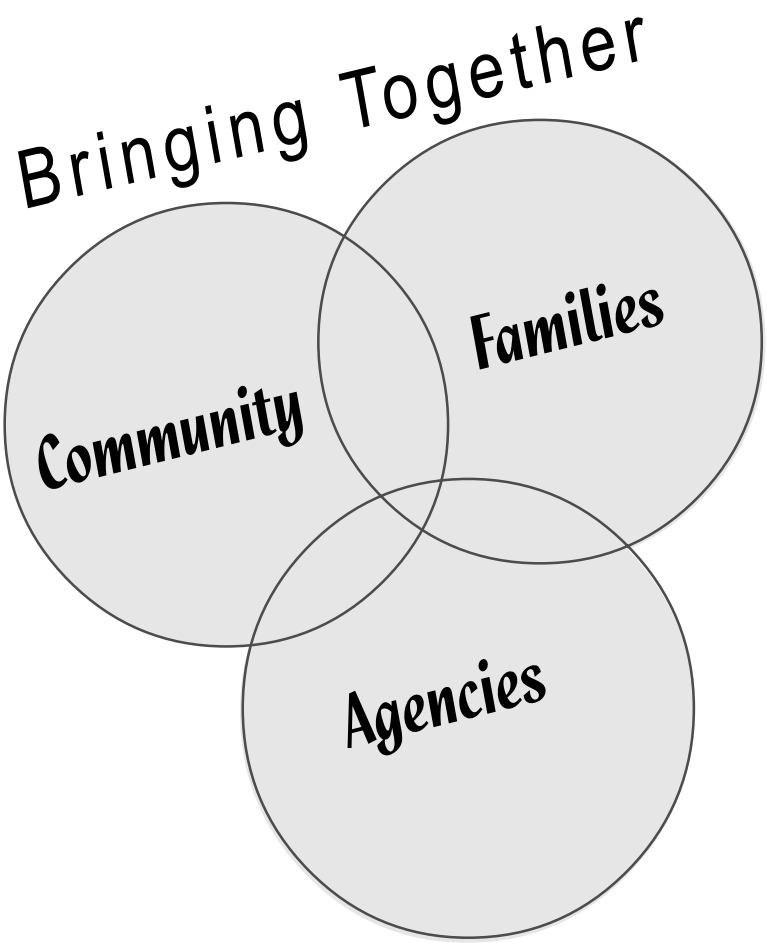
National Families & Community Conference on Drugs
"Voices to be Heard"



Organised by:
Family Drug Support &
Families and Friends for Drug Law Reform

At Soka Gakkai International Australian Culture Centre, Homebush Bay

Conference Proceedings

10 – 11 November, 2000

National Families & Community Conference on Drugs "Voices to be Heard"

Conference Proceedings

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Family Drug Support

Family Drug Support is a group of family members and interested people who have chosen to support each other in dealing with the effects of drugs in their families and communities.

FDS aims:

- to provide support to families and friends of drug users in the most appropriate way to meet their needs,
- to assist families to deal with drug issues in a way that strengthens relationships and achieves positive outcomes,
- to provide a safe nurturing and confidential environment for clients to address alcohol and drug issues,
- to maximise resources in the drug and alcohol field through regular networking, liaison and information sharing,
- to contribute to the development and skills of volunteers, and
- to work in partnership with governments and other agencies to achieve these objectives effectively.

FDS provides:

- a 24-hour, 7 day a week volunteer telephone support line,
- a Parent Education Kit: *A Guide to Coping,* which provides practical, down-to-earth coping strategies plus information about drugs,
- *Stepping Stones to Coping* course: a nine week course guiding family members through the difficult process of dealing with drugs,
- Family Drug Support Groups: regular open and informal groups that are held in various parts of NSW. The aims are to allow interaction and sharing of personal stories and strategies for coping,
- *Hero*Insight Newsletter - a regular monthly publication which provides interesting articles and information on FDS activities and events, and
- advocacy, lobbying and community awareness activities to promote the needs and rights of families.

Families and Friends for Drug Law Reform (ACT) Inc

Families and Friends for Drug Law Reform began in the ACT in March 1995. By the end of the Easter break that year eight people had died in Canberra as a result of using heroin.

For one father, the death of his son caused him to question the laws and wonder how a very potent drug, believed to be 70 per cent pure, could have been sold to his son with no controls whatsoever. This father together with Michael Moore, Independent Member of the ACT Legislative Assembly, called a meeting. Those attending the meeting included parents who had lost sons or daughters to heroin, people whose friends had died, and concerned members of the community. As a result of this meeting Families and Friends for Drug Law Reform was formed.

Families and Friends for Drug Law Reform wants to put an end to the misery associated with illicit drug use. It seeks enlightened and appropriate control and restrictions on drugs.

The present law is counter productive because:

- it makes drugs more available,
- it treats people who have a drug problem as criminals,
- it makes social outcasts of drug users,
- it splits families,
- it leads to crime,
- it costs our society more than we can afford, and
- it corrupts our society.

Families and Friends for Drug Law Reform challenges negative and judgemntal attitudes. It combats the stereotypes and bias that makes rational debate and effective solutions on drugs difficult. It does this through organising guest speakers for its monthly meetings; speaking to different groups; speaking to Members of Parliament; issuing media releases; collecting, publicising or publishing the true life stories of families; taking an active part in the public debate; correcting myths and refuting claims that are clearly wrong; making submissions to public inquiries; preparing discussion papers; assisting political parties to formulate their drug policies; participating at relevant conferences and organising an annual remembrance ceremony.

The Conference in Outline

The purpose of the conference was to bring together service providers from small alcohol and other drug agencies and families affected by drugs, as well as interested community members. The idea behind bringing these key players together was to enable them to network with and learn from one another.

Families are often left out of the process, but in fact have knowledge and understanding of their own situation which should be included in any intervention or treatment. By sharing that knowledge and understanding, the conference aimed to develop the collective wisdom of families which when combined with the skills and knowledge of service providers would enable constructive outcomes.

The organisers aimed also to provide a valuable conference that was affordable to family members and smaller agencies.

Unique conference

No other conference in the alcohol and other drug field has brought these two players together to the extent which happened at the National Families and Community Conference on Drugs. The cost of registration for most conferences puts them completely outside the reach of family members, which is a great pity since families have so much to offer. Families are the ones who are directly affected by drug use and their contribution at all conferences relating to drugs should be sought.

The cost is also often prohibitive for smaller agencies, which may restrict their knowledge and ability to provide good quality services.

Conference organisation

The conference was organised by Family Drug Support and Families and Friends for Drug Law Reform.

The significant efforts and time volunteered by members of the groups involved in organising the conference enabled the registration fees to be kept to a minimum.

The organising committee appreciated the efforts of the volunteers from Family Drug Support and Families and Friends for Drug Law Reform, and also the following organisations:

- Soka Gakkai International who kindly donated their premises at Homebush Bay,
- The Australian National Council on Drugs, which provided a generous grant that enabled the attendance of many to be subsidised and which sponsored the Friday Workshops,
- The NSW Government for its encouragement and assistance,
- The NSW Government staff who facilitated the workshops,
- The Centre for Information and Education on Drugs and Alcohol (CEIDA) and the Network of Alcohol and Drug Agencies (NADA) who planned and coordinated the ANCD Workshops,
- Meriel Schultz, LMS Consulting, who provided valuable assistance in designing the workshops, and
- The organising committee: Brian McConnell and Tony Trimingham (Co-chairs), Marion McConnell (Secretary), Peter Watney (Treasurer), Committee Members: Nobuko Aizuara, Bill Bush, Dianne Cumming, Michael Dawson, Ann Symonds, Tirrania Suhood.

Feedback on conference and workshops

Many favourable comments were received by the organising committee throughout and following the conference.

Those who had come from remote areas were particularly grateful to be able to attend such an event. Their remoteness and the cost of travel meant that they rarely make contact with others working in

similar fields. As drug use is spreading quickly into country areas it is of paramount importance that alcohol and other drug workers are supported.

Family members were pleased to be able to relate their stories so that others might begin to understand the devastation caused to families, and to be involved in finding solutions.

Conference participation

A total of 210 persons attended the conference. Of these 154 attended both days, 33 attended the Agency day only (Friday), and 20 attended the Family day only (Saturday).

115 persons sought financial assistance and 109 were approved by the organising committee.

ANCD financial assistance for travel and full and part registration costs enabled a wide spread of participants from across Australia. Delegates came from as far afield as Cullacabardee and Bunbury in WA, Whyalla and Kent Town in SA, Alice Springs, Tennant Creek and Darwin from NT and Kowanyama in Cape York in Qld.

Conference resolutions

The conference adopted three major resolutions:

1. A call for a series of "Voices to be Heard" conferences for indigenous communities.
2. A call on governments and government agencies to work toward reducing the overdose death rate by half by the year 2008.
3. A call for a one cent per drink levy on all alcoholic drinks that would be applied to treatment services.

Conclusion & discussion

The National Families and Community Conference on Drugs – "Voices to be Heard" - enabled delegates to learn and establish contacts with fellow workers and families with like interests and concerns. The technique of story telling was particularly effective in promoting understanding.

It was of great benefit also that members and staff of NGOs from remote country areas could attend. Such people often find it difficult to attend such gatherings, either because of the tyranny of distance, or because of the prohibitive cost.

The organising committee hopes that this conference will have long term benefits for families and agencies involved in alcohol and other drugs. The committee has also produced these proceedings as a reminder and record of the conference and as a resource for future action.

Tony Trimingham & Brian McConnell
Organising Committee Co-Chairmen

MEDIA RELEASE

from
Tony Trimingham
President, Family Drug Support
and
Brian McConnell,
President, Families and Friends for Drug Law Reform

Family Drug Support

A project of the Damien Trimmingham Foundation

A MAJOR NATIONAL CONFERENCE ON THE DRUG CRISIS GETS GOING THIS WEEK

On Friday and Saturday of this week (10-11 November 2000) a major national conference on families and drugs will be held at the Soka Gakkai International Australian Culture Centre at Homebush Bay.

It is organised by Families and Friends for Drug Law Reform and Family Drug Support.

Thanks to financial support from the Australian National Council on Drugs it will provide a rare opportunity for those across the country – including those from regional and remote communities – from Bunbury to the Alice, Cape York and Tasmania - to get together and address drug use, policy and programs.

No issue looms so large from the personal, family and community levels to the national level. It is a bond of suffering that brings us together.

We forget that families, users, drug workers and the community are in the same boat. All too often we are paddling in different directions. This conference will provide a special opportunity to work out how we might pull together. We must do this if we are to overcome the drug crisis.

- At present we as a community are at odds with ourselves. We seek to protect our children from drugs yet the spread of drug use shows that we are manifestly failing. No family is 'safe' from drugs.
- The family is changed forever when addiction enters. So often parents are set against children; brothers are at odds with sisters. Friends cease to be.
- At times we want to grab our addicted child by the scruff of the neck – we even demand that the law should help us – yet we know that compulsion can sever the links of love and trust that alone can turn around that child.
- Some see harm minimisation measures that focus on keeping users alive and in reasonable health in spite of their addiction as encouraging others to take up drugs.
- Those who regard getting a user drug free to be the first and foremost duty are at odds with those who believe it is possible and more important to keep an addicted user alive and connected with the community.
- Drug workers who strive to connect with drug users on the streets and help them enter and stay in treatment are seen as attracting criminals and down and outs.
- Drug users who take steps to help themselves are deterred by shortage of services and a mindset that looks on them as worthless.
- Drug using youth is regarded as a threat. It is marginalised and forced in on itself. Age is thereby set against youth. Our sense of community is lost

The conference will not shirk tough questions like these. We do not expect it to come up with a complete set of answers but we are confident that it will be a big step along the road to finding them.

The first step is to give an opportunity for voices to be heard. Those voices will articulate different experiences and view points. We will listen and respect each other. We will not talk past each other as so often occurs.

The core of the "Voices to be Heard" conference is therefore the stories of families, users and drug workers. The courage and endurance they reveal are triumphs of the human spirit. They are available at http://www.ffdlr.org.au. They will be related in plenary sessions and also in workshops where they will be the spring board for discussions on:

- keeping our family together,
- the role of the community and community based services in this process,
- how to access the right treatment and advice,
- the difficulties of getting treatment for users with mental health and drug use problems,
- what treatments can do to change patterns of drug use,
- grief and loss,
- families, drugs and the law, and
- communication between users and their families.

The first day, Friday, will be devoted to issues facing small organisations seeking to provide drug services in local communities. Workshops will consider:

- threats to their survival,
- recruitment, training and nurturing of volunteers,
- working with parents,
- preparing funding submissions,
- staff development,
- performance measurement and continuing improvement, and
- current issues and future perspectives.

The NSW Government and its agencies are providing substantial help to facilitate these workshops and *the Hon. John Della Bosca*, MLC, Special Minister of State will open the conference.

This and the other support that the conference has received gives hope that we can lift the veil of shame that stifles voices and hides possibilities: that we can build co-operation where now there is conflict and denial.

Keynote speakers will include *Rev'd Tim Costello*, Prof *Ian Webster, AO,* who is President of the Alcohol and other Drugs Council of Australia, *Isabel Norvill* and *Douglas Walker* of the Aboriginal Drug and Alcohol Council (SA) Inc and *Anne Deveson, AO*.

At Homebush success is ours if we can learn to pull together like our team athletes who crowned themselves with Olympic success.

8 November 2000

Contacts: Brian McConnell 0408 022 870 and, until am 9 November, (02) 6254 2961
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Ann Symond (02) 9389 6806

Programme with stories available as a pdf file on: http://www.ffdlr.org.au/Conference/

MEDIA RELEASE

from
Tony Trimingham
President, Family Drug Support
and
Brian McConnell,
President, Families and Friends for Drug Law Reform

Family Drug Support

A project of the Damien Trimmingham Foundation

CALL TO DEPOLITICISE THE DRUG DEBATE

Governments must depoliticise drugs; they must engage in 'evidence based politics' as well as evidence based evaluation of drug policies, John Della Bosca, the NSW Special Minister of State, said today.

He was speaking to 200 plus participants at the opening of the National Families and Community Drug Conference at Homebush Bay. He added that many unaffected directly by drugs prefer to pretend that the problem was not relevant to them. The community needs to own it.

"Australia is a country ravaged by drugs," said Brian McConnell and Tony Trimingham, whose organisations, Families and Friends for Drug Law Reform and Family Drug Support have sponsored this two-day conference. "But today's proceedings were heartening. They evidenced a willingness to do what should be done to tackle the situation."

The conference heard that an array of small community based organisations play a valuable but scarcely acknowledged role in helping families to cope with drug use issues. According to Professor Webster, Executive Member of the Australian National Council on Drugs, they represent, core communal values of activism and concern.

In an environment of inadequate resources these values can be compromised by fear that funding will be withheld if the organisation is seen to rock the boat too much.

In spite of distance and shortage of money and time there was a strong call for a national network to foster continuing collaboration among small organisations.

"We should not be surprised that our young resort to illicit drugs when the culture we have created for them is itself highly addictive," observed Rev'd Tim Costello who also addressed the first day. "We turn to analgesics of all sorts and are hypocritical."

He is a Baptist minister, whose urban mission works with young people on the streets in Melbourne.

"No one," he said, "takes up drugs to become addicted. For young people it is a peer pressure thing and, sadly, something that gives them a sense of purpose that society has failed to provide."

Tomorrow the conference will hear the stories of families and users.

10 November 2000

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Additional material

We should be under no illusion about the size of the drug menace. Every corner of the country now has a bad and worsening drug problem. Georgie Clarke based at YWCA in Toowoomba told of the predicament of remote and regional communities and the absence of support and treatment facilities for those seeking help for their addiction.

Rose Isherwood described establishing a drug and alcohol service on the Atherton Tablelands of North Queensland with minimal finances and maximum resourcefulness. Other speakers mentioned the grudgingly acknowledged need for parent bereavement support in Western Australia and sibling peer support in Melbourne. A working group discussed the importance of engaging parents in the drug rehabilitation process.

Whether in those places or in Sydney's Blacktown, the issues are much the same: resources dwarfed by the size of the problem. On the other hand we learnt from those present that their spirit and dedication remains intact.

The nation must find solutions to the drug crisis for it is our young who are threatened. Professor Ian Webster stressed that it is overwhelmingly young people who are affected by illicit drugs.

NOTE:

It is likely that someone is attending the conference from your area. Please contact one of the above if you would like to speak to such a person.

Programme with stories available as a pdf file on: http://www.ffdlr.org.au/Conference/

MEDIA RELEASE

from
Tony Trimingham
President, Family Drug Support
and
Brian McConnell,
President, Families and Friends for Drug Law Reform

Family Drug Support

A project of the Damien Trimmingham Foundation

HALVE DRUG DEATHS AND LEVY ALCOHOL TO PAY FOR TREATMENT

The final day of the National Families and Community Conference called on Governments to commit themselves to the firm goal of reducing drug deaths by half by 2008 and to levy 1c on every alcoholic drink to fund treatment.

Bereaved family members from across Australia made up a high proportion of the 200 plus who unanimously adopted these resolutions at this Sydney conference organised by Family Drug Support and Families and Friends for Drug Law Reform.

It is intolerable that the drug overdose death toll has grown from six in the mid 1960s to 737 in 1998, is estimated to be over 800 in 1999 and 900 this year. The measures that Governments are taking now are just not good enough. We know, for example, that some countries that have introduced prescription heroin or medically supervised injecting rooms for severely dependent users have already halved their overdose death rate.

2008 was chosen because that is the year that the United Nations has set itself to rid the world of illicit drugs. Participants from across the country testified to the naivete of that goal. Drugs are more and more available in spite of record seizures. The $8 billion a year Australian illicit drug industry is out of control.

The serious problem of excessive consumption and addiction to alcohol, prompted the call on Governments to place a 1c levy on every drink sold to fund harm minimisation measures for alcohol as well as other drugs. A levy or hypothecation of existing duty to this purpose is required.

Participants listened in silence to two Aboriginal elders of the decimation of Aboriginal communities, particularly in recent years by heroin. “Virtually all participants have been exposed to the death and mayhem of illicit drugs,” said Brian McConnell and Tony Trimingham, “but we heard that whole generations of Indigenous families are being wiped out by the death of their young.”

The Conference unanimously called on Governments to provide funding for a Conference of Aboriginal and Torres Strait Islanders “Voices to be Heard” to be organised by the Indigenous Community.

The conference heard of young people trying drugs for no other reason than teenage experimentation and rebellion. It is wrong that they should be treated like criminals and die for such foolish decisions leading to addiction.

Those suffering from addiction have a chronic health problem. Our obligation is to provide them with the best treatment available and support them during their inevitable relapses - not turn them into pariahs.

Our children do not loose their humanity because they are addicted as some in the community would have us believe. They always remain whole human beings and always our children.

12 November 2000

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BACKGROUND:

The National Families and Community Conference on Drugs, sponsored by the Australian National Council on Drugs and the NSW Government, was held at the Soka Gakkai International Australian Culture Centre at Homebush in Sydney on Friday and Saturday 10 and 11 November 2000. Participants were drawn from all States and Territories across Australia. The conference brought together a wide range of non-governmental service providers and family and community members with the aim of jointly discovering ways to contribute to improved support for each other and for people experiencing problems from drug use.

Story telling was a central feature of the conference. Stories too often revealed that:

- families had not only to deal with addiction but with difficulties thrown up by the law and criminal justice; and
- treatment and support organisations were struggling with lack of resources and were wasting precious effort competing amongst each other for meagre funding.

The conference programme with stories by parents, brothers, sisters and drug users themselves is available as a pdf file on: http://www.ffdlr.org.au/Conference/

Comments by Delegates

I wanted to thank you for all your efforts in making the "Voices to be Heard" such a wonderful conference. I encouraged a colleague to attend and it just wore her out. I think her reaction would be typical of a lot of professionals and encourages the team stance to be improved in dealing with family members....

First of all let me congratulate you on the terrific job that you have done on this forum. I found the forum to be informative and a very useful way to network. It's great to see that there are people out there who operate on a very practical level and enjoy sharing information - what works and what doesn't.

The conference was invaluable. The speakers were excellent and informative. The organisation was easy to follow and the venue was ideal..

Some ideas for next time. (I hear you groaning already but I'm sure it's easier the second time!) Include more information on alternative or new treatments and relaxation techniques. I would also like to see some people like police commissioners and politicians attend and have focus groups on particular issues (such as options available to families who are dealing with violence at home, need to remove son or daughter from home, but don't want them thrown on the street!)....

... a great benefit, not only to encourage my small efforts but assist the recovery of those who seek out the program I have to offer.

Thank you again for such inspiration

I was impressed hearing about all those small agencies that just put such a wonderful effort in to keep afloat and impact the serious drug issues and loss of lives in our communities.

I thought it was good having people's stories but perhaps they could have been spread over the two days as I did begin to feel a little overwhelmed with all the grief, a very sad reality for many. However, for those workers that have had very little experience with working with families it was an opportunity to gain greater insight into the issues presented to families.....

Speakers were really good. I liked Tim Costello and I felt Anne Deveson was fantastic, especially when she read out a poem written by a person with drug and psych issues.

With 18 years experience in the prison system, I was aware that families do it hard outside, but hearing the stories confirms my feeling that for the most part, the families of offenders are worse off than the drug-related offender incarcerated.

Comments by Delegates

The parents' stories too were very essential, something all D&A workers should hear, although I would have liked them interspersed throughout whole conference rather than in a big solid block...

I feel one area we need to be very aware of is parents who are drug users. This is an area our service is starting to look at and we must not forget that these families are often very victimised and ostracised and we should include them in our family conferences. Overall a job well done....

I learnt so much about the plight of the indigenous people and I am still reeling.

The comparing of notes that people from all over the country were able to do was a strong positive feature. The conference was thus very useful in breaking down the isolation that so many people facing drug problems had....

I am pleased that I was able to attend. I learned so much and I felt the pain of so many and I shared with many their grief on my own account. There were so many positive things to come from your conference and I will be reporting on this to our membership, some 11,000 women...

The Aboriginal speakers really made an impact on me, we really have no idea what Aboriginal families are going through and the more we learn about this the better.

I was stunned by the conference. I met so many impressive people (Imogen Clark for example) another English teacher, so we had something in common to start with, besides our daughters and I discovered a lot of ordinary folk doing magical things against enormous odds.

I thought the Conference was a wonderful one.

The Conference was the first of its kind and aired issues that don't get a hearing usually...

Tim Costello was magnetic (note the crowd that gathered around him afterwards), while I thought Anne Deveson's talk was inspirational. Ian Webster is a man amongst men - obviously. Scott Wilson's team should have been compulsory TV viewing.

May I first congratulate you on the success of the conference at the weekend. It left indelible impressions and the energy to continue seeking focus on supporting the crucial role of the family in a society such as ours....

As a worker in a small organisation I found it fantastic that there were other workers who were willing to share information and ideas, something larger organisations don't do well....

Premier of New South Wales
Australia

Message from the Premier

The Hon Bob Carr, MP

As Premier of New South Wales, it is a pleasure to commend Family Drug Support – a Project of the Damien Trimingham Foundation and the other organisers – for hosting *Voices to be Heard,* the National Families and Communities Conference on Drugs.

Through its volunteers, Family Drug Support provides counselling and educational services for the parents and families of people affected by drugs. Like you, the New South Government is working to find practical solutions to tackle the drug problem and ease the suffering of individuals and families caught in the cycle of drug use.

Following the Drug Summit, more than 400 new programs are being rolled out across NSW – a $176 million commitment over four years. A major initiative is the Drugs and Community Action Strategy, which is seeing Community Drug Action Teams set up across the State,

This conference provides a valuable opportunity for participants to share their knowledge and experience. I urge NSW delegates to get involved in their local Community Drug Action Team. More information is available on www.communitybuilders.nsw.gov.au.

I wish you all the best in your deliberations over the next two days. Congratulations once again on an initiative which will help us build a healthier, happier and safer community.

Bob Carr
Premier

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Official Opening

John Della Bosca, MLA, Special Minister for State

Mr Chairman, Ladies and Gentlemen

Thank you for asking me to open this Families and Communities Conference - "Voices to be Heard". Families and communities play a key role in our struggle against the rising toll of drug abuse in this country.

I don't need to tell you how complex the drug problem is. Although each individual story is unique, the effort to combat the problem must be shared – by Government, the community as a whole, and families and individuals. No-one can do it alone.

We must learn from one another and listen to each other.

The role of Family Drug Support and Tony Trimingham is greatly appreciated. Family Drug Support provides vital assistance to families and friends of drug users across the country through counseling, education and referral services.

The NSW Government acknowledges the important contribution made by Family Drug Support to drug and alcohol services nationwide, recognising it is a worthwhile and noble undertaking to provide help and comfort to people in their time of great need. The NSW Government has been pleased to provide Family Drug Support with financial support, to assist in the running of its telephone helpline. This service provides clients with a sympathetic ear as well as practical support.

I would particularly like to acknowledge the families and volunteers who are here today and attending this conference. You have faced or are facing one of the most traumatic and difficult problems. Having a family member with a drug problem, whether it be a child, sibling or parent, is something we dread, yet something we never expect. To face this problem is one thing, to then share your experiences and help others going through their own trauma is another.

The many volunteers of Family Drug Support give freely of their time and experience every day to assist others in difficulty. The Volunteer Spirit, always held in high regard in this country, and so celebrated at the Olympics and the Paralympics, is strong within Family Drug Support. You deserve great praise.

One of the most impressive things about the NSW Drug Summit was the number of times various speakers mentioned the word compassion. Family Drug Support was represented at the Drug Summit and played an important role in the proceedings.

The Drug Summit was also about listening and sharing – about putting the experts together with the families and the politicians and coming up with concrete ideas as to how we as a Government and community can act to combat the growing drug problem.

The drug problem and the Drug Summit

The ideas and enthusiasm that will flow during this conference will also provide some assistance towards finding some answers to the complex issue of drug misuse.

Obviously there is no one simple solution. In treating drug misuse, it is known that what works for one person may not work for everyone.

As a result of the Drug Summit the NSW Government agreed to work with the community in gathering the evidence and applying resources to a range of areas where they can be most effective. It is

recognised it is more likely to be an attack on many fronts which is the most productive – and that is the approach the NSW Government is taking.

As a result of the Drug Summit, the Government has committed $176 million in extra funding over the next four years to enhancing drug programs. Four hundred plus drug projects cover the key planks of prevention, education, treatment and enforcement. Most importantly, the approach is evidence based. Resources will be allocated to those things that work.

I would like to outline briefly some of the key initiatives of the Government's Plan of Action.

Key NSW Government Initiatives

Drug treatment services plan

The *NSW Drug Treatment Services Plan 2000-2005* was released by the Premier on 29 June. The primary purpose of the Plan is to ensure New South Wales has in place an effective, responsive and adaptable service delivery system for people affected by drug use.

The Plan was developed by an expert working group comprising representatives from NSW Health, Area Health Services, the National Drug and Alcohol Research Centre and the Network of Alcohol and other Drug Agencies.

The working group examined ways to improve the capacity of the health system to address drug and alcohol problems and made recommendations for innovative models for future service delivery. Services to be developed under the Plan include inpatient and home detoxification, rehabilitation, methadone, naltrexone, counseling and services in correctional centres.

The Government is committed to helping people break their drug dependence and the measures contained in the Plan aim to achieve this objective. As the Premier stated when the Plan was released: "The plan has one central theme – to get more people into treatment, and out of the cycle of crime and drugs".

Additional rehabilitation beds

In May of this year, I announced funding for 62 new rehabilitation beds across NSW. This effectively means an extra 521 clients can be treated at rehabilitation services across the State each year. $5.25 million will be committed over four years as part of the Government's increase in drug treatment services following the 1999 NSW Drug Summit.

Increased methadone services

Between April and September 2000, new drug and alcohol counsellors in seven regional areas had provided 2141 additional counseling sessions. For the same period, 434 people had been treated under the home detoxification program across five Area Health Services. 1,756 new patients were placed on the revamped methadone program between April and September 2000. 27,406 methadone counselling sessions were provided to methadone clients across NSW in the reporting period. 2 966 methadone treatment plans were completed between April and September 2000.

Heroin overdose strategy

Research studies show that drug overdoses are on the increase. It is reported that in 1998, 737 people across Australia died from a heroin overdose. 358 of these deaths, almost half, occurred in New

South Wales. The Government is taking these findings seriously and wants to get addicts away from heroin use and into treatment.

The Drug Summit *Plan of Action* provides $93 million for new treatment initiatives over four years including new methadone places, new counselling, detoxification and rehabilitation services. Under the *Plan of Action*, the Government has developed the *Heroin Overdose Prevention and Management Strategy*, with an accompanying *Action Plan*. These blueprints have been examined by the Expert Advisory Group on Drugs, and the Government has been advised that they are to be made publicly available shortly.

The strategy, which will be aimed at both fatal and non-fatal overdose incidents, is built on approaches that have proven to be effective. It proposes a range of programs including:

- training for families and carers;
- trialing Narcan availability for users;
- ambulance intervention;
- law enforcement approaches;
- police officer training; and
- community education and information.

At the July meeting of the Ministerial Council on Drug Strategy, which comprises Commonwealth and State and Territory Health and Law Enforcement Ministers, I moved a successful resolution on behalf of the NSW Government, that a national heroin overdose strategy be developed as a matter of urgency. The Inter-Governmental Committee on Drugs is progressing this initiative, and a plan should be ready for consideration by Ministers within the next 6 months. NSW will work closely with the Commonwealth and other States and Territories to ensure that national approaches to this issue are developed and acted upon.

Additional Juvenile Justice Counsellors

As a result of the Drug Summit eight new drug and alcohol counsellors have been employed in Lismore, Gosford, Bateman's Bay, Dubbo, Grafton, Riverina, Orange and Queanbeyan to work with young offenders through the Juvenile Justice system. Two more positions, in Kempsey and Broken Hill, have been re-advertised. The counsellors will help young people in juvenile detention centres and those in the community under supervision.

These counsellors have recently completed training that included managing acute intoxication and overdose, motivational interviewing and an overview of Youth Justice Conferencing.

Regional drug rehabilitation programs

Tenders are being finalised for new residential rehabilitation services in Dubbo and Coffs Harbour. They will provide a comprehensive treatment program for adolescents between the ages of 14 to 18 in regional NSW who are clients of the Department of Juvenile Justice or at risk of becoming clients of the Department, and are experiencing alcohol and other drug problems.

The rehabilitation programs will provide developmentally and culturally appropriate services, which address issues that impact on a young person, such as the family, school, work and peer groups.

Services for vulberable young people

As part of the NSW Drug Summit, the Government is introducing a number of new services for young people at risk of drug misuse.

The Department of Community Services (DOCS) received funding over four years to establish trial service models for case management that will help young people address the underlying factors contributing to their drug use. This will include reconnecting young people with their families if appropriate.

Seven new case management services are being established in Kings Cross, Darlinghurst, Redfern, Broken Hill, Campbelltown, Mt Druitt and one additional rural location yet to be determined. Contracts have been awarded and services have commenced.

In addition, funding to five existing and similar services has been enhanced in Newcastle, Wollongong, Cabramatta, Penrith and the Northern Beaches. This program known as 'Getting it Together' provides an approach that will help young people address the underlying factors contributing to their drug abuse. It involves a specialist case manager brokering or otherwise ensuring delivery of services such as treatment, education and vocational services, accommodation and interpreter services specific to the needs of the individual.

