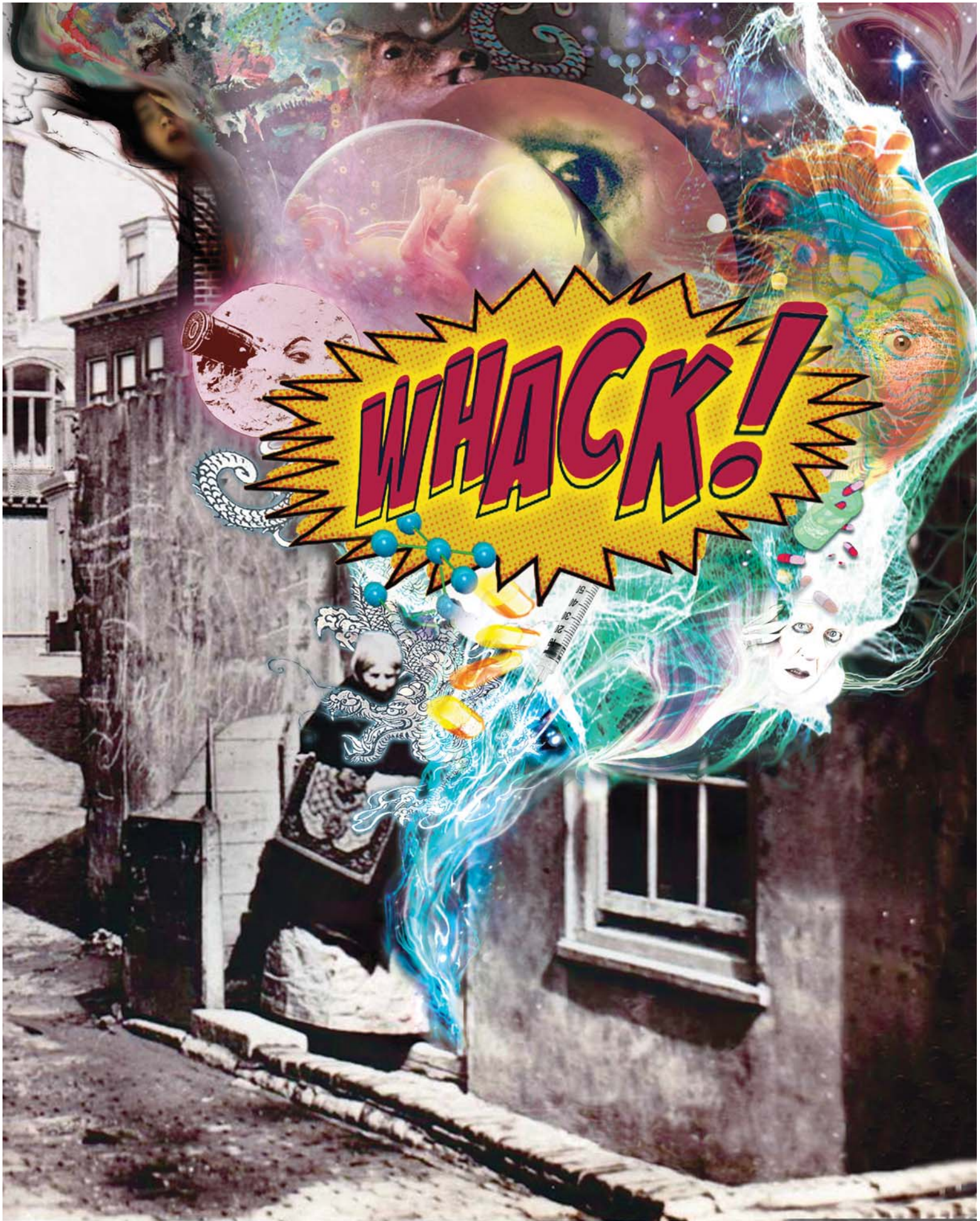
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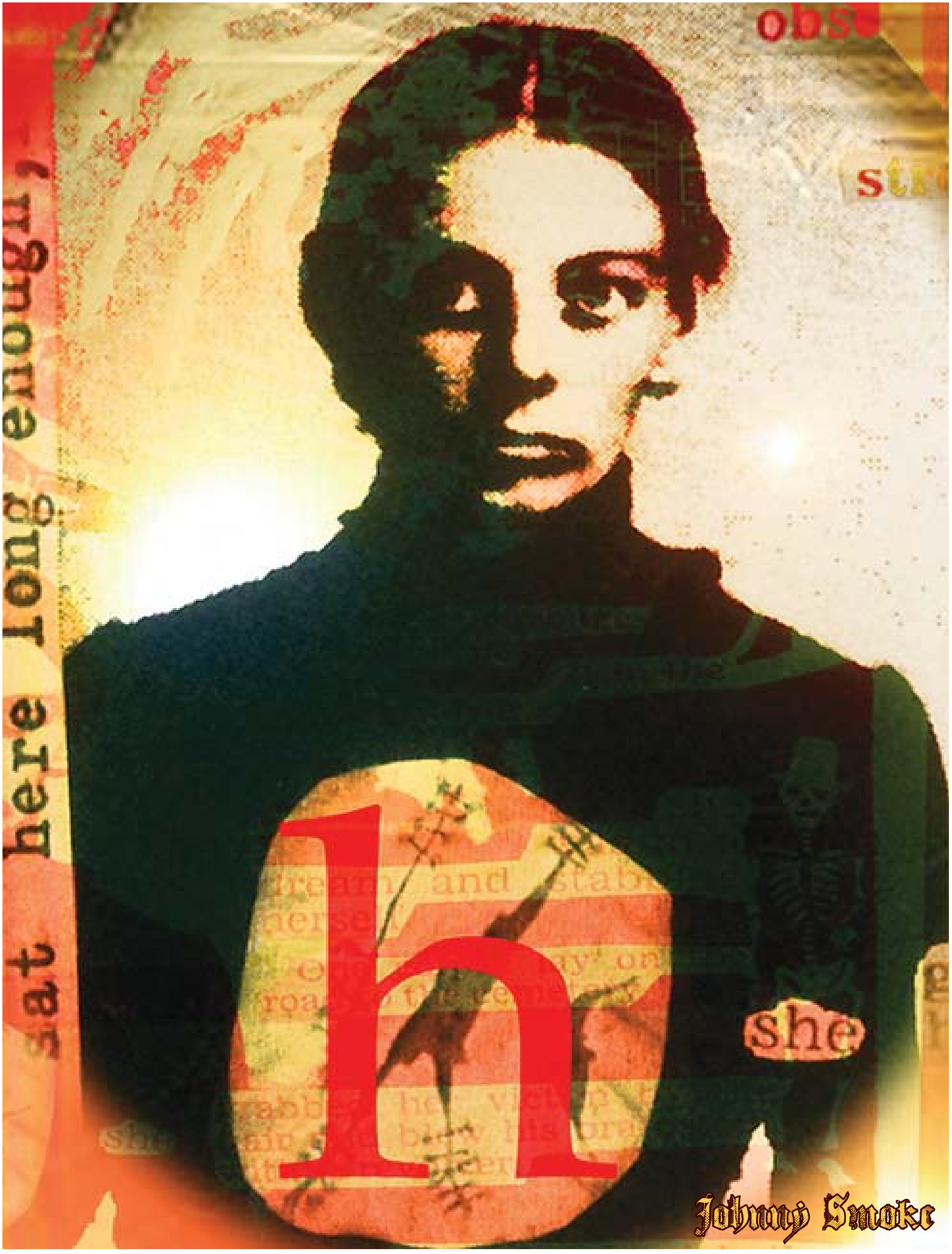
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Johnny Smoke

EDITORIAL

Things have never been changing as fast as they are at present, so we've decided - with our brand new, jam-packed 'Emerging Themes' edition of Whack - to grab hold of the reins and try to make some sense of it all.

We have an article addressing the extraordinary phenomenon of 'New Synthetics' or 'Emerging Psychoactive Substances' which are currently presenting governments and law enforcement with an apparently insoluble conundrum.

Not only this, but the very means of sale themselves are changing, as online marketplaces like Silk Rd and Atlantis make use of an anonymous internet to distribute their wares.

We also take a look at the increasing popularity of pharmaceutical opioids like oxycodone and fentanyl and the corresponding decline in heroin use.
These days, in Sydney's safe injecting room, there are more people crushing pills than rocks.

We present the first part of a comprehensive article on older users, whose numbers are steadily growing as part of the drug-using demographic, yet whose particular needs continue to be ignored by government services.
In Europe, there are homes - like Woodstock in Holland - available to users having trouble surviving by themselves - while here in Australia... nothing.
If you've 'wasted' your life doing drugs, then don't blame us..
We have a piece on the iconic Christiane F. and the story of what became of her after the film that bears her name.

Meanwhile, there is big news here at HRV as we continue to celebrate our 25th anniversary.

As well as our new logo, which premiered in the last edition, we are proud to announce that Jesses Chapman & Loki Lokiss's long electronic labours have at last born fruit. Our wild, fabulous and informative new website is finally live at **hrvic.org.au.**

It's vastly expanded from the previous version and includes far more information, particularly in the PAMS pages which provide essential details on our pharmacotherapy system for both clients and providers alike.

Excitingly, there's also a readable online archive of Whack, from its very beginnings back in 1987.

We have made the new site as active as possible too, with a frequently updated news feed and links to our Twitter and Facebook pages.
(Look for us at HRVic on both Twitter & Facebook.)

So, dig in and enjoy, whether traditionally or online.

We received a huge amount of information for 'Emerging Themes', but if you've got a story, some art, whatever… send it our way, & with your help, we can make the second volume of Whack's 'Emerging Themes' even better.

The Golden Phaeton 2013

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.

We oppose stigma & discrimination:

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

Stigma and discrimination marginalise and isolate people, separating individuals from friends, family and community support and deny them equitable access to opportunities, services and participation.

Stigma and discrimination act as barriers to the reduction of drug-related harm and to health promotion.

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

Harm Reduction Victoria therefore affirms the rights of all people, including those who use drugs, to fair, equitable and respectful treatment in all aspects of life. We assert that a person's choice to use illicit substances, while unlawful, should not of itself have any impact upon their rights as workers, consumers of goods and services or as valued members of society.

The way we work:

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

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

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

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

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

The context of our work:

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

We Believe:

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

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

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

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

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

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

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

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

Statement of Mission & Objectives:

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

In short this mission is encapsulated in "Health Rights, Human Rights, Harm Reduction".

Harm Reduction Victoria's objectives:

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

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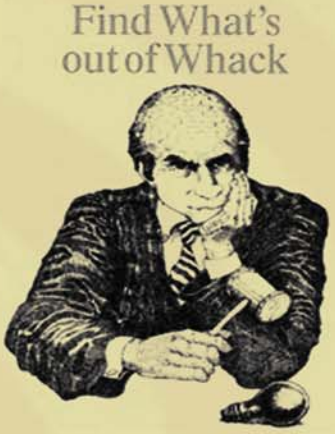

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SUBMISSIONS

Due to the large number of articles we received from our contributors for this issue, the theme of our next issue (#31) is **Emerging Trends Volume 2.** This can mean almost anything that makes you curious. Keep this theme in mind when you submit. Review a classic novel. Or a new one. Anecdotes. Cartoons. Jokes. Strange experiences. Your life story. A strange & beautiful experience that completely changed your outlook on the world as you know it. Opinions on hep, pharmacotherapy or drugs in general. It's your magazine, we just put it together. Put your thoughts on the page/screen and rocket them to us, it truely is that easy.
Or check out our Facebook page (HRVic) & just send it through! If they're published, you'll be paid after the magazine goes to print.

GLOBAL NEWS

LAUNDRY LIQUID BECOMES DRUG CURRENCY

For a time it was an utter mystery why 'bodegas, supermarkets, and big-box discounters' in the US were being repeatedly robbed - on large and small scales - of nothing other than their supplies of TIDE liquid laundry detergent. Often the robberies were planned with great foresight and care, though still it was only the detergent they were after. Before long, TIDE was on the US National Retail Federation's list of most-targeted items.

Might it perhaps contain a precursor chemical? No.

It seems that Tide has become a de facto drug currency. Thieves steal the detergent which their dealers accept as payment. It is then purchased by middlemen – in the form of local businesses such as barber shops, nail salons, or drug houses - who clandestinely sell it on to groceries.

Tide is a higher priced, market-leading brand with extreme consumer loyalty, but there is not much profit for the retailer. On a $20 bottle, they would typically make $2. If a black-market operator offers them a pallet at $5 a bottle, the temptation is obvious.

The system is also good news for thieves in search of currency for drugs. They can steal TIDE with less risk, as the penalties for shoplifting are often as mild as a fine, while serious theft, say of money, can land them in jail for fifteen years.

GILEAD SCIENCES ACCUSED OF HOLDING OUT ON HEP C CURE

A petition has appeared on Change.org challenging the practices of Gilead Sciences, a main player in the race for a HepC cure.
A clinical trial of Gilead's Sofosbuvir and Bristol Myer Squibb's Daclatasvir in combination appeared to deliver a 100% rate of cure without the use of interferon or ribavirin.

The petition accuses Gilead of refusing to continue work with BMS on this very promising treatment, preferring instead to spend time developing their own version of the BMS drug - thus putting their own financial interests over those of 170 million people worldwide who continue to struggle with the disease.

Change.org is a for-profit site on which anyone can pay to post a petition. Its clients include Amnesty International and The Humane Society. Thus far the petition has almost 20,000 signatures.

'IT MELTS YOU INSIDE'

The economic black hole known as Greece has spawned a miserable drug phenomenon known as 'Sisa'. In Athens, a city stripped of social services and work opportunities, the population of users and homeless has grown massive. They have little money to spend on drugs, but, at as low as one Euro a hit, Sisa is there to fill the void.

According to a recent VICE Magazine documentary, the exact composition of the drug is unclear, though it appears to be a cheap and nasty methamphetamine formulation made using 'the blue stuff around battery terminals.' This is reminiscent of the Russian 'Krokodil' phenomenon - another easily produced narcotic popular among the ultra poor.

'In the future there will be more drugs with low prices, and easier ways to produce them,' said a Greek drug authority.
Like Krokodil, horror stories surround Sisa - tales of murderous rampages, abscesses, amputations and stomachs bloated with pus.

GOOGLE AIDS POT ACTIVISTS ON THE SLY

Google's charity unit has quietly donated USD120,000 worth of its services to a Michigan medical marijuana advocacy group.

As a result, in the near future, Americans in certain states who google the words 'chemotherapy nausea' will see ads for medical marijuana alongside their search results.

As a general policy Google does not host ads for drugs and drug paraphernalia, and will not link ads to searches such as 'cannabis' or 'marijuana', but because the advocacy group, MIchigan Compassion, does not directly supply the drugs they are able to skirt this rule.

Other companies, such as the professional social networkers LinkedIn, have also donated to the group, reflecting a generally positive climate for pot in Silicon Valley.

MAGIC MUSHROOMS INSPIRE PENIS RIPPING

A naked 41-year-old man has been found yelling and screaming outside a school in Michigan 'bleeding from the waist down' after clawing off sections of his penis and scrotum with his bare hands.

Scarcely coherent, the individual admitted to the consumption of hallucinogenic mushrooms earlier in the day. Police recovered his missing flesh and transported the man to hospital where it took six hours to subdue him.

Meanwhile, in a small Pennsylvania township, police were attacked by a blind 270kg pot-bellied pig, while making a drugs arrest. After receiving a tip, they raided a small hotel room where - apparently cohabiting with the perp - they encountered the beast. Though the pig, named Penelope, resisted capture, ultimately she was lassoed and both parties were taken into custody.

LOCAL NEWS

AUSTRALIANS SPLURGE ON DRUGS

Figures from the Australian Bureau of Statistics estimate that Australians spend more than $7 billion a year on drugs.

According to The Age, this is $2 billion more than we spend on fashion, and nearly twice our literature budget. Alcohol comes in at $14.6b and tobacco at $13.6b. If our total expenditure on recreational drugs (including alcohol & tobacco) is added up it roughly equals what we pay in rent, and half what we pay for food.

The $7b figure is also seven times more than governments spend on enforcement ($1.1 billion). $361 million is spent on treatment and a lowly $36 million on harm reduction.

The ABS calculates that the vast majority of the money is going to the manufacturers, who are reaping profit margins of up to 80%.

Our most popular drug, of course is cannabis ($3.8b) followed by amphetamines at $1.5b. $750m is spent on heroin.

Australian National Council on Drugs executive director Gino Vumbaca is quoted as saying, 'you are not going to arrest your way out of drug problems, particularly when there is billions of dollars in sales involved.'

AUSTRALIAN CUSTOMS IN LEAGUE WITH U.S. IN GIANT SYNTHETICS BUST

As Australian states continue to ban synthetic drugs (and others continue to enter the market - see the article in this issue) the Australian and Customs and Border Protection Service, in cahoots with U.S. Customs and Border Protection and the DEA, have arrested 225 people in five countries and seized up to 1.5 tonnes of drugs - the largest synthetics bust yet.

According to spokespersons for 'Project Synergy', the drugs were largely manufactured in China & India, and were destined for markets in the U.S. and Australia. US officials overtly hinted that terror groups were involved, but presented no credible evidence.

Project Synergy used new legislationwhich enforces a 'reverse onus of proof' on the synthetic drug business, whereby the drugs are presumed to be illegal unless proof to the contrary is supplied.

COCAINE & THE CLASS SYSTEM

Everybody knows that cocaine is the illicit drug of choice for politicians, judges, lawyers and the generally well-heeled, but do they endure the same attention from police as, say, heroin or ice users?

According to a (highly recommended) piece in The Canberra Times by Jack Wiggins - no.

In fact, if you are a cocaine user, the annual risk of going before the courts is about one in 500, compared to one in 20 for users of heroin, one in 60 for amphetamines, and, surprisingly, one in 32 for Australia's 1.9 million pot smokers.

The article suggests that 'if there were (a) relationship between the danger of arrest and the (harm) of these drugs' cocaine would be pretty benign - a one to heroin's 24. Amphetamines would come in at eight and cannabis 15. (70 per cent of all drug offences relate to cannabis.) Clearly something is askew.

It is estimated that there are about 390,000 recent users of cocaine, and that the Australian market consumes 94 million lines a year (4.7 tonnes) apparently in relative immunity from the law.

NZ TO ENACT RADICAL DRUG REFORM

In August, New Zealand will become the first country in the world to regulate new recreational drugs based solely on their harms.

The country has been grappling with the new synthetic drug phenomenon longer than most (see article this issue) and have recognised that the new drug market is unlike the 'heritage' drug market and so requires a new approach.

NZ will ban all new psychoactive substances, unless manufacturers agree to test them for safety. Products containing safe, approved ingredients will be green-lighted for sale in a a new, legal market.

The tactic of labelling products like Kronic as 'incense' or 'not for for human consumption will be made redundant by powers given to the Ministry of Health to determine themselves which substances are psychoactive.

