October – November 2015

FDS insight

1300 368 186 FAMILY DRUG SUPPORT

Supporting families affected by alcohol and other drugs

Family Drug Support Line 24/7 – Phone 1300 368 186

T: (02) 4782 9222 F: (02) 4782 9555 www.fds.org.au ISSN: 1833-4997

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Your kids on ice – What to do next

Tony Trimingham

Senator Jacqui Lambie's story has of course highlighted the emotions and struggles that families across Australia face when they discover a family member is on crystal methamphetamine or 'ice'. Without referring specifically to Senator Lambie's situation, as I am unaware of the full circumstances of her situation, I would like to discuss what families can do for positive outcomes.

Whilst we are seeing an increase in calls about 'ice' on our support line – from 18% of calls three years ago to 32% in the recent financial year we have seen a drop in calls about base amphetamines from 18% to 5% - which suggests many ice users are speed users that have shifted to 'ice'. Also at least a third of current callers that are reacting to media reporting of the problem – much of it exaggerated. Some things are true – ice use is widespread – across all areas and communities, all states and territories. Rich and poor are using it. Many industries are affected, road transport, hospitality, fishing and mining. Volatile behaviour, aggression, temporary psychosis, increased sexual activity can all be part of the stuff that families have to deal with.

So if someone in your family is using ice what can you do?

A few facts on the usage of ice. About 2% of Australians have used ice. More than 70% of users are using less than once a month, about 71,000 Australians are considered dependant on the drug and about 10% of this number are exhibiting the chaotic and problematic behaviour mentioned above. Most of these people are using other drugs as well.

So, many people using ice will not be long term problematic users. They may try it and give it up, they may use for a while and then give up, so the first thing is to not panic and react.

Staying calm and not panicking is the first suggestion – not easy but definitely helpful. Calm communication using 'I' statements rather than 'you' directive messages will be more effective. Remember that listening is the most important communication skill but usually not done well. Listening and understanding will give many clues to what is happening and often dealing with it. I know this may be easier to say than to do but practice will produce results. You may have to look for cues for when they are willing to talk and again it is important to take opportunities. If verbal communication has broken down try a written form – text, email or a good old fashioned letter using the same 'I' messages. Tell them you love them and want to support them. Encourage honesty and model trust. Let them know that you would like to know the truth – by letting them know you can take it. You won't abandon them, you won't fall apart, and you can accept reality even though you may not like it. Speak honestly about your thoughts, feelings and wishes – but accept that they may not agree. If you

want to trust them – model trust. Do not search their rooms, read their Facebook etc. Nothing you find will help you and by resisting this you will encourage their honesty. Look after your self – keep pursuing your interests and hobbies, relationships, faith, exercise, diet, emotional, spiritual and physical wellbeing.

Get support from helpful areas. There are support groups, courses and telephone lines that can help you keep your sanity and acquire skills to cope.

FDS is not a tough love group. We do not encourage abandonment or silly notions like 'rock bottom' but we believe in having effective boundaries with consequences that everyone can live with.

We believe that violence in not acceptable and it may be necessary to ask them to leave or even take out an apprehended violence order if aggression and violence is present. This can be done with love and connection, address the behaviour not the person. Planned exits where you assist them to leave and get other accommodation are better that throwing them out. Have emergency plans in place even though you hope never to need them. Keep exits clear. Remove potential weapons from view and walk away from conflict.

Australian treatment services are very good and available for all who seek help. People have to be motivated and ready for change and must get there in time. In the meantime reducing risk, harm and keeping people healthy are so important.

Do not give up on hope. We have witnessed many positive outcomes. This is a drug like any other and it can be addressed effectively. It is not easy but we must strive to assist where we can. One thing is certain – families need to be assisted and therefore support services need sufficient resources to assist them.

2016 subscriptions now due

FDS 1300 368 186 FAMILY DRUG SUPPORT

Please renew your membership as soon as possible and continue your support for FDS, as well as receive FDS Insight and access our events for another year.

Please phone/fax or email/mail us in the office.

Phone (02) 4782 9222 to pay by credit card

Fax: (02) 4782 9555; Email: general@fds.ngo.org.au

Mailing address: PO Box 7363, Leura NSW 2780

Thank you

INSIGHTS OUT

By the time you are reading this I will probably be in New York City, along with several people from around the world. I have been invited to consultations with public officials and community forums because of the massive heroin problems they are experiencing over there.

Dr Marianne Jauncey, from the Sydney Medically Supervised Injecting Centre, will be travelling with me and hopefully I will be catching up with some family groups in order to pass on the FDS model.

There has been a strong movement away from the tough approaches of families in the States and more of them are taking a harm reduction approach which is spreading across the country. They are happy to establish an injecting centre in New York City. It is also likely that one will be established in Dublin within the next few weeks.

In October, I have been invited with 24 other community representatives to be embedded for three days with the NSW Police Force. We will be eating, sleeping and living with them, and taking part in activities such as water policing, terror incidents, police pursuits, domestic violence and mental health interventions, and firearms training. It is very exciting but also quite daunting.

We lost one of our former volunteers from Canberra recently. After a long illness, Max passed away. With his wife Trish, Max was on the telephone line and attended Mulgoa after dealing with their families' drug issues. They are in our thoughts.

We are coming up to a very busy time at FDS with our Mulgoa workshop at the end of October and volunteer training in Sydney and Adelaide, as well as several Stepping Stones courses around the country. You can see details of all of our events in the middle section of this bulletin.

We also have a new Prime Minister! Everyone is hopeful that this will translate into more action, money and better policy for drugs. We will wait and see.

Please renew your subscription to FDS as soon as you can to ensure our work will continue.

Regards, Tony T

Advertisement from Medical Journal of Australia 1975

PRESCRIBING INFORMATION
MOGADON
INDICATIONS: Sleep disturbances. **DOSAGE:** 1-2 tablets (5–10 mg) before retiring. Elderly patients ½-1 tablet. **CONTRAINDICATIONS:** Myasthenia gravis, severe chronic obstructive airway disease with incipient respiratory failure. **PRECAUTIONS:** Mogadon may modify the patient's reactions (driving etc.), and if combined with centrally acting drugs such as neuroleptics, tranquillizers, antidepressants, hypnotics, analgesics and anaesthetics, it should be borne in mind that their sedative effect may be intensified. Since elderly patients are often particularly sensitive to drugs, the dosage should be adapted accordingly. In elderly patients, especially with cerebrosclerosis or cardiorespiratory insufficiency, caution is indicated, as with all hypnotics and in rare cases paradoxical reactions in the form of restlessness and confusion may occur. **REPRODUCTION STUDIES:** Laboratory studies and clinical experiences with nitrazepam have revealed no signs of noxious effect on foetal development with doses administered in animals, corresponding to up to 500 times the normal therapeutic doses in humans. However, according to an established medical principle, nitrazepam should be given to women who are or who may become pregnant only when the potential benefits have been weighed against possible hazard to mother and child. Nitrazepam was administered to 5 lactating women to investigate the excretion of the drug in breast milk. Very low levels of nitrazepam were detected — 0.05 to 0.1 µg of nitrazepam and/or metabolites per ml of milk. It seems unlikely that such small concentrations would produce any pharmacological or toxic effects. **SIDE EFFECTS:** Mogadon is well tolerated. In high doses (up to 200 mg orally) the muscular and psychosomatic relaxation characteristic of the benzodiazepines is marked. Rare cases of ataxia have been observed. Respiration and blood pressure are unlikely to be affected by therapeutic doses of Mogadon. **PRESENTATION:** Tablets 5 mg. Bottles of 25, 150, and 1000.

ROCHE Roche Products Pty. Limited. Sydney.

MOGADON: a change for the better.

N.H.S. GENERAL BENEFIT

Martin, E.W.: Hazards of medication, J.P. Lippincott Co., Philadelphia (1971).

Mogadon = Trade Mark

RPS 4

1199/1075/46

Are we in the midst of an ice epidemic? A snapshot of meth use in Australia

Nicole Lee, *The Conversation* (8/4/15)

Prime Minister Tony Abbott today launched a taskforce to tackle the growing problem of ice. 'As a citizen and as a parent I am appalled at what is happening on our streets and in our homes,' he said, adding that the taskforce will canvass the problems and report back with a strategy by mid-year.

But while Australia certainly has a problem with ice, it's hardly an epidemic. Let's consider the data on use and harms. But first, what is it?

Methamphetamine is a potent stimulant drug that comes in several forms: a powder, speed; a crystalline form, crystal meth or ice; and a base form, resulting from poor conversion of methamphetamine oil to crystalline form.

While the chemical composition of these three forms is the same, the potency varies, with ice the strongest.

Illicit methamphetamine use is relatively high around the world, but Southeast Asia in particular is a major hub for production. This impacts on Australia, which has one of the highest rates of use in the world.

Yet, the prevalence of methamphetamine use in Australia has remained stable since 2001, at around 2% of the population. That is, the number of people who use methamphetamine has not changed in at least the last ten years.

However, there have been significant shifts recently in the way methamphetamine is used that have created significant issues for users and the community.

Changing use

First, the number of methamphetamine users who prefer ice over other types of methamphetamine has doubled, from 27% in 2007 and 22% in 2010, to 50% in 2013. The proportion of people using it at least weekly has grown, from 9.3% in 2010 to 15.5% in 2013.

There has also been a significant increase in smoking as the main route of administration, from around 20% of regular users to 40%.

Other data show an increasing purity of ice, from an annual average of 21% in 2009, to 64% in 2013. The purity of traditionally lower-grade speed has also

been increasing, from 12% to 37% between 2009 and 2013.

The price of both crystal and powder methamphetamine, based on purity, is now more similar than in previous years, making ice a more economical purchase for users.

Growing harms

There has been a corresponding increase in people seeking treatment at drug and alcohol clinics. The proportion of treatment 'episodes' where methamphetamine was the principal drug of concern doubled from 7% in 2009-10, to 14% in 2012-13.

There has been an 88% increase in ambulance call-outs in metropolitan Victoria and a 198% increase in call outs for methamphetamine-related incidents in some regional areas. People in regional areas are twice as likely to use methamphetamine as those in major cities (and are more likely to drink at risky levels and smoke cigarettes).

Hospital presentations for methamphetamine-related problems are the second-highest among the four major illicit drug types, with 182 'separations' per million people in 2010-11.

Finally, arrests for methamphetamine-related crimes have increased by 30% between 2010-11 and 2011-12. And a review of more than 80,000 Queensland roadside drug-tests between 2007 and 2012 found methamphetamine to be present in 41% of positive results.

Getting help

Data we are currently analysing from the government's National Drug Strategy Household Survey suggest these changes are driven primarily by those who use more than once a month. This group is more likely experience harms from regular use, such as dependence, mental health problems and sleeping troubles, and would benefit from early treatment.

Irregular users are not at high risk of dependence but may experience acute harms, such as overdose, and require harm-reduction strategies.

Both of these groups are, in some ways, hidden populations. They may not disclose their use of methamphetamine to their GP or other health professionals unless asked, and may not present to tertiary treatment services until their problems are severe. There is a time lag of around five years between early methamphetamine-related problems and treatment.

While investment in policing and prevention is important, the bulk of the changes in use and the resulting harms are due to the small proportion who use more regularly and are at risk of dependence.

We know that for every dollar spent on drug treatment we save A$7 to the community, compared with A$2 for stronger policing. We need to ensure that treatment is a significant part of the solution to the problems created by changes in methamphetamine use.

Nicole Lee is the Associate Professor at the National Centre for Education and Training on Addiction at Flinders.

Not the boat people

'Another desperate group of people fearing persecution and inhumane treatment if they return to their own country – it's the Australian cricket team.'

Alcohol still the worst

Sam Rigney, *Newcastle Herald* (5/8/15)

It's been labelled an epidemic, a pernicious scourge sweeping the nation and leaving broken families in its wake.

But, according to Family Drug Support (FDS) program manager Julie Clark, alcohol is still Australia's most damaging drug and causes more harm in society than methamphetamine or ice.

Ms Clark will host an award-winning program for families of alcohol and drug dependents at Carrington Community Centre during two weekends this month.

The course, entitled Stepping Stones to Success, aims to increase people's confidence and competence in managing drug issues.

It provides a reality-based education approach, which includes gaining a

new perspective and breaking the 'cycle of shame and blame' which often ensnares families.

Most of all it's about giving people the tools to cope and providing hope that they will survive.

FDS have been providing a range of specialised support services designed for family members coping with alcohol and drug dependents for the past 17 years. The Stepping Stones course has been delivered for more than a decade, helping more than 1200 family members of the drug dependents.

'I have seen the enormous difference this course makes to people's lives,' Ms Clark said.

'They are stronger, better supported and have taken on skills to better manage their relationship with the user. 'This will in turn help the user towards better outcomes.'

Mr Clark said excessive alcohol and drug use impacted everyone in the family.

'Often the journey is long and painful,' she said. 'Sadness, isolation and loss of hope are common feelings. 'Nothing prepares families for these impacts. 'Yet they continue to support those who are dependent despite all the chaos. 'However, in return families are often judged and discounted. 'Rather than getting support, families are left to deal with huge amounts of blame, shame and stigma.

'This program is about getting family members to be resilient and learn how to cope. 'To get healthier and not be so consumed by the drug user. 'To give them coping skills, communication skills particularly.'

Mr Clark said despite the hype around ice this year, alcohol remained the country's worst addiction. She said talking about ice as an 'epidemic' made people 'fearful and panicky' and gave the impression the situation was helpless.