The NSW Government is serious about helping young people deal with their drug addiction and recognises that the reasons that young people use drugs are complex and varied. The Government is developing alternative education programs for students with special needs designed to re-engage young people with behavioral problems.

Drugs and community action strategy

The NSW Government is harnessing the creative power of the community through its Drugs and Community Action Strategy - bringing together local interests and efforts in tackling the drug problem. We recognise that each community is unique, and there is no one solution that will work for everyone.

The main feature of the strategy is the development of local Community Drug Action Teams. Community Drug Action Teams involve local police, schools, health workers, local government, businesses and families in addition to other community groups. These teams will work towards identifying local issues and developing plans to deal with them more effectively. A team of eight (soon to be nine) highly skilled project managers is implementing this strategy across NSW.

The experience and understanding of people like yourselves will play a valuable role in these Teams.

Conclusion

The government realises the vital role you play in working for a common cause. I trust we can work closely together. I applaud the work you do and admire the dedication, compassion and commitment with which you do it.

I wish you all the best in your deliberations, and the NSW Government awaits with interest the outcomes of "Voices to be Heard".

Plenary Speakers

Rev'd Tim Costello

Rev'd Tim Costello, lawyer and Baptist minister, is well known for his stance on social justice issues. Tim is the Director of the Urban Mission Unit for the Collins Street Baptist Church in Melbourne, which provides hospitality and community for the underprivileged. This work among street kids and outreach to the disadvantaged includes a lunch program which feeds 40-50 people each day.

Tim's speaking commitments take him all over Australia. He is spokesperson for the Interchurch Gambling Taskforce, a member of the Australian Earth Charter Committee, a council member of the Australian Centre for Christianity and Culture, and an Ambassador for the Council for Aboriginal Reconciliation. In November 1999, he assumed the responsibilities of the National President of the Baptist Union of Australia.

Tim is the author of two books: 'Streets of Hope: Finding God in St Kilda', 'Tips from a travelling soul searcher' and co-author with Royce Millar of the just-released 'Wanna Bet? Winners and Losers in Australia's luck myth'.

I thank you for your welcome to this very important conference.

I don't think the issues that you are discussing over the next few days are the fault of problem people whom we call 'addicts' or 'junkies'. We do tend to scapegoat these people as being 'failures' or to see them as a shame to an otherwise successful society, but the issues you are dealing with today have to do with the very nature of our culture. They are to do with how we envisage who we are. They have as much to do with the way we define our successes as they have to do with our failures. They are the inevitable outcome of a culture which essentially says we could all be happy if only we just had a little bit more money, if only we just had a little bit more success.

Many of those who suffer and live with drug problems are a little bit like the miners' canary. In mining towns, well before technology, the canary was used to see if the air was poisoned. You would send the canary down the shaft to indicate to the miners whether the air was going to be safe or not. Young people and even older people who are addicted to drugs are performing the role of those canaries for our culture. They warn us that in this culture the air has pockets of poison. We no longer have the clarity and honesty to face the superficiality of the definitions of success that we live by, and hence we are no longer alert to the poisons that we breathe.

Let me suggest that the drug problems we face in our culture are not simply the problems of some sad pathetic failing individuals. We live in a highly addictive culture which permeates every strata and sector, a culture that chooses at lots of levels to deal with pain, hurt, disappointment and betrayal by turning to all manner of analgesics. Most young people in this culture have grown up modelling themselves on parents, family members and friends who have another drink or take a Serepax or some happy pills when life gets a bit difficult. That's the way they are taught to deal with problems. And I do think that unless we can have a mature discussion about our use of often legal drugs to take away our pain alongside our rage and anger toward the younger generation's use of illegal drugs, young people will continue to accuse us of hypocrisy.

Let me hasten to say that I am not denying that medication can be an important tool for dealing with depression and other mental illness. These drugs certainly have their place and I would not want to deny that their discovery has clearly been a major breakthrough in helping many suffering from a clinically recognisable disease. But at least some of us suffer from anxiety and depression because

our culture or community is lacking and failing us. Recurring anxiety and depression may be a very real, even healthy response to lack of contact with other people. I often find myself talking to colleagues who have recognised an inadequacy in their community, and who have gone out into the world attempting to improve a situation which has made them and others miserable. These activists seem to overcome their anxiety and depression through the very process of doing something with other people, establishing a child care centre or a playgroup or a book discussion, sporting or bush regeneration group. It is as though they use the energy generated by their frustration and anger (which can underlie the depression or anxiety), and use it to draw people together and to make the world a better place. It is important not to dissipate that valuable energy in an attempt to eradicate emotional pain. A certain level of emotional discomfort may, in a sense, be another canary. We should heed what it might be saying about our culture.

But how do we teach our children about drugs? With three teenagers I have discovered that teenage kids rarely do what their parents say. This is not very stunning insight, I know, but teenagers as they grow into adults commonly do what their parents do. Modelling by example is always much more scripting and much more powerful than what we say. Australians are very good at 'sniffing bull' and kids are even better at sniffing it and as they look at the way we as parents abuse alcohol, they are unlikely to hear any messages we give them about their drug of choice.

Most parents recognise what Ronald Conway said ten years ago to be true. He said that 40 years ago the most powerful influence on children was families. The values of the families were reinforced by churches and most kids at least went through Sunday School. The values of families and churches were reinforced by schools, and then came the influences of peers and media. Conway says now that families are still the most significant influence on children and young people but only just – only just. He says churches by and large have floated off the horizon and so have lots of parallel secular groups, like scouts or guides. For many, even schools have floated beyond the horizon as a major influence.

The influences on our children which have now jumped into the place just behind parents and families are their peers and the media. Most of us who have kids often feel that peers are bringing up our kids more than we are. Why do my boys who are 14 and 16 have to have Nike or brand name basketball shoes? Why do they *have* to have them? It seems to me that there is a black American they idealise, because they play basketball, who has a lot more influence on their upbringing than I do. His name is Michael Jordan and he has an ad that says 'just do it'. This is what I love about these advertisements, they are not even inviting or persuasive, they are fascist. In fact they are totally authoritarian - there is no discussion here… 'just do it'. We are living in a culture where my boys regard it as a fundamental denial of their human rights if they don't have Nike. Now for our family that's not so devastating because I have a good job and my wife works. We can afford Nike. We don't want to pay for the brand but we can actually afford Nike. But for lots of the friends of my kids it is devastating. Single parent families can't afford Nike or other well-known brands, and having famous brand name clothes isn't just about greed, but about belonging.

The role of brand names has become one of reconstituting community in a culture where community is fragmenting. They're saying that unless you have brands how do you know who your mob is and who you identify with? Advertisers say to us, you tell us who you want to identify with and we will tell you where they shop, where they dine, where they holiday, what sort of clothes they wear, what sort of music they like or cars they might drive.

It goes further than this. We have a culture that actually brands young people not just with labels like Nike but with drugs. Taking particular drinks or drugs labels you according to the group you belong to. I have not yet met a young person… and we see 40 or 50 mainly heroin addicted young people every day in the back of Collins Street near my church and for the last six years I have sat and talked with young

people on heroin… I haven't yet met one young person who set out to be a heroin addict. Have you ever met any one like that? What I have met is young people who started out in the drug culture because it was relational. Often they had a boyfriend or girlfriend who might be using, but they were never going to. However the nature of using is very social and relational and belonging, and once they were using, it wasn't very long before using was important not to feel good but to feel normal.

It is amazing how many of the people we work with are using, just to cope with life each day, to feel normal, to get through, to avoid the awful pain of not belonging. When we take in some young people for a week - we have a community of twelve who live with us at the Urban Mission Unit and each year three or four people move out and three or four move in. To move into our community you need to live with us for a week. One of the nights of that week we give people $2 and we say about 4 o'clock on a Thursday afternoon, "we will see you tomorrow morning at breakfast about 8 or 9. See you later", and with $2 they have to go onto the streets, find a bed if they are lucky, find food if they are lucky, hang out just to see what it is like to have that little money, beg if they want to, do what ever they want just to survive. What is absolutely amazing is that the next morning, when they come back with a whole range of stories and experiences, what they all say is that it's amazing how out there in the street people looked after us. Someone says, we'll show you how to get a meal, we'll show you where we are dossing down tonight or where to get a blanket. The mission associates are very moved by this street solidarity.

I am involved in two projects concerned with illegal drug use. We have some rehab beds where we work, and there is also a rapid detox, naltrexone clinic. We send people down to the naltrexone clinic as well as to normal seven day detoxes. The amazing thing is when people at detoxes are trying to go straight, you hear them say, "you know my parents are really pleased that I am trying to go straight, be clean, but I don't want to be like my parents." You ask: "What do you mean?" and they say: "Well my parents, you know, they have to have diaries to make dinner dates just to see their friends. Nobody drops by, nobody comes over. My parents are really lonely. On the streets there are people to laugh with, cry with, score with, hang out with. They are actually people who are connected." It is amazing how often underneath this trying to rebuild a life, is this question: "Do I matter to anyone?" "Are there going to be any people who will journey with me, who are actually committed to me?" "Is there any community, any communal experience for us when we come off the streets?"

This brings me back to where I started: we are living in a culture with much poisoned air. The culture in which we are living is built around efficiency, speed, performance, and competitive individualism. It is a culture whose dominant ethic says, my only duty to anybody else is to do whatever is in my best interest. If I do whatever is in my best interest, magically, because this is how the market and invisible hand laissez faire capitalism works, I benefit everybody. That culture destroys communities.

Most parents, will tell you this. They'll say - that as kids, we seemed to have a lot more rituals in our lives, you actually had family meals and you sat at the same table and emotionally downloaded. To have a meal in the modern family today, is a bit of a cosmic coincidence. Ever armed with individual schedules and timetables, very simple rituals actually are changing. Some of you would have heard me recount the extraordinary insight I had into the changes from my world to my kid's world when I pulled up at a self serve petrol station. We filled up, I got out to pay, got my change, jumped back in the car, roared off and realised that I had gone through the whole transaction without exchanging any words. There was a person behind the window but he was doing something, he gave me my change without even exchanging a glance, and off I drove. Wonderfully efficient! Who wants to be held up at a service station?

But I thought back to when I was a kid. My father, whose first car was an FJ holden and whatever successive cars he had he would pull up, at what we used to call a garage. He would get out and there were three of us kids in the back, mum in the front. He'd lift the bonnet and he'd look under it. My father

was a school teacher so he really didn't have a clue what he was looking at. He was actually waiting for the garage attendant to come over. It was often inefficient, you had to wait awhile, but the attendant would come, do oil, air, water, petrol. What I remember in this flash back was that my father always had a conversation. He would talk about football, weather. He'd talk about politics. He taught politics at school for 33 years and as some of you know there is still a tad of politics in the family. I remember him cracking jokes and I remember as a kid marvelling, thinking, how does he know what to say? This is a stranger. How does he know what to talk about? I remember my next thought - that I hope when I am older I can do that.

I realised my children were rarely seeing any mentoring like this, any informal modelling. A community needs to share a common story like the ones about weather and football, and by the way I am talking about real football here. It is the common story of things that unites us together and even if we are strangers we can share the story. Community comes from that common story. I thought about how my kids rarely see me tracing a theme to this common story.

The next time I had my kids in tow it was at a McDonalds. To be honest my kids prefer not to be seen in public with me but if I am paying they will turn up. So there I was at McDonalds. I thought I'm going to learn from this. I went up to order. The young girl behind the counter had a name tag on. I said: "Hi Karen, are you having a nice day." She looked shocked. I said: "Oh sorry, my name is Tim. You know it is not fair you don't know my name and I know yours." She looked curious as I put my order in. As she was getting it I asked: "Do you work here full time or after school Karen?" She said: "Oh full time," and I said: "Are they training you to sort of manage a place like this, is this where it is going for you, what do you hope to do." Ah, she is warmed up: "No I don't want to be in McDonalds all my life," and she started to tell me what she wanted to do. So good, I thought, this is a commercial transaction but at least there is some conversation and community and I turned around to see that my children were absorbing my modelling. Well to my shock and embarrassment my kids had disappeared.

I walked out and found them. My daughter turned on me and said: "You are such a nerd," and I asked: "Why"? She said: "Why are you trying to humiliate us. You are not meant to talk to her, you are not meant to call her by name." So I said: "Well sorry, but you know if I am not meant to talk to her or call her by name why has she got a name tag on." My daughter said:, "She has a name tag on because if she stuffs up you know who to report."

Well this is my little parable about the loss of community. I thought and maybe even some of you thought, that a nametag was about being personal and connecting and being able to share something. Did you think that? At least for my children's generation, and clearly I haven't researched it properly, a nametag is to facilitate complaint: "That's the person who kept me waiting, that's the person who stuffed up." Now customer service is important but let us recognise that we are increasingly living in a culture which defines the good life as increasing efficiency and a vast range of choices, but it's a culture that's done very little to nourish what we might call community. We live in a benchmarking culture which says that if you can't benchmark it, it isn't real, and if you can't put a price tag on it, it doesn't exist.

It is curious, how even in an underworld of drugs there are benchmarks and monetary goals. Young people say, and not just young people, older people who are doing smack say to me: "Well when I'm off heroin, what do I do, what do I do?" A hundred or two or three hundred dollar a day habit can give a person a great purpose. According to the culture's norms which put a monetary figure on what you are worth, by the end of the day you know what you are worth. A two or three hundred dollar a day habit curiously even fits some of those quite strange norms because there is a clear benchmark.

I am suggesting that what matters most to people is that they matter to someone, that there are people who are going to be with them to rebuild purpose and meaning and hang out with them. As many of you know when people start using, particularly heroin, they often emotionally freeze almost at the age they started using. When they stop and try going straight - it might be 10 years later - that person is still trying to solve problems as a 17 year old. So the most important thing is to have mentors, friends and community who are there when the griefs, betrayals, relationship breakdowns, job rejections and disappointments hit. In the past they have been most easily dealt with by another hit, but you need other people in order to deal with those disappointments in another way. They need community and people who will say, "I will travel this distance with you".

Let me finish by saying that recreating rituals for people is fundamentally important. One of the sad achievements, of western culture, is deconstructing our rites of passage and rituals. In indigenous cultures where rituals are still intact you go out for say two weeks and you learn the law. It helps you move from adolescence, which says, 'you know I am the centre of the universe, my happiness is everything' to the understanding that 'if my mob is going to survive, I have to assume some obligations'. It happens with bar mitzvah in Jewish cultures, with baptism, confirmation in Christian cultures with maybe Queen scouts' badges, with other guide and scouting cultures, but so many of these rituals have been deconstructed, and as a result the transition experience from adolescence to adulthood often doesn't occur. No one teaches our young people the self talk that they need to use, talk which should go something like this: "I don't just look for quick solutions to disappointment, betrayal and pain, I have to journey with this pain and find other supports."

Rites of initiation to help people move toward that new and adult understanding. When you don't have rites of initiation and rites of passage you often have negative ones that flow into the culture. They are not all negative but they have negative dimensions. Schoolies week is one. It is negative in so far as most young people go to schoolies week, and I am now an authority on this because my daughter is going this year. We have been talking about this a lot. Most of her friends assume that it is not a good time unless you get totally drunk. Now that's very worrying, particularly for young women. It is the heavy duty blokes, the older blokes who know that that is what young women plan to do. During schoolies week drinking and driving a car becomes a rite of passage. Even drugs, it seems to me, take on that role. It is an adult world that says this is dangerous, don't do that, but it is also an adult world riddled with hypocrisy. For many young people because we have deconstructed rites of passage, drug taking takes on importance in their self definition.

We have in this culture people of 20, 30 even 40 years of age who are still essentially adolescents. We live in a very adolescent culture. When a culture gives priority to individual happiness, drugs become a much greater problem. When a culture says an individual's absolute right to happiness allows them to dissolve and relativise other responsibilities, communal, environmental, spiritual and relational that culture is in deep trouble.

One antidote is to rediscover or reinvent rites of passage and rituals which will confirm identity by linking it to more profound and lasting values, and I refer you to my book *Tips from a Travelling Soul-searcher* for a fuller development of these ideas. I come from a tradition which has as its cental ritual the simplicity of a shared meal, and a shared meal may not be a bad way to start if you want to mend a culture.

Thank you very much for the opportunity of talking to you.

PLENARY SPEAKERS

Prof Ian Webster AO

Prof Ian Webster is president of the Alcohol and other Drugs Council of Australia, Chair of the National Advisory Council on Suicide Prevention, Chair of the New South Wales Expert Advisory Group on Drugs, Member of New South Wales Clinical Council, and Board of the South Western Sydney Area Health Service, Executive Member of the Australian National Council on Drugs. He is Clinical Associate Dean of the South Western Sydney Clinical School, Professor of Public Health the University of New South Wales and Director of the Division of Population Health South Western Sydney Area Health Service and he is visiting physician at the Matthew Talbot Hostel for the homeless and physician in Drug and Alcohol.

NGOs, Community Organisations and Families in Drug & Alcohol

What is the role of voluntary organisations in modern communities?

David Scott, a remarkable Australian, a leader of social change, in his book, 'Don't mourn for me - organise…" said:

> the large and diverse voluntary sector, with its many facets - service, education, innovation, protest, advocacy, mediation, research, self-help, local action, national action, co-ordination, choice and involvement - has vitality and dynamism. It provides promising structures for providing services and promoting change in ways that are consistent with democratic and co-operative values.
>
> It has also been argued that voluntary organisations are significant in drawing people into contact with social issues in ways that increase understanding of the structural causes of poverty and disadvantage, and widen the political base for reform.(1)

We can learn from the Olympics and the paralympics. Everyone has praised the volunteers and we might think about what made this so successful:

- people were trained,
- they were well-equipped,
- the media was supportive,
- it was a defined task,
- it was time-limited, not on-going as many tasks in welfare are, and
- there was celebration.

There are some principles we could adopt more widely. Mental Health Week this year was well celebrated throughout the country with the 'white flannel flower'.

'Treatment Works Week' was well celebrated this year. More than 40 MPs were identified with their local D&A groups in this event.

In all there was a positive approach to celebrate.

Community organisations in mental health

I have seen remarkable work in NGOs from which the professions, our formal institutions and governments could learn a lot. I have seen the work of the St Vincent de Paul Society amongst the homeless through the Matthew Talbot Hostel for the Homeless in Woolloomooloo. In this Catholic lay

organisation, ordinary people provide support and shelter for homeless people. They do this in an "ordinary person" way. Their non-professional approach is important. Does it help the mad homeless person to be treated as if they are mad? Does it profit the alcoholic homeless person to be treated for alcoholism without shelter?

David Scott says of voluntary organisations:

> In some instances, resources are wasted but they are probably more focused on consumers than in the government sector. Staff are not always efficient in the bureaucratic sense, but this may not be as important as the quality of the service and concern for whom they are working . *(2)*

I think that these values of 'other orientation' are even more important now, in Australian society.

Self-help

One of the most important aspects of voluntary organisations is their goal of self-help. In addition to providing services, self-help encourages individual and group development. Probably some of the best examples of self-help organisations are AA, NA, Damien Trimingham Foundation, Families and Friends for Drug Law Reform, AIVL and so on. In mental health there are ARAFMI, GROW, the Schizophrenia Fellowship and the Mental Health Association. There are others in mental health - DMDA, Panic and Anxiety groups, OCD groups TOP. All extremely successful community-based organisations.

This characteristic of mutual support is increasingly important. Demone, in an introduction to a manual on mutual aid said:

> It matters not what you call them - self-help, mutual aid, support systems - they are the fastest growing component of the human service industry.
>
> Nor is it surprising. Man is a social animal who through history has banded together for problem solving and survival ... thus they are as old as man in one sense or a contemporary solution to complex problems in another. (3)

What is more they can have a profound effect on society as a whole. Preventive action - community development and education - about harm reduction, is one of Australia's success stories. We have the lowest world rates, and falling, of HIV/AIDS in gay men and IVDUs, and some early indicators that Hepatitis C may be responding to such efforts.

Australia of course has a history of outstanding achievements in social reform - aged and disability pensions, blind pension, 8 hour day, minimum wage, women's suffrage, adoption and fostering. Our successes with TB, other infectious diseases, heart disease, smoking and alcohol are greater than almost any other country.

We are prepared to innovate. We can change. Above all, we listen to the evidence of what might work. Politicians are starting to do this. Our national approaches of recent times in drugs, mental health suicide, early childhood, homeless young people, are examples of these more enlightened approaches. But there is still more to do.

What are some of the characteristics of voluntary organisations?

Voluntary organisations start with a vision - a problem to be overcome or a matter to be put right. Often that vision starts in the mind of one person. Voluntary organisations started services for disabled people. Very many of them have formed around particular disabilities. For instance, developmental

disability, multiple sclerosis, mental illness, Alcoholics Anonymous, Narcotics Anonymous, etc. Others have formed around losses, losses of family members and loved ones. These family responses have driven the reform in mental health and are now driving drug and alcohol reforms.

These community-based organisations humanise the archetypes - of medicine, of welfare, of the church, of law, of education. Without exploring alternatives our social institutions would become obsolete and irrelevant. As the Rev'd Ted Noffs has said, "Like the dinosaur they would die".

Unfortunately, once the initial enthusiasm is over, organisations become preoccupied with survival - gathering funds and maintaining their eligibility for government grants. The need for the organisation to survive becomes paramount. How many beds are filled, how many meals provided, and staff employed? Are the budget and accounts presented in the correct way? Enthusiasm can give way to disillusionment.

These are forced on organisations by government funding and accountability. And even more so is this a problem as church and charitable bodies sign up on government contracts.

Social justice

David Scott has said:

> Another reason for using voluntary organisations, as a matter of public policy, is that they are efficient and effective and involve people, they will reduce the opposition to increasing resources for social development that is based on the fear of government bureaucracies. (4)

Why should social justice be addressed first?

Where social pressures create unemployment, alienation, and disenfranchisement - the needs and access to the amenities of modern life can be compromised.

For young people, but also for those adults who fail, these factors can exacerbate mental illness, with high rates of depression, suicide and mental hospital admissions they are ground upon which drug and alcohol problems grow.

We have found in studies of unemployed people, and in a survey of their general practitioners, that depression and psychological disturbance are common among people out of work and with boredom, substance abuse increases.

Families need material assistance from community organisations, as well as counselling and support for their well-being. Some families require shelter and food when poverty is severe. This has been the traditional role of churches and charitable bodies. They have picked up the tab when others have failed them - shelter when people have had no where else to go - care for the care-less. That, particularly, is the situation of the homeless in Sydney among whom substance use and mental problems are of epidemic proportions.

Opposing discrimination

When the Minister for Community Services introduced the Disability Services Legislation into Parliament on June 10th, 1986 the psychiatrically ill were excluded.

It was an NGOs that 'belled the cat' - the Psychiatric Rehabilitation Association.

The Federal Government was concerned that de-institutionalisation in New South Wales could throw people onto Commonwealth programs. Fortunately the Human Rights Commission upheld the public concern expressed at that time. In the Senate the Democrats had the legislation amended but there are still concerns that the spirit of the amendment may not be fulfilled. There are also concerns that the Home and Community Care Program does not provide for persons with mental disabilities.

The Commonwealth's concern had been that persons discharged from closed psychiatric beds would seek admission to nursing homes. Can you imagine that choice? It took Brian Howe, Health Minister of the day to convince the Cabinet that it had responsibilities for mental health. The government cannot fairly discriminate between people with mental and physical disabilities who have the same needs. Nowhere can this be seen more clearly than in people with drug and alcohol problems.

Prevention

Community organisations have demonstrated their capacities in prevention, with some innovative approaches to educate young people about their bodies and health. I have already referred to the effectiveness of community involvement in prevention in blood-born virus infections. But in the prevention of drug and alcohol problems more fundamental initiatives will be required that deal with our basic social infrastructures of family life, education, work and health.

These are the areas in which the people here assembled have the capacity to produce change.

The value of community organisations

Voluntary organisations are generally undervalued - they are regarded as inconsistent and capricious, and not particularly effective. But voluntary agencies may be the only groups responding or providing a service to marginalised people.

The size of the volunteer effort

From a study of 592 non-government welfare organisations in 1982, the Social Welfare Research Centre of the University of New South Wales calculated there were 16,198 volunteers. There are estimated to be 36,967 non-government welfare organisations (a range somewhere between 25,397 to 48,537). Thus, the researchers estimated the total number of volunteers in Australia as between 751,399 and 1,436,398, i.e. between 7 and13 percent of the population over 15 years of age.

Volunteers worked about four hours per week on average, which is the full-time equivalent of 125,000 jobs, a wage bill of $1.5 million equal to about 1.1% of Australia's GDP. (5)

A study in Canada estimated that volunteer work contributed between 1.1 and 3.0 percent of GDP. In Britain the number of volunteers has been estimated to be 13% of the population and a study in the US estimated that 24% of the population aged 14 and over do volunteer work. (6)

There are problems with this type of calculation, but Hardwick and Graycar believe their calculations under-estimate the volunteer effort since they surveyed formal NGOs only, and did not contact the informal networks. They do represent a large community resource and output.

I have not had the time to discuss those wonderful International NGOs that maintain the human spirit in times of adversity, Red Cross, Red Crescent, Amnesty, MSF and so on.

Conclusion

Now, as the idea of welfare has turned sour and governments have embraced tax cuts, economic rationalism and efficiency, voluntary effort and NGOs are needed desperately to counter declining government effort. In mental health, in children growing up, in the welfare of young people, in preventing the casualties of alcohol and other drug abuse, these grass roots movements are needed to humanise the accusatory rhetoric of public discourse.

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Isabel Norvill

Isabel's initial involvement with substance misuse began with the development of the State substance misuse body WOMA in the late 1970's. Isabel's involvement eventually saw her being appointed WOMA Chairperson. During her time with WOMA she was involved in setting up the Nunga Farm (Kalparrin residential rehab), the Jerry Mason Centre and Baroota Farm (residential rehabilitation). Throughout her involvement with substance misuse projects, Isabel was also working as a Child Protection Officer and the development and implementation of the first Indigenous Women's Domestic Violence shelter

Isabel's most recent involvements include being a community representative with Aboriginal Drug and Alcohol Council (SA) Inc of which she is Chairperson. She was involved with the planning committee, which saw the development of the South Australian substance misuse and strategic framework document 'Bringing It All Together'.

Isabel is an active Chairperson for ADAC and substance misuse organisations in South Australia and she is on the following committees: Lower Murray Nungas Club Committee; Chairperson Aboriginal Drug and Alcohol Council (SA) Inc.; Aboriginal Health Council Ethics Research Committee; Aboriginal Justice Advocacy Committee; South Australian Elders Council; Women Leaving Prison Reference Group.

The chair of this session was Scott Wilson, who acknowledged the traditional owners of the area for allowing us to be here today.

I will briefly give you an understanding of our organisation. Even though we are a small NGO the Aboriginal Drug and Alcohol Council is the largest Aboriginal community drug organisation in South Australia with 28 organisations who are members. We only receive recurrent funding for three positions but we are so productive that I suppose NGOs can be successful. We've managed to employ 12 people on average for the last five years.

On behalf of the Aboriginal Drug and Alcohol Council we thank the organisers for inviting us here to speak today. Our first speaker is Isabel Norvill. She has a 30 year involvement in substance misuse in SA both on a professional and personal basis. As in a lot of communities, Isabel was touched in a direct way by substance misuse. About 12 years ago her first grandchild suffered irreversible brain damage due to the baby being shaken in a speed rage. This tragedy saw Isabel's daughter turn to heroin and for the past 12 years has seen Isabel trying to pull the family back together. Her daughter was eventually sent to jail for drug related crime and has spent four of the last .nine years in jail This saw Isabel, at the age of 60, becoming the primary care giver to three small children, ignoring her own serious health issues. (For example a by-pass operation which she put off for a year and a half.) Isabel's focus and energy turned to heroin and its associated problems. Isabel's involvement led to her being awarded the South Australian NAIDOC committee female elder of the year award in 1999 and an Australia Day Achievement Award in the same year. I introduce Isabel.

Good morning everybody. We have a court in SA which is called the Nunga Court – Nunga being the word for Aboriginal. I attend that court every second Tuesday and the purpose of the court was to allow Aboriginal people to go through the court without being put in jail because as people know from black deaths in custody, a lot of people die in prison. So one day I was down at the court and I saw this particular old fellow who I had not seen for a long time. His daughter had died that year. Unfortunately, I could not get to her funeral. That's another thing, we attend a lot of funerals. I went up and spoke to him.

I went back that evening and spoke to Scott and his wife about that poor old fellow still trying to battle on even though he had lost his daughter. His daughter had three children. The mother and her three children were all users. They all used together. The mother died. She was about 41 and her three children were in jail when she died. It was a really sad time. As a community we all got together to try and get the kids out of jail to attend their mother's funeral and fight the bureaucracy so they wouldn't have to wear handcuffs at the graveside. This is part of our day to day normal life, the things that we get involved in. I asked the old fellow what he was doing down at the court and he said: it's my grandson, he is going up today. The magistrate is going to give him bail and we are going to take him home. I asked about his sisters and he said 'they are still in jail'.

After having a yarn to the old fellow I went to Scott and his wife and told them about the old fellow. It is really sad. And I started thinking and I thought that another child had died in that family and we were sitting there till 3 o'clock in the morning doing graphs on the family tree. Helen is very good on the computer and she came up with the colour coding. And when we looked at it we realised how terrible it was.

And when you look back historically, when you go back to the girl who died, the little one on the top is her grandparents, blue is alcohol, green is marijuana, pink is polydrug use and the red is heroin. [Isabel displayed a family tree coded in this way. It showed many deaths.] That's the snapshot of one family without even going out and doing research and looking at what's in the extended family. It was just from talking to the old fellow at the court that day. Looking at it the next day we realised that we needed to start looking at these charts and honing in on the families and giving them support. Even though there are lots of agencies around many people fall through the gaps and don't get any support whatsoever.

Next day I phoned a cousin of mine who works in one of the remand centres in Adelaide. I told her what I wanted to do. Just off the top of her head she gave me another family. And again the chart shows all the reds are heroin deaths out of one family. [Isabel showed another chart.] We deal with cluster deaths. We don't have one death, we have cluster deaths. And this was another one. We did four more charts.

It goes back to where years ago Aboriginal people first left the reserves and the drinking started and people became alcoholics. Family breakdowns came along and kids went straight into heroin. If there is a black line inside the red box it means this was a black death in custody. They died as a result of being in prison for heroin use and they hanged themselves. In one family eight people died from heroin. It is horrific.

We looked at a couple in Adelaide and then decided to look at some at the other end of the country. The yellow in this [chart] represent people from the stolen generation. So that's another colour added and as you can see from the hierarchy those people were fostered and placed and lost forever. Some are still missing. Some did come back and have families. This is a snapshot of a particular family. [Isabel displayed another family tree].

As a result of doing these charts and the horrific number of deaths in our community it became evident that injecting drug issues had been ignored. I was instrumental in getting ADAC (Aboriginal Drug and Alcohol Council) which is our body and NCETA (National Centre for Education and Training on Alcohol and other Drugs) to undertake a rapid assessment procedure and research in my community. I live in the community of Murray Bridge, which is about an hour's drive from Adelaide. This led me to being employed in a grief and trauma project part time, due to the rise in numbers of drug related deaths. I became a grief and trauma worker in the community.

