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RELEASE HEROIN HELPLINE

020 7749 4053

MONDAY TO FRIDAY 10.30- 5.30pm

A service for heroin users and people
who work with them

RELEASE 

Release, 388 Old Street, London EC1V 9LT
Release Legal Emergency Drug Service Ltd.
Registered Charity no. 801118
Company Limited by Guarantee (England) no. 1966619

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A BOOKLET DESIGNED FOR HEROIN USERS
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Safer Heroin – A harm reduction perspective on using opiates

This booklet looks primarily at the health and welfare implications of using heroin and offers suggestions and practical alternatives to some of the more damaging learned behaviour associated with opiate use.

The advantage of producing accessible harm reduction advice is clear. Conversely, harm reduction advice which begins, 'The safest way to use drugs is not to use drugs...', may not only serve to undermine the credibility of other more pragmatic messages in the same text, but actually discourage users from reading further. Obviously, the use of unprescribed controlled drugs is illegal, however, many of the consequences of unsafe practice could be avoided by access to quality health related information at the beginning of people's using careers. For long-term users, much of the work done on HIV/ Hepatitis C transmission suggests that even entrenched users will change their behaviour if they are presented with a compelling argument for doing so.

This booklet aims to set out some of those arguments.

A comprehensive understanding of the term, 'sharing', an awareness of blood borne viruses, particularly to injectors and a better understanding of how (and if) people will 'graduate' to injecting are all key issues in user empowerment and effective drug working. The information in this booklet, has been collected and checked for accuracy by current and ex users, drug workers and practitioners specialising in drug use and working with drug users.

The Heroin Helpline also publishes a booklet for people looking to stop their street drug use and get into treatment and a home detoxification fact sheet for people looking to stop using drugs. Details available from the address below.

Any comments, suggestions, observations or criticisms on this document should be addressed to:

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By Gary Sutton

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Using Heroin

Heroin is a semi-synthetic drug derived from the opium poppy, *papaver somniferum*.

Some types of heroin are known as smoking (base) preparations, others are more soluble and have different, higher melting temperatures. These are either a pharmaceutical diamorphine hydrochloride or 'No 4' (white, Thai) heroin. The majority of heroin in the UK is brown and originates in Afghanistan or Northern Pakistan and smokes efficiently although it requires an acidifier such as citric or ascorbic acid (vitamin C) to dissolve for injection.

Purity varies with street heroin in the UK usually being about 45–55% pure. Heroin is usually presented as either an effective, benign analgesic (pain killer) or one of the most dangerous and addictive drugs in the world, depending on your point of view. Interestingly, most medical literature tends towards the former, while traditional drug education information will often reflect the latter. Consequently, we see context as an important factor in deciding how we arrive at conclusions, particularly when dealing with something as emotive as drug use.

Important – This information is provided to be of use to the widest range of heroin users. Some people use heroin as an occasional treat to relax or chill out. The problem with this is that it is not difficult for your 'occasions' to become very frequent. Heroin not only dims physical pain but can act as a very effective way of distancing the user from the harsher realities of life. If you are using drugs on a regular basis to help you get through the day or because life is becoming increasingly intolerable without heroin then you may well need to reassess where you are heading.

Heroin users are faced with a range of health and lifestyle difficulties. The aim of this booklet is to examine ways in which these issues can be managed to reduce the harmful or detrimental consequences of occasional and habitual heroin use.

Heroin has an image problem. Recently, as criminal justice issues have become part of the government's drug strategy, heroin (and crack/cocaine) users have been indicted for many millions of pounds of acquisitive crime. Consequently heroin users are stigmatised and reviled, and an honest response to the full range of issues presented by the drug continues to elude us.

You and the Law

Heroin is a 'class A' drug, which carries very strict penalties, for possession up to seven years imprisonment and a maximum 'life' penalty for supply.

This type of sentence is only handed down for very large quantities but it is not unusual to find 'ounce' dealers serving upwards of five years.

'Social supply', the buying and sharing of drugs within a social network is a serious offence. People sometimes say to police that they are only scoring for their own use and for their mates if they are stopped carrying a quantity of drugs that might be regarded as more than may be required for personal consumption. This is to avoid being considered as money-motivated dealers, nevertheless this is very unwise, it will only result in an intent to supply charge and possibly serve to get everyone else implicated arrested and questioned.

There has been some attempt to re examine the law in this area but as of yet, in statute, it remains as serious as dealing for financial gain. Even 'helping out' someone in withdrawal by providing them with heroin, methadone or another opiate is 'supplying'.

As a general rule you should carry as little heroin around with you as you possibly can.

Firstly, this will help you from a legal point of view if you are found with drugs and it may also reduce the amount you use during the day. If you can, plan when you are going to take your next dose and do not get stuck in the High Street and end up trying to use in the toilet in a busy pub. This will greatly increase your chances of detection and arrest particularly if you are a 'chaser', if you are an injector, public toilets present other difficulties, including major hygiene concerns (see injecting section).

