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NSPs are often one of the only interactions drug injectors have with health services. They have the potential to be pathways to other social services, such as housing, legal advice and drug treatment. This edition of the Bulletin speaks with NSPs to find out how they go about building trust with clients.

SOCIAL INCLUSION MODEL FITS TRANSIENT MINING WORKFORCE

Booming iron ore mining around Port Hedland in the Pilbara region is a magnet for thousands of hard working high earners who fly in from right across Australia.

Port and South Hedland are almost 1800km north of Perth, and the closest towns are Broome which is 600km north and Karatha which is about 230km south.

The number of ships transitioning through Port Hedland has increased from 888 in 2006 to 1214 in 2009. The vast bulk of the ships have come from either China, Singapore, Indonesia or Thailand – all important drug transit nations.

Janet Brown manages the Well Women's Centre in South Hedland, which is 16 kilometres from the Port. The Centre runs an NSP, which Ms Brown says increasingly caters to workers within the mining industry.

"It's a very transient town. People come up here with a bit of baggage sometimes. To work, to make millions, to hide. … it's a very interesting mix," said Ms Brown. "People work long hours, they earn a lot of money, and there's not a lot to do. Speed is the ideal drug."

According to the Officer in Charge at South Hedland police station, Snr Sgt Peter Pope, "anecdotally, amphetamines are within the community. I don't believe there's a huge amount of heroin around. The main drug of choice up this way appears to be cannabis, which is brought in because it's generally not grown up this way due to the lack of water."

"Ganja stays in the system longer, but people can use speed on their days off and it can be out of their system before they return," said Ms Brown.

"We certainly know that there are unfamiliar clients, so obviously they are working up this way – they come into the NSP in their work clothes, obviously just off shift," she said.

"People are working 12 hour shifts in 44 degree heat in the middle of nowhere. When you take people away from social supports and social constraints, they behave differently as well.

"2008/2009 was the first time we had a drop in our NSP stats. That probably directly relates to the downturn in the economy. In October 2008 our stats started going down and didn't come up until April 2009. It coincided with the conclusion of some large mining contracts coming to an end at the time, and the economy started to go downwards. It [NSP throughput] really matched the stock-market and the economic situation overall," Ms Brown said.

The NSP was integrated in the Women's Centre. "Most of our clients are still very locally based. 69 per cent of clients in 2008/2009 were male, and 53 per cent of the total number of clients were Indigenous. We have an ability to attract very marginalised Aboriginal males who are always comfortable coming in here."

Between July 1 2009 and March 31st this year, the service had received 1112 client visits and distributed 10,665 fit-packs.

Having the NSP in the centre of the health service meant clients quickly get to know all Centre staff and soon become comfortable attending the service. Ms Brown suggests that because the Centre is a busy women's health service, NSP clients tend to flow through the service often without even being noticed.

"NSPs are usually stuck round the back of places and it was interesting at the Anex conference, [where] I heard comments about children, you know children go there [to health services] so you can't have NSP," Ms Brown said.

However, Ms Brown asserts that all of the Centre's clients are comfortable with the position of the NSP, with NSP clients often coming in and picking up equipment when mothers' groups or other events are running without any disruption.

"One comment I get is how nice and how pleasant they are [clients] and I always say, touch wood, in 10 years we have had a few that warmed up but we have never… [had] a problem".

Ms Brown claims that on days when there are a lot of NSP clients, Centre staff know that a new delivery of drugs has come into town. "We know when there has been a delivery in town when there are a lot of clients coming in the next day."

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Anex's vision is for a society in which all individuals and communities enjoy good health and well-being, free from drug-related harm. A community-based, not for profit organisation, Anex promotes and supports Needle and Syringe Programs (NSPs) and the evidence-based approach of harm reduction. We strive for a supported and effectively resourced NSP sector that is perceived as part of the solution to drug-related issues..

Chief Editor
John Ryan

Editor
Dr Patrick Griffiths

Writers
Lorraine Mapfumo
Elke Mitchell
Dr Patrick Griffiths
Crios O'Mahoney

Correspondence
Anex: Bulletin
Suite 1, Level 2,
600 Nicholson Street
Fitzroy North VIC 3068
Australia

Telephone: 61 3 9486 6399
Facsimile: 61 3 9486 7844
Email: info@anex.org.au
Website: www.anex.org.au

Layout and Design
Kontrast Design

Production
L&R Print Services

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news briefs

MEPHEDRONE/MIAOW MIAOW

Mephedrone, also known as miaow miaow, plant food or m-cat is a synthetic substitute of cathinione, which is commonly found in the leaves of the khat plant, *Catha edulis*. Khat leaves are commonly chewed in certain parts of the world including East Africa. Mephedrone use has been reported in countries such as Finland, Sweden, the UK, Ireland and Australia. Mephedrone is often referred to as a 'legal high' because it is legally sold in countries such as Britain and Ireland. However, it is illegal in Australia.

The majority of mephedrone is manufactured in China and can sell for between £4,450 and £7,120 per kilogram. It is then sold to users, usually online, for £18-£27 per gram or less.

Mephedrone use is increasingly becoming popular and is now ranked the fourth most used drug after cannabis, ecstasy and cocaine. Users have described mephedrone as having similar effects to amphetamine type stimulants, i.e. euphoria, increased heart rate, increased sex drive, pupil dilation and excessive sweating. The increasing popularity of mephedrone use, particularly in Europe has been attributed to successful crackdowns and decreased purity of drugs such as cocaine and ecstasy.

Mephedrone has received significant media attention recently following a number of deaths in the UK reportedly linked to its use. According to British media, mephedrone has been linked to 27 deaths. As a result, the British Government recently announced that the drug has been banned and would be classed in the same category as amphetamines and cannabis.

However, according to New Scientist, 'while mephedrone has been implicated in at least 27 deaths in the UK, it has been confirmed present in just 11 of these cases and at the time of writing found to be a contributing factor in just one.'

Source – YDHF
New Scientist 29 March 2010, – Miaow – miaow on trial: Truth or trumped-up charges?
Available online http://www.newscientist.com/article/dn18712-miaowmiaow-on-trial-truth-or-trumpedup-charges.html?full=true March 2010
News.com.au - Drug 'miaow miaow' banned after deaths
Available online http://www.news.com.au/world/drug-meow-meow-banned-after-deaths/story-e6frfkyi-1225847245185 Accessed March 2010

Preventing Transition to injecting amongst young people: What is the role of Needle and Syringe Programs?

A recent paper published in the *International Journal of Drug Policy* looked at the possible role that NSPs could play in preventing people who are yet to inject from transitioning to injecting.

