

Family Drug Help

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www.familydrughelp.sharc.org.au

Welcome readers to the Autumn edition of the Family Drug Help newsletter. This edition continues the drug information articles so well read by families and workers across Victoria.

Our lead article edition is titled 'Amphetamines: your most frequently asked questions'. Recent reductions in availability of heroin has led to users changing their drug of choice. This change affects families who then have to cope with very different behaviours and consequences of other drug (amphetamine) use.

Tony Trimmingham from Family Drug Support, an agency supporting families of drug users (based in NSW), made public comment on John Howard's policies toward a range of drug issues. His informative article is reprinted here.

A book review on Dual Disorders by Daley and Moss is contained in this edition and thanks to George at Living Solutions Bookshop for making this copy available for review. Dual Disorders by Daley and Moss will benefit Mental Health Practitioners and Drug and Alcohol Workers in developing an understanding of the complexities involved in treating dual/multiple disorders.

Family Drug Help are holding a camp for our Helpline Volunteers -more about this inside.

Family Drug Help has a new website please take the time to explore the pages of info, links and past editions of the newsletter in pdf format.

Best Wishes
The Editorial Committee.

Inside this edition

Article: Amphetamines Your most frequently asked questions

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Doxa Camp

What's on? Training in the Drug and Alcohol sector....

AMPHETAMINES

Your most frequently asked questions

This article has been compiled by Angela Ireland, Project Coordinator at Family Drug Help, to provide families with information that might benefit them in their attempts to understand drug use and limit the associated harm.

What are amphetamines?

Amphetamines belong to a group of drugs called 'psycho stimulants', also commonly known as 'speed'. These drugs stimulate the central nervous system and 'speed up' the messages between the brain and the body.

Most amphetamines are produced in backyard laboratories and sold illegally. Amphetamines are often mixed with other substances that can have unpleasant or harmful effects.

What do they look like?

- Amphetamines vary in shape, colour and taste.
- Amphetamines can come in the form of powder, tablets, capsules, crystals or red liquid.
- They can be white through to a brown powder, sometimes even orange and dark purple.
- They have a strong smell and bitter taste.
- Amphetamine capsules vary considerably in colour and are sometimes sold in commercial brand shells. They are packaged in

'foils' (aluminium foil), plastic bags or small balloons when sold on the street.

- Amphetamine tablets vary in colour, and can be a cocktail of drugs, binding agents, caffeine and sugar. This form of amphetamine is becoming increasingly popular.
- MDMA, or 'ecstasy' as it is more commonly known, is a designer drug related to amphetamines. It is usually swallowed in the form of small tablets, but is sometimes injected.

What is meant by impure amphetamines?

Most amphetamines sold illegally contain a mixture of pure amphetamines and other substances, such as talcum powder, sugar, glucose, bicarbonate of soda and ephedrine. These additives can be highly poisonous. They can cause collapsed veins, tetanus, abscesses and damage to the heart, lungs, liver and brain. And because the user does not know whether they are using 5% or 50% pure amphetamine, they can easily overdose by accident.

Why are they used?

People use amphetamines for different reasons. As amphetamines reduce tiredness and increase endurance, some people use the drugs to get 'high' and dance all night. Others use

(Continued on page 4)

FAMILY DRUG HELPLINE 1300 660 068

Fostering Hope: The Volunteer's Theme

If I ask people whether they *hope* that one day the following outcomes will be achieved, I guess many would stay 'Yes':

- Road rage will decrease.
- Bob Hawke's pledge that 'no child will live in poverty in Australia' will be achieved.
- All school children will receive the support they need to become happy, healthy members of their community.
- Everybody in the world will have access to fresh drinking water.

If I ask the same people if they believe that all or some of these events *will occur*, I imagine that many would say 'No'. I can't help but believe that hope, and the expectation of a positive outcome, are currently in very short supply at both national and international levels. They may also be lacking at an individual and family level.

One of the vital ingredients for families and friends looking for resolution to a drug or alcohol issue is to maintain their optimism that the person can and will change. This gives strength to continue to support that person through a process which may take many years.

An important question to me is: 'How do people gather and maintain their hope for so long?' The degree of optimism evident in many callers to the Helpline is remarkable.

However, for others, living with the regular alcohol or drug use of someone close to them has depleted their optimism and understanding. They feel overwhelmed and hopeless. Sometimes they attach blame to themselves or others, further depleting their resources.

For people who experience a sense of hopelessness, the peer support available from the Family Drug Helpline can be very beneficial. After 20 or 30 minutes on the phone, a caller can be refuelled. The reasons for this change are varied, but perhaps the theme running through many calls is that someone is prepared to take the time to listen to their story. A volunteer's support and encouragement can help the caller to make sense of their situation, think about what to do next, and to be accepting of themselves and the person they are concerned about.

I once read that 'it is just the *briefest of human connections* that can start or contribute to someone's healing or growth'. The connection a caller can have with a Helpline volunteer who listens and supports them may be just that type of connection. So many of our daily

interactions do not involve us telling people how we are - even if we are asked, 'I am fine thanks' may be our response. When we do try and tell someone, often they may not have the time or be willing to hear and connect with us.

I remember one caller who, through talking to a volunteer, began to dissect the complexities of his 17-year-old daughter's life. By the end of the call he had totally changed the way he saw 'everything that was happening'. Not that he accepted his daughter's regular use of cannabis and alcohol, but he began to put all the pieces of her life together. He began to see how complex her life was and, consequently, felt more connected to his daughter. He also felt less need to 'blame' her. 'Hope' and 'optimism' were two things that he gained from that call.

In addition to the support the caller received during the call, the volunteer sent him:

- information on the effects of both alcohol and cannabis
- details of a peer support group for parents operating near his home
- written material on strategies for coping in the future.

She encouraged him to ring back next time he needed support. A great outcome for that father through a Helpline volunteer's input.