The law allows officers to use the cautioning system for very small amounts of heroin, – for first time offenders, but this is far more likely with adult offenders, to transpire at busy police stations where the officers are loathe to waste a day in court when they suspect the magistrate or judge will impose a minimum sentence anyway. If you are arrested with a small amount of gear, expect a home search, which can include communal areas. Consequently some thought should be given to how drugs (and paraphernalia) are stored at your address (particularly if you are sharing or live in a squat).

If you are caught with heroin while "driving or in charge of a motor vehicle on a road or in a public place whilst unfit through drugs" you will be tested to

see whether you have used. Urine tests will show heroin, or more accurately morphine, and codeine and other metabolites which is what the tests actually detect, up to three days after your last hit. A heroin dispensing clinic in Australia proposed to ask anyone who attended for on site consumption to wait up to 4 hours before driving home. The point is that long after the drug's effects have worn off you can be charged for driving under the influence. If you are convicted you will lose your licence, you will probably be fined a lot of money, you may go to prison. Furthermore, you will find it hard to get your licence back or get insurance in the future.

Landlords and housing associations have been known to evict people involved in drug using.

Routes of Administration

There are five ways of taking heroin: snorting, rectal, smoking, oral and injecting.

Snorting

Snorting involves drawing a quantity of powder up the nose through either a straw or a thin tube. The powder is crushed and chopped into thin lines. These should be prepared on a clean hard surface (to avoid picking up adulterants). If you are snorting, divide up the amount of heroin you intend to use. Rather than doing all the heroin in one go, increase your dose carefully and progressively allowing more and more time between lines. Always be prepared to re evaluate if you feel you have already done enough. It is very possible to overdose snorting and for maximum safety you should always try to make sure that someone else is around. The majority of overdoses occur after a long break from opiates (while in detox, prison, etc.), when the victim is by him or herself and as a result of mixing drugs (particularly one or more opiate and alcohol and/or benzodiazepines, such as diazepam or temazepam). The section on 'Overdose' (p.11) contains some bullet points you should commit to memory.

You should always blow your nose to remove blockages before snorting. Heroin is unlikely to do your nasal membranes too much damage. Although the best advice is probably to switch nostrils many people prefer to use one side or the other.

Do not share straws or tubes, even with someone you may be having a sexual relationship with, as blood can be transferred intra-mucously.

Rectal

Diamorphine is available in suppository form, but it is very rarely encountered these days.

Some people do advocate an 'up yer bum' protocol for users whose veins are damaged but who still like the ritual of preparing heroin for injection. This entails using a syringe without a needle and inserting, with the help of a lubricant, the barrel up your rectum. The plunger is slowly pushed down (or in this case up) and the solution absorbed across the rectal membrane. More information on this practise is available from 'The Healthy Options Team' (H.O.T.) in London's Bethnal Green (020 8983 4888)

Smoking

Smoking heroin on foil (a.k.a. chasing the dragon or chasing/booting) is the commonest way to smoke heroin. Incidentally the term 'booting' (rhyming slang-boot lace-chase) is sometimes also used to refer to flushing a syringe (see Injecting section below). Smoking is the best way to avoid overdosing (as it's impossible to inhale a lethal dose in one lungfull) and obviously precludes the type of tissue, organ and circulatory damage evident in some injectors smoking greatly reduces the risk of transmission of blood borne viruses, particularly HIV and hepatitis. Smoking heroin in pipes is rare in this country. A few drug services prescribe heroin 'reefers,' (50mg or 100mg of the drug dissolved in chloroform and inserted into a tailor-made low-tar cigarette) to clients, but concerns around health authorities being seen to endorse smoking has kept this innovation at the margins. From a user's perspective, putting heroin in home-made 'reefers' maybe regarded as an extravagance as a lot of smoke escapes.

'Chasing' involves depositing powdered base heroin ('base' heroin can be anywhere from light beige to near black) on cooking foil, which should be pre-heated to reduce ingestion of toxic fumes. Anecdotally there may be some danger from the inhalation of fumes from aluminium foil. Aluminium has been implicated in progressive motor neurone degeneration, although the connection with 'chasing' is unproven.

Many people say foil dull side up is the best way to smoke. Gas lighters are better than matches (burnt fingers/ fire hazard) or petrol lighters (fumes) and a quality lighter should avoid overheating. A tube made of foil with two inch out folds around the edges allows smokers to recycle the residue deposited by the fumes in transit to the lungs without the edges of the foil catching alight and the smoker scalding his or her mouth. Keep the tube one inch above the foil to avoid inhaling particles or molten heroin. Smokers, particularly 'chasers', are sometimes recognised by resolidified heroin deposited on the front teeth as the fumes collect, this is more likely to occur if you hold the tube to the end of the lips and inhale through the teeth.