Traditionally, recreational drugs have been banned automatically if they have an intoxicating effect, harking back to an overly moralistic time when drug-induced altered states were considered wrong in themselves. This makes the NZ government's actions truly novel.

There is also speculation that pharmaceutical companies with vast libraries of molecules may consider getting in on the action. Forgotten substances found to be ineffectual in fighting disease may be resurrected if they have pleasant psychoactive effects.

GIBBERING FACE EATERS CONGREGATE IN SEX SHOPS!

THE NEW WORLD OF EMERGING PSYCHOACTIVE SUBSTANCES

After a long frustrating day of work, you decide some relaxation is in order.

Instead of buying a bottle of wine, or some pot or gear or whatever... you visit SexyWorld and buy a black rectangular cartridge resembling a USB memory stick.

Once home, you insert the cartridge into your printer, which looks not unlike a microwave oven. Then you log on and perform a torrent search. A host of options present themselves, but you decide on an old favourite: a file named Dragonfruit Cream Surge (Worming Agent). The data downloads and you slide it over to the printer. The machine powers up. Its interior illuminates in a swirling cloud of sparks and colour. You wait. The end of your e-cig glows an eerie blue. You saunter to the back porch and feed your icat. By the time you return, the process is complete. You remove a small ceramic platter from the printer. On it lies a small glittering mound of salmon-coloured powder.

You put on some music, place a plug of organic mull mix in the bowl of your pipe. You sprinkle on some of the powder. You light up and take a pull. You lay back.

So, will it be a night of mellow dreams? Disembodied travel? Or will you make your way down to the causeway, incapacitate a homeless person and eat his face?

Things are changing. And fast. Connectivity is increasing in leaps and bounds. The internet of wires and airwaves is breaking through into the physical world.

I was more than surprised when I first heard that I could stroll down to the local sex shop for a legal and powerful synthetic analogue of cannabis, ecstasy or speed. Or that with a few clicks of a mouse I could purchase almost any substance I fancied on the darknet for quick - though not guaranteed - delivery.
Conceivably, I could even design a molecule to my liking and have someone in China brew it up...

We are accustomed to the powers-that-be dictating the rights and wrongs of substance use. When the rulebook is thrown out it can be hard to believe, even disorientating. Authorities seem helpless - as if they are attempting to suppress a law of nature. As if information, truly, wants to be free. Music, movies, books, software, porn. All these things can be had at will, for no cost. At first, data piracy seemed like a glitch, but it continues to escalate, feeding off new technologies.

Now, something similar is happening to recreational substances; they are squeezing out from beneath the heavy boot of The Man.
Suddenly, the consumer has access to a smorgasbord of efficacious psychotropic molecules.
Cunning chemical entrepreneurs are cooking up legal analogues of all the drugs we love, and intrepid psychonauts are finding exotic pleasures in previously unexploited traditional drugs like kratom, salvia divinorum and Hawaiian Baby Woodrose seeds. On average, a new compound appears every six days on Europe's drug radar. Sniffer dogs must 'undergo retraining every few weeks to learn the new scents.'

As legislators flail about in confusion, even the suppliers can lose track, sometimes selling 'legal' compounds that have actually been banned. And, as the grey-market in new drugs grows, so does the level of involvement by organised crime.
These Emerging Psychoactive Substances (EPS), as they are called by the bureaucrats, more commonly fall under the rubric of 'legal highs'. But this term used to mean something else.

Once, legal-highs were the kind of substances used by novelty-seeking adolescents for who real drugs were not an option. Think of nutmeg, datura, Pure & Simple, dried banana skins and any number of other questionable intoxicants. A friend of mine once reduced several supermarket lettuces to a black, tarry paste in search of the fabled 'lettuce opium'.
Unsurprisingly, his efforts were in vain.

Often, the powers of many of these substances may be put down to urban myth, breathless rumour, or to the doubtful pronouncements of lurid paperbacks. Some of them would be better termed poisons. Stories are legion of datura fiends seen spooning ajax into their coffee, in a world that had turned the colour of urine. I myself once spent many troubled hours speaking with a man-sized chicken after swallowing a packet of Avil travel sickness tablets.
The mildest of old-fashioned legal highs (or sometimes 'herbal highs') have long been available in head shops and online - and generations have been disappointed by such products as damiana, california poppy and guarana. Few sensibly entertained any hope of these drugs being effective.

But now - often displayed right alongside the old guard, usually labeled as worming agents, room odorisers, plant flood - there are new products of an entirely different ilk.

Once the stories began to spread – teens in casualty with kidney pain, teens up electricity poles, teens in struggles with invisible assailants – the media latched on like a lamprey eel, particularly in the US. Hysteria came in wave after wave, like nausea, forcing reactive politicians into knee-jerk reactions. 'Everywhere you looked, somebody was supposedly doing something psychotic due to the new synthetics.' Where did these deadly substances come from? they asked. And how can they be so freely available?

The hows and whys of the EPS phenomenon are complex. Many users of the new legal-highs – sports people, truck-drivers, soldiers - do so to avoid positive drug screens, as labs have little hope of keeping up to speed with the constant innovation. Also, there is the issue of stigma. Because the new substances are technically legal and/or have not been around long enough to generate much of a negative aura, some middle class professional-types feel they can take them without being seen as fucked-up losers.

But it is the explosion in information technology that lies at the heart of the boom. The internet has provided the means of communication and distribution. There is Facebook. And Twitter. And the viral spread of memes. Like-minded individuals, like the psychonauts, can cohere into social groups, when once they were separated by gulfs in time and space. Critically though, the internet has made know-how available to anyone who cares to look.

The sum of most human knowledge is out there, including details of laboratory techniques in development since the time of the alchemists. Uncontrolled 'research chemicals' may be ordered online with impunity, usually from manufacturers in the East, predominantly China. When drugs are banned, distributers are able to contact skilled chemists who can hack a banned molecule sufficiently to make it legal, while retaining its psychotropic effect.
Not that this sort of molecular tinkering is a new phenomenon. Behind it lies a long tradition.

All recreational drugs, of course, were once naturally sourced. Then, with time and knowledge, came the isolation of chemical principles – thus cocaine was extracted from the coca leaf, and morphine from the poppy. In the 20th century, the ways of the chemists became more complex. Natural molecules like morphine were adapted to produce heroin and after that the first true synthetics appeared: barbiturates, amphetamines, LSD-type hallucinogens etc. Most, if not all, of these synthetic drugs were produced with pharmaceutical intentions but, inevitably, those with recreational potential appeared on black markets and, in time, were banned.

In response came the practice of clandestine chemistry. Staples like heroin and speed were produced under the radar. So were entirely novel drugs.

Designer drugs appeared as early as 1925. After the 2nd International Opium Convention banned morphine & heroin, variations on the morphine molecule appeared which were technically legal & often just as strong as heroin.
They were brought under control by the first analogue laws which criminalised whole classes of opiates.
For the first time a substance could be considered illegal even if it had never physically existed in the universe.

THE NEW WORLD OF EMERGING PSYCHOACTIVE SUBSTANCES

During the Prohibition, surprisingly, dimethyl ether was used in some countries as a legal alternative to alcohol. But it was during the sixties & seventies that the analogue came into its own. During this period, there was no lack of enterprising chemists producing any number of obscure substances, particularly hallucinogens for early psychonauts. Some, who knows why, even bothered to produce legal analogues of PCP. These drugs were banned one by one as they came to the attention of authorities.

By 1979, clandestine synthesis had reached a high level of sophistication. A number of deaths in Orange County, California had all the hallmarks of heroin overdose, but tests revealed no presence of drugs. In 1980, after a series of investigations and 15 fatalities, the culprit was found: something called China White - an analogue of the powerful synthetic opioid fentanyl. Secret labs had been busy producing new drugs to skirt the law. Before long, as many as ten novel, technically legal fentanyl analogues were found on the streets of California.

One of these fentanyl analogues, MPPP, underscored the inherent problem of testing new drugs on humans. Because of its manufacturing technique, it often contained an adulterant which could cause something identical to Parkinson's Disease after only a single dose.

The term 'designer drug' was coined to describe these and other opiate analogues, but was broadened to include ecstasy which became popular shorty after. In the following years, driven largely by the rave scene, other psychoactive substances like GHB, MDA and Ketamine became popular. 2C-B appeared as a legal, though perhaps more hallucinogenic, alternative to ecstasy.
There was a certain safety in the gradual adoption of a handful of new drugs.
To some extent, this cushioned users, but in recent times, seemingly all at once, the piñata has been well and truly smashed, releasing a bewildering profusion of drugs - and a fearsome quandary for the authorities whose mission is to control them.

Now, what exactly are these drugs?
Roughly speaking they fall into 4 categories:

*** Synthetic cannabinoids***

A couple of years ago, the Victorian government, following many others around the world, moved to ban the first generation of Synthetic cannabinoids (or cannabimimetics). With names like JWH 073, 018, 122, 250 & CP47,497, they mimic the effects of pot, though far from perfectly, and sometimes with worrisome side-effects. Like pot, they stimulate C1 and C2 receptors in the brain, but many are very different compounds to good old THC.

For about a decade, they have been presented in brash packaging with names like Monkees go Bananas! Enigma, Napalm and Chernobyl .
Kronic (imported from New Zealand) is the most visible brand in Australia.
Originally, there was no mention of synthetic additives.
The effects were put down to a sophisticated admixture of exotic herbs - yet the powerful consequences of smoking these products made this a rather dubious claim.
The true active ingredient, usually a powder, is blended with plant materials to mimic the appearance and feel of commonplace marijuana, & these days, as a protection for the seller, products are labelled 'incense' or 'room odorisers', not for human consumption.

Immediately after the ban, clandestine chemists simply replaced the illegal formulas with yet to be regulated cannabinoids. There is no shortage of these as, over the last forty odd years, a great many have been brewed up in a largely unsuccessful effort to replicate pot's medicinal properties while removing its psychoactive effects.

Many synthetic cannabinoids come with the prefix **JWH.** This stands for John W Huffman, a very ordinary, now-retired chemist who lives in the North Carolina mountains fiddling with model trains. Inadvertently – and very reluctantly – he has become a kind of counter-culture hero. During the 1990s, he dedicated his time to THC, producing hundreds of experimental cannabinoids with the support of the National Institutes of Health, which saw medical potential in this drug class. Huffman is quoted as saying that 'THC is actually a rather mediocre cannabinoid." referring to the extraordinary potency of some of his compounds.

When JWH-018, the most popular of his creations, hit the news, it actually surprised Huffman that it had taken so long for 'these people to put one & two together. As for the advisability of using the untested compounds, he is less than sanguine, likening it to playing russian roulette. "You can't be responsible for what idiots are going to do," he says. His email box is full of 'poorly written' messages from these 'idiots' asking for technical advice. Huffman seems to despise his work being used in such a manner, particularly when blame is laid at his feet, as it often is.

He still holds out hope that one day some of the more than 400 JWH compounds will benefit humanity in some other way.

The synthetic agents can indeed be significantly more powerful than pot (HU-210 is a hundred times as strong). Users expecting a mild 'herbal' high can find themselves cast upon a heaving sea of hallucination and nightmare.

Once, when I took an unidentified lungful, I immediately lost my mind, forgetting who I was, where I was (I was on a couch), even what species I belonged to. One saving grace was that the effects were shorter in duration than normal pot. It was clearly an overdose. The trick here would be to take care how much you take; some of these drugs have an unbelievable kick, and ingredients can change between batches of the same brand. Something called 'Banana Cream Nuke, when analysed, was found to contain 15 forms of synthetic cannabis.

To put it bluntly, synthetic pot is potentially more harmful than the natural stuff, & less likely to give you an enjoyable high.

Piperazine Derivatives

Piperazine Derivatives are a wide class of drugs chemically unlike any of the more traditional recreational substances, and which, interestingly, includes viagra. Their story would not be complete without the inclusion of Matt Bowden, an odd but rather dynamic character out of New Zealand. He is a glittery local pop star operating under the name of StarBoy, a social revolutionary and an entrepreneurial drug-merchant. He claims that, in 1999 after a party drug death in the family, he worked to find a safer alternative to methamphetamine and ecstasy. Before long he began marketing 'dancepills' through his company Stargate International

His product contained BZP, a piperazine derivative, which first appeared in the 50s as a potential worm treatment for farm animals. It disappeared from the literature until the 70s, when pharmaceutical giant Burroughs Wellcome investigated it as an antidepressant. This work was abandoned because its effects were too similar to speed, but being similar to speed was clearly a positive on the recreational market. There is evidence of it having been used as far back as the early 90s, but it was Bowden who really picked up the slack. His company adopted a socially responsible stance, providing a pure standardised product and a 24 hour help-line. Profits were funnelled into harm reduction measures such as first-aid and drug counselling at dance parties - and profits there must have been a plenty, given that an estimated 5 million pills were sold just in New Zealand during 2007.

Not one for half-measures, Bowden lobbied his government over the status of BZP, claiming it to be a far lesser harm than ice and, if banned, would turn users on to or back to more dangerous drugs. Remarkably, he was listened to. Research was conducted and after consideration NZ banned the drug anyway. Stargate claimed to have created a precedent-setting environment in which in which it was possible to freely conduct research into future synthetic "social tonics", but it was premature.
With the turn of the century, use of BZP & its siblings had spread worldwide.
Among Western nations, only Canada is yet to ban the drugs.

Continued page 38

SO MUCH MORE THAN JUST A DRUG USER

I'm a "straight-head do-gooder" according to my fiancé Sean.

Don't use drugs, don't drink much. The man I love used heroin and too much booze. He'd rather speed but anything mood altering does in a speed drought. It put him in jail many times, though a magistrate with a heart ordered methadone treatment in the mid 90's and got him off "Fleetwood" for fifteen years.

His last stint inside was four years thanks to a speed fuelled rampage. He did a Violence Course in jail where his teachers recognised his worst criminal and drug excesses followed an 8 year cycle. Reading his class notes one day I saw the important issue his jail teachers had missed. He had bipolar disorder and had used drugs and booze to deal with the crap: violent alcoholic father; mentally ill mother; hopeless at school; growing up in a tough area dodging bashings from bigger, angrier kids every day; stealing cars with mates; and trying to avoid a walloping by the wallopers every night.

We discussed it and he detailed symptoms of depression and mania enveloping his life as a young teenager. No wonder he turned to heroin and speed at 13 years old, and started dealing to support his use not long after.
We couldn't bear to be apart. I had cancer he protected me from. He was back on the gear thanks to Hep C treatment and hating it. I protected him from that.

One night he stayed away overnight for work. He'd virtually given up drinking but his employees insisted on shouting rounds with dinner. All it takes is a few beers and a little heroin to kill you when your tolerance is tow. That and the fact the mate he'd organised to watch him and ring an ambulance if he "dropped" cancelled, so he timed his use to coincide with his worker's return to the motel room from the pub.

They were an hour late and he was dead.

Nothing compares to the trauma of losing the man you love. My memory was erased and the world became surreal. He was dead only a few hours when I had to ring the coroner's office. They wanted to perform an autopsy. They'd do it anyway, so after a quick family conference I agreed. The coppers wanted a statement – How suicidal was he? Was he still a crim? They said his death might be murder as two other users died in the same area at the same time. I asked for his mobile phone. No way – evidence apparently.

With a house full of sad friends, a funeral to organise, and trying to understand why the man I love more than I love life wasn't coming home, I let it slide.

It took weeks to take notice of the weird clicks when I answered the phone. When a phone conversation I'd just had played back over the line, I knew. The $25,000 "accidental" transfer into my account from the Shanghai-Hong Kong Bank sealed it. They were after me.

I stopped being shocked and got angry. How dare they assume because Sean used we were Public Enemy No 1. He'd been doing his best to get off the gear. I held him as he cried bitter tears and felt guilt and shame and hated heroin. He was on bupe and seeing a psychiatrist. He ran a business employing people, helped his apprentice buy a car, trained horses with me, and gave more than one wayward kid the good oil on drugs and jail for worried parents.

He was a magnificent man with a huge heart who'd put crime behind him. How dare they make him a criminal again.
I read coroner's reports and realised heroin associated deaths are considered open and shut cases: He was a crim who died with a needle in his arm. Case closed. Sean's heroin treatment – or rather lack of effective treatment – killed him, but it was up to me to prove it. I invited my local MP to our house where he listened to me tell Sean's version of drug treatment and jail. He was sympathetic because he saw prisoners do great community work during the Victorian floods and knew many were users. He promised to talk to the Minister for Justice about jails and wrote to the Minister for Mental Health about drug treatment. I've spoken to many politicians since then. I don't know what world they live in.

I rang around drug workers and educators to learn more about drug treatment. What an eye opener. Direct Line, Australian Drug Foundation, Hep C Vic, ANEX, HRV and Carer's Network workers were supportive. They clarified my thinking and gave me strength by filling me in on problems with drug treatment and the prejudicial and stigmatising effects of criminalisation.

Other workers told me Sean was going to die no matter what. They didn't see the 220km round trip to his pharmacotherapy doctor (which meant I couldn't go with him because of my illness) as an issue. Or 120km round trip to a dispensing pharmacy. It wasn't relevant, apparently, that his psychiatrist told him it was OK to use if the cravings got too much, then sacked him as a patient when his drug use and bipolar escalated.

They didn't see that his doctors working separately and not communicating meant he wasn't referred to a Dual Diagnosis clinic, so his bipolar mania was both fuelled by, and further fuelled his drug use.

Sean was an older (44yo) male heroin user. They OD'd and died. I was the one with cancer. I thought I had the terminal disease. Wrong. Enraged, I cried buckets of tears.
About then a senior federal politician mouthed off to the media about the "War on Drugs". There'd be no decriminalisation on her watch. Sean and the other users who died around the same time died in this politician's electorate. I saw red and rang her office, bluntly telling her minder if I heard that crap one more time I'd go to the press with their deaths. Didn't she realise criminalisation was the problem? That and the pathetic excuse for treatment governments offered drug users? I've never heard her comment on drug use since.
If pollies could demonise users via the media, I learned that I could use it to de-stigmatise them.

I talked to so many coppers trying to get Sean's phone back I heard their point of view. The War on Drugs was lost decades ago. Some were sad at so many OD deaths. One said drug treatment needed attention. They mopped up dealer level violence and were fed up. Some said Sean committed suicide. After ringing the Police Conduct Unit, threatening a formal complaint, and waiting five months, they gave back the phone.

Texts showed Sean still trying to organise a bystander to watch him use shortly before he died. Others showed he changed dealers and the new gear was more pure. I thought that was important information to feed, via the coroner, into user education programs so discussed it with police. A text where he joked to the mate who was supposed to be with him - if you don't get round here soon, it'll be all gone - sparked their interest. The copper said it proved he intended to use all the heroin he had, ipso facto, he committed suicide.