The volunteer drew on several resources to support the caller:

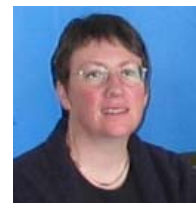
- Her own personal experience of her son's drug use
- Her preparedness to give her time
- Her generosity of spirit
- Her preparedness and ability not to judge, but to listen
- Family Drug Help's comprehensive training program for volunteers
- Family Drug Help Resource Centre.

Would you like to be a volunteer?

Family Drug Help runs regularly training courses for people interested in working on the Helpline.

If you are interested in joining our dedicated team of volunteers, please ring me on 9573 1706.

On a sad note, Zoë Sweett, Volunteer Coordinator at Family Drug Help has resigned and moved on to other ventures. On behalf of the steering committee, staff, volunteers and friends of Family Drug Help, I would like to wish Zoë the best for the future and thank her for her outstanding work developing the Helpline at FDH.



Zoë Sweett

Alan Murnane
Manager
Family Drug Helpline

Family Drug Help Newsletter Editorial Committee: Leigh Fisher, Kathy Crow, Hazel Hayes, Angela Ireland, Nina Bruni, Kerri Dunn and Rosie Spears. Thanks to all our contributing authors. To submit articles for the Winter Edition of the Family Drug Help Newsletter, send contributions or comments to Leigh Fisher by email on lfisher@sharc.org.au, fax 9572 3498, or write to Leigh Fisher, Editor FDH Newsletter, 1242 Glenhuntly Road, Glenhuntly 3163.

Disclaimer: Family Drug Help is a Victorian service providing information and support to the families and friends of the people who use drugs. The ideas and views of personal contributions to the Family Drug Help Newsletter are not necessarily those of Family Drug Help, its auspicing agencies or the editorial committee. Any comments should be made via letters to the Editor that can be published or directed to the authors/artists themselves. All articles and artwork in the Family Drug Help Newsletter remain the copyright of the original artist/author and may not be reproduced without written permission.

BOOK REVIEW

Dual Disorders: Counseling Clients with Chemical Dependency and Mental Illness (Third Edition)

Authors:

Denis C. Daley, Ph.D.
Howard B. Moss, M.D.

Publisher:

Hazelden Foundation
Center City Minnesota

Date Published:

2002

Chapter Headings

- Ch 1 Dual Disorders: An Overview
- Ch 2 Chemical Dependency: Treatment and Recovery
- Ch 3 Recovery from Dual Disorders
- Ch 4 Family Involvement in Treatment and Recovery
- Ch 5 Personality Disorders and Chemical Dependency
- Ch 6 Antisocial Personality Disorder & Chemical Dependency
- Ch 7 Borderline Personality Disorder & Chemical Dependency
- Ch 8 Depression and Chemical Dependency
- Ch 9 Bipolar Disorder and Chemical Dependency
- Ch 10 Anxiety Disorders and Chemical Dependency
- Ch 11 Schizophrenia and Chemical Dependency
- Ch 12 Cognitive Disorders and Chemical Dependency
- Ch 13 Relapse Prevention and Dual Disorders
- Ch 14 Group Treatment and Dual Disorders
- Ch 15 Issues in Dual Disorders Program Development

Layout of Chapters:

Chapters are organised and easy to read. The format of each chapter is as follows:

Chapters 1-4 are an introduction to various aspects of dual disorders, client treatment and recovery and family involvement in treatment and recovery. The work is written from a clinician's perspective and is useful for families in setting a context for information about dual disorders.

Chapters 5-12 focus on the disorders and their treatment. Each chapter is consistent in the setting out of the information. Chapters usually begin with an overview of the area, are then followed by DSM Assessments, types of related disorders, and clinical interventions used to treat the disorders. A summary of each chapter is a particularly useful way of giving information to parents who may then elect to explore the chapter more fully.

Chapters 13-15 focus on relapse prevention issues, group treatments for the user, and program development issues. These chapters relate more specifically to the clinician. Group facilitators of Family Drug Help support groups will find chapter 14 a useful insight into managing group processes.

Availability:

George Thompson
Living Solutions Bookshop
74 Station Street
Somerville 3912
Phone: 03 5977 6366
Fax: 03 5977 6388
Email: livingsolutionsbookshop@bigpond.com
Website: www.livingsolutionsbookshop.com.au



Family Drug Help announces its New Website!!

Go to

www.familydrughelp.sharc.org.au



Message Board
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Helpline Information
Links to Services in Victoria



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the drugs to help stay awake for long periods of time, to improve performance in sport or at work, or to boost their self-confidence.

How long do amphetamines stay in the body?

After ingestion amphetamine is rapidly distributed throughout the central nervous system. Amphetamine has a half-life of 4-15 hours and stays in the user's body for 12 –72 hours after use. Usually it can only be detected 1-2 days after use.

What are the effects of amphetamines?

Their most potent and well-known effect is to stimulate the central nervous system, an effect that accounts for the drug's popularity. The effects of any drug, including amphetamines, vary from person to person, depending on the individual's size, weight and health, how much and how the drug is taken, whether the person takes it regularly and whether it is taken with other drugs. It also depends on the environment in which the drug is used; for example, whether the person is alone, with others or at a party.

The effects of a low dose:

Elevation of mood and euphoria
Decrease in fatigue and increase in wakefulness
Decrease in the need for sleep
Increase in alertness
Increase in talkativeness
Increase in self-confidence
Increase in performance of simple tasks

Physical effects can include:

- Increased heart rate
- Increased breathing rate
- Irregular heartbeat
- Facial flushing
- Dry mouth
- Foul taste in mouth
- Diarrhoea
- Suppressed appetite
- Retraction of gum tissue
- Impotence
- Increased urine output
- Increased temperature
- Fainting
- Sweating
- Fever
- Convulsions
- Coma
- Haemorrhage

The effects of a large dose

- Amphetamine psychosis - the person misinterprets the actions of others, hallucinates, and becomes

unrealistically suspicious

- Anxiety reactions –the person becomes fearful, trembles and has concerns about his or her well being
- Exhaustion syndrome -the person feels intensely fatigued and needs to sleep
- Prolonged depression - the person is intensely sad for weeks at a stretch
- Prolonged hallucination - the person experiences visual and auditory hallucinations long after the drug/s has been metabolised.

