Association of Participating Service Users (APSU)

APSU believes that individuals who use alcohol and other drug treatment services are the reason the system exits; their needs, strengths and expertise should drive the system. APSU is run by and for people who use or have used services.

We invite you to join us in having a say. We need your help to give us all a fair go. If you would like to become a member, (at no cost), please fill out the form below.

Membership Application

I wish to become a member of APSU. I would like to:

- ☐ Receive the quarterly FLIPSIDE newsletter
- ☐ Be sent information about how to become involved.

Name _____

Address _____

Phone _____

Email _____

Signature _____ **Date** _____

Are you: ☐ service provider ☐ service user ☐ family member ☐ other _____

CONFIDENTIALITY STATEMENT

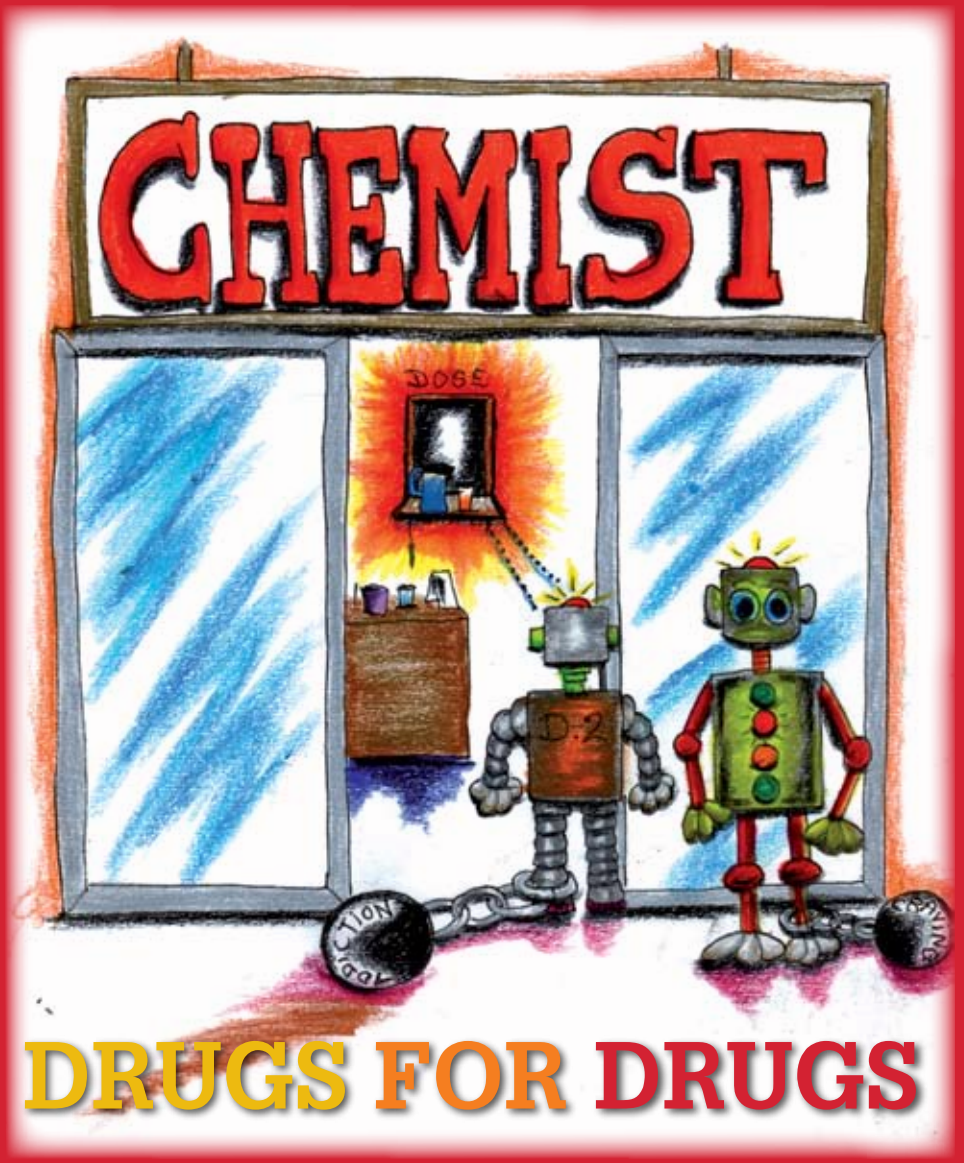
All personal details obtained by APSU will be kept confidential and will only be used for the purposes outlined above. Personal details will not be given out by APSU to other members.