Preventing people from transitioning to injecting has been shown to be more successful than attempting to influence people to change from injecting to other routes of administration, the article noted.

Consultations were conducted from April to June 2008 with 13 key stakeholders who either work with young people at risk of transitioning into injecting or work in the drug and alcohol field.

There are important considerations for NSPs before taking on any role in preventing transition to injection. These are the primary role and success of NSPs, traditional clients who access NSP, risk of alienating clients due to a focus on prevention and workforce development issues.

NSPs should therefore take a partnership role with services that work with at-risk young people,the authors argued. It is also important for NSPs to ensure that they do not marginalise and stigmatise their clients by focusing on prevention of injecting, as this may lead to a decrease in access to NSPs.

Source: Brener L, Spooner C and Treloar C. Preventing transitions to injecting amongst young people: What is the role of Needle and Syringe Programmes? International Journal of Drug Policy, vol. 21, no. 3 (2009), pp160-164

Centre for Excellence in HIV/AIDS: New Report Finds Drug Prohibition, Stricter Law Enforcement Key Sources of Violence and Gun Crime

A number of Canadian cities have experienced an increase in gun-related violence, which has been linked to the drug trade. In response, the Canadian Government is proposing to introduce new compulsory minimum sentences for drug-related offences.

However, studies have shown that similar legislation that has been in place in the US and Mexico has not been effective in decreasing the illicit trade in drugs. Removing judges discretionary power to not sentence people to incarceration may increase harms, as well as resulting in an additional burden on taxpayers due to increased rates of incarceration.

The Urban Health Research Initiative (UHRI), a program within the British Colombia Centre for Excellence in HIV/AIDS has reviewed scientific literature on drug law enforcement and its effect on drug-related violence. Of the 15 studies reviewed, 87% showed that drug law enforcement can lead to an increase in drug-related violence.

According to one of the researchers, Dr. Evan Wood, "widespread drug-related violence in places like Mexico and the US, as well as the gun violence we are increasingly seeing on Canadian streets, appears to be directly attributable to drug prohibition."

"Prohibition drives up the value of these substances astronomically, thereby creating lucrative markets exploited by organised crime. Any disruption of these markets through drug law enforcement seems to have the perverse effect of creating financial opportunities for organised crime groups, and gun violence often ensues."

Based on this evidence, the report recommends the implementation of other measures for controlling drugs in order to reduce the rates of drug-related violence.

Source: http://www.marketwire.com/press-release/BC-Centre-Excellence-HIV-AIDS-New-Report-Finds-Drug-Prohibition-Stricter-Law-Enforcement-1136285.htm Accessed March 2010

SITUATIONAL ANALYSIS OF DRUG AND ALCOHOL ISSUES AND RESPONSES IN THE PACIFIC 2008-2009.

On 18 March 2010, the Australian National Council on Drugs (ANCD) launched a report titled, Situational Analysis of Drug and Alcohol Issues and Responses in the Pacific 2008-09. This report, prepared by the Burnet Institute, provides a detailed overview of drug and alcohol issues in the region.

Alcohol and cannabis are the two most commonly used drugs. Alcohol in particular is recognised as contributing to many health problems in the Pacific, including heart and liver problems. In addition to health problems, there is concern over associated risky sexual practices among young people in the Pacific region.

Robert Power from the Burnet Institute who co-authored the report says, "This extensive report clearly identifies alcohol as the main substance of concern in the Pacific region and shows that cannabis is the key illicit drug of concern in the region."

The report also highlights a number of issues in the region, including the lack of reliable data on drug and alcohol use; the over-reliance on law enforcement and under-investment in health or at least an appropriate health response and the lack of a skilled workforce.

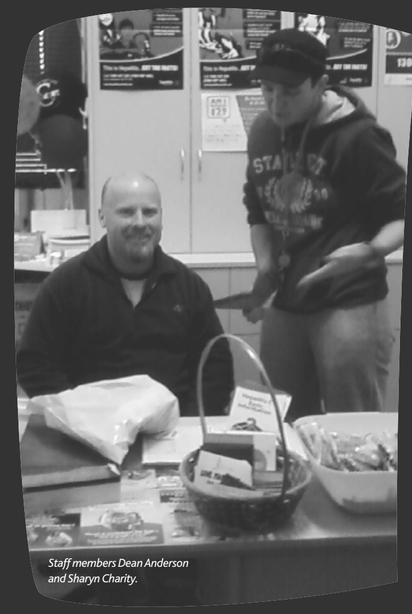
In order to address these issues, the report makes a number of recommendations including the need for increased surveillance and improved data on drug and alcohol issues in the region, the provision of specific funding for research into drug and alcohol issues and the implementation and evaluation of drug and alcohol interventions.

Available online: http://www.ancd.org.au/media-releases/situational-analysis-of-drug-and-alcohol-issues-and-responses-in-the-pacific-2008-2009-18-march-2010.html

IN THE QUIET OF NIGHT

CLIENTS TAKE TIME TO RELAX AND OPEN UP

Ms Tanya Reardon is an Outreach Case Manager for Mission Australia's Sobering Up Centre in the Adelaide suburb of Hindmarsh. The Centre runs a clean needle program (CNP) which is open 24 hours Monday to Friday, and from 5pm to 9.30am on the weekends and public holidays.



Staff members Dean Anderson and Sharyn Charity.

CNP client's age ranges from 16 to 70 years of age with most around the age of 30 to 55 years, according to Ms Reardon.

The Centre is one of the busiest CNPs in Adelaide which Ms Reardon puts down to its location close to town but in an isolated, industrial area where client's anonymity is protected. Team Leader, Dave Porter, said the NSP throughput for 2008/09 was "361,225 needles, or almost 1000 a day. We had 14,174 clients visits, with a return rate of 74 per cent. You put the work in to remind clients and they bring it back, but if we forget, so do they."

Clients come in through the night

Night time sees the most CNP clients at the Centre, with many of them stopping to chat with staff. Ms Reardon, like many of the other Centre staff, shares a good rapport with clients and many feel comfortable chatting with her about personal issues.

"The people who work here are very non-judgemental and I think that's one of the major things that makes the place work so well - it's that people here genuinely want to be able to help and support people," Ms Reardon said.

"The CNP clients coming through I have known for a number of years, I know about their grandchildren. I have got to say they love a chat. If you get treated with respect and dignity then they are going to be returning that. I have had nothing but pleasure from dealing with the CNP clients over the years".

When asked why she thinks clients feel so comfortable and protective of Centre staff Ms Reardon suggested "It's got to do with the workers. That fact that our workers, and I have got to say they are fantastic, they really engage well with them".