What is the cause of dramatic mood swings?

A methamphetamine, or Ice, 'run' of 3-5 days can produce euphoria which is replaced by agitation on the second day, along with frightening visual images and exhaustion. An amphetamine 'run' may produce psychosis, which can bring on uncontrollable violent behaviour similar to paranoid schizophrenia. A urine test is often required to confirm the diagnosis. The paranoia, hyperactivity, and mood swings that accompany high-dose use causes abrupt changes in the emotions of the dependent person, causing them to swing from one intense emotion to an opposite but similarly intense emotion.

What happens to the person after they have experienced their high?

As the effects of amphetamines begin to wear off, a person may experience a range of symptoms, including uncontrolled violence, tension, radical mood swings, depression and total exhaustion.

Are there any long- term effects?

Regular use of amphetamines may result in chronic sleeping problems, anxiety and tension, high blood pressure and a rapid and irregular heartbeat. In order to combat these drug-related effects, people who use amphetamines often also use alcohol, benzodiazepines, other sedatives/ hypnotics, cannabis and opiates.

Other possible effects

Malnutrition: Amphetamines reduce appetite, resulting in people being less likely to eat properly.

Psychosis: Frequent heavy use can cause 'amphetamine psychosis'. Symptoms may include paranoia as well as delusions, hallucinations and bizarre behaviour. These symptoms usually disappear a few days after the person stops using amphetamines.

Reduced resistance to infections:

Regular amphetamine users often don't eat or sleep properly and are generally run down, so their resistance to infections is reduced.

Violence: People who use amphetamines regularly or in high quantities may suddenly become violent for no apparent

reason.

Brain damage: There is some evidence that brain cells can be damaged by regular use of MDMA (ecstasy). This damage will result in reduced memory function and possibly other impairments in thinking.

What does the term "dependence" mean?

Dependence on amphetamines can be psychological, physical, or both.

Psychological dependence

People who are **psychologically** dependent on amphetamines find that using them becomes far more important than other activities in their life. They crave the drug and will find it very difficult to stop using it.

A psychological dependence can be triggered by a variety of environmental and situational factors, such as wanting to stay awake all night, to party or accommodating to peer pressure. While the drug 'helps' them to achieve their desire it then becomes the desire.

Physical dependence

People who are **physically** dependent on amphetamines find that their body has become used to functioning with a particular level of amphetamines. A person may feel very 'flat' as their natural endorphins have ceased functioning and their receptors are receiving strong messages to use the synthetic drug again in order to feel 'normal'. This is a physical process, and causes a physical dependence.

How to people withdraw from amphetamines?

If a person who is dependent on amphetamines suddenly stops taking them, they will experience withdrawal symptoms because their body has to readjust to functioning without the drug. Amphetamine withdrawal symptoms may include: hunger, extreme fatigue, anxiety, irritability and depression. People may also have a long but restless sleep, often interrupted by nightmares. Some experience severe distress or feelings of panic.

Common Symptoms in Amphetamine Withdrawal

From 1-3 days after last use, the user may feel exhausted, a need for increased sleep and the onset of depression.

From 4-7 days after last use, the user may feel strong urges to use amphetamines again, have increasing mood swings, which may include irritability, restlessness and anxiety, to feeling lethargic (tired), run down and lacking energy. The user may experience headaches and generalized aches and pains, increased appetite,

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feelings of paranoia and visual hallucinations. I.e. seeing things that are not there.

Between days 7-28 after last use of amphetamines most symptoms start to settle down for the user. Common symptoms may persist including the mood swings, poor sleep and cravings for the amphetamines.

1-3 months after last use the likelihood of normal sleep patterns returns and there are noticeable improvements in the health and mood of the person in recovery.

What are the treatment options for amphetamine use?

A number of drug treatment options are available in Australia. While abstinence may be a suitable treatment aim for some people, many programs recognise that for others this aim may not be possible or realistic. Most programs adopt strategies that have an overall aim of reducing the harms and risks related to the person's drug use.

Treatment options include: counselling, withdrawal (detoxification) and pharmacotherapy. Residential and 'out-patient' programs are available.

What is the best treatment available today?

We asked Dr Nicole Lee, Senior Psychologist & Senior Research Fellow, Turning Point Alcohol & Drug.

"Given that there aren't any specific pharmacotherapy treatments available for amphetamine treatment at this stage. The best treatment available is of psycho-social nature, which includes Cognitive Behavioural Therapy (CBT) and motivational interviewing. We need to be offering specialist programs for amphetamine dependent people and there is a dire need for more research into this area".

This treatment is available at most Drug & Alcohol treatment centres including Turning Point, call 8413 8413.

Why do people take other drugs to 'come off' amphetamines?

Taking other drugs as a way of coping with some of the undesirable effects of amphetamines can result in a 'roller coaster' dependence on several drugs. For example, some people come to need amphetamines to get going each day, and benzodiazepines to get to sleep each night. This type of dependence can lead to a variety of serious physical and psychological problems.

What is Ice?

A newer form of methamphetamine, called **shabu** in Japan, **hippoppon** in Korea and **Ice** in Australia, is the current manifestation of the amphetamine problem. Its name derives from its clear

crystal form. Smoked in a pipe it is odourless, colourless, and hard to detect - which may account for its popularity. Ice is as addictive as crack and cocaine and its 'high' lasts longer - 8 to 24 hours. The immediate intense euphoria and increased alertness it produces also account for its popularity.

