Heroin Helper: The Book

Introduction

Heroin Helper went live two decades ago but it's been well over one decade since it received any of the care that it deserved. So I've decided to take down the individual pages from the site and put everything into this PDF.

You are free to download it and print it as long as you don't do it commercially. Having said that, understand that much of it is out of date. And none of it should be seen as a recommendation. It is mostly of use as a look inside the thinking of an idiosyncratic mind.

Good luck in all that you do and stay safe.

Curious

I doubt that there is a person in the United States who does not have some curiosity about heroin. Even though over 95% of the population will never see a sample of the drug first hand, *everyone* knows what heroin is — in the sense that they know what a Norse God is.

For almost everyone, heroin is a mythic substance. Unfortunately, real laws are created based upon these mythic notions. Real humans spends real years in real jails because our culture judges them on myth rather than fact. The degree of punishment is the only difference between the junkie doing ten years in prison today and the mid-wife being burned at the stake in the 17th century.

There are facts about heroin that are so contrary to common knowledge that most people would simply not believe them, regardless of how well documented.

- It is common knowledge that all people who use heroin become junkies.
- All junkies are slow-moving, dim-witted, bottom feeders.
- Heroin is an extremely potent drug that drug addicts use as a last resort when none of the other drugs will do it for them.

The millions of controlled heroin users cannot dispel such knowledge. Nor are the countless examples of highly successful junkies of any help. And you can forget the endless pharmacological studies that show that heroin's effects on the body are fairly minor and its effect on the brain so subtle compared to cannabis, that most regular pot smokers can't even feel it.

But if you're here, you must be looking past the mythology. Maybe you're a user; or a free-thinker; or a former happy resident of Fantasyland who suddenly found himself in the real world when his son was arrested for possession of heroin. It doesn't matter, to all of you I say the same: welcome to the real world of heroin. It isn't a perfect world, but also, it isn't the demonic region that the mythology assumes.

More than any other part of *Heroin Helper*, this section grows because of the questions that readers e-mail to us. So if you can't find some information you want, you are encouraged to...

Must Reading
: Here are the books that I have written on this subject. They give a thorough introduction and answer most questions people have about heroin and the opioids.

Other Books
: A list of books that will help you understand heroin and the heroin user, if you aren't one; or help you live a safer and happier life, if you are.

Chemistry
: Heroin is not that interesting a drug from a chemical standpoint. But if you have questions about chemistry, you will find most answers on the pages here and the sites that we link to.

Cultivation
: Information on the cultivation of opium and heroin. This section is not focused on how it is done (but it's coming) so much as what is done: how much heroin is produced, how much it sells for, and so on.

Glossary
: Want to be able to "talk the talk" without having to "walk the walk"? Here's your chance.

History
: You want the truth? Then go to a biased source — at least you know where they're coming from. *Heroin Helper* believes that heroin is illegal because it is part of social structure designed to keep those in power, in power.

Law
: Articles related to drug law with particular focus on heroin and the other opioids.

Pharmacology

There is a lot of cross-over with the chemistry section here, but pharmacology is focused on the effects of heroin and opioids.

Sociology

Drug taking is a social activity. This section of *Heroin Helper* deals with the social aspects of heroin use.

My Books

This website started as means to publicize the hardcopy books that I was having published. Of course, over time, the website took on a life of its own, and any promotion of my hardcopy work is now purely incidental. But make no mistake, I am proud of the books I have written. When I found out that *The Little Book of Heroin* was selling well to high school libraries, I was thrilled. The reason is that I want to educate people about heroin and the opioids. I love the idea that high school students have access to objective information, instead of the drug "education" books that fill most high school libraries — hysterical information that more often glorify the drug than anything.

Thus far, I have published three books. One of the books, the one about opium was co-written with my wife, *The Helper*. Other books are in the pipeline, however. The links below give you overviews of the books along with corrections and updates.

From my extensive experience reading drug books, I have found these books fall into one of three categories:

1. **Professional Books** These are books written for and by doctors. Often, they have a lot of really valuable information; the problem is that they are highly technical. I have a Ph.D. in physics and most of the time, I have to work very hard to decipher these kinds of books.
2. **Anti-Drug Propaganda** These books appear to present objective information about drugs but instead they are entirely rhetorical. Such books can be dangerous. Take, for example, *Heroin* by Sandra Lee Smith. This book is aimed at teens and their parents. It paints a picture of heroin as this evil drug that teens cannot help but encounter. It is melodrama masquerading as objective information. In this case, the author has no credentials. In many cases, the author has impressive qualifications and this makes the situation even worse.
3. **Pro-Drug Propaganda** Although these books are just as subjective as their anti-drug counterparts, they have the advantage that they are up-front about their purpose. These are books that show how to grow marijuana or make opium tea, or clean street cocaine.

The books that I have written fall most closely into category 3, but they are not propaganda. I have tried my best to show the good and bad aspects of drug taking. I don't want people to take drugs but if they are taking them, I want them to know how to do it properly and safely.

Recommended Reading

This is a list of books that should be of interest to readers of this site. Most of the books have a direct relationship to drugs, but some do not. Of this subset, some have fairly obvious relation, like books about the law and law enforcement while others less clear — like the books about general psychology. I have read all of these books, and I can attest to the fact that they are valuable. I haven't (like too many sites) just listed books related to the subject at hand. There are many, many books that could have been placed here which are simply not worth your while. I believe that you cannot go wrong by reading any of these books.

Drug Books

A Primer of Drug Action

by Robert M. Julien, M.D., Ph.D (W. H. Freeman and Company, New York, 1996).

Despite its cover advertisement, this is a fairly technical introduction on how drugs work on the body. After discussing the nervous system and drugs in general terms, the book discusses all of the major drug classes and how they act on the body. This is a very informative book.

Physician's Desk Reference, 53rd Edition

by Ronald Arky and others (Medical Economics Company, Montvale, NJ, 1999).

This is the standard "pill" book. You may find others more readable. If you are technically minded, this is the one to get. Unfortunately or fortunately, it is heavily steeped in the industry's emphasis on brand names and product manufacturers. There are a lot of pill references; shop around and find the one that works for you.

Licit & Illicit Drugs

by Edward M. Brecher and the Editors of Consumer Reports (Little, Brown and Company, Boston, 1972).

This book has a lot of good history in it and it debunks the idea that heroin is a dangerous drug. Just the same, the authors believe that "once and addict, always and addict" and so recommend methadone maintenance. Remember that when this book was written, no one had really studied ex-addicts. So all of the data came from the very worst addicts who, not surprisingly, were destined to continue on in this addictions. Other than this issue, however, this is a wonderful book.

The Encyclopedia of Drug Abuse

by Robert O'Brien, Sidney Cohen, Glen Evans, and James Fine (Facts On File, New York, 1992).

This book is really good to have if you want to be able to find out what a drug does (and so forth) but you are intimidated by more scientific works. There is a lot of information packed into this book. The only down side can be seen in its title: Drug Abuse. The authors think that drug use is bad but this does not blind their science which is mostly first rate.

Cocaine Handbook: an essential reference

by David Lee (And/Or Press, Inc., Berkeley, California, 1981).

This is as close as I've come to the present book but for cocaine. If you are using cocaine, this is a good book to have. But note that it is still anti-drug-use.

Heroin Books

Little Book of Heroin
by Dr. H (Ronin Publishing, Inc, Berkeley, CA, 2000).
This book is an overview of heroin rather than a user's guide like the *Heroin User's Handbook*. As such, it has more information about the science of heroin. It makes a good companion to *Heroin User's Handbook*, but there is much cross-over.

Opium for the Masses
by Jim Hogshire (Loompanics Unlimited, Port Townsend, WA, 1994).
Hogshire provides an excellent introduction to the opiates. This will be of interest to anyone interested in heroin.

Little Book of Opium
by Dr. H and The Helper (Ronin Publishing, Inc, Berkeley, CA, 2003).
This book gives a lot more information about the science of opium than Hogshire's book. It has detailed discussions of cultivation and pharmacology. It is an excellent companion to the Hogshire book.

Medical Readings on Heroin
by Oliver E. Byrd and Thomas R. Byrd (Boyd & Fraser Publishing Company, 1972).
This is a collection of summaries of medical papers on heroin use and abuse. It is old but it still contains most of the important information on diseases related to heroin use.

"It's so good, don't even try it once": Heroin in perspective
edited by David E. Smith (Prentice-Hall, Englewood Cliffs, New Jersey, 1972).
This is a collection of essays about heroin. It all focuses around the 1970 heroin scene but it provides some interesting insights into the many aspects of heroin use.

Flowers in the Blood: The Story of Opium
by Dean Latimer and Jeff Goldberg (Franklin Watts, New York, 1981).
This is a great overview of opium, especially its history. It is somewhat out of date in terms of its science, but it is well worth reading just for the history.

Heroin User's Handbook
by Dr. H (Loompanics Unlimited, Port Townsend, WA, 2000).
This was a labor of love. It covers almost everything a heroin user might need to know about this drug. It is also invaluable as an insider's look at the life of a heroin user. If you have a loved one who is a heroin user, this book will give you a good idea of just how hard his life is.

Addicts Who Survive
by David Coutright, Herman Joseph, and Don Des Jarlais (University of Tennessee Press, Knoxville, TN, 1989).

Detox Books

How to Get Off Drugs
by Ira Mothner and Alan Weitz (Simon & Schuster, Inc., New York, 1984).
You will find a lot of interesting material on getting and staying off drugs in this book, but be aware of its conservative assumptions about drug addiction. It is still a good book to read.

The Small Book
by Jack Trimpey (Dell Publishing, New York, 1992).

Rational Recovery: The New Cure for Substance Addiction
by Jack Trimpey (Simon & Schuster, 1996).
Trimpey presents a rational approach to getting past drug addiction. Unlike NA, there is a scientific basis of Rational Recovery. Either book works as an introduction to Rational Recovery. If you have been forced to go to 12-step meetings and you really hated it, you might find *The Small Book* more fun to read. Otherwise, *Rational Recovery* is a better introduction. If you feel the need for a support system, start with Rational Recovery or SMART Recovery. I recommend NA to people, only as a last step when *everything* else has failed. These books are also good for people who love someone with a substance abuse problem because they put the blame where it belongs: squarely on the shoulders of the user. There is no "enabling" and "co-dependent" nonsense here.

Heroin Addiction: Theory, Research, and Treatment: The Addict, the Treatment Process, and Social Control
by Jerome J. Platt (R. E. Krieger Publishing Company, Malabar, Florida, 1995).
Platt wrote three heroin addiction books, mostly focusing on methadone. All of his knowledge is put together in this revised version. The book provides an excellent overview of the literature on the issue of heroin addiction. Be careful to distinguish the facts from the conclusions Platt has a tendency to play a little fast and loose with his conclusions — stating them as fact. However, for the serious student, this is the book you start with. After digesting this book you will be able to draw your own conclusions, which will be as valid as anyone's (and more valid than most's).

History & Politics Books

The Birth of Heroin and the Demonization of the Dope Fiend
by Th. Metzger (Loompanics Unlimited, Port Townsend, WA, 1998).
This is an excellent history of the opiates which dispels many myths and explains how we got to our current, troubling cultural situation. It is also a fun read. It is filled with surprising facts like the huge amount of beer the "Puritans" brought with them to the new world and the founder of the AFL linking opium with Chinese immigrants because of the threat they posed to "native" laborers who were not as productive. It has an unfortunate cover, but it is a wonderful book.

Drug Warriors and Their Prey: From Police Power to Police State
by Richard Lawrence Miller (Praeger, Westport, Connecticut, 1996).
This book is so frightening and accurate that it will make you want to leave the country. It is a perceptive look at how illegal drug

users are treated in the United States and why they are treated so. Do you ever feel like you're living in Germany in 1938? You should, and Miller shows why. A book that goes well with this one (although it has nothing to do with drugs) is The Ominous Parallels by Leonard Peikoff (Plume, New York, 1995).

The American Disease
by David F. Musto, M.D. (Oxford University Press, New York, 1987)

Medical & Psychology Books

Please Understand Me II: Temperament Character Intelligence
by David Keissey and Marilyn Bates (Promethean Nemesis, Del Mar, California, 1998).
This book provides a very readable introduction to the theory of psychological types. It will give you a useful model that you can apply to interactions with other humans (and cops).

Merck Manual of Medical Information: Home Edition
edited by Robert Berkow (Pocket Books, Whitehouse Station, NJ, 1999).
This is the best disease book I've found. It is detailed and inexpensive.

Drug, set, and setting: the basis for controlled intoxicant use
by Norman Earl Zinberg (Yale University Press, New Haven, 1984).
When I first discovered Zinberg's work I felt that I had been exonerated. Many people had told me that it was impossible to use heroin casually. Zinberg shows that there were many such users. He also shows what users do in order to control their use.

Diseasing of America: How We Allowed Recovery Zealots and the Treatment Industry to Convince Us We Are Out of Control
by Stanton Peele (Jossey-Bass, Hoboken, NJ, 1989).
This book blows the lid off the idea that addiction is a disease. It can be very helpful in putting drug addiction into perspective and making you feel less like some sick creature who will always walk around with a monkey on his back.

The Lippincott Manual of Nursing Practice (7th Edition)
by Sandra M. Nettina and others (Lippincott-Raven Publishers, Philadelphia, 2001).
Truthfully, this book is a bit much. It contains far more information than you would ever need, but there is no better source for information on the proper procedures for things like intravenous injection. You might try looking for simpler (and smaller and cheaper) nursing texts; these may suit you as well.

Legal Books

Mad At Your Lawyer
by Attorney Tanya Starnes with Arthur G. White and Jennifer A. Becker (Nolo Press, Berkeley, 1996).
If you are ever in the unfortunate position of needing a lawyer, you will learn why lawyers are some of the most hated people. Most likely, you will pay a large amount of money for almost nonexistent defense. This book shows you what to do if you are mad at your lawyer, but more important, it shows you how to get the right lawyer for you and how to make the best use of him.

A Speeder's Guide to Avoiding Tickets
by James M. Eagan (Avon Books, New York, 1999).
Although it may seem odd to put this book in this collection, I have yet to find another book that comes close to to this book in providing insights into the motivations of cops. Perhaps because the author was a cop, he pulls no punches. Although the book is overall pro-cop, it is a very worth while read for anyone, because, as the title indicates, everyone will have to deal with a cop at one time or another.

Thinking Cop, Feeling Cop: A Study of Police Personalities
by Stephen M. Hennessy (Leadership Inc. Publishing, Scottsdale, Arizona, 1995).
This guy seems to think that cops are just ordinary people and so he has applied normal psychology to them. This is very useful but I think more insights would be gained by applying abnormal psychology. This is a good book to combine with Please Understand Me II: Temperament Character Intelligence.

You Are Going To Prison
by Jim Hogshire (Loompanics Unlimited, Port Townsend, WA, 1994).
There is no doubt that every heroin user should own and study this book. It guides you through the process of being arrested right through to frying in the electric chair. I wish I had read this book before I had my legal problems.

Controlled Substances: Chemical & Legal Guide to Federal Drug Laws
by Alexander T. Shulgin (Ronin Publishing, Inc, Berkeley, CA, 1992).
This book is a little out of date but there is no book like it. It lays down the U.S. drug laws in a clear and coherent manner.

Chemistry

Injecting Pills
Here is all of the information we here at *Heroin Helper* have regarding the practice of injecting pills.

Basic Brain Chemistry
This is small excerpt from my *Little Book of Heroin*, which explains the chemicals that heroin affects in the brain.

Problems with Urine Tests
This article addresses some problems with urine tests and explains how urine tests work.

What's Acetic Anhydride Used For?
In case you were wondering what God put this chemical on the planet for, besides making heroin.

Making Vicodin Less Toxic
Vicodin is made up of two things: one is harmless and one is deadly. Guess which one is illegal.

Opioid Stats

This is a list of stats on the base opioids.

Extracting Codeine

Two procedures for extracting codeine from commonly available pills. These procedures remove aspirin, acetaminophen, and caffeine from the pills, leaving mostly pure codeine.

Purifying Heroin

This is the standard procedure for purifying adulterated heroin. **Be very careful with it.** It can kill you easier than the adulterants.

Purifying Heroin Again

This is a second way to purity street heroin. It is probably better and safer than the "standard" procedure.

Isolating Codeine From 222s

Using only room temperature water, it is possible to isolate codeine from 222s.

UNDCP Heroin Lies

The UNDCP perpetuates the same old lies about heroin. We set the record straight.

Two to Three

The effectiveness of heroin is normally stated as "2 to 3" times that of morphine. Why the large range?

Rhodium Drug Chemistry Archive

This site is *the* place on the web to find information about drug chemistry. Most of it is over the head of the average reader — but there is a lot of value to the average reader, nonetheless. We have a listing of the available articles related to opioids along with how accessible the information is.

Injecting Pills

Heroin Helper is against the practice of injecting pills. Pills are meant to be swallowed; that is why they were made into pills. However, we get *so much* e-mail requesting information that we have had to provide the information we have. Some information is better than none.

If you are really interested in this subject, I suggest that you check out the Network Against Prohibition website. They have a detailed article about this subject called Filtering Morphine by N.N.. The information looks reasonable, but I have no means or inclination to test it.

Swallow Pills

After receiving at least two questions per week about how to inject pills, I have written the final word: don't. Don't bug me about it. From now on, all such e-mail will be gleefully deleted. When I start OxycontinHelper.com, then I'll answer these questions. Let me know when the first flurries form in Hell.

Better Pill Injection

In response to the following article, here is a procedure for getting pills into solution that works well and is easy to do.

Better MS-Contin® Injection

An anonymous reader has sent us this recipe for preparing time-release morphine tablets for injection. It seems to be better than the others.

Internet Pill Injection Recipes

This article contains various procedures for removing everything but the narcotics from pills that contain narcotics. The pills include morphine, Dilaudid®, and oxycodone.

Swallow Pills

I want to take a moment to prove that turning OxyContin® pills into injectable oxycodone is a waste of time. There are two issues that relate to this. First, oxycodone is meant to be taken orally. Second, if you are going to extract oxycodone from a pill, OxyContin® is the absolute worst choice.

Oxycodone is Absorbed Well Orally

Between 60% - 87% of oxycodone is absorbed orally compared to IM injection. So unlike heroin (or morphine, but less so), oxycodone is not wasted when taken orally. The only reason a recreational user would want to IV it is to get a rush. There is not likely to be too much of one, however; at least not for the experienced (tolerant) user. Only about 100 mg of oxycodone can be dissolved in 1 cc of water. Under most circumstances, filling a syringe over half-full is difficult. Thus one might get 70 mg of oxycodone into a syringe. Since oxycodone and heroin are fairly equal in strength, the best oxycodone injection would be equal to a 70 mg heroin injection That isn't that large a heroin dose. It shouldn't cost even $20.

Injecting Oxycodone is Dangerous

Then there is the question of safety. Oxycodone, like morphine, can produce a histamine response that is potentially lethal. What's more, I remember a rumor from back in the 1960s that it was dangerous to inject oxycodone, because in muscle tissue it tends to cause abscesses. (Few IV injections are perfect, so some will normally get into muscle tissue — sometimes quite a lot more than some.) I haven't confirmed this, but it hardly matters. It is no accident that there are no commercial injection oxycodone preparations. Here is what Purdue says about OxyContin®:

> OxyContin consists of a dual-polymer matrix, intended for oral use only. Parenteral venous injection [IV injection] of the tablet constituents, especially talc, can be expected to result in local tissue necrosis and pulmonary granulomas.

OxyContin® Is Filled With Junk

Removing the oxycodone from OxyContin® is going to be difficult because of all the garbage in these pills. Let me quote from the 55th Edition PDR (2001) in describing OxyContin®:

> The tablets contain the following inactive ingredients: ammonio methacrylate copolymer, hydrooxypropyl methylcellulose, lactose, magnesium stearate, povidone, red iron oxide (20 mg strength tablet only), stearyl alcohol, talc, titanium dioxide, triacetin, yellow iron oxide (40 mg strength tablet only), yellow iron oxide with FD&C blue No. 2 (160 mg strength tablet only) and other ingredients.

Compare this to the same PDR's description of Roxicodone™ a 5 mg immediate-release oxycodone tablet:

> The tablets contain microcrystalline cellulose and stearic acid.

The difference is not only because OxyContin® is time-released. OxyContin® is made by Purdue Pharma L.P. Their immediate-release oxycodone has a lot of junk in it that Roxane Laboratories, Inc. doesn't have in Roxicodone™. But it doesn't matter because Roxane doesn't make OxyContin®.

Maybe Oxymorphone?

I believe the reason people are so excited about removing oxycodone from OxyContin® pills is that OxyContin® pills have a large amount of oxycodone in them. They come in 10 mg, 20 mg, 40 mg, 80 mg, and 160 mg tablets. Roxicodone™ has just 5 mg of oxycodone. This does not matter, however, if only a small fraction of the oxycodone can be removed from the OxyContin® tablets.

Wouldn't it make more sense to extract oxycodone from Roxicodone — a much easier process, I'm sure (don't write and ask) — and then transform the oxycodone into oxymorphone? The oxymorphone is ten times as potent as oxycodone, and it doesn't have all the uncertainties as to whether it should be IVed under any circumstance.

Pills are made to be swallowed.

Better Pill Injection

In the *Heroin Helper* article Internet Pill Injection, five procedures were presented for getting pills into an injectable solution. Some people undoubtedly have managed to make them work. Most people, however, have found that they end up with a pile of thick gunk, which is still thick even after filtering through a cotton. Injecting such a "solution" can pose serious health risks.

An Easier, Safer Way

I agree with the original article: injecting pills is not the best of ideas. However, given that people are going to do this anyway, I am presenting a method that yields a solution that has fewer health risks. This process also has the advantage that it is quite simple.

The Procedure

1. Scrape off the outside coating from the pill. This can be done with a knife or even your finger-nail. (note 1)
2. Place the pill on a sheet of aluminum foil.
3. Bake the pill on the foil in an over at 350 F for 4 - 8 hours.
4. Remove the foil and let it cool.
5. Transfer the pill to a mixing vessel such as a spoon. You will find that the pill crumbles easily, so be careful transferring it. (note 2)
6. Combine a small amount of water with the pill. (note 3)
7. Heat the solution. The binders will separate out.
8. Draw the resulting solution through a cotton filter. It will have more or less the consistency of water.

Notes

1. If you want, you can leave the coating on. This will make transferring the pill in step 5 easier.
2. If you've left the coating on, try not to let it get in the water. Just roll the pill between your fingers and it'll split open and the contents will sprinkle out.
3. I'd recommend using saline solution rather than water — tap water is pretty gross when you look at it. Saline solution is sold very cheaply for cleaning contact lenses. If you've ever been to the doctor and had an IV, you will have noticed that they use saline not only to clean the lines, but also as a medium for any other stuff that has to be diluted; regular water is really bad for blood; it destroys red blood cells on contact. Saline is the same weight as your tears and mixes freely with blood. This'll cut down on the soreness etc. if using injection sites repeatedly, and you'll lessen the chance of injecting something that you'd rather avoid.

Better MS-Contin® Injecting

I have used morphine (MS-Contin®) in the past and find the other method useless compared to the cold method which I explain bellow.

1. Clean wax off pill. Masking tape or brown packing tape is excellent for pealing the colour off.

2. In a large spoon (a soup ladle is best) crush the pills with the back of a teaspoon until it is a fine powder, like chalk.
3. Add one ml of cold water per tablet and mix it into a paste.
4. Measure an amount of water equal to 2 ml per tablet. Add this water to this past and mix to a milky looking liquid.

   There should now be 3 ml of water for each pill that is being prepared.
5. Let the solution stand for at least 5 minutes so that morphine has time to disolve; the longer it is left, the stronger it is.
6. Put a large cotton "bud" into the solution in the spoon allow this to soak up solution.
7. Draw the solution into the syringe through the cotton bud. You may need to move the tip around the cotton bud to get it all, but you should be able to suck up 90% of what you put in originally
8. Do a of wash: squirt a couple of mills of water around sides of spoon to get any residue missed and suck up as before.
9. Repeat the wash process at least twice.
10. Test: There is none left in the spoon when the filter is flavorless. Morphine tastes bitter, so you will know when you have it all.

When MS-Contin® is heated, the wax expands and the morphine particles get trapped within the wax. This prevents the user from getting the maximum morphine from the mix, because it remains trapped in the wax that is left in the filter. I have experimented a lot with both the hot and cold methods. I find this to be by far the best method. For example, an orange, 60mg tab mixed the cold way is equal to a 100 mg, gray tab mixed with heat. Hope this helpful to you.

Internet Pill Injection

We at Heroin Helper suggest that you do not inject pills. However, we get so much e-mail asking for information on how to do this that we are providing the information here. Remember that pills are designed to be eaten, not to be injected. Injecting pills is thus inherently dangerous. Concider not injecting them, but if you do, use great caution.

Below are a number of procedures for injecting pills. They have been culled from the newsgroup alt.drugs.hard. The copyrights are the authors'.

MS-Contin®

Morphine Sulfate Controlled-Release: 15 mg, 30 mg, 60 mg, 100 mg, and 200 mg Tablets. Another, probably better method is explained in Better MS-Contin® Injection.