Mail to:
The Association of Participating Service Users,
140 Grange Road, Carnegie 3163.

AUTUMN/WINTER NEWSLETTER 07

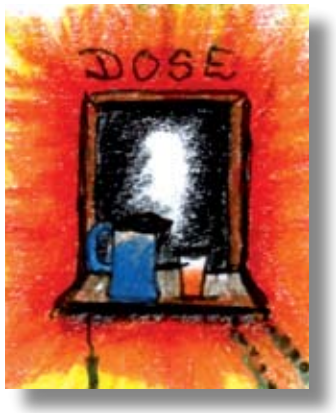
FLIPSIDE

The Association of Participating Service Users



DRUGS FOR DRUGS

INSIDE



Check out our new website at www.sharc.org.au and click on APSU

Editing: Regina and Miriam
Artwork: Thanks to John T for the artwork, and to all those who contributed articles.

Please send any articles you would like to see in Flipside via EMAIL to apsu@sharc.org.au or by post to 140 Grange Road, Carnegie Victoria 3163. Telephone: 9573 1736 ABN: 18052525948

A READER'S LETTER

I LOVED YOUR LAST EDITION OF 'FLIPSIDE'. AT THE TIME, MY CELLIE WAS A TOP BLOKE NAMED 'B' AND IT WAS HE WHO INTRODUCED ME TO IT. GREAT WORK! IT WAS COMFORTING TO KNOW SOMEONE OUT THERE CARED ENOUGH TO MAKE A NEWSLETTER/MAG THAT GIVES PEOPLE SOME IDEA WHAT'S GOING ON IN THESE SEWERS THEY CALL PRISON.

If the general public really knew what went on in here, this place would be closed down. Someone has a lot to answer for. The amount of mentally ill people that have nowhere to get help and so then fall into crisis and break the law ending up in prison is a disgrace! To this state, its past and present government and for those who enable it to continue, someone great said once that 'All it takes for evil to flourish is for good men to do nothing'.

And apathy is everywhere; mostly because no-one knows what really happens on the inside. Many people think that, 'Well, you deserve it, you're a criminal'. But not everyone of the 745 prisoners at Port Phillip is a rapist, murderer or robber as the daily papers would have you believe. Very many made a once in a lifetime mistake for which they will pay society. The question is will society accept we have paid our dues and accept us back into the real world? I hope so. I know my priority is to protect my child and provide for all that's needed to prevent a next generation on the inside. I look forward to the day I can go to work and be a contributing member of a community. I just hope I survive this place and the lasting impact it will have on me.

This letter was in response to the summer 'Flipside' – Boulevard of Broken Dreams

This is not a place for rehabilitation, it's a place you must survive. My name is 'B', I am 40 years old this month. I don't get visitors (severely embarrassed my family) and I lost most friends in the divorce and my crime was that I burnt down the office of The Family Report Writer after five and a half years of family law, fighting for custody of my daughter, (which I won). And I've never been in trouble or jail ever before, I simply broke down after fifty-five court hearings and years of living in the no-mans land of family law courts of Australia. As a father I had to fight to parent my daughter. Even to this day, I'm trying to arrange to be involved in Morgan's life, but to no avail. Anyway enough about me. Would you please put me on your mailing list for Flipside. I'd really enjoy getting some mail. And if I can contribute in any way please just ask. Thank you and love your work!

EIGHT YEARS

8 years. 8 whole years! How could I have been on methadone for 8 years? But that's how long it was. I remember swearing I would never go on it. But of course the sickness of heroin withdrawal got the better of me, and let's face it, it couldn't be worse than that... could it?

