



WHACK

NO. {34}



**DRUGS
IN
MY
BODY**

EDITORIAL

Welcome to our hep C edition of *WHACK!*

We at Harm Reduction Victoria are acutely aware of the hep C epidemic, which has quite simply overwhelmed our community. We are also very mindful of the fact that many of us who are living with the virus are ageing and starting to experience the longer term effects of hep C due to the toll it takes on our livers over time. In fact many of us are running out of time. As a result, the prevention of blood borne viruses like hep C & HIV is at the heart of most of our health promotion and peer education activities.

However it's been a while since we aimed the spotlight squarely on hep C. We often find that the issue of hep C comes to life when we put it into some sort of broader context, like safer drug use or vein care. Hep C, in & of itself, can be a dry & difficult topic especially when it is couched in medical or scientific terminology.

But there is so much happening in the hep C space at the moment we figured we needed to devote an entire issue of the magazine to it. We particularly wanted to unpack some of the more dense information into plain language. And a lot of the breaking news is good news for a change - & it is great to be the bearer of glad tidings of any description at this time of the year.

Recent developments in treatment for hep C are especially encouraging & have the potential to stand the whole treatment saga on its head. Different drugs called DAAs or 'Direct Acting Anti-virals' with high success rates and minimal side effects are replacing Interferon-based treatments. Unfortunately, there are still a number of barriers, including the high cost of these drugs, to be addressed before DAAs can become the standard hep C treatment for all people living with hep C in Australia. In the meantime, the main avenue of access is via the many trials which are investigating various aspects of DAAs & the impact & outcomes of these new treatment medications.

We are delighted to feature in this edition a wide range of different people & perspectives about hep C including some of the key stakeholders & luminaries of the hep C sector. We are also pleased to capture the voices & stories of hep C patients & recipients of the new DAA treatments, which are producing such great results.

Especially exciting are the experiences of those intrepid individuals who took it upon themselves to source the new treatment drugs from other countries at greatly reduced cost. It is pleasing to note that local Melbourne ID specialists were happy to assist these people and to check that the generic meds they imported from India & China were the real thing and to monitor their progress throughout treatment. We are also pleased to feature an article about our own Tasmanian based buyer's club and the driver of this local initiative, the resourceful Greg Jefferys.

This edition of *WHACK!* is a perfect opportunity to launch our new hep C treatment blog which will soon be a feature on Harm Reduction Victoria's website. We hope you visit it for yourself, & use it as a way to keep abreast of the dynamic state of play regarding hep C treatment.

Note: A matter of hours before this issue went to print, the Turnbull Government announced that they will invest more than \$1 billion to make new hep C treatments more accessible and affordable for all Australians who need it. This long awaited announcement is cause for celebration for many of our community who are living with the virus, and it puts a whole new slant on several of the articles featured in this edition of the magazine. The new PBS listing will mean a dramatic reduction in cost to the consumer i.e. the consumer will pay the regular PBS co-payment as for other prescription medications (\$6.10 for concession card holders or \$37.70 for general patients).

Despite our elation at this announcement, Harm Reduction Victoria is acutely aware that we have a lot of work to do to ensure these new treatments are provided in an appropriate way, and to address other major barriers to treatment, in particular stigma and discrimination towards people who inject drugs, in healthcare settings.





Self determination & empowerment:

We respect the sovereignty of individuals over their own bodies and respect and affirm peoples' lifestyle choices. We believe that individuals and communities have the right to be heard and to determine their own goals and paths through life, provided always that the equal rights of others are not diminished.

We oppose stigma & discrimination:

Stigma and discrimination cause unwarranted harm to people who use drugs and their families and to the wider community to which they belong.

Stigma and discrimination marginalise and isolate people, separating individuals from friends, family and community support and deny them equitable access to opportunities, services and participation. Stigma and discrimination act as barriers to the reduction of drug-related harm and to health promotion.

Stigma undermines human dignity and self-efficacy. It makes it harder for people to participate in the social, cultural and economic life of the community and it undermines individuals' efforts to develop their potential and to deal with challenges and problems.

Harm Reduction Victoria therefore affirms the rights of all people, including those who use drugs, to fair, equitable and respectful treatment in all aspects of life. We assert that a person's choice to use illicit

substances, while unlawful, should not of itself have any impact upon their rights as workers, consumers of goods and services or as valued members of society.

The way we work:

Harm Reduction Victoria is a peer based organization. We are of and for our communities. Our membership, staff and supporters include current and former drug users and people who support the values and objectives of Harm Reduction Victoria.

Harm Reduction Victoria is a community organization that is accountable, in the first instance, to our membership and our constituent community.

We prioritise the issues and concerns of people who use drugs in all the work we do.

We believe that working with other groups and organisations leads to better outcomes for people who use drugs and the wider community.

We operate within the harm reduction philosophy, with a strong focus on promoting the health and rights of people who use drugs.

The context of our work:

Harm Reduction Victoria is committed to working lawfully and responsibly at all times. We do not seek to promote the use of any substances, but neither do we condemn individuals for the choices they make concerning their own bodies and lifestyles.

We Believe:

That drugs have positive as well as harmful effects (for the individual and society).

That many of the negative effects associated with drug use are not simply caused by the drugs themselves but are the product of legal, psycho-social and economic factors surrounding their use.

That the current distinction between drugs that are legal and illegal is not evidence-based.

That this demarcation does not accurately reflect the capacities of the various substances for harm and that the application of criminal sanctions in relation to one group of substances, and not the other appears to be arbitrary and counterproductive to the aim of reducing drug-related harms to individuals and the community.

That prohibition creates a barrier to accessing services and creates hidden harms which cannot be addressed whilst prohibition exists.

That drug use and drug related harm should be viewed and managed as a health issue and not a legal issue.

In a social model of health, which views health not merely as the absence of disease, but as a resource for living.

That "promoting health means addressing the social, economic and political factors that impinge upon people's capacity to enjoy good health" Ottawa Charter for Health Promotion 1987.1

Statement of Mission & Objectives:

As the state-wide user organisation, Harm Reduction Victoria's mission is to be a drug-user-based and user-governed organisation. We promote a harm reduction approach to drug use, with a philosophy of self-determination and empowerment. Harm Reduction Victoria aims to provide a voice for people who inject and other users of illicit drugs, and to address the health and social justice issues experienced by people who inject and other users of illicit drugs. In short this mission is encapsulated in "Health Rights, Human Rights, Harm Reduction".

Harm Reduction Victoria's objectives:

- a) To be a drug user-based, user driven and user governed organisation for people who inject and other users of illicit drugs
- b) To address the issues of Blood Borne Virus transmission and infection, amongst people who inject drugs, through peer education, peer support and advocacy
- c) To promote the reduction of drug related harm
- d) To provide non-judgmental advocacy, support and referral to people who inject and other users of illicit drugs
- e) To initiate and participate in ongoing community debate and discussion of issues affecting people who inject and other users of illicit drugs
- f) To represent the views of Harm Reduction Victoria, and its' constituents, to government and non-government bodies.
- g) To challenge social and legal barriers to the health and well being of people who inject and other users of illicit drugs, in Victoria.



CONTENTS

04	NEWS
06	THE HEP C BUYERS CLUB
10	STOPPING A SILENT KILLER
11	THE HEPALOGUE
12	UPDATE / HCV TREATMENT UPTAKE
14	THE DOCTOR AND THE DEA
17	HCV GENOTYPES WORLDWIDE
18	THE CUPID PROJECT
20	HEPATITIS SEE
22	36 YEARS/HEP C & ME
24	ELIMINATING HCV
28	SAFER USING
30	THE THINMAN AFFAIR
35	A ROAD LESS TRAVELLED
36	THE TRIAL
41	DON'T WAIT
42	REVIEW: TALKING SMACK
43	CROSSWORD
45	MEMBERSHIP FORM
46	SURVIVAL GUIDE



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WOULD YOU LIKE TO SEE YOUR WORK PUBLISHED IN WHACK!?

Here at Whack! magazine, we strive to be an authentic voice for drug users and & wholeheartedly encourage people to submit their work for publication. "Novel Psychoactive Substances" are the theme for the next issue & we would love to hear your thoughts, stories, artworks, etc. We are very open to new ideas in the continuous evolution of Whack!

Put your thoughts on page/screen and rocket them to us via web/post or crow, it's that easy. Or check out our Facebook page (HRVic) & just send it through.

If you're published, you'll be paid after the magazine goes to print.

NEWS / WORLD

Cannabis Psychosis: males outnumber females by four to one

There has been much research exploring the nature of the relationship between cannabis -- the most widely used illicit drug in the United Kingdom -- and psychosis, however the role of gender in relation to cannabis psychosis is less well explored and understood.

A new study by researchers in the Department of Health Sciences used large datasets over a period of 11 years to investigate the differences in men and women as they progress from exposure to cannabis through to developing cannabis psychosis. The research is published in the Journal of Advances in Dual Diagnosis.

Trends in cannabis use suggest that twice as many males as females use the drug. This gender ratio is mirrored in rates of psychosis with males outnumbering females by 2:1. But a research team found there is a significant widening of this ratio for cannabis psychosis, where males outnumber females by four to one.

Ian Hamilton said: "The marked gender difference in rates of cannabis psychosis is puzzling. It is possible that mental health and specialist drug treatment services, which have a disproportionate number of men, are identifying and treating more males with combined mental health and cannabis problems. However it is also possible that women with cannabis psychosis are not being identified and offered treatment for the problems they develop.

"When it comes to cannabis psychosis gender does matter."

<http://www.emeraldinsight.com/doi/abs/10.1108/ADD-12-2014-0039>

Are Drugs helping fuel the Islamic State?

The ISIS propaganda machine has been pushing a very specific image, one of strict adherence to Sharia Law. These codes are often brutally enforced by ISIS, and those things deemed Haram (sinful or forbidden) are not tolerated.

Falling under the category of Haram are items considered to be intoxicants, such as alcohol, tobacco, and drugs. The Islamic State has made a very public display of carrying out a strong anti-drug policy. But this image conflicts with reports coming out of Syria which exposes the Islamic State as being major users and distributors of powerful narcotic drugs.

Ekram Ahmet, a Kurd who fled Kobani with his family, told Mirror: "They have lots of pills with them that they all keep taking. It seems to make them more crazy if anything."

"They become agitated and excited, desperate to punish even children for the smallest thing."

Captagon pills.

Captagon, it turns out, is the biggest thing to hit the Middle East since oil. Since 2014, Reuters reported on Syria becoming a major consumer and exporter of amphetamines, the most popular being captagon.

According to Reuters, captagon "generates hundreds of millions of dollars in annual revenues in Syria, potentially providing funding for weapons, while the drug itself helps combatants dig in for long, grueling battles."

Captagon is a brand name for the drug Fenethylamine, invented in 1961 by Degussa AG for the treatment of "hyperkinetic children," or children diagnosed with ADHD.

Fenethylamine is metabolized by the body to form the compounds amphetamine and theophylline. Theophylline is a chemical from the Xanthine class, which also includes caffeine.

However, a study conducted in 2005 by Alabdalla MA for Forensic Science International of 124 batches of seized captagon, revealed they contained no fenethylamine at all. Rather, these counterfeit captagon tablets contained amphetamine, methamphetamine, ephedrine, metronidazole, caffeine, theophylline, chlorphenamine, procaine, trimethoprim, chloroquine, and quinine. In short, a drug cocktail far more potent than the original name brand version.

<http://www.reuters.com/>

3D printing drugs is the future

Chemist Lee Cronin is working on a 3D printer that, instead of objects, is able to print molecules. An exciting potential long-term application: printing your own medicine using chemical inks. Of course when there's the possibility to print medicine using chemical links, it won't be too long before people use this application to print their own drugs.

LSD, Psilocybine, DMT, MDMA and THC too will be manufacturable using the same technique. And that's just the tip of the iceberg: what about all the designer drugs?

Obviously more important will be the possibility to quickly spread the blueprint for a medicine using the internet, as Lee Cronin expresses in his TED talk.

'The future sure is exciting, but at the same time, very scary' according to 'the stoned society' website.

Don't try this at home kids..!

<http://thestonedociety.com/>

NEWS / LOCAL

Branson calls on Australia to to decriminalise drugs

Billionaire Richard Branson has called on Prime Minister Malcolm Turnbull to decriminalise drugs in Australia.

Sir Richard, owner of the Virgin empire and a commissioner for the Global Commission on Drug Policy, issued the challenge to Mr Turnbull in a personal submission to the federal government's National Ice Taskforce.

The federal government's National Ice Taskforce was debating a bold move away from its long-held, hardline law-and-order strategy when Sir Richard last month weighed in with his own thoughts, calling for an end to "counterproductive drug-law enforcement" and to "scale up" evidence-based prevention, harm reduction and treatment measures.

In briefing notes forwarded to Mr Turnbull on November 12 via his Australian adviser, David Ryan, Sir Richard spoke of the "enormous momentum" towards decriminalisation which in recent months had seen countries, including Ireland, Canada and Mexico, flag radical shifts in drug legislation.

"Drug use should be treated as a health issue, not as a crime. While the vast majority of recreational drug users never experience any problems, people who struggle with drug addiction deserve access to treatment, not a prison cell," he said.

Sir Richard added that, combined with harm-reduction efforts, decriminalisation of drug possession for personal use would "save lives" because people would no longer "fear arrest and punishment when accessing healthcare services".

He noted that since Australia's National Drug Strategy was launched in 1985, it had "always prioritised harm reduction" alongside supply and demand policies.

"Sydney's medically supervised injection centre (the only one in the southern hemisphere) is an outcome of that," he said, adding: "The [ice taskforce] strategy under discussion now will guide drug policy in Australia from 2016 to 2025."

The taskforce final report moved to strengthen future treatment services when it raised the "current short-term funding cycles" that thwart "longer-term service planning and workforce retention". It added that such limited cycles also "inhibit" services from "committing to the longer term treatment programmes that would benefit many ice users".

<http://www.smh.com.au/>

AOD treatment spending in Australia

Alcohol and other drug treatment spending in Australia amounted to \$1.2 billion in 2012/2013. While this seems a lot of money, it is just under one per cent of health care spending in Australia. Information about national treatment spending is useful because it: enables analysis of spending between different funding sources; it allows us to compare AOD treatment spending to other areas of health care; and lastly it creates the base for tracking trends over time.

The research by NDARC's Drug Policy Modelling Program found that of the \$1.2 billion, state/territory government funding accounted for half of AOD treatment expenditure (50.7%), with the Commonwealth funding just under a third (31.4%) and the private sector just under a fifth (17.8%). This balance between the two levels of government spending for AOD treatment differs from the total health care spending, where the Commonwealth makes a largest proportional contribution.

Community based treatment accounts for over half of the treatment spending with the majority of that funded by states and territories. Public hospitals account for around 15 per cent of AOD treatment spending and private hospitals around 10 per cent.

<http://onlinelibrary.wiley.com/doi/10.1111/dar.12248/abstract>

Naloxone Endorsed

The Australian Capital Territory's innovative opioid overdose management program, which makes take-home naloxone available to potential opioid overdose victims, has been overwhelmingly endorsed by an independent evaluation supported by Burnet Institute.

The evaluation report, co-authored by Professor Paul Dietze, Head, Alcohol and Other Drug Research in the Centre for Population Health, shows that take-home naloxone, a Schedule 4 medicine that reverses the effect of heroin and other opioid drug overdoses, saves lives.

The first of its kind in Australia, the ACT program has been operating since 2011. It involves training in opioid overdose management and the prescription and supply of naloxone to eligible participants, usually drug users, their partners, family and friends, who are not health professionals.

"Canberra has led Australia by implementing a program that trains potential overdose witnesses in basic life support and provides take-home naloxone," Professor Dietze said.

"Naloxone is a medicine that has just one effect: it starts people breathing again after an overdose. It saves lives."

www.tga.gov.au

THE HEP C BUYERS CLUB

“How can this little jar of tablets be worth so much money? Only because it holds the power of life and death. What kind of heart is in the man who makes the price so high that many will die because they can not afford the medication?”

There are two main characters in this rather inspiring – and very timely – story: Sofosbuvir, a life-saving hep C treatment drug, and Jefferys, a man whose tireless efforts have helped create a means of safely exporting that drug to Australia and elsewhere in the world at an affordable price, i.e. literally 1% of the price currently charged.

First I'll explain the Sofosbuvir (or 'Sof' as it tends to be called by anyone who has to say it a lot). Currently, it's the most versatile and potent of a new class of hepatitis C virus (HCV) treatment drugs called Direct Acting Antivirals (DAAs). Technically speaking, it's a nucleotide analogue, which inhibits viral reproduction at a site named NS5A. Generally, it is used in multi-drug regimens, depending on the particular hep C genotype involved.

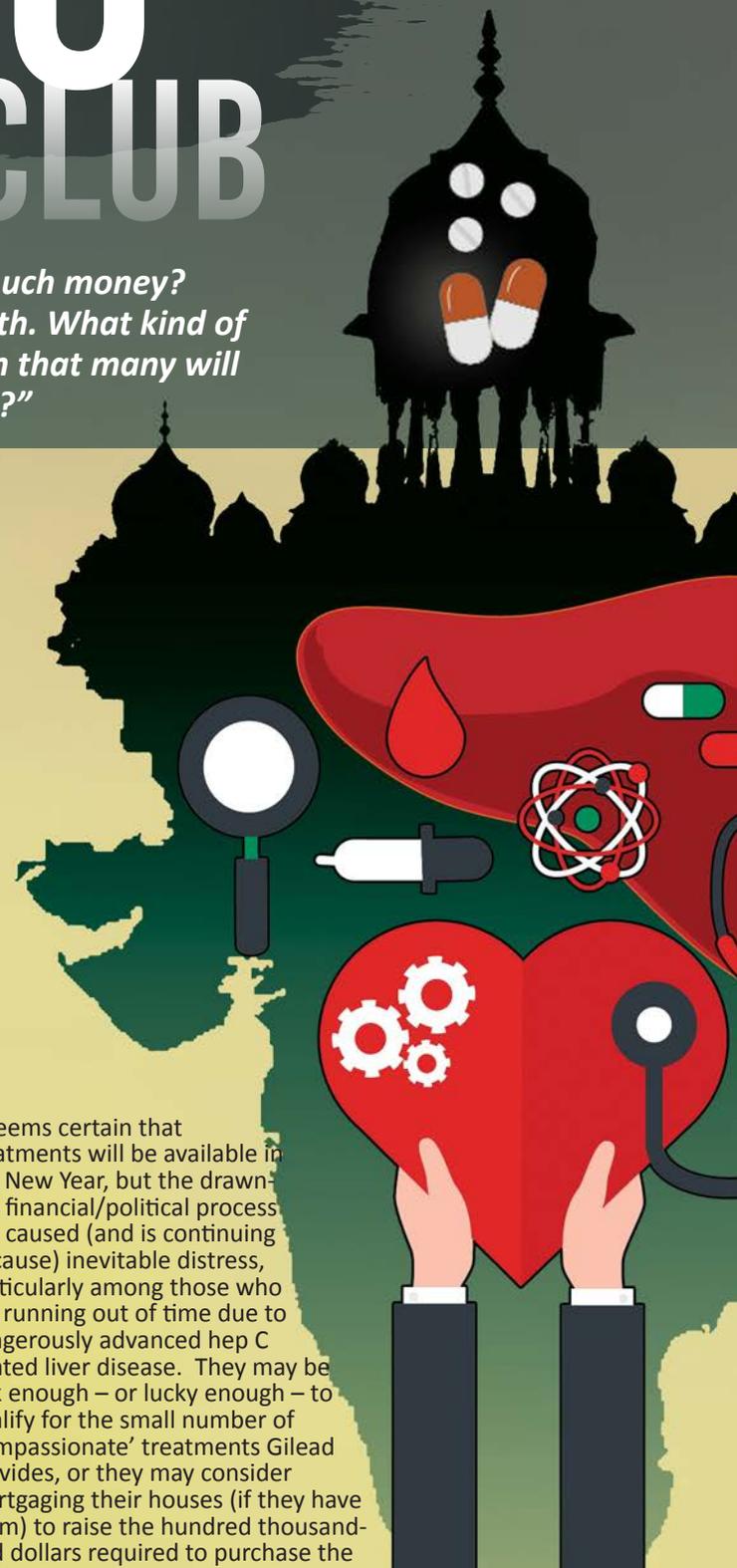
Simply put, it's a lynchpin of a series of recently developed and highly effective hep C treatments – treatments which at present are priced well beyond the budget of most of us with the disease, and which are not (yet) available through Australia's PBS.