1. Wash the color off the pill.
2. Put it on a tablespoon and add 1.4 mls of water. (Use a 1 cc insulin syringe, 1 full syringe of water plus 40 units more).
3. Heat the water with a lighter until the pill JUST starts to dissolve on the edges.
4. Stop heating. Mash the pill thoroughly with the end of the plunger, mixing with the water.
5. Reheat the mixture just a little! Until the wax floating on top is melted again. Don't EVER heat so much that it boils. (The second heating is very short, it takes some practice. If you have heated too long you will find that the mixture is too thick and hard to draw up. In this case add a drop of water and reheat a little).
6. Blow the waxy stuff off to the side of the spoon gently.
7. If it is heated just right, you blow on the wax and it all floats over to the side very easily. At this point the mixture should also have cooled down a little. Draw up the liquid, staying away from the wax. If you blew it to the side and it has cooled, it will not go into the syringe. You may find toward the end a little bit of thicker stuff. Take your time and it will draw up too. With practice the whole thing takes about two minutes. Good luck.

—Snipe

Dilaudid®

Hydromorphone Hydrochloride: 2 mg, 4 mg, and 8 mg Tablets.

1. Take *one K4* or 4mg of generic the first time.
2. Fold up a glossy magazine cover (think playboy center-fold) or a crisp new bill into quarters.
3. Insert the pill inside. Crush it forcefully and thoroughly with the back of a tablespoon or a hammer (crush, not bang).
4. When you open the paper, you should see a finely powdered version of what used to be a pill. Transfer the contents to a spoon (or whatever you use to cook your drugs).
5. Add 0.75 cc (0.75 ml) of *warm* water. Stir, stir, stir.
6. Draw the contents into a syringe through a cotton.

—Bullwinkle

OxyContin®

Oxycodone HCl Controlled-Release: 10 mg, 20 mg, 40 mg, 80 mg, and 160 mg Tablets.

1. Scrape the coating off and crush the pills as finely as possible.
2. Use about 100 mls [*I think she means 1 cc — 100 units -Ed.*] of hot tap water, dissolve the powder as much as possible (which is really hard with OxyContin® tablets).

3. Once you get all of the clumps covered with water, heat it *gently*; don't boil it. When heating, you can actually see the fillers and crap move around and come together.
4. When you see enough clear water to insert the point, stop heating.
5. Draw what is in solution into your syringe.

And as far as cotton goes... Well, umm, I was a bit desperate, and decided to skip the cotton part. I'm not dead, and using a 29 gauge fit, the big clumps never made it into the barrel. Okay, okay. So not a good excuse for not filtering, but I was too afraid to lose some good stuff!!!

You won't miss any "good stuff" by using a cotton for filtration. ***Use a cotton!*** *-Ed.*

—Michelle

OxyContin® & MS Contin®

OxyContin®: Oxycodone HCl Controlled-Release: 10 mg, 20 mg, 40 mg, 80 mg, and 160 mg Tablets. MS Contin®: Morphine Sulfate Controlled-Release: 15 mg, 30 mg, 60 mg, 100 mg, and 200 mg Tablets.

1. Take the pill and gently scrape off the coating. For the coating inside the imprint, use the end of a needle and pick away at it gently until it falls off. There are some who take a moistened paper towel and wipe the coating off, but I've never done that.
2. Place the pill in between a folded piece of heavy-weight paper. Fold the sides and top so that when you crush it, no pulverized pill gets out. Take a hard object and slowly crush the pill. With a straight edge blade, open the folded paper and spread however much you crushed around and close it and crush some more. Do this until you have nothing left but powder. The drug is bound to the carnauba wax. In the next step you'll be able to extract it.
3. Take a 1/2 cc syringe and twist and bend the needle until it breaks off. Then with pliers (or your teeth) remove the plastic tip. You will now have a syringe that quickly takes up water and quickly eliminates it when you plunge it. Fill the syringe with *ice cold water* and set aside.
4. Take the powder and pour it into a mound in a large spoon (that is bent so that when you put it down, the spoon will be flat and not tip over and spill your stuff). Add water just to the point of getting all the powder immersed in liquid.
5. Run the spoon over a flame. The best thing to do is to take some 91% alcohol and place a small amount in a shallow dish. Light it on fire and run the spoon slowly over the flames until you see it begin to boil. You do not want to boil what is in the spoon, you just want to liquefy the water and the powder. This will make the wax come up to the top like scum.
6. After the powder is liquefied, immediately set the spoon down and add the ice cold water from the syringe you set aside. This will make the wax harden, leaving the remaining water with the drug.
7. Now use the same needle that you had the cold water in and stuff the end with a tightly packed piece of cotton that you've rolled around in your fingertips and stuff it in the end of the syringe.
8. Put the syringe with the cotton end directly into the spoon. Begin to draw up the solution. It will be cloudy, but see-through.
9. Take a new syringe and remove the plunger. Take the cotton off the tip of the syringe with the solution and inject the solution through the back side of the new syringe. The point here is not to mess with the needle, since you want it to remain as sharp as possible for comfort.
10. Once the solution is the new syringe, but the plunger back in, tap the syringe so all air -bubbles are gone. You may have to move the plunger up and down a bit inside the syringe to have all of the solution settle. You are now ready to inject the solution. The scum on the spoon can be eaten, since there will always be some of the drug left in it, or you may repeat the process of boiling the scum and adding cold water after boiling to have the wax harden, again drawing the solution that is left. If you're using a 1/2 cc syringe though, you may want to inject it on the next round.

—otGar

Morphine Tablets

There have been a lot of questions and confusion about how to make Morphine tablets soluble for intravenous injection. The following is an easy, fast, reliable, safe way to turn Morphine tablets into base Diacetyl-morphine or Morphine Hydrochloride for injection.

Things You Will Need to Have

1. Tablespoon and Teaspoon (use glass if using hydrochloric acid)
2. Syringes x3
3. Baking soda
4. Citrus acid or white vinegar(don't use if using hydrochloric acid)
5. Cigarette filters
6. Acetic Anhydride or Hydrochloric Acid

If you cannot get Acetic Anhydride you cannot make Diacetyl-morphine, however if you can get Hydrochloric Acid which is available at hardware stores you can still make Morphine Hydrochloride which is not as powerful as Diacetyl-morphine but can still be injected.

1. Take the Morphine tablet and carefully remove the colored coating with a damp paper cloth.
2. Place the tablet in a table spoon and add a small amount (the same size as the tablet)of baking soda.
3. Add one mil of water and gently heat the mixture over a low heat (the lowest setting on the stove element) when it is bubbling slowly break up the tablet with the end of a teaspoon and slowly evaporate the water off, you should now have a light brown / white dry mixture.
4. Place a small amount of Acetic Anhydride or Hydrochloric Acid on the mixture to make it damp and let it sit for 2min, then gently heat the mixture over a low heat until dry (brown). Do not breath the fumes. Make sure that the mixture is dry.

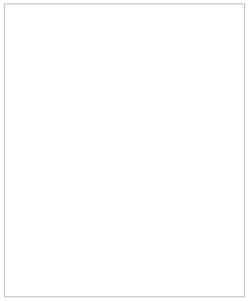
   (Skip step 5 if you are using hydrochloric acid.)

5. Place a small amount of citrus acid or white vinegar on top of the mixture.
6. Add water and gently heat the mixture over a low heat for 30 seconds, place a cigarette filter on top of the mixture and then get your needle and suck the Heroin or Morphine thru the filter you may repeat this 2 or 3 times to get all the Heroin or Morphine.
7. You can now inject the heroin intravenously, to work out the dosage is simple, if you used a 30mg pill and only wanted to inject 15mg just divide the solution into two needles, if you wanted only 10mg divide the solution into three needles and so on.

—GarethP

Brain Chemicals

There are three important brain chemicals — neurotransmitters — that relate to heroin: dopamine, norepinephrin, and the endorphins.



Dopamine

Dopamine helps to control human appetites for both food and sex. Large amounts of this substance are also associated with being out-going and exuberant. Parkinson's Disease and depression are related to having too little dopamine in the brain whereas schizophrenia is related to having too much. Heroin, like pretty much all drugs that get a person high, causes a release of dopamine.

Norepinephrin

Norepinephrin governs the sympathetic nervous system — the nerves of the body that cannot be voluntarily controlled. It's primary purpose is to stabilize blood pressure so that it does not get too low. When a provocative situation arises, the brain's release of this substance stimulates the *fight or flight* response. Heroin depresses the middle brain — the locus coeruleus, in particular—and so provides the user with the opposite feelings: safety and contentment.

Opioid Receptors

There are sites in the body — primarily in the brain and spinal cord — called opioid receptors which are involved in happiness and feelings of safety. These sites were originally discovered by scientists searching for mechanisms that allowed morphine to cause pleasure and relieve pain. All of the opioids attach to these sites where their effects are felt. There are at least five different kinds of opioid receptors but only four that are closely associated with the effects of the opioids: mu, kappa, delta, and sigma. The mu and kappa sites affect pain relief, the delta sites are involved with feelings of euphoria, and the sigma sites relieve depression.

Endorphines

It makes sense that the body would not have these receptors unless it created its own chemicals which would fit into these sites and before long, scientists had discovered endorphins — morphine-like chemicals used by the body for many purposes but primarily to modulate mood, promote pleasure, and manage reactions to stress.

The way that morphine differs from the natural endorphins — and there is some indication that the body creates its own morphine, not just morphine-like substances — is that it is possible to bombard the receptors with it whereas under most circumstances, the body only produces a small amount of endorphins at any time.

Urine Tests

Dear Dr. H,

I was recently thrown off probation because of a dirty urine test. Let me tell you the story. When I started probation, I was still smoking marijuana. So of course, my first urine test came up positive for THC. My PO told me that this was okay as long as I stopped using right then. He said that as long as the concentrations on my subsequent tests went down, he would not violate me.

Things went well at first. The second test was indeed lower than the first. The third test was negative. I figured I was out of the woods but the fourth test was positive, although at a level lower than the second test. As a result, my PO violated me and I am now doing a year in the county jail.

Please help me. I didn't use any drugs. Why did my fourth test come back positive?

Sincerely,
Rotting in Jail

Dear Rotting,

Before I start, I want to point out that you marijuana smokers have been none too kind to us heroin users. You have been as bad or worse as the general public at vilifying **our** drug of choice. NORML, in particular, is very keen on making arguments like, "if marijuana were legal, law enforcement could concentrate on stomping out dangerous drugs like heroin." But since you are in jail and you bring up an interesting issue, I will take pity on you and explain.

Drug testing is a billion dollar a year business in this country and given that its use is probably the single greatest threat to the little freedom we have left, it may come as a surprise that as a scientific enterprise, it is poorly run. Those who **do** the actual testing understand the uncertainties with the whole enterprise but those who **use** the results, do not. The worst offenders are judges, prosecutors, and probation officers, because they have no one to whom they answer.

Detection Limits

When a urine test comes back negative for THC (or any other substance) it does **not** mean that there was no THC in the urine. All it means is that the THC concentration was below some set limit determined by the test. This is called the "detection limit" of the test. Think of it this way: when you look at an eye chart, there are some letters which are large enough for you to identify and others that are just a blur. The blurry letters are below your visual detection limit. The letters are still there, just like the THC.

So if the detection limit of this particular test is 90 ng THC per ml of urine, a negative test means only that the THC level was less than 90 ng/ml. For example, 89 ng/ml would be called negative. Note that this is **not** 0 ng/ml even though a negative test is normally assumed so.

Urine Density

Everyone notices that sometimes their urine is a dark yellow whereas other times it is colorless. The darker the urine, the more impurities are present. As a result of this, a person's urine THC will vary throughout a day being higher when the urine is dark and lower when the urine is light.

So what happened with you and your PO? I can't say for sure without having the numbers from the tests. But I believe that you are telling the truth. When you took your third test your urine may have been fairly dilute and so the THC concentration fell below the detection limits of the test. When you went for your fourth test, your urine may have been much more concentrated and so the THC concentration was back above the detection limits **even though the amount of THC in your body had declined between the two tests.**

There are two things to be learned here. First, always drink a lot of water when you are subject to urine testing, even when you are not using any drugs; doing this will lessen the chances of a false positive. Second, people in the legal system—and even those working in the testing industry—are often very ignorant of the errors inherent in drug testing and their ignorance can and will be used against you in a court of law.

Acetic Anhydride

Dear Dr. H,

Can you tell me some of the things acetic anhydride can be used for apart from making heroin and making aspirin? Thanks.

Sincerely,
Wondering Down Under

Dear Wondering,

According to the ultimate authority on such issues — Uncle Fester, in his classic book *Secrets of Methamphetamine Manufacture*, "Acetic Anhydride... [is] commonly used in the chemical industry, especially for making dyes."

I hope that you are asking for this information because you are writing about heroin or such. Possession of Acetic Anhydride is tantamount to possession of heroin. No matter what you do, however, be careful and *don't be stupid*.

Making Vicodin Less Toxic

Editor's Note: *The information listed below (as simple and painless as it is), is most likely illegal in the United States and also possibly less oppressive nations. My feeling is always that if you are doing such chemistry for the purpose of detox, you are probably okay (even if not technically so). If you are doing it to get high, you are certainly running afoul of the law.*

I was in jail with this kid who had been there for a week waiting for arraignment because he couldn't afford bail. He was in for faking scripts for Vicodin — an illegal act he had committed almost daily for the previous four years without detection from law enforcement.

He told me he was doing 40 Vicodin per day. Vicodin consists of two parts: 5 mg of hydrocodone and 500 mg of acetaminophen. Let's see now, 40 times 500 mg is: 20 grams of acetaminophen per day! Acetaminophen is toxic to the liver. I'd rather expose my liver to Hepatitis C than this kind of daily bombardment.

What of the 200 mg of hydrocodone this young man was ingesting daily? It's nothing. About the worst you can say is that he was addicted to the stuff. But his withdrawal was not very bad; this quantity of hydrocodone is equivalent to a 25 mg heroin habit — about $5 per day.

Despite what the authorities tell you, drugs are not legal or illegal based upon their danger. This kid was rotting in jail, not because of what he was doing to hurt himself (acetaminophen) but rather because of what he was doing to get high (hydrocodone). The government doesn't want you taking control over your own life and recreation.

But you can have your hydrocodone and keep your liver too. In fact, it's really easy. Acetaminophen is not very water soluble and hydrocodone is. Crush your Vicodin with a mortar and pestle and put it into some kind of vial with water — a test tube works really well for this. Mix the solution for a few minutes. Let the solution settle for a few minutes and strain it. Discard the particulate matter. Voila! The solution is non-toxic hydrocodone. Now all you have to worry about is The Law.

Opioid Chemistry Stats

The information listed below uses some terms and abbreviations that may be unfamiliar to you. They are listed in the following table. If you have any questions, feel free to contact us.

Term	Description
brand name	This is the name that the drug is normally sold under. In many cases, there are any number of brand names and the band name may not refer to the drug itself, but rather a pill or other concoction that contains the drug.
name	This is the chemical or generic name of the drug.
formula	This is the chemical formula for the drug.
mol wt	Molecular weight. This is the number of grams that a mole of the drug weighs.
melts	This is the temperature at which the drug melts. Unless otherwise stated, this is under atmospheric pressure.
sol	This is the solubility of the drug in whatever liquid is listed — usually water.
LD_{50}	This is the lethal dose (LD) of the drug in whatever animal has been tested. The "50" indicates that this is the amount of the drug that caused half of the animals to die. The values given are mass of the drug per mass of the animal. So an LD_{50} of 100 mg/kg would mean for 100 mg of the drug for every kg the animal. LD_{50} is a good indication of how toxic a drug is, but note how much it changes from one species to another. There is a three-fold difference in the LD of heroin for mice versus monkeys.
IV, IM, SC	Intravenously, intramuscularly, subcutaneously

Heroin

brand name Heroin
name Diacetylmorphine Hydrochloride
formula $C_{21}H_{23}NO_5HCl$
mol wt 369.42
melts 243-244^{o}C

sol 1 g / 2 g H_2O
LD_{50} mice 22 mg/kg (IV)
LD_{50} monkeys 7 mg/kg (IV)

Morphine

formula $C_{17}H_{19}NO_3$
mol wt 285.34
Fraction of Opium 9% - 14%

Morphine Sulfate

formula $C_{34}H_{40}N_2O_{10}S$
mol wt 668.77
melts ~200°C
sol 1 g / 15.5 g H_2O (25°C)
  1 g / 0.7 g H_2O (80°C)

Morphine Hydrochloride

formula $C_{17}H_{20}ClNO_3HCl$
mol wt 321.80
melts ~200°C
sol 1 g / 17.5 g H_2O (25°C)
  1 g / 0.5 g H_2O (80°C)
LD_{50} mice 226-318 mg/kg (IV)

Codeine

formula $C_{18}H_{21}NO_3$
mol wt 299.37
Fraction of Opium 0.7% - 2.5%
melts 154 - 156°C
sol 1 g / 120 ml H_2O (25°C)
  1 g / 60 ml H_2O (80°C)
LD_{50} mice 300 mg/kg (SC)

Codeine Phosphate

formula $C_{18}H_{24}NO_7P$
mol wt 397.36
melts 154 - 156°C
sol 1 g / 2.3 ml H_2O (25°C)
  1 g / 0.5 ml H_2O (80°C)

Notes: Codeine in pill form is usually found in this phosphate form.

Codeine Sulfate

formula $C_{36}H_{44}N_2O_{10}S$
mol wt 696.82
sol 1 g / 30 ml H_2O (25°C)
  1 g / 6.5 ml H_2O (80°C)

Extracting Codeine

Below are two procedures for removing the "garbage" from pills that contain codeine. There were taken from newsgroup postings and credit is given. The opinions expressed are those of the writers who are less cautious than we here at Heroin Helper. In particular, to the comment made below that "you only live once," we would add, "you only die once."

Procedure 1

This was the first extraction I ever worked out. It is a simple method of extracting about 500mg of Codeine Phosphate salt from 100 8mg Panadeine tablets. Comes in mighty handy if you're hanging out with nothing more then $10, a 500ml enamel cup, a 40cm length of 20mm poly pipe, and some toilet paper.

Dissolve your 100 tabs in about 250ml of *cold* water. When dissolved, mix and let settle in a fridge. If the water is cold, most of the chalk and undissolved paracetamol will settle out leaving the solution near clear.

If the solution is clear, carefully siphon off the clear top layer and discard the chalk layer. If it's not clear, you will need to filter it. To do this, you will need to make a simple filtering coulomb. You do so as follows: roll up a neat even sausage of toilet paper Make it a size so that it fits fairly sight in the end of the 40 cm length of 20 mm poly pipe. Pour the un-clear Panadeine solution through the filtering coulomb. Collect the clear solution (filtrate).

Place the clear solution in the enamel cup and boil it down to about 20 to 30 ml. Remove the cup from the heat and place it in the freezer for a couple of minutes. Upon cooling, a white precipitate of Paracetamol will form on the bottom of the cup. Using a piece of cotton wool and a 20 ml syringe, remove all the solution and a 5 ml cold water wash.

Rinse out the cup and replace the filtrate. Put it back on the heat, reducing the solution to about 10ml. This time upon cooling, the Paracetamol will be about half the solution. Using the cotton wool and syringe, remove the concentrated Codeine solution.

Warning: There is a [a lot] of Codeine Phosphate there, about 300 to 800mg. So don't blow your head off if you shoot it. Injecting Codeine is not quit advisable to the average weekend user, but ... you only live once.

What I use to do was have a 300mg shot of Codeine in the doctor's car park then crawl inside with a massive Codeine headache and 9 out of 10 doctors would do me a shot of Peth. But like I said Shooting Codeine can cause brain haemorrhage, due to high blood pressure. Maybe just eat it.

—Doctor Dave DOBYC (David J Hall)

Procedure 2

Over the years, I have developed my own technique for extracting codeine from OTC aspirin products. [*Such products are over the counter (OTC) in places like Canada and the United Kingdom — not the USA -Ed.*] I have read the FAQ and think that the cold water method is a good process, but that my process is better since it eliminates the bulk of the caffeine and is much easier to do. The only drawback of my process is that it doesn't work with Tylenol containing tablets. Thus the procedure below only is useful with AC&C type tablets from Canada.

Advantages:

- Removes almost all the aspirin.
- Leaves very little caffeine in the product.
- Is faster to prepare.
- Requires no power, refrigeration, or complicated equipment.
- Has built in filtration.
- Necessary equipment can fit in a small pouch or bag.
- None of the equipment is restricted.

Disadvantage:

- Doesn't work with tablets containing Tylenol.

The equipment needed is readily available and will fit into a relatively small pouch or bag. I will list the equipment below:

- 20 cc or 30 cc syringe, either glass or plastic (available at hobby or craft stores)
- Small piece of paper towel about 3 x 3 inches
- Mortar and Pestle (to grind tablets, or suitable substitute)
- Funnel
- Water
- Small collection bottle

Procedure:

Take the small piece of paper towel and fold it up so that it forms a plug about 1/8" thick that will fit the circular area of the 20 cc syringe that you have chosen. Get it soaked with water and push it down to the bottom of the syringe. Insert the syringe plunger and push it all the way down and press the paper at the bottom. The paper should form a plug that fits the shape of the syringe about 1/8 inch thick. Your filtering syringe is now ready for use. You only have to do this part once.

Grind about 20 AC&C tablets (160mg codeine) into a fine powder. I use a thick walled juice glass about 2 inches tall and a steel rod about 1/2 inch in diameter and 6 inches long. I place the 20 tablets in the bottom and break them each by placing the end of the steel rod on each tablet and pressing while twisting. After all are broken up, move the steel rod around against the walls for about a minute to grind into a fine powder. It is important that a fine powder be obtained. Note: AC&C tabs come from basically 2 manufacturers. One

makes a little larger tablet that is much easier to grind. I get this one as a brand name called "Life." The other maker usually is the "Big V" brand. Both work well, the slightly larger tabs just grind easier.

Pour the powder into the open syringe. It should go in evenly. Use a funnel or a paper water cup with the bottom cut off to pour it in. In a 20cc syringe, it will fill about 10cc or so. Gently tamp down the surface of the powder about a quarter inch or so to make a firm surface. I use the steel rod to do this. Pour down the sides about 5 to 8cc of room temperature water. Pour it down the sides as to not break up the surface of the powder. Gently insert the plunger into the syringe and apply gentle pressure. You want the water to take about a minute to travel evenly through the powder. It is important that it travel evenly, if not then you made a mistake in grinding, pouring, or packing the powder. As the water travels through the powder, codeine's large solubility makes it concentrate in the leading edge of the water inhibiting the dissolution of the aspirin and caffeine.

Collect about 3 to 4 cc of the solution, about 60 to 80 drops depending on the syringe tip. This small volume of solution will have virtually all of the codeine and very little of the aspirin and caffeine. When done, withdraw the plunger. Then, many times, you can blow hard on the end of the syringe and the plug of aspirin will come out making it ready for next time.

This solution can be sterilized and IM injected or just taken orally. I usually do 2 of these batches into a 20cc small bottle. For oral use, I'll fill the rest of the bottle with water so that I can judge the dose more accurately. For IM injection, I'll put one batch in the bottle and add an equal volume of water. Then loosen the lid to allow pressure to escape and put it in the microwave for 10 to 60 seconds depending on the oven. Watch through the window and stop it when it starts to boil. Allow it to cool and it is ready for injection into one of many enjoyable spots. A fine point for IM, they put an acidic powder in the tabs which makes the product solution irritating when injected. This can be neutralized with a very small amount of baking soda. Don't add too much though, if the solution goes basic in pH it will be much worse than the original. If the solution doesn't fizz when you add the baking soda, you've added too much.

This simple technique is fast and efficient. I can perform this procedure in a couple of minutes. If you try this with tabs containing Tylenol, it will form a solid plug of powder and no matter how hard you apply pressure you won't be able to get any solution out. For Tylenol products, use the FAQ cold water technique.

Purifying Heroin

[Editor's Note: The following text is taken from Heroin User's Handbook, but the procedure has been floating around for years and I have no idea who "invented" it. I do not recommend using the part of this process that involves ether — unless you really know what you are doing.]

The impurities found in street heroin range from coffee to quinine to glass particles. Most impurities, like coffee, are harmless. You might even like some of them. Coffee, for example, is tasted after injecting heroin that has been cut with it. Some impurities, like glass and maybe even quinine, can be deadly. I strongly encourage you to remove the impurities from the heroin you buy. What follows is a recipe that works despite the fact that it has been widely distributed on the Internet.

Removing Particulate Matter

The use of cotton for filtration when heroin is cooked before being used is a small attempt at purifying the heroin ingested. But a much better job can be done with a little hydrochloric acid (HCl). Place about a gram of heroin in a small glass container (a test tube is best, but any glassware that will allow mixing will work). Add a couple of drops of 28% hydrochloric acid and allow it to react for a couple of minutes. Next, add 5 ml of distilled water and mix vigorously so that everything dissolves that can.

At this point in the process, the heroin is in solution. The non-soluble material in the container is garbage that you do not wish to ingest. Let the solution sit so that the particulate matter settles to the bottom and then pipette out the solution, leaving the particulate matter behind. The simplest kind of pipette is an eye-dropper. If a pipette is not available, it is possible to pour the solution out of one container into another, being careful not to allow any of the particulate matter to be transferred.

