicit drug use in Redfern (an inner city suburb of Sydney), not surprisingly, is steeped in controversy from the furore that erupted over the photo of a teenage boy using drugs in Caroline Lane in 1999 to the split of the Aboriginal community over what came first: the drug or the needle bus.

Despite the controversy, evidence from both the Federal Government's National Drug Strategy and the recently released *Return On Investment in Needle and Syringe Programs Report* shows that needle programs do not encourage drug use.

Services like the needle bus in Redfern were shown in the reports to have a positive effect in minimising the negative impacts associated with injecting drug use.

It appears that the area health service and other proponents of harm minimisation have won out over fierce opposition from sections within the NSW Government. The needle bus stays for now but with reduced hours and an enhanced needle collection role.

The premier, Bob Carr, recently announced that the government has implemented a policing strategy in Redfern already successful in reducing drug use. But public health experts caution that when countries such as Canada downgraded harm minimisation programs, the transmission of blood borne diseases such as hepatitis C and HIV increased substantially. They fear that Redfern could go the same way.

Some people living around the Block say that while they would ultimately like a drug-free community, they understand the need for a needle bus. One resident backed this up, 'I'd like to see the bus stay. My son's a drug addict, my daughter's a drug addict. I don't want them having to go up into Kings Cross to get clean needles. You don't know what other kind of trouble they might get into.'

The Head of the Aboriginal Medical Service, Naomi Mayers, says she supports harm minimisation but believes a 24-hour service from a fixed site near Redfern railway station would be more appropriate than the needle bus. 'Drug users would be able to access safe injecting equipment continuously and our children would not be exposed to the tragedy of drug using adults on a daily basis.'

Secret Report Hid Hep C "Epidemic"

Misha Schubert, *Australian* 13/6/03

The Federal Government's conservative tough-on-drugs policies have triggered an explosion in hepatitis C infections, a secret health department report has found.

And the disease has become an 'epidemic', with half a million Australians likely to have the debilitating virus by 2020.

The paper, prepared by independent experts for the federal Health Department, lashes the Howard Government for 'abrogating responsibility' and refusing to provide leadership and resources to fix the 'urgent' public health problem.

Health Minister Kay Patterson has kept the report from the public since she received it last November.

But a copy obtained by The Australian reveals a damning critique of the Government's failure to act.

'The (Government's) strategy has not succeeded in controlling the hepatitis C epidemic in Australia. The urgency of this situation cannot be overstated,' it says.

The experts are particularly critical of 'zero tolerance' policies adopted by conservative state and federal leaders.

The 'zero tolerance' approach tries to stamp out illicit drug use•instead of trying to make their inevitable use safer.

'There is a growing recognition that criminalisation of injecting drug use . . . has contributed to increased transmission rates,' the report says.

The experts call for a national public awareness campaign and better partnerships with groups working with injecting drug users.

The hepatitis C virus causes chronic liver disease in up to 85 per cent of those infected. It is transmitted through blood•with up to 90 per cent of new infections from injecting drug use•but rarely spread through sex.

Labor senator Jan McLucas said it was 'unforgivable' that Senator Patterson had refused to share the secret report with the public.

'It's simply appalling that she could let this languish in her in-tray when more people are infected every day.'

A spokesman for Senator Patterson said part of the report would be released next month, while the Government had allocated \$16 million to reduce transmission.

Methadone Versus Buprenorphine

Does Clonidine Work?

Andrew Byrne, Medical Practitioner, Drug & Alcohol Redfern

The April 2003 edition of *Addiction* journal reveals an extraordinary wealth of clinically relevant research material . . . but also shows an intriguing reversal of health priorities by the editors. Some truly 'landmark' research is 'buried', while the first two reports and their related editorials are on subjects of modest, local and/or historical moment. The injecting of methadone syrup in Adelaide from 1996/7 and opiate deaths in England 1993-98 are both subjects deserving of clarification. But as is so often the case with *Addiction*, the tenor seems to be to question whether methadone treatment is a valid intervention rather than how to use it more effectively. After 35 years of positive research, *Addiction* should abandon its persistently negative focus on methadone treatment. Agonist treatments are not perfect, but they are now used by most western health authorities as one helpful approach to opioid addiction.

As a lead research journal, *Addiction's* main focus should be how to maximise the benefits of this proven treatment, not to question its very existence. The first page of the April edition is entitled: 'Methadone syrup injection in Australia: a sentinel finding?' The writers state that there is a lack of reports of methadone injecting outside of Australasia. They relate some alarming consequences of methadone injecting, each being potentially paralleled for street heroin injecting, yet neither the nature nor extent of the problem is backed up by references. In fact, one of their suggested solutions is to examine introducing a type of methadone which is suitable for injection. In fact, since this study was completed, a safer water solution of methadone has begun replacing the older 'syrup' mixture. It is disappointing that the Adelaide researchers only had two questions: (i) Had subjects ever injected? and (ii) Was there any injecting in the previous six months? Thus, the story lacked quantification. Hardly fodder for the lead research paper in the world's most venerable dependency journal!

Addiction might care to ask a guest writer to look at why agonist treatments are still so restricted and why so much is of such poor quality, especially in England, where *Addiction* is published. Established guidelines are almost completely ignored by doctors to the cost of their patients and the UK community. Professor Dole, who originated the use of agonist treatments in New York, states that injecting behaviour (and therefore its complications) can be almost completely eliminated in up to 95% of subjects by using adequate doses of methadone with appropriate supervision and sufficient support services. All treatment should be judged according to whether it is in accordance with established treatment guidelines (eg. Strang's UK guidelines). Maintenance treatments save the health care system more per dollar invested than most other interventions. They reduce crime, prevent HIV infection and probably also hepatitis C yet they are still maligned in a way which is not based on logic.

Amongst the plethora of clinical material, the April edition has two important items on subjects after my own heart. Mattick et al. have published their three-city study of double blind methadone versus buprenorphine maintenance (see my detailed review elsewhere). At three months they found only minor differences in retention, drug use and side effects between these two drugs. This trial is very important scientifically and of substantial clinical relevance. It probably should have been the first item in *Addiction* and certainly deserves an editorial, considering buprenorphine was released in the USA recently. This may seem a small criticism, but not so the fact that Hickman's study of opiate deaths in England gives

text references as numbers, while the actual list is alphabetical, making the article incomprehensible to the reader. The author was kind enough to send me an earlier draft with his own numbered references. I am bemused by the lack of editorial control at *Addiction* which led to this error. One wonders that the proper peer review process did not prevent such an error. The management at *Addiction* owe Hickman and colleagues an apology for this humiliating error.

The content of Hickman's article relates to an issue into which I had a personal input back in 1997: that 'methadone kills more people than heroin'. It is a sad fact that the issue is still being debated rather than being acted upon. In fact, the last time *Addiction* published my name unrelated to some gossip or ridicule from house writers, was on the issue raised by Newcombe. The item by Hickman shows that there are still many (possibly unnecessary) deaths from methadone in England and Wales, but not as many as caused by heroin, and the number is still increasing. Both Hickman and the editorialist touch on clinical practice in England, but neither seems able to state that there is strong anecdotal evidence pointing to abysmal compliance with clinical guidelines in England and Wales. The drug is usually prescribed by doctors with no training in addiction medicine, without supervision of the medication and at dose levels which are often inadequate to quell cravings for 24 hours. Such deficiencies are inconsistent with Strang's detailed official UK Dependency Treatment Guidelines (1999). There appears to be no coherent plan either by professional groups, the NHS nor the National Addiction Centre to address these failings, despite them probably leading to the deaths of many people annually. This edition would have been an ideal place to address the issue. I offered to write such a piece but editor Edwards, while conceding the need, has not followed up on the matter it would appear.

Another item, from the group at Johns Hopkins, gave trial subjects on 30mg daily doses of methadone injections of naloxone and medicated them with clonidine or lofexidine without placebo control. Approval was granted by The Johns Hopkins Bayview Medical Centre Institutional Review Board and individual consent given. We are not told if this is a properly constituted ethics committee, but it is gratifying that subjects were offered either a 90 day reduction course of methadone and/or assistance with referral to a long term maintenance facility in Baltimore after their services in this somewhat brutal trial (for which they were paid volunteers). It is a moot point as to whether currently addicted individuals can consent to a single option, especially one which is not an appropriate treatment for addiction (fixed 30mg of methadone daily). Unsurprisingly, six subjects who agreed to participate dropped out at the prospect of naloxone injections. However, eight of 14 who completed the twice weekly experimental in-patient protocol effectively showed that neither lofexidine nor clonidine did anything significant in reducing withdrawal symptoms. My patients have told me for years that clonidine does little for withdrawal symptoms. Now here at last is proof!

