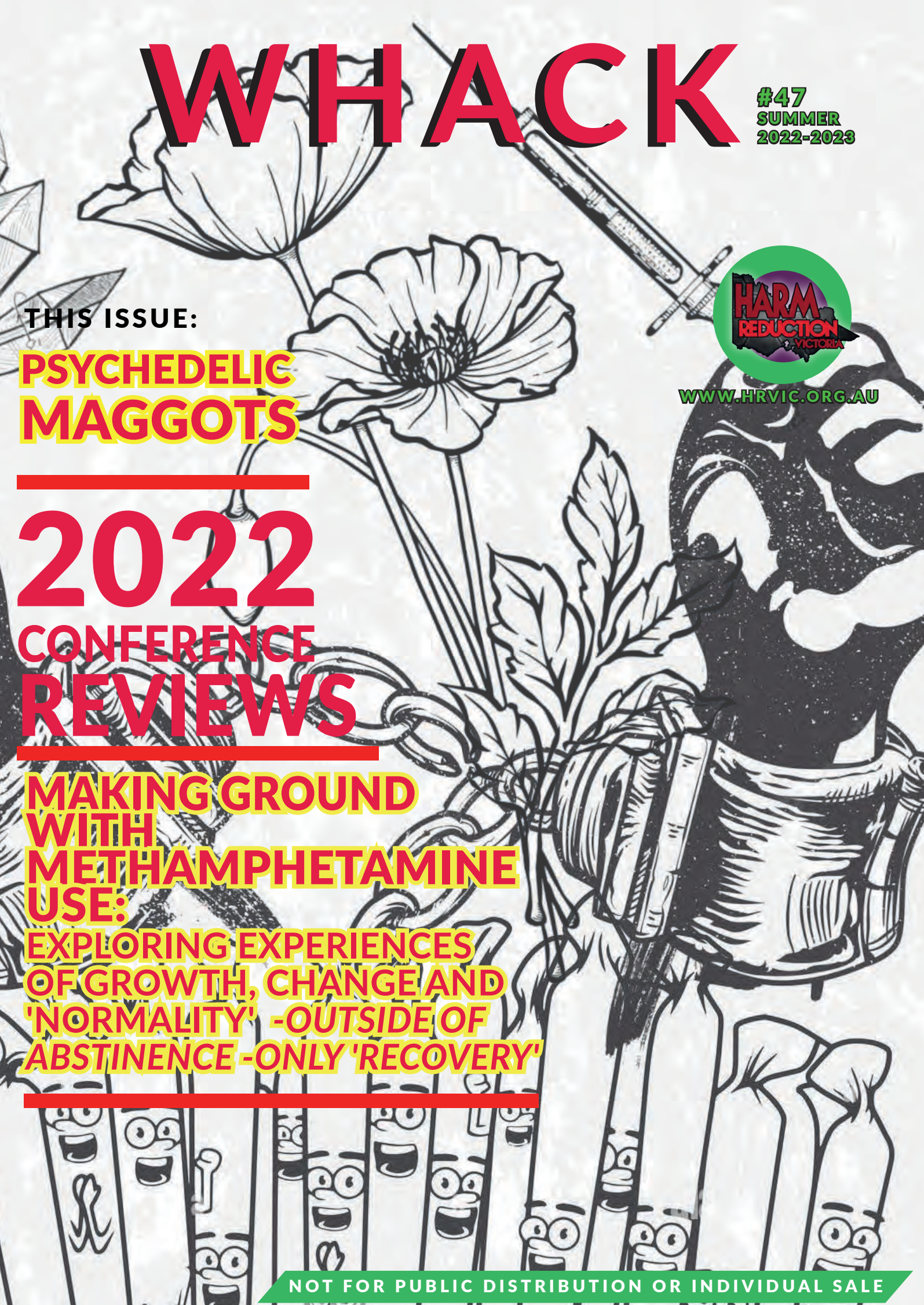
# WHACK

#47
SUMMER
2022-2023



HARM REDUCTION VICTORIA

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THIS ISSUE:

## PSYCHEDELIC MAGGOTS

## 2022 CONFERENCE REVIEWS

## MAKING GROUND WITH METHAMPHETAMINE USE:

### EXPLORING EXPERIENCES OF GROWTH, CHANGE AND 'NORMALITY' *-OUTSIDE OF ABSTINENCE -ONLY 'RECOVERY'*

This resource is produced by Harm Reduction Victoria
to serve as a voice for the Victorian drug user community
and to provide a forum for debate
and comment on the issues affecting
people who use drugs in Victoria.

**The contents of this magazine
do not necessarily represent the policies
and/or views of the Victorian drug user organisation
-Harm Reduction Victoria.**

**Harm Reduction Victoria (HRVic) *does not condone nor condemn drug use* and does not promote illegal activity.**

**HRVic recognises and acknowledges that drug use happens
and as such, focuses on drug safety and harm reduction messages.**

**HRVic seeks to reduce the potential harms that are sometimes associated with drug use
through the provision of factual, useful information, peer education, support, advocacy and referrals.**



**The distribution of this publication is targeted. WHACK is not intended for general distribution**. ISSN #1440-4753.

HRVIC acknowledge the Wurrundjeri people of the Kulin nation as the traditional owners of the unceded lands and waters, on and around, where WHACK is published. We respectfully acknowledge all elders past, present and emerging throughout Victoria where this magazine is distributed.

# WHACK©

#47 SUMMER 2022/2023

# CONTENT











WHACK© Magazine is **your** magazine and as such we want **your** contributions!!

Submissions are paid for - if chosen for publication.

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Do you write a blog or draw/ paint/do digital artwork or take photos?

Do you want to learn to put together a magazine? WHACK is putting together a Production Team made up of **us** -*the community*- that want to learn to put together a community magazine and/ or that want to mentor others who'd like to.

If you are interested, please email

samj@hrvic.org.au


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**WHACK©** is another **HRVIC** initiative.
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# DELIVERY DEMAND

BY PATRICK CERNJAK (c) 2022 PCX

**It's the middle of the night,**
**turn it up real bright.**
**Show us what you got,**
**this beat it real hot.**
**Delivery demand, so you think you can.**
**Delivery afternoon, now gone missing,**
**2 base and 4 T's high are hissing.**
**Next morning, magic wishing,**
**miss go blissing, lets go,**
**there's no end in sight.**
**Suspension, rock bottom apprehension,**
**get up,**
**illogical question.**
**Reply yes and answer no, base!**
**What you wanna know?**
**Deep down trepidation wax,**
**score yes and flirt the hazy tracks,**
**wanna go down, wanna get down.**

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# DOCTOR J AND MORELAND HALL

## (EARLY METHADONE PROGRAMS IN VICTORIA)

BY DAVID RAY

**In the early 80s, some 40 years ago, I finally admitted that I needed help with my heroin dependence and the legal problems that came with it.**

There were no methadone maintenance programs that you could get on at the time.

I think no more than 200(?) people were on methadone maintenance back then in Victoria, but these were leftovers from programs of the 70s that were effectively closed to any new users by the time I needed them. These were run from the SS Clinic in Fitzroy (which became Turning Point), and from a well known hospital in the north east of Melbourne. This hospital was well known for operating “blockade” programs, which used such high amounts of methadone, 180mg and more, that it was assumed that users would not be able to feel any heroin they might use.

This wasn't good for the drug using community's health, and these programs were gradually faded out, though not for that reason.

I did have a friend who was on some sort of a methadone program at Smith Street in the mid-seventies, but I don’t recall the details. I think it was similar to the Moreland Hall program that I describe below.

Psychologists had big input into the attitudes towards treatments for opioid dependence at this time. Some had the view that a positive attitude 'cured all'.

From the 1970s, 'behavioural psychology' was on the rise. One of its most well known proponents, being infamous for establishing the psych department at La Trobe University, (and running questionable therapy sessions involving a double bed 'for research purposes') who later became President of the Australian Psychology Society, was found to have conducted 'unethical experiments' and was recently convicted of historical sex crimes against children.

It was these groups of so-called 'professionals' who considered methadone maintenance defeatist, and just an 'addiction to another drug.'

Harm reduction and harm minimisation had no meaning to these people who were sometimes well intentioned, but who always came across as ignorant and often bigoted.

General bigotry within society played a large part, but these pseudo-sciences, particularly behavioural psychology, provided a veneer of reason to the bigotry and ignorance.

*Note regarding behaviourism – with this rather sub-human version of psychology, the problem was not with their research, but with their **belief** that this animal/mechanical view of life explained everything, denying the existence of all that makes humans human.*

**This kind of view, that one group knows all, and their understanding applies to everyone, no matter how different they may be, is always a problem, whatever the system of belief may be.**

One good example of this in the 70s/80s was a well known and one of Melbourne's largest rehab centres, both then and now a major treatment centre, which was utterly opposed to harm minimisation and hence to methadone maintenance.

They used an AA style American model and in the 70s and 80s their influence was profound. (I hope they have changed their attitude now). Despite the fact that they were able to treat only a few dozen of the thousands of 'junkies' needing treatment each year, they were utterly opposed to methadone maintenance.

*Junkie= people who loved 'junk'- what heroin was called back in the day-ED )

Perhaps they believed that a life of methadone dependence was not worth living. I had nothing against their methods, but it was obscene to insist that only their model was useful, while heroin users died all around them.

The only people I knew who went into rehab were those facing long jail sentences. They thought that a chance to be sentenced to undergo treatment at ths rehab was preferable to Pentridge prison. Some decided that prison was better than the strict socialising practices of places like this rehab. They were pretty much the only centres of that type at that time, but many more such treatment centres exist now. The more choices available to an ailing opioid lover, the better it is, as far as I am concerned.

**The problem comes when some group insists that *their way* is the *only way*.**

As well as Moreland Hall, there were other inpatient/outpatient treatment centres in the 70s and 80s.

Pleasant View, a government centre in the northern suburbs, was another one I attended as an outpatient for quite a time. There were other regional treatment facilities, although these tended to deal more with alcoholism.

Another of these was “The Buttery” in rural New South Wales, made famous by the Paul Kelly song “To Her Door”, about a recovering alcoholic returning home to his partner after some months of treatment at The Buttery, wondering if his love and his normal life would still be waiting when he made his way back “on Olympic” (tyres) to her door.

This reminds me of a quote I’ve heard many times, though I’ve never been able to trace the source, although it has been attributed to a number of different people.

**With dependence as with many other situations,**

**"The answer is not to find a cure, the answer is how to live.”**

Despite the fact that psychologists had a zero success rate in ‘curing’ junkies, their theories prevailed until the mid 80s when a great number of politicians children became heroin dependent, including the younger daughter of the then Prime Minister, Bob Hawke.

There followed a national drug conference in 1986, which paid attention to people who actually had learned something from their work with users, and methadone maintenance programs expanded enormously. This was when I got onto a long-term maintenance program. Psychologists had a valuable role in exploring the underlying problems that contributed to dependence, but they provided no real solutions. Like all the social sciences, they weren’t very scientific.

But back to the darker ages of the early 80s: There were 2 doctors in particular, who were respected by the junky community: the two Johns, John Sherman in St.Kilda, and John Jagoda in North Melbourne.

Following advice from an older user, I found myself in Doctor John Jagoda’s North Melbourne office after a 2-hour wait in a room full of junkies and aged Italian men and women, all dressed in black.

I was there to get onto a 6-week methadone reduction program. I think this program began in the 70s, but I’m not 100% sure about that. This reduction program was the best you could do at the time. You started at around 30mg and dropped by about 5mgs a week until you were 'cured' and all 'was well'. (I never got past a few weeks. I don’t recall ever meeting anyone who did complete one of these, but they provided an 'assist', a break from the killing difficulties of living with a large habit.)

There was a longer-term maintenance program that

you could get onto in the mid 80s but it required a drastic move. It involved getting a referral letter from a Melbourne doctor who was a specialist in 'addiction medicine', then catching a bus to the Brisbane suburb of Fortitude Valley. You then took your referral to a clinic there and they would start you on a methadone program the same day. It was a profound life change and few took up this option unless they had a pressing need to relocate for legal, or other, reasons.

Back in Doctor J's office - after a brief chat he pulled out a form and started filling it in: "Registration of a Drug Addict". This was to be expected, but it still was a bit of a shock to see in writing like that. A Permanent label;

## I was now a "Registered Drug Addict".

Over the next few years I would come to do many of these programs as well as many in-patient programs. I never completed one but they kept taking me back. It became like a second home to me in some ways, and without these time-outs I doubt I would still be alive today.

Before they could accept you onto the methadone reduction program they had to be sure that you really were a drug addict, so on the morning that you were to begin the program you were required to undergo the "Narcan (naloxone) Challenge".

You would get an IM (intra-muscular) shot of narcan from the nurse, then she would wait to see your reaction. I was soon bug-eyed (wide pupils), with sweaty palms and goose bumps, so I passed the addiction test and was soon on my way to Coburg. If you had someone to drive you it wasn't too painful, but if you had to catch the tram it was tough, sinking into full-on withdrawal in a packed tram.

I didn't have too bad a time with the challenge because I showed obvious

withdrawal signs quickly, but if you were someone who didn't show the signs so readily, then you would get an intra-venous shot of naloxone to speed up the process.

This tended to be a mess, as you would go into full withdrawal right away.

If you passed this test you then had to make your way to Coburg each day. It was a lot easier after that first day.

By Sydney Road tram or by train to Moreland station, it was then only a few minutes walk, to Jesse St then along the driveway to the back of the hall.

By car you drove around the back to Hall Street and the dusty car park. The front of Moreland Hall was very pleasant, a two storey brick building surrounded by wide, treed lawns edged by gardens. The car park, pharmacy and waiting area around the back was a dump.

Before collecting your dose each day, you had to give a supervised urine specimen. A nurse would stand in the toilet doorway while you pissed in a little plastic jar, not always easy for a nervous urinator. Once you had squeezed out a little for the jar you screwed the top on and handed the jar to the nurse, who then left you to complete your business.

Then you went to the little pharmacy and, if you were lucky, Peter was there.

ILLUSTRATIONS LEFT AND INSET BY RESET

Peter, the main pharmacist, was friendly and kind and easy to talk to. For a time he had played guitar in the 'Captain Matchbox Whoopee Band'. He knew the drug world and was sympathetic to our problems.