Removing Soluble Impurities

Add ammonium hydroxide to the solution, one drop at a time. This will cause a white precipitate to form. Continue adding the ammonium until you are certain that there is no more precipitate being formed. The solution is then gently mixed to assure that the ammonium is evenly distributed. At this point, the solution will have a milky look.

The solution is then added to about 100 ml of ethyl ether-a chemical with which great care must be taken, since it is quite combustible. This new solution is then vigorously mixed and left to sit. This will cause the water to settle at the bottom of the container; it is removed with a pipette and then discarded.

A mixture of 5 mL of HCl and 5 mL distilled water is created and added to the ethyl ether mixture. This is stirred vigorously for several minutes. Afterwards, a water layer will form at the bottom of the container. You then pipette this out and into a small container such as a petri dish.

Deacidification

Slowly add baking soda to the solution in the petri dish. This will cause the solution to bubble. When the bubbling stops, this process is finished. The resulting solution is then air-dried, which yields pure heroin and table salt (NaCl). The salt is harmless and may be ingested along with the heroin.

Purifying Heroin Again

[Editor's Note: The following method for purifying street heroin comes to us from a once infamous clandestine heroin chemist who has "gone straight." He has asked to remain anonymous for obvious reasons. He also asked that we be very clear that this recipe explains a serious chemical process with the resulting risks: (1) accidents made during process could cause harm in the form of explosions, toxic vapors, and unknown other threats to the safety of the would-be chemist and those in close proximity; (2) even if performed exactly as written, this recipe will not increase the quantity, only the quality of what was already there; (3) the very act of using this recipe breaks drug manufacturing laws (along with many others besides) that can result in multi-year prison sentences and even death as punishment. The recipe is provided for educational purposes only — and as such, it will likely be quite useful to students of beginning organic chemistry.]

I was curious about the procedure for cleaning street heroin [that is on your site: Purifying Heroin]. Most of my practical laboratory experience was with various opiates, street, pharmaceutical or self made, so this is definitely something that I know about. In fact I purified some street heroin for a friend of mine one day. It requires only a little knowledge of basic organic extraction technique.

This is what I did:

1. Dissolve the street heroin in water.
2. Use the easily available Hydrion pH papers to monitor the pH during this procedure. Add Sodium Hydroxide in solution dropwise while checking the pH. Use a narrow glass or plastic rod to touch a minimum of the drug solution to the paper to avoid loss. Stop when the pH reaches about 9.
3. Extract with chloroform. Chloroform is far superior to diethyl ether in that it is **non**-flammable and does not present storage problems, where explosive peroxides can be formed. **Note:** Chloroform is an ideal solvent for heroin, codeine, and most other opiates, with the major exception of morphine which requires a mixed solvent.
4. Separate the chloroform layer and wash with a minimum quantity of cold water: 1-2 ml works well. Evaporate the chloroform taking care not to burn the residue on the bottom of the beaker. **Note:** Chloroform is a known carcinogen, so plenty of ventilation (and a respirator) would be advisable. The chloroform is so volatile that this step is actually quite easy to perform.
5. Add a dilute solution of HCl dropwise while stirring with a glass rod. Monitor the pH closely. As the acid is being added, the diacetyl morphine base is being neutralized and converted into the water-soluble hydrochloride salt form.
6. When all the solid material has just dissolved, stop adding the HCl. I found that this takes place around pH 5-6. **Note:** If one tries to bring the pH all of the way up to 7, the free base alkaloid precipitates back out requiring addition of more HCl.
7. The resulting solution will be in an injectable form; it will now be completely clear with no colored impurities or particulate matter.

Having clarified this procedure, I would hope that nobody would actually attempt it. To an experienced chemist this is all so routine that you could do it blindfolded. But I noticed that even the college students in my Organic lab class, who had no prior organic chemistry experience, were remarkably clueless around a separatory funnel the first time. This is to say that what is trivial in the hands of an experienced chemist will likely be unusable (at best) and dangerous (at worst) in the hands of an amateur. This chemistry isn't to be played with.

Isolating Codeine From 222s

In the detox section of Heroin Helper is an article on detoxing with codeine. But this begs the question, "but where do I get the codeine?" This is a valid question given that codeine *is* a controlled substance — available in the U.S. only with a doctor's prescription.

Luckily, countries other than the U.S. have a more reasonable policy towards codeine. Canada, for example, allows morphine's under-achieving brother to be bought over the counter. There is a wrinkle however: it is never sold in its pure form. It may be bought as part of a cough syrup (in very dilute form) or in a pill form, as long as it is combined with two other active ingredients. This most often takes the form as a kind of headache medicine with acetaminophen and caffeine. It is this pill (commonly called "222s") that you want to acquire because codeine can be isolated from it.

OTC Codeine

Any drugs that can be bought over the counter in another country may be carried into the U.S. by the user or may even be mail ordered. For more details on how to do this check out any of the books on "smart pills" or *How to Buy Almost Any Drug Without a Prescription* by James H. Johnson (Avon Books, New York, 1990).

The last thing you want to ingest is a bunch of acetaminophen, so this clearly needs to be filtered out of this concoction. In addition, while detoxing, you certainly don't want to be ingesting caffeine because it will keep you awake and dehydrate you — common withdrawal symptoms themselves. I am now going to give you a method of isolating the codeine in these pills using only water.

Warning

The legal status of the following procedure is unclear. It almost certainly is illegal (in the U.S.) to do so for the purposes of getting high. For the purpose of detoxing yourself it *may* be legal. Consult an attorney if you have any questions.

The 222 tablets consist of 350 mg Acetaminophen, 15 mg Caffeine, and 8 mg of codeine. They have solubilities of 14.3 mg/ml, 21.7 mg/ml, and 434.8 mg/ml in 31 degree Celsius water. As you can see from this, Codeine is *much* more soluble than the other two.

If we could do so, we could dissolve 50 pills (roughly 435 mg of Codeine) in 1 ml of water. This would give us a lot of un-dissolved garbage and 435 mg Codeine, 22 mg Caffeine, and 14 mg Acetaminophen dissolved. That would be great — this is a small amount of Acetaminophen and Caffeine (about a fifth a cup of coffee) and a whole lot of Codeine (equivalent to about 20 mg of heroin — a street bag, perhaps). But this just can't be done from a practical standpoint because there is so much pill and so little water.

Procedure

What follows are steps for isolating Codeine from these pills. You will need water at 31 degrees Celsius (88 F) but if it is a little hotter or colder it won't make much difference. You will also need a few glasses, something with which to measure water accurately, a glass stir rod, a mortar and pestle, and an eye-dropper. Everything should be very clean to start.

1. Take 100 pills and grind them to a very fine consistency with the mortar and pestle. There should be no "chunks" left. Transfer the crushed pills into one of the glasses.
2. Add 500 ml of water to the glass with the pills and stir vigorously. When finished, let the mixture sit so that all of the non-dissolved particles settle to the bottom of the glass.
3. Transfer the liquid from this glass and put it into the other. This may be done simply by pouring but you may wish to use the eye-dropper. Clean the remaining glass.
4. Let this new solution sit in a dry area at 31 degrees. As the water, evaporates particulate matter will form at the bottom of the glass. When the water volume is down to one-fifth of its original, transfer the solution only to the other glass.
5. Again, let this solution evaporate. When it is down to 10 ml, the solution will have 140 mg Acetaminophen, 220 mg Caffeine, and 800 mg of Codeine.

Clearly, there are an infinite number of procedures for getting the codeine out of these pills. The overall idea is the same: Codeine is more soluble than the other things in the pills and so by trying to dissolve the pills (but always with less water than necessary to dissolve the entire pill) you concentrate the Codeine.

*[**Editor's Note:** Thanks to Jim Hogshire for providing the solubilities and clarifying the difference between Codeine and Codeine Phosphate.]*

UNDCP Heroin Lies

The UNDCP is generally a good source drug information. But they are far too much under the thumb of the United States not to falter when discussing heroin. In an otherwise excellent article called The Structure of Morphine they have the following to say about heroin:

> Although its analgesic action is stronger and faster than that of morphine, heroine has only limited use because of its great drawbacks and dangerous features. It is more toxic than morphine, and very rapidly produces habituation and addiction, accompanied by intense euphoria and excitation. These latter effects make the heroine addict particularly dangerous. The manufacture and use of heroine are prohibited in many countries, including the United States.

This short passage has six (count 'em, six) errors. Check them out:

Stronger
: Heroin is a pro-drug that depends upon being chemically converted to morphine. Heroin is more effective than morphine because it is easier to get heroin to the brain. But if the heroin didn't turn into morphine once there, it wouldn't be of any value.

Faster
: This is the single most common error made by medical writers. The common statement is that heroin crosses the blood-brain barrier three times faster than morphine. Writing this (and I have done it myself) is to use the language loosely. Three heroin molecules cross the barrier for each morphine molecule. Thus heroin does not have a greater rush (at equivalent doses) as is often stated.

More Toxic
: Heroin is more toxic in mice and rats. All evidence suggests that heroin is less toxic than morphine in *humans*. Clearly, the rodent community should be outraged, however.

More Addictive
: Since heroin's effect is that of morphine, heroin is not more addictive than morphine.

Excitation
: Where the UNDCP came to the conclusion that heroin makes the user excited is unclear. It does not.

Dangerous User
: Heroin users are less dangerous than "normal" people. The *only* thing that makes heroin users dangerous is their need to get money for an extremely expensive drug that would cost pennies per day if it were legal.

Conclusion

Now if I could just get the UNDCP people to read Heroin Helper, we might get somewhere. But just about any article on opioids will contain this kind of misinformation about heroin. If it doesn't, the author will be accused of being "pro-drug." So live and lie or die with the truth.

Two to Three

How Does Heroin Compare to Morphine?

It is often reported that heroin is "two to three times as powerful as morphine." But most research is based upon *intramuscular* injections. The standard numbers are that it takes 5 mg of heroin to relieve as much pain as 10 mg of morphine when both are administered intramuscularly. Orally, the numbers are 40 mg of heroin and 60 mg of morphine.

The longer it takes heroin to get to the brain, the more it acts just like morphine. Administered intramuscularly — hardly a very direct means of ingestion for a drug destined for the brain — heroin is 200% as effective as morphine. Administered orally, heroin is only 150% as effective.

The numbers indicate that a lot of morphine is destroyed when it is ingested orally. One needs to ingest six times as much orally as one does when IM injecting. Surprisingly, codeine is quite efficient taken orally — almost 70% as effective as IM injection.

But if heroin is turned into morphine as quickly as stated in the main article, isn't it reasonable to assume that heroin administered intravenously would be even more potent compared to morphine? The answer is: yes. This is where the "two to three" number comes in. IV heroin is believed to be three times as powerful as IV morphine. It may be even more powerful.

This fact should be taken into account when you are attempting to detox yourself using some kind of opioid substitution. In matching doses, a higher potency for heroin should be assumed if it is being administered directly to a vein. On the other hand, a lower potency should be assumed if it is being ingested in a less direct way like inhalation.

Rhodium: Drug Chemistry Archive

In keeping with the *Heroin Helper* added value mission, rather than simply provide our readers with a link to the rhodium archive with a comment that it has "lots" of drug chemistry information, we are providing individual links to its articles with a brief description and (more important) the level at which the article is written.

Each article is graded as to how difficult it is to understand. The following scale is used. In general, I have graded the articles liberally. This is to say that an article I rate as written for a general audience will require a member of that audience to work a little to understand the article. (Otherwise, nothing on Rhodium is for a general audience anyway.)

1. General Audience
2. High School Level Chemistry
3. One Semester College Organic Chemistry
4. Chemistry Bachelor's Degree
5. Research Scientists

Level 1 Articles (General Audience)

Opium - Poppy Cultivation, Morphine and Heroin Manufacture
: The official government "how to" guide for growing opium, extracting morphine, and producing heroin. This version has an introduction and afterword by Jim Hogshire. It is very useful information. Level 1.

Morphine and Opium Alkaloids
: This is a student report on opium. It is easy to read and contains a good deal of useful information. Unfortunately, it contains a number major errors. It is not recommended. Level: 1.

Codeine FAQ
: This is the standard codeine FAQ that you can find everywhere on the Internet. It is quite good. It includes a procedure for isolating codeine from pills that is good. Level 1.

The making of heroin
: This is Samson's condensation of the process of producing heroin, taken from the U.S. Drug Enforcement Agency's book *Opium and Heroin Cultivation in Southeast Asia*. It is an excellent overview for interested parties, with enough detail that one could actually go into the business if he was so inclined. Level 1.

Level 2 Articles (High School Chemistry)

Identification Tests of Morphine
: If you need to test a substance to see if it is morphine, you have found the article. You might not think that there would be a lot of need for testing a substance to see if it is morphine. You might be right. However, I can think of two good reasons right off hand. The first is that morphine is often sold as heroin. A heroin addict could die by injecting an amount of morphine equivalent to his normal heroin dose. (This is due to the histamine release that morphine causes.) The second reason, is that lawyers know little about chemistry, and so do most "expert chemical witnesses." People have been acquitted of drug charges by questioning the chemical results of the police lab work. One weakness of this article is that it deals only with morphine HCl and not morphine SO_4.Level: 2.

Morphine and Structurally Related Analgesics
: The actual title of this article is "The Structure of Morphine," but the title Rhodium gives it is much better. This is a good overview of the morphine like opioids. It does however, suffer from the usual heroin propaganda. Most of the article can be understood by a general audience. Level 2.

Theoretical study of 2,3-seco-Fentanyl and other Fentanyl analogs
: Various physical and chemical properties of these Fentanyl analogs are presented along with the potencies relative to Fentanyl. Level 2.

Level 3 Articles (College Organic Chemistry)

Codeine to Morphine Conversion Review
: This is a surprisingly clear review of how a chemist would go about converting codeine into morphine. It includes four methods that work. Level: 3

Synthesis of Dimenoxadol
: This is a queer article about a compound almost no one has heard of. Even the author admits that he is not certain that Dimenoxadol is an opioid. It is certain however, that Dimenoxadol is a pain reliever with about one-quarter the potency of morphine. Two procedures are given for the synthesis of this chemical, but the article is mostly worth while for its introductory material. Level 3.

Codeinone from Thebaine
: This is a simple procedure for the recreational chemist. Codeinone, along with codeine, is the chemical most used to create morphine in the laboratory (except that as a society, we get a lot more morphine directly from poppies than we use). Should someone have thebaine just sitting around, this procedure could probably be carried out by anyone. However, the text assumes the reader knows a few things so I've set the level a little higher. Level 3.

Conversion of Thebaine to Codeine
: This is a surprisingly simple process. One would think that taking the next step (from codeine to morphine) would be similarly easy, but it isn't. This article is very well written and give a reader with little or no organic chemistry experience a good idea of what organic chemistry is all about. Level 3.

The original article on the synthesis of heroin
: This is an edited version of the original article on the synthesis of heroin and its pharmacological effects on dogs and rabbits. It has some interesting chemical information, but it is mostly interesting from a historical perspective. Level 3.

Level 4 Articles

New Patent on the Extraction and Purification of Morphine from Opium
: Although this article is not hard reading, it does not contain enough details to make it of much value to any but a well-trained chemist. It is of quite a bit of interest to readers interested in an over-view — that is, ones not planning to use the information in the lab. Level: 4.

Levorphanol (l-Dromoran) and Racemorphan Synesis
: This is an excellent article, which almost anyone can read and gain from the process. The chemistry is very high level however. These two drugs are potent synthetic opioids (about as strong as heroin). The first third of the article is easy to follow and worth the time. Once it gets over your head, it doesn't much dip back down again. Read as much as you can. Level 4.

Pethidine (Demerol, Meperidine) Synthesis
: This is a very terse discussion of the synthesis of Demerol and a Demerol-like compound. It is only of use to people interested in the chemistry, which means it's a pass for most people. Level 4.

Methadone Synthesis Overview
: Who ever thought the United Nations would be good for something? After being a big reason that we have internation drug prohibition, they provide some very useful information on drug chemistry. This is an excellent overview of methadone synthesis with lots of references. It is written at a high level, but with a lot of work it could be useful to someone of lesser knowledge. Level: 4.

Pethidine-type Analgesics Overview
: As with all of the UNDCP articles, this one is well documented. However, this one is riddled with typos that make it very hard to read. It will take real digging to get to bottom of it. Level 4.

The Stereo Chemistry of Morphine
: High level theory is all you will find here. It isn't terribly hard to understand, but it is only of interest to researchers. Level 4.

Total synthesis of Morphine
: This is similar to the other "total synthesis" articles, but it has some text that explains a little of what is going on. Of all these, this is the one to check out. Level 4.

Catalytic rearrangement of Morphine/Codeine to Hydromorphone/Hydrocodone
: This is an English translation of German patents for changing morphine and codeine into hydromorphone and hydrocodone. These are chemicals used to create semi-synthetic opioids. The discussion is terse, but surprisingly understandable. It probably isn't of much interest to most recreational chemist. Level 4.

Quantitative Conversion of Codeine to Hydrocodone
: This paper discusses a cheap method of creating hydrocodone in a free base from codeine. It is a fairly straight-forward process, but it requires a lot of knowledge to understand. Level 4.

Synthesis of Methadone
: Although this article is rather long, it describes in great detail how to synthesize methadone starting with almost nothing. It is assumed that the chemist is fairly well trained, but an advanced degree is hardly necessary. For the non-chemist who can get past the jargon, it is an interesting paper to read — especially when put in historical perspective of being invented by the Germans because they had lost access to opium growing regions (and thus morphine) during World War II. Level 4.

Oxycodone and Codeinone from Codeine
: This lengthy article presents three procedures for creating oxycodone from codeine. There is a lot of information on making intermediaries such as the process for changing codeinone to 14-hydroxycodeinone with hydrogen peroxide (H2O2). The descriptions are fairly terse. Level 4.

Fentanyl Synthesis
: This article goes step-by-step through the process of synthesizing Fentanyl. It is quite technical, however — hard to follow even for the chemistry educated. Level 4.

Carfentanil synthesis
: Carfentanil is a Fentanyl analog that is 10,000 times as potent as morphine. This article provides the process for creating it by two different, patented techniques. The techniques seem simple enough, but they require chemicals that may be hard to get. Regardless, you might consider if you really want to be monkeying around with anything this strong. Level 4.

Level 5 Articles

Total Synthesis of Morphine: Page 1
Total Synthesis of Morphine: Page 2
: This is not an article. It is two pictures (starts on page one and continues onto page two) of the chemoenzymatic synthesis of the morphine skeleton. It might be useful a regular chemist, but the resolution is really not great enough to tell what is going on unless you already pretty much know. Cool images though. Level 5.

Theoretical Study of Acyclic Fentanyl Analogs
: This article presents some pretty high-level information on Fentanyl and its various analogs (although there are many more than are discussed in this article). There some interesting 3-D illustrations of the compounds that are worth a look. Otherwise, this one is just for the professionals. Level: 5.

Synthesis of a Clonitazene/Etonitazene Analog
: Clonitazene and Etonitazene are extremely potent Schedule I opioids with roughly 1000 times the strength of morphine. This short article describes how to synthesize analogs of these two chemicals with terse instructions on how the process should be changed to create the actual chemical. This article shows just how easy it is to create extremely strong opioids. Chemists should always use great care. Level 5.

Discussions on a Fentanyl analog suggested by Drone #342
: A very long and confusing discussion of how to synthesize a Fentanyl analog that is rough 1000 times as potent as heroin. This is not for the weak at heart. Level 5.

Cultivation

This section provides a lot of information on global opium and heroin production throughout the world. We will update it as we can; it is badly in need of updating. However, the data are valid. Things have not changed that much in the last ten years. If you have questions or need more information, please contact us. Just...

Licit Opium Production: Traditional
: Roughly 60% of licit opium is produced in the traditional manner of making cuts in the pods and collecting the opium that oozes out.

Licit Opium Production: Non-Traditional
: The new method for "opium" production extracts the alkaloids directly from poppy straw. Many of the alkaloids found in opium cannot be isolated by this method, however. But it is very effective at producing morphine which is the most important opioid.

Illicit Opium Production
: Illicit opium production is much more stable than the licit production. The illicit market is much more free than the licit market in an economic sense, making it more responsive to fluctuations in supply variables.

Total Opium Production
: On average, only 20% of all the opium on the global market is produced with government licensing.

Licit Opium Producing Countries: Traditional
: The licit production of opium in the traditional manner is dominated by India, which is responsible for almost 95% of all of the opium so produced world wide.

Licit Opium Production Products
: Most of the opium produced licitly is used to make morphine and codeine; these two compounds make up over 90% of all the substances produced.

Heroin Retail Prices
: Heroin retail prices have been cut in half over the past decade.

Heroin Wholesale Prices
: Heroin wholesale prices have been cut in half over the past decade.

Cultivation Data
: This is all of the data we have in text format.

Licit Opium Production: Traditional

Opium produced directly from *Papaver somniferum*. This is cultivation done in the traditional manner of making shallow cuts in the seed pod of the plant and then harvesting the resulting opium which oozes out.

The AREA column is the total area of land on which *Papaver somniferum* is planted. The area is given in hectares (Ha) which is equal to an square which is 100 meters on a side. It is an area roughly equlialent to three football fields or 2.5 acres. The OPIUM column represents the opium produced throughout the entire world. The units are given in metric tons. A metric ton is roughly equivilent an imperial ton: 2000 pounds. The YIELD column is the amount of opium produced per unit area. It is reported as kilograms per hectare. This is roughly equililent to a gram per square meter.

YEAR	AREA	OPIUM	YIELD

1989	15,500	500	32
1990	14,000	420	30
1991	14,500	405	28
1992	14,500	510	35
1993	12,000	370	31

Licit Opium Production: Non-Traditional

Increasingly, commercial opium production does not produce opium at all. Instead, it produces *Papaver somniferum* straw from which alkaloids are isolated. Obviously, there are no figures available for opium yields for this kind of production. However, there are numbers for morphine yields and these allow us to work backwards to determine equivalent opium yields so that we can compare this kind cultivation with the traditional.

Equivalent opium production can be determined for *Papaver somniferum* by making three assumptions. First, the number of kilogram of straw yield per hectare harvested is 600; we will call this variable Y. Second, straw yields 0.2% of its weight in morphine; this is variable M. Third, opium is 12% morphine; this is variable P. We can thus convert the straw areas to opium production:

AREA * (Y kg/Ha) * (M kg/kg) / (P kg/kg)

On the basis of this, the equivalent opium production in kg is equal to the area planted in hectares times ten.

YEAR	AREA	OPIUM	YIELD
1989	40500	405	10
1990	32000	320	10
1991	47000	470	10
1992	39000	390	10
1993	24000	240	10

Illicit Opium Production

Virtually all illicit opium is produced directly from *Papaver somniferum*. There are two things worth noting in the table below. The first is that the amount of land used for illicit opium production is five times that used for all licit production combined. This is roughly equivalent to the the contrast of licit and illicit opium on the world market.

The second noteworthy element of this table is the opium yield which is half that for licit production. It is most likely the result of the fact that illicit opium is produced on a large number of small farms whereas licit opium is produced on large commercial farms which have been optimized. It is also probably due to the limited availability for the small illicit farms of fertilizer and other farming production tools.

YEAR	AREA	OPIUM	YIELD
1989	225,000	3,650	16
1990	210,000	3,200	15
1991	225,000	3,520	16
1992	230,000	3,550	15
1993	250,000	3,850	15

Total Opium Production

It is widely accepted that drug use is a natural human behavior. But modern governments try to eliminate this behavior when it comes to drugs that they have decided they don't like. The table below shows that, as important as opium is as a medical agent, it is far more important as a recreational agent. Five times as much opium is used illegally (for recreational purposes) as legally (for medical purposes). It is certainly true that the laws probably limit the amount of opium used medically, but this is also true of the opium used recreationally. This division (five to one), is probably about what we would see without government involvement.

The PART column represents the percentage of all opium that is produced legally.

YEAR	OPIUM		
	LICIT	ILLICIT	PART
1989	905	3,650	20%
1990	740	3,200	19%
1991	875	3,520	20%
1992	900	3,550	20%
1993	610	3,850	13%

Opium Producing Countries: Traditional

These are the major countries producing opium legally in the traditional manner. The data are taken from from 1993.

COUNTRY	AREA	OPIUM	YIELD
India	11,907	345,708	29.0
China	240	19,870	82.8
Japan	1	5	6.8

Licit Opioid Production

Licit opium is rarely distributed to consumers as opium. Instead, components are isolated and transformed and sold as single drug medications or mixed into chemical "cocktails." The data below are from 1993.

CHEMICAL	PERCENT
Morphine	45.8%
Codeine	42.5%
Dihydrocodeine	5.4%
Pholcodine	1.9%
Hydrocodone	1.5%
Thebaine	1.4%
Oxycodone	0.9%
Ethylmorphine	0.6%

Heroin Retail Prices

These are the prices (in inflation corrected dollars) of a gram of heroin in Western Europe. It was determined by the United Nations International Drug Control Programme, based upon data from Austria, Belgium, Denmark, Finland,France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, and the United Kingdom.