Ms Reardon believes that the open, non-judgemental attitude of Centre staff means that clients actively seek them out to have a chat. She also asserts clients don't feel judged and therefore feel safe and secure accessing the CNP.

Mr Porter said that because the service was primarily an alcohol recovery centre, it was no trouble to provide CNP overnight because it did not require extra staff.

"That's when our busiest time is – after hours all through the night even. We have people coming from far and wide. People tend to use different drugs at different times of the day. A lot of people come in early in the morning, when they do have time to talk," he said.

"In the day, people are generally in a hurry. At 3am in the morning, not much is happening so people have time to have a yarn. That's the strong point - we have the opportunity to catch up with people," Mr Porter said.

"We are a sobering up unit, so at that time of the day most of the clients are sleeping – it's pretty boring then, so it's good for the staff to have something to do by talking with CNP clients."

When asked about whether she thinks there could be anything done to improve the Centre's engagement with clients Ms Reardon answered emphatically: "God no! After 8 years of being here, if it ain't broke don't fix it!"

Gentle approach to new clients

Often Centre staff wait until CNP clients stop and look at health information, such as pamphlets displayed on the entrance door, before approaching them. Ms Reardon believes these are perfect engagement times, particularly when new CNP clients appear nervous or uncomfortable."

"Some of them might be a little bit cagey until they get to know you, especially if it's their first or second time in the service," Ms Reardon said.

When new clients access the CNP Centre staff provide them with basic information including opening hours, equipment availability, disposal facilities and safe injecting.

If the CNP clients are aged between 12-24 years, Centre staff will inform them of the Sobering Up Unit. The Sobering Up Unit can benefit clients who may have lost their accommodation, may be intoxicated and have no other place to go.

Model of service delivery

Although Ms Reardon suggest there is no one model that the Centre operates within, she asserts that Centre staff work on a principle of non-judgemental, open and friendly service delivery.

The Centre provides two types of services for CNP clients depending on their age. For those CNP clients that fall within the Centre's 12-24 year old age bracket, outreach services can be offered and clients can go on to be case managed.

One-off support is provided to CNP clients who fall outside of the Centre's 12-24 age group.

Ms Reardon explains "CNP clients who use the service overnight, and want support/information regarding an issue or withdrawal services can be referred to the outreach team. The outreach team will contact the CNP client the next day and assist with the requested information; this could be a referral or being linked into an appropriate service. The outreach team follows up with the CNP client to make sure they have received the desired information and referral.

This one-off support can be thought of as a brief intervention where clients are referred to another appropriate service and referrals are followed up by Centre staff to ensure the service meets the needs of the CNP client.

"The unfortunate thing is that we can't continue on [case manage] if they are outside of our age group. We can start by linking them up to those services and hope those services do give them continued support," Ms Reardon said.

Case study

Sarah* is a young woman Ms Reardon met through the Centre's CNP service. Sarah is a methamphetamine user. Sarah contracted hep C and went onto Interferon treatment approximately 4-5 months after diagnosis. Initially Sarah was concerned that treatment would result in increased depression and anxiety, resulting from rumours she had heard about hep C treatment. Ms Reardon said: "Unfortunately there are a lot of rumours out there that you'll die if you go on it (Interferon)". Sarah was already suffering from depression and anxiety caused by the domestic violence she was enduring.

Sarah was diagnosed through a local clinic and the Centre was able to assist her with a contact at the hospital for treatment. Ms Reardon was also able to assist Sarah with referrals and advocacy in relation to safe housing and support for her depression. Ms Reardon put Sarah in contact with the housing trust where she was able to be relocated to another residence.

Because Sarah was outside of the Centre's age group she was unable to be case managed by Centre staff. However, the Centre was able to provide one-off support and refer Sarah onto appropriate services. Ms Reardon suggests -"Basically you can look at it as a brief intervention. I remember one night she came in and I was out the front talking to her for like an hour because of a domestic violence situation that had just occurred so referring her to DV services is important".

Beyond the initial brief intervention Ms Reardon also ensured she was always available when Sarah came in and needed to have a chat. Ms Reardon asserts that making herself available and allowing Sarah to unload and talk through her issues was really beneficial in the long run. "Always being available when she did pop in to get clean needles to have that moment with her and if she wanted to say something she could say it, she was heard".

Sarah has since completed her hep C treatment and is hep C free. She is no longer experiencing domestic violence and has also cut down on her drug use. Recently Sarah started exercising and has gained employment.

**Sarah is not her real name. Name was changed to ensure anonymity.*

NIGHT-RIDERS BUILD TRUST AS DISTRIBUTION SURGES

The Bendigo Community Health Service's mobile outreach team plays the vital role of providing after hours access to clean equipment and health information.

Zach Miller, Lauren Butler, Jinie Fox, Lyndall Blandthorn.

The number of needles and syringes distributed through the health service increased from 73,000 in 2008 to 110,000 last year. There was a 45.5 per cent increase in the overall Loddon-Mallee region last year, by far the biggest increase among Victoria's eight governmental regions.

One possible explanation for the increase is a shift in the regional and local drug market. According to AOD Treatment and Support Programs Manager, Shaun Rosaia, there are unconfirmed reports that heroin may be more commonplace than has been customary for Bendigo in recent years.

'We have noticed in treatment that there has been an increase in opiate use; it has been a trend over the last quarter and again this quarter'

"We have noticed in treatment that there has been an increase in opiate use; it has been a trend over the last quarter and again this quarter," Mr Rosaia said. "There seems to be increased opiate use, and therefore increased injecting. Generally it has been synthetic morphine, such as Oxycontin, but also some heroin as well.

"Since I have been in Bendigo for the past four or five years, we have not had much heroin use itself, but it seems to be used by some people as well now, which in my experience hasn't been the case. So there may be an increase in heroin on the market as well."

Rather than there being more injectable illicit drugs on the market, two outreach workers, Ms Lauren Butler and Ms Lyndall Blandthorn, said the increased NSP demand was due to improved health promotion by the service.

"Our yearly promotion has changed a lot in the past two years," said Ms Butler. "Last year we ran a safer using campaign where we encouraged people to take that extra two- pack, or extra five-pack, or grab an extra bucket so they don't have loose needles lying around."

Bearing in mind that most deliveries are to drug injectors' actual homes, Ms Blandthorn said that it appeared that clients who pick up large quantities may be doing so on behalf of friends who are too nervous to contact the outreach workers.

"It appears as though lots of people are helping out their friends, getting 100 packs and returning for their friends who think 'Oh, I dunno if I want to use the service.' So they go 'Okay I'll organise it for you'. They are probably getting it for themselves and their friends."