The other pharmacist was a horribly unsympathetic woman who thought herself above the junky scum she had to deal with. If your previous day's urine specimen was positive for heroin and you were being kicked off the program she would smirk with pleasure. If it were Peter who told you, he would wish you well and give you a final dose to send you on your way. With the witch, there was no final dose, just the nasty smirk. Maybe she treated others better, but no-one that I'd met.

Sometimes a legal situation would arise and you might avoid jail if you could get a good behaviour bond conditional on getting supervised drug treatment. To arrange this you needed to start seeing a psychologist at Moreland Hall. There were other agencies, but this was the one I knew best and trusted. You would see a psychologist on the outpatient programs as well. In my experience the Moreland Hall psychologists were pretty good. Some had wacky theories, but all had compassion and saw the welfare of the junkies as more important than the social theories they had been taught.

One of them told me that he didn't feel he had really started learning until he left uni and started working with people. He made wooden flutes and was a kind man.

Another one liked to discuss the spiritual values of LSD. Personally, I'd always felt that LSD, mescaline, mushies etc. could give an insight into the workings of the mind and a changed perspective on life, but no great spiritual awareness, although it might add a thought or two to the little bag of wisdom we gather as we wander through life.

When I was an in-patient at MH I met quite a few older junkies who came from the 60s generation and the alternative art culture of the time. This was based in Carlton and Fitzroy and thereabouts. There was a famous book written at the time, 'Monkey Grip', by Helen Garner, which was reality based and told the story of a woman writer whose boyfriend was a junkie. The older junkies would tell me stories about various characters in the book, but their perspective was somewhat different from that of the author.

I liked the book but found the 'real' stories more interesting. Many people I spoke to did not like the picture of their world that she'd portrayed.

Initially I just wanted to tell a personal version of the story of what preceded the enormous expansion of methadone programs in the late 80s. But as I hunted through old documents and memories I realised that more needed to be said about how ignorance and bigotry have always been the basis of the treatment of opiate dependence or what they term so flippantly- addiction.

There are periods of enlightenment, as came about in the late 80s, but the understandings of that time have largely disappeared. The rules that were set up then no longer apply. They spoke then of different types of users – "category 3" was that group of people who were suited to medium/long term methadone maintenance.

Now all users are again lumped together, despite the reasons for using heroin often being quite different. In particular, there are some for who opiates act as a specific 'cure' to their problems. Ongoing maintenance with opiates is the best treatment for these. Others seem to want anything that curves consciousness. For them, nicotine, alcohol, amphetamines and benzodiazepines also have a place in their mix, so a treatment drug may be harder to find. There are also vast arrays of underlying physical and psychological circumstances that play into the situation.

Dependence itself is difficult to describe as the real medical problem as doctors prescribe drugs of dependence all the time. Anti psychotics, anti-depressants, anxiety medications and many others are highly physically addictive and many have horrific withdrawal symptoms. In the years when I was connected with 'the Hall' they would deal with junkies and alcoholics but benzo lovers were just too crazy for them to deal with. This changed after the expansion of methadone programs as residential programs became less popular with junkies and these programs had their funding greatly reduced (methadone maintenance is really cheap in comparison), so places like MH had to add poly substance users to their mix to survive.

A further aside regarding the changing social understanding of opiates - in the 1800s many artists used opium, and it was writers in particular who came to understand the nature of dependence. The medical community at this time treated opium addiction as a chronic illness that could only be treated with opium. Really, it is obvious that users would come to understand things that the medical community (who didn't partake in opioid use themselves) could not. Some doctors did learn from users -some still do- and these are the best doctors.

Alot do not make use of this obvious resource, however, relying on little knowledge, much

ignorance and an assortment of prejudices.

Back to the main story.

After the 1986 conference interested Victorian doctors could apply for a permit to take on 10 methadone maintenance patients. MH told me I could be one of their first ten maintenance people, but they also said that you had to agree to stay on methadone for 4 years.

**As I was sure that I could get my act together in a shorter time than this I turned them down. I may have been overly confident, however, as I'm still on methadone now..... 36 years later.**

Further legal problems at the time led to me being treated as an outpatient at PV on a 'section 13' bond. A few months later I became one of the first ten on their methadone maintenance program under the new regime.

There is more to say, obviously, about what happened to 'treatment programs' from this point, and treatment turning into a recovery vs. maintenance narrative but this story is already overlong.

**From rapid detox and naltrexone to Biodone and take home doses, onto Suboxone strips and long acting bupe depots to -fingers crossed -a regulated or safe supply in the not to distant future - perhaps this is where I pass the torch so to speak, onto the next generation of maintenance consumers to continue this story.**

ILLUSTRATIONS BY D ROQ SQUILLIONAIRE



# PSYCHEDELIC MAGGOTS

BY RHIANNA WHITTRED

It was early 2001. I was barely 15, enjoying a sleep over weekend with my 2 best mates Sammy and Cameron. We were at Cameron's place in Sydney's Northern suburbs, close to the train line but far removed from the hustle and bustle of the central city. Cam's older brother Tony was up north in Nimbin for the day mushroom picking with his mates. The 3 of us came to the conclusion it would be a good idea to get some for ourselves. This may have taken some slight persuasion on my part, but we placed our order non the less.

Tony had introduced me to cannabis and had taught me how to smoke my first cone. In Sydney stylez "Never pack a cone you can't punch". For this, I remain forever grateful, for those mushrooms- perhaps not so much.
He arrived home late in the evening and handed me a bag that was a soft gooey mess of mud, mushrooms and maggots. MAGGOTS!

Without hesitation, I handed over my 50 bucks and he swiftly disappeared back to his room. I presume to 'punch some more cones'.

Delighted with my purchase, I turned to show my friends this 'wonderful gift'.

Their faces quickly turned from gleeful looks of anticipation to ones of pure disgust. An argument swiftly ensued. Both of them refusing to touch the mushrooms while I begged and pleaded that we soldier on in our mission to become psychonauts. Eventually I won out by forcibly yelling "I PAID FOR THIS SHIT NOW WE'RE GONNA FUCKING EAT IT!" They both resentfully agreed.

It was I who took the first mushroom from the bag and hurriedly gobbled it down in distaste. We then passed the bag around, each taking a turn to force one of the mushy fungi down our throats. We were barely through half the bag when they both declared they could eat no more. Like a true warrior I accepted their defeat and munched the rest of the bag in a single gulp.

Next came the wait. The longest wait of my life. I had a few days earlier obtained some weed off Tony and we proceeded to smoke that. Cone after cone, after cone until Sam and Cameron begged me to stop. But the wait was not yet over. My friends tried to occupy me by making me watch TV, but it was late evening on a Saturday night, and back in the noughties this meant there was never anything on. We endlessly channel hopped through aerobics classes, horror films and infomercials till I finally snapped and turned the TV off. I nearly broke the remote in my attempts to steal it and free myself from the endless loop.

It was about this time I decided to look in the mirror. Up until that point I was certain I felt nothing, but my reflection told a different story.

My eyes had disappeared. The sparkling green they had once been turned into an obtrusive white filled with nothing but an endless black hole. I quickly turned away, but it was too late.

The effects had started to kick in. Maggots came pouring from all corners of the roof and my friends not having reached their tipping point yet cackled with laughter as I lay terrified on the bed.

Sam and Cam eventually managed to rouse me from my nightmare by putting on the radio. They too were now starting to see the maggots, and someone suggested we go visit another *(very straight I may add)* friend, who lived one suburb away.

It was past midnight now and though leaving the house may seem like a good idea when your only 15 and meant to be asleep, the paranoia of sneaking out while peaking can entirely consume you.

As we walked down the stairs to reach to ground floor, our intended escape point, the fear hit me. Sammy and Cameron disappeared, and I was standing face to face with Cam's much older brother and his wife who lived downstairs. They wanted to take me away and I started yelling "No, no, I've done nothing wrong! I won't go with you!".

It was Sam who snapped me out of it, thank god. Cam's parents were asleep on the ground floor and my yelling could have got us sprung. All it took was one hard slap to the face and I was back in 'reality' creeping down the stairs with my 2 best friends. We all hugged and made for the back door; it was locked. We climbed out the window and headed up the driveway into the great unknown.

As we reached the footpath, we were enveloped by overhanging trees and suddenly I was in the jungle. I could see the leaves rippling to the sound of the birds' song, as a sloth hanging upside down from a tree branch stared me right in the eye. Moments later I had to jump back to let a tiger cross the worn pathway that traversed through this exotic paradise. No one else saw what I saw but I will never forget that nanosecond I shared with the jungle, immersed by its raw primal instincts and the softness of its natural beauty. As we reached the top of the hill the canopy started to dissipate, and the harshness of the bright streetlights returned me once more to reality.

We hit the top of the street and turned left, we were faced with our next obstacle, the Pacific Highway.

It was quiet at this time of night but there was still an intermittent flow of cars streaming by at what seemed like the speed of light. We had a fair way to walk and continued down the footpath, crossing the small side streets without incident.

The phone rang.

It was Cam's mobile. The abrupt sound put me straight back into a wave of paranoia. Who could it be? Was it the police? Was it one of their mums? Was it MY mum? How did they know? What would they say? We were in BIG trouble. The call was answered without a second thought and what did I hear? My mother's voice threatening and demanding, screeching down the line. No one else seemed phased by the phone call and they couldn't understand why I was in such distress. I

begged for them to cut the call. To not say anything. I started yelling again “I swear I’ve done nothing wrong”. Cameron reassured me that it was not in fact my mother but our friend Alex.

I insistently denied this and was swiftly handed the phone to hear for myself. Once again there was that voice demanding and terrifying wanting to know what I was doing up at this hour. But it was a fuzzy connection and in between the accusations and threats of punishment, I could hear Alex. “M..te I.. me, I’m no.. yo.. mm..”

I immediately ended the phone call, too paranoid for anyone to know what we were up to.

"WHY WOULD YOU ANSWER THAT?!” I accused Cameron. This was followed by another sharp slap in the face from Sam. They showed me the caller ID on the phone, and I could see clear as day that it was in fact Alex that was on the line. I was back in the real world again, but the paranoia remained.
My mind like a carousel, spinning through every possible outcome of the phone call. All of which ended up with me- dead.

My friends insisted we call Alex back to reassure them that we were fine, but I declared that this was a top-secret mission, and no one must know our plans. Anyone could be a spy, trying to gain information and turn us in to our mothers. Seeing the pure terror in my eyes, they agreed to turn their phones off, but only after sending a quick text to Alex. Once again, we embraced and headed further up the highway.

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Next came ‘The Crossing’. It was miles between pedestrian crossings out these ways. We couldn’t wait. We just HAD to cross the highway and leave the negativity behind. We reached a point where we could easily see in both directions. There wasn’t a single car coming from the right, so we quickly made it to the median strip. We were delighted but looking to our left we realised this second juncture would not be so easy to traverse. For some reason there was a stream of cars heading south, we stood and waited, watching the road looking for a gap.

Then we saw it. Off in the distance. It was the police, and they were going to drive right by us. This time it was Sam and Cam that freaked out. I quickly snapped out of it and announced, “Chill guys, just act cool, ok”. The effects of my words were instantaneous.

**We all immediately entered ‘The Fonz’ mode. Standing on the tiny median strip, the 3 of us streaking back our hair and putting hands on our hips. The cop car was getting closer. We continued to ‘act cool’.**

A little too cool perhaps. We were all slowly grooving to an unheard song.

The car passed and we all gave it a quick head nod. As it continued off into the distance, we realised we may have over done it, but then we also realised it was just a taxi.

We all bent over in laughter.

With the phrase “act cool” forever burnt into our memories, the cars had all moved on and we were able to reach the other side.

It was much calmer over here, more peaceful. I didn't know the way, but Cam knew the area like the palm of their hand and proceeded to lead us through the rabbit warren of suburbs until we finally reached Alex's house. They had agreed to meet us to come roam the streets on an 'epic night out', but no one was answering their phone. There were 3 of them in there but not one was 'contactable'.

Sam and Cam debated our next move. The bright idea was to sneak around the back and knock on the back doors as they would all be sleeping in the lounge. At this, I drew the line. "Are you fucking crazy?" I hurled, "if they're not answering, they don't want to be a part of this. We should go knock on the back door and have them see my eyes like this?!!?" I spread my lids to show the hollow black pits in the now red and white streaked domes bulging from my face.

**"Who do you think they'll blame?! Who always takes the fall?! You can do what you bloody like but I'm going back to Cam's!"**

**They pleaded "Please, please! You don't know the way! What if you get lost?"**

I was adamant that it would be better than facing another overbearing mother who Alex herself already was. By this time, Sam was starting to see my point of view and joined the side of 'the manic'. The 'wise manic'.

After further debate it was agreed that we go back to Cams place. An anti-climax of our mission, leaving us all on a downer as the paranoia seeped into all of us. I do not know how we found our way home I only remember the path.
We took a short cut or maybe we'd come that way earlier- I really did not know. My sense of direction has always been somewhat lacking. There was a long and narrow footpath ahead. Only room for two of us to fit on it. One MUST walk in the grass. As usual, I was bare foot- the others in more appropriate footwear. We all held hands in a line, and it was Sammy who went first on the right edge- the edge full of thick, sharp, blades of grass with wriggling creatures and snakes that we could all feel lurking.

We made it a few metres before jumping on the footpath and declaring it too dangerous. I declared that we must remain linked, and we should take turns rotating from a right to left for as long as we could handle in those dark grasslands. None of us lasted more than a few second. Each time I could see the paranoia overtaking them, as it had me earlier. I felt responsible for this, and I snapped to attention. We were nearly in tears, so I took my place as 'captain of this sinking ship' that was our minds and said "Don't worry! I've got this. I'll walk through the grass but promise me you won't let go of my hand." They tried to offer their footwear, but we all knew my hobbit feet wouldn't fit. The pact was made and with hands clenched tightly we moved at a brisk pace down that never ending alley. I stomped as I walked, and my strength gave them power as their love gave me strength. By the time we reached the end of the path we were skipping along singing a song I can't remember but it brought us back from the shadows none the less.

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The rest of the journey home is a blur to me though none of it could compare to that alley. We were only 15 and even on the north shore there could have been much worse things than snakes it that darkness.
As we finally snuck back in and reached Cam's room, we could see a bright white light. It was the TV. It was still on. I rushed to embrace it as a mother would a child. We were safe. We had made it.  Our epic journey through the suburbs.

Though it may have seemed it was all for nothing, that day changed my life for good. We all fell into the bed and embraced, happy to be safe again. The paranoia melted away and we all fell asleep...

