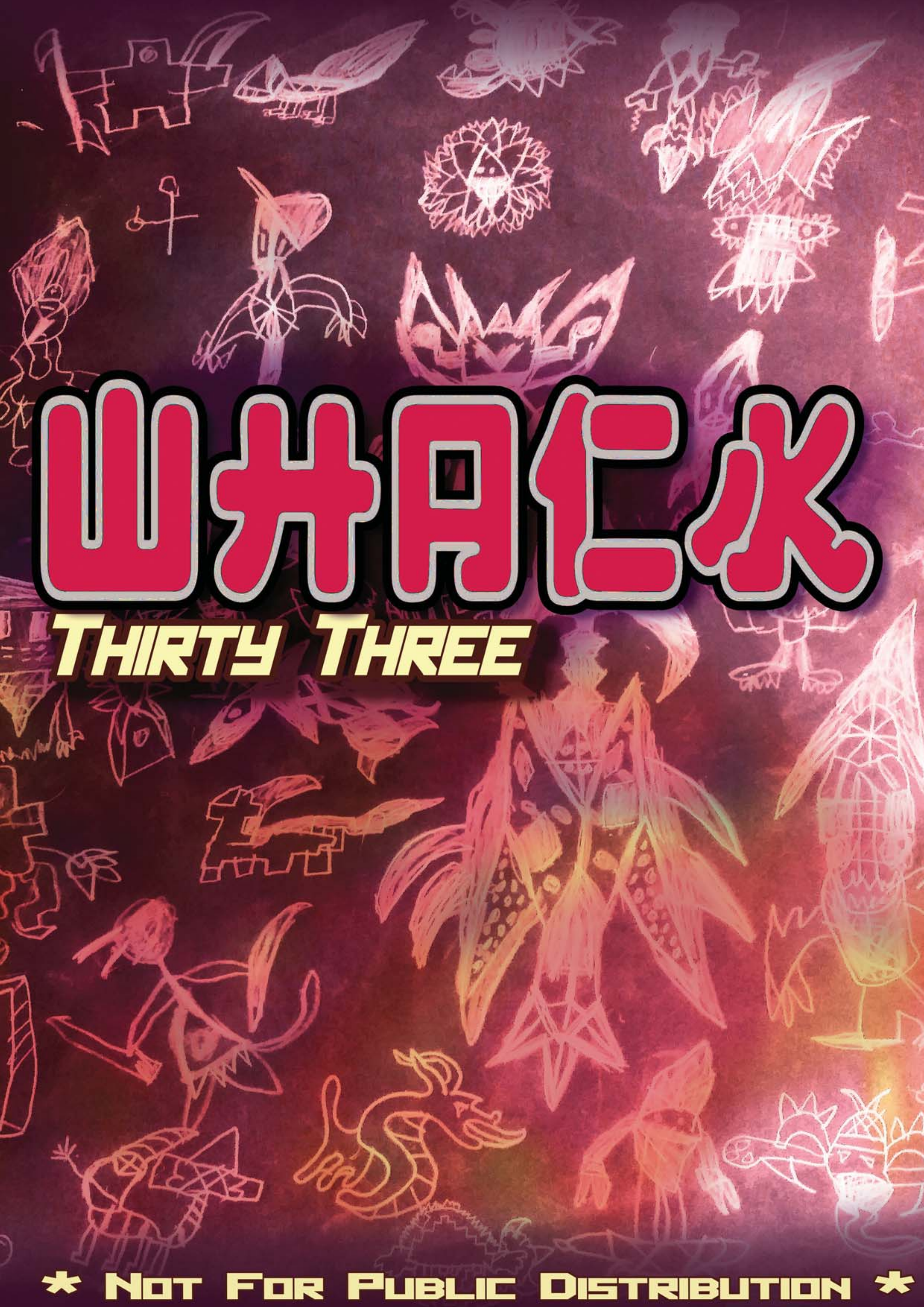


WHACK

THIRTY THREE

* NOT FOR PUBLIC DISTRIBUTION *


Milk
of the
Poppy
induces
unconsciousness
BRANDI

Editorial

This edition of WHACK! explores the family and more specifically, drug use and the family. We were interested to explore the experiences of parents who use and inject drugs and how they are perceived and treated by health care and child protection services. We are also delighted to include the voices of adult children and their experiences of growing up in a family with parents who used drugs (See **'She Worshipped the Ground I Walked On.'**)

These days, families come in all shapes and sizes. The nuclear family (*mother, father and their biological 2.4 children*) - once 'the norm' and the primary unit of society - has declined dramatically in the last few decades and now accounts for only around 20% of all families. In fact, the traditional nuclear family is just one of a vast variety of family structures and arrangements, including blended families, extended families, single parent families and same sex parent families, etc.

The family as we know it is changing. There is simply no such thing anymore as a typical or average family! Clearly a wide range of social forces have contributed to the transformation of the postmodern family, including higher divorce rates and the increasing number of women in the workforce. We at Harm Reduction Victoria are concerned that another contributing factor is the enforced removal of children due to parental drug use.

Given the complexity of the issues, it's hard to drill down into official statistics and identify the number of children who have been removed from their biological families due to drug related reasons. As a result, our evidence is largely anecdotal and unsupported by robust data. However the scale of the problem has led some to liken it to another 'stolen generation' of children, with the same potential for devastation and dislocation.

Visit any supermarket or shopping mall during business hours in Melbourne and you can't help but be struck by the proliferation of grandchildren in the care of their grandparents. Some will simply be providing day care while both parents (their sons and daughters) work; but others are undoubtedly the primary carers of their grandchildren, who will not be picked up at the end of the day and whose permanent residence is with their grandparents.

This edition of WHACK! contains several tragic stories of abusive and discriminatory attitudes and treatment of parents who use drugs on the part of healthcare providers (See **'Love, Oxytocin & Other Drugs'** and **'Frankie's Story'**)

Sadly these sorts of experiences are not uncommon among parents who use drugs and regularly reported to us at Harm Reduction Victoria.

We do not deny that people who use drugs come in all shapes and sizes and some are unable to provide a safe and secure environment for their children. And we appreciate that the safety of the child is paramount. To be fair, Child Protection Services regard the removal of a child as a last resort option and do everything in their power to keep families together. Harm Reduction Victoria also acknowledges the enormity of the task entrusted to Child Protection Services staff, which are left to deal with increasing numbers of notifications with limited resources and high staff turnover. However, it is the cruellest of ironies when vulnerable children, deemed at risk within their families are removed into the care of the state, only to be subjected to further abuse by agents of the state as recent investigations have revealed.

Sadly, we know that stigma and discrimination towards people who use drugs are the norm in our society. When children are added into the mix, levels of stigma and discrimination are exacerbated 100 fold and parents who use drugs are judged even more harshly. As the article on **'STIGMA: Its ugly head and what it eats'** demonstrates, parents who use drugs are viewed through a particularly suspicious and distrustful lens, by dint of their drug use alone. It is acutely apparent in many of the stories in this issue that it is simply and solely the use of drugs and/or pharmacotherapy which precipitates open hostility from health care staff, despite the absolute devotion of the parents in question towards their children and the absence of any suggestion of neglect or abuse.

We hope that this issue of WHACK! will throw into question some of the common assumptions and practices routinely adopted by healthcare providers when working with parents who use drugs. One of the most distressing spin-off effects is that parents are reluctant to request help if and/or when they need it, for fear of these sorts of reprisals – and so they remain silent and unsupported. One of the most distressing spin-off effects is that parents are reluctant to request help if and/or when they need it, for fear of these sorts of reprisals – and so they remain silent and unsupported. We trust that this edition will help to end the silence and lack of support for parents who use drugs and their children.

HARM REDUCTION VICTORIA

Our Values

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.

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.

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.

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:

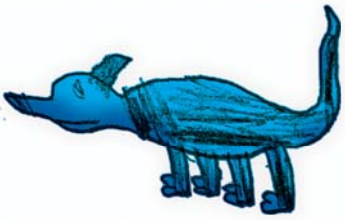
As the state-wide user organisation, Harm Reduction Victoria's mission is to be a drug-user-based and user-governed organisation.
We promote a harm reduction approach to drug use, with a philosophy of self-determination and empowerment. Harm Reduction Victoria aims to provide a voice for people who inject 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



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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. "Hep c Treatment " is the theme for the next issue & we would love to hear your thoughts, stories, artworks, interpretive dance or performance art. Well maybe those last two may be a little hard to print, but 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.

ICE ICE BABY.

Unless you've been living under a rock over the past few months, you may have noticed that the drug that's on everyone's radar at the moment is ice – chemically known as methamphetamine, formerly known as crystal meth, speed's stronger, scarier, big brother.

Just like Crack in the 80's and Heroin though out the 90's, ice is our supposed latest and greatest drug threat. Every day there's new stories in the papers and online about the harms to kids and families through ice-related violence and crime. Here a selection of recent headlines illustrate the bias:

Deadlier than ever: Welcome to the new ice age, Ice town: A Victorian region's 'terrifying' scourge , Ice-related crime set to escalate, 'Ice' assaults on the rise, Chemists dealing ice, Coaches supplying ice to players in grassroots footy crisis, Ice addicts clog our hospitals ***(Insert Celebrity name here)*** arrested for ice possession etc. etc.

So it would appear that everyone is either hopelessly hooked on ice or a victim of an ice-powered maniac. The Australian media just can't get enough of this excitingly, dangerous drug and the endless possibilities of combining ice hysteria with almost any news article (regardless of the truth) creates alluringly sensationalist articles and feeding the morally outraged, general public's insatiable appetite. Below is a small selection of relevant ice related articles that have been gripping the imagination of a frightened public in recent times.

ICE AND TRUCKIES

Police say that on average, one in twelve truck drivers are using Ice to stay alert while driving long distances. Commissioner Robert Hill said that there is an increase in ice use among all drivers, but the sheer number of those who are driving heavy vehicles under the influence is worrying. 'Using illicit drugs and jumping behind the wheel of a 60 tonne truck is a selfish and irresponsible act' says Mr Hill.

Police are also investigating claims of an alleged drug syndicate after claims ice is being sold to heavy haul drivers. A former Melbourne truck driver has also spoken about the culture of ice use among certain groups of truckies. He spoke about drivers taking drugs regularly and meeting areas were often set up between drivers over radios using codes, where drugs were then sold. "Yes, some people take speed and ice but there is ¬always going to be rampant drug use if truckers are -required to work these long hours" the truck driver said.

Last year 156 truck drivers were caught with methamphetamine in their systems in Australia.

ICE AND FOOTBALL

Politicians are calling for lifetime sports bans for officials or coaches dealing ice to players.

Early in March, a large commercial Australian radio station aired a call from a football player who claimed that as many as 27 players in his team played under the influence of ice. He said that ice use was rife in his club and he felt 'obliged' to take it, as he needed to perform to keep making money from football. ***"Out of those 30 players (in the practice match) about 25 to 27 players smoked ice before the game. It was the first time I ever tried it and it was terrible,'' he said. "You could definitely feel the physical effects and to be completely honest I could have broken my nose and I wouldn't have flinched. You just don't feel any pain. By the end of last season it was very acceptable and this season it's widely acceptable and widely used."***

Football personality EddieMcGuire said it might be time for wider drug testing in community sport after revelations players were using the drug as a performance-enhancing substance. Politician Darren Chester said penalties must be dramatic for anyone found guilty of trafficking ice through sporting clubs. ***"A trainer, coach or the team official is put in a position of trust in a football club. If they are caught trafficking illicit substances like ice, in addition to criminal penalties that may be applied, they should be banned from all football matches at all levels.***
We need to hit these scum-bag traffickers where it hurts."

ICE TREATMENT

Addiction treatment facilities are struggling to keep up with demand from people seeking help for ice usage with ice use escalating.

Almost 1 in 10 Australians have used ice or amphetamine type drugs - leaving drug treatment facilities struggling. The 2013 National Drug Strategy Household Survey (NDSHS) reports 7 per cent of Australians have used ATS (Amphetamine type substances) at least once in their lifetimes. It also reported that 2.1 percent had used in the last 12 months, with one quarter of ice users consuming the drug regularly. The same report has found that 1.2 per cent of Australians have tried heroin.

Addiction specialists say that there are not nearly enough treatment facilities or trained medical staff to address the level of ice addiction now present in Australia. Many services are being overwhelmed by the growing number of ATS cases, with people being asked to wait up to six months for treatment.

Clinical Director of Drug and Alcohol Services at St Vincent's Hospital, Dr Nadine Ezard, said "moral panic" about ice was not helping sensible debate about the drug ***"The message we want get across is that treatment does work and people are much better off in treatment, the earlier they present."***

Dr Mathew Frei, President of the Royal Australasian College of Physicians Chapter of Addiction Medicine said that there was a serious lack of medical addiction specialists, with only 200 currently in both Australia and New Zealand, with many due to retire during the next decade. ***"We are thin on the ground and we are finding it very hard to attract Junior Doctors"*** he said.

MEDICINAL MARIJUANA TRIALS *(THE NON- ICE RELATED NEWS)*

Protocols are being drawn up for the clinical trial of medical cannabis to treat children with severe epilepsy.

The clinical trial will be the first of its kind in Australia and part of a handful of similar studies carried out worldwide. Victorian Premier Daniel Andrews announced Victoria will join the NSW government for the medical cannabis clinical trials. Scheduled to start enrolling eligible patients in mid-2016, the results from the trial are expected to be available within two to five years. Up to 200 children from as young as six months of age may be included in the trial said Dr John Lawson, paediatric neurologist at Sydney Children's Hospital and a principal investigator on the trial. Those enrolled will be at the severe end of the epilepsy spectrum, and at least a couple of standard medications will have to have failed to help them.

Unlike street marijuana, which contains high levels of the chemical compound THC, the oil extract used in the trial will have high levels of cannabidiol or CBD, and low levels of THC. ***"This maximises the anti-seizure potential and decreases the risk of mind-altering psychoactive effects',*** Dr Lawson said. The medicinal cannabis will be in the form of a tincture or edible product. But Dr Lawson is cautioning against parents expecting miracle cures.
"The best estimates at the moment are maybe one-third will benefit and even in those who benefit, it's not necessarily a miracle – their seizures might be reduced," he said.

Global

THE DARK WEB'S DOCTOR X

Spanish family physician and illicit drug expert Dr. Fernando Caudeville has been donating his time to provide tailored harm reduction advice to drug users via dark web sites. Using the pseudonym Doctor X, Caudeville has answered hundreds of questions relating to illegal drug use during the last few years.

"I would like to contribute to this forum offering professional advice on topics related to drug use and health," wrote Doctor X in a discussion forum on the now defunct Silk Road website in April 2013.

The response was staggering and the Doctor was inundated with queries about dosage levels, drug interactions, adverse effects and toxicity. Questions ranged from alleviating cancer-related pain to how to store psychedelics to ensure maximum longevity. The only question that he didn't answer was one where a user was trying to get information about using benzodiazepines to knock a person out without their knowledge.

Caudeville's harm reduction message was tailored to his audience. By the time someone has become a member of a dark web marketplace, he believes that they have gone far beyond being curious about drug consumption. ***"Global Drug policy is based upon a repressive legal system that has proven to be ineffective and has caused more problems than the ones it is supposed to solve. I think dark web marketplaces will be an important factor that will force a change in drug policy in the near future."***

CRACK BABY STUDIES YEILDS UNEXPECTED RESULTS

After almost a quarter of a century, a US government funded study evaluating the in-utero effects of crack cocaine exposure on babies has ended.

When the study began in 1989, crack cocaine use in Philadelphia was at a record high. One in every six new mothers was testing positive at inner city hospitals. At the same time, the media portrayal was overwhelmingly bleak with social workers on TV predicting that a 'crack baby' would grow up to ***"have an IQ of perhaps 50."***

Print articles quoted psychologists as saying ***"crack was interfering with the central core of what it is to be human,"*** and other articles predicted that crack babies were ***"doomed to a life of uncertain suffering, of probable deviance, of permanent inferiority"*** The 'crack baby' became a symbol of bad parenting and many cocaine-using mothers had their babies taken from their care and adopted out to other families, or were arrested.

The study enrolled 224 near or full term babies born between 1989 and 1992 at the Albert Einstein Medical Centre. Half of the babies' mothers used cocaine and the other half, the control group, did not.

Despite the dire predictions, the researchers constantly found that there was no significant difference between the cocaine-exposed children and the control group. At age 4, the average IQ of the cocaine-exposed children was 79, and 81.9 for the non-exposed children. Yet strangely, both groups were well below the average of 90 to 109 for US children in the same group.

Researcher Hallam Hurt reflected: ***"We went looking for the effects of cocaine, but after a time, we began to ask, was there something else going on?"***

In time, Hurt and her team realised that the other significant factor was poverty.

As the children grew, the researchers began to look for other environmental factors that could be affecting their development. They realised that children who were raised in a nurturing environment – measured by factors such as caregiver warmth and affection, - were developing much better than kids in less nurturing homes.

The years of tracking led the researchers to a conclusion that was completely unexpected.

"Poverty is a more powerful influence on the outcome of inner city children than gestational exposure to cocaine."
Hurt said at a recent lecture.
"Given what we learned, we are invested in better understanding the effects of poverty. How can early effects be detected? Which developing systems are affected? And most important, how can findings inform interventions for our children?"

The research team plans to stay in touch with the participants each year. They have embarked on a new study that uses MRI and other tools to explore the neural and cognitive effects of poverty on infant development.

NEVADA CONSIDERING HEROIN TREATMENT PROGRAM

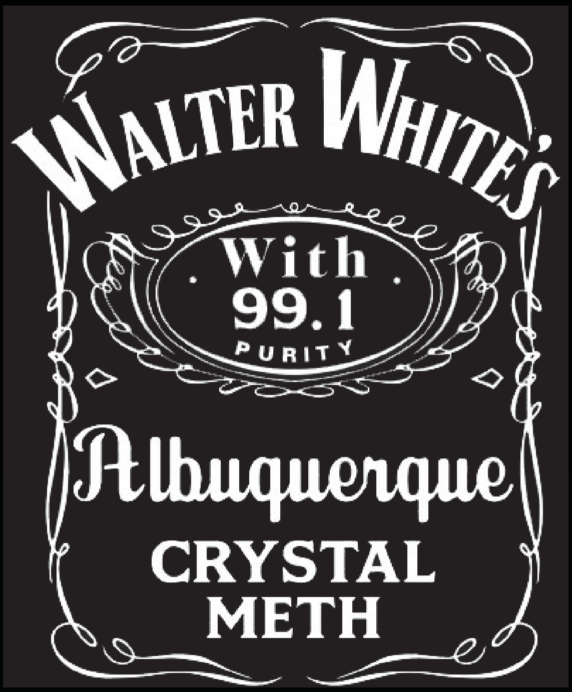
Heroin assisted programs have been highly successful in treating overdoses, disease and crime in countries such as Germany, Spain, the UK and Canada.

Heroin assisted treatment, also known as heroin maintenance, refers to the supervised administration of pharmaceutical grade heroin (***diacetylmorphine***) to users who have failed traditional forms of treatment, such as methadone, suboxone and subutex.

In March this year, Nevada State Senator Richard Segerblom introduced legislation through Senate Bill 275, to create a four year treatment pilot project.

"The war is over, we lost" said Sen. Segerblom.***"Now it's time to face reality and look for new solutions. SB 275 is one of those solutions."***

SB 275 would task the Nevada Division of Public and Behavioural Health with modelling the heroin assisted treatment pilot program, which is slated to begin treating patients by Jan 1 2017, on programs similar to those used successfully in other countries.



RUBY
is 11 yrs old

Ruby is eleven years old.

Ruby is intelligent and independent with a well-developed sense of self. Ruby likes to discuss big ideas and to be challenged mentally. She also loves to dance and sing. Ruby is immersed in a loving family. Both of Ruby's primary carers are drug users.

Grace and I have been together for two years so Grace has had nine more years raising Ruby than I have. One of Grace's most influential ideas about parenting is the importance of providing open and honest information about the world around us. Grace believes that this will encourage Ruby to make decisions and choices based on her own moral and cognitive abilities and equip Ruby with the necessary tools to learn about life through self-reflection and critical thought. Grace's commitment to honesty extends to all areas of life including one that is often considered the most challenging, i.e. communication about drugs.

Ruby has grown up immersed in festival culture, surrounded by a large group of people who are also drug users. However, Ruby sees them simply as fun, happy adults who take care of her, spend time with her and care for her. All of these people quickly subscribed to similar values when interacting with Ruby, once they observed that Ruby's world combined childhood and innocence, with a level of compassion and understanding not obvious in many adults.

As a result, Ruby is very knowledgeable about drugs, their risks and effects, why people choose to take drugs and their political implications. On a more specific level, Ruby is aware of our drug taking, the kinds of drugs we take, and when we would typically consume them (just as alcohol is dealt with in a typical family environment).

Though Ruby has been raised with knowledge of drugs, we have chosen to limit the exposure she has to our use. While we have no problem indulging in an alcoholic beverage while Ruby is around, we are less comfortable with consuming other drugs in her presence. As such, we have used LSD and ketamine in the safety and privacy of our home while Ruby has been in her bedroom. We let her know when this is going on but abstain from active consumption in front of her.
We see it a bit like our sex life; Ruby knows it goes on, but we obviously wouldn't do it in front of her because that would be completely inappropriate.

Although we are perfectly comfortable and content with our beliefs about the way we raise Ruby, life is not without its challenges. These challenges rarely stem from within our family unit but invariably come from external sources, from extended family, friends, and services. In line with our beliefs around parenting honesty is a big part of all of our relationships, and at times, we share our beliefs about drugs with others. This is usually met with judgemental attitudes and a range of different opinions.

Ruby is still developing her ability to read social cues and nuances which Grace and I constantly rely on to discern how much we share with others. We have had to discuss at length the sorts of attitudes, judgements and biases that her family and society at large may have towards drugs, which impacts on her ability to seek knowledge and discuss her beliefs. She knows that the laws which her formal supports operate within - such as school, doctors and her art therapist – are not open to the idea of drug users being good parents. This has resulted in a closed approach to sharing her life and thoughts with those around her. For fear that her world may be ripped apart if a service like the Department of Human Services (DHS) were to learn of our lifestyle and parenting choices, Ruby has developed a sense of 'socially appropriate' conversation with her friends and family.

Which brings me to the biggest adjustment I have had to make in response to my new family: my fear of what might happen if the outside world were to learn of our drug use.

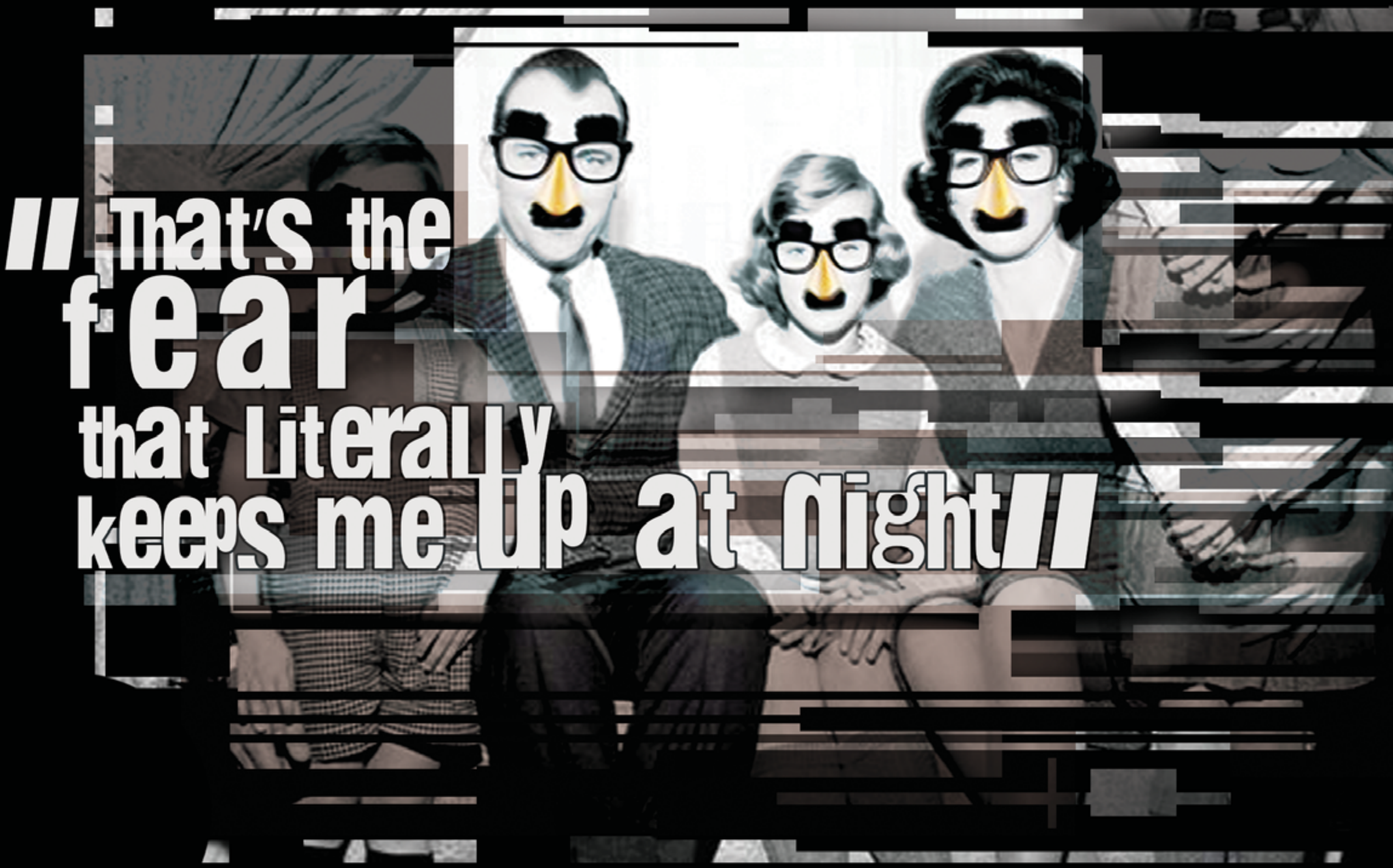
That's the fear that literally keeps me up at night.
It has penetrated my dreams.