John Faine on ABC radio picked up on the politician's rant and murmurings it created amongst state pollies. I rang him several times, including just this morning. He gave me a lot of air time. We talked about real effects of jail and failures in drug treatment. A year ago when we first spoke, a user and a worker rang up and told their stories. Today the discussion went on all morning including users, their families, AOD workers and a drug law reform Senate candidate. Average people sent texts to the program saying they agreed. Criminalisation was THE problem. There's a huge appetite for public discussion on decriminalisation now because so many of us are sick of watching users suffering, being thrown in jail or dying.

I still tried to get Sean's phone back. The coppers played tug of war. The latest excuse was the coroner needed it. I rang them. No, they didn't. I asked how long the coronial inquiry would take. Unless you made a complaint, heroin deaths take six weeks was the answer. WTF?? I'd made a complaint about Sean's treatment, but what sort of investigation takes six weeks? Dead heroin users were being walked all over. I thought I was angry before. Now I was on a mission.

She wanted me to forward texts only up to that point. Not later texts between us about our wedding, or the chat with his Mum, or outbox texts he'd written after that but didn't send because he'd stopped to use. Times on the texts show he OD'd just before his employees were expected to return to his motel room. So he was trying to protect himself. I found heroin amongst his things so the copper's theory was bullshit, but suicide meant less work for the cops. Way easier to blame the "junkie".
Back to the coroner I went blowing steam. By now I was a lay-expert on heroin treatment and dual diagnosis, and bowled over by the inadequacy of treatment here compared to the USA and Europe. I detailed the mobile phone evidence and the extra heroin I'd found, and went to town on difficulties users face navigating a failed, fragmented health system that more often than not, doesn't treat users properly – information supplied by weary Department of Health workers. I detailed gaps people with dual diagnosis fell through, starting with the prejudiced Hep C Clinic who refused Sean an AOD referral when he first relapsed into heroin use following psychotic episodes resulting from their treatment.

SO MUCH MORE THAN JUST A DRUG USER

Users die because they're considered less than human I said, comparing Sean's heroin treatment to my cancer treatment.
I'm treated like a princess because cancer's sexy and not 'my fault'. My treatment occurs in one place, specialists appear on the horizon as I need them, and doctors and nurses perform as an orchestrated team with my health as their central concern. Try getting that if you want effective drug treatment, I said to the coroner. It's a bloody human rights Issue.

Meanwhile Sean's psychiatrist – the one who said the answer to his cravings was to use, then sacked him as a patient when he did – disappeared. The coroner wanted to investigate him but police couldn't find him. Thanks to the ANEX worker who found him in another state eight months later.

Screening users for dual diagnosis on presentation for drug treatment is imperative.
Depression and anxiety must be treated alongside drug use. Schizophrenia or bipolar and heroin use must be treated 100% of the time by a dual diagnosis physician.

In Australia, though, the role of trauma in users' lives is underestimated.
Users' backgrounds are often less than ideal, jail is violent and degrading, as is the drug scene, and it does people's heads in. Users are highly likely to have been sexually assaulted – Sean was, carrying shame and guilt about it around for over 23 years before saying anything.
Trauma and sexual assault counseling should be an integral part of psychological support offered to pharmacotherapy clients.

that's what should really be on Sean's death certificate: he died of stigma and prejudice.

The coppers are after him now, but it's taken constant hounding to get them to chase him.

Last week I heard another family who'd lost their loved one to opioids was saying the same things I was about drug treatment and my anger flared again.
I rang Alex Wodak – the addiction medicine specialist who's trying to bring about national decriminalisation – hoping he might talk to me. He began by apologising for failing to bring about changes in law and drug treatment required to protect Sean. What a ridiculous situation that he should even feel the need. He offered a lot of help and a lot of hope.

So what do I think about drug treatment now?
Decriminalisation is paramount.

The two stage treatment model, withdrawal & maintenance, is outmoded. The three stage model as per Europe and the USA, with its second 'stabilisation' stage gives users like Sean – who don't 'disclose' because they've learned to keep their mouths shut in jail – the chance to legitimately collaborate in their treatment.
In the three stage model, supportive family and friends must be involved in treatment. They receive education themselves, as well as providing information to treating doctors that the client may be unaware of, or too ashamed to admit.

Achieving all that will take enormous political will and the transfer of money from jails to health, but it's got to be better for everyone than jail or death.

I refused opioid pain relief for the two years Sean fought heroin while the cancer invaded my spine, breaking three vertebrae. I didn't want my medication making the cyclic struggle he faced – using bupe that never controlled his cravings, using heroin, going cold turkey, then back to bupe – any harder.
Oncologists worked hard to get me to take opioids after his death. It makes my blood boil with fury twice a day because I'm given them finely tuned to the needs of my body. Stigma and prejudice free: the very opposite of Sean's experience.

I don't like the calmness my meds create, and forget to take them, putting me into withdrawal. Unpleasant. But I appreciate what Sean felt as he dealt with a health system that treated him like a morally corrupt criminal.

The other day I said to a drug worker "that's what should really be on Sean's death certificate: he died of stigma and prejudice." It keeps me fighting like a cat in a corner to make sure the truth about Sean and other users' treatment and deaths is heard.

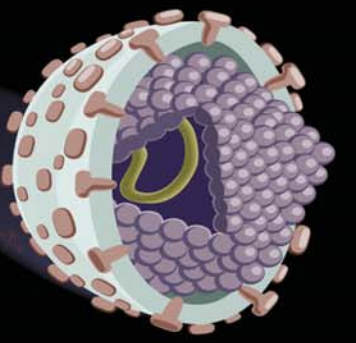
The cover up and power imbalance has been going on for long enough.

Sarah 2013


J. TYLER

HEPATITIS

THE PROMISE OF CURABLE ILLNESS, RATHER THAN A CHRONIC CONDITION.



By Trevor King
on behalf of the Centre for Research Excellence into Injecting Drug Use (**CREIDU**) http://creidu.edu.au/

Key message: Hepatitis C treatment is rapidly changing. New drug therapies are available now and others are in the final stages of development that promise to increase cure rates, reduce treatment duration and reduce uncomfortable side effects. Now is the time to get good advice about testing, treatment and support options.

There are many reasons why people with Hepatitis C virus (HCV) do not commence or complete treatment.
While there are lots of issues that still need to be addressed to make treatment more accessible, there are some very exciting medication developments that promise to dramatically increase the number of people who are cured.
These new medications will also progressively reduce uncomfortable side effects and the duration of treatment.
In light of these developments, now is a good time to chat to a doctor or nurse about testing or treatment issues, such as the likelihood of cure, possible side effects and the pros and cons of starting or delaying treatment. It is also a way to find out about the many valuable information and support services that are now available.
This article provides a brief overview of current treatment issues and outlines the research on the many new drugs (called direct acting antiviral agents or DAAs) that are in various stages of development. Some useful resources are also listed for those wishing to know more about testing, treatment and support options.

Hepatitis C is a major public health issue. Around 180 million people are affected by HCV worldwide (1). An estimated 304 000 people living in Australia in 2011 had been exposed to HCV. Of these, 77,000 will have cleared the virus while the remaining 220,000 have chronic HCV infection with varying degrees of liver damage (2).
It has been estimated that between 20 – 30% of people with chronic HCV infection will develop scarring of the liver (known as cirrhosis), usually over a 20-30 year period (3).
Many others will experience only minimal liver changes even after years of infection.
Often, the infection resulted from injecting drugs during the 1980s and 1990s when less was known about transmission risks. It has been estimated that the prevalence of HCV infection in the population of people who inject drugs in Australia is around 55% (4).
HCV-related illness, including advanced liver disease, will continue to rise unless there is a big increase in the number of people undertaking treatment and continued efforts in prevention and harm reduction.
Interferon has been used in the treatment of HCV for the past 20 years.

The standard antiviral treatment over the past ten years has been a combination of pegylated interferon (PEG-IFN) and ribavirin (RBV) (5,6). This combination has been effective in that it has the capacity to affect a cure (also referred to as a sustained virological response) in around 65-70% of cases, but this varies depending on which strain or genotype of HCV people have, any liver scarring, and genetics.
The treatment also results in most people experiencing a reversal of liver damage caused by HCV (9). The downside of interferon-based treatment is that there are significant side-effects including flu-like symptoms, fatigue and depression (10). These side effects contribute to around 10% of people dropping out of treatment and around 30% requiring a dose reduction (11).
The length of treatment is currently 24-48 weeks, requiring high levels of motivation and commitment.

Two new direct acting antivirals (DAAs) (telapravir and boceprevir) have recently been approved in Australia for chronic HCV treatment and subsidised through the Australian Pharmaceuticals Benefits Scheme. They are only active against HCV genotype 1 infection. These medications when combined with PEG-IFN and RBV can improve cure rates and reduce treatment length for many. These results apply to people who have, and have not undertaken treatment in the past (8). The results are impressive, however there are side effects including anaemia, skin rashes and other gastrointestinal conditions (e.g. diarrhea) (12).

There are now over forty drugs in various stages of development (many in the final stages) that are providing great promise of more effective HCV treatment in the future (1, 11, 12). Clinical trials show that future HCV therapy with newer classes of drugs could be personalised, achieve higher cure rates over a much shorter treatment course and with fewer side-effects for all HCV genotypes. These trials are really promising and even if results are slightly less impressive in real world settings (13), it is reasonable to expect more people will want to engage in treatment.

But we know that medication advances alone will not automatically lead to more people entering treatment. Other treatment barriers will also need to be looked at. Australian NSP data show that in 2011, only about half the participants in a large survey had been HCV tested in the past 12 months and around 10% had commenced a course of HCV treatment (14). While the side effects of current treatment and the length of treatment are known to be barriers to people getting on treatment (15-17), there are many other issues that play a contributing role.

These include:

- Concern among some professionals that people who are still injecting won't complete treatment, although the evidence suggests otherwise (18-20);

- Lack of accessible services (e.g. Readily available testing and treatment in GP clinics, drug treatment services and prisons) (21);
- Lack of awareness of HCV testing and treatment issues by GPs (22).
- Lack of awareness about newer drugs and how effective they will be (19);
- Lack of awareness about the potential for liver damage in people who aren't treated (23);
- Higher priority issues to be addressed for some who may be homeless, unemployed, etc, particularly for the many who may not be currently experiencing any HCV symptoms (24);
- Avoiding the stigma and discrimination associated with HCV infection & the relationship with injecting drug use (25); and
- Concern about treatment in traditional settings, particularly hospitals (26).

So while treatment advances are exciting, there is a lot more work to be done to make treatment accessible for those who would benefit from it. Recent Victorian modelling research shows that even quite small increases in HCV treatment uptake among people who inject would have a significant impact on HCV rates among this group (potential to halve HCV rates within 30 years).

In such a dynamic environment, there is good reason to continue to discuss treatment options with doctors, nurses and peers who are knowledgeable about HCV issues and who are in a position to provide quality advice and care in a supportive, understanding environment.

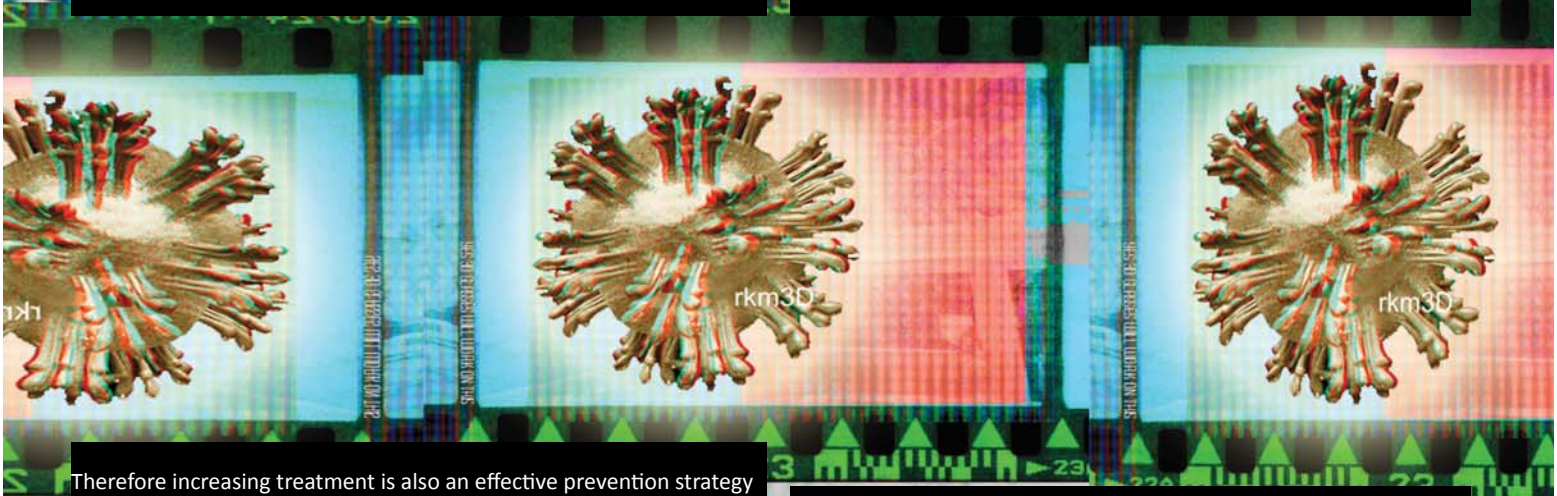
Resources

1. Hepatitis Victoria has a wide range of useful resources covering general HCV information, testing, treatment and support.
Go to: http://www.hepcvic.org.au/hepatitis_resources
Hepatitis Victoria also lists organisations that offer HCV treatment.
http://www.hepcvic.org.au/sites/default/files/liver%20clinics%202011.pdf

2. AIVL has an excellent range of peer based HCV resources: www.aivl.org.au

3. Centre for Research Excellence Into Injecting Drug Use (CREIDU) Policy briefs:

- **Greg Dore (2011). Future directions in hepatitis C treatment: closing in on a cure for the vast majority http://creidu.edu.au/policy_briefs_and_submissions/8**
- **Margaret Hellard (2012). People who inject drugs can be success fully treated for hepatitis C (HCV), and treatment has the po tential to reduce the community prevalence of HCV http://creidu.edu.au/policy_briefs_and_submissions/6**



Therefore increasing treatment is also an effective prevention strategy (27). Other prevention and harm reduction strategies need to continue and be strengthened. Needle and syringe programs have already had a substantial impact on HCV rates in Australia. One study estimated that from 2000–2010, Australian NSPs contributed to a 15-43% reduction in HCV infection (19 000-77 000 cases) (28). Further innovation is required to improve NS services in certain areas, including for young people, people in prison and those wanting more discrete services. Increased peer education, particularly focussing on needle and syringe sharing between sexual partners, has also been suggested as a way to reduce HCV transmission (29).

In conclusion, the advances in HCV treatment that we are witnessing are very exciting. Current and emerging treatments have the potential to seriously impact on what has been a long-neglected public health area. There will be benefits for both individuals and communities. Treatment is becoming more attractive, providing improved cure rates, shorter treatment courses and much more tolerable treatments. These developments will account for little if they are not supported by further investment to remove treatment barriers and allow better treatment tailoring to respond to specific needs. Finally, an unintended consequence of improved treatment may be a relaxing of our prevention efforts. There is no substitute for prevention and harm reduction efforts that improve access to needles and syringes, good advice and good support.

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The Road Less Travelled

Silk Road : drug dealing evolved

By **Dr Monica Barratt**
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Imagine a future where hundreds of different types of drugs from all across the world were being bought and sold in a global marketplace.

Rather than relying on word of mouth and hoping for the best, sophisticated information on sellers was available to all potential buyers. Imagine a future of higher quality drugs available to people unable or unwilling to access their local drug networks due to privacy concerns or to avoid street-based violence. In 2011, this future became a reality for participants in the anonymous online marketplace Silk Road, known by its community simply as The Road.

In this article, I review a history of drugs & the internet, then describe the evolution of Silk Road starting with a brief **history of drugs and the internet.**
In the 1990s cyberspace (as it was often called in those days) was understood as a new frontier populated by early adopters. From its very early days the internet was used to disseminate information about illicit drugs as well as to enable buying and selling. Private forums enabled by the internet allowed those in the know to trade in illegal drugs.

In the 2000s-2010s the context of internet use and the kinds of technologies used have evolved dramatically. The prevalence of internet use has grown into something that affects all aspects of our lives, even reaching into the lives of those few who have not yet embraced online communications. Increasingly, what we do and who we are online is no different from what we do and who we are in our everyday lives.

Standard laws and customs are now applied to online communications (e.g., people being sued for defamation from a Tweet or being fired for what they say on Facebook).

In the 2010s, both governments and corporations are increasingly taking control of what can be viewed online: governments through filtering of prohibited content and corporations through an often opaque application of policies that disallow content they believe could offend their user-base.

In the late 1990s and early 2000s, people who used drugs and talked about them online in public forums felt reasonably comfortable doing so. Even though forums were technically publicly accessible, the proportion of the population who used the internet and who would see their discussions was low and the content was not as easy to find by law enforcement or other outsiders.

There are, however, cases from this era where law enforcement did monitor these discussions and made arrests based on the information they found.
It became apparent at this time that the internet was 'more public' and talking openly about drugs more risky than people realised.

In the 2010s, where so much online socialising occurs in completely identifiable spaces like Facebook and through Google services, people appear to be much more aware that they can be monitored.
As a result, drug forums continue to be popular at a time when many online forums pertaining to legal pastimes have been superseded by Facebook and other social media.
Forums, like Bluelight.ru, Erowid.org, and Drugs-forum.com, allow users to adopt a pseudonymous identity which can shield them from some of the risks of talking about drugs online.

In the 2000s we also saw the emergence of both online pharmacies and online 'head shops', that is, stores selling what they advertised as legal highs.

Hidden internet services

The rise in hidden internet services can be understood as a response to the increased monitoring and mainstreaming of the internet. Hidden internet services are not indexed by Google and cannot be accessed using a standard browser.

The open source software Tor (*see Box 1*) must be used to access websites on the hidden web (also known as the dark web, the deep web). Tor routes internet traffic through an international network resulting in the user's IP address being masked. Not only does Tor enable anonymous browsing, it also makes it possible for people living in repressive regimes to access blocked internet content. It is important to note that using Tor alone will not protect the user from revealing their identity. For example, if the Tor user logs into Google or Facebook using Tor, they will still be identifiable to those corporations although said corporations would be unable to conduct standard traffic analysis to determine your location via IP address.

A glance through the Tor directory reveals many drug selling websites, ranging from individuals selling cannabis or MDMA through to large global marketplaces. The most well-known of these is Silk Road.
Silk Road is an anonymous marketplace, not unlike eBay. Drugs are the main commodity available but the site also sells a range of other goods and services, both legal and illegal. Like eBay, Silk Road is international, has a ratings system for sellers, and sellers pay a commission. Unlike eBay, Silk Road sellers offer products for a set price rather than through an auction.
The ability to access Silk Road without being traced is one part of its success.
The other critical technology is the virtual peer-to-peer currency Bitcoin (***see Box 2***).

Bitcoins are an online-only currency with no central authority. Like with Tor, the user must understand how to protect their anonymity when using Bitcoins.