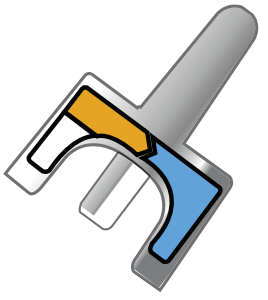
but not before I punched a few more cones.

Another Harm Reduction Victoria Initiative

# RECOGNISE & RESPOND

# OVERDOSE

# Using NALOXONE



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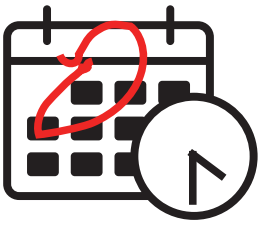

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# THE LUMP

BY 'B' OCT. 2022

I was living at one of the infamous asylums called the “homeless hotels” during the Covid lock down. Approximately 160 homeless people, mostly drug users probably with criminal records all locked up with a curfew.

What could go wrong?

I used to sit out the front reading. Others would smoke bongs and some would shoot up. It was *the* place to socialise. Guests were not allowed at the hotel so residents had to fraternise with other residents. We would sneak people in at the start they hired tight security and that soon stopped.

I made a new friend and we had a big weekend. We remain friends to this day. It was normal for me to meet someone and end up tattooing them within hours but she was great and we had a good little party. Aside from a bit of weed, she didn't use 'drugs'. I shot up a few times to calm myself for the inking, and when I got back to my room, I continued -due to being over stimulated - until I passed out.

The next day, a Sunday, I hit the hammer hard.

I would buy all my gear from outside the hotel when my dole came in because the prices inside were overinflated, the quality low, and I didn't want anyone knowing I had at least 6 grams of good gear in my room, among other sought-after things. Thanks to Covid the Centrelink payment was doubled so lots of gear. That way I couldn't accidentally spend money on useless stuff like food and not have any money for extra gear at the end of the fortnight. I would manage my drug use to avoid running out.

That day I had 15 points, 15 shots, and ran out for the first time since starting daily use. No problem I thought; I would time travel into the future to Friday payday by going into a Seroquel coma. Except I realised I had run out of that. I was fucked. I had to face the terrifying reality: cold turkey. I had sold my favourite well used balaclava to my new friend for 60 bucks to get 3 points, but that was it, there was no one I could borrow money off and nothing to sell.

It was bad, really bad. My stash of methadone take-aways had already dwindled, before I stopped using the ‘done on my dealers advice. I watered it down and slammed the last of it in small doses but it wasn't enough. I even whacked some velaxafine anti-depressants I had left over, as I had read it helps with smack withdrawal. Whacked some valium, even a micro of LSD and left-over specks of DMT. Anything to try to offset what was about to happen. Even if I had the sleepers I wouldn't of been able to keep them down.

I started puking so much: even a teaspoon of water would make me sick. I looked forward to spewing every 20 mins, as I felt better for about 10 mins afterwards. I couldn't sleep, eat, hydrate or drink booze. Just laid in my bed in a semi delirious state wanting a hit so fucking bad.

TV was on but I couldn't watch or enjoy a second of it. I realised I would end up in hospital from dehydration before payday. And even if I made to payday, I would be too sick to go score: it was a 90 min round trip on a train. I wanted to go outside and jump in front of a truck.

On day 3 of no sleep and endless nausea, cramps, shitting, headache, feeling like I was dying, you know the drill, I was desperate. I couldn't leave my room, but realised I had to do something. So, I thought about something one of my dealers told me about, something called a “bupe depot”. He knew the 3.5 grams+ of gear from him was just for maintenance, but he didn't know about the other 5.5 grams from elsewhere…and I wasn't even getting high much.

“This is pretty good gear you know, but I got this injection the other day, it’s called a bupe depot” he said. “It will probably get you more wrecked than this stuff” he said while giving me a smoke and some free weed with my score.

That had stuck in my head. So, in total desperation, I called the local community health as I knew they did pharmacotherapy. I just needed something to get through to payday. Anything. It was getting late in the afternoon. They said come in and I should be able to see a doctor. I puked one last time and didn't put any more water in me, grabbed a plastic bag just in case and dragged my sweating lethargic body to the tram, and suffered the ride to Richmond from CBD with my head in my hands.

They gave me an anti-nausea injection while I paced around the waiting room for the doc. I had met the doctor at my first detox in another service, but he didn't remember me.

“Something, anything, but has to be today. I want that depot, but has to be today” I said to him.

After a lot of working things out I ended up on the long acting bupe injection – I call it the lump

I found I needed the monthly every 3 weeks, and kept it at that. Still using on top, but more out of habit, and my bank account slowly started inflating, which I liked, and mostly spent on nice food.

That led to being off gear for over 4 months as of writing this.

I am pursuing a dream that makes me happy. - genuine 'high on life shit.' Having a goal and AOD counsellor helps keep those days and long nights focused on a better, cleaner life.

Of course I want another hit, who doesn't, but life is great now due to the lump and it was worth all the trouble. I hope that if that’s what you want it may happen for you too. And the money you save, the ability to just buy shit you never could is great.

**"H kept me alive long enough to get off the street, and now I can credit the lump with another new lease on life."**


# RETHINK 'ADDICTION'

## UNLIKELY ALLIES IN A WAR ON ~~DRUGS~~ PEOPLE

BY NICK KENT

**The word addiction, or even worse, "addict", is often used against people who use drugs. Drug use and drug dependence is complicated and ever-changing, but words like addiction have long been used to simplify a drug user's experience in a way that casts a negative light on us.**

This word and the ideas around it are at the root of many institutional responses to drug use. We have research institutes, treatment centres, government policies and tabloid headlines that all revolve around this simplistic notion of "addiction". Of a Powerlessness against a bigger, badder opponent- in this case drugs

Traditionally, dominant society and government have leaned on people who have "recovered from addiction" to assist in their narrative that all drugs, and all drugs users, are morally corrupt. Those who have a history of


Panelists L-R: Stephanie Tzanetis and Sione Crawford. Photo from Rethink Addiction

drug use, but for many reasons have decided to stop using drugs, have been pitted against those who continue to use drugs. The "reformed drug user" and the "junky" are key archetypes in society's understanding of drugs.

But recently, people from these Institutes and Centres came together, alongside people with lived and living experience of drug use, for a conference in Canberra called "Rethink Addiction". Like with many things in this semi-post-COVID era.... everything seems up for debate:

key foundational concepts are up for serious discussion.

It was fascinating to attend this is my new role as HRVic's Policy Lead. I was a bit uncertain going in, as I wasn't sure how much it would be focused on the "recovery narrative". But actually, overall, I left pretty optimistic!

One of the keynote speakers, who has lived experience of drug use, acknowledged harm reduction approaches as the way forward: saying that "if I'd had access to supportive peers, safer using tips and harm reduction education, my use might not have gotten so bad." I was expecting him to get up there and talk about how all drug use is evil and inherently bad! But here was someone who no longer uses drugs, acknowledging that some people use drugs, and that those people should have access to peer-based harm reduction! The conference also included a panel with leaders from harm reduction, peer-based drug user organisations around Australia, and it felt like we were genuinely listened to, and respected as people with good answers to many of the complex issues around drugs. "Living experience" of drug use is being increasingly valued, ever so slowly.

**T**he Rethink Addiction Conference is a part of Turning Point's wider Rethink Addiction campaign. From the perspective of a drug user organisation, the campaign and its messaging still leaves a bit to be desired. It still seems to see drug use itself as a problem, and often seems to frame people with dependence issues as so called 'victims' of drugs … rather than victims of bad policies that criminalise people rather than support them in their choices.

But the interesting thing is, for once, folks on the "addiction, drugs are bad, recovery" side of things seem increasingly willing to accept that criminalisation and stigmatisation of people who use drugs, are themselves the biggest problems. And that we need to address this as a starting point. Also, at times begrudgingly, they seem to be realising that harm reduction peers have a very strong evidence-base behind what we're doing!

In that way, we might be finding ourselves some new allies?


**Prohibition is harmful.** It perpetuates stigma, causes delays in help-seeking, and has expanded the drug market and resulted in a more dangerous drug supply.

# NUAA's PEERS & CONSUMERS FORUM

## SYDNEY 2022

BY BRIT CHAPMAN

**New South Wales Users and AIDS Association (NUAA) held their annual Peers and Consumers (PAC) forum recently on the 26th and 27th of September on the lands of the Gadigal people of the Eora Nation. The theme this year was "Engage, Empower, Educate" and a few of us peer workers from HRVic and a couple other orgs were lucky enough to be able to head up there and attend in person.**

As someone who is still pretty new to peer work and who has only worked for a peer drug user org for a few months, I was super overwhelmed and feeling a bit nervous and out of place initially.

It didn't take me too long to settle in and start feeling inspired and motivated by the sense of community I felt at the forum. The hardest part was choosing which session to go to when there were

two on at the same time.

Well, the first choice wasn't hard – one of the first sessions was a closed session about fatherhood, being a drug user and how to make it work.

Being neither a man nor a father, this one wasn't for me obviously. The report I got back from some of the fathers who attended was really good though. Fellow peer worker, Baden, said that he's never felt so unified with a group of others, and so supported regarding his experiences – a real contrast to the feelings of loneliness while negotiating family court stuff.

**He said "there was a good balance of humor, seriousness, and emotional vulnerability in the closed fatherhood and drug use session."**

Also (and importantly), there was no hatred of women/mothers in the conversations. He said it was very respectful in that way. The conversation was more about drug use being weaponised and the experience fathers go through specifically. There was acknowledgement of things generally being worse for mothers/people who carry and birth children, because of gendered notions of expectations of responsibility and ideas of whose role it is to be the primary carer, along with the narrative of "boys will be boys" as an excuse for poor parenting.

As a dad who has experienced so much stigma around his drug use, he felt really empowered, proud and grateful. Other men who attended who aren't fathers, backed this up and said it was amazing to be part of such a powerful and moving conversation, to witness so much support in the room about a very hard thing and agreed that there was real sense of unity.

The session that I went to was ***"Innovative Hepatitis C Prevention, Testing and Treatment programs with peer leadership: Lessons from the field".***

With the 'It's Your Right' (to live free of hep C) Campaign just launched in Victoria, this session was extremely valuable and relevant for me as a health promotion peer worker.

It was great to get different perspectives of what has helped with the campaign interstate. The panelists included peers who had expertise spanning decades in blood borne virus education and treatment, including lived experience of hep C diagnosis and treatment, and being involved in IYR campaign in the ACT. They highlighted the importance of incentivising community members to encourage accessing testing and treatment, but said there was a fine line between getting punters in the door and keeping them engaged.
Other barriers to engagement that were talked about were the mutual fear felt between peers/punters and nurses, fear of the side effects of treatment and the clinical nature of test and treatment settings. Solutions discussed in how to overcome these barriers included development of mutual respect between peers/punters and nurses through better communication, particularly in communicating expectations, addressing others fears with reassurances and knowing what you are talking about when educating community and creating peer-driven environments where people are able to feel safer and more comfortable.

Relationships between peers and peer workers that are built on trust and respect were key to not only initial engagement but also to supporting someone to complete treatment. The value and effectiveness of point of care (POC) testing was so clear – where this kind of testing is used in other states and territories there have been heaps more

people coming forward for tests.

In the afternoon of the first day, I had to miss the session on 'How I overcame stigma in my daily life' to check out the 'Peers and Health Partnerships' one. The panel was a big one, with nurses, government worker-allies and peer workers from heaps of different backgrounds and experiences. I really liked what one of the nurses had to share about how peer workers and healthcare workers have different boundaries in their work and how they must look after each other within this, and how she said that it was so important that healthcare workers should be careful not to crush the enthusiasm that we bring to the work as peers. She added that when peer workers are eventually allowed into healthcare spaces, the results are immediate – peer workers can support people to access healthcare in ways that nurses just can't. This is because we can relate to other drug users in ways that they just can't, we speak the same language and are able to meet people where they are at. The work that NUAA are doing with the assistance of Justice Health (JH) I thought was really interesting. Peers are being allowed into prisons, sometimes without corrections staff in the room, delivering harm reduction education to incarcerated drug users. Though a challenging space to be in, it's made possible by the efforts of healthcare workers within JH elevating peer voices while knowing the limits of their own work. JH panelists explained the importance of being able to open up a space for peer workers to occupy, and then stay out of the way while protecting that space and doing the support work (such as coordinating logistics). One huge take away I had from the discussion of harm reduction programs in prisons was: as an incarcerated person, there is so much that is out of your control, and so the aim of the work must be to help people get good at the stuff that they can control.

**There were heaps more interesting conversations in this session, way too much to cover here, but some other points were:**

**- whether peer workers should only be employed by drug-user orgs**

**- lived/living experience non-identified peers as a wasted resource/their responsibility to step forward and advocate for peer workers**

**- the huge expectations we place on peer volunteers**

**- broadness of definition of "peer" – what about when we don't share the same experiences as punters? Or do we?**

The second day started with a keynote plenary session from Danielle Russel, PHD candidate, and peer activist from the USA who is the 2022 winner of the International Jude Byrne Award. She presented "Evidence to Action: Translating Research into Advocacy", about her research into Community Based Participatory Research (CBPR) vs. Extractive research. Extractive research is academic and part of the non-profit industrial complex. The research findings are never shared with the drug-using community, the participants are kept alone in the process and are never reimbursed for their expertise. Those who do research on us are disconnected from our communities and they treat us with distrust about the knowledge we hold of our own bodies.

The key principle of **CBPR**, on the other hand, is that participants are collaborative partners in the production of knowledge and their needs are positioned front and centre. To demonstrate what this can look like and the challenges that may be faced, Danielle shared experiences on the Drug Policy Research and Advocacy Board (DPRAB), a community research board whose challenge was to work collaboratively with methadone providers.

She discussed how her actions on the board could impact her access to methadone, highlighting the power imbalance between herself and other board members whose actions had no impact on their access to healthcare. She also talked about peers as “evidence ambassadors” – peers are trained up as field researchers, working collectively to develop questions and interpret the data. When this happens, more nuanced questions get asked, meaning that the data is different, more accurate and reflective of what is going on at the ground level.