For those with Genotype 1 (by far the most common genotype in this country) the current treatment of choice is 'Harvoni' – a pill devised by Gilead (a major pharmaceutical company) taken over a 12-week period that contains both Sof and Ledipasvir (another nucleotide analogue which targets the NS5B site). Although there are other DAA combinations that are almost as effective, at this stage Harvoni leads the pack with a cure rate upwards of 95%.

For those with Genotype 3 (a smaller percentage of our hep C positive population), Ledipasvir is generally replaced with Daclatasvir. Genotype 2 is very rare in this country but it is simpler to treat: Sof with added Ribavirin (an older anti-viral medication with significant side effects that has traditionally been used with interferon-based regimens) has proven to be a reliable treatment.

Negotiations between the Australian Government and Gilead have been dragging on for some time now. Meanwhile the lives of 200,000 plus Australians struggle on, at the mercy of this faceless, all powerful opponent with whom, obviously, there can be no negotiation.

It seems certain that treatments will be available in the New Year, but the drawn-out financial/political process has caused (and is continuing to cause) inevitable distress, particularly among those who are running out of time due to dangerously advanced hep C related liver disease. They may be sick enough – or lucky enough – to qualify for the small number of 'compassionate' treatments Gilead provides, or they may consider mortgaging their houses (if they have them) to raise the hundred thousand-odd dollars required to purchase the medicines outright.



Typically, hep C manifests as a chronic disease that can take many decades to cause serious harm, but the virus can also cause a dangerous acute condition, and this is where our other character steps into the picture.

Last year, Jefferys was a healthy sixty years old – somewhat of a rusty old hippie living with his wife in the Tasmanian bush. During a holiday up north, his wife, and then he, came down with a nasty bout of flu. His wife recovered normally, but, about a month later, Jefferys began to notice some disturbing symptoms: he was chronically fatigued; his urine was dark and smelt unpleasant and, regardless of how strong, coffee was ‘practically sending him to sleep.’

After trawling the Internet, his wife insisted upon a doctor’s visit, and the culprit was revealed in the results of a liver function test. ‘Enzyme levels 20 to 50 times higher’ than normal indicated acute hepatitis. Further tests revealed the presence of HCV.

The family’s life went into a spin. Jefferys was told that, most likely, given its acute nature, he had contracted the virus recently – yet he had not used intravenous drugs or shared used injecting equipment, received a transfusion, or engaged in any behaviour that might have exposed him to the virus.

Ultimately, he was told that the most likely explanation was a youthful flirtation with intravenous drug use, after which the virus had lain dormant in his system – for decades – waiting for his

immune system to weaken sufficiently with age, and for a triggering event like a bout of flu.

Speaking for myself, and probably for many of our readers, the complexities and frustrations of treatment seem almost commonplace. Even the stigma of hep C – sadly, a brutish reality – is something I, and many others, am used to dealing with, and after thirty years my reactions to it are more or less formulaic.

Not so for Jefferys and his wife. All these experiences were new – and predictably stressful. Even the myth that HCV can be transmitted via normal heterosexual activity came briefly into play. For a time, Jefferys agonised over the decision whether to keep his condition secret or not – opting finally to disclose and describe his experiences via a blog which continues to help others pick their way through the bewildering world of hep C.

Also, he elected to take his health seriously and face the virus head on. He eliminated alcohol from his diet, reduced his coffee intake, maxed out his exercise regime, and basically made all the health-promoting lifestyle changes he could.

Then he went in search of pharmaceutical agents that might flush the virus from his system and allow his liver to heal.

It was 2014, and he was lucky that the old-style interferon-based treatments were already considered out of date. As we know, these 6–12 month regimens were depressing at best, and utterly debilitating at worst for many patients. And, even when combined with earlier DAAs like Telaprevir, their rate of success was far from impressive.

Jefferys focused on the new DAAs in the pipeline – clever, vastly more potent drugs – but as his health deteriorated (bloating, cramping, brain fog) he found it impossible to secure a place on a trial, and, to his boundless frustration, learned he was not sufficiently unwell to qualify for compassionate treatment.

Being of a curious, inquiring bent, Jefferys began to dissect the strange, venal world of Big Pharma, disseminating his discoveries via his blog.

During a consultation with one doctor, it was explained to him that ‘because of the high cost of Sofosbuvir (\$90,000 (USD) per treatment) the government would not be able to make (it) available to everyone’. If all 250,000 Australians with hep C were treated, it ‘would cost over \$200 billion and bankrupt the health system.’

“The doctor told me that the government would only make ... Sofosbuvir available to the sickest of people. My response was to quote a metric version of the old saying “A gram of prevention is better than a kilo of cure.””

“How is this any different to someone being diagnosed with cancer and then being told they cannot get treatment until the cancer has reached a more advanced stage?”

Although Gilead Sciences owns the patent for Sof, the drug did not originally emerge from their research division (unlike Ledipasvir, the other element of Harvoni). Originally, Gilead hoped to partner Ledipasvir with another of their drugs, known by the experimental name GS-6620.

However, in 2011, GS-6620 was performing poorly in trials, Gilead’s stock price was dropping, and the tremendous wealth that might be garnered by producing a sure-fire cure for hep C (Genotype 1) was slipping from their grasp.

At the same time, a smaller company, Pharmasset, was achieving positive results with PSI-7977, a nucleotide similar in action to the failed GS-6620. Sensing opportunity, Gilead pounced. \$11 billion (USD) later, PSI-7977 became GS-7977 and then Sofosbuvir.

Jefferys soon realised that technically he was out of options. As he waited to get sick enough to warrant treatment, he carried on doing the best he could – but there is only so far you can fine-tune a healthy lifestyle.

It was around this time that he received a game-changing phone call from a friend. It was an extremely fortuitous event, not just for himself, but ultimately for hundreds of others. To paraphrase Jefferys blog, he learned that...

‘The Indian government’s patent office had refused Gilead a patent for Sofosbuvir (... partly because they did not develop it themselves, but also because ...) the drug did not demonstrate sufficient new or innovative concepts, and simply used a different configuration of known antivirals.’

THE HEP C BUYERS CLUB

According to Jefferys' friend, Indian pharmaceutical companies planned to manufacture a generic version of Sof – a process made easier, ironically, by access to the formula provided by Gilead in their patent application. This drug would be sold in India (a hotbed of Hep C, by the way) not for Gilead's \$1,000 a pill, but for \$5 – amounting to about \$500 for the three month course.

Jefferys' luck was beginning to change.

For starters, he was infected with the rare but easier to treat Genotype 2. Anything other than this and he may have had trouble acquiring the extra drugs needed to eliminate the virus. According to his doctor (again I am paraphrasing Jefferys' blog) a 12-week course of Sof, in combination with ribavirin (see above) was very likely to result in success.

Jefferys realised that India might provide a solution to his problem.

To quote:

'Australian law allows an Australian to bring in a three month supply of a prescribed drug from India. The drug must be prescribed by a medical doctor and the prescription must be with the drug when you bring it in. The problem is that an Australia doctor cannot write the prescription...'

Predictably, there were to be a great many hoops to jump through.

As already mentioned, it is appearing more and more likely that Harvoni, Sof and Daclatasvir will soon be listed on the PBS in Australia. Opinion is unanimous among health professionals with whom I have spoken. So, some of Jefferys' friends were happy to wait for what, hopefully, would only be a few short months – but not Jefferys himself.

'I am feeling pretty good but I can definitely feel the virus in me now, feeling a bit bloated in the torso and somehow just aware that things in my body are not quite right.'

Jefferys examined the possibilities, including the risky option of buying online, *'but it soon became clear that the easiest, fastest, safest way to get my Sof was to go to India'*.

Spurred by a fear that Gilead would find a way to plug the leak, Jefferys acted. The entire exercise was to cost him more than \$3,000 (AUD), but he raised it, partially with the help of friends, and he booked a flight to Chennai.

Importantly, his Australian GP was supportive, seeing similarities with the important role Indian pharmaceutical companies had played in reducing the cost of HIV drugs during the 1990's. (NB: Local medical support and oversight is critical when taking Jefferys' treatment route.)

Jefferys' experience in India involved a steep learning curve. His blog describes, step-by-step, how he came to get a handle on the unfamiliar world of Indian pharmaceuticals: the wide variance in prices, the differences between buying from pharmacies and distributors and, possibly more important than everything else, he learned the habit of patience.

Things never happened on time: emails invariably disappeared into black holes, so he always backed-up with marginally less frustrating phone calls.

Added to all this was the basic difficulty of getting from place to place.

He pursued several routes to acquiring the drug, all the while keeping the world up to date via his blog. Soon emails began to arrive, offering and seeking advice.

With every attempt, it seemed he was required to produce a prescription (from an Indian doctor) and evidence (FibroScans, pathology reports) that he suffered from the disease – as well as a Passport and ID.

The first delivery was late and contained only one bottle of Sof. Out of the blue it was explained to him that a person is only allowed to carry one bottle out of the country on any one occasion. But by this stage, Jefferys knew better than to believe everything he was told. Another of his options involved a company that was actually licensed by Gilead to produce Sof at a vastly reduced price for the developing world. The brand name was Sovaldi, the price was higher, and, he was told, they sometimes throw in the Ribavirin for free.

The next day he accepted delivery of a complete 12-week course, and prepared to leave the country, having decided to take the course in Australia where he had reliable medical support in the event of any side effects.

"It seemed totally absurd. Three little plastic jars, each with 28 little tablets in them. It was like some kind of weird magic, some kind of genie in a bottle."

The next day he accepted delivery of a complete 12-week course, and prepared to leave the country, having decided to take the course in Australia where he had reliable medical support in the event of any side effects.



Jefferys response is simple and cogent:

'there are seven, reputable, long established companies licensed by Gilead to make Sof in India. These are ... huge, well established pharmaceutical companies who have been manufacturing medical drugs for many years (supplying) local and international markets.'

Basically the Sof you buy in India is exactly the same as the Sof you buy in Europe or the US – indeed, in many, if not all, cases it comes from the same factories. However, Internet fraud does exist – as evidenced by the appearance of advertisements for online Indian Harvoni well ahead of the commencement of manufacture. To my mind, this merely underlines the pricelessness of Jefferys' work in helping to provide a safe secure pipeline.

Upon arriving home, Jefferys commenced his treatment. He noticed immediate improvements and no side effects.

As he waited for the results of his first blood tests, emails continued to flood in and an article appeared on Bloomberg describing the phenomenon of 'Reliable, Safe, Genuine, Not Fake Mail Order Generic Sofosbuvir'.

Jefferys set about creating an information package for those who wished to follow his example. Most of all, he wanted to find a dedicated facilitator who would source the drugs in India and then post them worldwide. He was lucky. He identified a not for profit, volunteer-based organisation that had originally been set up to supply generic HIV drugs to people in need around the world. (For more information Jefferys asks that you contact him directly through his blog).

Several months into his treatment, Jefferys received the results he had been waiting for: *'no detectable virus load'*.

'I almost cried. Until this moment in the back of my mind I was worried that something might go wrong, that the virus would still be there. But no, it was gone....'

He has gone on to finish his treatment and achieve what is called an SVR – Sustained Viral Response. *'Everything is looking rosy now... everything is as good as I hoped it could be.'*

But Jefferys has not abandoned the other side of his relationship with HCV, electing, selflessly, to continue his efforts in helping others. He has established communication with at least one of Australia's leading liver clinics, which has tested drugs sourced by their patients in India with uniformly positive results and, rather amazingly, referred some patients to Jefferys for information.

As more and more people became aware of his efforts – and the resultant success stories – other well-meaning souls have helped put the information out there. The very informative (and trustworthy) FixHepC.com site run by Dr John Freeman, based in Tasmania, is one example. Also there is a Facebook group called Hepatitis C Treatment Without Borders, which has only one motivation: disseminating factual information regarding hep C treatment, particularly the Indian connection.

On the ABC's 7.30 Report Jefferys said, *The only difference between me and the guy in Dallas Buyers Club is I'm not running it as a business and I'm not making any money out of it, as much as I like to see him with his big wads of dollar bills.'*

Predictably, with increasing media exposure, some of Jefferys' fears have indeed been realised. On his blog, he describes his discovery that Gilead has appointed a 'crisis team' to counter precisely the kind of 'threat' he poses, and suggests that the many doctors who have told their patients that sourcing drugs from India is illegal are victims of misinformation spread by Gilead.



Being the inquisitive soul he is, Jefferys does not shy from investigating the murky world of Big Pharma. *"How can I not seek to understand what forces have created this situation where a cure is available to some and not to others simply on the choices of some board of directors on huge salaries sitting in the luxury of their well-appointed office? How could I not get involved in the politics?"* His writing is well seasoned with accusations born of his outrage at the behaviour of drug companies – and who can blame him? We must merely be thankful that such selfless souls exist in our community, individuals for whom the welfare of others is just as important as their own.

The Golden Phaeton

Note. Much of the information in this article is derived from Jefferys' blog – *My Hep C Travel Diary*, published at: blogs.hepmag.com/Jefferysjefferys/2015/04/my_hepatitis_c_story.html

STOPPING A SILENT KILLER

Liver disease progression in individuals with hepatitis C.

Promising news to stop a silent killer of people who inject drugs

Hepatitis C is a virus affecting the liver. The liver has two main functions in the body. First, it processes nutrients. Second, it acts like a blood filter, responsible for processing substances like drugs and hormones and detoxifying harmful substances. No one can survive without a functioning liver. It is estimated that there are about 230,000 individuals living with hepatitis C in Australia. People who inject drugs are at greater risk of having hepatitis C. For instance, about six in 10 Australians who have injected drugs for three years or more may be living with hepatitis C.

Although yellow skin colour (jaundice) is a typical symptom of hepatitis C, the majority of individuals who acquire the virus experience no symptoms, or mild and non-specific symptoms such as tiredness and muscle pain that can resemble the flu or common cold. Given that most individuals with hepatitis C infection do not feel any symptoms, it is recommended that people who inject drugs do a blood test for hepatitis C every 12 months.

In about one in every four individuals who get (or who are 'exposed' to) hepatitis C, the body's immune system can clear the virus. These people will be spontaneously cured. This is why it is important to have a hepatitis C virus (HCV) RNA test (also called a PCR test, which tests for active virus), not just a HCV antibody test (which only tells you if you have ever been exposed to the virus, but not whether it's active). Individuals who have naturally cleared their hepatitis C infection (or who have successfully been treated) will still have a positive HCV antibody test, but will return a negative HCV RNA test. On the other hand, about three in four individuals with hepatitis C will not spontaneously clear their infection – the virus will remain in their body. This group of people is at risk of liver disease progression unless they receive hepatitis C treatment.

The progression of liver disease in individuals with hepatitis C involves the slow development of scar tissues in the liver, called liver fibrosis. As liver fibrosis progresses, liver function gradually deteriorates. While there are no major symptoms in the early stages of liver fibrosis, people with advanced stage liver fibrosis usually have multiple symptoms like yellow skin colour (*jaundice*), swelling in their legs (*edema*) and stomach (*ascites*), and confusion. Very severe scarring of the liver is called cirrhosis, in which healthy functioning liver tissue is replaced by scar tissue. Individuals with severe liver fibrosis are at greater risk of having liver cancer. Liver biopsy used to be the most accurate way to assess the stage of liver disease. However, a new test called a *FibroScan* is now available to assess the liver disease stage. A *FibroScan* is like an ultrasound for the liver and is painless, easy and fast.

On average, it takes about 30–40 years to progress from first getting hepatitis C to cirrhosis. Some factors accelerate the process like older age, moderate to heavy alcohol use, HIV, and obesity. To avoid this, it is recommended that people with hepatitis C reduce their alcohol intake, control their weight and, if they are also living with HIV, seek HIV treatment. Although all of these interventions are effective in slowing the progression of liver fibrosis, the only way to stop the disease and save the liver function is through treatment.

Unfortunately, the number of individuals who have ever received hepatitis C treatment is very low. Only 1–2 in 100 individuals with hepatitis C receive treatment each year. One of the reasons for this low treatment number was that interferon-based hepatitis C treatments, which used to be the only approved treatments available, could have severe side effects. Interferon-based treatments were also lengthy (24–48 weeks).

However, the good news is that new hepatitis C treatments have been developed and will be available in Australia soon (probably by 2016). These new treatments do not involve interferon, are simple (one pill, once a day) and short (8–12 weeks), have almost no side effects and, most importantly, will cure nine in 10 individuals with hepatitis C!

Considering the average time of 30–40 years from hepatitis C infection to cirrhosis (which can be shorter in people who have one or more of the accelerating factors), individuals who acquired hepatitis C in the 1970s and 1980s are at greater risk of developing cirrhosis and liver cancer. This is why there are increases in the number of people in Australia with hepatitis C related advanced liver disease and hepatitis C related deaths.

The new treatments inspire considerable optimism to stop hepatitis C as a major silent killer of people who inject drugs.



Behzad Hajari, Jason Grebely

Viral Hepatitis Clinical Research Program,

The Kirby Institute, UNSW Australia,

Sydney, Australia

THE HEPALOGUE @HRV.ORG/ HCV BLOG

So, given that we are in an exciting new age of Hep C treatment, Harm Reduction Victoria has decided to keep a blog, the first instalment of which you are reading now. It's aim is to keep you up to date with developments in world of hep c treatment, particularly in Victoria, but also in the wider world. We'll endeavour to keep you up to speed on anything that helps make straight the way for an end to hep c: how to seek treatment, current clinical trials, potential pitfalls and side-effects, and stories of those who are making – or have completed – the journey to the holy grail of SVR (Sustained Viral Response – or in common terms: a cure.)

At the time of writing, a potent regime called Harvoni (a pill produced by US Pharmaceutical giant Gilead Sciences containing sofosbuvir and ledipasvir) is well on the way to being funded by Australia's Pharmaceutical Benefits Scheme (having been approved by the TGA (Therapeutic Goods Administration) earlier this year (together with another new drug: daclatasvir)). Harvoni is targeted at those with Genotype 1 – by far the most common in Australia – although treatments for those with Genotypes 2 and 3 are sure to be forthcoming.

Not only do these drugs offer an extremely high rate of cure, but there is a possibility emerging that, instead instead of receiving outpatient hospital care, treatment may be available from a conveniently located GP.

Only the god Mammon stands in the way. Currently, price negotiations have been underway for some time between the Australian government and Gilead, who who have been criticised for their extreme pricing (\$1000 a pill is widely quoted). At the recent International Symposium on Hepatitis Care in Substance Users a call was made, in concert with 27 health organisations, urging Health Minister Susan Ley to step in on the haggling and demand a result by the end of the year. As things stand, the medical community is expecting Harvoni, at least, to be listed some time in early 2016.

Whatever the outcome, you will read it here in a timely manner, week by week.

Our next post will give you the skinny on those living with hep c who have decided not to wait for an end to government procrastination, nor to pay ridiculous sums up front for the drugs – but to take advantage of an affordable pipeline from India.

The Golden Phaeton

HRVIC.ORG.AU/CATEGORY/HCV-BLOG/

UPDATE ON HCV TREATMENT UPTAKE

*Jenny Iversen and Lisa Maher
Kirby Institute for Infection and Immunity,
UNSW Australia, Sydney, Australia.*

Currently around one in every two people who inject drugs in Australia have been exposed to the hepatitis C virus. Of those who have been exposed to the virus, around one in four people will get rid of the hepatitis C virus on their own (known as spontaneous clearance) but most people will remain infected (known as chronic infection). Chronic hepatitis C infection can cause scarring of the liver (cirrhosis), particularly among people who have been infected for several years. The risk of liver scarring increases as people get older.

The good news is that hepatitis C infection can be treated so that the body gets rid of the virus completely. The down side is that the side effects of current medications to treat hepatitis C in Australia (which include pegylated interferon injections and ribavirin tablets) need to be taken for long periods (six months or more) and a cure is not guaranteed. The exciting news is that the medications available to treat hepatitis C have improved remarkably in the past few years, with a number of new Direct Acting Antivirals (DAAs) [*sofosbuvir* (Sovaldi®), *ledipasvir/sofosbuvir* (Harvoni®), *daclatasvir* (Daklinza®), *paritaprevir with ritonavir, ombitasvir and dasabuvir* (Viekira Pak®)] coming onto the market. The new DAAs have several advantages over the current treatments, including a shorter course of treatment (12–24 weeks), higher cure rates and fewer side effects. It is hoped that these drugs will receive Government subsidy (they are very expensive) and that they will replace the existing treatments soon.