In yet another item from Baltimore, 120 subjects were offered a three day course of buprenorphine using 'high' (4mg) or 'low' (2mg) dose. This can hardly rate as 'reduction treatment' since the drug takes at least five days just to stabilise. It is not stated which professional protocol this 'treatment' is taken from. One wonders at the wisdom of giving a 'treatment' which has little if any scientifically proven benefit and then reporting near 90% failure rates in an international journal. There was apparently no safety net reported by these researchers who noted frequent relapses in their patients. At one, three and six months, there were progressively fewer patients were contacted (80%, 55%, 47%). The authors' first statistics do not take lost subjects into account and their 6-month abstinence figure of 62% (self report) and 25% (clear urine test) are then translated for clarity to 35 and 14 subjects out of the original 119 (29%, 12%). A proportion of those lost to follow up may have been dead but this is not addressed by the Gandhi and co-authors. Their conclusion that there was 'reduced frequency and intensity of drug use' following their 'intervention' is based on respondents only and is thus of limited validity, like their 'treatment'. All patients deserve appropriate treatment and this means regular

assessments and if agonist prescription is appropriate on one day, like insulin, lithium or Prozac, it is nearly always appropriate on the next. Discharge from treatment should never be arbitrary as it was for all of these patients.

Zero Tolerance In A Modern Community

How To Recognise The Zealot

The following is an address by Bill Bush of Families and Friends for Drug Law Reform at the Community Forum, `Society's Treatment of Drug Users' Brunswick Street Mall Rotunda, Fortitude Valley, Brisbane Thursday, 26 June 2003.

`It's not a nice feeling when it's seven in the morning, you're already atrociously ill and you just know it'll be about nine at night before you manage to scam yourself a shot. Plus you know you don't get to just lie in bed and be sick for that 14 hours. No, you have to get up and walk and beg and walk and steal and walk and walk . . . unless you've got yourself a convenient chauffeur, then you may still have to wait 14 hours, but at least you'll be sitting comfortably in a car rather than trekking through rain, hail and snow.'

A local Canberra politician objecting to injecting rooms asserted that `addicts' were beyond cleaning their own teeth. A columnist responded that whatever the case with teeth an `addict' had circumvented formidable barriers to rob his home.

Neri wrote the first paragraph I read. It is from a set of some of the funniest essays I have come across. I suspect Henry Lawson, another drug user, would have been proud to have called them his. They are full of grim, tenacious humour that can come only from profound self awareness.

Neri fought many battles with her habit. She was determined not to die from heroin. She chose death from carbon monoxide. Neri was 21.

All these quotations bear out that there are many contradictions in illicit drug use. There's much that seems to justify an attitude of zero tolerance. That being so, why is zero tolerance so misguided, so cruel and so counter-productive? In short why is it wrong?

It is important that we are clear about the things we can accept as well as the things on which we necessarily differ.

I would suggest that one thing on which we do not need to differ is the desirability of a drug free goal.

I can hear you drawing in your breath when I say this. There's not been one society in human history that has been drug free, not even, I'm told, Eskimo societies that were once thought to be so. It seems they consumed mind altering substances derived from fungi that grew in igloos.

But adhering to an ideal is not undermined by contrary practice. The fact that we are never likely to rid the world of cruelty, lying, stealing or killing does not make them right or justify us throwing in the towel to prevent them.

Now I suggest that there are many in the community including families and even users who would whole heartedly wish that we could be rid of some illicit drugs.

Equally, many associated with zero tolerance admit that their efforts will never be 100% successful.

Major Watters has told a federal parliamentary committee:

'There will always be some drug problem, just the same as there will be other social dysfunctions and crime occurrences. We are never going to eliminate them; we are never going to live in that utopia. That would be very nice but it is not going to happen.'

Sweden has an official drug free policy yet its National Institute of Public Health concedes that:

'Sweden is not a completely drug-free society, but,' it asserts, 'the target has been achieved in that use of drugs in Sweden occurs on a limited scale by international standards.'

So no, you're not going to cut much ice with a zero tolerance advocate (or a lot of others) by showing that a drug free society is impossible. Turning the proposition around, zero tolerance is not a misguided, cruel and counter-productive approach to drug policy because those who hold to it aspire to a drug free society.

It is misguided, cruel and counter-productive for two different reasons. I call them moral absolutism and a dark ages dogmatism.

You cannot miss moral absolutism when you meet it. It was abroad here in Brisbane not so many years ago when U.S. television judge Judy Sheindlin told her lunch time audience at the Carlton Crest that the debate about needle supply to heroin addicts is an indulgence led by 'liberal morons'. 'Give 'em dirty needles,' she said, 'and let 'em die.' This year a magistrate in Adelaide in sentencing a woman on a prostitution charge told her:

'We dicks pay for your life. It's your choice to be a junkie and die in the gutter. No one gives a shit, but you're going to kill that woman who is your mother, damn you to death.'

In Melbourne, Tony Abbot, the Federal Minister, was asked why he was opposed to supervised injecting facilities. He said that people who are on drugs are virtually dead anyway.

Crude language should not hide the fact that zero tolerance is compatible with much help to the user but there is a bottom line. It is that the user must overcome his or her addiction.

Moral absolutism when it comes to drugs sees becoming drug free as the pre-eminent moral aspiration. Those who hold to it go well beyond welcoming a drug free life as being the best way of fulfilling one's full potential. For them being drug free is more important than life itself.

Sacrifice often goes with this attitude• not self sacrifice but sacrifice of the addicted drug user for the greater good. Preparedness to sacrifice others lurks behind phrases such as 'sends the wrong message'. When he vetoed a heroin trial in Australia the Prime Minister

stated that 'we are concerned that a heroin trial sends an adverse signal'.

Pushed to it, many opponents of such a trial or a trial of a medically supervised injecting room will concede that such a step may keep some users alive but reject it because they believe those measures would encourage others to use. The interests of the 'innocent' non-user is pitted against the interests of the addict.

There was a classic statement of this position within the past week by a contributor to ADCA's DrugTalk list. The subject was death rates among cohorts of heroin users in various European cities:

'... Sweden's cohort did indeed die sooner. But isn't this because [Sweden does] not have much in the way of harm minimisation and [thus just] what you might expect? And the reason they don't major in harm minimisation measures is because they believe that these measures only create more drug use via normalisation, and thus more deaths.'

In drug wars as in other conflicts, unfortunate collateral casualties are to be expected. I may concede the possibility of circumstances that would justify such a sacrifice but not without the clearest evidence that there was no other acceptable course.

This brings me to 'evidence'. Someone who takes a position of moral absolutism on drugs is also likely to have a dark ages mentality towards 'evidence'. Judge Judy's reference to 'liberal morons' suggests this.

I would suggest that the drug debate has little to do with left and right divides in the political spectrum. It has a lot to do with what causes what.

All of you have probably been struck with how debates about the 'facts' of drug policies never seem to get very far. You might also note that the two sides tend to take a different approach. One may make a factual assertion. The other may reply that on the best evidence this does not seem right. She will cite the research literature to support her scepticism. Arguer One may then come back with an 'I told you so. You don't have proof that I'm wrong'. For a variation Arguer One may reply with a slightly different factual assertion that has Arguer Two scurrying back to the research literature to check it out. Alternatively Arguer One may riposte: 'I know of a study that contradicts what you've told me'. He gives no citation or indication that the outcome of the study was subject to peer review.

Now I'm no medical or epidemiological researcher but as someone trained as a lawyer I can recognise the difference between what lawyers do • argue a case • and a dispassionate scientific investigation of the truth.

Sceptical questioning is at the heart of science. The scientist should question everything, not just one side. In legal imagery she must combine the roles of judge and opposing counsel. The traditional peer review process has open minded scepticism at its heart.

So the scientist is not a good match for the dark ages dogmatist.