This raises the sensitive issue of distribution by and amongst clients themselves, as Ms Sobczyk explained: "We have a lot of our clientele who are the 'on deliverers' of equipment. There are some key relationships with some key people who are, I suppose, the 'secondary NSP' for their own little community or their own user group or whatever."

The requirement for the outreach team to establish trust-based relationships with clients is in part attributable to the fear of disclosure that drug users encounter in rural communities more so than in large cities.

"This is a rural regional city so there is some degree of people wanting to be anonymous. You are not [completely anonymous] when you walk into a public health setting," said Ms Sobczyk. "In reality this is a small town, your sister or your mother or your brother is one of the staff. Or, you may know someone that knows somebody. I think that is the difference between the city and rural/regional areas. Our clients are contending with the smallness of our city. We are not overly multi-cultural, we are an Anglo Saxon Protestant Catholic conservative city."

Team member Ms Jinie Fox stressed that building trust with clients took time. It was usually best to start off being informal in order to open up conversations over time. "Generally when people are fairly new they don't want to talk much. It's usually quite brief few sentences. People usually don't stand around talking".

"My approach is 'Have you used our service before?' I let them know we have information about safer using or have other community resources in the town. If they are interested we let them know we have condoms and other sorts of things, different sized needles and things like that," Ms Fox said.

Ms Butler said: "I think initially they are scared because of the fear of judgment – they don't realise we are not there to judge them, it is not what we do. It's like they think they are going to get into trouble: 'Hey mate, I'm not gonna tell you off you can talk to us'.

"And the second time they will chat a little bit longer, then a bit longer next time," said Ms Butler. "Now our regulars, we will talk to them for 10 or 15 minutes – it could be about what they did that day," or as Ms Sobczky said, in a country area it could be as simple as "talking about the footy".

Appropriate non-verbal communication was essential given that most worker-client contacts tended to happen out in the open. "I think we are aware of clients' body language. We are not going to get out of the car with our arms crossed, or stand at the back of the car reading and stuff," said Ms Fox. "We need to be careful of the level of our vocals too. You don't speak very loudly, because people are nervous because they are concerned that neighbours could be watching, that sort of thing."

"There is a difference between outreach and an office setting," said Ms Sobczyk. "Sometimes you actually take the cue from the client. Some people just want to put their hand straight out and say, 'Hi I'm whoever'. But it really is variable and I think it's more the staff ability to have a sense of comfort in responding in an appropriate way. I don't know that it's something you could teach, or that you would be suggesting that there is a right or wrong approach.

'Even the simple things require trust. Trust is demonstrated in that ability for people to then have a conversation with you, even if it is just about the footy'

"I think it's something about an individual's nature and how they have been brought up. Everything is overlaid by your own personality, that would be my perception of it. What has occurred in your upbringing, and the professional training or approach you have experienced."

Mr Rosaia said: "You wouldn't want to try and change your personality to suit the scenario. Because that would come across as fake and it would potentially put off that engagement process if you went in like 'well, I'm doing NSP so I should be really quiet', even though you're really a bubbly person. They'd be going 'Well, they seem to be a bit off.' Clients can actually read body language."

Once relationships were established and clients were comfortable enough to spend 10 or so minutes on the roadside chatting with outreach workers, opportunities for referral to other services such as treatment naturally open up.

"Even the simple things require trust. Trust is demonstrated in that ability for people to then have a conversation with you, even if it is just about the footy," said Ms Sobczyk. "It's a level of trust that they are inviting you to their actual address. For people to do that I think there is a real sense of trust, that this service can turn up outside their door and they have this sense of trust that this is okay.

"You [then] have extra conversations with people, they take their time, they are not just 'Can I have a five-pack?' and then go. The fact that they want to stand and have a chat and then have people engage in that, it builds the relationship to the point that they may start asking some difficult questions.

"It's then how you engage with the opening … with regards to referral to treatment, a client might say 'oh I've had enough of this', or there is an issue. Depending on what they say creates the opportunity. Our staff have had a lot of training on how to create that opportunity for engagement, and then be able to provide information. Primarily it has to be driven by the client," said Ms Sobczyk.

"We let people know treatment services exist, but we have to be mindful of where people are at within their stages of change," said Ms Fox.

Ms Butler said: "We had a recent client ask us about vein problems . So we go through the process of getting all the information about what can we provide to this client. And we tell them to give us another call and we will come back to them when we have all the full information. I think it comes down to trust – it's the most important thing. Making sure they know we do care and that we will work to the best of our ability."

PILOT COURT PROGRAM CASE MANAGES DRUG RELATED OFFENDERS

Prisons' revolving doors, in which people reoffend after release, is an all-too-familiar reality for many people with problematic drug use. Based on the concept of therapeutic jurisprudence, the innovative Court Integrated Services Program (CISP) was established in three Victorian Magistrates Courts in 2006.

"It operates in the La Trobe Valley, Melbourne and Sunshine courts. It's about reducing the risk to community by putting supports in place and also trying to stop that recidivism," said CISP program manager Jo Beckett.

CISP provides offenders with short term social and health assistance before sentencing , including assistance with drug treatment and pharmacotherapy. In return they have to commit to a schedule of attending appointments, and reporting to Court on a monthly basis.

According to Chief Magistrate, Ian Gray, CISP attempts to address causes of offending through individualised case management support, provide priority access to treatment and community support services and reduce the likelihood of re-offending.

"A big per centage of clients - we are mostly working with 28-and-over age group - have been using drugs for at least 10 years. Most have been incarcerated at least once, but a big per centage have been incarcerated many, many times, and so it is just this in and out, in and out of prison," said Ms Beckett.

A multi-disciplinary team case manages bailed offenders, providing referrals and linkages to support services including drug and alcohol treatment, acquired brain injury services, accommodation services, disability and mental health services, as well as the Aboriginal Liaison Officer program.

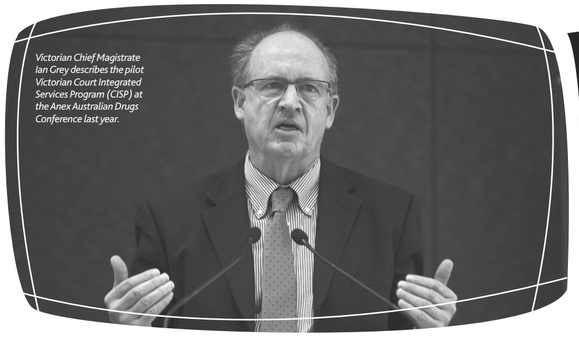
"The reality is that it has saved a number of people lives," said Magistrate Clive Alsop who is based in the La Trobe Valley.