Well, for a start it wasn't that bad at all. All I had to do was see my doctor, give a bit of a sniffle and he would up my dose, as easy as that. Before I could sneeze, I was on 55 ml and coasting. The first week was great. I felt pretty stoned, and I even projectile vomited in the toilet at work one day. Things were good. But after a few days, the 'stone' wore off. Yeah, it stopped the severe withdrawals, but it certainly didn't stop me from wanting to use. Wasn't that meant to be the point? Wasn't this going to stop me from using and give me a life? And the 'hell of all hells' was that I had to use 5 times as much to feel it. It was then that I started the dangerous practice of mixing pills with the methadone and smack to try to get stoned. This worked too, but I was dropping and having convulsions all the time.

And this was how it was pretty much for the next 5 or 6 years. My initial, doctor- recommended, one-year reduction plan had certainly never eventuated; I was stuck in the cycle of methadone / smack addiction. At this point the miracle 'naltrexone' drug was introduced. 'This is it' I thought. The only problem was I had to get clean first. So I hatched a plan to go the country with my Mum for a week, get clean and come back to Melbourne and be cured. The only problem was I was jumping off about 20 ml of methadone and a heroin and pill addiction on top of that. Needless to say, my mother will probably never be the same again. I was dangerously sick, had to go to emergency twice and lost 2 stone in two weeks. Got on the naltrexone, took it for a few days and was using again within 5 days!

In 2002, I attended my first NA meeting. It was there that I was able to reduce off methadone, and stop using all other drugs. I've now been clean for over 4 years, and one of my greatest incentives to stay clean was that I never wanted to set foot in another condescending chemist and take my dose out of a smelly plastic cup. I still almost throw up at the smell of orange cordial. Methadone certainly had a place for me. I did go back to school during those years; I held part-time jobs, then a full-time job and at times had some kind of life. But for an addict like me, it was swapping 'the witch for the bitch' and it wasn't the answer.

Kelli

Drugs for Drugs

I'VE HEARD LOTS SAID ABOUT DRUG REPLACEMENT THERAPY. SOME SAY THEY HATED IT, SOME SAY IT SAVED THEIR LIVES. SOME ASK WHAT THE POINT IS IN REPLACING ONE DRUG WITH ANOTHER THAT'S JUST AS ADDICTIVE. SOME SAY YOU CAN'T CURE A DRUG PROBLEM WITH A DRUG. TWELVE STEP FELLOWSHIPS DON'T ACKNOWLEDGE A PERSON ON METHADONE OR BUPRENORPHINE AS CLEAN. SOME OF THE PUBLIC DON'T EVEN REALISE THAT THESE DRUGS ARE MUCH THE SAME AS HEROIN AND HAVE THE SAME, OR WORSE, WITHDRAWAL EFFECTS. THOSE THAT DO REALISE, MAY THINK THAT ADDICTS SHOULDN'T GET LEGAL DRUGS.

I wanted to write an article on drug replacement for this newsletter, but was having trouble getting started. The problem was that I didn't have a strong opinion about it, so I didn't know what to write. I'd found information supporting the idea that people got their lives together on this treatment, but I'd also known those on it for years who still didn't seem to have much of a life. So, I decided to do something unusual for me, I decided to just write up the info I'd found and let you make up your own mind.

There are approximately 75 000 people dependant on heroin in Australia (Drugs and Poisons Regulation Group, 2006) and about 40 000 receiving pharmacotherapy (NOPSAD, 2005). (I'm not sure if those on replacement are counted in the 75 000 or not). Most people are on Methadone (72%) with a smaller number on Buprenorphine (28%) some of whom would now be on Suboxone (NOPSAD, 2005). Most people are given scripts from a private G.P. and receive their dose from a pharmacy. Some doses are prescribed by a doctor in a public clinic or hospital and people are dosed in the same place.

People have many reasons for going on heroin replacement treatment: avoid drug related crime, avoid 'cold turkey' withdrawal and its associated pain, gain control over a chaotic lifestyle, improve health, improve relationships (Christie and Hill, 2000). Some want to reduce the stigma associated with illicit drug use, get help, reduce their dependence on drugs or become completely drug free. Others want greater control over their lives and to feel better about themselves (Christie and Hill, 2000).