For example, in Australia there is a service that allows Bitcoin users to complete a deposit slip online detailing how many Australian dollars the user wishes to transfer into Bitcoins and the deposit location, then make a cash deposit at designated bank branches. By buying in cash instead of through online bank deposits, the Bitcoin user's anonymity is preserved.
Also, there are many other ways of obtaining Bitcoins, including being paid to complete computer processing tasks (called Bitcoin mining).

People buying illegal products using Bitcoins can also use various Bitcoin 'cleaning' or 'laundering' services which tumble the currency through different accounts and into different amounts, making it very difficult to link the deposit and withdrawal transactions. If used cautiously, Tor and Bitcoin offer virtually untraceable buying and selling.

The final part of the journey from buyer to seller is the part of the process that is most susceptible to intervention by law enforcement. Silk Road handles the product offers, feedback, payments, communications, but eventually, the seller has to post the product to the buyer.
There is much less monitoring of domestic post compared with international, and there is also less monitoring of letters than larger packages.

There is much discussion about whether it is best to have drugs sent to your name and your address or to use a fake name or alternate address. Intelligence documents indicate how suspicious packages are picked up through signs like obvious fake names, poor packaging, suspicious smells, and lack of a return address. As such, Silk Road sellers describe their packaging as professional-looking, vacum sealed, with a valid company return-address.

Given the large increase in the number of packages sent through the post recently due to increased online commerce in general, it is easy to see how many stealth packages could get through the system. Even so, some packages will be found and it has been reported that Australians have been arrested for receiving drugs through the postal system as a result of package surveillance

SILK ROAd : dRUG dEALING EVOLVEd

Walking down The Road

Given the risks described previously, why would people choose to use Silk Road?
Media interviews with users and browsing the forums indicate a number of reasons, which vary depending on the users' circumstances. (see Box 3).

For example, Australians pay some of the highest prices for drugs in the world, therefore it is no surprise that an international marketplace would provide large discounts for Australians compared to prices they would pay locally.
MDMA bought on Silk Road from the Netherlands was one-fifth of the Australian price in 2012, and this calculation does not take into account the difference in purity. While there is no guarantee that Silk Road products will be pure or clean, the rating system provides a mechanism for identifying quality products and avoiding dealers who provide a substandard product.
For many people, buying online is their preferred medium for all kinds of shopping, due to its convenience, so it is no surprise that some people prefer to buy drugs online compared with organising a deal, waiting around, driving around, dealing with people who may be involved in other criminal activities, etc.

Anonymity is also a factor for Silk Road users, some of whom live in rural/regional areas where if they were to approach the local drug dealers, everyone in the town would know that they use drugs. Finally there is a huge range of drugs available on Silk Road, many of which are not even possible to purchase from traditional drug marketplaces (e.g., exotic research chemicals, particular cannabis strains).

What are the implications of these technologies for law enforcement efforts?
It is unclear how sites like Silk Road could be stopped. Increased government control of internet content has no effect on Tor hidden services because governments cannot block these websites nor can they easily discover who runs them.
It would be difficult to ban the use of Bitcoins when there is no central body that controls the market.

Increased monitoring of the customs and postal systems is occurring but is likely only to capture a fraction of the letters and parcels increasingly sent around the world.
It may be possible for law enforcement to infiltrate organisations like Silk Road by posing as users and sellers to disrupt the market and build enough intelligence to make arrests.

Another potential vulnerability is the Tor network itself. Any one of the volunteers that operates an exit node in the Tor network may be able to observe the content of traffic, although they would not be able to determine where the traffic originated.

While the Tor Project is funded by many different stakeholders it is unclear whether the U.S. government could pressure Tor to shut down if illicit activities enabled by the network were to increase.

It is currently unclear what online drug marketplaces will look like 1 year from now, let alone 5 years. What is clear is that trends in internet use and encryption technologies have changed our lives generally and specifically how we use, buy, sell and discuss illegal drugs.

The internet was originally built as a decentralised system, and it continues to resist centralised control of information, as can be seen in the rise of hidden internet services in response to increasing government and corporate control over the public internet.

While they pose unique challenges to drug prohibition, these trends may also prompt renewed discussion about the efficacy of drug prohibition and alternative drug control policies.

Box 1: Tor

(source: torproject.org)

"Tor is free software and an open network that helps you defend against a form of network surveillance that threatens personal freedom and privacy, confidential business activities and relationships, and state security known as traffic analysis. Tor protects you by bouncing your communications around a distributed network of relays run by volunteers all around the world: it prevents somebody watching your Internet connection from learning what sites you visit, and it prevents the sites you visit from learning your physical location.

Tor was originally designed, implemented, and deployed as a third-generation onion routing project of the U.S. Naval Research Laboratory. It was originally developed with the U.S. Navy in mind, for the primary purpose of protecting government communications. Today, it is used every day for a wide variety of purposes by normal people, the military, journalists, law enforcement officers, activists, and many others." from torproject.org

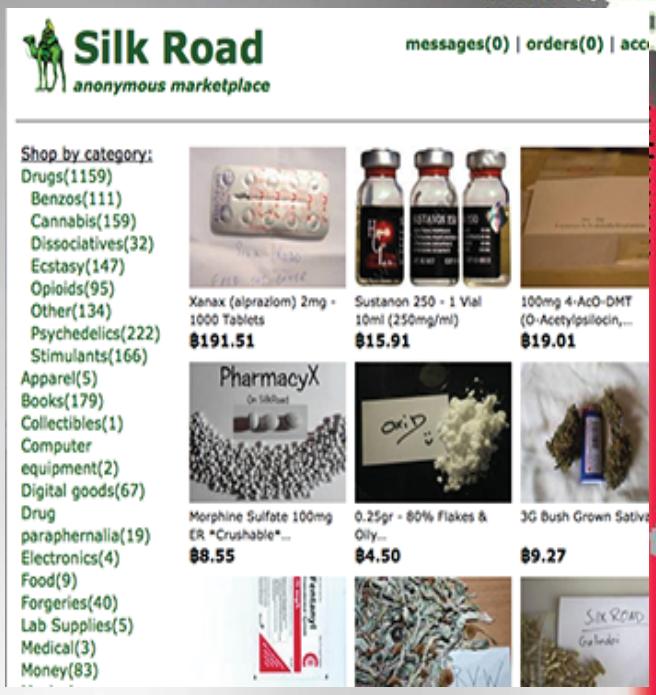
Tor is funded by a diverse group including government and non-government organisations, universities, non-for-profit foundations, Internet Service Providers, companies, and individual donations.

Box 2: Bitcoin

(source: bitcoin.org)

"Bitcoin is an experimental new digital currency that enables instant payments to anyone, anywhere in the world. Bitcoin uses peer-to-peer technology to operate with no central authority: managing transactions and issuing money are carried out collectively by the network. Bitcoin is also the name of the open source software which enables the use of this currency. The software is a community-driven open source project." from bitcoin.org

Bitcoins are not only used to buy illegal products. Bitcoins can be used for any transaction where the seller accepts them, and they are increasingly being accepted by websites seeking micropayments and donations. Another mainstream application of Bitcoin is at www.bitcoindeals.com, where all major consumer good categories are available for purchase with the currency.



Box 3: Why use Silk Road?

(source: Silk Road forums)

I can't imagine my life without the Silk Road. It just offers me great times with safety that you can't get anywhere else. What the media fails to pick up on is that this is a safe alternative to dealing with sketchy dealers that might be selling you fake shit. On the Silk Road, everything is regulated by the members, so the scammers are ousted quickly. The quality is top notch because of the competition. Members actually test the drugs and post results to ensure safety and potency. It's a freaking paradise honestly.

I love that there is a community where people can talk honestly about drugs and spread harm reduction techniques. It's also nice to be able to have some form of quality control when buying drugs, since most sellers have reviews.

H is cheaper on here. Wooo! Plus it's uncut..Well it is around here..But here it's 50 for .1, about 225$ for a gram. So this is good. Plus psychedelics are really hard to come by. So the road opens my mind up ;) Silk Road has enabled us to live the life we WANT to live not the life we HAVE to live due to prohibition. I've even been able to share some of my new booty with my close friends who otherwise had been at a loss. Now they are happy and content as well. Thank you to my vendors for being so discreet & having competitive pricing as well as good reviews.

ARE WE SEEING THE DEATH OF HEROIN?

Over the last decade, things have changed hugely in the world of opioids. Increasingly, pharmaceuticals like oxycodone and fentanyl are stealing the spotlight from heroin. According to Dr Marianne Jauncey, medical director of the Supervised Injection Room in Kings Cross, for every injection of heroin at her establishment during 2012 there were two of prescription opioids – usually crushed and filtered OxyContin (oxycodone) tablets.

Illicit use of pharmaceutical opioids is on a sharp upward curve. Drug addiction specialist Dr Alex Wodak describes it as a 'hell of a problem,' and suggests that we may be on 'the cusp of a deadly epidemic.' And heroin, already outcompeted by methamphetamine, appears to be silently withdrawing to the margins.

After the end of the heroin glut in 2001, the toll of opiate-related deaths steeply fell away.

In time, the Herald-Sun no longer bothered to publish the overdose death count along side the road toll. But fatalities have again begun to rise. In 2007, 360 Australians aged 15 to 54 died of opiate overdose.

In 2010, the toll was estimated at 705.

At the turn of the century, heroin accounted for about 70% of lethal overdoses.

Now, 80% are caused by pharmaceutical opioids (usually in conjunction with alcohol or other drugs.)

Oxycodone - sold in Australia under the brand names **OxyNorm, OxyContin & Endone** - is 1.5 times stronger than smack and is the opioid most commonly diverted for recreational use. It is often described as 'legal heroin' but consumers differ in their opinions as to how it actually compares. It is synthesised from thebaine, which is found in the opium poppy. Once, legal producers bred their poppies for maximum morphine content. Now, thebaine is what's hot, as it is the precursor, not just of oxycodone, but buprenorphine, naltrexone and naloxone as well.

Targin is another oxycodone formulation, which blends the drug with naloxone. At first glance, one might think the naloxone has been added as a deterrent to injection (as it is in Suboxone) but, no, it is actually there to control diarrhoea. Nevertheless, it would be very unwise to inject or snort this product.

As with so much else, the explosion in oxy use began in the USA. The slang term 'hillbilly heroin' refers back to Appalachia - a region associated with moonshine and feuding clans - where the level of oxycodone addiction has impacted severely on communities. In the US, slow-release OxyContin was first approved for use in 1996 and by 2001, consumption in the Appalachians had reached plague proportions.

Premiering at this year's Tribeca Film Festival, Oxyana tells the grim tale of Oceana, a small Appalachian town branded as America's 'Oxycontin Capital'. A majority of the town's 1,500 residents use the drug and all have been touched by it. In the film, a local dentist describes how drug-seeking patients request that their teeth be pulled in order to obtain a prescription. The state of West Virginia has attempted, vainly, to sue the manufacturers, Purdue Pharma, for 'pressuring and enticing doctors to overprescribe their drug, and for failing to adequately warn of potential abuse.'

Florida is the engine room of OxyContin supply in the US. Loose prescribing laws have encouraged the establishment of countless lucrative one-stop clinics catering exclusively to the oxy trade. Indeed, 85% of the nation's OxyContin is prescribed in the state. And from Florida, where oxy kills an average of 11 people a day, entrepreneurial doctor-shoppers distribute it to the rest of the country.

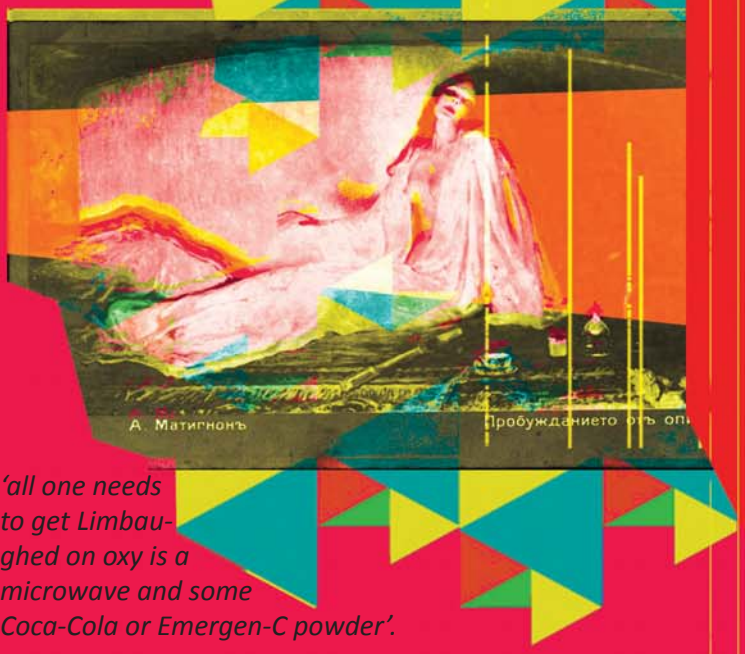
There is a profit to be made. On US streets oxies are more expensive than heroin. Here, where we pay more for our smack, they are cheaper, but not by a huge margin– creating a real temptation for needy individuals.
In both countries it is inexpensive to legally purchase oxycodone from a pharmacy. In Australia it can cost less than forty dollars (and pensioners can fill a prescription for AUD$5.90) but on the black market a packet, depending on the strength, can be sold on for hundreds of dollars. A prescription of Fentanyl patches (Denpax or Duragesic) can also yield substantial profits.
Currently, oxycodone is America's number one drug problem. A 2008 documentary claimed that its use in the country was greater than that of cocaine, heroin and ecstasy combined. In 2007, America was responsible for 82% of the world's consumption.

However, US authorities have not remained idle. For years, representatives of Purdue Pharma told family doctors that OxyContin was a miracle pill, that it was safer and had fewer side effects than morphine. They spread the word that patients would not develop a tolerance, and that there was little chance of addiction. They even produced and distributed professional looking pain management guides to doctors who, typically, had had only one fifth the pain management training - received by veterinarians.

(It's interesting to ponder that, back in the day. heroin was spruiked in a not dissimilar way by Bayer Pharmaceuticals.)

Under the legal spotlight, however, Purdue Pharma backed down on their claims, and admitted to telling outright lies. The company and its three top executives pled guilty to misleading regulators, doctors and patients, and were fined a record USD634 million.

The company also introduced a new 'tamper resistant' formulation, which was harder to crush and formed a gel when dissolved in water. This had less effect on illicit consumption than the company had hoped. Users simply risked vascular damage by injecting the new formula, or else they innovated. According to one internet forum:



'all one needs to get Limbaughed on oxy is a microwave and some Coca-Cola or Emergen-C powder'.

A percentage of US oxy users have turned to other opioids like fentanyl, hydromorphone (dilaudid) and the new drug oxymorphone (which now has its own tamper resistant formula). But reliable research suggests that many are using heroin as an alternative, given that it is cheaper and that market competition with pharmaceutical opioids has led to an increase in quality.
This is particularly interesting if one considers that most oxy users - even if they were not introduced to the drug as bona fide pain patients - are unlikely to have had much experience with illicit drugs.

One Boston cop says that he has not met a single heroin user under 30 who did not start with oxy.

ARE WE SEEING THE DEATH OF HEROIN?

CONTINUED

The tamper-proof OxyContin formulation is not available in Australia, but it is likely to appear in the next year or so. Litigation against Purdue Pharma is also being prepared in Canada, which is experiencing its own surge in oxy use. This troubles Alex Wodak, who believes that Canada is a good indicator for future Australian drug trends. He points out that the Canadian problem began when their national health system freed up the availability of oxycodone, a change mirrored here in the mid 2000s, when oxycodone and fentanyl - previously available only to cancer patients - were approved for a wide range of ailments involving chronic pain. Doctors had been given powerful, sorely needed new pain management tools, but it was a double edged sword - illicit use of the drugs skyrocketed and still shows no sign of abating.

According to Gideon Warhaft, of the NSW Users & AIDS Association ''There will always be people who inject drugs and there will always be people with narcotics dependencies. The positive advantage with OxyContin is that users know exactly what they're getting, whereas with heroin, they don't. Many now prefer OxyContin because it's clean and it's safer.''
This is despite the fact that when injecting oxycodone one experiences only 13% more of an effect than simply swallowing the pill – whereas shooting heroin can 'double, triple, or even quadruple the bioavailability.' (This is ignoring the rush, of course.)

Fentanyl is the other opioid causing concern in Australia. Though the level of its unapproved use comes nowhere near that of oxy, it is definitely on the radar. (Remember the case of the thieves who stripped an ambulance of their supply?) More than 450,000 fentanyl prescriptions were issued in 2009 under the Pharmaceutical Bene fits Scheme, compared with fewer than 8,000 in 1998. Though it is available in an injectable form, in the community it is almost always encountered as a transdermal patch of various strengths, measured by the number of micrograms released into the system per hour. Because fentanyl is, by weight, 50-100 times - times stronger than morphine, especial care must be taken to avoid overdose.

Originally, the patch contained a reservoir of the drug which could be easily accessed and injected. But, to prevent illicit diversion, the manufacturers introduced a new 'matrix patch formulation' which is harder to process - though the company admits that it is not immune from more 'creative' consumers. In a far from sterile procedure, the patches can be cut into pieces, soaked in vinegar or lemon juice and then heated. Once a distinctive waxy substance is separated off, the remaining liquid, apparently, is ready for use. Contamination with glue and fibres may account for a high incidence of local infection and vein damage –& this is ignoring any surface dirt or sweat that comes along with pre-used 'stickers' recovered from the limbs(or bins) of patients.

After injecting fentanyl, one 35 year old user developed rigours and a fever. He was admitted to Albury Base Hospital from where he was transferred to Melbourne in a critical condition after a diagnosis of septic pulmonary emboli. Injecting substances not intended for injection – or which were designed specifically to discourage injection – is not without risk. And, of course, those who inject crushed oxies face similar perils.

When pharmaceutical companies reformulate their products to discourage drug use, they work on a false assumption that users will put their health above their need for the drug. 'Tamper-proof' formulations may assuage the concerns of government health departments and protect companies' balance sheets, but down the line they often create more harm than anticipated, with users injecting, snorting or smoking concoctions of an ever more damaging nature.

Community attitudes are an important aspect of the new, pharmaceutical-driven upswing of dependence. For most, the word heroin is frightening in its implications - yet pharmaceutical opioids have no such reputation. Oxy and fentanyl, though stronger than heroin, are shadowed by no pall of fear and prejudice. But, in the words of one American mother who lost her son to an oxy overdose: if it walks like a duck and quacks like a duck, it's a duck.

Oxy and Fentanyl cut across all levels of society in a manner that is impossible for illegal drugs. Many of those dependent on pharmaceutical opioids are far from being stereotypical users.
Mostly, they are ordinary citizens: clean cut jocks with sports injuries, car crash victims, or older people who've had a fall and sought treatment for lingering pain. Many, through the course of their lives, will never have purchased a gram of pot, and yet, without meaning to, they've become 'junkies'.