In the light of its dangers, a recent correspondent of the *Sunday Telegraph* in Sydney called for the abandonment of the NSW trial of medicinal use of cannabis unless the 'AMA declare [s] publicly there are no legal drugs with equal/similar pain-relieving potential.' It would be difficult if not impossible for a scientist to make an unequivocal declaration like this. She

certainly couldn't without trialing cannabis.

Democracy•many would say demagoguery•has infected technical assessment when it comes to illicit drugs. I for one would find little comfort in knowing that the surgical operation I am about to undergo or the plane in which I am about to step into has an approval rating of an overwhelming majority of the voting age population.

This is why such a responsibility hangs on ethical political leadership in determining drug policy and in this Australia falls short. In the same way as the *Sunday Telegraph* correspondent did, the Prime Minister dismissed calls from expert bodies for a trial of medically prescribed heroin on the ground that overseas trials had not established to the point of scientific certainty that the intervention had in fact saved lives and reduced crime. Of course they hadn't, but they had produced strong evidence in favour of that conclusion.

The political arena is the right forum to debate the objectives that should guide drug policy and the morality that should underpin them. Having clearly established what those objectives should be, it is imperative that we be guided by the best expert evidence available in order to achieve them.

Let me try and draw things together. Wanting a drug free community is not a sign of a zero tolerance zealot. Certainly, those who embrace zero tolerance share that ideal but so do many, many others. The zealot even as much as others will probably recognise it as unachievable. Even so, many will still believe it is worth aiming for even though it gets complicated when distinguishing between acceptable and non-acceptable recreational drugs.

Unfortunately I haven't got time to go into that or the libertarian arguments in favour of unqualified individual choice.

What distinguishes a zero tolerance zealot are two things: firstly a moral viewpoint that sees being drug free as of paramount importance and, secondly, a refusal to apply scientific principles of open minded inquiry to the assessment of evidence.

Are the moral absolutists so bent on stamping out drug abuse that they commit themselves to a set of measures that actually encourages the reverse? Many fear that the flood of methamphetamines shows this is actually happening. Because they are also dark ages dogmatists, the moral absolutists are unlikely to want to know.

Has zero tolerance become drug promotion? It would be hilarious if it were not tragic. Neri would have seen the irony. She probably did.

Supervised Drug Injecting Room

Trial Considered A Success

Bob Burton, Canberra

An evaluation report into an 18-month trial of Australia's first medically supervised injecting centre has cleared the way for the continuation of the \$A2.4m (•1m; \$US1.6m; E1.4m) a year project.

The 233-page evaluation found that from May 2001 to October 2002, 3810 registered individuals made 56861 visits to the centre. A total of 409 incidents of drug overdose were recorded•including 329 from heroin and 60 from cocaine•though none were fatal.

The report estimates that at least four lives were saved as a result of the proximity of users to medical staff. The report was prepared by the evaluation committee headed by John Kaldor, professor of epidemiology and deputy director of the national centre of HIV epidemiology at the University of New South Wales.

The establishment of a supervised injecting centre followed a drug summit in May 1999 hosted by the New South Wales government. The summit canvassed options for reducing the impact of drugs on society and users. After a protracted debate•and an unsuccessful legal challenge from the local business community•the centre opened in May 2001 (*BMJ* 2001, 323:532) in Kings Cross, a district in inner city Sydney long associated with gambling, prostitution and drugs.

The government approved the trial in the hope that it may `decrease overdose deaths, provide a gateway to treatment, reduce the problem of discarded needles and users injecting in public places.'

The evaluation found that the injecting centre made 1385 referrals to drug treatment services `especially amongst frequent attendees' and that there was no negative effect on the community nor any evidence of an increase in crime. Support for the centre among local residents rose from 68% to 78% during the trial period.

Launching the report, the special minister of state for New South Wales, John Della Bosca, backed the continuation of the centre beyond its legislated end date of 30 October 2003. `The centre did save lives; there was no `honey pot' effect detected, no increase in crime or drug related loitering in the Kings Cross precinct,' he said.

Draft legislation will be introduced in September to make the injecting rooms permanent. The New South Wales branch of the Green party•one of the parties holding the balance of power in the upper house•are advocating that centres be established outside Sydney.

The report has not persuaded the Australian prime minister, John Howard. `I've never supported heroin trials and I've never supported heroin injecting rooms, and this government never will,' he said.

The Australian Capital Territory's government has indicated that it too will now consider establishing a medically supervised injecting room.

The Sydney trial is one of only 59 equivalent drug consumption centres operating in 33 cities in Germany, Switzerland, the Netherlands, and Spain.

Final Report of the Evaluation of the Sydney Medically Supervised Injecting Centre is available at <http://druginfo.nsw.gov.au/druginfo/reports/msic.pdf>

Injecting Room Likely For Canberra

Scott Emerson, *Australian* 11/7/2003

Canberra, which has the highest levels of heroin use in Australia, is likely to become home to the nation's second supervised injecting room after a NSW trial was judged a success. But all other states yesterday ruled out introducing heroin injecting rooms.

An independent review of Australia's only medically assisted heroin injection room at Sydney's Kings Cross, which opened 18 months ago, credited the centre with saving lives. It found more than 400 drug overdoses had been treated without a single fatality.

ACT Health Minister Simon Corbell will take plans for an injecting room to cabinet within six to eight weeks.

The proposal is likely to gain approval given that it was part of Labor's election-winning policy in late 2001 and legislation to support a heroin injecting room has already passed through the assembly.

Mr Corbell was confident the federal Government would not intervene in any plans for an injecting room in Canberra, despite previously blocking plans for a heroin trial and John Howard's strong objections to such projects.

A spokesperson for the Prime Minister said he would wait and see the ACT proposal before making any specific comment.

NSW Special Minister of State John Della Bosca yesterday ruled out the expansion of medically supervised injecting centres to the state's regional centres. Mr Della Bosca said the Kings Cross centre was only possible because of the uniqueness of the suburb's long-term drug problem. 'This is not the solution to heroin abuse,' the Labor MP said. 'It's something that can keep some people alive long enough to make a better decision on their own lives.'

In Victoria, a spokesman for Victorian Health Minister Bronwyn Pike said the Bracks Government made it clear at the last election that heroin injecting rooms would not be introduced in Victoria. 'We've taken the clear position that investing heavily in treatment and prevention is much more effective in tackling the problem,' the spokesman said.

And in Queensland a spokeswoman for Health Minister Wendy Edmond said the 'situation in Queensland is very

different to that in NSW. The state Government does not support heroin injecting rooms for Queensland and has no plans to establish one,' she said.

Western Australia's Premier Geoff Gallop said he remained opposed to the introduction of injecting rooms. 'The concept of medically supervised injecting rooms has been rejected in WA because we don't have one particular area, like King's Cross, where drug taking is concentrated,' Dr Gallop said.

The South Australian and Tasmanian governments yesterday also rejected introducing injecting rooms.

Sydney Medically Supervised Injecting Centre

Medical Director's Report

The Sydney Medically Supervised Injecting Centre (MSIC) commenced its third year of clinical operations on 7 May 2003. The final results of the independent evaluation of the MSIC's first 18 months of operation (ending in October 2002) have now been publicly released. This is likely to herald vigorous public debate about whether the service should continue beyond its current trial condition. We hope that this debate is informed by the final evaluation report's findings. We also hope that there is an appreciation that any service evaluation process, no matter how comprehensive and rigorous (and there is no doubt that this service evaluation was peak in this respect), also has its limitations.

Particularly the more intangible and human aspects of clinical care are often hard, if not impossible to quantify. To help inform you, the Kings Cross community, I provide the following summary of the MSIC's achievements for its first two years of clinical operation.

Client registrations

The MSIC registered 4,736 individual injecting drug users (IDUs) to the end of April 2003. Every client registration involved a full assessment of the person's drug use and overall health and social situation. This determined what other assistance was provided at the MSIC eg primary health care, emergency accommodation, and referral to drug treatment and rehabilitation. Only about half had ever had contact with a health agency focusing on drug-related harms in Kings Cross ever before. In this sense the MSIC has significantly 'widened the net' in terms of the proportion of the IDU population now in contact with health professionals able to address the issues underlying their illicit drug use.