YEAR	PRICE
1984	$200
1985	$189
1986	$225
1987	$243
1988	$250
1989	$200
1990	$211
1991	$179
1992	$168
1993	$129

1994	$132
1995	$125
1996	$111

Heroin Wholesale Prices

These are the prices (in inflation corrected dollars) of a gram of heroin in Western Europe and the United States. It was determined by the United Nations International Drug Control Programme. The Western Europe numbers are based upon data from Austria, Belgium, Denmark, Finland,France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, and the United Kingdom. Exactly what data were used to get the United States numbers is not stated.

YEAR	PRICE	
	Europe	USA
1984	$100	$289
1985	$83	$232
1986	$131	$207
1987	$116	$221
1988	$112	$179
1989	$100	$157
1990	$94	$196
1991	$72	$179
1992	$84	$167
1993	$61	$160
1994	$59	$157
1995	$57	$159
1996	$54	$151

Cultivation Data

```
Licit Opium Production: Traditional

Opium produced directly from *Papaver somniferum*. This is
cultivation done in the traditional manner of making shallow
cuts in the seed pod of the plant and then harvesting the
resulting opium which oozes out.

The AREA column is the total area of land on which *Papaver
somniferum* is planted. The area is given in hectares (Ha)
which is equal to an square which is 100 meters on a side.
It is an area roughly equlialent to three football fields
or 2.5 acres. The OPIUM column represents the opium produced
throughout the entire world. The units are given in metric
tons. A metric ton is roughly equivilent an imperial ton:
2000 pounds. The YIELD column is the amount of opium produced
per unit area. It is reported as kilograms per hectare.
This is roughly equililent to a gram per square meter.

YEAR AREA OPIUM YIELD
1989 15500 500 32
1990 14000 420 30
1991 14500 405 28
1992 14500 510 35
1993 12000 370 31


Licit Opium Production: Non-Traditional

Increasingly, comercial opium production does not produce
opium at all. Instead, it produces *Papaver somniferum*
straw from which alkaloids are isolated. Obviously, there
are no figures available for opium yields for this kind of
production. However, there are numbers for morphine yields
and these allow us to work backwards to determine
equililent opium yields so that we can compare this kind
cultivation with the traditional.

Equivilent opium production can be determined for *Papaver
somniferum* by making three assumptions. First, the number
```

of kilogram of straw yield per hectare harvested is 600; we will call this variable Y. Second, straw yields 0.2% of its weight in morphine; this is variable M. Third, opium is 12% morphine; this is variable P. We can thus convert the straw areas to opium production:

AREA * (Y kg/Ha) * (M kg/kg) / (P kg/kg)

On the basis of this, the equivilent opium production in kg is equal to the area planted in hectars times ten.

YEAR	AREA	OPIUM YIELD
1989	40500	405 10
1990	32000	320 10
1991	47000	405 10
1992	39000	390 10
1993	24000	405 10

Illicit Opium Production

Virtually all illicit opium is produced directly from *Papaver somniferum*. There are two things worth noting in the table below. The first is that the amount of land used for illicit opium production is five times that used for all licit production combined. This is roughly equilivent to the the contrast of licit and illicit opium on the world market.

The second noteworthy element of this table is the opium yield which is half that for licit production. It is most likely the result of the fact that illicit opium is produced on a large number of small farms whereas licit opium is produced on large commercial farms which have been optimized. It is also probably due to the limited availability for the small illicit farms of fertilizer and other farming production tools.

YEAR	AREA	OPIUM YIELD
1989	225,000	3650 16
1990	210,000	3200 15
1991	225,000	3520 15
1992	230,000	3550 15
1993	250,000	3850 15

Total Opium Production

It is widely accepted that drug use is a natural human behavior. But modern governments try to eliminate this behavior when it comes to drugs that they have decided they don't like. The table below shows that, as important as opium is as a medical agent, it is far more imporant as a recreational agent. Five times as much opium is used illegally (for recreational purposes) as legally (for medical purposes). It is certainly true that the laws probably limit the amount of opium used medically, but this is also true of the opium used recreationally. This division (five to one), is probably about what we would see without government involvement.

The PART column represents the percentage of all opium that is produced legally.

YEAR	OPIUM		
	LICIT	ILLICIT	PART
1989	905	3650	20%
1990	740	3200	19%
1991	875	3520	20%
1992	900	3550	20%
1993	610	3850	13%

Opium Producing Countries: Traditional

These are the major countries producing opium legally in the traditional manner. The data are taken from from 1993.

COUNTRY	AREA	OPIUM YIELD
India	11,907	345,708 29.0
China	240	19,870 82.8
Japan	1	5 6.8

Licit Opioid Production

Licit opium is rarely distributed to consumers as opium. Instead, components are isolated and transformed and sold as single drug medications or mixed into chemical

"cocktails." The data below are from 1993.

CHEMICAL PERCENT
Morphine 45.8%
Codeine 42.5%
Dihydrocodeine 5.4%
Pholcodine 1.9%
Hydrocodone 1.5%
Thebaine 1.4%
Oxycodone 0.9%
Ethylmorphine 0.6%

Heroin Retail Prices

These are the prices (in inflation corrected dollars) of
a gram of heroin in Western Europe.
It was determined by the United Nations Internation Drug
Control Programme, based upon data from Austria, Belgium,
Denmark, Finland,France, Germany, Greece, Ireland, Italy,
Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden,
Switzerland, and the United Kingdom.

YEAR PRICE
1984 $200
1985 $189
1986 $225
1987 $243
1988 $250
1989 $200
1990 $211
1991 $179
1992 $168
1993 $129
1994 $132
1995 $125
1995 $111

Heroin Wholesale Prices

These are the prices (in inflation corrected dollars) of
a gram of heroin in Western Europe and the United States.
It was determined by the United Nations Internation Drug
Control Programme. The Western Europe numbers are based
upon data from Austria, Belgium,
Denmark, Finland,France, Germany, Greece, Ireland, Italy,
Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden,
Switzerland, and the United Kingdom. Exactly what data
were used to get the United States numbers is not stated.

YEAR   PRICE
 EUROPE USA
1984 $100 $289
1985 $83 $232
1986 $131 $207
1987 $116 $221
1988 $112 $179
1989 $100 $157
1990 $94 $196
1991 $72 $179
1992 $84 $167
1993 $61 $160
1994 $59 $157
1995 $57 $159
1996 $54 $151

Glossary

Abuse
: The USFDA defines abuse as "deliberately taking a substance for other than its intended purpose, and in a manner that can result in damage to the person's health or his ability to function."

Abuse Potential
: A measure of how likely a drug is to be "abused."

Adatuss®
: Hydrocodone antitussive.

Administration
: The means by which a drug is taken.

Acquirer
: A middle man between a dealer (usually) a chipper or another on the outer edge of the heroin scene.

Adulteration
: The process of diluting a drug.

Agonist
: Any opioid that produces morphine or codeine like effects on the body.

Agonist-Antagonist
: Any opioid that produces that has both agonist and antagonist activity at opioid receptor sites. The drug may be primarily one or the other. For example, butorphanol is more an agonist than an antagonist.

AIDS
: Acquired Immune Deficiency Syndrome.

Alkaloid
: A molecule that contains nitrogen, carbon, oxygen, and hydrogen. All opioids are alkaloids.

Alphaprodine
: A short-acting morphine like synthetic analgesic.

Analgesic
: A drug which relieves pain without rendering the patient unconscious.

Anexsia-D®
: An analgesic soup in pill form consisting of aspirin, caffeine, phenacetin, and Hydrocodone.

Anileridine
: A synthetic opioid similar to Demerol®.

Antagonist
: A drug that blocks the effects of an opiate. They are used in cases of overdose and to show that a user is an addict, usually for the purpose of allowing him into a methadone program.

Antitussive
: A drug that relieves coughing.

Apomorphine
: A non-euphoric morphine derivative used to induce vomiting.

Artillery
: Works.

Back up
: Pull-Back.

Bag
: A dose of heroin, usually between $10 and $20.

Balloon
: This often refers to a single does of heroin — usually an eighth gram. Heroin is often distributed in small balloons so that it can be stored in one's mouth and swallowed (without loss) should law enforcement appear.

Barbiturates
: A class of sedative, hypnotic drugs which depress the central nervous system. The longer acting barbiturates are removed by the kidneys; the short acting ones are removed by the liver.

Beat
: To cheat.

Benzodiazepines
: A class of minor tranquilizers with lifetimes anywhere from a few hours to a few days. These are removed by the liver.

B & O Supprettes®
: An anal suppository containing powdered opium and belladonna extract.

Booting
: repeated flushing and pull-back when IV injecting. It is often stated as a means of prolonging the high but seems more often to be mere play.

Bundle
: Usually 20 bags of heroin but it depends.

Buprenorphine
: A narcotic agonist-antagonist.

Business
: All the assorted things that a junkie must do to maintain his habit. It is most commonly used in the phrase "Taking care of business."

Butorphanol
: A narcotic agonist/antagonist used as an analgesic.

Burn
: To cheat.

Chasing the Dragon
: Smoking heroin.

China White
: White powder heroin from Asia — usually referring to heroin funneled through France. Not all white powder heroin is China White.

Chip
: To use drugs in a non-addictive manner.

Chipper
: A non-addicted, casual drug user.

Chiva
: This actually means marijuana but for some reason it means heroin in the US.

Cirrhosis
: Chronic destruction of the liver.

Clonidine

A blood pressure medication that is highly effective at modulating opiate withdrawal symptoms.

CNS
: Central Nervous System: the brain and spinal cord.

Cocktail
: A mixture of different drugs taken at once.

Cold Turkey
: to detox off of heroin abruptly without medication.

Cold Shot
: Heroin dissolved in water without boiling it.

Common Knowledge
: Knowledge that everyone has and never questions, but which is usually wrong. Example: "It is *common knowledge* that heroin is the most dangerous drug."

Connection
: dealer.

Cooker
: Spoon or other device used to cook heroin for injection.

Cop
: To acquire drugs.

Cut
: The act of diluting a drug. Also the substance with which a drug is diluted.

Cyclazocine
: A narcotic antagonist.

Darvon®
: An analgesic soup containing propoxyphene.

Demerol®
: Brand name for Meperidine, a synthetic opiate similar to morphine but only about as potent as codeine.

Dextromoramide
: A very potent synthetic opiate.

Dihydrocodeine
: A semi-synthetic opiate similar to codeine.

Dihydromorphinone
: Dilaudid®.

Dilaudid®
: A semi-synthetic opiate, about three times as potent as heroin.

Dime
: $10.

Diphenoxylate
: A mild semi-synthetic opiate used as a anti-diarrhetic.

Dolene®
: An analgesic soup containing propoxyphene. Dolophine Hydrochloride®

Done
: Slang for Methadone, as in "meth-a-*done*."

Duragesic$reg
: Fentanyl transdermal system.

Dysphoria
: A withdrawal symptom that distinguished by feelings of uneasiness and malaise.

Endocarditis
: A bacterial infection of the inner lining of the heart.

Endorphins
: Compounds produced by the body which are used to regulate pain and create a sense of well-being. They are very similar and act in the same ways are opioids.

Enkephalins
: Short chain amino acids that act as opioids. They are a form of endorphins.

EMIT
: An acronym for "enzyme multiplied immunoassay technique." It is common system used for detecting drug use from urine samples.

Fentanyl
: An extremely potent opioid, roughly 100 times as powerful as morphine.

Fit
: Syringe.

Front
: a loan of drugs.

GC/MS
: Gas chromatography/mass spectrometry. This is a device that is used for many valid application that can also be used to to do drug screening tests. These tests are expensive, so employers and bureaucracies don't like to use them but they are the only tests that are reasonably accurate (99.98%). They are also the only tests that can distinguish between morphine and a poppy-seed bagel.

Gimmick
: syringe.

Golden Crescent
: An important area in the production of opium. It encompasses Pakistan, Iran, and Afghanistan.

Golden Triangle
: An important area in the production of opium. It encompasses Thailand, northern Laos, and eastern Burma.

Halflife
: The amount of time it takes for half of the amount of a drug in the body to be removed.

Hardness
: A mostly meaningless measure of a drug's dangerousness. Drugs like caffeine are considered "soft" while drugs like heroin and cocaine are considered "hard."

Hepatitis
: Inflammation of the liver.

Heroin Slag
: First, I'll give you the ones I've actually heard. Brown, black tar, China White, chiva, dope, H, horse, junk, Mexican, rock, scag, scar, shit, smack, tar, white. I've collected a number of slang terms from books. Some of these are so silly that I sometimes wonder if a playful junkie wasn't just pulling some clueless sociologist's leg: big H, blanco, blanks, boy, brother, brown sugar, caballo, ca-ca (counterfeit), cat, chick, Chinese red, cobics, crap, cura, dogie, doojee (duji), flea powder, goods, hard stuff, Harry (hairy), Henry, joy powder, ka-ka, Mexican mud, poison, red chicken, schmeck, snow, stuff, sugar, tecata, thing, white stuff. You can find localized references to heroin in just about any word starting with an "H"

Hit
: To inject.

Hycodan®
: An antitussive containing hydrocodone mixed with homatropine methylbromide.

Hycomine®
: An antitussive containing hydrocodone mixed with Phenylpropanolamine.

Hydrocodone
: A codeine derivative which is roughly six times as potent. It has the same chemical formula as codeine but a different geometrical structure.

Hydromorphone
: Dilaudid®.

Hypnotic
: A drug that induces sleep.

Hypodermic
: Syringe.

Imodium®
: The antidiarrhetic medication Loperamide.

IM
: Intramuscular.

IV
: Intravenous.

Jones
: To desire heroin.

Joypopper
: Chipper.

Kick
: to stop using or withdraw from a drug.

Kicking Down
: using less than your normal dose of heroin to reduce your tolerance; a limited form of withdrawal.

Kit
: works.

LAAM
: Levo-alpha-acetylmethadol. It is a synthetic opiate with a three day halflife which has been used instead of methadone in maintenance programs.

Laudanum
: A tincture of opium.

LD50
: Lethal dose in 50% of the sample.

Levallorphan
: A narcotic antagonist.

Levo-Dromoran®
: This is basically pure levorphanol in pill or injectable form.

Levorphanol
: A long acting synthetic opiate with fewer side effects than morphine.

Lomotil®
: An antidiarrhetic containing the synthetic opiate diphenoxylate.

Loperamide
: An non-euphoric opioid that can be used in detox.

Lorfan®
: Levallorphan.

Mainline
: Intravenous injection.

Mark
: a person who is easily tricked or cheated.

Meperidine
: A synthetic opiate commonly known as Demerol®.

Methadone
: A synthetic opiate with a long halflife.

Mixed Agonist-Antagonist
: an agonist-antagonist.

MPTP
: A "designer drug" with effects similar to morphine which can produce permanent systems resembling those of Parkinson's disease.

Nalbuphine
: A narcotic agonist/antagonist.

Nalorphine
: A narcotic antagonist derived from morphine.

Naloxone
: A narcotic antagonist.

Naltrexone
: A narcotic antagonist.

Narcan®
: Naloxone.

Numorphan®
: Oxymorphone.

Noscapine
: An opium alkaloid used as an antitussive.

OD
: Overdose.

One and One
: Heroin and cocaine sold together in a single bag.

Opiates
: Technically, morphine and codeine and any drugs derived from them. It is often used to refer to any substance with opium-like effects.

Opioids
: Synthetic opium-like drugs.

Opium
: The dried juice from an unripe seed pod of the flower *Papaver somniferum*. The word "opium" is thrown around very loosely but the definition is very specific.

Oxycodone
: A semi-synthetic morphine derivative, about half as potent.

Oxymorphone
: A semi-synthetic morphine derivative, about ten times as potent.

Outfit
: syringe.

Pantopon®
: Quite literally, opium in a syringe. This contains all of the alkaloids of opium in a purified form. It is no longer produced.

Papaverine
: A non-euphoric alkaloid of opium which is widely used in the creation of semi-synthetic opiates.

Paraphernalia
: Works.

Paregoric
: An opium tincture with a high alcohol content.

Parenteral
: Injection in any of its many forms.

Patch
: Transdermal System

Pentazocine
: A mild narcotic antagonist which is also an analgesic.

Percocet®
: Oxycodone mixed with Acetaminophen.

Percodan®
: Oxycodone mixed with Aspirin.

Phenergan
: An injectable drug for the treatment of many things, including nausea and vomiting.

Propoxyphene
: A weak synthetic opiate (~1/10 as strong as morphine) which is the primary ingredient of Darvon®.

Pull-Back
: Pulling the syringe plunger back so that the syringe will fill with blood if the needle is inside of a vein.

Pusher
: a drug dealer. This is a misnomer based on the idea that dealers get users started.

Quinine
: A bitter tasting alkaloid commonly used to cut heroin.

Reinforcing
: A measure of how driven one is to use a drug after using it the first time.

Relapse
: An NA word meaning to become unaddict to abstinence.

RIA
: Radioimmunoassay. It is common system used for detecting drug use from urine samples.

Ritalin
: A form of amphetamine used paradoxically to help hyperactive children.

Roll
: When a vein moves to the side as it is being injected into so that the needle does not enter the vein.

Roxicodone™
: Unadulterated oxycodone.

Rig
: Syringe.

Run
: A period of constant use. With heroin this is generally a period of time addicted.

SC
: Subcutaneous

Score
: to acquire drugs.

Script
: A prescription.

Sedative
: A drug that depresses the central nervous system and causes drowsiness.

Shoot Up
: Inject.

Skin Pop
: Subcutaneous (under skin) injection.

Slam
: To inject, especially intravenously.

Sniff
: To inhale a liquid or solid through the nose.

Snort
: To inhale a liquid or solid through the nose.

Speedball
: This is heroin and cocaine mixed.

Stadol®
: A narcotic agonist/antagonist used as an analgesic.

Step On
: The act of mixing a drug with an inert substance to make it seem to be a larger amount — the same as cut.

Straight
: A non-drug using person.

Strung Out
: Addicted to heroin.

Subcutaneous
: The layer of blood vessels just under the skin.

Sublimaze®
: Fentanyl.

Syringe Slang
: Fit, gimmick, hypodermic, outfit, rig, works.

Talwin®
: Pentazocine.

Taste
: An archaic method of determining the purity of white powder heroin. With it, the user literally tastes a small amount of the drug; if it is bitter, the sample is assumed to be fairly pure. It fell out of use when the bitter tasting alkaloid quinine became a widely used adulterant. A "taste" can also be a small amount.

Thebaine
: An alkaloid of opium used to make several narcotic antagonists as well as codeine.

Tie
: Tourniquet.

Tolerance
: The capacity of the body to become less responsive to a substance with repeated use; the necessity to ingest more of a drug on subsequent episodes to achieve the same effect.

Transdermal System

A patch places on the skin that administers a drug at a constant rant.

Tracks
: Repeated needle entry scars along a vein.

Tussionex®
: An antitussive that contains hydrocodone.

Vicodin
: A medication widely used for moderate pain which contains hydrocodone and acetaminophen.

Works
: A syringe or other device for administering heroin into a vein.

*[**Editorial Note:** The basis for this glossary is the book Heroin User's Handbook. Additions and corrections have been made to it since its publication — one of the many advantages to online publishing.]*

History

This section of the site deals with the history of heroin, dating to well before the its invention. As a result, this area of *Heroin Helper* contains a lot of information about opium and its other derivatives as well. Some historical material will also be found in our angry section, which is where we keep political information. Articles in that section are more focused on opinion than the story-orientation of articles found here.

Opium History
: This is a brief history of opium, taken from my book *Little Book of Opium*.

French Connection
: By destroying the "French Connection," government forces allowed the heroin market in the United States to become open to competition. The results were good for heroin users, but exactly the opposite of the government's stated intention.

Opium/Heroin Timeline
: 6000 of events in the history of opium and heroin.

Frontline Letter
: Frontline is a PBS news program that does investigative reporting. They did a highly biased story called Opium Throughout History. In support of this, they posted an opium timeline which is equally biased. This is a letter to the producers of the program, which corrects a number of problems with this timeline.

Opium History

Use of opium dates back further than there is history. Archeological digs in Switzerland have found Opium Poppy seeds and pods, dating from the Neolithic age — the "New Stone Age," a period running from 5500 B.C. to 8000 B.C. This makes opium the oldest known drug.

The Sumarians

The first people known to have used opium are the Sumarians who lived in lower Mesopotamia (now western Iraq). The Sumarians are best remembered as the culture that invented writing. But in most ways, they were far ahead of their time. They produced ten times as much food as other farmers in the region — largely due to their use of irrigation. They traded extensively with their neighbors, especially food and the drugs opium and beer — it is estimated that as much as half of the Sumarian barley crop went to beer production.

The use of opium by the Sumarians dates back as far as 3500 BC (5500 years). It is known that they used opium medicinally. Some contend that it was not used recreationally. This is highly unlikely, however; the Sumarian name for the opium poppy is *hul gil*, which means "joy plant". Plus their use and export of alcohol indicates that recreational use of drugs was as important to the people of that time as it is today.

Opium Moves West

Thanks to the trading ties of the Sumarians with their neighbors, the secret of opium — how to produce it — eventually traveled westward. By 1300 BC, the Egyptians were cultivating poppies for the production of opium. The opium they produced was an extremely popular commodity; they traded it as far away as Greece and even central Europe.

The Greeks

The first mention of opium by the Greeks was made around 330 BC by Hippocrates — the father of medicine. He wrote about opium's usefulness in curing a number of diseases, especially diarrhea.

Later, around 150 BC, another Greek physician — Galen — took up opium as a kind of cause. Even though he is credited with writing the first description of an opium overdose, he still advocated its use for a number of medical purposes.

Dioscorides made the last real Greek investigation of opium in the first century AD. His analysis is as valid today as it was then. He noted that it was highly effective at relieving nausea, diarrhea, and insomnia. He even noted its use as an aphrodisiac.

Opium Moves East

Opium has a much greater association with the Far East than it does with the West. People often assume that opium originated in the East and was exported to the West — part of the "yellow menace." Even though opium was first produced in the Middle East, the introduction of opium to the Far East took a circuitous route. It was only after opium was being produced in the west — Egypt and Europe — that it was exported to the Far East.

Persia

At around 330 BC, Alexander the Great introduced opium to Persia. This was not the first time that opium had been sent to Persia, however. Some 3000 years earlier, the Sumarians were trading opium with them. With the decline the Sumarians, however, opium stopped being imported. As a result, opium vanished from Persian culture. So when Alexander brought it there, it was a new commodity.

China

It was much later that opium finally arrived in China — 700 years later. It came by way of Arab traders, but the opium itself came from Egypt.

Smoking Opium

Although the Chinese are usually imagined to ingest opium by smoking, it was primarily drank (just as it was elsewhere) for the first 1000 years it was used there. It was the Dutch who began the practice of combining opium with tobacco and smoking it in a pipe around 1500. This practice was introduced to the Chinese about 200 years later by the Portuguese. Smoking opium quickly caught on in China.

The practice did not stay in use for long, however. The Chinese gave it up in favor of the direct vaporization technique, which is still the most widely used by smokers today.

Laudanum

Around the same time as the Dutch began smoking opium, Laudanum was invented. This was in 1527. Although laudanum can contain many different ingredients, it is — in its most basic form — opium dissolved in alcohol. The most famous of these was Sydenham's Laudanum, which was a combination of sherry and opium; the sweetness of the sherry made the bitter taste of the opium more palatable. Sydenham's Laudanum is also distinguished as being one of the first "patent medicines." Laudanum is important in the history of opium because users in the West most often used opium in that form for the next 400 years.

China Opium Import

Over the next few centuries we see an increase in the export of opium from Europe into China. This was due largely because Asia had many commodities that Europeans wanted but the Europeans had little the Asians wanted. The thing the British most wanted from China was tea. About the only thing the Chinese did want from the Europeans was opium. The Chinese grew their own opium poppies, of course. But they were not very successful at it. As a result, they did not produce nearly enough opium to satisfy their own market. In addition, the opium they did produce was of a low quality that was little coveted.

England Takes Over

Even though the Portuguese and Dutch had been big exporters of opium to China, by 1800 England had a near monopoly on opium exported to the region. The East India Company was responsible for this export, but they were so involved with the British government by the time of the Opium Wars, that it doesn't make sense to talk about the opium traders as anything but "England."

Business was booming. The market was growing almost every year due to a number of causes. First, the population of China was increasing rapidly at this time — roughly doubling from 1750 to 1850. Second, the number of per capita users was increasing. Third, per user consumption was increasing.

Opium Wars

The Chinese government had made opium illegal in 1796. For the 40 years following the enactment of the law, the government did nothing much to enforce it. When the government did finally try to enforce the opium ban, it led to the two Opium Wars, although in fact they are pretty much just one war with a long cease-fire in the middle.

Modern Interpretation

The Chinese government was concerned about its large trade deficit with England. No country likes to have large trade deficits, because it means that the wealth of the country is being moved to another country — especially when exchanged for an ephemeral product like food or drugs. It is true that the Chinese government made opium smoking illegal much earlier than the 1796 law. This was based mostly on hysteria — "Opium smoking makes the face shrivel up" — and the government did nothing to actually stop opium from coming into the country, until it became economically unpleasant to lose so much of the country's wealth. During all this time, the Chinese government had no problem with the use of the poor quality opium that China was producing.