Although it's hard to collect information on this type of thing, there seems to be many positive outcomes of pharmacotherapy both for those taking it and for the wider community.

The few large studies that have been done all indicate that receiving Methadone or Buprenorphine:

- Reduces heroin use
- Decreases criminal activity
- Improves mental health
- Improves physical health
- Increases stability (including paying rent, bills ect) and
- Decreases risk taking behaviours (such as sharing needles).

(Christie and Hill, 2000; Mattick et al 2001; Drugs and Poisons Regulation Group, 2006; Turning Point, 2003)

The cost benefit to the community (due to reduced crime, less illness etc) is estimated to be $4-5 dollars for every $1 spent. (Mattick and Hall, 1999)

I haven't found any long term studies (and by long term I mean years) that show what eventually happens to people on replacement, whether many actually get clean.

In one study, the average number of months that people were on treatment was 53, that's over four years! (Mattick et al , 2001) Looking retrospectively, the 'Pathways' study (Laudet and Story, 2006) recorded that of those that had achieved over 12 months of 'recovery' from addiction as defined by the DSM IV-R, 33% had been on replacement at some stage, about half of those listing heroin as their main drug. Nearly two thirds of those that had been on it were still on it.

A four year study of people in Switzerland who were using prescribed, legal heroin showed similar benefits to the user as being on pharmacotherapy in Australia, i.e., reduced crime, better health etc. It also showed that after four years a third had left to go on to abstinence based treatments.

Both of these sets of figures might indicate that about a third of people who start on pharmacotherapy (heroin or replacement) eventually get clean, but we're really not sure.

In addition to all the benefits to users and the community there are negative effects of replacement. People experience a lot of frustration with the whole process (Christie and Hill, 2000). There is enormous stigma associated with picking up a dose from the chemist (I've heard horrendous stories about having to wait until last, breaches of confidentiality, making children wait outside, being asked to shower before coming in or having to keep hands in pockets and stay away from the lipsticks). The cost (around $5 per day) is a problem for someone trying to get their life back together. The restriction of takeaways makes moving house or going away difficult, and employment nearly impossible. The most common thing I've heard is the notion of being a 'slave to the chemist'. The side effects can be challenging, especially in the early stages and teeth are permanently damaged. For those who stop treatment, the withdrawal effects last for weeks or months.

So, there you have it, a few facts and figures on drug replacement therapy. It seems it has good points and bad. One thing for sure, it's here and it isn't going away.

Miriam

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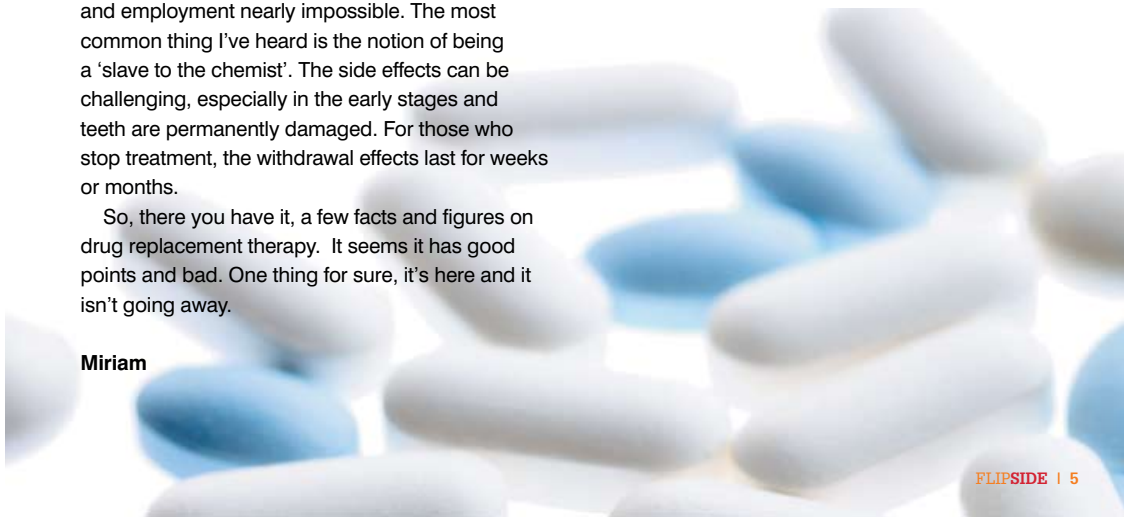


THIAMINE UPDATE

You might remember the article in one of our recent Flipside's about the use of injectable thiamine (vitamin B1) in the treatment of alcoholics.