Individual clients

In the course of one month the MSIC currently has contact with just over 900 individual IDUs. On a daily visit basis, 80% of visits were by clients who spent the previous night in the South Eastern Sydney Area Health area, and two thirds in the immediate Kings Cross area. The most common reason cited for being in Kings Cross was to buy drugs.

The clients who attended the MSIC most frequently were those among the MSIC's core target population of heavily heroin dependent, street-based, sex working IDUs who dwell in Kings Cross. As well as being in a safer environment at the MSIC risk, treating such marginalised people with dignity and respect as occurred at the MSIC, hopefully increased their sense of self-worth and esteem, essential to effecting personal change at an individual level.

The MSIC has also made contact with people who were still early in their drug using, who were not yet as heavily heroin dependent or entrenched in the street-based lifestyle. This provided an important opportunity for early intervention, which is well known to be most effective in the prevention of drug-related harms.

MSIC visits

The MSIC accommodated 88,322 injecting episodes in the first two years. An average of 226 visits (ranging up to 340 visits) currently occur each day; 74% to inject heroin, 4% cocaine and the remainder a mix of benzodiazepines and methamphetamine. These injecting episodes would presumably otherwise occur in less safe, unsupervised, back street circumstances elsewhere in Kings Cross, also reducing public amenity.

The MSIC is now operating at more than twice the level of service utilisation and is accommodating almost three times as many visits to inject heroin as during the 18 month evaluation period, further increasing its overall impact at community level.

Drug overdoses

In the first two years, 554 drug overdoses were managed at the MSIC without fatality; 83% heroin and 11% cocaine overdoses. While one may speculate about how many of these would have otherwise resulted in death, it is very hard to know for sure without examining where each and every individual drug overdose would have otherwise occurred and what the likelihood of ambulance assistance being provided in time would have been. However the clinicians at the MSIC know the background and circumstances of the overdoses they deal with, they witness first hand clients becoming cyanosed (blue) and who often stop breathing completely. The clinicians involved in the resuscitation of these drug overdose cases at the MSIC know that a significant number of lives were saved.

Probably even more significant would have been the morbidity otherwise associated with heroin overdose, prevented by the MSIC. In community-based situations heroin overdoses are not usually identified until the person is unconscious and no longer breathing and only then is the ambulance service called to provide assistance. In contrast, at the MSIC, drug overdoses are identified within minutes of onset, thereby enabling immediate treatment with life support measures. In this way the irreversible damage that may have otherwise occurred as a result of temporary lack of oxygen to all vital organs and in particular the brain, was prevented at the MSIC.

The 62 cocaine overdoses managed at the MSIC included cases of acute severe hypertension (high blood pressure), hyperthermia (increase in body temperature), cardiac arrhythmias (irregular heart rhythms), convulsions (fits), paranoid states and acute psychosis. These were also managed on-site without fatality.

Referrals to other relevant health and social welfare services

It is important to appreciate that the primary aim of supervised injecting centres is to keep people alive and well so that they still have the opportunity to address the underlying causes of their drug dependence and associated lifestyle. Nonetheless, supervised injecting centres do potentially have an important role in bringing people into contact with drug treatment and rehabilitation services, so that this usually long and arduous journey can commence sooner rather than later, and hopefully well before it is too late.

On more than 1,800 occasions clients were referred to other relevant health and social

welfare services; 44% for the treatment of drug dependence, which included the full range of options from naltrexone, drug abstinence and 12 step programs to detoxification, methadone and buprenorphine programs. Referrals among the clients who attended the MSIC more often were most effective, confirming the role of the MSIC in facilitating the establishment of trust and rapport with IDUs, necessary to effect successful referrals to other relevant services.

Cost benefit

The MSIC was able to demonstrate that its benefits outweighed its cost during the trial. This is a particularly impressive result given the extraordinary costs that were associated with start up (refurbishment etc), and the delays due to legal action taken to stop the MSIC. The extension of operating hours subsequent to the evaluation period has already resulted in a further 50% increase in daily visits, further improving the cost efficiency of the MSIC.

Cost effectiveness

Particularly since the expansion of drug treatment and rehabilitation services following the NSW Parliamentary Drug Summit in 1999, it makes even more sense to also be investing in keeping this most marginalised part of the IDU population alive and well so that they too can benefit from such programs.

Community support

Support in the Kings Cross area was high and increased during the evaluation period to 78% among local residents and 63% among local businesses. Community feedback was generally very positive throughout, with many reporting that they were proud to be part of a community that was taking a balanced and humane approach to the public health and public order issues associated with street-based drug use in Kings Cross. I would also like to take this opportunity to thank the local community for its courage and fair-mindedness in supporting this initiative.

The 'honey-pot' effect and drug-related crime

There was no evidence of an increase in drug using, drug dealing or other drug-related crime in the Kings Cross area or in the immediate vicinity of the MSIC (source: Kings Cross Police Service and NSW Bureau of Crime Statistics).

Public amenity

There is much being said at the moment about the public amenity in Kings Cross. Various hotels are being converted into up-market apartments, thereby increasing the residential population and potentially changing the nature of Kings Cross. The MSIC supports all efforts to improve the public amenity, including all efforts to stop the supply of illicit drugs and associated anti-social behaviour in the area.

We consider that the relocation of much of the public drug injecting that used to occur in Kings Cross into the MSIC over the past two years has been an essential element enabling the improvement of public amenity in Kings Cross. There should be no doubt that closing this service now would result in the shift of at least 226 drug injecting episodes (and associated injecting paraphernalia) a day, back into the local environs of Kings Cross, surely a backward step for the local community.

Other achievements with Public Health implications at population level

1. A greater understanding of the patterns of drug overdose and approach its management was gained during the trial. The MSIC's clinical protocols developed to manage heroin overdoses and the various manifestations of cocaine toxicity are now being communicated to other relevant services in NSW.

2. The rate of drug overdoses occurring at the MSIC reduced during the trial as a result of education about risk factors before people used the MSIC and again when overdoses occurred at the facility.

3. As a result of health professionals observing injecting rituals among IDUs, a greater understanding of injecting risk behaviour from an HIV/hepatitis B&C perspective was gained. This has enabled the development of more targeted health promotional messages about blood and needle awareness, which are now also being disseminated more widely.

4. The MSIC was in a unique position to provide an early warning system in terms of drug trends in Kings Cross. The MSIC alerted the Kings Cross Police and other relevant services when it became aware of new or higher purity drugs on the streets.

Conclusion

There has been a great appreciation amongst all the MSIC staff, of the public health significance of this trial initiative, not only for Kings Cross, but for all jurisdictions in Australia. Every nurse and counsellor at the MSIC worked well beyond the call of duty throughout this trial, often in very challenging circumstances. I would like to take this opportunity to express my admiration and respect for them all. I also know that there was nothing more that any of us could have done to improve the final outcomes of this trial and that regardless of the final verdict, the service's key objectives were achieved. We are very grateful to have been given this opportunity to demonstrate the benefits of this harm reduction strategy and again, would like to thank the community for their support.

Aboriginal & Torres Strait Islanders Facing Gaol

A Review of Division of Aboriginal & Torres Strait Islander

Youth from Juvenile Detention, an ANCD Research Paper

Evan Thomas

There were 604 young Australians [aged 10-17] in gaol on 30 June 2001 [the number has been falling for 20 years] •about 240 were Indigenous. Indigenous juvenile offenders are much more likely to be held in correctional institutions than other Australian juveniles.

The national rate of incarceration of Indigenous juveniles is 284 per 100,000 compared to 16.3 for other juveniles. The over-representation of Indigenous persons in gaol [about 16 times] is reported in each State and Territory.

A study [National Drug Research Institute: *Indigenous Drug and Alcohol Projects 1999-2000*] published in 2000 identified 277 alcohol and other drug intervention projects conducted by or for Indigenous Australians.

The States and Territories with largest Indigenous populations (NSW, ACT and Queensland) had, proportionately, the lowest number of intervention projects.

The Juvenile Justice System

The juvenile justice system differs from the adult system in court arrangements and law. It emphasises developmental appropriateness and rehabilitation over punishment. Most jurisdictions have three tiers of juvenile justice: police cautions, conferencing, and youth courts. There are similarities but also significant differences among jurisdictions.

The guiding principles suggest that children should be given the opportunity to develop into responsible and useful citizens.