I am so terrified that DHS may find out about our lifestyle and subsequently tear our loving family apart that I have woken in a panic from dreams where it has happened.

Not because we are bad parents or bad people.

Ruby is always fed, clothed, and well cared for. We face the same parenting decisions that all parents face and we put as much thought and care into those decisions as any other family.
But the stigma associated with drug use means that regardless of those efforts, drug users are seen as unfit to be parents.

So does our parenting style make drug use more appealing to Ruby?



"That's the fear that literally keeps me up at night"

Well, does sex education make sex more appealing to 11 year olds?

By creating an open and honest environment in which all topics are up for discussion, if Ruby has a question about drugs (or anything else) she can ask us.

This allows us to debunk the misinformation fed to her by fear campaigns about drugs and to give her a more accurate perspective. We don't play down the risks involved with drug use, but the information we share with her is based in fact rather than dogma.

Ruby knows that, sadly, the taboo surrounding sex and drugs means that they are often off-limits and there are limited people she can discuss these sorts of issues with or look to for support.

Hopefully when she reaches an age when the issue of drug use is more relevant to her and her teenage friends, she will still feel comfortable coming to us for information and support. Grace and I never alter who we are when we are around Ruby.

Our conversations in our home commonly concern who is cooking dinner that night, our work, and our plans for the weekend. And sometimes drugs are mentioned, because, just sometimes drugs are a part of our life.

ANONYMOUS

FENTANYL

100 times more potent than Morphine?

For some time now I have been asked to describe my recent adventures with the much hyped “super” opioid, fentanyl. But as a die-hard opioid user, I was in no hurry to precipitate a backlash by highlighting a new area of illicit use. Nor did I wish to compromise the position of those for whom fentanyl slow release patches offer stable pain relief. However, the recent explosion of material in the media about fentanyl use makes my initial concerns appear somewhat paranoid now.

The reference which most intrigued me and prompted me to end my silence was contained in a US Drug Enforcement Administration (**DEA**) report entitled **“Future Trends in Drugs of Abuse”.** It stated that *“one kilo of carfentanil (a potent form of fentanyl) is equivalent to six metric tons of heroin”.* You can’t beat advertising like that!

The report goes on to mention many novel drug types and analogues of great interest to the clandestine chemist. **DEA all the way!**

The morphine skeleton forms the structural basis of most opioids that we know and love, such as heroin (diacetyl-morphine), oxycodone or even buprenorphine. The only viable sources of morphine are from the natural product, opium. Pharmacologist and Nobel Prize winner, Dr Paul Janssen first discovered fentanyl in 1960, while attempting to find useful variations of the synthetic opioid, pethidine. Fentanyl is said to be a hundred times as potent as morphine, though derivatives can be up to ten thousand times more powerful.

The first use of fentanyl was in general anaesthesia in the 1960s. It was not long before the illicit drug market figured out the virtues of a substance that weight for weight was far stronger than heroin, but could be locally made from synthetic chemicals, thereby avoiding the dangers of border crossings.

Marketed under the brand-name ***“China-white”*** Fentanyl’s first appearance in the clandestine drug market in the mid-1970s was accompanied by many analogues of the basic drug, some of which were far more potent and often novel to medical science. This appearance coincided with a spate of opiate user deaths with all the hallmarks of overdose, but toxicology reports showed only minimal amounts or no opiates detected.

In fact it was the appearance of these analogues which then led to the introduction of analogue laws in USA and throughout most of the western world. Before this, all types of drugs had to be individually legislated for. By making small tweaks to the basic chemical structure of the drug, chemists were able to produce new and most importantly, legal substances for the market.

I still haven’t managed to produce my lifetime supply, i.e. one kilo of carfentanil, but I have had some experience with the substance. I believe that most long term users of “heroin” would have tried fentanyl, as well as a host of other synthetic and semi-synthetic substitutes marketed as the real thing. Most users will have experienced dope which stops you hanging out, but has no rush, or is just plain, not quite like heroin.
Now seems the appropriate time to add a word of warning.

This stuff is really dangerous!

And it’s difficult to gauge a safe dose.
I don’t intend to explain how to use the patches, but if you look past all the warnings on the internet, you will find directions. And if you really can’t work out what is needed by looking at a MIMS, stick to a safer opiate.

My own background is thirty years as an opiate user and I’m on around 50 mg of methadone, which gives me a kind of stability. Although I don’t actually hang out when I use nothing but methadone, it holds me at a comfortable level for only about eight hours and after this, I experience varying levels of discomfort. It is this methadone half-life which keeps me home at nights and makes employment difficult. According to my doctor, I’m a freak!

This is in spite of the fact that all the people I know on methadone, also use heroin to fill in the gaps. Only heroin users on methadone treatment are expected to make methadone last twenty four hours, as opposed to the six to eight hour dosing regimen when methadone is prescribed for non-heroin users.... but that’s another story.

My first experience with fentanyl came about because a friend was prescribed the slow release transdermal patches, but found they didn’t live up to his expectations. I gratefully took possession of the largest size fentanyl patches and using information from a MIMS, quickly devised a way to extract and use the active substance. I found my long sought after opioid to be rather short acting (about two hours) with little rush or euphoria.

My next experiences with fentanyl came about after realising that a friend was using patches to deal with chronic pain from a horrific car accident in his youth. I didn't really feel comfortable asking about his used patches, but after a while he started to give me a couple of his used patches twice a week. If I managed things carefully, I could have a taste every night of the week and a nicely balanced life, at last. However, the less desirable effects of fentanyl, combined with my undoubted weakness for opioids and the growing ravages of age combined for a less than ideal outcome.

Some of the effects of fentanyl are very different from what the heroin user comes to expect from an opioid. Sure, it's a mu opiate receptor agonist of great strength, but many users report disappointment. This is because people expect a heroin-type euphoric rush on administration. **Here lies the first danger.** The only way to get anything resembling a rush with fentanyl is to consume it while in withdrawal, or to use so much that you overdose. When I first worked with the patches, I offered some to a person who claimed to have a huge opiate tolerance. On two occasions he dropped and I spent my stone doing CPR to keep him alive. After the second time, I refused to use with him again. It was clear the drug only gave him what he was looking for when he overdosed. The euphoric effects of an opiate are independent of its strength as a pain reliever.

I also had some unusual experiences in the early days. Friends reported that after I had a dose I would sometimes *blank out*, unable to be roused, but still breathing and not strictly overdosed. This would last maybe five minutes, after which someone calling my name would bring me back to earth as though nothing had happened. Yet I still would not feel stoned in the heroin sense.

The other negative is the short duration of action. If I had the supply, I could easily dose every hour or two and consumption at this rate takes its toll on your veins. There are analogues of fentanyl which last longer, but this is not the case with fentanyl patches. These days I only use fentanyl to fill in the gaps left by an inadequate methadone program.

Attempts by pharmaceutical companies to make pills and preparations harder to inject usually result in more damaging formulations. Exceedingly rare is the opiate user who refuses some horrible pill mixture on health grounds. I mourn my beautiful veins which carried me through thirty years of heroin use, only to disappear over ten years of intermittent pharmaceutical use.

For people using fentanyl patches in the prescribed manner for pain, the above mentioned restrictions do not apply. The patches can be a great advance over other older opioids and delivery methods. The shorter duration is not a problem, as the patch slowly and evenly releases small volumes of the drug to be absorbed through the skin and slowly released through the body fat. It has given my friend a new lease on life compared to prior oxycodone, which between making him groggy and requiring ever increasing doses for less effect also kept him confined to bed.
I wish I could be prescribed fentanyl patches, rather than methadone. The stability to be gained by adequate dosing of slow release fentanyl, used as directed, would far outweigh the ups and downs of injecting fentanyl, or heroin, or oral methadone for that matter.

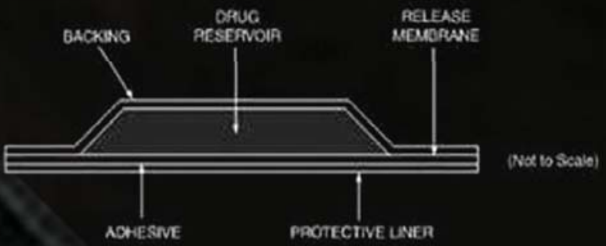
I can't really say that my life has improved over the last two years of bi-weekly fentanyl use. While hepatitis C and age were taking a toll on my energy levels before fentanyl, my health and energy are not what they used to be. Sure, I can get lots done on the fentanyl days, but the days in between are spent in limbo. Probably I'd be better off sticking with the inadequacies of methadone, but living half sick, half well, takes its toll and I don't blame myself or any other long term methadone user who looks for ways to iron out the ups and downs. Once I might have looked to heroin to fill the gaps. But with quality being what it is on the black market, I along with many others in the western world are turning to diverted pharmaceuticals.

For me, fentanyl is far from ideal, though it does give me some control over my opiate management, a need the medical establishment refuses to acknowledge. I resent that I have to resort to what I know to be dangerous drug practices to obtain this control and that my friend's attempts to assist me could prejudice his own supply. As an opiate dependant person I certainly look forward to patch change days, but I fear that my friend will begin to feel like a narcotic crop, harvested by me every few days. I also fear that my friend may feel unjustly responsible for my drug use and any negative impact this may have on my life.

Those of us who access the meds of ill people have a responsibility to protect their legal and medical security. As a very kind person, he should not have to take on a role which I, or at the very least, a doctor should and can play.

Fentanyl use is the inevitable outcome of a market where poor or unreliable heroin quality leads long term consumers to use more dangerous and less suitable pharmaceutical preparations. We live in an unjust society where the fate of the chronic drug user and the chronic pain sufferer are bound together by the forces of poverty, inadequate support, poor health care, etc. It is sad that some people are so financially compromised that they have to sell some of their desperately needed meds. Also sad is the lack of flexibility in treatment options for long term opioid users. There are worse things in the world than adults making an informed choice to consume opiates. Worst is the stigma suffered by legal and illegal users of opiates which compel both sides to settle for inadequate pain management.

Lord Elwood of Kadath



STILL LIVING

It's 40 degrees out and I'm in a portable office on the edge of a paddock in Event Operations listening to six radio channels at once. Punters are dropping like flies from a drug called *MXE* that's been sold as ketamine, similar but with three times the potency and I've never heard of it til now.
Medical have been dispatched, but I feel as if some of the problems the festival community faces in 2015 might be better dealt with in other ways.

Skip back to 1997, when I was seventeen years old and I went to my first outdoor party. My crew drove for fifteen hours from Adelaide to a party in the temperate rainforest in Victoria.

When we arrived we danced around coloured installations in the trees that turned to laser cathedrals at night. Crazy, costumed freaks stomped under majestic nature, lit by stars with giant, black speakers vibrating in place of my heartbeat. If you dance from dark till dawn, you can't help but glimpse of the divine. It was connectivity, personal but transcendent, the individual as part of the universe….and I belonged.

That was fifteen years ago now and here I am at a bush doof in the dust and extreme conditions, still working for something I believe in.

With a multitude of music festivals now, from one-day shirtless, meat markets playing popular anthems, to hipster bush parties with boutique line-ups, to non-profit events trucking along decades after they were a crazy idea, there is definitely something for everyone.

While the formula and locations are similar, the growing populations and the commercialisation of the electronic dance music scene means that we are losing some of the sense of community that was present at smaller parties.

But that doesn't have to result in a dilution of the bigger picture. It doesn't have to mean we stop looking after each other. We need to actively use knowledge and compassion to perpetuate this feeling, so it can follow us from the dancefloor into everyday life.

Two important concerns arising from the outdoor festival scene's growing population that require addressing are reducing harms from drug use and waste and recycling systems. Participants could benefit from learning what the 'leave no trace' mentality really entails.

Despite outward differences, to be human is to chase experiences. We challenge ourselves to understand more about our place on the earth, to blow our minds and gain perspective and context to the world. Throughout generations and geography, subcultures and fringe movements have often been inherently linked with these explorations through drugs. The drugs may change over time, but the reason we experiment with them remains mostly the same.

Taken in a good environment, equipped with a little caution and the right information, I have felt the connectedness of every atom on the earth flow through me in rainbows. I have raised my face to the heavens and felt intrinsically part of the universe. I have felt music reprogram me and upgrade my understanding to a level I haven't felt before. I have found new models of thinking and made lifelong friends from strangers. While I will probably revisit various drugs throughout my life, it must be acknowledged that I have also seen a darker side.

When once working at **Rave-safe** (Now known as **Dance-wize**), I spent six hours with a guy on his first acid trip. He was fielding calls on his tiny Nokia mobile in one hand, and a lebanese cucumber he had clutched in the other. In his mind, he was making deals, making things happen. I sat with him till the cucumber didn't ring anymore, and sent him back to the dancefloor when he was calm and rational, phone stashed in his pocket again, the useless vegetable given to me as a gift.
In recent years, whether as a punter or working in various festival roles, I have helped both strangers and people I know triumph over similar challenges brought on by drugs. I've had a few of those times myself.

THE DREAM

I watched a kid no older than eighteen turn blue in a few seconds from more speed and ecstasy than was rational, and I prayed to a god I may not believe in as chopper blades cut the air over the campsite. Luckily, the boy lived.

Driving back from a festival last year, I picked up a hitchhiker whose skin oozed the chemical smell of methamphetamine. He told me a sad and horrible story about his addictions and the social shunning because of them. He had been ditched by his friends to hitch home and offered me a slew of dodgy pharmaceuticals in lieu of petrol money.

Each of us makes our own choices when it comes to drug use, but these choices carry consequences, and it's up to us, as individuals and our crew as a whole, to watch out for each other. Occasionally, even the most seasoned drug taker can find themselves not coping due to mixing substances, or even worse, being sold something that's not what it was advertised as. Thankfully the high (or low) wears off eventually.

We are aiming to have a good time, all of us, together. Make sure you know what your friends are up to, don't leave someone alone and freaking out. Often a drink of water in the shade and a hug can ground most people's dangerous moments. Please seek help from medics or support services on festival sites, they're not there to judge you, just to keep everyone alive and well. In addition to proactively looking after our mates, we also need to take the preservation of these natural environments that we borrow more seriously; so we can lessen the effects of our temporary, mini-city invasions.

Nitrous oxide should always stay at camp and be disposed of responsibly, not left in a litter of empty bulbs on the dancefloor. The bulbs are shiny, pink and careless and won't be biodegrading in this life time. Some events have now taken a strict policy, and banned bulbs due to the litter. I would like to believe that users can self-regulate and we don't need our choices to be 'policed' like this, though the festival organisers I work for have had to cart literally tonnes of waste out, from abandoned couches, to rubbish, to actual shit-filled tents, left behind with no conscience.

It was humbling to go to Burning Man this year and be a part of a crowd of 70,000 people at the biggest 'leave no trace' event in the world. They have actually made a brand out of **"M.O.O.P" (Matter Out Of Place)**. The punters themselves police it, with sayings like *'don't give me that moop'* or *'you are losing your moop'* or *'that outfit looks moopy'*. In true American style, the subject of waste is addressed head on, directly, and in-your-face, but it works. Pack it in, Pack it out. There are consequences for camps who don't abide by this ethos. I want to live in a world where our festivals are 'leave no trace' for real and there's someone with a tutu on and a megaphone screaming in the faces of litterbugs.

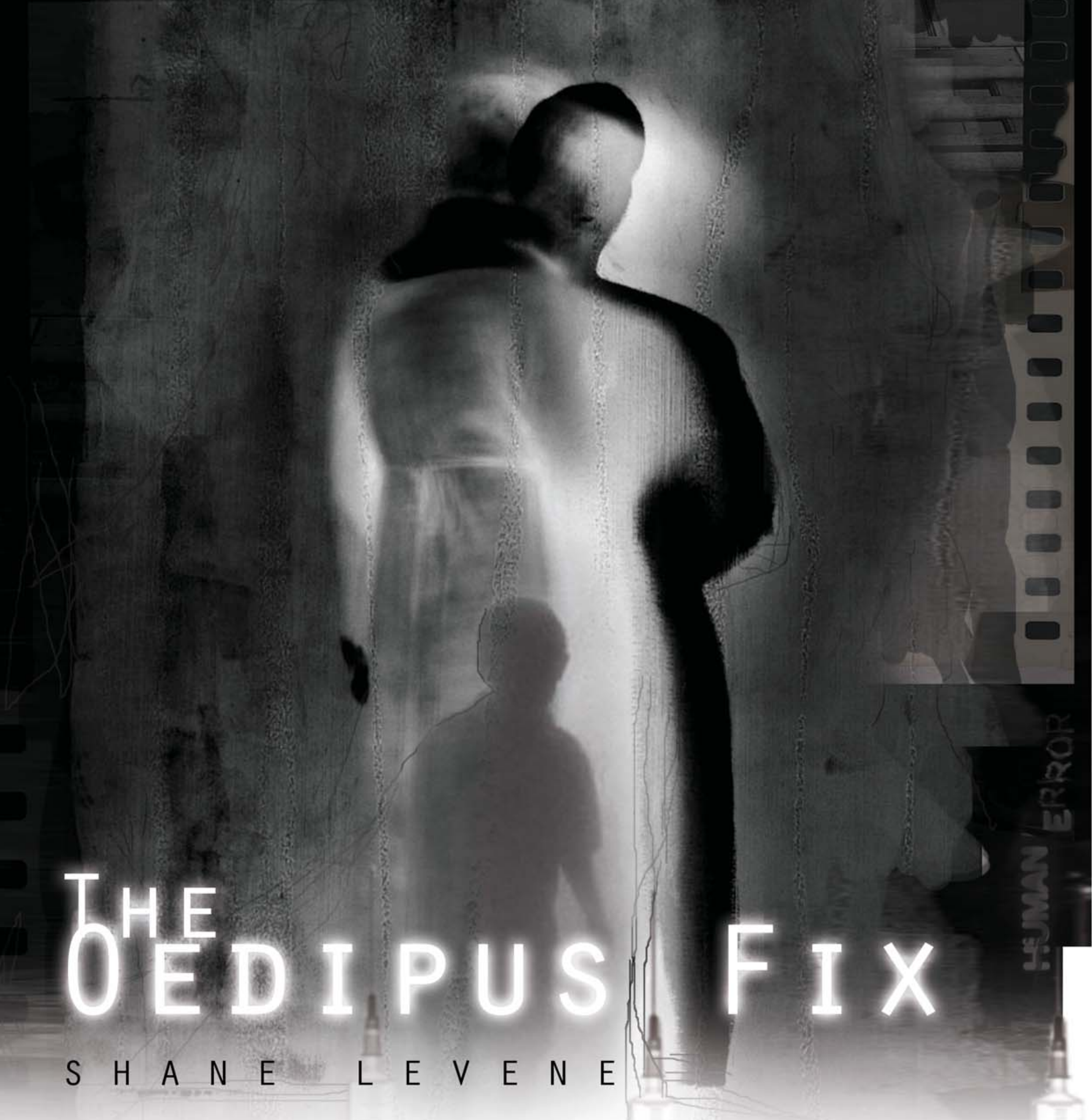
So as we head into another season of day parties under city bridges, and convoys of cars heading off to paddocks with feather boas streaming out of the windows, I write this article with honesty to begin these discussions and to continue them. There is a need to foster the growing community, to nurture the family, to share knowledge on a deeper level, not just asking each other where the closest porta loos are, or who's playing tonight.

It's up to you, because you decide what the party is going to be like with your choices. Please be mindful about the greater issues, be proactive about the environment, and act as an ambassador for the togetherness we are all hoping to feel part of.

If you take drugs, choose them wisely. Get educated. Get involved. Educate others. Keep hydrated. Bin your butts. Trust your posse. Set an example for the next generation of young ravers coming through. Pick up that rubbish or even better, tell the guy who dropped it to pick it up!

Let's create a new reality, even for a weekend.

BO KITTY



THE OEDIPUS FIX

SHANE LEVENE

When my mother quit drinking and became a crack and heroin addict those were the start of the good times. Finally we had some common ground, a common plight, something which drew us together in a shared effort to feed the beast of addiction, adapt with what we had and survive. Through heroin and crack cocaine we were to suck and shoot and chase out the ghosts of the past, come full circle in our relationship and return to each other what had been lost through a bizarre and tragic event in our lives. In the midst of those days of addiction, what was gone or had happened in the past became unimportant. All we cared about was the present and maybe tomorrow. But yesterdays were out. Yesterdays were redundant. Nothing will ever happen yesterday.

A family tragedy can have one of two effects: it can blow a family wide apart or it can bind one together for life. Our family tragedy resulted in the former, in my mother going off the rails and becoming a chronic alcoholic and suicidalist. We lost her at that point. And although it was a family tragedy – it affected my brother and two sisters and stepfather – a small matter of biology, that which had not been so significant before, suddenly took on grave proportions and sent my mother and I careering off on converging orbits around twenty years of time.

It was the disappearance of my father which started it. He left one night after an argument with my mother when she refused to lend him money for heroin and never returned. And although this was not the first time he had disappeared, it was the first time he had done so without soon making some kind of contact – even if just to say he was once again in prison. After weeks and then months of receiving no news, my mother conceded to the inevitable that something tragic must have happened to him. She would later say that she imagined he had quietly overdosed and died somewhere, been marked down as one of the many unidentified young deaths in the capital each year.

It was some months after my father's disappearance, in the first half of the New Year that news started breaking across the country of a "House of Horrors" in north London. A man had been arrested after human remains were found clogging up the drains outside the house in which he resided. It transpired that over a five year period, between two houses, 16 young, mostly homosexual men, had been murdered, dismembered, and disposed of in various ways. As with the entire country my mother was gripped by this story and followed in shocked interest as the gruesome tale unfolded. The news broke, went from the front pages to the second, from the second to the third, and then faded away completely awaiting the big trial. It was one afternoon during this quiet period that my mother opened the door to two uniformed police officers and two detectives. Her life would never be the same again. On that humdrum day, with nothing going on but what was on the stove, my mother was informed that my father's skull had been discovered in the flat of Dennis Nilsen: The House of Horrors. My mother's world went silent. She did not hear her own screaming. I heard it, and it did not stop.

My mother changed after that; life changed. Post-murder she would lock herself away in her room, sobbing, drinking and threatening suicide. She became sexually promiscuous, taking lovers of the lowest order, of both sexes and all colours, shapes and sizes. The murder also had a great impact on my life: it greatly magnified my significance of being. I was no longer just my father's son (the only child of four born of him) but I was now the only physical thing left of him. As a consequence, I became my mother's favourite child, the one she would call on for everything and keep always by her side.

"You have your father's chest," she would say, crying while fingering the indent below my sternum. Then she would lay her head on me and her tears would collect in the little well of my pectus excavatum. I would stare at the top of her head, at the dark roots which she no longer bothered to bleach. Her hair smelled of vomit. I was terrified to touch her.

My mother's slobbering and drunken affection was one thing, but there was something else going on below, something altogether darker and contradictory and all the more difficult to understand. As often as she would hold and bathe me in tears and alcohol fumes, she just as often rejected me – seemed to despise me. It was as if I were being punished for something. She would constantly call on me, only for me to find her sitting on the floor holding a carving knife and sporting cut and slashed wrists. On other occasions she would screech my name and sobbing, tell me she had cancer and was dying. Through evenings of drunken sex with multiple lovers she would have me remain in her room. At night I would be beckoned to sleep with her. Through the blackest hours, the dystopian hollow of late night radio crackling through the dark, she'd sit naked and sobbing on the edge of the bed, hurting herself and saying she wanted to die and that this life is a rotten life. I'd listen to the top being unscrewed from her bottle of vodka, the chink of glass against glass and the gulping sound of neat alcohol pouring free. Far from being a treasured remnant of my father it seemed that I was a constant reminder of him, never allowing my mother to forget him, or the murder, for a second. And so, with a special kind of hatred reserved in her face, my mother would tell me that she loved me, all the while glaring at me as if I were the murderer himself.

The feeling of love and hate was mutual: my mother was two different people. Her spectre after the murder attracted and repelled me; beguiled and haunted me. From behind – mid-length blonde hair, slim punkish figure – she held all the promise of the love, comfort and protection that I craved, only for her to turn around to be wearing the hideous made-up mask of chronic alcoholism. It hung lopsided over her real self, covering all my dreams and yearnings. It was in trying to prise away that mask, to get to the woman underneath that I first began down the road in life I did.

Between that mental longing for my mother, being saddened by the carnage of her sexual life and yet conscious of the types of wild men she admired, a certain path of history was marked out for me. By the age of ten I was going to school with a mock tourniquet tied around my bicep. I'd sit at the back of class acting like I was drugged. My role models became the kind of men who could fuck my own mother, and more than just fuck her: keep her. I realised in that time that we are not only ourselves in life, that we have an historical destiny of being other people as well. I began head-butting brick walls and cast iron doors, cutting words into myself, emulating the psychotic behaviour of the Alan Bleasedale character Yosser Hughes who was so in vogue at the time and my mother's latest hero. I studied these people, incorporated them into my character. They were all leading to one person, a man I was destined to rival and replace: my father.

In the years that followed, as I grew and matured, I became ever more rebellious. I romanced my mother with a progressive descent into wild reckless living, passionate behaviours and self-harm. By the age of 12 I was smoking and from 14 I was a regular drug user – using in front of my mother as she filled her glass with vodka. She would condemn my behaviour, but in the way she spoke of me to friends and neighbours – or in the way she looked at me as I chopped up lines of speed - I could tell that in some ways it secretly thrilled her, reminded her of someone she had lost. For my part I guess I wanted to impress and hurt her. I was duelling for her heart but also pushing into her face the damage I felt she had caused. I was young and had not yet learnt that adulthood does not make one responsible, and even if it did, there are certain events which occur in life which make your own survival a matter of the greatest importance. And sometimes, to survive, it is necessary not to exist for a while, to block out the trauma and subdue the body to the point of being anaesthetized. In time I would learn that for myself. It would be the point where I understood my mother and where all blame and hatred began to disappear.