In Australia, people who inject drugs are eligible to receive hepatitis C treatment, so we took a look at how many people who have been exposed to hepatitis C had received treatment. The Australian NSP Survey is conducted at NSPs throughout the country every October and relies on the good will of about 2,000 NSP clients completing a questionnaire and providing a couple of spots of blood from a finger prick. These blood spots are tested to see whether they contain antibodies to hepatitis C (which indicates whether a person has ever been infected with the hepatitis C virus). If someone has never been infected with hepatitis C then treatment isn't necessary, so we looked at how many of the people who had been infected (and who knew they had been infected) had ever received hepatitis C treatment.

In 2014, 21 people (around two in every 100) reported that they had been treated for hepatitis in the past 12 months. However, one in 10 people reported they had ever had hepatitis C treatment. Men were more likely to report ever having hepatitis C treatment than women.

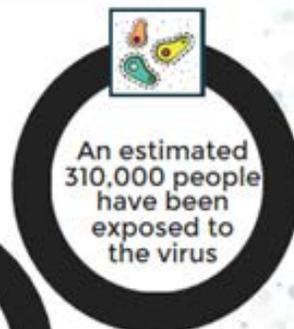
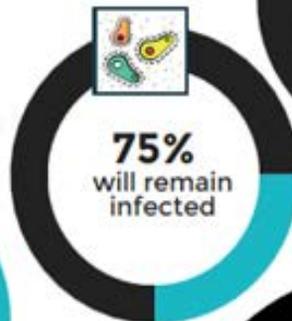
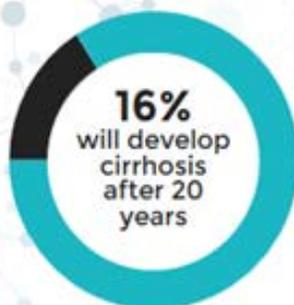
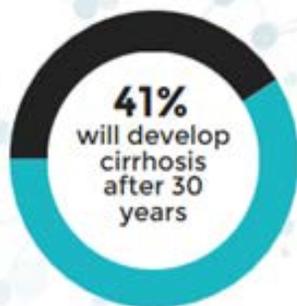
Several reasons have been put forward to explain the low treatment uptake among people who inject drugs. These include things like drug toxicity or side effects related to the current treatments, a lack of knowledge about where to go to get assessed and treated, concerns about not being eligible for or able to afford treatment, and fears about being discriminated against when seeking or undergoing treatment. Some doctors have also expressed concerns about whether people who inject drugs will take their medication regularly (adherence) and, sadly, some physicians feel that drug users are not worth treating because they might get re-infected. However, recent research has shown that these concerns are not based on evidence. Another important set of reasons for limited uptake of hepatitis C treatment among people who inject drugs relates to the treatment system itself and includes things like the lack of a clear referral pathway and the fact that most treatment is currently provided in hospitals rather than through primary care centres. These factors can be changed by providing the community with information about hepatitis C treatment options, educating doctors about people who inject drugs, and developing integrated models of treatment and care that move beyond hospital-based specialist clinics. In Australia, some alternative models of hepatitis C assessment and treatment targeting drug users have been established within primary health care, opioid substitution therapy clinics and prisons.

A key challenge over the next decade will be to increase access to treatment for people who inject drugs while ensuring that they continue to have access to hepatitis C prevention, including needle and syringe programs. Given growing evidence that treatment of people who inject drugs not only works but is cost effective and has the potential to decrease the prevalence of hepatitis C in the community, services that engage with drug users must consider how to best inform this group about the new treatments and how to access them.

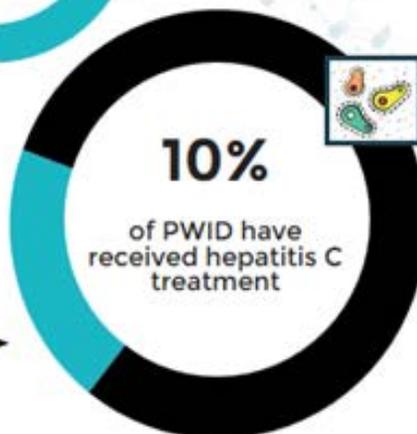


In Australia in 2014

1 in 2 people who inject drugs have been exposed to the hepatitis C virus



1-2% of PWID are treated for hepatitis C each each year



Health policy makers and service providers need to think about how to provide treatment and care in a way that best meets the needs of people who inject drugs. Finally, once the new drugs are available it will also be important to monitor how many people access hepatitis C treatment to ensure that people who inject drugs have equal access, particularly if these new treatments obtain government subsidy and become widely available.

Acknowledgements: We would like to acknowledge the Needle and Syringe Program clients that have participated in the Australian NSP Survey over many years, as well as the ongoing support and assistance provided by both staff and management at the participating NSP services. Jenny Iversen is a National Health and Medical Council (NHMRC) Early Career Fellow and Lisa Maher is a Professor, Program Head and NHMRC Senior Research Fellow at the Kirby Institute.

Further reading:

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THE DOCTOR AND THE DEA

Sarz Maxwell visited Australia some years ago as a strident advocate for naloxone distribution among people who inject drugs. Many of you may remember her – I know I do. She was one of those rare and unforgettable champions and she was truly charismatic and inspirational.

“The casualties of the war on drugs aren’t just those that use them”.

In every battle there are winners and losers. In the fight between the conservative politics of abstinence vs the often more humane, accepting harm reduction approach, the battle lines are clearly drawn – although the winners and losers aren’t always so clear.

The most obvious victims of this war on drugs are those that remain the most disenfranchised, stigmatised and most poorly represented – i.e. people who use drugs.

So much of how we see, think and feel about drugs has been drip fed by the media. The nightly news of ‘methamphetamine monstrosity’ – never more distant from the truth – has created a pervasive sense of fear in the Victorian public. The statistics don’t support this news, but such is the way of the media room – when statistics don’t support the story, the narrative seldom changes, the statistics are just omitted.

So, this war on drugs, this war on people, has many causalities: the users, the parents of drug users, fed on a diet of fiction and fear, and the sector itself, in the bun fight for money, trying to survive, to continue to support those they serve.

And what about the medics? The doctors who put themselves for their patients, who give endlessly of themselves to ensure that their patients actually get quality healthcare, without the discrimination? Well, sometimes they fall victim too.

The systems underpinning treatment are enough to dissuade most GPs from helping in the first place. For those that do, they take on an extra work load due to the complex needs of those most in need, because stigma and discrimination have prevented them from getting timely care.

So these ‘saints’ (and I choose the word purposely) exist out there, like beacons of light for those whose health and wellbeing has been left in the dark to fester. And they bring health and life and hope to people the system chooses to neglect.

So, when they themselves fall prey to the system, they fall, often alone, usually without support. And we all suffer. Sarz Maxwell is one such figure, one such saint.

I met Sarz first, albeit briefly when she visited Victoria to speak about Naloxone. ‘Dead addicts don’t recover’ was one of Sarz’s oft quoted statements and it stayed with me for some time; it galvanised my work and inspired me to bring Naloxone to as many people as I can.

But Sarz was known to others for so much more. Her work has touched many lives, and saved the lives of many, many, more. So the cruel fate that befell Sarz is all the more difficult to bear... but I’ll let Sarz tell you the rest...

Craig Harvey

I've always preferred working several different gigs to being in the same office 40 hours a week. My part-time private practice gave me freedom to work at homeless shelters, to do talks and trainings, to volunteer with Chicago Recovery Alliance (CRA).

When Suboxone was approved in October 2002 I was one of the first physicians to prescribe it. I love opiate substitution treatment (OST) and those who are dependent on opiates, and Suboxone let me bring it all into the comfort of my private practice, which I ran out of my apartment so my cat could be co-therapist. My practice had a certain reputation: many, possibly most, of my patients had been fired by other doctors, thrown out of treatment programs, and otherwise set adrift. My colleagues would ask incredulously, "You allow your patients to use drugs?!" I would counter with "Do you allow your cardiac patients to eat steak?" to which they would reply, "Naturally I advise against it, but if they decide to do it anyway, what can I do?" "Do you throw them out of your practice?" I would ask. They'd look as if I was the crazy one and say indignantly, "Of course not!" And then they'd be puzzled when I'd just nod.

One rule I had with all my Suboxone patients: I was the only doctor prescribing them opiates. If they had a root canal or knee surgery or whatever, all their pain meds came from *me*. Other docs don't like prescribing pain meds to people who use drugs and they usually do it very badly. And this way my patients could teach me how to combine Suboxone with pain meds – theoretically it can't be done, but we figured it out together.

Beginning about 2006, I noticed that many of my new Suboxone patients were not dependent on heroin but on prescription opiates, a trend observed nationwide. A few of these patients (a total of seven from 2006 to 2012) had chronic pain and I kept the same rule: I prescribed their pain meds; for these seven I just kept prescribing the pain meds chronically.

In 2010 Angelia Young of the DEA came to my office and informed me I was not qualified to treat pain. Silly me, I responded – I distinctly remember going to medical school. Doctors treat pain. Dentists treat pain. Even podiatrists treat pain. How could I not be qualified to treat pain?

She asked if I was certified in Pain Management. No, I told her, I am an Addiction Psychiatrist and as such I am uniquely qualified to treat pain in opiate users. Not so, said she – only doctors certified in Pain Management are qualified to treat *chronic* pain.

This is, of course, insane: there are only a few thousand doctors in the entire country certified in Pain Management; they can't manage everyone who has chronic headaches or back pain! And remember, in my practice we're talking about seven patients. Not exactly a Pill Mill. But it's not her job to be reasonable.

She made various allegations over the next year, none of which made sense. She told me a patient was getting opiates from other docs. I confronted the patient and he was devastated.

He provided proof of his innocence; thankfully he was a forgiving soul so we were able to repair the rift in our relationship caused by my false accusation. So when Angelia told me other patients were doing naughty things, I checked it out before I traumatized the patient, and it was always untrue. Not one of her allegations had any credibility; I believe she out-and-out made them up. Worst of all, *she went to a patient's home* and asked him about his prescriptions, then ordered him, "Don't tell Dr Maxwell I was here". That's when I got really mad. Harass me if you will, but do NOT mess with my patients!

Switch gears: I've been a Tolkien fanatic since I first read the Trilogy at age 12. I had dreamed of living in New Zealand since 2000, especially after I visited NZ in 2002. Angelia Young's harassment was not the reason I emigrated to New Zealand ... but she helped! I remember thinking, "If you don't like the way I practice medicine, I'll find someone who does." For a multitude of reasons, in April 2012 I moved to Palmerston North New Zealand.

In January 2013 my DEA registration was due to expire and I renewed it online. It's not possible to use an overseas address on a DEA certificate so I used the address of Chicago Recovery Alliance: I had worked with CRA since the mid-1990's, had been their medical director since 1999 [when we unleashed Naloxone!] and CRA agreed to be my US address for professional correspondence.

I was in New Zealand from April 2012 through October 2013. I was back in the US only 36 hours when Angelia contacted me by email. She told me that using CRA's address was falsification (because I was in NZ when I made the application), so she had cancelled my application and I now had no DEA Certificate. I had also (naturally) used CRA's address on my medical license so she invited Illinois Department of Professional Regulation (DPR, the licensing board) to join the party; within two weeks I received a letter informing me DPR was lodging a formal Complaint against my medical license.

Is all this alphabet soup kind of confusing? Believe me, I'm simplifying it to try to make it more comprehensible. Agencies, be they State or Federal, delight in discombobulation and adore obfuscation.

In December 2013 I'm still thinking that all this is going to be worked out – it's about an *address* for chrissake – and I'll be going back to work. I wasn't worried about looking for work; I haven't had to look for work since I graduated medical school in 1984. Work looks for *me*, and then I decide which gigs to accept.

But at this point I'm not working, and my savings are evaporating, and no landlord is going to give me a lease. That's when Dan Bigg rides in on his white horse and tells me I can stay in the CRA warehouse as long as I need to. CRA also pays the retainer for a lawyer who specializes in this sort of dispute.

Now begins the waiting game. My lawyer assures me that DPR will probably just put my license on probation.



THE DOCTOR AND THE DEA

But I've got Angelia spreading good cheer, so there was a real possibility DPR might completely revoke my license.

I certainly couldn't job-hunt when I couldn't tell employers *if* I would be licensed at all, let alone *when*.

In October 2014 (one year after my return to the US), DPR agrees to issue my license on probation. There are lots of conditions, like I have to hire a Practice Monitor, a doctor who would review 10–15 patient charts quarterly and report to DPR that I was being a good girl. All this is par for the course with a license on probation, but they added a twist, one that my lawyer said she's never seen before: my probationary license specifically states that I may not have a private practice.

In the past, doctors whose licenses were on probation could always work at Federal hospitals (Veterans Administration; Armed Services); they knew that grateful docs were likely to be great docs. But today, Federal facilities are prohibited from hiring a physician whose license is on probation. I get 20 or 30 job emails daily, but they all specify *no probationary license*.

And even if an employer were willing to overlook my probationary license, I've got this big red **DEA** embroidered on my breast; I am under DEA's spotlight, and hiring me brings that spotlight on to your practice. And you don't need to do anything wrong for DEA to take away your life. You just need to come to their attention and they'll make it up from there, like that some doctors can't treat pain or your address is wrong or whatever. It's not their job to be reasonable.

Other doctors whose license is on probation find a friend or a colleague to hire them as a favour, but I can't do that to a friend! Other doctors on probation see private patients; particularly in psychiatry, where the only equipment needed is a box of tissues. It's hard, it takes years to build up a private practice, but it's *something* coming in. But I am specifically prohibited from operating a private practice.

Just before Christmas 2014 I moved into my sister's basement. My sister and brother-in-law (Marty and John) have been great. They live at a Fundamentalist church camp where John is the facility manager. My car was repossessed but John works there at the Camp so he lets me use his car. They've been wonderful, but Marty and John want their home back. They just got the last of their three kids out, working or married, and they deserve the luxury of an empty nest after all these years.

It hasn't been a total waste of time, these past 20 months. It's harder to quilt without a sewing machine, but I now have a quilt on my bed that's been stitched completely by hand. I've

also written a novel; I'm just doing the final editing on that. I've written two novels before, but this one I'm going to publish. Anybody out there a fan of gay romantica, set in Chicago's Boystown? I'll let you know when I self-publish on Amazon!

And there's somebody I need to acknowledge here. My cat Zach has played with weta bugs in New Zealand, has prowled among the syringes in CRA's warehouse, has chased squirrels at Marty and John's house in Camp Hickory. He doesn't care much for travel but he's happy wherever we are, so long as we're together. He has been the most loyal friend and the staunchest little companion anybody could ever want. I very literally would not have survived the past twenty months without Zach.



My last meeting with DEA was this past Spring. At that meeting Angelia told me she could not issue my DEA certificate because for a DEA certificate you need an employment address, and I do not have an employment address. She informed me that just as soon as I get a job, I can submit my application to her – NOT online and NOT to National DEA – Angelia specified that if Washington receives the application they will send it right back to her. Angelia will then personally review my application and decide how she feels about issuing a DEA certificate to me.

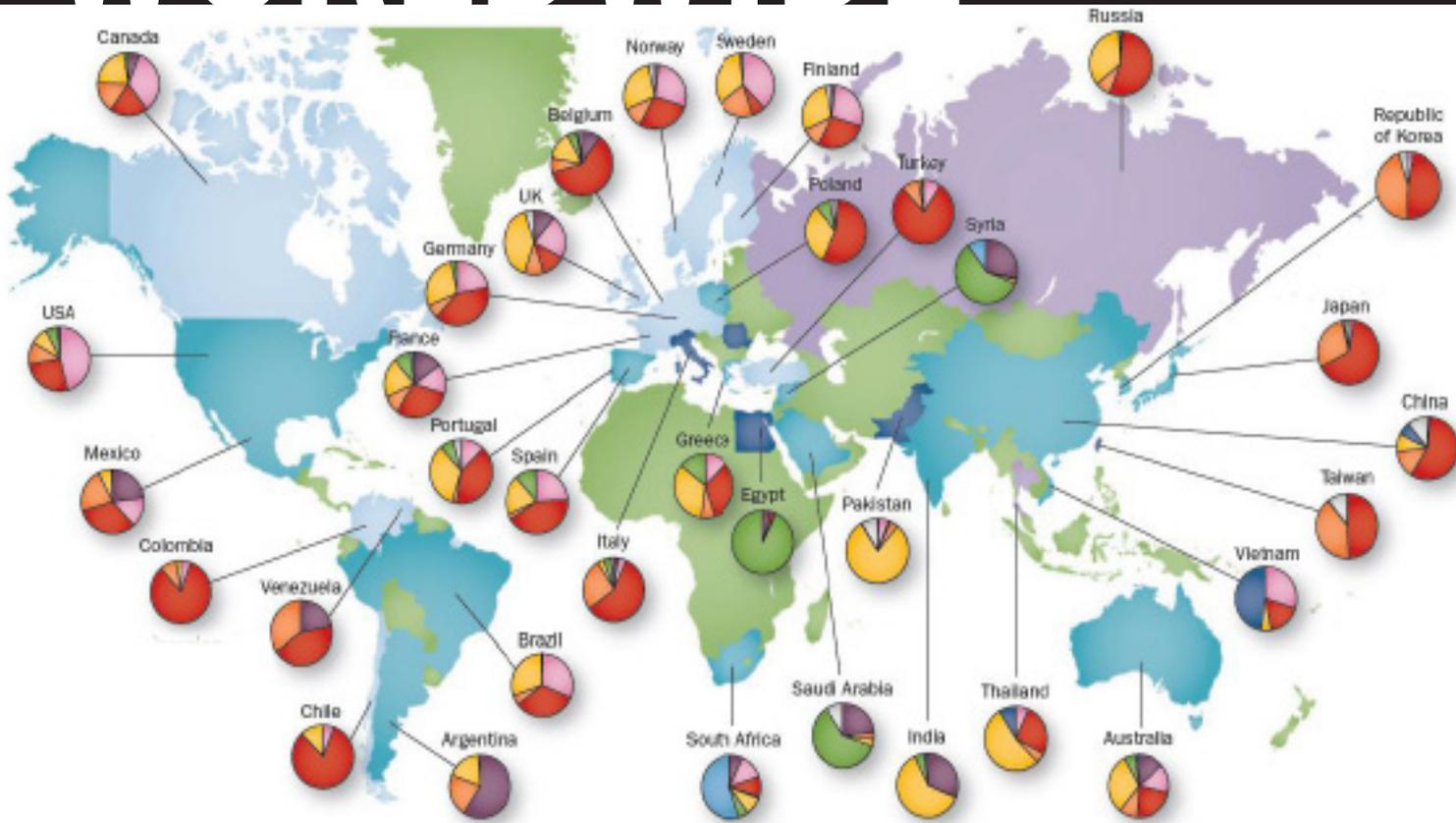
I'm slow; these things take me awhile, but it all finally came clear to me. If I had done anything *wrong* I'd be in prison; Angelia would absolutely love to see me in orange. She has had to be content with seeing me on Medicaid and Food Stamps, and she will do everything in her power to ensure I remain on Medicaid and Food Stamps. She will never allow me to work as a physician.

I won't practice medicine again. That's hard to get used to; I've been working at or toward being a doctor since the 1970s. And I've had *so much fun* as a doc! As a doc I got to be out front for higher-dose methadone. As a doc I got to be out front for Suboxone. Best of all, as a doc I got to be out front for *naloxone*! I am prouder of my role in naloxone distribution than of anything else I've done in my life.

Is this the price I pay for all that joy?

People who use drugs are only the most visible of the Drug War's victims. Because of our insane laws, drug users have done something 'wrong', so it's easy to victimize them. But you don't have to do anything wrong. All you have to do is come to DEA's attention, and they can step in and – *whoosh!* – they can take your life away.

HCV GENOTYPES WORLDWIDE



GENOTYPES

G1 G1_A G1_B G2 G3 G4 G5 G6

* * MIXED OR OTHER

PREVALENCE OF HCV INFECTION

<1.0% 1-1.9% 2-2.9% >2.9

* * NOT STUDIED

THE CUPID PROJECT

COUPLES WHO INJECT DRUGS

This project focuses on hepatitis C risk and prevention in couples who inject drugs. Couples are important to think about for a number of reasons.

Transmission of hepatitis C occurs when more than one person is present. Surveys of people who inject drugs show that about half report sharing injecting equipment with a sexual partner. Relationships between couples have unique qualities – love, trust, intimacy – that typically aren't present between friends or acquaintances and may also lead to the increased likelihood of sharing.

We also know that hepatitis C health promotion and prevention materials are typically developed for individuals. The social environments and relationships of people who inject are not acknowledged in these materials. Our research provides a great opportunity to understand how couples negotiate injecting and hepatitis C risk in their relationships.

We also wanted to consider how couples who inject are usually talked about. Couples who inject can be seen as not as “authentic” as other couples. That is, stereotypes of couples as more in love with a drug than each other may influence how workers or services perceive them. This has been a very important stereotype for our research to avoid.