Ice has the same physical side effects as other amphetamines, including kidney failure. Its psychological side effects include aggressiveness, hallucinations, and paranoia. The psychological damage can be long lasting. 'Ice' research in America at the Substance Abuse Centre in Hawaii has identified dysfunctions in a person two and half years after they have stopped using the drug.

What is Ecstasy? Is it an amphetamine?

The pharmacological name of ecstasy is "3,4-methylenedioxymethamphetamine", or MDMA. MDMA is classed as an 'hallucinogenic amphetamine', meaning that it combines some of the effects of hallucinogens (like LSD or magic mushrooms) with the stimulant effect of speed.

In 1912 MDMA was made in Germany and used in controlled environments by psychotherapists. During the 1980s, MDMA, (now called ecstasy), was being used recreationally and in the dance scene, giving users the energy to dance all night. 'I want to dance all night I want to dance all night and still go on for more'. As the rave and dance phenomenon spread to Australia so too did the drug ecstasy.

What are the short-term risks of ecstasy use?

The main short-term effects are dehydration and overheating. Most people who have died after taking ecstasy have suffered from these effects. Dehydration and overheating happen because ecstasy has a direct negative effect on the body's ability to control temperature. Its temperature increases no matter what the person is doing. But dehydration and overheating are also partly due to the environment in which ecstasy is taken: hot nightclubs, where people dance all night and do not replace the fluids lost in sweating. When ecstasy is taken with alcohol, which also dehydrates the body, the risk of problems is increased.

The warning signs of overheating and dehydration are:

- Feeling very hot, unwell and confused
- Not being able to talk properly
- Headache

- Vomiting
- Not being able to urinate or passing thick and dark urine
- Not sweating, even when dancing
- High heart rate and pulse when still or sitting
- Fainting
- Collapsing

IF ANY OF THESE SIGNS ARE OBVIOUS THE PERSON MUST BE GIVEN FIRST AID IMMEDIATELY OR TAKEN TO HOSPITAL: KEEP THEM COOL WITH DAMP CLOTHS ON THE WAY.

We at Family Drug Help feel that knowledge & support can help limit the harm associated with drug use.

REFERENCES

Material was drawn from the following references.

Ecstasy, in **Facts and Fiction**. The National Drug & Alcohol Research Centre, University of New South Wales. 2002

Hafen B Q & Soulier D 1990 Amphetamines, in **Facts, Figures and Information**. Hazelden: NY. USA

Mc Ketin R. 2000 Amphetamine Dependence and Withdrawal. **GP Drug & Alcohol Supplement** No 12 February 2000

Amphetamines Drug Info Clearinghouse druginfo@adf.org.au/article.asp?id=2199

For more information on amphetamines contact the Australian Drug Foundation Drug Info Clearinghouse at www.adf.org.au

If you would like to speak with someone about your concerns re a loved ones amphetamine use then call Family Drug Helpline on 1300 660068

If you currently take speed and want more info on how to reduce your use or detox from amphetamines then contact direct line on 9416 1818 or contact Turning Point Drug and Alcohol Service on 8413 8413.



COPING SKILLS

Managing Emotions

It is common to have a range of emotional responses upon learning about a drug problem. Emotions are real and powerful and some can feel unpleasant or overwhelming. But they are also important and valuable **signals** which give us information about what we need and what is important to us. Strong emotions usually pass relatively soon: while experiencing strong emotions it is helpful to breathe deeply and slowly, and to give yourself time to reflect on your emotions and the thoughts connected to them. Learning to give attention to our emotional experience and to *think about* our emotions, rather than *acting them out or avoiding them*, is a valuable skill. If we can give consideration to other people's emotions, needs and wishes while maintaining awareness of our own, we open the way to constructive communication and improving our relationships. Some common emotional responses may include:

- **Guilt.** Because illicit drug use is still demonised by parts of society, people can fill themselves with self-blame, agonising over what they may have done wrong. Remember, feeling guilty does not mean that you are to blame.
- **Panic.** Many people can feel overcome with anxiety and helplessness, which can make thinking and reflecting very difficult.
- **Shame.** This feeling can stem from the taboo around drug use, and from any beliefs you may have about being an inadequate parent. Family members may feel they cannot tell others, that all must be kept secret. They may start to feel like social outcasts.
- **Fear.** This is a paralysing feeling. Fear can make people anticipate the worst-case scenario and feel overwhelmed with dread. Thinking of ways to reduce the harms and risks associated with drug use can help relieve fear. Getting support from trusted friends, family or professionals, and focusing on one thing at a time, can also be helpful.
- **Anger and rage.** These feelings may arise from the sense that your life has been tipped upside down. Crises, unpredictability and emotional turmoil may seem to have replaced a more orderly life. Anger is often expressed by blaming the person using drugs, or society in general. Anger often covers deeper feelings of fear, hurt or loss. While it is understandable to feel angry, anger can interfere with all your relationships, including your relationship with your partner, if not handled carefully.

"When I found out our son was on heroin I became terrified that he would overdose. I used to lie awake at night waiting for him to come home, wondering if the phone was going to ring with the news that he was dead. His peers were studying and all our friends with kids his age were able to have lives of their own. Sometimes I just got so full of rage I felt like I hated him - I used to yell at him, 'How can you do this to us? Why don't you just stop?'"

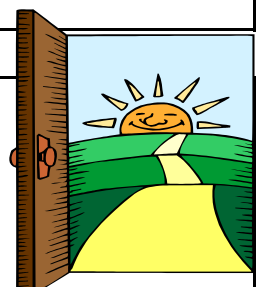
- **Sadness or Grief.** People can experience sadness in relation to what seems like lost opportunities: the loss of one's dreams and hopes for that child or loved one, the feared loss of the relationship, the loss of security and of a sense of well-being. Talking about these feelings can help.