'Alcohol causes more harm to society than any other drug,' Ms Clark said. 'Including ice, cannabis, heroin and prescription drugs.

'If you look at the statistics, the amount of people using methamphetamine hasn't increased, there is just a change to people using ice. 'Alcohol causes the most harm, it is responsible for more than 60 diseases in the body.

'We're not saying that people shouldn't worry, it is really difficult for families to deal with. 'BUt we want to give families the message of hope, that they can learn new skills and get the support to survive.'

The Stepping Stones course runs over two weekends on August 15 and 16 and August 29 and 30 at Carrington Community Centre on the corner of Young and Hargraves Street.

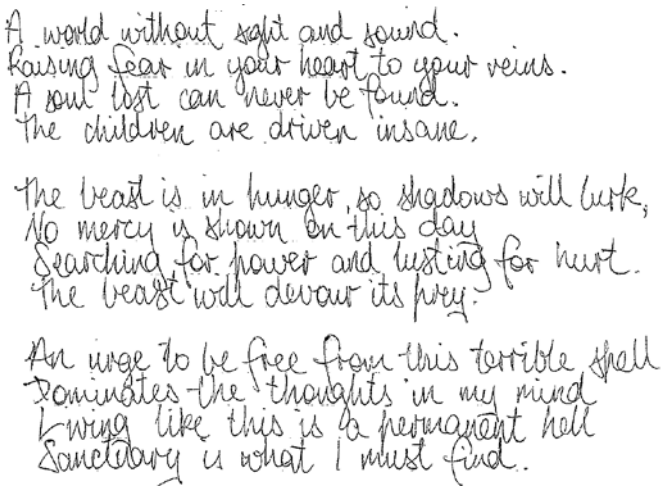
Bookings are essential and should be made as soon as possible by calling Julie Clark on 0400 113 422.

For 24/7 help or support, call the service's free support line on:

1300 368 186

Damien's poem

While going through Damien's things recently I came across this piece he wrote when he was struggling with drugs – Tony T.


A world without sight and sound.
Raising fear in your heart to your veins.
A soul lost can never be found.
The children are driven insane.

The beast is in hunger, so shadows will lurk,
No mercy is shown on this day
Searching for power and lusting for hurt.
The beast will devour its prey.

An urge to be free from this terrible spell
Dominates the thoughts in my mind
Living like this is a permanent hell
Sanctuary is what I must find.

Reflection

Reflection – in the mirror I see me
Reflection – in my eyes I see my life
Some happiness, some sadness
A woman, a mother, a wife.

Over time, things have changed
And I wonder
Am I the best I can be now?

The past is just that – it's over and done with
The future is yet to come
The present is my focus
On me, and my two beautiful sons.

I have an idea where I am going,
My sons … I'm not so sure
I know it's not up to me
But loving them through their trials, is the cure.
So when I look in the mirror

If I'm not happy with what I see
I've decided the answer is simple …
I choose to change me!

Carol M.

ACT drug overdose reversal program should be rolled out nation-wide, expert panel says

Adrienne Francis, *ABC News* (31/8/15)

A trailblazing ACT initiative to prevent drug overdoses has been given a ringing endorsement by an independent panel of experts.

The evaluation team, made up of experts at institutions including the Australian National University (ANU), Curtin University and the Burnet Institute, found more Canberrans die from opioid overdose than in road accidents.

The opioid deaths included overdoses involving heroin and the widely prescribed drug Oxycodone, which is also called Endone.

In 2011, Canberra became the first place in Australia to train injecting opioid drug users and their families and friends to reverse overdoses with Naloxone.

The schedule four opioid antagonist is designed to reverse overdoses and is administered by injection into fatty muscle.

'The most stark finding of the report was that Naloxone has been successfully used in the Canberra community,' ANU social scientist Dr Anna Olsen said. 'We have 57 recorded uses of Naloxone to revive people in the community and I think that really shows that this program can save lives [and] non-medical professionals can appropriately use Naloxone in the community.'

ANU social scientist Dr Anna Olsen

Dr Olsen and others on the expert panel said as a result of the findings, they were recommending the ACT Naloxone program be expanded nationwide.

Alcohol Tobacco and Other Drugs Association ACT (ATODA) executive officer Carrie Fowlie said doctors should routinely prescribe Naloxone to anyone who uses opioids, and to their families and friends.

'We would like take home Naloxone to be a core business of the health sector in annual funding and in routine GP practice,' Ms Fowlie said. 'So if you have an Endone script, and it is highly dependent-forming, you also get a script for Naloxone.'

In the recent ACT Budget the Government funded the take home Naloxone program for a further 12 months.

'That funding is only for 12 months and it is important this program is recurrently funded, both in the drug and alcohol sector and the broader health sector,' Ms Fowlie said.

Since the ACT began the pilot in 2011, it is understood that New South Wales, Victoria, South Australia, Western Australia and Queensland all followed the ACT's lead by introducing community-based overdose reversal schemes.

'Canberra has been a real trailblazer with this,' Ms Fowlie said.

The evaluation of the ACT initiative is also being studied by the Therapeutic Goods Administration which is currently considering whether to re-schedule Naloxone from prescription-only to over the counter availability.

'Overdoses don't have to be fatal'

CAHMA manager Sione Crawford

Canberra Alliance for Harm Minimisation & Advocacy (CAHMA) manager Sione Crawford said he has injected heroin 'on an off' for the past 20 years. Earlier this year he had a frightening experience at home with a close friend.

'She was completely unresponsive to me [and] her lips were turning blue,' he said. 'She was snoring, her breathing was really irregular and she would stop breathing.

'I knew at that point that things were going badly for her. She appeared to be quite close to going.'

Mr Crawford said he knew even if an ambulance was fast, it may still have been too late to save his friend. Fortunately, Mr Crawford was among the 200 Canberrans who had been trained to administer Naloxone.

All Naloxone does is give us an opportunity to reverse the mistake. It increases the likelihood of … surviving something that doesn't have to be fatal.

'Although I had been trained around overdose management, seeing someone that you know and care about in that circumstance and close to death was immediately frightening,' he said. 'But unlike in the past when I had been around overdoses, I didn't panic.'

Mr Crawford successfully revived his friend by administering Naloxone to her.

'I feel incredibly grateful that we have had an opportunity in the ACT to have this prescribed to us,' he said. 'All Naloxone does is give us an opportunity to reverse the mistake.

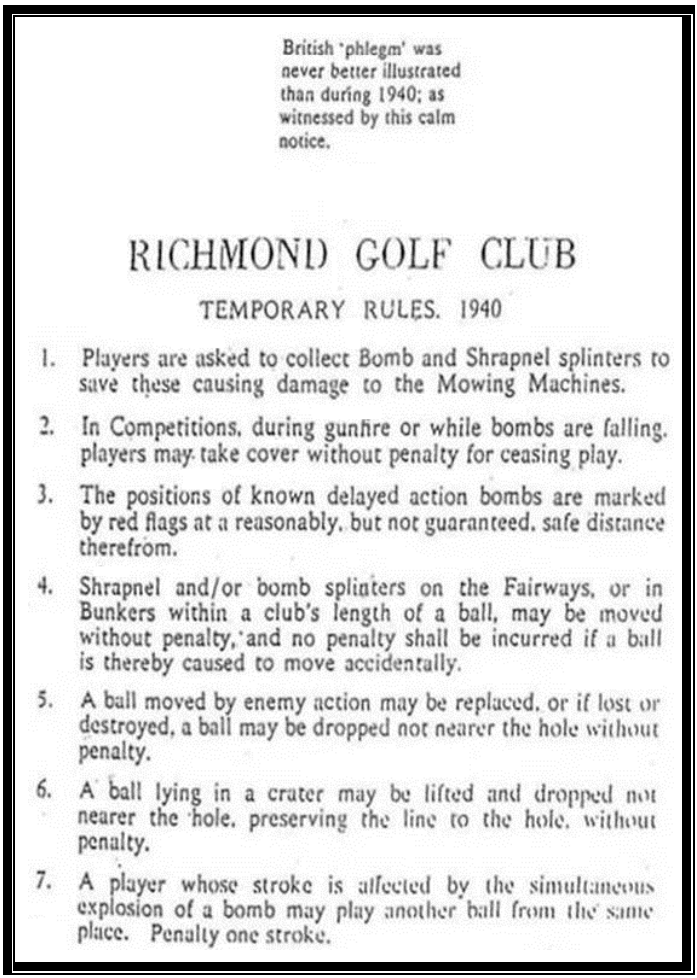
'It increases the likelihood of people in our community surviving something that doesn't have to be fatal.'

British golf rules in 1940

You have to hand it to the British, when it comes to golf. You thought you were a tough weather golfer?

This notice was posted in war-torn Britain in 1940 for golfers with stiff upper lips. You have to admit – these guys really had guts!

German aircraft from Norway would fly on missions to northern England; because of the icy weather conditions, the barrels of their guns had a small dab of wax to protect them. As they crossed the coast, they would clear their guns by firing a few rounds at the golf courses. Golfers were urged to take cover.



British 'phlegm' was never better illustrated than during 1940; as witnessed by this calm notice.

RICHMOND GOLF CLUB

TEMPORARY RULES. 1940

1. Players are asked to collect Bomb and Shrapnel splinters to save these causing damage to the Mowing Machines.
2. In Competitions, during gunfire or while bombs are falling, players may take cover without penalty for ceasing play.
3. The positions of known delayed action bombs are marked by red flags at a reasonably, but not guaranteed, safe distance therefrom.
4. Shrapnel and/or bomb splinters on the Fairways, or in Bunkers within a club's length of a ball, may be moved without penalty, and no penalty shall be incurred if a ball is thereby caused to move accidentally.
5. A ball moved by enemy action may be replaced, or if lost or destroyed, a ball may be dropped not nearer the hole without penalty.
6. A ball lying in a crater may be lifted and dropped not nearer the hole, preserving the line to the hole, without penalty.
7. A player whose stroke is affected by the simultaneous explosion of a bomb may play another ball from the same place. Penalty one stroke.

Drug binge culture growing part of Sydney nightlife says paramedic after woman overdoses at The Ivy

James Gorman, *Daily Telegraph* (8/7/15)

City paramedic Hamuera Kohu in Kings Cross

A frontline Sydney ambulance paramedic says Sydney's party set is bingeing on drugs like they once used to with alcohol.

His comments came after a 50-year-old woman became an unlikely victim of the city's drug plague after she was rushed to St Vincent's hospital suffering a suspected overdose during a recent weekend dance party at Merivale's popular Ivy nightclub.

The woman, old enough to be the mother of many of the other revellers at the party, recovered and was released the following morning.

Sydney station officer of intensive care and 20-year veteran paramedic Hamuera Kohu said the explosion of drugs made emergency service workers more vital in the CBD than ever before.

'It used to be heroin that we dealt with, then it became a little bit of speed but now it is primarily methamphetamines,' he said.

'Then, of course, you still have your ecstasy and GHB. It mainly comes down to cash flow when determining what a person is using.

'In the last 20 years the need to have more emergency service workers has increased due to the nature of the drugs being used in Sydney.

'Drug use has always been here in Sydney however it is becoming more prolific and the drugs people are using are becoming more problematic in terms of requiring more management from ambulance and police. People are bingeing on drugs nowadays just like alcohol.'

Police outside the Ivy in March 2014

Sydney City LAC Crime Manager John Maricic confirmed that the incident at The Ivy involving the 50-year old woman occurred on Sunday, June 28 at 9.40pm during the I Remember House event.

A Merivale spokeswoman denied police reports that officers had shut down the party following the incident.

‘Any reports suggesting that the I Remember House party at Ivy was shut down early are entirely inaccurate,’ she said.

‘The third-party event at Ivy was always due to conclude at 10pm. The final song of the evening was played at 9.55pm.

‘The enjoyment of our guests in a safe environment is our number one priority and we work closely with NSW Police to achieve this.’

While it was uncommon for a 50-year to suffer a drug overdose, Mr Kohu said it was not unheard of.

‘It all comes down to where you are in the city and the demographic of your surroundings, if the venue has 18-26 year olds there then it will be 18-26 year olds using drugs,’ he said.

‘When you have an event catered for older crowds you will see a lot of people trying to relive their youth.’

Mr Kohu said methamphetamines were one of the most prevalent types of drugs in Sydney. ‘Ice and those types of drugs are rampant in Sydney and we quite often put ourselves at risk to control those people that we treat and restrain them,’ he said.

‘Where Ice is concerned you can have excited delirium where people get so hyped up on drugs they will literally use all of their reserves through violent outbreaks that they can go into panic alert and their body can just stop. It is very rare but it happens.

‘We always look at how to proceed when dealing with someone on drugs and one of things we have the capacity to do is sedate people.

‘I have been assaulted many, many times whether it’s a slap or a punch unknowingly.’

Trust

Trust in self: Ability to accept and forgive self. To meet own needs. To deal with the internal critic.

Trust in others: Respect + self-respect. Recognise other people’s needs. Letting go of unfinished business.

Trust in the future: Ability to move forward despite the fear. Look at options realistically. Ability to live with uncertainty.

Solid self trust: Intimacy. Health decision-making.

FDS Remembrance Ceremony – 18 July 2015

Tony Trimingham

In 1997, Tony Trimingham and Rev. Bill Crews held a ceremony at the Ashfield Uniting Church to remember those people who have lost their lives to drug overdoses.