APSU has been concerned that injectable thiamine is being under used by doctors, and that this may result in unnecessary brain damage. So we wrote to various medical bodies requesting that guidelines for the use of thiamine in the treatment of alcoholics/heavy drinkers be developed and issued to doctors. The NHMRC (National Health and Medical Research Council) has replied that while they don't wish to create full clinical guidelines, they will conduct a review of the current scientific literature (beginning in the next six months) and publish evidence based statements regarding this issue. This is a positive outcome although it may only be the beginning. Thanks to those service users who brought this to our attention.

Megadrone Methadone or Missed Opportunities

I FIRST USED METHADONE IN THE LATE EIGHTIES. WHEN I COULDN'T GET ONTO ANYTHING ELSE, I WOULD USE METHADONE INTRAVENOUSLY WITH THOSE HUGE 23 GAUGE FITS. I LOVED THE WARM RUSH, THE SENSE OF PEACE & RELAXATION. I LOVED NOT BEING SICK ANYMORE. I LOVED THE FEELING THAT 'DONE' GAVE ME, BUT I WASN'T ON A METHADONE PROGRAM BECAUSE IT SCARED ME.

I thought I could control it and besides, I knew about the night sweats, the weight gain or loss, the hanging out & begging doctors for a better dose, takeaways etc. No-one I knew had ever come off 'done' & the thought of life-long dependency wasn't a good option for me. I also knew the history of 'done', that it had been created by the Nazi party during the second World War, that when they couldn't get opium from China, they had to create a synthetic narcotic to treat wounded soldiers. I knew that methadone had originally been called 'adolphine', & the Nazi connection scared me.

By the early nineties my habit had increased. I'd had several attempts at getting clean, & although I could get clean, I always went back to using, often even harder than before. Although I didn't know this at the time, because I had periods of abstinence, my tolerance was all over the place. Also the quality of the gear changed quite frequently & due to these reasons, I kept dropping. How I survived that period I don't know. I do know that I was shit-scared of dying, but I couldn't stop using & stay stopped.

It was relatively easy to get onto the methadone program, just a few blood & urine tests, interviews etc. I started on 60mls a day, then dropped down to 40mls, a dose I stayed on for the next 2.5 years.

My methadone counselor gave me a book by Dr Scott Peck called, 'People of the Lie'. This book spent six pages stating that evil only has as much power as you give it, then the author spends a few hundred pages outlining who & what is 'evil'. Included in this book is the concept that drug addicts are 'evil'. I wondered what my methadone counselor was trying to tell me?!

Not exactly a great way to build trust & rapport.

Not once was I linked up with other services for housing, counselling, medical or educational support or assistance during the whole time that I was on 'done'. My methadone counselor told me that my recovery didn't begin until I was off the methadone. I remember telling that counsellor that if I had that attitude, I'd never get off the bloody stuff. Not once did they mention reducing, although my urine tests had been heroin free for years.

I remember feeling so frustrated that; one, I had been left to fend for myself and two, because I had to build a bridge from being on done to being completely off it on my own.

I so wanted to be free from the liquid chemical handcuffs & the coercive social control that in late 1995 I jumped off 40mls. It nearly killed me. I spent 2 weeks on the floor in the dead man's yoga position listening to Jeff Buckley feeling alternately euphoric & suicidal. I didn't sleep for months. All the dental problems I had that 'done' had masked I could now feel. No-one tells you when you go on 'done', that it can wreck your teeth because it inhibits your saliva flow. I found that out 3 dental abscesses and 6 extractions later.