Families in need of further support may wish to call one of the services listed below:

Family Drug Helpline	1300 660 068
Griefline	9596 7799
Care Ring	136 169
Directline	9416 1818 1800 136 385

Not all who wander are lost

JRR Tolkien



Supervision & Support Group

For workers in the Alcohol or other Drug field who have personally experienced recovery from substance abuse



Why should I attend?

- * For external professional supervision to facilitate excellence in practice
- * Share your unique experiences
- * Receive support through the challenges of working in the field
- * Grow personally & professionally
- * Learn new self-care skills
- * Meet & interact with others who share their experiences



Initial Inquiries to...

Matt or Rebekah
TASKFORCE
421 South Road
Moorabbin
(03) 9532 0811



The Reconnect Program has been run by Youth Substance Abuse Service (YSAS) for over 15 months in the Local Government areas of Monash and Whitehorse. The Program aims to improve connections between young people and their family, school and the wider community. It is a **no cost service** that is available to **families and young people (aged between 12 – 18)**, where there is conflict or problems arising from substance use.

YSAS Reconnect aims to:

- Prevent family breakdown and homelessness
- Improve the level of engagement of young people with family, work, education, training and the community
- Assist young people and their families to identify skills and resources available to them to help in resolving difficulties associated with substance use.

By providing:

- Individual and family counselling
- Education about adolescent development and substance use for parents, carers, teachers etc.
- Support for parents, other family members and young people
- Community education.
- Secondary consultation to other professionals.

How to contact us:

Families can contact us directly, or other professionals can make referrals to us and we will then contact the family.

YSAS Box Hill Office
Ph. 98907855
Family Counselors
Petra Henn Mob. 0408 596 945
Sonja Skocic Mob. 0419 532 519

Has Australia's National Drug Policy Changed?

Tony Trimmingham
Family Drug Support NSW

The Prime Minister, John Howard, has quashed any suggestion that he is 'going soft' on drugs and has used several recent media interviews to show that he remains as zero tolerant as ever.

Talking to Prue Mc Sween on Sydney's Radio 2UE, Howard said, "I don't believe in harm minimisation. This only supports and condones drug use. Our policy Tough on Drugs has a zero-tolerance approach that incorporates tough law enforcement, preventing the uptake of drugs and rehabilitation that gets people off the stuff."

This approach may mean we risk losing vital strategies, such as needle and syringe programs.

This possibility echoes Howard's response to a 'Dorothy Dixier' in Parliament early in December, 2003, in which he said, "The path to success [with drugs] does not lie in giving in to the drug barons. It does not lie in giving in to the harm minimisation policy. It does not lie in heroin injecting rooms nor the prescription of heroin."

The truth is that Australia has had a National Illicit Drug Strategy since 1985. The policy is 'Harm Minimisation' using three arms supply reduction (customs, law enforcement, the criminal justice and prison systems), demand reduction (prevention, education and wide treatment options) and harm reduction (user education, needle programs, pharmacotherapies, etc).

The four-yearly review of the strategy is monitored by the Inter-Governmental Committee on Drugs and the Prime Minister's own creation, the Australian National Council on Drugs (ANCD). The strategy for the next four-year period is being reviewed this year.

Howard is not the only Coalition member who is either unaware of the national policy or regards it as having changed. Bronwyn Bishop, in her role as chair of the Federal Inquiry into Crime, has stated, "Our policy is no longer harm minimisation it is now zero tolerance."

In the annual report of the ANCD, the following Howard ministers are quoted: Trish Worth: "The Council continues to provide expert guidance on the

implementation of the National Illicit Drug Strategy, Tough on Drugs."

Chris Ellison: "The National Illicit Drug Strategy represents a balanced approach that includes law enforcement, education and treatment."

Major Brian Watters in the same report comments that the heroin shortage "is largely the result of the more effective supply reduction component of the national strategy". In his response to my previous question about the Prime Minister's statements, Watters suggested that Howard was "not against harm reduction but was against the way some people used the term as a euphemism for liberalising drug policies".

I do not agree. I believe that the policy is in the process of being changed and that 'Harm Minimisation' is no longer the national policy or may not be for much longer.

This change of policy may mean that we risk losing vital harm-reduction strategies, such as needle and syringe programs, medically supervised injecting rooms and even pharmacotherapy programs like methadone and buprenorphine.

Indeed, there is a rumour in the drug and alcohol sector that methadone approaches may change from the very established, very effective maintenance system that it is, to an abstinence regime where methadone is a short-term step to a (mythical) abstinence.

It is also disquieting that the Federal Opposition and all of the states as well as moderate Coalition members are silent about this possibility. Perhaps there is a perception that harm minimisation is not a popular cause with the Australian public.

Another example of politics before principle perhaps!

The ANCD members are split on the issue and the more moderate members of the Council are reluctant to take stands for fear of ending up with even more restrictive policies. Self-interest may also be a factor with jobs and funding possibly on the line. Australia has been a world leader in harm reduction and we have an enviable

record on HIV rates among injecting drug users. Howard's rhetoric over the past few years has alarmed the international harm-reduction community and this new right-wing swing comes when most of Europe (especially Britain and Canada), and New Zealand are moving to more reform and less hard-line policies.

For those most affected, drug users and their families, this current shift in policy in Australia is frightening and we urge an open debate rather than this apparent change by stealth.

I believe that drug policy should be evidence-based, flexible, innovative, wide ranging and apply across the spectrum from prevention through to abuse and dependence.

Harm minimisation is an accepted and logical approach to any risk and is acceptable when applied to alcohol use, bushfires, pool and beach safety, electricity and, of course, all elements of road safety.

As a father who has lost a son to drugs I would like our kids to be able to say "No", for dependents to get off drugs quickly and all drug dealers to be jailed and drug sources eliminated.

Long ago I had to realise that these hopes were in fact fantasies and that we have to operate in the world of reality.