Offending by Indigenous Youth

Most offences concern theft, good order, and violence. Diversion for violent offences is not typically permitted. While alcohol and other drugs often contribute to offending behaviour, drug offences per se are not common.

Indigenous youth are over represented at all stages of the criminal justice system. Negative impacts of contact with the system include stigma, alienation, family relationships and effects on future employment. For young people it may engender a criminal identity that perpetuates offending.

Drug Use Among Indigenous Adolescents

There are some indications of greater drug use among Indigenous youth than among other youths, with particular pockets of problems, including cannabis use and IV drug use in urban areas, and petrol sniffing in some rural communities. This suggests the need for community approaches.

Causes Of Substance Use Problems

Historical and cultural factors contribute to substance abuse by Indigenous youth, including the impact of separation of children from families, resulting in the loss of parenting skills and community strength; an emphasis on the autonomy of individuals, resulting in tolerance for behaviours such as drug use.

Risk factors, such as unemployment are prevalent in many communities and some offending can be an act of defiance against the non-Indigenous community.

The ability of women to lead community action indicates resilience in some communities, as does pride in Indigenous identity.

Diversion From The Criminal Justice System

After police have detected an offence, there are multiple opportunities for diversion.

- Pre-arrest. Includes fines, warnings and cautions, sometimes with educational material or referral to assessment and treatment.
- Pre-trial. Treatment as a condition of bail, conferencing and prosecutor discretion.
- Pre-sentence. Delay while assessment and treatment are sought.

- Post-sentence. Suspended sentences, drug courts, non-custodial sentences and circle sentencing.

- Pre-release. Before release, on parole.

Circle Sentencing

Offenders need to show that they are committed to healing the harm caused by their actions and commencing rehabilitation.

Participants include the presiding judicial officer, the offender, defence counsel, the offenders family or supporters, the victim and his family or supporters and a community Elder.

Seats are arranged in a circle and the Crown's case is explained. The offender is allowed to comment. A general discussion follows which covers every conceivable factor that could impact on the case and the victim.

Healing the victim and the offender is decided and the sentence and all other relevant matters. The process can take two or three hours or several days.

The circle is reconvened after several months to review the offender's progress. The problems associated with Circle Sentencing relate to costs, consistency and community involvement.

Youth Conferencing • Restorative Justice Programs

There has been increased interest in these programs in which offenders, victims and significant others discuss the offence and decide how to repair the damage resulting. Conferencing places emphasis on rehabilitation and taking responsibility for actions rather than punishment thus rendering them especially appropriate for juveniles.

Admissions of guilt are generally necessary for a child to take part in a conference. In most jurisdictions drug offenders may participate although suppliers are excluded.

Not surprisingly programs that exclude youths with prior offences have limited impact on youth diversion. The programs vary greatly in each State and Territory.

Interventions For Reducing Recidivism

US evaluations of interventions for reducing juvenile recidivism have concluded that, compared to large goals, community based programs run privately, involving the family plus high levels of intensity and duration, multiple modes of intervention and highly structured, resulted in positive outcomes.

The evidence does not support the use of boot camps or 'scared straight' programs for juvenile offenders.

There are no published evaluations of recidivism interventions for indigenous people.

Summary of Recommendations

The consultants who prepared this ANCD report made six recommendations.

1. Aboriginal and Torres Straight Islanders located in areas of high need should be provided with a greater number of culturally appropriate diversion options for young people. In other mainstream areas where A&TSI numbers are insufficient to warrant specific programs, an increased capacity to deal with A&TSI youth is recommended.

2. Future diversion and treatment strategies should be in accord with these key principles:

- Services should be culturally and developmentally appropriate, with meaningful involvement of Indigenous people, and where possible community based.
- Treatment services should address multiple risk and protective factors, and offer interventions proportional to the behaviour, eg long term for psychoactive substance use disorders [PSUD]
- Diversion strategies should increase the intensity of treatment with increasing offending history and PSUD and adopt restorative justice principles

3. Police and magistrates knowledge of diversion options should be improved where deficient.

4. Prior convictions should not disqualify A&TSI youths from diversion programs.

5. All jurisdictions should collect data on the full range of diversion options and involvement of A&TSI youths to inform future policy and program development.

6. Broader social justice programs are required for sustained improvements in PSUD interventions among A&TSI youth. Good community services• schooling, health and policing services, and access to a `real economy' and economic opportunity•are crucial.

In particular, there is a need for health services and justice services to work in partnership at all levels, but especially at local levels, to ensure that A&TSI people receive appropriate justice, care and support.

Acknowledgements

Diversion of Aboriginal and Torres Straight Islander Youth, ANCD Report No. 6 by Siggins Miller Consultants, Catherine Spooner Consulting, Professor Wayne Hall and Marianne Jago.

News From Overseas

United Kingdom

Ex-Scotland Yard Boss Says Legalise All Drugs

The former operational head of Scotland Yard's drug squad today praised a woman who uses cannabis for medicinal purposes for speaking out saying he backs the argument for legalising all drugs.

This week, the Evening Post has highlighted the plight of Sybil Lucas-Brewer, of Preston, who relieves her crippling pain with marijuana. The 48-year-old mum spoke out to defend her right to use the 'God given herb' and appealed for a change in the law which currently labels people like her as criminals.

Mr Ellison, 59, retired 10 years ago after a varied career in the police force. The former pupil of Kirkham Grammar School said: 'I am very proud of Sybil for making the huge step of being so frank and open about her drug use.

'It is just illogical that if someone has found a way of treating their pain, they are branded as criminals. I personally would like to see all drugs legalised. But having said that, I am very strongly anti most drugs. However, I do not approve of the effects of using the criminal law to deal with drug use.

'Legalisation does not mean we'll all have to take drugs. It doesn't mean that we even encourage drug taking. It doesn't even mean I approve of drug use at all.

Originally from Lancashire, Mr Ellison applied to join Lancashire Constabulary, but was turned down after being told he was half an inch too short.

He joined London's Metropolitan Police and quickly progressed his career working for the murder and drug squads.

Since retiring, Mr Ellison has been involved as the trustee of a drug charity and is a patron of a lobby group for changing the drugs laws.

Mr Ellison said: 'All the legalisation argument does is present an alternative policy for reducing the problems caused to society by the growing use of drugs.'

He says keeping drugs illegal causes all sorts of problems such as presenting a supply monopoly to criminal organisations with high levels of illegal profits and maintaining a high crime rate. He said: 'In spite of the many years of repetitive official claims, drugs do not kill.

'Bad drugs kill, bad use of drugs kills, competition between criminal drugs suppliers kills and lack of supporting resources kills. But the evidence is clear, most drugs do not kill and with a more compassionate, supporting and informed approach, we have a clear chance to reduce the harm that using drugs can cause to both the user and the wider population.

'As far as punishing people who use drugs for pain relief, I think it is ridiculous.

` In the UK, almost half the cannabis is home-grown and some people who have an excess supply it to medical support groups to distribute it to whoever has an acknowledged medical problem. This is illegal and these people are labelled serious drug supplying criminals. The system is all wrong.' **Aasma Day**

Lancashire Evening Post (UK) 11/7/03

Sweden

Response To Kakko et al Buprenorphine Comparison

Tragically, individuals who are heroin dependent are being denied life-saving treatments in Sweden. The correspondents' frustration would be better aimed at those responsible for prevention of treatment than at those working to improve the situation. Our own position is clear: `all persons dependent on opiates should have access to methadone maintenance therapy (MMT).' Commitment to evidence-based practice and tenable ethics must lead to this conclusion. Yet, MMT in Sweden is restricted to 800 individuals, in a heroin population of 8000. Unless a patient is aged older than 20 years, has four years of documented dependence, and abstinence-oriented treatments have failed, access is denied. Once in Stockholm's MMT program, destabilisation, even after long-term successful treatment, leads to discharge. Unsurprisingly, deaths associated with drug use have risen sharply over the past decade.

Buprenorphine promised an opening for treatment outside the MMT system. Pending its approval in 1999, we tried to develop this treatment. However, the director of Stockholm's MMT program maintained that efficacy of buprenorphine was unsubstantiated, and that maintenance treatment was illegal except in accord with the criteria above, within the MMT program.

Opponents of pharmacotherapy agreed. We had neither acceptance nor funding for buprenorphine treatment, and were facing continued frustration, and death of our patients.