Smoking heroin from foil can cause chest and respiratory problems, especially asthma. The more you inhale the greater the risk. This is compounded by the numbers of heroin users who smoke cigarettes heavily. Another common tell-tale sign is the burning away of the thumb print on the dominant hand as smokers often get callouses and scorched by overheating lighters. Buy the best lighter you can afford, as lighters can cause explosions risking serious damage. This also applies to people who pipe or chase crack cocaine. Always allow your lighter time to cool down a bit.

Oral

Diamorphine is available in tablet form (10mgs) or as a linctus (not to be confused with Methadone linctus), and used in palliative and terminal care, although morphine is regarded as equally effective. Concentrations can vary, the standard is 3mg/5mL but as with all 'grey' market products adulteration is an issue, in other words, it may be watered down. Diamorphine linctus has a short shelf life and will break down to morphine.

Injecting

Although smokers and snorters combined probably outnumber injectors, it is often perceived that injecting is still the commonest route of use in the U.K.

The most frequently given reason for injecting is that it is the most economical and effective route of getting the drug into your body. This is to say that the immediacy and intensity of the experience cannot be duplicated by other routes of administration. There is also a 'needle fixation' syndrome that is only partially explained by the above.

Many injectors describe the act in overtly sexual terms and there is an increased sense of anticipation inherent in finding a vein, pumping it up and piercing the skin before experiencing the rush and subsequent relief.

Despite a common fear of injection, at the beginning of a career, this reservation often develops into a fascination causing a bonding process with the needle as the blood 'mushrooms out' into the barrel.

Many injectors 'flush' or 'boot' their syringes during the injecting process (drawing blood back into the barrel and re-injecting it after the dose has been administered). Folklore and poor understanding of the mechanics of injecting have led to an overestimation as to the efficacy of 'flushing' or 'booting'. As the injection takes a few seconds to take effect, users confuse the second or third flush with the rush caused by the first depression of the plunger as these are usually simultaneous. Repeated flushing will cause damage to your veins and circulatory problems.

When preparing an injection it is vital to ensure that your **syringe is new and that your other paraphernalia is clean and sterile.**

You will need:

- water ampoules or clean or fresh tap water,
- a spoon, two surgical swabs (one to swab the spoon and one to swipe once across the proposed injection site before puncturing the skin, although, we are unsure how effective swabbing is in terms of preventing infection) and some cotton wool or clean tissue to press on site post-injection
- an acidifier (ascorbic acid – vitamin C or citric acid)
- a lighter or a box of matches
- a needle disposal bin
- a tourniquet
- a new cigarette filter

You should also try to operate in a uncluttered and clean environment.

Anecdotally, preparation H is good for rubbing on needle marks, after the bleeding has stopped. It may reduce bruising and seems to preserve injecting sites.

On the issue of which acid you need to choose to break down your heroin, it's a matter of personal choice. Very oily compounds respond better to citric acid; human veins find vitamin C kinder, although greater quantities of vitamin C are required. Citric is usually mixed with heroin in a ratio of around 1 part citric: 4 parts heroin, and may be partly implicated in the serious health complications, particularly vinegar and lemon juice should never be used in place of citric or vitamin C as they can cause fungal infection affecting vital organs particularly the eyes.

People often get disorientated when they are stoned. In this environment used syringes left lying around are dangerous, as despite knowing the dangers people do reuse works, particularly if it is difficult or impossible to get new, clean ones. It is very easy to get confused over which syringe belongs to whom. Additionally there is a risk of getting a needle stick injury unless used works are safely disposed of. Always put your used syringes in a needle disposal ('cin bin') immediately after using them. If people are using with you try to encourage them to do the same.

Advice on vein selection varies. It is important to be aware that if you don't want your drug use advertised then injecting in your hands or wearing T-shirts when you have prominent 'track' (injection) marks is unwise. The general public perception of injecting drug users is very poor: advertise yourself as an injector and you will experience discrimination.

The veins on the inner forearm (below the elbow and above the wrist) are probably best. The prominent major vein here is the 'mainline' often referred to. Outer forearm veins running down the back of the arm are also quite durable.

It is important to remember to inject into veins only, with the needle pointing in the same direction that the blood flows, towards the heart. The pointed end of the needle should pierce the skin and the needle should be removed gently after the injection. Bleeding should be staunching by firmly pressing a tissue to the site (helps prevent bruising).

Never inject into arteries

Arterial blood can be identified by colour (bright red/pink) and is likely to spurt rather than ooze out of the vessel. If you do hit an artery pull out immediately and press hard on the site for at least three minutes then check to see if bleeding has stopped, if not keep pressing until it does. If you cannot stem the flow of blood – call an ambulance or rather than moving around get someone to call one for you.