We made these arguments to the National Health and Medical Research Council who funded this research into heterosexual couples who inject. We recognise the importance of hep C for other couples and the need for specific research in these areas too.

What did this research do?

In this project, we interviewed couples and harm reduction workers in Sydney and Melbourne. We asked them about injecting drug use, hepatitis C and partnerships. Was hepatitis C relevant to their relationship, for example; or how was injecting with their partner different from using with friends? We wanted to focus on participants' 'lived experiences' of relationships. We particularly wanted to better understand the role of couples, as not only crucial sources of care, support and stability but as influential sources of injecting practices, including those negotiated around injecting drug use.

What did the couples say?

For many participants, trust was the important feature of their relationship, and of their drug use. Trust was related to safety and security generally, as well as a part of how couples negotiated hepatitis C risk. Nearly all participants described rules they had negotiated with their partner around injecting drugs with others. Following these 'rules' was central to creating and maintaining trust and intimacy within the relationship. For some couples this meant agreeing not to inject with anyone outside the relationship.

Many of our participants reported doing 'everything together'. Being together (physically and emotionally) meant that couples knew 'everything' about each other. That is, couples came to know about the details of each other's injecting practices, blood test results, and medical check-ups. This knowledge helped build trust between partners and influenced how couples managed hepatitis C risk.



Importantly, participants' perceptions of risk (and safety) were not fixed but changed over time. Couples' sense of which injecting-related practices were risky evolved over their relationship. For some couples, a growing sense of emotional closeness led to a 'relaxation' of attitudes towards hepatitis C. In these cases, efforts to keep injecting equipment separate decreased as the relationship became more 'serious'. For others, however, their injecting

practices became 'stricter' over time – after gaining a clearer understanding of 'genotypes', for example, or after beginning hepatitis C treatment.

Decision making about managing risk was a complex, confusing and at times contradictory process for these couples. Most saw their relationship as a safe and trustworthy space. Sharing needles/syringes with one's partner was almost always described by participants as a 'last resort' and not something to be considered with anyone else.

Our study challenges the stereotypes of couples who inject drugs as 'drug-driven' and 'unhealthy'. Participants commonly talked about love, care and commitment when describing their relationship. The priority for participants was to keep themselves, their partner and their relationship healthy and safe. For many, their relationship was an emotional refuge or safe haven. Couples relied on their relationship as a form of protection in a world that participants saw as often hostile and stigmatising.

What did the workers say?

The experiences and opinions of workers we spoke to in Sydney and Melbourne were similar in many ways. Most workers felt that they had little experience working with couples in harm reduction. Some felt that couples have the same needs as individuals for hepatitis C prevention. The stereotype of couples (as being more in love with the drug than each other) was also discussed by some workers. Workers also tended to focus on relationships that were “in trouble” with issues such as domestic violence. The love and care that couples have for each other were rarely mentioned. This led us to conclude that there is a lot of work to be done with harm reduction workers when discussing how the strengths of couples could be used for hepatitis C prevention.

So, then what? Developing hepatitis C prevention for couples

If we want to do better in hepatitis C prevention, and reduce the sharing of injecting equipment, we need to recognise and work with the strengths that are to be found in the relationships between couples who inject drugs. This also means that we need to change how we do hepatitis C prevention to include messages and strategies that are relevant and meaningful for couples.

With these findings, we decided to challenge ourselves to think about how hepatitis C prevention could be done differently. We set about trying to design new messages that “speak” to couples and their experiences. We also challenged ourselves to look at injecting equipment and how it is delivered – does it work for couples?

We produced a series of new posters specifically tailored to reflect on the care and love of couples. We also wanted to frame these positively, rather than use negative language or images. To accompany these, we also thought about whether the “fitpack” could be redesigned. We used a 3D printer to produce our “fitpack prototype”. The prototype had the same overall size of a regular fitpack, but it was designed to have two separate chambers to hold sterile equipment and included separate disposal slots. The two chambers were labelled as “yours” and “mine” and could be snapped apart to practically and symbolically split the two chambers.

We also included some information aimed at a more equitable distribution of responsibility for hepatitis C prevention. Rather than just blaming the individual or the couple in this case, we tried to indicate that government, society, and the health system all have a role to play in hepatitis C prevention. If these things aren’t in place, we just can’t blame people at the end of the chain if hepatitis C transmission does occur.

We gave these new messages and fitpacks to couples for their feedback. We didn’t expect to produce the perfect new message. But we did want to get the conversation started. How can we do hepatitis C differently and in a positive way that acknowledges the love, care and intimacy of couples?

So what’s next?

When we think about this project we have to acknowledge that some couples who inject have major difficulties and these difficulties take priority in any interaction. However, most couples have relationships that are based on genuine care and love. In most other areas of health, a person’s partner is seen as a resource to draw on. It seems strange, then, that couples have been so absent in hepatitis C prevention efforts.

We hope that this project is the start of more work in hepatitis C that has a broader focus than the individual and tailors efforts to specific groups of people. We know that best results are achieved when strategies match the needs and experiences of the target group. This project has focused on how to best connect with and mobilise heterosexual couples for hepatitis C prevention. Even within this group, different couples will be reached via different messages. For example, “new” couples have different experiences compared with couples in longer-term relationships; or homeless couples may need strategies that recognise they are not able to store extra equipment, unlike couples in stable housing.

Hepatitis C prevention efforts to date have had limited success. We need to do something different, something out of the box, something that cuts through and hits the mark. We hope that we have helped to kick start a new era of innovation.



nsw.edu.au/research/projects/cupid-project

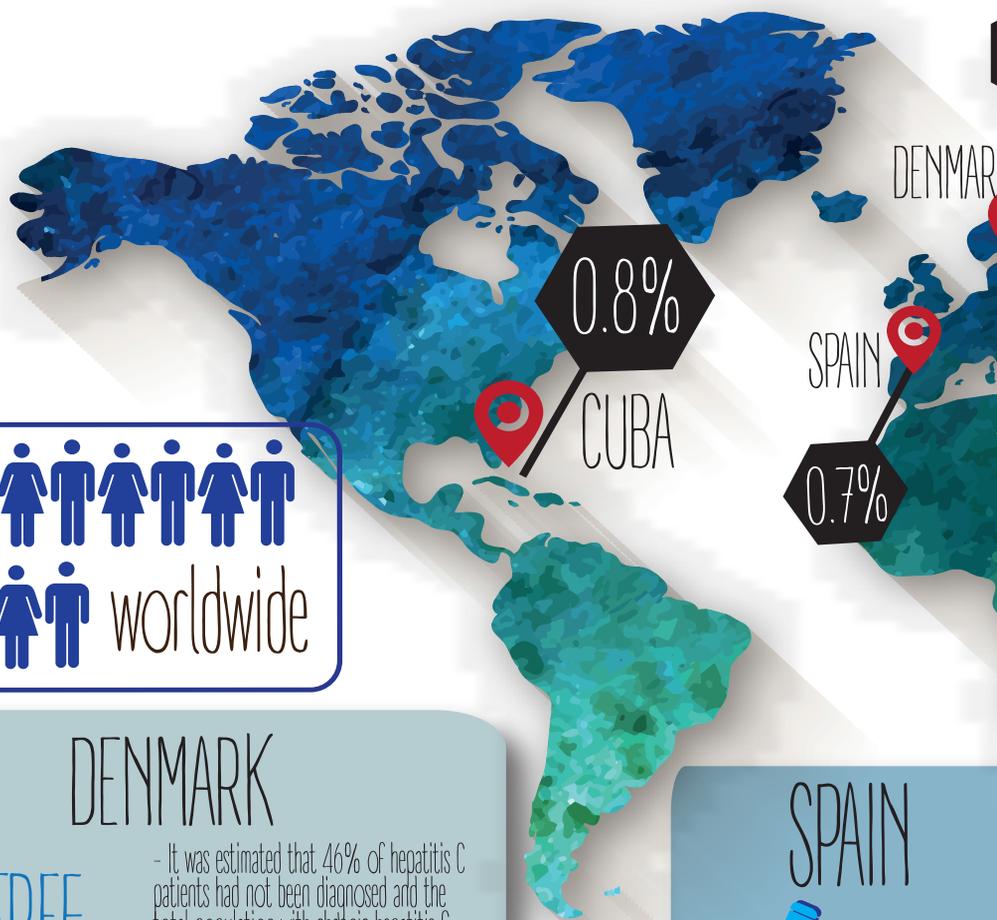
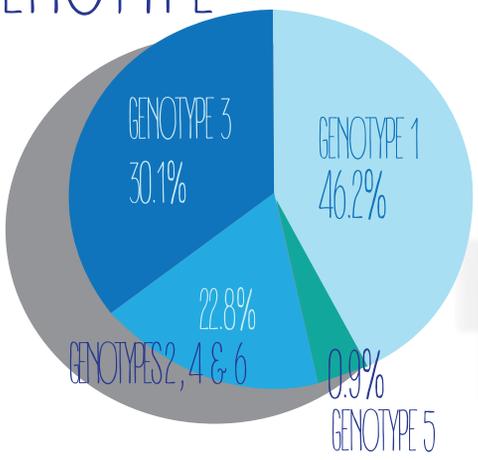
Acknowledgements

We would like to thank all the participants who so generously shared their time and insights. The chief investigators of this project are Carla Treloar, Suzanne Fraser, Joanne Bryant and Tim Rhodes, along with the associate investigators, Nicky Bath and Mary Ellen Harrod and researcher, Jake Rance.

HEPATITIS

GENOTYPE

PERCENTAGE % OF WORLD POPULATION



150-170 MILLION INFECTED worldwide

CUBA

FREE

PUBLIC \$

- Government has strategies in place for Hep C prevention
- Dedicated government dept- 22 full time staff responsible solely for Hep C related activities

DENMARK

FREE

PUBLIC \$

- It was estimated that 46% of hepatitis C patients had not been diagnosed and the total population with chronic hepatitis C in Denmark was 16,888 (95% C.I. 16,474-18,287), corresponding to 0.38% (95% CI 0.37-0.42) of the population over 15 years of age.
- Government collaborates with civil society groups to implement and control programs.

SPAIN

FREE

PUBLIC \$

- Government has NO written national strategy or plan for viral hep prevention or control
- Government doesn't collaborate with civil society groups

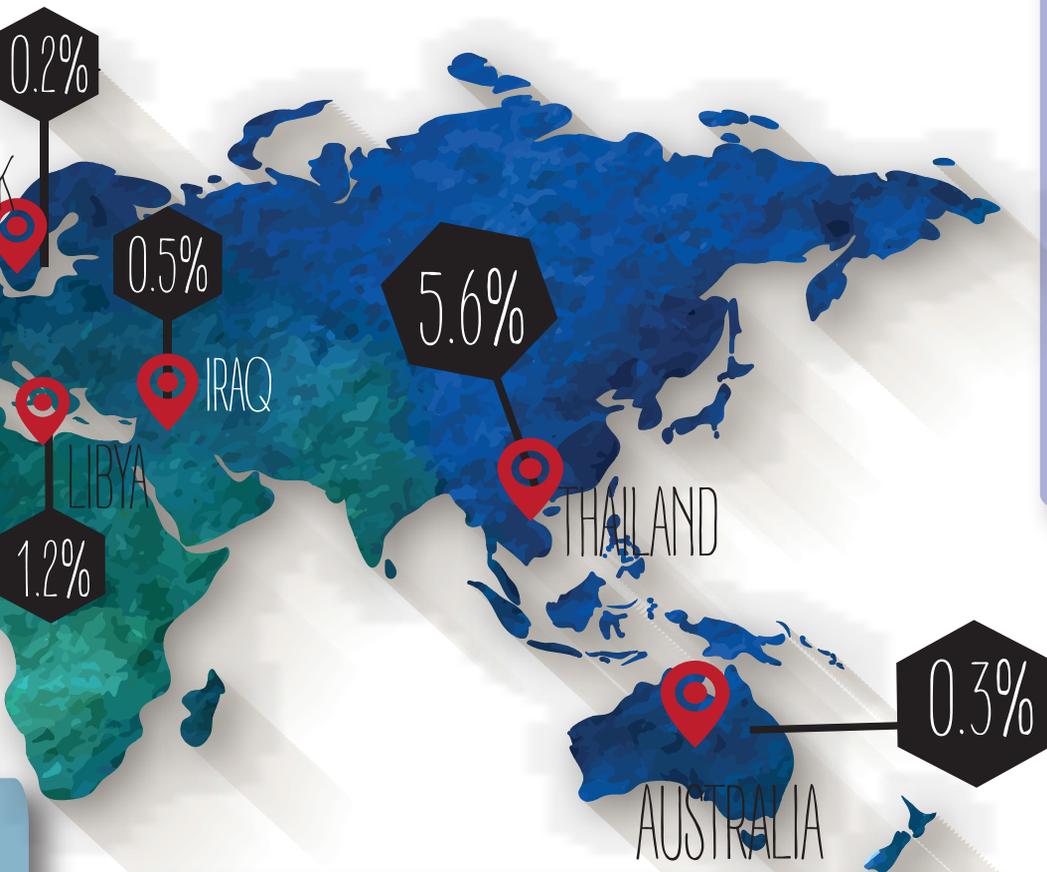
LIBYA

- Prevalence increased gradually after the age of 30 years (0.7-0.9% for < 30 years; 3.6% for ≥ 60 years)
- There was an association between literacy and hepatitis C prevalence

KEY:
 = TESTING = TREATMENT

IS...SEE?

POPULATION LIVING WITH HEP C



THAILAND



FREE For Blood Donors, Pregnant Women & Civil Servants



NO HEPC drugs On essential medicines list

- Government has NO written national strategy or designated government department
- Government does not collaborate with civil society groups

ONLY
85% OF AUSTRALIANS living with CHRONIC Hepatitis C have been **DIAGNOSED**
WHICH MEANS

* **15%** are UNWARE that they HAVE been infected

WHEN
 WERE YOU LAST
TESTED?

AUSTRALIA



FREE With a MEDICARE CARD

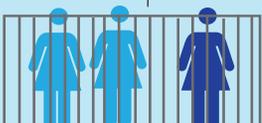


NEW INTERFERON FREE TREATMENTS are STILL YET to be AVAILABLE THROUGH PBS - the GOVERNMENT is STILL NEGOTIATING with drug companies

-Trials of new interferon-free treatments are currently the only way to access these medicines.



Recent studies indicate that 1 in 3 male prisoners now has hepatitis C antibodies.



2/3 of all female inmates are, or have been infected with hepatitis C

36 YEARS

HEP C AND ME

Hello, my name is Humble Ginnens and for the last few years my sleep has been full of dreams that wake me three, four, five times a night. They aren't exactly the same dream, but the theme is always the same. Every time I go into a supermarket or any kind of business, I can't get served. People ignore me, shut up shop or stop serving the line I'm in just as I get to the front. I have a theory on why I have these dreams, so please indulge me for a minute.



I have only been able to formulate this theory since my dreams have begun to ease. You see, I've been living with the hep C virus for 36 years. Five years ago, four weeks after my brother died from hep C and eight weeks before my oldest friend also died from the virus, I found out that I had cirrhosis of the liver. It was decided by the head of the Liver Clinic and at my urging that I would undergo the standard treatment for hep C (i.e. Interferon and Ribavirin) for the third time, with the hope of reducing the ongoing damage to my liver until new treatments became available.

I popped along to my appointment to start treatment and in came a doctor I had never met before, very upset that I had been put on his list. In fact I've got to say he was 'livered' (livid).

He wandered out to the front desk, which was in a crowded waiting room, demanding at the top of his voice, "Why is he on my list?" He then strolled up and down the hall, checking rooms, trying to find whoever was responsible. When he came back, I suggested I leave so that his humanity could remain intact and I did just that.

I went to another liver clinic but after four months I was told that the new drug regimens were still year away. I transferred to yet another clinic that claimed to be starting to use the standard treatment drugs, Interferon and Ribavirin, in combination with Telaprevir . . . But it also never came to be.

In October 2011 I received a letter from my new liver clinic welcoming me to the new program, which they hoped to be starting before Christmas. I didn't start the treatment until July 2015, almost four years later. In that time I saw many doctors, always consultants and I never actually met my treating doctor. One thing they all had in common was that they moved me along as fast as possible. Maybe I wasn't sick enough to warrant their undivided attention. Even when I was told that I had liver cancer, I was with the doctor for less than two minutes. The doctor called me in and confirmed my name and patient number. He then informed me that my ultrasound was clear, to my great relief, as my blood tests had indicated I may have cancer and it had taken another seven weeks for me to get a confirming scan. However, there was no mention of the CT scan. "What about the CT?" I asked. "Uh?" he grunted, without looking at me. "The CT" I said again. He looked through my file and found it straight away. "Oh, yes, here it is. It looks like you have a tumour on your liver. Someone will call you next week. Bye". I stand corrected – total time with the doctor was nearly three minutes!

I'd been waiting more than three years to start some kind of treatment, because I was worried about the possibility of this exact scenario. "Don't draw any conclusions," they said. I was quickly booked in for surgery to have the tumour 'cut out' and the surgeon did a great job and treated me with true humanity and compassion. The only downer was the anaesthetist, who despite access to all the relevant information, refused to give me the appropriate amount of anaesthetic and I woke up as soon as they began cutting into my liver. A wonderful nurse helped me through those traumatic moments and even apologised to me afterwards in recovery.

Two days after the surgery, they decided to drop my pain medication to Panadol only and that's when I asked them to pull the drain out of my ribs and I went home. One year later, I finally got to start the new liver treatment, this time with the new antivirals.

I'm no shrinking violet and I know how to stand up for myself. It has been a long, hard struggle to be heard, which only leaves me to wonder what happens to people who aren't so bold or so loud. I've been subjected to a long history of abuse and prejudice, and I know that I'm not alone. I watched my brother die as he was suspended from the liver transplant list for smoking a cigar on Christmas Day, his sole transgression. We had both long ago given up drinking and were craving a treat for Christmas. Six months later he was reinstated to the transplant list and to our joy he soon received a healthy liver. But it was too late. Within two weeks, a secondary cancer was found in the flesh around his ribs and two months later, seven young kids lost their Dad and my mother lost her son. I've watched many of my old friends die preventable deaths.

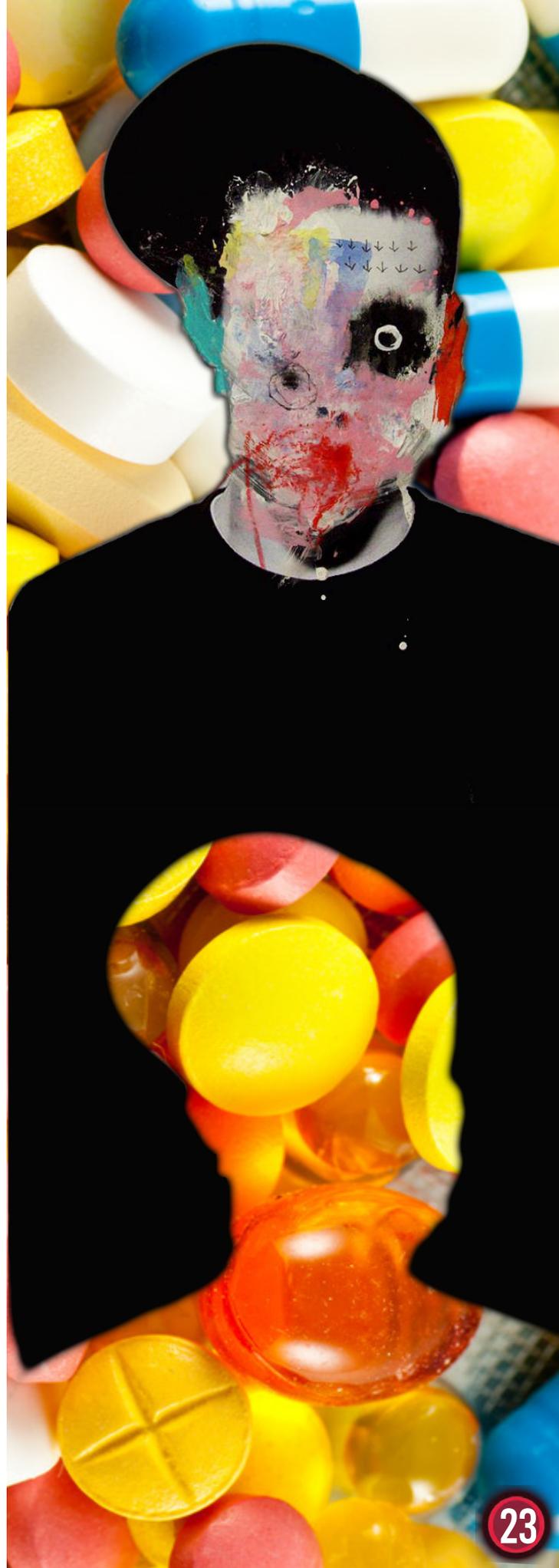
Although it is only a fraction of my story, I have had trouble writing this article without weeping because my story is also the story of my friends and family and all those I love.