Through the trial, Magí Farré and Marta Torrens refer to as `seriously flawed', we secured acceptance and funding for introduction of buprenorphine. Our design was only a slightly more stringent version of comparing intervention with (enhanced) `treatment as usual', widely accepted when multi-modal interventions are examined. If the trial had not been done, not half but all our patients would have continued cycles of admissions using this detoxification scheme, discharge to the street at the nadir of their tolerance, and psychosocial attempts at relapse prevention, which do not work alone, and could provoke relapse through conditioned cues. This pattern would also have continued for the patients' category as a whole, except the 10% who qualify for MMT. The ethics committee and the Medical Products Agency hence approved our protocol. Every effort was made to rescue drop-outs through referral to our most experienced consultant at a different site.

Farré and Torrens claim that outcome in the buprenorphine group must result from selection, and high-dose treatment. For the former, they provide no basis other than a disbelief of our successful outcome. In fact, the MMT program we have been inspired by has reported similar outcomes; program structure and psychosocial treatment make all the difference. On the second point, we agree that dose is an important implication of our study. We cannot see how that could lead to criticism.

Based on our data, buprenorphine is gaining acceptance. The Swedish Board of Health and Welfare, although slow, seems committed to revision of treatment regulations. We have devoted endless efforts advocating access to treatment. I paid for my commitment by being

prematurely discharged as the director of our addiction medicine service in the spring of 2001.

I wish this study had not been necessary. It was.

Markus Heilig, Div of Psychiatry

Huddinge University Hospital, Stockholm

Indonesia

Strict Indonesia Backs Free Needles For Drug Users

While some Asian countries mount futile wars on drugs, Indonesia takes the initial steps towards an evidence-based response to hepatitis and HIV.

The atmosphere at the Denpasar clinic seems jovial. But Budi is in no mood to linger. Having gotten what he needed, he slips out onto the busy street, on the move again. His immediate plan: find a safe place to shoot up with his new syringe.

Budi's heroin drug habit make him a prime target for needle-exchange projects like this one, run out of a nondescript house in Bali's capital. Using donor funds with a quiet nod from local authorities, Yayasan Hati-Hati (Take Care Foundation) hands out hundreds of needles a month to local drug users.

For Indonesia, whose strict drug laws include penalties for carrying a needle without a doctor's prescription, helping addicts to inject safely would have been unthinkable in the past. What has forced a sea change in attitudes, at least in some government circles, is an alarming rise in needle-borne infections from hepatitis and HIV.

'There's no ambiguity. Indonesia's youth are injecting in large numbers,' says Jane Wilson, country director of the United Nations program for HIV/AIDS in Jakarta. 'If we want to do something about infections in the drug community, we only have a limited window open to act.'

A similar shift is under way in other countries in Asia, where traditional law-and-order responses to illegal drugs are mixing, often uneasily, with efforts to reach out to drug users. In doing so, they are following a lead set by European countries that have long recognised the limits of law enforcement efforts against drug addiction.

China recently approved needle exchanges in six provinces, while India already has similar projects running in Manipur state, a prime heroin-smuggling route. In the Middle East, state-sanctioned needle exchanges and methadone projects are up and running in Iran, with support from the World Health Organisation.

Harm reduction

Advocates of 'harm reduction' say Asian leaders must be pragmatic if they want to stem the transmission of HIV both among drug users who share needles, and into the wider population through unsafe sex.

'What we're doing is protecting young people who use drugs, and ultimately that helps

everyone,' says Patrick O'Hare, executive director of the International Harm Reduction Association, a campaign group in Melbourne, Australia.

That includes Budi, who so far has escaped HIV. But 24 of 35 drug users at the same centre have tested positive, an infection rate mirrored at other drug clinics. It is estimated that Indonesia has up to one million injecting drug users (IDU).

Experts say high-risk groups like Bali's needle users, who are young and sexually active, often act as a reservoir for hepatitis C and HIV.

Budi says he knows the dangers of using dirty equipment. 'Clean needles don't help me to stop [using drugs], but at least it's less risky,' he says.

The Bali project is one of two needle exchanges in Indonesia that, while already quietly operating, has received government backing, if not explicit legal approval. Six more plan to open around the country by year's end using Australian and US funds.

Staff workers in Bali say that police are so far taking a hands-off approach and have recently issued identity cards for workers who distribute needles. But the notion that drug addicts should be helped, not hindered, remains controversial here, as it does in many countries.

'Harm reduction is a new approach in Asia, so of course it can be hard for police to accept . . . because in the meantime the drug laws haven't been changed, so it requires some pragmatism,' says Dr Sandro Calvani, regional director of the UN's Office on Drugs and Crime.

Sending the wrong message?

Across Asia, police and narcotics officials worry that harm reduction sends the wrong message to young people, undermining years of stern anti-drug campaigns. Many continue to insist that medical treatment and abstinence is the answer to addiction.

'A lot of police grow to hate and despise drug users. They don't understand why they don't just give up the drugs,' says Drew Morgan, an Australian policeman based in Hanoi for an HIV/AIDS awareness training program for Asian security officials.

The result is often a clash between public health officials, who tend to support harm reduction•even if it breaks the law•and security officials who dislike bending rules. Advocates of harm reduction insist that they aren't promoting drug use, rather accepting that, until users can break their habit, safer behaviour is paramount.

Abridged from the *Christian Science Monitor*, 8 May 2003.

Taken from *The Hep C Review*, ed. 41, 8 May 2003. Also www.hepatitisc.org.au/reviews/reviews.htm>

Philippines

Public Burning, Shame Campaign In Anti-Drugs Drive

MANILA: President Arroyo on Wednesday ordered weekly public burnings of illegal drugs

seized by the police, as well as the publication of mug shots of arrested drug dealers.

'Let us put a face and identity to these people and get the public involved in hunting them down,' Arroyo said in a statement that detailed fresh initiatives in her highly publicised war on illegal drugs.

She ordered police to publish pictures, names and aliases, passport numbers, immigration records and addresses of 'every personality suspected to be involved in a drug case'.

Arroyo said the campaign has led to 'discoveries of large stocks of shabu (metamphetamine hydrochloride, a stimulant also known as 'ice') as a result of the cooperation of the public'.

She ordered narcotics police 'to set aside a regular day of the week for the public burning of drugs, raw materials or precursors so that these cannot be recycled for the illicit market by unscrupulous law enforcers.

'I want a strict accounting of drugs confiscated and drugs destroyed to the last gram,' she said. 'Once charges are filed covering a drug stash, the latter must be immediately destroyed, save for the amount needed to be used as evidence in court.'

Police announced late last month that nearly 16,000 people, including a number of alleged Chinese and Japanese drug dealers, had been arrested over the past year.

In June, Arroyo announced a heightened anti-drug campaign that she said was inspired by the crackdown launched by Thailand's Prime Minister Thaksin Shinawatra.

The Thai leader declared a war against drugs in February and proclaimed the results as a success despite an outcry from human rights groups over the draconian methods used.

Police said at least 70 percent of all crimes in the country were drug-related. They said drug users number up to two million in a population of 80 million.

Authorities have said 175 international and local drug gangs operate in the country.

Sunstar Bacolod (Philippines) 16/3/03

USA

Drug War Enlists Church Youth Groups

WASHINGTON: The Bush administration's latest effort to expand the role of religious organisations in government services enlists church-based youth groups in anti-drug programs.

The Office of National Drug Control Policy is offering guides, brochures and a Web site with information for leaders of religious youth groups to use in teaching - or preaching - a message against the use of marijuana and other drugs.

'Religious institutions are an enormously powerful influence on young people,' John P. Walters, director of the office, said in announcing the program yesterday. 'A lot of faith-based communities don't know how to talk about drug use. There's a need for a tool like

this.'

A study published in March by the American Psychological Association found that teenagers were less likely to use marijuana if they thought religion was important to their lives.

Joining Walters to tout the initiative were representatives from Christian, Jewish and Islamic organisations.

'Our churches must be a vehicle through which valuable information can be disseminated,' said Brenda Girton-Mitch, associate general secretary for public policy for the National Council of Churches.

Critics of the administration's religious initiatives said spiritual groups were already fighting drug use among their members and did not need the federal government to get involved.

'It's another example of how the Bush administration is obsessed with finding a faith-based solution to every social and medical problem,' said the Rev. Barry W. Lynn, executive director of Americans United for Separation of Church and State, a watchdog group.