THE OEDIPUS FIX

Soft, class C and B drugs were one thing, but the real spectre that had forever been in my life, romancing me, was that of heroin. It came from my father, from all the stories which existed of him:, from the memory of having found him after an overdose, waiting with my mother in the dark street while looking to the distance for the swirling lights of the ambulance to appear. It was a route I was someday sure to take, maybe even a route I needed to take. From the age of 15 on I began seriously enquiring about heroin amongst friends and other drug users I knew. But heroin was not part of their vocabulary and they all, without exception, damned the drug and told me to never touch that shit. It was finally, and quite surreptitiously, that a heroin-like opiate first entered our lives. It came via my mother's latest partner, Geoff, who she had met while he was serving a fifteen year prison sentence for firearms charges and hostage taking. He was up for parole and my mother had agreed that he could be bound over to our abode.

He arrived one Friday with a single black Adidas sports bag, pin-prick pupils and strips of small white prescription pills called Temgesic. He said that they were morphine based, an active drug called buprenorphine. He crushed these pills, snorted them and would then sleep. Not long after his arrival my mother began sleeping inordinate amounts as well.

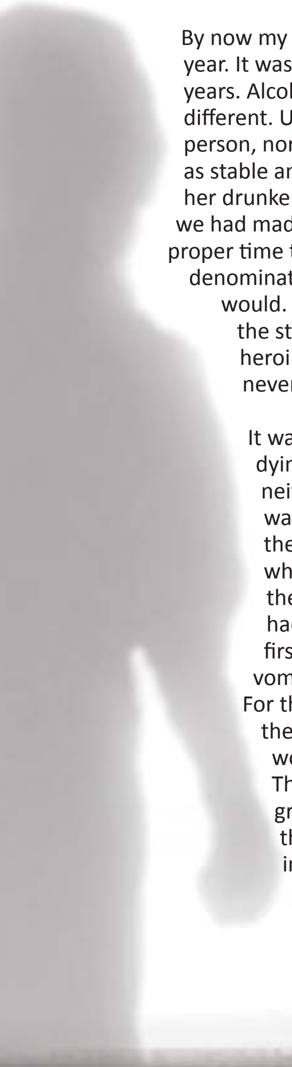
"Geoff, give us a couple of them pills, "I asked him one afternoon. He gave a cautious look around and, satisfied that my mother wasn't coming down the hallway, popped two little pills free from the strip and gave them to me.
"Half at a time," he said. "And for Christ's sake don't tell ya fucking mother!" I did as Geoff had said. Within an hour I felt like a hero, like my body and soul were finally united. Instantaneously, all other drugs became irrelevant and obsolete.

Within months of Geoff's arrival we were all psychologically hooked on these pills. As our usage increased, so our tolerance built up and we needed ever more for the same ends. We were soon in the position where we could no longer score enough to last us even a week. Each time we had to wait to the end of the month for our contact's prescription to be renewed. We would pass those dry weeks using amphetamines. As the speed dealer was my contact so I began not only scoring for myself but for my mother too. In a joint effort to subdue the opiate cravings we were starting to come together, use together and pass the days high together. It was the beginning of us transgressing the mother/son relationship. From there it was only a matter of time that I would one day arrive home with heroin and use it in front of my mother. And that's what was soon to happen... almost.

Buprenorphine was a dead duck. Our contact's mother finally died from the cancer which had been eating her alive during the past 18 months. In a single flat we now had three people with psychological opiate addictions and no opiates. For a while Geoff and I hit the streets and homeless shelters looking for a new contact. Buprenorphine was a very rare drug in them days, not yet used to treat heroin addiction. Our search was always fruitless. On occasion we managed to score methadone and a wide range of tranquillizers and anti-psychotics, but they either did nothing, or not enough, or just were not the same. Our collective attention now turned to heroin. We enquired about scoring at every opportunity. Geoff and I would take evening walk-throughs of what we thought were likely places we could score. Heroin is rampant in London, but it is a hidden, secretive world and not at all easy to find that first swing-door in. As complete novices to the scene we looked for it in all the wrong places, asked all the wrong people. We had no idea of the few obvious signs which cut heroin users out. Finding ones way into the world of smack is akin to one of those magic eye puzzles. You stare at the confusion of pattern and see nothing, but once you've cracked the code, revealed the image lying beneath, you can thereafter see nothing else. The world of heroin is like that. It is invisible until you are a part of it, and then it is everywhere and inescapable. It hangs about on every street corner; sits inauspiciously along the bench in the park. It stands waiting at bus-stops and takes no bus, is found pushed up, two at a time, in public telephone booths. It is the man with the army jacket and the limp and the swollen hands, it is the couple down the road who you think are mentally ill. It is the neighbour who begs to borrow five pounds, repays it and borrows it once more. It runs rampant through the old toothless woman who has nothing but a stinking husband with a missing leg. It is in the young man who walks hurriedly past your window six times a day, yabbering into his phone while quickening his pace some more. It is in the emaciated woman in cheap shapeless denim jeans with bloodstains down the inner thigh. It is the beggar who sits alongside the cash machine with two blankets, a bag and a dog, in the transvestite who waits outside the fruit market on warm summer nights like he's touting for last business. It is in 30 year old men with walking canes and crumbling bones and something grey and lost in the face and eyes. It comes hunched and snivelling out of the local hostels at 8am, hobbling off to the methadone clinic in a commotion of disputes and disorder and stale smells. It is in the skeletal woman with pink shades and flip-flops, pulled down the high-street by five mongrel dogs off a single leash.

It is everywhere and all around. And that is only the start, the illusion that comes forth out the puzzle. For the epidemic is worse than that. Heroin is in that man who just passed you by, in those who have nothing of which to be described. It is in the desk sergeant who books you in and in the lawyer who takes your case. It's in the Good Samaritan's other life, the one where he is going under fast himself. It's in the shopkeeper and the taxi-driver and the sober television presenter. It is in the secretary and dental assistant and in the gynaecologist peering between your legs. It's in mansions and terraced houses and the family home, well fed and stable and without the slightest sign of malnutrition or disease. Domesticated and camouflaged, peeping out from behind white nets like any other dying neighbour on civvy street. It passed from the father to the son and now was in the mother too. The holy trinity of the nuclear family. Silver spoons and citric acid and 1ml insulin syringes. Filtering life and shooting away the ghosts of the past, heads bowed between the knees, supple spines and dribble hanging from the mouth. And just like that she came, Our Lady of the Flowers, heroin – brought home to exaltation: the cure to modern life.

It was Geoff who found the first dealer. His name was Mark, a white guy who served up across the other side of town. What began as a weekend thing soon progressed to us having a mid-week break out too. Three months further on and we were using every other evening. The fishy scent of smoked heroin gradually replaced the smell of the evening dinner, my mother and I anxiously awaiting Geoff's return home and then all of us rattling around squares of tin foil before slowly retracting into ourselves. It remained like that for some time and then one day, for no reason I can explain, it felt right to smoke what I had left from the previous evening on waking. And my crinkling foil and sparking lighter were soon not the only ones piercing the quiet of the still dark morning. Geoff and my mother were now doing the same. Once that started heroin then became a daily thing. And if for any reason we did not have our waking fix then we would take the morning off work, score, get ourselves mended and turn in for a half day with some fantastic excuse as to why we were so late. Then, one evening, after less than five months into the heroin scene, the first bizarre tragedy occurred: the police knocked us up and took Geoff away for questioning after the dealer Mark had been shot dead 25 minutes after serving him. Nothing came off it, but we had lost our main dealer and now the onus fell on me to supply the household.



By now my mother had not drank for the best part of a year. It was the longest she had been sober in almost 20 years. Alcohol had been replaced by heroin. Yet heroin was different. Under its influence my mother was not a nasty person, nor did it make her want to harm herself. She was as stable and caring as when she was sober. Finally, without her drunken binges blowing up and destroying any headway we had made during drink-free days, we were spending proper time together. But still, even with heroin as common denominator between us, we had not bonded. We soon would. Something would happen which would heighten the stakes, ensure that from then on we prioritized heroin and worked together to ensure that we were never without it.

It was sickness. It came creeping in like a poisoned, dying rat and shook us all to the core. Until then neither of us had understood what addiction really was. We thought that like the buprenorphine, when the drugs or cash ran out, we could just leave it until whenever and try in whatever way we could to pass the days. But heroin was a different beast; one we hadn't encountered before. By the evening of the first day we were all bedridden and my mother was vomiting and crying and saying she couldn't take it. For three days we lay on our backs, sick through to the marrow of our bones, with all the poisons of the world breaking out through the pores in our skin. The clock ticked by in hour length seconds. We groaned and swore at invisible pains and cursed the day we were born and the world we were born into. We damned the rich and the fortunate and we bellyached about not having a pittance between us. We cursed our employers and bemoaned the banking system that makes one wait four days for a cheque to either clear or bounce. We cursed almost everything, but we never cursed heroin: we prayed for that - each of us sending out silent messages to a God that none of us believed in. On the fourth day I managed to get hold of a friend who had been out of town. She bailed us out and sat and watched with tears in her eyes as a whole family recovered from heroin sickness within 2 minutes of ripping open our bags. From that day forward heroin changed and our relationships changed. For the first time in our lives my mother and I had the same agenda and were living an extreme life experience together - both in need of heroin to survive. Our relationship tightened. With debilitating junk sickness we found empathy with one another. From a single event years ago, for our own distinct reasons, we now suffered the same consequences and were fighting life together. And the bond would tighten further still. Firstly due to crack cocaine, and then grace to the syringe and finally from the departure of Geoff.

A year into our drug addictions and many things had changed. Geoff was taking on extra private work and I had landed myself a top paying job with a huge annual budget which could only get me into trouble. By now we were not only doing heroin but crack cocaine and my habit had evolved to the needle. I really had become my father, could feel his presence in myself as I lived his life. I took a strange delight in stabbing those first few weeks of injections into myself in front of my mother. She watched and it made her think of the man she had lost, and now here was his son, the same age as the father was when murdered, continuing on with exactly the same thing. With Geoff and I out working to earn the cash to supply our habits, my mother's job each day was to score the heroin and crack so as it would be waiting for us when we arrived home. My mother also had the added chores of picking me up fresh syringes and dropping my old ones off at the exchange, along with ensuring I always had Vit C and fresh filters.

As our drug use mounted Geoff, single-handedly trying to supply his and my mother's habit, ran into financial problems. I, on the other hand, for the most part, had only my own habit to supply and could cope quite well. This led to tensions within the house. On the nights where Geoff could not afford any crack (which was more and more often) I'd secretly supply my mother with rocks. Not that it was much of a secret. It's quite obvious when someone is bug-eyed and cracked up, and so Geoff was often left alone in the adjacent room, knowing what was going on, craving crack himself and becoming frustrated and angry. My mother had become a kind of drug whore, rushing between the two of us with her crack pipe and getting what she could from each. When Geoff's financial problems escalated further, and then after he fell 75ft from a roof and broke both ankles, his time beside my mother was coming to an end. Laid up in hospital following his operation, Geoff caught a superbug infection which eventually led to him having both legs amputated at the knee. Two months after the amputation he returned home, but in his absence things had changed and so had he. With no legs he used mum as a housemaid and nurse, and began shouting orders for crack cocaine at me from the bedroom, threatening to chuck me out the house if I didn't comply. Finally, we had all had enough... Geoff too. My mother was in no position to look after a disabled and demanding crack-head, and after months of incessant arguing and fighting, Geoff left. I carried him downstairs and wheeled him to the Social Security offices. I rolled him to the reception desk and left, putting two rocks of heroin and 100 pounds in his top pocket. With no handshake and no goodbye I left - though in all honesty I expected to see him later, hear some half-arsed story as to why he couldn't be re-housed and was back. But he never did come back. I, nor my mother would ever see him again.

Now it was just my mother and I. Our crack problem was enormous and getting worse and I had began pilfering money from the work budget to support our habits. Now we spent all our evenings together. We scored together, used together, rattled through the jitters and sickness together. When funds got low we concocted schemes together and pawned our belongings. It all made for a life of the intimacy that only drug fiends ever know, a total honesty of the condition amongst one another. We would get cracked up and speak of the past and of my father and growing up. But without alcohol violating her emotions my mother now seemed a victim and not the victimiser. I had by then experienced a tragic love-split myself and understood the great trauma that losing someone so important can bring. I understood my mother and I loved her. I expressed that love in rocks of crack and in ensuring that she didn't get ill. When she thought we were all out of gear for the night I'd call her and surprise her with bags I had bought and hidden just for that very moment. For her part she loved me through her total acceptance of my habit. She would not only ensure I always had clean needles and a safe place to use, but would extract dangling needles from my body as I nodded out and help with tricky injections when my venal system began fucking up. She almost certainly kept me alive and healthy. Even when she quit heroin herself she still allowed me to use in the house, in front of her, and still scored for me so as I could get to work. Not once did she bemoan my continued addiction and not once did she relapse herself. By living together through over 5 years of chronic heroin and crack addiction we gradually found ourselves in that oblivion of smack and smoke and dream states, helped one another through it and made the hardest times as least wearing on our bodies as possible. I've no doubt some will see it as perverse, will condemn and immoralize both our behaviours, but for me they were the greatest days of our lives and I look back on those desperate times with a fondness that rips my heart in two by the sheer fact that they are over now.

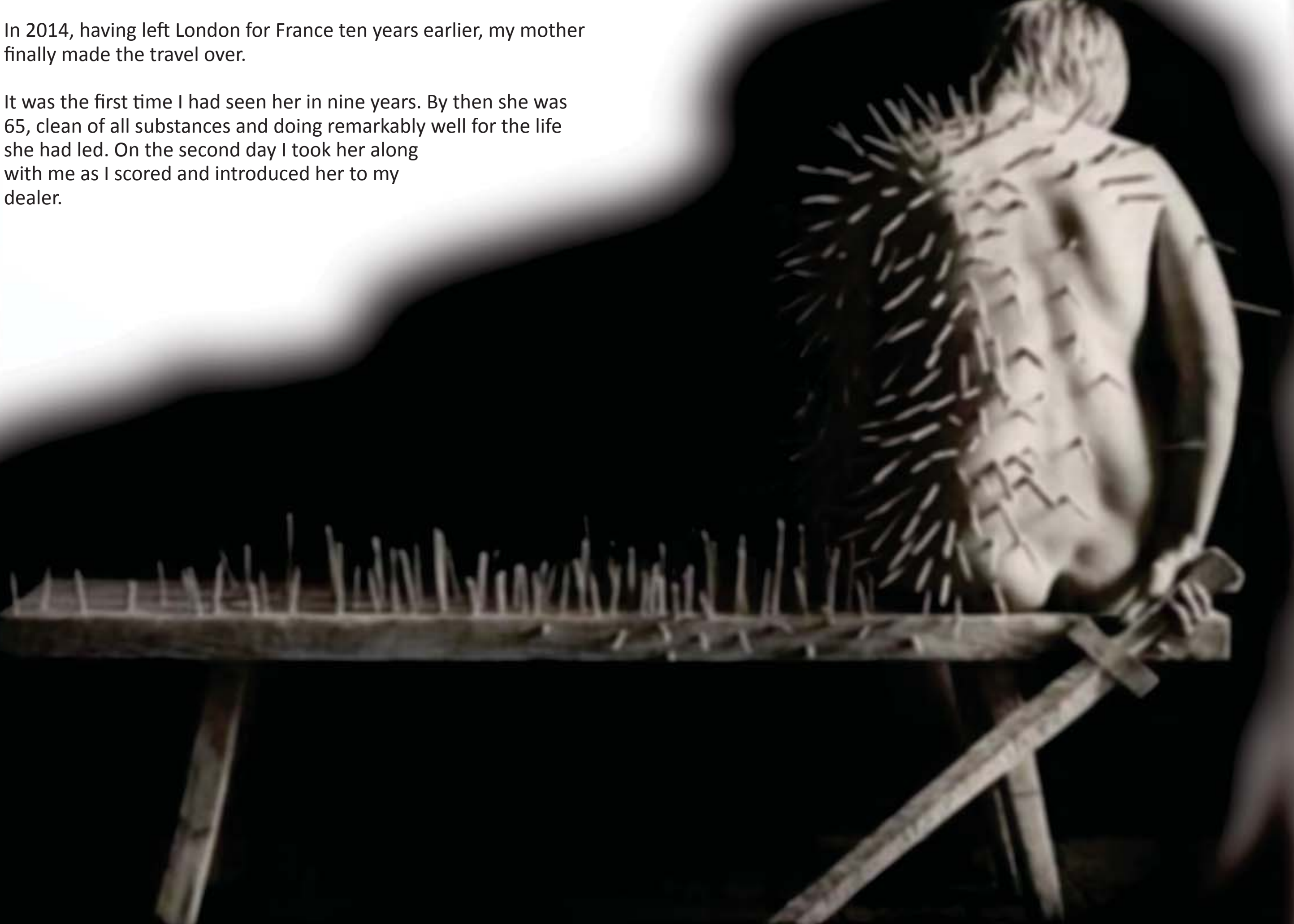
In 2014, having left London for France ten years earlier, my mother finally made the travel over.

It was the first time I had seen her in nine years. By then she was 65, clean of all substances and doing remarkably well for the life she had led. On the second day I took her along with me as I scored and introduced her to my dealer.

Back home I said to her: "One for old times' sake, mum?" She looked at me, screwed her face up and shook her head: "I'm done with all that, Shane... I don't wanna start down that road again."

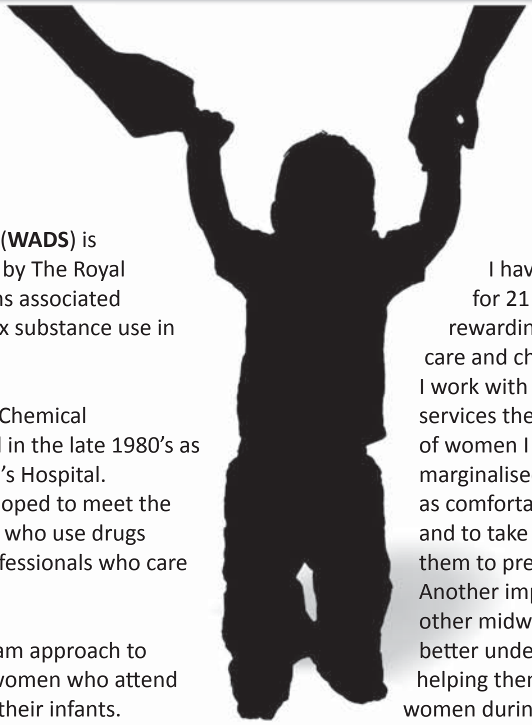
I nodded and then excused myself and went in the bathroom and cried. It wasn't that she was done with it, nor that there was any real chance of her falling back into addiction. The truth was that she had gotten old and soon she would not be here at all. It was the cruelness of time, the terrible fate of ageing. Our joint heroin and crack days were over, lost to another time and gone forever. My mother was just my mother now, a little less wild, a lot less young but as beautiful as ever. I composed myself, dried my eyes and returned to the room. I cooked a fix and took an injection and lay down beside her. From behind me I could feel her breath and the heaving of her chest as she watched television. I watched the images too and after only moments felt a calmness descend upon me that I had not felt for many years. Soon my cigarette was being lightly lifted from my fingers.

"Shane, you're fucking burning yourself," she said, chiding me. But before I could reply I was off again, my eyelids closing over on another evening of life, drifting off heavy now and dreaming of nothing in my graceless heroin state.



W.A.D.S INTERVIEW

Womens Alcohol & Drugs Service
The Royal Womens Hospital Melbourne



What is WADS?

The Women's Alcohol & Drug Service (**WADS**) is a unique, state wide service provided by The Royal Women's Hospital to reduce the harms associated with alcohol dependence and complex substance use in pregnancy.

The service (previously known as the Chemical Dependency Unit – CDU) commenced in the late 1980's as an obstetric unit of The Royal Women's Hospital.
Over the years it has grown and developed to meet the needs of the client group (i.e. women who use drugs during pregnancy) and the health professionals who care for them.

WADS provides a multidisciplinary team approach to address the health and wellbeing of women who attend the service and the medical needs of their infants.
We offer access to a wide range of clinical services to care for pregnant women and their infants including:

- **Addiction medicine**
- **AOD counselling and assessment**
- **Obstetric care**
- **Paediatric care**
- **Midwifery care**
- **Methadone stabilisation program**
- **Mental health assessment**
- **Nutritional care**
- **Pharmaceutical advice and assessment.**

WADS also provides a number of services to health professionals throughout Victoria including:

- **Training and education services**
- **Mentoring and secondary consultation**
- **Research**
- **24 hour on call obstetric service**

What does WADS do?

I have worked as a midwife with **WADS** for 21 years and it has been a most rewarding time. I enjoy providing pregnancy care and childbirth education to the women I work with and assisting them to access the services they need during pregnancy. The group of women I work with often feel judged and marginalised and my aim is to make them feel as comfortable as possible in the hospital setting and to take joy in their pregnancies as we assist them to prepare for birth and parenting.
Another important part of my role is educating other midwives and health professionals to better understand alcohol and drug use and helping them to work in collaboration with women during pregnancy.

Why do we need a service like WADS?

Women who use alcohol and drugs need access to non-judgemental pre and post natal care. They frequently need information about safe detox or management of opioid substitution therapies (OST) e.g. methadone or buprenorphine during pregnancy. They may have high risk pregnancies and be at higher risk of miscarriage; they may give birth to premature and small babies who require specialist care. Our clients may also have other medical conditions (e.g. chronic hepatitis C, poor nutrition and dental concerns) as well as mental health and psychosocial issues (e.g. safe housing, etc.) all of which can impact on their pregnancy. Some may need access to AOD counselling and other psychosocial supports to prepare for the birth of a baby and to ensure good outcomes for themselves and their infants.

W.A.D.S INTERVEIW

Womens Alcohol & Drugs Service

The Royal Womens Hospital Melbourne

Patterns of drug use observed at WADS

A lot has changed over the years since I first started at **WADS**. Initially we were seeing predominately women who used heroin and only methadone treatment was available at that time.
Since then, we have seen the advent of new pharmacotherapies such as Subutex and Suboxone. We have also seen changes in the different types of benzodiazepines that woman use, from Rohypnol and Serapax, to Xanax and over the years we have developed significant expertise in the management of benzo use. Cannabis and poly drug use have been consistently reported by our clients.
However, in recent years women seem to be disclosing more alcohol use and we are currently seeing a lot of women using methamphetamines or ice. We have developed a partnership with De Paul House (St Vincent's Health) whereby pregnant women can be admitted for detox from alcohol, cannabis, benzodiazepines and methamphetamines.

Key Issues and Concerns

Women are often concerned about disclosing or discussing their drug use with health professionals as they fear Child Protection will become involved. Health professionals are required by law to make a report to Child Protection if they believe substance use poses a risk to the infant (mandatory reporting).

At **WADS**, we work with the pregnant woman to assist her to address her drug use and other areas of concern so that by the time her baby is born, the concerns have been addressed and the woman and her baby are safe and well supported. Not every family attending WADS has Child Protection involvement.

How to access WADS?

For pregnant women to access WADS clinical services, they can call the WADS Duty Worker (**PH: 03 8345 3931**) Monday to Friday, **9.00AM to 5PM**.

In order to access **WADS** a phone or face to face screening is done to assist the couple to access the right service for their pregnancy care. If they are considered suitable for **WADS**, the Duty Worker will describe the **WADS** multidisciplinary model of care to the couple and if they decide to attend **WADS**, they are invited into the clinic for a more comprehensive assessment which involves information about general health, obstetric history, current and past AOD use, mental health, housing, legal and other psychosocial issues.

The woman then sees a **WADS** midwife and an obstetrician for a pregnancy booking appointment. All women are allocated a midwife and a social worker or psychologist to work with her throughout her entire pregnancy. The women attend the **WADS** antenatal clinic on Friday afternoons, on a weekly or fortnightly basis, where they see their midwife or obstetrician for pregnancy check- ups and childbirth education and their social worker or psychologist. The women also have regular access to the dietician and other members of the team as required, including Addiction Medicine Specialists, psychiatrists, physiotherapists and pharmacists.

When the woman attends the hospital to give birth, she is looked after by the hospital midwives and doctors in the birth suite and then transferred to the postnatal area. Her **WADS** workers visit her daily and assist her to link into supports in the community upon discharge. Generally, mothers and babies are cared for together in the postnatal setting and the hospital midwives teach new mothers and their partners how to care for their baby. Some babies need to be assessed for signs of withdrawal and some may require admission to the Neonatal Intensive Care Unit to manage the withdrawal process. Following discharge from hospital, **WADS** offers a postnatal appointment and paediatric appointments for the woman and her baby.

I think generally, over the years, the care of pregnant women with AOD issues has improved. Overall attitudes have got better and I think health professionals have a better understanding of drug use issues.

Over many years now, **WADS** have provided training and education across the state to health professionals and students working with pregnant drug using women and gradually barriers to optimal care are being broken down.

