Volume 5, Issue 1 January 2011

A communication periodical for our clients, staff & the community at large

The Chronicle

A Paterson Counseling Center Newsletter

Special points of interest:

- PCC provides services for a variety of addiction related illnesses
- A board certified doctor and nursing staff are available during the day
- Privacy and confidential treatment is emphasized during visits to the center
- PCC has an appeals and grievance process for clients and administrators are onsite to address any concerns or issues that the staff may have.

Inside this issue:

Heroin Profiled

COMMON NAMES: big H, blanks, boy, brother, brown, brown sugar, caballo, ca-ca,, Chinese red, chiva, cobics, crap, doojee, dope, flea powder, goods, H, hard ` stuff, Harry, horse, joy powder, junk, ka-ka, Mexican mud, poison, scag, scar, schmeck shit, skag, smack, smeck, snow, stuff, sugar, te-caba, thing, white stuff.

That pretty red poppy growing in the window box alongside ; the gladiolus has a not-so-pretty side to it called heroin. Actually, calling heroin not-so-pretty is like calling a nuclear explosion a nuisance. Heroin is the king of narcotics and the drug of choice of America's addict population. If the drug doesn't get you, the lifestyle will ... ask any addict who's been using the stuff for thirty years, if you can find one that old.

Heroin is a white or brown, crystal-like, odorless, bitter tasting soluble powder. The color depends on its origin: Mexican heroin is brown, Middle Eastern and Asian junk is white.

The drug is made by scraping the residue of poppies, boiling the gum into opium, then extracting morphine, which is ultimately converted to pure heroin. All of this can be done using nothing more than simple, inexpensive laboratory equipment.

The easily cultivated poppy grows primarily in Mexico, Turkey, China, and India; and in Burma, Laos, and Thailand, whose plentiful. poppy , fields have been dubbed the Golden Triangle. This name has more to do with the money to be made from heroin than with the drug's effects. It is a semi synthetic derivative of morphine, but is up to three times as potent as morphine, and much more addictive. Heroin is a narcotic analgesic of the opiate class, which means it is a stupor-producing painkiller derived from opium.

Heroin was first commercially produced in Germany around the; turn of the century. Initially it was used as a substitute for the proved addictives, morphine and codeine. The drug was -assumed to be so benign that it was prescribed as an alternative to liquor for chronic alcoholics. Heroin was also prescribed as a cough suppressant and sold over the counter in patent medicines for pain relief, and as a sleep-inducing tranquilizer. It suppresses coughs, all right, along with everything else controlled by the central nervous system. Intestinal muscles contract, causing severe, chronic constipation. Eye pupils constrict. Some theorize it depresses certain brain, areas, reducing normal thirst and hunger desires, although this hypothesis has not been proved with certainty.

What has been proved beyond a shadow of a doubt is that heroin is highly addictive, and a habit can be picked up in as little as a week to three weeks of daily or frequent use. Physical dependence and a tolerance to the drug are, the hallmarks of addiction. Such physical dependence leaves the addict with waves of withdrawal pain if he fails to get his necessary dose very four to six hours. What is considered. "necessary" depends on how much heroin the addict has been using and for how long. First-time users may begin with a dose of 2-8 mg, but addicts can use as much as 450 mg each day as tolerance

Heroin (Continued)

is acquired.

All addicts and some users inject themselves with a syringe, sometimes primitive and homemade, after diluting the heroin with a small amount of water in a teaspoon with a bent handle or a small metal bottle cap and dissolving it under the heat of a match. The drug can be injected intravenously into any vein, using a belt as a tourniquet to make a vein stand out, or subcutaneously by skin-popping just barely under the skin surface: Injection is called "mainlining" and is the preferred . route, since none of the costly heroin: is wasted and the initial rush of the drug: is enhanced. Some addicts mix cocaine: or speed (amphetamines) with their heroin; such mixtures are called speedballs or bombitas. Junk can also be sniffed or smoked. Smoking is sometimes considered too uneconomical, since much of the drug can escape -into the air. All these methods can lead to addiction, though it may take the sniffers and smokers a longer time to get hooked. An incalculable number of weekend snorters, called chippers, seem to manage occasional use without getting addicted, although some do.