If tourniquets are needed to bring up a vein, loosen before pushing down the plunger to reduce pressure and watch for blood being transferred onto the tourniquet when the needle is taken out either directly or via the hand. Rotating your injecting sites means that individual veins get less abuse but it also means you may have more sites to hide.

The groin (femoral vein) and the neck are usually cited by treatment agencies as no-go areas. The neck is certainly a very high risk area, and should be avoided. As for the 'groin', there is an agency in London which uses the following unofficial femoral guideline for clients they know to be having problems finding a vein – *'not to be considered unless there is no realistic alternative and a qualified individual is able to instruct on finding the femoral vein'*.

Many agencies might consider this as inappropriate advice for moral, clinical and probably, insurance imperatives. Repeated injections in the groin with a long needle, which is normally needed to access the vein, can create a hole at the site which is very prone to infection.

If you 'miss' (by which we mean inject all or part of your 'hit' into the muscle or surrounding tissue) you may get an abscess develop. If this happens (a lump under the skin at the injection site gets bigger, more inflamed and possibly sorer) make sure that you get advice from your needle exchange, chemist, GP or local A&E as soon as you can. It may need to be drained.

To improve your chances of hitting a vein, you need to be able to see it or feel it. There are a variety of ways to bring veins closer to the surface of your skin by expanding them. Using a tourniquet is best. These may be belts, laces or ties, but they need to be kept clear of injecting sites and should not be shared. Tighten above the area you intend to inject into and make sure you can loosen easily (or you may accidentally dislodge the needle from the vein), always loosen before depressing the plunger. Other ways of pumping arm veins up include doing a few 'curl' lifts with a weighty object, clenching and relaxing fist repeatedly while mimicking 'curl' movement and heating up the body either by taking a hot bath or limbering up in front of a fire which helps access to veins in other parts of the body as well. Get out of the bath before you inject and make sure you move away from the fire as both can be dangerous if you 'gouch' or nod off.

Don't use a bigger needle or barrel than you need. 'Street' powders can nearly always be dissolved in less than 1mL of water per hit. Injecting pharmaceutical opiates may require a larger syringe and may be injected intramuscularly (where indicated on the patient instructions). This is **not** advised with oral methadone or tablets. Heroin bought on the street should only be injected intravenously because of the possibility of tissue damage and abscessing (see paragraph on clostridium).

Often, while making sure all air bubbles are removed a small quantity of liquid will leak out from the tip of the needle. The practice of licking the needle pre-injection is unhygienic and unwise. While air should be completely removed from a loaded syringe, it would take a very considerable amount of air to inflict harm, probably upwards of 5mL.

A transition to injecting?

It used to be received wisdom that there was a 'transition' path towards injecting from other routes of administration. That is to say as the addiction became more pronounced users would gravitate towards injection. Today, it is considered that financial circumstance, cultural factors and initiation experiences may be equally influential. Many user groups and self-help organisations recognise this by advising members never to teach initiates how to inject or to inject in the presence of non-injectors.

Many people make the 'transition' back to smoking from fixing up, often after a period of abstinence or through lack of access to their veins. This process has major health and safety bonuses and you can learn to live with chasing (again?). This issue occurs commonly and is well worth a try.

In addition to the very real risks associating injecting and blood borne viruses such as HIV and Hepatitis, all injectors need to be aware of vein damage, thrombosis, abscessing, cellulitis (infection of the skin), bacterial infection and septicaemia (blood poisoning). Contaminants in the prepared injection can also cause 'a dirty hit'. Most injectors will experience a 'dirty hit' during their injecting career. It normally involves a migraine-type headache, cold chills, sweating and a very dry mouth. A major danger in attempting to rectify this situation is heroin-using folklore, which advises a 'hair of the dog' approach, i.e. another fix, which while offering a solution in some cases ignores the possibility that the heroin supply itself is in some way contaminated and more importantly leaves the user at risk from overdose. The best course of action is to lie still in a dark room with a blanket, a cool flannel for the forehead and a bottle of cool drinking water. A couple of over the counter headache tablets might help take the edge off.

'Speedballing'

Speedballing is mixing heroin and cocaine in an injection (sometimes known as a 'snowball'). The two drugs, a seemingly paradoxical mixture,

one being a stimulant, the other being a depressant, produce a much sought after euphoric effect. The main dangers of speedballing are the essentially repetitive nature of cocaine (or acidified crack), which allows dose accumulation of heroin, introducing a real risk of overdose. Cocaine, as a local anaesthetic may cause numbing around the injection site particularly after rapidly repeated injections. This increases the likelihood of a 'miss'. As we have seen the result of missing the vein may well be an abscess which if untreated and operating in a weak immune system could lead to blood poisoning. Anaerobic bacteria, such as clostridium seem to thrive in a solution of cocaine and citric acid, such as you would find if a base heroin or crack were part of the mixture. Injecting cocaine can place a considerable amount of extra pressure on the heart. There has been a major increase over the last two years of the number of people presenting to services with dual heroin and crack dependencies. From both a health and financial viewpoint dual dependency can be ruinous.