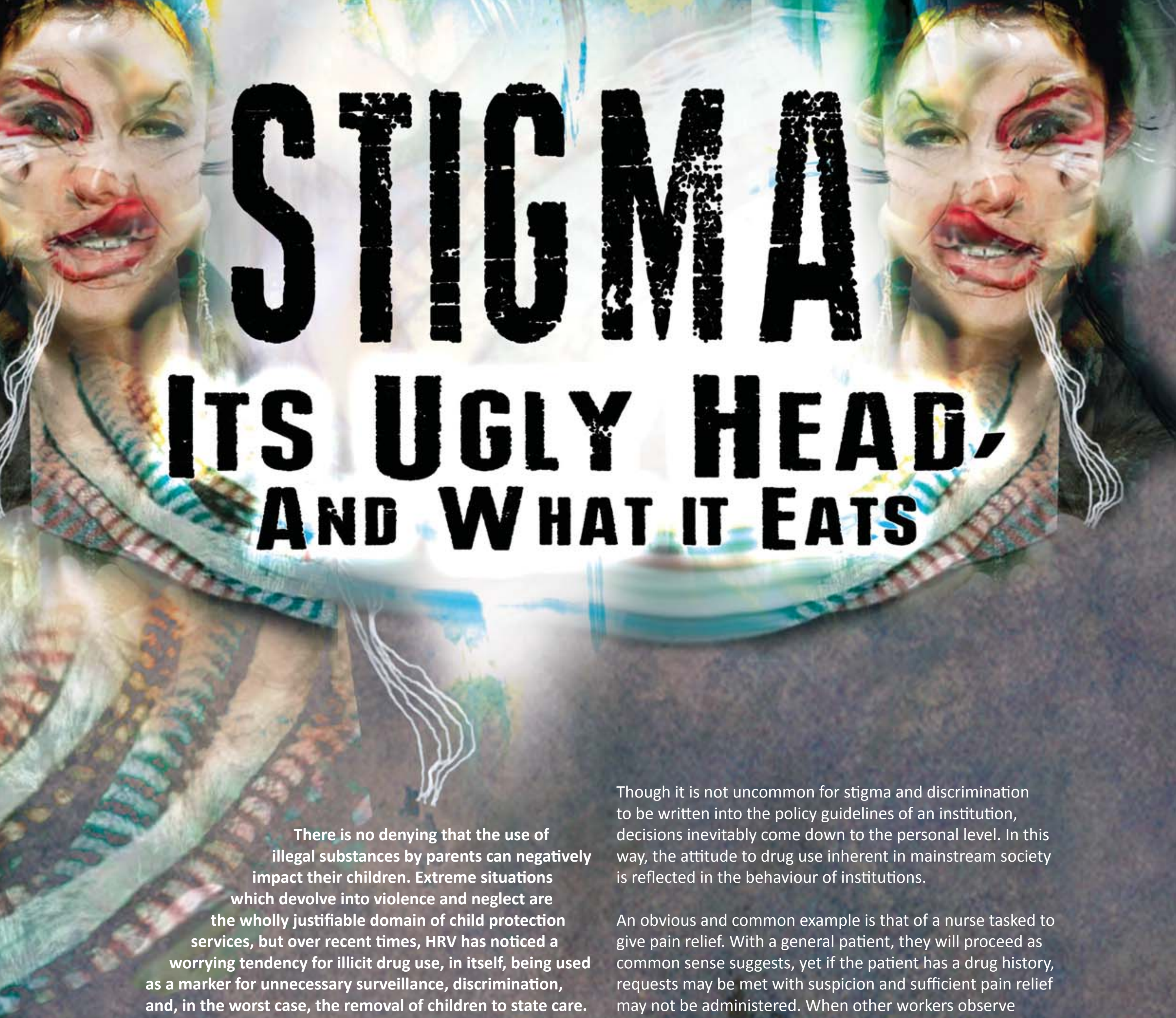
Another important change is the better health status of pregnant drug using women, which, hopefully, is a reflection of better access to care, and that women feel more comfortable disclosing their drug use and by doing so, obtain the care they need for themselves and their babies. Another really important point is the part AOD services and in particular NSPs have played in keeping women as healthy as possible. Better vein care, overdose prevention, reduced risk of BBV infection, etc. have all played a part and contributed to healthier mothers and babies. The big challenge ahead of all of us now is managing and assisting women who use methamphetamine in pregnancy and its related problems.

There have been lots of personal highlights over the years. Overall, the greatest thrill for me seeing the women feel accepted and comfortable in our hospital and seeing them enjoy the wonders of their pregnancies and learning about pregnancy, birth and parenting and of course, eventually meeting their beautiful babies and going home with them. And then it is always a pleasure to see the women with their babies back in our paediatric clinic over the following months.

It is definitely the women we care for who keep me working at **WADS.** I have great admiration for their strength and resilience often in the face of adversity.

I think it takes a lot of courage to talk about your drug use when you are pregnant, but we want women to know that when they do, there is help available. We know change is possible and we are constantly seeing women making those changes and achieving healthy outcomes for themselves and their babies.

Mary Lazzaro



STIGMA

ITS UGLY HEAD, AND WHAT IT EATS

There is no denying that the use of illegal substances by parents can negatively impact their children. Extreme situations which devolve into violence and neglect are the wholly justifiable domain of child protection services, but over recent times, HRV has noticed a worrying tendency for illicit drug use, in itself, being used as a marker for unnecessary surveillance, discrimination, and, in the worst case, the removal of children to state care.

As part of our day-to day operations as a front line harm reduction organisation, we come into frequent contact with drug users and their families. As a result, we are well placed to recognise trends at an early stage. Though any evidence we offer remains anecdotal at this stage, we feel there has been a sufficient accumulation of anecdotes to warrant further investigation.

Stigma against illicit drug users is something we are forever at pains to mitigate. It stems from an assumption, common in society, that users are either inferior humans with an incurable character flaw, or else simply criminals.

When users, past-users or pharmacotherapy consumers interface with general society, they inevitably encounter stigma in some shape or form. But it is particularly concerning when government or medical services – which one might expect to be more rational and less discriminatory – display as much ignorance and often more than the general populace.

Garden-variety citizens are awarded an implicit trust when dealing with these services. Drug users, however, must earn it, and can lose it at the drop of a hat.

Though it is not uncommon for stigma and discrimination to be written into the policy guidelines of an institution, decisions inevitably come down to the personal level. In this way, the attitude to drug use inherent in mainstream society is reflected in the behaviour of institutions.

An obvious and common example is that of a nurse tasked to give pain relief. With a general patient, they will proceed as common sense suggests, yet if the patient has a drug history, requests may be met with suspicion and sufficient pain relief may not be administered. When other workers observe such 'precautions' being taken, they are likely to imitate them, if only as a matter of job protection. Thus the seeds of institutionalised stigma are sown.

When children are brought into the mix, stigmatisation rises to another level. Even workers well versed in the vagaries of drug use and dependence, may - out of fear for the children involved, or of personal consequences - enforce unnecessary restrictions or responsibilities on parents.

In less palatable cases, workers may make things difficult for parents, out of sheer distaste for their drug use and for their daring to bring innocents into the world, only to inflict them with their own iniquity. This brand of behaviour – and it does occur – simply equates to punishment and is manifestly unfair.

The following case provides an example: a woman on two occasions was a guardian to children. Both times she had ongoing contact with support agencies. The first child was a victim of an acquired brain injury and the relationship with government services was a friendly, supportive one. In the case of the second child, however, drug use in the family was an issue, and - as the guardian describes - the whole tone of the relationship was changed.

It was typified by mistrust, disapproval, impatience and implied threat.

Stigma expressed merely as an attitude – without associated impositions - is a milder expression of the phenomenon, but is not without its consequences. Effects upon victims have been studied, showing they can:
"internalise the hate it carries, transforming it to shame and hiding from its effects... people with alcohol and drug problems and their families begin to accept the ideas that addiction is their own fault and that maybe they are too weak to do anything about it... The stress of hiding often causes other medical and social problems for the individuals and their families."

In this way, a child growing up in an (otherwise functional) family stigmatised by drug use, may suffer an impact on his/her "emotional and psychosocial wellbeing."

In my own case, I recall my daily pickup of buprenorphine from a pharmacy near my daughter's primary school. If another parent wandered in at the wrong time, I would hide in an adjacent aisle (or outside) until they had left – on the mere assumption of a disapproving attitude. This is the implied stigma, which is dissolved into the very air some of us breathe. Even if I was recognised by parents with whom I maintained good relations – waiting in the booth of shame with my daughter – I still felt contaminated and guilty somehow of contaminating my daughter.

On the more positive flip-side, a shop assistant, who saw me pick up (buprenorphine) every day, had three children attending the school and one was a friend of my daughter. She never once baulked at my giving her child a lift or having my daughter over for play dates.

Naturally, things get worse when stigma takes a more physical form. When prospective parents monitor their pregnancy through a hospital, inquiries are made in order to identify risk factors. When my partner and I were faced with questions regarding our drug history, we simply lied (as we were not using and there was no risk of neonatal withdrawal). Others, like Fern (see her story and others, including 'The Truth Doesn't Always Set You Free', elsewhere in this edition) 'believing that the best thing she could do for her baby was to be completely honest... laid bare her mental health past, which included drug use, family violence, addiction issues and an eating disorder'. At this point, things completely changed. Fern was told that "substance use can be an indicator for abuse and family dysfunction." From this point on, she and her partner were perceived in a different and very negative light. Incredibly, during an interview, her partner was required to leave the room so that she might be quizzed regarding domestic violence.

Neonatal abstinence syndrome is a real thing and doctors certainly need to know if birthing mothers are currently drug dependent. For her baby's sake, Fern was obliged to disclose that she was on a pharmacotherapy program, but her honesty yielded some unpleasant fruits.

As a result of a difficult birth and subsequent internal bleeding, Fern experienced severe pain. She is certain she was denied appropriate pain relief because of her history, and believes her pleas were regarded as drug-seeking behaviour - until an actual haematoma was discovered, a result of the forceps used during delivery.

(The attitude of medical workers and their institutions towards the analgesic requirements of current or ex-drug consumers remains an outrage. Personally, I have heard horror stories about patients left in agony since the early eighties and little seems to have changed.

Just weeks ago, at The Alfred Hospital, a close friend was prescribed Endone (oxycodone) to treat a headache caused by meningitis. When he went to pick up his medication, he was told the prescription had been withdrawn due to his (ancient) drug history. Simple as that! No apologies. (***Thankfully, his GP was able to intervene and assist***.)

Their sudden (and permanent) categorisation as 'drug addicts' caused a great deal of grief for Fern and her partner. A process designed to protect children appears to have generated a worryingly high level of collateral damage – both psychological and physical.

Stigma can act on families in more tragic ways still. Those identified as dysfunctional – whether fairly or not – may be tracked beyond the medical setting of the hospital into the wider world. Again, there are often good arguments for this, but, unless the quality and objectivity of the support given to families is of a sufficient standard, inequities will inevitably occur.

Parents may be subjected to punitive drug testing or mandatory rehabilitation programs. There have been cases, quite contrary to current medical thinking and clinical evidence, where pharmacotherapy customers are not considered to be free of dangerous dependence, unless they are actually reducing off their ORT, regardless of their stability.

And then there is the issue of a child's removal from his/her parents and home. Obviously, it is a sensitive matter and is doubtlessly addressed as such by workers with a very demanding job; but let's remind ourselves of the facts with this quote from a recent report from the (now defunct) Commission For Children and Young People:

"Some studies have even shown that in general, mothers with drug addictions cared for their children in the same way as non-addicted mothers. Overall, these mothers tended to use less physical punishment and be less strict in parenting. But they also had some fears about their children's future and thought they weren't as good a parent as they could be."
Despite what the above seems to indicate, it appears that once drug use has been identified, the eye of Sauron turns remorselessly upon the family in question. What has been considered a 'marker' for dysfunction, seems to be becoming dysfunctional itself.

STIGMA

A family coming under scrutiny for no reason other than drug use may find themselves obliged to meet unnecessary obligations, may have their child held for ransom against proof of their abstinence, or ultimately may face the loss of a child – all for reasons quite independent of their child-rearing ability.

HRV is aware of a great many functional, loving families in which there is parental drug use – and in which sensitive, mindful parents adapt to ensure that their children are not negatively impacted. They are aware of the dangers, address them and always act in their child's interests. Yet some of these families, in their dealings with institutions are unnecessarily exposed to the negative psychosocial effects of stigma – which manufactures extra stress within the family group.

The issue of a child's removal from a family is complex. I have read reams of material intended for workers, offering many strategies for addressing issues, without actually fracturing the family - all predicated on a strong belief that all other avenues need to have been tried and that the situation must have degenerated to an unambiguously dangerous level, before a child should be removed. This is good sense, obviously. Particularly in mind of the dubious outcomes in store for children forcibly removed from their biological parents.

So, why do we seem to be hearing of a surge in child removals? It may be nothing, just part of the natural ebb and flow of such things - but then again, it may not be. Often, given its role, HRV can get a sense of what's happening on the street before studies can actually confirm it.

Perhaps the upswing in ice use fits into the mix? Many would agree that methamphetamine use in a family setting is, on the face of it, more worrying than that of opiates or cannabis. Additionally, the generalised alarm over ice in the community could be impacting the attitudes of front-line workers, who may not be thoroughly versed in the psychology of methamphetamine use and who, in an atmosphere of fear, may regard the removal of the child as the safest route...

Might there have been an increase in enforcement funding among the responsible agencies? Are they uncovering more cases as a result? I doubt this. Not in the current season of budget winnowing. Has there been a shift in attitude; one of the cyclic fluctuations between the understanding and the misunderstanding of human substance use?

In the end, we simply don't know.

We believe in compassionate, case-by-case, family-based intervention, where an intervention is truly necessary, yet we acknowledge that the issue is fraught and requires examination. What we are certain of, however, is the role of stigma in undermining the lives of both individuals and families. It cannot be underestimated as a root cause. When chaos reigns, when truths are abandoned in a climate of panic, when education is not given its proper place, when hatred is nurtured for political ends, stigma – with its insatiable appetite - will raise its ugly head and feed.

The Golden Phaeton '15

DHS AND PEOPLE WHO USE DRUGS

In August 2002, the Department of Human Services published the Protocol between Drug Treatment Services and Child Protection for Working with Parents with Alcohol and other Drug Issues (the 'Protocol').
In the introduction, the Protocol asserts:

"Not all parents and caregivers with alcohol and other drug (AOD) issues harm their children".

From the perspective of an advocate for people who use drugs (PWUD) this is a concerning starting point for a document that was created with the intention of reconciling the often mutually exclusive goals of Child Protection Services and AOD service systems. It indicates just how negatively PWUD's parenting capacity is perceived to be.

Unfortunately, the Protocol's second paragraph does little to dispel the largely unsubstantiated stigmatisation and discrimination of PWUD parenting:

"Approximately half of all child abuse and neglect cases investigated by Child Protection in Victoria involve some degree of problematic AOD use by the child's parent".

The danger is in those little words 'some degree'. What percentage of cases involves problematic AOD use to a material degree? (The Protocol does not note such a differentiation; it does not disclose what percentage of cases that are reported to Child Protection, and involve AOD issues to some degree, actually conclude that the child's needs were compromised because of their parent's drug use). More than 50% of cases could involve poverty or geographic remoteness to a more significant degree than a parent's drug use. Hell, if the benchmark for singling out contributing factors and identifying parents on that basis is 'some degree' maybe the impact of gluten intolerance or pollen allergies should also be investigated?

The unhelpful nature of 'facts' like this in the Protocol is compounded when you acknowledge that approximately 50% of Australians have used illicit drugs at some time and alcohol consumption is so commonplace in Australia that failing to differentiate between illicit drugs and alcohol may artificially inflate the percentage of Child Protection cases that involve AOD issues to some degree.

Child Protection investigates cases when they are put on notice by absolutely anyone who takes responsibility for making such a report. Some professionals are mandated to report cases to Child Protection, but anyone can report their concerns about a child's safety and wellbeing; and herein lies the floodgates for the arbitrary discrimination of parents who use drugs, because some people assume that PWUD cannot be reasonable parents. It's that widespread assumption that leads to a protocol like this having to start with the assertion that *"Not all parents and caregivers with...AOD issues harm their children".* Despite the Protocol's outwardly neutral choice of prose (e.g. "AOD use" is qualified as *"problematic AOD use"* so as not to assume that all AOD use is problematic), they are simply words written on paper by bureaucrats and implemented in a world where the health and human rights of PWUD are undervalued and unfettered negative stereotypes are perpetuated in the media on a daily basis.

Only a small percentage of professionals are mandated to report certain circumstances to Child Protection; and *'that a child receives care from a PWUD parent or guardian'* is not, by itself, a reason to report. But the Protocol makes sweeping invitations for glasshouse dwellers to report their two cents worth on PWUD' parenting skills to Child Protection, where it states:

"It is the responsibility of all members of the community to contribute to the protection of children and young people from physical, sexual or emotional abuse or neglect" 1

"Any person in the community can make a notification to Child Protection" 2

What about the emotional abuse children experience because their reasonably capable PWUD parents are routinely subjected to discrimination by a society that classifies PWUD as substandard citizens?

Under the Children and Young Person's Act 2005 In Victoria (which replaced the 1989 Act) Section 182 notes that the following professionals are legally mandated to report *"physical or sexual"* abuse specifically:

- **Doctors**
- **Nurses**
- **Police officers**
- **Teachers (primary and secondary)**
- **School Principals**
- **Midwives**
- **Youth justice officers**
- **Parole officers**
- **Registered psychologists**
- **Some youth and child welfare workers (cross-referenced in the Public Administration Act 2004).**

Equivalent legislation exists in all other Australian states and territories, except Western Australia, but In addition to state and territory law, Commonwealth legislation has mandatory reporting provisions too. Under the Family Law Act 1975, section 67 ZA:

"All Family Court of Australia personnel must notify a prescribed child welfare authority if in the performance of his or her duties, he or she suspects a child has been, or is at risk of, being abused".

In conclusion, while the scope of mandatory reporting of child abuse is relatively narrow and does not explicitly note that the children of PWUD parents are assumed to be at risk, all policy on the issue is geared to stress the importance of reporting any suspicions that the safety or wellbeing of any child is at risk. Considering this predisposition, combined with prevailing negative stereotypes of PWUD as irresponsible and unwell criminals, it's not surprising that PWUD parents are over-represented in reports to Child Protection. Further, it is clear that the Protocol was not written by PWUD for their peers.

SASS

HEROIN SAVED MY LIFE

I'm watching 'The Better Man' on SBS, a TV mini series about that poor kid Van Nguyen who got the death penalty in Singapore for heroin trafficking.

I find his story as heart breaking now as I did when they murdered him 10 years ago. I know the film's not strictly sticking to the facts, but it's true in spirit and it's reminding me of something that, thank goodness, I don't have to think about every day anymore...how badly our society discriminates against and stereotypes heroin users (not that Van Nguyen was a user anyway).

That poor kid didn't deserve to die anymore than a bottle-shop owner or a car dealer. But they show him praying to God and saying *I'm sorry* over and over again, like he did something unforgivable. Fuck God-who-is-dog-backwards and fuck this stupid system. And fuck the death penalty.

Sometimes people who self medicate with opiates are simply trying to survive the most unbearable pain they've ever been through and it takes courage to do that when dying feels like the easy way out (even if it does steal your soul a little bit each time you use it and it represses the masses like television & Facebook does).

Why does one choose to become a habitual heroin user?

Boredom?

Apathy?

Or an inexorable craving to escape from the grinding disappointment of life once the naive expectations of youth have been well and truly crushed by the brutality of reality?

When depression, despair and desperation backed me into a darkened corner what was it I howled to an indifferent universe?

Give me death, or give me heroin.

These are my terms.

Whilst the blessed forever-young taste and exult at will (be it in love or anger, fear or joy), live in the moment and never once look to the horizon to confront whatever shit box doom it is that inevitably awaits them down the track...meanwhile the rest of us mortals exist in a generally more corporeal place where the idea of suicide is, if not a familiar old friend, at least a passing acquaintance.

A dude we all know of, although perhaps not personally.

And some of us have him on speed dial.

Always. In the back of our mind.

One wicked night, completely off our faces in the wilds of Sydney's inner western suburbs, my sister told me;
"Don't you leave me all alone to deal with this shit. Please promise me you won't do that to me".

My grown sister-woman who, when I dream of her, is still a child. And so, I'm not saying I didn't 'try' once or twice after that. I did, but not very hard.

Instead, I made a deal. I'll get through this I told her maybe, told myself I think; and spoke it without speaking to a completely disinterested and inconceivable universe.

I'll get through it by feeling absolutely nothing, by denying all pain, by blanking out every disagreeable emotion and anesthetising the daily humiliation of basic bodily function.

I don't want to feel my white guilt.

My first world problems.

The inevitable loneliness of an existential nothingness.

I don't want to feel myself living, breathing or taking a god damn shit.

Give me heroin or give me death.

And fuck your chemical handcuffs; your methadone and shitty antidepressants. Fuck your cretinous post-Christian NA/rehab/nascent counselling culture that fetishizes and makes a cult out of abstinence. I'm not addicted to not being addicted.
I survived suicide, depression and a fucked up system by making a fully informed, self-aware and conscious choice.
A pro-choice, autonomously activated decision.

And I survived.

Somehow miraculously, relatively unscathed and all the more enriched for having passed through the murky belly of the abyss. Thanks to heroin.
That dirty, shitty, all-consuming and brutally bleak as fuck substance, which enabled me to feel absolutely nothing for as long as I needed to. To which I hocked my soul for many long and seedy years of my precious life.

And I survived.
Heroin saved my life.

So stick that in your discriminatory stereo-pipe and smoke it, my friend!

Nicky Conway

Love oxytocin & other Drugs

Whether or not to have a child was a dilemma I wrestled with for much of my 20s. I wanted to experience everything that being a woman could offer, but I struggled with my relationship with opiates and other drugs. Although I had lived through long periods with and without opiate dependence, I also live with an infuriating sense of perfectionism that disrupts my ability to just get on with doing the things I enjoy without criticising myself heavily in my attempts. If I was going to be a mother, I wanted to be the best mother possible.

I was married to a man who wanted to be a father as long as we could provide a stable base for our future child. When we made the decision to try to have a baby, we didn't know how long it would take, we didn't know if we *could* have a baby, so when we fell pregnant straight away, it was a shock and a relief all at once. We had just been through a huge life change - we had detoxed a few months earlier and hadn't used opiates since. We were physically healthy and I finally felt ready to take on the massive challenge of parenthood. I was at a point in my life where I thought I would never use again; I could abstain while pregnant and be the mother I wanted to be: open, engaged, loving and able to put my baby's needs above my own.

My first pre-natal appointment at the hospital involved a long mental health questionnaire. Believing that honesty was the best policy and the best thing I could do for my baby, I laid bare my mental health past, which included drug use, family violence, addiction and an eating disorder. At one point, my husband was asked to leave as I was quizzed about domestic violence. I was asked about my state of mind at each appointment and reminded that not every baby is planned and that some pregnancies come at inopportune times, with partners who might not be excited about changes to their family and relationships.

As my pregnancy progressed I started to suffer from pre-natal anxiety and depression, which grew worse as my due date grew closer. Many things I had used in the past to manage my anxiety were off limits now. I used yoga and breathing to try to calm myself and talked to other pregnant women online about managing stress. I read extensively about the effects of different drugs on the developing foetus and I reached out to services that helped women who were at risk of relapsing while pregnant. My partner J had relapsed by my late pregnancy and, with me being around seven months' pregnant, I felt I had little choice but to begin on a very low dose of methadone.

Like most things in life, expectations are often far removed from reality. The fairy-tale of the expectant parents beaming with joy and excitement was the image we continued to project, but behind closed doors our anxieties and insecurities were wearing away at us. We had moved interstate, away from friends and family to a beautiful beachside location and while the place was paradise, it had its own problems, like isolation and poor work prospects. The unemployment rate was a lot higher than we realised and we struggled to pay our exorbitant rent with my part time work while my husband J started his third job in four months.

I struggled to stop smoking and the mental anguish it involved was ultimately part of my undoing. I have always struggled with self-care and I found it difficult to separate my own needs from the need to look after the tiny body growing inside mine. The shame I felt every time I wanted a cigarette simply fuelled my self-loathing; I cut down to three a day, I took lots of vitamins and minerals, I exercised, I attended my appointments, I ate as much as I could and I counted down the days as they dragged on. Finally I was 33 weeks pregnant; I had worked my last shift and we were booked in for birthing classes. I knew if my baby was born early, it would be fine now, and I was able to relax a little.

When I went to my pre-natal appointment that week, my blood pressure was high and I was given a pathology slip for a blood test before I went home. My mum was staying with us for two days while she attended a conference and we spent the night catching up and talking about everything. The next day the hospital called to ask if I had been to pathology. I said 'no' as I hadn't understood the urgency and promised to come in to the hospital the following morning. Instead, I woke up with labour pains.

For the next hour, I had to stop every six or seven minutes and grab onto something as the pains were like nothing I had ever felt before – they gripped my stomach and shot down the front of my thighs, making my legs shake. I called J and off to hospital we went.

At the hospital, I was given a wheelchair and J pushed me up to the labour ward where I was ushered into a birthing suite. When they examined me the midwife said "How about that, you're fully dilated!" totally surprised that I wasn't making it all up. They gave me something to slow down the labour, put a monitor on my stomach and left us for the meds to do their thing. When I asked for my methadone, I was told it was best to wait until after I had given birth.

The next couple of hours are a blur, but I know I was given something to slow the labour down and then later something to speed it up. I was grunting and groaning through the contractions but I didn't really get the urge to push. When I asked, half joking "so what about this gas I've heard of?" I was told I was doing well and didn't need it.

Then the monitor on my stomach started pinging and everything got frantic. The room filled with people and a large pair of forceps made their appearance. I was stuck on my back the whole time, which was supremely uncomfortable and went against everything I had read about moving, squatting, etc. The Doctor tried turning the baby around inside me, which was agonising and came without any warning. "What on earth are you doing?" I yelled through clenched teeth. Then I was told to "push, push, push"! I doubled down and using every bit of energy I could muster, I pushed with all my might and the doctor pulled my baby from me and placed her on my stomach. I arrived at the hospital at around 10.30am and our daughter was born at 2.52pm.

We had already chosen her name, but for now I'll refer to our little girl as 'Daisy'. For whatever reason, the Doctor seemed to rush birthing the placenta and this was again very painful. I felt a massive shudder come over me and I got very cold. I asked for a blanket and shivered beneath it as they sewed me up. Although I was unaware at the time, I was going into shock.

Daisy was left with me for all of 30 seconds before she was rushed away for tests. Though she was rated a 9/10 AGPAR (survival) score, she was tiny, weighing only 1.7kg (3.2 pounds) and was taken to the special care nursery. J left to go home to get everything I would need to stay in hospital. Once I was stitched up, I walked in to see her and marvelled over her with my Mum, who had arrived just as she was being born. Feeling a little faint, I lay down on the nursery floor and was guided back to a bed once one was made available for me. My bed happened to be in the furthest corner of the ward, away from the nurses' station and the special care nursery.