Findings from that research were that intoxication with drugs, alcohol or both were perceived to increase the risk of suicide. Intoxication was also believed to contribute to death by accidental overdose. Mental health problems were experienced by 64% of all participants. Depression 40% and paranoia 60% were most frequently reported. Over half of the sample, 52%, had attempted suicide at least twice. 92% of those who had ever attempted suicide admitted to having been intoxicated on at least one attempt. They stated that intoxication often facilitated the decision to go through with an attempt.

The drug crisis in the Aboriginal community in SA had reached frightening levels and in 1999 older people came together to establish a group of concerned grandparents (they call us the 'granny group') who had children caught up in the heroin cycle. Part of belonging to this group meant that I drove a 200 kilometre round trip every fortnight to attend the Port Adelaide Nunga Court to offer support and comfort to the people who have drug related issues and who are facing court that day. My involvement has been as a professional but more importantly as a grass roots person, an advocate for change, through drug support, personal tragedy and being where hurt and death continue to arise.

We are trying to advance the 'granny group' to bring about change for the younger generation. In SA there is a complete lack of facilities for Aboriginal people - facilities that focus on families. If they are going to send their people to any kind of program they can't do it alone. It is a terrible thing to say but they die together so we believe they should all recover together. We are a family people.

What services are available are based on models suited to meet the needs of the organisation's deliverer. If an Aboriginal person fails within these systems it is the fault of the Aboriginal person, not the organisation, and it is a perpetuation of the urban myth about walkabout. It is too uncomfortable to face the reality that walkabout is attending yet another funeral to bury another relative and all too often a young person, all too often a result of alcohol and other drugs.

When I return to Adelaide I will get involved in another Aboriginal Drug and Alcohol Council (ADAC) project to produce a body of information about the impact of alcohol and other drugs misuse by individual and family groups. The findings will be produced in the main as diagram representations of family histories. We will trace back the history of substance misuse to previous generations and examine its impact on the family. Events in the family history are associated with substance misuse that will be recorded in histories and will include domestic violence, suicide, mental health, criminality and other incarcerations, voluntary and forced removal of children, sexual and physical abuse, poverty and unemployment. The picture created by this information will present the connections between substance misuse and other traumas and dysfunctions experienced by indigenous families and trace these relationships across generations.

As you can see, the impact of alcohol and drugs on indigenous families is huge and it is spreading. We, as community people, find it difficult to deal with the traumas of constant death and dying but also a high rate of imprisonment. I overheard a member of the community state that they should change the name of the Adelaide Remand Centre to Aboriginal Remand Centre because there is 90% Aboriginal people in the centre waiting to go to trial.

Thank you for your time and thank you for listening.

> Scott Wilson: Thanks a lot Isabel. As Isabel said drug abuse and addiction amongst Aboriginal people is huge. We believe that it is something that not a lot of people take a lot of interest in. I had a phone call from one of the journalists from Sydney the other day who asked me some questions because he thought that the drug abuse problem was only a Sydney problem. He was quite stunned to realise that it extended further than Sydney.

Douglas Walker

Douglas is a Senior Aboriginal man from Oodnadatta, 1,000 kilometres from Adelaide. Douglas has since a teenager, had problems with alcohol. He eventually overcame a 20 year alcohol addiction and has devoted his life to helping Aboriginal people deal with alcohol related problems. Doug helped establish the Central Australian Aboriginal Planning Unit in Alice Springs, which is the only residential treatment service outside Adelaide. Douglas has had a variety of positions throughout Central Australia and works with the Aboriginal Drug and Alcohol Council's 'Makin Trax' project. This is a 4 year funded project that is attempting to help communities deal with substance misuse and in particular solvents. Their project covers an area from Adelaide to Kalgoolie and up to Alice Springs. Douglas was recently saying that when he looks at his family tree the branches are bare due to alcohol related deaths and in one year Douglas attended 18 funerals for family members who died as a result of alcohol.

I introduce Douglas Walker.

Good morning. Thank you for having me here. I would like to thank the traditional owners of the country and also thank the people whose place of worship we are standing in.

You guys out there and we are all on a journey, a journey of recovery and our paths meet because we are on two journeys. We are going to talk about walkabouts and today we have the other journey of addressing alcohol and drugs. Our journeys cross each other's paths and we are on the road of recovery. The road of recovery looks at sadness, anger, tears and grief and trauma, loss and death.

I first started drinking when I was 13 in a place called Alice Springs where I went to school. I found the school system wasn't catering for my needs and wants, so after getting a few taps on the knuckles I found that school wasn't doing much for me. The best thing I could do was 'see you later'. I told the teacher: "It's not working, I'm going." The Welfare Department in those days made sure that I didn't go through the gates of the school because the police were waiting there. We found a way of going around the police and went back up the hills and, in the old saying, wagging school.

I left the system and 20 odd years later went back into the system. That education system was no better than 20 years before. That was my interpretation of course. I said to education again 'see you later' and I went away.

There was another 10 years before I finally came back. When I did come back I got the biggest shock of my life. At 46 years of age, this year in May, I graduated at Latrobe University. That is a plus for me in my life. I never thought that at 46 years of age I would be still alive. The doctor told me when I was 37: "Mr Walker if you don't stop drinking you'll be dead by the age of 42". I have survived by five years.

But my story is like yours. We have the same journey and my story that I would like to share with you is the story of my family tree. My family tree was like the old desert oak. In the desert the old desert oak is very strong, very tall, it has a lot of branches and the wind and storm come along and try and blow it away but it still stands and the leaves are still green and very strong.

Today, when I look at that family tree, that old desert oak, it is old, the branches have fallen, there are not many leaves on the family tree and so when I talk about my family system I talk about the family tree. There is nothing much left - there are no leaves. Where the leaves were there are crosses. Something similar to what Isabel has shown you.

Our family has too many funerals - too many funerals. You go back home and you have a death in the family. The following day, while you are still grieving, you hear of another death and the sad thing is that

they are mostly young people, very very young people, similar to your family, your sons and your daughters and your nieces and nephews or your grandchildren.

Some of you spoke yesterday. I heard you talk about losing a loved one, but your family tree is still strong like the old desert oak, still got plenty of leaves. Maybe only one leaf is missing, of your loved one. But my family tree is dying. The branches are all gone, the leaves are all gone, so what I am doing today is just like you. I am on a journey of recovery and my journey is looking at your world and my world because what has happened is that we went away from our world and we lived in your world but we found that your world, if we didn't know how to live in it, would kill us.

The thing that is killing us in your world is alcoholism and drugs because it is not part of my family structure. My grandfathers and his grandfathers and their grandfathers never drank, never smoked. They had a value system. I am not saying that we should not live in your world. What I am saying is that we all can live together but our journey of recovery has already crossed over and we need to sit down and hear my people's voice, as the theme of your two day conference is "voices to be heard". We need to talk out loud. We need to tell our stories. We need to share and in this very short time I hope to give you some idea that we are also grieving with pain and sorrow and we have funerals all the time and the sad thing about going to our people's funerals is that 20 years ago when you walked into a church for a service you could smell the church. Today when you go into a church you smell alcohol, grog, our people trying to grieve under the influence of alcohol.

It is very sad. It is also sad because it is like your sadness. You are still grieving. Some of you have made headway. A lot of our people are still grieving but they are grieving through the very thing that caused their grief, that is a bottle or drugs so there is not much left of the family tree. The old desert oak doesn't need the wind to blow it away, alcoholism has done the job of the wind. Maybe next time we meet for a conference like this instead of having a big sea of white faces we will look at a sea of black faces because after all, like I said before, our paths have crossed on this journey of recovery.

One of the things we do in addressing alcoholism and drugs is that we look at treatment and rehabilitation programs, early intervention, harm minimisation. It works in some areas and some areas it doesn't and I am a true believer in recovery and I'm a true believer in treatment because I am in the 11th year of recovery. I gave away alcohol, gave away the 5 litre cask and said: "See you later, I've got no taste for you any more, I want to live." Part of my recovery, my treatment program, is that I want you to understand that if you come to our treatment program you are welcome. You are welcome to join us on our walkabout. After all our paths have already crossed. I am talking to you today in English but my language is for you to come and listen to and understand because my language helps me to be sober today and helps me to stay on the journey of recovery.

Some of the good things we are doing is looking at treatment and rehabilitation programs, looking at awareness education and in all those programs the traditions, the spirituality and the language has to be endorsed and incorporated. It is not that your world and my world don't fit together. They do. It's a matter of saying this works better for me than it would work on your side.

Its a big journey. There is no end. We just have to stay on it and stick together, work together and put into place programs, elements that will help us not to cure ourselves but help us progress and identify our pain, our hurts and our tears, our sorrow.

Thanks for listening.

> Scott Wilson: We hope that this morning's snapshot to look into the lives of two Aboriginal people who work for our organisation has given you an indication of what it is like to be Aboriginal in the 21st century in Australia.

Obviously death and dying are not easy to talk about. What Doug was letting you know was that in the last three years he has had about 30 family members who have died from alcohol related illnesses. Isabel as well is the Chairperson of the Aboriginal Drug and Alcohol Council and she could attend a funeral in Adelaide every day for either a family member or other extended family members and most of those, are young people dying of drug overdoses and car crashes that are a result of drug related issues.

But as Doug says we are here on a journey and we hope that you have taken away something of what we have talked about today.

Anne Deveson, AO

Anne Deveson is a writer, broadcaster and documentary film-maker with a long involvement in social justice issues. She is a member of the NSW Government's Expert Advisory Group on Drugs, and a member of the NSW Medical Tribunal.

Her best selling book about the impact of schizophrenia on family life - 'Tell Me I'm Here' - was published by Penguin world-wide, won the 1992 Human Rights Award for Non-Fiction, and a new edition was released in 1998. Radio and television documentaries on social issues have won widespread recognition including a World Medal in the recent International Media Festival in New York for a program on mental illness.

In 1993, Anne Deveson was made an Officer of the Order of Australia for services to community health and for services to the media. She holds honorary doctorates from the University of New South Wales and the University of South Australia and, in 1995, was an inaugural winner of the Australian Producers' and Directors' Lifetime Achievement Award.

She has chaired or been a member of many major government bodies such as the Commonwealth Government's Advisory Committee on Homelessness, two ministerial committees on mental health legislation, the National Working Party on the Portrayal of Women in the Media; the Better Health Commission; the NSW Anti-Discrimination Board and the Royal Commission on Human Relationships.

She has published five non-fiction books, been represented in several anthologies and her novel about humanitarian aid, 'Lines in the Sand', was recently published by Penguin Books. She is now writing a collection of essays on resilience.

My experience with drugs - drug usage, drugs and the law, drugs and stigma, drugs and community involvement – first came about because my son, Jonathan, who had schizophrenia and who died after seven years struggle with the illness, also used drugs, as do many people with mental illness. From around the time he hit high school, Jonathan began disappearing in clouds of marijuana. I remember a lot of my time was spent after school trying to find him in people's back yards, the bush, everywhere, I never knew where he was, and that's probably a familiar scene for many of you.

Three or four years after Jonathan died, I wrote the book 'Tell Me I'm Here'. I never dreamed it would have the impact that it had. During the time of Jonathan's illness, there was little support, little knowledge about mental illness - just as today, there is little knowledge in many sectors of the community about drug usage. I helped set up the Schizophrenia Fellowship of New South Wales, and then we established a national organisation which is now known as 'Sane Australia'. So I come with a background of direct personal involvement as well as considerable experience in government commissions and enquiries concerned with policy and legal issues. Out of this experience, public and personal, has come a strong conviction, a passion, about the need to tackle issues such as these on a very broad front. It is important to lobby, to work with the media, and to ensure there is adequate counselling and programs of support. There are many areas where involvement is possible, and therefore everyone has a part to play. This is why it is fantastic to come here today and find a group like this where people have obviously come from very varied backgrounds and in some cases travelled long distances.

I thought I would first talk a little about Jonathan and then concentrate on the work I have tackled on helping to overcome stigma against mental illness, because I am also well aware of the very punitive attitudes that exist towards drug usage. community. When Jonathan first became ill I remember encountering a lot of hostility, neighbours who would even say he was evil. He was still only in second year high school when he became known as the scourge of Hunter's Hill – and this was particularly in regard to his use of marijuana. Later he used many different drugs – but usually the cheaper ones like cough mixtures and sleeping remedies. There was even a punitive response from members of the medical profession. One of my most vivid recollections was after Jonathan had attempted to kill himself. It was his second or third attempt and I went to see the doctor at St Vincent's who said in a cold voice: "I really can't help you much with your son's schizophrenia because he is a drug addict." I still remember the anger I felt then and, indeed, these problems of dual diagnoses still continue. I learned in this period that sometimes it was good, indeed necessary, to express anger at punitive attitudes or at neglect, just as it was important to give thanks when people were kind and helpful.

Jonathan once spent nine months in Long Bay Gaol on remand. He was picked up by a taxi when he was psychotic, and because there had been a recent bout of taxi cab murders, the driver became nervous, drove Jonathan to the metropolitan police station where he obediently walked up the steps and told the police he was about to hold up the cab driver for his heroin habit. The words were put in his mouth; he did not ever have a heroin habit – he never used the harder drugs – and he had no weapon to use for a hold-up. Nevertheless, he was charged with attempted armed robbery and it took nine months to get the charges dropped - twenty four hours before the case was due to come to court.

Out of those experiences and out of my own feelings of shame and blame, came eventually the kind of strength that I can see around me here today. And it is okay if you have times when you are not quite so strong, and when your courage cracks, because at times, it will. Let me tell you now that it is 14 years since Jonathan died but there are still occasions when I can be overcome by grief. What has happened or is still happening to us, is often very sad, sometimes unbearably so, and that's why gathering together like this in mutual acceptance, understanding and support is critically important.

I recognised the need for open communication, quite early in Jonathan's illness. In the beginning I was a stiff upper lip person. My parents were English, and I had the sort of upbringing that found me saying: "I'm fine, fine!" when perhaps my leg was falling off. But when Jonathan became ill and was also involved in all sorts of criminal activities because of his drug habit, I recognised that I wasn't going to get through this unless I admitted that I wasn't always fine, and that I needed to reach out for help. That help came in amazing ways. I remember a plumber who came to the house one day, and who stayed the night - with permission from his wife - because at that stage, Jonathan was psychotic and I was scared to be on my own. I remember the police sometimes being kind. I remember the probation officer, Brenda, who was the most helpful person I met in the whole history of Jonathan's illness. She was the one who took the trouble to come to our house and have tea with the other kids so they knew who she was. She said: "I'm Brenda, and if you ever want me, ring me."

So I learned to seek help wherever I could find it. I also had to be prepared for let-downs, like the social worker who said, "I don't know if there are any support groups, if you don't hear from me you know there aren't!"

I also realised it was important to talk to the media. That's not surprising because I had, and still have, a strong media background. Mostly, the media were responsible and helpful. However I must admit when Jonathan died I was let down badly. I received some pretty sensationalised stories in the tabloid press and one or two from people I would have expected better of. In spite of that I believe that bearing witness about the reality of our lives is extraordinarily important. I remember always telling my other two children to talk about what was happening, and they used to tell me to shut up. It is only since they have grown up that they say they are glad that I did talk openly about what was going on. I recall Joshua being in the kitchen with some friends when he was about 11, and Jonathon was behaving pretty weirdly when one of the kids said to Joshua, "What's wrong with him?" And Joshua said, "That's my brother, he's got schizophrenia". When that happened I felt a huge sense of relief, because I am convinced it's important not to hide stuff. Once you hide, once you keep secrets, it's like saying you are ashamed, and that's an awful way to feel and behave

Some time after Jonathan's death, I began working with the media in recognition that the media needed educating in mental illness, and we needed educating in the best ways of enlisting media help. Our aim was to overcome stigma and misinformation. We ran workshops all around Australia dealing with small groups of media – perhaps 20 at a time. What we did was very low key. Over sandwiches and coffee we would spend a couple of hours making friends, and exchanging information. We would have people who talked about mental illness, including drug abuse – a doctor, a carer and a consumer – and we would ask the media for their help and this was the key to the workshops. We were breaking down the 'them and us' barriers by saying: "Look we need your help, what do you suggest, what do you advise?" It helped us develop media networks around Australia that became strong and powerful. This approach, to break down the barriers, was used by the Minister for Health, Neil Blewett when I was on the Better Health Commission. He ran a two day seminar in Canberra involving a cross section of media people, publishers, editors and journalists; television and film producers, actors and writers. At this workshop we used role-playing to help break down the lack of understanding and suspicion that historically had existed between journalists and doctors.

For a media person, this has practical outcomes. For example, when you work as a journalist, particularly on radio, you devour an enormous amount of material. For nine years I ran a daily current affairs program on the Macquarie network and I used to sit there and cannibalise the early morning news. What I needed was reliable contacts and friends who would give me information across a wide range of topics. For example, if a story were to come in on drugs then hopefully I would have one or two key people I could turn to, I could trust.

Then I took the communicaton workshops to the next stage where I helped people with mental illness and their families develop media skills. We workshoped how to turn the personal into the political. I took a similar approach with the Brotherhood of St Laurence. The Brotherhood was concerned about single parents being stigmatised because whenever there was a story about single parents and poverty, it would nearly always be 'a blame the victim story'. Television cameras would come in and instead of filming the person they were talking to - the single parent - the camera would be scouring the ground looking for a dirty nappy on the floor - that kind of thing. These workshops were to empower people to tell their own stories and to take control of them. Again, they were small and informal. We didn't need expensive media consultants, we didn't need expensive equipment, we just had an ordinary old video camera and a monitor. Let me give you an example. If the interviewer said something derogatory about

single parents always holding out their hands, the person learned to say: "Yes, I am a single parent," and "Yes, we are very poor, but we wouldn't be poor if only there was decent income support or if only we weren't financially penalised every time we worked."

These workshops were effective in two ways. They were effective in their immediate outcomes - which was how to work with the media - but they were also very affirming . If you have to tell your story and if you continue to tell your story, once you do it in public, then you are saying: 'This is the truth, this is part of a common human experience, it is a part of what can happen to any of us, and I am not ashamed."

Lobbying is another arm in this effort to break down discrimination and to improve services and information. Again, some people are excellent at lobbying, some aren't, so it's a case of finding where your skill is most directed. I know there are people here who are highly skilled.Tony and Brian and many of you have been doing this now for years. Yes, it is exhausting, you have to be strategic, you have to find who your friends are in the political scene, or in business, or in the media, and use your contacts to get across your story or to raise the broad profile of your concerns.

Stigma and a lack of information about drugs and drug usage is changing , but it is a pretty slow change, and at times that can be overwhelming, which is why I return to that issue of support, particularly family support. It has always struck me as extraordinary how often families are left to flounder on their own. I assume that's what happens to a lot of you. Is that true? When something like this happens the whole family is obviously involved. You need information, but you need support - a whole range of support. In the field of mental illness, we know now from research that if there is support for families, for the whole group, then the outcome is infinitely better, particularly for the person who has the illness.

And finally there is the way we support each other, and the way we support ourselves. That can be hard, if you're trying to hang onto all the pieces, the family around you as well as the person who is using drugs or who is in trouble in other ways.

I remember thinking I was getting a lesson on management when I first went to run the Australian Film, Television and Radio School. I had never managed a big organisation before and I thought I knew how to do it until I actually arrived. By the end of the first week, I realised I was way out of my depth, so I went to a friend, a marvellous woman called Stella Cornelius, who was extremely successful in the business world, and she headed up Australia's program in the UN Year of Peace. She is a phenomenal woman of great integrity and courage and compassion and she has been a mentor for many people. So I rang Stella and said: "Stella, I need help, I'm not coping," and Stella said: "Come around.". I thought when I walked into the room, I was going to get a lesson. I almost pulled out my notebook and wrote: 'Point number l. How to be a good manager.'

Iinstead, she took me by the hand and said: "Just lie down there." So I lay down and she covered me with a blanket and gave me honey and warm milk and a packet of gold stars. A packet of paper gold stars, the kind they give little children in playschool. I looked at it, and I said: "What on earth is this for?" And she said: "For you." She went on to explain that after her husband died, and she became prominent in different initiatives, she recognised that she was in the front line and it was unlikely that people were going to look after her. She knew she had to look after herself, and this meant rewarding herself every time she did a good job. She bought herself these gold stars and every time she felt she had a good day or achieved something worthwhile, she would give herself a gold star. This may sound naive, but for me, it also worked. I still have these gold stars.

I am honoured to be here, I am touched, I have found it very moving. It is only through sharing our stories, acknowledging our vulnerabilities and rejoicing in our love and our courage that we become truly human. Today, we are sorely in need of honesty and integrity, we need compassion and kindness, we need

to give and receive love. Sometimes, as money becomes the measuring stick of a great many things in our life, we lose sight of the fact that we don't live in piles of money, we live in a society made up of people, people who run heroic journeys and who should be supported and praised. So I salute you, and thank you for asking me here today.

Stepping Stones to Success

Tony Trimingham's life was changed when his son Damien became addicted to heroin, and it turned upside down when Damien died of an overdose. For 20 years Tony had worked as a relationship counsellor, with people recovering from divorce, separation and bereavement. He looked desperately to this body of ideas to find a way through his despair. He also heard the heart-rending stories of other family members who joined Family Drug Support (FDS). As he met people who had developed tremendous resilience, he noticed changes in himself and in many of the others who worked with FDS.

He began with the body of knowledge from relationship counselling, and in particular to a rebuilding concept which helped people to identify major aspects of the divorce process.

The elements of this rebuilding concept are that:

- they are not alone in their journey,
- their emotions, behaviour and thoughts are not abnormal or unusual,
- there is a road map to identify exactly where they have reached in rebuilding their lives,
- knowing the nature of the whole journey helps them to see that going through 'negative' stages is a necessary part of healing,
- they can and will recover,
- they can learn skills to help them, and other family members, to survive, and
- they can learn more about themselves and their relationships to make future relationships more fulfilling.

This model must be modified to meet the needs of families touched by drug addiction, because there are two obvious differences between divorce and drugs. It usually takes much longer for a family to deal with drugs; and they can expect much less help, support and understanding. In this modification, Tony was greatly assisted by the work of Jon Rose and Claudia Houareau from Drugnet, Western Australia. Their presentation to FDS volunteers about the concept of 'Collective Wisdom' led to a series of conversations. The "Stepping Stones" model emerged from this collaboration.

The program recognises the value of families as the most important resource in managing drug use. The family can be strengthened by the collective wisdom of other families and professionals. In fact their ability to cope and survive is directly related to the assistance and support provided to them. Especially with such support, the family achieves success by identifying stumbling blocks and barriers and transforming them into stepping stones.

Every family situation is unique, but there are commonalities. The Stepping Stones 'maps' therefore help people to see where they are, and where they are going. They also demonstrate that other people travel these roads successfully.

Values inherent in the program

Family Values

- Family members can grow and adapt.
- Drug users have the right to be treated with respect and dignity.
- Open and direct communication is the most constructive approach.
- Confidentiality is not necessarily a barrier to including the family.

Program Values

- Working in collaboration is better than working alone. The course embraces the philosophy of harm minimisation and a shift in focus from problems to solutions and enhancement of life goals.
- The overall outcome swings in favour of the good.

Assumptions

The program makes the following assumptions:

- If the interest and involvement of the family is nurtured it will maintain the energy required for change.
- Most families have influence over the drug user. This influence may be strengthened when the drug user is more dependent on family support.
- The influence of family-peers-partners can be positive or negative.
- Change is inevitable – it can be positive or negative.
- Ventilation of emotions and acknowledgment of feelings is therapeutic.

Tapping into the Collective Wisdom

- The family has skills, knowledge, resources and expertise in dealing with their drug issues.
- It is useful to collect and share the practical wisdom of group members.
- Professionals may have knowledge, skills and expertise, which may be useful to families.
- Every family member is important and every relationship within the family is important. Each family member may require support at any time and all family members may be able to enhance change.

Involvement

Involvement of all family members is preferable – however effective change can be (and often has to be) achieved with one or two supportive and committed members. Families generally do the best they can with the circumstances, information and support available in their particular situation.

Acknowledgment

Acknowledgment of achievements (even if things seem to be going badly) is important. Success is determined by the belief that you have done all you reasonably can to improve the situation.

Goals

Most family members' primary stated goals are to solve the problems and achieve drug free status. The reality is that these goals may take a long time and may not be achievable. However, redefining goals around important life areas and working to incremental steps will lead to these sustainable results.

- Improved wellbeing of the entire family, including the drug user.
- Improved problem management skills.
- Increased confidence and competence in managing drug use issues.
- Group members gain a realistic view of where they are in the process.
- All relationships are acknowledged and strengthened.
- A balance of emotional management and strategic development is achieved.
- Family members regularly use processes that effect and sustain change.
- Members identify and work through the 'stepping stones' model.
- They adopt a solution-focussed approach and action learning methods.
- Support mechanisms allow further development.

A matter of definition

One of the key concepts of 'Stepping Stones' is re-defining 'success'. Our definition of success does not incorporate drug-free status as a definite and primary outcome. Instead we find that the by-product of having support, collective wisdom and coping skills is that the drug user is often healthier and moving more positively and quickly through his or her 'Stages of Changes'.

Families engaged in support react much more positively to setbacks. One family recently had their daughter and son-in-law lapse after 26 months drug-free. This family was able to reframe and help them back on track. Another family whose son was caught up in gang warfare was able to think rationally and give practical help, where previously they may have fallen apart in despair.

Family support does not guarantee success for the drug user when dealing with heroin use. Death, disease and the criminal justice system are ever present. However, the successful outcomes that we have witnessed nearly always have strong family support. The other comment we often hear is that 'through these troubles we have become better parents and our family is now stronger'. That's success in anyone's book.

Agency Stories

Chair of this session was Ann Symonds

Passion, Challenge and Hope

Tirrania Suhood, Blacktown Alcohol and other Drugs Service

How wonderful to have a conference that gives small organisations a voice. This is so much needed. There are so many stories that I could tell. This story will be about Blacktown Alcohol and other Drugs Family Services (BADFS) as well as being my personal story. It acknowledges the service that BADFS provides, though equally important discusses organisational concerns - recognising that without the organisation there is no service.

I have worked at BADFS for eight years. My family and friends and colleagues from other services regularly as: "Why do you not just move on. After all the conditions are not good, there's no career prospects, it just doesn't have the status. Why stay somewhere where you have to fight to maintain your own position. Its not that important a job or organisation. After all it's only small!"

Some colleagues who work in large organisations, suggest I consider working for them. I have not been encouraged to stay with this organisation. I do have skills and qualifications that would make it easy for me to move, my most recent being Masters in Community Management. What has kept me here has been the relationships, the needs of the community and my own need to be satisfied in what I do and to make a difference. This period has been hugely challenging and exciting.

I realised after a short time co-ordinating BADFS that a small organisation can make a lot of difference at the local level and beyond. BADFS is a family service. We recognise family and social context when we address drug issues. This understanding has in turn supported me to understand wider systems. We recognise alcohol and other drug use can be both a problem and a symptom of other problems. We offer individual, couple and family counselling as well as participating in health promotion activities around relationship and alcohol and other drug (AOD) issues. Many recognise the value of BADFS. We continue to receive positive feedback on our approach to AOD issues. We continue to see clients who tell us there is nowhere else they can go.

The work BADFS and other small organisations do at the local level is very important. I think there is general agreement on that. However, people seem to be less clear on the significance and influence of a small organisation beyond the local level. While the previous National Drug Strategy(1993-1997) identified family issues, it did not include them in strategies. The last NSW

Drug Strategy (1993-1998) did not even mention 'family'. Before family members like Tony Trimingham and Brian McConnell found their voice in the media, I often found myself at state, regional, local conferences and meetings alone in advocating for families in relation to AOD issues. It made no sense to me that I was raising these issues when I came from such a small organisation. It soon became clear that small organisations often carry national issues and are not recognised for this. I cannot know the impact my organisation made on these issues. I do know that this organisation has been and continues to be important in influencing thinking in the field. The influence is now also on issues beyond the AOD field.

For some years I have recognised the importance of such a small organisation to both address the needs of our society and influence future directions. I have also recognised the importance of encouraging dedicated staff to use their potential. I was sure that we would be supported to further develop the service. After all, small businesses are supported financially to be innovative. Yet, with funding increments not meeting increased costs, for a number of years staff meetings discussed the possibility of our hours being dropped unless funding could be found. Decreasing an 80 hour per week service meant decreasing the hours of all three staff who work at BADFS. (No wonder people ask me and other staff why we stay!). Additional funding was found to delay this process. However we have now had to reduce the core hours of the service. To receive such positive feedback about the organisation but little support to encourage workers to stay or support the organisation just did not make sense. One of our workers did eventually leave.

I was also seeing skilled workers leave other small organisations for better conditions and status in large NGOs, government departments and even the private sector. I could no longer stay in this organisation without sharing my concerns. BADFS had also reached a point where it needed more support soon in order to survive. I wanted to stay if the support was there but otherwise I was prepared to leave. I decided to seek support and share my concerns. This resulted in a meeting of 17 stakeholders including directors of regional government departments and peak body representatives to look at ways forward for BADFS. The attendance of such senior representatives renewed my optimism, hope and trust. While no funding was received from this meeting, new valuable relationships were formed. These relationships have supported further work of the agency and indirectly they are supporting BADFS survival.

BADFS has since received funds to co-ordinate a community and inter-agency project called 'Bridges'. The project seeks to enhance relationships between young people, adults and agencies while creating an environment that develops knowledge and skills to better work together to address drug issues. The project involves a series of gatherings to achieve its goals. It is a very exciting project.

However, core funding for the agency is reducing in real terms and long-term (possibly short-term) survival of the organisation has never ceased to be a concern. Raising these issues to funding bodies and peaks has not resulted in quick enough action to assure me that my organisation will survive. I have also realised that this is a national

issue and many small organisations are struggling. We are in an economic and competitive climate where large is valued over small. When funding is available it is often the large organisations that receive large sums, while small organisations struggle to obtain an additonal $10,000 or $20,000. We do not have the resources or profile to address issues for our survival. We also do not have a body that represents us, unlike small business that has a chamber of commerce and even a State Minister.

Hence this year BADFS has been involved in initiating and facilitating 'VOICE for SONG - Small Organisations Non Government' - a group of small organisations from various fields to find our voice and no longer be alone in our struggles for survival. Our mission is to ensure the survival and development of small-non government, not-for profit organisations, through developing and implementing local strategies and promoting the development of a national body to represent them.

We recognise that there is little awareness of the value and issues for small not-for-profit organisations. Without such recognition, local strategies are unlikely to be successful. Hence we seek to address our mission by being a VOICE for small organisations, challenging the small/large culture as well as developing local responses. We believe small and large organisations are both important. Neither structure is better. We are pleased that we are being resourced by our regional peak body - Western Sydney Community Forum. And by the time of this presentation we would have held a forum entitled 'VOICE, Value, Survival and Co-operation of Small Organisations'.

The development of VOICE for SONG has also helped me to stay at BADFS. To be part of a group that is challenging the small/large culture gives me hope and strength and excitement to be part of a movement that seeks to maintain grassroots decision-making and further community and not-for-profit motives in a society that is increasingly motivated by profit.

Like many of our clients who need a voice to survive, so too do organisations - so that **we** can still be around to support them and strengthen our community.

Drug and Alcohol Issues in Rural and Remote Areas

Georgie Clarke
Project Self Discovery Co-ordinator
YWCA, Toowoomba

My role is that of a Project Co-ordinator for Project Self-discovery based at Toowoomba in the Darling Downs, Queensland. My current and previous roles have brought me into contact with many rural communities and their young people who travel to Toowoomba looking for work and education.