When preparing a 'speedball', it is vital to ensure that you have a sufficient supply of clean syringes. After each injection put the used works in a 'cin bin'. You will not need to cook the cocaine or crack up. With crack just add your acidifier with water and mix by stirring until the 'rock' dissolves (you may need to crush it up first). most people cook up heroin first and then add the crushed rock to the solution as it cools down.

Overdose

Spotting whether someone is overdosing involves a range of observations. If someone is just 'gouching' they will not thank you for calling 999. What do you know about the persons habits? What drugs do they take? Are they a regular heroin user? Can you get information from anyone that may have seen them go over?

- Are they conscious ?
- Are they breathing?
- Can you detect a pulse?
- Have their lips and finger tips turned blue?
- Do they respond to stimuli such as sound and touching?
- Are there any syringes or pill bottles near the person? (Beware of needlestick injuries).

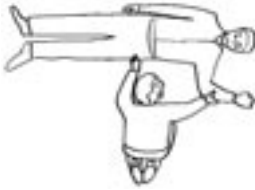
If you are in **any doubt** –

Call 999 and ask for the ambulance service. Tell them you think someone has overdosed and give the address or location you are at as clearly and accurately as possible.

Clear the airways by ensuring that there are no obstructions such as food, vomit or false teeth in mouth-ensure they have not swallowed their tongue.

If the Person is Breathing Regularly

A



A: Kneel beside the person, and bend the arm nearest you as shown in the picture.

B



B: Take the other arm and place this hand under the head as shown. Take hold of the person at the hip and pull them over towards you.

C



C: Bend the upper leg as shown so the person can't roll onto their front.

D



D: When you have finished check that the bottom leg is straight. Check that the upper leg is bent as shown, and that the person's head is supported as shown in the picture, with the head tilted to the side.

If the Person is not Breathing

If you cannot feel any exhaled air from the victim commence mouth to mouth until they begin to breathe independently or until the ambulance arrives. It is difficult to deliver mouth to mouth unless the person is on their back, lying flat with the head tilted slightly backwards.

If mouth to mouth is having no effect **and only** if you cannot detect any sign of life-begin heart massage (CPR) as well. If possible send someone out to guide the ambulance to the victim. You may find you need two people to carry out mouth to mouth and cardiac resuscitation as it can be very tiring. The correct ways of performing all these life saving interventions can be learned from a First-Aid manual and practised on a friend. Better still see if you can get yourself on a course, many agencies

offer places if you cannot find one locally Release will attempt to find one for you, if you call our Heroin Help-line on 020 7749 4053. If you are a heroin user or you mix or work with heroin users, research indicates you have around a 90% probability of experiencing or witnessing an overdose at first hand.

Overdoses are not usually fatal. The classic overdose scenario involves a person who has become abstinent for some time (immediately post-release from prison or treatment) someone who has mixed heroin or another opiate such as methadone with a tranquilliser or alcohol. This can cause profound respiratory depression and ultimately, death.

There is a drug used by paramedics to reverse the opiate action in overdose. It is called Narcan (Naloxone). Some agencies are piloting prescribing Naloxone ampoules to opiate using clients. This leads to our final observations on injecting and overdose. It is very much safer not to inject when you are alone or unlikely to come into contact with another person in the immediate future and if you are unsure about your tolerance or the strength of the drugs – don't inject your whole dose in one hit. Either divide or push half in and wait for the effect to come on. Then use your judgement to decide whether to continue or whether to remove the syringe. **If in doubt – take it out.**

The police: There are regions where the police, in line with recommendations in 'Reducing drug related deaths' (HMSO), will not necessarily chase ambulances. You need to find out what policy is in your area. If a fatality results, you may find yourself in serious trouble over a duty of care issue if you knew someone's life was in danger and you failed to take appropriate action by calling an ambulance or abandon the victim. If you stand around and do nothing you may find you have somebody's death on your conscience.

Key Overdose Issues

- Mixing drugs is very risky.
- Alcohol and 'down' drugs such as opiates, tranquillisers and sedatives are a dangerous cocktail.
- You are more likely to overdose if you inject or snort your heroin rather than smoking it.
- Methadone – Because oral methadone takes a while to kick in, people who are not used to the way the drug works often think they need more. They then increase the dose or take other drugs, 'potentiators', (benzodiazepines, cyclizine, alcohol etc) which can lead to overdose. Oral methadone needs three to four hours before peak absorption levels are reached.
- Using after a period of abstinence, during which your tolerance has reduced.