As I lay there, quietly talking to my Mum, the pain between my legs got stronger and stronger. I had no idea what to expect or what to compare it to, but I told the nurse, who said perhaps the local anaesthetic was wearing off and that the stitches would be painful.

I was given an ice pack and a couple of Panadol and left again. By this stage I was almost out of my mind with agony. I had no idea what was happening to me, only that the pain was getting stronger by the second. It felt like a heavy weight was crushing my pelvis and my leg.

J returned to the hospital at around 4.30pm, to find a raving mad woman and he couldn't work out what was wrong with me. I demanded to be taken outside for a cigarette and I stated loudly I didn't give a fuck what the nurses said, I was going. It appeared that I had gone mad; something about the birth had made me snap and J and my Mum were both very scared and concerned about me. Both were aware of my high pain tolerance and my usual reluctance to make a scene. Obviously, something was drastically wrong with me.

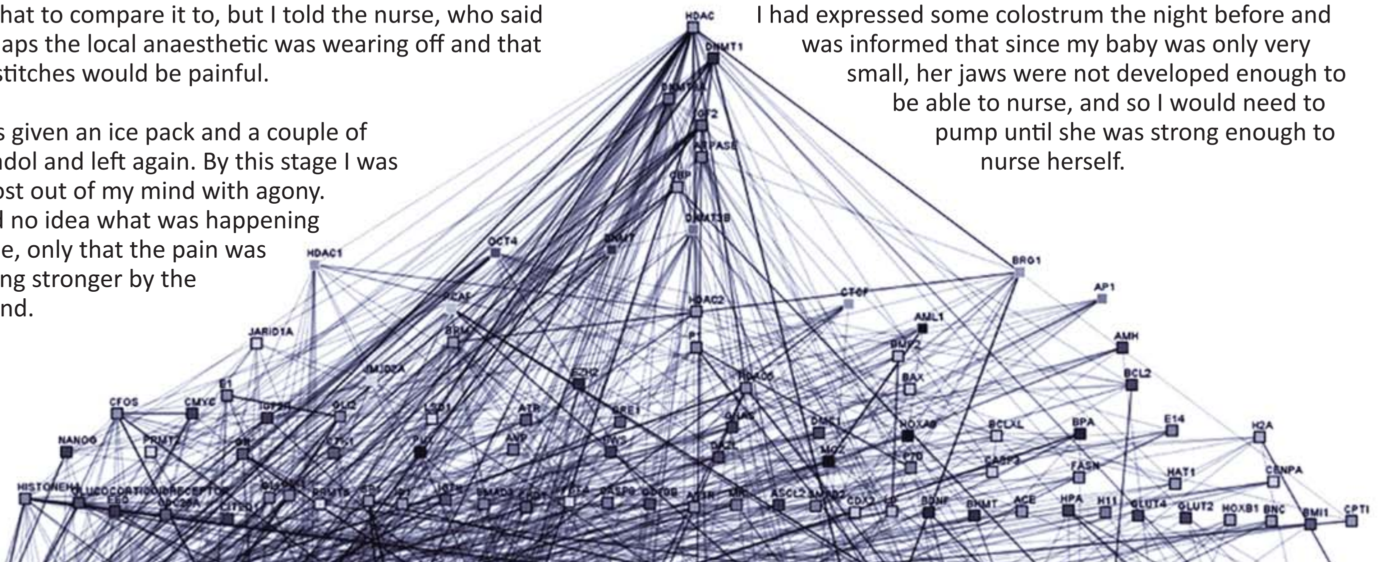
To my great shame, I remember telling my mother I felt like I was being fucked with a concrete pole. I had lost all sense of decorum and the intense pain, which was so much stronger than the birth pains, left me involuntarily whimpering and groaning. J went to the nurses' station and told them something was really wrong and I was offered Panadine again. I asked for my methadone and was told it would come soon.

I was left for around three hours, writhing in agony, before the midwife finally agreed to examine me. It was obvious that they thought I was 'putting it on' either to get my methadone quicker, or something stronger. I felt a sense of satisfaction when I saw the shock on her face as she and the other nurse who was examining me whispered "haematoma" to each other. Now my pain was validated, I was treated with more care and my methadone arrived, followed by a shot of morphine, but I waited another 45 minutes before a doctor came and signed me off to surgery.

I finally saw that blessed gas just before going into theatre. All I can remember is feeling out of control, gripping J's hand and J holding the gas up to my mouth, urging me to take as much as I could and me begging anyone and everyone to "knock me out, please, please knock me out…"

Later that night, around 8pm, I awoke from the anaesthetic and was overjoyed to not be in pain. Sometime later, my obstetrician and midwife arrived and explained what had happened. I had had a haematoma, an internal haemorrhage; it was very rare, and the blood that had pooled inside of me had blown up all the tissues in my vagina and vulva. I was so grateful to not be in agony anymore, I didn't press them about their guilty looks or their admissions that "we thought you were just exaggerating". I was still groggy and I fell back to sleep soon after.

The next morning I woke, ready to meet my new baby. I padded slowly down the corridor to the special care nursery and met the nurses there to learn how to care for her. I had expressed some colostrum the night before and was informed that since my baby was only very small, her jaws were not developed enough to be able to nurse, and so I would need to pump until she was strong enough to nurse herself.



LOVE
oxytocin
& other drugs

My mother had been a breastfeeding advocate and I was well aware of the benefits of nursing and how much more important it was for a premature baby. So I decided that I would breastfeed Daisy as long as I could. Although I was disappointed, I threw myself into learning how to express by hand and work the pump.

The special care nursery at this small, regional hospital had a large window overlooking the Pacific Ocean and I remember sitting there watching the sunrise, just me and my baby, and a couple of other babies in their humidicribs and the nursing staff, behind the desk. All is quiet, but the whirring and blipping of the machines; I am sleepy and full of hormones as I marvel at my daughter, pump my milk and sit in the moment falling in love with her. The intimate bond between mother and child feels like a drug; in terms of neuroanatomy, the release of naturally-occurring oxytocin, provides an overwhelming sense of peace and wonder, and a perfect foundation for a lifetime of love.

Over the next few days Daisy was monitored closely for any sign of neonatal abstinence syndrome (NAS) as a result of my methadone treatment, but thankfully she was fine and had no symptoms.

About a week after I went home, it was 3am and I had just finished another pumping session when the phone rang. It was the special care nursery. One of the nurses told me the doctors needed to speak to us. What followed was a five minute conversation of which I took in very little. J stirred next to me as I listened in shock, trying to make sense of what I was hearing. I said goodbye to the doctor and then attempted to relay the conversation to J.

“There’s something wrong with her lungs, they think; they are going to send her up to the Mater Hospital in Brisbane in the morning.” We looked at each other, scared and bewildered. I sat there, stunned and drained of all emotion. I flicked through all the photos of her on my phone, and let all the shame, guilt and self-loathing swallow me up. “You caused this”, “You gambled with your baby’s health and you lost”, “You couldn’t even stop smoking.” J was going through the same self-hatred. His hollow reassurances of “It’ll be fine, don’t worry” were like the promises of a traitor.

The next morning one of our favourite nurses was preparing to join Daisy for the journey. We watched, like spectators, as Daisy was loaded into the back of the ambulance, her tiny body covered in leads, padded with pastel blankets and her tiny mouth mewing, but soundless behind the steel and glass. After stopping briefly at home to tell our neighbours who offered to care for our cat and packing haphazardly, we followed our baby up to the city.

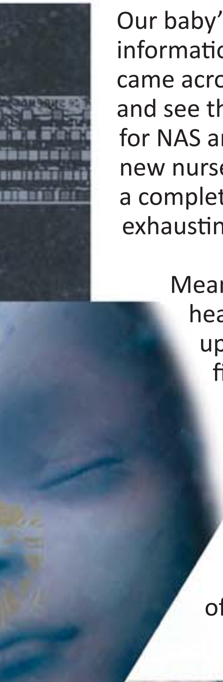
The Mater Hospital in Brisbane is a huge complex, with four different hospitals: Adults, Children’s, Mothers and a Private hospital; all intersecting, a monolith on a giant hill overlooking the river and freeways. Daisy was taken to the Mothers’ Hospital and we found a park and rushed in to find her. We were directed to a closed ward of eight beds with tight security. The social worker gave us some forms to fill out to assess our need for accommodation and we were told to expect to be here at least a week. We were given a room at Ronald McDonald House, which was subsidised and provided great relief as it was just around the corner, and we were told to come back in the morning around 8am to see what the Doctors had to say.

The house had strict rules and was run by volunteers; older women who had their own experiences with the Mater and their own children. We made our way to a rotunda, the outside smoking area and sat down. Other families and individuals came and went, some saying hello, others silent. Eventually we were alone with just one other woman, whose face had been turned away from us.

“Hi, I’m Fern and this is my husband J” I said, by way of introduction. The woman wiped her eyes and introduced herself as Debbie. Debbie was also a mother of a new baby, her first little girl who had been at the Mater for 3 days since her birth, transferred from somewhere in western Queensland and she had already had 2 open heart surgeries. Her baby was currently in recovery after another operation where she had gone into cardiac arrest on the table and Debbie could only wait to be told she could return to be with her baby and get her prognosis. “We don’t know what’s wrong with our baby, something to do with her lungs” we told Debbie. Although we still didn’t know what was going on, Daisy wasn’t having open heart surgery or heart attacks and it put our worries into perspective and for a moment we felt fortunate.

The other parents we met at Ronald McDonald House were a constant reminder that things could be worse.

Daisy was diagnosed with Congenital Lobar Emphysema which meant her left lung lobe was hyper-inflating, pushing her heart and organs to the side. Daisy needed surgery to remove the top left lung lobe. Dealing with different staff, different rooms and our baby’s fluctuating health was a minefield. After Daisy reached her birth date she was moved to the children’s hospital to the paediatric intensive care unit (PICU) in preparation for her upcoming operation, once she was expected to hit 3kg. Things were different again in the children's hospital which brought its own challenges. Our baby's file was a huge brick, full of all of her and my information. Every nurse, doctor and staff member who came across Daisy could flick through the pages of her file and see that I was on methadone, that she was monitored for NAS and god only knows what else. Dealing with a new nurse and their new ways every couple of days and a complete lack of privacy in bonding with my baby was exhausting and at times frustrating.



Meanwhile, my injuries weren't healing and my health was rapidly declining. The constant stress and upheaval was taking its toll. I had been told at our first hospital that I could continue to get care for my haematoma and birth injuries at the Mater, but staff members were reluctant to do anything besides examine me, although it was obvious it wasn't healing like it was supposed to. Then another issue grew into a larger problem; I have suffered from asthma since I was 14 years old and especially during times of stress, like plenty of other mothers, I left myself last.

In the week of Daisy's operation, I went down to casualty twice to have my worsening asthma treated. The next morning, I couldn't breathe or get any ventolin in and I started to panic. J called the ambulance and I was promptly admitted into the Adult's Hospital. Daisy was just recovering from her operation and was all ready to be 'roomed in' when this happened, which meant that she and I would have a room together up in a ward, away from intensive care that we could use to bond, learn to nurse and prepare to go home. Instead, J got the honours of spending the first substantial time alone with our child.

So thus began another strange scenario where I would wake up in the mornings, pump, eat breakfast, get dressed and call for a wheel chair. J would come over from the Children's Hospital, usually with a coffee for me and would wheel me back to the children's hospital for the day. At times, I would have to go back to see my own doctors or to do tests. All up I spent seven days in the adult's hospital. My nurse Anne was just beautiful to me and whether it was getting me ready to visit Daisy or supervising my methadone, she was so very kind and I was incredibly grateful for her lack of judgement. It is distressing how often we as drug users are grateful for being treated like everyone else.

Daisy's operation went really well and her recovery was strong. I was also getting better and I began formulating a plan of escape. I wanted to begin my time as a mother and I wanted comfort, familiarity and privacy.

The day I was discharged we waited for Daisy's doctors to do their rounds so that we could ask to go home. When the Doctors finally arrived they were sceptical, but they reluctantly agreed.

At last, we were free!

As we drove home away from the city a large rainbow appeared fittingly stretching across the freeway.

I returned to the regional hospital for a check-up and it was clear that I had not healed as expected.I was booked in for more surgery in two months and told that this was normal procedure, though J and I felt pretty sure we were being lied to. It was clear that I had not been treated properly.

J recalled the conversations that went on during the birth, that one medication was given at a time when it shouldn't have been, that I was denied any pain relief though forceps were used, that I wasn't told what they were doing when they were doing it, so I could try to relax or prepare myself, that our birth could have been managed better with more communication between the staff and us and that their attitude towards my drug use and methadone treatment had clouded their care of me, allowing a burst blood vessel to develop into massive swelling.

J and I discussed all of this while our baby slept.

Love oxytocin & other drugs

Now that Daisy was ok, we tried to process what had happened to me and we were shocked and bewildered that a woman could be effectively left for dead and ignored after such a fast and traumatic birth.

That the first conclusion health care professionals could come to after I had given birth without any pain medication was "She is just exaggerating and manipulating for pain meds" is a cruel and careless supposition and an example of the stigma and discrimination that drug users regularly experience in medical settings.

I had further surgery which was again traumatic; they used dissolving stitches again, and it broke open again. We were told that we had to allow the wound to heal from 'the inside out' and that it would heal eventually. It was over a year before we could be intimate again, and even then it was painful.
I was very self-conscious about the damage I had sustained.
I contacted a couple of no win, no fee lawyers to discuss my options. The process of suing for medical negligence is lengthy and there were no promises. You cannot sue for pain and suffering, there must be lasting damage. At the time, we were assured it would heal, so the lasting damage could not be proved.

I discussed my concerns with our baby's paediatricians who were concerned with our general wellbeing as a family, as substance use can be an indicator of family dysfunction, a lens I felt we were viewed through throughout our hospital experience. They made an appointment for me to see the prenatal obstetricians with the idea to get some closure. I didn't really want to sue; I just wanted what happened to me to not happen to another woman. It was obvious to me that a procedure, a mandate that women who complain of severe pain post birth are examined immediately for potential problems, could save lives. While it was rare, some women still haemorrhage and bleed to death after birth today in Australia. I was lucky that the haemorrhage was internal and the pressure had not broken before I was operated on or I could have easily bled to death.

A post-birth check should not be something that has to be pleaded or begged for.

After waiting for weeks, I returned to the hospital for this appointment feeling good and strong. J and our baby were with me, and I had notes and lists of questions I wanted answered. After a long wait, my name was called and I was surprised to see a total stranger beckoning me into the room. I was assured that I would be talking with one of the staff that had treated me, but apparently the reason for my visit was either not communicated or not deemed important enough, or perhaps nobody wanted to give me the answers I so badly wanted. As I explained the reason for my visit, the doctor told me that because she didn't know me or my case, she probably couldn't answer my questions. All she could do was look through my file and read what was there. The main thing I remember from that meeting was how it ended. Flicking through my file, with many questions about my treatment hanging unanswered in the air, the doctor honed in on the one piece of information that seemed to her to make sense of everything.

"It says here that you were on methadone"

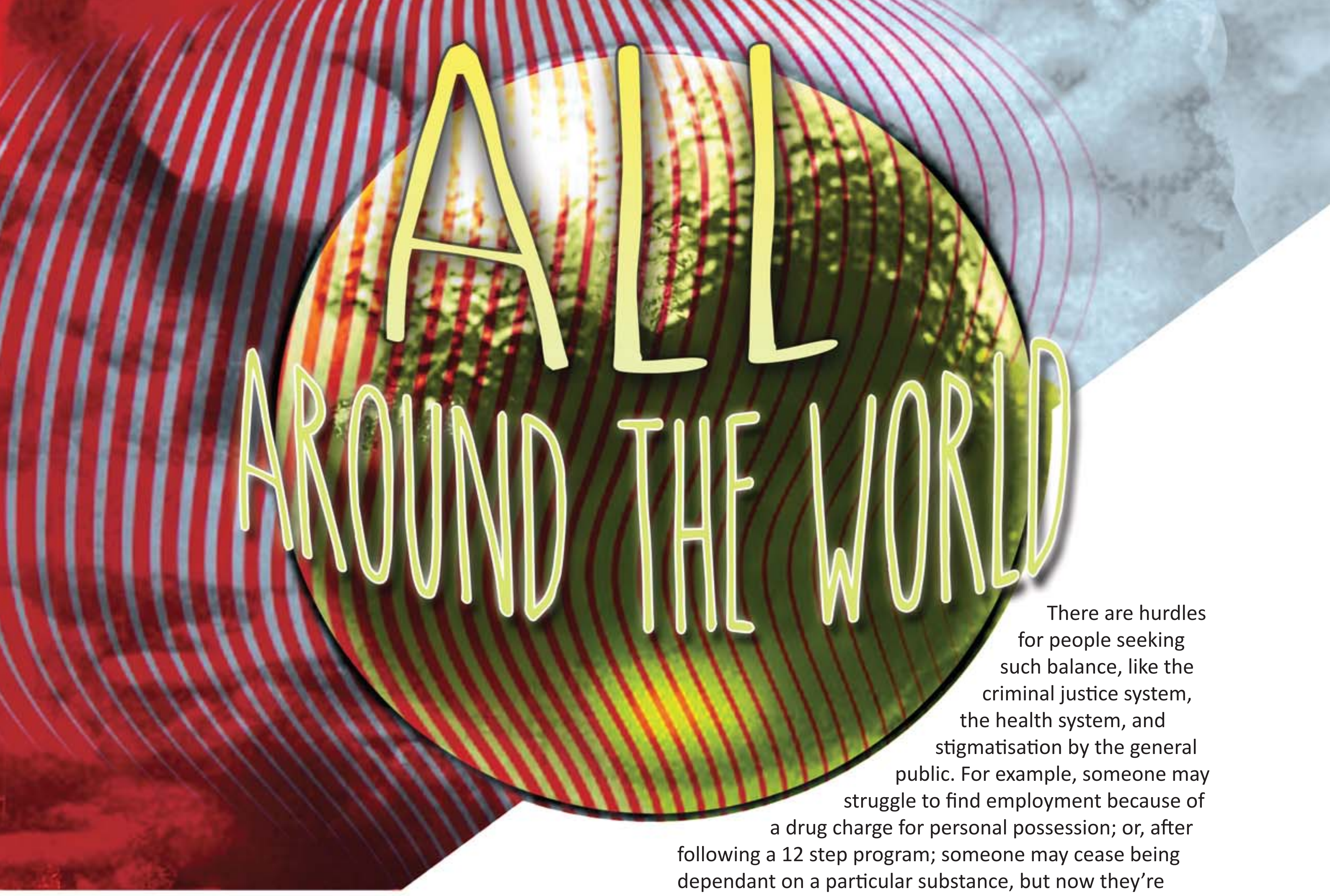
"Yes" I replied "what difference does that make?"

I don't remember her response now, three years later. But it was clear to her that the methadone made all the difference. It excused her colleagues' behaviour towards me, it explained my poor care, no matter how careless, how degrading. We left that appointment and gave up looking for answers or trying changing the system. Instead, we decided to focus on looking after our new baby and ourselves.

Fern

My Family

ALL AROUND THE WORLD



Bruger Foreninger: A Recovery Model

Wiki reference: ***A recovery approach to substance dependence emphasises and supports a person's potential for recovery. Recovery is generally seen in this approach as a personal journey, rather than a set outcome and one that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning. Other names for the concept are recovery model or recovery-oriented practice.***

The concept of '*recovery*' within in the context of the Alcohol and Other Drugs sector is often collapsed and a set outcome, namely abstinence, is prescribed on 'patients' /'clients' /'consumers' /'persons with lived experience's' behalf.

Often that nasty C-word comes out, and people talk about being 'clean' when really what they want is to be healthy and well, irrespective of whether or not they use drugs. That's the reality that a lot of people don't want to accept or have never been reassured is possible: drug use and a healthy lifestyle do not have to be mutually exclusive, but it becomes increasingly challenging for people who use drugs to maintain a healthy lifestyle when they're socially excluded, have lost their sense of self and lack a network of supportive relationships.

There are hurdles for people seeking such balance, like the criminal justice system, the health system, and stigmatisation by the general public. For example, someone may struggle to find employment because of a drug charge for personal possession; or, after following a 12 step program; someone may cease being dependant on a particular substance, but now they're told they cannot use any other psychoactive substance ever again because they're 'sick' and they always will be. Practically, such instruction makes someone who formerly used heroin a 'failure' if they subsequently choose to participate in rituals like a celebratory toast or Eucharist even if they've never been alcohol dependant.

Psychologically, this 'all or nothing' approach to recovery is disempowering. How can a 12 step program be a personal journey? If abstinence is the only goal for all, who will recognise when people make positive, personalised lifestyle amendments, like starting to practice safer injecting practices, modifying one's diet to meet their nutritional needs, or stabilising on substitution therapy with the goal of maintaining that dose for life? Well, drug user activists and harm reductionist's celebrate these achievements of their peers, even if normative society still has a Nancy Reagan-just say no-hangover.

(FYI: you may know that as well as being staunchly opposed to drug use, Ronald and Nancy Reagan opposed women's reproductive autonomy rights too. Then, once Ron was diagnosed with Alzheimer's disease, they founded the Ronald and Nancy Reagan Research Institute; as his health deteriorated, Nancy advocated increasingly for embryonic stem cell research. That is, for Nancy, fertilised embryos were the beginnings of human life with moral status, until they were subjects of scientific research that may save her husband's life.

My only point is, you need empathy, an open mind and willingness to listen, and/or lived experience before you're qualified to make decisions that seriously impact the lives and human rights of others).

That was a long introduction, and thank you for your patience, but these are the ponderings inspired by my time in Copenhagen, Demark, staying at the ***Bruger Foreningen***, a drug user activist association founded in 1993 by a group of peers. I arrived early in the morning last Thursday where I received a warm welcome and a thorough tour of the organisation's vast complex from key long-standing member-activists, including President Jørgen Kjær. On my second day I visited ***Sunhedsrummet*** (a monitored consumption space), ***Maendenes Hjem*** (a men's residence connected to another consumption space, with designated spaces for injecting and smoking) and ***Fixelancen Stofindtagelsesrum*** (their mobile consumption space). I met Anja Plesner Bloch, who founded the ***Bruger Akademi*** (Danish for Drug User Academy) and shares an office with ***Gade Juristen*** (founded by Nanna W. Gotfredsen, these street lawyers perform outreach on fixie bikes at sites chosen in order to support people who use drugs.

I'm not going to detail in this article the specific services provided by such organisations, the individual stories that moved me, the policy reforms and challenges ahead (I will though, I promise, but that's for another day), instead here, I'd like to summarise what I interpreted as the essence of ***Bruger Foreninger***: the lifestyle its members practice and promote.

At the end of my first day at the ***Bruger Foreninger***, before retiring to my sleeping quarters in the association's library, I was invited to join the activists (that's the preferential term given to their volunteers) and any members present for dinner (their membership is approximately 700 people, all of whom are welcome to appreciate the association's services at their own accord, and in one day about 30-50 members would actually visit).

Everyone sat together and ate together; I got my 5+ fruit and vegies and then some, and supplements were offered as additional condiments (Omega, Magnesium, and a multi-vitamin). After the dinner, I hung with one of the ***Bruger Foreninger's*** founding members, Annalise Grønkjær, and she shared some her life experiences with me in such a way that I felt even more confident than ever before in two points:

1 **Peer-based models are essential in the AOD sector; and**

2 **Abstinence-focused programs cause more harm than good.**

With reference to the varying degrees that some members engage with ***Bruger Foreninger*** and its services compared to others, she said, *"as long as someone is doing their best, that's enough".*

Anna's words resonated with points their President Jørgen made to me earlier in the day. When explaining why activists perform services for their peers, he said to the effect: we want to be responsible for ourselves and show people that we can be responsible. *Recovery-as-abstinence* is contentious because the focus is solely on the behaviour of the engaged individual, and the success of their recovery is based on an objective (external) measure: are you using or not.

But individuals make up communities and any recovery they engage with needs to be integrated as such. Also, abstinence is not synonymous with wellness; one's lifestyle shouldn't be defined by what one does not do.

Sometimes all that is required for an individual's *'recovery'* is for those around them to accept them exactly as they are.

Sass

THE TRUTH DOESN'T ALWAYS SET YOU FREE

I never wanted to have a child while on Methadone, I can't imagine anyone would. But a lot of the time, that's just how things happen.

I was 30 years old, on 60 mg of methadone, hep c positive and pregnant with my first child. To say I was scared is an understatement. My partner Max, who was also on a program, was just as worried as I was. We both were very familiar with the stigma associated with illicit drug use, but adding pregnancy into the mix was guaranteed to raise eyebrows, to say the least.

And just as we expected, from the first appointment we experienced constant discrimination, based solely on the fact that we had once been injecting drug users.The first word from my doctor's mouth was 'abortion'. It seemed to be a given, according to the medical establishment that we would be bad parents, even though we both had stable lives and good jobs and we had been on a pharmacotherapy program for years.

During my pregnancy and the birth of our son, I kept a diary. I have selected relevant entries about the treatment we experienced from many in the medical profession. I must add that while we were treated terribly by many, there were some outstanding individuals that fought for us and maintained our faith in the human race.

June 20 2012: I have just found out that I am pregnant! Really overwhelming – equal parts scary and exciting, but it explains a lot. I had suspected as much for some weeks.

June 28: At our first doctor's appointment, we are told we should abort as soon as possible. When I decide against this, I am told that I must get off methadone as soon as possible and that I only have until my second trimester to stop. To try and change my mind, the doctor tells me about neonatal abstinence syndrome (NAS) and possible complications that could occur. I leave the clinic in tears with an ultrasound appointment for the next day.

June 29: It looks like this little person was conceived in the last week of April which makes me nearly 9 weeks pregnant. I am blown away when I hear the heartbeat.
The idea of termination is now completely impossible.

July 01: While at work I have a bleed, I make an appointment for the next day and the doctor tells me that it wouldn't be that bad if I had a miscarriage, now would it?

July 02: We have another ultrasound and everything is ok. I am so relieved, as I know this pregnancy wasn't planned and won't be easy, but I really want this baby and couldn't bear to lose it.