I have observed many differences between rural and remote communities and the larger regional areas and therefore differences in the way the issue of drugs and alcohol should be managed. In order to offer effective support, awareness of these differences needs to be raised in order for the rural and remote "voices to be heard". The following are some of my observations.

So what is different in rural and remote areas?

The mean consumption rates of alcohol and tobacco increase in rural and remote areas of Australia. The further you move from the coast, the more this increases. Many variables can contribute to this statistic such as drought, the economic decline of the rural sector, small population, boredom and unemployment. But the cause aside, it is a social norm in these communities to consume to excess on a regular basis. It has become part of the rural culture and the pressure to be a part of this is increasing.

Due to a smaller population there is less choice for young people in their peer associations and this can create increased peer pressure and therefore increase the use of drugs and alcohol. Binge drinking in both youth and the older

population often is a form of self-harm, unrecognized and under-acknowledged by communities and professionals alike.

Confidentiality and lack of anonymity in care is a critical issue. For these reasons many people, particularly young people, do not seek or receive the care or support required.

Much of the treatment for people with a drug and alcohol problem in rural communities comes from local GPs. It is widely acknowledged that rural and remote areas face extraordinary difficulty in securing essential medical practitioner services. The Federal Government has recently developed incentives to lure young graduates to take up positions in rural communities. A concern in rural communities is that these young doctors will take positions only for the required short-term contract placement and then move on to more lucrative and professionally supportive urban practices.

The lack of training opportunities for young medicos in rural areas also compromises 'contracted placements'. This set of circumstances is not limited to GPs. Other workers in the social sector, i.e. youth workers and counsellors, face the dilemma of training versus the cost and time in the community where their services are desperately needed.

With GPs as the primary service providers to those with drug and alcohol issues, few non-medical forms of treatment are available. Unfortunately, this can often mean that the symptoms are being treated, not the cause.

For other issues to be addressed effectively, individuals may need to travel to larger regional centres, leaving their properties, children, families and support networks behind. One must ask how effective treatment will be in these circumstances.

Rural Women

Why is it different for women?

Statistically women have greater rates of depression than men and this is even greater out west. I believe this is grossly under-reported as women in these communities often struggle on without professional support or assistance.

Women in rural communities often experience extreme isolation. While their partners and families are out working the property, often interacting with staff and business contacts, women are back in the home raising the children and doing the household duties. Such lifestyle options are immensely rewarding and stimulating for many women, but for those who are experiencing difficulties their situation can be terribly lonely and painful.

In rural towns the lifestyle and choices are on display and open to intense scrutiny by the community. This can be a good thing, in that it can make you accountable and answerable for your behaviours. On the other hand behaviours that are not socially acceptable or have a stigma attached, such as domestic violence and abuse, depression and self harm, are hidden from the community. Such scrutiny and perceived judgement can affect, for example, a decision to obtain assistance. This can lead to depression and other negative side effects.

Finally, and maybe most importantly, drugs and alcohol are easily accessible and often a good alternate mechanism to cope with many of the pressures both women and men face. The pressures are compounded by the fact that drinking is a social norm.

But people in the bush are battlers and the creativity that comes from lack of funding and resourcing is something that is not often seen in the larger centres. And like any other area there will be an element of trial and error. The bush, like the city, has particular hurdles to overcome in addressing the issues of drugs and alcohol. If workers are aware and understanding of the issues, the assistance we provide will be much more effective.

Parent Bereavement Support Group for those Affected by Drug-Related Death

Charl Van Wyk
Palmerston Association Inc

The "Voices To Be Heard" Conference provides a great opportunity to showcase the innovative work being pioneered in Perth by this group. The results have so far not been published and the conference represents an ideal opportunity to make those working in the field aware of the significantly improved grief outcomes which have been achieved. It also highlights the need for additional support for families.

The group works in the area of grief and bereavement, linking work in the drug field with the establishment of a bereavement support group for parents who have lost children in drug related incidents.

This group has run for three years. Its funding is provided by Mareena Purslowe & Associates (funeral directors) and the West Australian Drug Abuse Strategy Office. Premises and administrative support are provided by Palmerston Association Inc.

Over the last decade thousands of Australian families have been affected by drug-related deaths. Where are their stories? Where are the voices of the grieving mothers and fathers?

Many families experience marginalisation because of a child's drug use. The death of that child through drugs further stigmatises and alienates families who have already been pushed to the outer.

Forty Perth parents have shared their mourning, supported each other in their journeys through grief, and readjusted shattered lives in what is believed to be the only professionally facilitated bereavement group of its kind in the country.

Parents attending this group consistently report: reduced mental and physical health problems; less sick days; no substance abuse and increased sense of well-being. Most startlingly, in the three years since the group began there has

been no partner relationship breakdown, in spite of oft quoted figures that fifty percent of partnerships break down within a year of the death of a child. This figure rises to seventy five percent within five years.

Members of the group have written of their experiences - painful, devastating but ultimately inspirational. They want the message to be heard that there is a meaningful life to be lived by parents after their children's drug related deaths.

A workshop at the conference should explore:

- what makes grief experienced as a result of drug-related death different to other grief,
- the grief needs of parents,
- the issues faced when working with this client group, and
- helpful strategies for parents.

If time permits, a paper looking at the difficulties faced in establishing this group and in publicising its existence could be useful for other people considering forming a similar group.

A New Sibling Peer Support Group

Janet Bramich & Elizabeth Gregg
Centre for Adolescent Health,
University of Melbourne and Royal Children's Hospital, Melbourne

Background

The Sibling Peer Support Group is an innovative 12 month pilot project coordinated by The Centre for Adolescent Health and North Eastern Outreach Drug & Alcohol Service (NEODAS). This project is a *Turning the Tide* initiative and will be completed in February 2001. The group is for young people, between the ages of 13-18, who have a problematic drug user in their family. The group aims to provide support and information, promote harm minimisation and reduce the sense of isolation. This project was born out of the recognised need for specific support for adolescent siblings of problematic drug users.

Research has identified that there is a greater risk for drug use in the siblings of young people who already have a drug problem. Those with siblings (particularly older siblings) with drug problems are often introduced to drug taking behaviour at an earlier age and are influenced by the modelling of drug taking behaviour by their siblings (Barnes, 1990; Clayton & Lacy, 1982; Brook *et al.*, 1983; Duncan & Petosa, 1994; Lloyd, 1998). This research supports the notion that siblings of problematic drug users are vulnerable to risk taking behaviours.

In a fortuitous coincidence NEODAS, which has been running a parent support group for over two years, had identified the need for such a group and approached The Centre for Adolescent Health to form a collaborative relationship to initiate the project. The first author (Janet Bramich) coincidentally approached NEODAS to draw attention to the special needs of these young people. At the same time, a family known to The Centre for Adolescent Health offered the Centre a large donation with the request that the money be used to support young people with a problematic drug user in the family.

Peer work as a strategy

The use of peer work as a strategy for prevention of drug use with young people is based on the social development model (Catalano & Hawkins, 1996), which recognises the influence of peers during adolescence. Young people often develop their values and norms through the experiences that they share with their peers. Peer support groups provide a supportive and positive peer environment in which the exploration of these values and norms can occur.

The efficiency of peer work in substance use prevention has long been documented as beneficial to increasing well-being while contributing to health promotion. Indeed, the Victorian Premier's Drug Advisory Council report recommended its adoption. It has been shown that young people who have access to supportive social ties are more likely to avoid negative coping strategies such as drug abuse when under stress (Cassel, 1976; Cob, cited in 1992; Lawson *et al.*, 1992). Theory states that peer group bonding can lead to unhealthy behaviours where the peer group norms are favourable to drug use and antisocial behaviour. In these situations connections to adults who promote

healthy behaviours and beliefs can be critical in promoting resilience and encouraging healthy peer group norms. The proposed intervention includes the critical component of an adult group leader who will assist and mentor a peer co-leader. Training components, adapted from the Centre for Adolescent Health's CHIPS intervention have been designed to encourage participants to develop positive leadership qualities and healthy norms.

Evaluation

The Centre for Adolescent Health is evaluating this project. The design comprises both qualitative and quantitative methodology. Initial findings will be presented, with early indications being very encouraging.

Authors

Janet Bramich is a youth worker with a post-graduate qualification in addictions and has worked with high risk young people for 13 years. Her experience ranges from working in secure welfare services for males and females in crisis, residential units in the community and a residential withdrawal unit. For the past year Janet has worked for the Centre for Adolescent Health as a peer support project worker at Metropolitan Women's Correctional Centre (Deer Park prison) and has been the project worker on the Sibling Peer Support project.

Elizabeth Gregg has been a Senior Research Fellow at the Centre for Adolescent Health for over two years. She has evaluated projects involving adolescent risk behaviour. She has co-authored a generic evaluation model for peer support for the Victorian government, and is completing a PhD.

A Small Voice from Far North Queensland

Rose Isherwood
Tablelands Alcohol & Drugs Service (TADS)

I would like to introduce our new service on the Atherton Tablelands. We are funded by the Commonwealth Department of Health through the National Illicit Drug Strategy. The project is funded for 4 years. This new service commenced late in July 1999.

The aim of this service is to provide a dedicated drug and alcohol service on the Tablelands targeting 12-25 year olds. Our geographical area covers Mareeba, Atherton and Ravenshoe. Our objectives are:

- to provide an effective and efficient treatment service for individuals and families where illicit drug use exists,
- to determine the prevalence of the harmful use of inhalants among young people and develop strategies to implement effective treatment, education and prevention programs, and
- to reduce the non-medical use of drugs by young people and prevent the initiation or uptake use of alcohol, tobacco, illicit drugs and solvent use.

This being a new dedicated alcohol and drug service on the tablelands there was a need to network with existing health services. TADS is a non-government organisation. The original service proposal was to have a team in Mareeba, Atherton and Ravenshoe. Unfortunately, funding was available for only one registered nurse, one health worker, a part time coordinator and a part time administrative assistant. As Atherton is central in the region, premises were located in the Main Street of Atherton, close to public transport (which is limited), set up with duress alarms, IT infrastructure and disability facilities.

With the limitations of human resources there was a need for the cooperation of existing health services, such as hospitals, community health, indigenous health services, GPs, rehab services (what are they in rural areas?) and other support services such as the basic human needs like accommodation, food, money and security.

TADS therefore developed resource manuals. One was drugs information and fact files, and and the other human resources such as accommodation, Centrelink, family support services, transport services, etc.

TADS staffing consists of:

- a Coordinator/RN/A&D counsellor employed fulltime,

- an indigenous health worker, continuing studies, employed fulltime, and
- part time administrative assistant.

The population of the area served is:

- Mareeba Shire 18,900 (town area 8,500)
- Atherton Shire 10,500 (town area 5,500), and
- Herberton Shire which includes Ravenshoe – (5,100_

After 12 months and from stats collected for the service, the funding body agreed to some service changes which are:

- to open the age group,
- to respond to alcohol, tobacco and other drugs,
- to maintain a youth focus, and
- to support the upskilling of health professionals in our geographical area.

Our service stats identified a demand for alcohol dependence counselling.

TADS developed a data collection tool in line with the National Minimum Data required by the Commonwealth funding body. Other administrative paperwork had to be completed including client survey forms and grievance procedures.

TADS is now into the second year of operation. Our first annual report has been completed for the Commonwealth Department of Health and Aged Care. We have operated within our budget. Our client statistics are as follows:

Enquiries & clients -

- number of enquiries for the year is 158,
- number of referrals for the year is 67,
- number of active registered clients is 44, and
- number of active registered clients at the end of this period is 15.

Substances

The following are the substances that the enquirers/clients required information/counselling for:

	Clients	*Enquiries*
General enquiries	44	25
Alcohol	25	37
Anger Management	-	1
Hypnotics	-	1
Inhalants	1	2
Marijuana	3	8
Mushrooms	-	1
Opioid	7	12
Other stimulants	-	2
Pain Management	-	2
Suicide Management-	3	
Speed	6	17
Tobacco	11	3
Caffeine	-	1
Methadone	-	1
Sedatives	-	3

NOTE: All our registered clients are included in these numbers.

Conclusion

I believe TADS has responded well to the community's alcohol, tobacco and other drugs concerns in a very short period. We continue to liaise with and support various community groups and have developed strong partnerships to reduce drug related harm. There is still a lot of work to be done to reduce drug related harm for individuals, families and communities.

Our vision remains. It is to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reduce the harmful effects of licit and illicit drugs in our community by working in partnership with the community.

This service is sponsored by the Wuchopperen Medical Service, Cairns.

Life Education

Richelle Arnott
Assessor and Workplace Trainer
Life Education NSW

Life Education NSW this year celebrates 21 years of providing quality drug and alcohol education to primary and secondary school aged children across the state. Life Education has provided an effective drug education service to young people that has incorporated:

- anatomy and physiology,
- effects of drugs and alcohol on our bodies,
- acquisition of skills to overcome and understand pressures to abuse our bodies,
- awareness of our own uniqueness and the potential of other human beings,
- training of others, and
- provision of facilities to train.

Life Education NSW is a community-based not-for-profit company. We maintain strong partnerships between the community, the corporate sector and government departments**.**

We are a registered training organisation accredited by VETAB to provide:

- Certificate II, III and IV in Community Services (Alcohol and Other Drugs Work),
- Certificate IV in Assessment and Workplace Training,
- Statement of Attainment in Training Small Groups, and
- Department of Industrial Relations Modules.

We also provide instruction to frontline workers in:

- communication with clients – oral and written,
- funding submission preparation,
- working with volunteers,
- advocacy skills,
- client and community need assessment,
- empowerment,
- working with families,
- running parent sessions,
- community education and
- training and skills development.

As part of our own internal training program, we have links with the University of Technology in Sydney and collaborate on a Graduate Certificate in Adult Education in Drug and Alcohol Education.

The theme of the conference "Voices to be Heard" reflects our organisation's values of community partnerships and positive outcomes. We are keen to empower agencies and families through our training programs and can tailor our programs to meet the needs of the client group.

In accordance with National Assessment and Training Principles, our trainers are qualified and accredited by VETAB as appropriate personnel to provide instruction. They have many years experience in the Community Services and Health Industry and Vocational Education and Training.

Agency Workshops' Outcomes

Workshop 1 - Networking and Support

Members attending this workshop identified the extreme difficulty for any one agency being able to keep up with the details of the many, varied programs, projects and services relating to drug issues. If any one agency tried to keep tabs on these it would be very difficult and time consuming.

In this environment networking for small agencies is very important because services need to deal with every problem a client presents regardless of what the problem is. Networking enables agencies to know about other services and make appropriate referrals where they do not have the ability to deal with that particular issue.

The workshop also identified the issue of the different perspectives taken by service providers, clients and their families. This was considered so concerning that it was referred to as a divide or a gulf between families and service providers.

The different terms and language used are also a problem. For example, illicit drugs and alcohol may be regarded as being different i.e. alcohol not being regarded as a drug. The use of terms to describe drug use are defined differently by different services, clients and their families i.e. abuse, addiction. Some may see certain drug use as abuse or even addiction and some may use different definitions. Sometimes the criminality issues interfere with the effective treatment of drug issues as a health problem. Organisations need to be aware of these different perceptions when networking.

Collaboration between services is needed but collaboration is difficult to foster in a competitive funding environment. All parties (government, non-government, professional, volunteer etc) need to develop interpersonal skills and respect for difference, and importantly recognise the need to work collaboratively despite the difficulties imposed by the funding environment.

Networking

The most effective and powerful approach for networking is face-to-face. It should not just include those involved in alcohol and other drugs but should include related areas e.g. mental health, bereavement etc.

A variation to face-to-face is to talk to professional groups, interagency meetings, or seminars to promote your service. This also provides an opportunity to learn about other groups. Remember however that when attending a conference or meeting you need to talk to people, interact and participate fully.

Another option is to use personal contacts – friends, or friends of friends in influential positions. In every organisation of a reasonable size there are 'natural networkers'. If you can find such persons in your organisation and give them the job, then your organisation's networking should improve substantially. If you can formalise the position (e.g. through funding for worker/networking project) then so much the better.

The production of cheap easily copied flyers or newsletters describing your service is another way of initiating a network.

State and local governments (i.e. councils) need up-to-date information regarding services in their area – people think local when trying to access help and support. In establishing a network governments, both state and local, should not be forgotten. Indeed funding may come from one or both and it will therefore be important to keep them involved.

A centralised data-base of services and the production of a directory that is up-dated annually and for which appropriate organisations could have access would be a valuable tool.

No agency can afford to be without internet and email access. In addition to the ability to gain access to information that is up-to-date it is also an excellent means of networking without the overheads of travelling.

Support

Workshop members recognised the need for support. This could take the form of peer support, some form of clinical supervision, mentoring, or use of an employee assistance program. For small agencies these methods would overcome isolation.

Peer support was seen as important because grief and loss are very real issues for employees of small agencies where close relationships develop. Reference was made to peer support services and confidential counselling services in the US.

Clinical supervision, if identified as necessary by agencies, could be an external service, possibly a contracted service, but made available on site.

Mentoring could take place outside the agency's workplace, thus recognising the difficulty of size that smaller agencies might have. Two small agencies could for example cooperate in that respect, sharing their skills and experiences. The establishment of a register of mentors prepared to provide peer support was suggested (perhaps by NADA).

Workshop 2 -Threats to Agency Survival: Internal and external issues of governance and management of small organisations

Presenters: Peter Connie, Larry Pierce, Anne Basic

Representation of interests of small organisations

The workshop provided an opportunity to set up a working group to establish a national secretariat for small organisations.

A strength of community movements is that they can generate community support for their cause in aid of government support and funding. However tensions exist between mobilising activity at the grass roots and the top down planning demanded by government.

There is an opportunity for small organisations to develop bottom up approaches that address drugs. To do this they should identify their similarities as well as their differences

Small organisations should organise conferences and events like the present one to raise the profile of their issues. They feel that peak bodies have failed to represent issues of concern to them. These bodies are dominated by large non-government organisations.

The conference should recommend the establishment of a reference group for small and emerging organisations.

The development of models of co-operation and networking was a key theme. Small organisations need to think strategically about where they are going and sources from which they can secure their funding. ADCA suggested consideration of the establishment of a reference group or that the existing

ADCA reference groups integrate small organisations issues into their work. An objective is to have peak bodies giving top priority to the concerns of small organisations.

Funding

Although small organisations depend on governments for funding it was felt that government money belonged to the community. This affects the extent to which small organisations should be subject to interference from official funders.

It was suggested that funding should not be the barrier that the conference was saying it was. It was observed that governments are not as open as they were to influence by lobbying from peak groups or, indeed, from any other lobby group. Drug use is not seen as a vote winner.

It is a challenge to manage services in the new economic environment. Small organisations lose staff due to the lack of resources. There is a disparity in pay rates between the government and non-government sectors. Resources and accountability are real bones of contention.

Administrative burdens imposed by funders on small organisations need to be recognised. This is particularly so in the case of short term project funding and reporting requirements that are hard to comply with.

Peak bodies need to press the right 'buttons' to secure government funding.

Concerns about funding must not take over from the grass roots passion of small organisations and the sense of community that they exemplify.

Workshop 3 - Volunteers – Recruitment, training and nurturing

This workshop was presented by Roison Smith from Quality Management Services which is developing standards and quality models for the NSW Health-funded non-government organisations. A co-presenter, Joy Barnett is Director of the School of Volunteer Management from Volunteering NSW. The facilitators were Roison Smith and Vivien Crawford.

Five key issues were identified as relevant to this workshop. Some basic strategies were worked through as guidelines in dealing with each.

Standards needed for volunteers:

- recruitment,
- nurturing, treatment and retention of volunteers,
- Prohibited Persons Declaration, and
- insurance.

Several resources are available for groups using volunteers. Volunteering Australia has a 'Standards' booklet, and much expertise in the field. The booklet provides guidelines for 'best practice' for volunteer involvement in providing services. Issues include planning, reviewing and accountability. There is also the 'Quality Management and Services' guidelines for small organisations (five or fewer volunteers).

Volunteers NSW or Volunteers SA (among others) are state based groups which help with recruitment. The time-honoured method of advertising in newspapers is another approach.

Clear definition of roles and tasks of volunteers and their overseers is a basic requirement for smooth relationships, and is part of the nurturing and positive treatment of volunteers. Such smooth working relations ensure that the group retains its volunteers. Other practical aspects include reimbursement of costs – e.g. train travel, refreshments. Volunteers should not work more than six hours a week. Respect to volunteers shows that they are valued members of the team, whose contribution is as much appreciated as that of their paid supervisors. Supervision and debriefing help to keep the service running smoothly and help to retain volunteers.

Volunteers working with children must sign a 'Prohibited Persons Declaration'. In NSW this document is on the Department of Community Services website.

Cross-cultural issues can be eased by ensuring a diversity of backgrounds of the volunteers. It is impossible for every service provider to have volunteers from all cultural backgrounds, so that volunteers must be sensitised to cultural issues. The service provider needs to ensure that literature is available to inform volunteers.

Protection for the organisation in the form of insurance for staff and volunteers is crucial. AON Insurance is very helpful and has expertise.

Workshop 4 - Working with Parents – Where do you start?

Presenter: Ross Mortimer

These workshops were led by NEODAS, the North East Outreach Drug and Alcohol Service, based in outer suburban Melbourne. The discussions began with the observation that social workers and agencies almost always treat people suffering from drug addiction as individual clients. The clients' parents and families are often ignored. Social workers prefer one-to-one encounters, and commonly contrive this by insisting on the principle of confidentiality (a principle rarely invoked by the clients themselves).

This individualistic approach flies in the face of the fact that 50% of people seen (by NEODAS, for a typical example) have parents who are still married to each other. There is no evidence to support the popular expectation that most addicts are the children of single mothers. A significant number have no continuing family involvement, but (at 34% of clients in treatment) they are the minority. It was clear to all workshop participants that the marginalisation of families is a serious obstacle to successful treatment. The involvement of the family does not guarantee a happy outcome for the drug-user, but it increases the chances substantially. Equally, family involvement helps to minimise the damage to the family itself.

The NEODAS working model is an exciting exception to this rule, and the workshop focused on it. It includes individual parent work; parent group work; and mediation to reduce conflict between clients and their families. Parent group work involves support meetings, which are informal in structure and encourage parents to tell their stories and discuss them.

Several illuminating perceptions arise from NEODAS's experience with parent groups. There are, for example, intense issues of blame and guilt to be resolved, which otherwise impede the search for support and cooperation within the family. The issue of client confidentiality is a problem if it is merely a device whereby a social worker can exclude the family. At first, parents and users can hold diametrically opposed views on the nature of the problem and how to resolve it. NEODAS's role is to help them to find or to negotiate a position in the middle ground, where they may be relatively comfortable.

NEODAS provides continuing support and education to parents on drug issues, so that families are not misled by the many myths which circulate about drugs. NEODAS also fosters family communication and parenting skills. This combination of negotiation and education helps to clarify and reconcile the values of clients and parents.

Usually it is the drug user's mother who first comes, alone, to parent group sessions. The next most common pattern is that both parents attend. It is rare for a father to come forward on his own. This reflects the syndrome in which drug use by one member of the family provokes conflict between the parents over the best way to handle the crisis.

To summarise: NEODAS has adopted and advocates these Key Strategies:

- harm minimisation,
- education of users and their families,
- conflict resolution within the family,
- the working model (individual parent work; parent group work; and mediation),
- support groups for parents, and for siblings,
- development of coping strategies, and
- communication – open and honest dialogue.

Recommendations

The workshops endorsed recommendations for parents, as a Twelve Point Plan.

- There is no such thing as a perfect parent. It is seldom useful and often destructive to argue about blame, or guilt, or parental responsibility for a child's drug-taking. It is perfectly reasonable to love your child but hate their behaviour.
- It is important to recognise that it takes a long time to overcome drug addiction.
- Parents must 'let go' some expectations of their child.
- It is critical to explode myths about drugs. The most common is probably the belief that detox is in itself the solution and the end of drug use.
- This issue affects the whole family. Do not forget the role of siblings in supporting the drug-user and the parents.
- It is essential for the family to get solid information and education on this subject.
- Remember that parents know their child better than anyone else. If in doubt, they should trust their intuitions.
- Drugs in the family sharpen other sources of conflict and it is very important to reduce these as much as humanly possible.
- Parents must, as much as possible, be open and honest about their feelings.
- Mothers and fathers usually do things differently. If this difference is acknowledged, it can offer each of them a fresh perspective, rather than cause them division and dispute.
- As in all counselling matters, one must focus first on fixing oneself.
- Finally, every family needs help and support and they should find it and tap into it.

Workshop 5 - Staff Development and Small Agencies – New options

There were two significant areas of focus for this particular workshop. The first was the recruitment and retention of staff and the second, which was related to the first, but took a different angle, was marketing an organisation as an attractive employer.

Salary issues are of significant importance to small agencies. Aspects discussed were the pros and cons of fringe benefits and salary sacrifices. Flexible payment arrangements such as the provision of benefits paid for by salary sacrifices could prove to be an attractive drawcard for staff to work in non-government organisations. Such a flexible arrangement could mean that an employee received fringe benefits for which they forgo an equivalent amount in their salary. In some circumstances this could be a more valuable arrangement. Examples might be the provision of a company car or the payment for child care.

Another issue of significance in respect to salaries was the disparity between salaries of NGOs and salaries of government employees. It is not unusual to find that the salaries of NGO employees are lower than those of government employees in similar positions. It is also possible that NGO employees would be asked to undertake a wider range of tasks than their counterpart in the government. The workshop participants recognised that funding for NGOs played a significant role in this disparity. However the workshop agreed that with some creative application of enterprise agreements it might be possible to provide attractive salary and employment conditions for potential and existing NGO staff.

Funding for NGOs is of continuing concern. Many NGOs are funded on a short term, year to year basis which provides no guarantee of continuity of employment of staff. However it was noted that for some NGOs triennial funding is available which allows those NGOs to undertake longer term planning and development. The workshop also noted that the National Drug Strategy core funding had not been increased nor indexed which means in real terms that funding from this source was a reducing amount.

On the matter of staff training and development NGOs felt that they were being constantly squeezed between the time needed to put into dealing with clients and the time needed to provide for staff training and development. In some NGOs where the staff numbers were small, attendance at a training course meant that the client contact time was significantly reduced. The importance of training and development was recognised both for the individual employees and to address issues of organisational culture, that is to develop a culture with beliefs and attitudes that are consistent with the organisations philosophy.

An additional strategy in developing the appropriate culture and organisational philosophy could be through the recruitment process, one element of which would be the development of appropriate job descriptions and selection criteria.

It was noted that service review and accreditation processes associated with quality assurance programs were being encouraged. The workshop supported this approach but at the same time had to acknowledge that undertaking such programs, irrespective of the potential benefits, and because of financial restrictions, still detracted from the time available for contact with clients.

Recommendations

- Implement a national training competence review.
- Approach Democrats in respect of the issue of fringe benefits tax and salary sacrifices.
- Explore fully the application of enterprise agreements.
- Seek the re-introduction of a 3% training guarantee.

Workshop 6 - Performance Measurement – Steps to continued improvement

This subject must be examined from the perspective of the small agencies for whom (along with families) this conference was planned. Some agencies comprise one worker (see Rose Isherwood, Far North Queensland) or two only (see BADFS Blacktown, NSW).

The first issue raised was the clash between the philosophy of the agencies whose concern was to deliver effective programs, and the requirements of funding bodies (usually State and Federal governments) for accountability, expressed in demands for measurement, that become time consuming compilations of statistics. Governments seem more concerned with 'outputs' (how many?) than 'outcomes' (how do you evaluate the success of the program?).

Noting the occupancy rate of places in a program, or numbers accessing the program, does not indicate whether the service meets the objectives of the organisation, which is to reduce the harm related to abuse of alcohol and other drugs. Admittedly, collection of statistics can demonstrate the demand for services, but workers resent onerous requirements of clerical reporting when their motivation, and their core work, is to provide quality care for service users.

The question is what capacity have small agencies to meet accountability requirements, and how can they be helped to meet government reporting demands? Workers are concerned to offer quality care to consumers and vulnerable individuals and groups certainly deserve informed, caring staff to respond to them. Workers suggested that performance indicators, developed by government or academic agencies, would assist them to evaluate their services.

The workshop supported the philosophy of developing partnerships between governments and small organisations to service community needs, which are expressed differently in diverse cultural, social, economic and geographic circumstances. Sufficient resources must be provided to small organisations to make this partnership effective.

The suffering, death and disease caused by misuse of alcohol and other drugs are now widely acknowledged, and prevention and treatment programs require not only dedicated workers in small organisations but active support, in the form of information, policy development, finance and links to public institutions to ensure their maintenance and enhancement.

Accreditation of agencies working with the health needs of individuals and families is essential to quality care. The workshop recommended that accreditation and review should be aligned to service planning and staff development. Such a system would provide better information to describe the service needs in any application for resources.

Although client outcomes are hard to measure, the workshop encouraged the idea of seeking client input through surveys designed for particular groups. The workshop recommended that the findings of QMS reviews be disseminated, and (where appropriate) followed up via the funding bodies. Only when these measures are taken will performance measurement become a positive process for steps to continued improvement.

Workshop 7 - Current Issues, Future Perspectives

Issues for Families

The obstacles in the way of families helping a member with a drug problem constitute the main concern of families.

Families often find there is a lack or shortage of timely treatment services needed by users. It is imperative that treatment be available when users are willing to avail themselves of it – not next week or next month. That will generally be too late. Treatment should also be available in the locality in order to maximise the possibility of family support.

There is a lack of services for young people with a drug problem. Treatment facilities generally cater for older people and are unattractive and inappropriate for young people;

Families themselves often find that professionals exclude them from any significant role in therapy of their family member. This is in spite of the conclusion of a Victorian Government report that the chances of recovery are improved by 80% if families are involved.

Confidentiality is often given as a reason why parents are not involved. This response often reflects a failure to ask the user whether he or she wants family involvement, a failure to appreciate its value and the absence of a strategy to bring the family on board.

The family of users, including the extended family, need to be involved in continuing care. Families are one of the few if only constants in the chaotic life of many users. Families are therefore able to provide support between treatment and other professional interventions. They have the greatest interest and opportunity to help users.

It is imperative that the safety net role of families be mobilised against the prospect of relapse when users are on abstinence treatment or under naltrexone maintenance. Users with a low tolerance who are discharged from treatment facilities or prison have a high risk of overdosing. This has often proved fatal.

The workshop reached the following conclusions in respect of family issues:

- Families need information and support.
- There is a need for a 'safe' place with multi-skilled resources to which parents can have recourse for guidance and support.
- School nurses with appropriate skills may be able to help fulfil this role.
- Workshops should be arranged on health issues relevant to drug use.
- Families are also concerned that treatment is often less than optimum because the users themselves are often not involved in formulation of treatment programs.
- Users should be involved in conferences such as the present one.
- The voice of users should be listened to much more than they are – voices such as those of Jason van den Boogert who contributed chapter 1 of *Heroin Crisis* (Bookman Press, Melbourne, 1999) and users whose stories were told to this conference.

Effectiveness and diversity of treatment

There is a diversity of philosophies guiding drug treatment. The working group believed that it is essential that all drug programs should be subject to the discipline of 'evidence based' approaches. At the same time a broader range of effective treatment options should be provided. The working group believed that a lack of funding is limiting implementation of this basic principle.

Users and their families have a right to be confident that programs are effective in achieving clearly defined treatment goals. Users should not be made scapegoats. Drug addiction should be dealt with for what it is a health and not a law enforcement issue.