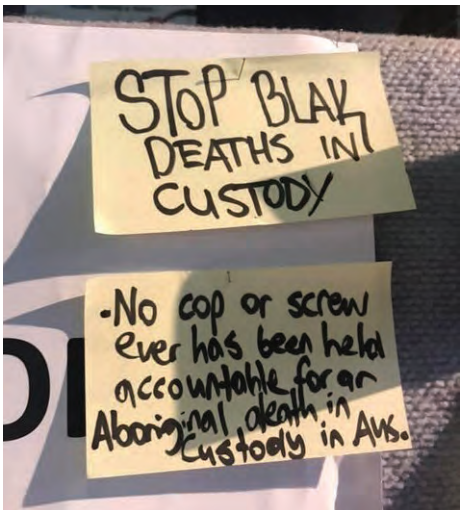
**Reflecting on this afterwards, we wondered about the accuracy of the research that we often read and that we use to inform our work.**
**If the knowledge that those researchers suck out of us was interpreted with our needs in mind, what might that look like?**

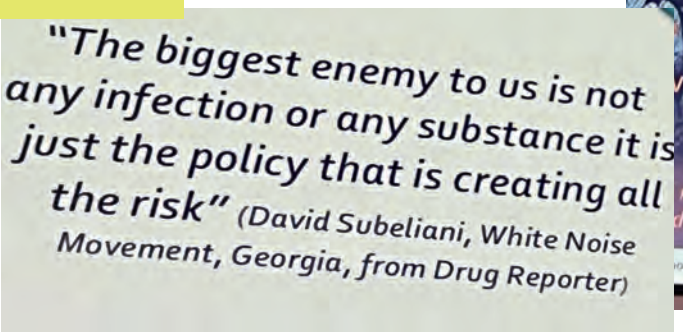
There was an interesting panel on medicalisation vs. decriminalisation of drugs next.

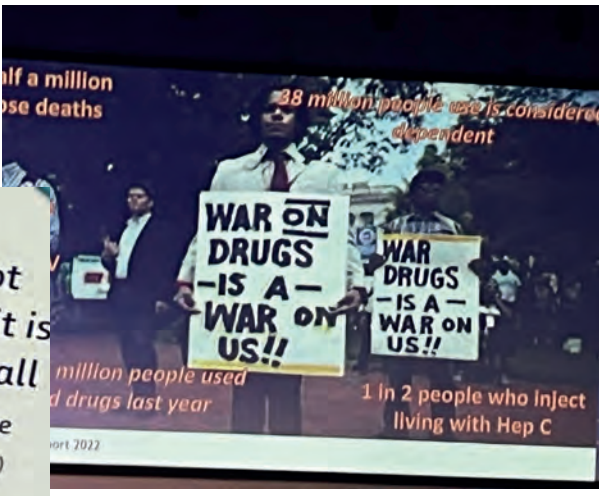
The main point to take away from this regarding a medical model, is that drug use is always pathologised and there is no space left to talk about drug use for pleasure. Considering that a lot of drug use isn’t for medical reasons, where does this leave us? In terms of decriminalisation, the panelists (including our own Nick Kent) agreed that so-called Australia still needs a cultural shift toward it’s thinking around illicit drugs before a model for decriminalisation can be conceived of that doesn’t leave the same groups of people who are marginalized in our society open to targeting and harassment for their drug use choices. Also agreed upon – decrim should be viewed as a step toward legalization!

The very last session I went to before I had to leave and head back to my home on Wurundjeri Woi Wurrung soil was on ‘The impacts of communication technology on drug use, safer using and connection’. Although I was really interested in this one because I think that an understanding of social media and the dark net is important in staying relevant to younger generations of drug users as I get older, I’ve gotta say that my brain was reaching information capacity. What I did find interesting though was according to the panel, there is a real sense of community in the harm reduction corners of the dark web, and people are seeing an increased access to harm reduction information and a filling in of gaps where people are needing supports. They see drug vendors involved in harm reduction conversations and references to local drug-user orgs as places people can go to irl for information and services.

It was a whirlwind trip and it felt like we were leaving too soon, but I feel really grateful for the opportunity to go and learn about the work that other peer-based orgs are doing. It was awesome to meet some really cool people and to share some of our experiences too. Thanks heaps to NUAA for having us and to everyone else who was involved in making the PAC forum such a welcoming and valuable space!






# INHSU 2022 GLASGOW, UK

## DIVIDE AND POWER IMBALANCES AT CONFERENCES

BY JASON WALLACE - SCOTTISH DRUG FORUM

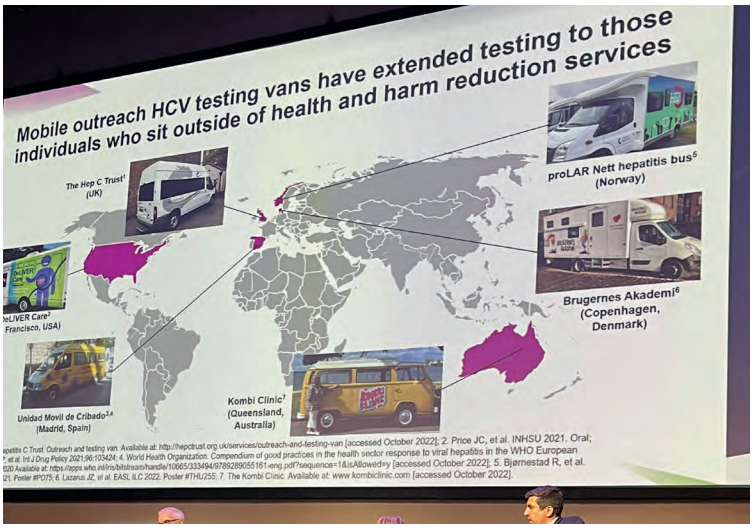
**As an attendee and sometimes speaker or workshop facilitator at national and international conferences it has always struck me the power imbalance often displayed intentionally or unintentionally, by the attendees and sometimes the organizers.**

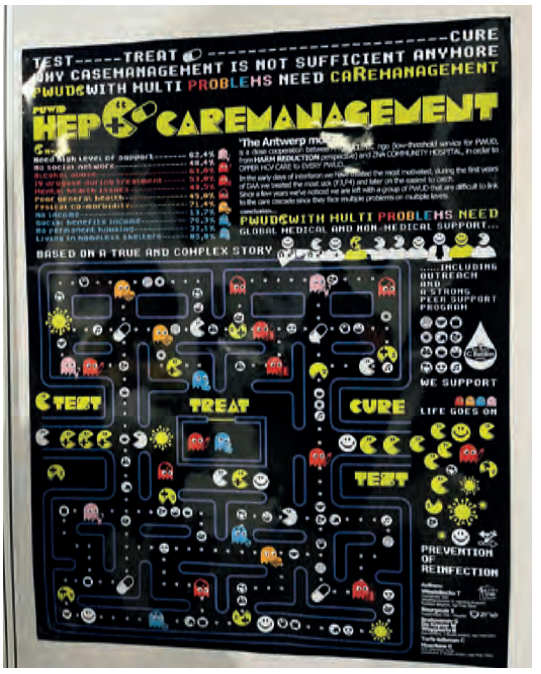
So, let's start with looking at the people who attended INSHU 2022! There was a wide representation of people from around the globe, who came in different guises, community members actively using substances or abstinent based recovery, researchers, program managers, front line workers the list goes on. Everyone brought their own areas of expertise.

The program was diverse and had a range of speakers over the days of the conference. The conference started with the community day, which was well attended and had a strong feeling of unity and support from peers across the globe. However, as you looked at the core program for the remaining days of the conference it was dominated with academic presentations/speakers and experts in their respective fields! The living/lived experience was represented in some panel discussions and workshops.

**HOWEVER, THERE WAS POINTS WHEN IT DID FEEL LIKE THE "COMMUNITY HAVE HAD THEIR VOICE HEARD ON DAY 1" IT'S OUR TURN NOW!**

I make note of this as over the days of the conference I heard several discussions between community members and either academics or other professionals around drug use, service delivery, provisions etc. It felt like there was a lack of awareness to understand living/lived experience perspectives from some people and quickly conversations turned to the individual trying to explain, justify or convince community members of their theory, decision or rational for doing certain things. This is when you see power at play the most at conferences! When you have professionals or "Experts" who come along with no real intention of trying to understand lived or living experience perspectives, but more so to convince community members of their approach and why it is the right way to do things. This leads to conflict usually




between communities and academics/government or other professionals. This then usually triggers a battle of the quality of evidence between both parties. With the community evidence often being referred to or dismissed as antidotal in a disparaging way! This view will continue to happen until researchers actively engage communities and there is a real meaningful discussion in involving lived/living experience at the heart of research. There is no way to turn antidotal evidence into scientific evidence until you conduct the research with the people who are living in this community and ensuring that they are involved in the idea, planning and delivery of the project at every stage.

When we look at conferences taking place all over the globe around people drug use, BBV or other topics relevant to this field. The ones that have lived or living experience represented are often overseen or directed by a “Professional” If we think of the panel discussions at INSHU 2022 the ones with lived/living experience were chaired mostly by a “Professional” But I don’t recall a panel of professionals being chaired by a member of the community with living or lived experience! This is an indication of the unintentional power dynamics at play in conferences-One of the reasons for this is that some professionals would feel uncomfortable taking part in a panel discussion chaired by someone with living experience as it is often viewed as being too unpredictable and professionals are not sure where the conversation will lead and therefore don’t wish to take part in such discussions.

Whether we want to admit it or not! there is still considerable stigma towards people still actively using substances and people with a history of using substances, sadly some of this comes from the very individuals working in the field! Therefore, we rarely see anyone with living experience and a background in academia presenting at conferences where they can refer to their current drug use and use that to emphasize the research or work, they are carrying out. This is one of a range of things that continuously adds to the power imbalance at conferences and possibly why most speakers or presenters and workshop facilitators continue to be “Professionals”

If we want to see real change at conferences and our work, we need to know how to be in meaningful relationships with people who stand on the other side of the power imbalance.

**Over the years of attending conferences including INSHU 2022 I have witnessed people expressing sympathy towards community members with lived and living experience due to the difficult life or situations they are in or have been in, this creates divide with that very community when sympathy is expressed! People don’t want sympathy, they appreciate empathy, dignity, and respect. if you can’t express any of that to a community member, I would suggest that you don’t express anything!**

# THE DECLINE OF METH AND THE RISE OF PHENYL-2-PROPANONE (P2P)

ORIGINAL ARTICLE BY ADRIAN GORRINGE FOR AIVL'S 'THE SUBSTANCE'

SOME OF THIS ARTICLE HAS BEEN ADAPTED FROM SAM QUINONES' NOVEL 'THE LEAST OF US: TRUE TALES OF AMERICA AND HOPE IN THE TIME OF FENTANYL AND METH'.

## "I don't know that I would even call it meth anymore..."

**– Joe Bozenko, DEA Chemist & Professor, Shephard University.**

Methamphetamine is arguably the most demonised, stigmatised and generally misconceived drug in global circulation. Within the Australian context, we have all seen the confronting, graphic and gratuitously violent imagery of anti-ice advertisements, depicting 'ice' users in diabolical fits of rage lashing out at authorities, families, loved ones and innocent bystanders, seemingly consumed by a vile addiction to be condemned by civil society.

As stigmatising and stereotypical as these images are, one cannot deny they are factual, albeit they are by no means an accurate representation of all ice or methamphetamine users. For inquiring minds, the viewer is left with arguably more questions than they have answers. What exactly is methamphetamine? Is it truly as addictive as authorities would have you believe? Why and how has this drug saturated the market to the extent that Australia sees itself in an 'ice epidemic' where of per capita consumption per 1,000 people per day, we consume on average 49 doses, compared with 60 doses for the highest-ranked country, Czechia; Australia has the third highest consumption of methamphetamine in the world. For those of us with a penchant for drug related health sciences, the big question is 'is it really methamphetamine that we are seeing at street level in its purest form and if not, why might this be?'

To answer these questions, we need to look at the chemical composition of methamphetamine over the course of history. Methamphetamine for a considerable duration of time was derived from ephedrine, a naturally occurring substance derived from the ephedra plant. For centuries ephedrine was used as a decongestant, anti-asthmatic medication, and stimulant. The first known chemical alteration of ephedrine molecules for the synthesis of crystal methamphetamine occurred in Japan in 1919. Fast forward to World War II and it was being marketed in Japan under the name hiropon a word that combines the Japanese terms for 'fatigue' and 'fly away' (Much like Red Bull giving you wings!) it was given to Japanese armed forces to increase alertness.

Throughout the 1980s and into the 90s ephedrine was the active ingredient in the over-the-counter decongestant Sudafed, this followed a long boom in the methamphetamine and MDMA market as production was cheap and relatively easy to make. Come the turn of the millennia and health authorities were clamping down on this, eventually making drugs containing ephedrine and pseudoephedrine

prescription-only medication almost universally.

What followed from here on in was a decline in Sudafed based methamphetamine and MDMA and a rise in another method used to make methamphetamine, that in the 80s and 90s was largely confined to outlaw bikie gangs, the Hells Angels is the most notorious of which. The meth cooked up by the Hells Angels during this period only had a small niche market, due to the fact that the base ingredient was not ephedrine, but rather a far more toxic chemical known as phenyl-2-propanone (P2P).

**What IS P2P?**

P2P is a clear liquid that is mostly derived from phenylacetone, however, all kinds of toxic ingredients can be used to manufacture P2P; cyanide, chloroacetone (tear gas), benzene, lye, mercury, sulfuric acid to name but a few, and the process is as volatile and highly toxic method that can only really be done safely in hazmat suits in rural or desert outposts (think Walter White and Jesse Pinkman in the TV series 'Breaking Bad' who use the P2P method to make meth, hence Jesse's infamous line 'chili P is my specialty!').

The multitude of chemicals that can be used are cheap, legal and unlike ephedrine is readily available in a wide array of industries; fuel, tanning, mining, perfume, cosmetics, photography, and many others where law and health enforcement cannot restrict the chemicals in the same way it has with ephedrine, not without damaging legitimate sectors of the economy. Additionally, this creates numerous ways of making P2P, a drug that is essentially not subject to weather or soil erosion, only chemical availability, which is effectively limitless, thus ramping up production of P2P meth globally.

Adversely, the P2P method produces two types of methamphetamine that produce very different effects. D-methamphetamine has neurological effects and produces a powerful stimulant high, whereas L-methamphetamine will increase blood flow and heart rate, but has little neurological effect, thus it does not produce a high, it is essentially a waste product that if more widely known amongst meth cooks would be disposed of. However, the reality is the separation of 'D' and 'L' meth is far beyond the skill sets of your average clandestine chemist, and what results is a product that is significantly inferior to ephedrine-based meth, so much so that it begs the question 'WOULD YOU EVEN CALL IT METH ANYMORE?'