The first Opium War started due to the seizure of 95 tons of opium from British merchant ships. In effect, China was simply enforcing a law that it had created but not enforced for almost 50 years. Just the same, it looked very much like simple theft given the English had

been doing this business for the previous 50 years.

England Wins Opium Wars

Britain won the war in 1842. But the Chinese government never really complied with the ambiguous terms of the surrender treaty. As a result, hostilities resumed in 1856 over an incident very much like the one that started the first Opium War (seizing a ship's cargo and charging its crew with drug smuggling). The Chinese government finally admitted defeat in 1860.

Opium Use In China

The end result of the two Opium Wars was that the Chinese people were allowed to buy good quality, opium, imported from India. Due to this, opium use and addiction continued to increase for the rest of the 19th century. But these rates where only comparable to the rates that existed after opium importation by the English was stopped in the early 20th century. In addiction, they were nothing compared to the rates for other drugs such as alcohol, nicotine, and caffeine — then or now.

At the end of the first Opium War — the opium addiction rate was extremely low: less than 1%. Even at the turn of the 20th century when opium imports were stopping, the addiction rate was 3.4%. It is hard to compare this number to modern China, because for years the communist government made China isolated from most other countries. Food as well as opium did not get imported very much. As a result, opium addition stayed very low, just as hunger stayed high. As soon as China became involved in global legal commerce, the opium started flowing in and the addicts started piling up.

The opium addiction rates for modern Iran — the highest per capita opium users in the world — at the time they were deciding to dismantle their "opium dealers get death" program because it didn't work, was right at 2.8% — very close to the Chinese peak, when opium was freely available. If opium use as medicine is included, this number is certainly higher than 3.4%.

An interesting aspect of opium use in China during this time was that users still made rational economic decisions about their use. While England kept opium imports to China low in order to increase the market price, the number of opium users stabilized — even though plenty of high-priced opium was coming in from other sources. When England increased imports and decreased prices to stop other countries from selling to China, use went up. In other words, opium users decided how much they would spend on opium, based on price, just like they would with any other commodity.

Addiction

Especially when talking about opium and its related drugs, there is a strong tendency to make the unstated assumption that addiction — in and of itself — is harmful. This assumption is simply untrue. Addiction is not necessarily harmful. This is especially true when the drug in question is legal, readily available, and cheap. Under such circumstances, addicts are usually able to lead normal and productive lives. For example, caffeine causes little harm to the hundreds of millions of people throughout the world who are addicted to it.

Productivity

In some cases, addiction can even be helpful. Again using the caffeine analogy, coffee drinking is normally associated with higher employee productivity in corporate environments. In fact, there is much evidence that indicates that the increase in stimulant and depressant use during the 19th century was caused by changes in the work environment. Before the industrial revolution, people were allowed to work as their body's dictated. With industrialisation, people were expected to work specific times. Thus, they needed stimulants to get them going in the morning and depressants to make them relax at night.

As discussed before, the Chinese immigrants who helped build the intercontinental railroad where known for their high level of productivity and their high level of opium use. Their opium use allowed them to bear the physical pain and mental boredom of the job. But it is likely that the high level of opium consumption was a result of these difficult aspects of the job.

Meanwhile, Back in the Laboratory

While all of the political machinations were ensuing in Asia, Friedrich Setuerner was doing work in his laboratory that would change the world forever. He isolated the drug found in highest abundance in opium: morphine — named after Morpheus, the Greek god of sleep. It turns out that morphine is also responsible for the majority of the opium effect — especially for the euphoria and the "dream like" state it creates in the user.

The Beginning of Modern Medicine

This marked the beginning of modern pharmacology. Science began investigating all of the natural drugs to see what was inside them. This has been done more to opium than to any other drug. Since Seturner's work, scientists have isolated over fifty distinct alkaloids in opium. And the search continues with no end in site.

The isolation of morphine also brought about a change in the way medicine was used. Doctors and patients alike expected drugs to be very specific in their actions. In western countries, drugs like opium are simply not prescribed. Instead, one particular compound from opium is given to a patient — usually in pill form.

The Death of Opium

The beginning of the 20th century saw most countries creating laws that banned the use of opium. The United States banned opium for a number of reasons. Probably the most important, at the federal level, was that the government wanted to cozy up to China in order to gain access to its lucrative markets.

The Science of Racism: Eugenics

At the local level, opium was banned because of its association with the Chinese. In fact, many of the early laws banned opium use by the Chinese; whites were exempt. This kind of racism was also responsible for much of the global pressure to make drugs illegal: the Eugenics movement.

The idea behind this movement was to make human bloodlines stronger by, among other measures, keeping them free of impurities. The banning of drugs was supposed to create better humans because drugs "dirtied" the body and the soul. Eugenicists thus saw the phrase "cleanliness is next to Godliness" as discouraging the listener from soiling his body with alcohol and other "polutants" — *not* as encouraging regular bathing.

A big part of this "pollution" existed because different races inter-bred. The global Eugenics movement gave us the Nazis, the Drug War, and Narcotics Anonymous where people proudly announce how long their bodies have been "clean." Very few NA members know with what they are allied. But the Nazis knew very well; Hitler was favorably inclined towards the United States largely because of the history of the Eugenics movement there.

A common message found in Nazi concentration camps at the beginning of World War II proclaimed, "There is a road to freedom. Its milestones are Obedience, Endeavor, Honesty, Order, Cleanliness, Sobriety, Truthfulness, Sacrifice, and love of the Fatherland." It was signed "Adolf Hitler," but it could just as easily have come from many modern day politicians. George Orwell put it most bluntly: "Freedom is slavery."

The Eugenics Movement saw its greatest triumph in the creation of drug laws that had not existed outside of religious rule. It basically stopped the use of opium anywhere except right near the source. But the ban did not work in the way the idealists had wanted. Since opium was now illegal, it became important for distributors to increase the potency of what they were distributing — out went opium and in came heroin.

Black Market Distribution

This is always the case: illegal commodities are sold in their most concentrated forms. Today, most alcohol is distributed as beer and wine. During prohibition — when it was illegal — alcohol was mainly distributed as whisky. So today, most illegal inter-country distribution of opium is done with heroin. Heroin is a slight chemical alteration of morphine — the most active of opium's many active ingredients. But heroin is much more potent than opium. And since heroin is very expensive, users commonly inject the drug right into a vein rather than simply drinking or smoking it.

Misguided Government Regulation

So the governments of the world, in trying to solve one problem, created a much bigger problem. Today, there are more addicts as a percent. Since they inject their drugs, there are more sudden deaths. In addition, there are more diseases spread and more deaths associated with them. Finally, since the cost is high, many addicts resort to crime to acquire the money they need to buy their drugs. The laws the governments make continue to be more of the same — making bad problems worse. And there is no public acknowledgement of this. In fact, it is worse than that.

Inverted Catch-22

Government agencies are in a position to grow regardless of their success or failure. If drug use goes up, they make the argument that they need more resources to fight the drug problem because it is getting worse. If drug use goes down, they make the argument that they are doing a great job and would do even better if they were given more resources. "Paid if they do, paid if they don't."

Profoundly Invisible

Today, opium is appreciated by drug users, as much in a sense of nostalgia as anything during those rare instances when they can get it. Opium use is still quite common, however, in areas that are close to the opium poppy growing regions. But even if opium is not used very much directly — either for medicine or recreation, it is still profoundly important to the modern world.

Opium and all the drugs that have been derived from it are the most important pain relievers in existence. Similarly, recreational drug users still use vast numbers of drugs derived from opium. Such users run the gamut from the guy who takes the occasional teaspoon of codeine cough syrup to get high, all the way to the prostitute heroin addict who sells his body to get his daily supply of drugs. For good and for bad, opium continues to have a profound effect on the cultures of the world.

French Connection: Why Purity Has Increased

You may remember the movie *The French Connection*. It is based on actual events. In the early 1970s, pretty much all of the heroin that was coming into the United States originated in France. Opium, cultivated in Asia, was imported to France (primarily Marseilles), where it was chemically purified and converted into heroin for the world market. This was well know, even by law enforcement who must have

taken some offense at this flaunting of international drug law.

The fact that the "heroin trade" was so centralized allowed law enforcement efforts to focus on Marseilles. Most of the time, such law enforcement efforts are useless. But the centralization of the enterprise and probably also a certain cockiness on the part of those involved in the illegal trade, allowed for a rare Drug War victory. The Marseilles operation was pretty thoroughly demolished.

The effect of this "victory" was not what the drug warriors had hoped, but it was exactly what economists would have predicted. It is simple to understand. Black markets are not free markets, and it is possible (especially through the use of force) to acquire a monopoly. And this is exactly what American heroin users were burdened with in the 1960s and early 1970s: a monopoly in the form of the French connection.

The destruction of the French connection allowed competition to enter the market. The French connection didn't stay dead, of course, but there was enough disruption in the market to allow others to enter the market and for alternate distribution channels to emerge. Today, there are three major players in the American heroin trade: France, Mexico, and Colombia.

Heroin users now have a choice and the heroin distributors are acting more like legal businesses. For example, the heroin coming out of Mexico was relatively poor in the late 1980s and early 1990s; it had purity levels in the 20% to 30% range. At the same time, Colombian heroin was coming into America with purity levels averaging above 60%. The Mexicans were losing market share and so they started to increase their purity levels. Today, Mexican heroin has an average purity level above 40%.

In addition to increased purity levels, the heroin being sold throughout the world has come down in price. From 1984 to 1994, the price of a gram of heroin was cut in half (in real dollars).

Many people think that the primary purpose of governments is to provide free and competitive markets (*HEROIN helper* does not agree; we think markets work best when governments leave them alone). Although this was not the purpose of the attack on the French connection, it was the result.

Governments often attempt to change the laws of nature — as if an act of congress can make the rain fall or the temperature rise. The laws of economics are no less fundamental and immutable than the laws of physics. Governments are bound to fail when they try to stop people from getting the recreational substances they want. But sometimes, in failing, they do some good.

Opium/Heroin Timeline

3500 BC The Sumerians, of lower Mesopotamia, are the first culture known to have used opium. Their name for "poppy" translates to "flower of joy" — a name that almost certainly indicates that opium was used recreationally.

1300 BC Egyptians cultivate poppies for the production of opium. The opium produced is much desired, and is distributed throughout the region — it is transported as far away as Greece and even into central Europe.

460 BC The great Greek physician, Hippocrates ("the father of medicine"), writes about the usefulness of opium in curing a number of diseases, especially diarrhea.

330 BC Opium is introduced to Persia and India by Alexander the Great.

400 Egyptian opium is introduced to China by Arab traders.

1300 Around this time, opium becomes a taboo in the European Christian churches because of its link to the east. It remains more or less an unmentionable subject for 200 years. But in truth, our present day laws against opium date back to this period.

1500 The Portuguese begin the practice of smoking opium.

1527 Laudanum is introduced as a medicinal drug by Paracelsus.

1606 Indian opium is imported into England.

1680 Sydenham's Laudanum (mostly a combination of sherry and opium) is introduced onto the market. It is one of the first patent medicines.

1700 Opium smoking is introduced to the Chinese by Dutch traders.

1729 The emperor of China, Yung Cheng, prohibits opium smoking and the sale of opium except by those licensed to do so for the use of medicine.

1753 Linnaeus first classifies and names *Papaver somniferum*.

1780-1800 The British East India Company has a near monopoly on the opium trade in India and China due to its political influence.

1729 The emperor of China, Kia King, bans opium.

1803 Friedrich Sertuerner isolates morphine from opium — this is the first alkaloid to be isolated from a medicinal plant. It was named after Morpheus, the Greek god of sleep.

1821 Thomas DeQuincey publishes *Confessions of an English Opium Eater*.

1827 Commercial manufacture of morphine is begun by the German chemical company E. Merck & Company.

1839 The Imperial Commissioner of China orders all foreign traders to give up their opium. In response, the British send warships. This marked the beginning of the First Opium War.

1841 The Chinese lose the First Opium War; the British gain, in addition to other things, Hong Kong.

1843 The hypodermic syringe is invented by Dr. Alexander Wood.

1852 Britain begins importing opium into Burma.

1856 The Second Opium War is started and ended. As a result, opium is legalized in China.

1874 *Diacetylmorphine HCl* (better known by its brand name "heroin") is invented in England by C.R.A. Wright. This is done by combining morphine and acetic anhydride, a weak acid chemically similar to vinegar. His results are published in the *Journal of the Chemical Society*, though his theoretical understanding of the new molecule was incomplete and incorrect.

1874 Opium smoking is banned in San Francisco. This was one of the first anti-opium laws aimed primarily at marginalizing the Chinese population of California.

1874 The Society for the Suppression of the Opium Trade was founded in England.

1878 Britain passes the Opium Act — a largely racist act that determined how (and if) one might use opium depending upon one's ethnic background.

1881 Codeine is isolated from opium.

1886 The British acquire the Shan State of Burma in their attempt to enforce an opium monopoly there. Despite this, the black market in opium thrives, as it does today.

1886 The United States outlaws the importation of opium by any subject of China.

1890 The United States begins taxing opium and morphine.

1890 Hearst newspapers begin publishing the fiction of white women being seduced by Chinese men in opium dens. Although we laugh at such obvious lies today, the newspaper coverage of drugs is really no better today. Take, for example, recent mainstream media statements that Kurt Cobain died of a "heroin-related suicide" or that River Phoenix is another of "heroin's well-known victims." Such statements, which are false, are simply accepted because "everyone knows" that heroin kills people, just as everyone knew, in 1890, that Chinese men were trapping white women with opium so that they could take sexual advantage of them.

1890 The German chemist W. Dankwortt re-synthesized *Diacetylmorphine HCl* and performs experiments that provide much great understanding of its chemistry than was provided by the Wright work.

1898 Heinrich Dreser of the German chemical company Bayer publishes the results of his experiments on the use of *Diacetylmorphine HCl* as a cough suppressant. Bayer names the drug "heroin" and begins commercial production.

1898 Bayer begins sale of *Diacetylmorphine HCl* under the brand name "Heroin"

1905 Congress passes the Pure Food and Drug Act which requires patent medicines to label their contents.

1909 The importation of opium into the United States is made illegal. This led directly to the opium smokers turning to heroin "snorters."

1909 The International Opium Commission meets in Shanghai to discuss the evils of opium.

1910 The English agree to stop the importing opium into China.

1912 Maintenance clinics that provided drugs to addicts began to open in the United States.

1914 The Harrison Narcotics Act is passed by Congress. Nominally a tax act, it effectively makes opium and cocaine illegal and stands as the principal drug law of the United States for 55 years.

1914 As a result of the passage of the Harrison Narcotics Act, the street price of an ounce of heroin increases from $6.50 to $100.00 (1500%) while the purity falls leading addicts to switch from "snorting" to injecting.

1921 Maintenance clinics are closed because of rising drug hysteria.

1924 United States Congress passes a bill by Stephen G. Porter that banned the production of heroin. The hearings for the bill contained the usual hysteria disguised as science. A particularly egregious example was entered into the public record without question, "Heroin contains, physiologically, the double action of cocaine and morphine."

1925 The structure of morphine is determined by Gulland and Robinson.

1930s The majority of heroin imported to the United States comes from China — refined in Shanghai and Tietsin.

1940s Heroin importation is greatly limited due to the war. 1950 United States heroin distribution changes. Turkish opium is converted to heroin in Marseille. This distribution channel remains dominant until the mid-1970s.

1956 The United States Federal Government outlaws the use of heroin for all purpose. It could no longer be prescribed.

1970 The "Controlled Substances Act" is passed. It replaces the Harrison Narcotics Act as the primary drug law in the United States. This also marks the beginning of "no-knock entry" — the use of military style attacks on the homes of suspected draw law violators

1972 The Golden Triangle becomes an important source of heroin.

1973 (July 1) The United States creates the Drug Enforcement Administration (DEA).

1975 Mexico enters the heroin market.

1978 Golden Crescent becomes an important heroin source.

1990 Columbia becomes the most important heroin exporter to the United States — almost over night.

Frontline Letter

Dear Sir/Madam:

There is a lot of useful information in your webpage FrontLine: Opium Throughout History, and it is devoid of glaring factual errors. Its main problem is that it lacks impartiality.

Nowhere in this piece is there any mention of the pain and suffering that opium use relieves or its enormous importance in medicine. Instead, we are given highly emotional, and often misleading statements about the harm that supposedly has been caused by opium. Image a chronology, "Cars Throughout History" which listed only fatalities and pollution associated with cars — this is what you have created for opium.

Below is a list of the most disturbing statements made on your webpage.

- The webpage states that the 2000 chests of opium imported into China in 1767 is "staggering." A subjective and emotional word such as "staggering" does not belong in a piece of journalism. Even worse than the use of such a manipulative word, no reason is given as to why this amount is large. In fact, it is not a large quantity given the number of people living in China at that time: it represents under half a gram of opium per person per year — less than half the amount used today, worldwide.
- It is stated that Elizabeth Barrett Browning "falls under the spell" of morphine, but that it does not impede her writing ability. Browning suffered from anxiety; today, she would be given Valium — a drug at least as dangerous as morphine. In addition, Browning loved morphine and did not think of it as a vice that she had to work around. Instead, it made life and art possible.
- Dreser at Bayer did not find that heroin lacked morphine side effects, he found that it was a more effective cough suppressant than morphine. The article also implies that Bayer was somewhat responsible for the development of heroin chemically, which is not true.
- The article also perpetuates the myth that it was widely believed that heroin was non-addictive and that it was advertised as a cure for morphine addiction. It is unclear why this myth is so popular. It probably has something to do with the wish to make heroin the output of a science that is unreliable. Only an unreliable science could unleash such an evil substance as heroin upon the world.
- The article states the heroin addiction reaches alarming rates in 1903. Again, the article uses a word that is highly emotional. But regardless of the level of addiction, the heroin addiction itself caused almost no negative effects on the lives of the addicts. Would anyone say that "coffee addiction has reached alarming rates"? The reason it seems acceptable to say such a thing about heroin, is that heroin addiction is assumed to be bad *by definition*. This is a most questionable assumption.
- The article mentions that the availability of opium to users declines significantly, at this time. It does not point out, however, that users switch to other opiates — most significantly, the far more potent semi-synthetic heroin which was still legal.
- The article states that in 1910, "After 150 years of failed attempts to rid the country of opium, the Chinese are finally successful in convincing the British to dismantle the India-China opium trade." The implication of this statement is that opium was (at least in practical terms) eliminated from China. This is not true, of course. Opiate addiction in China is still far greater than it is in the United States, despite the fact that the Chinese punish continued opiate use with death.
- Exactly what the purpose of the Harrison Narcotics Act was, is unclear. For many years, however, it was used to control public access to drugs.
- Heroin was not banned in 1923. Its *production* was banned in 1924. It was not until 1956 that heroin was officially banned from the United States.
- To say that River Phoenix died of a speedball overdose is typical of the belief that these drugs (heroin and cocaine) are so harmful that if they are found inside a dead person, they must kill him. Phoenix had countless drugs in his body when he died — including large amounts of alcohol. The article also mentions John Belushi. It is not certain what killed Belushi, but it looks like he died of a heart attack brought on as much by his weight as the cocaine he was injecting. Regardless, it does not seem that heroin was responsible for his death at all.

If you care about reporting the truth in as objective a manner as possible, please consider the comments in this letter and make the appropriate changes to your website. Thank you very much for considering these important matters.

Sincerely,
Dr. H
Heroin Helper, Managing Editor

Law

This section of the site deals with some legal aspects of heroin and the other opioids.

Syringe Law
A loophole in the California syringe law makes it possible for users to acquire syringes by claiming to be diabetics.

Syringe Law

Editor's Note: *This article explains how to do something that is illegal. It is placed here for informational purposes only. Do not use this information to break the law. From a practical stand-point alone, this article may be out of date and the information no longer valid. Or it may never have been valid. Regardless, we don't recommend breaking the law, even if you are likely to get away with it.*

Using "Right to Life" to Acquire Syringes

As I write this, I am serving six months in a California jail for a misdemeanor: violation of section 4140 of the Business and Professions Code. This code states that it is against the law to possess a hypodermic syringe, although the actual language of this code makes it sound like I was involved in unfair business practices. Six months is the maximum sentence for this "crime" so I received the maximum sentence.

How Does A Guy Get Six Months for a Syringe?

You may wonder why I am serving six months for this "crime." There are three primary reasons.

1. I was not in possession of *a* hypodermic syringe; I was in possession of 93 hypodermic syringes. In court the DA and the judge made a big deal out of this; they both thought this was a lot of syringes. I wanted to tell them that I could go through thirty in a good night but my attorney suggested that this would not help my case.
2. They did not like me. The DA said, "Mr. Sodenberg *loves* the junkie lifestyle." I don't actually know what the "junkie lifestyle" is; it sounds to me like the "gay lifestyle" — a phrase that is literally meaningless but is used to vilify a diverse minority. But I *was* unrepentant. I had just chosen to leave a drug treatment program for jail. So in a sense, he was right.
3. They were going to add a "public intoxication" charge. This stems from my showing up in another court high. *[Editorial Note: this kind of behavior is a very bad idea. Proper court etiquette is discussed in Heroin User's Handbook.]*

Jail Is a Learning Experience

I met a guy in jail who had diabetes. He was also a speed freak and so we naturally worked our conversation toward the subject of syringes. I told him about my syringe woes. I was tearing up my veins because I was reusing syringes so much.

He looked down and said under his breath, "You can buy syringes in California." He explained to me that insulin is a "right to life" drug and that those who need it will die without it. Therefore, you do not need a prescription for insulin or syringes. I checked this out and sure enough, he was right.

Syringe Law Loop-Hole

Section 4145 of the Business and Professions Code does provides a loop-hole. It states that pharmacists, physicians, and veterinarians may provide syringes without a prescription or a permit under certain circumstances. These circumstances are explained in the following quote from the code.

> [A] person may, without a prescription or license, obtain hypodermic needles and syringes from a pharmacist or physician for human use in the administration of insulin or adrenaline, or from a pharmacist, veterinarian, or licenseholder, for use on poultry or animals; if all of the following requirements are met:
>
> (a) No needle or syringe shall be furnished to a person who is unknown to the furnisher and unable to properly establish his or her identity.
>
> (b) The furnisher, at the time furnishing occurs, makes a record of the furnishing in the manner required by Section 4146.

Clearly, there are many ways that this law can be used to acquire syringes. Maybe you have a sick chicken. I will outline the procedure here for using insulin.

Using Insulin to Get Syringes

You need to get in touch with someone who is taking insulin so that you can get the top off of the box that the insulin ampule comes in. The box top will most likely have a large "N" or "R" written on it. "N" stands for NPH insulin and is a long-acting variety. "R" stands for regular insulin, the kind people inject a couple times a day. There are other kinds of insulin, however. If the box top has something else on it, make sure you find out what it means. Paste this box top to the back of your ID.

Go to a pharmacy and give them your ID, upside down — showing the box top. Tell them what you need. Say something like, "I need a bottle of insulin." And then add, as if you almost forgot, "Oh, and a box of syringes." Most likely they won't mess with you but they may ask any number of questions.

You may be asked how long you have been a diabetic. Diabetes can develop at any time in life, so any answer will do. The main thing is to not stumble on the question. Another important point is that you can't have just been diagnosed with it, because if you had, you would have a prescription — and you don't.

They may ask you how much you are using. Make sure it is more than 15 units because you don't want to get stuck with those half CC syringes. Say something along the lines of 35 units in the morning and 25 units at night.

What are your sugar levels? Normal sugar levels are between 80 and 100. Yours should be higher than this. Something between 140 and 150 will work nicely. Be exact if it is your nature. Normally, you test your sugar level with a "poke test."

What size syringes? My preference is for 27 gauge syringes but you can't ask for these because they are too associated with IV injection. Remember that you do not IV insulin. IM injections are usually done with larger syringes. You can be non-comital on this point or just ask for 28 gauge which is small but still quite common.

If the pharmacist asks you for a prescription, tell him that you don't have one. Have a story ready. A good one is that you are new in town and you don't have a doctor yet. You might also be too poor to pay a doctor to prescribe what you already know you need.

You will most likely be asked for a signature and an address. Make an illegible signature and put down a false address. They will most likely not check and if they do, just tell them that you moved. This might be part of your story anyway.

Conclusion

States that do not control hypodermic syringes have HIV infection rates among IV drug users that are two to three times lower than states that do. In addition, making syringes widely available has no effect on drug use itself. It is extremely short-sighted of policy makers to control these bits of plastic and metal. But until they wake up to this fact, IV drug users will be forced to circumvent the law. It *is* a matter of life and death.

Pharmacology

This section of the site deals with the effects of heroin and other opioids. Other aspects of pharmacology can be found in the chemistry section of *Heroin Helper*.

Why Users Inject Heroin
: Heroin is associated with injection more than any other street drug. Although it is rarely discussed, there *is* a reason for this. It makes more sense to inject heroin than it does most other drugs. This article explains the why.

Strength of Opioids
: The relative strength of the opioids — for those times when you need to know just how many milligrams of morphine equal a gram of methadone.