The ceremony has been held every year since and this year's event on Saturday, 18 July 2015 at Ashfield was well attended with over 70 people coming together to remember, share and support each other with their loss.

Tony Trimingham, CEO of Family Drug Support, said, *'It is always pleasing to see families showing the courage and the strength to come to this event. Lighting a candle to remember their loss of a loved one and supporting others grieving similar loss is important and uplifting. It does also sadden us however that so many new families came out this year as it shows the significant losses that continue to occur in our community.'*

The speeches given by leading figures in the sector and families all reflected on how many of these deaths were preventable and the need for our drug policies to be far more humane, compassionate and evidence based. The need for political leaders to stop the lip service approach to families and start listening and engaging with affected families was also highlighted many times.

Speakers included Prof. Ian Webster, Mr Gino Vumbaca, Dr Craig Rogers, Rev. Bill Crews and family members.

The names of Andrew Chan and Myuran Sukumaran were also remembered on the evening – again highlighting the brutality and cruelty of many of drug laws that families face.

For support for families and friends dealing with drug use please contact the Family Drug Support, 24 hour/ 7 day phone line: 1300 368 186.

Senators give medical marijuana the green light in Australia

Carol Adl, *YourNewsWire.com* *26/7/15)

Senators from across the political divide will endorse a bill to legalise medical marijuana despite warnings it could create a regulatory nightmare.

Fairfax Media can reveal that a committee made up of Coalition, Labor and crossbench senators will strongly recommend that Parliament pass a cross-party bill to set up a medical marijuana regulator.

Spearheaded by Greens Leader Richard Di Natale, the Regulator of Medicinal Cannabis Bill would effectively make the federal government responsible for overseeing the production, distribution and use of the drug.

Richard Di Natale spearheaded the push for legalising medical marijuana

The bill was introduced into Parliament last November and sent to a committee in February. After conducting public hearings around the country and attracting almost 200 public submissions, the committee is due to deliver its report on August 10.

Sources say the committee will back the bill despite strong concerns from the Health Department.

In its submission to the committee, the department said the bill would set up a new regulatory system that would create 'complexity and uncertainty' and potentially clash with the Therapeutic Goods Act.

Department secretary Martin Bowles warned the bill left important legal and practical issues unidentified or unresolved, 'leading to the risk of regulatory gap, overlapping laws and a lack of clarity about the exercise of jurisdiction by agencies and possible inconsistency with other existing laws'.

The department also warns the bill could contravene some of Australia's international obligations under the Single Convention on Narcotic Drugs.

But sources say the department is just 'flexing its muscles' because it doesn't like the idea of an independent regulator it cannot control.

Senator Di Natale last month conceded there were obstacles to the bill but insisted none of them were insurmountable. He pointed out other countries had managed to legalise medical marijuana without falling foul of the single convention, and said Australia could do the same.

The regulator is necessary because the Therapeutic Goods Administration was set up to process pharmaceutical products and is not equipped to deal with approvals of herbal medicines, he says.

A recent survey by Palliative Care Australia found more than two-thirds of Australians now back the use of medical marijuana. Just 9 per cent of people oppose it.

Prime Minister Tony Abbott last year threw his support behind the legalisation of the drug.

'I have no problem with the medical use of cannabis just as I have no problem with the medical use of opiates,' he said.

Families need support

Besieged families can continue to expect limited support from state government as the ice problem worsens throughout Victoria.

State funding for drug rehabilitation programs has been promised, yet support for families continue to fall by the wayside. Since March this year, the Victorian government released the Ice Action Plan which focuses on reducing and rehabilitating users addicted to the drug methamphetamine.

Commonly known as Ice, the drug's destructive consequences have roused a nation-wide call to action. Under the initiative, Premier Daniel Andrews pledged $4.7 million to facilitate support for families and friends who are often the silent victims in the war against drugs.

However, there is a deficient in long-term support. Recovering users attend and complete rehabilitation programs, often financed by their own families. Still, there is a lack of resources available to them afterwards. Ongoing support is essential to the families of those who are recuperating. According to Tony Trimingham, director of the non-profit Family Drug Support organisation, assistance is available but resources are spread thin. In addition to providing a 24/7 national helpline run by volunteers, Family Drug Support offers support meetings that gamers upwards of 1294 participants in metropolitan areas alone.

‘We can provide extensive support for families, but there's been no word of funding for these programs,’ Mr. Green said. ‘Funding would cover training for volunteers and allow us to duplicate these programs to other areas in the state.’

Programs, education and counselling groups that help prepare family members on what to expect and how to handle post-rehabilitation situations is essential. David Giles, who works at Anglicare Victoria, understands the demand. ‘There needs to be a holistic approach to help better equip families to deal with these situations. If these programs are funded and made available, there has to be campaigns to raise awareness for them.’

The Salvation Army in Victoria runs its own helpline to provide counselling to family members. However, Nick Bell, who worked as a volunteer on the helpline, points out shortcomings in inadequate support. ‘We'd have parents calling up, uncertain where to tum to when their kids relapse,’ he said. Promises of funding are a small step in the right direction, but concrete solutions are crucial for families.

Family Drug Support website

www.fds.org.au

For up-to-date information on drug support and activities

Tackling ice scourge needs more than police crackdown

Chloe Booker, *The Age* (16/8/15)

Leading drug experts are concerned there is too much emphasis on law and order when it comes to tackling the country's ice problem.

Eminent public health campaigner David Penington and Victoria's drug court magistrate, Tony Parsons, have renewed calls for an approach that equally focuses on treatment and prevention. Their calls come as the federal government is expected to announce a national crackdown on ice dealers.

A spokeswoman for Justice Minister Michael Keenan referred questions to Prime Minister Tony Abbott's spokesman, who said he was unable to provide more details.

Fairfax Media understands the crackdown will include a campaign similar to some states' existing 'dob in a dealer' programs, which encourage the public to report drug trafficking.

Professor Penington, who has advised on government drug policy, is critical of the idea.

'I'd be surprised if it's effective at a statewide or national level,' he said.

Instead, Professor Penington said the focus should be on treatment, rehabilitation, education and family support. 'Senior police have said again and again, they can't arrest their way out of this ice problem,' he said.

'Every so often politicians want to be seen to be fixing things just by pronouncing, and that's why there is always the temptation to say "let's arrest more people".'

Professor Penington said he strongly agreed with the suggestion of Ken Lay, the head of the National Ice Taskforce and former Victorian Police Commissioner, of encouraging communities to work with police instead of using a reporting hotline. 'It's a way this information can be usefully relayed without people fearing they are going to expose themselves to major risk,' he said.

Mr Parsons, who was on Victoria's ice taskforce, agreed the initiative wouldn't work. 'I don't think it will do any harm, but I also don't think it will do any good,' he said.

'People who use ice aren't going to dob their dealers in, that would be shooting themselves in the foot.'

Mr Parsons said combating the supply of drugs was important, but demand and harm reduction needed to be equally addressed.

'Dealing with just one of the limbs is not going to work on its own,' he said.

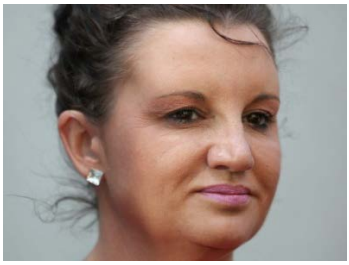
'I just hope they don't spend a lot of money on that kind of campaign when it's so desperately needed to fund treatment options.'

When the taskforce was announced in April, Mr Lay called for a new strategy after millions had been spent on a failed approach of arresting users.

'I'm driven by outcomes, I've been given a free hand here to try and drive some change, [and] I am fairly confident I can do that,' he said at the time. 'We talk about it as a crime, [but] I don't think we can lose sight of the fact this is also a very, very significant health and social issue.'

Forcing young ice addicts into detox won't solve the problem

Matt Noffs, *Sydney Morning Herald* (11/8/15)



Jacqui Lambie is incredibly brave for standing up in Parliament and telling the world about her son Dylan's ice addiction. The reality is that there are thousands of parents across Australia who share her pain. As the use of ice becomes more widespread, so too do the family problems and breakdowns that it causes.

Many parents go down the same path as Senator Lambie – kicking your child out of home seems like the only option when they have stolen from you or threatened violence. As the senator has suggested, it feels like you're talking to a drug not to your child.

Regrettably, there are only a few services that parents can turn to in this time of need. Programs like Family Drug Support and the Ted Noffs Foundation operate at the coalface and, with little financial support from governments, work with thousands of families each year to help them through this critical time.

One thing these agencies have learnt from their years of experience is that forcing teenagers into drug treatment or 'tough love' or 'boot camp' type services simply doesn't achieve the desired results.

When compelled to attend treatment by their parents, kids tend to stay a short while, go back to their previous life and start using all over again. As hard as it may seem to some families, emotions need to be put to the side and a strategic approach to solving the problem adopted.

However tenuous the current relationship with your drug-using child is, it is crucial that it be maintained. The bond between family and the drug-dependent young person is vital for their recovery. It could be just the thing that saves their life.

On the very same day that Senator Lambie revealed her family's struggles, the *Mornington Peninsula News* reported on an ice forum recently held in the area.

At the forum a local resident, Kerrie Knight, spoke movingly about her own daughter Indya's addiction to ice. She told how her daughter was now in her second stint in a rehab facility and her hope that Indya, with this help, could re-establish a positive life.

Central to Knight's speech was the point that the family had always provided consistent and loving support to their child. She also noted that 'what we were lacking in our approach were knowledge and the skills to know how to support her without enabling her addiction'.

'Simply advising young people not to take drugs is not the answer. Family and community are the key elements to help deliver education, early intervention and harm minimisation. We have a huge gap in the community for a local family support network,' she said.

Knight is quite correct. Drug addiction is traumatic and it has a profound effect on the families of young users. Her approach, by emphasising the continued relationship with her daughter, is more likely to lead to a positive outcome than forcing the child into treatment.

Kids need to trust that their parents will be there for them when times get tough. Forcing them into detox won't achieve that. Working with your kids, encouraging them to access professional help, and being with them throughout the journey to recovery can achieve it.

We need governments to commit to proper funding, not just for adolescent drug treatment services throughout the country, but also for family support services to help parents and families deal with this devastating problem.

Matt Noffs is CEO of the Ted Noffs Foundation and co-founder of Street Universities.

My mother the political stunt

Stephen Drill, *Sunday* (13/9/15)

SUNDAY SEPTEMBER 13 2015

JACQUI LAMBIE'S SON HITS BACK AT ICE ADDICT LABEL

MY MOTHER THE POLITICAL STUNT

EXCLUSIVE

STEPHEN DRILL

JACQUI Lambie's son says he feels betrayed because his mother publicly labelled him an ice addict without warning him first.

Dylan Milverton, 21, spoke to The Sunday Telegraph in a face-to-face interview in Burnie and said he was disappointed the Tasmanian Senator did not tell him that his personal issue would be played out in federal parliament.

He admitted to using the drug "socially", but denied he was an addict.

He said he wanted to get his side of the story across.

Mr Milverton said he had a range of emotions about his mother's decision to talk about his drug use publicly.

"Disappointed, a bit betrayed. A little bit of anger about it," he said. "I hadn't talked to her. She won't come to see me for an hour to see where I live."

Senator Lambie made headlines last month when she said Dylan was an ice addict and called for involuntary rehabilitation during a speech to the Senate.

Mr Milverton said he first heard of it when he watched the television news the next day. His mobile phone lit up with text messages.

"I wouldn't mind finding out her side as to why she done that. I do believe it was probably for her own political pull," he said.

Senator Lambie last night said her first priority was her son's health and wellbeing.

"My first priority will always be my son's safety and wellbeing. I'm doing every thing I can, after contacting medical, rehab and legal experts, to get Dylan help and good legal advice," she said.

"I'm not sure how much trouble he's in.

"And I only have one message for him today: Come home, darling. Lets get you safe and in rehab – and let's get you some good advice from a lawyer.

"I love you always."

But Mr Milverton said the Senator did not have enough time for him.

"Oh nah, but it's never been about me, man, at the end of the day," he said.

"Growing up, my brother he was the footy star and stuff like that and it was always about him. Everyone knew me as his little brother and then my mum became a Senator and all that s... and now I'm just known as a f...ing meth head."

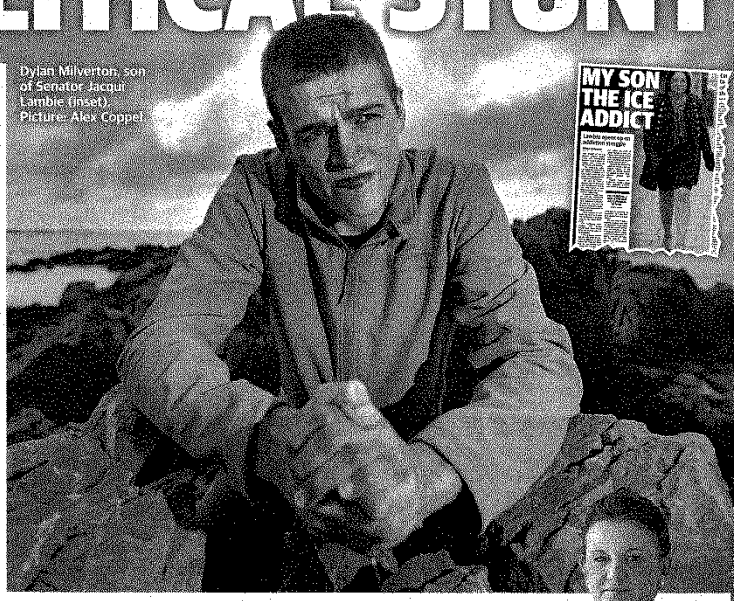
Mr Milverton said that involuntary rehabilitation would only lead to rifts within families.