I had one bright young doctor claim that I was too sick for treatment, and then that I was not sick enough to warrant a place on the new treatment list only six weeks later. My job network provider made an appointment for me to come in for an interview three days after my operation. Even when the surgery was confirmed and verified by my doctors, my in-attendance constituted a 'breach' and I was cut off my benefits. Nice one, mate! These days I'm so broke I can't even afford the correct spelling of my Nom de Plume!

I wonder sometimes if these people realise that I am just like everyone else, that I wake at four in the morning, and I try to face death with some dignity. I wonder what will happen to my two young boys if I die tomorrow. I think of my brother with too much dignity to lie about having a cigar.

When I contracted HCV I was only 17 years old and very lonely, trying to connect in a big city, 800 miles from home. Still, there are those that will condemn me. I think maybe the zealots make their decisions based on their beliefs and bigotry, rather than on the evidence. It's my belief that no one has the right to control another adult's life, body or thoughts, when they're not harming others. In fact, prohibition may just be the product of mass insanity.

Yours Truly,
Humble Ginnens



ELIMINATING

HCV

THE ELIMINATION OF HEPATITIS C AS A PUBLIC HEALTH PROBLEM FROM AUSTRALIA BY 2030. THE NEED FOR A STRATEGIC APPROACH THAT STARTS NOW!

By Margaret Hellard and Campbell Aitken

I believe that in medicine and in health there are *moments* where in a short space of time incredible advances can occur that change the course of an infectious disease and lead to major improvements in human health.

I have now had the privilege to be part of two such moments. The first was in 1996 with the advent of highly active anti-retroviral treatment for HIV. Many of my patients who were sick and dying from HIV/AIDS were able to access treatment; it enabled them to recover their health and although still infected with HIV, remain well and fully engaged in their lives. Most are still alive and well today – it was and still is a wonderful thing!

The second moment is right now: with the advent of highly effective interferon-free treatments (direct-acting antivirals, or DAAs) we have a cure for hepatitis C. This cure only requires the administration of tablets (with minimal side effects) for 8–12 weeks.

We should not underestimate the significance of this moment. The advent of these new treatments means that if we work together and develop a clear strategic pathway we can **eliminate hepatitis C as a public health problem by 2030 in Victoria, in Australia and globally.**

Background

By way of background, hepatitis C affects approximately **130–150 million** people globally and an estimated **350,000–500,000** people die each year from hepatitis C related liver diseases. Over **230,000** Australians are living with chronic hepatitis C infection and **630** Australians died from liver cancer and liver failure caused by hepatitis C in 2013. Currently only **1–2%** of people with chronic hepatitis C are treated annually in Australia.

If there is not a substantial increase in the delivery of hepatitis C treatment in Australia, the number of people with chronic hepatitis C infection will continue to grow, as will cases of cirrhosis and hepatocellular carcinoma and deaths due to liver disease.

However, with the new interferon-free therapies and improved understanding of the effectiveness of harm reduction interventions the infections and deaths can stop. It is possible to **eliminate hepatitis C as a public health problem in Australia by 2030.**

Elimination targets

At the World Health Assembly to be held in Geneva next year, it is highly likely that targets will be set for the



elimination of both hepatitis C and hepatitis B. The World Health Organization (WHO) has already developed these targets; I was privileged to be part of the working group advising WHO, and I assure you they weren't plucked out of thin air. For hepatitis C they were based on our understanding of the impact of harm reduction programs to reduce transmission, quality tests that can accurately detect the infection, and the new treatments that can stop deaths and stop the transmission of the virus.

The global targets currently proposed for hepatitis C (HCV) are:

- ◆ 80% reduction in HCV incidence by 2030 compared with 2010; and
- ◆ 65% reduction in HCV-related deaths by 2030 compared with 2010.

Achieving these targets by 2030 will require reaching ambitious milestones:

- ◆ 90% of people with HCV diagnosed by 2030;
- ◆ 80% of eligible people treated by 2030; and
- ◆ 90% of those treated are cured by 2030.

This is not pie in the sky or the stuff of dreams. For reasons I will outline in a moment, it will be possible for Victoria and Australia to achieve these targets by 2030. Key to our success will be to decide *right now* to achieve elimination by 2030, and then to develop a clear strategy that starts us along that path.

To successfully eliminate hepatitis C we require a multipronged approach that includes engagement with affected populations. In Australia the vast majority of people infected with hepatitis C have a history of injecting drug use. Other key populations include prisoners, Aboriginal and Torres Strait Islanders, men who have sex with men, and people born in countries with high levels of hepatitis C. To successfully eliminate hepatitis C we must engage with all these populations.

Other key things we must address, some of which I will touch on briefly and others I will consider in more detail, include:

- ◆ reducing the stigma associated with hepatitis C;
- ◆ increased testing for people at risk of hepatitis C;
- ◆ increased access to high-quality harm reduction programs, namely opioid substitution therapy (OST), needle and syringe programs (NSPs) and peer education about safer drug use; and
- ◆ increased access to treatment for all people – including people who currently inject drugs (PWID).

In our strategic approach:

1: We need to make hepatitis C antibody testing and hepatitis C RNA testing easily accessible to all people at risk of hepatitis C.

It is vitally important that people know their hepatitis C status so they are aware they should access care. Other benefits include PWID reducing their injecting risk. Work undertaken by the Burnet Institute and others has shown that PWID who know their hepatitis C status reduce their injecting risk behaviour. As well, from a clinical perspective, people can be advised about safe levels of alcohol use and whether it would be advisable that they reduce their alcohol intake.

We need to think about how to expand access to testing – where tests should be performed, the use of rapid point-of-care tests, one-stop shops and the like. We need a variety of models to increase testing; no one who has hepatitis C should be undiagnosed.

2: We need to develop guidelines that specify frequent and regular HCV testing for PWID

As a model, we already have STI/HIV testing guidelines for gay and bisexual men, and chlamydia testing guidelines for young people.

ELIMINATING HCV

In addition, people in other high-risk groups should be offered hepatitis C testing. As outlined previously, timely detection of disease reduces injecting risk and offers the opportunity for early treatment.

3: We need to build capacity and train health service staff.

Service staff working with high risk groups need the skills and knowledge to offer hepatitis C tests, to provide accurate information about tests results, and to provide up-to-date information about hepatitis C care and treatment to all people with chronic hepatitis C.

4: We need to increase treatment.

We need to stop the deaths: people with Stage 3 liver disease should be treated so they do not develop liver cirrhosis and be at risk of liver cancer and liver failure; people in Stage 4 should be treated to reduce their risk of developing liver cancer and liver failure and dying from hepatitis C related disease. This means

ongoing support for high-quality tertiary care programs that treat people with significant liver disease and, for people who have already developed cirrhosis, ongoing management of their cirrhosis and monitoring, as they remain at increased risk of developing liver cancer.

We need to stop transmission. Mathematical models by our group at the Burnet and others internationally (Peter Vickerman and Natasha Martin) show that if we treat PWID we can reduce transmission (“treatment and prevention”). Treating only 1,000 PWID in Victoria annually over the next 10 years will substantially reduce hepatitis C incidence and prevalence.

Victoria has already done an excellent job in supporting community-based nurse-led treatment programs. We need to build on that.

People talk about the cost of the interferon-free therapies and whether we can afford to roll out these expensive treatments to all. Really, the question is can we afford **not** to do this?

Also, my view is that we should regard the current cost of interferon-free therapies as a barrier. The often-quoted \$80,000 a course, \$1000 a tablet, will not be the case forever. The price is already falling globally and these drugs will become affordable. The current *assumed* cost of these drugs is not an excuse for not implementing a sustained program of care and treatment for hepatitis C.

5: OST and NSPs work.

OST and NSPs reduce injecting risk behaviour and HCV transmission. They should not be wound back, but expanded. They are key to the success of our strategy. There is increasing evidence from Lisa Maher’s group in Sydney and internationally that such programs reduce HCV incidence and prevalence.

6: We need to increase the capacity of community-based hepatitis C services ...

... to treat people with hepatitis C, and improve engagement and retention in care of vulnerable populations such as PWID.

7. We need to resource organisations that provide peer-based education

... and other modes of engagement with affected populations to improve pathways into hepatitis C treatment and care.

8. We need to reduce the stigma associated with hepatitis C ...

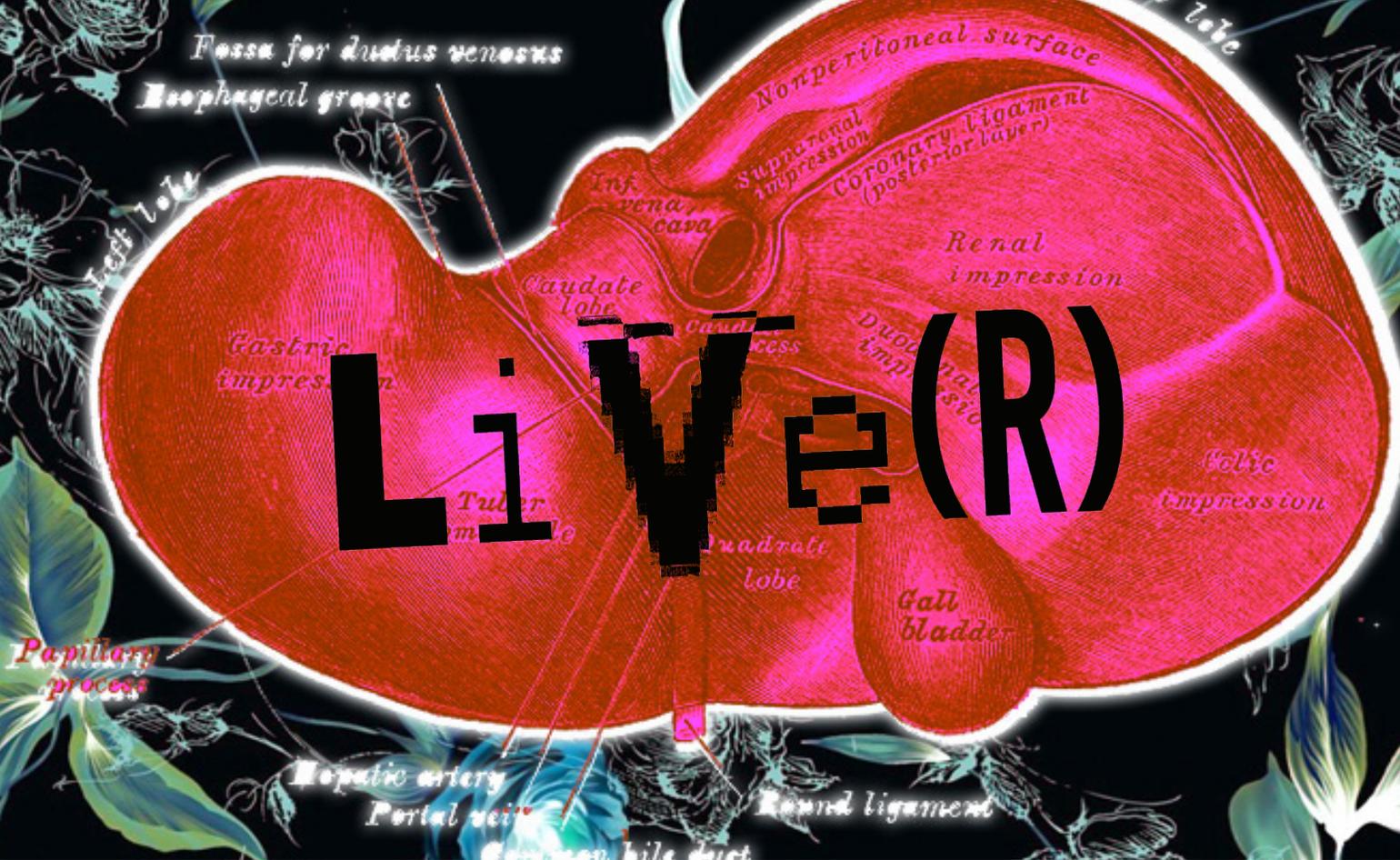
... by promoting an evidence-based approach to the provision of treatment that does not exclude key populations from health care.

9. We need quality surveillance systems ...

... to measure hepatitis C prevalence and incidence over time, enabling us to evaluate the impact of our elimination program – for both transmission and deaths due to hepatitis C.

10. We need funding of research ...

... to support these activities and to provide a sound evidence base for implementing our programs. We also need to support research into the development of a hepatitis C vaccine.



In Summary

Tuesday 28th July 2015 was World Hepatitis Day.

I would like to set the challenge that by World Hepatitis Day 2016 Victoria and Australia will have a clear strategic plan for eliminating hepatitis C by 2030.

Victoria and Australia are in a unique and privileged position to lead the world on hepatitis C elimination; we can stop the deaths and we can stop transmission. Unlike many places in the world:

- ◆ We have quality NSPs and OST – the challenge is to increase access and coverage;
- ◆ We have a health system in which people can get access to high-quality hepatitis C testing – the challenge is to ensure everyone has access to testing and timely diagnosis of their hepatitis C and seamless referral into care and treatment; and
- ◆ By late 2015 or early 2016 we are highly likely to have a health system that will give people with chronic hepatitis C infection access to the new direct-acting antiviral medications through the Pharmaceutical Benefits Scheme, so it will be affordable to them. The challenge will be to roll them out and increase access.

Importantly, there is still stigma and discrimination against people infected with hepatitis C and the populations at risk of hepatitis C. Similar to what was done for HIV, we need a public health promotion program to say we have had **ENUFF of that!** If we are to be successful in eliminating hepatitis C from Australia, stigma and discrimination must stop.

As I said at the beginning of this article, this is a key moment in time. As a group – community organisations, government, health workers and researchers – we have the privilege and opportunity to make a change. We can stop hepatitis C deaths, we can stop hepatitis C transmission, and we can eliminate hepatitis C as a public health problem in Victoria by 2030. We can lead the world in this endeavour.

Our challenge for today, over the next month, over the next year and beyond, is to develop, implement and maintain a clear, coherent and evidence-based strategy to ensure we are successful in eliminating hepatitis C.

90%

OF HEP C TRANSMISSION IS ASSOCIATED WITH SHARING INJECTING EQUIPMENT—ACCORDING TO NATIONAL SURVEILLANCE DATA (NCHECR 2002)

SAFER SNORTING

1. USE A STRAW. USE YOUR OWN STRAW.

STRAWS ARE CLEANER THAN ROLLED DOLLAR BILLS. MONEY CARRIES HEAPS OF GERMS WHICH CAN LEAD TO SINUSITIS (SINUS INFECTION)



CUT THEM IN HALF AND TAKE THEM WITH YOU WHEN YOU GO CLUBBING OR TO FESTIVALS.

YOU CAN FIND THEM FOR FREE IN MOST FAST FOOD RESTAURANTS.

2. RINSE YOUR NOSE. BY SNORTING WATER BEFORE AND AFTER SNORTING

HOW?

* FILL YOUR HAND WITH WARM WATER AND INHALE THROUGH EACH NOSTRIL.

WHY? THIS WILL MOVE ANY EXCESS SUBSTANCES ALONG THE NASAL PASSAGE. THAT ARE HARMFUL TO THE SENSITIVE NASAL MUCOUS MEMBRANE

* DO THIS UNTIL YOU FEEL SOME OF THE WATER MOVE DOWN THE BACK OF YOUR THROAT.



3. BUMP AHEAD

IF YOU DON'T HAVE A STRAW, SNORT BUMPS OFF YOUR OWN HAND — NOT YOUR FRIEND'S HAND.

ALWAYS WASH YOUR HANDS FIRST.



SAFER INJECTING

1. CLEAN UP YOUR ACT
 - * WASH HANDS AND INJECTION SITE WITH SOAP AND WATER
 - * WIPE DOWN YOUR MIXING UP AREA
 - * SWAB INJECTION SITE WITH ALCOHOL/ CHLORHEXIDINE SWABS



3. BETTER SAFE THAN DEAD

* TEST YOUR GEAR— START WITH A SMALL AMOUNT TO REDUCE YOUR RISK OF OVERDOSE

* USE WITH A BUDDY— ONE AT A TIME

* KEEP NALOXONE ON/NEAR YOU WHEN USING—IT'S NO GOOD AT HOME IF YOU USE AT A MATES PLACE!



2. BE SELFISH
 - * KEEP YOUR OWN 'WORKS' INCL. SPOON/CUP, TOURNIQUET TO YOURSELF—DON'T SHARE.
 - * USE ONLY NEW
 - SYRINGES/NEEDLES
 - SWABS
 - FILTERS
 - STERILE WATER



USE CLEAN WATER FROM A RELIABLE SOURCE—COOLED, BOILED WATER OR FILTERED WATER IN A NEW CONTAINER IS A GOOD SUBSTITUTE IF STERILE WATER IS NOT AVAILABLE OR TOO EXPENSIVE.

* BOTTLED WATER IS NOT STERILE!

4. SHOOT WITH SKILL
 - * BE PATIENT!
 - * SHOOT TOWARDS THE HEART— HAVE YOU EVER SWAM AGAINST A CURRENT?
 - * ROTATE INJECTION SITES
 - * DRINK WATER! HYDRATION IS KEY TO GETTING A VEIN



SAFER SMOKING

1. STICK THAT IN YOUR PIPE!

* USE YOUR OWN MOUTHPIECE OR PIPE AVOID GETTING OR SPREADING INFECTION.

* USE A SHATTERPROOF PYREX PIPE OTHER PIPES CAN GET TOO HOT OR GIVE OFF TOXIC FUMES.

* AVOID USING BROKEN OR CRACKED PIPES DAMAGED PIPES CAN LEAD TO BURNS, CUTS AND INFECTIONS.

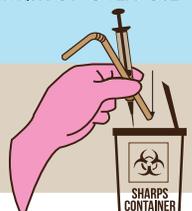
2. ALL UP IN YER GRILL

* DRINK WATER, USE LIP BALM AND CHEW GUM THESE THINGS WILL HELP KEEP YOUR MOUTH MOIST AND REDUCE CRACKS, BLEEDING, BLISTERS AND RISK OF INFECTION AND HEP C TRANSMISSION

3. USE OR IT LOSE IT

* TEST YOUR GEAR— START WITH A SMALL AMOUNT TO REDUCE YOUR RISK OF OVERDOSE

* USE WITH A BUDDY— ONE AT A TIME. THERE IS SAFETY IN NUMBERS.



ALWAYS DISPOSE OF EQUIPMENT SAFELY!!

WHAT DOES IT MEAN?

DICTIONARY DEFINITION

SHARE:

VERB

VERB: SHARE; 3RD PERSON PRESENT: SHARES; PAST TENSE: SHARED;
PAST PARTICIPLE: SHARED; GERUND OR PRESENT PARTICIPLE: SHARING
1. HAVE A PORTION OF (SOMETHING) WITH ANOTHER
OR OTHERS. *GIVE A PORTION OF (SOMETHING) TO
ANOTHER OR OTHERS.

NOUN

NOUN: SHARE; PLURAL NOUN: SHARES

1. A PART OR PORTION OF A LARGER AMOUNT WHICH IS
DIVIDED AMONG A NUMBER OF PEOPLE, OR TO WHICH A
NUMBER OF PEOPLE CONTRIBUTE



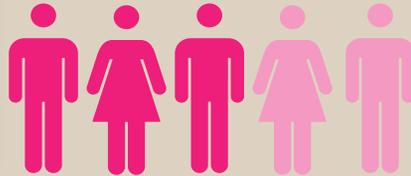
90%



NEW INFECTIONS OCCUR
BETWEEN PEOPLE SHARING
EQUIPMENT
USED FOR INJECTING

SHARING INCLUDES
BORROWING, LENDING, PASSING ON, REUSING, BUYING, SELLING, TAKING, OR RECEIVING
OF **ANY EQUIPMENT** USED BY SOMEONE ELSE

3 OUT OF 5



PUNTERS SAID THAT
LAZINESS
IS ONE OF THE MAIN REASONS
FOR SHARING



9700

NEW HEP C INFECTIONS PER YEAR

“SHARING” OR REUSING EQUIPMENT
WITH A CLOSE SEXUAL PARTNER
(LIKE A BOYFRIEND OR GIRLFRIEND)
IS NOT SEEN AS RISKY BY SOME PEOPLE
RISK EXISTS EVERYWHERE—
WITH EVERYONE
SHARING IS NOT CARING

THE

THINMAN

A F F A I R

A T O X I C S T R A I N

They had been found dead in cars, slumped in doorways, crouched on their haunches in telephone booths and flat out at the bottom of stairwells; men and women, young and experienced addicts alike. Eleven deaths in North London, seventeen in Scotland and multiple others dotted around the UK. Other addicts were turning up in Accident & Emergency rooms, often taxi'd in and dragged to the front desk, terribly ill and on the point of death. From the very early news reports it seemed that the only common denominator tying all the casualties together was that they were all intravenous heroin users and they had all shot up just prior to going over.