Lycaeum Opioid Strengths
: This is a compliment to our own table. It contains some opioids that ours does not, along with some information that we are missing (e.g. legal schedule). Eventually, we will integrate this information into ours, but for now, both tables are of value. Note, however, that this table does have some incorrect information (not much, however).

Why Users Inject Heroin: Is It Greed, Gluttony, or What?

Only recently, with the high purity levels of street heroin, has it become well reported that heroin may be ingested in a manner other than injection. This has, in fact, caused those leading the Drug War no end of consternation. First, their vicious war seems to have made matters worse (from their perspective): heroin is cheaper and more available than when they started. Second, they have to fight the propaganda portion of their war on a whole new level. This brings us the current wave of Partnership for a Drug Free America anti-snorting heroin ads: "This is your brain. This is what happens to your brain when you snort heroin." (Check out "Why Purity Has Increased" for a history lesson on the unexpected results of the Drug War.)

It is true that one reason that heroin has traditionally been injected is that the street heroin purity levels have been so low. It reached its nadir in 1970 at about 3%. But even at this low level of purity, a novice could certainly have gotten high smoking without mortgaging the house. This is not to say that price and quality do not have an effect on the administration route; they do; but they are not the only factors.

As an example, let's look at the situation during the first few years of this century, when heroin could be bought over the counter — just like aspirin. At that time, it was mostly administered orally. This usually took the form of heroin cough drops. (Imagine that: cough drops that actually work!) The point is that people weren't dissolving these things and injecting them — just like people don't inject alcohol or nicotine today.

But there *is* a reason that heroin is naturally associated with intravenous injection. Heroin is the least stable of all the opioids. Whereas morphine and codeine have half-lifes in the human body of about three hours (and the synthetic opioids can have half-lifes measured in *days*), the half-life of heroin is about two *minutes*. When heroin breaks down, it becomes morphine, primarily.

Heroin is usually reported as being two to three times as potent as morphine (check out "Two to Three" for a discussion of what this really means). But this gives the wrong idea about heroin because it does not actually get the user high. Heroin acts as a transport chemical, delivering more morphine to the brain because it crosses the blood-brain barrier more quickly than morphine. Once in the brain, it is morphine that heroin breaks down into that gets the user high.

So if heroin breaks down into morphine before crossing the blood-brain barrier, it is much less efficient: about 1/3 as efficient. With a half-life of two minutes, most of the heroin ingested orally breaks down into morphine. More or less the same thing happens when inhaling. Inhalation is a very efficient means of ingesting drugs — there is very little drug loss. But it is slow and as a result, most of the heroin inhaled is converted to morphine before it reaches the blood-brain barrier.

Heroin is most effective when administered in a way that delivers it to the blood stream quickly: intravenous injection, subcutaneous injection, and smoking. This is why it does make more sense to inject heroin than other drugs — morphine, for example.

Relative Opioid Strengths

This page gives information on the generic and brand names of the major opioids along with the relative strengths of the drugs when administered intramuscularly and orally. Finally, the half-life of the drugs in the human body are given.

"Generic" is the generic name of the drug and "Brand" is the brand name of the drug. Often, a drug will be sold under more than one brand name; in this case, the most common brand name was selected. "IM" is the number of milligrams of the drug administered intramuscularly to be equivalent to 10 mg of morphine administered intramuscularly. "Oral" is the number of milligrams of the drug administered orally to be equivalent to 10 mg of morphine administered intramuscularly. "Half-life is the half-life of the drug, measured in hours. This information is taken from *The Little Book of Opium*.

Generic	Brand	IM	Oral	Half-life
Buprenorphine	Buprenex®	0.3	1.2	2.2
Codeine	Tylenol® III	130	200	3
Diacetylmorphine	Heroin	5	30/60	2
Dihydrocodeine	Synalgos®-DC	65	100	3
Fentanyl	Duragesic®	0.1	NA	2
Hydrocodone	Vidodin®	20	25-30	4
Hydromorphone	Dilaudid®	1.5	7.5	3
Levorphanol	Levo-Dromoran®	2	4	12
Meperidine	Demerol®	60-80	150-250	1.5
Methadone	Dolophine®	10	20	24
Morphine	MS Contin®	10	30/60	2
Oxycodone	Percocet®	10	15-30	3
Oxymorphone	Numorphan®	1	10	1.5
Propoxyphene	Darvon®	NA	200-300	9

Notes

1. Heroin metabolizes to morphine very quickly — with a half-life of roughly 3 minutes. The half-life of morphine is reported.
2. The most quoted figure for the half-life of Fentanyl is 2 hours. This seems to be taken from the *Drug Information Handbook*. I have seen numbers as low as 0.5 hours. The effective half-life of Fentanyl delivered through transdermal and transmucosal systems is roughly 7 hours.
3. The 30 mg value is for the treatment of chronic pain, the 60 mg value is for the treatment of acute pain.

Sociology

This section of the site deals with social aspects of heroin use.

Fictional Heroin
: A novelist wants help writing about heroin.

Heroin Experiences
: This is a collection of true stories written by people who were heroin users about the times when they were using.

Teen Challenge
: A Christian group that is supposed to be saving our children from drugs is really just spreading the same old drug lies with no care for accuracy or the harm their lies might do.

Help Me Write My Novel

Dear Dr. H:

I am writing a scene for a piece of fiction involving heroin use. I need details. I remember some users in college talking about hearing bells when they shot up, but that might have been from shooting coke/heroin. I also remember they said they would shoot up and then pull back the plunger and reshoot to get a better buzz. Is this common among heroin users? Also wondering if there's another word for the tourniquet used to tie off the arm. Details, details, details. Thanks. Martha

Dear Writer:

*Write what you know. I hate reading fiction about heroin users that is inaccurate. But since you asked: the "bells" comes from high doses of cocaine; it has nothing to do with heroin. The tourniquet is universally called a "tie." Pulling blood into the syringe and then re-injecting it is called "booting." Done once it *might* get a little more heroin into the body; people who do it, do it over and over again; I want to slap them. Generally, it is just a bad habit, like biting one's fingernails. It is not a good thing to do.*

If you really want to know, buy Heroin User's Handbook; it will answer all your questions and help me pay the bills.

Good luck.

Teen Challenge

The Teen Challenge website claims to be "The Proven Cure for the Drug Epidemic." As its name implies, it focuses on young people; what is not clear from its name, is that Teen Challenge is a Christian group. I sent two letters to them concerning the content of their pages. They did not respond, nor did they correct *a single* error I pointed out. The people who run the site seem more interested in getting donations than they do in providing accurate information. They are typical of the "as long as we say heroin is bad, we can say whatever we want" school of teaching.

From Junkie to Human
: Teen Challenge published an article by a former junkie who found God and became a respectable person.

Heroin (Mis)Information
: Teen Challenge provides all kind of information about heroin. A great deal of it is wrong.

Teen Challenge Letter

Dear Sir/Madam:

I am writing to you in regards to your web page From a Heroin Addict to a Respectable Citizen. This letter is part of the Heroin helper mission to improve the lives of heroin users. An important part of accomplishing our mission is to educate the population as a whole about heroin; to replace myths with accurate, objective information; to transform hysteria into rational discourse. I hope that you will give our comments serious consideration and make the changes suggested.

Below is a list of statements made on your webpage, why we think they should be changed, and how they should be changed.

1. The title itself ("From a Heroin Addict to a Respectable Citizen) is offensive. It implies that a heroin addict cannot be, by definition, a respectable citizen. We could certainly spend days discussing what exactly makes up a respectable citizen. I doubt we could say that a respectable citizen must be one who never breaks the governmental laws, because it is almost impossible to not break the law in the United States given the enormous number of laws we now live under.
   I think we could agree that a respectable citizen should not hurt anyone. Many heroin addicts qualify in this way, at least. Many (perhaps most) support their drug habits entirely through legal means. They thus break the law only in that they use a drug that is prohibited by the government.
   I do not mean to imply that following the governmental laws makes one a respectable citizen. Instead, I want to show that there is no reason to say that a heroin addict is disrespectable, *by definition*.
2. The article states that Phil's experimenting with drugs led to a 23-year addiction to heroin. I question this statement, but before I discuss that I question the use of it. The statement only serves to vilify heroin and reinforce in the mind of the reader, that heroin is the ultimate (hardest) drug; this is a bad idea to reinforce given that it is wrong. Also, it blurs our recognition that our legal drugs are amongst the most damaging drugs available in physical, psychological, and sociological terms.
   I suspect that Phil was addicted to drugs other than heroin during this 23 year period. In particular, I suspect that he was addicted to alcohol — a far worse drug to be addicted to — according to DEA statistics. Also, it is questionable that Phil managed to stay addicted to heroin for 23 years without interruption.
   I cannot say how this paragraph should be corrected, because I do not know Phil's complete story. What I would like to see, however, is exactly how, during this 23 year period, Phil lived an immoral life. What we are given instead is, "Phil lived an immoral life; and as proof, just note that he was addicted to heroin." This is an insult to all heroin addicts who are trying to live the best lives they can.
3. The article takes it as given that addiction to heroin is bad in God's eyes. I can see how heroin addiction could distance one from God; I can even see how the life that a heroin addict might lead would be an affront to God; but I do not see how heroin addiction in and of itself is something of which God holds much of an opinion.
   Even though opium (heroin is derived from opium) use was common during the centuries in which both testaments of the bible were written, there is no mention made of the ill effects of opium; certainly, no opium prohibition is found in the bible. It was not

until around 1300 that Christian Churches in Europe made opium a taboo. And it is not because of the effects of opium that it became a taboo. Rather, it is its link to Eastern cultures which were considered influenced by the Devil.
Heroin does not turn those who use it into monsters. I believe it is possible for a person to be good and still use heroin. You may disagree and I may be wrong. But certainly, it is an issue to be discussed, not simply taken as fact.

4. Alcohol is a drug. Using the phrase, "drugs and alcohol" implies that it is not. Just because a society makes one drug legally available does not suddenly take it out of the scientific category "drugs." Let us not forget that for a number of years in the 1920s, heroin was legal and alcohol was not.

If you care about helping people (and you seem to), please make the changes I have suggested. When heroin users are dismissed as evil things, they are further marginalized and thus placed further from leading the best lives possible.

Sincerely,
Dr. H
Heroin helper, Managing Editor

Teen Challenge Letter

Dear Sir/Madam:

While searching your site for an address to which I sent my last letter, I came upon your heroin information pages. These pages contain some valuable information. There are two important problems with the pages, however: there is a great deal of misinformation in the pages and some of the text actually romanticizes heroin use which I think is not your intent. I am more concerned with the former issue, but I will touch on the latter in this letter. Below are quotes from your web pages and the HEROIN helper response.

"Heroin ... is one of the most addictive drugs on earth."
Heroin is not one of the most addictive drugs on earth. In terms of addiction potential, heroin is packed firmly in the upper middle of all drugs. Its reputation as being highly addictive comes from the fact that withdrawal from heroin — though not life threatening — is quite unpleasant. The best single gage of a drug's addictive potential is how reinforcing it is; that is, after taking the drug once, how inclined is a person to repeat the experience. Heroin is less reinforcing then nicotine, alcohol, and cocaine.

"It is classified as a depressant"
Heroin is not actually classified as a depressant; it is a narcotic analgesic. Although its primary effect is the decreasing of respiration and thus is calming, its effect on a user's behavior is not necessarily to decrease activity; some users do, in fact, become hyperactive when they use heroin.

"Heroin may be smoked when in pure powder form."
Heroin may be ingested in just about any way at all. When heroin was first made available to the public, it was sold as a cough drop. It is incorrect that only pure powder heroin can be smoked; all forms of heroin can be smoked. The same goes for snorting and injecting.

"Addicts place a small amount of the heroin in a spoon."
The second paragraph of this piece is curious because it reads more like a "how to" guide than anything. What is even more troubling is the instruction that beginners would use a half pea sized amount of heroin. Under most circumstances, this would be far too much for a beginning user. The statement that an "addict" places heroin in the spoon — the implication being that only addicts use heroin is absolutely false.

"This [being able to smoke it] makes the use of heroin more acceptable to middle and upperclass [sic] students and business folk."
The third paragraph shows a certain amount of economic bigotry when it claims that heroin used in the way cocaine is used is more acceptable to middle and upper class students and business people. People of all economic backgrounds are taught that being a junkie is bad, and all of them shun the syringe for this reason. Heroin use is not more acceptable to poor people.

"133;the risk of becoming infected with the AIDS virus through the use of dirty needles."
This is true, but currently three times as many people die from Hepatitis C each year. Hepatitis C is also a blood carried disease which is highly associated with unsterile injection technique.

"Some of the long term physical conditions that accompany heroin addiction include ... lack of motivation when it comes to involvement with any activities other than those associated with obtaining [sic] their next 'fix'."
To say that heroin causes addicts to have no motivations other than acquiring more heroin is to show a complete lack of understanding of the sociological situation that heroin addicts find themselves in. The Chinese opium addicts who helped to build the transcontinental railroad were able to work long and hard hours precisely *because* they used opium which made the pain and boredom of the work bearable. When heroin is legal and cheaply available, addicts live pretty much the same lives as everyone else. They are far more healthy and productive than alcohol and cigarette addicts, who they outlive by many years on average.

"Those 'associated activities' include burglery [sic], robbery, prostitution..."
It is true that heroin addicts commit a lot of property crime in order to support their habits. But this has nothing at all to do with the effects of the drug. This is an artificial situation created by the laws that make heroin illegal and thus very, very expensive.
It should also be pointed out that most heroin addicts do not support their habits with illegal activities. Most heroin addicts have regular jobs which they use to support their habits. It is a great offense to all of these "hard working junkies" If you want to encourage young people to stay away from heroin, you might tell them that these people work very hard, only to have almost all of the money they *earn* go to supporting their drug habit which most likely doesn't even get them high anymore.

"Those [cigarette burns] are a couple of the physical signs that might identify a heroin user."
Heroin addicts spend very little time nodding because of their high tolerance to the drug. As a result, it is unlikely that one will find a heroin addict nodding; it is a good way to spot a novice user, however. Cigarette burns are associated with heavy alcohol consumption much more than they are with heroin use. The heroin "nod" is a light state of semi-sleep which is not compatible with activities such as driving which require acute attention. But it is also not a state that makes the user oblivious as do drugs such as alcohol and barbiturates.

"... the most common site for injections are the main arteries located in the inner portion of the arm ..."
: Injections are *never* made into arteries. This web pages makes the mistake of using the words "arteries" and "veins" interchangeably. They are not the same. Injecting into an artery will cause tissue damage at the very least and can cause the loss of a limb or even death.

"Soon the user is 'shooting up' more than once a day."
: Heroin users and addicts are as individual as anyone else. Exactly what course a person's heroin use will take cannot be said. Don't make the mistake of treating heroin use and addiction as a monolithic thing that is the same in all cases.

I hope you will make the changes that I have mentioned in letter. You owe it to your readers.

Sincerely,
Dr. H
Heroin Helper, Managing Editor

User

This section contains information for heroin users. Unfortunately, more because it is illegal than anything, using heroin is a dangerous activity. Knowledge is the greatest tool to keep heroin users safe and free. The information contained here is a supplement to the thorough discussion of this subject in my book *Heroin User's Handbook*. This book is must reading for anyone who uses heroin or who is seriously thinking about using it. I also think it is highly education for "treatment professionals" and users' friends and family who *really* want to understand the heroin user and the world he lives in.

Administration
: Articles related to the administration of heroin. The topics range from basic to advanced with lots of on-site material mixed with the best off-site information. See the health section for related information.

Health
: Articles on health related issues of interest to heroin users. It covers everything from disease to sudden death. See the administration section for related information.

Acquisition
: Articles to help make acquiring the heroin user's "tools of the trade" easier and safer.

Detox
: Although not commonly acknowledge, all heroin addicts (*addicts* not *users*) must be experts at their own detox. Addicts commonly detox themselves for a variety of reasons (the lack of money or drug sources, kicking down a habit, or getting clean). Here are the the tools with some links to information on that *isn't* "do it yourself."

Misc
: Things that didn't fit anywhere else.

Heroin Experiences

Administration

The Sting of Withdrawal
: This is not an article about detox

Purifying Heroin
Purifying Heroin Again
: Two methods for purifying street heroin. The first procedure is the standard one — widely distributed on the web. The second is a better and safer procedure. It was developed by a Heroin Helper reader, and is not available elsewhere. (It should be, however. I grant the right to distribute it as long as it is presented as it appears — including copyright notice and editor's note — along with a note that states that it is provided through the courtesy of Heroin Helper.

Cold Shooting
: "Cold Shooting" is injecting a solution of heroin that was not boiled first. Some users feel that boiling the solution is wasteful. It is, but the problems associated with cold shooting don't make it a good idea.

Bleaching Syringes
Sharpening Syringes
Sink Joy
: These articles contain information on keeping the administration of heroin as clean and safe as possible.

Avoiding Arteries Part 1
Avoiding Arteries Part 2
: Injecting into arteries is a waste of drugs, very painful, and potentially deadly. Learn to minimize the risk of injecting into arteries.

Removing Track Marks
: What is the difference between tracks and scars and how do you get rid of them?

Where to Inject
: Some parts of the body are safer to inject into than others.

Smoking Heroin
: Many of the problems associated with using heroin can be avoided by smoking it rather than injecting it.

Can You OD Smoking Heroin?
: Although it is hard, you can OD smoking heroin.

Why Users Inject Heroin
Two to Three

The Sting of Withdrawal

After injecting heroin, users often find that they experience a small pain, or "sting," when withdrawaling the needle from their flesh.

Heroin is an Acid

Heroin is an acid; this is why it burns when it is injected into muscle. The sting that is experienced, is the result of this, even though it may not be clear how.

Pressure

The pressure applied to the plunger pushes most of the heroin out of the syringe. Some is left over — some on the tip of the needle. When the needle is pulled out, this remaining heroin burns the skin as the needle is removed.

The Solution

One way to get around this problem is to repeatedly boot the solution. This is not suggested, however. Better is to pull the syringe out of the vein; pull the plunger out slightly; and remove the syringe from your flesh. Pulling the plunger out reverses the pressure gradient, and removes the remaining heroin from the outside of syringe where it can come into contact with the skin.

Purifying Heroin

*[**Editor's Note:** The following text is taken from Heroin User's Handbook, but the procedure has been floating around for years and I have no idea who "invented" it. I do not recommend using the part of this process that involves ether — unless you really know what you are doing.]*

The impurities found in street heroin range from coffee to quinine to glass particles. Most impurities, like coffee, are harmless. You might even like some of them. Coffee, for example, is tasted after injecting heroin that has been cut with it. Some impurities, like glass and maybe even quinine, can be deadly. I strongly encourage you to remove the impurities from the heroin you buy. What follows is a recipe that works despite the fact that it has been widely distributed on the Internet.

Removing Particulate Matter

The use of cotton for filtration when heroin is cooked before being used is a small attempt at purifying the heroin ingested. But a much better job can be done with a little hydrochloric acid (HCl). Place about a gram of heroin in a small glass container (a test tube is best, but any glassware that will allow mixing will work). Add a couple of drops of 28% hydrochloric acid and allow it to react for a couple of minutes. Next, add 5 ml of distilled water and mix vigorously so that everything dissolves that can.

At this point in the process, the heroin is in solution. The non-soluble material in the container is garbage that you do not wish to ingest. Let the solution sit so that the particulate matter settles to the bottom and then pipette out the solution, leaving the particulate matter behind. The simplest kind of pipette is an eye-dropper. If a pipette is not available, it is possible to pour the solution out of one container into another, being careful not to allow any of the particulate matter to be transferred.

Removing Soluble Impurities

Add ammonium hydroxide to the solution, one drop at a time. This will cause a white precipitate to form. Continue adding the ammonium until you are certain that there is no more precipitate being formed. The solution is then gently mixed to assure that the ammonium is evenly distributed. At this point, the solution will have a milky look.

The solution is then added to about 100 ml of ethyl ether-a chemical with which great care must be taken, since it is quite combustible. This new solution is then vigorously mixed and left to sit. This will cause the water to settle at the bottom of the container; it is removed with a pipette and then discarded.

A mixture of 5 mL of HCl and 5 mL distilled water is created and added to the ethyl ether mixture. This is stirred vigorously for several minutes. Afterwards, a water layer will form at the bottom of the container. You then pipette this out and into a small container such as a petri dish.

Deacidification

Slowly add baking soda to the solution in the petri dish. This will cause the solution to bubble. When the bubbling stops, this process is finished. The resulting solution is then air-dried, which yields pure heroin and table salt (NaCl). The salt is harmless and may be ingested along with the heroin.

Purifying Heroin Again

*[**Editor's Note:** The following method for purifying street heroin comes to us from a once infamous clandestine heroin chemist who has "gone straight." He has asked to remain anonymous for obvious reasons. He also asked that we be very clear that this recipe explains a serious chemical process with the resulting risks: (1) accidents made during process could cause harm in the form of explosions, toxic vapors, and unknown other threats to the safety of the would-be chemist and those in close proximity; (2) even if performed exactly as written, this recipe will not increase the quantity, only the quality of what was already there; (3) the very act of using this recipe breaks drug manufacturing laws (along with many others besides) that can result in multi-year prison sentences and even death as punishment. The recipe is provided for educational purposes only — and as such, it will likely be quite useful to students of beginning organic chemistry.]*

I was curious about the procedure for cleaning street heroin [that is on your site: Purifying Heroin]. Most of my practical laboratory experience was with various opiates, street, pharmaceutical or self made, so this is definitely something that I know about. In fact I purified some street heroin for a friend of mine one day. It requires only a little knowledge of basic organic extraction technique.

This is what I did:

1. Dissolve the street heroin in water.
2. Use the easily available Hydrion pH papers to monitor the pH during this procedure. Add Sodium Hydroxide in solution dropwise while checking the pH. Use a narrow glass or plastic rod to touch a minimum of the drug solution to the paper to avoid loss. Stop when the pH reaches about 9.
3. Extract with chloroform. Chloroform is far superior to diethyl ether in that it is **non**-flammable and does not present storage problems, where explosive peroxides can be formed. **Note:** Chloroform is an ideal solvent for heroin, codeine, and most other opiates, with the major exception of morphine which requires a mixed solvent.
4. Separate the chloroform layer and wash with a minimum quantity of cold water: 1-2 ml works well. Evaporate the chloroform taking care not to burn the residue on the bottom of the beaker. **Note:** Chloroform is a known carcinogen, so plenty of ventilation (and a respirator) would be advisable. The chloroform is so volatile that this step is actually quite easy to perform.
5. Add a dilute solution of HCl dropwise while stirring with a glass rod. Monitor the pH closely. As the acid is being added, the diacetyl morphine base is being neutralized and converted into the water-soluble hydrochloride salt form.
6. When all the solid material has just dissolved, stop adding the HCl. I found that this takes place around pH 5-6. **Note:** If one tries to bring the pH all of the way up to 7, the free base alkaloid precipitates back out requiring addition of more HCl.
7. The resulting solution will be in an injectable form; it will now be completely clear with no colored impurities or particulate matter.

Having clarified this procedure, I would hope that nobody would actually attempt it. To an experienced chemist this is all so routine that you could do it blindfolded. But I noticed that even the college students in my Organic lab class, who had no prior organic chemistry experience, were remarkably clueless around a separatory funnel the first time. This is to say that what is trivial in the hands of an experienced chemist will likely be unusable (at best) and dangerous (at worst) in the hands of an amateur. This chemistry isn't to be played with.

Cold Shot

A cold shot is a solution of heroin dissolved in water that was not boiled. There are two reasons that users inject cold shots: necessity and frugality. Sometimes users don't have easy access to a flame, so they spend a lot of time mixing heroin in cold water. More often, users think they are wasting money because boiling the solution causes evaporation and thus loss of money.

In general, it is a bad idea to inject cold shots. The minor benefits do not compensate for the major benefits of boiling the water when dissolving the heroin.

Speed

White powder, as well as black tar heroin can be dissolved in cold water. But it can take a long time mixing to do so. Most users heat their dope because it is the fastest way to get it dissolved. Heroin, like most things, dissolves much faster in hot water than cold water.

Heating does not allow *more* heroin to get into solution. This is because the solution is cooled before injection (and if it isn't, it should be). If the higher temperature did allow more heroin to be dissolved, the extra heroin would solidify out of the solution as it cooled.

Safety

Boiling your heroin solution makes it less dangerous. Although boiling won't kill everything harmful that might be found in any given sample of street dope, it is helpful.

Bacteria

Bacteria can live in samples of heroin. Bringing the solution to a boil will kill most kinds of bacteria This means that if you boil the solution, it will be safer to inject.

If you have had heart valve problems, or pins from something like a broken limb, you should *definitely* boil the solution because these are places where bacteria readily grow. For more information, look up endocarditis in a disease book or in my book, *Heroin User's*

Handbook. It is also discussed in the disease article on this site.

Boiling will not kill *all* kinds of bacteria. In particular, it will not kill any spore-forming bacteria — like the flesh eating bacteria. Never forget that using any black-market item is dangerous.

Viruses

Boiling also incapacitates viruses. I recall in Portland that Hepatitis C was rampant among cocaine users, but not heroin users because the cocaine users were not boiling their dope. Again, boiling is not a perfect defense, but it is an easy way to make heroin use less dangerous.