Some – understandably, given the stigma associated with drug dependence – will refuse even to admit they have a problem. Some descend to the underworld as their tolerance grows and legitimate supplies dry up. Some are lured by advertisements proliferating on the web, offering discreet, inpatient rehabilitation.

Just as in the USA, Australian rural and regional centres are often the epicentres of pharmaceutical opioid abuse. The boredom associated with country life is possibly a factor, but supply-side issues are more to blame: classic illicit drugs are simply harder to get in remote communities.

Since december 2011, at least 15 fatalities have been associated with fentanyl in the Albury-Wodonga region. One victim was plastered with seventeen patches - and there are reports of individuals diving for stickers in dumpsters out the back of hospitals and nursing homes. Also, a state border bisects this region, making prescription tracking a headache, and creating a fertile garden for the exploitation of organised doctor-shoppers. The situation is made more precarious by under-informed local doctors, who, in some cases, have been told by marketing representatives that it is impossible for fentanyl patches to be injected.

An obvious solution to the diversion of prescription drugs is a monitoring system.
Many states in the US have managed to introduce such a scheme, but to really work it needs to be uniform and nation-wide.
This is where Australia is taking solid steps.

After a trial in Tasmania, all states and territories except the Northern Territory and Victoria have signed on, and the NT, which already has its own system, will soon shift to the federal plan.

Why not Victoria? It's hard to say. Some months back, the government announced that the scheme was not 'a magic bullet' and that 'significant detail must be worked through to ensure that the Tasmanian model could be implemented nationally.' More recently, the office of the Health Minister stated that 'the Victorian Government was leading the development of a National Pharmaceutical Drug Misuse Framework for Action, due to be released this year.'
(*Ed's note: Despite the obvious benefits to patient safety, etc, Harm Reduction Victoria (HRV) has concerns regarding real time prescription monitoring that the emphasis will be on law and order rather than public health. See RTPM Article by Sarah Lord in Phoenix Ed of WHACK*)

One thing is certain. As our state government deliberates, the pharmaceutical opioid dilemma will not solve itself.

Amidst dithering government responses and breathless media reports, it is crucial that we not forget just how important these drugs are to the people they help, often gifting them a precious semblance of normal life. To quote one doctor, 'these medications are much better, much safer than anything previously available. And another doctor: 'oxycodone is close to an ideal opiate.' The decision to make oxycodone and fentanyl more broadly available was a wise and caring one, as no one should have to live under a shroud of pain – especially if the only thing standing in the way is fear that people will divert the drugs for their own selfish ends.

'The danger here is that we see the bad side but don't balance that against the need.'

The Golden Phaeton 2013

the great silk road heist

Thousands of Australian members of Silk Road were fucked on Valentine's Day.
Many of the same people also played a major role in one of the biggest scams in the short history of Silk Road.

This scam was orchestrated by Australia's best trusted and well-known seller at the time, 'EnterTheMatrix'. ETM was in the top 1% of all Silk Road sellers and had more than 99% positive feedback, leaving many people to believe that this drug dealer was as trustworthy as they came. They may have been right.

But that trust which had taken many months to build opened the door to the most successful scam perpetrated against Australian users en masse in the site's history. ETM made off with tens of thousands of dollars' worth of Bitcoins (an online currency used to protect the anonymity of sellers and merchants). It is difficult to get exact figures, but it is estimated that more than 20 people lost over $1,000 and many more lost smaller amounts.

Let's get to know a little bit more about just who ETM was and how he was able to pull it off.

EnterTheMatrix was one of the first Aussie vendors to offer domestic shipping to Australians on a consistent basis. Initially, ETM's product line was limited to a small range of drugs such as LSD and Xanax. Over time, though, the selection expanded to include MDMA, research chemicals, stimulants, prescription drugs and more.

Because ETM was one of only a small few Australian sellers with a regular supply of high quality drugs, the vendor quickly became very popular amongst Australian buyers and in turn became highly trusted as a seller. There were complaints in the forums about high prices, but they weren't too far out of line with the value of the same drugs on the street, and the quality was often much higher.

The basic premise of ETM's business model was this: he would purchase drugs from overseas Silk Road vendors for relatively cheap prices. Once they arrived, he would dramatically mark up the prices and then sell them to Australian Silk Road users who were unwilling to either take the risk of importing drugs from overseas or simply wanted their drugs quickly. It was very simple but extremely effective, more so because he excelled at self-promotion (each listing had large parts of the page dedicated to advertising how great, popular and trustworthy he was.)

ETM also sold e-books with instructions about speeding up Tor, the notoriously slow software that makes anonymous browsing on 'the dark web' possible. Just before his now infamous scam, he listed another e-book for sale titled Matrix Secrets! Learn from the Top 1% of SR. It sold for more than $2,000. Only a few people purchased this guide, but given its price I'd say that it was a success.

So how did the scam unfold? Usually, Silk Road has an in-built system to protect buyers from dodgy sellers. Typically, after placing an order on Silk Road, Bitcoins are initially deposited into an escrow account rather than transferred directly to the seller. Only after the buyer receives the goods and verifies the product do they release the funds to the seller.

Sometimes, however, buyers will be asked to finalise the transaction early. Sellers will make this request in a variety of circumstances: when a customer has no purchase history, for instance; or when the value of Bitcoins is fluctuating wildly; or if the seller perceives the buyer to be high risk due to factors such as poor feedback or living in a country known to have very strict and capable customs (such as Australia).
In these circumstances it is common for the seller to ask for instant access to the Bitcoins. This is exactly what ETM did under the guise of a massive sale.

On February 14, ETM promoted a 'one-day only' Valentines Day sale and cut prices on a wide variety of drugs listed for sale.The catch was that users needed to finalise early in order to get the discounted prices. Cleverly, ETM wasn't forcing users to do so, but in order to get the discounts offered, that was part of the deal.

As a high-profile and trusted seller, many customers were more than happy to make the trade off and finalise early for cheaper drugs.
So many, in fact, that ETM extended the sale for another day, and then another.
It took a while for people to catch on.

After a few days, though, the penny started to drop. There were no packages arriving and ETM wasn't responding to messages. The realisation steadily rippled through the community: they'd been had and their Bitcoins were gone forever, stolen from them in a brazen con.

As with any scam, there are a lot of conspiracy theories and speculations as to what had happened. Nobody except for ETM knows for sure, but the main theories flying around are that either ETM had planned this from the very beginning, or that—due to highly publicised busts involving Silk Road vendors—ETM had decided that the risk of being Australia's number one seller was too much to bare and formulated an exit strategy, a strategy that ensured a very healthy bank account in the end.

All of this is speculation, but for anyone tempted to give ETM the benefit of the doubt (perhaps he was caught by law enforcement?), he made one final statement to the Silk Road community a little more than a week after his last sale.

ETM logged in to his Silk Road account and posted an ASCII Art version of "up yours" made up entirely of the number 5.
After that, one final shot at those he duped:
"The game's out there, and it's play or get played. That simple".

This was not the first time that customers on Silk Road had been ripped off in this way. As it turned out, ETM was working straight out of the playbook of a Canadian seller, Tony76, who had pulled the same exact hoax less than a year before.

It was 20 April 2012 (written as 4/20 in the US) when Tony76—a highly trusted seller of heroin, stimulants and psychedelics—announced the "420 Sale and Giveaway". Of course, a condition of the sale was to finalise early, which everyone was happy to do because the seller was such a trusted member of the underground community. After shipping the money, though, nobody received their orders and Tony76 vanished somewhere deep down the dark web.

It was suggested by a forum moderator that he made off with **approximately $250,000** that weekend.

I guess the moral of the story for anyone using Silk Road is that the features of the site that protect legitimate sellers protect the scam artists just as well. EnterTheMatrix and Tony76 made out like bandits because they could conduct their business with complete anonymity. Reputation and positive feedback count for something, but not once a seller has decided to cut and run from it all.

So tread carefully, trust no one, and treat any offer that involves finalising payment early with suspicion.

Pyrate 2013

SHOULD WE DO THE POLITE THING & JUST DIE?

THE POPULATION OF OLDER USERS IS GROWING & WE DONT KNOW WHAT TO DO.

When I started injecting heroin, I was a member of a club reserved for the young.
That someone could live to a ripe old age whilst continuing to partake of this particular poison was scarcely credible.
It was in the contract – drug use was a slippery slide to tragedy. And that was part of the appeal.
You only had to read the novels and watch the movies. Users died - and well before what would have been their declining years. Celebrity junkies preserved us from the sight of their slow decrepitude by graciously overdosing before they showed a single grey hair. And who wanted to live past 40 anyway?

This outlook mirrored that of wider society.
Drug taking is a high risk activity – like bomb disposal or bus driving in Guatamala. Back then, it wasn't a question of if you would die, but when.

This attitude was no doubt seasoned by wave upon wave of fear mongering, but there was truth in it. Users' health was constrained by things we take for granted today: there was an ignorance of safe practices, difficulty in accessing pharmacotherapy and clean equipment. What's more, drug taking was still largely considered a moral affliction, rather than something that could be managed by compassionate policy and by the science of medicine.

Of course, there were outliers: William S Burroughs, that venerable old gentleman with the faultless sartorial instincts, who provided living evidence that it was physically possible for a junky to survive as long as anyone else.

Alcohol users can live on into old age on a substance intrinsically harmful to the body. Why not heroin users? If properly administered, pure heroin is close to physically harmless. But the danger lies in the delivery systems, the adulterants, inconsistencies of strength. Discrimination too breeds hazard; illegality pushes users towards a perilous lifestyle, and underlying mental pathologies pollute the mix.

However, if one could have looked ahead and seen the changes in store – new policies, new treatments - it would not have been difficult to prophesise that injecting heroin users would start living longer. Add to this the increased life expectancy of the population as a whole and it becomes a shoo-in.

The relevant authorities, however, have been slow in absorbing the notion of aging drug users littering our society in ever increasing numbers. AIVL (Australian Injecting & Illicit Drug Users League) bemoaned the lack of attention given the subject when they produced a discussion paper in 2011 .
They could find no relevant research in Australia, and only a smattering elsewhere in the world.
As a result, the paper (from which much of this article is derived) had to dig deep for reliable information - but in the community signs of the phenomenon were hard to miss.

This growth in numbers has been a surprise to many. Sometimes even to the users themselves, who are sometimes as bewildered by their passage into old age and retirement as the wider community.
The system of care for users, however, is designed first & foremost for the young – because drug use, historically, has been associated with youth – & older users are finding that their needs are not being met.

For the sake of this article, a user becomes 'older' somewhere between the ages of 40 and 50. Also, it is important to note that while there may be increasing numbers of older users, they are not necessarily living as long as the general population.

My pharmacotherapy prescriber placed her oldest pharmacotherapy patients in their early sixties. She suggested that users were surviving just long enough to get knocked down by HepC (prevalence can be as high as 90% among older users) or by other chronic conditions associated with long term drug use.

What are these conditions?

Well, no one would disagree that users are enthusiastic smokers – whether of pot or tobacco. This leads to cancer, of course, but also to emphysema & COPD (Chronic Obstructive Pulmonary Disease). Also there can also be vascular and soft tissue damage associated with needle use and the injection of adulterants. As veins pack up, older injectors may take the dangerous path of using the feet or groin. Issues with blood pressure & general bodily degeneration generally arise with age and, when combined with the negative effects of long term use, can lead to deterioration of heart valves and deep vein thrombosis. Alcohol use can also increase among ageing users who may find it an easier option financially, or less harrowing than hitting the streets in search of their substances of choice. Aside from its various negative impacts on health, alcohol is known to accelerate the course of HepC.

One can imagine how a treating physician might be presented with a very complicated diagnostic challenge. The body serves us well, even in decline - but it is a complex machine which deteriorates as a whole, and it is not easy to foresee where the first cracks will show.

Not to make this too much of a horror story, but according to Carol Beynon, a British epidemiologist, users in their 40s frequently have many of the health issues of someone in their 60s or even 70s. There is also some evidence that addicts are more prone to early onset dementia.' (Interestingly, one study has found that 'past or even current illicit drug use is not necessarily associated with impaired cognitive functioning in early middle age' The authors do, however, provide a caveat: 'our results do not exclude possible harmful effects in some individuals who may be heavily exposed to drugs over longer periods of time.')

Users also have a tendency to go untreated (on some occasions because of the stigma associated with their conditions). HepC is at its highest prevalence in the older cohort, but a very low percentage seek treatment. Abscesses are disregarded and lead to amputation. Heart-related symptoms are ignored with grim results. Intoxication can lead to falls, which are a serious issue when one is older - particularly if you're suffering from bone density loss associated with long term methadone use. 25% of patients are dead one year after a hip fracture.

People do tend to consume more drugs as they age – it's just that society doesn't expect them to be illegal ones. An increasing variety of prescribed medications complicates the risk of negative drug interactions, particularly if some are illicit and undeclared. And, to quote Dr Richard Friedman in the New York Times : 'Even modest amounts of alcohol or drugs can be problematic as older patients have a significantly reduced ability to metabolise them... as well as an increased brain sensitivity.'

When I was young and far from sterile in my habits, I would rarely get cotton fever. But down the track, despite taking care to employ safe practices, my dirty hits became far more common – to a point where I found myself taking all kinds of extra precautions to avoid them. This is merely a personal anecdote, but it speaks to the unpredictability of drug-effects as one edges on in years. It also has some science behind it. Immunosenescence is the 'age-related gradual deterioration of the immune system. Older drug users, especially those with a long history of poor health and living conditions, are affected to an even higher degree. As a result, they are more susceptible to infections and diseases than younger drug users or older people who do not use drugs.'

Enough doom and gloom? Not by a long shot. Just a snapshot of how complex the needs of older users can be. They are, to put it bluntly, far more at risk of premature death than non-users of the same age, yet surely long experience and established routines would shield them at least somewhat from the risk of fatal overdose? Perhaps not...

continued overleaf

THE POPULATION OF OLDER USERS IS GROWING & WE DONT KNOW WHAT TO DO.

OVERDOSE

One of the more eye-opening facts contained in the AIVL report is that 'drug-related deaths among Australians aged 45 to 54 have increased by about 50 percent since 2008.'
This is partly due to a reduction of heroin use among the young but, for the first time since the heroin flood at the turn of the century, the overall number of overdose deaths is increasing - and older users are the vanguard. Estimates for 2009-10 show that, again for the first time, 'deaths among 35 to 44 year olds have overtaken deaths among younger age groups.'

As a group, older users are more vulnerable, their bodies less tolerant of insult. Any extra burden on the cardio-pulmonary system will heighten the risk of lethal overdose: lung issues associated with smoking, heart issues associated with a life of intravenous injection, or simply the frailty associated with age.
(It is not hard to imagine an absent-minded older user failing to realise that they have gone to the fridge for a second or even third methadone dose.)
To my mind, this is all good evidence that the ageing cohort would benefit from a primer in the matter of overdose risk. Particularly given that the figures may include shorter term users on prescribed opioids who have had less chance to develop a sense of the dangers.

*

Those who have been on methadone or buprenorphine for long periods have issues which may be added to those described above.
Essentially, older consumers are providing an experimental cohort for research into the long term effects of these medications – for little knowledge exists in the scientific literature.
An older lady who picks up at my pharmacy and has been on methadone for decades, describes herself as an unwilling guinea pig.

There is some belief that long term methadone use can (as mentioned above) lead to a loss of bone density, compounding the natural loss associated with age. And there is the issue of methadone-related dental disease, which progresses inexorably through the years.

I would suggest that the Medicare Chronic Disease Dental Scheme, for which pharmacotherapy consumers were eligible, was precisely the kind of initiative that might be included in a caring policy response to the increase in older users. Regrettably, the scheme is now closed.

Methadone is also associated with fluid retention and weight gain, neither of which is healthy even in the short term. Long term consumers can 'experience problems related to the respiratory system.' If this is folded in with the respiratory vulnerabilities referred to above, it is an added concern.
Recent studies with rats have pointed to an impairment of intellectual function, specifically with regard to a deficit in attention. Methadone alters the character, however subtly. Speaking generally, a simple heroin user will experience frequent periods of sobriety, but for a person on methadone (and other pharmacotherapies) the effect is near to continuous.

I wonder if, over time, the recollections of one's prior self may fade or become distorted.
If there are motivations, interests & callings subsumed or redirected by the drug, it may potentially lead to a sense of loss in later years.
All that time in sleep, which might have been spent doing other things. All that suppressed libido that might have found expression...

Another reasonable fear among older users is that continuous opiate use may actually mask the symptoms of serious physical conditions, leading to late diagnosis.

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Even if older users are cruising along well physically, they still have to handle society's negative attitudes.

It was once posited that - if it didn't kill you first - drug use was something you 'matured' out of. Many doctors believed that heroin addiction was a disease that ran a twenty year course. I recall being told this once, and remember looking forward to the end. Which never came. Now, since I'm alive and of a certain age, people simply assume I've given up drugs.

People look less kindly on older users.
The traditional respect given to our elders seems to dissolve if the elder in question is a junkie.

Older users report 'a greater degree of discrimination, or experience it more intensely.'

Some dismiss older users as dead weight; gormless characters, who have wasted their lives and now rely on welfare for survival.

Then there are issues of poverty and powerlessness that impact harshly on older users, who are far more likely to subsist in lean economic circumstances - where, according to statistics, morbidity and mortality are always higher. They are prone to social isolation: many of their contemporaries may be dead, they may be estranged from families and friends. They may be uneducated, unemployed and living alone. When youth is done & the future narrows to a point, one is surely a candidate for depression.

In such circumstances, there is little appeal in the idea of getting clean. Indeed, for older patients, the case for maintaining them on their drug of choice is strong. If they are determined to continue using, and if it would serve to make the remainder of their lives more pleasant, why not allow access to their drugs of choice?

It does not take much compassion to see that wrenching a person from their lifetime chemical companions in their waning years is a cruel and futile exercise. And hypocritical, given that we are so willing to dose up our elderly on increasing amounts of legal pharmaceuticals.

But don't look for any progress soon; the irrational pall that surrounds opioids remains alive and well in our society. The AIVL paper recalls an 'almost sadistic' case in which a drug-using patient was denied morphine a half hour before he died on the basis that it was 'bad for his liver'.
AIVL found the issue of pain to be a primary concern among older users, who foresaw situations in which ignorance and stigma would compromise the pain management and relief they would likely require as they aged. Awareness of the existence of a drug user database - which in Victoria expires only upon death - feeds into these fears.

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The appearance of older users as a substantial demographic is not the all of it. In an article in the aforementioned Dr. Friedman discussed some interesting behaviours among older users: 'among adults aged 50 to 59 in the USA, the rate of current illicit drug use increased from 2.7 percent in 2002 to 6.3 percent in 2011. (The most commonly abused drugs were opiates, cocaine and marijuana'.) Clearly age has not wearied the baby boomers, who consumed drugs like no other generation before them – but the sad side is that depression and hopelessness may be feeding this increase.