"Some of the people we deal with are in dire straits with addiction and mental health problems, and other problems that affect disadvantaged people, particularly in the context of criminal cases. CISP has saved lives. I've said this from the bench, and it's not a theatrical comment, it's a statement of fact," Magistrate Alsop told the Bulletin.

Ms Beckett explained the evolution of CISP and stressed that it is essential to take a holistic approach to addressing offenders' social needs in order to stabilise them and reduce the likelihood they would re-commit drug-related crimes.

"Magistrate Brian Barrett asked me to come across and set up a program. I started assessing guys and their needs. Half had no housing, and there was nobody to organise pharmacotherapy after their release. A lot of them had been on methadone prior to custody, but once in custody for a few days their pharmacy cuts them off. So I started to put together some case management," said Ms Beckett.

"What was a surprise was the number of people who would normally be granted bail, but the Magistrates couldn't bail them because a lot of them didn't have a fixed address – they were homeless. So they would have to be remanded until a further date. It shocked me, the numbers".



Victorian Chief Magistrate Ian Grey describes the pilot Victorian Court Integrated Services Program (CISP) at the Anex Australian Drugs Conference last year.

"The other issue was that if they had been remanded for a few days and then got out, the pharmacy cuts them off (methadone). Plus if they had been remanded for one or two weeks, Centrelink had cut them off because they hadn't put in their forms," said Ms Beckett.

"So they would come out with a habit, with no 'done', they haven't got Centrelink benefits and they are homeless. So you are not going to expect someone to start looking at behaviour change programs or drug and alcohol treatment if they don't have a fixed address, even if it's only crisis accommodation.

"I went and saw all the regional managers of Centrelink - all of them. I said we need to have some sort of understanding that when any of our clients are coming out of custody they can access Centrelink quickly rather than have to wait three or four days for an appointment, because in the interim, they are going to be at risk. Like, if it was you or I coming out of custody and have nowhere to go we are going to have to steal to get food, and that's what these clients were doing.

"The Centrelink managers agreed that on the day they were released we could write a form explaining how long they've been in custody. Each Centrelink agency would have at least one person in there who would understand the program and would be able to assist that person getting them onto Newstart allowance that day.

"We then met with DHS and talked about drug treatment and having some sort of pathway for our clients. They would be assessed at Community Offender Advice and Treatment Services (COATS) and they would organise the treatment. I started talking to all the Magistrates and providing them with reports that would state at the time of bail applications, that should a person be released (from custody) this is where that person will reside – I had organised the accommodation – he is currently on methadone in custody and we have organised for this doctor to do another assessment and we'd do the permit."

Magistrate Alsop said: "CISP works on the concept of therapeutic jurisprudence. It was certainly cutting edge when it was introduced. Instead of sitting on the bench providing penalties, we can get assistance provided for people as part of bail conditions which enforce their need to continue with treatment."

Magistrate Alsop said the benefits of case-management are extraordinary, "and this is something this Court can be very proud of".

"The way that it is structured, if a person is accepted on the program they stay on it for three months, and at end of the end of each month they have to appear in Court and we can monitor their progress," said Magistrate Alsop.

"The Magistrates love it," Ms Beckett said. "They get regular updates on the clients, they have seen what they have achieved. The Magistrates often make themselves available to follow the clients. They bail you, and in the system they will mark themselves as the Magistrate to hear all your matters. So next time you come in for progress reports every month you will see the Magistrate."

CASE STUDY

"There was a bloke who'd done 36 years in prison, in big sentences. From 16 to 48, he had only ever spent 11 months in the community," said Ms Beckett.

"And I go to prisons and talk to guys about the programs and the support. And one day out of the blue this bloke turned up at our counter here in the Court. He said 'You're the bitch that came out to prison and said you'd work with anyone. I'm anyone - start working with me'.

"The bloke had very few social skills on the outside. He was on bail and not on parole. So I had to work with him after hours. I'd take him to a café. And in the first couple of months I'd have to find different cafes because he would scare them. He was fearful of living in community, had been a massive drug user in prison and out – a very very angry man, who did not know how to express it appropriately. For example, in the first few weeks, we'd go to a café and there was a young girl behind the counter and he goes 'Hey bitch, give us some f@%Sing coffees, and make it quick!'

"This poor girl brought these coffees out and he goes 'God, these coffees here are quick here aren't they!.' I go, 'You scared the shit out of her, you don't know how scary you are to some people; you come across as really quite evil. Well, he goes 'No-one told me that'," said Ms Beckett.

"So we worked on how he spoke, acted and things like that. Even down to pitch of the voice, how to sit, how to ask for things, how to walk down the street and react if someone accidentally bumped into you. We had to work from that basic level.

"I did the research to find out the right kinds of counselling. It took a couple of goes, including on the anger management. We got him a psychologist, we paid for that. He realised it was his time he could talk about things.

"He completed his first ever parole, and on that day one of the chief prosecutors who locked him up years ago came through, bawling his eyes out at the news. This guy has never looked back. He teaches pottery to elderly citizens, lives in his own place now.

"Now he comes and has coffee with me every three weeks, and he tells me off: 'Ms Beckett, you really need to do something about your language'."

It's apples as Tassie IDUs get first NSP-based doctor visits

The Tasmanian Council on AIDS, Hepatitis and Related Diseases (TasCAHRD) and The Link Youth Health Service are trialling on-site clinical consultations for IDUs.

According to TasCAHRD program officer, Ms Tania Joughin, most (IDUs) are "reluctant to access mainstream health care providers to address injecting-related health issues due to confidentiality concerns, discrimination, stigmatisation, costs associated with medical treatment and lengthy waiting lists at general practices."

"Perhaps the most significant theme to emerge from the clinical consultations to date was IDU perceptions of being heavily stigmatised and discriminated against by health care service providers in the community. Many IDUs indicated that they feel neglected, punished and denied input into their treatment."

A prevention and early intervention trial – which ended in June - is improving access to quality treatment, information and referrals. It is the first time clinical services have been available exclusively for IDUs throughout Tasmania.

A preliminary evaluation has found that it is addressing an identified gap in clinical services for IDU in southern Tasmania, increasing access to quality primary care for IDUs, improved health outcomes for IDUs including information access, treatment, referrals and increased capacity for individuals to respond to their own health needs.

The Tasmanian IDU community has a long-established culture of injecting pharmaceutical drugs such as methadone, morphine, benzodiazepines and also amphetamines.

The high prevalence and subsequent use of pharmaceutical drugs has had adverse health implications for many IDUs such as irreparable damage to the vascular system.