He said that his mother and the local community only saw him as a drug user, rather than the things he did to help people privately.

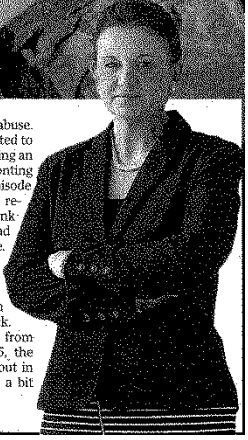
He also revealed how he grew up with alcohol abuse. Senator Lambie admitted to being an alcoholic during an honest and confronting Australian Story episode last year. She also revealed during the frank interview that she had tried to commit suicide.

Mr Milverton still appears to be scarred by the incident. "I looked after my mum when she was sick. When I ran away from home when I was 15, the next day she walked out in front of a car. It was a bit f...ed up," he said.

"I stood by her."



Dylan Milverton, son of Senator Jacqui Lambie (inset). Picture: Alex Coppel



Reply to Herald Sun article about my son

Jacqui Lambie, Media Statement (13/9/15)

PARLIAMENT OF AUSTRALIA

SENATE

Senator for Tasmania
Putting Tasmania First
Jacqui Lambie

Media Statement

13.9.15

Reply to Herald Sun article about my son: Lambie

http://www.heraldsun.com.au/subscribe/news/1/index.html?sourceCode=HSWEB_WRE170_a&mode=premium&dest=http://www.heraldsun.com.au/news/victoria/dylan-milverton-says-mum-jacqui-lambie-let-him-down-by-revealing-battle-with-ice-addiction/story-fnpp4dl6-1227524566921&memtype=registered

Independent Senator for Tasmania Jacqui Lambie will refer an article by journalist Steven Drill in today's Herald Sun to the Australian Press Council for investigation and has issued the following statement:

"Last Friday the 11th of September I was warned that the media was going to use my son to politically attack me and "goad" me into a response. I didn't think that they would stoop so low. However I was wrong. The warnings were correct.

Today, using the excuse of allowing my son to have his say, the Herald Sun has exploited a young man who is in a very vulnerable and dangerous situation. For commercial and possibly political reasons, the Herald Sun has manipulated my son's circumstances.

And in doing so they have either deliberately or unknowingly interfered with his medical treatment - and his ability to receive timely legal advice. On the day that the journalist and photographer from the Herald Sun met with my son and interviewed him, (Friday 11th) my son had an appointment to meet with two workers from Teen Challenge – Ice rehab and Detox specialists – as well as a barrister.

My son failed to keep that appointment where arrangements were being finalized with medical professionals and the police in order to transport him to a Rehab Center on the mainland.

My son reached out to me at the beginning of last week and asked for help and because I was in Canberra - I contacted the experts at Teen Challenge http://teenchallengeqld.org.au who specialize in getting people medical treatment and into rehab.

A director of Teen Challenge traveled from Launceston to Devonport and met with my son last Monday.

Tuesday afternoon my son signed papers presented to him by a director of Teen Challenge which allowed the medical and legal process for his rehab to begin.

Wednesday my son returned home in preparation for the meeting on Friday where his acceptance into a Rehab program in ether WA, QLD or NSW was going to be finalized.

PARLIAMENT OF AUSTRALIA SENATE

Senator for Tasmania
Putting Tasmania First
Jacqui Lambie

I believe that between my son returning home on Wednesday 9th of September and Thursday evening 10th of September when he left my house – my son was contacted by Journalist Steven Drill from the Herald Sun who flew to Tasmania to conduct his interview in person on Friday 11th of September.

There are many questions that need to be answered by the journalist – but one fact is clear, when Mr Drill conducted the interview, my son was ***vulnerable, drug affected, with diminished capacity and officially part of a drug rehab program*** – having signed official documents two days earlier.

I will now refer journalist Steven Drill to the Australian Press Council for investigation to see whether he has breached any professional, ethical and legal standards or codes of conduct.

I want to know why my son decided to stop his rehab process after speaking to Mr Drill?

Through my staff, I have asked the Herald Sun journalist to provide me with a full transcript of his interview with my son, whose life is not only in danger from the drug he's addicted to, but also the people who supply and make it.

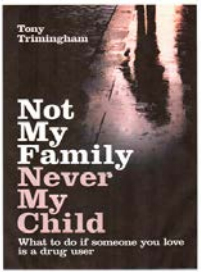
Unfortunately the journalist refuses to comply with my request. He also refuses to explain why he held onto this information about my son for at least 24hrs - and only approached my office less than 2 hours before his Sunday paper's deadline?

These are matters I hope the Australian Press Council will take up on my behalf. In the meantime I will work closely with the professionals at Teen Challenge, my legal advisors and the police in order to help my son beat his addiction and put his life back together.

This week I will attend Parliament and keep working there to ensure that all Australian parents have the right to involuntarily detox their children.

Early intervention and rehab for drug addicted young people must be guaranteed right now. That way other Australian parents will be saved the heartache my family is forced to experience – because of a drug called Ice." said Senator Lambie.

Contact 0407 904 134



Not My Family Never My Child
A guide for families affected by drugs

Members $20; Non-members $24.95 plus $6.60 postage
Please phone/fax or email/mail us in the office.
Phone (02) 4782 9222 to pay by credit card.
Fax: (02) 4782 9555; Email: general@fds.ngo.org.au
Mailing address: PO Box 7363, Leura NSW 2780
Signed copies are available upon request.

Events diary

STEPPING STONES COURSES

Unless indicated, the courses run over two consecutive weekends. As soon as course dates and venues are set for 2016, they will be displayed on the website www.fds.org.au.

Contact the facilitator (listed below) or Head Office 02 4782 9222 for more information.

10-11 & 17-18 Oct **9.30 am – 4 pm**	**GOSFORD/NARARA NSW**	
	Venue:	Narara House, 21 Bellbowrie Ave, Narara
	Hosted by:	ARAFMI
	Enquiries:	Julie 0400 113 422
7-8 & 14-15 Nov **9.30 am – 4 pm**	**BURWOOD NSW**	
	Venue:	Burwood Council Library, Ralston Room, 2 Conder St, Burwood
	Enquiries:	Liz 0417 429 036 or Head Office (02) 4782 9222
7-8 & 21-22 Nov Weekend break in-between **9.30 am – 4 pm**	**HAWTHORN VIC**	
	Venue:	Inner Eastern Community Health Services, 378 Burwood Rd, Hawthorn
	Enquiries:	Michael 0448 169 205 or Debbie 0412 382 812
14-15 & 21-22 Nov **9.30 am – 4 pm**	**ADELAIDE SA**	
	Venue:	Safe Place Training, 147 Goodwood Rd, Goodwood
	Enquiries:	Theo 0402 604 354 or Devushka 0428 271 743

STEPPING FORWARD INFORMATION SESSIONS

Session 1: Stages of Change and 'Balance Pole'

Session 2: Alcohol and Other Drug (AOD) Information

Session 3: Effective Communication

Separate modules can be provided for Treatment and Recovery, Boundary Setting and Dealing with Conflict. Each session runs for approximately two hours and are open to the public.

For bookings or enquiries about sessions running in your area, please phone Emma at Head Office (02) 4782 9222

14 October **11 November** **3 February** **From 6 pm**	**LEABROOK SA**	
	Venue:	Knightsbridge Baptist Church Hall, 455 Glynburn Rd, Leabrook
	Module:	Stages of Change (14 Oct); Effective Communication (11 Nov); AOD Information (3 Feb)
	Enquiries:	Devushka 0428 271 743

Stepping Forward Information Sessions cont …	
15, 22 & 29 October **6 pm – 8 pm**	**GLEN WAVERLY VIC** **Venue:** Link Health, cnr O'Sullivan Rd & Euneva St, Glen Waverly **Module:** Stages of Change (15 Oct); AOD Information (22 Oct); Effective Communication (29 Oct) **Enquiries:** Michael 0448 169 205
17 October **9.30 am – 4 pm** **BYO Lunch** **Morning & afternoon teas provided**	**WANGARATTA VIC** **Venue:** TBA **Module:** Stages of Change; AOD Information; Effective Communication **Enquiries:** Michael 0448 169 205
19 October **16 November** **8 February** **From 6 pm**	**HINDMARSH SA** **Venue:** Anglicare SA, 184 Port Rd, Hindmarsh **Module:** Stages of Change (19 Oct); Effective Communication (16 Nov); AOD Information (8 Feb) **Enquiries:** Devushka 0428 271 743
21 October **18 November** **10 February** **From 6 pm**	**HALLET COVE SA** **Venue:** Hallet Cove Baptist Church, 1 Ramrod Ave, Hallet Cove **Module:** Stages of Change (21 Oct); Effective Communication (18 Nov); AOD Information (10 Feb) **Enquiries:** Devushka 0428 271 743
21 October **28 October** **4 November** **6 pm – 8 pm**	**HAWTHORN VIC** **Venue:** Inner East Community Health, 378 Burwood Rd, Hawthorn **Module:** Stages of Change (21 Oct); AOD Information (28 Oct); Effective Communication (4 Nov) **Enquiries:** Michael 0448 169 205
24 October **9.30 am – 4 pm** **BYO Lunch** **Morning & afternoon teas provided**	**BENDIGO VIC** **Venue:** Bendigo Community Health, 8 Olinda St, Bendigo **Module:** Stages of Change; AOD Information; Effective Communication **Enquiries:** Michael 0448 169 205
12, 19 & 26 November **6 pm – 8 pm**	**FOOTSCRAY VIC** **Venue:** Western Health Drug Services, 3-7 Eleanor St, Footscray **Module:** Stages of Change (12 Nov); AOD Information (19 Nov); Effective Communication (26 Nov) **Enquiries:** Michael 0448 169 205

VOLUNTEER TRAINING		
14 & 15 November	**BURWOOD NSW**	
9.30 am – 4.30 pm	**Venue:**	Shop C9, 1-17 Elsie St, Burwood (entrance via George St)
	Enquiries:	Volunteer Manager 0416 212 426 or (02) 4782 9222
28 & 29 November	**ADELAIDE SA**	
9.30 am – 4.30 pm	**Venue:**	147 Goodwood Rd, Goodwood
	Enquiries:	Volunteer Manager 0416 212 426 or (02) 4782 9222

Man charged with eradicating ice in Victoria wants to decriminalise it

Nick Whigham, *news.com.au* (8/9/15)

The head of a taskforce charged with combating 'ice' wants it to be considered for decriminalisation.

Police Senior Sergeant Tony Francis from Geelong, is tasked with eradicating what Tony Abbott has called a 'deadly scourge' in the Australian community. But he believed there needed to be a different approach.

'The idea is so radical it might just work,' Mr Francis told the *Geelong Advertiser*.

'We need to have a proper debate about this, without the discussion being hijacked by self-interested groups. We need to have the conversation.'

It stands in stark contrast to the tough rhetoric of the government, but Mr Francis was far from the only one championing the idea.

John Rogerson, CEO of the Australian Drug Foundation, praised Mr Francis for taking a 'gutsy' stance.

'The most important thing is we have to have the conversation,' he told news.com.au

'Good on Tony for raising the issue.'

The current government has taken a strong public approach to the growing use of the drug but some, such as former Victorian police commissioner Ken Lay, believe authorities are not going to be able to arrest their way out of the problem.

'The reality is it doesn't work that well,' Mr Rogerson said. 'The Prime Minster is just reflecting what people in the community think works.'

For him, it's as a health issue and not a criminal one. He would like to see a

policy designed to help users of the drug and punish those who produce and traffic it.

Mr Rogerson doesn't think the Australian public is ready for a conversation about decriminalising methamphetamine but is hopeful it will happen soon. He points to other countries such as Portugal, which has had success with decriminalisation and hopes Australia will adopt a more evidence-based approach.

'When your police are telling you it's not the most effective way, you have to listen to them,' he said.

Others in the field have expressed a similar desire to shift the focus from criminality to the health concerns of those using ice.

Matt Noffs, the CEO of child services group the Ted Noffs Foundation, has long called for a decriminalised approach to the drug and wants to see the government regulate it. Under his plan, the government would produce the drug for a fraction of the street price and provide a safe place for users.

'The reason we were able to get in front of heroin is because we were brave enough to think of something as crazy as saying we are going to help someone inject heroin, and you can tell everyone's response to that at the time, was "this is ludicrous",' he told *News Local* earlier in the year.

It's a radical idea and one that is unlikely to gain serious traction any time soon. But Mr Rogerson believes the more experienced police like Tony Francis speak out, the easier it will be for politicians to have a thoughtful conversation about the issue of decriminalisation.

Changing face of opioid dependence

Marion Downey, University of New South Wales Newsroom (15/9/15)

A study by UNSW's National Drug and Alcohol Research Centre has found the number of Australians receiving treatment for dependence on the painkillers codeine and oxycodone trebled between 2002 – 2011.

The research found of those people in treatment for opioid dependence, one in five were being treated for dependence on pharmaceutical opioids – most commonly morphine, codeine, oxycodone and fentanyl.