Practical Matters

Boiling does waste a certain amount of dope because it gets vaporized. If you boil your solution, don't do it for long. Bring it to the point at which it just begins to boil and remove the flame. Anything that isn't killed by that will need to be boiled for far longer than is practicable.

The bottom line is this: boiling makes the dope dissolve faster and it makes it less dangerous to ingest. The down-side is that it also wastes some of the heroin — but not that much if care is taken.

Conclusion: Avoid False Economies

It is not necessary to use to boil a heroin solution, just as it is not necessary to use a cotton to filter heroin before injection, either. But it is foolish to not do so (cotton actually filter out some bacteria strains because they are large — use a tight cotton ball for filtering). Not using a cotton; not boiling; these are false economies. Doing so may save you a dollar, but you can only spend it if you're alive.

Update

A few people on alt.drugs.hard have pointed out that cold shots can be safer than boiled shots because boiling allows the final solution to contain more of the adulterants found in heroin samples. This is true, but two points must be considered.

1. The solution should never be injected hot. The solution should be cooled first. This will cause these adulterants to separate out so that their concentration is no higher than it would be if the solution had never been boiled.
2. Most of the things that heroin is cut with are more soluble than the heroin itself (e.g. coffee and sugar). Thus, this isn't much of an issue.

Regardless, injecting any street drugs has dangers associated with it that cannot be eliminated.

Bleaching Syringes

Providing information on the Heroin Helper site is a practical matter. We can't pretend that heroin users can or will do what is in their best interests. So it is with this article on syringe cleaning. In a perfect world, people should never reuse their syringes; they become dirty and the needles become dull. But sometimes, reusing syringes is necessary, and so we provide users with the information on how to clean them.

In addition to cleaning used syringes, it is important to sharpen the needle. You should read the Heroin Helper article, Sharpening Syringe Tips. Dull syringe tips can cause many problems. Cleaning syringes is still the most important thing a user can do, however — even when he doesn't share them.

There is a lot of information floating around on how to bleach syringes. A lot of it is contradictory. Don't let this bother you. There is really only one part of the cleaning process that is absolutely essential:

- Rinse the syringe thoroughly after bleaching.

Other than that, you can pretty much make up your own recipe for cleaning syringes. What follows is a good procedure — well worth using if you don't have a way you already use.

1. Find a work area and clean it. Bathrooms are okay, but kitchens are better. Regardless, make sure that the area in which you are going to work is as clean as you can get it.
2. Wash your hands.
3. Rinse the syringe with cold water several times. This can be done in any number of ways. (a) Draw clean water into the syringe from a small receptacle of water, and flush the contents into the sink. (b) Remove the plunger from the syringe and pour the water into the syringe barrel; replace the plunger and flush the contents into the sink. (c) Start the faucet flowing at a steady rate; draw water into the syringe directly from the water flow flush the contents into the sink. Note that this last procedure can be difficult to do well.
4. Pour regular household bleach into a small clean receptacle. If bleach is unavailable, you can use isopropyl alcohol or hydrogen peroxide.
5. From the small receptacle, draw up bleach into the syringe until the barrel is about half full.
6. Pull the syringe plunger out as far as it will go without detaching it.

7. Shake the syringe for about a minute.
8. Empty the syringe contents into the sink.
9. Empty and clean the bleach receptacle. Do not reuse the bleach!
10. Rinse the syringe several times with cold water.

There is controversy about how long the syringe should be kept in bleach. It appears that 30 seconds is long enough to kill HIV. No amount of time seems to kill Hepatitis C. There is some word that hydrogen peroxide will kill Hepatitis C. If you really want to be careful, rinse with both.

Regardless of what you do, understand your risks. If you share syringes with others, you are putting yourself in danger. Under the best circumstances, never reuse a syringe. Barring that, only reuse your own syringe that you have cleaned. Barring that, only reuse another's syringe that you have cleaned.

Sharpening Syringe Tips

I was a junkie for a number of years in Portland, Oregon where syringes are not a controlled item. As a result, a user could (and still can) walk into a drug store and buy a bag of syringes. The cost there is still about $20 for a box of 100 which comes out to about 20 cents per rig — a hell of a lot better a price than the $2 you pay on the streets of San Francisco or New York.

The Evils of Reusing Syringes

In order to get away from the scene in Portland, I moved out to San Francisco where syringes are controlled in an evil effort to "send a message." This message must have something to do with the government's interest in spreading disease but I digress. In eight months of moderate chipping in California, I did *much* more damage to my veins than I had done in years as a junkie in Oregon.

The reason for this damage was that I reused syringes a lot whereas I never reused a syringe in Oregon. People talk about needle exchange programs and how it is not necessary to reuse syringes. These programs are wonderful and I have a great regard for those who run them. But they are only a partial solution; most junkies and many chippers simply inject too often for these limited budget programs to keep up with.

There is a lot of good information floating around on how to clean syringes — like this link. But as long as you are not sharing rigs, sharpening your needles is every bit as important as cleaning.

People have some very strange ideas about syringes. Just yesterday a guy — a former IV drug user — was telling me that syringes have little hooks on the end of the needle. Maybe he was thinking of a crocheting needle but probably he was referring to the fact that syringe tips are cut on a real angle: about 30 degrees. This allows them to penetrate the skin more easily with less pain to the injectee.

Why dull syringes cause body damage

The more a syringe is used, the more jagged and blunt it becomes. This is especially important to remember if the user has bad veins or bad injection technique; each needle insertion damages the tip. So a single perfect injection will not greatly harm the needle. On the other hand, if it takes ten entries before a vein is found, substantial damage may take place. And as the tip becomes more blunt, it becomes harder to find a vein, thus accelerating the damage done to the syringe tip.

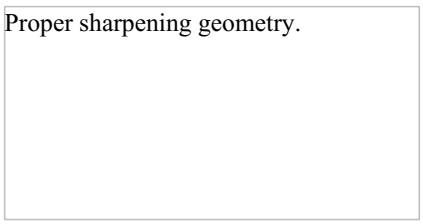
Procedure for Sharpening Syringes

In order to sharpen a syringe, it really helps to have a magnifying glass. The large ones with internal lighting sources used by jewelers and cosmetologists are particularly good for this. These can sometimes be acquired at yard sales and flee markets.

Choosing a Striking Surface

Classically, people have used the striking surface on match boxes for the purpose of sharpening syringes. This is not a particularly bad choice and will certainly do in a pinch. The best choices are the *Arkansas Stone* or the *Carbide Stone* which can be purchased at most medical supply stores. It is a slightly odd item to buy so users should buy in person and pay cash.

Syringe geometry


Proper sharpening geometry.

Place the tip with its bevel (the angled part) flush with the sharpening surface at its edge. Drag the needle tip backwards along the surface. It is not necessary to press very hard. When finished with one pass, repeat the process. Always move in the one (backwards) direction. Just a couple of passes will do it in most cases but this is where a magnifying glass really helps.

Clean Syringes Carefully

After the sharpening is complete, it is very important to clean the syringe thoroughly. There will be a lot of little pieces of metal which would be very dangerous if injected. The user should clean the syringe before sharpening it because blood and other substances provide more surfaces for metal shards (and other byproducts of the sharpening process) to adhere to. After the sharpening, re-clean the syringe. Remember: there will be metal shards *inside* the syringe after it is sharpened.

Caution: No amount of cleaning and sharpening of used syringes will bring them back to their original perfect condition. And cleaning and sharpening, if done incorrectly, can make them *more* dangerous than they were before.

Sink Joy

Those wonderful people at the Harm Reduction Coalition have put out a great little pamphlet called "Think Sink!! Think Light!!" The point of the pamphlet is that using near a well lit sink will make the process safer. Below are some quotes from the pamphlet. Before we get to them, however, I want to point one thing out: bathrooms can have a lot of unseen risks. Be careful and avoid obviously dirty bathrooms. Kitchens are better, but unfortunately not private.

People don't want you to get off in their bathrooms *but* every time you get off near a sink, it makes your injection safer.

- You can wash up before *and* after you get off...
- Plenty of water to mix your shot...
- Plenty of water to rinse out your syringe... need to use it again!
- Plus you can freshen up in the mirror!

Washing your injecting spot with soap and water is as good as alcohol.

People want you to suffer so that you'll stop using drugs. This includes:

- Getting infected with HIV, Hepatitis, endocarditis and abscesses
- Blowing your veins
- Getting busted
- Overdosing
- Death

All in the name of taking care of yourself! You don't have to agree. Chances are, you know more about the harms of your drug use than they do.

Don't be ashamed to take care of yourself!

Lots of people do things they're ashamed of. Rich important people, from presidents to preachers to TV stars all have stuff they are ashamed of. But drug injectors face a lot more risks than those guys!

Next time you use a bathroom to get off, give yourself credit for doing the right thing.

Avoiding Arteries (Part 1)

One of the easiest ways for IV injectors to hurt themselves is by improperly injecting. This is illustrated in the following letter we recently received:

> My question [concerns] something that happened last week. I went to inject in the back of my left wrist and as I went to inject — wow — what excruciating pain! I again aspirated the syringe and blood came back. I started to push again and had to pull the syringe back out due to the pain. This was worse than any miss I've experienced. Well, immediately my left hand became discolored and swelled up until I couldn't make a fist. What happened? The swelling decreased over the next few days. No lasting problems but what a scare. That kind of pain was scary!

What the writer did was inject into an artery. This is one of hazards of IV injection. People should *never* inject into an artery. Since arteries carry blood from the heart to body tissue, the heroin interacts with this tissue (in concentrated form) before making its way to the heart and eventually the brain where the user wants it. Unlike an IM injection, where the heroin is put into a single location, an injection into an artery transports the heroin to a large area.

Why Arterial Injection is Painful

Injections into arteries cause pain for a number of reasons. First, heroin is an acid and (just as with an IM injection) it burns the tissue that it touches. Another reason is that arteries have far more pain receptors than do veins. Both of these kinds of pain are short-term, however. What is more important about arterial injections is that they cause a swelling of the tissue as noted in the letter above.

Distinguishing Arteries and Veins

The terrible thing about injecting into arteries is that there is no way to distinguish an artery from a vein based upon the pull-back. When the user aspirates the syringe in either case, the syringe will fill with blood.

Similarities

Most of the time, there is no problem because veins are closer to the surface of the skin. So any thing an injector sees that looks like a vein usually is a vein. But there are veins that are close to the surface, especially in places like the hands, wrists, and neck. Another thing to keep in mind is that arteries tend to run along with veins — just deeper beneath the skin. So if the injector goes too deep, he may inject into a vein.

One thing that I would really like to drive home is what would have happened if the writer of the letter above, instead of injecting into his wrist, had injected into his neck. It is very possible that his neck would have swelled up and he would not have been able to breath. This is the best reason I can think of for injectors to stay away from their necks.

Differences

Arteries are distinct from veins in the following ways:

1. Arteries are red
2. Arteries are smaller and less numerous
3. Arteries "pulse"

Because of the properties of arteries, blood tends to flow more quickly through them. As a result, a pullback from an artery is usually very strong. This is often a factor in people hurting themselves; they just can't believe that they aren't in a vein because of the very strong pullback they are getting.

Testing Veins

Regardless of what an IV injector does, he should test any vein in which he is going to inject. He should release a small amount into the "vein," first. If he gets a good pullback but the injection is painful and he is still "in" — then he should withdraw the syringe and try another location.

Arteries Provide No "Rush"

If safety isn't enough to make an IV drug user stay away from arteries, he should remember this: injecting into an artery dilutes the drug and so there is no rush from injecting into an artery.

Conclusion

Whether for safety or pleasure, users should always take care to avoid arteries. Keeping in mind the ideas in this article will help. Regardless of the precautions taken, it is still possible to inject into an artery. This is a danger inherent in the IV injection procedure.

Avoiding Arteries (Part 2)

In the last article in this two part series, we discussed the differences between veins and arteries and how to avoid the dangerous and painful act of injecting into an artery. Regardless of the precautions taken, however, sometimes, users inject into arteries. In this article, we discuss what to do when a user injects into an artery.

How Arteries Work

Oxygen and nutrients are transported to the various parts of the body through blood delivered by the arteries. The blood moves from large arteries to progressively smaller arteries — called arterioles. Eventually, the oxygen and nutrients in the blood end up in capillaries where they are absorbed by the tissue.

Blood Absorption by Tissue

The oxygen and nutrients in blood are transported across the capillary walls into the tissue. Because of the volume of blood that must be moved around, there needs to be a large area of capillary wall. This is accomplished by having a lot of capillaries, because any given capillary is extremely small — about 0.025 inches long (the width of perhaps ten strands of hair) and 0.0005 inches in diameter (this can't even be seen by the naked eye). But because of the enormous number of capillaries, the total area of capillary walls in the body is large — about 5000 square feet — that's the size of two fairly large houses.

Heroin in Arteries

When heroin is injected into an artery, it is treated just like blood — each molecule is transported to a capillary where it can be absorbed by the tissue. The chemical reactions that occur hurt the tissue and cause pain.

One doctor I spoke to indicated that another reason for the pain from injecting heroin into an artery was that the arteries themselves had a

large number of pain receptors compared to veins. I have not found corroboration for this theory, however.

The biggest long-term concern about injecting heroin into an artery, is that blood clots may form. Blood clots can stop the flow of oxygen to near-by tissue — causing the tissue to suffocate and die. In addition, pieces of a blood clot can break off and lodge in another location — in some cases, they can lodge in a more dangerous location like the brain, causing a stroke.

Threat to Life

Rarely, an arterial injection may pose a threat to the user's life. In most of these cases, this will not happen right when the injection is made — as when a blood clot breaks away from a limb, for example, and gets caught in the brain. In some cases, however, there will be an immediate threat to life.

If an injection causes such a threat — causing the user to be unable to breath, for example — medical attention should be sought immediately. Call 911 or go to a hospital, whatever makes the most sense.

An Ounce of Prevention

The only way to assure that a user will not inject into an artery, is to not inject drugs at all. The fact of the matter is that if a user injects enough times, he will eventually inject into an artery. It is only a matter of time because there is no iron clad method of differentiating between veins and arteries.

But by taking the proper precautions, users can greatly reduce the risk that any given injection will be into an artery. For example, one user I talked to had a five year run of daily using; he injected into an artery only once. That represents between 5,000 and 10,000 injections. This is a pretty good track record and it comes from following the advice found in the first article in this series.

Infection

Although it is not common, and it is a problem with injections of all kinds, not just arteries, the tissue affected can become infected. As with any injection, great care must be taken to assure that the needle, hands, and injection area are clean. In addition, the user should try to administer heroin in clean surroundings. For example, avoid dirty places like public rest rooms and dusty places like barns.

Short-Term Care

When heroin is injected into an artery, it follows the same path to tissue that blood does. Of course, the last thing a user wants is for the heroin to do this because it is painful, wasteful, and damaging to the body. When this happens, the user should slow the blood flow as much as possible, in order to limit the area with which the heroin interacts.

Stop!

The moment you determine that you have injected into an artery, you should stop. If you have not flushed all of the contents of the syringe, stop flushing the syringe and remove it from the injection site. The less that is injected into the artery, the less damage will be done.

Ice It!

As soon as possible, the injection area should be iced. Since this limits the area to which heroin spreads, it will also limit the swelling of the tissue and the amount of tissue that is damaged.

Massage It!

Massaging the area that has been affected also can be helpful. This encourages the flow of toxins out of the tissue. The user must be careful, however. This should only be done as much and as intensely as is comfortable. It is possible to do further damage to the tissue. **Don't** follow the philosophy, "No pain, no gain"!

Long-Term Care

After 24 hours, the swelling of affected area should have gone down substantially. It should be within 90% of normal. Even though the area will look much better, the user should still monitor it and treat it until the area is completely normal.

Ice? Heat?

Professional opinions differ regarding the long-term care of the swollen tissue from an arterial injection. Some say that the patient should continue to apply ice to the area. Others say that the patient should apply heat to the area. Still others say that the patient should alternate applications of heat and ice. All sources agree, however, that ice should be applied for the first 24 hours.

Massage

Massaging can also be used in the days following the arterial injection. The same precautions taken immediately following the injections should be taken later.

Cleaning

One thing should definitely be done: keep the area clean. How often the sufferer cleans the area will depend upon his environment and activities. It should be done at least once a day. This should be done gently with soap and water, under most circumstances.

If the wound is opened — this is called a fistula and is normally a sign of an infection — it should be rinsed with hydrogen peroxide. Sterile syringes work very well for this purpose.

Medical Attention

If after 24 hours, the swelling has not reduced substantially or it is still quite painful, the user should seek medical attention. The body responds quickly to a normal arterial injection. If it has not repaired itself within a day, it means something more is wrong that should be investigated.

Conclusion

If an IV injector uses long enough, he will eventually inject into an artery. This is simply a risk that anyone who injects drugs into his veins must accept. Knowing this, he should prepare for this event and think through what to do after an arterial injection.

Removing Track Marks

Dear Dr. H,

I was wondering how long these awful track marks will last. The ones on my hands are the most shameful.

Sincerely,
Maria

Dear Maria,

You need to distinguish between tracks and scars. What you have are almost undoubtedly scars. Tracks are made up of needle holes which have coagulated closed. Tracks go away in a week or so if they are not replenished by fresh injections. If you inject into the same area long enough, the skin will become damaged — scarred. This usually happens because when users find a good vein, they use it until they can't anymore.

There are a couple of things that will help — how much is unclear. You might try cocoa butter, aloe vera, or vitamin-E oil or cream. There are more "high tech" creams that are said to remove scars. I have not tried any of these but I am highly skeptical about them.

Where to Inject

Choosing an injection location should not be determined solely on where veins can be found. Some areas of the body are more safe to inject into than are others. Below is a list of injection areas in order from safest to least safe.

1. **Arms:** The upper arm is the best place in which to inject — there are relatively few nerves there and the veins are large. Just the same, the veins tend to roll, so this must be taken into account.
2. **Hands and Wrist:** There are more nerve endings here and the veins tend to be smaller and more delicate and thus more prone to damage. On the positive side, they are easy to find and stable.
3. **Legs:** These veins are at greater risk of forming blood clots. Interrupting blood flow in the legs is particularly serious because these veins are the most important for bringing blood back to the heart.
4. **Feet:** These veins are even more delicate than those in the hands. There is also relatively poor circulation to the feet which means that damage done is repaired slowly. Special care should be taken to clean the feet if they are used for injection because of the possibility of infection.
5. **Groin:** The largest vein in this area — the femoral vein — is very close to the femoral artery. It is easy to miss the vein and hit the artery — causing the usual problems.
6. **Neck:** Just as in the groin, it is easy to miss a vein and hit an artery. Hitting the carotid artery is potentially fatal. Even apart from injecting into an artery, damaging the veins that go from the brain is very dangerous. The brain needs blood more than any other part of the body.

Smoking Heroin

Editor's Note: *The information contained in this page is culled from my book, Heroin User's Handbook. For more information on smoking heroin, see this book.*

Introduction

Smoking is naturally associated with brown tar heroin in much the same way that snorting is to white powder-probably because of its association with opium. Because of its obvious wasteful nature (the heroin just goes up in smoke), smoking is often derided by other users. Although, this method can be highly wasteful, its wastefulness depends entirely upon technique; the obvious "up in smoke" aspect of waste can be entirely eliminated, as is discussed below.

A little know fact of drug taking is that smoking is the fastest way to administer a drug. This goes against most notions of drug use because it would seem that pumping a drug directly into your vein is the most direct means of administration. But getting the drug into your circulatory system will not get you high-you have to get it to your brain. Drugs taken intravenously take a circuitous path to the brain: through the veins to the liver and heart before delivery to the brain. Smoking causes a drug to be absorbed by the lungs where it is transferred to the arteries and delivered directly to the brain. But don't be misled: mainlining will get you higher than smoking. The fact of the matter is that it takes time to smoke heroin; you can't smoke a gram all at once. Smoking will give you a rush but it is not the same as slamming.

In general, smoking is safe; it will get you higher than any method other than mainlining; it's easy to do and doesn't require any special or illegal equipment. The down-side of smoking is varied. Smoking is the middle-ground procedure for heroin administration. Since it uses a direct pathway to your brain it is inherently less safe than less direct means like snoring. It is somewhat wasteful to very wasteful depending upon your technique. It is fairly difficult to smoke heroin alone, which is both good and bad: it makes smoking a good method for social drug using.

Smoking is my favorite method of ingesting heroin. It is highly ritualistic and has more of a communal feel to it. But this is not always the case.

The Procedure

Smoking heroin can be done efficiently alone but it is much easier as a couple. The basic idea is that heroin is placed on some surface which has a low heat capacity. A flame is applied to the surface from below in order to heat the heroin and start it boiling. This vapor is then inhaled with the help of some kind of tube. I will start by describing the smoking process for couples and then end with a few ideas on smoking alone.

Surface

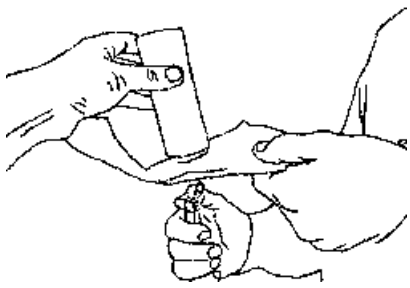
The choice of a smoking surface is the most important one. I have tried any number of surfaces and almost all have failed because they lacked a low heat capacity. What this means is that most surfaces heat up and cool down very slowly. An example of this is asphalt; even long after the sun has gone down, the asphalt which has been heated by the sun all day stays warm. So if you take even a relatively thin piece of glass (one-eighth inch thick) and apply a flame to it, it takes a long time for the glass to get really hot and once it is hot it takes a long time to cool down.

The perfect surface is one that gets hot the instant you apply a flame and cools off the instant you remove the flame. The reason you want this is that it allows you control of when the heroin is vaporized. When you apply the flame you want the smoker to be able to inhale the heroin vapor and when he is finished you want the heroin to quit boiling right away so that none is lost. A nearly perfect surface exists in aluminum foil. It heats up quickly and cool down quickly and is generally a joy to use.

Tube

After the smoking surface, the most important decision you will need to make is what to use for a tube. I recommend toilet paper tubes. They are commonly available and they are large enough so that you are likely to loose very little smoke. It is possible, of course, that you will find something better. In fact, I've been looking for a large plastic tube for some time myself. But in all such endeavors you should use the toilet paper tube as the prototype. You do not want the tube to be too long because long tubes cause more smoke to stick to the tube and so this increases loss. I have found that the width of the toilet paper tube is also perfect. Tubes that are too big or too small will result in loss. If the tube is too small, smoke will escape around the edges. A tube which is too large does not allow you to get good suction.

Couple's Procedure



There are several variations to smoking. In each, one person acts as the smoker and the other the helper. The main procedure is given below. The helper holds the foil flat and level. The foil should be about five inches (13 cm) by five inches so that it stays rigid when held from one side. The smoker places a small amount of heroin onto the center of the foil. The helper then lets go of one end of the foil. With his free hand, he lights the lighter. The smoker puts the tube up to his mouth in a comfortable position and bends to a point where the end of the tube is roughly an inch directly over the heroin. The lighter is positioned directly below the heroin underneath the foil.

When the smoker is nearly finished, he signals the helper which tells him to remove the flame. The heroin will continue to smoke for as long as 2 seconds after the flame is removed. It takes a little while to get used to the exact timing but before long you will be able to smoke using this procedure with almost no direct loss.

There are a few variations to this method of ingestion. The smoker can hold the foil. This has the advantage that it allows him immediate control of the flame; when he is finished he can simply pull away. The disadvantage is that it gives the smoker one more task. Another variation is to let the helper hold only the foil, letting the smoker hold the tube and the flame. If you have problems with foil folding on

you, then you might try this. In my experience it is very hard for the smoker to gauge where the flame is relative to the heroin. But some will no doubt be able to make this work.

Solo Procedure

Most people who smoke heroin alone use a very small tube so that they can hold it in their mouths (generally a plastic straw), freeing their hands for holding the foil and the lighter. But due to the smallness of the tube, it is easy to lose much or even most of the heroin smoked. You may now be imagining holding a toilet paper roll in your mouth, but this is not how it's done; when your mouth is so contorted it is hard to inhale properly.

In order to smoke alone, you have to remove the hand's control of either the flame, the foil, or the tube. As pointed out above, the tube is out. Luckily, there are reasonable methods using the other two. It is possible to use a couple of blocks spaced by about five inches apart, to hold the foil (some creative wire sculpting is also possible). Then you can use a lighter with one hand for the flame and hold the tube in the other.

I find the other method better. It involves the use a stationary flame. The easiest example of this is a candle although a Zippo lighter will also work. In this case you can hold the foil with one hand, the tube with the other and lower the foil toward the flame as you inhale. The down side of this method is that candle flames are very dirty and if you use one you will end up with a lot of soot. If you use a Zippo, you don't have to worry so much about soot but you have to be very careful that the lighter does not fall over and that if it does it does not start a bigger fire.

*[**Editor's Note:** There is a potentially fatal disease that is specific to smoking heroin; read all about it in our leukoencephalopathy article in the user health section of Heroin Helper.]*

Overdose Smoking Heroin?