"Limited access to after hours injecting equipment and treatment services in both urban and rural areas within Tasmania has also had a profound impact on IDU health outcomes," said Ms Joughin.

Before the trial, NSP consumers' needs were analysed. Results indicated that consumers were willing to access an IDU friendly GP to address injecting-related health issues such as vein care, general health, hepatitis C, drug withdrawal/reduction, safer injecting, blood tests, medication, mental health and nutrition.

The *Review of Alcohol, Tobacco and Other Drug Services in Tasmania – Final Report (2008)* supported the expansion of primary health services for illicit drug users in the non government sector and acknowledged a substantial return on investment through reducing demand on acute and specialist AOD services.

The project was endorsed by consumers, local council, the Department of Health and Human Services and key stakeholders in June 2009. Funding was obtained from the Community Support Levy Charitable Organisations Grants Program 2008/09 to assist with the implementation of the project.

"Given that a large proportion of IDUs were reticent to access mainstream health care providers a marketing campaign was implemented one month prior to the introduction of clinical consultations," said Ms Joughin.

"NSP consumers were informed of the sessions through brief interventions, information flyers, information handouts and internal publications. In addition, a large image of the clinician was displayed in the NSP outlets to address consumer concerns that the clinician could in fact be their pharmacotherapy prescriber."

Twenty-minute consultations are held at TasCAHRD and The Link Youth Health Service one day per week. Consumers are bulk billed for each consultation.

> *"The most significant theme to emerge from the clinical consultations to date was IDU perceptions of being heavily stigmatised and discriminated against by health care service providers in the community."*

"The GP addresses injecting-related health issues such as vein care, blood borne viruses and testing and refers consumers to appropriate health care providers in the community, where appropriate," Ms Joughin explained.

NSP staff assist the GP with follow up phone calls to individuals. It was determined that pharmacotherapy treatment, opioids, amphetamines or benzodiazepines would not be prescribed to consumers.

"Related to this theme was the presentation of harms, resulting from involuntary changes to treatment regimes. Some IDUs were self-medicating to offset withdrawal from a reduction in treatment medication, with others using large quantities of over the counter medication.

"Other themes to consistently emerge from consultations included vein care issues, such as bacterial infections and femoral injection, hepatitis C and mental health issues such as anxiety and depression."

"Findings from the consumer survey indicated that all service users felt comfortable discussing with the GP on-site. It was common to be told that they can 'openly discuss IV issues without compromising other medication', and that 'it was great being able to discuss issues with him that I can't with my GP,'" Ms Joughin said.

Despite a considerable number of people accessing the service, anecdotal information obtained through the NSP outlets suggest that many more consumers were interested in accessing the service, but remain reluctant to do so. "Disclosure, trust and embarrassment were identified as perceived barriers in addition to accessibility," Ms Joughin said.

Key recommendations outlined in the project evaluation report supported the continuation of the service with the view of exploring alternative site locations, dates and times for appointments. Other recommendations included;

1. That a conduit to treatment services be explored to advocate on behalf of IDU such as Advocacy Tasmania.
2. Develop and implement a risk management strategy for recruiting and retaining clinicians to ensure future sustainability of the project.
3. Enhance linkages with specialist treatment services within the community. Establish effective communication channels and referral pathways with the Alcohol and Drug Service and Division of General Practice.
4. Facilitate IDU information sessions to health care service providers within the community to address issues of stigmatisation and discrimination.
5. Develop and implement a comprehensive marketing strategy to promote the service to IDU and relevant health care service providers to generate awareness and attract IDU.
6. Locate or develop information regarding the risk of femoral injecting for distribution in NSP outlets.
7. Locate or develop information regarding mental health issues such as depression and anxiety for distribution in NSP outlets.
8. Identify and establish effective referral pathways with service providers in the community.

**Ms Joughin has left TasCAHRD and now works with Youth Link in Tasmania.*

> *"The most significant theme to emerge from the clinical consultations to date was IDU perceptions of being heavily stigmatised and discriminated against by health care service providers in the community."*

I WOULDN'T BUT THEY WOULD: SURVEY

HUNGRYBEAST

Hungry Beast presenter Kristy Drysdale.

Forty-two per cent of Australian's have tried or used illicit drugs at least once in their lives, according to a recent survey by the ABC Television program *The Hungry Beast*.

The online survey also found that 90 per cent of the 1008 respondents said they would not be more likely to use illegal drugs if they were decriminalised, but 66 per cent thought other people would be more likely to use.

"People's perception of decriminalisation was one of the most interesting results," presenter Kirsten Drysdale told the Bulletin. "It seems that everybody thinks everybody else would do more drugs if they were decriminalised, but they wouldn't do it themselves."

Ms Drysdale said the inspiration for the segment on people's experience with and attitude to illicit drugs came during the visit to Australia last year by former Seattle police chief, Dr Norm Stamper, who is part of the Law Enforcement Against Prohibition (LEAP).

"I saw Norm speak last year and set up an interview with him. We thought if we were going to do something on the issue of drugs, including arguments for and against decriminalisation, we thought it would be good to know what the nation thought about it."

The online questionnaire comprised closed-ended questions about using illegal drugs and people's attitudes to illegal drugs.

Sixty-three per cent of respondents said they did have friends that had tried or used illegal drugs. Seventy-one per cent of Queenslanders said a friend had tried illegal drugs, and overall, the rate was higher in non-metropolitan areas (69%) compared with cities (59%).

Queensland respondents were more likely (71%) to say they had friends who had tried or used illegal drugs, compared with the other States. Respondents from non-metro areas were more likely to have friends who have tried or used illegal drugs (69%), compared with metro areas (59%).

"Forty-seven per cent of men and 37 per cent of women said that they had ever tried or used illegal drugs," said Ms Drysdale. "The rate was highest in Queensland, at 52 per cent."

"This is higher than in the National Drug Survey of 2007, which is done by telephone. It found 38 per cent of people had ever tried illicit drugs" she said.

The survey found that 21 per cent of people had used an illegal drug in the previous five years, and 12 per cent in the previous year. Marijuana, at 19 per cent in the previous five years, was the most commonly used illicit drug.

There were large differences in people's attitudes toward decriminalisation of various kinds of drugs. Twenty-five per cent said they were against decriminalising any drugs, while only 10 per cent of people favoured decriminalising ecstasy and six per cent favoured decriminalising heroin use.

"Interestingly, 52 per cent of people thought that possession of small amounts of marijuana for personal use should not attract criminal penalties such as prison or a criminal record," said Ms Drysdale.

"We have had a lot of positive feedback to the program," said Ms Drysdale. "A lot of people were interested in Portugal, and were surprised that drug use has dropped even after drug laws were relaxed. We held an online forum, and it had the most comments we have ever had."