Clients being treated for pharmaceutical opioid dependence were older, less likely to inject and more likely to be living in rural and

remote areas. Although heroin is still the principal drug of concern for people in treatment for opioid dependence, prescription opioids are far more common than in 2002 when the vast majority of people (93%) were being treated for heroin dependence.

Women make up the majority of people in treatment for codeine dependence while men were far more likely than women to be in treatment for heroin and strong painkillers such as oxycodone and fentanyl.

Dr Suzanne Nielsen, who will present the research at today's National Drug and Alcohol Research Centre's (NDARC) Annual Research Symposium, says that there are a number of effective treatments for pharmaceutical opioid dependence, including opioid substitution therapy (methadone and buprenorphine).

'We need to adapt the way we deliver treatment given the changing profile of opioid dependence,' Dr Nielsen says.

'Compared with people in treatment for heroin dependence a decade ago, the people we are seeing now are older, more likely to be employed, more likely to be female and more likely to have a history to chronic pain. Some may be reluctant to come forward because of the stigma associated with traditional treatment for heroin dependence.'

In another paper to be presented at the symposium today, a study of 1,500 Australians who are being prescribed strong opioids, such as oxycodone, for chronic pain found that 40% were taking high doses (more than 90mg daily) or very high doses (more than 200mg daily) and were at high risk of becoming dependent.

Lead author of the study Gabrielle Campbell says her team found no difference in pain relief between those taking more than 200mg of oxycodone daily and those taking 90 mg daily.

'Both groups however were equally likely to become dependent, tamper with their medicines and use them other than as prescribed,' Ms Campbell says.

Those at risk for developing problems with their medication also had pre-existing mental health problems including anxiety and depression and were likely to have a history of dependence on alcohol and sedatives such as benzodiazepines.

Ice taking toll on Brisbane families

Rebecca Danslow, *Courier Mail* (4/9/15)

Tucked away in Carseldine is a place offering a door to a brighter future for families caught in the ever-deepening ice scourge.

Family Drug Support has two support groups in Queensland lending an ear to parents, siblings and partners dealing with the dread of relatives with problematic drug use.

Group facilitator Emily Fawthrop, 26, found value in Family Drug Support while trying to deal with her brother's addiction nine years ago. She says a lot of others whose relatives are addicted to ice reach out to the organisation after failing to find the necessary support elsewhere. Some travel from as far away as Morayfield, the Gold Coast and Ipswich for bimonthly meetings.

Carseldine resident Maree has parked memories of her 30-year-old son in a corner of her mind, preferring to remember the tall, handsome and loving son rather than the addict living on Brisbane's southside.

'He was a high achiever, educated at a private boys school. He doesn't fit the stereotype of a drug user (yet) in the last year he's lost his job, had his house repossessed and been involved in criminal activity,' she said. Maree said the meetings had helped her cope.

Michael, a father of two, moved his family from Townsville to Morayfield to create a fresh start, including for his 19-year-old son. 'When he was 15 he started with marijuana and alcohol and then it was a rapid decline,' Michael said.

'He started mixing with the wrong people and started using ice when he was 16. His behaviour was erratic, he'd disappear for days on end and when he'd come home he'd sleep for days.

'We had the house raided twice, we've had drug dealers knocking at our door. We've even had to call the police on him twice because he threatened his mum and his sister. All of that becomes normal for any family going through this.'

He, like Maree, believes secondary school children should be provided with reality based information about drugs, including ice, and the consequences. Both remain hopeful of their children recovering.

FDS Carseldine meets on the first and third Tuesday of the month at Shop 3, 521 Beams Rd, Carseldine (Australia Red Cross).

The FDS support line is available 24/7, 1300 368 186. For information about meetings, phone Emily, 0407 743 033.

NEWS FROM OVERSEAS

United Kingdom

BMJ ARTICLE: INCREASING OVERDOSES BUT THEY IGNORE KNOWN SOLUTIONS

There is no more 'final' statistic regarding drug use than overdose deaths. And in England the official figures go back to Victorian times, then often involving opium, laudanum and other strong drugs including alcohol. The British Coroner's Act of 1844 was ahead of its time and even pre-dated the famous Broad Street Pump reports of the London cholera epidemic of 1854. The latter is sometimes quoted as the first exercise in modern, scientific public health.

The BMJ has reported increasing overdose deaths in the UK which are little short of disastrous, reflecting experience in America – doubling in a few short years and overtaking other causes of death like a tragic game of leap-frog. The UK now has about 50 overdose deaths per million of population or 3346 in 2014 of which 952 were from heroin or morphine. In Portugal it is about a tenth of this rate according to EMCDDA.

The familiar story of increasing overdoses happened in Portugal before 2001 when a forward thinking and science based experiment was undertaken moving away from prohibition.

Portugal decriminalised personal drug use 14 years ago, heralding a new era in public health in that small country. Since the liberalisation experiment the country has gone from a pariah to a paragon of public health outcomes. HIV, overdose and addiction rates have dropped significantly while resources have been strongly diverted to treatment and social services. The UK and USA have comparable drug control laws strongly relying on punishment, in stark contrast to Portugal.

Like seeing refugees on a television screen, overdose deaths only come home to us when they are personalised by a friend, family member or particularly moving portrayal such as the recent footage of a dead young boy on a beach in Turkey. Why is nobody taking notice of one of the biggest and longest and most successful real-life experiments in drug law reform? Why are those supporting prohibition so successful in beating a drum which has no scientific or empirical basis? And their actions are leading to preventable deaths every single day. I recommend a 14 minute talk by Johann Hari about his 'journey' investigating addiction.

Andrew Byrne (10/9/15)

UK SEES HUGE RISE IN HEROIN AND MORPHINE-RELATED DEATHS

Heroin and morphine-related deaths have increased by almost two-thirds over the past two years, contributing to the mortality rate from drug poisoning rising to the highest level since comparable records began in 1983.

Official figures show there were 952 deaths involving the substances last year – their highest level since 2001 – compared with 579 in 2012, bucking a decline in previous years, according to Office for National Statistics (ONS) figures published on Thursday.

They contributed to the mortality rate from drug misuse rising to 39.9 deaths per million population.

Heroin-related fatalities – which are combined with those from morphine because heroin breaks down in the body into morphine, so either may be recorded on the death certificate – accounted for 42% of total drug misuse deaths.

Harry Shapiro, a drug information and policy analyst, described the figures as 'pretty shocking'.

The former director of communications for now-defunct independent monitoring body DrugScope said: 'There's been such a focus on legal highs, new psychoactive substances, that to some extent maybe we've been taking our eye off the ball a bit [regarding illegal drugs]. We've certainly had declining drug use [in the recent past].

'From a policy point of view, we might have got a bit "we've ticked all the boxes on this, we're doing well." There are figures here and from the Crime Survey of England and Wales, [which showed a spike in use of ecstasy and LSD among young adults] that suggest we are not ticking all the boxes.'

Public Health England calculated last year that around 60% of drug-related deaths between 2007 and 2012 were people who had not been in treatment at all, or in the previous five years.

Shapiro said the ONS figures raised questions about whether people were being let down by the commissioning process, leaving treatment too early, or being put off by an increasing reluctance to prescribe methadone.

He added that the 2013 abolition of the National Treatment Agency for Substance Misuse had put responsibility for treatment in the hands of local authorities but that they were under extreme financial pressures.

The ONS recorded an increase in the number of deaths involving heroin/morphine across all age groups bar people aged 70 or over between 2013 and 2014. Shapiro said ageing problems could be combining with complications from heroin use to increase the mortality rate.

The ONS highlighted an increase in supply of the drug, after a 'heroin drought', which it said had led to an increase in the purity of street heroin and declining prices, from £74.32 per gram purity-adjusted in 2011 to £49.55 in 2013. However, Shapiro suggested

this was probably the 'least controversial version of events'.

He said: 'The issue is really: is anyone going to do anything about it and come up with a national strategy to deal with drug-related deaths? It's not just in relation to morphine.'

Deaths involving cocaine increased sharply last year to 247 from 169 in 2013, reaching an all-time high of 4.4 deaths per million population, according to the ONS. It was the third year in a row the mortality rate for cocaine-related deaths had increased.

Rosanna O'Connor, director of alcohol, drugs and tobacco at Public Health England, described the rise in heroin-related deaths as 'a great concern'.

She said: 'Fewer people are using heroin but the harms are increasingly concentrated among older, more vulnerable users and those not recently in touch with their local drug treatment services. Reassuringly, overall drug use has also declined and treatment services have helped many people to recover but these figures show the need for an enhanced effort.

'We need to ensure the most vulnerable users can access drug treatment services.'

H. Siddique, *The Guardian* (3/9/15)

United States

HILLARY CLINTON ANNOUNCED $10 BILLION PLAN TO ADDRESS OPIATE EPIDEMIC

Democratic presidential frontrunner Hillary Clinton is proposing a $10 billion policy plan that aims to combat the opiate epidemic sweeping across America. Medication-assisted treatment (MAT) will play a major role in her efforts.

'Plain and simple, drug and alcohol addiction is a disease, not a moral failing – and we must treat it as such,' Clinton wrote in a recent op-ed describing her new plan.

Treating addiction as a disease means the use of medication, such as prescribing naltrexone for cravings, and using opioid medications such as Suboxone and methadone when necessary.

A pharmacological intervention coupled with counselling and other social support networks are argued by many to be the most effective way

known to date to beat an opioid addiction.

Clinton laid out an ambitious plan centred around five main goals. First, she aims to empower communities to prevent drug use among young adults; she wants to ensure that people with addictions have the resources to obtain proper treatment; all first responders are required to carry naloxone to reverse opiate overdoses; health-care providers will be required to receive training in substance use disorders as well as consult with prescription monitoring programs to prevent doctor shopping.

Lastly, as her coup de grâce, Clinton invoked mass incarceration, which she wishes to end by providing 'treatment over prison for low-level and nonviolent drug offenders.'

She admits that accomplishing such goals won't be easy, that 'it will take commitment from all corners – law enforcement, doctors, insurance companies and government at every level.'

Her push to address the opiate problem arose from the constant barrage on the campaign trail from communities pleading for help. 'Every town and city I've visited so far in this campaign has stories of families upended by drug addiction,' she wrote.

Clinton is the first 2016 presidential candidate to lay out a concise plan that addresses the opiate problem that's killing nearly 110 people a day.

Z. Siegel, *thefix.com* (3/9/15)

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GROWING AVAILABILITY OF HEROIN CHANGING THE FACE OF OPIATE ADDICTION IN THE US

The growing availability of heroin, combined with programs aimed at curbing prescription painkiller abuse, may be changing the face of opiate addiction in the U.S., according to sociologists.

While heroin abuse is still relatively rare, the use of the drug is not only increasing, but it is now being coupled with the abuse of prescription painkillers, said Shannon Monnat, assistant professor of rural sociology, demography, and sociology, Penn State. She added that the heroin-prescription drug combination is also hitting groups that were not traditionally viewed as widespread opiate users.

'One of the things we've found is that the simultaneous use of heroin and prescription painkillers together has increased dramatically among whites and especially among young white men,' said Monnat, who worked with Khary K. Rigg, assistant professor of mental health law and policy, University of Southern Florida.

Monnat described the recent trend as a domino effect of addiction that began in the 1980s and 1990s when the over-prescription of painkillers led to an increase in addiction to those drugs.

'Over the last several years there have been more restrictions put in place, including prescription-drug monitoring programs and the introduction of a

tamper-proof opioid, making it difficult to crush, liquefy and inject the substance,' said Monnat. 'What this has done is restrict access to prescription painkillers for people who previously became addicted to them. These people sometimes transition into heroin, which has become incredibly cheap and easily accessible.'

Some addicts who were introduced to heroin also turn to abusing both painkillers and heroin at the same time. While most opiate addicts are still addicted to only painkillers, the number of addicts using heroin and the number of users who are addicted to both painkillers and heroin are increasing faster than painkiller-only abusers.

'You don't eliminate the addiction simply by eliminating access to the drug,' said Monnat. 'People who are addicted to the morphine substance will find a substitute.'

The three groups of opiate abusers are distinct demographically, socioeconomically and psychologically, Monnat added. While heroin abuse is typically characterized as being a problem in black, poor and urban areas, an increasing number of heroin and painkiller-heroin addicts are white, employed and live in rural and small urban areas.

The researchers, who released their findings in *Addictive Behaviors*, currently online, said that people who are addicted to painkillers alone tend to be the most socially connected of the three groups. Painkiller addicts are also the least socioeconomically disadvantaged and have better physical and mental health.

Professionals who treat drug addiction should recognize the unique needs of each group of addicts, according to the researchers.

'It's not enough to know whether someone is just using a prescription painkiller, but the practitioner would also want to know if they are using heroin,' Monnat said. 'The use of heroin puts the patient at risk of all kinds of other complications, such as HIV and sexual risk-taking behaviors and a very high risk of overdose.'

The researchers used data from the 2010-2013 National Survey on Drug Use and Health. Respondents in the survey were grouped in three categories: heroin only users, prescription painkiller only users, and combination heroin and prescription painkiller users. Prescription painkiller-only users were the largest group, with 9,516 respondents. Combination heroin and prescription painkiller users were the next largest group, with 506 respondents, followed by 179 heroin-only respondents.