"Lucky fuckers," said Thinman, reading the news report, his filthy stained index finger, which had been running under the words, now jabbing at a certain part in the story. "Says here it's a suspected pure batch that's doing it. Apparently some uncut gear has found its way onto the street. Un-fucking-cut! Wouldn't half mind getting me hands on a bit a that."

I didn't respond. I sat watching Thinman as he read, as his eyes lit up and different expressions moved across his face like changing weather patterns. Heroin addiction had all but destroyed the man, eaten every morsel of fat from off his bones, bleached his skin a deathly yellowish grey hue and somehow faded his tattoos so as they looked like processing stamps from the mortuary. There he was, sat in the lounge of the local needle exchange, looking like he'd been air-packaged, and still salivating over the thought of one last great fix, of something that would relieve him of the fear and knowledge of an impending and premature death.

In the cramped store cupboard of the exchange the key worker bagged up my usual fifty pack of 1ml needles along with a button bag of citric acid and a handful of sterile water bottles. "Now, be careful," she said, "what with that bad batch going around. Take these guidelines and have a read through them on your way home." She handed me a leaflet, a list of bullet-pointed directions. I cast an eye quickly over them, over the

casual, childish font which had been used. "You're up," I said to Thinman as I came out the supply cupboard, "I'll wait for you outside."

Late morning, the air fresh and floral in the residential streets; the sky deep and blue and clear. From behind floated the subdued rumble of the high-street, the cogs of the day turning into lunchtime. I walked with Thinman up towards St Stephen's Church, to loiter hidden in the damp shade under her arch for Danny. Heroin was burning through our lives. I felt good in my habit, not yet tired and jaded and all shot out. As we walked I read Thinman the needle exchange's counsel to avoid dying that autumn.

"Smoke it!!!" Thinman yelled, repeating what I had read. "Well, they know that's not likely gonna happen, is it? I'd need two hundred dollars a day to smoke it. And how'd they figure that? Like the only time real serious shit hits the streets and we smoke it! Fuckin' jokers."

"They're talking toxic gear here.... not pure. Says it's maybe laced with fucking anthrax or botulism. Advice for those hellbent on injecting is to make absolutely sure to vein it... under no circumstance go intra-muscular."

Thinman laughed and flicked his hand out, as if batting away an annoying fly. "It's all just more anti-smack propaganda, more lies to scare the shit outta us, scare us into quitting. I've heard of bad gear... but toxic gear??? Do us a favour." I balled up the leaflet and tossed it down in the street. Even accepting the reports were true, barely fifty addicts in the entire country had died and so you'd have to be pretty unlucky to come across the contaminated heroin. And anyway, Thinman was correct: no-one seemed to really know what was going on anyway – maybe it had nothing to do with the heroin at all.



A week later and the so-called toxic heroin was the main talk of the IV'ing community. More junkies had dropped dead up North and the first rumours of addicts round our way turning up in hospitals with sorely infected limbs and skin necrosis had surfaced. As is always the case, the rumours never concerned anyone who one knew personally. They were all mostly third hand reports, gossip blowing around in the waiting rooms of methadone clinics and needle exchanges, people with very little going on in their lives and wanting to fan the fires in their dying grates.

On the street, the talk and rumours affected little. All it did was add an extra ounce of danger to the practice of shooting up, supply us with another element to use to blackmail money out of anyone who cared. Nobody cared. And so we hobbled on as ever, taking our chances and hoping our chances were good, not having the luxury of playing it safe for a while. We shot first and dealt with any consequences later. We scored and used as ever, more tales that week reported of addicts blowing out and toppling over, others staggering into A&E and put in intensive care having bloated up with some kind of bacterial elephantitis.

That's when Thinman disappeared.

Thinman's disappearance was strange. I was in his debt for two rocks of crack and only something terribly serious would have had him not be home to collect. But he wasn't home, and neither had he returned when I did another pass later on that evening. On the second day when he still hadn't turned up I called in on his brother. Together we travelled over to Thinman's, spoke to the downstairs neighbour and then forced the door. Thinman's flat was a shithole, a mattress on the floor surrounded by syringes and shooting paraphernalia. But there was no Thinman, and no sign that anything untoward had happened. Thinman's brother left a handwritten note on the mattress and said if there was still no news by the following evening that he would report him as missing. He said his brother often laid low for days at a time. That was true, but never when in credit for crack.

Later that evening I received a call to my mobile, a soft female voice asking me if I knew a Mr Saul Messinger. That was Thinman's real name. I said I didn't think I knew anyone by such a name and asked why. She explained that she was calling from the hospital concerning a recent inpatient who had been admitted with no contact details and that my number had been found amongst his possessions. I thought for a moment before telling the hospital assistant that I didn't know him very well but knew his brother. I gave the details of Thinman's brother and put the phone down. It was late. From what I could gather Thinman was in a poor way but still alive. I pondered over all that may have happened to him. It was impossible to know.



"No Saul Messinger here," said the fat receptionist, sat there in her XL mint hospital uniform. She returned back to her Sudoku puzzle, wishing me to go away and leave her alone.

"Will you look again, please" I asked. "He's definitely here. It was the hospital which phoned me saying so."

The receptionist froze with her pencil on her puzzle. When I didn't disappear she let out a little huff of air, snapped her pencil down and took up the mouse. She clicked the cursor into a blank field and started to type a name in. After no more than four letters she stopped and without raising her eyes to look at me, said, "What did you say the name was?"

"Messinger," I said.

She hit the back space rapid-fire and typed in the correct name, giving her return key a good whack to show me how pissed off she was that she had to work. She sat staring at the screen with an expression of contempt on her face. A few clicks of the mouse later and she said, "He's in the infectious disease unit."

"Infectious disease unit? Where's that?"

She pointed to a plan of the hospital on the wall over near the lifts. Then she raised her eyes and looked at me for the first time. She looked like a cow that had been interrupted while grazing.

"Are you family?" she asked, hoping I wasn't so as she could deny me access to the ward and possibly have the security come down and sling me out.

"Yes, I'm his brother," I said.

She didn't believe me but had no way to say that I wasn't. She lowered her eyes, going back to her game of numbers, brooding all the while, knowing her fat arse would be disturbed again soon.

The infectious disease unit looked like any other ward. I had expected to see isolation rooms and quarantine units, but there was none of that here. I wandered down through the ward, poking my head in rooms, looking for Thinman. Just as I spotted him a nurse came rushing down the hallway, calling after me. Thinman looked up. He was lain back in a bed with the right sleeve cut off his hospital shirt and his upper arm heavily bandaged. He looked awful; worse than usual. He widened his eyes in greeting.

"Excuse me, sir, who are you looking for?" the nurse asked, stopping.

"Him," I said, pointing to Thinman. "I'm his brother." I said that a notch louder so as Thinman would hear and confirm it if asked. The nurse told me to wait just there. She entered the ward and spoke to Thinman. As she left she gave me the OK to see him.

"What the fuck happened?" I asked Thinman. "We all thought you were dead!"

"Nearly fucking was," he replied, "got some of that fucking bad smack that's going around... almost had me. Wound botulism or some shite."

"Fuck! How d'you know?"

THE THINMAN AFFAIR



"Fuck all else it could've been. Ate my arm away right where I struck up. Was that little cunt Jay's gear." I thought of Jay and of his two cousins who also dealt and must be all holding the same stuff. I wondered how many more addicts in the area I knew would drop. It was a scary thought, and even more terrifying was the thought of how many unrelated dealers may have picked up from the same batch.

"Has your brother been around?" I asked.

"Passed by this morning. Was here when I fully came around. Was out of it for almost 36hrs. Not pleasant, mate... and was sick to boot. They dosed me up on methadone but still feel like crap."

Thinman shuffled himself up in his bed. He had a catheter in his neck which was dripping saline and antibiotics into his system. He began picking at the bandage covering his upper arm, his face creasing up in pain as he slowly pulled the dressing free from the wound.

"What the fuck are you doing," I asked.

"I wanna see what fucking damage I've done... ain't seen it yet. It stings and burns like fuckin' hell... I know that much."

As Thinman pulled the bandage back it first revealed a sore red swelling. Then the first wound was exposed, a small drawing pin sized hole in the skin.

"Fuck," Thinman said. He then pulled the bandage free, exposing the full extent of the damage beneath. It was a sight straight out of a medical book. His entire upper bicep was cratered in open wounds of various sizes, all through to the flesh and seeping a sticky, yellow, sap-like puss. The craters of the wound were raised and cracked. It looked like he had had sulphuric acid thrown over him. Thinman looked at his wound in horror. Then he looked at me. "All that from a fucking shot," he said. "What the fuck!" He studied his wound some time more, his eyes searching out the most rotten parts of flesh and squinting in on them. Now accustomed to the horrific sight he seemed to take some kind of sadistic pleasure from exposing his injury, like it was the embodiment of a life that was eating him alive. After a moment he replaced his bandage, grimacing and wincing in pain as it settled down once more against his wound.

For a moment Thinman closed his eyes. I watched his sickly transparent lids, thin and taut over the balls and run through with purple threadlike veins. I had the distinct impression that he could see me looking at him through them. With his eyes still closed, he said: "Mate, you still good for those two rocks you owe me?"

"Of course," I said. "Though I don't know anyone around here." He opened his eyes and looked at me like he was in pain. "I need something right now. D'you have credit on your phone?"

I nodded. Thinman said that he knew a user called John Lacey who lived in the flats behind the hospital and as long as he was still alive and well that he'd be able to score. Thinman called out the number for me to key in and call. When I'd finished, I handed the phone to Thinman.

"You've got ten mins," Thinman said to me, smiling. "He'll meet ya just round the back of the hospital... and try and be quick... I'm half fuckin' clucking here."



I met John Lacey in the grounds behind the hospital. He was dressed in a loose woollen top and piss-stained nylon tracksuit bottoms, walking around holding his stomach and cursing.

"How's Thinman," he asked, still partially buckled over.

"Not bad. Will be better after a shot, you know."

"Sure. Sure I fucking know. God, so will I."

"Must we go far?"

“No, not far,” John said. “Come on.”

Barely had we been walking a minute when John stopped abruptly and said, “I need to shit... me guts are gonna fucking drop on me.” He reached out and rested his hand gently on my forearm. He paused there like that for a moment before giving a little squeeze and rushing off, ducking into the nearest bush. The foliage barely covered him. I saw John yank down his tracksuit bottoms and underwear and a flash of dirty white thigh as he crouched down in haste. I turned around, staring over at the back of the hospital in disbelief. And as I watched the air-conditioning units, observed the odd rags of tissue which hung from the vents and ruffled in the out-blowing warm air, the sickly sweet smell of excrement floated up over my shoulder, John Lacey squirting his rotten junkie guts out onto the ground behind the bushes. It was the smell of London; the smell of those days and that time. Illness, shit and decay. Soiled clothes and pale unwashed skin. Doing things on the fly. The filth of a generation, dragging something dead and decomposing into the new millennium. God, the world had changed. But in the back hangouts, in the shadows of impoverished estate-lands, where the buildings block out the sun and the mildew grows up the walls and moss stands in for grass, it could have been any time in the last thirty years. I turned back around to see if John had finished his business. Almost. Still crouched down the bush was now being tugged and leaves being yanked free. When he finally emerged from the bush he was pulling up and fixing his trousers, the smell of shit hanging to him like it were his soul peeping out.

“God, that was violent,” he said, smiling. I looked at his hands and didn’t want them touching me. I thought of the bags of heroin he would have to soon hand over, and I didn’t want to touch them either.

Back at the hospital I gave Thinman his four bags of smack. He was itching for a fix, only now he realised just what a chore it would be to cook one up in the open ward. As he lay there looking at me, his face miserable with sobriety, I knew what was coming.

“Mate, could ya do us a last big favour? Sneak in the bogs and cook us up a hit?”

I didn’t want to, but I agreed. Thinman gave me a bag of his smack. He told me to cook the lot up and split it between two needles so as he had another fix for when I was gone.

In the toilet cubicle I went about doing as Thinman had asked. Halfway through mixing up his dose, just about to cook it down, I heard the main door of the restroom creak open and someone enter. I stopped what I was doing, the spoon in one hand and the un-struck lighter just beneath in the other, and listened. Whoever it was was just standing there, maybe listening too. I gently laid the spoon down on the top of the cistern and sat on the toilet. After a moment the person outside washed their hands, dried them and then the door creaked again and then creaked close. I wondered if the person was really gone or whether it was a bluff and they were still standing in silence in the bathroom, listening to what I was doing in the cubicle. I peeped under the door. No-one. I quickly sparked my lighter and finished cooking Thinman’s shots.

While sucking the second shot up the door squeaked open again and once more a presence entered and seemed to loiter in the room. So as to give the impression that I was just finishing up, I pulled some toilet paper free and then flushed the chain. Masked by the sound of the rushing water I hurriedly gathered up my cooking utensils, capped the syringes for Thinman and pocketed them. I composed myself and left the cubicle. There was no-one in the bathroom. As I made my way back down the ward the duty nurse surveyed me with narrow, suspicious eyes. I kept my casual. “Fuck You,” I thought, “you’ll never stop this.”

Barely had I given Thinman his two capped and loaded needles and he had concealed them beneath his blanket, than the nurse came wandering in from behind. She acted as if she were there just to prop Thinman up and take care of his comfort. Thinman was anxious and flushed hot. He didn’t want her messing about too much down besides him. The nurse didn’t speak a word but it was obvious that she knew we were up to no good. When she finally left Thinman was eager to shoot himself up, bring himself back in from out the cold of the sober light. He told me to go and distract the nurse, ask in private about his infection. He was already sitting on the side of his bed, his hospital trouser leg pushed up and prodding for veins down his inner calf.

I left Thinman that afternoon when his brother came to visit. Thinman said that he was feeling much better; he could barely keep his lids open. His brother stood there watching him with a look of absolute disgust on his face. Thinman said that if he was not given the all-clear to leave by the following morning that he would sign himself out. I nodded in agreement. That was heroin. I would have done the same; just about every junkie would.

It’s a weird feeling arriving at a hospital and not expecting the person you are visiting to be there. But on that autumn morning, on my second visit to see Thinman, the form of the distant sun reflected in the murky waters of the fish pond in the hospital grounds, I somehow knew I would find his hospital bed empty and Thinman gone.

Thinman was gone. Only he hadn’t shot through. The young ward nurse who I had located to ask about his whereabouts informed me that he was in intensive care. She said he had been found waxed out with a syringe under his bed cover and had gone down with septicemia. I stood looking at her in shock, my mouth unhinged and hanging open. In the past 18 months I’d known two junkies dead of blood poisoning and knew how serious it was – especially so with the contributing health factors, like hepatitis C, that which had affected Thinman’s hue so visibly.

“Is he conscious?” I asked the nurse.

“I don’t know his present condition,” she said, “you’ll have to go on up to the intensive care unit and see the doctors there... they’ll be able to tell you more.”

The intensive care unit was a place of death and detergent. You could smell and sense the empty spaces in wards where people who used to be no longer were.

THE THINMAN AFFAIR



It was a kind of factory, where people were trolleyed out covered on their backs, taken down to the morgue and then divided up amongst the competing vultures of the funeral parlours who'd wheedle the last pounds of worth from the corpses and sell them back to the family for burial or cremation. I could see it all; the start of the clean-up operation at least. This was a place where you went from being of the utmost importance to that of utter worthlessness in a second. And this is where Thinman was. I guess it was pretty serious then.

It was a youngish looking blond doctor I found. He looked like he was just coming to the end of a 48hr shift, like chunks of his own existence had departed with each death he had called. He pulled a hand down his face in an attempt to liven himself up to my question, but it only served to make his eyes look even more tired and baggy. Just the concentration needed to retain and think of the name I had given him seemed to drain him some more. He walked on a few steps, the smell of cheap hand soap hanging in his slip stream. He poked his head into a small, badly lit room full of supplies. "Do we have a Mr Messenger with us?" he asked to whoever was in the room.

"Saul Messenger," I reminded the doctor.

At those words there came a noise from a nearby ward and out came Thinman's brother. When he saw it was me who was asking after his brother he approached, shouting: "Get him the fuck outta here!" And then directing his words at me: "You here with more fucking heroin to finish him off? Come on, speak up you poisonous, selfish cunt!"

I had no words to reply to that and it would have been pointless besides. Thinman was in his mid 30's and if he wanted smack in the hospital then that was his call. As a friend and addict, knowing what withdrawals were like, I was obliged to do that for him if it was what he wanted. Seeing the anger rising in Thinman's brother, the young doctor stepped in front of me, blocking the route.

"Don't worry, I'm not gonna fucking hit him! But you need to get him the fuck outta here NOW. He's not family... he's not Saul's brother as he claims. He's just a low-life fucking junkie, out for his own gain and not fussed about who he helps kill in pursuit of it."

"I came to make sure Saul was alright," I said.

"Yeah, sure ya did. Alright for what? HEROIN? That stuff almost killed him, you imbecile."

"Dunno what you're talking about," I said, "I didn't bring him any heroin."

"Well, there's only been two visitors and I sure as hell didn't bring it in to him! Now fuck off. You're not wanted here."

I didn't argue. Sure, I was curious to know exactly what had happened to Thinman with the heroin I had brought him up, but the last thing I needed was the police turning up, shaking me down and pulling me in for half a day. And so I gave no response, just turned and left from the way in which I had come. Thinman had my number. If he needed me he would call.

Thinman never did call. It was almost a month before I saw him again. Even then I barely recognized him. Pacing around outside the Texaco garage, waiting on the same contact as I, he looked like he had shrunk in half. He had only been out three days.

"What the fuck happened?" I asked.

"Fuck knows. Feel like shit, like I'm dying. Got no appetite, fuck all and what I do manage to swallow I bring back up. Feels as if my bloods still sick or something."

"And the arm?"

"What's left of it is Ok... doing better than me. Still infected but is on the mend at least."

"And you're back on the gear then? You didn't think it was maybe better to not start up again after those weeks without?"

"You know how it is. I've done so much fuckin' damage now it seems pointless to stop. It won't save me any days now. At least it takes the world away."

I looked out into the world that Thinman was talking about. It was a shit one, alright. Autumn was on us proper and the city was damp from rain, a mist of vapour hanging in the distance below drab skies. In times gone by they would have piled corpses up and carted them away on days like this. I breathed in the air, wanting to extract some freshness from it, some cool that would unclog me of the smog and pollution and poison for a moment. But all I could taste was petrol, that and Thinman, mixing together and making me feel sad and ill, cars with rain speckled windows crawling by every now and again. Thinman was dying, that was obvious. Whether it was the botulism and septicaemia that was the cause, his liver, or just the life we led, who knew? What I did know was that the world which turned Thinman's stomach also turned mine, and together, on a low-hung autumn day, we stood outside the Texaco garage, our eyes flitting about this way and that, waiting impatiently for the only cure we knew.

A ROAD LESS TRAVELLED

Thecla was diagnosed with hep C long ago, in the days when it was still known as hepatitis Non A Non B. Despite having had the virus for more than forty years, its effects on her system have been relatively benign. Her ALT levels have stayed within the normal range and the results of a liver biopsy were fine. She had no way of knowing if she was feeling generally sicker than a normal person, but if she was, she had learned to live with it.

Her principal issue revolved around stigma and the attitudes that emerged when she disclosed her hep C status, for example, to health professionals taking blood. It was especially galling because she didn't drink and took a certain amount of pride in ceasing her drug taking during the mid-eighties.

By her own description, she became 'blasé' about having hep C. Whether true or not, she had been told by doctors that women seemed to tolerate the disease better and that if she had seen out 30 years with no ill-effects, it was unlikely things would change. When it came to interferon-based treatments, she stood firm, knowing the poor likelihood of success, and the horror stories about side effects. She elected to 'wait until treatment came in the form of a hand crème'.

But things started to change in Thecla's life. Her husband, Liam (also living with hep C) began showing the symptoms of peripheral neuropathy - a condition that causes numbness in the fingers and toes and a loss of balance. To their horror, the couple learnt that this was likely related to Liam's hep C. Hospital visits and tests ensued, and there were offers of places on trials of new hep C treatment drugs - but nothing ever eventuated.