Among the consequences of this shift, the price of meth collapsed due to increases in volume, and with this came a plethora of public health issues, as unlike ephedrine-based meth which tended to have more gradual associated harms, P2P meth which came to be known as 'bikie crank', among other various street terms seemed to accelerate associated harms, particularly damage to the brain. Whilst methamphetamine affects the brain no matter how it is derived, P2P meth has been shown to create a much higher order of cerebral damage.

The use of mind-altering substances by humans is no new phenomenon, but we are entering a new era, largely driven by a narrative of a shift in drug supply from plant-based drugs, such as weed, coke and opiates towards drugs that align with the human psyche to push boundaries. We want to go faster, higher, harder, longer in addition to meeting our insatiable need for convenience, quick, cheap, made anywhere, available always.

If we are to have a positive impact on the ice epidemic, then we need to examine the vast communities that partake in this behaviour. We need to cast aside our prejudice, stereotypes, stigma and discrimination, and understand that regardless of why someone may engage in this behaviour, it is human behaviour performed by people with human emotions. Many of which can be particularly vulnerable, and it is only until we begin to look out for the most vulnerable communities among us, that we can expect any reason for them to abate.

AIVL has been actively working on a project to do with people who engage in sexual activity under the influence of methamphetamine, a practice referred to as 'chemsex' . There are many reasons why people engage in chemsex, often it becomes a vice to feel free and disinhibited from the stigma, discrimination, shame or cultural taboos attached to various sexual acts, kinks, fantasies, desires, practices and sexual lifestyles and identities.

**AIVL will be producing a suite of resources and animated videos to help keep communities safe in chemsex environments and stop the spread of hepatitis C, BBVS and STIs in addition to promoting services that can assist people with methamphetamine addiction through harm reduction models of practice.**

**AIVL is the national organisation representing people who use/have used illicit drugs and is the peak body for the state and territory peer-based drug user organisations.**

# BORN TO BE A BROKEN PEOPLE

## A POEM BY RYAN J BARTOLOMEO

Why are we made to be a broken people? Denied to ever be whole.

To be respected -equal irrevocably and unequivocally.

To be derided, abused-destined to be refused.

Attacked- targeted for all forms of abuse.

Targeted- sought out, hunted with a pretext based on a rouse.

But how did we become the target of their hate. Alternate explanations, why not envy? jealousy? fear of thine own self, a projected self-loathing of detest, an inability to subject their own true self to the same acidic litmus test.
A rampant preoccupation to declare unnatural the simple pleasure of life enriched with family and love.

The pain is deep and endures -for the cruelty doesn't stop the ingrained hate we absorb as if to justify their vitriolic self-proclaimed puerile scorn- as if idyllically ornate.
Irrespective of the form, physical violent psychological and the one I dare not name because of the pain- inflicts like an acid burn.

Nerves damaged always, there no real way to cease, desist-forget sleep through- pretend it never happened -a sham existence that persists.

Intruding thoughts- heart racing - awakening from dreams so intense as if it happens at tempo to a tune ongoing repeat. All the while they hide behind uniforms ideology psychosocial manipulated alleged scientifically derived righteous psychobabble. There is only one thing worse when the outsiders we destined are begun to buy into their bigoted hateful rationale. All the hurt shame poison, self-blame like a fuel to a fire to consume us ourselves, that's what they most desire. For them to destroy us places them on the wrong side of history like ideology accepted as fact truth rewritten whitewashed and abated their own guilt shall be negated. I will not hate anymore I know I've said it all before, but I stand up declaring to be awake I shall not let them win a victory they surely will celebrate. I am a man no longer a victim but intent on becoming the Victor. Like a boulder no longer sand pebble rock or even solid stone. I am a man combined solid rock stone and boulder I'll withstand the test of time my sharp edges may decline but not frailty rebirth it is a new strength fearsome and proud. I am a man.

ILLUSTRATIONS BY RAPHAEL A. CILENTO


FIGHT • STORE
RAMEN BAR

# "MAKING GROUND" WITH METHAMPHETAMINE USE:
## EXPLORING EXPERIENCES OF GROWTH, CHANGE, AND NORMALITY - OUTSIDE OF ABSTINENCE-ONLY RECOVERY

BY SAMUEL BROOKFIELD,
UQ SCHOOL OF PUBLIC HEALTH

**"Yeah so,**

**I definitely feel I'm making ground, even though sometimes it's frustrating because it doesn't look like it to the other people that care about me and stuff.**

**Doesn't look like I'm going so well, and stuff, I definitely do feel like I'm making ground "**

For my PhD thesis, I spent six months conducting interviews and spending time with twelve people who use methamphetamine (sometimes called *'ice'* ) in South-East Queensland.

These men and women are complex, unique, kind, and generous individuals, many of whom I considered friends by the end of the project.

While they have many different trajectories in terms of drug use, they all felt like their meth use was having a negative impact on their life and were looking for ways to either reduce or to stop using. (My research was **intentionally** addressing *'harmful drug use*', and I use this term to acknowledge the fact that **most drug use is not problematic**).

During my research, however, it was not my role to promote either recovery and abstinence, or continued drug use, but just to be with them on their journey- to see and to understand the joys and hardships that made up their lives, much the same as anyone else.

## Carl

The quote to the left is from Carl, one of the participants. He was in his thirties, had been using methamphetamine since he was a teenager, and really wanted to stop. Carl had several health issues, had struggled with self-harm, and also had goals he wanted to achieve, such as travelling and becoming a primary school teacher, which he felt his drug use was holding him back from. Carl continued to use methamphetamine during the time we knew each other, but would also say:

**"Even though I have been using every couple of weeks, I still feel like, and constantly feel like, I'm in recovery"**

**– Carl**

When Carl talks about ‘making ground’ in terms of his goals around drug use, I think you can understand this phrase in a couple of ways.

First, people who use drugs can make ground in terms of making progress towards their own goals, whether this is abstinence, reduced drug use, or other goals unrelated to drugs. More broadly, however, I think there are many ways that people also create ground, create space in which they can live and talk about their experiences without reducing them to a binary framework of good/bad or using/abstinent.

Contemporary Australia frequently still takes a moralising attitude towards issues like drug use that separates everyone into two groups: the normal, responsible, upstanding citizens (or ‘general public’), and the corrupted, irresponsible, pathological group, that are usually called something else such as addict, patient, client, or offender. This binary way of thinking allows people to disconnect from people using drugs, to categorise them as different, and focus attention, praise, and legitimacy only on those that have demonstrated long term abstinence. But this simplified vision does not map onto the complexity of people’s real lives. Like everyone else, the lives of the people in this study were multi-faceted, ever changing, and involved many relationships, values, and priorities outside of drug use and also outside of abstinence-focused recovery.

Therefore, many people that use drugs must work to maintain their own sense of identity, self-respect, and humanity, within this dehumanising framework; to ‘make the ground’ upon which they can stand and tell their complex and unique stories. This process of making ground can be viewed as an act of resistance, and is something many marginalised groups must do, and have successfully done, in the face of stigma and exclusion; but it is also a burden that we can relieve by changing the systems and structures of power in society. In the context of prison reform, Jonson et al. [1] describe the need to create ‘ideological space’, by shifting people’s attitudes from being a ‘punitive public’ to a ‘rehabilitative public’. In the context of drug use, we might also aim for simply a respectful and empowering public, that understands and respects the different choices that different people (or different ‘publics’ [2]) can make regarding drugs. By talking about drug use compassionately and foregrounding the real-world stories of people that use drugs, space can be created wherein people’s stories and experiences have the opportunity to be expressed, understood, and appreciated. That is part of what I hoped to achieve with this research.

## Ethnography – 'Stalking' People *with* Permission

My project took what is called an ethnographic approach, which basically means observing people living their lives in the real world. As a nurse working mostly in emergency, I have cared for many people struggling with drug use, but that meant only seeing them through the small window of a hospital visit. By doing this kind of research, I wanted to be able to understand people more three-dimensionally. Rather than measuring people with surveys or seeing them only in the context of accessing healthcare, ethnography allows researchers to capture the whole picture, to see people at home, with friends, with family, going to court, going through counselling, or just taking the bus. It’s kind of like stalking somebody with their permission, and allows you get to know people more as you would a friend. In this way

ethnography can be a very humanising research method, working to break down artificial boundaries erected around groups such as people that use drugs.

## Living With 'Harmful' Drug Use

The participants would often vacillate on whether they wanted to stop using methamphetamine or not, because of the rich and diverse forms of pleasure it gave them, and also how they felt many of their social and family relationships would be damaged if they went through such a big change [3]. Bridget was a single mother of three who continued to use frequently during the time we knew each other. I visited her home many times, and went with her to visit doctors, friends, drug dealers, and do grocery shopping. Bridget would often emphasise how her drug use helped her get through the day, complete the tasks she had to get done with minimal external support, and relate to her daughters.

> ***Bridget:*** *"It's funny you know, even though I've got this 'problem' I'm actually quite happy within myself, at the moment, and the way, like, things are going with regards to my relationship to my kids and home and stuff.*
>
> *It's better than it's been in a long time. There are, like, certain things about [methamphetamine use] that aren't bad, that actually- I interact- I just get on better with [my daughters] sometimes when I'm in that state. … And we'll have deep conversations about school, and friends and whatever, … and with [eldest daughter] we've never got on better than we are at the moment, which is full on, we've had lots of ups and downs."*
>
> ***Sam:*** *"Why do you think that is, at the moment?"*
>
> ***Bridget:*** *"Um, because I seem, I uh, I'm not, um, depressed, I'm just more, I don't know, our relationship seems to be… improving… [Pause] … Yeah, I can't say there's nothing good about it."*

## Bridget

Bridget would still often say that she wanted to reduce her drug use but didn't see a way to do it while still being the sole carer for her children, and when drug use was prevalent throughout her whole social world, which included many strong and important friendships built up over the course of her life. Despite this, Bridget was active in caring for her children and maintaining what she called 'normality' in her home [4].

She was engaged with multiple services that could support her to reduce her drug use, and in the past had requested help from Child Safety when she felt her drug use getting out of control. For someone like Bridget, support could focus on pathways to abstinence, but it could also focus on finding ways to help her 'live with' harmful drug use. In healthcare we increasingly refer to people 'living with' other long-term issues that affect their health, such as depression, heart disease, or diabetes. These conditions receive much less stigma, and services are funded and delivered with much less controversy. Perhaps services for people using drugs can adopt a similar framework, and rather than requiring abstinence, help people find ways of living with and reducing drug related harm. This kind of service was not readily available to Bridget but could have been very helpful to her.

## Personal Progress

Participants would also experience important forms of change, growth, and progress in their lives without necessarily maintaining abstinence. People like Carl would often consider themselves 'in recovery' whilst still using, because from their perspective, they were still actively engaged in reducing their drug use, or the risks and harms related to it.

## Kira

Kira, a single mother of four, was intensely focused on regaining custody of her children through Child Safety Services, and so she did not consider going into residential rehabilitation an option. Meanwhile during the course of the research, she did regain custody of her youngest daughter, and find her own private rental accommodation, and noticed her own drug use reducing in response to her increased responsibility and access to family life at home.

As Kira said during her final interview:

> ***Kira:*** *Even with the little bit of using now, I might high five myself at the end of the day to get to where I am. It's kind of been a long time coming, it's just felt like forever. I know, I can feel that I'm definitely in a better place, a better*

*place in my head. [Tearful] I wanted these kids back, and I'm going to get them back. …*

***Sam:*** *What is it about what's happened in the last six months that makes you want to high five yourself?*

***Kira:*** *The relationship building that I've had to do, even though I've had a good relationship with Mum, I've still had to build so much with her, you know, since the last few years. I've had to show, I don't know, I guess, sometimes I didn't show the respect that I probably should have shown … it's made me grow a little bit in myself, too, even if it is only a little bit. I never saw my small steps, never saw anything moving, for a good year at the beginning, nothing mattered, it didn't matter if I took 10 steps forward, it didn't show that I took one. … Now it's like I can see these steps and each one is just getting a bit bigger each time. And the reward is definitely worth taking the steps forward."*

## Stephen

Likewise, Stephen was feeling positive at his last interview about progress he had made. I visited Stephen at his family's home several times where he was staying and went with him to see his parole officer. He had had episodes of use over the last six months, some that ended with *police* involvement, but he emphasised how for him 'personally' he was in a much stronger place in terms of controlling his drug use, rather than in terms of what others might believe recovery should look like.

***Stephen:*** *Since New Year's, yeah, good. Good. I mean, I fucked up pretty bad once, but, other than that, like, my personal, like, where I've been at, personally, if you cut out that one few days, fucking really happy … personally, drug wise I think I'm going good. I'm happy with it. I'm happy with the road that I've taken, bar that one mistake, so. It's all good.*

***Sam:*** *What is it that you feel really happy about?*

***Stephen:*** *Just happy, like I'm not feeling the urges as much, or hardly at all. Happy with the control I've got with it all, and stuff like that. I'm even sort of happy, well, with what's happened when I have used, last couple times, so. Like I do feel like I've made a lot of progress, compared to those other times, I don't feel like I've been anywhere near that crazy for a while, so happy.*

The way Stephen kept repeating how he was feeling good but only from a 'personal' perspective, was similar to how other participants would talk about their experiences in a way that always implied a wider context of abstinence-focused recovery. Many of them were familiar with the ideas of harm reduction and were putting them to effect in their own lives, but they would sometimes feel they had to excuse this approach, to try to 'make ground' upon which they could pursue their own idea of recovery.

## Jane

One such participant was Jane, who was part of the research with her partner Ian. Between them they had six children from previous

relationships, and while methamphetamine could take over their lives sometimes, Jane was very focused on changing, and on prioritising her family. During her last interview she used a positive framing to talk about the times they had been using.

"I think I've grown a lot since [the last lapse]. You know, every time we relapse, I learn more, and that's what I take from it rather than getting depressed and upset that I'm still using... it's not about having to give up, and staying stopped, it's about when you use and what you need to do with the kids and stuff and having that support network. I guess it's- it's not giving you permission to do it, but it doesn't make you feel like you've got so much pressure to stop and be stopped completely ." – Jane

Again, Jane felt the need to emphasise that she wasn't giving herself 'permission' to use drugs, while still trying to explain how she was progressing towards her goals and minimising harms.