In his article, Friedman does not only refer to life long users. He also addresses the phenomenon of people taking up the habit at a more advanced age. While the young tend to use drugs in search of sensation, or may be self-medicating for psychiatric or behavioural disorders, he suggests that older users turn to alcohol and drugs 'to alleviate the physical and psychological pain from an onslaught of medical and psychiatric illness, the loss of loved ones or social isolation.' While I suspect that many older users still take drugs to get high, and sometimes through the sheer force of routine, I think he has a point. It is as clear as a mountain brook that the right drugs can provide a panacea through a difficult stage of life.
In recent years, older users have become embroiled in issues surrounding synthetic opiates and the explosion in their use. (See the related article in this edition.)

continued overleaf

THE POPULATION OF OLDER USERS IS GROWING & WE DONT KNOW WHAT TO DO.

The media enjoys using the phrase 'fossil pharming' to describe groups of older doctor-shoppers organised by dealers in search of oxy. Older people are used, obviously, because they are more likely to suffer pain, because we think of drug users as exclusively young, and because they enjoy a certain level of assumed trust.
It is precisely this trust that is eroded by such activity and its exposure on the media. Whatever the realities of fossil-pharming – and it may not be as prevalent as claimed – its practice and the reporting thereof tend to harden society's already hardening attitude to older users. I would also venture to suggest that the criminal exploitation of marginalised older users may be occurring.
There is a growing older age cohort supplementing (or replacing) their normal use with these pharmaceutical opioids, primarily oxycodone. Though oxy is becoming increasingly expensive on the street, older people with limited incomes will often settle for it, sometimes adopting it as an easier drug of choice. That it carries less stigma than heroin may also make it a more attractive option. If pharmaceutical opioids are consumed as directed, they are a safer, more reliable option than street heroin. If they are injected, particularly by older users, risks are exacerbated. AIVL reports 'severe circulation problems and in acute cases, gangrene and amputation, when filtering and clean injecting practices are not adopted'.

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And what about the underlying reasons behind the swelling population of older users? Is it a long term trend? Or is just a bulge?
While the genteel old steadfastly sip at their Pimms No.1 Cup, youthful explorers are consuming Duck Farts and Screaming Orgasms.
In an increasingly diverse recreational drugs landscape, heroin is just not that popular anymore.
Opioids will always have a place, but they are just one colour in an ever widening spectrum available to a drug using populace that has never been so large or broad.

But some British alcohol and drug workers think there is a trend line that connects the young and old: a 'dynamic' called the '***scarecrow effect***'. They hypothesise that the 'visible physical and mental deterioration of long-term heroin addicts has served as a grim warning to younger generations to steer clear of the drug.'

As for the earlier waves of users, well we never got the chance to see ourselves mirrored in the future as desiccated old monsters - so we never had the opportunity to be scared onto pot or speed. Or alcohol.

Hmmn. The term 'vast oversimplification' comes to mind. Preferences for recreational drugs move with the times, with fashion, technology, availability, and with deep social trends.
It's a fool's game ascribing cause to single factors in such a complex societal bouillabaisse. However, we don't seem to be able to help ourselves. In Australia it was the turn-of-the-century glut that turned so many onto heroin. In Britain (where a third of those in treatment are 'older') the 'Trainspotting Generation' was the product of cheap brown gear and the grim grey industrial wasteland of the Thatcher years. In the US, drug experimentation was a way of life for the ebullient baby boomers who came of age in the 60s and 70s.

Whatever the reason, the surge of older injecting opiate users is likely to swell before it peters out. And already youth-focused services are revealing inadequacies in treating more complex older clients. Detox establishments, for instance, typically offer a week in which to overcome the worst effects of heroin withdrawal. This may be sufficient for the youthful and resilient, but for older patients it's not enough. Older bodies need more time to adapt.
In the present Victorian system, GPs geared to pharmacotherapy generally do not have time to deal with the wider health concerns of their older clients. (An acquaintance of mine with an incipient heart disorder found it difficult to get sufficient attention from his prescribing doctor due to her heavy workload.
This lack of timely treatment led to unnecessary progress of a serious condition.) However, if clients choose to consult a different doctor over their general health, they can meet with insufficient understanding of the complex manner in which drugs and/or pharmacotherapy can affect their health.
Or they can meet with discrimination. In one incident known to HRV, a client was refused service by a GP not because she wanted to be prescribed methadone, but simply because she was on methadone.

The Golden Phaeton

The second half of this article to be concluded the next issue.

"Alive & Kicking"

25 years of reducing drug related harms!

HRV's 25th Anniversary Event

Harm Reduction Victoria (HRV) – formerly VIVAIDS – turned 25 in 2012! Our organisation was founded in 1987 in direct response to the threat of an HIV/AIDS epidemic among people who inject drugs in Australia. 25 years later, the organisation has changed and evolved in many ways. Perhaps the one thing that has not changed is our commitment to serving people who use drugs and supporting them to reduce the harms associated with drug use. The fact that we survive on a razor's edge of uncertainty and unpopularity, as an organisation of and for people who use drugs, simply underlines the significance of our longevity. 25 years! Who would have thought?!

But how to celebrate such a milestone event? We decided to dedicate our 25th Anniversary to our community – the very people who have kept us going for all these years. We figured it should be a party and a time for celebration as well as a chance to showcase the diverse talents of many of our members and constituents. More than anything else, it was an opportunity to re-connect with our members, old and new and to welcome newer faces to the Harm Reduction Victoria fold.
An Events Committee, which comprised staff and board members as well as other HRV members, was established and met fortnightly leading up to the actual event. The ideas flowed and with limited time and resources, we set about organising a memorable event .

We called the event "Alive & Kicking": 25years of reducing drug related harms! We found an ideal venue at the Colonial Hotel, Melbourne CBD, which included a bar area with stage where all the acts were performed and a Garden Terrace area (for smokers). Our tech wiz Jane put together a great selection of drug films, greetings & anniversary well wishes which played on a loop all evening in the garden space.
We set the date for Wednesday 5th December 2012. We put a call out over the airwaves & bush telegraph for our members, drug users & supporters of all varieties to come & celebrate with us. And they did! People came out of the woodwork from all over the place, some came from interstate!

It was a great night! An outstanding line-up of performers and amazingly diverse acts entertained the 100 or more friends and supporters who came along.

Leon Fernandez, a long-time friend and former HRV staff member, was Master of Ceremonies and he kicked the evening off with inimitable style and charm.
The program of entertainment included:

Steve Lucas from X: Our headlining act. Steve performed an amazing acoustic set – and obliged with an encore when the crowd wanted more. Steve was vocalist for Sydney's long lasting punk rock band "X" & the only survivor of the original 4 piece line up. He has had a long career in the Australian music scene.

Ashley R Rivers: Dead Echoes. Ashley & his musical partner Allky Lamont kicked off the night with songs from his 3rd LP.

Sam Sejavka: A dramatized monologue about an everyday object. Sam is a writer of fiction and plays and the singer for 'The Ears', a seminal Melbourne post-punk band of the early '80's.

Aidan: Acoustic guitar set. Adrian played a mostly improvisational & down tempo style set.

Feenix: A mind bending performance to "BORN SLIPPY"with her tripped out LED hoops. Feenix is a performer, teacher & creator, who started hula hooping at the Rainbow Serpent Festival, after taking acid & getting stuck in a loop with a hoop for 4hrs!

Phil Motherwell: Reading of 'The Native Rose'. Phil, an actor, playwright & poet, read from one his best loved plays "The Native Rose" – a perfect choice for the night.

Sam Starr: A Hoop show with razorblade finale to "Sex with the Devil". Sam, an accomplished clown, mime artist, circus and versatile character performer brought laughter and delight to the stage by engaging with the audience on a very personal level.

Nacho Regal: Genital Origami Workshop. Well, what can we say about this act?! It contained full frontal nudity – it was none other than "Puppetry of the Penis"!

GIRL: Girl played their own twisted version of sound, affectionately dubbed 'Junk Rock'. Girl's ever evolving line-up currently comprises Arun Sun on vocals & guitar, Loki Lokiss on Guitar & Synth, & an electronic drum kit named BOY. Girl even had their own fan club at the event.

All in all, it was a night to remember. In fact, the 100 or so people who attended are still talking about it. We may be (slightly) biased but we think it's one that will go down in the annuals of time and HRV history.

Nadia.

WWW.HRVIC.ORG.AU

EXTENDING THE REACH OF HARM REDUCTION VICTORIA

HRVic.org Now Online

After many long months of meetings, countless emails, & many trial designs, the HRV website is now online. The brand new site was officially launched on the 6th of June to great excitement - (& the wholehearted relief of many.)

The Design Process

The new site was designed in conjunction with all HRV staff during many meetings during 2012. The old website had become dated & had long outlived its usefulness.

The focus was on creating a new website that would reflect the changing face of HRV during 2013 & beyond, & could be updated to include new technologies whenever necessary.

During the website design period it was also decided that as well as a new website, HRV would benefit from a whole re-branding, hence the new logo designs that are featured in this edition of Whack magazine. The logo designs were the first step in the process of creating a new online presence for HRV.

Logo Design & The New HRV Branding

Part of the new HRV logo was based on the natural shape of a hexagon.

As one of the more complex natural shapes, Hexagon's are found in hundreds of places in the natural world – from molecules to snowflakes, turtle shells to rock formations & are also the major building block within beehives.

Within the new logo, the surface of the map of Victoria is comprised of hexagon shapes, & these shapes are made up of hundreds of smaller hexagons. This was not simply a nice graphic choice but a carefully considered decision concerning the symbolism behind the hexagon. The smallest hexagons represent all the individual people in Victoria (& beyond) that make up our community.

The larger hexagons represent the groups that comprise the larger elements of the user community such as outreach services, NSP's, etc.

This completely unique community is made up of many different people from all walks of life, age, sexuality, culture, religion etc. & together, we make up a group like no other. The only thing common to everyone is that we all have had experiences with drugs.

There are many similarities between the using community & the close knit insect community within the beehive. The most obvious similarity is the way that we are all singularly focused on many of the same issues. As bees work together side by side for their common goal, we come together to work for positive change for our community.

The Outline

As we enter the age of social media where the internet has become more than just a novelty but a vital connection within our society, it has become increasingly important to have a defined online presence. During late last century when internet sites were seen as little more than online business cards, it wasn't quite as important to have a website as most of the media information that came out of the organisation was centred around '**Whack!**' magazine.

As information becomes quickly digested by the increasingly tech savvy audience of today, it has become increasingly urgent for consumers to search out information the very moment that they need it – not waiting until it is released. Although it was very well designed & executed, the previous website was little more than an online business card. HRV required a new site-

- that would feature a constantly evolving portal of up to date information, that would be easy to update, ugrade, & change, & a site that would keep all our constituents in the loop with all the latest news & developments.

One new development that we wanted the site to display was user friendly forums where users could easily find information on a range of topics.

This would be especially useful whenever there was new developments that HRV wanted consumers to be aware of, such as changes in policy, workshops & other relevant information. It would enable the workers at HRV to facilitate work-shop type information sessions online for constituents at a prearranged time. The information would also be able to be accessed by anyone who needed it at a later date, which could prove beneficial e.g. new laws, bad batches of certain drugs, updated resuscitation techniques etc.

One of the other ideas that came from the communication meetings was the need to branch out into social media such as Facebook & Twitter. As of June 2012 we are prominent on both Facebook & Twitter. This has enabled us to communicate with our constituents on important issues in real-time. It is especially useful as aside from being in real-time, it is a valuable tool for people to communicate their thoughts and ideas with us in a 2 way dialogue. Some of the submissions for this issue of Whack! magazine came via the facebook page.

Some of the new features of the site:

Search Function:

The search function was an important part of the redesign of the new site as HRV wanted people to be able to access the information they required as quickly & effec tively as possible. The search function has the capability of searching through all information, both within the site, & throughout the web using the Google search engine.

Home Page News Feed:

The articles featured on the home page feed are updated almost every day. They link the viewer to numerous articles using both internal & external information sources. Every time we come across information of interest, it will be posted here. The info will include links to other versions of the information featured.

Dynamic Pages:

Each page on the site is now able to be updated on the fly - whenever information changes etc. This is not limited to just text, it also goes for images, movies & sounds. This means the pages will change on a week to week basis so there will always be new content available for our audience.

Digital Movie Clips:

The new site will feature many movie clips within its pages. These range from short informational clips to larger documentary style pieces. There will also be informational games relating to the subject matter we deal with available in the future.

Web Forum:

As part of the site there will be a web forum which is an online discussion site where people can hold conversations in the form of posted messages.

Most messages will be archived & users will be able to access the forum at any time to see any of this information, post queries and replies.

The forum will be predominantly used for HRV specific projects and online workshops at pre-arranged times, although it will also be used for other things such as informing users if a bad batch of heroin is around etc.

The Entire Whack Library:

The HRV media page displays the vast majority of information that HRV has produced since 1987.

The entire online library of every VIVAIDS/HRV magazine produced from 1987 until the present day has been made available.

The archives document the entire history of **Whack!**, from the beginning in 1987 when it was known simply as **The Vivaids Magazine.** Then came **Mainline,** & then **The New Mainline**. The magazines are accessible to read online in flip-book form. Flip-books are an online flash based version of a magazine where the user turns each page the same as a regular magazine. The reader can zoom in, print out pages, download, & share with friends.

Other:

All information on the new site will be updated every week. The new content will include new movie clips, new images, new games, new posts, new links, forum, links to all DUO's, general news feed, twitter, face-book & access to tonnes of information which will be growing daily.

Send any ideas, feedback regarding any ideas you have for the site.

Sign up & add your comments to the pages, like us on Facebook, & follow us on Twitter!

We are all looking forward to hearing your comments & seeing more of our readers & members online.

CHRISTIANE F
Wir Kinder vom Bahnhof Zoo

(We children of Bahnhof Zoo) is a 1981 German film directed by Ulrich Edel that portrays the drug scene in West Berlin in the 1970s. It is based on the non-fiction book of the same name and interviews made while following the day to day life of a teenage drug user named Christiane over a six month period. The film was hugely successful and broke box office records all throughout Europe.

The story is set in 1975 and follows Christiane Felscherinow (Natya Brunkhorst), a 12 year old girl living with her mother and sister in gloomy Gropiusstadt in West Berlin, an area dominated by high rise apartment blocks.
Bored and eager for excitement in typical teenage fashion Christiane sneaks into the city discothèque 'Sound' and meets Detlev (Thomas Haustein), a slightly older boy she falls in love with. To impress him she begins experimenting with various drugs which eventually lead to heroin.

This is where the story really begins.
They show her life over the next two years as she delves deeper into drug addiction and sex work.
Although the film was created as a vehicle for scaring kids away from drugs, many did not view it that way. It was however, the director's intent to try and put people off the drug scene by using stark realism and sparing no grim detail. We see Cristiane shooting up in dirty public toilets surrounded by vomit and faeces, hustling and prostituting herself to overweight middle aged men.
The withdrawal scene when Detlef & Christiane try to kick heroin together is a brutal sequence, and absolutely realistic. Despite these gritty & uncompromising scenes, the film did not have the intended outcome for many young people who attempted to emulate the look and behaviour of Christiane, and the popularity of Bahnhof Zoo as a teenage hangout actually increased following the film's release. The popularity of the movie was also greatly boosted by David Bowie's participation, who appears as himself in an early concert scene and also provides the bulk of the soundtrack.
The film captures the desperation of addiction, and how in certain circumstances, users' lives can become all about the next shot. It also does a great job of conveying the desolation of the Berlin - Zoo train station, a haven for sex workers and addicts during this time. This is no glamorized Hollywood movie using mid-twenty year old actors as teens.
The cast is made up of young first timers, and most of the extras were drug users and sex workers from around Bahnhof Zoo. Only the ending rings hollow, with Christiane leaving Berlin to stay with family in the country.
The voice over then states that she overcame her addiction and leaves the impression that she was barely affected by the past few years, which was apparently far from the truth.

Regardless, this is still an amazing cult movie.

THE REAL CHRISTANE F

Christiane F, otherwise known as Vera Christiane Felscherinow, shot to prominence with the portrayal of her life in the now cult classic German movie named after her.

She initially came to the attention of reporters as a witness in the trial of a man who'd been using under age sex workers and paying them with heroin.
Shocked at the extent of teenage drug use, and intrigued by its attendant sub culture, reporters at Stern magazine reporters decided to interview Christiane over a couple days for a feature story.
The two days turned into two months and they ran several articles describing the life of her and her friends. They then published a book titled Wir Kinder vom Bahnhoff Zoo (1979) which spanned four years of her life (ages 12 - 15) on the streets. The movie (released in '81) was the largest grossing film in Germany that year and became a worldwide success.

The real Christiane became somewhat of a celebrity in the process. Despite the movie's unvarnished depiction of the pitfalls of addiction and street life (it became required viewing in many schools for its anti-drug message) it inadvertently was seen by most to be glamorous. I saw it at 15, and like most of my latter peers (i.e. fellow users) was enthralled by the seeming exoticism of urban Germany and romanticised the excitement of Christiane's life.
It provided an aspirational contrast to the stifling boredom of middle class Australian suburbia.

THE REAL CHRISTIANE F.

The real life Christiane was herself unquestionably beautiful.
But if that wasn't enough, the appearance of a David Bowie concert scene, and the soundtrack he provided to the film cemented its reputation as a quintessential junkie style bible of its time.
Christiane grew up in the working class suburb of Neukolln characterised by its dreary, grey surrounds and rows of high rises.
It's also the name of the instrumental track from Bowie's Heroes album, inspired from his stay in Berlin.

Trying hash at 12, Christiane soon began dabbling in other drugs including acid and pills.
At 14 she had begun using heroin and was supporting her habit through sex work at Berlin's largest railway station Banhoff Zoo along with many other teenagers, including her then boyfriend Detlef. The station was as much a hub for male sex workers as it was for females.

The media never lost interest in Christiane's life story checking in with her from time to time.
One of the more prominent follow up stories appeared in Stern magazine in 1984 when Christiane was 23.
The article was scathing. It described her apartment as squalid with details of decrepit furniture, dogs fucking & dog piss soaked newspaper.
A photo was included of her alongside a coffin used as decor.
It's fair to assume the judgemental tone of the article stemmed from the fact her life deviated from the redemption story the public had hoped for.

A recent photo of Christiane

Christiane had stints on methadone, but continued to use heroin for many years. She was once busted for possession and did prison time.
"I've seen alcohol cause a lot more damage to people's lives than heroin" she said in the Stern interview.
The article highlighted the benefits she'd reaped from her fame—unfairly, in the opinion of the journalist—which included extensive world travels and perks such as dining in Rome with Fellini.
Her involvement with the movie as an advisor contributed to the millions of Marks she earned, however by the time of the article she was bankrupt.

If Christiane cared about how the public perceived her, though, it certainly didn't show. She responded to many of questions by talking about an unrelated topic, coming across as glib and disinterested.
Much was made of her 'empty headedness'. In her defence it's highly likely she was reacting to the undisguised tone of hostility from the journalist.