There is a need for pre-treatment assessment of clients to determine whether a treatment program is appropriate as well as to judge its effectiveness. Promising new treatments should be assessed and introduced quickly.

Prevention

The working group was unclear about what is embraced by prevention in government initiatives and what are the expected outcomes. There is a lack of information about this.

It is essential to address underlying issues that contribute to drug use and not restrict ourselves to 'care taking'. Leaving underlying issues unaddressed will ensure that drug problems are perpetuated.

One such issue is the alienation springing from the priority that society places on wealth, the lack of equal opportunity and the social and economic dislocation brought about by economic reform and globalisation.

Alienation resulting from racial prejudice is another factor that increases the risk of drug use. Addiction reinforces such alienation.

Given that drug use generally commences during schools age years, schools themselves are likely to provide a good starting point for interventions.

Measures should be taken that remove the 'coolness' from drugs. The attraction of drugs to many children is that they represent a forbidden fruit the trying of which is a mark of adolescent rebellion. A big stick approach may appeal to adults but is ineffective with children. The more drugs are treated as a health issue the more 'boring' they are likely to be.

The economic value of effective prevention needs to be emphasised. It is much cheaper to fix the problems before they arise than spend large sums on fixing serious problems.

Drug laws need to be assessed in the light of the impact that they have on users, families and society. Changes are required when these are shown to have damaging social impacts.

- Laws need to be reframed to take away the profits driving the illegal drug distribution system.
- The impact of drug use and road safety needs to be addressed.
- There should be a major focus on the prevention of diseases such as hepatitis C.
- It is important that government agencies monitor trends in drug use to plan and implement flexible responses before problems develop

Local services themselves need resources if they are expected to respond to emerging situations in their area and thus prevent problems arising.

Drug action teams should be set up to respond flexibly and promptly to assist local agencies fill gaps in different areas as they become apparent.

Funding

Sustained funding is essential for treatment and other drug interventions that are shown to be effective. Funding should not be wasted on ineffective interventions – particularly preventative ones which may have cosmetic attraction. Treatment and prevention should be funded on an assured basis by a levy on alcohol sales and assets confiscated from drug traffickers.

Family Stories

This session was chaired by Marion McConnell

Julie's Poem

Somebody's daughter, son grandson, mother, father or brother.
Is it real? Can it be? It is. It's not just a nightmare.
It is real. It is happening to us and to him, our son.
Pain, shame heartache and grief. Hopelessness.
Drugs, crime, depression, psychosis, suicide thoughts,
Spiralling dysfunction.

Police, court, jail, probation, the street.
How can it be? What can we do? Where can we go?
A merry-go-round of try this, go here, go there.
No room. Go home. How can we stand this another moment?
A lone health worker with hundreds of kilometres.
How can she cope? Who will she see?

Small rural town. Everyone knows me.
Epidemic, funds, beds – or lack of – sorry mate no room today or next week.
Go home – remember 'he's your son'.
Detox and Rehab. Mental health. But where? No room.
Need to be motivated. Feel so low. Cry for help.
But not today. No-one there. Can't cope.

Too much pressure and stress on family –
Mother, father, siblings, aunts, uncles, grandparents.
All affected, all trying.
Grieving. Deep pain. Deep shame.
Am I a 'bad mother', 'bad father'. This has been said.
How can it be? Oh, how we have tried, how have we tried, and long we have cried.

How many more suffering out there? Is it just us?
Community attitudes, judgement, stereotyping, isolation.
Feeling alone, supportive friends, clergy, family.
How would we cope without them?
But what can we do?
Where can we start?

Finding the light at the end of the tunnel, and knowing it's not a train!

My son had been using drugs for several years before we discovered it. We had sought help from professionals since he was a child to help our family cope with his difficult behaviour. For a long time we had no idea that drugs had become involved at all. Nor were we aware of the childhood sexual abuse he had experienced and which was such an important factor in his anger, hatred of self and others, and depression. Having no knowledge about drugs we blamed ourselves for being failures as parents, which we believed had led to him being 'the way he was' since childhood. We completely over-reacted when we found he was using drugs and alcohol on a regular basis. Our reaction made the situation at home even worse when he was there. He often would disappear for days on end after walking out, or leaving in the middle of the night. No reasoning, threats, physical restraint, cajoling or any other strategy helped us control his behaviour. As he was only 12 at the time, our fear of what might happen to him was overwhelming. We also felt a great deal of shame and embarrassment because we were unable to keep him safe, get him to go to school, improve his behaviour or keep him out of trouble.

I was contacted by the mother of one of my son's friends and we formed an informal support group, along with other mums. We did this to educate ourselves about drugs, support each other and give us an opportunity to share our feelings and any new information, while trying to get our kids off drugs. We became vigilantes, checking and cross checking with each other, talking to police and other professionals and confronting the boys. This continually made the situation worse and alienated us from our kids even further. We were so fearful, angry, confused, frustrated, and felt so guilty. Our feelings of inadequacy continued to grow along with the escalation in the drug taking and associated problems, as our other family relationships fell apart. We knew of no formal supports in those days to help parents through the nightmare of a child's drug use and subsequent addiction. None of the agencies we had contact with could offer much help or advice for us as parents, and even close friends and family could not understand what we were going through. Their criticisms, advice and suggestions, and the rejection we felt, added to our shame and isolation. We continued to flounder in a black sea of despair, never knowing what crisis we would have to deal with next or whether our children would even manage to stay alive.

That was 13 years ago. The years that have passed have been filled with much trauma. The trauma for our family has been physical, financial, social, emotional and psychological. For my son there have been numerous hospital admissions, detox and rehab centres, doctors (some good, some dreadful), mental health services, suicide attempts, counsellors, support groups, jails, police, court appearances, debts, bashings, homelessness, poverty and all the usual things that go with addictions. In short, the destruction of lives, the anxiety and the depression associated with trying to control the uncontrollable.

It is such a complex problem with no quick fix. Caring doctors and counsellors, who have been committed to my son over long periods and during relapses, have made a world of difference to him, as has a 24 month jail sentence suspended on the condition that he continued with drug and alcohol counselling, worked on his issues and didn't get into any more strife. This sentence, 18 months ago, was truly the turning point for him and gave him a very real opportunity to stabilise and very slowly begin the process of reclaiming his life. This he is now doing - with a lot of support. It has been a long, slow, difficult journey so far, and I know there is still a long way to go.

I've had to learn to separate my son from his addictions and the effects of those addictions on our lives; to have more realistic expectations of my son, his father, myself, and agencies we've been involved with; to seek the encouragement and support I've needed on this long, slow journey. None of my training and experience as a Registered Nurse prepared me for the heartache of having a child who is drug dependent. My daughter has also been affected by all the turmoil in our family over

the years, and these relationships are slowly being rebuilt. I've learnt to love unconditionally without contributing to or getting caught up in others' problems. I've learnt to let go of the guilt and shame I felt, and I accept that there are limits to what I can do to help. Drug addiction is such an insidious, multi-faceted problem, and it requires a multi-disciplinary approach over a prolonged period if we are to make a difference. As parents, we don't have all the answers. It's difficult to remain hopeful and objective when so little changes. We become very weary just trying to do the best we can.

For me as a mum, many things have helped me enormously. I have received support, an opportunity to express my thoughts and feelings without being judged or criticised and access to correct information and referrals. I have learnt how to set boundaries and stick to them. I have got a life of my own and have learnt how to look after and care for myself. I have been blessed with a renewal of faith, an opportunity to develop compassion, patience, perseverance, strength; and now understand the real meaning of love. I would never have chosen to work in the drug/alcohol field before but I believe that I have had these experiences to enable me to understand, support and encourage others through the darkness and grief of dealing with an addiction in the family, just as others helped (and are still helping) me to get through it, one tiny step at a time. I've now been working in this field for 4 years. Now I am able to see each new day as a blessing, no matter what it brings!

"Phoenix"

A Personal Story

When I first discovered that my 18 year old youngest daughter was addicted to heroin, I was consumed with misery and guilt. Guilt that I had not managed to protect her from the recklessness of her decision to experiment and use drugs freely and regularly, guilt that I had not realised what was happening earlier and somehow headed it off, guilt that I had failed her as a parent. There seemed to be few more devastating examples of getting it wrong.

There were signs that things were not going well. Her friendship group had changed, her performance at school slackened, her appearance became very alternative and she began associating with many people generally older than she was, not from her school environment. But many teenagers display similar behaviour which does not necessarily indicate drug use.

Our first indication that she was involved with drugs came when she was fifteen, after she had gone missing for a weekend, ringing me Friday evening an hour after she was to be collected by us and she had not shown up, to tell me she was staying out that night and would return in the morning. We spent the night furious at what we saw as her rebelliousness, but never imagining it was more than that. We learned, much later, that she had taken an acid trip and was still too disoriented to return home in the morning. It was Sunday evening before our family tracked her down and the police returned her.

The police informed us that as she had been smoking cannabis daily, she needed to go into a detoxification centre. Feeling they must know best and certainly knowing no better, we reluctantly agreed. Jessie agreed too, but it is true to say she would have agreed to anything, so keen to make amends for her wayward weekend. She was placed in a detox centre with middle aged, male alcoholics, advice which now even the police would say was inappropriate. She left with our support after only five days.

For the next three years her life had a semblance of normalcy. She attended school, was involved in theatre, music and worked in the local supermarket on Sundays. We felt she was probably still experimenting with drugs, but assumed (and wanted to assume) that it was cannabis and we had assured ourselves that this was a relatively harmless pursuit. However, by the time she was seventeen, she had returned to a

detox centre at her instigation, assuring us that it was not for heroin, dropped out of school and temporarily, and against our wishes, left home.

She was always very careful to shelter us from what she was doing, not wishing to alarm us and very careful to cover her traces. At one stage she moved briefly to Melbourne. Only later we discovered that she was terrified by recent heroin related deaths in our city and grasped at geography to solve her problem with drugs.

One evening in February 1996, when she was flat-sitting for an acquaintance, she failed to show up for an arranged dinner. She had cancelled the night before and with her recent atypical unreliability, we became concerned. I drove over to her flat, waited for her to return and confronted her. It was then that she told me the shattering news that she was addicted to heroin.

We were much more fortunate than most, as she realised that her life was in complete disarray and wanted to stop using. We did not have to deal with a child who was not ready to face up to her addiction. But we had no idea of how to help her and the problem was overwhelming. Initially, we felt it was not appropriate to discuss what was happening in our lives with others, except with a few most trusted friends. Our child was doing something that was illegal and widely condemned and even while friends were kind and caring and if they were judgemental kept their judgements to themselves, they had no notion of the agony that parents of addicts live with. Had our daughter had any other illness which endangered her life, there would have been widespread understanding and support. It is not only the risk of overdose that is so distressing, but the disordered, dysfunctional lifestyle that is an addict's lot.

We sought advice and emotional support from drug counsellors. It was this which helped us realise that it was our daughter's choice to use drugs and that it was up to her to change her behaviour. We could not do it for her. Though we could rationalise the problem as hers, the sense of parental failure and guilt persisted. The counsellors advised us not to give her money and gently prepared us for her continued use. But at no time did anyone tell us what was advisable for her to do in order to recover, or what we could do to help her.

Over the next three years we watched, cared, supported, suffered as she did, made mistakes and bumbled along as best we could, as she struggled to become and remain clean. Initially, our reaction was for me to take her away to a friend's isolated farm to look after her as she detoxed. We naively assumed that she would detox and then resume a normal lifestyle. We knew no more than the average person who has not been confronted with this problem. We certainly did not realise that addiction was a chronic, relapsing condition. Gradually we came to understand.

She went to live interstate with her older brother, to try and break the ties with her using friends. She tried several rehabilitation centres, at one stage working and staying clean for nine months before relapsing once again. Finally, in January 1998, she completed a three month program at a women only rehabilitation centre in Sydney. She moved into supported housing run by the Salvation Army, living on her own in a bedsit, completed another course in relapse prevention and very slowly, not without significant setbacks, began to rebuild her life.

She has now been clean for almost three years. She still lives in Sydney, works as a waitress, has completed a course in acting, has many friends and a busy, happy life. On the surface her life appears like many other young women. But the reality is nothing the same. Each morning, she tells me, when she wakes, she resolves not to use 'just for today' and several times a week she spends an hour and a half at a Narcotics Anonymous meeting. She is not 'better' or 'over' it. She is in recovery.

Several months after we discovered Jessie's addiction I began to write about our experiences. I had searched constantly in book shops, eager to read about other families facing heroin addiction so that I could learn from their experience and validate the devastation and overwhelming despair I felt. I was sure that someone else would have written

something. No one had. Then, just as I had assumed that it would be some-one else's child who became the addict and it was mine, I became the some-one else who wrote about it. In March 1999, Random House published *Saving Jessie*, a mother's story of her daughter's battle with heroin, written by me.

Saving Jessie was not written in order for me to come to terms with what had happened, to understand it better, or to explain it. But I guess it has had that effect. The rest of the family found reading the manuscript and then the book extremely painful. Only recently my son lent his copy (something he never does) to a close friend to read, telling her only on condition that she not ask him anything or expect him to talk about it with her. Instead she wrote him a lovely letter. It is still, and probably always will be, too raw and painful for them.

My sense of guilt has now largely dissipated. But, of course, I am now seeing it from the perspective of a parent who has a child in recovery. We are always conscious that if our story is over we have been some of the very lucky ones. Only time, indefinite time, will tell.

When I reflect on those years of constant dread when returning home to see the red light flashing on the answering machine, of always expecting a phone call from Jessie in distress, or even worse, no phone call at all, of our great need to talk to each other daily, for me to know that she was still all right and for her to reassure me and be reassured, and compare it with now, a couple of phone calls a week and 'I'll catch up properly tomorrow, mum. I'm on my way out now', I know we have come a long way.

There are some lessons which may be learnt by reflecting on Jessie's and our journey. What was it that has enabled Jessie to turn her life around? Why has she succeeded so far where others have failed?

In the months before *Saving Jessie* was published I began waking in the night with panic attacks and was quite unable to sleep. My doctor sent me to a psychologist who listened to my story about Jessie and her struggle to recover and gain control of her addiction and said something that was a revelation to me: "You must have raised a very strong daughter."

Until that moment I had assumed I had raised a weak one, weak enough to succumb to drugs.

So where did Jessie get her strength and resilience? I am sure there are many other users who simply do not live long enough to exercise that same resilience and strength. Whilst ever we have a government determined to see drug addiction as a law and order matter, rather than as a health issue, young lives will continue to be lost. I have never asked Jessie if she has overdosed. She told me once of being present when someone else did, which may well have been her way of testing my level of readiness for her answer. We desperately need easily accessible supervised injecting rooms.

Our family takes no credit for Jessie's continued recovery. She has done it herself. But several things helped and hindered her along the way.

We were and still are a close family. Our obvious distress at what was happening to her upset her and she tells me was a great consideration. Had we not known about her addiction she would have continued to use for much longer.

She tells me she always had the expectation that she would have a good life and achieve something. Her disordered, dysfunctional lifestyle as a user was not what she had envisaged. While by conventional standards she has achieved virtually nothing compared with young women her age, I think she has shown courage, persistence and determination in the face of sometimes overwhelming odds, and enormous resilience. Quite an achievement.

These are attributes that she was fortunate to have. But external factors helped her too and from these we can learn and apply when helping others.

Detour House allowed her to finish her rehabilitation program as an out-patient after she had been asked to leave for resuming a sexual relationship with her long term boyfriend, when he

came to visit. While recognising that rehabilitation centres must have rules, their inflexible adherence to and application of penalties when rules are broken are not always in the interests of those they are trying to help. Insisting that clients leave for infringements of no real relevance to their commitment to recover has sometimes had disastrous effects.

Jessie lived in supported housing run by the Salvation Army for almost a year. This period was of inestimable value to her and once again she benefited from the flexible interpretation of the rules. She was only two months clean and therefore ineligible for assistance as their rules required three months. Their worker took a punt, impressed by her expressed commitment. She moved into a clean bedsit, supplied with everything a recovering addict, who has nothing, may need. Even a wettex.

During her time there she paid a proportion of what she earned as rent and had daily access, if necessary, to the support worker. This time, I believe, was crucial to her recovery. She had to learn what others take for granted, how to shop on a tight budget, how to pay bills on time, how to live responsibly. She tells me now, how hard it was to do all this with all her energy directed towards staying clean, sometimes going to two NA meetings a day. To put money into rehabilitation programs and not to address the dire needs of those in early recovery when leaving a centre, is dooming many to failure.

The key factor for Jessie was, and still is, her involvement in NA. NA works for her. It does not work for everyone. She chose a wonderful sponsor, a magazine editor, mother of two, eight years clean. Once she arrived on Jessie's doorstep within 10 minutes of her phone call, judging that a phone call was not sufficient. For months they had dinner together every second Sunday evening and still meet regularly for coffee, even though Jessie has now assumed the role of sponsor to someone else. This support base is still very important to Jessie and I know she would be reluctant to leave it for any reason, even though NA is to be found just about everywhere. She was not faced with leaving a rehab and establishing herself somewhere in a different town. Her support base was in place already.

Jessie was turned away from some rehabs because she was too young. Not because they were concerned they could not meet her needs because of her youth, but because her dole cheque was not sufficient to cover her costs. Surely false economy in the big picture. Government-funded rehabs for our young drug users are essential.

I sometimes wonder what the outcome might have been had we been given different advice from the police when she was fifteen. I certainly don't blame the police for her addiction, but I wonder if it might have been averted. If we had been put in touch with good drug counselling for her, rather than sending her to a detox centre with middle aged male alcoholics, perhaps we may have accessed support that was appropriate.

It is vital that police are well trained, restrained and wise in their treatment of young people and drugs. It may be a lost opportunity to intervene in a positive way.

And, as in much in life, circumstance and a bit of good luck played their part. She was fortunate that she did not have to wait for long periods to get into a detox centre or a rehab, once she had made the commitment, unlike so many I hear about who have to wait for three months to access help. Several times, detox centres took her the next day. Of the three rehabilitation centres she was at, all could take her within two or three weeks. This really was good fortune and unusual. It is agony for parents to watch their child wait, or give up in despair.

She found part time work nearby when she felt ready. She has around her a wonderful group of friends who are all in NA and support each other in a way that is heart-warming. On moving out of supported housing and into a house with friends, the estate agent saw her NA one year clean tag on her key ring, Sure it would mean forfeiting the house, she was touched when he handed it back to her quietly and said, "Eight years clean. AA.". They got the house. Knockbacks and

difficulties are hard to bear in early recovery. After some time she found an acting course she wanted to do which went a long way to restoring her confidence and self esteem and gave her a sense of purpose. The royalties from *Saving Jessie* funded it, which seemed appropriate.

All this has played a part in her efforts to rebuild her life. Others, in very different circumstances and against seemingly insurmountable odds, will also turn their lives around. As Jessie's drug counsellor once said to me: "My job is to keep young addicts alive long enough to help them." That's the real challenge for our community.

Imogen Clark

Author Biography

Imogen Clark is a writer and primary school teacher living in Canberra. She is married, mother of three and grandmother of one. She is the author of 'Saving Jessie', a mother's moving story of her daughter's battle with heroin. (Random House, 1999). Since publication of 'Saving Jessie' she has spoken to parent groups and at public forums and conferences. She is a member of Families and Friends for Drug Law Reform and represents the ACT on ADCA's (Alcohol and other Drugs Council of Australia) Treatment and Rehabilitation Reference Group. 'Saving Jessie' has been nominated for several awards and was short listed for the Queensland Premier's Literary Awards in the 'Works Advancing Public Debate' section. Her other publications include a chapter in 'The Heroin Crisis' (Bookman Press, 1999).

Betty's Story

July 1997

My daughter Kerrie is 40 years old and has been on heroin since May 1995. She met a guy at the local Salvation Army Op Shop, where we were both doing volunteer work. She started going out with him, first to the movies and coffee.

About a month after she met him, I noticed changes in her, which I thought were drug related, but was not sure if it was heroin. In July 1995 she told me she was using heroin again. This was the second time around. The first was from about 1976 until early 1980, when she became pregnant with her first child. She stayed off heroin until May 1995. In time she abused alcohol and pills but managed to lead a 'normal' life, being largely involved with her second child who was born in 1984 and is autistic. Daniel was diagnosed when about 3 years old and attended early intervention programs and the Western Autistic School, then slowly integrated into primary school. This year he started a four year secondary program for autistic kids.

In July 1995 Kerrie told me she was on heroin but had it under control and would be off it in two weeks. She had seen a doctor who used 'Coloscene' tablets. Of course that didn't work and in August 1995 she started her first methadone program at Vaucluse Hospital, eventually getting up to 90 mls. It sent her quite loopy and she was using heroin as heavily as before. They were shop-lifting to support their habits and were caught and charged on four or five occasions, resulting in fines, bonds and community work.

When I found out about Kerrie's heroin problem I was at my wits' end. I didn't know what to do or who to talk to. I went to Families Anonymous meetings for a couple of months and then I saw an article in the local paper about a group of people meeting at the Brosnan Centre in Brunswick. I went to my first meeting in late September 1995 and came away feeling what a great group of people. They had all been through so much and had so much courage. They made me feel stronger and I've been going to meetings since. I have learnt a lot and it helps greatly to talk to people who understand and for that I thank everybody involved with KOKA (Keep Our Kids Alive).

October 2000

In August 1997, Kerrie was admitted to Melbourne Hospital and found to have a heart block. It was eventually found to have been caused by a pill that a doctor had giver her to wean her off heroin. It was Melleril. She was also on methadone, which the Melbourne hospital

administered, while she was there for a week. She did very well for about six months but then started all over again. It was the same pattern except financially, mentally and physically she was deteriorating. There were more arrests and community based orders, until about June 1999 when another doctor told her to go up high on methadone and then very gradually come down, which she eventually did and finished methadone in August 2000. She is doing very well at the moment and hopefully it will continue. We can only hope and pray it will keep up.

Dianne's Story

I lost my 25 year old son to an overdose 17 months ago. He was in good health, still working as a bricklayer and only used on a recreational basis. An important point to me as a mother is that it can happen to anyone at any time and we need to be given rights in this situation to help the ones we love.

The experts say that it is up to the addicted person to seek help, but their minds are not thinking straight so I feel that the families should have a say in getting the help they need and not be excluded, especially if the addicted person is living at home. I would like to list a few times that I was excluded, to help you understand where I am coming from.

When we first found our son using marijuana, my son and I went to a counsellor, but I was not included in the meetings and it wasn't until a year or two later I was told he was smoking it with his natural father who we did not live with.

My son and I went to Odyssey House in the city when he was about 19 and using speed, marijuana and alcohol. I was not allowed into the interview to see if they would accept him into their program. When he came out he said that he had told them he had the ability to stop on his own, so home we went. If I had been allowed in, it would have been different.

Four months before he died, I was told he was smoking heroin. (Whether he was using a needle then I don't know.)

One day he was sick in bed. I rang a church group who help people with drug problems. The man said "put your son on the phone and if he says it is alright I will come now". But of course my son said "no" and that was that. Then six months later just after I lost my son this man rang to see how we were going. I felt such anger and frustration that only if he had listened to me and my needs for him to come to my son just maybe we would still have him.

In ending I just want to say that as a mother I know when my children need help, even when they don't.

Sandra's Story

In January 1996, my beautiful daughter told me, in a telephone conversation, that heroin was controlling her life. My world, and that of her father, brother and sister, fell apart. We were a stable family and had never considered drug addiction could strike one of us. We asked Emma to come home to us, which she would not do unless her boyfriend came too. So suddenly we were thrown into the deep end with not one but two heroin addicts under our roof. We were ignorant of the horrors of drug dependency, detoxification, withdrawal and rehabilitation, and soon realised we needed outside help.

Over the next two and a half years we fought the addiction along with Emma. Several times she went into a private clinic for detox and rehab only to relapse soon after coming out. She alternated between living with us and living with her boyfriend in rented rooms and boarding houses. He engaged in criminal activities and ended up in jail before being released into the custody of the Salvation Army.

We experienced the lying, cheating and stealing that is part of drug addiction. We tried all approaches we could think of to help and at times

despaired of there ever being a good outcome. My most painful memory is of driving her to Cabramatta one evening and sitting beside her in the car while she injected herself, using half the cap and saving the rest to ration as a means of weaning herself off the drug. Tears were streaming down my face as she apologised for what she was putting me through.

Emma has been clean for over two years. She has completed her university degree, has a good job and is about to embark on a postgraduate course. She has a wonderful boyfriend and has repaid the thousands of dollars she owed us. But most important of all, she is happy – our beautiful girl is back in the world where she belongs.

And what about me, her mother? I now see the world through different eyes. I appreciate all the little things in life that I previously took for granted. Having lived through that nightmare, I value relationships with people above all else. Every telephone call from my daughter gives me a sense of joy and I never forget how lucky I am.

A Mother's Story

At the time our daughter was starting to use heroin we were ignorant and lacked insight. Even when we started to suspect it, we believed her explanations. After all, she told us what we wanted to hear. Slowly our daughter's behaviour changed. From an open, lively girl she became evasive. I saw what I now know to be equipment for 'chasing the dragon' – smoking heroin. She still was achieving distinctions as well as passes at university.

At the end of last year came a three month working holiday overseas. We agreed to put up the money for the fare and she would pay us back with her earnings. She would still be able to save a substantial amount and enjoy herself. However, she returned with five dollars in her pocket. She started missing lectures, friends were ringing asking where she was and she wouldn't allow us into her room. Avoiding us became a major strategy. She took a job at the Cross. She looked unwell and didn't eat properly. One day when her speech was slurred I asked if she was using. She said "what to you think I am?" and walked off.

Not long afterwards my husband went to empty her bin and saw syringe wrappers and swabs. This prompted us to search her room. We found syringes and powder. Her diary told us of her abuse of a variety of drugs when she was overseas but not of heroin. We didn't know what to do or who to turn to. The phone book led us to Family Drug Support. We explained the situation to our younger son at home and the three of us attended the next group support meeting.

At the meeting we shared our situations. Tony gave us information and the reality then hit us. We joined and bought the 'Guide to Coping'. We have since read widely about heroin, detox, rehabilitation and so on but, for us as parents, the guide has been the best resource that we have come across. It guided us in our approach to our daughter. We scheduled a meeting with her after writing her a letter. We read it to her. This is an extract:

Dear Angela,

> We love you very much. You are our daughter and sister. As a family we know you are injecting heroin. We do not approve of your use of illegal drugs. We wish you hadn't chosen to use heroin. We understand that we can't make you stop. You are the only one who can choose to stop. We can and will support you when you are ready. We hope this will be sooner rather than later. What we would like and are asking for is honesty in our relationship. We agree to try and stay calm and listen to you when you are ready to talk about it. At present we are very worried about you, your health and well being and how you are injecting. We are also worried about your debts and at your working at Kings Cross to earn enough to buy heroin.

We gave her the letter. She looked at it and said: "I'll talk to you when I'm ready," and walked off.

Several weeks later she told us she wanted to get off heroin. We agreed to support her. She made an appointment and asked me to see the counsellor with her. I agreed to support her for home detox. Our local doctor prescribed two medications to alleviate certain symptoms. The next four days are now a blur in my mind. I can only say it was full-on. We shared a bed. On several occasions my daughter expressed her determination. I remember feeling emotionally drained witnessing her distress yet I became so fatigued that I would fall asleep as I massaged her aches and pains.

At the time she also gave up cigarette smoking, cannabis and alcohol. That was five months ago. She resumed university this semester and whilst her life remains chaotic she has not lapsed into using heroin and still doesn't smoke cigarettes

Lucy in the Sky with Diamonds

My eldest daughter has been a drug addict since she was fifteen. She is now thirty one.

This is what she tells me and for a change I believe her. I usually believe all the bad things but not the good.

My daughter started off by smoking marijuana, then proceeded to various party drugs and finally became addicted to cocaine. At this time I believed she didn't really have a drug problem. I knew she had other problems. We had been to see innumerable psychiatrists and various clinics. You see she had a history of self-mutilation. Her problems seemed to stem from my divorce when she was young and and from her always finding the wrong partner i.e. one who was unfaithful, married or violent.

As a parent I tried to do all the things parents should do. I gave her lots of love and encouragement, the best schooling, even trips overseas. I am sure I did things I shouldn't have and didn't do things that I should have but, all in all, she had a loving, secure childhood.

Eventually, she decided that rehab was the only way she would ever be better. She truly wants to be better. However despite the wonderful people who tried to help her in rehab all that happened was that the other clients taught her the joys of heroin and how to get it. So now she is a heroin addict. She is currently on a methadone program, living with another drug addict who has been in jail for armed robbery. They can't find accommodation because no one wants these sort of people. Who can blame them?

Her sisters have just about had enough. One has even moved to New Zealand. I have tried to move away from her emotionally and certainly have financially. Though we all love her dearly we are all so tired of being constantly sad.

I suppose I want some closure to this part of my daughter's life. I want an end. I am finding it all too much and I, who is supposed to be so strong, am falling apart.

What can I do? I can't give up my child but I also have two other children and they need me too. Is there any way to get Lucy out of the stars and back to where she belongs?

A Parent's Story

Our 23 year old son told us in August 1999 that he and his girlfriend had been using heroin for 10 months. He had been trying to get help and had been trying to get off heroin on his own but had been unsuccessful. By telling us, he admitted that he wanted us to know the situation and for us to offer support and help to them both. I immediately rang every government agency I could think of and enrolled my husband and me in a seven week information program for parents of drug users. The government agencies were not very helpful. The system was at breaking point and I was told that it would take at least three weeks to get into a hospital to detox and up to three months to get into a residential rehab. We were able, fortunately, to bypass the public system as we had taken out private health insurance for our son. This meant he was able to go into a private hospital for detox and

then into a drug and alcohol program in a private hospital. Between August 1999 and July 2000, he tried to keep off heroin but was unsuccessful. He lived in a variety of boarding houses (he was badly beaten up in one by the other residents), periodically came back to live with us, was detoxed twice in a private hospital, lived in halfway houses and continued to attend daily Narcotics Anonymous meetings. Finally he got into the residential rehab of his choice, after waiting for five months. He finishes the three months program this weekend and will go into a halfway house run by the same group for as long as he feels the need - and as long as he remains clean.

Our son comes from a happy and settled middle class family. He is the youngest of three children and neither of his siblings uses drugs now, although they experimented when younger as almost all young people do these days. Our son went to private school and on to university where he finished his degree with first class honours. He performed as a musician and taught music until he lost all his work due to his heroin habit. He suffered no trauma or abuse of any kind when he was younger and it seems that he started experimenting with drugs at an early age because of his experimental nature rather than because he had led an unhappy life.

He appears to have an addictive nature which means he is one of those people who become addicted very quickly to whatever he is using. We desperately need massive injections of money into detoxing facilities and residential rehabilitation as well as safe injecting rooms. If we can find hundreds of millions for the Olympics, we should be able to do the same for our young people.

About Candace

Our daughter Candace has had sleeping problems throughout her life. She woke three or four times every night for the first two years. Visits to doctors failed to identify a cause.

In her high school years, her sleeplessness continued to distress her and she had some relaxation therapy. In her final school year she visited a GP who prescribed mersyndol. This started her on her prescription drug addiction; she became dependent on benzodiazepines.

A short time later, after completing school, she left home to work at a job that involved shift work. Unbeknown to us, she came more and more to rely on benzodiazepines.