## Simon

Meanwhile some participants that did have long periods of abstinence, such as Simon, would still reject the recovery framework altogether. Simon's drug use decreased significantly after he found a new job with more social contact.

**"I believe that 'recovery' is the wrong word.....**

**in relation to me.**

**...I think what's happening to me is I've got a new sense of belonging somewhere else. And, maybe, I think it's what has been missing... what's driving my behaviour."**

**– Simon.**

These diverse experiences and ways of understanding drug use, recovery, and personal growth are often absent from public and policy debates around drugs. Rather than a linear 'recovery' process, most people go in and out of drug use, some harmful, some manageable, some recreational. Meanwhile, if we ignore how people can grow and change even while using drugs in a harmful way, then we risk excluding many people from receiving the sometimes lifesaving support they need. Harm reduction and abstinence-focused recovery do not need to contradict each other. For many of these participants, they still saw long-term abstinence as their goal, but were applying many aspects of harm reduction in the meantime. These two approaches were complementary and interwoven in the way people used them, even though many services separate them and provide only one or the other.

As a community, and also as practitioners and service providers, we must make sure we are listening closely to the experiences of people that use drugs, helping them to work towards goals that they have determined and that they value, and let go of outdated and harmful binary approaches that see people only as using or abstinent [5]. I believe that services should support people that use drugs to make the kind of ground they need on which to live the lives they want, engage in recovery as they understand it, and live by their own values. Services should also, however, be working to remove the burden of having to make this ground at all by fundamentally respecting people's choices regarding their own health and wellbeing, advocating for increased harm reduction, and challenging the assumptions upon which the current system is built.

## Conclusion – Making Common Ground

Conducting this kind of research is not easy, and not many researchers go down this path, because it can

require a lot of commitment in terms of time and emotional energy. It is unusual for the success of research to be determined by your own ability to forge relationships with people, to convince them to allow you into their life for such a long time. I was surprised by how willing the participants were to let me observe them, and how generous they were with their time and privacy. Many were motivated by the idea that their story could help others. I enjoyed having the opportunity to give people a voice, to show that I was genuinely interested and cared about their lives. At the end of her final interview, Kira said she had appreciated our time together.
As I went to turn off the audio recorder she said

**"…it's good when you have somebody, and I know it's for your study, but, that gives a shit, in a way, yeah?-**

**so thank you."**

That is what I think is so valuable about this kind of research, its ability to humanise people that can be so easily dehumanised in the eyes of the public.

In Australia over the last decade a 'moral panic' [6, 7] over methamphetamine use has exacerbated stigma and mostly provoked only an increase in law enforcement which has had minimal effect on supply or drug related harms [8]. I was hopeful, therefore, that my research might help to make the ground where people using methamphetamine could come together with everyone else, support everyone's right to define our own values and goals, and work towards a world without the aspects of drug related harm that result from oppression, marginalisation, and stigma.

If you would like to learn more about this research or would like copies of any academic publications, please feel free to get in touch with the details below:

Samuel Brookfield

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***Research participant names and some other details have been changed to protect confidentiality. Included photos are only illustrative and do not depict research participants.***

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Substance SPOTLIGHT

**WHACK's regular section**

## 'Substance Spotlight'

**focuses on providing factual, relevant, & practical information about different substances to assist you in making informed decisions around taking substances while promoting safer using.**

# COCAINE

Coke, yay yo, nose candy, snow, powder, toot, crack, rock, free base

Cocaine is a short acting stimulant that acts on the central nervous system (CNS) and works by blocking the re-uptake of dopamine, serotonin, and norepinephrine. It is known to increase euphoria, confidence, sex-drive, focus, body temperature, and heart rate. Cocaine can cause severe vasoconstriction and is known to be cardiotoxic and have a high potential for compulsive redosing and dependence. Cocaine is extracted and refined from the coca plant (Erythroxylum coca) grown primarily in the Andean region of South America. The leaf extract is processed to produce 3 different forms of cocaine.

**COCAINE HYDROCHLORIDE:** a white, crystalline powder with a bitter, numbing taste. Cocaine hydrochloride is often mixed, or 'cut', with other substances such as lidocaine, lactose and glucose, to dilute it before being sold.

**CRACK:** crystals ranging in colour from white or cream to transparent with a pink or yellow hue, it may contain impurities. Crack is often found in the US, UK and other countries but is not commonly found in Australia. As a result, this resource will focus on powdered cocaine only.

## ADMINISTRATION

Commonly cocaine is snorted (insufflated) or rubbed on the gums, smoked or injected. But it can be shelved or plugged (put up your butt). Compulsive redosing is commonly reported.

## DOSAGE TIPS

***In any system where drugs are illegal, a safe supply can never be expected nor guaranteed,*** *making drug use inherently risky. The mentioned doses below are based on information available to HRVic at the time of print and we* ***can NOT give any guarantee of safety as the effects of these doses can vary greatly from one person to another.***

Depending on purity, tolerance etc, dosage will vary.

**Insufflated(Snorted)**

Light: 20-50mg
Common: 50-100mg
Strong: 100-150mg
Heavy: 150mg

**Intravenous (IV)**

Light: ****VARIES-**

**NO DATA**

**AVAILABLE**

# WHAT DOES IT LOOK LIKE?

# WHAT DOES IT FEEL LIKE?

The following is a list of possible effects, which may vary from person to person.

## POSITIVE

- Elevated mood
- Being more social / talkative
- Euphoria
- Empathy increase
- Increased confidence
- Increased alertness
- Clearer thinking
- Increased focus & concentration
- Reduced social inhibitions
- Increased sex drive

## NEUTRAL

- Decreased appetite
- Increased energy
- Decreased fatigue
- Dilated pupils
- Increased heart rate
- Increased body temperature & Sweating
- Increased blood pressure

## NEGATIVE

- Substance is very "more-ish"
- Nasal discomfort upon insufflation
- Anxiety
- Insomnia
- Iritability, agitation, aggression
- Nausea, vomiting
- Dry mouth
- Restlessness
- Seizure
- Stroke
- Heart attack
- Psychosis
- Excited delerium
- Tremors
- Breathing difficuilties

## LONG TERM EFFECTS

- Dependence
- Lung conditions such as bronchitis
- Anxiety, paranoia and psychosis
- Sexual dysfunction
- Kidney failure
- Stroke
- Seizures
- Hypertension and irregular heartbeat
- Heart disease and death

## SET AND SETTING

**'Set'** is **the mindset** you bring with you to the using experience. It includes your physical, emotional & spiritual condition, what you expect about the drug's effects & how you react to it.

**'Setting'** is **the environment** that you are in. This includes the social environment, who you are with and the physical surroundings, e.g. at home, at a festival or an unfamiliar location.

# HOW LONG DOES IT LAST?

## DURATION

### HALF LIFE

Even though the apparent effects of the drug wear off after 1 hour, the drug is still active in your system for up to 2 hours after you have taken it. Remember this if using other substances or redosing.

Length of experience can vary greatly depending on the route of administration and amount consumed. As with all substances, differences in a person's physiology and psychology along with the set and setting in which it is taken can also create variations in effect strength and duration.

ALL ROUTES OF ADMINISTRATION

**ONSET: Rapid**

**DURATION: 1-1.5 hours**

**AFTER EFFECTS: 1-4 hours**

## REAGENT TEST KIT RESULTS

**THIS IS A GUIDE ONLY.**

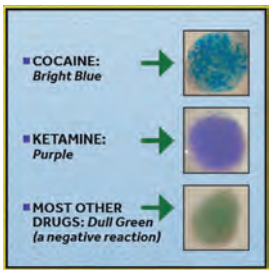
**SEE INDIVIDUAL TESTS FOR INSTRUCTIONS AND RESULTS**

Reagent test kits are available online or from Smoke Dreams, Off Ya Tree and other commercial ventures. We suggest you google it and check the forums for reputable sales options. Also, some services and Student Unions at Universities have been giving them out in the past.

**It is IMPORTANT to know that reagent tests will generally ONLY tell you if the substance you are testing for is in it- NOT how much iof it is in it or what other substances have been mixed into it.**

*Until Victoria/Australia accept and make Drug Checking services LEGAL, we need to stick to safer use and harm reducing techniques to keep ourselves and our friends safe while taking substances.*

**Test Name : Colour result**




**1.** Use **Morris:** Blue
then test with *(same sample)*
**2.** with **Marquis:** No reaction
**If your sample turns orange with Marquis it may contain amphetamines.*
If it turns orange use an amphetamine test to determine if it is true amphetamines or just a byproduct of the extraction process of the cocaine.

Next test a NEW sample with a Liebermann test to test for the presence of levamisole and/or lidocaine. *Unfortunately, at this time there is no way to tell which one it is; it could be one or both.*
**3. Liebermann**: yellow

| SUBSTANCES | MARQUIS | LIEBERMANN |
|---|---|---|
| **Cocaine** without amphetamines, lidocaine, or levamisole | NO REACTION or LIGHT PINK | |
| **Cocaine** with possible amphetamines, without lidocaine or levamisole | | |
| **Cocaine** without amphetamines, plus levamisole and/or lidocaine | NO REACTION or LIGHT PINK | |
| **Cocaine** with possible amphetamines, plus levamisole and/or lidocaine | | |

**WARNING**

**Tests should be carried out in a controlled environment with strict adherence to safety & instructions requirements.**

**Reagent tests contain toxic and corrosive chemicals. On contact, it will cause staining and damage, with a possible risk of burns. Take proper care to keep away from skin, eyes, mouth and clothing at all times. Do not breathe fumes or allow contact with skin or eyes. If possible wear protective gloves and eye or face protection.**

## SAFER USING TIPS

• Use around people you trust and somewhere you feel safe.
• Eat about 30 minutes before use.
• It is always a good idea to start with a very small amount to gauge strength and assess your sensitivity.
• Set a limit of how much you want to use and what time you plan to stop to avoid taking too much.
• Be aware of overheating or an elevated heart rate and make sure to cool down & chill out regularly.
• Keep your fluids up, but don't drink too much—1 cup of water (250ml) p/h when resting & 500ml per hour when active.
• Try eat every 2-3 hours, have a smoothie/sports drink to keep your electrolytes up.
• Sleep! Or at least lay down and rest during a 24-hour period to avoid sleep deprivation.

### *SNORTING*

• Crush to fine powder as crystals can cause little cuts.
• Snort water before and after to protect your nose.
• Use your own straw/spoon (& not money) to avoid infection or blood borne viruses (HIV/HVC)
• Repeated snorting can damage your nose, switch nostrils regularly and take breaks.

### *INJECTING*

• Use your own, sterile injecting equipment (inc. water when mixing).
• Wash your hands thoroughly before and after.
• Learn about safer injecting practices.
• Dispose of syringes & equipment responsibly.

### *SHELVING (DRY) / PLUGGING (WET MIX)*

• Use lubrication to avoid tearing the skin
• Use a condom or latex/vinyl glove to avoid internal scratches
• Wash your hands thoroughly before and after
• Use sterile water to mix with powdered pill
• Find a discreet and safe place to do it.

### *SMOKING*

• Cocaine cannot be smoked unless it has been converted to freebase or crack cocaine. Cocaine in its powder state requires a high melting point in order to vaporise it.


# AND.... WHAT ABOUT THE LAW?

## THE LAW & COCAINE:

In Australia, cocaine is seen as a drug of dependence. It is against the law to use, possess, cultivate or traffic a drug of dependence.
At present in Victoria, penalties range from a $2,000 fine and/or one year imprisonment for cultivation (if the court is satisfied that the offence is not related to trafficking), $3,000 and/or one year's imprisonment for possession/use (not relating to trafficking) to fines of up to $250,000 and/or 25 years imprisonment for commercial trafficking.

## DETECTION:


**Workplace:** OHS law gives employers rights to test employees for drug use. This should be contained in workplace policy, it should be reasonable, and a risk assessment should be done to determine whether testing of employees is appropriate
**Saliva:** 1-2 days
**Urine: 2-**3+ days after;
**Hair:** Up to 90 days;
**Blood:** 12hrs- 2 days

## ROADSIDE DRUG TEST:

Cocaine is **not** tested for in roadside drug tests, However- there is next to NEVER pure cocaine in Australian coke so the chances of you being picked up because your cocaine was cut with methamphetamine or MDMA IS possible.

**HARM REDUCTION VICTORIA HAS A SERIES OF SUBSTANCE SPECIFIC INFO BROCHURES AVAILABLE -**

**WE CURRENTLY COVER 18 DIFFERENT SUBSTANCES. YOU CAN ORDER THEM OR DOWNLOAD THEM TO PRINT YOURSELF, DIRECTLY FROM OUR WEBSITE'S RESOURCE PAGE:**

**WWW.HRVIC.ORG.AU/RESOURCES**

**IF YOU HAVE AN IDEA OF A SUBSTANCE YOU THINK NEEDS COVERING, PLEASE EMAIL SAMJ@HRVIC.ORG.AU**

# ATTEND HR23 FOR FREE!!

**This year we are proud that Melbourne is hosting the 27th Harm Reduction International Conference, convened by Harm Reduction International.**

**Held in a different city every two years, it attracts over 1,000 international delegates and has been held in almost every region of the world.**

**Over four days of presentations, workshops, films, networking events and more, the conference will continue its history of providing a dynamic forum to share the latest research and discussions on best practice in drug policy, harm reduction and human rights, bringing together people from around the world.**

**An exciting opportunity is available for Victorians who are unable to attend the conference due to cost.**

## SCHOLARSHIPS FOR PEER WORKERS

Harm Reduction Victoria & the Victorian Department of Health have partnered to deliver several scholarships for peer workers in Victoria to attend the HR23.

The scholarships are prioritised for Victorian harm reduction peer workers with lived and living experience, and we also welcome all AOD peer workers to apply. We also strongly encourage Aboriginal and Torres Strait Island peer workers and LGBTQI+ peer workers to apply. People in positions which are not in formally designated peer roles, but who use their lived experience may apply as well!

A peer worker is a person who uses their lived experience of alcohol and other drugs, plus skills learned in formal training, to deliver services in support of others.

Twenty scholarships will be granted in total. These will include a number of full scholarships for people in outer Melbourne and regional areas who will need travel and accommodation.

Are you someone with lived & living experience working in the ahrm reduction and AOD field? If so, scan the QR code & fill out the online form for a chance to attend the HR23 conference.