The next few weeks are nerve-wracking as I have a few more bleeds and decide to cut down my work hours. I work as an integration aide at a specialist school which requires a lot of lifting and hoisting kids in wheelchairs. I have never disclosed to anybody at work or the majority of the people in my life that I am on methadone. Looking in from the outside, we come across as a perfectly functioning couple expecting a baby.

It strikes me as strange that methadone - a medicine that I need to keep me healthy and safe, like an antidepressant really- instantly evokes such a strong, negative reaction. Sadly, I have come to the conclusion that keeping it to myself is much better than trying to change people's perceptions.

Despite many conversations with my GP about my reservations towards reducing my methadone dose while pregnant, which all fall on deaf ears, I try hard to reduce my methadone and after 3 weeks I am down to 50mg. But I feel tired, irritable, and like I'm getting the flu constantly. I begin to wonder whether I will be able to keep reducing if I'm feeling this bad already.

I begin researching online about reducing during pregnancy and am not entirely surprised to read that it's not recommended. We check all the available literature on methadone treatment during pregnancy we can get our hands on and the majority of information advises doctors to increase, not decrease the dose like my doctor has been saying.
It is almost always recommended that women on methadone have their dose increased due to the increase in blood in the body during pregnancy. There are many other reasons for increasing the dose but the main concerns are that the patient is completely stable and has less reason to engage in illicit drug use, and also that dropping the dose rapidly just isn't a good thing for a growing foetus. It puts the mother through extreme discomfort and high levels of stress, which in turn is passed onto the foetus. After a few hours of research, I am more confused than ever and very worried.

At my next appointment, I try to talk to my doctor about my concerns. He tells me to tough it out and the baby will be fine. He now thinks I should try to get down to 15mg before I reach 20 weeks, that there will be less chance of the baby having NAS on that dose. I leave the clinic feeling even more worried than before. I am extremely unsure whether I can do it.

I try to stick to the reduction schedule and spend the next fortnight feeling awful, I am barely sleeping and constantly in a state of withdrawal. My partner Max ends up giving me some of his methadone. I also start worrying that I might relapse. I am dreaming about drugs a lot, something I haven't done for a long time. I am taking extra methadone from Max regularly, which totally defeats the purpose of reducing, but I can't function without it, let alone work.

July 19: When I next see the doctor, I'm only down to 40mg and I'm forced to admit that I haven't been reducing like I was supposed to.

He is very angry and tells me that the baby will definitely be born with NAS now and that I will have to give birth at a different hospital, one that can deal with a situation like this. (We live in a small rural town and the hospital he is talking about is 150km away!)

I had wanted to ask him to increase my dose but didn't dare mention it after seeing his reaction. I request more information about what to expect when the baby is born and he gives me some pamphlets on NAS and the phone number for the paediatrician at the hospital we will be going to.

I also tell him about my lack of sleep and my level of withdrawal and he suggests Valium. I politely decline, but can hardly believe he would give me Valium, considering I have had numerous issues with it in the past, issues which he knows about and which took me months to recover from.

I also ask if there are any other tests I need at this stage of my pregnancy but he is in a rush and cuts the appointment short, giving me a referral for the 20 week ultrasound and the words "Keep trying to reduce!" as he hurries me out the door.

July 20: We are so excited to see our baby again at the next scan. Today everything goes well, the sonographer, who is unaware of our drug issues, is lovely. I wonder if it would be different if she knew - I suspect so. Max doesn't want to find out the baby's sex, but I can't wait! Max leaves the room and she tells me it's a boy; I know Max wants a girl but I am very happy and I'm sure he will be too. Our due date is now the 12th of February.

July 27: It's been a hard week. I still feel like I'm withdrawing even with the extra methadone from Max. I spend hours reading everything I can about women who have been in a similar situation and am convinced I have to increase my dose or risk going into premature labour. I make another doctor's appointment.

August 01: The doctor is not happy with my research and wants me to keep reducing, even though he said in the beginning that I should only reduce until Week 20. I hold my ground and insist I need to go up and he reluctantly puts me back up to 50mg. I was hoping for more but don't want to push it. Usually at this stage women have a sugar test to check for diabetes. I ask about it but somehow he again neglects to organise it. He makes another appointment for a month's time.

I feel like I'm constantly worrying, I worry about being on methadone, I worry about the baby and I worry about the effect all this worrying will have on the baby! In the rare moments when I'm not worrying, the guilt kicks in. It seems I can't enjoy my pregnancy at all.

September 01: I sit in the waiting room, sweating, knowing I'm going to get another lecture because I have given up trying to reduce. My ante-natal appointments seem to focus solely on methadone.

The doctor doesn't check my blood pressure or do a urine test, which I find out later are supposed to be routine. He weighs me, measures my belly and listens to the baby's heartbeat. I ask again about a diabetes test but again it is overlooked. I will see the doctor monthly from now on.

At Month 7 I need to increase my dose again. I am too scared to ask the doctor, so Max gets his dose increased and gives me extra. I know this is not ideal but I am scared of pre-term labour and everything I read suggests that this can happen.

THE TRUTH DOESN'T ALWAYS SET YOU FREE

October 03: The doctor finally orders a diabetes test.
It's all clear but that's not really the point - it should have been done ages ago! I also get a few other routine blood tests, which show that I have a low platelet count 1. My Doctor seems unconcerned and nothing further happens at this point. I have a little over 2 weeks left of work! *Woo Hoo!*

Christmas time: It's been hot and my feet and hands are very swollen; they have been gradually getting worse for the last 2 months. I have an appointment the day before Christmas and the doctor notices the swelling and finally takes my blood pressure. It is high but not crazy high. It is a worry though and he wants to monitor it closely. I will be seeing him fortnightly now.

January 02: The doctor decides I need to see an obstetrician and gives me a referral to one near the hospital where I'm to give birth. I ring and make an appointment and because I am so close to my due date they book me in for the next day.

January 03: I notice the difference in quality of care straight away. Before I see the doctor I see a midwife who goes through my entire medical history with me, as well as taking my blood pressure and doing a urine test. She's horrified when I say I haven't had one at all throughout my pregnancy. I spend nearly an hour with the nurse before I see the doctor. She's a small dynamo of a lady who makes me feel like I'm in safe hands. She is very concerned that I am seeing her so late into my pregnancy. In fact, she is bordering on angry. Apparently my original doctor has a habit of doing this and she is considering making a complaint. She orders a long list of blood tests that need to be done straight away. She says that the low platelet count from an earlier test is a huge concern and that if it is even lower in the next test, I will need to be induced. Apparently a low platelet count can cause haemorrhaging if there are complications during the birth.

I have also missed an important injection that I should have had at 28 weeks, again at 30 weeks and finally at 34 weeks. She is unsure whether it is still possible to catch up, but decides to give me the first shot anyway. As the appointment progresses, I feel more and more annoyed with my GP.

Towards the end of the appointment I get to see my baby again on the ultrasound; for a few moments all the negative stuff seems unimportant and it is a relief when she says he is growing well.
I have another appointment the following week.

January 10: My mother in law has accompanied me to this appointment as Max is away working and I feel safer having someone in the car on such a long trip at this stage of my pregnancy. The only problem is, she is unaware of much of our situation. None of our family knows about the methadone, and I am getting more and more worried about how we are going to explain this hospital stay to them. I am hoping if the baby does in fact have NAS that we will be discharged in a week, but I have also heard it could be as much as 8 weeks!

The results of my blood tests are not good. I will definitely need to be induced early, as my platelet count is even lower. The word induction is terrifying; everything I have read over the past 8 months says that it almost always leads to interventions of some sort, whether it's an epidural, or even the dreaded C section. But I guess we will have to go with whatever is safest for both of us. The doctor also books me in at the hospital and makes an appointment for me to see the nursery and the paediatric team, as I will most likely be seeing a lot of them once baby is born. NAS is almost a surety now according to all the medical professionals we have seen. I have read that some babies have been born without it to mothers on even higher doses than mine, so I am hanging onto a sliver of hope that all will be well.

Thankfully, my mother in law stays in the waiting room and I can talk to the doctor freely about my concerns about our families finding out that I am on methadone. She can't quite believe that no-one knows the full story. But I explain that we have made a huge effort to keep our double lives separate over the years and it would be a huge shock to all of them. I am particularly worried that someone will let something slip in front of visitors while we are in hospital. She says I need to talk to the doctors and nurses on the ward about the situation. She orders another lot of blood tests and makes an appointment for the following week. At this stage, if my platelets stay the same, I will be booked in for induction on January 30th, but sooner if my platelet count gets any lower. It's getting real now!
D day is approaching and fast!

We head to the hospital which is just down the road and I meet the midwives, doctors and nurses. I manage to get the head nurse on my own for a moment and quickly explain the situation regarding our families. She is fantastic and says she will make sure everyone knows not to bring up anything to do with drugs or methadone. I feel better, but I am still nervous. The hospital seems great and I am glad I will be here, rather than the local hospital. With a bit of distance between us and our families, it will be easier to control who comes and when.

They want me to talk to a social worker and the head nurse distracts my mother in law with a coffee while I talk to her. She asks a whole bunch of questions; whether I think we might relapse with the stress of a baby, whether I have ever used other drugs, and if I have a tendency towards depression. Despite selectively editing out parts of the truth that may seem unpalatable, she frowns a lot at my answers. She wants a group called Family First to be involved and also for Social Services to check up on us.

I am really shocked at this development, especially when she alludes to the fact that they could take our baby away, despite not saying this directly. I try as best as I can to make her understand that we have had drug use issues in the past, but that we have been on a stable program for a few years now.

Surely that counts for something?

But all she seems to hear is ‘Heroin addict’ and I leave feeling sick to my stomach. I later call Max and he seems to think that there is little to no chance of anything like that happening, we just need to dress the part, say what they want to hear and jump through their hoops and then they will leave us alone. I hope he’s right.

January 16: My platelet count is continuing to drop and I need to be induced the following week! This appointment is fairly quick. We go through what will happen the following week and she answers any questions I have.

I am going to see the paediatrician again this time on my own, so that I can ask him questions about what to expect if the baby has NAS.

They have a score sheet that is completed every few hours after the birth, which includes criteria such as muscle tone, excessive yawning, body temperature, etc., etc. If the baby scores high more than 3 consecutive times they will start him on morphine. If he still keeps scoring high they will keep increasing the dose until he is comfortable. After that they want him to stabilise and then they will start reducing it.

I break down crying while the doctor explains all this.
The guilt I am feeling is indescribable.

For the next week I am just getting ready for the impending birth. We work out a story to tell our families in case he has NAS. The doctor suggested we say that the baby’s body temperature and blood glucose levels are low and that he is being monitored. This will buy us a week at most and then we will have to think of something else. We have a lot of very anxious moments over the week, considering all of the possibilities.

January 22: We drive down to the hospital in silence; the enormity of what is about to happen has completely sunk in. Tomorrow they will start the induction process; tonight they are just going to monitor the baby and do a few last tests.

The nurses on the ward are all quite nice until they read my notes and I see their attitudes change instantly when they get to the page that says I am on methadone. Max and I take a long walk around the leafy hospital grounds. I am still hoping that my labour might start naturally, but it is very unlikely.

They let Max stay the night in my room, which makes me feel a lot better.

Not surprisingly, my GP forgot to transfer my methadone script to the hospital and there is some confusion about how I will receive my dose in the morning. It is late and no one wants to deal with it; they say it will be sorted in the morning. I usually take my dose at around 8am and I am worried that they will try and start the induction without giving it to me.

We try to sleep, but the anticipation keeps us both awake.
Our lives will be forever changed tomorrow.

January 23: We finally get to sleep. The sound of the cleaners at 6am jolts us awake and back into reality.

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I inquire straight away about my methadone dose, but no-one wants to talk to me, they are all too busy. The doctors do their rounds at 8am and I ask again; they say they need to talk to my GP and that they will come back. They don't. The nurses come to start the induction at 9am and they insert a pessary containing prostaglandin.

Still no methadone! I am starting to panic - I can feel the beginning of withdrawals. They don't seem to understand that withdrawals can kick in quite quickly, especially in times of stress. Labour can begin any time now and I really want my dose.

I go and talk to the head nurse and try to explain the urgency. She looks at me like I just want to get stoned and I start to cry from sheer frustration and anxiety, but this just seems to annoy her even more. It's 10am and I start getting pains. I am also sweating and yawning uncontrollably. Max tries to find out what's going on, but no luck.

11am: Labour is really gearing up now, it is full on and I am desperate for my dose. I try bouncing on an exercise ball and try to breathe through the pain but it's coming on stronger and stronger. Within half an hour I am screaming in pain.

Finally my dose turns up and the nurse comments that I can calm down now as if I am just doing it to get my methadone. Max again tries to explain that the methadone will do nothing for the pain and I see one of the nurses roll her eyes. The pain is so all encompassing and intense I am gripping onto Max with all my might. I am rolling around off the bed, writhing around like I'm possessed and twisting his jacket, biting his arm and screaming in agony. All my inhibitions have gone out the window; I honestly feel like I can't do this. I have never felt such brutal pain in my life before, it is simply beyond description.

Even though we had a birth plan and we said I did not want an epidural, I need it more than I've ever needed anything in my life before and I need it now!

The nurse checks my dilation and I am only 3 cm. I am completely flipping out now while Max looks on in horror. ***'Do something!'*** he says, ***'please!'*** They are reluctant to give me any pain relief although they do offer me gas, but it makes me feel sick and I beg for something stronger. They finally give in and give me a shot of pethidine that does *absolutely* ***nothing.***

After the nurses finally agree to an epidural, they contact the anaesthetist who is on a tea break. He says he will make the one floor journey via the lift if anyone else needs him, but won't do it otherwise. Luckily somebody in the next room needs his help, so he reluctantly drops by. He knows he is in complete control and takes what seems like hours.

I have to sit still while they put the needle in my back which is almost impossible with the contractions coming constantly, but then it stops, the epidural is in and I can hardly believe it. I apologise to everyone for making such a scene, I try to explain the pain to Max, and he tears up saying he felt so hopeless.

The nurses change shifts and two new ones arrive. One is lovely and talks to us for ages and I feel for the first time that I am not being judged. The other nurse barely wants to touch me. I hear her whisper 'Hep C' to the other one.

Now that the epidural is working, I have to sit and be monitored. My legs are numb and I am very tired. At some stage they break my waters and I'm not sure why, but I find this part extremely embarrassing. Now we just have to wait, my body will keep labouring while I sit back and watch TV and play on my phone. Max goes to get some lunch and I sleep for a few hours.

At around 6pm things start moving again, I am fully dilated. I have to push which is quite tricky when you can't feel a thing. But I push with all my might for over an hour. The Dr comes in and he wants to hurry things along - his shift is ending in 30 minutes and he wants this baby out. The baby is not in distress and there is no other reason to hurry. He will give me 10 more minutes, but then he will use forceps, which has been my worst nightmare. The 10 minutes go by quickly and it is hard to push under all the pressure.

When the doctor returns with a team of people in tow, he turns off our relaxing music and turns on the brightest lights possible (both completely contrary to our birth plan as we wanted Frankie born into a calm, dim environment). People start wandering in and out of the room, joking and laughing with one another about things unrelated to the baby being born, less than a metre away.

What are they doing here?

They put my legs in stirrups and pull out the forceps. I will spare the gory details, but 20 minutes later Frankie enters the world screaming! According to the doctor he is huge! He is over 4kg, which no one was expecting! All the pain really does fade away in that moment when you meet your baby for the first time. Max and I are overwhelmed.

The medical team all leave and we are left alone for a while to meet each other; we lower the lights and put on our music. It's a perfect timeless moment. After half an hour or so, they need to start the NAS scoring process. I notice straight away that he has tight muscle tone and he's sneezing, but he takes to breastfeeding straight away, which is a relief.

The worst of the withdrawals won't be obvious for 24 hours, but the doctors are sure that he has NAS.

It completely breaks my heart, knowing I have done this to him. My baby, the person I am meant to protect from the world and before he even enters it properly, he has to deal with the pain of withdrawal.

Max and I wait to tell our families about the birth. We want to see how he is and have a chance to talk to the doctors properly. The paediatrician is surprised at how big he is, as babies born to methadone dependent mothers are often underweight. But then, a lot of those mothers also smoke and have poor diets.

Proper statistics don't exist, but there sure are a lot of assumptions!

We ask the paediatrician what he thinks and he is almost sure Frankie will be put on morphine in the morning. I ask for a rough time line and he thinks at least 3 weeks before we will be able to go home. We have no idea what to tell our families. I am not allowed to keep Frankie with me, as he has to stay in the nursery. I tell them about what I have read regarding kangaroo care and NAS babies and how they need to be close to their mothers, but they refuse to listen. Instead, I sit in the nursery all night and hold him.

Max has to leave for the night. He will have to commute back and forth 150km each day, unless we can find him somewhere to stay in town. We cannot afford a hotel, but we are lucky that word of our situation has made it to the social work team and they agree to pay for Max's accommodation for the first 6 nights!

I wonder if they did that to soften the blow as to what's coming next, as after those 6 days I too will have to leave the hospital and leave Frankie. I just about break down when I hear this - it goes against everything in me to leave him. I beg, cajole and try everything I can to get them to reconsider and change their minds. This seems to work as she leaves and promises she will work something out. I am desperately holding onto what little hope or faith I possess in the system.

I make sure I stay with Frankie every second I can, to show them how dedicated I am. I wonder if other mothers in a different situation would be forced to leave their babies. Talking to the nursery nurses it seems that this is common practice for opiate users' babies. An older nurse who seems to dislike me from the word go tells me that I am lucky to be staying 6 days, as beds are limited and every day costs money to keep people here. I tell them I would sleep in a chair and bring my own food to stay with Frankie.

January 24: Only one day has passed and already so much has happened. I spend the night learning how to feed Frankie properly and just staring at his perfect little face. It's obvious he is in withdrawal. He shakes when I change him and has a high pitched cry. The older nurse is unsympathetic when she sees me cry. The guilt hurts so much. I know what she is thinking and in a way I don't blame her. I did this.

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I was selfish, I got pregnant when I shouldn't have and I couldn't reduce my dose and now he has to pay. She watches me like a hawk. I feel like they think I will abuse him or something, that I can't be trusted with my own child.

January 25: At 6am in the morning the shift changes and I am delighted to see the nurse who was there when Frankie was born. She is lovely and lets me express all the guilt I have inside me. She listens and tells me 'at least you tried to do the right thing; you did the best you could'. I will be forever grateful to her for those words. They came at the right time when I was full of hormones and confusion.

At 8am the doctors checked Frankie over and started him on his first dose of morphine. I can't remember exactly how much, but it was miniscule. He would receive it every 2 hours and his score would be checked before each dose. Those first scores were 13 or 14, which is very high. They wanted them under 4 before they would consider reducing or levelling out his dose.

I discovered early that different nurses scored differently - some tried to get a high score and others were more accurate in their observations. I made sure I was always present when they did it, once I realised. I knew the nurses who wanted to see me suffer as much as possible.

At 9 am I suddenly realised that no-one had brought me my methadone. I asked the nurse and she had no idea; the doctors were an hour away and nothing could be done. Nothing had been set up. Again I spent most of the morning in withdrawal. That and the fact that I had just given birth made me feel even worse. They refused to even give me Panadeine Forte, although other mothers on the ward were being given them freely. I called my clinic back at home and my GP was not yet in. I begged them to get him to call the hospital and sort it out as soon as possible.

Once again I was made to feel like a desperate drug addict trying to get a fix. A sympathetic nurse finally sorted it out for me, apparently the script had been faxed but not sent up to the maternity ward and all it took was a phone call to the front desk. Now I had to wait for the hospital pharmacy to make it up and bring it to me which took another hour. During this time I sat with my son and cried, cried from my discomfort, but mostly from the unfairness of it. I have never felt as helpless as I did that morning.

Frankie was getting worse, not better. By the time Max arrived that morning, he found a distressed, crazy woman waiting for him. On top of the NAS, Frankie had jaundice and needed to be put under blue lights. They take off all his clothes except his nappy which he hated. NAS babies want to be covered and held so it must have felt awful to him. They also had to put these little sunglasses on him to protect his eyes. He continually ripped them off, frustrating all the nurses. Watching him through the plastic box he was trapped in was beyond heartbreaking.

The only positive part of Frankie having jaundice was that at least we had something to tell our families, to explain why we had to stay at the hospital that wasn't a total lie.

We spoke to every nurse that came on during those first days and let them know of the privacy issue and by and large, they were understanding. The privacy policy in all hospitals means that they shouldn't talk about anyone's case in front of anyone other than the patient, but sometimes things slip out and we just couldn't risk that happening.

Max finally made the phone calls to our families. They all wanted to visit straight away, but luckily the 70 minute drive deterred them a little. My Mother, Max's Mum, Dad and Grandmother were all coming in the morning, which was a scary thought. I was petrified of them finding out.

January 25: Even though my methadone script is on the premises I still have to wait till after 11 am for my dose. I am far from a priority to this nurse and I am frequently reminded that they are going out of their way to do me a favour. The odd friendly face amongst a predominantly hostile nursing team keeps me sane.

I am extremely tired and the nursery team tell me to go and sleep, that they will look after Frankie, but I don't want to miss a feed as I know my breast milk is the best thing for him. I want to do my best for him now, I want him to thrive and prove them wrong. Some nurses try and tell me formula would be better because of my hep c, but unless I have a sore on my nipple, there is a 0% chance he will contract it. It amazes me how uninformed a lot of the nurses are, especially the older ones, who seem to be stuck in a different era. One in particular who has been on the ward for over 30 years, tries everything she can to bring me down. She has seen others like me she says with a knowing look, she undermines everything I do, seemingly forgetting that I am just a new mother like everyone else here; the only difference being that I take a medication that she disapproves of.

Frankie's morphine has been increased again. I really hope this will be enough, because the more he's on, the longer it will take to reduce him off it.

The paediatric team do their rounds every morning at 9am. I want to be there, no matter how exhausted I am. Max turns up in time for their visit - 2 paediatricians and a small group of student doctors. They stare at us as the head doctor explains Frankie's symptoms and our story. The students look young, much younger than us and appear to be almost scared of us. When the head doctor asks a young female student to feel Frankie's muscle tone, she does so with a look of disdain and runs off to wash her hands immediately after. Sadly this is not an uncommon experience in the following weeks. We are often ignored or spoken to as if we are stupid.

We have another appointment with a social worker later today. She is young, enthusiastic and nice and she seems much less judgemental. She wants to know my full story, which I tell her is rather straightforward. I used heroin for 10 years before starting a methadone program 3 years ago. She's actually very positive about everything, but says we have to have a family support worker when we go home, just to make sure everything is ok. I don't have a problem with this, because we have nothing to hide.

She is also incensed that I was told I would have to leave the hospital after 6 days; she assures me this is not the case, as I can be a "room in mother" after this time, which means I will be free to come and go as I please and the hospital will no longer be responsible for my care. She also organises another week's accommodation for Max. They will transfer my methadone script to a local pharmacy (*which I don't really understand since there's one at the hospital*) but I am so happy I can stay, I don't really care. I am so happy even the old nurse in the nursery doesn't bother me.

At lunchtime my mum turns up and it's good to see her, but I'm on edge. I know she would be devastated if she knew the truth. But all goes well and she can even hold Frankie briefly while he is out of the blue light. She doesn't seem to notice that he trembles a bit and that he is quite unsettled. Later Max's family arrive, but the nurses don't let them hold him and Max's Grandmother is very disappointed. The nurse on duty is one of the less friendly ones and I am sure she could have organised it if she really wanted to.

January 26: I am experiencing the 3rd day blues, but luckily today I get my dose before 11am. Frankie has had another bad night and it looks as if they will increase his morphine again. I have very mixed feelings about it because I want him to feel ok, but I also want to get out of here as soon as possible. This is the 3rd increase so far and the doctor predicts 2 more at least. They have started weighing Frankie twice a day and are saying he needs to gain more weight.

The Doctors want him part formula fed. I really want to exclusively breastfeed and I know from talking to other mothers that once you start supplementing with formula it's a slippery slope – the baby wants the breast less and less, which in turn reduces the mother's milk supply. This was another ongoing battle I had with the nurses during our entire hospital stay. But once the paediatricians put on his chart that he was to have a bottle of formula after every breastfeed, I seemed to have little say in the matter.

I remember one situation when the nurse who was most intent that he be bottle fed, decided that Frankie needed to finish his bottle, although he didn't seem to want it. Max's Grandmother was happily feeding him at the time and the nurse walked over and snatched Frankie from her and *literally* force fed him the remaining 50 ml. It was horrible to watch and he vomited the whole lot up straight afterwards. Max's Grandmother, who was 97 and had had many children and grandchildren, was absolutely furious and shocked at the nurse's cruel attempts at forcefeeding.

January 27: I have only been here 5 days but it feels like so much longer. Frankie is 4 days old today and seems a lot better, but is still getting high NAS scores. It will hopefully be the last morphine increase if he has a good night tonight. He is still under blue lights for most of the day. Max has been spending every day with us and has taken time off work. Financially it will be hard, but I need him here more than ever, otherwise it feels like it's them against me.

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Max stays until late at night and returns early every morning. Occasionally he drives back to our home to make sure the cat is ok and to get things that I need.

January 28: The paediatrics team are happy that Frankie is stabilising and are going to wait till their afternoon rounds to reassess him. Luckily all my favourite nurses are on today and they score him accurately.

He is also out of the UV light today; they plan to do a blood test tomorrow morning to check his bilirubin levels and if they are stable, he won't need to go back in. We have more visitors today and they ask when we're coming home. Even though I know we won't be leaving for at least 3 weeks, I say soon.

I need to think of reasons why we're going to be here longer. I talk to the paediatricians about possible reasons other than the neonatal abstinence syndrome (NAS). They suggest telling people he still needs to spend time under the UV lights, which will buy us at least a week.

January 29: Frankie is much better - his muscle tone is good and he is sleeping better. I ask when I can have him in my room, but they say as long as he is on morphine, he needs to stay in the nursery. Some nurses let me take him to the communal lounge room about 3 metres away, but others don't let me leave the nursery.