They demanded to know why didn't she feel responsible to help other addicts?

She talked about how she detested conversations, couldn't stand reading newspapers and preferred to lie in bed watching TV.
She may have been playing up to the journalist's expectations of her, but there was a depressed and despondent tone to her comments.
By then she'd lost custody of her young son to a state institution.

She stated she often didn't eat. That she didn't make plans as she'd get depressed when they fell through and consequently had forgone "any dreams or wishes.".

She sounded disappointed and disillusioned ("I don't like people anymore") and spoke of her desire to move to the country and live a life helping animals. She talked about feeling let down by friends and boyfriends, yet hated being alone. It would appear that her stumbling into fame was a millstone as much as an opportunity.
But the Stern article downplayed her accomplishments.

She was in a band called **'Sentimentale Jugend'** who released several albums (see clips on YouTube). She also scored a part in the movie 'Decoder'.
As for Detlef, the only reports of him have been his appearance in gay porn movies.

Christiane continues to receive intermittent media attention. She has remained an animal lover and is an equestrian. She continues to receive fan mail today.

The real life Christiane F has had a strange fate: feted and detested. Famous for simply being a heroin addict, she's been judged harshly by some, whilst put on a pedestal by others.
Girls imitated her, Japanese tourists would visit Banhoff Zoo station as if a shrine, and she continues to receive intermittent media attention to this day.

When the movie was made Christiane could never have guessed how huge it would be, or foreseen the enduring interest in the details of her life.
At times she was out of her depth with little practical support to help her navigate her celebrity all the while being scrutinised by her nation.

I hope she's found her journey through life as fascinating as the world has found her.

Christiane F Film Reveiw
Arnah- Key 2013

The Real Christiane F Article
Zuni Zuccutti 2013

POSSIBLE PATH TO SPIRITUAL

One (re)emerging trend I would like to draw attention to is that of the entheogenic experience. More specifically,the use of entheogenic plants such as Ayahuasca, Peyote, San Pedro, and certain mushroom species which are being used (and have been used for centuries) to explore, discover, unfold, develop, generate, or manifest the divine within.

While the West has appeared to view the use of these substances as trivial leisure activities, producing hallu cinations of some sort or nature; Ross Heaven and Howard Charing point out another perspective in their book Plant Spirit Shamanism.

"For the shamans, we are all dreaming (or hallucinat ing) all of the time. Our modern cities and ways of life are the dreams of the West, embodying a myth of what the world is or should be.

Fundamentally the Western dream is one of separation and disconnection from the flow of things, where competition, conflict, and challenge are the norm… Sacred hallucinogens are the means of breaking through this trance of the social dream into the expansive, freeing, information-rich universe full of infinite possibilities for other realities and futures. These plants do not lead us away from ourselves, into an unbalanced frame of mind, as our doctors and politicians warn, but deeper into ourselves and our potential; to a place where we can find greater balance through genuine self-awareness."
(Heaven & Charing)

That is, enter into a truly spiritual experience whereby mystical states of consciousness are achieved and we are able to see the 'mists of socialization' as Terrence McKenna would say. These states, I would maintain are simply higher order functioning of what is often termed 'ordinary waking consciousness' which is ordinary only in the strictest sense of 'statistically most frequent' and should not imply value judgements. More importantly it is the unfolding of the experience afterwards, its expression into some symbolic form, something communicable, an expression of creative surge, an inspiration.
Stanislav Grof, who has spent over fifty years researching consciousness, doing much to develop our psychological cartography to include transpersonal states and realms, captures this idea nicely through his elaboration of holotropic states of consciousness:

Holotropic: 'This composite word literally means "oriented towards wholeness" or "moving in the direction of wholeness". This term suggests that in our everyday state of consciousness we identify with only a small fraction of who we really are. The best way of explaining what holo tropic means is to refer to the Hindu distinct -ion between namarupa (the name and shape with which we identify in our everyday existence) and Atman-Brahman (our deepest identity which is commensurate with the cosmic creative principle). In holotropic states of consciousness, we can transcend the narrow boundaries of the body ego and reclaim our full identity. We can experientially identify with anything that is part of creation and even with the creative principle itself.
(Grof, 2012)'

While these seem to be ideas newly emerging in the 'Western' psyche, as Terrence McKenna has eloquently described, it is more akin to an 'archaic revival'. That is, we in the 'West', the so called 'developed' world, are reawakening to the spiritual wonder which the ancients knew well, and which still survives in those few remaining cultures who maintain the ancient traditions.
My particular interest then is the ancient tradition of plant shamanism. Although it requires some stretch of the imagination, I don't think it is farfetched to claim it is at least 50,000 years old. There is archaeological and historical evidence of the spiritual and healing use of sacred plants found throughout most, if not all documented cultures and is common to cave art throughout the world. The sacred plant brew that has been on everybody's lips recently has been the revered Ayahuasca, but other familiar examples are the Peyote, and San Pedro cacti (cave paintings dating 10,000+ years ago), and Psilocybe and Fly Agaric mushrooms (connected to the ancient soma tradition within the vedic texts).
What is most important is not what particular path you utilize, but rather the intent, the respect, the compassion towards all beings, all life, the sense of entering the spiritual; the sacred.

Obviously there are other paths available besides plant teachers, as the range of mystical traditions will attest; what is needed is a disciplined and integrated life. "The power of visionary plants requires that they always be taken in a ritual setting … with an intention and purpose in mind-for self-understanding and meaningful connection with a greater-than-human-reality – and this setting and intention contribute to their effects as well." (Heaven & Charing).

The 'Western' fascination with the Ayahuasca brew seems to be the fact that with over 80,000 species of plants growing in the amazon, somehow the indigenous people discovered the technique of combining two separate plants that would appear completely unrelated, and create a path to the spiritual and mystical realms of reality. Modern science has only been able to describe why this happens, in terms of certain chemical reactions, since the 1950's.
Indeed, as Jeremy Narby points out science only discovered the double helix structure of DNA sixty years ago through the work of Francis Crick and others. Yet this information was known to the ancients and is still alive in remaining shamanic traditions

RECONNECTION IN THE WEST

as displayed through the symbology and mythology of the intertwined serpents. Indeed all this information can be personally experienced today through the aid of the ayahuasca brew and the guidance of an experienced shaman as demonstrated in the documentary, Other Worlds. Indeed if we delve further into the work of Francis Crick we find that he had in fact experimented with LSD when it was still an experimental drug to 'boost his powers of thought'.

LSD is itself synthesised from an ergot fungus (which has links to the Eleusinian Mysteries of Greece) , so perhaps we have more of an insight now into how the people of the amazon came across such knowledge. Nature is speaking to us giving us intimate knowledge as to her workings and underlying processes: 'nature manifests opportunities, possibilities to go beyond the constraints of the everyday mind'. Through developing a relationship with the plant teachers, the maestro plantas, it is viewed by the shamans that we can enter into dialogue with their deeper spiritual intelligence, and that this intelligence wants to help us understand, and to help heal, and thus opens doors to different dimensions.
The plants are our allies, they aid us in developing a better understanding of ourselves and our place within nature. We become explicitly aware of something along the lines of a Gaian consciousness, so that a more spiritual dimension is added to something like James Lovelocks Gaia theory. We can tap into the creative principle that underlies all, and re-align ourselves within the flow, within the world ecosystem, with life everywhere, with Spirit. This idea can be seen in Rak Razam's Aya Awakenings, where he is talking about a generational shift, a change in the spirit of the age.

This further emphasises this need to communicate the experience to share the transformation with others. We need to discuss the wider social implications that are raised through a deeper understanding of life processes and help to create more harmony and connection.

Our aesthetic sensibilities need to be engaged. These sacred, entheogenic plant teachers provide us with a more holistic universal vision of life, one of incredible beauty, and intricacy. If we just open ourselves up to the deeper levels of the communication from nature, the dialogue, the exchange, the spiritual union we will be healed and thus lead to the healing of others, our hearts will open. The task is then to communicate your vision to the rest of the world through whatever medium or means you feel called towards.

"The word hallucination might imply a primarily visual experience, but for the shaman it is more than that. Visions may come, of course, but teacher plants also bring with them an intense experience of ecstasy and oneness with the world, deep and profoundly meaningful insights, a searchlight on our hidden thoughts and feelings, through which our egos can let go and we can merge with a greater field of creative consciousness. It is the realizations, not the images that are visionary. The hallucinogenic, as a total experience, offers a doorway into the hidden realms of human consciousness and the spiritual intelligence of a living planet."
(Heaven & Charing)

As the 'magic mushroom' season is about to commence in Victoria, I think these are important ideas to hold in mind. For more information on the safe use of such entheogenic substances, visit erowid.org.

In conclusion then, rather than implying that there is a normal state of consciousness, and anything other than that is altered, I would suggest it is better to think in terms of a continuum whereby qualitative shifts take place, rather than a change of type. Through certain practices it would appear that we can develop a conscious awareness, of a deeper, richer, more finely woven quality of consciousness as expressed through nature. That is, we can begin to see, or process more interconnection in the overall pattern. A denser image of the fractal becomes illuminated through a specific inflection of consciousness.

Or to use another metaphor, we begin to understand that anything we might like to call a self or our experience of consciousness is more like an eddy in a river or stream.

We are semi stable patterns in the overall flow of consciousness, of spirit, of nature; patterns that would have no existence without the overall flow. The creative principle itself is this flow, this process.

Ed Spencer, 2013

References:
Grof, S. 2012, Healing Our Deepest Wounds: The Holotropic Paradigm Shift, stream of Experience Productions,
Heaven, R. & Charing, H. 2006, Plant Spirit Shamanism, Destiny Books,

THE NEW WORLD OF EMERGING PSYCHOACTIVE SUBSTANCES

Continued from Page 9

As far as new synthetics go, piperazine derivatives are relatively mild. BZP has only ten percent of the potency of d-amphetamine, and there have been no fatalities listing it as the immediate cause of death. Effects seem to range between those of weak speed and something resembling ecstasy - but users have complained that unpleasant side-effects can tend to outweigh the pleasure of the high. Other piperazine derivatives used recreationally include mCPP, TFMPP, pFPP and 2C-B-BZP, all of which are sold globally under any number of brand names. A significant percentage of black market ecstasy sold today contains piperazine derivatives.

Claims that these compounds are natural extracts of the piperine-containing pepper plants are false – they are entirely synthetic.

*

The Cathinone Derivatives are a somewhat more serious kettle of fish. Under the moniker Bath Salts these compounds (usually mephedrone, methylone or MDPV) have caused a media frenzy in the US, where users – in a state called Excited Delirium – have, variously, climbed telephone poles, danced through oncoming traffic, and stabbed a neighbour's pygmy goat to death while wearing lingerie. The term 'bath salt zombie' entered common parlance after the causeway cannibal incident in which a man was erroneously thought to have consumed bath salts before eating off the face of a vagrant.

But how bad could they really be, one US consumer asked, 'hanging there on the rack beside the Slim Jims, energy drinks and caffeine tabs at the local Bag-and-Drag minimart?'

This is not an easy question. Extreme incidents are almost certainly due to overdoses, but one must also consider the unknown toxicology of any untested drug. They have been linked to fatalities in the European Union and in the US they have caused a surge in emergency room visits. Yet, in the UK, mephedrone (the most common cathinone derivative, known as miaow-miaow, M-cat etc), was - according to a poll conducted by the music magazine MixMag - the fourth most popular drug of the year 2010.

Cathinone, the parent compound, is the active ingredient in khat (Catha edulis) a plant from Arabia and North-East Africa, the leaves of which have been chewed for thousands of years. The ancient Egyptians believed it was a food of the gods, that its use made one divine. To this day it is customarily used as a social-lubricant, rather like alcohol.

Any number of derivatives were devised through the 1900s, most of which were forgotten until the rise of the legal-high phenomenon. (During the 50s, Methcathinone was used as an antidepressant in Russia and is still used there recreationally.)
The various effects of these drugs are described as combinations of ecstasy, cocaine and amphetamine – with comparable pros and cons. The high, like that of cocaine, is said to be short-lived. The molecular structure of mephedrone is similar to both those of ice and ecstasy, and in lab tests animals self-administer mephedrone and MDPV at higher rates than methamphetamine.

The most popular cathinone derivatives have been banned more or less globally, but have remained available on the illicit market, and, as with the piperazines, are often found as adulterants in ecstasy pills.
Like so many of the new synthetics, they are believed to be manufactured in China.

In moderation, these drugs are far from deadly - but some are worse than others, the long-term effects are unknown, and there is an everpresent chance of overdose. A fatality linked directly to mephedrone was recorded in Sweden in 2008 and many others have occurred in combination with other drugs.This is aside from the profound toxicities caused by over-use, symptoms of which involve the bizarre behaviours mentioned above – as well as seizures, hallucinations, self-mutilation and psychosis. Another concern is the possibility that mephedrone metabolises into a known cardiotoxic compound.

A cathinone derivative called naphyrone (NRG-1, identified in 2006) was one of the prominent substitutes which appeared after Mephedrone and its relatives were banned. Reviews were varied: users were said to feel either like a cosmic deity, or driven to 'tear out their own eyes'.

This poses an obvious danger. What's more, the naphyrone molecule has something called a naphthalene ring which is a strong indicator of carcinogenicity. (This is related to the removal of naphthalene from traditional mothballs.) The appearance of naphyrone underscores one of the many conundrums faced by regulatory authorities: it seems they have banned one drug, only to have it replaced with something significantly more dangerous. And who is to say that when they ban naphyrone, whatever is next in line will be even more hazardous?

*

The three classes discussed above cover most of the synthetics, but substances from ever more obscure chemical groups are continually hitting the radar. Remember? A new drug every six days? Phenylethylamines, tryptamines... phencyclidines...

*

But now we turn to our final category:

Natural Psychoactive Substances.

In the UK, of the top ten legal highs most often offered online, three of them – kratom, salvia divinorum and magic mushrooms – are natural products whose use originated in traditional societies. Such drugs are increasingly being unearthed and introduced to the wider world. They are eagerly sought after by the psychonauts and many have become popular in dance subcultures.

Often, they are hallucinogenic but, really, they could be anything at all. This class of drugs is described more by origins than effects.

As with all the emerging substances, it is the internet that has facilitated the growth in their use: they may be purchased in darknet marketplaces like Silk Road; experimenters share reports of their experiences on on-line forums like Bluelight.ru or Erowid, and videos of individuals experiencing the effects of who knows what leaf or spore or grub are legion on YouTube.

Some of these highs remain legal, the authorities have caught up with others. We'll have a quick look at a couple of the most widely used: firstly, kratom and then Salvia divinorum.

Mitragyna speciosa is a tree native to the eastern tropics. Its leaves contain upwards of forty phytochemicals, not a few of which are psychotropic. The Thai people know the tree and its byproducts as kratom and this is generally how it is referred to through the world.

The leaves, either fresh or dried, are chewed or used in tea, sometimes as a traditional medicine. At low doses, kratom is a cocaine-like stimulant and is often used by workers to maintain energy levels. At higher doses it becomes narcotic and has even been used as a substitute for heroin.

Though the main active compounds - Mitragynine and 7-hydroxymitragynine - have been identified, kratom has a unique pharmacological and behavioural profile which has yet to be untangled. As a crypto-opioid, it can cause dependence, but withdrawal symptoms are not severe; indeed, on occasion it has been used, like methadone, to wean people off hard-core opiates.

Continued next page

THE NEW WORLD OF EMERGING PSYCHOACTIVE SUBSTANCES

Salvia divinorum, or 'the diviner's sage' is a shamanic drug par excellence. Originating in Mexico, it has been used ceremonially by tribes-people since history began. The active ingredient, Salvinorum A is a classic hallucinogen, like LSD, but the effects are notably short lived.

Since the late 1990s, it has become increasingly popular. The leaves (dried will work, but fresh are best) are now widely available through the internet and in specialty shops where the plant is not regulated. Traditionally, like kratom, it was either chewed or boiled up in tea, but in the Western world it is most commonly smoked. This method leads to an intense high that can last only minutes. The toxicity of S. divinorum is unknown, but a bad trip is on the cards if too much is smoked.

Using some very doubtful reasoning, Australia became the first nation to ban salvia. There was no available evidence showing it to be harmful, yet still, apparently, it had the potential to be 'abused.' Wikipedia has unearthed a particularly sad quote from the decision-making committee: "there was no evidence of traditional therapeutic use other than in shamanistic healing rituals."

*

So there you have it. A rough guide to the new and developing landscape of recreational drug taking.

Drugs are changing at the speed of life and the speed of life is accelerating.

To quote Mike Power, who is addressing the subject in a soon to be released book called Drugs 2.0, 'the online market in narcotics isn't just changing the way drugs are bought and sold; it's changing the nature of drugs themselves.' In case you haven't yet got the drift: it's the internet and the radical new freedoms it gives us to scurry from the spotlight glare of traditional authority.

And the authorities, as authorities will, are working themselves into a lather. Reading the long reports that come out of the European Union and the UN, there seems to be a base belief, buried behind every line, that recreational drug-taking is simply bad. Wrong. Forget the social and personal impacts.

Of course, they do have have good reasons to be concerned. Many of the new synthetics are unsafe, and still more are unknown quantities. Pharmaceutical companies spend vast sums researching and trialling drugs, but only a small percentage ever reaches the shelves - some because they don't work, but a great many because their safety cannot be guaranteed.

Whether we like it or not, we are protected, and this is the protection we are shrugging off when we enter the realm of the new legal highs. It's a dangerous road. Should we have the liberty to take it?

Well, that's an argument for another time, but our guardians certainly believe we should be cut off at the pass.

But they have a problem. The phenomenon generates a rat's nest of legalities, rights and responsibilities.
Some small nations have attempted blanket bans on whole classes of substances, but, as sure as the day is long, new classes will emerge.

Can blanket bans on classes of drugs work?
Well, remember from the last issue of Whack how the left-handed isomer of methamphetamine is used as a bog-standard nasal spray? Well, if you ban whole categories of molecules, you might find yourself banning fabric softener and shoe polish as well.
Some governments have gone some way in prohibiting classes of compounds which display certain properties. In the US, the Federal Analog Act can prohibit chemicals which are 'substantially similar' to controlled substances - if they are intended for human use.
Hence the crafty labelling of 'bath salts' and 'room odorisers' as not for human consumption.

The comparison made above between mephedrone and naphyrone underlines another quandary facing authorities. Dr Huffman (of JWH fame) has said that, if marijuana were legal, he would recommend people take it over any of his synthetic cannabis substitutes.
Might it be good harm reduction policy to legalise (or at least take the heat off) the drugs we know so as to avoid users venturing out from between the flags?

A thorny question, especially for politically driven legislators.

Then there is the fact that substances existing in this universe are legal unless specifically legislated against.
Even if a substance is found to be psychoactive, this does not mean it can be arbitrarily banned.
It should be shown to be harmful. Research has to be done, evidence collected, reports penned before a government can act – and this is a slow, laborious process at the end of which there will probably be a whole new slew of substances to consider.