- ‘Speedballing’ – Injecting heroin and cocaine together. Firstly, cocaine and crack have a ‘disinhibiting’ effect which may cause reckless behaviour (such as unprotected sex) and secondly, because of the repetitive and compulsive nature of ‘speedballing’, dangerous levels of heroin may accumulate in the body causing eventual overdose.
- Using alone or in an environment where you are unlikely to be missed. The majority of fatal overdoses are ‘slip away’ deaths rather than instant respiratory shut downs.
- If you use with a group of friends you should all get basic overdose awareness training or information. The information contained in this booklet is the very least you need to know. Practice the recovery position with your friends. If you have a local users support group you should ask your local drug service to provide training. Organisations such as The National Drug Users Development Agency (020 8533 9563) or The Methadone Alliance (020 8986 5475) will advise you how to organise an event.

Being aware of Blood Borne Viruses and Other Infections

Blood borne viruses (BBV's) can be transmitted from person to person in a variety of ways. If you are taking heroin your chosen method of using (fixing, and to a lesser extent snorting, smoking) could increase your chances of contracting a virus like Hepatitis B and or C or the Human Immuno-deficiency Virus (HIV).

Whilst injecting with clean, new syringes should not present a threat of infection, there are other factors that we need to consider.

Once upon a time our definition of ‘sharing’ was restricted to reusing needles and barrels. We now know that viral contamination can infect spoons, water and most importantly filters. Even if using with good friends make sure that you see for yourself that the water is clean and the spoon swabbed, don’t just take someone’s word, it’s easy to get confused. It is very important that users do not share any equipment. The best way to ensure this is to dispose of your equipment as soon as you are finished with it in a ‘cin bin’.

As filters often contain a reasonable percentage of undissolved base heroin they are frequently stored for a ‘rainy day’. Until someone invents a filter that traps the cut only this is likely to remain a health risk.

We are not certain how long, the hepatitis C virus can survive outside the body. The answer appears to be somewhere around a couple of months

given favourable circumstances such as temperature and humidity. Even saving filters for yourself is not totally safe. They can become a host for bacteria which could have serious infection implications for injectors. You are better advised to re-cook the filter immediately with a touch more acidifier (vitamin C or citric acid) and save any extra powder for another hit, rather than putting all your heroin into one hit and relying on the filter to get you out of trouble later.

Clostridium – (clostridium novyi and clostridium botulinum)

More than 30 injectors died in the Summer–Autumn of 2000 (another outbreak was identified early in 2002) from systemic poisoning after using infected heroin. The infection eventually spreads from the muscle into the bloodstream. The superficial signs are similar to an ordinary abscess (local redness, swelling/soreness around injection site) but clostridium novyi infections seem to have a black centre around the injection entry site and onset of symptoms is very rapid. With clostridium botulinum a ‘descending paralysis’ occurs which can lead to respiratory shutdown. Preliminary symptoms may be blurred vision, dry mouth, vomiting and in some cases a rise in body temperature. An unusually high proportion of victims of the earlier outbreak were women and a common denominator among victims seems to have been injections that either by accident or deliberately missed the vein (skin-popping).

How to avoid clostridium related infection:

Clostridium is a species of anaerobic bacteria, they present a real danger to users as the strains mentioned above and clostridium tetani, which is the cause of tetanus are very hardy surviving conditions (such as heating, or fresh air, hence *anaerobic*). This makes advice around avoiding infection difficult.

The following tips should help keep you safe.

- Avoid injecting, particularly intra muscular or sub cutaneous injecting. ‘Misses’ from attempting i/v hits are high risk, most victims in the previous outbreaks had been as a result of missed i/v injections. Women seem more prone to infection than men due to their less obvious superficial vein structure. Infection is not related to sex. Citric acid may help the bacteria spread, as skin tissue around the site is damaged. Vitamin C may be safer, but it is hard to say with any real certainty.
- ‘Speedballing’ (injecting heroin and cocaine together), or injecting coke that has been broken down from ‘base’ may provide the bacteria with a better environment to develop. Again this is around failing to hit a vein.
- Infected filters may provide a fertile breeding ground for the bacteria. Smoking and snorting your gear will protect you from infection. If you get a swelling, post injection and any of the symptoms mentioned in this section, get yourself to a Doctor or A&E *immediately*. A botulism anti-toxin is available. Please tell your friends who fix about clostridium or ask your local drug service, user group or GP to photocopy this information to hand out.

- **Again – Don't share any paraphernalia with anyone.**

Hepatitis

Hepatitis literally means 'inflammation of the liver'. There are three main strains of viral Hepatitis – A, B and C, although others exist. These three are identified in many peoples minds with using drugs.