News-medical.net (18/8/15)

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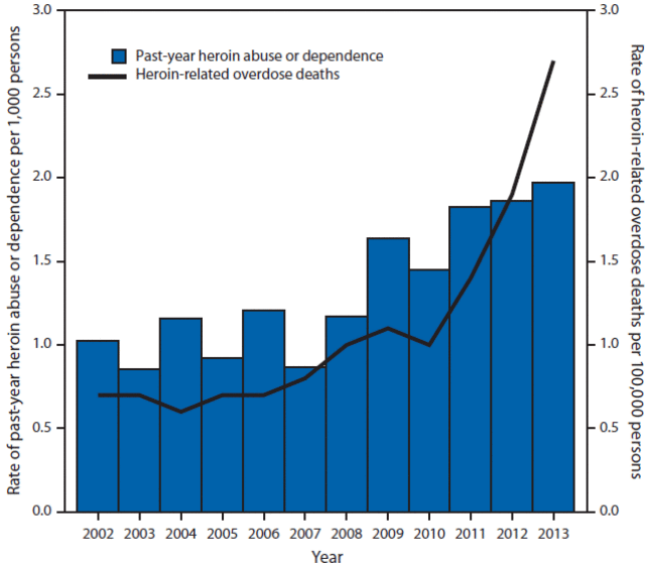
THE HEROIN EPIDEMIC IN NINE GRAPHS

The White House released a plan this week to pour $5 million into combating heroin use and trafficking. The plan followed months of warnings from the Centers of Disease Control and Prevention about the explosion in heroin use in the U.S.

Presidential candidates have also spoken out on the issue. Hillary Clinton

has called the heroin and methamphetamine addiction a 'quiet epidemic' and held roundtables to discuss the issue with voters. Rand Paul has spoken repeatedly about the racial aspect of the war on drugs and said that he would change minimum sentencing laws if elected. Chris Christie has enacted reforms in his home state of New Jersey, saying he favoured treatment instead of imprisonment, and calling drug addiction a disease that 'can happen to anyone from any station in life.'

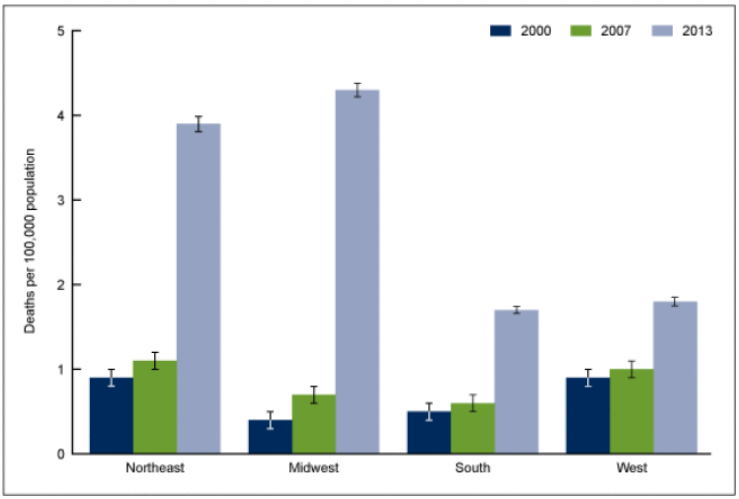
In the last decade, heroin abuse has skyrocketed. The rate of heroin-related overdose deaths increased 286 percent between 2002 and 2013. In 2002, 100 people per 100,000 were addicted to heroin but that number had doubled by 2013.



The CDC says males, non-hispanic whites, 18- to 25-year-olds and people living in large metropolitan areas are at the most risk for heroin addiction, which covers most of the U.S. Heroin addiction spans all ages, races, genders, incomes, insurance statuses and locations.

The problem of substance abuse touches many areas of public policy, from border security to the health system and criminal justice. The rise may have been spurred partially by an increase in supply: the amount of heroin seized at the border with Mexico quadrupled by 2013 from the 2000s, making the drug cheaper in the U.S. and more pure. During 2008-2011, there were about 1.1 million emergency department visits for drug poisoning each year, or 35.4 visits per 10,000 people.

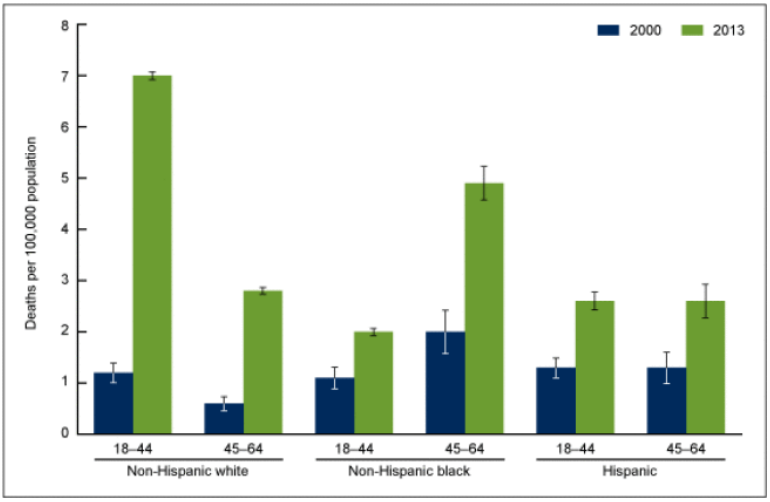
Abuse has increased most drastically in the Midwest.



Age-adjusted rates for drug-poisoning deaths involving heroin, by census region: United States, 2000, 2007, and 2013

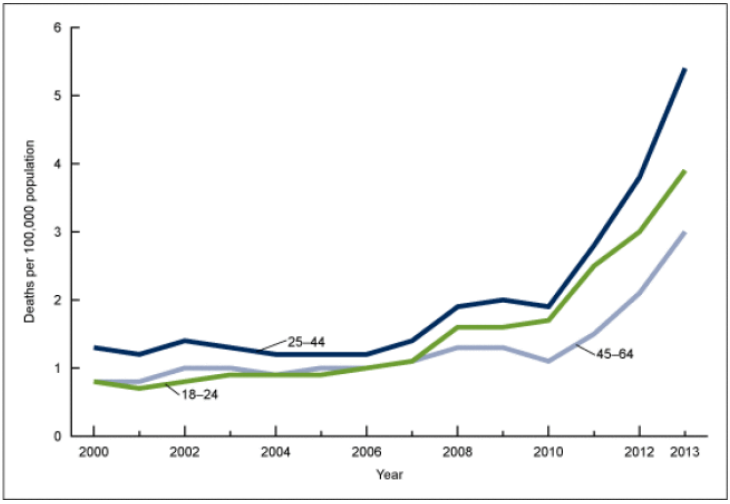
Who Abuses Heroin?

The average user of heroin has changed drastically in the last decade. In 2000, black Americans aged 45-64 had the highest death rate for drug poisoning involving heroin. Now, white people aged 18-44 have the highest rate. The share of people who say they have used heroin in the past year is actually decreasing for non-whites. Heroin has taken hold of the white suburbs, which has prompted more attention for what is now being called a 'health problem.'

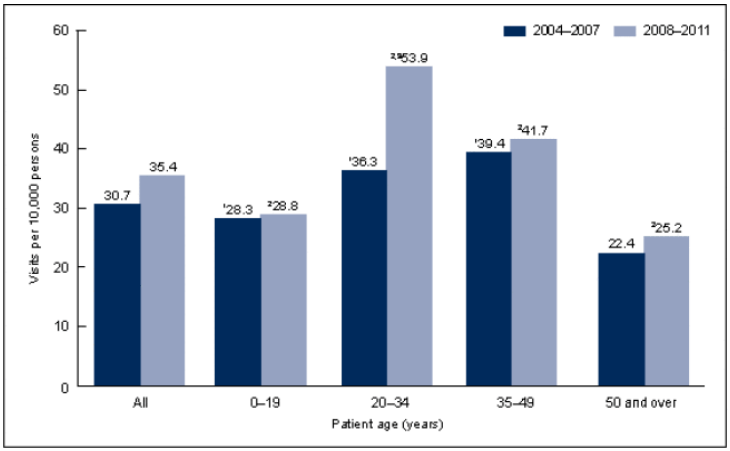


Rates for drug-poisoning deaths involving heroin, by selected age and race and ethnicity groups: United States, 2000 and 2013

The heroin epidemic is hitting young adults more than other age groups. The use among Americans aged 18-25 increased 109 percent from 2002-2004 and 2011-2013. For Americans 26 and older, it increased 58 percent.

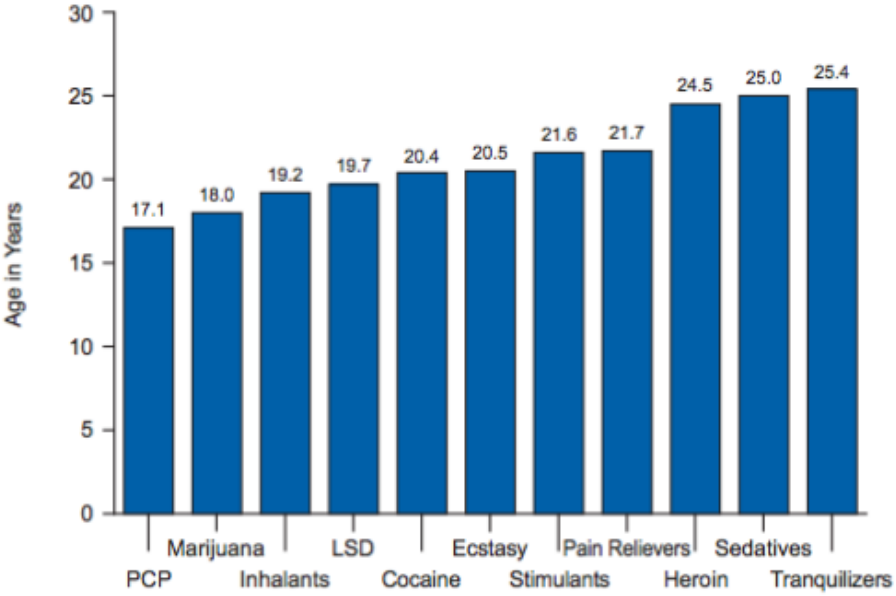


Rates for drug-poisoning deaths involving heroin, by selected age groups: United States, 2000-2013



Emergency department visit rates for drug poisoning, by age: United States, 2004-2007 and 2008-2011

Although people aged 18 to 25 are more at risk for heroin use, according to the CDC, on average, heroin is a drug for slightly older adults probably because it is perceived as being more risky (rightly so) and because most heroin users have used other drugs in the past. Nine in 10 people who use heroin use it with at least one other drug, most with at least three other drugs.



Mean age at first use for specific illicit drugs among past year initiates aged 12 to 49: 2013

Although heroin is perceived by teenagers as the most dangerous drug, the share of 12 to 17-year-olds who perceive the drug as very risky has declined slightly since 2002, according to the results of a 2013 survey by the U.S. Department of Health and Human Services.

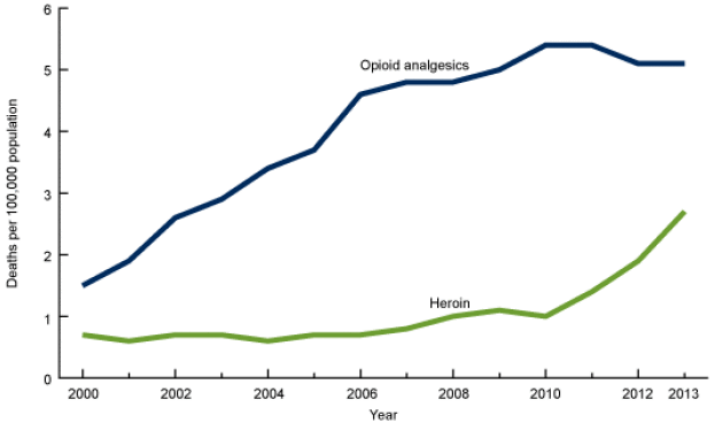
Teens also say it is the most difficult to obtain with the share of teens saying heroin is fairly or very easy to obtain declining from 15.8 percent in 2002 to 9.1 percent in 2013.

But prescription drug abuse is the bigger epidemic.

Heroin abuse is tightly tied to prescription drug abuse. Almost half of people addicted to heroin are also addicted to painkillers. People are 40 times more likely to be addicted to heroin if they are addicted to prescription painkillers.

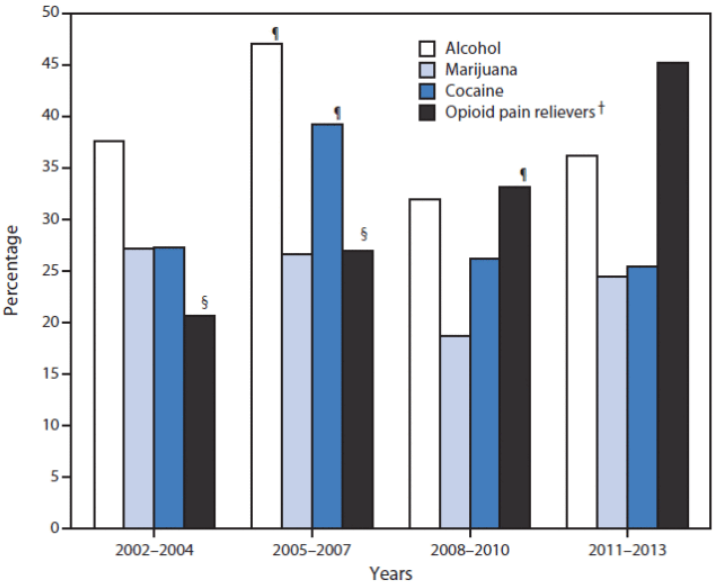
Abuse of prescription painkillers is incredibly common – one in 20 Americans age 12 and older reported using painkillers for non-medical reasons in the past year. While it's true that heroin abuse has skyrocketed in the last years, prescription drug abuse is more common.