Contact Harm Reduction Victoria for any queries.

The Harm Reduction International Conference #HR23 in Melbourne is set to be this year's biggest global gathering for professionals working in public health, human rights and drug policy.

Register now to avail of the Early Bird rate!

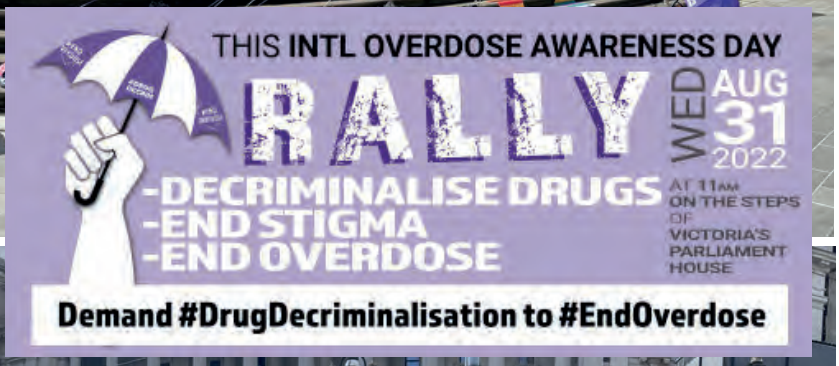
https://hr23.hri.global/registration/ganisation.

Join #harmreduction and #drugpolicy champions from around the world

at the 2023 Harm Reduction International Conference here in Melbourne, Australia.

Registration open now!



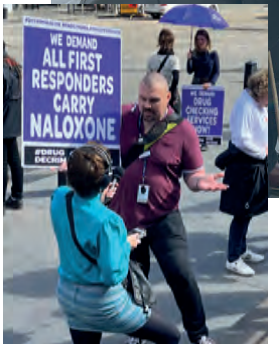



**Every year, thousands of Australians die from drug-related overdose. Thousands more are imprisoned because of personal drug use.**

**We have the right to live free from stigma and free from fear.**

**This International Overdose Awareness Day *(August 31, 2022)* we collectively decided that although we wanted to remember & represent our partners, friends, and family members who have overdosed, we were tired of 'being sad'.**
**It was time to make demands. To stop the cycle. To commit to fighting the good fight and make changes or at least keep demanding that changes be made!**

Leading up to the 31st August, we posted our demands- 1 per day-EVERY day- on our social media and website. Climaxing in a rally on Parliament steps, where we planted a pair of shoes for each of our loved ones who have fallen as a result of the failed policies of the war on drugs. Huge thank you to our community who came out in support and to our partners on the day Access Health and Southern Metro Harm Reduction Coalition.


# AUSTRALIA

## PATIENT GROUP WARY OF PAIN RELIEF CHANGES

**Plans to reduce opioid prescriptions may affect the quality of life for many patients struggling with chronic pain, warns a top Aussie patient advocate group.**

Encouraging doctors to deprescribe opiates may leave those without viable treatment alternatives in serious trouble, a leading patient advocate group says.

New standards of care released last month by the Australian Commission on Safety and Quality in Health Care have established a national standard for the prescription of opioid analgesics in emergency departments and after surgery.
Doctors are being encouraged to consider alternatives to prescribing opiates to protect patients from becoming addicted or overdosing.

If opioids are required, they will be asked to create a plan to wean patients off the drugs.
But the Australian Pain Management Association (APMA) says for some patients, taking opioids is the only way they can live a normal life.

"Chronic pain remains poorly managed in Australia and people try what is best for them, and in some cases that is opioids," APMA chief executive Renee Rankin told AAP.

"Our community tells us that taking their prescription opioid medication allows them to function.
"Without this assistance, simple tasks such as hanging the laundry, picking up children, being able to leave the house and maintaining employment become difficult for some people.

**"Deprescribing medication and offering no or ineffective alternatives impacts the quality of life of people with persistent pain."**

About 2.5 million Australians undergo surgery every year, and 70 per cent of hospitals discharge patients after surgery with opioids "just in case", according to a national survey.

**More than three million people are dispensed at least one opioid prescription a year, including oxycodone, morphine, buprenorphine, hydromorphone, fentanyl, tapentadol, tramadol or codeine, under various names.**

The commission's chief medical officer Anne Duggan says opioid analgesics are effective for pain relief, but care needs to be taken to prevent "short-term use becoming a long-term problem".

Ms Rankin says part of avoiding this problem could be investing in community-based multidisciplinary pain management programs.

"Pain management clinics in Australia are over-subscribed and waiting times are long, and patients in remote and regional areas often can't access them," she says.

Ms Rankin says community programs and services, such as those provided by APMA, "support the social needs of people who are impacted by their ongoing inadequate pain treatment", relieving the burden on health care providers.


***ALSO SEE: https://theconversation.com/one-in-three-people-with-chronic-pain-have-difficulty-accessing-ongoing-prescriptions-for-opioids-182678***

NEWS FROM OZ & NZ

Home Gro

## WESTERN AUSTRALIA

### 320KG COCAINE SEIZED AND TWO ARRESTED

**A NSW man and a German national with suspected links to organised crime have been charged by the AFP for allegedly importing 320kg of cocaine into Western Australia.**

The older man was arrested in a campervan where investigators allegedly found the illicit drugs, which were in 320 individual blocks, each weighing about one kilogram. Those blocks were in eight packages wrapped in plastic.
Police believe the cocaine, worth at least $128 million, was destined for WA and other states. The operation involving the AFP, Western Australia Police Force (WAPF), Australian Criminal Intelligence Commission (ACIC) and Australian Border Force (ABF) is another blow against organised crime groups preying on Western Australia.

Police will "allege" the 37-year-old, a German national, flew into Australia earlier this month to help retrieve the drugs.
He allegedly met a 49-year-old NSW man in Port Hedland and the pair travelled to Karratha, about 240km away, where they hired a 6.5-metre boat.
They drove it to Port Hedland before later launching it from a local boat ramp and heading about 28 kilometres out to sea on Thursday and Friday evenings.
Police suspect the pair used the runabout to collect the cocaine from the ocean off the Pilbara mining town.
...you reckon?!
The men's boat was seen idling close to an international bulk shipping carrier while offshore and investigations are continuing into suspicions that cargo vessel was used to import the drugs into WA waters from overseas.

**READ MORE HERE:**
https://www.police.wa.gov.au/About-Us/News/320kg-cocaine-seized-and-two-arrested-in-WA

## MELBOURNE

### AN ILLEGAL, ADDICTIVE OPIOID IS AVAILABLE AT GROCERY STORES-DOCTORS CONCERNED

Kamini is an Ayurvedic product typically taken as an aphrodisiac or as a stimulant, sometimes nicknamed 'Indian viagra'.
"The patients we saw told us that they were taking it because they'd been advised it would give them more energy, and enable them to work harder and longer," Dr Hayllar told The New Daily.
"Another group of patients said it helped with anxiety.
"Now, that's really weird, because generally, opioids make you sleepy and lazy. So it just doesn't fit."
In addition to the 12 south-east Queensland patients, health authorities have also encountered sporadic cases of kamini dependency in Sydney, Melbourne, Perth and even Far North Queensland. Australian laws prohibit the importation of kamini, but it is typically able to evade detection when shipped with other, legal goods.
A jar of 40 pills can go for $130, Dr Hayllar added.
"If you survey the grocery stores in Melbourne, you'll find many shops which have practically no grocery sales, but make their money purely out of selling kamini," one grocery store owner told the broadcaster.
Meanwhile, the Therapeutic Goods Association found that many Australians were able to purchase kamini online.

**READ MORE HERE:**
https://thenewdaily.com.au/news/national/2022/05/13/kamini-opioid-australia/

# IRAN

## THE FREEDOM PROTESTS ARE HUGE AND COUNTRY WIDE, BUT WILL WE WITNESS ANOTHER IRANIAN REVOLUTION?

MORE THAN THREE WEEKS AFTER THE MURDER OF 22-YEAR-OLD **MAHSA AHMINI** FOR WHAT THE SO-CALLED 'MORALITY POLICE' SAY WAS "DISOBEYING" IRAN'S STRICT HIJAB LAWS – **PROTESTS CONTINUE TO RAGE ON THE STREETS OF ALL MAJOR CITIES**.
This protest is being held on multiple fronts. On Saturday, protesters managed to digitally hack into Iran's biggest news channel to broadcast their own message to the whole country.

A broadcast featuring supreme leader, Ali Khamenei, in a meeting with state officials, was replaced by images of the leader with a bullseye on his head and many protesters who have died in the violent crackdown on dissent in Iran.


*LINK: https://youtu.be/1BIYCa0adwo*

The popular chant, **"woman, life, freedom"**, which has become the slogan of the protests, had been incorporated into a song, an excerpt of which was broadcast as were calls for viewers to "join us and rise up".

*Women have been cutting their hair in many Arab countries in solidarity the hijab protests.*

# NEWS FROM AROUND TH

# What in the World?!

It is estimated that 185 people, including at least 19 children, have been killed since news of Amini's death emerged on September 16. It has been reported that 14 members of Iran's security forces have also been killed.

The "hijab protests" have grown from the outrage of Iranian women at the country's oppressive 'morality police' to a general expression of resistance and discontent with the Islamic Republic itself. There have been reports of general strikes in several cities.

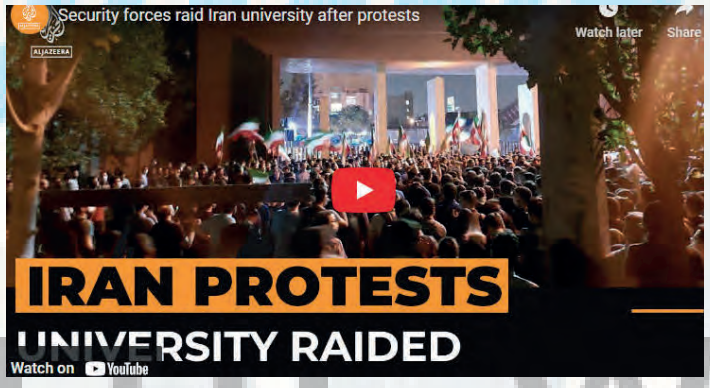
There are parallels with the 1979 revolution that toppled the last shah of Iran. Women played a major role in that uprising, too, wearing the hijab to show their rejection of the ban on the head covering decreed by the shah's father in 1936 – later overturned, but still a symbol of the repressive monarchy.

But, if the 1979 revolution delivered the long-sought-after independence from western imperialism, it also delivered the people of Iran to an authoritarian brand of patriarchy. And the hijab, which many women had taken to wearing in defiance of the shah's regime, quickly became a tool of the Islamic Republic's oppression of women.

One of the main enforcers for the Islamic Republic is the Islamic Revolutionary Guard Corps (IRGC). If the IRGC decided to remain in its barracks or refused to fire on protesters if ordered, this could change everything. This refusal to cause further bloodshed would need to be widespread and not merely sporadic.


There is, *so far*, no indication that this will happen. But the young peoples fury at the killing of Mahsa Amini – along with the deaths of several other young women and men for the crime of demanding justice and freedom – can only undermine the crumbling edifice of Iran's increasingly unpopular theocracy.
WATCH THIS SPACE.
OURSTORY IS HAPPENING IN FRONT OF OUR OWN EYES.

**Story excerpts taken from The Conversation** *https://theconversation.com/iran-the-hijab-protests-are-now-massive-but-a-revolution-will-need-the-military-to-change-sides-191786*






# IRAN

## WHAT STARTED AN UPRISING?

Anger flared after the 22-year-old Iranian-Kurd's death on September 16, three days after she was arrested by "morality police" for an alleged breach of Iran's strict dress code for women.

**"An investigation by govt. officials found Amini died of a " longstanding illness " rather than the marks of the blows to her head and body," Iran said on Friday, despite her family reportedly saying she had previously been healthy.**

Schoolgirls chanted slogans, workers went on strike and street clashes erupted across Iran as protests over the death of Mahsa Amini entered a fourth week in defiance of a bloody crackdown.
But the protests continued on Saturday even as President Ebrahim Raisi posed for a group photograph with students at Tehran's all-female Al-Zahra University to mark the new academic year.
**The government has described the protests as a plot by Iran's enemies including the United States, accusing armed dissidents – among others – of violence in which at least 20 members of the security forces have been reported killed.**

Raisi addressed professors and students. "They imagine they can achieve their evil goals in universities," state TV reported. "Unbeknownst to them, our students and professors are alert and will not allow the enemy to realise their evil goals."


**READ THE FULL ARTICLE HERE**
https://www.aljazeera.com/news/2022/10/8/not-afraid-anymore-clashes-as-iran-protests-enter-fourth-week

# THE DINING TABLE

PERIODICALLY, WE NEED A FEED
BUT HAVE NO FUNDS TO GET ONE.