Why do half a million Americans: risk life and limb playing Russian Roulette with these building blocks of death? Each of those thousands of users thought that he would be the one to escape the curse of addiction by using heroin indefinitely as a weekend super cocktail and what a cocktail it is,, at least at the beginning.

After the body develops a tolerance to the drug's sweetly depressant effects, a craving remains- that °is' far from orgasmic. With prolonged use, the addict shoots up only to stave off the crushing ache and misery of withdrawal. His fix dulls all the pain and joy of reality as he becomes drowsy, lethargic, apathetic, and detached. He can ignore the world for several hours, until it is time to hustle for=his next dose or fix. Things the rest of us consider vital--like food or sex or crossing the street--are of little or no importance to him. His mind is a leaded and relaxed blob. Continued use of the drug does nothing positive for him except erase pain, anxiety, fear, and depression, as it erases all human feeling. He becomes a passive junk machine, ingesting and reingesting oblivion just to keep running. The junkie knows it's time for his next fix because his skin begins to itch. He sweats profusely, his nose runs, he gets an upset stomach or cramps, hot flushes and chills, watery eyes, dilated pupils, and double vision. The only thing-that will make the pain and fear of increasing pain go away is more heroin, so the junkie shoots up again.

Since dosage must Increase merely to suppress pain, the addict uses more while enjoying it less. If he does not get his fix in three to eight hours he will enter the withdrawal phase, the nightmare of all addicts. For three or four days he will be caught in a maze of delirium, cold sweats, hot flashes, pain, violent yawning, nausea, diarrhea, cramps, tremors, depression, rapid breathing, fever, weakness, loss of appetite, crying, sneezing, headaches, and, seizures. An almost indescribable ordeal, it is referred to as "cold turkey," because the akin feels like that of a plucked fowl and the body a frigid wasteland.

Heroin itself does not cause inevitable mental or physical deterioration or permanent brain damage. The user can retain normal coordination and judgment, but is subject to a host of maladies from the injection of the drug and its corollary effects. Use of dirty or shared needles can cause infectious or serum hepatitis, septicemia (blood poisoning that leads to abscesses in the blood vessels), and subacute bacterial endocarditis. Tetanus, gangrene, lockjaw, and cardiovascular . and lung abnormalities are not uncommon occurrences. Abuse of the veins can result in their collapse or clotting and a resultant deadening of the limbs, Sleep may be fitful and a heavy dose can- lead to .unconsciousness. Because the addict is impervious to pain and hunger, his general physical condition is usually poor. Inadequate nutrition and the inability to cough can lead to malnutrition, pneumonia, and chronic bronchitis. The addict. has frequent accidents and may meet a violent death, either in the pursuit of his supply or as a result of his detachment from reality. Heroin addiction can cause severe obstetrical complications, including giving birth to a child addicted as a fetus.

Adulterants used to cut pure heroin can cause pulmonary edema, so it is to surprise to learn that the premature death rate for addicts is twice that of the nonuser population. The abuser an suffer shock, respiratory failure, or oxygen starvation of the, brain and enter a coma. Whether or not heroin itself is toxic and capable of causing death through an overdose is the subject of a current raging controversy. Little valid information exists as to the cause of death among addicts. Most medical examiners still refer to heroin overdose without . any proof that such a condition exists; for many years it was assumed that a dead junkie found on the floor with a needle in his arm had

merely overdosed. This assumption has been challenged recently. Tests on animals have shown that there is no such thing as a lethal heroin dose. A "lethal" dose for one addict on a certain day may not be lethal to another, on a different day. Theories exist that heroin itself is not the killer. Perhaps it is the quinine adulterant, a lack of sufficient dosage, or the shock like effect caused by the injection of crude heroin mixtures. . Most theorists in this uncharted territory believe that the most likely contributor to death is the injection of heroin while the user is drunk on alcohol or sedated with barbiturates, Lives could be saved if addicts were informed of the lethal crap game they play in the form of multiple drug use.