'Most of the denominations have anti-drug programs,' he said. 'Many combine good science with their own personal religious message, but they do so without federal funds, and that's how it ought to be.'

The government is providing a 100-page guide to youth leaders. 'As a youth leader, you are in an ideal position to influence youth by illustrating the practical power of faith in your life,' the brochure says.

It suggests that youth leaders discuss peer pressure and lead prayers asking for strength to say no to 'bad influences.'

A priority of the Bush administration is to break long-standing barriers to federal funds for religious groups. But it has been unsuccessful in urging Congress to pass sweeping legislation to open government programs to such organisations.

Jonathon Salant, *Philadelphia Inquirer* 9/7/03

Argentina

Medical Marijuana Bill Introduced In Argentina

Deputy Irma Parentella has introduced the first bill in the Argentine legislature that seeks to open the door to the medical use of marijuana in that South American nation. The bill introduced last week would allow cancer and HIV/AIDS patients to use the herb in clinical research trials.

'There are studies that demonstrate the efficacy of the use of this drug to alleviate pain in the sick,' Parentella told the Argentine daily *Pagina 12*. The primary pressure for the bill came from 'the opinion of hospital palliative care specialists who support the raising of the restrictions that exist today in order to be able to experiment and investigate' with marijuana, Parentella added.

But the Argentine Harm Reduction Association also deserves some credit for the movement

on medical marijuana. The introduction of the bill is an echo of the 'important debates recently encouraged in the media by the Argentine Harm Reduction Association and its marijuana marches in the framework of the Million Marijuana Marches 'Cures Not Wars' campaign in recent years,' wrote ARDA director Dr Silvia Inchaurreaga in a communique announcing the legislation. The last Million Marijuana March organised by ARDA on 4 May, which demanded the decriminalisation of drug use in Argentina and the medical use of marijuana, drew 12,000 people to a 'Festival Against Intolerance,' Inchaurreaga added. Specific demands included 'for the defence of scientific investigation of the therapeutic uses of marijuana' and 'help for those patients who require its therapeutic use,' she wrote.

'We want a medicine based on evidence, not myths and the demonisation of drugs, and marijuana in particular,' Inchaurreaga told DRCNet. 'ARDA is the only group in Argentina that makes advocating for medical marijuana a key project,' she said.

That presents some political difficulties, Inchaurreaga said. 'Even for some progressive deputies, decriminalisation is not a good word, and an openly anti-prohibitionist organisation like ARDA may not present the best face for a medical marijuana bill. But we are the only group that is making that demand. There are always political risks when mixing different issues. We always defend human rights and access to medical care, but we have to emphasise that we are not promoting medical marijuana because we want to decriminalise drugs. We do want to decriminalise drugs and drug users, but that is a different issue.'

The bill will face certain opposition, said Parentella. 'The response I anticipate to possible questions is 'what need is there that someone suffer when the possibility of easing his pain exists,'" she told Pagina 12. There will be 'bigoted questions,' she added. 'One of the questions I anticipate will be that possibility that the drug will generate addiction in its users, an argument that is refuted by comparing the rate of addiction for marijuana, which is less than that for tobacco and equal to that of legal pharmaceuticals,' she said.

ARDA is working with Parentella on educating legislators and the public on the issue, said Inchaurreaga. The group is organising a symposium on medical uses of marijuana at the National University of Rosario, Argentina's second largest city, which will include an appearance by Dr Aquiles Roncoroni, a leading academic authority at the National Academy of Medicine. Roncoroni recently appeared with ARDA on the Argentine TV program 'Key Hour' to promote medical marijuana, Inchaurreaga added.

The concepts of harm reduction have played a role in preparing Argentine society for the notion of medical marijuana, Inchaurreaga said. 'Not only does harm reduction imply an acceptance that some people will continue using drugs, it also allows us to address issues around the use of marijuana, whether recreationally or medically, such as marijuana in food form, the use of vaporisers and water pipes to reduce pulmonary damage, and avoidance of things like sharing pipes, driving while impaired, and not mixing it with alcohol,' she said. 'One result is that people can come out from the shadows and speak openly about the benefits and costs of marijuana use.'

And while ARDA recognises that getting the current bill passed will be a battle, it is already gunning for more. 'If we can speak out, if the patients can speak out, if the people can come out from the shadows as they do for the Million Marijuana Marches, if we can mobilise to say that we do not want our people arrested for marijuana use, whether therapeutic or otherwise, then things will begin to change,' said Inchaurreaga. 'We have this bill that seeks to legalise research on marijuana's efficacy for AIDS and cancer patients, but we will try to include Multiple Sclerosis patients, too. Then maybe we can actually begin the first study that has been proposed by the Drug Abuse and AIDS Advanced Studies Program at the

National University of Rosario and the Santa Fe AIDS Program,' she said.

`And then we will move on to the decriminalisation of marijuana. We are working hard through the Argentine Decriminalisation Campaign and we are working with some legislators and hope to have a bill presented soon.'

The climate is changing in Argentina, said Inchaurreaga, in part because of the opening created by ARDA, but also because of encouraging signs from the Argentine government of newly-installed President Nestor Kirchner. `I am optimistic because of the opening of debate around this issue in the last two years, but also with the nomination

of Dr Raul Eugenio Zaffaroni to head the Argentine Supreme Court. Zaffaroni is an anti-prohibitionist who wrote the prologue to the recent ARDA book, *Drugs•Between Harm and the Failures of Prohibition: New Perspectives on the Decriminalisation/ Legalisation Debate*.

It's always nice to have a friend on the Supreme Court.

Book Review

Don Matthews

Don Matthews has taken over from Elly Inta as our regular reviewer, and we look forward to many insightful and entertaining reviews.

••• ••• •••

DOPELAND

By John Birmingham

Random House, Sydney 2003

Well, whatever I expected Tony might send me for my first review, it certainly wasn't anything like this. *Dopeland* is a very unusual book by a well-known and versatile Australian writer. John Birmingham has created a 21st century `picaresque' novel in this 256-page rambling Australia-wide journey. Most of it undertaken , I might add, with the benefit of liberal lashings of marijuana.

If you need reassurance about this book, it might be a good idea to read the last two pages first. I have reviewed hundreds of stories and novels over the years and I cannot remember ever offering such advice: but in this case you might find some comfort in knowing that Birmingham has things under control, and that all these recollections and anecdotes are part of his rich and colourful background. That's the message, anyway, of the final paragraphs.

The book is full of dope and the dope community. It is rich in its recreation of recalled scenes and incidents associated with this community. Some of the memories border on the insane, others on the absolutely hilarious, and still others on frustrating dealings with the law. Applications of law (for example recent changes in WA) leave you not knowing whether to laugh or cry.

Birmingham tells a good story. The cover says that he is `taking the high road through

Australia's marijuana culture'. The high road, yes, and sometimes sprawled all over it and quite out of circulation. Thank God for the last two pages, so far as his personal comfort is concerned.

The book will certainly upset a lot of people for a lot of reasons. If you have any difficulty with two of the more popular four-letter words in the language, you would have to excise every page in this book before you can cope with reading it.

Birmingham's opening quote is from a song by The Whitlams. I recalled with a wry smile an earlier (gentler) pop song, *All of my friends are getting married* (Skyhooks, I think), as I read, on this occasion, *All my friends are fuck-ups but they're fun to have around*. After you read this book, no, after you read about twenty pages, you will simply nod in agreement. All Birmingham's friends certainly are/ were seemingly very much as described.

Among my favourites was a strange Dutch group that paid him a lot of money to introduce them to the pleasures of the bucket, and also the great bunch of weirdos that he met in Western Australia.

Throwaway short anecdotes are absolute blockbusters. My favourite is the lesson in dog training (suffice to say that you have to demonstrate to the dog your innate ability to overwrite his authority, tree by tree), and the midnight misdirection through the wrong door (with mother-in-law asleep in the room behind that wrong door). You just can't help laughing out loud.

I was genuinely absorbed with the real and mock research behind the historical chapter (*The Stoner Age*) with its riotous throwaway lines about the Greeks and Romans, and the ancient gods and devils of India, and the eccentricities of Chinese natural doctors.