I am in contact with a friend who was in a similar situation when her son was born in Melbourne. They spent a week in hospital and were then allowed home with a supply of morphine and a weekly home check-up. Their experience is so far removed from what I am going through.

I quiz the doctors, but they make it very clear that they are not interested in what other hospitals are doing. I try to argue the point, as all I want is to go home and start being a family. My defiance works against me and they attach a monitor to Frankie's foot so that he always has cords attached to him that make it even more difficult to move him around.

I ask if he can stay in my room for an hour or two with the monitor, but they refuse outright. I am also moved to the furthest room away from the nursery to make room for another patient.

January 30 – February 01: The next few days are up and down. Frankie seems a lot better, but then he has another bad night and they score him badly again. It's so frustrating, because all newborns have good and bad nights and it's not necessarily due to the NAS.
But the doctors have the final say and we have to toe the line.

Being stuck in here is beginning to really affect me. I am close to tears all the time and I feel like my methadone isn't holding me. I ask to speak to someone about increasing my dose. The doctor who comes has no knowledge of methadone at all. I try explaining what I'm feeling, but he doesn't seem to understand that due to hormones and other factors, patient's doses sometimes need to be adjusted. He doesn't have the authority to increase my dose but promises to find someone who can. He returns a few hours later sporting a big smile and saying he can increase me to 55mg. He seems so pleased with himself that I don't have the heart to tell him that an increase of 5mg is nowhere near enough.

We meet with the social worker every few days. She now wants twice weekly home visits for the first 6 weeks after we go home – and they are not optional. We will also have the maternal child health nurse visiting weekly for the first 4 weeks. I am no longer a "room in mother" and I no longer have my blood pressure taken every few hours, or need to report to anyone if I leave the ward.

They still supply my meals and they have decided that I can still get my dose from the hospital pharmacy, which is a relief since the pharmacy in town is a good 15min drive, but because Max has the car, I would have to take a taxi. I also don't want to be away from Frankie for any length of time.

The controlling nurse from the nursery has been particularly unfriendly today and as I am changing Frankie she snaps that I am not doing it properly. I lose it and start crying "what is your problem? Why do you think I am such a bad person? You have no idea about me or why I came to be where I am now!!" She is quite taken aback and actually apologises.

She admits she has no idea and asks if I would tell her my story. From this day onwards we have a completely different relationship. She is still very old fashioned in her ways, but she seems to see me through new eyes and even lets me take Frankie for a walk around the ward. As relieved as I am by her change of heart, I am annoyed that it's like this at all. Why should it have come to this? The assumptions and the stigma are just constant.

I was expecting it to some degree, but it's been much more extreme than I ever imagined. Max is experiencing it even more than me in some ways, mainly because he doesn't dress like all the other fathers around us, despite wearing the 'straightest' clothes he owns. I have been trying to blend in, but Max works in Melbourne most of the time and has kept more of his personal style intact.
Mary often jokes about him after he has left; she thinks he's gay, due to his choice of clothing. At first I argue with her, but soon I realise that there's little point. The more I express my opinions, the harder it is for me in here.

February 04: Frankie is well and truly stable and they will consider reducing his morphine soon if his scores stay low. He is out of the UV completely and we are now telling the family that his glucose levels are playing up.

February 06: After almost 2 weeks they finally start Frankie's reductions! They will decrease his dose by 0.1mg daily, possibly twice daily, depending on his scores. Finally it feels like there's an end in sight after all. I am breastfeeding him as much as possible, which also seems to help. He is gaining weight and you would not know there was anything wrong with him, apart from the pesky monitor still attached to his foot.

February 07 – 09: The next few days go well with family drifting in and out. So far our secret has remained just that – our secret. But my mum in particular is beginning to wonder why we are still here; she quizzes the nurses and luckily they all stick to the same story. We have a few close calls with visitors - when Frankie needs his medicine, but the nurse is quick to come up with a plausible-sounding explanation and says it's just sucrose to boost his glucose levels. I just hope none of them decide to google what we are telling them…..

We have been here for over 2 weeks now and at the rate Frankie's dose is being reduced, it will be another week or two before we'll be able to leave. I am utterly exhausted by this stage, because I try to be there for every dose and every score, as well as all his feeds, nappy changes and other general infant care. I feel like if I'm not there, they will score him higher than they should and we will be stuck here for even longer. Some nights are a little less stressful when a nurse I trust is on duty, but this is rare.

One night I ask the nurse why I can't have Frankie with me. Surely if he is close to me and attached to a monitor that will go off at the slightest change in his condition, little can go wrong. She agrees and lets me take him to my room and I get to spend the first night together with my baby without the interference of the nurses.
She makes a point of saying that she trusts me, which means the world.

The next morning, another nurse storms in while I am feeding Frankie and wants to take him straight back to the nursery. Apparently the night nurse has been disciplined.
I feel awful, because she was just trying to do the right thing and went out on a limb for me.

I'm now back to spending hour upon hour in the nursery, as I watch other mothers take their babies whenever they please, even ones that seem much sicker than Frankie. One of the paediatricians gives me a stern talking to later in the day, suggesting I had somehow put Frankie in some sort of danger. I'm furious and ask her why I would do that? If I felt he was at risk, I would never have taken him into my room. But it falls on deaf ears and we are back to square one.

Fortunately, however, the end is in sight - we should be able to leave in 4 days - which lifts my spirits considerably. I start to realise how depressed I have become in this endless Groundhog Day situation. But I could never mention this to any of the doctors or nurses, because I know it would just be used against me. Family are in and out the whole time and it is getting harder and harder to think of plausible reasons for our prolonged stay. At least it's nearly over.

February 10 – 12: Frankie is progressing in leaps and bounds. Two more days and we will definitely be out of here. Some of the staff in the nursery are not happy about this and think we should stay for at least another week. But luckily, for now, the paediatricians are on our side.

February 14: We should be able to leave today! I can hardly believe I will finally be able to take Frankie home and be a family with Max. I long for a sense of family with Max and just to do all the things new parents do. The doctors gave Frankie his last dose of morphine the night before and so far he has shown no further signs of withdrawal.

They now need to do the final few tests that all babies have before being discharged. They want me to keep feeding him a mixture of formula and breast milk and even though I say I will, I intend to breastfeed exclusively once we are home.

THE TRUTH DOESN'T ALWAYS SET YOU FREE

We see the social worker again and she gives us a pile of numbers and dates when they will be paying us home visits. Max brings the car-seat while I pack my belongings and we say goodbye to all the nurses and doctors. We both thank the ones who made our stay bearable.

And then we are leaving. I feel like any moment they will call us back; saying Frankie isn't ready to go home after all, but we make it to the car and make our getaway. It feels surreal. I feel so free!

Max has decorated the house with a big welcome home sign, balloons, flowers, chocolates, and he has re-decorated Max's nursery. It is super colourful and cosy and I am so happy to be home! I can't quite believe that it has happened. Waking the next morning in my own bed is just bliss. Everything is just awesome!

February 16: Frankie has been great. He is feeding well and seems quite content. Max and I spend hours just watching him. Our first social worker appointment is today. They go through every room in the house and take notes. They ask a million questions and even look at my arms for track marks! We have little choice but to go along with them, as they have the power to make our lives very difficult. When they finally leave an hour later, we are left a little traumatised.

February 17: The maternal child health nurse comes today. She weighs and measures Frankie and is generally very nice. She asks a lot of questions about how we ended up on methadone, but it seems more out of interest than anything more malicious.

Frankie is growing well and gaining lots of weight.

February 19: Another visit, this time from Family First. They are similar to the social workers, but they let us know what help is available if we need it.

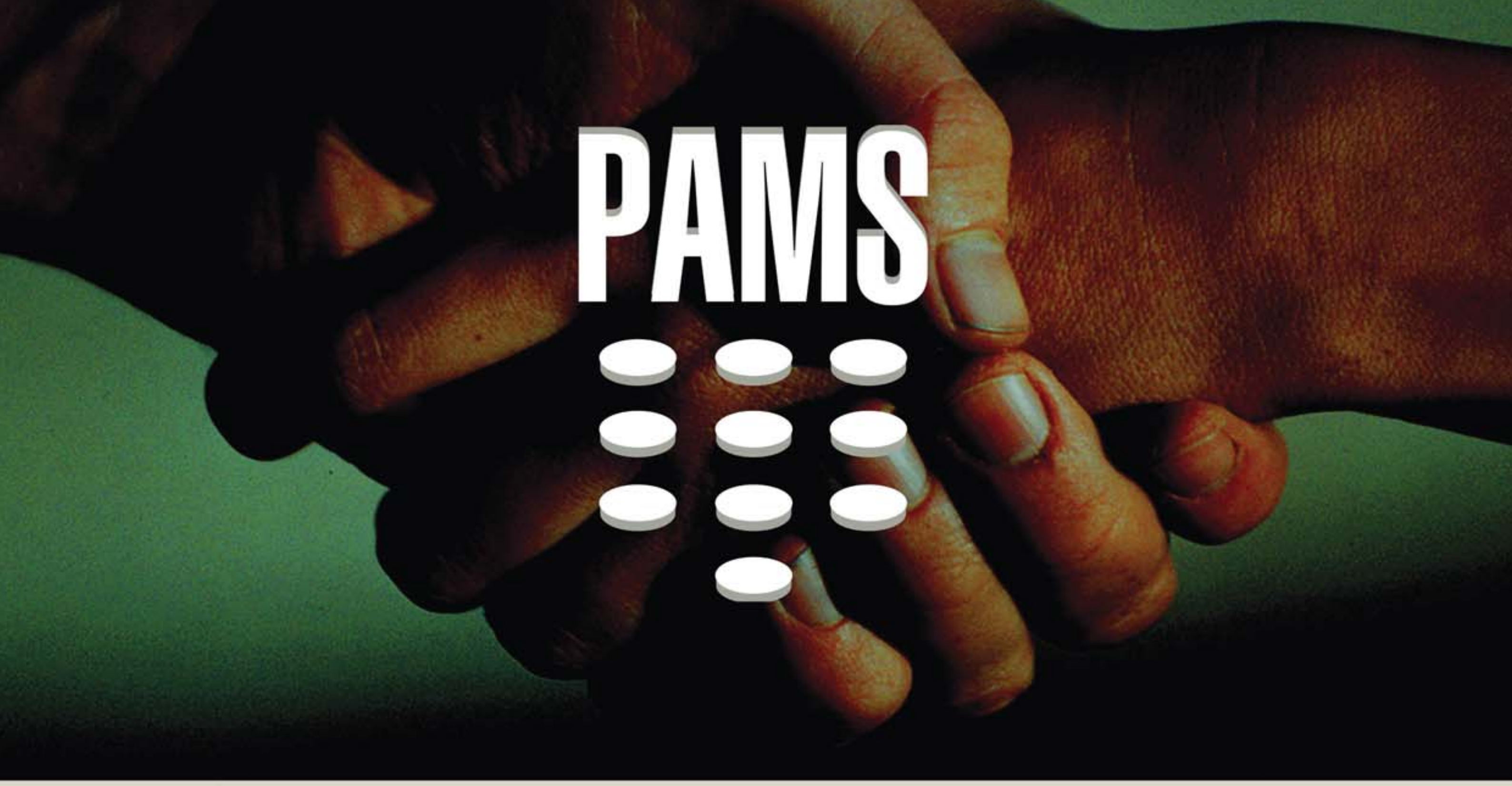
Life with Frankie brings massive changes on every level. We were expecting things to be different and intense, but this is a whole new world that doesn't let up for a second. It's quite amazing how such a little person can have such a huge effect on our lives. But despite the sacrifices, the constant waking, all night, every night, the squeaking and the crying, there are many moments of pure joy and we wouldn't trade it for all the world.

*****

Frankie is now almost 3 years old. He is extremely energetic, talkative and well- adjusted. He loves to draw, sing, splash in puddles with his gumboots, make up little stories using his toys as characters and he loves anything colourful with wheels. Frankie is an extremely happy and curious child. But sleeping a full night still isn't his strong point...

All in all, I think we have done alright.

Kendall



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There are days when you know that someone's story needs to be shared with others.

Parenting!
What is it?
And what is a good parent?

Everybody seems to have an opinion about what a good parent is and what a good parent looks like – especially people who don't have children. And there's a universal assumption that if you use or inject drugs there is no way on earth you could ever be a good parent.

This assumption really irks me, because I know so many parents who use or inject drugs, and they are good people and good parents. They see themselves as parents first and foremost and their drug use, injecting or not, is just something else they happen to do.

***I know* that some people will simply not swallow what I am saying**.
Well, I ask you to open your mind and not be so judgemental. I personally think the parents I know that use/inject drugs probably over-parent and over-compensate.

What do I mean?
Well, because of the bad rap parents who use drugs get and expect to get from so many people, they give 150% to parenting and they're constantly driven to do the very best they can when it comes to raising their children.

I know this one guy, a newly single parent, who does an amazing job with his son Johnny.

Rick was in an unhealthy relationship with his now ex-partner, Simone, for 6 long years and during their time together they had a little boy, Johnny, the apple of Rick's eye. Rick agrees that he stayed in the relationship far too long, but he didn't want to leave his son with his mother, because while he was at work she was living up to society's perception of what a parent who uses drugs is like.

So he hung around, until he finally couldn't take it any longer. He wanted to leave and take his son with him, but Simone refused to let Johnny go with Rick and he was forced to go through the courts to get custody.

Anyone who has ever dealt with the family court knows what a long, drawn out process it is, and that it can break the best of us.

Simone now threatened to wreck Rick. Rick's solicitor suggested he do an intensive parenting course to show the courts that he was more than capable as a single parent. Rick aced his course and passed with flying colours.
The only thing Rick needed to do before he could bring Johnny home for good was to get stable housing – and he did that too! Rick was kicking some serious goals - everything was going really well and Johnny was nearly in his full time care.
One morning a couple of weeks after he moved in to his new place, a letter was slipped under Rick's door giving him a week to vacate his house! He was totally perplexed. It had come out of nowhere and he was ahead with his rent.
He went to see the landlady and asked her about the eviction notice that he had received and she said ***"You know, you know! How dare you?"*** Rick was very confused with her answer and replied ***"What are you talking about?"***
The landlady stated point blank ***"I told you NO drugs! One of your friends dropped off a paper bag to give you"*** and she threw a paper bag at him. He opened the bag and saw it had fits / syringes inside! Rick was completely shocked and couldn't work out why, or who would do such a thing.
He asked the landlady a few questions about this so called friend, and from her description, he concluded that it was one of Simone's friends. Rick knew he couldn't talk his way of this one, and that the landlady would never believe or trust him again, so it was with a sad heart that he moved out that day.

It took another six months to get priority housing through the Office of Housing. Rick made sure he saw Johnny every other day; he picked him up from school, dropped him off at his mum's place and he talked to him at every possible opportunity. Finally, the day arrived where his housing came through and that was the day that Johnny came to live with him. Even though it was one of the happiest days of his life, it was also the beginning of a never ending battle with his ex-partner Simone and her family, who never gave up trying to find a way to bring Rick down.

Johnny was soooo happy to finally be safe with his dad! Unfortunately he hates his visits with his mum, especially when she spends all of the time fishing for information and saying horrible things about his Dad. He is still scared that one day he won't be taken home. I come from a broken home and I have so much respect for my Mum, as she never said a bad word about my father, even though there was probably plenty to say. She knew it would've just screwed with my head.

This is a story about a Dad who loved and fought for his son.
Rick says his priority has always been Johnny and his drug use is just something he does from time to time.

I was talking with Rick the other day about drug use and he told me that he always makes sure he gets up early before Johnny, or he waits until after his son goes to bed. That way, he is only ever using when Johnny is asleep or out of the house. This is in line with the way many other parents I know use as well.

I rest my case...

Coral Noltan.

safer using

USING DRUGS AROUND CHILDREN

Drug using parents get a bad rap.
But parents who use drugs are the same as most other parents – they want the best for their children and most of all, they want to make sure their drug use doesn't negatively affect their children.

Like a lot of other things in life, it's often that one bad apple in the barrel that gives everyone a bad name. These sorts of parents, who represent a small percentage of all drug using parents, are often casualties of their own excess and unfortunately, their children have to deal with the fallout. However, most parents I know who use/inject drugs are really good parents who succeed in raising stable, functional, well-adjusted children.

There are a lot of different ways to reduce the risk of your children finding your drugs and/or your drug paraphernalia, or even your prescription medications. It is a good idea to keep all your paraphernalia and drugs together in one place and to stash it up high and out of the reach of children. If you live in a house, a room or safe space where you can consume your drugs, away from prying eyes is the best option.
It could be:

A spare room/bedroom

Your bedroom (but not if your child sleeps in your bedroom)

A garage/workshop

The bathroom

The laundry

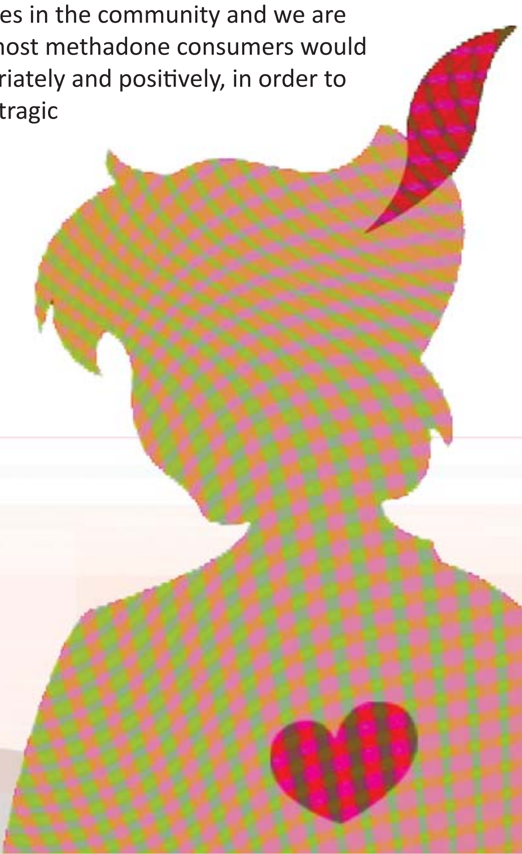
If you have to use in a communal space, stash your drugs and paraphernalia somewhere else, maybe at the top or back of your wardrobe. I used to have a locked box where I kept everything I needed. When I was on methadone, I always kept a locked box for my takeaways at the back of the fridge, behind fruit and vegies and it was never noticed.

When it comes to methadone, I made sure my child never saw me take my dose, at the chemist or at home; I felt that if they never saw, then their curiosity wouldn't get the better of them and they wouldn't go seeking out that curious looking little bottle that Mum or Dad had in their hand.

It is important to remember how strong methadone is, especially for someone naïve to opiates and especially for children. You can ask your chemist to make sure your takeaway dose is dispensed in a bottle that can't be mistaken for a regular drink bottle, with a child proof lid.

As a safety precaution, the Health Department in Victoria recently changed the guidelines, so that pharmacists no longer mix cordial with takeaway doses of methadone. When diluted with cordial, the bitter taste of methadone is masked and a child may be more likely to drink it, not realising it is medicine. Sadly, children have died from ingesting methadone over the years.

We at Harm Reduction Victoria think a fully-fledged safety campaign, focusing on takeaway methadone doses is long overdue. We would like to see a much greater emphasis on the safe and responsible handling of takeaway doses in the community and we are confident that most methadone consumers would respond appropriately and positively, in order to prevent further tragic accidents from occurring.



It is the same with Suboxone, any other opiate based medicine or benzodiazepines. If you can get hold of a little cash box or money tin, it's a really good place to stash all your pharmaceuticals.

Again, if you have the opportunity to take your meds when your children aren't around, it helps.

A mate of mine once told me about one of her friend's children; her daughter (5 years) used to get so panicked when she observed her mother's growing tension as it got closer to closing time at the methadone clinic and she had no way of getting there. It finally emerged that she thought her mum would die, if she missed her methadone dose. Nothing had ever been explained to this child; she had just put 2 and 2 together and got 5!

After hearing this story I realised, you either have to tell your children what is happening, so they don't jump to their own conclusions, or you just never let them see you use or take any sort of drug or medication, so they're none the wiser. That was the approach I took and my child remained oblivious - but it did take a lot of work. I understand you don't always have options, especially if you are a single parent and especially when your children are little and you have to take them with you wherever you go.

If possible, try to restrict your drug use to before your kids get up, after they go to bed, or while they're at school, if you have school age kids. I know it sounds a bit unrealistic, but it's all about coming up with your own strategies that work for you and your family, in your own day to day lives.

When it comes to using/injecting, if you can, it is a good idea to clean up all of your paraphernalia straight after you've mixed up and before you actually have your shot. Put everything away, except your fit, swab, tissue and disposal bin - and leave the lid off your disposal bin, so you can bin the fit straight away and then stash the disposal bin in its usual place, away from little eyes.

If you smoke ice or pot, it helps to keep you pipe or bong up as high as you can and out of reach, so that kids can't get hold of it and try to emulate what they see their parents doing. Children have been admitted to hospital after consuming left overs in crackies (ice pipes)! So whether you are using uppers, downers or going sideways, the safest place to keep your drugs and your drug paraphernalia is in a locked box, in a high or hidden place.

So what do I tell my children?

It's a hard question and no one can give you the answer. It's for you to decide what to tell them, how little or how much. After all, you know your children best and only you know what's best for them.

Coral Noltan

SHE JUST ADORED THE

‘She just adored the ground I walked on…’

‘Most loving’, ‘fantastic’, ‘really good’, ‘really great’ — these are descriptions rarely, if ever, awarded to parents who inject drugs.
Yet these are actual quotes from people who grew up with injecting drug-using parents.

When I was young I struggled to reconcile the idea of a selfish, dirty, immoral ‘junky’ with my experience of a loving mother who used drugs, had a job and put the needs of her children first. Injecting illicit drugs does not automatically equate to ‘bad’ parenting.

When I had the chance to complete an honours thesis in 2010, I used this opportunity to research the family lives of people who inject drugs and their children.
I learned about the experiences of 11 other Australians (aged 19-37) who grew up with one or both parents injecting drugs. My research focused specifically on ‘functional’ drug use. A functional drug user, for the purposes of this research, was one who managed their drug use as just another ‘unexceptional’ aspect of life. They worked, lived in private accommodation and had ‘normal’ families.

The stories I heard provided evidence for what those in the drug using community already know – people who use drugs are capable of providing a loving and safe environment for their children. Zara and Ella describe the love of their respective mothers:

“She loves me to pieces, I mean she still does. You know she’d do absolutely anything for me; she’s always been very doting like that…” (Ella)

“I think my mum was the most loving parent, you know, she just adored the ground I walked on… mum told me [she loved me] like 15 times a day... I don’t know anyone who is as close to their mum as I am” (Zara)

At 19, one participant was still struggling to connect with her mother; however, generally children were not ‘second to the drugs.’ It was generally not the case that participants had gone without food, clothing, or shelter:

“We never went without food or [had] no electricity or anything like that. We were always comfortable in our lives” (Ruby)

However, at some stage, drugs were commonly seen to be a strain on family resources. Some people made the connection between parental drug use and not being able to attend school camps, the movies or the bowling alley. Kate explained how the financial strain affected her:

“During the time when she was using, when school camps came up, I just didn’t even bother asking ‘cause I just knew that I couldn’t go, so I didn’t bother asking – I’d always say ‘oh I don’t wanna go.’” (Kate)

Not only did Kate understand why her mother could not afford to pay for the camp, she also pretended she did not want to go to avoid causing further stress. On the other hand, many participants spoke of how their parents tried to make up for using drugs. Kelly explained:

“My mum really overcompensated for being a drug user… I was a really spoilt kid. My Christmases were just ridiculous. My birthdays were ridiculous. She bought me something every week, every payday I could have whatever I wanted food wise, you know, just really overcompensated for being an IDU.” (Kelly)

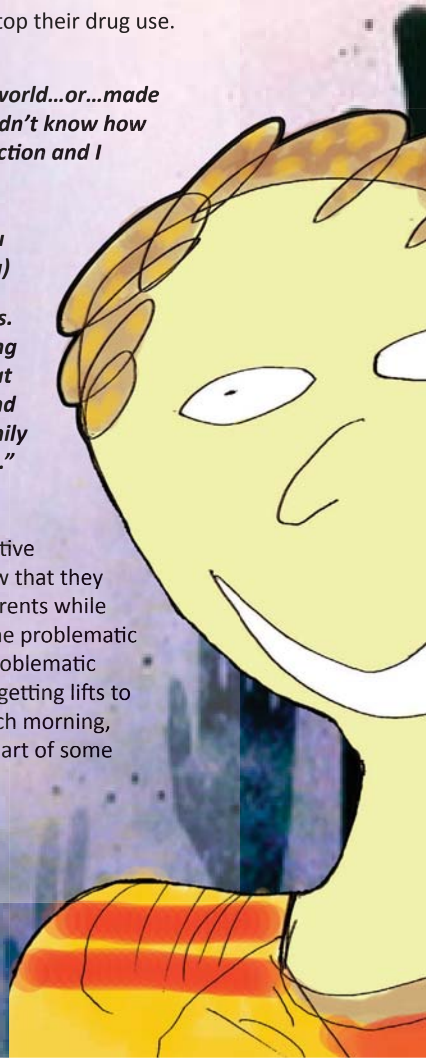
Injecting drug use affects parenting styles – but not always in the way people would expect it to. One of the most powerful themes to emerge was the love shared between participants and parents.

What struck me as I heard the participants’ stories, was how well many of them understood the nature and complexity of their parent’s drug use and in some cases also their attempts to minimize or stop their drug use. Ella and Sam explain:

“[Mum] would have given me the world…or…made things different but she couldn’t, didn’t know how to,couldn’t get away from the addiction and I think that’s why she was always trying again and again to make it better, yeah. But she was good, you know, she was a good mum…” (Ella)

“She didn’t want to be who she was. She loved her kids, she’d do anything for ‘em. She was just trapped in that world and she had a special soul and a special heart that me and my family could see but no-one else could see.” (Sam)

Ella and Sam knew that their respective mothers loved them. They also knew that they were doing their best to be good parents while also, at times, struggling to overcome problematic drug use. In these stages of more problematic use, family friends were vital. From getting lifts to school, to having their hair done each morning, supportive adults were an integral part of some of the participant’s lives.