Several years later, she married and had a child. The effects of her dependency significantly led to the breakdown of the marriage and to a costly legal battle over custody. Following the birth of her child, and well before separation, Candace had been diagnosed as clinically depressed and had commenced weekly visits to a psychiatrist who prescribed medication.

Before the custody case was heard, the court ordered a full psychiatric assessment and Candace was diagnosed by the court-appointed psychiatrist, after a desultory interview and no follow-up, as exhibiting symptoms of borderline personality disorder.

During the trial we discovered the extent of her addiction and 'doctor shopping'. She was awarded shared custody, but her husband stopped this by obliquely accusing her of mistreatment of her child. She lived with us and these accusations were groundless. By this time she was in a new and stable relationship, and was attending a drug rehabilitation clinic. She could not take her ex-husband to court owing to lack of finance and the associated, continued stress exacerbated by her enduring fear of court procedures. (She had been very abrasively treated by the husband's barrister).

It is a little-known fact of the family law court, that all psychiatric records may be read in open court and paraded before all present. This contributed hugely to Candace's slow progress, as she feared that any personal revelations might become fuel for future court appearances.

We submitted our own application for contact as grandparents. At this point we discovered FDS and through its meetings and conferences we gained much-needed insight into

the nature of our daughter's problems. The support offered to us at this point was vital to the success of our application, and Tony Trimingham played a personal role in assisting us through the legal process. His informative input has helped us to cope realistically with the management of Candace's dependency and mental problems.

A Sad and Unnecessary Waste of a Life

To the world my son is not dead; he is living. To me, my precious child died ten years ago. I came to Australia to give a better life to my children than the one fate dealt me. But it was not to be for my son. With a cask of wine available for only $4, my son became an alcoholic at the age of fifteen.

He has had many a brush with the police and paid heavy penalties. I cried for help. My son is not a criminal. He is an alcoholic. But no one cared to listen. I even wrote to the judge of the local court but to no avail.

I will give you a glimpse into our tragic saga. Whoever reads this please make sure that no other mother will ever go through the pain I have suffered and am still suffering.

It was the early hours of the morning. My son had fallen through the door of the Pizza Hut at Ashfield. He was charged and fined $900 for damaging public property. My son saw a man cleaning the windows and asked him for a drink of water. He was feeling parched after drinking wine all through the night. The man refused and a scuffle broke out with my son falling through the window. The cleaner may not have had the wisdom to understand the situation but the police and even the judge could not understand or could not care to understand the plight of a young soul.

When my son was charged and the fine was set I was not told about it because he was just 16. How did they expect a schoolboy to pay this fine? He cut school to work at Macdonald's. After a few such episodes he finally left school. A gifted child, who I was once told had an IQ of 185, he now works as a labourer and lives in a boarding house. He says he does not drink much any more but he is hooked on marijuana.

I have a daughter to take care of. I need to be sane to hold my job to support my daughter and myself. When I live with my son I become a total mess and am of no use to anyone. So we decided to live apart. We keep in touch and my son knows that I will be there for him if he needs me. But we are both miserable as our bond is very strong.

Day by day my son's brain cells are wasting away. I have tried and failed to find suitable rehabilitation for him. He finds comradeship among the people with whom he works, but they are in no position to direct him towards rehabilitation. My son feels very uncomfortable among family and friends as he feels he is not educated and socially on a par with them.

I have tried everything in my power to seek help but alas have had no success. All I do now is to cry secretly and pray silently.

Jennifer's Story

The recent publicity on heroin trials and the deaths of young people has opened scars for me, having lost two sons who used legal and illegal substances. I find it difficult to isolate heroin which was the cause of my eldest son's death at age 22 as the only factor. I will try to explain why I appear naive and out of step with many academics and practitioners in the D & A field.

My son as a little boy expressed disappointment. He felt he was hard done by over outings, sharing his portion and to my amusement at the time, suspicious that his can of drink wasn't as big.

This attitude became more sinister when as a teenager it expressed itself as a chip on his shoulder. He saw his frustration as the world turning on him, not of his own making. As an adolescent he was completely out of control. He made a pact with a friend to see who could get drunk the most nights in a row. They managed 30.

This was when he was 13. He stole money from me and a teacher at school. This came to the school's attention when he presented a $50 note at the canteen.

The most influential factor on him was a very boisterous group of friends. These boys were from the local church youth group. They got too much for the group leader and the group was disbanded. They regrouped at our house. This was encouraged so I knew where my son was, but it gave me pseudo power as the mob ruled. One thing I've learnt about boys is they are the same as puppies. One is no problem, two are playful, three there's a bit of mischief and four is a pack. These boys taught each other their bad habits. One wagged school, one ignored the curfew, one was defiant, one pinched things, one smoked a bit, one drank a bit and one smoked a bit of pot.

My son's wing spreading came to a crunch when he hid for a week in the bush to avoid coming on the family holiday. When I found him I asked the police to charge him with being uncontrollable. They were hesitant and agreed to give him a warning but when they spoke to him he was drunk and cheeked them. This was at 10 o'clock on a Sunday morning and he was 15. I was absolutely desperate. I had made contact with the school and despite some very good support from the school social worker the head master's attitude was that troublesome kids should be out of the school.

This was why I turned to the police hoping to get help. We went to court. There was a wonderful judge who indicated to him a way to make his life easier. He agreed to return to school and follow the house rules. He was allocated a case worker, I assume from DOCS. This young man came to see my son once and asked him if he had any problems. When my son replied no, we never saw the case worker again. So much for the help I had expected.

From then on things just deteriorated. I sent him to stay with his father in North Queensland. He seemed to enjoy being there but when his father moved on, he was sent home. While he had been away the old gang had got into speed. It was readily available at the local pub. I had returned alcohol to the pub and complained that it had been sold to under age minors. I rang the police regularly when the dealers were at the pub. The only arrests I ever heard of were kids being picked up for small amounts of grass.

By this stage nearly every one had hepatitis, including my son. The gang broke up into those who wanted to use needles and those who didn't. My son took a very hard road. He chose heroin. He stole from the house, lived at the local railway station, starved, but whenever detox or rehab got close a few dollars would arrive and he would score instead.

He finally learnt how to keep a roof over his head and got regular work. His first long term boss liked him and encouraged him the same way I had, but one too many sickies following pay day and he was sacked. In his next job he was again well thought of as a good worker but pay day was 'out of it' night. It was on one of these binges that he died, aged 22.

This brings me to my naive point. It was the same pattern as his grandfather except he drank. My husband as a child had to go and get his dad out of the pub on Friday nights. My husband swore he'd never drink but he ended up in jail for fraud - writing bad cheques to gamble with. When you've had three generations of addiction it's hard not to see addiction as a disease. My son spent six months with his grandfather as a one year old and I left his father when my son was six.

My other son was diagnosed with schizophrenia and hanged himself when he was 21, three months before his brother died. I believe acid and smoking grass in his adolescence contributed to his illness. The problems to get him medical help while he smoked dope were enormous. The door was closed from drug agencies because of his mental illness and closed from the mental health agencies because of his drug taking.

There is nothing I can do for my sons but I have chosen to work in the Drug and Alcohol field to help others. I have been working in a methadone clinic for several years as a RGN and

RPN. My training helped me get the job but my life experience has given me the knowledge to understand that people don't choose to be addicts.

I'm OK Mum!

Have you heard the usual expressions: I'm OK Mum. I know what I'm doing. Don't worry. I'm not using.

Well I have lived for 18 years with the horror of two of my four sons using drugs. Tony and Paul both were high achievers, very high IQs, extremely good at most sports.

There was very little around for me to know what to do, or how to get help for them.

You ask: How can you do this to yourself? Don't you know how dangerous drugs are? But they don't believe you.

Where do I go for help? How do I help them? Dozens of hours on the phone, referral to one person after another. Finally WHOS (We Help Ourselves) took Paul who was only 16 at the time, but he was a problem and he left. My support person told me that you couldn't have them under your roof while they are using. I did as advised and put my son out with no clothes, food or money. It was horrifying for me but more so for him. He came back and went back to WHOS but the downward spiral continued. At first it was cannabis, then speed, then cocaine, heroin and heaven only knows what else. Paul started getting into crime. I sat through many court hearings. Finally he was put into Long Bay, but was released after six weeks, on appeal. It is not the place for a young man.

This was to become a way of life for the next 10 years, in and out of various NSW prisons.

He had free plastic surgery on his face for a supposed fall in the garden at Parramatta Prison and two months in Long Bay Hospital. The murders and suicides he saw there made a horrid impact on his life.

The nightmare of living with drug users is almost unbearable. What they do to their bodies, the dirty clothes, the skin and bone appearance, the fear of HEP B & C, which Tony contracted but was lucky enough to be treated for with Interferon.

Sleepless nights. Where are they? Are they safe? Are the police going to knock on my door? Never having money on you so that you can not give it to them. Having to lock the house to keep them out when you're at work. Locking your bedroom so they can't get in there to search. Having your home robbed three times by people they owe drug money. Sitting for five hours while someone is threatening your son till you pay out $500. I had a friend do the exchange for me. The exchange point was changed three times. Eventually 9 o'clock at night they arrived home. My friend was the whitest Indian I have ever seen by the time it was over. But we welcomed their friends into our home at all times.

Tony on the other hand did not give us any real problems. His personality did not change much and he still worked, had very rare sick days and always rang to let me know he was OK. He met a lovely lady and married her in 1990. They built a home together and he had a management position in plumbing supplies. He became a Baptist and was heavily involved with the church, helping and counselling youth, attending Bible study groups and church drama groups, coaching soccer. Very few people knew of his involvement with drugs.

Unbeknown to his wife or us he had begun using again occasionally. On the 3rd February 1997 his wife returned home from gym to find him dead on the kitchen floor. He died almost instantly from a dose of pure heroin. But seeing him so peaceful and happy in death I knew his pain and anguish were over. His favourite saying comes to mind. "Yes, I'm OK Mum. I can handle it. I know what I'm doing".

It was the turning point for Paul. He was released from prison in November 1997 and has been working full time. I keep hoping that it can last. He is on methadone. I am very proud of his achievements so far.

What most people do not understand is the hell that the user goes through. They do not want to be on these drugs: the degradation, the filth, the fear of the people they owe money to. But they fear

the pain involved in getting off and the cravings. It runs your life as it ruins it and the suicide rate is very high. You love your child, but hate them for what they do to you and themselves.

I found Family Drug Support for Tony's wife as she could not cope. She was then able to receive the necessary counselling, and I now am a volunteer with phone lines and meetings. If I can help by just listening to people tell their story then maybe they can help save their families.

Living without Tony, the friendship we shared, the caring person that he was, looking for his car on the front lawn each Thursday night, not being around for special occasions, the grief his brothers share because they knew he was using again and could not help him. Only days before his death Tony had spoken to Craig about wanting to start a family but would not do so till he was off the drugs.

Laurel's Story

As a small child I remember my grandmother always talking to herself and working at chores around the house. Her name was Jean and she was a delicate small woman with a wonderful Scottish accent. When she became ill, she was placed at Rozelle Hospital but begged my grandfather to let her come home, which he did.

When my youngest sister Linda became ill, she also went to Rozelle Hospital. I didn't handle Linda's problems at all well and put her behaviour down to being spoilt, as she was the youngest of five children. Linda was diagnosed as schizophrenic. We, her siblings, were not told this until much later. I don't blame my parents. Even today there is such shame and stigma associated with mental illness. Linda passed away on 6th September 1985 due to an accidental overdose of prescription medication.

Two more of my sisters became ill and again I saw those I loved suffer so terribly, but at least this time I was better educated and could offer more comfort and support. Both have won scholarships and are beautiful, articulate, sensitive people. One isn't able to work and battles daily for normality in her life, while the other works in a highly demanding position as well as caring for her young child. I have nothing but admiration for both of them.

When my children entered their teens, I carried this fear that their lives may be altered as well, due to mental illness. I had such a terror of them using drugs and predisposing themselves to this scourge. My fears came to pass. My son began experimenting with drugs at 15, had a terrible accident at 18, developed a mental illness at 19. Shortly after turning 19 he began using heroin and died due to a heroin overdose at the age of 20, the same age as Linda and in the same month September.

Now I know how deeply my mother and father suffered, and once again they suffered. A day does not go by without a tear being shed, for Greg. I miss the very essence of him, his laugh, touch and love and the tragedy of it all is that I believe if people like him and his families were given more support a lot of these deaths need not occur.

Parenting a Heroin User

For years now, my daughter has fearlessly and stupidly ridden the back of a heroin addiction. The irony is that I'm a better parent for it.

While she has succumbed to a dangerous, unfocused, total abandonment to this drug, I have come to completely accept her, love her, and continue to believe in her. I see her not as I would like her to be, but as she is: a person with a serious problem with drugs.

There are many contradictions in parenting someone who is dependent. I feel an excruciating sorrow over losing her, yet I am at peace. I stay present for her while at the same time I have let her go. And although my heart is heavy with depression, I feel the lightness of our love for each other.

For a time I struggled to understand my daughter's heroin problem. Finally I discovered and ultimately accepted that her dependence makes no sense. I made mistakes but I accept that with my knowledge and awareness at the time I did the best that I could.

I want to look back at these troubling times and feel at peace with the kind of parent I was. In the meantime, I want to be the kind of parent my dependent daughter needs most right now.

What I believe she needs most is a parent who is stable, resilient and down to earth. She needs a mother to soothe the many bruises on her arms and on her heart. She needs a father to help her focus on her reality.

Mine is a still, calm, wise type of parenting that waits for an opportunity to be of real help. In the process, I create the space for my child to seek effective help from other people. This is a gentle parenting that welcomes the spirit to move and transform both of our lives. Soon I may see my daughter completely recover and prosper.

Most of all, this brand of parenting sets an example for my daughter and can help her decide in what way she can be a good parent to herself.

A Mother.

Steffie's Story

August 1998

Last week was the 10th anniversary of our son's death from a heroin overdose. Heroin was not his only drug of choice - he used alcohol and speed as well, but it was heroin which killed him.

At around the time it was estimated he died, between 9.30 and 11.30 on the evening of August 6th, my husband and I tucked a card and small posy of flowers into the space between the brick and paling fence outside the house in which he died. This act of commemoration seemed sombre and furtive, sadly befitting a death from an illegal substance.

Our son's death was an anti-social death, largely misunderstood and for the majority, socially unacceptable. For nine years, we did not encounter anyone else whose child had died this way, a situation which created a sense of isolation and despair. It was only last year when I heard of the KOKA (Keep Our Kids Alive) group that I encountered others who had lost children in this way and it was through this group that I received support and comfort and was given the opportunity to express my feelings surrounding my son's death and listen to others' experiences. The strength gained from this created a sense of unity and helped me with my perspective on life.

One of the horrifying factors of the last year is the rising incidence of deaths from overdoses, specifically heroin, and in the last few months I have been put in touch with many more people who have lost their children in tragic circumstances. To alleviate grief, part of the process involves the necessity to speak about it and share feelings and emotions and to this end, KOKA provide constructive and positive assistance.

KOKA is not only for those who have lost children. Much greater anguish is experienced helplessly watching loved ones caught up in the relentless cycle of drug taking and all the pain and suffering this entails. KOKA also provides support for these people, giving them hope where there previously was none. For it is hope which must sustain us all in the end. We can only help ourselves as we work together to achieve common goals for the future. We cannot promise a drug free world, but we can better the current situation through education, tolerance and wider communication. And to this end, KOKA has the opportunity to play a significant role. Thank you

The Last Time I Saw Damien

It was Sunday 23rd February – my life had reached its lowest ebb. I was at Katoomba station drunk on alcohol. My latest romance was over.

The sadness and despair I'd been feeling had gone. The pain and loneliness that had been part of my life had lifted. I just felt tired. My life had been

full of too many drunken and drugged hazes and I didn't know how to stop.

I was supposed to be moving to Sydney for another fresh start but I never made it past the pub on the day I intended to leave. Stumbling onto a bus I collapsed into a seat, looked up and sitting in front of me was my brother Damien and his girlfriend, smiling, looking fresh and beautiful.

I cried as my brother Damien moved to my seat and hugged me. Only months before I'd literally been babysitting Damien through a detox from heroin, not really knowing what I was doing. Changing sheets from night sweats, sharing my vodka and pot with him to get through the nights. Nursing him like a babe as he cried and screamed, telling him I loved him and we would get through this. Then, thinking it was over, helping him find a flat and get on his feet; drinking together and arguing; giving him a bed for the night when he'd had the occasional shot of smack and couldn't go home to his girl friend because he didn't want her to know; lecturing him the next morning about using smack as we shared a joint.

Now here we were on this bus to Katoomba. He looked gorgeous and happy. He told me he hadn't had a shot or a drink in weeks. He'd been to a wedding the day before, he loved his girl and life was good. I cried. I said I didn't know what to do. My life was a mess. Damien, his girlfriend and my friend David all screamed – "Go to rehab". I promised: "yes I would as soon as I got to Sydney. I would get some help."

We arrived in Katoomba, I hugged Damien, and told him I loved him. We promised each other we'd stay safe, we'd be okay. I went off to a friend's house to sleep it all away. When I woke up that Sunday night, without much of a thought, I shared a cask of wine with my friend – yes I'd go to rehab, when I got to Sydney.

The next two days carried on as usual – drinking, smoking, getting smashed, and talking about my move to Sydney. Wednesday morning I woke up hung over on a sofa. Today was the day, I decided. I was going to Sydney. I rang my friend Jade. She sounded scared. 'Ring your dad, Gill. You've got to ring him'.

"I will when I get to Sydney".

"No, you've got to ring your dad now".

"Why, what's wrong?"

"Just promise me now, you'll ring your dad!"

I rang. My fathers partner said "…… your dad…the police……he's on his way to the morgue. Damien, they think it's Damien."

And it was. Damien was found alone in a car park with a fit in his arm on Monday night. The day after I'd seen him looking so beautiful. He was gone.

The next few weeks were a blur. I tried to stop but I couldn't. The funeral, the wake, the pain and the drinking. Somewhere I'd remembered I had told Damien I'd go to rehab, so I did. That's another story. It has been hard work, painful and I have grieved.

Today I don't drink or use drugs. I am 30 years of age, I live in a beautiful part of Sydney, I've been to college. I have a job I enjoy, friends and family I adore, and a sense of peace in my heart.

And I miss my brother.

Dieter's Story

Born: 7/1/1967

I started smoking pot at around the age of 13 experimentally then heavily at age 15 after leaving school. I then started experimenting with amphetamines due to peer pressure and found a liking for it. I was introduced to heroin that same year and by age 18 I was hooked on the stuff. I tried a drug rehabilitation once, lasting only 10 days. I couldn't bear going cold-turkey any more.

The Salvation Army ran the rehab program. Their belief relies more on developing strength and religious therapies with no pain killers or drugs to sedate you and ease pain. I failed to complete this program.

To my high addiction ($300 a day) I needed some sedation or medication. My raging habit brought me into frequent trouble with the law. I had a whole string of charges related to my drug addiction. So I went on the Methadone Program and it is coming up to 14 years now that I've been on methadone, finding it harder and harder to get off.

Written by Dieter in August, 1999
Rapid Opiate Detox September 1999
Died 1st March, 2000.

Adam's Story

Starting off with drugs

I can't blame any one thing for where I am, in jail, what I've done or where I'm going. Most of my life has been full of all sorts of opportunities and choices. I guess being the eldest of a large family didn't help, and although my parents meant well and we lived in a pretty stable environment, with Mum cooking and mending and Dad providing – to the point of being a workaholic. (This didn't help!)

Communication between the family members was lacking. Certain issues could've had more time spent on them and researched better. Threats or punishment didn't really encourage trust and openness etc.

Dangerous drug use in jail

I've known people who have had pretty large habits prior to gaol but had easy access to heroin while inside which dwarfed any previous habit. The assistance one gets from the medical staff is a joke (a few panadeine forte or doloxine if you're lucky – maybe a valium – like giving cordial to an alcholic). And, with an officer within hearing range (and/or no confidentiality i.e. the staff, nurses and doctors answer to the superintendent and report breaches of rules and security) the only result from telling the medical staff about withdrawals is a mark against your name on your file and punishment of one kind or another and no relief!

I heard today from one of the medical staff here that in one section of the gaol (maximum security) one needle is being used between 20 odd people. I went to a funeral a couple of years back where a guy died from heroin overdose in Goulburn maximum security – what a joke high security is.

Recently two guys needed to use my cell to have a hit (to inject heroin) that had been brought in on a visit. They didn't clean the needle between hits. It's a worry! There's no real harm minimisation as such available even on demand. I persisted for months while in Goulburn in trying to have a basic first aid course but no go! It was the same result for a HepC/HIV course. Even peer support courses are nil!

The general public and the system forgets it's in everyones' best interest to have educational and self awareness courses and encourage harm minimisation practices because inmates tend to get out sooner or later. Wouldn't it be better to release them skilled, equipped with constructive behaviours, healthy without raging HepC and HIV, and a bad attitude all getting shared amongst the wider population?

There's not much access to resources to better oneself, whether it is academic, fitness wise, self awareness or living/social skills concerning issues like drugs alcohol and violence. Or if they

are available there's little incentive to get involved or follow through!

I've been attempting a correspondence course for nine months – still haven't got one text book!

I'm a Canberra prisoner and I'm in Sydney away from family, all of whom are seriously ill. Though I'm a minimum security prisoner I'm in a maximum security gaol. Though I'm either doing courses or jumping up and down trying to do one and keeping fit, I'm with guys not doing anything positive and people with top of the scale offences.

It is a concern for me to be two-out [in a cell]. I've been locked in a room with someone using drugs including heroin, hash and grass and it really did test my resolve. I couldn't bring it to the attention of the wing officer who does cell changes because I'd put my well-being at risk for dobbing someone in. Things sorted out after a week or so and the other occasions were shorter but still dangerous!

Many times I've nearly made a wrong choice and days/nights are so slow and at times painful in a sense – but I'm still clean and can see me making it to the twelve month mark. Next year while out and about will be as hard or harder, I'm thinking! I'm still alive and haven't been stabbed but I've seen a few stabbings and bashings. I haven't given in to depression/anxiety etc and harmed myself or made a noose! I have persisted (which can really annoy most officers – even when attempting to achieve good etc!) and maintained a resemblance of sanity, fitness, constructive activities, and avoided negative or risky situations.

In gaol inmates mostly get messages from many directions that they are bad and will continue to use drugs and do crime. When I've been flat, down, depressed, anxious or stressed and thought I may end up using on release (or before) and end up full of guilt and regrets and go into manic overdrive, I contemplate escape to get it out of the way (not caring about the high chance of getting caught and returning as either way I'll be back) or suiciding and save myself the anguish.

I think there needs to be more alternatives to gaol for everyone, not just drug users, better programs in gaol, a bit less ignorance and more logic within the staff (to lessen anger, frustration and anxiety and tension on both sides), incentives to apply oneself to these courses (remissions – early release – less parole and/or less parole supervision – real rewards of some kind, a one -out cell etc?)

I'm in with career criminals and guys that have handled kilos of heroin and cocaine. Wouldn't home detention be more suitable for a drug user – access to services better for starters and less negative input?

Support on release

I worked out today that I get released in two months on a Saturday – very handy. Pubs and clubs open and counsellor offices closed. Hopefully I'll get to an NA meeting (just remembered the Saturday night one is at Ainslie village - ahot spot - and very close to Civic). I tell you gaol doesn't build confidence! Though I passed a few temptation tests and been drug free for ten months – totally, I even gave up cigarettes after two months and only drink herbal tea but I'm only human plus I've an extensive drug history – why do I feel I need a touch more attention than I'm getting!

More support is needed on release. There is a massive contrast even if only in gaol for months or a year or so. Imagine having limited access to a TV, didn't read books, newspapers and/or magazines or get the chance to use a computer and for one reason or another stayed in maximum security (or worse segro/isolation) for much of the sentence which was at least 5 to 10 years and was on large amounts of methadone (say twice the maximum for ACT clinics) and all of a sudden you're out there amongst it all in a hectic world hugely different to what you have known (the gaol world) and also changed somewhat from the world you knew when last amongst it – plus you have changed to cope with gaol, to survive, and are different also – no wonder people return and their stay outside is short (and probably not even sweet – quite bitter I'd say!!)

Problems with rehabs

I intended to go to rehab but had a few hiccups. One was that I missed the phone assessment by five minutes. I couldn't find a public phone that worked and they wouldn't assess me for another week or so which really stuffed up my plans for rehab.

Getting help can be pretty tricky for a few reasons – lack of services (residential) and limited places within those services. Accessing any place involves a waiting period so a potential client can get distracted while waiting and/or have trouble moving from one department to another therefore exposure to risk results. Also people in need have to ring on a daily basis, usually at the crack of dawn which is a big ask if you are sick, have no phone (or only have incoming calls available), have limited funds, or it's below zero, raining etc; and then getting there is one more hurdle – though they give you a few hours. If you are late – unlucky. Entry on weekends and public holidays is usually a no no. Twenty four hours a day, seven days a week would be nice with at least a day's notice.

Then there's the question of money – fees to get into some detoxes and most rehabs. Not many users are financial, and when they get their fortnightly payment, unless they get into a safe environment that day, it disappears. Couldn't fees be covered by Medicare? Couldn't agencies ring the client daily at home or leave a message at a place frequented by the client (methadone outlet, drug counsellor, family home, friend) and have a pick up service integrated into the system for each agency or a couple that deal with Canberra as a whole? The service could be used for methadone access also (in certain situations).

Family support

I'm one of the lucky ones and have support from my parents. At times they have given me money, driven me to the place of purchase and doled it out to me or hidden it around my flat and given me directions when I'd ring them daily! That sort of help slowed down a lot of negative things, and reduced my drug intake, eased stress, depression, anxiety, desperation and other extreme thoughts, feelings and behaviour and encouraged stability and rational thinking. It's amazing what a little extra food and sleep, a regular shower and fresh clothes and safe surroundings can do.

Their support in gaol has made a big difference and gives me a feeling of worth. My mother told me once that I'm not the black sheep of the family, just at times the lost sheep!

I could use the family home as a stepping stone between gaol and my own place but I have decided to play it safe by opting for a halfway house to minimise a few potential risks and increase the chances of survival and success and lessen the chances of a return visit to gaol! This particular place is less than ideal and in some ways being there will be a chore in that it is run by a ministry and will be somewhat of a culture shock. (I can see some interesting discussions and debates happening). I couldn't have picked a better (worse) time to be there –Christmas!!! Ah well, hopefully they'll concentrate on helping and not preaching and/or converting (and I won't corrupt/ convert them – well I may test their faith a little!)

Another issue I just thought of is regarding the family and/or friends of a person who has been released from gaol – actually inmates as well. Knowing someone inside gaol or who has been released can be stressful and/or scary. Good intentions are no good by themselves. The inmate can benefit from getting advice and guidance while inside and debriefing when released and both the inmate and people around him/her would also benefit with some information available to those people intending to interact with an inmate in and/or out of gaol. Ignorance isn't bliss – understanding is a better plane to be on.

Grant's Story

My name is Grant and I am 36 years old and have spent over one third of my adult life in gaol. I am in prison for having committed armed robberies to support a heroin addiction.

I first started using heroin when I was 16 and have only been 'clean' for about 15 months.

Prison was no deterrent to my heroin use as I still used regularly and even overdosed on a few occasions. Truly sick of my life and the circumstances I found myself in I made a decision in 1998 that I had to stop using or I would end up dying in gaol. There was very little or no help available, other than availing myself of courses on substance abuse and relapse prevention, all of which I had completed a number of times before. I felt there was no use in talking to drug and alcohol counsellors employed by the prison, as I did not trust them and the best advice I would receive would be to stop using.

But how to stop using? How to stop thinking about using? How to stop being obsessed about using? I wanted to stop but had no idea how I could. Fortunately I had a loving, caring and supportive family who really wanted me to be able to get real help for my addiction and not just token gestures.

After intense lobbying and refusing to give in, my sister finally won approval from the Queensland Corrective Services Commission for me to access Naltrexone. It was agreed that if I took Naltrexone I would also see a counsellor and attend weekly Narcotics Anonymous meetings at the gaol.

This arrangement was brokered through myself, my sister, the head nurse and the Drug and Alcohol Supervisor (at the correctional centre). I was very sceptical prior to taking Naltrexone as I firmly believed there wasn't anything I could take that would make me stop wanting to use or stop thinking about using.

I was amazed by the results. I had finally found something that really did assist me with my addiction and truly helped overcome my persistent desire to use heroin. Within a couple of weeks I had even stopped thinking about wanting to use. After 19 years of obsession, craving to use as often as I could and thinking of little else, I was finally free. This may seem a strange choice of words for someone who is in prison but when you are an addict it's like being a prisoner in your own mind.

When you are in active addiction it's as if there are two people inside your brain. There is the real you, the person who does want to stop using, who wants to stop hurting the people who love them, who wants to free themselves from the guilt, the depression and the misery of the treadmill that is addiction. Then there is the addict who just wants to get as stoned as he can as often as he can and he wins every time, regardless of the risk or hurt that may cause.

After a couple of weeks of taking Naltrexone the addict that shared my brain no longer got a say in my life. Unfortunately he didn't die and he didn't move out, he has just been silenced.

Addiction is a very complex problem and no one solution will help everybody. I can see the wisdom in the requirement for me to attend Narcotics Anonymous as this is also of great assistance and now I have stopped taking Naltrexone.

I greatly value the support, friendship and fellowship of Narcotics Anonymous. By taking Naltrexone for twelve months I gained the confidence to remain drug-free but am very much aware that I will always be an addict and that I must remain vigilant and be willing to use what is available to me so as not to return to heroin use.

At present I am trying to get parole but if this is unsuccessful I have about two and a half years' imprisonment to go. Regardless of the outcome I look forward to my release from gaol with the knowledge that there is no reason why I will return. If you are still using when you get out or have that desire to use, you are fully aware that it is only a matter of time before you go back to gaol, if you haven't died from an overdose.

I know that if I relapse or believe I am going to continue to relapse I have access to medication that will help me to avoid that. With the knowledge I now possess I have choices. If I chose to start and continue using again I would quickly return to a life of selfish acts, hurt myself and those who love me, commit crimes and return to gaol. Obviously I would choose to take Naltrexone and in effect choose life, remain emotionally and physically

healthy and remain in the community living a proper life.

I don't recommend Naltrexone for everyone, as it can be very dangerous if you take it for a while, stop taking it and use heroin again. I believe a person must be truly sick and tired of being an addict and must possess a true desire to want to stop using heroin. You usually only find this desire with people who have used for a long time, 10 to 15 years or longer.

It seems, for most young people who have only used for a few years, that the true desire to stop is still a long way off. A person can only stop for themselves. A lot of people try and stop for their families and for the people who love them because they really do feel terrible about hurting their loved ones and they think they're a bad person because they can't stop.

So they take Naltrexone and they stop using and everyone is happy except the addict because deep down they didn't want to stop so they cease taking Naltrexone and then they use again and a lot of the time they die. You have to be patient with people because a dead person never gets better but if you can keep someone alive, once they have spent enough time in misery they will willingly return and ask for help.

So that's my story and it's turned out okay and I reckon my life is going to continue getting a whole lot better. I hope it's the same for the addict you love and care for.

PS:

Following are the steps taken by Grant's sister to get treatment for him in gaol.