To watch the segment, download the report and read or provide feedback go to Http://hungrybeast.abc.net.au/stories/drug-survey-results

SOCIAL INCLUSION MODEL FITS TRANSIENT MINING WORKFORCE

Continued from cover…

The 'social inclusion' model

The Well Women's Centre works within a model of social inclusion. This holistic model of service delivery recognises that every individual has the right to live a healthy life. This model recognises that a number of interrelated factors such as: unemployment, poor skills, low income, poor housing, basic health, poverty and family breakdown may affect and be barriers to, a person's ability to leading a healthy life and becomes a barrier.

When asked what the service does well Ms Brown suggested that the Well Women's Centre provides a welcoming environment for clients, "when they want help, when they are ready for anything, we're there and we do our very best for them".

Ms Brown believes the model of social inclusion provides an environment of trust and relationship building between NSP clients and Centre staff. "I have had clients turn up who were told to come and see the 'old girl' and trust does get built up".

The Well Women's Centre's enhanced secondary NSP model also means that female clients can benefit from on-site nursing staff who can assist with health related needs such as BBV/STI testing, pregnancy testing, Pap smears and counselling. The Centre's capacity to refer NSP clients on-site for other health services means that client's needs are addressed quickly and smoothly, Ms Brown said.

When clients are not able to be managed on-site they are referred to other local services and sometimes to drug treatment services in Perth. The Centre also provides advocacy for clients through housing and/or court support letters for long term clients. Ms Brown believes that some NSP clients have had good physical outcomes in different aspects of their lives due to the Centre's close relationships with other services including the local GP, where clients have been supported in seeking treatment such as pharmacotherapy.

New Clients

When new NSP clients come into the Centre they are given Fit News, a newsletter that also provides background information on the services offered at the Centre and alternative places where injecting equipment can be obtained. For new NSP clients, staff at the service adopt a casual approach, letting clients know who they are, seeing if there is any information they need and generally ensuring they feel comfortable.

Usually after only a couple of visits conversations starts between clients and Centre staff and trust builds up to a point where clients feel relaxed and comfortable at the Centre. Ms Brown suggests that a laid back approach to new clients is important where staff are open and friendly: "we don't put any pressure on them and we are just very friendly, very open and, reassuring that they are fine and they are in the right place and that we are here to help them".

> *"People will come in here in crisis, we certainly have had our fair share of NSP crisis's over the years… angry clients needing help, needing advocacy and clients needing to get to the hospital… over the years have dealt with that."*

The Well Women's Centre has no specific policies for new NSP clients, with the Centre's philosophy focused on treating all clients the same, in a reassuring and respectful way. And besides, as Ms Brown points out "it could be a new client for me but not for someone else".

The Well Women's Centre offers a wide range of pamphlets and information on safe injecting, blood borne virus information as well as information on other services in Port Hedland and Perth. Ms Brown suggests that most clients come into the service pretty well educated, but there is always information there if they need it.

Ms Brown said: "The women are always interested in reading what we've got, you will see them, they will go look through things. We never find information we give out lying around the car park, they are very respectful in that area".

Positive referral outcomes: a case study

Lisa* is in her mid 40s, a grandmother and has been accessing the services at the Well Women's Centre for the past 10 years. Lisa has been a long term opioid user and has been unemployed for the majority of her life. She has been physically and mentally unwell for many years as a result of her drug use.

Ms Brown and other staff members have supported Lisa through major crises over the years. In one particular incident Ms Brown recalls taking Lisa to the hospital where she was diagnosed with endocarditis. The Centre became a place Lisa could turn up to when she was unwell. "She has been one of those clients who over the years we have been there for, who we've been able to support".

The Centre was equipped to offer Lisa with on-site services such as NSP, counselling, health checks and advocacy and was also able to assist with off-site referrals and link ups to other services, including helping her to start on a pharmacotherapy program. The Centre also provided advocacy to both Lisa and her partner, and over the years her extended family have become regular users of all of the Centres services. As Ms Brown explained, it's one of the pluses of the Well Women's Centre: "families [of NSP clients] become part of the normal clients who use our service because they feel comfortable coming here. So [NSP clients] and their families just start using all our normal services."

Lisa is now doing well on a work program and training program, according to Ms Brown. At Lisa's most recent visit to the Well Women's Centre she spoke with Ms Brown about her long term battle with drug addiction, and all the years she felt she had let slip by. When Ms Brown spoke about Lisa she was full of praise and admiration for how far Lisa had come: "it's lovely just to see the difference in that woman now".

Ms Brown believes that the Well Women's Centre and the model of social inclusion it adopts has meant that Lisa has been provided with the support and services she needed to get her life on track. "Just seeing the difference in her now I take a tiny bit of credit, just a tiny bit of credit. We have been consistent - she has always known there is help here".

Ms Brown has retired since this column was written. We wish her well.

**Lisa is not her real name. Name was changed to ensure anonymity.*

Anex 2010

AUSTRALIAN DRUGS CONFERENCE

Public Health and Harm Reduction

KICK GOALS FOR HARM REDUCTION AT THE MELBOURNE CRICKET GROUND, OCTOBER 25-26

Join your peers and other experts at the MCG to help set new priorities to expand efforts to address the health and social implications of drugs at the individual and community level.

UP FOR DISCUSSION

- Tips and points: ask and advise other frontline workers how to improve services.
- Smarter data: improve and standardise stats and analysis.
- Health reform: what will national health reform mean for your service?
- Behaviour change communication: crafting strategies for unique sub-populations.
- Feminisation of risks: prison, higher sharing rates and child-protection threats.
- Overcoming barriers to NSPs: how to deal with opposition when starting or expanding programs.
- Pain and pills: Doctors' prescriptions leading to addiction.
- Stepford wives: Range rovers, private schools and their secret drug worlds.
- How it is done in the bush: Special challenges facing rural and regional workers
- Alcohol: influence on illicit drug risks, is binge drinking worsening?
- BBVs: what's happening with hepatitis prevention and treatment?

For further information or to register go to **www.australiandrugsconference.org.au**

GENERATION X WONDERS Y SUB-CULTURAL RULES AROUND INJECTING ARE SHIFTING

The Bulletin again speaks with an experienced and articulate injector. We discussed if there are any inter-generational differences between younger and older injectors.

What differences are you noticing about the 'dos and don'ts' of drug use?

"Older people are more set in their ways, the younger generation now with their use it's more freely ongoing, more open about it. Older people are still willing to hide things, keep it under wraps. Because we are more used to it (being less open).