There is an effective medical treatment for the serious overdose symptoms of abusers. The user' should be taken immediately to a hospital, where Narcan or Nalline can be administered to reverse heroin's severe depressant effects. Most junkies still believe that injecting milk or saltwater fluid will stem the tide. This fork remedy is not only ineffective, but can lead to complications such as- coma, brain damage, severe lung swelling, and the ultimate complication, death.

Previously described sensations and symptoms relate to the drug's actual properties. There is another whole list of likely effects caused by the lifestyle of the user, not the heroin he's injecting. These effects apply to the dog-eat-dog existence of the average street junkie, who pays inflated prices in the black market for his diluted and adulterated fix, and must run the gauntlet of ghetto crime and disease just to stay alive. There are also many middle-class, "respectable" addicts who get their legal opiate supply from the pharmacist. A high_ rate of such addiction exists among health professionals: ;doctors, their wives or husbands, nurses, and druggists, who can easily and quietly feed their habits for pennies a day. Although these users are no less addicted, society saves its scorn for the stereotypical junkie--the minority-member street runner, who steals, lies, cheats, or sells to other addicts in order to get his next fix. The street junkie's degrading and degenerative lifestyle is not caused by heroin, but by its lack of legal availability. When it is readily available as opiates can be for middle-class professionals, the drug does not have to affect the user's life, family, or job in a negative way.

Heroin tends to reduce aggression. Most crimes associated with it are crimes against property, not people. A street addict's habit can cost from $40 to over $100 a day in nickel ($5) or dime ($10) bags, or small amounts of heroin in glassine envelopes called decks in order to keep the supply coming, the junkie must steal property worth five times the money needed, since a dealer in stolen goods is likely to pay only a small fraction of the property's actual value. That accounts for a lot of TV sets, stereos, and jewelry missing from middle- and upper class homes across the country. To some degree, it is the unmentioned tax we pay for refusing to deal rationally with the heroin problem. We are treating a medical and sociological problem as a legal one, punishing the victim for being sick. This approach to drug control has never worked. Even, law enforcement officials admit their annual crackdowns on heroin smuggling and use have not made a dent in the number of new users or the drug's availability. The only clear effect of such action is reflected in the price of the drug, which shoots sky-high during heroin panics, requiring the street junkie to steal more and more cameras and furs to feed his never relenting habit.

The American heroin story was not always rooted in a punitive and puritanical legal approach. During the late nineteenth century there were more opiate addicts in this country than there are today. Since morphine, opium, and heroin were routinely prescribed for coughs, headaches, and menstrual cramps, it should come as no surprise to learn that the overwhelming majority of users were women and children. Ad diction was not seen as a scourge on society, since users continued their daily routines and the legal cost of such drugs was affordable. Though not exactly viewed as a social plus, addiction was tolerated somewhat as closet alcoholism is today. In 1914, Congress passed the: Harrison Narcotics Act, which required opiate producers and sellers to apply for a license and register for a newly imposed tax on the drugs. Cumbersome licensing, tax, and record keeping regulations discouraged doctors from prescribing the drugs. By 1924, federal law prohibited all domestic manufacture of heroin, and the black market swelled. The government set up legal narcotics-dispensing clinics for existing addicts, but un fortunately, poor diagnosis, distribution, and admini-

stration led to their demise before the effect of free heroin could be accurately measured. The junkie population did not just fade away, however; rather, it entered the netherworld of crime -and addiction.