## Br Breakfast

## Ln Lunch

### INNER WEST

**Brotherhood of St Laurence - Coolibah Centre**
67a Brunswick St.
**Fitzroy**
ph. 9483 1323
**Mon-Sun 8:30am**
**Sat 10am-2pm**
**LOW COST**

**St Mary's House of Welcome**
165-169 Brunswick St
**Fitzroy**
ph. 9417 6497
**Mon-Sat 8:30am**
**$2 DONATION**

**Ozanam Community Centre**
268 Abbotsford St
**North Melbourne**
ph. 9329 6733
**Mon-Fri**
**12pm-1pm**
**$2 DONATION**

**St Brendan's Catholic Parish**
103 Wellington St
**Flemington**
ph. 9376 7378
**Mon**
**(NOT Public Holidays)**
**12pm-1pm**
**FREE**

### INNER NORTH

**Salvation Army**
869 Bourke St
**Melbourne**
ph. 9653 3299
**Mon-Fri 9am-1pm**
**FREE**

**Collingwood Neighbourhood House**
253 Hoddle St
**Collingwood**
ph. 9417 4856
**Wed 10:30am**
**FREE**
**Men Only**

**Food Not Bombs - Fitzroy**
Cnr Brunswick & King William ST
**Fitzroy**
fnbmelb@riseup.net
**Mon 12:45pm**
**FREE**
**V***

**Church of All Nations**
180 Palmerston St
**Carlton**
ph. 9347 7077
**Tues** *Light Lunch*
**Wed** *Full Lunch*
**11:30am-1pm**
**$2 DONATION**

**Ozanam Community Centre**
268 Abbotsford St
**North Melbourne**
ph. 9329 6733
**Mon-Fri**
**9:15am -10am**
**$2 DONATION**

**Inner Space** NEW
4 Johnston Street
**Collingwood**
ph. 9448 5530
**Mon,Tues,Wed & Fri**
**11am-1pm**
**Breakfast Program**
showers & washing machine facilities available

**Inner Space** NEW
4 Johnston Street
**Collingwood**
ph. 9448 5530
**Mon- Fri**
**3pm-5pm**
**Afternoon Drop In**
**(Food Parcels Avail)**

**Anglicare- St Marks Church Community Centre**
250 George St
**Fitzroy**
ph. 9419 3288
**Mon- Fri**
**10:30am-2:30pm**
**FREE**

### INNER SOUTH

**Sacred Heart Mission- Community Meals**
87 Grey Street
**St Kilda**
ph. 9537 1166
**Daily (incl. Weekends & Public holidays)**
**9am**
**FREE**

**Star Health - Wominjeka BBQ**
Veg Out Community Garden (opposite Luna Park)
Cnr Shakespeare Grv / Chaucer St, **St Kilda**
ph. 9525 1300
**Mon 11:30am**
**FREE**
**Aboriginal/TSI**

### INNER STH EAST

**Hare Krishna Food for Life Melbourne**
197 Danks Street,
**Albert Park**
ph.9699 5122
**Mon-Sun 8:30am**
**FREE**

**Sacred Heart Mission- Women's House**
65 Robe St.
**St Kilda**
ph. 9537 1166
**Mon-Fri 11:30am**
**FREE**
**Women Only**

Fd =food
Sv =soup van
Kr =Koorie & TS Islanders
Mn = men
Wn = women

V* = Veg/vegan



**Table to be updated regularly-if you know where to get a good feed for free**

LUCKILY THERE ARE PLACES ALL OVER MELBOURNE,
EVERY DAY OF THE WEEK WITH SOMETHING ON OFFER.
WASH YOUR HANDS AND COME TO THE TABLE!

# DnR
## Dinner

**Asylum Seeker Resource Centre (ASRC)**
214-218 Nicholson St
**Footscray**
ph. 9326 6066
**Mon-Fri**
**12:30pm**
**FREE**

**Kensington Neighbourhood House**
89 McCracken St
**Kensington**
ph. 9376 6366
**Tues 5:30-8pm**
**FREE**
**Women 55+ Only**

**Society of St Vincent de Paul - West Melb Soup Vans**
Queen Victoria Market (Car Park), Peel St
**West Melbourne**
ph. 9895 5800
**Daily 9:15pm**
**FREE**

**Society of St Vincent de Paul - Nth Melb Soup Vans**
Cnr Boundary Rd / Macaulay Rd
**North Melbourne**
ph. 9895 5800
**Daily 7pm**
**FREE**

**Society of St Vincent de Paul - Footscray Soup Vans**
Whitten Oval, Cnr Barkly St / Gordon St
**Footscray**
ph. 9895 5800
**Mon-Fri, Sun 8pm**
**FREE**

**Brunswick Uniting Church**
212- 214 Sydney Rd
**Brunswick**
ph. 0431 193 810
**Wed**
**12:30pm**
**FREE**

**Food Not Bombs - Fitzroy**
Cnr Brunswick & Gertrude ST
**Fitzroy**
fnbmelb@riseup.net
**Tues 7:30 pm**
**FREE**
**V***

**Society of St Vincent de Paul - Collingwood Soup Vans**
Cnr Smith St / Stanley St
**Collingwood**
ph. 9895 5800
**Tues,Thurs,Fri,Sun**
**7:30pm**
**FREE**

**Food Not Bombs - Footscray**
Barkly ST
Outside Western Oval
**Footscray**
fnbmelb@riseup.net
**Mon 7:30pm**
**FREE**
**V***

**Food Not Bombs - Coburg**
Coburg Library
**Coburg**
fnbmelb@riseup.net
**Wed 7pm**
**FREE**
**V***

**Open Table**
125 Napier St
**Fitzroy**
ph. 0403 218 123
**Visit website for dates/time**
**hello@open-table.org**
**FREE**

**Nth Fitzroy Seventh Day Adventist Church**
27 Alfred Crescent
**Fitzroy North**
ph. 0409 422 064
**Sun**
**6:30-7:30pm**
**FREE**

**Society of St Vincent de Paul - Fitzroy Soup Vans**
All Saints Church
174 Brunswick St
**Fitzroy**
ph. 9895 5800
**Daily 7:45pm**
**FREE**

**Missionaries of Charity Men's Service Fitzroy**
Rear, 69 George St
**Fitzroy**
ph. 9417 1704
**Mon,Tues,Sat,Sun**
**4pm**
**FREE**
**Men Only 18+**

**Hare Krishna Food for Life Melbourne**
197 Danks St
**Albert Park**
ph.9699 5122
**Mon-Sun 8:30am**
**FREE**

**Society of St Vincent de Paul - Southbank Soup Vans**
Hanover House
52 Haig St.
**Southbank**
ph. 9895 5800
**Daily 9pm**
**FREE**

**Society of St Vincent de Paul - Fed Square Soup Vans**
Federation Square
Cnr Russell St / Flinders St
**Melbourne**
ph. 9895 5800
**Daily 8:15pm**
**FREE**

**Society of St Vincent de Paul - Batman Park Soup Vans**
Rebecca Walk (Spencer St)
Batman Park,
**Melbourne**
ph. 9895 5800
**Daily 8:30pm**
**FREE**

**Society of St Vincent de Paul - Richmond Soup Vans**
Cnr Hoddle St / Wellington Pde
**Richmond**
ph. 9895 5800
**Mon 7:30pm**
**FREE**

**Parish of the Parks St Silas Church Hall**
99 Bridport St
**Albert Park**
ph. 9696 5116
**Sun**
**5pm sharp**
**FREE**

**Hare Krishna Food for Life Melbourne**
197 Danks St
**Albert Park**
ph.9699 5122
**Mon-Sun 8:30am**
**FREE**

**ee or cheap, email whack@hrvic.org.au with the info so we can share it.**

## COMMUNITY HEALTH SERVICES

***Non judgmental healthcare: doctors and nurses as well as a range of other services incl. counselling, dentists, showers, NSP, info re. Pharmacotherapy, Rehab & Detox info, Hepatitis testing & treatment & MORE!***

Your local community health centre (CHC) is a great place to access free or low cost health services- drug related or not.

**You can find your local CHC by looking up the health department's directory:**

**www.health.vic.gov.au**

**CoHealth Collingwood**
365 Hoddle St.
Collingwood
10.30am-5pm (Mon-Fri)

**InnerSpace (CoHealth)**
4-6 Johnston Street
Collingwood
Ph: 03 9448 5530

**Fitzroy CoHealth**
75 Brunswick St. Fitzroy
12.30am-5pm (Mon-Fri)

**CoHealth-Healthworks**
4-12 Buckley Street
Footscray
10.15am-12.30pm/1pm-5pm
Mon/Tues/Wed/Fri
1-5pm Thurs
**Ph: 03 9448 5511**

**CoHealth Braybrook**
107/139 Churchill Ave,
Braybrook
9am-5pm Mon/Tues/Wed/Fri
1-5pm Thurs
Ringing ahead is advised
**Ph: 9448 6284**

**Monash Health Drug & Alcohol Service**
***(SECADA)***
***Intake & Assessment Team***
122 Thomas St
Dandenong
**Ph: 03 9792 7630 or**
**Ph. 0434 601 300**

Youth Projects/**The Living Room**
7-9 Hosier Lane
Melbourne CBD
Ph: 03 9945 2100
**Ph. 1800 440 188**

**CURRENTLY MOVED_CALL FOR INFO**
**Access Health Program**
31 Grey Street
St Kilda
**Ph: 03 9536 7780**

## SEXUAL HEALTH

**Melbourne Sexual Health Centre**
580 Swanstson Street Carlton
Ph: 03 9341 6200 or
**Ph. 1800 032 017**
*(Toll free outside Melb only)*

**Family Planning Vic**
901 Whitehorse Road
Box Hill
Ph: 03 9257 0100 or
**Ph. 1800 013 952**

## WOMEN'S SERVICES

**Safe Step's 24/7 Family Violence Response**
**Ph. 1800 015 188**

**W.I.R.E. Women's Support Line**
327 Spencer Street
West Melbourne
Weekdays 9am – 5pm
Ph: **1300 134 130**
*Telephone interpreter service available*
**Walk In service closed until further notice**

**Women's Health Vic**
Nurse on call
Ph: **1300 606 024**

**Women's Legal Service Victoria**
Tues & Thurs
5.30pm – 8.00pm
Ph: 03 8622 0600 or
**1800 133 302**

**Women's Welcome Centre**
20 Flemington Road
Parkville
Ph: 03 8345 2000

**Flat Out: Statewide Support for Women Leaving Prison**
255 Ballarat Rd
Footscray
**Mon- Fri 9.00 am – 5pm**
**Ph: 03 9372 6155**

**Women's Health West**
317-319 Barkly Street
Footscray
**Mon- Fri 9.00 am – 5pm**
**Ph: 03 9689 9588**

**Women's Health North**
680 High Street
Thornbury
**Mon- Fri 9.30 am – 5pm**
Ph: 03 9484 1666
www.whin.org.au

## NEEDLE & SYRINGE PROGRAM (NSP)

**These lists are always changing.**
You can also find an NSP in your area, by calling **Directline (1800 882 360)** or if you don't mind paying, **basic** equipment can be purchased & disposed of at many chemists for anywhere between $3 and $10 dollars.

### NIGHT MOBILE SERVICES

**Call and arrange to meet.**
**Monday - Friday ONLY**
**7.30pm – 10:45 pm**
(Except CBD foot patrol)

**Inner North**
Ph: 0418 179 814
**North East**
Ph: 0418 545 789
**Inner South**
Ph: 0419 204 811
**CHOPER (Eastern)**
Ph: 0414 266 203

**Frankston/Dandenong**
*7 days a week*
*6.30 pm – 9.45 pm*
*(Except public holidays)*
**Ph: 1800 642 287**

**North West (NWOS)**
*7 days a week*
*5.00 pm – 10:30 pm*
Ph: **0418 170 556**
or **1800 170 556**

### DAY MOBILE SERVICES

Call and arrange to meet.

**Geelong**
**Ph: 1800 196 850**
**Mon- Fri 9.00 am – 4pm**

**Foot Patrol CBD**
Ph: **1800 700 102**
Foot Patrol operate from:
**Mon-Fri** 12.30-4.45pm & 5.30pm-9.45pm
**Sat & Sun** 12.00-3.15pm & 6.30pm-9.45pm
**OPEN PUBLIC HOLIDAYS**

### FIXED SITE SERVICES

(call in & pick up your equipment)

**CoHealth Collingwood**
365 Hoddle St. C'wood.
10.30am-5pm (Mon-Fri)

**Innerspace**
4-6 Johnston St.
Collingwood
10.30am-5.30pm (Mon-Fri)

**CoHealth Fitzroy**
75 Brunswick St. Fitzroy
12.30am-5pm (Mon-Fri)

**Healthworks**
4-12 Buckley St
Footscray
10.15am-12.30pm and 1-5pm Mon, Tues, Wed and Fri.
Thursday's 1-5pm

**CoHealth Braybrook**
*107/139 Churchill Ave, Braybrook*
*9-5 Mon,Tues, Wed & Fri.*
*Thurs 1-5pm.*
***Ringing ahead is advised***
***9448 6284***

**Salvation Army Health Information Exchange**
29 Grey Street
St Kilda
**24 hours 7 days**
**ph: 03 9536 7703**

**Monash Health Drug & Alcohol Service**
Needle Syringe Program
122 Thomas Street
*(Ground Level)*

**Dandenong**



**THIS TABLE IS UPDATED REGULARLY- EMAIL whack@ hrvic.org.au TO ADD OR UPDATE YOUR SERVICE**

Ph. 03 9792 7630

**SHARPS**
20 Young Street
**Frankston**
**Ph: 03 9784 7409**

**Youth Projects Glenroy**
6 Harington St
**Glenroy**
Phone: 03 9304 9100
**Mon-Fri 11:00-5:00 pm**
(*Except* Public Holidays)

**Whitehorse CHC**
43 Carrington Road
**Box Hill**
Ph: 03 9890 2220

**Corio CHC**
2 Gellibrand St.
Corio
10am-4pm weekdays
Ph: 1300 094 187

**Belmont CHC**
1-17 Reynolds Rd
Belmont
Weekdays 8.30am-5pm
**Ph.03-4215 6800**

**Newcomb CHC**
104-108 Bellarine Hwy
Newcomb
**Ph. 03-4215 7520**

**Anglesea CHC**
McMillan St
Anglesea
**Ph. 03-4215 6700**

**Torquay CHC**
100 Surf Coast Hwy
Torquay
**Ph. 03-4215 7800**

**Ballarat CHC**
12 Lilburne Street
Lucas
**Ph: 03-5338 4500**

**Bendigo CHC**
171 Hargraves Street
Bendigo
**Ph: 03-5448 1600**

## *NSP VENDING MACHINES*

**75 Brunswick St. Fitzroy**

**365 Hoddle St. Collingwood**

**Healthworks, 4-12 Buckley St Footscray**

**107/139 Churchill Ave, Braybrook**

**Geelong**
Outside Barwon Health Building B on Ryrie st, *(between Bellarine and Argle Streets).*

**Corio CHC**
Outside
2 Gellibrand St.
Corio

## OTHER SERVICES

**MSIR** *(Medically Supervised Injecting Room)*
23 Lennox St
Richmond
**PH. 9418 9811**

**Call for opening hours**

### Directline

**Directline** is an info & referral phone service able to provide assistance if you want to detox, start a pharmacotherapy program or find a GP etc.

*24 hours 7 days*
**1800 888 236.**

### Victorian Aboriginal Health Service

Ph: 03 9419 3000

### PAMS

Pharmacotherapy Advocacy Mediation & Support

Phone Service

HRVic's PAMS service can assist with program maintenance-financial help, transfer local & interstate, mediation of disputes with prescribers or dispensing pharmacy.

11am-5pm Weekdays
Ph. 1800 443 844

## *AIVL's NATIONAL NSP DIRECTORY*

**https://nspdirectory.aivl.org.au/nsps-in-victoria/**