GROUND I WALKED ON..

There was a range of different parenting styles encountered when it came to drug use and talking about drug use in the family. However, everyone had known about their parent's drug use, in some way, before it was openly discussed. Sarah explains:

"I don't know how I knew what drugs were, but I just did. I remember when I was little 'cause they'd go into the bedroom and close the door and I'd try to look under the door and that, always try to bust them [laughs]. I was probably like 4 or 5 then. They always did it behind closed doors,so to speak." (Sarah)

Wendy was older when she realized her parents were using drugs, but she knew something was going on before then:

"I don't know, it was just one of the things I knew. Not that I ever saw them doing anything. I guess I would have been about 9 when I realised what was actually going on." (Wendy)

The overarching message was that the participants wanted to be protected from situations, but not information. Most of the parents were reluctant to talk about their drug use when their children were young. Even when they did talk about their drug use, the act of injecting was always private – no participant ever saw their parents injecting drugs.

However, Zara recalls going with her mother to buy drugs when she was nine years old. That was a situation that she preferred not to have been in, though she did not want to be kept in the dark about her mother's drug use either.

Even if parenting styles differed, everyone grew up in the same society. Everyone I spoke to had an understanding of the 'junky' stereotype, the discrimination that goes along with it and the consequences of the 'authorities' finding out. Witnessing discrimination against their parents was the catalyst for the participants to learn about the social status of people who inject drugs in Australia.

Paul, Wendy, Sarah, Sam and Kate had all seen their parents discriminated against due to their drug use. Paul and Wendy described the following specific examples:

"I remember one time on the bus someone called her a junky, something that had nothing to do with drugs or anything… the girl was like 'oh you fucking junky' … [Mum] started crying… When I was younger, I'd sit there and try and hide, but as I got older, [I felt] like no-one's gonna treat my family like that." (Paul)

"When she had gallstones. We were in the hospital and they were trying to give her some medicine behind the curtains and I could hear her going, 'try this vein, try that one, try this one.' And they wouldn't give her any pethidine, even though she was in the most pain and they say gall stones are one of the most painful things you can ever endure and they wouldn't give her anything 'cause she was a known drug user... I thought it was really unfair, I mean the woman was in pain give her some frikken pain relief! She's not going to be faking this just to get some drugs." (Wendy)

While others, such as Kate and Sam, didn't describe specific examples of discrimination. They were aware that people were judging their parents:

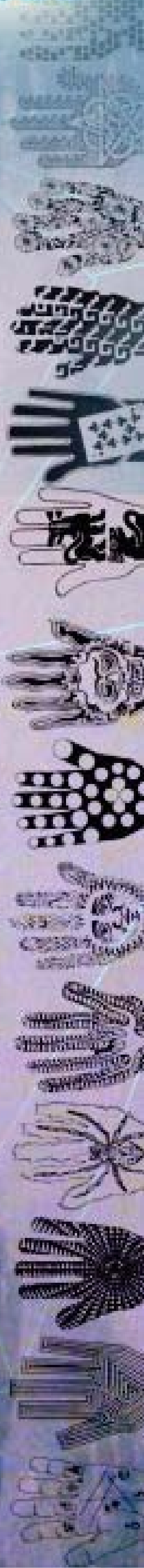
"I just knew…. I just knew what they were thinking. I didn't see it, I just knew, if that makes sense?" (Kate)

"We'd walk to the shops, just do the shopping whatever, and people would look at my mum and just know, 'she uses drugs' and just look down on her… me and my brother and my sister knew what was going on, how people looked down on our family and it pissed us off." (Sam)

Amy gives another example— one which emphasises the complications that could arise from bringing friends into the family home and also highlights the consequences of people 'finding out' about her parents:

"Sometimes there'd be like a drug needle at my house and my friends would see and I would like freak out … I remember this one girl used it to her advantage when I was in primary school, making me do all this stuff for her. She was like, 'I'll tell people' and I knew what happened to my friend, like DOCs took her away, so I'd do whatever she said. I remember crying to my sister, 'cause I knew I couldn't tell my parents and I told my sister and she was like 'don't even worry about it Amy, like don't let it stress you.'"

Amy was deeply affected by how this young girl treated her after finding out that her parents were using drugs. She experienced discrimination due to her parent's drug use.



SHE JUST ADORED THE GROUND I WALKED ON..

In this story, she describes how it directly influenced how she interacted with her peer – she did whatever this girl said to avoid being exposed as the child of injecting, drug-using parents.

Amy, who went to a school where many of the children's parents used drugs, was not so much afraid that her peers would find out. Rather, after hearing stories of children being taken away from their parents if they were using drugs, she was afraid that she may be put into foster care. There can be little doubt that this level of stress and responsibility, which was also felt by Zara and Paul, has a far-reaching effect on a child.

As children, everyone went to friend's houses to play, they went to school socials and they played sports. In some cases, however, they learnt to be ashamed of their parents' drug use:

"I remember playing footy when I was in high school… two or three people in my team knew about my Dad's drug use. That whole month there was a knockout, like a tournament thing. Everyone's Dad was there and mine wasn't and they were saying 'your Dad would rather fuckin' shoot up drugs than fuckin' be here for you and watch footy' and that sort of hurt me a bit." (Tom)

"I was always a sporty kid, I played sport with 'em no matter what, but I'd go to sport and I'd get picked on at sport. No matter what, every day at school I got picked on about something in my family… just smart-arse remarks, 'your mum's a junky,' 'the only thing your parents know how to do is make a bong'… So it was sorta weird having friends that picked on you about your family but they're the friends you hang out with on the weekend, it was weird … and annoying but it's the way it happened." (Sam)

This must have been exceptionally difficult for Tom and Sam, who both loved sport but experienced discrimination because of their parent's drug use. For Tom especially, these comments had a profound effect on him, reaffirming what he was already thinking and feeling — that his Dad was not like other Dads and was not available to him emotionally.

That these 'friends' felt comfortable telling Tom and Sam that their parents effectively did not love or care for them and that they were incapable of making a useful contribution to society (instead only making bongs), shows how the 'junky' stereotype has taken hold of the popular imagination. Even more disturbingly they also show how the actions of their parents were seen to reflect on the children. It is hard to underestimate the damage that remarks such as these can cause a child and they put into perspective the benefits to be had from passing as normal and keeping 'home' and 'school' lives separate.

Kelly drew attention to how the social construction of drug users became a means of isolating her from her school peers:

"I think there were times when kids weren't allowed to play with me when their parents cottoned on … found out that my parents were my parents… I went to this friend of mine's family's house for dinner and everything was sweet until they dropped me off at home and I introduced her to my Mum and Dad and then next day at school, I wasn't allowed to play with her. She said 'no my Mum says I'm not allowed to play with you'. I was pretty pissed off, I thought I'd done something wrong. But I think I got over it." (Kelly)

Here Sam describes how teachers sought to 'protect' other students from his 'influence', which was presumably based on perceptions of the type of child that an IDU parent was 'capable' of raising:

Do you think you were treated differently in school?

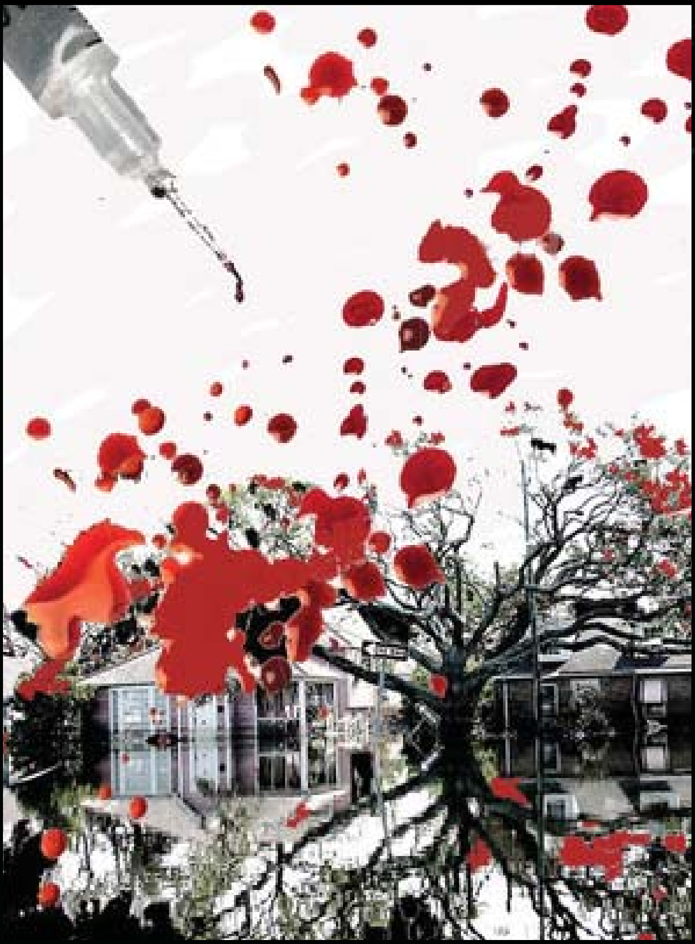
[Very quickly] "Yep. By the teachers, yep. They just treated me different, like because I acted out 'cause of what was going on at school, they were, 'like father, like mother, like son'… that's what I thought that they thought. Yeah, teachers, a lot of teachers knew and there was even times when a teacher would speak to one of my so-called friend's parents and they'd say 'well you know Sam's parents are doing this, Sam's parents are doing that, you shouldn't have your kids hanging around he's a bad influence' and the kids at school would come and tell me what the teachers had said to their parents. So yeah, I hated … I was very pissed off with teachers 'cause of things like that. That's one of the reasons why I moved to Sydney 'cause I hated, I despised teachers." (Sam)

Growing up in Australia with a parent who injects drugs can profoundly affect you. You are not just a child, you are the child of a 'junky'. You inherit the stigma and discrimination awarded to people who inject drugs before you take your first steps. The assumption that people who inject drugs are not good parents denies the children of people who use drugs the space to tell their stories.

Our stories are important. After all, the children of people who inject drugs are best placed to comment on how injecting drug use can affect parenting and families. And in the main our stories stand in stark contrast to the assumptions and stereotypes about parents who use and/or inject drugs.

Immogen Law

REVIEWS : Book



Hurricane Katrina, Heroin and the Howling Within

Eliza Player.

Do you remember what you were doing when Hurricane Katrina ripped through the Gulf of Mexico in August 2005?
I can remember seeing news footage of the devastation it caused and images of all the displaced people and I remember thinking to myself….imagine if that was me! What if all of a sudden there was no chemist to dose me with methadone, what would I do?
I guess I'd have to go get on, but what if I went to my dealer's place and that too had been ripped away by a hurricane? I can't begin to imagine how unbearable that situation would be, I just know it would be awful. There have been quite a few books written by people who lived through Hurricane Katrina but this one grabbed my attention when I read in its description…

When Hurricane Katrina bore down on the city of New Orleans, I did not even consider leaving. The reason was simple, really - I did not have enough heroin to leave without facing the impending doom of withdrawal.

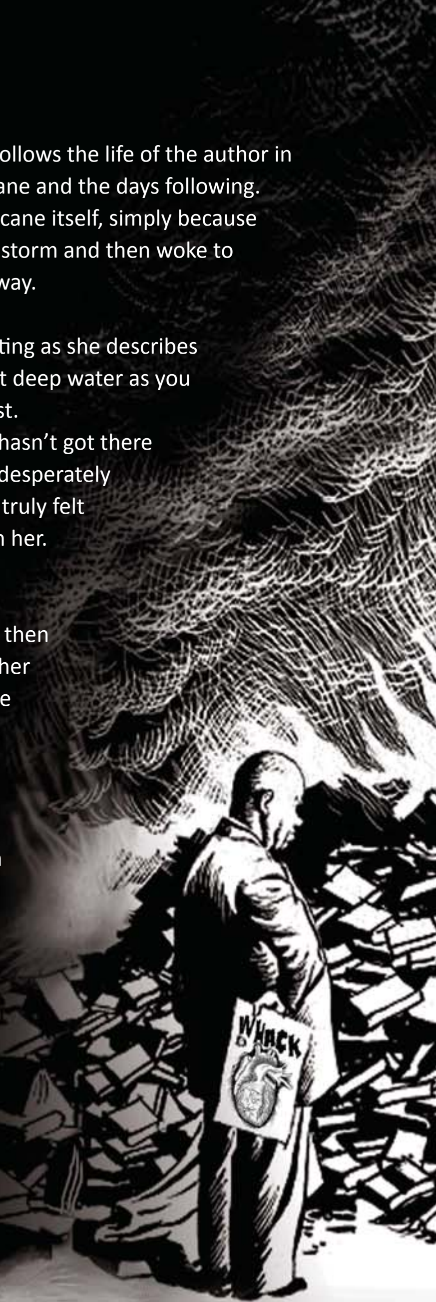
Classed as an *addiction memoir* it follows the life of the author in the weeks leading up to the hurricane and the days following. There is no description of the hurricane itself, simply because she managed to sleep through the storm and then woke to find her world had been washed away.

That's where the story gets interesting as she describes what it's like to wade through waist deep water as you make a beeline for the local chemist.
Hoping and praying that someone hasn't got there before you and taken what you so desperately need! Her writing is very raw and I truly felt like I was living the experience with her.

She talks about the 13 days spent wandering around after the storm, then the evacuation process and finally her return to New Orleans a short three months later, all with the added burden of opiate dependence *(the howling within).*

If you enjoy reading memoirs, then this one is worth a look.

Rosie D'vulge



WIN AN IPAD FOR YOU AND ONE FOR A MATE!

Join Harm Reduction Victoria or renew your membership and help a friend to join and both of you will go in the draw to win!

At Harm Reduction Victoria we want to represent every single drug user across Victoria. The more members we have, the stronger we become and the better we can advocate for everyone. Let your voices be heard and your issues taken seriously. Join us in ensuring that the health and well-being of people who use drugs is a priority, regardless of what drugs you choose to take.

How to Enter:

1. Sign up or renew your membership by filling out the form with *Your details*
2. Ask a friend to join with you and get their permission first!
3. Fill out the second form, entering your friend's details under *Referred Friend Details*
4. Make sure you tick a membership format for both of you:
   a. **Rolling Stone** gives you an online subscription – perfect for those who are on the move, but you must have an email address for this option;
   b. **Rock Steady** gets you each edition of WHACK Magazine sent to your home in a discreet envelope.
5. Make sure your fill out *all* the fields, post it in to us and you and your friend might win!

***One correctly filled out form with you and your friend's details = 1 entry ***

Enter as many times as you have friends to refer, the more entries, the more chances you have at winning.

What Else Does HRV Do?

In the past year, HRV has continued to speak up for the rights and health of drug users by:

- *Contributing to the Victorian Government methamphetamine inquiry*
- *Educating the public on drug user issues through seminars and workshops including the 2014 International AIDS Conference.*
- *Petitioning the coroner to retain access to methadone take away doses*
- *Running overdose prevention and safer using workshops every week*
- *Campaigning for equitable access to new hepatitis C treatments*
- *Establishing a robust, state wide, peer education network.*
- *Promoting harm reduction and providing a voice for users in the media, to the government and at conferences, forums, and reference groups across the state,*

Post all your entries in the one envelope where possible and send your form/s in to us by **August 15th 2015** addressed as below, *No stamp required.* Too easy!

HRV Membership Drive
Reply Paid 87627
A'Beckett Street
Melbourne Vic 8006

Fill Out Your Details Here

*Name:
*Address:
*Suburb: *State: *Post code:
*Phone: Email: @
(please tick one)
*Subscription Format: ☐ *Rolling Stone* Online *(Electronic)* ☐ *Rock Steady* Print *(sent in mail)*

Fill Out Your Referred Friend's Details Here

*Name:
*Address:
*Suburb: *State: *Post code:
*Phone: Email: @
(please tick one)
*Subscription Format: ☐ *Rolling Stone* Online *(Electronic)* ☐ *Rock Steady* Print *(sent in mail)*

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(please tick one)
*Subscription Format: ☐ *Rolling Stone* Online *(Electronic)* ☐ *Rock Steady* Print *(sent in mail)*

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*Phone: Email: @
(please tick one)
*Subscription Format: ☐ *Rolling Stone* Online *(Electronic)* ☐ *Rock Steady* Print *(sent in mail)*

** Indicates required fields. All memberships require full names, addresses and phone numbers. The first correctly filled out entry form drawn at random will win. Winners will be notified by phone. Rolling stone subscriptions must provide a valid email address. Individuals only, organisational members not eligible.*

SPOT THE DIFFERENCE

SCRAMBLED..?

UNSCRAMBLE THESE SIX JUMBLES TO FORM SIX FAMILY THEMED WORDS

EENCI ○ ☐ ☐ ☐ ○
MILYFA ☐ ☐ ○ ○ ☐ ☐
NEAPRT ○ ☐ ○ ☐ ☐ ☐
SIOUCN ☐ ○ ☐ ○ ☐ ☐
RITMSE ○ ☐ ○ ☐ ☐ ☐
RHEOTBR ☐ ☐ ○ ☐ ○ ☐ ☐

NOW ARRANGE THE CIRCLED LETTERS TO FORM THE NAME OF TVs DUMBEST DAD

☐ ☐ ☐ ☐ ☐   ☐ ☐ ☐ ☐ ☐ ☐ ☐

Answer to both puzzles on bottom of page 59.

SURVIVAL GUIDE

The following information contains range of resources for when you're in need. Keeping this information up to date is a constant challenge, but we hope this guide can help when you need it most.

DirectLine: 1800 888 236 is now the number to call to access any services for drug and alcohol related issues across Victoria, such as finding an NSP or starting a pharmacotherapy program. The Fitzroy Legal Service www.fitzroy-legal.org.au/cb_pages/drugdirectory has an Online Service Directory for users that's currently being updated and is another good resource.

Local councils can give you info on services in your local community.

The Victorian government has an online Human Services Directory humanservicesdirectory.vic.gov.au.

AIVL have completed their NSP & Legal Guide, which can be accessed here: www.nspandlegal.aivl.org.au

AIVL's website is a treasure trove of information for users in Australia.

LEGAL

Community Legal Services: (03) 9602 4949
PILCH Homeless Outreach: (03) 9225 6686
Fitzroy Legal Service: (03) 9419 3744
Victorian Outreach Service: (03) 9419 8355
Footscray Legal Services: (03) 9689 8444

Legal Aid Victoria: 1800 677 402
    Melbourne Central: 9269 0234
    Bairnsdale: 5153 1923
    Broadmeadows: 9302 2388
    Dandenong: 9791 5522
    Frankston: 9784 5222
    Geelong: 5229 2211
    Morewell: 5134 8055
    Preston: 9478 8844
    Ringwood: 9879 5500
    Shepparton: 5823 6200
    Sunshine: 9311 8611
Victorian Aboriginal Legal Service
For Koorie people (24 hours)
(03) 9419 3888 or 1800 064865 (country)
Youth Advocacy & Legal Service: (03) 9794 5428

CRISIS PHONE SERVICES

Lifeline - 131 114
Suicide Helpline Victoria -1300 651 251
Beyondblue.org.au (depression) - 1300 22 4636
Narcotics Anonymous (www.navic.net.au) - 9525 2833
PAMS pharmacotherapy advice - 1800 443 844
www.pillreports.com - a global database of ecstasy pills
Victorian Ombudsman (www.ombudsman.viv.gov.au) - 9613 6222
Resourcing Health & Education in the Sex Industry RhED : 9534 8166 (for sexworkers)
Association of Participating Service Users (APSU): 9573 1700

CRISIS ACCOMMODATION

Crisis accommodation information line: 1800 627 727 (Free call) 10 am till 12 midnight 7 days
Flagstaff crisis accommodation: 9329 4800
HomeGround: 9417 2500
St Kilda Crisis Centre: 9536 7777
Ozanam House: 9329 5100
Hanover Southbank: 9699 4566
Argyle Street Housing Service: 9537 7797

INTERSTATE ADVOCACY GROUPS

Australian Injecting and Illicit Drug Users League (AIVL)
02 6279 1600/www.aivl.org.au
Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) cahma@aivl.org.au 02 6279 1670
NSW Users & AIDS Association (NUAA)
02 8354 7300/www.nuaa.org.au
Queensland Injectors Health Network (QUIHN)
07 3620 8111 or 1800 172 076 www.quihn.org
Northern Territory AIDS & Hepatitis Council (NTAHC)
08 8944 7777 www.ntahc.org.au
Western Australian Substance Users Association (WASUA)
08 9321 2877 www.wasua.com.au

EMERGENCY NUMBERS

Police fire ambulance: 000
Child protection: 131 278 (24 hours)
Reverse charge calls: 12550
Directory assistance: 1223

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 Abbottsford St,
North Melbourne
Mon - Sun 9.15am-10am Free

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

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

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

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

Ozanam House
268 Abbottsford 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
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

DINNER

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

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

Loophole Community Centre
670 High St. Thornbury
Sunday's 6pm Free
Ozanam House
268 Abbottsford St, North
Melbourne
Wednesday's 5pm–6pm Free

7th Day Adventist Church
27 Alfred Crnt, 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 10.30–11

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

H.O.P Community Centre
- 659 Plenty Road Reservoir Thursdays 7pm

HEALTH TREATMENT

Including Pharmacotherapy, Rehab, Detox...

Your local Community Health Centre is a great place to access free or low cost health services. You can find yours by googling or by accessing the health department's directory: www.health.vic.gov.au/pch/commhealth/directory.htm

Changes have been made across the AOD sector so services are more accessible for consumers. Services are now delivered based on the consumer's location and intake and assessments can be conducted over the phone.

To find out who your local service is, call DirectLine on 1800 888 236.

Directline is again the first place to go if you would like to detox or start a pharmacotherapy program. Call Directline 24/7 on 1800 888 236.

If you're having problems with your pharmacotherapy program please call PAMS (Pharmacotherapy Advocacy Mediation and Support Service) on 1800 443 844, or 9329 1500, 10-6pm Monday-Friday.

DirectLine -1800 888 236 (24/7)

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

Sexual Health

Melbourne Sexual Health Centre
580 Swanston St, Carlton VIC 3053
Phone: (03) 9341 6200
Hours: 8:30 am – 5:00 pm

Action Centre (for people under 25)
Level 1, 94 Elizabeth St, Melbourne, 3000
Ph: 9660 4700 or free call: 1800 013 952

Sexual Health Advice Line: 03 9257 0116.
Family Planning Clinic: 03 9257 0100 or free call 1800 013 952
The HIV & Sexual Health Connect Line 1800 038 125 (M-F 10-6pm)
Hepatitis Infoline: 1800 703 003
Victorian Aboriginal Health Service: 9403 3300

Women's Services

Safe Steps 24/7 Family Violence Response: 1800 015 188 free call
WIRE Women's Support Line: 1300 134 130
Drop in to the **Women's Information Centre** at 372 Spencer Street, West Melbourne, 9-5pm, M-F.
Women's Health Victoria - Nurse on call: 1300 606 024
Women's Legal Service Victoria: 03 8622 0600
Free call: 1800 133 302
Women's Health Information Centre: 03 8345 3045 or 1800 442 007 Free call (rural callers).
Flat Out: Statewide Support for Women Leaving Prison:
03 9372 6155

Spot The Difference Answers

1. left border of Disney sign
2. missing part of "N" on Disney sign
3. car park reads cor park
4. missing eyebrow on mickey
5. brickwork missing to the right of his eyebrow
6. brickwork missing under his right ear
7. missing dot on his nose
8. brickwork missing on right hand side near bottom
9. line on his right foot moved
10. missing stitch from inside his left leg

Answer to "Scrambled" - *Homer Simpson*

SURVIVAL GUIDE - SHARPS

www.aivl.org.au

NIGHT TIME MOBILE SERVICES

(CALL & ARRANGE TO MEET)
Every Night of The Year 7.30 - 11.15pm
(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	**1800 642 287**

7 days a week 6.30pm – 9.45pm, except public holidays

North West	**0418 170 556**
7 Days a week	**6pm - 2am**

DAYTIME MOBILE SERVICES

(CALL AND ARRANGE TO MEET)

Geelong	**1800 196 850**
Mon - Fri - 9am - 4pm	

Foot Patrol CBD	**1800 700 102**

Mon - Fri - 3 shifts: 12pm- 3.15pm, 4pm - 6.45pm, 7.30pm -10.45pm

Sat, Sun & Public holidays 3 shifts: 12-3.45pm, 4pm - 6.45pm, 7.30pm-11.15pm.

As these lists are always changing, we would 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). Basic equipment can be purchased and disposed of at many pharmacies for a few dollars.

FIXED SITE SERVICES

(CALL IN AND PICK UP YOUR EQUIPMENT)

Victoria's only 24hr, 7 day needle & syringe program is located at 29 Grey Street, St Kilda - The Salvation Army Health Information Exchange.

The needle and syringe programs below are more likely to have the full range of equipment available. Please be aware that items such as sterile water and wheel filters are not always free.

InnerSpace
4 Johnson St
COLLINGWOOD
Ph: 039468 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

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

Barwon Health
40 Little Malop St
GEELONG
Ph: 1300 094 187 (24/7)

Ballarat CHC
12 Lilburne St
LUCAS
Ph: 03 5338 4500

Bendigo CHC
171 Hargreaves St
BENDIGO
Ph 03 5448 1600

Whitehorse CHS
Level 2/43 Carrington St
BOX HILL
Ph: 03 9890 2220

LATE NIGHT CHEMISTS

TAMBASSIS PHARMACY
Cnr Sydney & Brunswick Rds
BRUNSWICK
Open: 8am - Midnight
Ph: (03) 9387 8830

MULQUEENY MIDNIGHT PHARMACY
418 High Street, PRAHRAN
Open: 9am - Midnight
Ph: (03) 9510 3977


Little BoSS

* WWW . HRVIC . ORG . AU *