So again I ask the question, "Has our national drug policy changed?" If the answer is "Yes" then someone should tell us; if not then someone should tell Howard.

Tony Trimmingham is founder, and is CEO, of Family Drug Support, a Sydney-based organisation that educates and supports families affected by drugs. He was a founding member of the Australian National Council on Drugs but the Prime Minister did not renew his term in 2001. trimmo@fig.com.au



You Can't Kill The Spirit

Pam McAllister

New Society Publishers

Philadelphia, PA and Santa Cruz, CA 1988

In Argentina, the mothers were watching with a wide-open-eyed rude glare that helped bring down a death-dealing kingdom. Ever since the military coup in 1976, their children and their children's children had been disappearing. They disappeared if they raised their fist, raised their voices, raised their eyebrows. They disappeared if they joined a union, sang freedom songs, were seen with the wrong people in the wrong place at the wrong time. And occasionally they disappeared if they had done nothing at all. Heavy footsteps came at night, muffled screams, and then nothing--no bodies, no proof of torture, no world outrage.

For the bewildered families of the "disappeared" there was neither word of assurance nor word of bad news. With no word there could not be no funerals, no closure, no coming to terms, no time to grieve or heal. There was only time to wonder, hope, pray and wait and wait and wait. The mothers' children were silently disappearing and no one was supposed to see a thing. They were to look the other way if they knew what was good for them.

Everyday many of the mothers of the "disappeared" went to the Ministry of the Interior in Buenos Aires seeking information from the officials. The mothers waited in long, barren corridors. When a woman finally met with an official, she was told that her case would be "processed" but that, in all likelihood, her missing child had run off, had abandoned the family, was having a secret affair somewhere, or was a terrorist who'd been executed by other terrorists. The official smirked and told the mother to go home. Still, the mothers went day after day and waited in the long corridors.

One day an official smirked when he dismissed Azucena De Vicenti. She was a sad and aging woman, well into her sixties. Her suffering was not his concern. But that day Azucena De Vicenti was angry. As she passed the other waiting, anxious mothers on her way out, she muttered, "It's not here that we ought to be—it's the Plaza de Mayo. And when there's enough of us, we'll go on to the Casa Rosada and see the president about our children who are missing."

And that is how it all began.

The next Saturday, April 13, 1977, fourteen women left their homes to do the bravest thing they had ever done. At a time when all public demonstrations were forbidden, they had decided to stand together as witnesses to the disappearance of their children. They came separately to the Plaza de Mayo carrying only their identity cards and coins for the bus and wearing flat shoes in case they had to run. Only after several years were they able to look back at the day with a sense of humour, joking about the first lesson they had learned--- that even in the heart of the most vicious dictatorship, no one cares if you demonstrate on a Saturday afternoon in a deserted square where no one is around to see you.

After that, the women decided to gather on Thursday afternoons when the Plaza was crowded. From that time on, they walked every week in a slow-moving circle around the square carrying pictures of their lost loved ones. Their numbers grew as daughters, sisters and grandmothers of the disappeared joined the circle. People began calling

them "the Mothers of the Plaza" or sometimes "*las locas de la Plaza*" -- "the mad women"

The women were watching and making their witness a public act of defiance against the military regime. When they realized that the newspapers were afraid to write about their action, they got together enough money to buy an advertisement. It appeared, against great odds and despite efforts by the military to stop it, in *La Prensa* on October 5, 1977. Above pictures of 237 "disappeared" and the names of their mothers was the headline, WE DO NOT ASK FOR ANYTHING MORE THAN THE TRUTH.

Ten days after the advertisement appeared, several hundred women carried a petition with 24,000 signatures to the congress building demanding that the government investigate the disappearances. The police repression, which followed, was severe. Hundreds of people were harassed, arrested and detained during the month, including American and British journalists who tried to interview some of the mothers. Still, the women refused to hide their actions. Every Thursday, two or three hundred women would gather to walk around the Plaza. On other afternoons the Mothers held open meetings. Many desperate people came seeking information about loved ones who had disappeared. The Mothers were no longer looking for their individual sons or daughters: they were seeking each others' children and the truth about what had happened to the children of Argentina.

At some point during the fall of 1977, a young man named "Gustavo" began coming regularly to the meetings, seeking information about his disappeared brother and helping the women in whatever way he could. A sweet-faced, blue-eyed blonde in his mid-twenties, sincere, friendly, generous and compassionate, Gustavo seemed every mother's dream child.

Then in December, two days before another advertisement was to be published, this time in *La Nacion*, nine of the women left a planning meeting by a side door and walked directly into a trap. Five or six men, one of them armed with a machine gun, had been lying in wait for the women. The men had been well informed. They, demanded the money the Mothers of the Plaza had collected for the advertisement and forced the women into a car. The women disappeared forever. Two days later three more women disappeared; one of them was Azucena De Vicenti.

There was no doubt that young Gustavo had orchestrated the whole manoeuvre. His real name turned out to be Alfredo Astiz, later recognized as one of the most notorious kidnapers and torturers in ESMA, the Navy Mechanics School in Buenos Aires, where an estimated 5000 people were imprisoned and tortured, and whom only estimated 200 survived. Astiz's nickname at ESMA was "the blonde angel."

The Thursday following the kidnapping, only forty women came to the Plaza; even some of these stayed hidden in the shadows. When the Mothers of the Plaza called a press conference, only four journalists dared attend, all of them foreigners.