The number of overdose deaths from prescription pain medication is larger than those of heroin and cocaine combined.



Age-adjusted rates for drug-poisoning deaths, by type of drug: United States, 2000-2013

By 2011-2013, painkiller dependence among heroin users was more common than alcohol, marijuana or cocaine dependence.



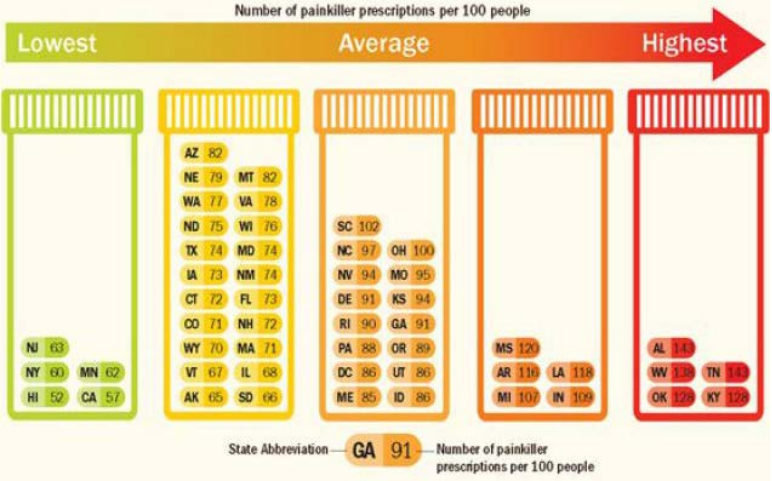
Annual average percentage of past-year heroin users* with past-year selected substance abuse or dependence, by time interval – United States, 2002-2013

One of the main differences between the two issues is that while the issue of heroin is intertwined with border security, the abuse of prescription drugs is largely the fault of our own health system. Enough painkillers were

prescribed by American doctors during one month in 2010 to medicate every American around the clock for an entire month.

A majority of those who take prescription pain medicine for non-medical reasons get them free from a friend or relative. In nearly 85 percent of those cases, the friend or relative obtained them from one doctor. One in five users obtain prescriptions themselves from one doctor.

States have more ability to increase the monitoring of prescription drugs, identify people showing signs of problematic use earlier, and stop inappropriate prescriptions of painkillers (which can lead to abuse and then, abuse of heroin).



Number of painkiller prescriptions per 100 people

While some have warned that a crackdown on prescription drug abuse will only spur more abuse of heroin, one analysis of death rates in 28 states found that while heroin overdose rates were associated with an increase in overdose rates for prescription medication, a decrease in the prescription drug rate was not associated with an increase in the death rate for heroin. Still, more research is needed to combat both issues.

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NEW DOCUMENTARY MAKES THE CASE FOR SUPERVISED HEROIN INJECTION SITES IN NEW YORK

A new documentary is shedding light on the thousands of residents of New York state who inject heroin in public or semi-public places, with dire consequences for their health and their communities.

'Everywhere But Safe,' which will premiere this week in Manhattan,

features interviews with heroin users in New York City, Albany and Schenectady, as well as in Columbia County, a more rural area upstate. Most of the people interviewed in the film have at various times injected drugs in places like hallways, subways, alleyways, parks, parked cars, restaurant bathrooms, streets and other public areas, primarily due to homelessness.

This kind of public injection, as the film makes clear, can often create a public health emergency.

'If we don't come up with a plan, we're going to lose a lot of human life,' one man says in the documentary's trailer. That's because people who shoot up in public spaces are statistically more susceptible to overdoses and disease.

A forthcoming report from the Injection Drug Users Health Alliance shows that a majority of needle exchange participants in New York City injected in public spaces in the past year, and were therefore more than twice as likely to have overdosed as users who didn't. They were also twice as likely not to have a steady supply of sterile injection equipment, and four times as likely to reuse injection equipment, which often leads to the transmission of disease.

'In New York, we're seeing people in our community dying of overdose, contracting HIV and hepatitis C and being pushed to the edges because of the shame and stigma associated with injection drug use,' said Taeko Frost, one of the film's two directors and the executive director of the Washington Heights CORNER Project, a needle exchange program. 'As harm reduction providers, we're engaging individuals on safer drug use and providing the tools and resources to prevent overdose and transmission, but the reality is there isn't a consistent, safe space to apply these strategies.'

The problems of public injection have been compounded in recent years by the sharp rise in the homeless population, particularly in New York City, and the surge in heroin use across the northeastern U.S., including in New York state.

There are at least 56,000 people in New York City sleeping in homeless shelters each night – a near-record high, according to the latest count. And in 2013, more people in New York City died of heroin overdoses than of murder. Meanwhile, nationwide, the number of heroin-related deaths jumped by 39 percent in 2013.

'Public injecting is real problem in New York, but fortunately it is one for which we have a clear solution supported by a large body of research,' said Julie Netherland, deputy director of the New York policy office at the Drug Policy Alliance, in a statement Monday. 'Countries around the world have opened supervised injection facilities to address the kinds of public health and safety problems so poignantly illustrated in 'Everywhere But Safe.' It's time for New York to follow the science and implement evidence-based strategies, such as SIFs, that can save lives.'

Australia, Canada and some European countries operate SIFs, or supervised injection facilities, where users can

inject heroin with sterile equipment in a clean environment, under professional supervision. There are currently no such facilities in the U.S.

Matt Curtis hopes 'Everywhere But Safe' can help change that.

Curtis, who co-directed the film with Frost and serves as policy director at VOCAL-New York, an advocacy group that also operates a needle exchange, told The Huffington Post he hopes the documentary will 'humanize' the problem of public injection and make the idea of supervised injection sites more palatable to an American audience.

'New York is not taking responsibility for this problem,' Curtis said in a statement. 'We do not have to have thousands of New Yorkers injecting in public.'

Creating SIFs, he said, would 'remove a major public health threat, make our communities safer, and save the city money.'

It would also be a step away from the drug war's aggressive, enforcement-heavy approach to the country's heroin epidemic – an approach in which most users are simply thrown in jail – and a step toward what's called a 'harm reduction' model. In the 1980s, under the philosophy of harm reduction, the city opened its first needle exchanges to help stop the spread of HIV. More recently, the city has equipped its police and emergency responders with naloxone, a drug that can prevent death in people who have overdosed on heroin.

'Everywhere But Safe' premieres Friday, 28 August at the Maysles Documentary Center in Harlem. Curtis said the movie marks the beginning of a campaign by a new group called SIF NYC, which next month will begin a push for SIFs in the city.

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EXTENSIVE HEROIN USE IN US: THE REAL AFGHANISTAN SURGE IS IN OPIUM PRODUCTION

Recently I worked in another Maine city and was astonished at the number of patients I encountered who were using heroin. I had never seen anything like it, during a lifetime practicing medicine. In New Hampshire, it was said, deaths from heroin now exceed deaths from car accidents. Nationwide, CDC noted, 'Between 2002 and 2013, the rate of heroin-related overdose deaths nearly quadrupled, and more than 8,200 people died in 2013.' Massachusetts (population under 7 million) had 1,000 deaths related to (all) opioids in 2014, 'the highest ever recorded.'

I've heard stories on NPR about insufficient state funding of heroin

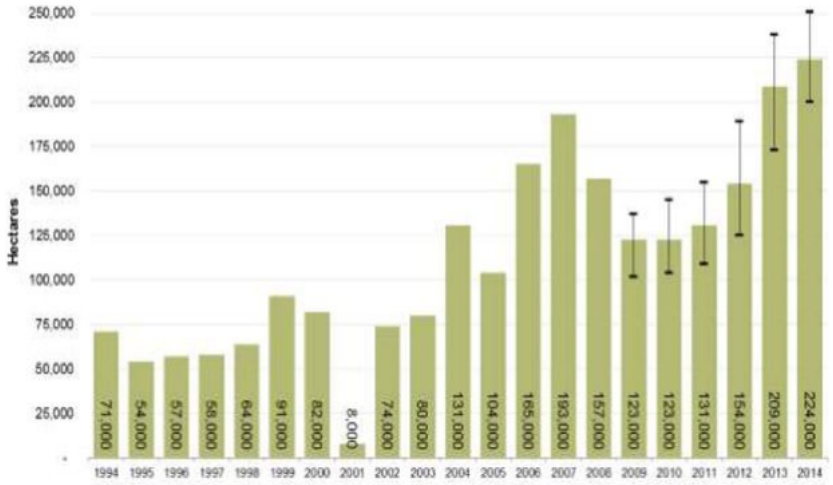
treatment facilities. I've heard about plans to make Narcan injections available to iv drug users, for overdoses. Another popular angle I've seen repeated multiple times (and one currently pushed by the US Drug Enforcement Agency) claims prescription narcotics became harder to get, so users switched to heroin, instead.

However, the DOJ-DEA 2014 National Drug Threat Assessment Summary notes that cocaine availability 'remains stable at historically low levels throughout most domestic markets along the East Coast.' So users are switching to heroin, but not switching to cocaine from prescription narcotics. Hmmm. Might this be because we have no large military-CIA presence currently in cocaine-trafficking areas, as we did during the 1980s Contra war in Nicaragua, when cocaine use was at high levels? (Coca leaves are only grown in Latin America.)

According to a 2010 UN document, 'Based on seizure figures, it appears that cocaine markets grew most dramatically during the 1980s, when the amounts seized increased by more than 40% per year'. (See this 1987 Senate hearing and this for evidence of CIA and State Dept. connivance with cocaine trafficking by the Contras.)

You can frame stories about the current heroin problem in many ways. But the real heroin story isn't being discussed– which is that since the US military entered Afghanistan in 2001, its opium production doubled, per the UN Afghanistan Opium Survey, 2014, p. 34. The area under opium cultivation in Afghanistan tripled. And the resulting heroin appears to more easily make its way deep into our rural, as well as urban communities. The graph below is from the 2014 UN Opium Survey:

Figure 1: Opium cultivation in Afghanistan, 1994-2014 (Hectares)



The world supply of opium increased 5-fold between 1980 and 2010, according to the UN. 'Afghanistan account[s] for around 90% of global illicit opium production in recent years. By itself, Afghanistan provides 85% of the estimated global heroin and morphine supply, a near monopoly' (pp. 37-38).

> 'The narcotics trade poisons the Afghan financial sector and undermines the Afghan state's legitimacy by stoking corruption, sustaining criminal networks, and providing significant financial support to the Taliban and other insurgent groups,' John F. Sopko, the Special Inspector General for Afghanistan reconstruction, said in an October 2014 letter to the heads of the Departments of Defense, State and Justice, which have all played major roles in the failed drug intervention effort. 'Despite spending over $7 billion to combat opium poppy cultivation and to develop the Afghan government's counter-narcotics capacity, opium poppy cultivation levels in Afghanistan hit an all-time high in 2013.'

Despite the (now) US $8.4 billion spent to defeat this trade, it just keeps growing. The costs of US reconstruction efforts in Afghanistan total '$110 billion, after adjusting for inflation, [which] exceeds the value of the entire Marshall Plan effort to rebuild Western Europe after World War II' according to the Special Inspector General for Afghanistan Reconstruction, speaking in May 2015.

The Special Inspector General noted elsewhere that, 'US reconstruction projects, particularly those devoted to "improved irrigation, roads, and agricultural assistance" were probably leading to the explosion in opium cultivation.'

Only 1.2% of the acreage used for Afghan opium production (est. 224,000 hectares) was eradicated in 2014, according to the UN. Also according to the UN, Burma is the world's second largest producer of opium, currently growing only about 10% as much as Afghanistan. But Mexico has been increasing production.

According to the UN World Drug Report, in the 1990s Afghanistan supplied opium that was converted into half the world's heroin production. By 2010, it supplied 90% of the total.

But the DEA, White House and other official US sources claim that US heroin derives almost entirely (96%) from Latin American opium (based on seizures of shipments); the DEA in 2014 claimed that Latin America was the source for the vast majority of US heroin, with southwest Asia (i.e. Afghanistan) accounting for only 4% of US heroin in 2012.

This is highly unlikely. In 2008, the UN estimated that the US and Canada accounted for 13% of global heroin use. With about 95% of global heroin derived from Afghanistan, Burma, Thailand and Laos, Latin America (mainly Mexico with a small amount from Colombia) does not produce enough to supply the majority of US heroin, let alone 96%. In fact, the White House Office of National Drug Control Policy undercuts this claim when it says Mexico had 10,500 hectares under poppy cultivation in 2012, while Afghanistan alone had

154,000 hectares in 2012 and 224,000 hectares in 2014, per UN estimates.

This DEA claim, based on heroin interdiction, suggests a different explanation. Perhaps heroin shipments from Afghanistan are at lower risk of being seized than heroin coming from Latin America. Might some be entering through government channels, when so much materiel and so many personnel (soldiers, aid workers, diplomats and contractors) fly directly between the US and Afghanistan?

Putting aside the issue of the provenance of the US heroin supply for the moment, surely we can look at heroin as we would any other global commodity.