- Through correspondence between myself and head health consultant, Dr Tony Falconer mention was made that under the Corrective Services Act, inmates may have access to treatment. After further research I found Section 52.(1) of the Corrective Services Act 1988 private medical examination or treatment. Through this 'window' our family pursued the relevant course with regard to prescribing Naltrexone.
- Queensland Corrective Services Commission updated their Health and Medical Services Policy & Procedure Manual in April 1999 to include Naltrexone.
- From initial correspondence (November 1998) to Grant's signing of 'Advice for Prisoner's policy' on 21 July 1999 was approximately nine months before Grant was able to orally take his medication.
- Our family had been responsible for meeting costs of Naltrexone. $180 per month was deposited into Grant's trust account at correctional centre.
- Grant's taking of medication was supervised by nursing staff in the medical centre on a daily basis.
- The medical policy for Naltrexone was devised after correspondence between our family, the head health consultant for Corrective Services, Dr Tony Falconer and general manager for the correctional centre. Copies of this correspondence were forwarded to many people in government, legal, judiciary, medical departments, law enforcement and the ombudsman.

Jessica's Story

Just one bad choice! Resulting in a billion more. For me starting out using was just a bit of fun, something risky, and something forbidden. The offer was there – get together with a friend of a friend and feel something you have never experienced before, it's instant, it's amazing you've gotta try it – I was in.

My first encounter with heroin was both amazing and horrible. I vomited uncontrollably on and off for several hours, but the feeling, which is indescribable in words, is what seemed to dominate the memories of my first experience.

Over the next few months I used on and off. I guess I did it also as a bit of a release from the stress of school, but really it was a bit of risky fun with long weekend journeys to Cabramatta. Faster than drive-through McDonalds it was. Within

minutes you could score and be in and out of the chemist with everything else you needed, then a minute's drive around the block for the ultimate rush.

This phase did seem to end for me along with the end of school and new challenges in life to focus on. But it wasn't long before I fell back into the same scene with a newly found bunch of friends. I had already had a taste for it, so beginning again was no big deal for me.

Looking back, I never ever acknowledged the danger and risks involved with using heroin until it was too late. In fact, initially, I felt that people who became addicted and dependent on drugs were weak and such a thing would ***never*** happen to me. ***How wrong I was!***

I soon moved in with friends and it wasn't long before I developed a heavy dependence on the drug. This was easy because, for a while, supplies were abundant, but inevitably this did not last very long.

In the time I was using, one thing I managed was cutting off from the world around me. All that mattered was being able to score. I cut off from my family and friends. Fortunately my family never gave up on me, always keeping in touch. However much I resented it at the time, when I was finally ready to try and sort myself out (once again!) they were still there to help.

Once in a while the idea of stopping would enter my mind. It took a number of failed attempts and eventually I found the only way it would work for me. The methadone program gave me plenty of time to readapt to a 'normal' lifestyle.

I was on methadone for longer than I was actually using, but in the end it didn't matter. Slowly but surely I would win the battle. I now had the chance to rebuild my life – the way I always wanted it to be.

Now I am in a position to reflect on my experience. I feel I have learned a lot about myself and what I am capable of. I can use it as a learning experience which I think will stop me from making some of those not-so-guided choices in my future.

Looking Between the Lines

I am involved in a 'Drug Support' telephone line. Week after week I listen to and console parents regarding their wayward kids. It's heart-rending. I listen to parents or the users express their fears and concerns. The sheer chaos that comes down the phone line is so distressing. For half an hour I have a brief insight into what people are experiencing.

Not that I don't know. I have had the benefit of 18 years experience using, all types of drugs, but mainly heroin. I have never been clean in my life until now. Now I have twelve months up. I am not so far away from drugs that I don't remember. I remember the personal battles it caused me. I remember the daily guilt. I will never forget the pain I caused to those who loved me. And I don't pretend to forget the enjoyment I thought those toxins gave me.

I always thought that I loved heroin. Heroin gave me pleasure, didn't it? Heroin was my release, wasn't it? I think in the beginning this was exactly what heroin did. In the beginning ... But not so very much later heroin was not so much creating pleasure as stopping pain.

My problem was I couldn't distinguish between the two. Every time I had a taste I thought 'this is pleasure' when in fact the only pleasure that I felt was the cessation of pain. It got to be that I didn't know the difference. Try and imagine that. The only happiness you ever experience is when you stop the pain.

All of this I understand better in hindsight. Through most of my using life I never considered stopping, not because I didn't want to but because I couldn't. I mentally and physically could not fight heroin. I had tried, really tried, only to fail and go through all that hard work and be back where I started. So I stopped trying. What was the point of battling mind over body, heart over soul, to go through all that pain and stress to start again at the beginning? I imagine there are a lot of users who feel the same.

I know I was lucky. I stayed alive. I didn't get AIDS. I didn't go to jail. God knows I could have. My kids are healthy and my relationship is intact.

Even though I haven't been clean long, I have been clean long enough to know real joy – real happiness and enjoyment from living, not just existing. Laughing and taking pleasure from the simple things in life, like a sunrise, like the smell of flowers, a brilliant star-filled sky. The sun on my back and most importantly, waking up as I've always wanted to – bright and fresh and healthy with my only worry being whether it will rain or not, like a child.

I know I will never use drugs again. I have had distance from them. I can feel now and I can see way into the distance rather than just tomorrow. It's a beautiful life. I know it's early but drugs don't even tempt me these days. I can do things I never believed were possible. Like walking through Cabramatta with a pocket full of money.

When I think of drugs now they frighten me – the way they should haven 't when I was young. They scare me because they represent taking from me all that I now hold precious. I don't feel guilty anymore. I don't have to guard secrets and watch what I say anymore. I feel useful. I feel worthwhile. I have learnt to love myself a lot and forgive myself a little.

I wish I could give you the answers. When I think back, I have to wonder. Why did I get clean? How did I get clean? I've spent a long time thinking about this one. There is no 'one size fits all' answer. Part of the solution for me was that I wanted to be clean. The other part of me had no idea what clean was – but somewhere deep down I knew there had to be more to life than this. I was sick for weeks and sometimes I felt like I was going backwards. But I had a good doctor and I was surrounded by good people who believed in me, so eventually I got better – without using.

But that's me. What about all the people who are stuck? I talk to them. I hear from their relatives. I know how the user feels and I don't underplay it. And I know how the parents feel. I am able to sit on both sides of the fence. I tell each of them what I know. I tell the user there is hope. I tell the parents not to give up hope. Their addict is a person, who only acts badly because they are most likely stuck in a rut. They are angry with themselves for feeling weak; they are angry because deep inside they hate hurting the ones they love. They are truly defenceless and their anger is their only weapon. It's a way of pretending that they are happy with their life, and their biggest burden is just you and your interfering ways. They can't change – like I couldn't change – so the best defence is to pretend they don't want to. And frankly, some of them truly don't want to.

I don't tell people who I am or what I've done. I'm not sure how relevant it is. I try to diffuse their anger and their frustration. I offer sympathy and empathy for those who can discern the difference. I offer a shoulder to cry on. I try to give out hope to the most wayward of causes. I believe in what I say and I hope that that in itself will convey my story. I wish I could travel down the telephone cord to those most desperate of families to see them, to touch them, to hold them, until they are spent – to show them that my concern is real and not just a distant voice on a phone.

Each time I finish a shift I literally feel a bit broken. It's almost like I'm carrying some of the burden. I don't mind. I think it's important. If, when the people who ring me hang up, feel a little bit lighter it's all worthwhile. When I put the phone down I just relax and think about each of my calls and go over it in my mind. Could I have said more? Have I helped? I convince myself that this is so and then I am able to let go of you all. If I didn't always feel this way, if I didn't feel a bit bruised, I would not believe that I had connected with you and I would believe my effort was useless.

I never used to feel this way but where there is life, there is hope. Sometimes I admit the burden can become overwhelming. When this happens, it is necessary to let go. Your addict may be trying to destroy all those in his path. He may be too angry to live with. Sometimes for your own sanity and the well-being of your family you must step aside. This doesn't mean you will stop loving him; it merely

states you need a break. Families become very fragile when they live with drug abuse. You let the users know exactly that – that you love them no matter what. You will support them in their darkest hour and you will always be there, but you need respite. Everyone needs respite even those who are addicted.

Try to remember that no matter how bad life gets, no matter how ugly your addict becomes, he is still a person – only this person has lost his dreams. He never feels good unless he has the drug. The drug allows him to dream, if only for a moment. But he pays a price. He doesn't always know this because he lives on credit, always promising to cash in on another day, a better week. This is the nature of the drug, not the person.

But if you look very closely, underneath that metal armour which every user needs to wear, you will see a semblance of someone you used to know. Just look between the lines.

If they are all panicking when you open your eyes, you probably really did drop

The same goes for waking up to the paramedics. While chances are that you are of the belief that you merely closed your eyes for a second - or half an hour or whatever - generally, if everyone around you is verging on a heart attack or giving you intense medical attention, you've probably overdosed.

The first time I saw someone drop was a bit of a shock. I knew this idiotic junkie called Nathan, and one afternoon Jenny and I ran into him and this revolting f——— junkie, Matt. At the time, Nathan had owed me $50 or drugs to the equivalent for about a month. On account of it being Nathan's birthday and all, he chucks in $100 for a half, but he and Matt are still $25 short. Nathan assures me that he will give me one-and-a-half caps for the $25 on account of the $50 he owes me. Good deal, off we go.

After great dramas over scoring the actual drugs, because I won't let Matt or Nathan. out of my sight, we finally go back to Jenny's flat to split the gear. Naturally, there are more dramas because junkies are incapable of dividing heroin without arguing, but we get it all sorted and I have my shot with Jenny. I feel it, but I am not remarkably stoned or anything.

Jenny and Matt and I are chatting while Matt and Nathan split what remains. None of us really notices when Nathan then falls asleep on the bed, until about five minutes later when he starts gurgling and turning blue. Matt, being the kindly and helpful chap that he is, grabs his gear, jumps up and runs for it, with the parting comment, "Call an ambulance - I'm outa here."

That leaves Jenny and I alone in the flat with a half-dead Nathan. I call an ambulance and Jenny and I contemplate Nathan. We figure the ambulance will be at least five minutes and Nathan at this point is a really frightening shade of grey-blue. The problem is, I'm none too keen to press my mouth against Nathan's and give him mouth-to-mouth. Looking at Jenny, I can see she is thinking pretty much the same thing.

We sit there in silence for a bit and then I give in and start resuscitating him. When the paramedics turns up, they have to give Nathan three shots of Narcan before he comes to. Once the plunger is depressed for the final time, the results are really quite spectacular. Nathan jumps up in a flash, takes one look at the paramedics, realises they've given him Narcan and he is no longer stoned and starts to scream: 'This is the third f——— time in two weeks people have called the f——— ambulance," and turns to Jenny and I, "What the f— is wrong with you?"

I don't think either of us actually got a chance to answer that question because then Nathan gets into an argument with one of the paramedics about gratitude.

When the paramedics leave quite shortly afterwards there is a brief argument about whether Nathan should give Jenny and I - or ME at f——— least - another 20 lines or so. He finally left 10.

The first time I dropped gave me a chance to see Nathan's perspective. Again, Jenny and I are at Jenny's flat. It's about 6.00 o'clock in the evening in the middle of winter. We score on the way home. As soon as we get to the flat we each begin mixing up a shot. I have a smallish one, but am not particularly stoned so I mix up another small shot. After having that, Jenny and I both nod off.

I wake up because I go to scratch my nose, and can't. I keep coming up against this plastic barrier. Pissed off and a touch confused, I open my eyes to a paramedic hovering above me with an oxygen mask on my face and the paramedic saying, "You just overdosed," a bit too cheerfully for my liking.

I manage to focus and see another paramedic at my side. I don't realise what she is actually doing until I feel the needle. I will testify to the fact that Narcan is a most unpleasant drug. Personally, I threw my guts up. I was also a little bit doubtful at the whole overdose thing at first. I mean, I just fell asleep. Finally Jenny managed to convince me that she did not call the ambulance for her own personal amusement.

I've dropped a couple of times since then and to give you an example of how stubborn a junkie can be on the 'I didn't drop' point, I am still arguing with my friends about whether I actually did drop on one occasion. Yes I fell asleep on a candle, melting my skirt and giving myself second degree burns, and yes it took them 10 minutes to wake me up, but no one had to give me mouth-to-mouth, and I was awake before the paramedics arrived. In my definition, being a touch difficult to wake up is NOT dropping. I know people who aren't on heroin and take 10 minutes to wake up at least every f——— morning, but I don't call the bloody ambulance.

Once I dropped in the quad at school when I was in year 12. I had a shot in the toilets and went outside. My next clear(ish) memory is of me lying on my back on the ground and some strange girl and my friend Trish going, "Get some water! ... Oh, ***thank god*** you're awake." I was looking at them like they were mad and said something along the lines of, "What's wrong? Why did you wake me up?" It was briefly explained to me that I'd come into the quad, sat on a bench, fallen off it, turned bluish and they had been trying to rouse me for about two minutes.

Being half asleep still, I said, "But didn't I just lie here in the first place?"

Apparently not. It took about five seconds of them looking at me and then each other, obviously wondering whether they should in fact call an ambulance or something, before I figured out what had happened. I then grabbed my bag, said, "Right, thanks," stood up and left.

I think I might have looked a touch odd, in hindsight. The girl I didn't know and all their friends (who were fortunate enough to witness my little episode) certainly gave me rather odd looks after that.

Make friends with an agreeable, easily manipulated person who owns a car

Because you won't be able to afford your own or, if you already own a car prior to starting your heron habit, you won't be able to afford to run it any more and will probably end up selling or hocking it. We hocked one of my friend's cars eight times. What amazes me is that we kept coming up with the money to get it out again.

Anyway, cars are handy things to have when you're on heroin. They can make a lot more drugs a lot more accessible. We used to have a dealer who needed to get across town once a day to see his dealer. So for a while I rarely had to spend money for smack because we'd drive him in exchange for a shot.

A different dealer needed to get to Sydney to pick up and told me that if I could get him a lift, he'd give me about $150 worth of gear. Fortunately, I was with my friend Ashton at the time, who does things like drive a friend on a drug run to Melbourne at one in the morning when he

has to be in court at 10am, just because he wants to see an ounce of speed.

So I knew I had a lift, I was just a bit worried because this was with Ash, and **everyone** I know has a scary Ashton driving story. We all sit around and exchange them: "You think that's bad, he was driving down the Clyde with no brakes when I was in the car."

Anyway, it all worked out quite nicely, until we got the gear and Bronwyn (who came with us) had a shot and dropped. But we resuscitated her and all in all it was a very successful trip.

But the best reason for having access to a car is that junkies are lazy and if you're one, chances are, you are too. Yes, you'll walk 10 miles on broken glass for heroin, but if you had a choice, you'd drive. There's nothing worse than being sick and having to spend five hours trekking half way across the world for a shot and I **guarantee** that when you're ill, where there is normally an abundance of dealers, there will be **none**. And when you ask anybody where you can get some drugs, they'll say: "If you've got a car I can get you something." It's like a conspiracy. For a while, if things are going well, you may not think you need a car at all. If you're not sick, drugs will be easy to find. There're always dealers and drugs ***everywhere*** when you don't need them, but the one day in six months that you're hanging out will be the day no one's around.

That's the bastardly thing. Heroin takes up a lot of time. It's certainly more time consuming than this nine to five, five days a week thing most people do. You can very easily spend every waking hour, and without smack that can be every hour (or with it, it can be about one hour in 20, it depends on how rich you are) hunting the stuff down.

It's not a nice feeling when it's seven in the morning, you're already atrociously ill and you just know it'll be about nine at night before you manage to scam yourself a shot. Plus you know you don't get to just lie in bed and be sick for that 14 hours. No, you have to get up and walk and beg and walk and steal and walk and walk ... unless you've got yourself a convenient chauffeur, then you ***may*** still have to wait 14 hours, but at least you'll be sitting comfortably in a car rather than trekking through rain, hail and snow. Don't doubt that you would either. If you are hanging out, you will be five times as cold as normal, but 100 times more likely to be outside in nasty weather. Desperation has marvellous powers of motivation.

There are a million other examples, but one is much the same as another with the odd amusing variation. It really does happen, with what is - I suppose to people who have never used heroin - surprising frequency.

The fact is, most of the time in the case of heroin, you are completely unaware of the fact that you have overdosed.

Neri - Born 19 April 1978, Died by her own hand, 5 December 1999.

Neri's life started out propitiously. She was the second of two daughters raised in a caring and loving environment with opportunity for travel, education and all the trappings of a professional, middleclass Canberra household. Her parents separated when she was six but the love and care was carefully maintained. Neri always said that the separation didn't bother her and retained her bubbly and enchanting personality. She was quite extraordinary and till her teens she excelled academically and in sport. She was a finalist in the ACT Primary Schools Public Speaking competition when she was eleven. At high school she started experimenting with cigarettes and alcohol and by the time she was seventeen and beautiful, had started using smack and just about everything else. Most of this was not known to her parents and in their ignorance, they had no idea of the enormity of the problems she faced. Her sister was more aware but equally helpless. Neri never admitted to a habit and of course, never asked for help.

Neri always loved a thrill. She was tremendously aware that the price of the transient joy that drugs bought was far too high and she fought many battles to get rid of her habit. She was so determined not to die directly from the effects of

heroin that she chose death by carbon monoxide poisoning.

She left a handful of extraordinary essays about her life as a drug user and a diary. The previous two essays are two such examples.

A User's Story

I am 28 years old and live in Cessnock, a rural town two hours from Sydney.

I left home when I was 17 years old and lived in Newcastle. This is where my using started. I dated a nightclub manager who used to deal in speed. I took a quick liking to this as I lost a lot of weight and was very thin. I thought I needed to be thin to compete with all the girls that went to the club. I only snorted it at this stage.

When this boy friend got caught and was sentenced to twelve months' jail, I had to go elsewhere to score. I knew a girl who did this so I befriended her. She was a junkie and I never really trusted her as she was on heroin – a dirty drug. It fascinated me watching her shoot up so I asked her to do me and she did and from that day I never snorted speed again. From then on I was the classical junkie, loved the rush and couldn't get enough.

Coming down off speed was the worst. This friend offered me a taste of heroin to help coming down. I never really liked it at first as it made me vomit all the time and I could not lift my head off the floor. But I tried again and found out what all the fuss was and I loved it. I was told the first time you try it you are addicted. I thought that to be bullshit, but within a few weeks I started getting leg cramps and couldn't sleep but didn't realise that I had started forming a habit. Basically for the next two years I used day and night and whenever I could get a fix. I had a great job in television and changed jobs to radio in hope that this would make me stop. Well it didn't, it just got worse. I lost this job and went down hill fast, pawning everything I owned, writing dud cheques and stealing what I could to get on.

My parents found out and tried to put me into rehab – William Booth Institute. I lasted three days and left, as I shouldn't be in a place like that. I was not as bad as the other people in there. I was OK. Then I went to a two week rehabilitation program in Newcastle as a day patient and basically used the whole time I was there. I then went hack to Booth lasting this time two weeks but met a guy who I fell for, replacing my problems for him. During one night he left so I left in the morning. I went then to a Salvo half way house for a couple of weeks, scoring what I could from the cross, getting ripped off, getting coke instead of smack. So I started going out to Cabramatta and getting on.

One day I went there and woke up three days later in Liverpool Hospital. I had been in intensive care for three days. Lucky for me someone found me in the street. I don't remember anything of that day but I do remember that day changed my life. I went back to Booth and completed a nine month program which at times sucked but changed my life and myself. I found when I came home to Cessnock that I had my family back and today four years later, I am still clean and I have some of the best friends anyone could ever ask for, a boyfriend who understands and loves me for me.

I don't regret anything that I have done in my life because I would not be where I am today if I didn't do what I did in my past. I don't try to hide my past to anyone. I am open about it as I am proud of my recovery. I have lost a lot of close friends who just could not fight the drug and miss them dearly and it hurts to see what using friends that I have left (I don't have direct contact with them – my choice) that continue to use knowing the only outcome is death if they don't stop.

I have a lot of mixed thoughts over safe injecting rooms, but it is better than using in an alley way. Maybe someone might not be as lucky as I was to have someone find them.

The Life of a Drug Addict – By a Drug Addict

I began using drugs at the age of 17. I started the usual way using the 'soft' drug, marijuana. Then I became more involved with an older bunch of people, who introduced me to a whole new world of drugs. Then because of these 'new' drugs like heroin, it didn't take long for the obligatory 'habit' to kick in. Therefore I needed money and lots of it. So to support my habit, I turned to thieving and robbery ... sometimes violent, sometimes not. I've always had a supportive family, (they still are this day), but they still do not understand why I use drugs. It's been my experience that people use drugs for a whole variety of reasons.

My reasons were like most drug addicts, to escape reality. And after being on drugs for so long, I lost sight of the fact that I even had a loving family who cared about me and loved me, as the only thing that mattered in my life was to wake up every day and work out how I would obtain the money to buy my daily drugs and escape yet another day of reality.

It wasn't until two years ago that I decided to change my lifestyle and try living in reality for a while. Since that time I have dealt with reality in all shapes and forms, and I finally feel that I can now say that I have control of my life, rather than having a substance do it for me.

Now that I look back on my life as a drug addict, I can now realise the enormous hurt and pain that my family endured for the years and years I was drug addicted.

The cost of being drug addicted has been expensive to say the least, in both monetary terms as well as emotional torment, loss of freedom, friends, being sentenced to jail time and time again. (My current sentence means that I've got myself four more years' imprisonment, which I am now at the end of.) Because of my continual imprisonment, I have been unable to have any kind of relationship, so at the age of 38 I still find myself alone in the world.

It is not until you have walked in a drug addict's shoes that you can possibly understand what goes on in their mind. People often ask me why I began using drugs. I think that it was to gain a feeling of belonging, and fitting in with the older crowd.

I now say to people, education on drugs has to commence at a very young age, so that the young people of tomorrow can feel confident and content within themselves without having to resort to any kind of chemical stimulation, and I believe that like learning to walk and talk, it starts in the home.

So I say to parents, even if there is something you don't want to hear from your children, please sit down with an open mind and listen and really hear them. Most of all, let them know that no matter how big or small the problem is that they can turn to YOU and discuss it with the confidence and trust that you must show to them.

A Police Officer's Story

As a junior detective working at a small Central Coast police station, my first experience with heroin was as shocking as it was career defining. Since that day I have struggled to understand the role of law enforcement when the police officer and the drug user cross paths.

The powers given to a Constable of Police include the discretion to decide outcomes in individual instances. An anomaly of that discretionary power emerges when dealing with a person in possession of heroin. There are few options available other than arrest and charging for heroin possession.

My first contact with heroin involved the arrest and detention of a group of males caught inside a tobacconist early one morning. Among the group was a 15 year old boy named Adam. He was runtish and pimply with a capricious, yet cop-hating demeanour.

As he was a juvenile I required an adult to be present during the interview. Adam was set aside

while the other males were processed. At the time (5am in the morning), I was having some difficulty locating an independent adult to sit in.

After an hour and a half I approached Adam in a separate interview room. He remained cockie and venomous to me, although I feel he may have been intimidated by my being twice his size.

After observing him for a few moments I realised he was becoming increasingly agitated and pale. Suddenly to my surprise he contorted his face and began crying.

Without warning he thrust his hand down the back of his pants and removed seven small yellow and blue balloons about half the size of a Chuppa Chupp. I did not have a clue what was in the balloons. I was careful not to show my ignorance. I quickly realised he had hidden some form of contraband in his anus. I bluffed and asked who owned the drugs, not knowing what drug was in the balloons. Adam would not betray his older mates.

I asked why he was agitated and he said his abdomen was hurting and he thought the contents of the balloon, although he wouldn't reveal those contents to me, were being absorbed into his system. He was scared he would die.

I left the room to further question the older men. I discovered that the balloons contained heroin and that Adam was given the 'stash' to hold in case they were caught by the police. A juvenile was less likely to get a prison sentence if caught in possession of a prohibited drug. They were right.

I charged Adam with possession of a prohibited drug and various other offences. I thought that was the best thing to do as it was a criminal offence and I am a police officer. I didn't think about the likelihood that he was a user and that he had a treatable problem. I later learnt that Adam had been injecting heroin since he was 13.

A month later I was advised by the Local Court that Adam and his older mates had failed to appear to answer the charges. I made a few inquires of his family and was told that he had died of a heroin overdose three weeks earlier.

I can still see his elf-like frame and angry smiling face when I think about him. Adam was 15 when he died.

Detective Senior Constable Ted Bassingthwaighte

God please help: where do we turn next?

For eight years our family have struggled to cope with our youngest member, a boy now 25. He has a brother 31 and a sister 29 and me, his mother. His natural father chose to leave for a gay lifestyle when my youngest son (whom I'll call John) was just three. I remarried when John was 7½. That seemed to be OK for a while until he was regularly bashed and emotionally abused with constant *mind games* played on him and us all! Consequently that marriage broke up late 1993 for a multitude of reasons.

When John was 14-15 he lost three grandparents to cancer and his natural father to AIDS. The stigma from this was horrific for all three children who were still at school, with the rubbish dealt to them by classmates.

When John was 18 he started being evasive and quite different. Shortly after, we realised he was well into marijuana. He held a job as a cook for three years at Kentucky Fried Chicken. He left year 11 to start a six months TAFE course in automotives and did well. He played trumpet and drums in various bands including the school orchestra. An excellent replica of Louis Armstrong, everyone was amazed at his talent.

One thing led to another with drug offences but never breaking and entering or theft, just bad bizarre behaviour. He lived at home sometimes or on the streets. We had constant trouble with threatening and abusive pushers at all hours of the day and night. We finally had to have him evicted hoping that this would be a learning curve, but it wasn't to be. In fact this was just the beginning. He would be totally off the planet, derelict in appearance and hibernating from the aliens up above in some poor person's front garden down the road. Desperate for a smoke, he would collect butts from the gutter and smoke bin to get enough tobacco to

put in a rollie. He *once* was so self-conscious of his appearance. I still can't cope with these thoughts.

He became delusional and quite frightening (violent, bashing windows, walls, doors and crockery etc). My profession is Administrative Officer but there is one profession I have an informal Bachelor of Arts in and that's plastering, spakling. and sanding. By 1994 I had become quite qualified at patching up holes in things and painting over them. These acts of violence happened for no apparent reason. Bizarre behaviour and delusional speech were just the norm.

Of course we had everyone telling us to get tough, throw him out, don't feed him, don't give him any money so he will be forced to realise what he was doing to our family. He couldn't handle himself – he was so far into it, it wasn't possible. Every time I went looking for help all I was told was "he is an adult now madam he has to help himself". We had just about every police officer in the Albury station at our house at some time or another. I soon realised that they are just not trained to handle, cope or understand the problems these people have. They just don't understand. Their only action is to pick them up and put them in the cells and await a court appearance!

From early 1994 we have tried endlessly to seek some kind of help for his problem and have been pushed from pillar to post with very negative attitudes and no help whatsoever.

In 1996 he was so bad and so depressed he took to me with his bow and arrow he had purchased seven years before. Luckily I could run fast. The drug squad were involved. Much to the humiliation of our family (all well positioned in public areas) the local paper had open slather for days. I was beaten and bashed just minutes before the bow and arrow appearing. I was admitted to outpatients for Xrays. For weeks I found it difficult to breathe - even to move a limb, let alone the emotional effects it had on me and our entire family. John was placed in a prison hospital for twelve months.

Three psychiatrists said that he is one person who should never take marijuana. He came out under Community Mental Health (CMH) to a nearby city and did extremely well in a hostel situation, came back a year later to our city, did well in a flat on his own for six months, then back into his black hole as he calls it. From then on it's been a constant struggle in and out of the psych wing at our base hospital. Eighteen months ago he was really bad again and hadn't had his medication (depot injection) for eight months. In my home he took to my daughter, then aged 27 with an 18-month child by her side, with a hammer. His taking of marijuana at that time was extremely heavy.

I called the police and stated very sternly that they had to find him but I pleaded with them not to put him in the cells but to take him straight to hospital because he was a psych case. I asked them to let me know when they had found him because I could not live at home until he was constrained. He needed to be placed back on medication. He was far too dangerous in the community but try telling the authorities that; it just falls on deaf ears.

He spent eight weeks in hospital, came out under CMH with a Continuing Treatment Order (CTO) and a case manager who was fantastic at getting him involved actively.

He did quite well once again but the major problem is there is no backup for these users. What they need at the time the magistrate is issuing a CTO is an order to attend a self-esteem, anger management or skill building sessions. This is an excellent way to keep them from being bored, which guarantees that they will re-enter the wrong areas and be led astray again. Yes I know they will usually re-offend but if they have an order it can eventually be their making.

Last February he fell back again, missed medication whilst his case manager was on holidays. The case manager found him in a bad state and had him admitted. He ordered a CTO but the hospital discharged John as a voluntary patient. The case manager nearly tore the staff apart for such irresponsible actions, particularly when they knew of his history.

Our family have talked ourselves frantic to courts, police, probation and parole officers, public prosecutors and psychiatrists, you name it, trying to get help and to be heard. Something *more* secure for the user's life has got to be put in place.

There is a huge gap between correctional centres and psychiatric hospitals and the first fortnightly injection. Let's face it. If you broke your hip or had a road accident you would not be discharged from hospital until you had been seen by

an occupational therapist who would visit you on a very regular basis at home to see how you were travelling.

It is imperative that there be constant follow up. It is this need that makes these cases so different. It's almost as if the users need a buddy - like the buddy system in the States. There must be someone who can get shoulder to shoulder with them in an unthreatening way and relate to them - someone outside the family circle.

It is all very well for people to say "they got into it themselves; let them get out of it". Sometimes they have no choice because of their addiction and, horror of horrors, because of the pushers who know when to strike.

Without support these people, suffering an illness or drug psychosis, are totally unable to function. They have lost all their decent friends and only lean on the wrong lifestyle because it is a comfort zone for them. They lack so much self-esteem and insight into why they constantly have a problem.

I believe the majority of my son's problems lie in the areas of:-

- unresolved hurt,
- rejection, and
- unresolved anger

For him drug use is a band aid.

All these issues are areas that many a young person needs one-on-one counselling to help them through. In my son's case he has never had counselling and won't pursue it. This is why I feel they should be placed with an order that addresses these issues to jump them over the first hurdle to help.

At present we have restraining orders on my son for two years. We hope he will be stable on medication. It is far too risky with small grandchildren around not knowing when he will explode. As a mother I have great difficulty and heartache not being able to have him present at Christmas, family get togethers, or grandchildren's baptisms. I have had many a tear which I don't hide. He is not a bad boy. He was and still is very likeable and placid. I long for the day when I can give him a big hug and tell him I love him.

I have been constantly harassed by a neighbour who referred to John as my 'mongeral brain dead son'. She would wait for me to arrive home from work to address her issues. I found it difficult to garden or put the bin out, as she would attack me. We were suffering enough from what has happened without the added trauma of intimidation. It could well have been her 18-year-old grandson!

I try to deal with criticism now from those who seem to think they know it all when they have never walked in the shoes or experienced the world of a drug user's mum. My words are:

Think about heart attacks, cancer and road accidents

Drugs are the same, they spare no family, or no one!!

No matter where you live, or how you bring your children up. What morals and financial security you have. No matter what school your children go to.

Drugs are everywhere.

Marilyn's Story

When our son was running around with 'the wrong crowd' why could we not see that he was part of that wrong crowd?

When our son came home from interstate for a visit why did we see that the girlfriend who accompanied him was a bad influence on him, not that he was a bad influence on her?