Was it worth it? Well, being on the methadone program probably saved my life by reducing my need for other drugs & probable overdoses. The perfect opportunity to link me up with other services, to improve my housing, education &employment options, & quality of living was, however, ignored completely.

Jumping off 40mls, I wouldn't recommend to anyone. Everyone I know who has jumped off 20mls or more has ended up using again, in the psyche ward &/or in jail

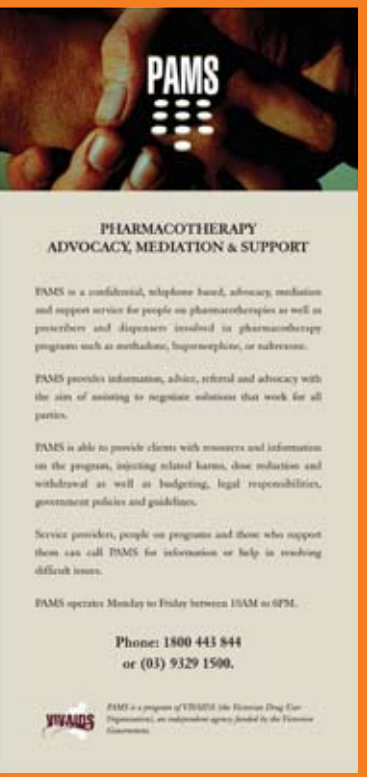
I am just grateful to say that I haven't touched 'done' since August 1995! & that I have not used intravenously since 1997. Would I go back on methadone? Only as an absolute last resort if I were dying.

I just want to send my best wishes to everyone who is on, is trying to get on or has been on drug replacement treatment. Also to remind service providers that addicts are not 'evil', we are human beings, & that drug replacement treatment can be the perfect opportunity to link client's up with essential services to help us turn our lives around.

ANON

The Pharmacotherapy, Advocacy, Mediation and Support-service **(PAMS) at VIVAIDS Inc.**

VIVAIDS (THE VICTORIAN DRUG USER ORGANISATION) IS A STATE-WIDE, MEMBERSHIP BASED ORGANISATION WITH A MISSION TO PROMOTE THE HEALTH OF PEOPLE WHO USE ILLICIT DRUGS AND TO REDUCE DRUG-RELATED HARM.



VIVAIDS receives funding from government to deliver a number of peer-education, health promotion, advocacy and support programs specifically for people who are currently using drugs or at risk of drug-related harms. VIVAIDS also offers training and advice to practitioners and agencies working with drug users and provides input into policy making to help services and systems better respond to the needs of drug users, and to reduce ill-health and harm in the community.

The Pharmacotherapy Advocacy and Mediation Service, PAMS, is a VIVAIDS service that seeks to support people involved in the Victorian Pharmacotherapy Program. That is, people on methadone and buprenorphine and their families and friends as well as dispensing pharmacists and prescribing doctors. People experiencing difficulties with their program or needing information can contact PAMS on Monday to Friday from 10 am to 6 pm on 1800 443 844 (free call). People calling outside these times can record a message with the PAMS answering service.

The majority of calls received by PAMS are from consumers of pharmacotherapy services. Often they are calling because they have a problem with their dispensing pharmacy or prescriber that they are not able to work out for themselves. For instance, they may be unable to get a dose because they owe money to the pharmacist, or they are having trouble getting takeaway-doses that they need in order to travel for work or family reasons.

While PAMS' prime objective is for better service outcomes and experiences for consumers, PAMS always tries to negotiate win-win solutions in any situation of real or potential conflict between service providers and consumers. Ultimately, the consumers' interests depend upon the quality of their relationships with their prescriber and dispensing pharmacies and any solution or negotiated settlement to a problem will need commitment from both parties to work, and to preserve a trouble-free relationship.

Occasionally, people want to make a formal complaint about the way they are being treated, and PAMS can give them information about the complaints processes that exist. More often, people want to be listened to and to have an opportunity to de-brief and discuss their problems with someone who understands. This can be really important, even in cases where PAMS can't help solve the problem.