Congruent with the US occupation of Afghanistan, Afghanistan expanded its opium production, and the global supply of heroin increased dramatically. The price dropped as a result. New buyers entered the market. And the US now has several hundred thousand new addicts. Russia and Europe have even more. The resulting social problems are hugely tragic and hugely costly for millions of families, and for our societies as a whole.

If we start being honest about why there is a major heroin epidemic, maybe we can get serious about solving the problem with meaningful eradication and interdiction. Aerial spraying of crops with herbicides or similar methods has been prohibited in Afghanistan, but it works. In 2014, Britain's former Ambassador to Afghanistan (2010-2012) called for legalization and regulation of illicit drugs as one means of attacking the problem.

Looking beyond the Mexican border for heroin, and inspecting all flights from southwest Asia, including military and CIA flights, could have a large impact on supply as well.

Serious measures are needed. Total world production of opiates always gets consumed: historically, the market for opiates has been extremely elastic. Land under poppy cultivation (in Afghanistan, Southeast Asia's Golden Triangle and Mexico) continues to increase. Without meaningful efforts to reduce opium production and entry of narcotics into the US, the epidemic of heroin addiction may become a considerably bigger problem than it is today.

UPDATE: From the Sept 7 *Wall Street Journal*, we learn that a US 'friendly fire' airstrike in southern Afghanistan on Sept 6 'hit a 30 member elite counternarcotics police unit as they were on a mission …'

At least 11 died in 'one of the deadliest friendly fire incidents in the country in recent years.' Here is the Reuters story. The US denied the strike in Helmand province, but admitted to airstrikes in the adjacent province of Kandahar. According to the *Guardian*, 'The US is the only member of the NATO coalition known to have carried out bombing raids in Afghanistan this year.' The *AP/WaPo* on 9/8/15 reported that, 'Brigadier General Shoffner [Deputy Chief of Staff for Communications in Afghanistan] said 'based on information we received [on 9/8], we feel it is prudent to investigate

the airstrike our forces conducted in Kandahar.'

The airstrike killed approximately as many people as died in counternarcotics efforts in all Afghanistan throughout 2014.

I will have more to say about the subject of heroin in a later post.

☐ Meryl Nass, M.D. is a board-certified internist and a biological warfare epidemiologist and expert in anthrax. Nass publishes *Anthrax Vaccine*.

Chile

CHILE CANNABIS DECRIMINALISATION: LAWMAKERS MOVE TO LET PEOPLE GROW THEIR OWN MARIJUANA

Chile looks set to decriminalise cannabis after the country approved a bill to allow its people to grow small amounts of marijuana for medical purposes.

The public gallery in the lower house of congress erupted into cheers and applause as 68 members – compared with 39 – voted for the bill.

The announcement has been praised as being a 'big step forward' in the usually socially conservative country's stance on drugs.

Until now, planting, selling or transporting marijuana in Chile has been a punishable offence which could have resulted in up to 15 years imprisonment.

Now, Chileans will be able to able to grow six plants at home, allowing the possession of up to 10 grams (0.35 ounce).

Protesters marching in Chile's capital, Santiago, calling for legalisation of cannabis in the country

Those who voted against the bill on Tuesday criticised the outcome, saying it would only encourage the use of drugs throughout the county – particularly among younger people and students.

If this new bill passes before a health commission and then the Senate, it will also decriminalise recreational use.

Communist lawmaker, Karol Cariola, who is a part of President Michelle Bachelet's leftist coalition, spoke with the press after the vote and said it was important for the country.

Calling it ‘a historic day for medicinal users,’ she added the vote was for those ‘who wish to stop being persecuted and be able to access a medicine that they can grow in their gardens.’

So far, on a worldwide scale, Uruguay became the first country in 2013 to create a legal marijuana market and Jamaica followed suit this year too by decriminalising personal use of the drug.

In America, more than 20 states have also relaxed their laws on marijuana being used for personal and medicinal purposes.

Memorial corner

To remember loved ones who have lost their lives to illicit drugs

For inclusion on this list, please call the office on (02) 4782 9222

Given Name	Family Name	Date of Birth	Date of Death	Age
Paris	Avenell	20/07/1994	20/10/2012	18
David	Beecroft	08/03/1974	01/11/2008	34
Gena	Brown	11/08/1965	13/10/2000	35
Ronnie	Byrne	27/04/1976	16/10/2003	27
Christopher	Cameron	22/09/1975	09/10/1999	24
Simone	Chalmers	30/05/1905	17/11/2000	23
Craig	Condon	23/03/1965	23/11/1999	34
Michael	Deane	26/06/1980	21/11/1998	18
Jesse	Dunbar-Kittel	18/11/1973	28/10/1999	25
Mandy	Finch	18/08/1972	27/10/2006	34
Mark	Fussell	27/07/1975	14/11/1999	24
Russell John	Gordon	09/01/1975	23/11/2000	25
Benjamin	Gosling	23/07/1980	15/11/2000	20
Timothy	Green	09/10/1957	21/10/1984	27
Donna	Greenbank	19/08/1960	18/11/1996	36
Ben	Hatten	09/08/1979	03/10/1997	18
Jamie Dene	Johns	21/03/1971	01/11/2005	32
Noeline	McGregor	09/01/1977	07/10/1998	21
Naomi Blanch	McLernon	22/03/1974	12/10/1995	21
Craig	Miller	27/05/1970	28/11/2000	30

Given Name	Family Name	Date of Birth	Date of Death	Age
Paul	Mowbray	18/04/1963	27/10/1997	34
Lauri	Mujunen	21/06/1961	05/10/2001	40
Rohan	Murphy	25/03/1969	20/10/1999	30
Erin	O'Brien	19/08/1966	04/11/1997	31
Ryan	Pearson	21/03/1977	10/11/2011	34
Miranda	Ranks	20/12/1981	11/10/1998	16
Emily Kate	Rinder	18/10/1978	19/11/1999	21
Yasmine	Roberts		21/10/2002	17
Jeremy	Rose	05/02/1975	06/10/2000	24
Craig	Rosewood	04/02/1968	11/11/1989	21
Todd Anthony	Schou	12/07/1975	06/10/2009	34
Tony	Terroni	13/05/1975	01/11/1997	22
William	Thompson	29/08/1960	22/11/2000	40
Jamie	Valentine	10/12/1973	26/11/1997	24
Erika	Von Cerva	07/04/1957	18/11/1987	30
Darryl	Webster	14/10/1971	06/11/2000	29
James	Williams	16/05/1961	11/11/1991	30
Daniel	Wren	22/03/1982	17/11/2008	26

Need help?

Family Drug Support – Support Line	1300 368 186
Family Drug Support – Office	(02) 4782 9222; fax (02) 4782 9555
Alcohol & Drug Information Service (ADIS)	(02) 9361 8000 / 1800 422 599
AIDS HIV Information Line	(02) 9206 2000 / 1800 063 060
Compass Directions ACT	(02) 6122 8000
Families & Friends for Drug Law Reform (Canberra)	(02) 6169 7678
Hepatitis C Information & Support Line	(02) 9332 1599 / 1800 803 990
Nar-Anon	(02) 9418 8728
Narcotics Anonymous Self-help for drug problems	(02) 9565 1453 / 1300 652 820
Cannabis Information & Helpline (NCPIC)	1800 304 050
NSW Users & Aids Association (NUAA)	(02) 8354 7300 / 1800 644 413
Parent Drug Information Service WA	(08) 9442 5050 / 1800 653 203
Parent Line NSW	13 20 55
Ted Noffs Foundation Centre for youth and family drug and alcohol counselling services	1800 151 045

Contributions to FDS Insight do not necessarily reflect the opinions of FDS or its Board.

Family Drug Support PO Box 7363 Leura NSW 2780

Family support meetings Sep – Nov 2015

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. Please phone facilitator (listed below) to check on dates prior to attending. ***General enquiries:*** **FDS Head Office (02) 4782 9222**

Note: MEETINGS ARE NOT HELD ON PUBLIC HOLIDAYS – 5 OCTOBER (LABOUR DAY)

FDS support groups

NSW – Burwood — **every Monday (7 – 9 pm)**
Burwood Council Library (Ralston Room), 2 Conder St, Burwood
Enquiries: Janet 0414 531 272 or Head Office (02) 4782 9222

NSW – Byron Bay — **Fortnightly, 1st/3rd Tuesday (7 – 9 pm)**
INTRA meeting room, 75 Johnson St, Byron Bay (entrance to stairs between WBC and Johnson/Marvell Sts corner). *Enquiries:* Margaret 0427 857 092 or Jane 0410 494 933

NSW – Kincumber — **1st/3rd Monday of month: 19 Oct; 2 & 16 Nov**
Arafmi Cottage, 6/20 Kincumber St, Kincumber. *Enquiries:* Marion 0439 435 382 **(7 – 9 pm)**

NSW – Port Macquarie — **1st Monday of month: 2 Nov**
Education Rooms, rear of Community Health Centre (next to water tank) **(6 – 8 pm)**
Morton St, Port Macquarie. *Enquiries:* Pam 0438 994 269

NSW – Coffs Harbour — **1st/3rd Monday of month: 19 Oct; 2 & 16 Nov**
The Mudhut, Duke St, Coffs Harbour. *Enquiries:* Theo 0402 604 354 **(7 – 9 pm)**

SA – Leabrook — **Wednesday fortnightly: 30 Sep; 14 & 28 Oct; 11 & 25 Nov**
Knightsbridge Baptist Church Hall. 455 Glynburn Rd, Leabrook **(7 – 9 pm)**
Enquiries: Kath (08) 8384 4314 or 0401 732 129 or Devushka 0428 271 743

SA – Hallett Cove — **Wednesday fortnightly: 7 & 21 Oct; 4 & 18 Nov**
Hallet Cove Baptist Church, 1 Ramrod Ave, Hallet Cove **(7 – 9 pm)**
Enquiries: Kath (08) 8384 4314 or 0401 732 129 or Devushka 0428 271 743

SA – Hindmarsh — **Monday fortnightly: 5 & 19 Oct; 2, 16 & 30 Nov**
Anglicare SA, 184 Port Rd, Hindmarsh **(7 – 9 pm)**
Enquiries: Kath (08) 8384 4314 or 0401 732 129 or Devushka 0428 271 743

QLD – Carseldine — **1st/3rd Tuesday of month: 6 & 20 Oct; 3 & 17 Nov**
Shop 3, 521 Beams Rd, Carseldine (room in Aust Red Cross). *Enquiries:* Head Office (02) 4782 9222 **(7 – 9 pm)**

QLD – Nerang — **1st/3rd Monday of month: 19 Oct; 2 & 16 Nov**
Girls Guides Hall, 40 Ferry St, Nerang. *Enquiries:* Dom 0419 689 857 **(7 – 9 pm)**

VIC – Bendigo — **Wednesday once a month: 14 Oct; 11 Nov**
Olinda Centre, 8 Olinda St, Bendigo. *Enquiries:* Michael 0448 169 205 or Head Office (02) 4782 9222 **(7 – 9 pm)**

VIC – Geelong — **Wednesday fortnightly: 30 Sep; 14 & 28 Oct; 11 & 25 Nov**
The Swanston Centre, cnr Myers & Swanston Sts, Geelong **(7 – 9 pm)**
Enquiries: Kevin 0487 949 745 or Debbie 0412 382 812

VIC – Glen Waverley — **Thursday fortnightly: 1, 15 & 29 Oct; 12 & 26 Nov**
MonashLink, cnr Euneva Ave & O'Sullivans Rd, Glen Waverley. *Enquiries:* Debbie 0412 382 812 **(6 – 8 pm)**

VIC – Hawthorn — **Wednesday fortnightly: 7 & 21 Oct; 4 & 18 Nov**
Inner Eastern Community Health Service, 378 Burwood Rd, Hawthorn **(6 – 8 pm)**
Enquiries: Debbie 0412 382 812

VIC – Ferntree Gully — **Tuesday fortnightly: 6 & 20 Oct; 3 & 17 Nov**
Knox Community Health Service, 1063 Burwood Hwy, Ferntree Gully **(6.30 – 8.30 pm)**
Enquiries: Michael 0448 169 205

VIC – Footscray — **Thursday fortnightly: 8 & 22 Oct; 5 & 19 Nov**
Drug Health Services, 3-7 Eleanor St, Footscray. *Enquiries:* Michael 0448 169 205 **(6 – 8 pm)**

VIC – Frankston — **Tuesday fortnightly: 29 Sep; 13 & 27 Oct; 10 & 24 Nov**
Frankston Hospital, Hastings Rd, Frankston. *Enquiries:* Debbie 0412 382 812 **(6 – 8 pm)**

Non-FDS support groups

NSW – New Lambton, Newcastle — **1st Friday of month: 2 Oct; 6 Nov**
New Lambton Community Centre, 14 Alma Rd, New Lambton. *Enquiries:* Head Office (02) 4782 9222 **(7 – 9 pm)**

SA – Berri — **20 October**
Mental Health Resource Centre, Seekamp St, Berri **(3 – 5 pm)**
Enquiries: Kath (08) 8384 4314 or 0401 732 129 or Devushka 0428 271 743

ACT – Canberra — **Wednesday fortnightly – NB: Please call to confirm dates**
Compass Directions Act, Level 6, Cosmopolitan Centre, Bowes St,, Woden. **(5.30 – 7.30 pm)**
Enquiries: Switchboard 6132 4800

WA – Mandurah — **every Tuesday**
South Metropolitan Community Drug Services, 22 Tuckey St, Mandurah **(6 – 7.30 pm)**
Enquiries: Anne (08) 9581 4010