When they were both off with the fairies for most of the visit, moping around when they were not out for 'a couple of hours' (which was often a couple of days, usually arriving home while we were asleep and not getting up till we had gone to work). Why were we delighted when they took off interstate again – out of sight, out of mind. We may have been able to influence them to seek help if only we had been brave enough to face the fact that they each had a major problem.

When their relationship was five years old they returned to our place to have their first baby. Horrors! They could not look after themselves, how could they look after a child? To be fair they did appear to pull themselves together quite a lot and ate healthy meals She regularly picked up her methadone. When questioned, he insisted that he was only using prescription medication. Of course we believed him. This was our son. He promised us. We came to know them both a little better. Sure they acted strangely sometimes. Just tired. Took extra painkillers because my back is killing me. (Sorry son it was the medication killing you, not the back.) Train was late so I could not get my 'done' today so I'm feeling too poorly to spend time with the family. I'll have to go and lie down. We like the smell of incense in our room, it helps us relax. Pay you back that money? Love to but someone pinched my wallet. Wasted money? No. Had to help out a friend. Needed to buy stuff for the new baby but must have left the parcel somewhere.

Beautiful baby boy arrived. He was kept in neo-natal intensive care till withdrawal from methadone was complete.

They came home to their own rented place – very rundown property which they organised for themselves. They couldn't find anything cheaper. But at least we were on our own again. They had no experience in paying regular bills – no need when you sleep on a beach in North Queensland. Behind with the rent. Can't get the place warm as there are cracks in the walls, space around the windows and doors. Stove doesn't work. No hot water. Have a decent place lined up. It will be ready in ten days. At the most. Please can we move back in home till it is available. Can't let them sleep in the car with a twelve week old. OK.

After six long weeks we had really enjoyed getting to know our grandson. His parents were a worry though. Two hours late for a meal when you promised to be home in time to cook it. Oh, the car broke down, again. You can't be that tired, you've slept most of the day. Are you sure the Dr prescribed all those pills. Your wallet was stolen ***again***!!!!

Police and DOCS at the door. We are not permitted to take part in the conversation. Hang on, this is OUR home. What is all the yelling? Where are they taking our grandson? Won't somebody tell us what is going on? Oh, son, you have been caught. Again. What? We did not know. You overdosed while the baby was with you. Again. We did not know. You have both been using heroin. Again. We did not know. You have used your last warning. You have been doctor shopping. You have put our grandson in danger. We had no idea. Our grandson is in foster care.

You are devastated. You don't blame each other but both blame yourselves jointly. You go back to the counsellor who was trying to help you before. We did not know. You commence rehab as a day patient. Your girlfriend goes to a detox centre. You miss a day and expect that it won't matter. Bad attitude, you are out. She lasts three days and she is out too. She is hurting, still recovering from giving birth and her baby snatched away. Detoxing. Too hard? You have jointly reached your rock bottom. Your rehab will take you both but you have to be clean. She stops her methadone cold turkey and you nurse her through her withdrawal. There are only five days before admission.

You enter rehab together. We say heaps of prayers. We are learning a lot, reading a lot. Educating ourselves. We need help to cope. We did not dream we'd ever be in this position. You have your groups and counsellors. What about us? I find a number in the phone book – Family Drug Support – the very patient lady on the line listens for over an hour as I poor out my story. The literature posted to me is helpful. We attend FDS meetings and to my

surprise I am able to share my feeling with these people. Until I speak I am not sure what will come tumbling out. These thoughts have never been expressed even to myself. Really, do you mean that we are not the only family experiencing these troubles? You folk have been there before us and survived! Some of your addicts have also survived, but alas, not all. This is scary stuff.

The rehab is going great. It is hard work. There are times when you are tempted to quit. You are allowed very limited, brief, supervised access visits with your baby. How hard it is to hand him back! You have met his foster mother and it does help to know that she is nice and that she cares for him as if he were one of her own. You reach your first milestone, six weeks clean. Both of you. Big celebration. Your baby is your incentive. Unbelievable, another twelve weeks clean! You both now say that as well as doing it to get your son back you are also doing it for yourselves. Thank you God. Please stay with us all. We all have a long way to go still.

You are having another baby. This one won't have to suffer withdrawal. Your access with No 1 son is increasing greatly. Will you be able to cope with two babies? There will be only 14 months between them. You both have our love and support. We like the people you have turned into. Your new son arrives and is healthy. You are still attending rehab but are living in your own place. Thank you to the agent who was willing to give you a chance. You were honest enough to admit to your past. The rent is expensive but you are coping. You now have two beautiful sons with you.

Graduation, a whole year clean! You have both changed so much. It is a pleasure to look into your eyes and see that someone is home. You are beautiful, vibrant human beings. In your time you have lost many friends and acquaintances to drugs. We have learned, son, that you have overdosed eleven times. You have seen and experienced many more horrors than we could imagine. How lucky we are to have you and your family. You have seen some others at the rehab centre succeed and many more fail along the way. Many of them have tried over and over. Thank you to the centre management for taking you both into their program. We have witnessed many miracles at work. Both of you, and your sons are living proof of that.

Addiction is a lifetime thing but you and your beautiful girlfriend are in recovery. You have found a joy in living. Having your baby taken from you was traumatic but shocked you into reassessing your whole lives. We have all grown up. Keep up the good work. You are worthwhile members of the community now. Well done!

Families and Community Workshops' Outcomes

Objectives of the workshops were to:

- identify a range of issues affecting families and community members,
- identify opportunities for strengthening cooperative effort between family and community members and support services,
- identify opportunities for sharing knowledge and skills between family members/groups and community organisations/services/support groups,
- identify the infrastructure (and gaps in infrastructure) in which families and community members provide support on drug related issues, and
- identify the special needs of particular communities (eg Aboriginal and Torres Strait Islander people, linguistically and culturally diverse communities).

Expected Outcomes

- The listed outcomes of the workshops will assist the development of a statement of principles and actions related to effective ways in which family and community members contribute support to those experiencing problems with drug use.

Strategies

- Hear stories from family members and keynote speakers, demonstrating first hand experience of drug related issues.
- Workshop a number of issues commonly identified by families and community members who are or have supported a person experiencing drug use that causes problems in their lives.
- Related to workshop topics, and based on participants experience, formulate a set of principles, strategies and direct actions linked to:
    - the key roles and support actions that family members are well placed to undertake,
    - opportunities for effective partnerships, networks and links between family members, the person experiencing drug use and community based agencies,
    - the knowledge and skills family and community members need to effectively provide support, and
    - existing opportunities for support for family and community members in relation to the issues raised and of any barriers to, or gaps in support.

Set out below are the themes suggested for each of the working groups and a summary of the conclusions reached. Two workshops were ususally conducted for each theme. The outcomes of all workshops considering the same themes have been consolidated.

Workshop 1 - Keeping Drug Users and Families Engaged in the Community. How can the community/community based services help keep people experiencing drug-related problems and their families together?

Workshop theme:

Many experiences and reactions of society to drug related problems result in increased alienation or 'disconnection' of the drug user from the immediate community. For example: a school may expel a child; an employer may sack an employee; a court may impose a jail term. Actions such as these impact significantly on families of those affected.

Participants were asked to:

- listen to a story related to the workshop topic,
- identify best points of intervention to prevent escalating drug problems,
- discuss the up-side, and the down-side of family/community support,
- explore ways of sustaining support, even during 'down-times',
- discuss specifically what schools, employers and community agencies can do to maintain family connectedness as part of their response to drug use, and
- identify ways in which treatment and support agencies can work with family and community members to maintain motivation and sustain effective support.

Workshop outcomes:

How can the community and community-based services help keep people and their families together when they are experiencing drug related problems? The efficient flow of information, especially on services, resources and supports for rehabilitating drug users and families, as well as the co-ordination of drug education programs, could emerge through a coalition of leaders of support groups concerned with a harm minimisation approach to the use of illegal drugs.

One workshop suggested that disengagement of the user from the family, or of user and family from the community, may be a healthy, conscious decision. However, the same group suggested that it may be necessary to find ways of preventing families or users from disengaging. Both groups emphasised reintegration (from jail, from being in recovery, from or during treatment, or into the school community). It is important to support the family, as the family supports the drug user's attempts to be reintegrated into the community. 'The community' means those people and institutions relevant to the drug user who probably has great need to be accepted at their stage of rehabilitation. This requires education and accessible information and resources for the user, the community and the supporting family.

For schools, the 'whole of community' approach is needed. A few schools use this approach and the coalition of key leaders/groups could gather and share and replicate successful 'whole of Community' approaches used by this small number of schools.

Reintegrating drug users into society after a jail term needs a system of co-ordinated education, programs and dissemination of information about support networks, services and resources. Society should be educated about the rehabilitation of drug users and how to help reintegrate them into their communities. It is difficult for the individual to do it alone. Family members sense that support is crucial. Isolated families or individual family members who want to help may not be able to continue supporting their drug using member without easy access to resources and information.

Although one group suggested that employment may not be an option for some rehabilitating drug users, both groups agreed that there is emphasis on employment as a 'marker' for reintegration. Paid employment for most adults in their productive years is one way of knowing that one is part of the community. The community also judges that an individual is part of the community if the individual is in worthwhile employment, as a paid employee or as an effective 'at home' parent or volunteer. There are extra hurdles for drug users and their families if the user is attempting to find employment after a term in jail.

Dissemination of information about services for drug users is critical before discharge from gaol. Some of the specific problems are a lack of any services. Some areas have better collaboration of services and support groups than others. Some systems allocate a mentor to prisoners before release. Mention was made of the difficulties faced by drug users regarding methadone medication.

Workshop 2 - What about us? How do we keep our family together?

Workshop theme:

Drug use by a family member can have wide ranging effects on the rest of the family/community. Survival of the 'family' may sometimes seem to be at the expense or exclusion of the person experiencing the drug problems. Family and community members are usually initially motivated to support and make a difference to the life of a person experiencing drug use problems. But support may need to be ongoing, often for many years.

Participants were asked to:

- listen to a story related to the workshop topic,
- consider family structure, family relationships, family connectedness and the strengths they may offer during times where drug use can also cause family stress,
- consider whether and how family-negotiated limits for the person using drugs should be set,
- explore strategies that help balance the negative effects experienced with the positive strengths offered through 'family' and 'community', and
- identify which types of community based agencies may be well placed to assist in maintaining strong families/strong communities.

Workshop Outcomes:

This workshop was concerned with families coping with addiction in the family. Participants worked through issues of concern to families and sought solutions or approaches that might help, particularly in keeping the family together.

Typical questions or cries for help are:

- My family is falling apart, my marriage is heading for divorce. HELP!
- Am I to blame for these drug problems?
- Many fathers have difficulties in going to counselling or keeping an open mind.
- What about other siblings?
- What about respite care for me?
- Drug problems can lead to family splits, each parent blaming the other for child rearing.
- Parent focus may be concentrated on the user and alienate siblings.

The workshop identified some general advice for families:

- Maintain honest and open communication.
- Respect each other's space and feelings (allowing all family members space because each deals with issues in their own way): in other words recognise individual needs.
- Deal with one issue at a time.
- Focus on agreed desired outcomes and address the means of (and barriers to) their achievement.
- Look after yourself (allow yourself to grieve if necessary, or find ways to give yourself respite care - you will be of little value if you are not well).
- Recognise individual needs. Every member of the family has individual needs.
- Give yourself some praise. Recall the talk by Anne Deveson about giving yourself gold stars.
- Include extended family in counselling.

Discussion also raised some cautions:

- When you set boundaries, these should be realistic. Do not set rules that you cannot carry out.
- Try to avoid 'shoulds', eg you should do this or that.
- Try to separate the behaviour from the person.

Specific advice:

- Counselling services that are in tune with the values of the families dealing with addiction.
- Education. One of the most important issues for partners and family members is the need to become educated on matters relating to addiction.
- Addiction can strengthen personal resolve. This may be for the better - but it may not.
- Helping the user in some circumstances (enabling) can perpetuate the problem. In some cases the family needs to stop enabling. Other cases may require a change on the part of the family member.
- Counselling services for parents may be needed so that they get through together.
- Families may need to find services that are suited to their needs, for example Family Drug Support or some other support group.

The workshop identified specific outcomes that we would like to see:

- A registry of support services, detailing what they do.
- Influence pre-service and in-service training of health professionals in family sensitive practice.
- An Indigenous Family and Youth Conference similar to National Families and Communities Conference on Drugs – "Voices to be Heard".
- More services to include family.
- Specialised counselling which is in tune with families dealing with addiction.
- A forum for discussing issues, particularly for Aboriginal and isolated communities.

Workshop 3 - Accessing the Right Treatment and Advice.

The following are commonly asked questions:

Is the person using drugs able to consider *options* for treatment?
Is the treatment of choice available? Affordable? Accessible?

Participants were asked to:

- listen to a story related to the workshop topic,
- discuss the role family members can play in supporting the person using drugs in finding suitable treatment,
- list the ways in which agencies could/do include family and community members in the process of accessing treatment and in the development of treatment plans,
- identify the gaps and list possible solutions for ways in which community agencies can support families and drug users, and
- Explore ways in which coordination of support could be improved and 'agency shopping' be reduced for those seeking information, treatment or support.

Workshop Outcomes:

This session discussed the philosophies underlying various treatment modalities. Mention was made of the dignity of all individuals, and recognition for the 'wisdom of the whole family'. The need to recognise small improvements and the balance between confidentiality and the families involvement were also discussed. Parents and families need to be involved in the rehabilitation plan. However they needed skills, information and support to do so. There was also discussion on measuring success, acceptance that the concept of being cured may need clarification to include successful long term maintenance.

Training for families is important, so that they understand all the treatment options and help the patient to comply with the treatment. The benefits of families networking was stressed. Various treatment options were mentioned including AA, Narcanon, naltrexone, methadone and other. The attitudes of staff are sometimes a concern if they are judgmental. The need for counselling to overcome underlying problems was raised several times, as well as the immediate availability of detox beds when an individual is seeking abstinence or tolerance reduction.

Some time was given to discussions of methadone, as families have a poor understanding of this treatment and undervalue it as a way to reduce crime and give stability to an individual in difficulty. Methadone needs to be highlighted as success in itself and as a valid medical intervention; and clinics should assist families to learn about the treatment. When people detox off methadone, the continued support for them and possible reacceptance back into methadone treatment was discussed. This acceptance was needed to reduce the relapse and overdose.

Concern was expressed for the impact of drug and alcohol on indigenous communities. The workshop emphasised the need to support them to come together at their own conference to discuss their needs. Involvement of the medical profession was also encouraged.

Lastly the workshop briefly mentioned prevention and early intervention at school. Although many education programs have been trialed, there is little hard evidence of what works. There was however a need for early identification of problems and intervention in the hope of reducing the long-term impact of drug use on the individuals health and future.

Workshop 4 - Falling between Stools - Co-morbidity/dual diagnosis

Workshop theme:

What if it is not just drug use but problems with mental health, communicable disease, or other issues of co-morbidity?

Can family and community members assist in establishing a coordinated approach to treatment and care?

Participants were asked to:

- listen to a story related to the workshop topic,
- explore strategies that may help prevent the person experiencing the problems ending up labelled as someone else's problem or in limbo between services, and
- identify how family and community members may assist in collaborative, coordinated (streamlined) case management.

Work outcomes:

There is a real need for parents and other carers to work in partnership with professional service providers to treat, educate and support the client. Often a therapeutic treatment or support regime is worked out by professionals independently of parents or carers, yet they can provide much insight into effective care and treatment for the person, and can be important as part of the treatment and care team. The wisdom and experience of the client, carers, parents and the professional need to be pooled to achieve the best outcome. It was agreed it was important for care givers not to give up - to ensure that their views were heard.

In order for services to be integrated, and consumers, young people, carers and professionals to work effectively together, there must be a shared vision, and more information sharing, and willingness to give and receive feedback.

Concern was expressed about the legal situation, that discourages participation of parents or carers and an integrated approach. Fear of legal repercussions often prohibited shared care and therapy between professionals and others. There should be much better integration of service delivery between mental health and drug and alcohol and other specialist services. They operate as separate services, yet the root causes of depression, attempted suicide and drug addiction were often the same, and a person should not be treated independently by two or three groups of professionals.

Workshop 5 - What Can Treatment Do? Pharmacotherapies and other ways of making changes to patterns of drug use

Workshop theme:

Family and community members often ask:

- What's available? What works? Is it just a question of pharmacotherapies?
- How do families keep up to date with information on options for treatment?
- How can families influence availability of treatment?

Participants are asked to consider:

- a story related to the workshop topic,
- the best links between community agencies and families in ensuring the best possible options are available to people experiencing drug use problems, and
- the role of family /community members in the continuum of prevention and harm reduction.(e.g. experimentation, regular use, polydrug use, modes of administration, overdose).

Workshop outcomes:

Participants in this workshop included several parents of people who are currently using illegal drugs. They reported that their children had unsuccessfully tried 'cold turkey', as well as currently available treatment pharmacotherapies such as methadone and naltrexone. With one voice, these parents said that they and their children were desperate for information on, and access to, a wider range of options. The participants also included drug and alcohol service providers working in detoxification services, drug rehabilitation and agencies catering for indigenous people who use drugs.

Given these diverse backgrounds, there was useful cross-fertilisation of ideas and experiences. There were some questions from parents on the action and availability of buprenorphine. The facilitator explained the dual agnostic/antagonistic action of the drug. One service provider had some experience with caring for clients in one of the buprenorphine trials. She noted that most clients reported less severe withdrawal symptoms with buprenorphine than they had experienced with previous withdrawal treatments. The group facilitator explained that although the drug had, to date, only been available for research, it will probably be approved by the TGA soon, and available as a treatment option before very long.

There was some discussion of alternative and complementary therapies. One participant had heard success stories from people who had been hypnotised. One practitioner told how medicated detoxification could, where appropriate, be used in tandem with other therapies such as massage. There was also some discussion of acupuncture. A service provider working with indigenous people reported that - based on the knowledge of female indigenous elders - her agency used bush medicine treatments.

The workshop considered the 'Naltrexone referral controversy'. The point was again made that a range of treatments was required since people are different. Related to this issue was the need for better options. There was discussion of creativity as an alternative to drug use. Rehabilitation in general was mentioned, as was the particular point that people experienced 'vulnerability' following rehabilitation. The workshop also highlighted the problem of the 'cross' of pharmacotherapies for people also being medicated for mental illness. The subject of information was raised. In this session there was discussion around links with information sources, misinformation and access to information systems. The question 'How often do you try?' (a particular treatment option or withdrawal *per se*) was also asked.

Workshop 6 - Grief and Loss

Workshop theme:

There are many different occasions during the period(s) of drug use that affect a family member when others in the family or community experience grief and loss. The most acute time may be associated with bereavement, but grief and loss occurs at other times too, for example:

- on discovery that a family member is using drugs,
- following arguments,
- when the family member they know seems to have become 'someone else',
- when a young person leaves home unsupported,
- not knowing where a family member is,
- fear that a family member is unsafe,
- believing support and treatment is inadequate,
- not being allowed to help, and
- mixed reactions in a family about the person and their drug use.

Participants were asked to:

- listen to a story related to grief and loss,
- identify the full range of issues that are connected with family grief and loss,
- explore options for support and practical resources that may assist families to work through periods of grief and loss, and
- identify coping mechanisms and sources of practical support for repeated periods of grief and loss.

Workshop outcomes:

Scribe: Rosemarie Nugent Facilitator: Jenny Melrose, CEIDA

Several themes were identified from the experience of grieving families. The loneliness of the death is the most obvious, compounded by the particular loneliness of parents grieving for a child. In this tragedy, family support is critically important. Just as drug-addiction in one family member can shatter a family, so can bereavement. Survivors may feel an inappropriate and paralysing embarrassment or even guilt at being alive. Many people feel awkward in the company of a bereaved parent, since it is so 'unnatural' for children to die before their parents. This embarrassment is magnified when drugs are involved.

These problems become obvious when one is asked: "How many children do you have?" The simple response is to list those who are alive - but that answer may provoke a sense of betraying the child who died. The more complex response, which includes the lost child, can be confronting to the acquaintance who asked the question.

As if parents' grief is not a great enough burden, pain also flows from the stigma which often attaches to the family of a drug-user. Even if there is no such stigma in the minds of neighbours, grieving parents suspect what is said behind their backs. This anxiety is, of course, intensified by any insensitive statements by friends, neighbours and strangers. In addition to general gossip, some police may express judgmental attitudes.

The awkwardness which people feel in response to any child's death is multiplied, and can therefore trigger avoidance, when drugs enter the scene. There is widespread lack of understanding about the grief of families: people often express impatience about how long it takes to recover from grief, and embarrassment in the presence of the family. Whether this can be remedied by education is a moot point.

It is important to remember that different cultural traditions attach very different values to the family of a drug user (including in some cases loss of face), and the appropriateness of making known and sharing a family's grief.

Here, as in other dimensions of social life, there are no hard and fast answers to the question of giving support. Support groups - and individuals - should be willing to be flexible, working through telephone conversations, chat rooms, or face-to-face encounters, whichever is most helpful to the people who need the support. That flexibility should also extend to the expression of grief through painting, drawing, acting etc.

Opinion was divided on the value and risks of blending groups of bereaved parents with parents of continuing users. The stories of grieving parents may cause despair in parents whose children are still using; yet each group does benefit from the experience and emotional support of the other. We acknowledged a range of separate issues for parents whose children are alive and at risk. For a start, these parents are constantly grieving, and must constantly work out the delicate balance in which they can express love for the user while they hate the behaviour. It is easy to say, but difficult to implement, the advice that each one must respect themselves, set clear boundaries, and thereby set an example to the drug user and other members of the family.

So long as a child is using drugs, parents know that their child will probably lie to them, and that trust has been lost, perhaps forever. When the child is in remission, trust can be rebuilt (though often with great difficulty), but there is always fear of relapse. It is hard, but essential, for the family to retain hope, and at the same time to hold realistic attitudes, by holding on, by talking, and by sharing their experiences.

Some recommendations emerged. One promising line of action is represented by the Harvey Report and recent changes to the West Australian Coroner's Act, which require medical authorities to secure a family's consent before harvesting organs, placing more control in the family's hands. A resolution to write to state health departments about protocols for post mortems and organ removal. [A positive response has been received from NSW - Ed].

More broadly, the anguish of contemplating a child's lonely death, and the pain of the family's own lonely grieving, can be alleviated by sharing. There are now support groups in most major centres, and more are likely to emerge. In these contexts, as well as informally, it is therapeutic to tell the story of the deceased, and of the family: the telling of these stories dissolves the shame which many parents feel. If people are indeed talking behind one's back, the only way to counter the criticism is to tell the story.

A common difficulty in dealing with other people is that so many fall into the trap of uttering platitudes, or offer the false reassurance that things have really turned out for the best, or expect grieving parents to obey a finite time-table of grief. In reality, the loss is irreparable, and we may never come to an end of the 'what if?' questions. Not knowing how to give real support and empathy, even people with good intentions may exacerbate the problem. The workshop felt that there is a need for public education in the domain of grief and bereavement.

Grieving parents need a special and secure space in which to experience and work through their pain. The company of other grieving parents is often helpful, as it encourages people to tell their stories, and reach (and then share) an understanding of their loss.

For both groups of parents, the best way to combat anxiety and pain is by telling their stories. Whether in organised support groups or in everyday life, it is important to find ways in which to keep good memories alive.

Workshop 7 - Families, Drugs and the Law

Workshop themes:

Discussion followed three paths: firstly, improvement of the existing law enforcement system as it applies to people with substance abuse problems; secondly, reform of prison practices and, thirdly, overall reform involving recognition that the criminal law has been ineffective in controlling drug use.

Improving the existing law enforcement system

Families with a child caught up in drug abuse need legal advice to help their child. They should know where to turn to for this assistance. Families are disempowered without access to information about the legal system, their rights, and how to help their family members. A court supported system similar to the Family Drug Support phone-line was suggested. It would also help if criminal lawyers spoke to parent groups. There should also be adequate legal aid.

Those involved in administering the legal system must be conversant in the medical dimensions of mental health and substance abuse disorders. Police and magistrates in particular should receive thorough training on these conditions that affect a high proportion of those caught up in the criminal system.

It was acknowledged that diversion was preferable to prison. Diversion systems go some way to recognising the importance of addressing drug abuse as a health problems.

At the same time it was important that much greater funding be injected into health interventions to help those with drug problems before they become caught up in the criminal justice system. A shortcut from substance abuse to treatment would lead to large cost savings in the justice system.

The workshop recommended that as much should be spent on the health budget as the law and order budget.

Restorative justice and addiction treatment should be the focus, not punishment.

Prisons

Great concern was expressed about the utility of prison for people with drug abuse problems. The working groups felt that prisons fail in rehabilitating inmates. They are extremely expensive and a waste of money in that they tend to breed worse criminals, increase social dislocation and foster long term unemployment.

Prison visiting: Impediments to prison visiting should be reduced and visits fostered.

Regular visits are an important means of keeping prisoners connected to their family and the community. Fostering of such bonds is in most cases essential to promote rehabilitation.

- Visitors – including families are often treated in a demeaning way.
- Visiting rights are denied for trivial reasons.
- There is an obsession with drug security which impedes the development and maintenance of links between the prisoner, his family and the community.

Attitude of prison system and its officers: Changing the attitude of the prison system and its officers is one of the major challenges.

Stereotypical and contemptuous attitudes about drug users (who form the large majority of prisoners) are one of the main impediments in the way of securing change required for rehabilitation. These attitudes spill over to families of prisoners.

Families need to speak up but families often remain silent in the face of unsatisfactory treatment of prisoners and conditions out of fear that calls for change would jeopardise the prisoner. This allows unsatisfactory prison conditions to continue.

Family links should be encouraged: The many impediments to maintaining family links need to be overcome. These impediments include**:**

- overly inflexible, opaque and unfair restrictions on visiting,
- absence of or inadequate transport for families to visit remote prisons, and
- families treated in a demeaning way when they visit prison (see above).

Community life skills: Prison programs should maintain and develop skills necessary to live in the community.

In many ways prisons cocoon prisoners from the outside world, prison destroys independence and employers do not want to employ ex-prisoners.

As a result of these factors, prisoners are less able to cope with the outside world

Re-integration into the community: Greater attention must be given to the reintegration of prisoners into the community and to lower the high risk of fatal overdose which presently exists for prisoners released into the community:

- Half way houses or prison annexes should be established and required to assist reintegration of prisoners into the community. They are needed to provide links to accommodation and employment.
- Prison and community drug support services should be integrated.

Drug treatment and mental health: Treatment in prison is of great concern. There is a crying need for more and better drug treatment. Prisoners should have access to the best available treatments.

Prisons presently serve as society's receptacle for many with mental health problems. These same prisoners generally have substance abuse problems.

Prisoner with mental health problems include some who have acquired a brain injury from overdosing.

Prisons are unsuitable for psychiatric treatment. Prisoners who require such treatment should be in a facility other than a prison.

Stigma: The stigma of drug use is compounded by the stigma that surrounds imprisonment. This stigma is debilitating and makes it very hard to reintegrate prisoners into the community.

Stigma needs to be addressed:

- within the family; and
- in the community attitudes towards the prisoner and his family.

Publication of stories: To promote change of community attitudes and rehabilitation, the stories of prisoners and their families need to be told and publicised with compassion and dignity.

Overall reform

We need policies that address drug abuse as a medical and social issue. At present the criminal law, and particularly attitudes of zero tolerance, is part of the problem rather than the solution. The criminal law should play only a limited role in activities surrounding personal use. These should be decriminalized.

The workshops recommended substantial changes to the present system. Prescription heroin and supervised injecting rooms, should be promoted to reduce the impact on the community of illegal activity to obtain illicit substances. Such measures would undermine the illegal distribution system by reducing demand and taking the profit out of the market.

As things now stand the criminal law creates obstacles to assistance. It is also ineffective in that it does not protect children from access to drugs. If anything it promotes that access. It undermines the rights of those who need help and fosters a culture of suspicion and silence. Sometimes people are too scared to seek help. It stigmatises health problems, divides families and undermines hope and compassion.

Workshop 8 - Communication Between Users and Families

Presenter: Annie Madden, Australian Intrevenous League

Workshop outcomes:

This workshop aimed at creating a space where current drug users and parents/family members could come together to discuss in an open manner some of the issues and feelings from a variety of perspectives. The shame and guilt that is so often experienced by both drug users and families when it comes to illicit drug use often keeps family members apart and unable to communicate with each other. This session was developed to begin the process of 'bridge building' and of assisting both family members and drug users to better understand the pressures and issues experienced by both parties.

Understandably many parents see their children's drug use as a negative activity. The stigma associated with drug use, especially illegal drug use leads to parents becoming enveloped in shame and guilt and this courses them great anxiety. Contrary to popular belief, many drug users are very aware and greatly concerned about the effect that their drug use may have on their parents and other family members. Feelings of guilt and shame about the anxiety and pain that their drug use is causing their families can often lead drug users to attempt to 'protect' their families. This type of 'protectionist' behaviour can involve lying to parents, family members and friends about using drugs or the extent of drug use, trying to deal with problems arising from drug use on their own and not seeking help from family members as well as creating elaborate excuses to cover behaviour, etc. Unfortunately such behaviour is often viewed simply as further evidence of the 'lying junkie' syndrome and can often cause more rather than less damage in the long term for both the drug user and their families.

As the workshop was focussed on family relationships and drug users perspectives, the session also discussed issues affecting drug using parents and their children. Issues such as how to talk to your children about drug use when you are a drug user and protecting your children from bullying and discrimination from other children at school were discussed. Drug using parents in the workshop talked about their guilt and pain associated with seeing their children hurt because of their drug use.

Building bridges between users and families is very important. It is also important that parents and family members share experiences with each other to gain knowledge, understanding and support, particularly in managing feelings such as shame and guilt. The misunderstanding between users and their

families, which often occurs because of the lack of trying to understand each other, creates more pain in families. Families and the drug user need to work together to create greater understanding of each others situation so that there can be change for the better.

As a way to begin the process of building bridges between users and families, the workshop was facilitated by a long term injecting drug user who shared with the participants some of her experiences and 'reasons' for taking certain actions when actively using. While this process raised some difficult and sensitive issues for both the facilitator and parents/family members in the group, it also presented a rare opportunity for family members to ask the detailed and sometimes painful questions that they are unable to ask their drug using family member. In this important way, this workshop provided a very real and tangible opportunity to create better levels of understanding between drug users and their families.

Families want information. They can get this through talking to other drug users and other families who have or are experiencing this issue. They need to ask questions and gain an understanding and make sense of what is happening. Often, when families have the chance to ask questions and gain the information that they need in an open and supportive environment many of the myths and misinformation that cause much of the pain, shame and guilt can be addressed.

Current legislation and society's perceptions push illicit drug use and illicit drug users underground which prevents drug users from seeking support and managing or controlling their drug use. The current system for addressing illicit drugs also prevents parents and families from seeking information and getting assistance due to stigma and shame. The workshop acknowledged that it can be quite difficult for many families to contemplate drug law reform because of the stress they face with a drug user in the family. Even so participants agreed that ultimately reform and change to the current system must occur if we are to address drug use effectively as a community. The group agreed that this issue was one for the whole community, not for families and drug users alone.

The White Cloud

A lonely cloud,
Blown into another world
By a wind that blows only one way.

Hated, a black mark on the clear sky
Bleached by the Sun,
Until finally he lives as one of them.

Cliff McConnell
Born 7/2/68 Died 8/9/1992

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