Luckily, an alternative presented itself. A fly-in fly-out oilrig worker, a friend of a friend with some time on his hands, had investigated the possibility of sourcing Sof and Dac from one of the big pharmaceutical manufacturers in China. It was expensive, over \$10,000 (AUD) but he had ultimately cured himself. Thecla and Liam decided to follow the same trail and managed to acquire the drugs (at a high but significantly cheaper price).

Problem was it needed to be capped up into doses. In a weird re-enactment of their drug-taking days, the couple acquired a set of jeweller's scales and patiently divided the big bag of powder into accurate doses.

Liam started his treatment immediately, despite uncertain medical support, and his first set of tests two weeks later indicated that he had cleared the virus. At the time of writing (18 weeks post treatment) he is still clear of the virus.

The Alfred Hospital, in particular, was delighted and very curious. They analysed the remnants of Liam's medications and discovered, of course, that they were exactly what they claimed to be.

Thecla, however, still had the disease, but was content to wait for the new drugs to come on line through the PBS. That was until she decided to write an article describing her husband's experiences.



By this stage she had heard of Greg Jefferys' appearance on the 7.30 report and decided to interview him for her piece. By the end of that interview - after learning, among other things, that she may have to wait much longer than she had thought if she followed the usual channels - she had decided to follow the Indian connection herself and purchase the drugs through Jefferys.

One week after forking out the cash, the Sof arrived on her doorstep. A week and a half later, so did the Dac. (She has elected not to use Ribavirin because she does not have cirrhosis). Amazing! Part of her didn't believe it could be true. So simple. And so cheap at around \$2,000 (AUD).

Thecla had an overseas trip planned, so she delayed her treatment until her return, which happened to be the day after I spoke with her. One cannot help but admire the gumption of people like Thecla and Liam, who are prepared to buck the system, and step out from the bcontrolling shadow of Big Pharma. We can only wish her the best of luck with her treatment.

THE TRIAL

OR \$140,000 WORTH OF PILLS

GRAZOPREVIR (MK-5172)

Grazoprevir (MK-5172) is an experimental drug for the treatment of hepatitis C. It is being developed by Merck and is currently in Phase III trials, following promising results in Phase II when used in combination with the NS5A replication complex inhibitor elbasvir, either with or without ribavirin.

Grazoprevir is a second generation hepatitis C virus protease inhibitor acting at the NS3/4a protease targets. It has good activity against a range of HCV genotype variants, including some that are resistant to most currently used antiviral medications.

ELBASVIR (MK-8742)

Elbasvir (MK-8742) is an experimental drug for the treatment of hepatitis C. It is being developed by Merck and is currently in Phase III trials, following promising results in Phase II when used in combination with the NS3/4a protease inhibitor grazoprevir, either with or without ribavirin.

Elbasvir is a highly potent and selective inhibitor of the hepatitis C virus NS5a replication complex. It has only been investigated as a combination product with other complementary hepatitis C antiviral drugs such as grazoprevir and MK-3682, and it is unclear whether elbasvir would show robust antiviral activity if it was administered by itself. Nevertheless, combination products of this type represent the most successful approach yet developed for actually curing hepatitis C, rather than merely slowing the progression of the disease.

Phone Call

I answered the call on the very last ring. It was my boss speaking in an urgent tone down the line. *"There is an opening on a trial that starts in a week or two and one of the key researchers just called to ask if I knew anyone that would be interested. You asked me the other day about trials for the new hep C treatment drugs and it looks like you may have a shot at it. They are actually looking for people on pharmacotherapy for this particular trial."* This was amazing news as I knew from my previous calls to various liver clinics that being on a methadone program disqualified me from participation in many other trials.

The voice on the phone continued: *"The only catch is that you will have to get to the Alfred Hospital in Melbourne tomorrow, and even then there are no guarantees. But if you are interested, I would suggest you come down on the early train. (I live about 4 hours from Melbourne in regional Victoria.) The chief investigators are under pressure to fill the last few spots and to get the trial started so you literally have about 10 minutes to make up your mind. I'll talk to you soon"*. And with that, the phone cut out.

I stood there in the middle of a large green paddock for 30 seconds, the sun beating down on me, trying to work out how I could do it. I had only just made the four hour trip home from work in Melbourne the previous night. As my boss had stressed, nothing was definite, but it was by far the closest I had come to actually getting onto a trial. Thoughts were whirling around in my head as I tried to figure it all out. How to get to Melbourne the following day? Who would look after my kids, in particular my two year?

Could I take him with me on the eight hour round trip? And what would my partner say? How could I possibly juggle hep C treatment along with everything else going on in my life at the time?

I asked everyone I could think of to babysit the next day but to no avail. Finally, I called my partner at work and explained what had just happened and asked her to cover for me. After much cajoling, she agreed to take the day off work to look after our son so I could get back to town. She has the same strain of the virus as me and I promised to try to get her into the trial too if it all worked out.

I called my boss back a little over 10 minutes later to tell her I was ready to go and she gave me the contact details of the researcher I needed to see the following day.

The train shunted out of the station with a jerk, and despite being exhausted from the early morning start, I just couldn't sleep as I usually do in the empty carriage. There was so much riding on this journey. My doctor had been pressuring me for a few years to consider hep C treatment but I had been terrified by the horror stories from people who had been through interferon-based treatment. They had experienced severe side effects, hardcore depression (which is something I struggle with anyway) and after all that, many of them were still living with hep C. The 'cure' seemed worse than the virus in many cases and a complete waste of time in others. As the sun started to shed its light and early morning promises on the stark landscape around me, my body slowly broke from its moorings and slipped into unconscious dreamings.

First Meeting

I woke in a carriage now full of passengers. After getting my bearings and taking a few deep yawns, I grabbed my bags when South Yarra Station was announced over the intercom. I left the warmth of the train and stepped onto the platform. It was icy outside with a wind that cut straight through me. Rubbing my hands together, I walked at a fast pace towards the ramp and onto the street.

After a 20 minute walk through the backstreets of upmarket Prahan, I finally arrived at the Alfred Hospital. As I got into the lift I noticed I was actually early. The floor I got off at seemed totally confusing at first, but once I found the main reception, the girl gave me directions with a smile to another reception area where another receptionist invited me to make myself at home with a hot drink, biscuits and at least 10 years of *The New Yorker Magazine*.

I found my way to a vacant seat through a river of people. This hidden part of the hospital was a hive of frantic activity. Researchers, doctors, nurses, and humans of all shapes and sizes were rushing up and down the small walkway, turning it into a runway of sorts. Doors were opening and closing, and the phone was ringing constantly. Like an extremely well timed ballet performance, it was all colour and commotion.

After some time, a friendly voice called my name and a lady beckoned me over and spoke to me about the program I had come so far to find out about. She talked a mile a minute – which I quickly learnt was a common trait among the majority of the people working in this part of the hospital.

I met with a crew of highly motivated people. They all introduced themselves and explained what their roles were in the study and how often I would be meeting with them, some once or twice throughout the three month trial period and others like Michelle whom I would see at every visit.

The visits would be quite frequent in the first part of the trial but later they would peter off.

I was then introduced to Dr Margaret Hellard, a wiry energetic woman with a staccato gunfire manner of speaking. I had heard her name many times over the years, in conjunction with HCV treatment and her willingness to work with drug users – an attitude that distinguishes her from many of her colleagues. I had never met anyone like her – she was organised chaos, fabulously generous and straight to the point, with at least 10 things going on at any one time. She took multi-tasking to a whole new level: while talking to me and explaining what I needed to do in order to *possibly* become a trial candidate, she was also answering phone calls, emailing people, signing forms, etc. etc.

Beginning

I have been HCV positive for close to 20 years now without experiencing any major symptoms. During the last few years, however, I began to notice a definite malaise bearing down on me including extreme tiredness, uneven skin tone and increased moodiness and depression. I just don't have the enthusiasm and energy that once was a defining factor in my everyday life.

My GP has been relentless about reminding me that I need to seek treatment – and soon. Every visit lately has featured scare tactics about the likely damage to my liver like fibrosis (liver scarring) and cirrhosis.

Pegylated Interferon and Ribavirin used in combination has been the standard HCV treatment in Australia and the side-effects can be severe. In order to combat some of these side effects, many doctors prescribe strong anti-depressants before you even start the treatment. So, with my history, I have never seriously considered this type of treatment.

However, the new direct acting antivirals (DAAs) like Sofosbuvir – a combination drug of several DAAs – Elbasvir & Grazoprevir are a whole different story. These have few side effects and a success rate of > 90%, which has researchers, doctors and HCV sufferers alike very excited. If the claims about the new DAAs are true, they have given many people hope and enabled me to seriously consider treatment for the first time.



THE TRIAL

Trial

I am on the trial taking a combination of *Grazoprevir (MK-5172)* and *Elbasvir (MK-8742)* ! It blows my mind that the cost of one course of treatment is **\$140,000 (AUD)** which means that each little tablet is worth more than **\$1,500** over 12 weeks! Unfortunately, it's only available at the moment to a select few trial participants and there are still a lot of questions about its possible effects and side effects – hence the ongoing trials. Every visit I am reminded about using adequate protection to rule out the possibility of pregnancy – because they simply don't know how the drugs might affect an unborn foetus. It serves as a stark reminder that this medication is not yet available to the general public for good reason.

As the trial is a double blind trial the patients and the researchers don't know who is actually getting the 'drug' as it's referred to. I won't know if I have been on a placebo or the real thing until after the trial when the final result will indicate what I have been taking for all these weeks. The researchers have their suspicions and Michele, my main 'contact' has a list of people (including me) she thinks are on the 'drug'.

Each visit follows a similar pattern: after meeting with my researcher I provide a urine sample, and we go through how I have been feeling, and any changes in drugs used, exercise regimes, and mood changes are noted before a script is provided for more of the 'drug' to be collected before I leave. Then my bloods are taken. I do this myself as I dislike anybody else stabbing away at my veins when I know through many years of experience exactly where to hit, and my researcher provides a backdrop of friendly conversation throughout. There is something quite comforting about the whole session, similar to talking to the hairdresser while your hair is being cut.

Dilemma

The dish water is steaming on my hands and my mind is miles away with the sound of the school children at play drifting over the back fence. It is one of those rare days when I have the house to myself and I've been trying to catch up on all sorts of domestic tasks. Despite the chill in the morning air, the sun has begun to make its presence felt through the kitchen window next to the sink.

The sound signaling the end of morning recess echoes through the back yard when the phone rings. Turning to get the phone, I splash suds all over the floor and all over the legs of my pants as well. It turns out to be a private number and I decide not to answer it.

I finish the dishes and I put on some music to accompany a well-earned cigarette I have just finished rolling. Walking outside into the bright sunshine I hear my phone ring again. I rush back inside and pick up the phone to see the number of my local doctor. The doctor's voice has an edge of urgency to it, as he asks me where I am and what I am doing at the moment. Momentarily confused, I explain that I am spending the day at home and I am not doing anything particularly important.

My doctor explains that I could be in some sort of grave danger and that I should – as soon as humanly possible – make my way into his clinic. He says he will explain more when I get there.



He adds that the people from the HCV trial have been trying to contact me for the last 24 hours without success. (Unfortunately I smashed my phone earlier in the month and they have been calling the wrong number.) I am left with the impression that something has gone horribly wrong with the trial, and I am at the mercy of some sinister side effect that hasn't surfaced before or something equally nasty.

I am not sure what to think, and running on pure adrenaline I quickly pack a bag of clothes in case of a hospital stay. The more I rush around the house the more panicked I become and by the time I get into the car I am completely freaking out, imagining all sorts of worst case scenarios. Cursing at the unfairness of it all, I drive off, as all the vivid landscape colors around me smear together like a bad water colour painting. That's when the tears finally break. When I get to the clinic, I realise I can't remember anything of the entire journey and I have been speeding the whole way. I park on the nature strip and run inside the clinic where my doc meets me and quickly walks me into his consulting room.

With a very serious look on his face he explains that the results of some of my recent blood tests are extremely concerning.

"Hmmm OK. So, did you do any other exercise, or any other physical activity?"

I mentally replay the weekend. *"Well, I went for a hour long bike ride, and there was an hour or two at the school next door skateboarding, and I guess, I did a couple of pushups and. . ."*

He gives me a wink.

"I think that explains it then. Yes, completely. We were quite worried as the bloods we got back showed a huge spike. We attributed it to the "drug" and we were on the verge of pulling you out of the trial last night in case something bad happened. But the levels of protein that were showing up – those sorts of levels only show up on sports people after extreme training sessions. Your body, which is not used to this sort of exercise, produced massive amounts of this chemical, which is really quite normal considering how much exercise you did."

"It's amazing really, how quickly into the trial your body is beginning to function regularly again. You seem to have much more energy than you used to."

"IT'S AMAZING HOW QUICKLY YOUR BODY IS BEGINNING TO FUNCTION REGULARLY AGAIN"

Although it is a test for a relatively unimportant protein, my results have blown up from a normal level of 3,000-4,000 to 15,000. The doctors assume it is a mistake and order a number of re-tests but the protein is still showing up at astronomically high levels. I am so terrified, I can't take in what he is saying, and my mind is spinning all over the place. I have a sense of the ground slipping out from under my feet. The gentle serenity of the day has been shattered beyond repair and everything seems broken and surreal. Further bloods are to be sent express to the city, and I am to catch the next available train to Melbourne.

After the overwhelming early morning rush of the journey to town, the waiting room is a slow dream. After a time, my doctor appears and gestures me through the babbling throng of people into a vacant room. Reclining back he explains that the result of my most recent test is much less alarming but he is still anxious to go through the last week of my life to find some explanation for my previously elevated levels. Hour by hour I recall the days of the last week, and when I get to the previous weekend the doctor stops me mid-sentence.

"So you did 100 sit-ups?" he says in disbelief. I nodd. *"Just out of the blue? You don't exercise though do you?"*

"Not usually, I was just watching my son play video games, and I thought I might as well try and be constructive with my time."

He sits there for a moment, his eyes glazing over, playing with theories in his head.

I relax.

Neither the staff nor the patients get to see the results of most of the blood tests taken at each visit, so no one really has any inkling of what the trial will reveal. Strangely enough, though, one of the results we do get to see are the ALT scores (liver function test results) which are very telling. My ALT scores didn't change for the first few weeks, which is why I thought I was on a placebo, but during the last few visits they dropped dramatically. I have a feeling I am on the 'drug' after all and the doctors and researchers have been quietly confident as well during these last few weeks.

Last Week. {12}

So here I am – lying shirtless on a hospital bed, wired up to an ECG machine. The nurses are friendly and efficient as they buzz around the room connecting the wires to the various circular stickers all over my body and conducting a conversation about the heart as a piece of art.

At my final appointment, things are very comprehensive. There are questions about my diet during the last 24 hours, when I ate, what I ate, if I exercised and if so how long etc. etc. Then a final questionnaire is filled out on an iPad. The researchers are all very confident about navigating their way through the tests and written questions, but they stumble their way through this part of the session.

THE TRIAL

There is the obligatory humor about new-fangled technology but once it is all sorted, I log in and answer the questions while they talk shop among themselves.

The questions seem to be broken up into a two different themes: general health and mental health. The general health questions concern things such as: do you get tired after walking up a flight of stairs? The questions all have multiple choice answers ranging from 'Never' to 'Always'. Altogether, the questionnaire teases out an in-depth image of the patient's health. The mental health section poses questions which attempt to rate the patient's level of depression e.g. "are you ever so anxious that you find yourself not able to socialise with family or friends?"

After carefully answering all questions, I meet with a doctor so that he can "identify any underlying issues that we may have missed". We finally part company and I slowly meander towards the lift replaying points of the conversation in my mind. I travel to the basement, stepping out into the Pharmacy where I give back all the 'drug' I have had as backup for the last few months. I am not sure now whether I have been on a placebo or not.

I have made it to the end of treatment! It hasn't been a walk in the park but it hasn't come close to the horror stories about interferon-based treatments I have got so used to hearing. I experienced some side effects, but all up they were pretty minor. I grappled with mental fog and a sort of vagueness that started one month into treatment as well as weight gain, which my doctors regarded as evidence that my liver was functioning normally again and better able to process food. On a more positive note I also had much more energy and needed much less sleep. Before treatment I slept as much as I could but I was always tired.

Final Result

I still had to wait another six weeks before I got my final result – I had cleared the virus! Although I had had my suspicions that I was on the treatment rather than a placebo (because of my LFT results and my general state of improved health), it was a relief to get official confirmation of Sustained Virological Response (SVR) or cure.

Because I had never had severe hep C symptoms I chose not to think about it much or the damage it was doing to my liver. But it is definitely one less thing to worry about and I feel very fortunate that I got the chance to do it. (I am still trying to get my partner Anna into a trial as my doctors promised.)

Six months post-treatment, I don't feel like a new person. In fact, in many ways the changes have been way more subtle than I anticipated. I expected to feel very different like those people who report feeling 'well' for the first time in their lives. Although it hasn't been as life changing as I hoped, there have been definite benefits like my increased energy levels and the prospect of a long and productive life.

Old Scratch





DON'T WAIT

Early last year, 66-year-old Patricia happened to hear that untreated hep C patients were, on average, dying 10–15 years earlier than the general population. It didn't take her long to do the math and realise that, if she was an average woman, she had five or so years left to live.

There is no motivation quite as keen as the threat of looming death, particularly if you are enjoying your life and have two young grandchildren to watch grow up. Patricia, by her calculation, has carried Type 3 HCV for about 40 years. Her liver counts had always been mildly elevated, but she was shocked to find upon testing that they had lurched beyond a hundred and, what's more, that she had developed cirrhosis. A dark cloud descended over her life, so distracting her that on one occasion she avoided a serious car accident by a mere mille-second.

Alcohol had always been her drug of choice, but however insanely difficult it must have been she chose life and stopped cold. A feat I can only marvel at. What's more, she enacted every life-change she could think of in order to fight the virus that was 'beaver away at her liver' (including, interestingly, upping her in-take of coffee, which many are saying can have a positive effect on fibrosis).

She was rewarded immediately with normal ALT levels and a halving of her viral load. But she was still, to her mind, on death row – with the health establishment advising her, again and again, that new treatments would soon be arriving. Soon. She just had to wait. But Patricia didn't want to wait. It was a bind. She had nowhere to turn.

Then, like St Paul on the road to Damascus, she had her epiphany, by chance catching the last few moments of the 7.30 Report featuring Greg Jefferys and the India connection. She did not hesitate. She contacted Jefferys at the first opportunity and followed his directions on how to buy the medicines she so desperately needed. (Little need to add that there is no end to the respect she has for the man.)

Patricia has Genotype 3, so she needed Sofosbuvir. She acquired it from India together with Ribavirin, which was thrown in for free. She sourced the Daclatasvir from Mesochem in China. (A note here: until very recently, Mesochem was not filling orders for this drug.

It is thought they were under pressure from patent holders Bristol-Myers Squibb, but whatever the case, they are at the time of writing selling courses of the drug, as long as you have a prescription. Patricia also informs me there is now a compounding chemist in Sydney who is filing prescriptions.)

There was something very special about receiving those packages in the mail. Patricia could scarcely contain her excitement, and not just because she was in possession of a potential cure. There was another element: an appreciation that she had done it all herself. She had seized the reins of her life and stuck it to Big Pharma and our forever-procrastinating medical system. It must feel very good to wrest control of your own destiny in this way.

Patricia has been on treatment for 11 weeks now and things are looking good. In her particular case – owing primarily to the cirrhosis – the hep will be 'a hard little nut to crack' so she has elected to treat herself for 24 weeks, rather than the usual 12, leaving as little as possible to chance.

With a double-digit viral load (down from 2.5 million ppm) she cannot stress powerfully enough how good she is feeling, both physically and mentally. As it is for many of us, she had over the years forgotten what it feels like to feel well, and today is living in a state of constant surprise at how wonderful it is to simply not be sick, and to have had a truly enormous burden lifted from her shoulders.

Her feelings on the issue are extreme. She believes that if people knew how great the results can be, they would not hesitate in scabbling up the money for generics. Like Jefferys before her, she is now spreading the good news wherever and whenever she can.

'I'm almost an evangelist,' she says.