On the medical front, Birmingham makes great claim for marijuana as a memory aid and a buffer against absent mindedness. Or the reverse. He is not quite sure. Again, you just can't help laughing along with this wandering, hazy persona he has created.

If you get as far as page 200, you will find a certain sobriety appearing in the writing as he comes up to date. But overall, he ranges from the absurd to the genuinely depressing, and to the outrageously funny. He can make a sudden, incisive observation which you realise is extremely important, such as his satirical debunking of hypocritical differences within and between State laws. But if you do not have some interest in the drug scene, you may not want to read this book.

Essentially it is what I said in the first paragraph, a rambling picaresque with marvellous anecdotes and a lot of highly perceptive observations. But it is highly focused (even when stoned).

Magic Circle Of Shame That Breaks The Crime Cycle

Jonathan Pearlman, Sydney Morning Herald 28/6/03

Dale Longbottom, who has been in and out of prison and local courts for most of his adult life, appeared before 140 of the state's magistrates this week and said he didn't intend seeing any of them again.

'Maybe there is some help out there for us,' he said.

'I reckon if this circle sentencing goes through to other towns and places, the statistics for all of us Aboriginals going to jail will go down.'

Actually, his first words were: 'Gee, this is a big surprise. I haven't talked to this many people since I was in AA.'

Mr Longbottom, 34, was describing his experience of the 'circle sentencing' courts being trialled in Nowra to an audience including the magistrates and the NSW Chief Justice, James Spigelman, at the local courts conference at Brighton-le-Sands.

Eighteen offenders have been sentenced in the 18-month trial in which indigenous offenders are sentenced by a 'circle' which includes local elders, a magistrate, a prosecutor, family members and victims.

'Telling them all what I'd done was shameful,' said Mr Longbottom, who received a sentence of 500 hours' community service for assault earlier this year. 'It was a lot harder for me to face up to a circle sentence than to face up to a local magistrate, because I was going in front of my elders my aunties and uncles. I'd let my elders down.'

Two seats from Mr Longbottom at Thursday's conference was Patrick Tynan, who reluctantly participated as the victim in the circle sentencing of an offender who had broken into his Shoalhaven electronic store.

'I was sitting virtually opposite this offender who had instigated his eighth break-in in the previous 12 months,' he said.

'I wanted to see him put away, to make him pay for his actions. The participants allowed me to state it as I saw it. The Aboriginal elders took up the victims' concerns and said he'd let down his heritage and his community. By the time it was over, I was satisfied. I had my day in court and felt justice had been done. The victim was remorseful. It worked because the offender wanted it to work.'

Shoalhaven's police prosecutor, Craig Veness, said the circle courts were helping to bridge historically troubled relations between the police and indigenous people. 'I was driving home an elder from a circle court and he said to me, 'This isn't white man's law anymore. It's the people's law.' 'Is this not what we have always wanted to achieve? I think it is.'

The NSW Attorney General, Bob Debus, has said the trials will be extended to Dubbo, Walgett and Brewarrina.

Newman Set For Grog Curbs

Simon Penn, *West Australian* 19/7/03

Rocketing crime and anti-social behaviour mean Newman will become the latest northern WA town with community-wide restrictions on alcohol supplies.

A six-month trial of restrictions will begin in August after an inquiry by Liquor Licensing director Hugh Highman.

Newman police Sen. Sgt Steven Gosney told the inquiry that arrests and charges were increasing at an astounding rate and the number of drunks beyond being able to care for themselves had increased alarmingly.

He said the number of arrests in the first four months of 2003 had risen 54 percent from 2002 averages. For the seven months to 25 April 2003, 77 percent of incidents attended by police were caused by alcohol.

The restrictions limit the availability and strength of take-away alcohol and ban big containers such as 750ml beer bottles and wine casts over two litres.

Mr Highman said take-away alcohol posed a very serious, increasing problem in parts of country WA. He had received a request from health authorities in Carnarvon for an inquiry and it was likely restrictions would be considered in other towns.

A report by the State Government's Drug and Alcohol Office showed alcohol consumption per capital in the Kimberley, Pilbara and Gascoyne regions increased 12.7 percent from 1990 to 1998 to a level 1.89 times higher than the State average. Consumption of spirits increased 75 percent and alcohol-related assaults rose 74.7 percent.

In Meekatharra, a six-month trial of restrictions began this month after police reported almost 70 percent of incidents in 2002 were alcohol-related.

In South Hedland, police reported 60 percent of call-outs in 2001 and early 2002 were alcohol-related. A 12-month trial of restrictions in Port Hedland and South Hedland was due to begin in June but was postponed because of a Supreme Court challenge from a liquor outlet.

Restrictions also apply in Halls Creek, Onslow, Nullagine and Wiluna.

In Derby, police and community groups are opposing an application by a hotel to extend opening hours.

Derby Local Drug Action Group spokesman James Pillsbury said the move would make big problems worse.

'A plethora of issues will be exacerbated and new ones created in a community where alcohol-related problems including violence and other sexual, mental and social dysfunctions occur all too frequently,' he said

MERIT Site Contacts At A Glance

Area Health Service	Contact Person	Telephone Number
Central Coast	Lyn Bond	4320 3752
	Steve Childs	4320 3057
Central Sydney	Craig Cooper	9797 9930
Far West	Gerard Garry	08 8080 1572
Greater Murray	Bronwyn Buller	6921 3159
Hunter	Clare Felton	4924 6800
Illawarra	Mark Buckingham	4228 8211
Macquarie	Nicole Maher	6884 7089
Mid North Coast	David Rogers	0408 477 832
Mid West	Kylie Crawford	6392 6800
New England	Lyn Gardner	6766 8081
North Sydney	Matt Jessimer	9906 7083
Northern Rivers	John Scantleton	6620 7650
South East Sydney	Julie Carter	9521 8922
South Western Sydney	Sandra Sunjic	9602 6777
	Andre Van Altena	
Southern	Susie Wallis	6299 1725

Wentworth	Angela Keating	4734 3739
Western Sydney	Tanya Merinda	8838 2003
Wellington OPTIONS	Leon Smith Nicole Maher	6845 3300

Drug Programs Bureau

<p>Martin McNamara</p> <p>MERIT Program Coordinator</p> <p>(02) 9424 5748</p> <p>mmcna@doh.health.nsw.gov.au</p>	<p>Kevin Roberts</p> <p>Database Management & Support Officer</p> <p>(02) 6620 7685</p> <p>kevinr@nrhs.health.nsw.gov.au</p>
<p>Simon Johnston</p> <p>MERIT Project Officer</p> <p>(02) 9391 9286</p> <p>sijoh@doh.health.nsw.gov.au</p>	<p>Marianne Kennedy</p> <p>A/Project Officer</p> <p>(02) 9391 9057</p> <p>mkenn@doh.health.nsw.gov.au</p>

Other Agencies

<p>Joanne Jousif</p> <p>Attorney-General's Department</p> <p>Senior Policy Officer</p> <p>(MERIT)</p> <p>(02) 9228 7625</p> <p>joanne_jousif@agd.nsw.gov.au</p>	<p>Neda Dusevic</p> <p>NSW Police</p> <p>Senior Policy Officer</p> <p>(Drug Diversion Program)</p> <p>(02) 9384 6595</p> <p>duse1ned@police.nsw.gov.au</p>
---	--

Thought Of The Month

Walk on, walk on with hope in your heart, And you'll never walk alone.

Oscar Hammerstein II

Memorial Corner

To remember loved one's who have lost their lives to illicit drugs.

Family Support Meetings

Non-religious, open meetings for family members affected by drugs and alcohol. Open to anyone and providing opportunities to talk and listen to others in a non-judgemental, safe environment.

Information/Education Nights

Refresher night for FDS volunteers on the telephone service.

A Guide To Coping

Our family education kit *A Guide To Coping* is receiving acclaim across the country. Many professional agencies have praised the soundness of the information and strategies contained in the kit. This revised edition contains extra information and information sheets introducing the new model of family coping and management, *Stepping Stones to Success*.

Subscribe to FDS Insight for 12 months and receive *A Guide To Coping* without additional cost. (Note: Additional copies of *A Guide To Coping* can be purchased for \$12.50 - with a discount available for bulk purchases).

For more information Phone **9715 2632**

Contributions to **Insight** do not necessarily reflect the opinion of Family Drug Support or its Committee.