Throughout 1978 the Mothers tried to maintain a presence in the Plaza, to let Argentina and the rest of the world know that the women were still watching, despite great odds. But the police violence against them was great and each week a few women were arrested. By the beginning of

1979, the Mothers of the Plaza were finding it almost impossible to endure the violence. Each Thursday they met in the shadows, hurried across the square and quickly formed their small circle for a few minutes before the police closed in. Finally, even that became impossible. No doubt the military men felt smug that as they chuckled over their afternoon cocktails; it seemed that guns, billy clubs, tear gas and terror could defeat even the Mothers of the Plaza. Little did they know that in churches around the city the Mothers continued to gather. Every meeting was illegal and dangerous but the women had found a way. They entered the dark sanctuaries as women do in cities all over the world every day. Some lit candles and knelt before little altars murmuring special prayers, and then they found a place in the pews to rest and pray. There was nothing unusual in this. What the authorities couldn't see was that the woman in the churches, sometimes numbering over 100, were passing notes to each other as their heads were bowed. These were "meetings" at which decisions were made without a word spoken aloud.

It must have been a great surprise to the authorities when, seemingly out of nowhere, the Mothers of the Plaza stepped out of the darkened churches in May 1979. Determined to formalize their structure, they held elections, legally registered as an association and opened a bank account with some of the financial support which begun to come in from around the world. In 1980, they rented an office on Uruguay Street and opened the House of the Mothers. They even started publishing their own bulletin and within several years counted their membership in the thousands.

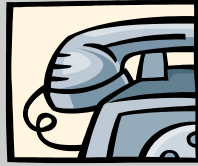
The women returned to the Plaza. They wore flat shoes and white scarves embroidered with the names or initials of the relatives they were seeking. They came to the Plaza carrying photos of the "disappeared." Some days after walking the circle, several women would leave the square, take a megaphone down a side street and each tell her personal story. They had learned that it was easier for people to understand the horror of one missing child than it was to grasp the picture of thousands who had "disappeared." The police met the women in even greater numbers than before and the women continued to face tear gas, nightsticks and arrest. But something had changed. The Mothers of the Plaza were determined that they'd never again retreat into silence and shadows. Their visible courage was contagious. Onlookers who had been too afraid to stop long enough to acknowledge the women now stood still to applaud the Mothers as the circled the square. Argentina's bloody military regime could not hide from the eyes of the Mothers of the Plaza de Mayo. The women were watching and the world was watching them. With their persistence they inspired women in other countries (such as the mothers of El Salvador and Guatemala) where children were disappearing. And they helped bring the day in December 1983 when the people of Argentina inaugurated President Raul Alfonsin as the head of a democratic government.



REFLECTIONS ON BEING A TELEPHONE HELPLINE

VOLUNTEER: 'challenging and rewarding'

by "Anna"



The Family Drug Helpline

A pivotal service provided by Family Drug Help (FDH) is the telephone Helpline. As a call-in service, 'Staffed' Monday to Friday during office hours, it offers anyone within Victoria the opportunity to talk about a problematic situation involving the use of drugs and/or alcohol. However, unlike other drug and alcohol telephone services, its target population is the user's 'significant other' – their parents, partners, friends, and children – not the user. Trained volunteers operate the telephones – people who have experience of the problematic drug/alcohol use of *their* significant other. Currently 26 volunteers 'work' on the Helpline. Callers are offered support, referral and/or printed information. Since its establishment, in 2000, calls to the Helpline have increased rapidly. From the January - March 2002, quarter to the July - September 2002, quarter calls increased by 40 percent. Clearly, the service is meeting a need.

In this article I offer some insight into my experience of being a Helpline volunteer.

My reflections reaffirm the value of the service, point out that its impact is probably greater than initially intended and, perhaps, incite in you, the reader, and a sense of curiosity about the possibility of becoming a volunteer. As I learn, participate in a democratic work community and seek to help others, I am constantly challenged, uplifted and rewarded.

Becoming a Volunteer

I have now worked on the Helpline for the past year. For the preceding five years I had sought help through completing a short program for people affected by another's drug use and participating in a Support Group. I came to believe that there were both similarities and differences in people's experiences of another's drug use. No two situations were the same. People needed to devise strategies which 'fitted' their circumstances. At the same time I was struggling with my need to change some of *my* behaviours: how could I stop making sure 'he' had enough food, his bills were paid, that he kept appointments? Wasn't I stopping him from learning through experience – learning the dreaded *consequences of his behaviour?*

So, when I read a newspaper item calling for Family Drug Helpline volunteers I felt excited and daunted. What could I offer? Well, certainly I had some experience in the area. But did I know enough? Could I learn more about the 'drug scene' and, perhaps, benefit personally? I called the Volunteer Coordinator and was reassured that potential volunteers undertook a rigorous training program. Readiness to work on the Helpline was assessed by both the trainee and the coordinator. Somewhat reassured I commenced the Training Program.

For two days I joined a group of 20 men and women in an informal setting. The trainers were skilled counselors well known in the field of Drug and Alcohol Services. We learnt about each other's circumstances, our hopes for ourselves and our troubled, and troubling, 'other'. Sessions included the structure and focus of current drug and alcohol services, the philosophy of FDH, the users' and their family's cycles of change, and reflective listening skills. We received a folder of written material – for revision and reaffirmation. Towards the end of the second day we participated in several role-play telephone calls. By this stage most of us had decided we would like to join the Family Drug Helpline. We were assured that

training would be on-going so that we could continue to develop our emerging skills. To date I have attended workshops on suicide and media strategies – both enlightening and useful.

On the Helpline

A few weeks after the Program, with some trepidation and excitement, I began taking calls on the Helpline. I was not alone: the Volunteer Coordinator was nearby; other staffs were also handy. I was able to debrief after a call – talk it through to help reflect on its impact on me and my ability to work with the caller. Had the caller triggered some point of vulnerability in me or challenged my beliefs about drug use? Perhaps the caller's situation mirrored my own? Did I advise rather than listen and help them to develop *their* strategies? Could I locate suitable resources? Perhaps the caller could be referred to another service?

Reflecting on each call has become a normal practice for me. Whether on my own or with the coordinator I ask myself several questions: What did the caller want? What did I do? What was the likely outcome of the exchange for the caller? Doing so has helped me to identify some of my 'weaknesses' – reactions that I had not acknowledged as problematic.