After World War 11, the number of addicts grew as morphine and other opiates (see Morphine; Opium), prescribed for the pain of battlefield injuries, became a necessity for the Stateside veteran. Alarming numbers of Vietnam veterans returned as casualties of heroin addiction. Their battlefield days and nights , were so- full of dread and fear that locally produced high-grade heroin, available for a few cents a dose, seemed the likely cure.

Affluent, cynical, suburban flower. children of the sixties and seventies accounted for the next wave of addicts, in large part because of the official misinformation being spread about all drugs. When Uncle Sam continued to rail about the dangers of marijuana and hallucinogens, long after youthful users had tried these drugs themselves and repudiated such scare stories, information about the dangers of heroin also came to be questioned. The logical conclusion reached was that "official" drug information was not to be trusted, and so heroin was thought to be far safer than touted.

The law today includes stiff penalties for heroin use and sale, and coordinating statutes for civil commitment to rehabilitation centers in lieu of imprisonment. The federal law provides for one year in jail or a $5,000 fine for first -offender users, and two years or' $10,000 for subsequent heroin infractions. Under Schedule I of the Federal Controlled Substances, Act, manufacture or sale of heroin the first time out brings a maximum of fifteen years in jail or a $25,000 fine, and the second time can lead to thirty years or a $50,000 fine.

Then there is the growing number of therapeutic communities, known as TCs, which create a rigid but protective environment, for addicts, who often enter into such programs under the threat of incarceration. These communities, such as Phoenix House, Daytop, and Synanon, strive for total drugfree behavior modification by teaching nutritional habits and vocational skills and encourage searing personal revelations through encounter therapy, peer-group pressure, and rap sessions. Infractions. of the rules lead to expulsion for those who have not dropped out during the first week. The therapeutic communities are generally run by "ex-addicts" who, it is felt, have the only nitty-gritty experience the addict initiate respects. These "ex-addicts" often lecture to schools or church groups citing their own recoveries to validate the success of such communities. As their own records disclose, however, the problem is that the only addicts who seem to be cured are those who still reside within the community, subject to constant pressure. Relapse figures of those who "graduate" are as dismal as for any other course of treatment. Once again, the simple fact that heroin is addicting, and likely to remain so even after withdrawal, is forgotten in the rush to find a "cure." It is particularly dangerous to preach. the gospel of cures to schoolchildren and other potential users, since there is no. evidence that a drug-free solution exists. They may foolishly experiment with heroin under the mistaken belief that even if they become hooked, they will be able ultimately to leave their addictions by the wayside.

Methadone maintenance is the latest miracle to come down the heroin-cure pike. While, In fact, it may be the most effective treatment available today, it is by no means without its pitfalls. Methadone is a 'synthetic chemical mixture that not only lessens the torturous craving for heroin, but actually blocks heroin's dizzying rushes and pleasures, just in ease the addict tries to mix his old friend with his new medicine. Originally, it was thought that large amounts of methadone could be administered by tablet or liquid to the detoxifying addict and then continued in ever-decreasing amounts until it could be totally eliminated. The addict, it was assumed, could then walkout the clinic door drug-free with a good chance for long-term recovery if he just exercised willpower over his nasty habit. Again, the realities of the nature of addiction were dismissed. "Ex-addicts" who walked out the door with all good intentions quickly succumbed to that inner voice screaming for heroin. Methadone treatment is now generally considered to be a lifelong maintenance plan, and its problems do not stop there. Methadone is itself addictive, and the addict is justifiably wary of trading his existing problem for an unknown bag full of authorized junk. Although one taking methadone can perform all normal functions without having to direct his life toward his next burglary or mugging, he must report to a clinic on a daily basis to receive his dose of methadone or face -a milder form of withdrawal. Many areas of the United States have yet to open full-service methadone clinics, and others have long waiting lists of the walking dead. The returns on methadone (and the even newer LRAM) are not yet in, and no accurate information, as to "success rate" will be available for many years. Source drugtext.org.