"Back in our day, even in the 1980s anything - sniffing or injecting - was 'hard usage'. Now it's more outgoing. Look at the newspapers, that footballer dude. He has been charged with trafficking cocaine. I mean f@$c%k me 'how much more money do you want?' That's the way I take it. I mean, haven't you got enough money and pride in yourself that you go and do something stupid like that?

"Heroin, it's still a very underground drug. People sorta shy on that, but all these other party drugs – everybody's into 'em. Even speed. In the early days people didn't like speedies, but now people are more accepting on that, like the ice when that first come out. I knew heroin addicts for 10 years and they would go and have that now and again because they couldn't get on. It was just that dry, but they would go and use that. They never liked f@*!en speed or ice, but they thought 'It is just that feeling, that rush'. That's all it ever comes down to for most people – it's what you can feel, you know, 'what is it going to do to me? How much is going to peak me out, rush me out?'

"Older people have got more of an etiquette of cleaning up your mess - you never leave nothing around. That's why certain of us will have that terminology 'junkie'. To us, that's what a junkie is: just a younger bloke who is starting to use it, he doesn't give a f@*#k. He's too worried about his whack. But we think 'you can spend all day stealing or rorting, but it's only gonna take you five minutes to have a whack. You just leave everything there and get up and f@*#k off'. To us, we don't do that. You clean up your mess, it's respectable. We think if we can go out of our way to get this s*@$t and do this, well the last thing we want to be doing is leaving needles around for someone to step on. I think we are more clued on with what you can get, what (disease) you can catch, stuff like that. Whereas the younger generation are just still more worried about this feeling, 'yeah it's great, I'm stoned and I just don't give a shit or care about the consequences'.

"There are more now sorta eccies [ecstasy], stuff like that. … the older crowd don't really like that openness. They don't like it. I think it's more that you kick back and think you'd do anything to be that age again and change certain things. People are still so willing to sit back and think 'If only I was that young again there are different things that I coulda done'. Especially given you know what you know now, what it can do to you. Especially the way people 'shine on you', look down on you. Like you get a tram and a lady will be sitting beside you and she will move to the side. First thing she will think looking at you is 'drug addict, he could take my bag'. It really affects me I get really upset with s*@$t like that. It's a certain pride. The thing that gets me is that I'm the only gentleman on the train who would get up and give someone a seat. That's a totally big f@*%ing spin around for me."

Do some of the older lads help the younger ones with stuff?

"It's more so with the heroin. I've noticed a few blokes do that, take the younger ones under their wings and sort of give them some information on what it can do to you. Like sharing and hep C - that's a big one. A lot of people weren't really into hep C back in them days, but they know now what it can do to your system, especially with drinking."

"Yeah, I'd say back in the earlier days you'd show some blokes and then later you'd say 'you owe me a taste'. In a way it's bloody ridiculous because the older you get the more smarter you get and think 'F@%*k I wish I didn't show that person that."

"Older people are more hidden about things, more worried about it still. Young kids go to raves and it's just so open. Like you go to a rave and you're the only one drinkin' alcohol and everyone looks at you like 'F%@*k, why aren't you on something?' Like that really spins me out. Back in my day it would be totally different. If you were the only one drinking water they'd all be looking at you and think 'What the f@%k are you on?'"

"Yeah, generation gaps keep getting more different and different. I still think heroin's a more shone on drug, you know because people still think heroin addicts will do just about anything to get it, which certain people will in the beginning you know, but other people know how to better support their habits in rorts, stuff like that. You know, they know certain ways of getting money and s*@$t. It's like (in the past) you're saying - with the young guys - you wouldn't hand your dealer over to 'em because they would always have to keep going through you."

"So you'd say 'alright you want a half, I want a taste out of that'. So you could sit home all day and not even have to score because people are ringing you up always wanting your dealer so that's why you wouldn't hand them (a dealer) over to them you know, you're always getting a free taste for nothing. But these days it's just so easily accessed, it's like on the streets and stuff like that."

Are there any crimes or rorts that are now considered as 'you don't go there'?

"Yeah, I'd say nicking girls handbags stuff like that. That's really pulled up now. People shine on stuff like that – stealing you know, s*@$t like that. Other ones are like job sites, stealing copper all that sort of stuff - people don't give a s*@$t about that. Burgs, I've noticed a lot of people starting to pull up on people doing that – burging houses. Yeah, it's not on. It's more the older crew with the younger people. In the earlier days in the 1980s and 90s, that's all anybody ever knew - going into a house and stealing everything and going selling it at Cash Converters. Now it has flipped the other way. People are more into shop rorting. Stealing clothes, that's a big one. Cars, breaking into cars, that's another big one."

"It's more karma. A lot of people these days are into karma sorta thing. It's like 's*@$t you shouldn't do that because it's gonna happen to you later'. And I've noticed it myself. Like when I pulled up doing certain stealing things, I've seen the less s*@$t that has happened to me. It's weird to say, but it really does happen like that. And I think people are starting to realise that - the more bad s*@$t you do, the more s*@$t you get into trouble. Especially in jail, a lot of people don't like that sorta thing - you know stealing handbags off women – they shine on you, that's likes 'You're a weak person. There's so many different rorts out there that you could do.' You know … yeah, like cars and stuff like that (they could do instead)."

Is there any acceptable 'taxing' among users where drugs are cut down etcetera?

" When I first started I used to be able to get two really good rocks for 50 bucks , or .1 or so of a gram, or a 50 - that's what you'd call it. That would be mid '80s, early '90s. From 2000 on that's when points and all this sorta stuff started coming out and people started learning that they could cut certain dope with certain s*@$t, make it go further. Alright it might be s*@$t, but if this is the only person you know - I mean you're pretty f@%$d and that's where it comes back to again: how long you've been in the scene who you know where you can score. Like with a younger kid, he's f$%!d. He's gotto constantly keep going there until he finds someone else he can relate to. You can start comparing you know, differences between what's s*@$t, what's good, what's not."

What about rules around the police?

"Yeah of course there is. Like never lag your dealer in. It's weird too. I've noticed with the younger kids with the eccies and stuff they're even the same. They won't tell people where they've got it. They're starting to learn too. I think it's more they don't want to go to jail too. Like you hear all these stories like 'Pentridge and all that' back in my day… you get stabbed or raped or s*@$t like this, people extort you if you're doing a couple of months or a couple of years, and as a young bloke you'd think 'f@$*k that's pretty scary, I don't want that'. But these other jails now, it's more to make a name for yourself. That's the thing. I'd say there's two jails you could go in with a habit and come out with even more of a habit. You'd be quite surprised at how much drugs there are in the system."