I became aware of my tendency to react to the person – not their concern. An angry caller could make me feel defensive: I wanted them to be 'reasonable' over the telephone. I realised that I must move beyond my concern with personality to the *reason* for the call. Only then could I help the caller. I have also become conscious of my beliefs regarding the 'danger' of different drugs. But, rather than adopting a particular 'correct' view, I put my beliefs aside and listen to the caller. For them the situation is fraught: my judgment or assessment of their world is not relevant. Equally, I try to refrain from making assumptions about their situation (such as: 'Yes, the situation *is* out of control'; 'You *do* need some anger management'). Not only do I have limited information but my interpretation of their circumstances is again irrelevant. My beliefs and biases are just that: mine.

Self care retreat

A bush retreat in comfortable cabins is being planned for Family Drug Help Volunteers and Support groups. The weekend is fully catered for so participants can relax and gain the greatest value. Planned activities such as aromatherapy, Yoga, craft, & guest speakers on a range of topics.

Laze by the log fires, or stroll on bush walks around Malmsbury

**Date: Friday 18th
July – Sunday 20th**

*Time: come when you can,
there are activities planned
all weekend, we can even pick
you up from the train station*



Another initiative of Family Drug Help. A Fee of \$10-00 per day covers food & accommodation, all other activities are FREE.

For more details or booking information please contact:

**Angela Ireland
Project Coordinator
9572 1782
aireland@sharc.org.au**



Family Drug Help

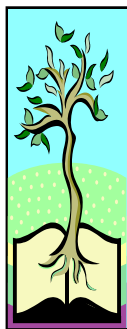
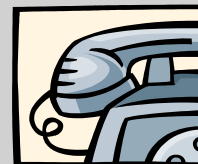
So, for me being a telephone Helpline volunteer means *being a learner*. I learn continuously - from the callers, from the FDH staff and from other volunteers. I also learn from my 'significant other' as I practice my listening skills with him. His feedback suggests that more practice is needed! For me patience and humility go with learning; I need to cultivate these qualities.

Being a volunteer also means *being a member of a community*: a unique community made up of the small band of FDH paid workers who are committed to those 'on the end of the phone', the volunteers and their families. I believe we accept our differences but share a belief in the value of our efforts to help those beset by dilemmas of drug use. To this end the FDH community values all participants: a democratic ethos prevails - not that of a rigid hierarchy of control. All members are asked for input on the conduct of the Helpline. Review meetings are held regularly: members' opinions are sought and considered. For example, the Training program has been reworked to accommodate participants' feedback on the Programs and the trainers' observations. (The most recent Program was conducted over two months, on two Saturdays and some evenings. It included additional issues (such as Dual Diagnosis), and the opportunity for practice telephone calls

between participants.) I joined this program to reaffirm and enhance my skills.

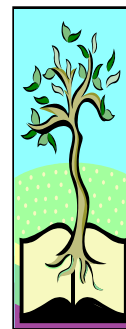
Finally, for me being a Family Drug Helpline volunteer is about *being a helper*. I am there for others, learning how to 'help' them, and also for myself. For I have no doubt that my emerging knowledge and skills are helping me live with, and perhaps rethink, aspects of 'my' problematic situation. The self-help ethos has seeped into all areas of my life.

If you would like further information about being a Helpline volunteer please contact the manager, Alan Murnane, at Family Drug Help on 9573 1706, or email Alan at amurnane@sbarc.org.au



Family Drug Help Autumn Education Series

**Further Information Please Contact:
Angela Ireland on 9573 1782**



PROGRAM ONE Date: Thursday 22nd May

Helen Barnacle & FDH present

“Coping Skills for Families”

Time: 7. 00 pm

Place: Youth Central in Broadmeadows

Address: Pearcedale Parade Broadmeadow (opposite Safeways)

PROGRAM TWO Date: Thursday June 26th

Family Drug Help presents

“Alcohol & Reducing the Harm”

Speakers : Janet Carnegie, Turning Point & Hugh Mc Kinnon Oxford Houses

Time: 7. 00 pm

Place: Moreland Hall

Address: 10 Jessie St Coburg.

Upcoming Events

SUMITT TRAINING CALENDAR 2003

Special Interest Series

- Alcohol- Thinking and Drinking -13th June
- Amphetamines- The need for speed - 20th June
- Relapse Prevention and Dual Diagnosis- 27th June

Intro workshops

- Drug and Alcohol One -26 September
- Drug and Alcohol Two -3rd October
- Drug and Alcohol Three -10th October
- Mental health One -31st October
- Mental health Two -7th November
- Dual Diagnosis General -14th November

Book through SUMITT on 8345 6682
Charges apply.



TURNING POINT TALKING POINT SEMINARS

- Future Directions for Aboriginal Youth - 9th May
- Management Dilemmas in Severe substance Abuse: What can we achieve? -13th June

For bookings contact Turning Point on 8413 8413



Family Drug Helpline has a new Spanish Speakers Service

For those Spanish Speaking community members who care for someone using drugs or alcohol - Family Drug Help is now providing a Spanish speaking Helpline volunteer service.

**Call Lucy at Family Drug Help on
SATURDAYS from
12-00 and 5-00 pm**

9573 1702

Litany Against Fear

I must not fear
Fear is the mind killer
The little death that brings total obliteration
I will face my fear
I will permit it to pass over and through me
And when it has gone past
I will turn my inner eye to see its path
Where fear has gone there will be nothing
Only I will remain.....

Frank Herbert Dune 1965

Please put me on the Family Drug Help Mailing List

Name: _____

Organisation: _____ Email: _____

Address: _____

Suburb: _____ State: _____ Postcode: _____

Fill in this form and return it to 'Family Drug Help, 1242 Glenhuntly Road, Glenhuntly 3163' to receive mail out newsletters and other information on training events, drugs and family and friends support groups.