Regrettably, PAMS is not funded to pay dispensing fees for consumers who are unable to pay for their doses. In many cases, however, we are able to negotiate re-payment agreements so that the consumer can remain on the program without missing doses. PAMS can also refer people experiencing money troubles to services that might be able to help with financial or welfare assistance or with financial counselling.

Pharmacotherapy service providers are welcome to call PAMS with any consumer-related problems. Hopefully, some advice, support or mediation at the right time can help prevent more serious problems. The last thing we want is for a consumer to be terminated from their program or for a pharmacy or GP to pull out from the pharmacotherapy program.

PAMS is a peer-based service and is the only one of its kind in Victoria. Consumers can be assured that the person they speak to will have a personal understanding of what it is like to be on methadone or buprenorphine. Everyone can be assured that PAMS workers are highly skilled and committed to high standards of service and to better experiences and outcomes for everyone involved in opioid substitution pharmacotherapies in Victoria.

Sarah Lord – VIVAIDS Inc.

The Process of Not Using

G,day everyone, I went to the meeting held at Turning Point for the Blueprint community consult facilitated by Human Services in Fitzroy on the 31st of January, and I was particularly impressed by two people that attended the meeting that day. You see they met face to face for the first time that day; up until that day they'd had only been able to support each other over the phone.

For me these two people showed how the hidden inner strength will prevail even when the odds are stacked against them. Sadly, in this gentleman's case, the odds stacked up against him due to lack of emotional and psychological support. These two people inspired me to write this piece.

A person is determined to give up drugs and that whole way of life usually when they get sick of playing the game. People can stop when they decide enough is enough. We become sick of using drugs usually because the drugs no longer numb the pain and then suddenly when we do stop using, we have to start dealing with the problems that surround us as a result of our old life style. This can be as simple as just learning to sit through feelings and emotions.

Also, we need to deal with old thought patterns which can be so overwhelming that we end up running back to the old lifestyles. This is because we are scared and feeling vulnerable. Having another person to talk to truly halves the problem. It helps break the old thought pattern of "this is too hard," or "I'm not strong enough and or good enough to overcome this mess" This of course isn't true. Everyone is good enough, strong enough. After all, to survive drug use you need to be strong, so I suppose what I'm trying to say is when we stop using we try to find ourselves.

We all have been through similar experience's of not believing in ourselves because we've been kicked around so much by the 'jacks', courts, human services, doctors, pharmacists, our families, etc. After a while, we start to believe what we're constantly told: that we aren't good enough or strong enough to make it through to the other side, to be drug free and contribute to society. But everyone let me tell you anyone that says that to us is greatly mistaken. People that speak to us like this have serious issues themselves. Please remember that the next time someone speaks down to any of you. We have lived a lot, more than the majority of these people, and we all have so much to contribute because of what we experienced, mainly the injustices of life, the truth and what really happens to people that can't speak up for themselves. When I first stopped using, life was so lonely and I could never explain what I wanted. I was in a rush to fix the world, but what I learnt the hard way through falling on my arse (started using again) was the world will just have to wait until I've healed myself, addressed my own issues and then, and only then, can I take on the task of contributing to society.

Di

PHARMACOTHERAPY

It is well known that Heroin addicts are stigmatised, more so than any other drug user. Why? I don't know. Generally speaking I guess it has a lot to do with crime and the devastation it can cause, but not all users are reduced to crime and total devastation.

In fact there are a great number of addicts that live quite functional lives according to the mores of our society. However, there are measures we as a society can take to minimise stigma associated with the experience of addiction. Education, which if ever there was a panacea then education is it. For those open enough to hear the message; education facilitates understanding and tolerance in those that are receptive. However, at this point there is no message or policy directed at shattering the myths of Heroin.

One area that can assist the user is the policy of dispensing pharmacotherapy for Heroin addiction. However it has its faults. It makes ex-users slaves to the chemist, namely having to pick up everyday, therefore prohibiting a person's ability to travel or relocate without the considerable effort required to transfer chemists. Whichever way you approach it, a person's lifestyle is limited. Furthermore, when you go into a chemist you often have to wait long periods, other patrons are aware of what you are doing, some pharmacists have very bad attitudes and make users wait until last and a lot of chemists will only open for 2 hours on a weekend. All the aforementioned serves to demoralise the recovering user and inhibits their lifestyle greatly.