Hep. A has a faecal-oral transmission route and is often encountered in squats with no running water or in crowded communal living situations. If you are in the infectious phase with Hep. A it can be transmitted through someone sharing your works. Hep. B can be very infectious and is transmitted in bodily fluids. This means that you would be putting yourself at risk if you were to share a works, a pipe or a tube with an infectious person. Both Hep. A and B can be transmitted sexually, although the risk of contracting Hep. B is significantly higher. **Safer sex (particularly the use of condoms) can go a long way to eradicating the sexual transmission of Hepatitis.** Hepatitis C is a blood to blood virus closely associated with injecting. Sex is unlikely to be involved in the transmission of the virus. There may be some exceptions such as S&M practices and as an example, while a woman is menstruating if she was to have unprotected sex with a man with raw abrasions on his penis. Some women report that their drug sue makes their cycle erratic and, particularly with stimulant use they do not produce the usual levels of vaginal secretions to lubricate themselves sufficiently. If you feel your sex life involves the possibility of blood to blood contact, be protected and be aware of the risk you may be taking.

If you have had hepatitis A or B previously you will have antibodies (the body's natural defence system), which will prevent re-infection. If you are not sure then it may be worth getting a test. Talk the issues through with a drugworker or nurse, a GUM clinic will sort out a test for you. There are issues that you need to consider before taking a test. Not everyone is capable of coping with the issues that a positive diagnosis may bring up. A vaccination is available for Hepatitis A and B. If you know you have Hep. C or HIV it is very important to avoid co-infection (with A or B) if possible. The vaccination offers ten years cover by turning up for a series of jabs although even one course does offer a degree of protection (two for A, three for B).

There is no vaccination for Hepatitis C. If you think you may have come in contact with the virus through a person who is infected, you may want to consider getting tested to verify your status. A syringe can carry amounts of virus that are detectable only under a microscope. The virus is hardly and can survive some time out of the body. It may well take up to six months from the point of coming into contact with the virus before a test is able to confirm your status. This is called the 'window period'. Don't share works or any paraphernalia. You may think you are doing someone a favour by lending them your kit, it truth, you could be putting you both at

risk. Infection rates among injectors are related to age, length of using career, local needle exchange services and from international multiple sub strains, some more aggressive than others, so even if you are infected or your partner or using friend is you can reinfect yourself or someone else if you don't observe the *don't share* rule.

In many cases treatment for hepatitis C will not be offered to people who are still using heroin. There are exceptions and some consultants are more broad minded than others. Generally, heroin smokers may have a better chance than injectors of getting therapy, which is usually Interferon (or pegylated interferon, a longer acting variant) and Ribavirin. There are a number of variations and you will probably need to undergo a rigorous screening process before being accepted into treatment. Some users feel they benefit from either herbal remedies or Traditional Chinese Medicine (TCM). This is not the place to look into such a complex field but information is available. Release can help you find a resource close to you. Mainliners have a Resource Centre (020 7582 5434) The British Liver Trust produce educational resources (01425 463080).

HIV (The Human Immuno-deficiency Virus)

HIV infection remains a real threat for injectors. HIV infection can lead to AIDS, the Acquired Immune Deficiency Syndrome. Although reported prevalence rates had dropped below 0.5% among injecting drug users (meaning that less than 1 in 200 users across the country had contracted HIV), there are strong indications that they are beginning to rise again. There is always a risk through sexual transmission as well as 'sharing' paraphernalia. Infection rates in some parts of Europe, particularly the old 'Eastern bloc' countries and along the illicit trade routes across Europe from the Balkans are high and getting higher. The drop in HIV rates was directly attributable to the introduction of needle exchange programmes and safer sex education in the UK.

HIV combination therapy has greatly improved survival rates among infected people. HIV combination medication can affect the rates at which other drugs are metabolised. Always read the patient instructions carefully to avoid problems or speak to your GP or specialist worker. The virus itself is quite fragile although there is some evidence that mutation is naturally occurring and the virus may be able to survive longer than we had previously thought possible out of its environment (the bloodstream). Nevertheless we are still looking at minutes rather than the figure of a couple of months cited for the Hepatitis C virus.

One problem that is often overlooked with opiate users and viral infection, is that many of the symptoms of the hepatitis viruses and HIV are ameliorated by strong painkillers. Many people who may have felt their using career was coming to an end have sought relief in opiates out of necessity as much as choice.

Managing Your Dose and Cutting Down

It is a fact of life that the more heroin you use the more you need to get a similar effect. Many long-term users report that they rarely get stoned and use just to stay 'straight'. If you feel you would like to cut down, the following ideas have been suggested by users, ex-users and drug workers to help.

It takes time to reduce your tolerance: put five to seven days aside and try to ensure you are not required to be at your most alert and conspicuous. If you can get support from someone who doesn't use, so much the better.

Some people say that they prefer to detox away from the area they live or score. Abroad is an idea, if you can afford it, but finding somewhere, preferably warm, where no heroin is available is tricky. If you are in a foreign country and your motivation disappears you can get into real problems. Don't rush into this one.