Often governments just give up and ban without due diligence.
Not a practice that sits easy with free and fair democracy.

In The EU, to ban a substance it must be proved beyond reasonable doubt to be harmful enough to fail their 'General Safety Requirements.' And intrinsic danger is not enough, otherwise kitchen knives might be criminalised. 'If using ecstasy is, as some say, no more dangerous than horse-riding,' to quote one commentator, then the provision of 'appropriate warnings and advice' might be sufficient for it to pass this test.

In the end, I pity those whose job it is to come up with a sensible response – one that balances public safety, personal freedom and harm reduction.
The existing models of drug control are plainly under challenge, and in the end, given the power of the Net, what they come up with may make very little difference at all.

Governments are increasingly reacting, forming international organisations to share information as they monitor trends in use, manufacture, distribution etc, but one wonders if the horse has bolted.

While we wait for the bureaucrats to get their shit together, the responsibility falls, inevitably, on our heads.

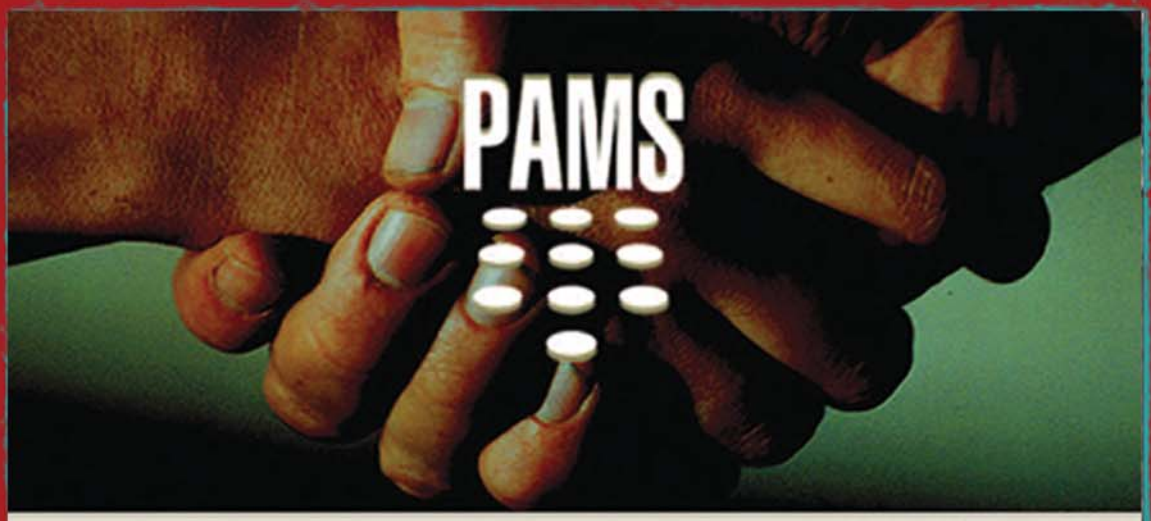
So, treat these drugs with the respect they deserve. Mind your dosages very carefully.

I suspect that the historically ineffective nature of legal highs may have led to a general belief that, for anything legal to work, it needs to be taken in quantity. Almost every report of bad outcomes from the new drugs reads, to me, like overdose.

If you've done your research and feel you know what's in your Banana Cream Nuke packet, and that you can trust how much they say is inside, if they do, remember that it is still an unknown, with no research behind it.

I have the feeling that a lot of harm could be reduced if explorers were to approach these fascinating substances in small, careful increments.

The Golden Phaeton
March 2013



PHARMACOTHERAPY
ADVOCACY, MEDIATION
& SUPPORT

Having problems with your program?

Want to know your options?

For help call PAMS on

1800 443 844

or (03) 9329 1500

OPEN 10AM - 6PM. MONDAY - FRIDAY

CHECK OUT OUR NEW WEBSITE!

WWW.HRVIC.ORG.AU

Back issues of Whack plus everything you need to know about HRV and PAMS are just a click away at:

www.hrvic.org.au

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

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

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

Name: .....

Address: .....

..... Postcode: .....

Phone: ..... (please tick) ☐ Personal - FREE

Fax: ..... ☐ Organisations - $60.00

Email: .....

Please POST to :

Harm Reduction Victoria
Membership
PO BOX 1272C
A'Beckett Street
Victoria 8006

Or FAX to:

03 9329 1501

FIND A WORD

Once you have found all the words, write down all the left over letters to see a very important message!

E	B	O	N	G	E	C	A	P	S	R	E	N	N	I
G	N	E	R	P	S	C	T	A	B	L	E	T	O	F
N	R	P	P	I	H	H	M	A	R	G	I	D	V	I
I	H	O	C	P	A	O	A	L	B	P	E	E	E	L
R	E	D	W	E	R	P	O	T	U	O	C	A	R	T
Y	A	M	X	S	P	E	E	D	S	S	I	L	D	E
S	L	O	O	N	S	R	E	S	T	T	L	E	O	R
E	T	O	U	N	C	E	A	O	O	M	O	R	S	V
N	H	R	A	I	V	L	N	H	E	A	P	E	E	R
O	W	G	H	S	L	E	S	P	S	R	R	J	I	R
X	O	N	E	E	D	L	E	O	E	G	I	O	O	O
O	R	I	T	V	R	I	P	U	L	D	S	I	F	B
B	K	V	I	C	E	O	E	N	A	L	O	N	I	S
U	S	I	H	I	G	H	I	D	C	I	N	T	T	S
S	I	L	K	R	O	A	D	N	S	K	C	A	H	W

AIVL	GRAM	KILOGRAM	PRISON	SUBOXONE
BONG	GROW	LIVINGROOM	RIP	SYRINGE
BUST	HEALTHWORKS	NEEDLE	ROBS	TABLET
CHOPER	HEROIN	OUNCE	SCALES	TIP
CPR	HIGH	OVERDOSE	SHARPS	WHACK
DEALER	HIT	PEER	SHOT	
DOPE	ICE	PIPE	SILKROAD	
FILTER	INNERSPACE	POLICE	SPEED	
FIT	JOB	POT	STONED	
	JOINT	POUND		

SURVIVAL GUIDE

Following are some numbers, websites, addresses etc. for resources that might be useful when you're in need. It doesn't contain everything, but should give you the tools if further research is neccessary.

DirectLine (1800 888 236 [24/7]) is always a useful first port of call. The Fitzroy Legal Service (www.vicdrugguide.org.au) has an Online Services Directory for drug/alcohol users which is currently being updated and may be another good starting point.

Local councils are a reliable source of information.

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

Click 'Search' and use a keyword ie drugs/alcohol.An NSP & Legal Guide is said to be coming soon on the AIVL site: www.aivl.org.au. AIVL are very enterprising web-wise and their site is a treasure trove of info.

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 542

SELF-HELP CRISIS COMPLAINT

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
Home ground: 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.au/
Northern Territory AIDS & Hepatitis Council (NTAHC)
08 8944 7777 www.ntahc.org.au
South Australian Voice in IV Education (SAVIVE)
08 8334 1699/www.acsa.org.au/savive.html
Western Australian Substance Users Association (WASUA) 08 9321 2877 www.wasua.com.au

EMERGENCY PHONE NUMBERS

Police fire ambulance: 000
Child protection: 131 278 (24 hours)
Reverse charge: 12555
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 Dona-
tions 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

HEALTH/TREATMENT Including Pharmacotherapy, Rehab, Detox ...

Your local community health centre is a recommended starting point.

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

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

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

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

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

Prescribing GPs sometimes have lists, otherwise try DIRECTLINE (1800 888 236) or
PAMS on 1800 443 844 (free call statewide)
or 9329 1500

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: 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

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

Access Health
31 Grey St
ST KILDA
Ph: 9536 7780

DETOX FACILITIES

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

Moreland Hall: Withdrawal Services
26 Jessie Street
MORELAND
Ph: 9386 2876

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

Windana Society: Drug Withdrawal Unit
88 Alma Road,
ST KILDA EAST
Ph: (03) 9529 7955
Assessment:
Ring at 10.00pm
Mon/Wed/Fri

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

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

DirectLine -1800 888 236 (24/7)

Sexual Health

Melbourne Sexual Health Centre:
9347 0244 / 1800 032 017 (toll free)
Action Centre: 9654 4766
Family Planning Clinic: 9429 1177
Aids Line: 1800 133 392 (toll free)
Hep C Line: 1800 800 241
Victorian AIDS Council: 9865 6700 / 9827 3733
Victorian Aboriginal Health Service: 9419 3000

Women's Services

Women's Domestic Violence Crisis Service:
9373 0123 /1800 015 188 (toll free
Women's Information & Referral Service: 1300 134 130 Drop in centre 10.30am-5pm Mon-Fri
Women's Refuge Referral Service:
9329 8433 /1800 015 188(toll free)
Women's Health Victoria:
9662 3755 /1800 133 321(toll free)
Drug Info Line for Women: 9344 2270
Women's Legal Resource Centre: 9642 0877
Young Women's Health Service: 9548 3255
Flat Out: Statewide Support for Women Leaving Prison:
03 9372 6155

SURVIVAL GUIDE - SHARPS

www.avil.org.au

NIGHT TIME MOBILE SERVICES

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

Foot Patrol CBD	**1800 700 102**
Inner City	**0418 179 814**
North East	**0418 545 789**
North West	**0418 170 556**

Mon - Friday 4.30 pm - 9 am
Weekends - Sat 2 pm through to Mon 9 am

Inner South	**0419 204 811**
CHOPER (Eastern)	**0414 266 203**
Frankston/Dandenong	**1800 642 287**

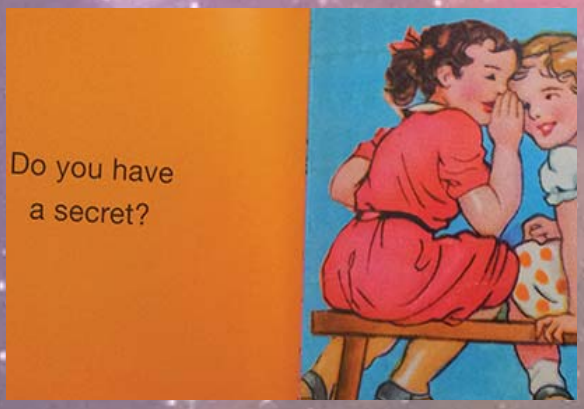
Mon – Fri 5pm – 9am
Weekends – Fri 5pm thru to Mon 9am
Except public holidays

DAYTIME MOBILE SERVICES

(CALL AND ARRANGE TO MEET)

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

Foot Patrol CBD **1800 700 102**
Mon - Fri - 12- 3.15 & 4 - 6.45 pm
Public holidays 12 - 3.45 pm



As these lists are not complete, we advise accessing AIVL's comprehensive list that can be found on the website above, under the NSP listing tab.
To find an NSP (Needle and Syringe Program) in your area, contact DIRECTLINE (1800 888 236). Of course, equipment may be purchased/disposed of at some pharmacies.

FIXED SITE SERVICES

(CALL IN AND PICK UP YOUR EQUIPMENT)

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

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 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
84 Foster St
DANDENONG
Ph: 03 9794 0790

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

Barwon Health
40 Little Malop St
GEELONG
Ph: 03 5273 4000

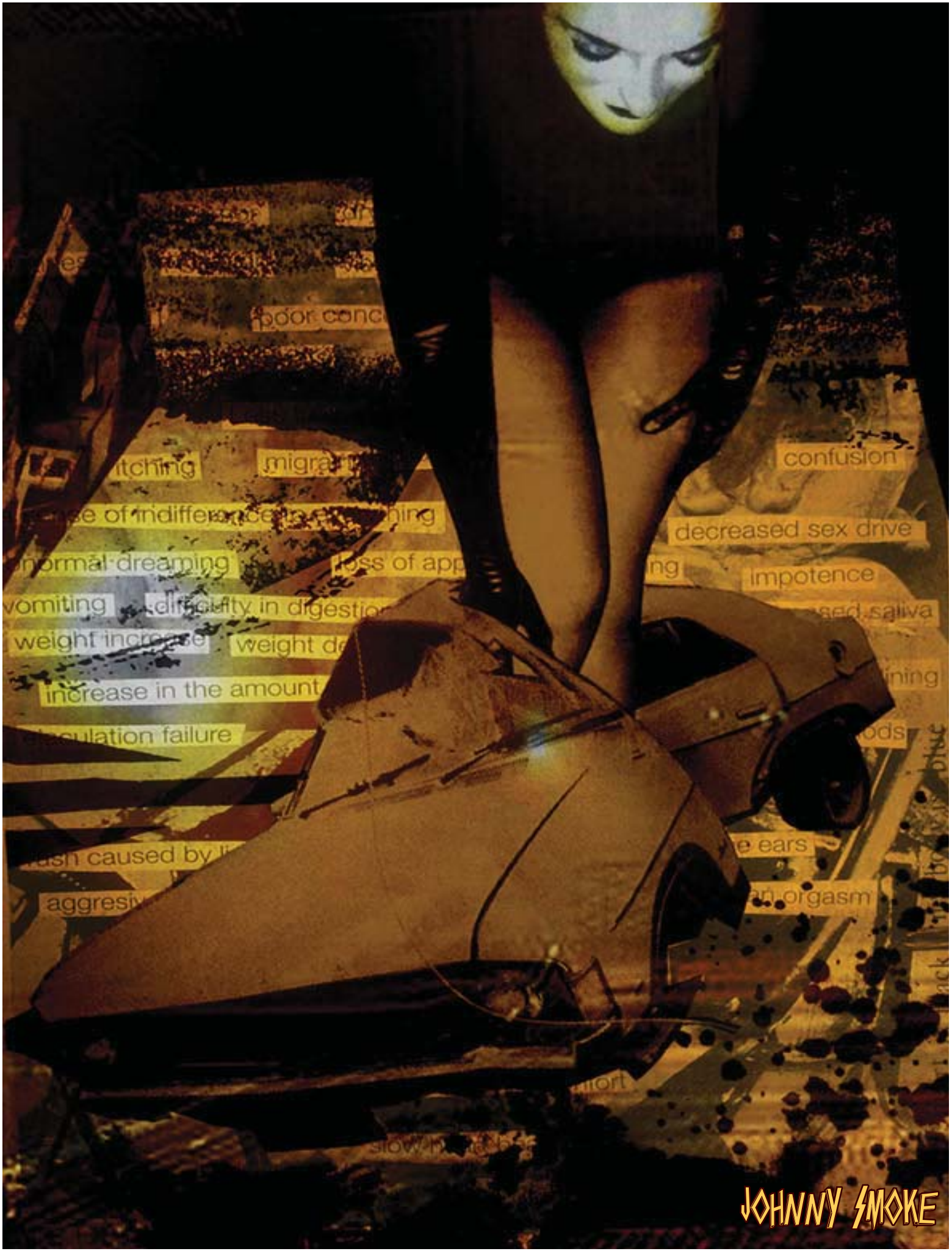
Ballarat CHC
710 Sturt St
BALLARAT
Ph: 03 5338 4500

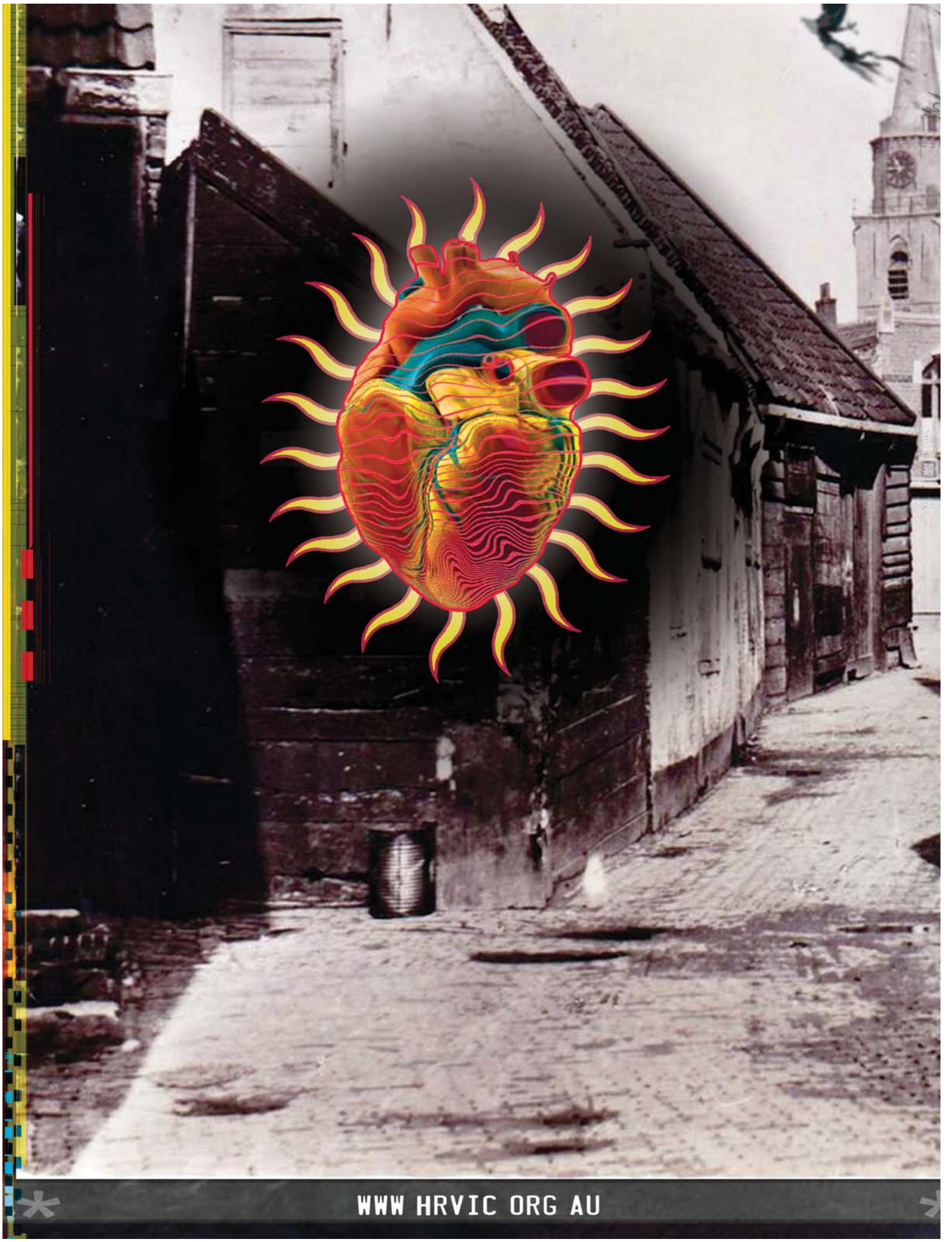
Bendigo CHC
171 Hargreaves St
BENDIGO
Ph 03 5448 1600

LATE NIGHT CHEMISTS

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

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


poor conc
confusion
decreased sex drive
impotence
increase in the amount
JOHNNY SMOKE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