CURRENTLY A HEROIN USER HAS THREE PHARMACOTHERAPY OPTIONS:

One – Naltrexone, which can be implanted under the skin or a bottle can be dispensed on prescription. If you're an alcoholic (naltrexone is used in alcoholics to reduce cravings) it is on the PBS, subsidised for around $4 for a health care card user. However, if you're not an alcoholic then you have to pay around $180 for a script of 30 tablets to take away. Alcoholics also use antabuse which again can be taken away on script. (Naltrexone's effect is that of nullifying the effects of any heroin used, although it was originally used to reduce cravings in alcoholics).

The second option is methadone which at best will allow you takeaways on weekends after a qualifying period. It is understandable why you need to pick up methadone as it is a synthetic opiate and far worse than heroin to come off. It will, in sufficient doses, stone you or even kill you just as heroin can. Methadone is really worse than heroin, but for an ignorant public, it sounds better than heroin. In reality, it is a strong opiate that is a euphemism for ignorance. (Methadone is similar to heroin, but doesn't produce the same feeling and lasts longer. It is used to relieve heroin withdrawal symptoms, but it is addictive itself and produces withdrawal symptoms).

Thirdly, there is buprenorphine which is crushed and dispensed under the eye of the pharmacist to be taken sublingually (placed under the tongue to dissolve). Buprenorphine was dispensed in this way because a percentage of people worked out you could inject it and get some sort of stone. Thus, you were not able to take it away as per a script based medicine. (Buprenorphine is sort of similar to heroin and methadone but doesn't produce much of a stone, relieves heroin withdrawal. It also is addictive and has its own withdrawal symptoms). Recently there is a new form of buprenorphine, called suboxone, which cannot be injected as it contains naloxone. Suboxone is there to discourage people from dissolving the tablet and injecting it. When Suboxone is placed under the tongue, as directed, very little naloxone reaches the bloodstream, so what the patient feels are the effects of the buprenorphine. However, if naloxone is injected, it can cause that person to quickly go into withdrawal. Suboxone at the appropriate dose may be used to: suppress symptoms of opioid withdrawal, decrease cravings for opioids, reduce illicit opioid use, block the effects of other opioids, help patients stay in treatment.

Now there is a medication that cannot be abused any more, or at least is less able to be abused than medications such as valium, anti depressants, anti anxiety drugs and the like. It is high time recovering addicts were given the medication on script to take away and dose themselves, just as with any other medication, to break out of the SLAVE TO THE CHEMIST mentality that diminishes people's ability to live. Current dispensing practises force people into conditions that are anything but dignifying, like lining up in pharmacies or being moved into little rooms to take meds out of sight, besides having to attend the pharmacy every other day. Why aren't we giving ex users the rights and dignity of every other Australian on medication such as the ability to receive a script, have it filled and taken as per any other script? Just to get a script, a person in recovery has to locate a qualified doctor with the necessary DEA identification numbers. These doctors are always booked in advance and even with appointments, you are left to wait for anywhere between one & two hours. Pharmacists are given these medications – methadone, buprenorphine and suboxone for nothing by the government yet they charge $60 a fortnight to dispense them. It doesn't take much to work out how lucrative it can be to be a dispensing pharmacy. Now that we have a medication that can finally free up and remove some of the demoralising factors in being on medication, how about those who are in control coming to the fore, and dispense medication that is far less harmful than many other medications dispensed freely every day. In fact the figures indicate that around 90% of Heroin related deaths occur when there is something else other than just heroin in a persons system e.g.: benzodiazepines or alcohol and we haven't made them restrictive. Do the right thing and free up recovering addicts and allow them to restore their dignity and self esteem in one little way by giving them the same rights as every other Australian; The right to dispense a now relatively harmless medication themselves or do the Pharmacies have too much to lose?

Pharmacists are given these medications - methadone, buprenorphine and suboxone for nothing by the government yet they charge $60 a fortnight to dispense them.

ANON