In fact, don't rush into anything. You need to try and work out exactly what you are attempting to achieve. Ask what it is about your heroin use that you need to alter. You may find that what you are attempting cannot be achieved through cutting down, you may find you need to consider a more drastic remedy. Have you tried cutting down before? Did it work? What did you learn from it? Anything that helped last time might help now. Write down the main points as a reminder. An example might be that you found watching videos of films that you wanted to see at the cinema but missed helped to pass the time. Conversely, you recall that you struggled with sleep deprivation. Try to address this by being prepared.

Your doctor may help by prescribing for you. Usually GP's want something more drastic than a commitment to reduce your dependence on illegal drugs but you can decide if it is worth a try. Some drug specialist clinics may offer a home detox package which are discussed in the Release detox factsheet. The anti nausea and diarrhoea tablets will be helpful if your reduction is a particularly drastic one. Ask your chemist for assistance although most of the effective medications are available on prescription only. You might find that speaking to a friend or professional counsellor every day on the phone and feeding back a progress report helps you feel you are working towards your goal. Plan a detox (changes in intolerance) regime based on a realistic assessment of what you can achieve. Heroin lasts around eight hours in the system after which a dependent individual will begin to experience withdrawal symptoms.

You need to decide how many doses a day you are going to use, how much you will use in each dose and how the reduction element fits in. Plan well ahead and decide your programme. It is pointless going through

a reduction process unless you use your reduced tolerance as a reduced dependence, meaning less money going on heroin, less time spent chasing drugs, less risky behaviour and more opportunity to do the things you feel your habit has prevented you doing in the past.

If you are planning to cut down to say, half your intake, you need to start from your current dose level and make sure you have enough to make the transition without going out to score and risking a stable cut down on the vagaries of the black market (i.e. not being able to score).

Some people prefer to get their supplies daily but this takes matters out of your hands and if something goes wrong your planning will be compromised. If you can't control your reduction you have little or no chance of managing to control your heroin use. If you can't manage this then perhaps you will have to consider trying to achieve abstinence or a maintenance 'script. If you are cutting down it is useful to remember that the lower your dose gets the more you will notice a similar cut down. In other words, £10 less of heroin a day will be much more noticeable to you if you are doing half a gramme a day than it would be if you were doing three or four times that amount.

With this in mind plan your reductions in smaller increments as you approach the second half of your cutting down week. Think carefully about dividing your doses up in advance into separate bags. If there is any chance you might get raided, it is very difficult to claim you are not dealing if you have fifteen wraps in your possession. Conversely, you may think it is easier to have the doses worked out and labelled (e.g. Monday morning, Monday evening etc.), this may stop you dipping a little bit extra if you are preparing the doses while you are feeling unwell. You have to discipline yourself not to bend the rules even once. It is an important measure of your self control and your ability to put order in your life.

A couple of practical tips that may help. If you have any spare money or are expecting any, consider asking a friend to look after it until your week is over. Similarly if you have that type of relationship tell your dealer what you are doing and ask him or her not to call for a week. If it will make a difference and you won't need the phone for support /counselling give your mobile and dealer numbers to a trusted friend to store or remove the SIM card and post it to yourself without postcode and with a second class stamp on the envelope.

Tell your friends what you are doing and if you would prefer solitude request that you are left alone. Get as much shopping as you think you need for the week. It is unlikely that you will be that unwell, but get easily digestible foods anyway. Relax, try and be aware how your emotions change and determine that you will stay on the finishing dose after the week is over.

Withdrawal symptoms vary from person to person. Tolerance, is of course a major consideration. Generally the bigger your habit the less comfortable you will be in withdrawal. If you ever hear someone say 'don't worry, it's no worse than a bad dose of flu', you can be sure they have little or no idea what they are talking about. Physically it is not a million miles away (if you ignore the insomnia and diarrhoea issue), but flu will respond to honey, hot lemon, bed rest and paracetamol; opiate withdrawal with its associated psychological trauma will not. It can take many weeks to begin to recover your sense of physical well being, often longer to establish an emotional equilibrium. If you feel sad don't bottle it up, cry or talk to someone you trust, you will be vulnerable – take care not to be exploited by the person who appears to empathise with you.

The protracted sleep deprivation associated with withdrawal is covered in our home detox fact sheet. If you are looking to reduce or stabilise and can't get the time, space or resolve together or if you want to keep using but do not want to be illegal all the time it is worth considering getting a script. The problem is that although things are slowly improving there is still a huge variation in what you can be offered depending on where you live, how well you can put your own case and if you can afford private treatment.

Your local GP should be able to help or refer you to a specialist service. If you need some help about where to go in your locality you can call Release's Heroin Helpline who will offer advice.