And her core message? **Don't wait.**



REVIEW TALKING SMACK

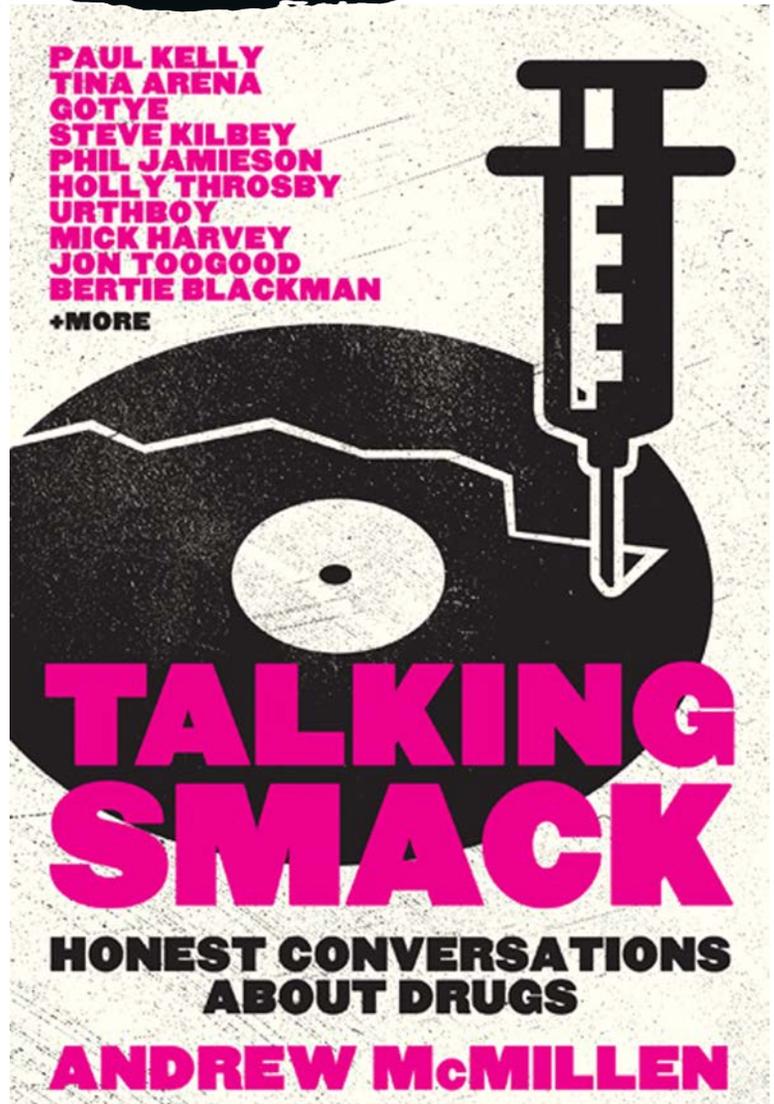
Talking Smack by: Maurice D. North

I started reading a book I bought over a year ago, while on an international flight to the INPUD AGM (International Network of People who use Drugs Annual General Meeting) in Kuala Lumpur. The book was *"Talking Smack: Honest conversations about drugs"*, written by an Australian journalist, Andrew McMillen. *"Talking Smack"* features discussions with some of Australia's best known musicians – including Paul Kelly, Tina Arena, Gotye, Steve Kilbey, Phil Jamieson and Holly Throsby and it delves into their thoughts on and experiences with illicit, prescription and other legal drugs. It was probably the perfect time to read a book like this – just before meeting with drug user activists from around the globe. Many of INPUD's members manage to live very functional lives even in some of the most adverse settings, where simply being a drug user can get you sentenced to years in forced treatment facilities, committed to hard labor camps, or beaten and even killed.

McMillen explores the truths and realities of a topic that is rarely discussed candidly in public. Society has very fixed beliefs when it comes to drugs and drug taking, and the only acceptable sort of drug story is the redemption narrative which describes an individual's salvation from drugs and the benefits of a drug free life. I guess the only arenas where drugs are considered acceptable are the music and film industries; again, they are only barely tolerated but allowances are made because these individuals are deemed 'special' and include some of our most beloved, successful and creative artists. McMillen writes *"Of all the creative industries, the most distinct link between drug use and creativity lies within music. The two elements seem to be intertwined, inseparable; that mythical phrase "sex, drugs and rock and roll" has been bandied about with a wink and a grin for decades"*. It is one of the strengths of the book that McMillen establishes a strong link between drug use and creativity.

One of my favorite paragraphs starts: *"Prior to 21 September 2010, Australia had never known a champion of recreational heroin use; that night on national television, the singer and songwriter Paul Kelly stepped up to fill that space, much to his initial reluctance and increasing discomfort, during a prime time interview on ABC TV's 7.30 Report"*. I don't think we talk enough about recreational and/or functional drug use, so McMillen's approach is very welcome and refreshing.

"Talking Smack" is an interesting read, with very diverse stories about drug use, from the highs and the lows and from hitting rock bottom to embracing a sense of recovery and finding a life after drugs. So, find the time to locate a copy and have a read of this book. I think you will find yourself reading something you haven't read before.



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55					56		57		58					
				59			60						61	

Clues: ACROSS

- 1.type of judge
7. stay in a tent
10. proceed
11. singers
12. precious stones
15. perish
16. blend or combine
17. legendary band " _____ stones"
21. see
23. slim
24. edible sea snail
25. headquarters
- 27 objective case of I
28. national drug user org
- 29 south Australia (abbrev)

30. most excellent
33. exist
- 34.emergency room (abbrev)
36. weild a tool
37. upper limb
- 40 picture theatre
44. electromotive force expressed in volts
47. talking horse
48. large wading bird
49. slang for cocaine
51. look for
53. bird of prey
55. droops
56. large Aust bird
- 58.plant starter
59. short for identification

60. plant support
 61. overdose (abbrev)
- DOWN.
2. internet search engine
 3. tension
 4. colour
 5. dry
 6. public transport
 7. boundary
 8. edible molluscs
 10. leave
 13. cat sound
 - 14 cricket score zero
 18. oily fruit
 19. deep long handled spoon
 - 20 firm hold
 22. keeps time

26. type of roadside drug test
28. collection of pus
31. knotted
- 32.dimethyltryptamine
25. alcoholic spirit
38. score, get ____
39. give pleasure to
41. notion
42. listening devices
43. hurt
45. first number
46. can do
- 50.unwanted plant
52. mature
54. precious stone
57. we



PAMS

**HAVING PROBLEMS WITH YOUR
PROGRAM?**

GIVE PAMS A CALL.

PAMS is a confidential telephone service for people on a pharmacotherapy program such as methadone, buprenorphine (Subutex and Suboxone) or naltrexone.

PAMS is able to provide clients with resources and information on the program, injecting related harms, dose reduction and withdrawal as well as budgeting, legal responsibilities, government policies and guidelines.

Call PAMS on 1800 443 844 or (03) 9329 1500

Open 10am - 6pm. Monday - Friday





HARM REDUCTION VICTORIA

WANT TO MAKE A DIFFERENCE?

JOIN US.

As a community based organisation, Harm Reduction Victoria depends on maintaining a strong & active membership committed to the health and well-being of illicit drug users.

Join HRV and not only will you be aiding in the cause, but you'll receive Whack Magazine delivered to your mailbox plus the right to vote and nominate for positions on the HRV committee of Management.

You can join on the HRV website or by filling out and posting us the form below. Any queries? Don't hesitate to call on 03 9329 1500 or email to admin@hrvic.org.au



Name:

Address:

Postcode:

Phone: (please tick) Personal - FREE

Fax: Organisations - \$60.00

Email:

Please POST to :

Or FAX to:

Harm Reduction Victoria
Membership
PO BOX 12720
A'Beckett Street
Victoria 3006

03 9329 1501

SURVIVAL GUIDE / FOOD

with thanks to *HealthWorks*

BREAKFAST

Hare Krishna Food For Life
197 Danks Street, Albert Park
Mon- Sun 9am Free

Ozanam House
268 Abbotsford St,
North Melbourne
Mon - Sun 9.15am-10am Free

Prahran City Mission
211 Chapel St, Prahran
Mon - Fri 8am-9.30am Free

LUNCH

Church of All Nations
180 Palmerston St, Carlton
Monday's 11.30am-12.15pm
\$1

Fintry Bank
100 Hodgkinson St,
Clifton Hill
Thursday's 11.30am-1pm
Free

Ozanam House
268 Abbotsford St, North
Melbourne
Mon - Fri 12pm-1pm Free

Prahran City Mission
211 Chapel St, Prahran
Mon - Fri 11.30-1pm Free

Sacred Heart Mission
87 Grey St, St Kilda
Mon- Sun Free
11.45am-1.15pm

DINNER

Food Not Bombs
Barkly St, outside Western
Oval
Monday's 7.30pm Free

Cnr of Brunswick & Gertrude
St Fitzroy
Tuesday's 7.30pm Free

Loophole Community Centre
670 High St. Thornbury
Sunday's 6pm Free

Ozanam House
268 Abbotsford St, North
Melbourne
Wednesday's 5pm-6pm Free

7th Day Adventist Church
27 Alfred Cres, Nth Fitzroy
Tue & Sun 6.30pm Free

SOUP VANS

- St Vincent de Paul**
- Cr King William St & Brunswick St (All Saints Church / Fitzroy Police station)
Mon - Sun 8pm
 - Smith Street, Fitzroy (opposite Safeway)
Mon- Sun 8pm
 - Victoria Market, Carpark, City. Mon - Sun 10.30-11pm

- Matthew Talbot**
- Hanover (52 Haig St, Southbank) 9.45pm
 - Hotham Hotel (Cnr Spencer & Flinders Sts) 10.30pm

- Chatterbox bus - Open Family**
- St Paul's Cathedral, city
Tue, Fri & Sat 9pm
 - Behind Luna Park, St Kilda
Tue, Wed & Fri 9pm

Sacred Heart Mission
87 Grey St, St Kilda
Mon- Fri 8.30am-10am Free

St Kilda Drop-in Centre
Cnr Carlisle & Chapel St,
St Kilda
Mon - Fri 8.45am-10.30am
Free

St Mary's House of Welcome
165 - 169 Brunswick St,
Fitzroy
Mon - Sun 9am Free

Food Not Bombs
Cnr of Brunswick & King
William Street Fitzroy
Monday's 12.30pm Free

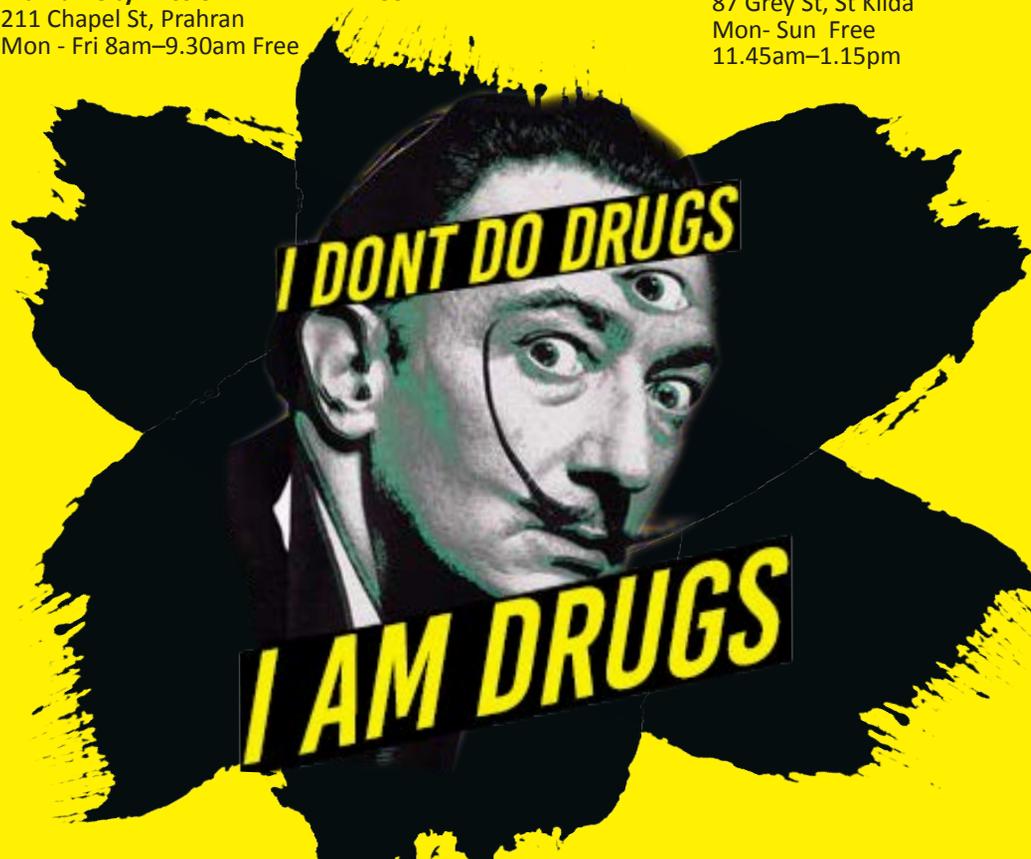
Hare Krishna
123 Swanston St, Melbourne
11.30am-3.30pm
\$5.50 with concession card

Outreach Mission
93 Geelong Rd, Footscray
Wednesday's 12.00-1.30pm
Free

St Kilda Drop-in Centre
Cnr Carlisle & Chapel St,
St Kilda
Mon, Wed & Fri
12.30pm-1.30pm Free

St Luke's
59 Scotchmer St, Nth Fitzroy
Wednesday 12pm \$2

St Mary's House of Welcome
165 - 169 Brunswick St,
Fitzroy
Mon - Sun 1st sitting 12pm
2nd sitting 12.30pm
Donations welcome



I DONT DO DRUGS

I AM DRUGS

SURVIVAL GUIDE / HEALTH / TREATMENT

Including Pharmacotherapy, Rehab, Detox etc.

Your local community health centre is a recommended starting point.

Our partial list concentrates on urban resources and those that do not focus on certain groups. If you are regional, young, or an Aboriginal/Torres Straights Islander, try Direct Line or the Fitzroy Legal Service Guide for services specific to your needs.

There is a lack of affordable detox/rehab services in Victoria and increasingly people are turning interstate. (NUAA [the NSW version of HRV] is online at www.nuaa.org.au and provides a list of resources in NSW.

DRUG-RELATED SERVICES

Primary Health Care Units for drug users: non judgemental health care, doctors and nurses as well as a range of other services e.g... counselling, showers.

InnerSpace
4 Johnson St
COLLINGWOOD
Ph: 03 9468 2800

SEADS
86 Foster St
DANDENONG
Ph: 03 9794 0790

HealthWorks
4-12 Buckley St
FOOTSCRAY
Ph: 03 9362 8100

Living Room
7-9 Hosier Lane
MELBOURNE
Ph: 9662 4488/1800 440 188

SHARPS
20 Young St
FRANKSTON
Ph: 03 9781 1622

Access Health
31 Grey St
ST KILDA
Ph: 9536 7780

DirectLine -1800 888 236 (24/7)

SEXUAL HEALTH

Melbourne Sexual Health Centre:
9347 0244 / 1800 032 017 (toll free)

Action Centre: 9654 4766

Family Planning Clinic: 9429 1177

Aids Line: 1800 133 392 (toll free)

Hep C Line: 1800 800 241

Victorian AIDS Council: 9865 6700 / 9827 3733

Victorian Aboriginal Health Service: 9419 3000

The Buttery, a notable holistic rehab near Byron Bay has always been popular with Victorians (02 6687 1111).

If you are looking to begin a pharmacotherapy program, the listings below may be relevant.

Finding a pharmacy to dispense is usually considered your responsibility and can sometimes be hard.

Prescribing GPs sometimes have lists, otherwise try

DIRECTLINE: 1800 888 236 or

PAMS: 1800 443 844 (free call in Vic) or 9329 1500

DETOX FACILITIES

Salvation Army Anchorage
81 Victoria Cres,
ABBOTSFORD
Ph: 9495 7611

ReGen: Withdrawal Services
26 Jessie Street
MORELAND
Ph: 9386 2876

DAS West: Medical Withdrawal Service
Western Hospital,
3-7 Eleanor Street,
FOOTSCRAY
Ph: 8345 6682

Windana Society: Drug Withdrawal Unit
88 Alma Road,
ST KILDA EAST
Ph: (03) 9529 7955

Assessment:
Ring at 10.00 am
Mon/Wed/Fri

DePaul House
38 Fitzroy Street,
FITZROY
Ph: 9288 2624
Assessment: 9288 2016
(1.30-3.30 Mon-Fri)

Royal Women's Hospital Chemical Dependency Unit
Phone: 9344 2386

WOMENS SERVICES

Women's Domestic Violence Crisis Service:

9373 0123 / 1800 015 188 (toll free)

Women's Information & Referral Service: 1300 134 130

Drop in centre 10.30am-5pm Mon-Fri

Women's Refuge Referral Service:

9329 8433 / 1800 015 188 (toll free)

Women's Health Victoria:

9662 3755 / 1800 133 321 (toll free)

Drug Info Line for Women: 9344 2270

Women's Legal Resource Centre: 9642 0877

Young Women's Health Service: 9548 3255

Flat Out: Statewide Support for Women Leaving Prison:

03 9372 6155

SURVIVAL GUIDE / SHARPS

www.aivl.org.au

NIGHT-TIME

MOBILE SERVICES

(CALL & ARRANGE TO MEET)
Every Night of The Year 7.30 - 11.30pm
(except CBD Footpatrol 7.30 - 10.45pm)

Foot Patrol CBD	1800 700 102
Inner City	0418 179 814
North East	0418 545 789
Inner South	0419 204 811
CHOPER (Eastern)	0414 266 203
Frankston/Dandenong Mon - Fri 5pm - 9am Weekends - Fri 5pm thru to Mon 9am Except public holidays	1800 642 287
North West Mon - Friday Weekends - Sat 2 pm through to Mon 9 am	0418 170 556 4.30 pm - 9 am

DAY-TIME

MOBILE SERVICES

(CALL AND ARRANGE TO MEET)

Geelong Mon - Fri - 9am - 4pm	1800 196 850
Foot Patrol CBD Mon - Fri - 12- 3.15 & 4 - 6.45 pm Public holidays 12 - 3.45 pm	1800 700 102

CROSS WORD ANSWERS:

ACROSS: 1. Magistrate 7.camp 9.err 10.go 11.choir
12.diamonds 15.die 16.fuse 17.rolling 21.notice 23.lean
24.winkle 25.base 27.me 28.avil 29.sa 30.best 33.be
34.er 36.ply 37.arm 40.cinema 44.voltage 47.ed 48.crane
49.blow 51.search 53.eagle 55.sags 56.emu 58.seed 59.id
60.stem 61.od
DOWN: 2.google 3.strain 4.red 5.arid 6.train
7.confines 8.mussels 10.go 13.meow 14.duck 18.olive
19.ladle 20.grasp 22.timer 26.saliva 28.abscess 31.tangled
32.dmt 35.rum 38.on 39.please 41.idea 42.ears 43.ached
45.one 46.able 50.weed 52.age 54.gem 57.we

As these lists are not complete, we advise accessing AIVL's comprehensive list that can be found on the website above, under the NSP listing tab.

To find an NSP (Needle and Syringe Program) in your area, contact DIRECTLINE (1800 888 236). Of course, equipment may be purchased/disposed of at some pharmacies.

FIXED SITE SERVICES

(CALL IN AND PICK UP YOUR EQUIPMENT)

There is only one 24hr 7day needle & syringe program (NSP): The Salvation Army Health Information Exchange which is located at 29 Grey St. St Kilda.

Health Info Exchange
29 Grey St.
ST KILDA
Ph: 9536 7703

InnerSpace
4 Johnson St
COLLINGWOOD
Ph: 03 9468 2800

HealthWorks
4-12 Buckley St
FOOTSCRAY
Ph: 03 9362 8100

SHARPS
20 Young St
FRANKSTON
Ph: 03 9781 1622

SEADS
86 Foster St
DANDENONG
Ph: 03 9794 0790

Needle and syringe programs (NSP's) are more likely to have the full range of equipment available. (Please be aware that items such as sterile water and filters are not always free.)

North Richmond CHC
23 Lennox St
NORTH RICHMOND
Ph: 03 9418 9830

Barwon Health
40 Little Malop St
GEE LONG
Ph: 03 5273 4000

Ballarat CHC
710 Sturt St
BALLARAT
Ph: 03 5338 4500

Bendigo CHC
171 Hargreaves St
BENDIGO
Ph 03 5448 1600

WHITEHORSE CHS
Level 2/43 Carrington St.
BOX HILL
Ph: 9890 2220

LATE NIGHT CHEMISTS

TAMBASSIS PHARMACY
Cnr Sydney and Brunswick Rds
Brunswick
Open: 8am-midnight
Ph: (03) 9387 8830

Mulqueeny Midnight
Pharmacy
418 High Street, Prahran 3181
Open: 8am - midnight
Ph: (03) 9510 3977





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