I go to some length in my book *Heroin User's Handbook* to show that the casual user is best to ingest heroin by smoking. One of the main reasons that I believe this is that it is very hard to overdose by smoking heroin. But it can be done. I knew a man who died as a result of smoking heroin. His death was due in large part to the fact that he was drunk when he smoked the heroin. Had he not been drunk, he probably would not have died. Just the same, had he not smoked the heroin, he probably would not have died.

Don't Mix Heroin and Alcohol

Before I go on, remember the number one rule of heroin use: **Never, never, never, never, never use heroin with alcohol.** That means, don't drink and then use heroin. Don't use heroin and then drink. Don't drink and use heroin at the same time. If you die, you can't read *Heroin Helper*, and that just isn't acceptable. (You might be able to come up with some other reasons not to die; so don't mix heroin and alcohol.)

"Snorting" Isn't As Safe As You Think

People think snorting is safe, but it isn't. The problem is that it takes a long time to feel what you have snorted. So you can snort *way* too much before you even begin to feel the effects. The same goes for IM and SC injection. It's like setting a time bomb.

IV Injection Has Different Problems

IV injection is dangerous for another reason: you feel what you are doing quickly, but you can do an enormous amount all at once. I suppose this wouldn't be a problem if you felt it *right* as you did it. But there is a 15 - 60 second delay - more than enough time to ingest enough to die.

Why Smoking Is Safe...

Smoking is the safest way to ingest heroin because you are always "up to date" with the effect of the drug. By smoking, you ingest a small amount of heroin. You feel the effect within 10 - 20 seconds (yes, faster than an IV injection). So under most circumstances, you will pass out before you can smoke enough to overdose.

...But Not Completely Safe

There are other ways to die from using heroin, however. You could smoke a lot, pass out, vomit, and suffocate. Or you could pass out in the wrong place and be murdered. Or you could pass out, knock over the candle you were using, start a fire, and burn up.

Be Careful

There are no guarantees. Heroin is not a particularly dangerous drug. It isn't Rice Krispies®, and even Rice Krispies® can kill you. By using smoking as an ingestion method and always using with someone else, you greatly reduce your risks.

Why Users Inject Heroin: Is It Greed, Gluttony, or What?

Only recently, with the high purity levels of street heroin, has it become well reported that heroin may be ingested in a manner other than

injection. This has, in fact, caused those leading the Drug War no end of consternation. First, their vicious war seems to have made matters worse (from their perspective): heroin is cheaper and more available than when they started. Second, they have to fight the propaganda portion of their war on a whole new level. This brings us the current wave of Partnership for a Drug Free America anti-snorting heroin ads: "This is your brain. This is what happens to your brain when you snort heroin." (Check out "Why Purity Has Increased" for a history lesson on the unexpected results of the Drug War.)

It is true that one reason that heroin has traditionally been injected is that the street heroin purity levels have been so low. It reached its nadir in 1970 at about 3%. But even at this low level of purity, a novice could certainly have gotten high smoking without mortgaging the house. This is not to say that price and quality do not have an effect on the administration route; they do; but they are not the only factors.

As an example, let's look at the situation during the first few years of this century, when heroin could be bought over the counter — just like aspirin. At that time, it was mostly administered orally. This usually took the form of heroin cough drops. (Imagine that: cough drops that actually work!) The point is that people weren't dissolving these things and injecting them — just like people don't inject alcohol or nicotine today.

But there *is* a reason that heroin is naturally associated with intravenous injection. Heroin is the least stable of all the opioids. Whereas morphine and codeine have half-lifes in the human body of about three hours (and the synthetic opioids can have half-lifes measured in *days*), the half-life of heroin is about two *minutes*. When heroin breaks down, it becomes morphine, primarily.

Heroin is usually reported as being two to three times as potent as morphine (check out "Two to Three" for a discussion of what this really means). But this gives the wrong idea about heroin because it does not actually get the user high. Heroin acts as a transport chemical, delivering more morphine to the brain because it crosses the blood-brain barrier more quickly than morphine. Once in the brain, it is morphine that heroin breaks down into that gets the user high.

So if heroin breaks down into morphine before crossing the blood-brain barrier, it is much less efficient: about 1/3 as efficient. With a half-life of two minutes, most of the heroin ingested orally breaks down into morphine. More or less the same thing happens when inhaling. Inhalation is a very efficient means of ingesting drugs — there is very little drug loss. But it is slow and as a result, most of the heroin inhaled is converted to morphine before it reaches the blood-brain barrier.

Heroin is most effective when administered in a way that delivers it to the blood stream quickly: intravenous injection, subcutaneous injection, and smoking. This is why it does make more sense to inject heroin than other drugs — morphine, for example.

Why Users Inject Heroin: How Does Heroin Compare to Morphine?

It is often reported that heroin is "two to three times as powerful as morphine." But most research is based upon *intramuscular* injections. The standard numbers are that it takes 5 mg of heroin to relieve as much pain as 10 mg of morphine when both are administered intramuscularly. Orally, the numbers are 40 mg of heroin and 60 mg of morphine.

These numbers prove the point of the main article: the longer it takes heroin to get to the brain, the more it acts just like morphine. Administered intramuscularly — hardly a very direct means of ingestion for a drug destined for the brain — heroin is 200% as effective as morphine. Administered orally, heroin is only 150% as effective.

The numbers indicate that a lot of morphine is destroyed when it is ingested orally. One needs to ingest six times as much orally as one does when IM injecting. Surprisingly, codeine is quite efficient taken orally — almost 70% as effective as IM injection.

But if heroin is turned into morphine as quickly as stated in the main article, isn't it reasonable to assume that heroin administered intravenously would be even more potent compared to morphine? The answer is: yes. This is where the "two to three" number comes in. IV heroin is believed to be three times as powerful as IV morphine. It may be even more powerful.

This fact should be taken into account when you are attempting to detox yourself using some kind of opioid substitution. In matching doses, a higher potency for heroin should be assumed if it is being administered directly to a vein. On the other hand, a lower potency should be assumed if it is being ingested in a less direct way like inhalation.

Why Users Inject Heroin: Why Purity Has Increased

You may remember the movie *The French Connection*. It is based on actual events. In the early 1970s, pretty much all of the heroin that was coming into the United States originated in France. Opium, cultivated in Asia, was imported to France (primarily Marseilles), where it was chemically purified and converted into heroin for the world market. This was well know, even by law enforcement who must have taken some offense at this flaunting of international drug law.

The fact that the "heroin trade" was so centralized allowed law enforcement efforts to focus on Marseilles. Most of the time, such law enforcement efforts are useless. But the centralization of the enterprise and probably also a certain cockiness on the part of those involved in the illegal trade, allowed for a rare Drug War victory. The Marseilles operation was pretty thoroughly demolished.

The effect of this "victory" was not what the drug warriors had hoped, but it was exactly what economists would have predicted. It is simple to understand. Black markets are not free markets, and it is possible (especially through the use of force) to acquire a monopoly. And this is exactly what American heroin users were burdened with in the 1960s and early 1970s: a monopoly in the form of the French connection.

The destruction of the French connection allowed competition to enter the market. The French connection didn't stay dead, of course, but there was enough disruption in the market to allow others to enter the market and for alternate distribution channels to emerge. Today, there are three major players in the American heroin trade: France, Mexico, and Colombia.

Heroin users now have a choice and the heroin distributors are acting more like legal businesses. For example, the heroin coming out of Mexico was relatively poor in the late 1980s and early 1990s; it had purity levels in the 20% to 30% range. At the same time, Colombian heroin was coming into America with purity levels averaging above 60%. The Mexicans were losing market share and so they started to increase their purity levels. Today, Mexican heroin has an average purity level above 40%.

In addition to increased purity levels, the heroin being sold throughout the world has come down in price. From 1984 to 1994, the price of a gram of heroin was cut in half (in real dollars).

Many people think that the primary purpose of governments is to provide free and competitive markets (*HEROIN helper* does not agree; we think markets work best when governments leave them alone). Although this was not the purpose of the attack on the French connection, it was the result.

Governments often attempt to change the laws of nature — as if an act of congress can make the rain fall or the temperature rise. The laws of economics are no less fundamental and immutable than the laws of physics. Governments are bound to fail when they try to stop people from getting the recreational substances they want. But sometimes, in failing, they do some good.

Cooking Ahead

Dear Dr. H,

Would it be safe to cook up at home, load the shot and save it for later? I'm going to an amusement park where they check your bags. What I wanted to do was get everything ready at home, cap the needle - and when I get there, before going into the park, slip away into a restroom, do my thing, recap, tape it up so its all safe and sound, and enjoy my day... Is this okay to do? Thanks.

Sincerely,
Doper at the Amusement Park

Dear Doper,

To answer your question: Maybe. I have noticed that the solution tends to break down and the syringe will be filled with "sediment" or particulate matter. If you do this, cool the solution first and then filter very well. This should keep this to a minimum.

Another related issue has to do with the solubility of heroin in water. If you prepare a very concentrated solution, part of the heroin will precipitate out when the solution cools. To avoid this, simply keep the concentration relatively low.

I have never heard of injecting small amounts of this kind of solid material hurting anyone, but there is no doubt that it could. What's more, a small particle lodged in the wrong place could kill you; this is unlikely of course. Doing heroin — mostly because it is illegal — is inherently dangerous. When one uses it, he must acknowledge and manage the risks associated with it. This particular risk is like the risk of getting AIDS from a mosquito: you can get AIDS from a mosquito, but there are more important things to worry about.

Health

Leukoencephalopathy

Heroin Helper recently received a letter from a reader. The main part of the letter stated:

> Why does this site recommend use of aluminum foil even though there is extensive literature over the last 6 years associating aluminum and black tar smoking with brain anomalies and death. Further, there are currently a number of deaths and permanent brain damage in Vancouver associated with smoking on aluminum foil.

Aluminum Foil Is Not the Problem

While working on my heroin books, I researched the possible ill effects of smoking anything off of aluminum foil. This included extensive conversations with people at Reynolds Consumer Products — the makers of Reynolds Wrap®. Although the company does not recommend smoking heroin off their product (nor do they like the idea of their product being associated with heroin at all), there are no known problems stemming from the foil.

Aluminum is Stable

Aluminum neither melts nor vaporizes at the temperatures that it would be exposed to in the course of smoking heroin. It is, however, possible for acids to eat holes in it. This will be familiar to people who have stored acidic food — like tomato sauce — in aluminum foil. Heroin is an acid; this is why it burns when injected into a muscle. But there are two reasons why this would be unlikely to cause a problem to a heroin inhaler.

1. Heroin is not a very strong acid. What it is cut with, may be, of course. Black tar heroin is often cut with coffee which is extremely acidic. With the high-purity of the street-level heroin sold these days, this isnot such a big concern.
2. The products of th chemical reaction of aluminum with the most common chemicals found in street heroin do not vaporize at these temperatures.

Aluminum Myth is Harmful

All of this is not to say that there is no problem. There is a disease that seems to affect heroin users *only* when they inhale it. But aluminum plays no role whatsoever in causing the disease. I believe many people jump to the conclusion that aluminum foil is the culprit because of the widespread belief that drinks in aluminum cans and food wrapped in aluminum foil cause Alzheimer's Disease. (It doesn't, but once the public believes something it is almost impossible to change the belief.) There are real things heroin smokers can do to make themselves safer, but smoking from a different surface (such as from a crack pipe) is not one of them.

The Discovery

The disease is leukoencephalopathy. It was first noted in the 1930s as an unclassifiable disease. In 1958, almost 30 years later, the disease was finally delineated. Almost that much time past from that point, to 1982, when the first case was discovered that was caused by the patient inhaling heroin vapors.

Symptoms

The earliest symptoms are slurred speech and difficulty walking. Any heroin smoker showing these signs (which may come on many days after the last use), should see a doctor immediately. If treated quickly, at least partial recovery is possible. The symptoms of the disease progress to include mental deterioration, vision loss, speech difficulty, loss of coordination, paralysis, and, ultimately, coma and even death in as many as 25% of those with the disease.

The Cause

Our current understanding of heroin-related leukoencephalopathy, indicates that it is caused by an uncommon heroin adulterant. The reason that heroin inhalers are alone affected is believed to be due to the fact that this adulterant (which has still not been identified) must be heated to be activated. But it cannot be as simple as this.

Why Just Inhalers?

Injectors and black tar snorters heat their heroin before use. Since they do not get this disease, the chemical would have to be active only *when* hot. It could not be a matter of the heating of the adulterant caused it to change to a different chemical — a more reasonable explanation. This could only be true if the reaction reversed when the temperature fell — certainly a possibility. But all this seems unlikely, because some users inject and snort their heroin solution while still hot, and do not get the disease.

It could be as simple as an adulterant that can only be absorbed through the lungs. In all the research I have read on this subject, I have not found any mention made of this simple explanation.

Why Smoke?

The reason that *Heroin Helper* still recommends that users smoke heroin rather than use other methods should be clear. The risk of acquiring leukoencephalopathy via smoking is much lower than the risk of a sudden death via the other administration routes.

AIDS

What's more, both injecting and snorting are routes that can spread HIV. AIDS itself is a major source of leukoencephalopathy; between 4% and 5% of those with AIDS acquire it. That means a minimum estimate of the number of United States heroin users who are currently suffering from leukoencephalopathy because of AIDS is 6,000 — far, far more than all those world-wide who got it from smoking heroin.

Heroin Use is Not Safe

We have never claimed that smoking heroin was safe. In fact, we have gone out of our way to emphasize the fact that heroin use — in whatever form — is dangerous. When considering the options, we believe that smoking is *safer* than the alternative, not *safe*.

But if safety is the main concern, then the congress should repeal its unconstitutional drug laws, and other countries should follow along. The fact that heroin inhalers get leukoencephalopathy is the direct result of governmental regulations. These regulations force heroin users to buy adulterated heroin on the black market. No one inhaling pharmaceutical heroin would ever get leukoencephalopathy. That is a fact; leukoencephalopathy is not caused by heroin itself.

How to Be Safer

There are a number of things that a user can do to reduce his risk of contracting leukoencephalopathy. The most obvious is to not use, and it is important to remember that this is always an option. Many heroin users (addicts included) make that decision every day. For those who intend to continue using, here are a few tips that will help.

1. If there have been reports of heroin-related leukoencephalopathy in your area, don't smoke any heroin.
2. The problem adulterant does not seem to be used nearly as often with black tar heroin as it is with white powder heroin. For smokers with a choice, choose the black tar.
3. If you live in an area where you have easy access to syringes, switch to IV injection. The following conditions, which will simulate the advantages of smoking where the body is always experiencing the maximum heroin effect (no "time-bomb" effect), must be followed:
    a. Never re-use a syringe, even your own.
    b. Find a vein and inject a very small part that is in the syringe — 5 units maximum.
    c. Wait two minutes between such mini-injections.
4. Switch to snorting. Follow these rules:
    a. Always use a fresh straw; never share.
    b. Snort a conservative amount.
    c. Wait 20 minutes before snorting again.
5. If you do continue to smoke heroin, memorize the symptoms of this disease. If you notice any of these symptoms, go to your doctor right away. It is said that there is no cure, but doctors all over the world are having successes of varying degrees. The sooner you go to the doctor, the better off you will be.

Notes

Most Common Chemicals
: Given that heroin can be with just about any chemical, it is impossible to say what vapors might be produced. The most common chemicals that would be reacting with the aluminum or aluminum oxide would be the heroin itself (diacetylmorephine hydrochloride), quinine, various sugars, and coffee.

Minimum Estimate
: We assume 500,000 heroin users who inject. Next we assume that 30% of all IV drug users have AIDS, based upon the much higher HIV infection rates, and that those with advanced AIDS cannot continue to use heroin. Finally, we assume that 4% of people with AIDS get leukoencephalopathy — this is likely very low because most heroin adicts have poor health because of their lifestyles. Multiplying these three numbers gives the estimate of the number of AIDS-caused leukoencephalopathy: 6,000.

Abscesses

Abscesses are contiguous areas of the flesh which exhibit swelling, inflammation, heat, and pain. Inside an abscess is stagnant blood and puss (dead white blood cells). Abscesses often behave like pimples—coming to a head (actually, pimples are a kind of abscess). They will, from time to time break, releasing the blood and puss inside.

Why Abscesses Are of Concern

Abscesses can impair blood flow to neighboring areas. As a result, these areas are deprived of nutrients. This can cause a gangrenous condition which can result in the loss of a limb or even death itself. If an abscess is treated early on, it poses no real threat. Left untreated, however, abscesses can be deadly.

Causes

Abscesses are caused by a non-antiseptic injection procedures. This results in the introduction of local bacteria which normally exist on the surface of the skin, through puncture of the skin's protective barrier. These bacteria are introduced into the body where they grow and form an abscess.

Avoiding Abscesses

Abscesses are usually caused by *Staphylococcus aureus*. This is one of the kinds of bacteria that is responsible for endocarditis. The best way to avoid abscesses is to always use clean injection procedures. In particular, always use clean syringes and always clean the area in which you are injecting with alcohol.

Treatment At Home

You can do a lot yourself to heal an abscess. The first thing to do is to apply heat to the infected area. The extra heat will help to kill the bacteria which are causing the infection. Elevating the area is also helpful. In fact, the two together comprise the standard therapy with which to start.

If the abscess does not get better, it will be necessary to drain it. Before doing so, heat the area to make it easier to drain. Wash your hands thoroughly with soap and water. Then rinse your hands *and the infected area* with alcohol.

Get a *sterile* needle. This should not be a used needle that has been bleached clean. Find a new needle, from a pharmacy, needle exchange, or other dependable source. Diabetic finger lances may also be used.

Puncture the abscess several times with the sterile needle. The exact number of times will depend upon the size and severity of the lesion. This will allow the abscess to drain. Apply pressure around the outside of the abscess to encourage the removal of blood and puss.

Antibiotics

You might consider taking antibiotics. This must be done carefully, and only if you know what you are doing. Misusing antibiotics make you even more sick.

Antibiotics can be obtained without a doctor in a number of ways. They are available over the counter in Mexico. They can also often be found at Chinese pharmacies.

Finding things in a Chinese pharmacy can be difficult, because the people who work there rarely speak much English. As a result, you are left to hunt on your own, but this can be rewarding in a number of ways. Go to Chinatown and go to the shops the locals frequent. Not only can you find some highly useful drugs, but you can also find some great prices. In the past, I've found antibiotics without a prescription for one-tenth the price they would be at a regular pharmacy.

Calling the Doctor

If the abscess continues or you have a fever, you should seek medical attention. The doctor will most likely do a deep lancing of the abscess. In this process, he cuts out tissue selectively in order to allow drainage. Antibiotics are also normally prescribed.

Conclusions

The biggest problem with abscesses is that people ignore them. Don't make this mistake. It is easy to treat an abscess, but if you don't treat it, you can die from it. Pay attention to abscesses and treat them with the care that they deserve.

More On Abscesses

For an overview of abscesses, check out our earlier article. In this article, I will give a little more information on avoiding abscesses. Remember that abscesses are no joking matter. Left untreated, they can cause the loss of a limb and even death.

Ways to Avoid Abscesses

1. Use a new syringe every time you inject. If this is impossible, clean your syringes well before reusing them (next week I will post an article on how to do this).
2. Use clean cookers (spoons), water, and cotton. There is a strong tendency for people to reuse their cottons because they think they are losing heroin when they throw away a used cotton. While this is true to some extent, very little heroin is actually lost. Instead, the cotton is filled with junk that is not only useless, but which can be harmful. The cotton is used to filter these things out; reusing a cotton defeats the purpose of using one in the first place.
3. Wash your hands.
4. Clean the injection area with alcohol.
5. Avoid injecting into areas where veins branch.
6. Make sure you are in a vein well before injecting. Abscesses only occur when the user misses the vein.
7. **Most Important:** Once you have an abscess, leave it alone. Don't inject into or around it.

Blood Abscesses

I have already written two articles on abscesses (Abscesses and More on Abscesses), you would think I wouldn't have anymore to discuss. Unfortunately, I do. This is because I received some e-mail from a friend who mentioned that one should never inject blood into a muscle as this will likely cause an abscess. This annoyed me. "I'm *Dr. H* for Christ's sake!" I thought. "I *know* that this is one of the

easiest ways to get an abscess.

So I thought, "I'll show her!" And I searched the articles I had written online. Nope. I didn't talk about this issue there. So I did a search of the whole site. Not there either. Then I checked the books. Nope! This is a major over-sight on my part, especially considering what a terrible threat I know abscesses to be.

The Problem

Anything that obstructs the natural process of moving nutrients and wastes through the body can cause an abscess. This is because the very transport mechanisms that are stopped are the ones needed to remove the obstruction. So the obstruction — deprived of nutrients *and* waste disposal festers and becomes an abscess. This can cause the obstruction to grow — causing more of the body to be deprived of the nutrients it needs. The extreme results are limb loss and death.

The Cause

Blood is not a single thing — instead, it is a goop. When it is injected into muscle tissue, it *tends* to stagnate. Why? You might ask. Aren't blood cells running all around the body? Well, yes and no. Mostly, blood moves through veins and arteries. White blood cells, more than anything else, move through tissue as part of their primary purpose of fighting disease. Red blood cells (even though they are much smaller than white blood cells) do not move through tissue at all well. And the goop? It moves like you would expect goop to move: poorly.

So injecting blood into muscle tissue is something like injecting mayonnaise. It doesn't matter that it is *your* blood you are injecting. It is in the wrong place and therefore it is foreign matter doing what it always does: gumming things up.

Prevention

A guy goes into a doctor. He says, "Doctor, every time I inject blood into a muscle I get an abscess." The doctor looks at him seriously and says, "Then don't inject blood into your muscle." (Sorry for that joke, but I just flew in from Miami ***and boy are my arms tired.****)*

It seems pretty stupid to tell people the best way to avoid abscesses is to only inject into veins. They aren't injecting into muscle on purpose — especially if they get blood in their syringe. So I'm not going to mention this. There are really only two things a user can do to protect against a blood abscess.

1. Use as small a pull-back as possible. This will limit the amount of blood that eventually gets injected.
2. Once blood is mixed with the syringe solution, empty it into a spoon and re-filter through a clean cotton. Some users suggest lightly cooking the solution to coagulate the blood. I'm not sold on this procedure, but it may be a good idea.

Conclusions

Blood abscesses are usually a sign that your veins are in bad shape. Consider: (1) Looking to other parts of your body for fresh veins; (2) Switching to IM or subcutaneous injection; (3) Switching to smoking or snorting; (4) stopping (using or just IVing) for a while.

Cotton Fever

Cotton fever is a risk that IV drug users face, but which they worry about far too much. I say this because although it is painful, it is not terribly dangerous — there are better things to worry about. The reason for all the interest seems to be that no one can get a straight answer about what it is.

Different Definitions

Just about every information source provides a slightly different cause for this ailment. The Whitehouse Drug Policy's Street Drug Glossary, for example, defines cotton fever as, "Critically high temperature associated with accidentally injecting cotton fibers into the blood stream." Other proposed causes include "dirt in Mexican heroin" and fiberglass in cigarette filters. The connection between almost all the explanations is that cotton fever is caused by some kind of particulate matter that is injected into the blood stream. This is not really true.

Symptoms

There are a lot of different unintended things that happen to IV drugs users: hitting arteries and nerves, abscesses, blood clots. Cotton fever has specific symptoms that differentiate it from other ailments: fever, chills, and shortness of breath. In Europe, cotton fever is commonly called "the shakes" — a reference to another common symptom of cotton fever. Those with this ailment often experience violent shaking or shivering.

These symptoms normally occur immediately following an injection, but there are reports of lags up to an hour in length.

Course

Under most circumstances, cotton fever is relatively benign. It is possible for it to turn into something more serious such as pneumonia;

the user should watch for this, and seek medical attention if the fever does **not** go away. Normally however, the symptoms disappear after a couple of hours or less.

The Cause of Cotton Fever

Cotton plants are heavily colonized by a strain of bacteria known as *E. Agglomerans*. This bacterium causes mischief in the pulmonary system of the body which results in the symptoms of cotton fever. This was first noted in the early 1940s with farm workers who breathed in large quantities of unprocessed cotton.

Most injection drug users utilize small pieces of cotton to filter particulate matter from their drug solution before they inject. It is possible for this to introduce small amounts of *E. Agglomerans* into the solution. When it is administered intravenously, this small quantity of bacteria can be enough to cause cotton fever.

It is commonly believed that it is something about the solid state of the material (cotton or other) that causes the effects of the fever. This is not so; it is the bacteria found in the cotton. It is certainly true, however, that injecting a cotton fiber which will be broken down in the blood stream is a good way to deliver large amounts of the bacteria into the blood stream.

Avoiding Cotton Fever

It is impossible to completely avoid cotton fever except by not using cotton to filter drug solutions. This should *not* be used as an excuse to avoid filtering your solution — or for using a poor substitute. In most cases, cotton is the best thing to use for this purpose. Cotton fever is a fairly minor ailment, whereas the particulate matter filtered by the cotton can be deadly.

To minimize the risk of cotton fever, boil the cotton before it is used for filtration. This should kill the bacteria that cause this ailment. But this is no guarantee. Bacteria can be hard to kill.

In addition to boiling your cotton, make sure that you do not re-use your cotton. There are many reasons to avoid this practice, and only one is to avoid cotton fever. Old cottons break down, making it more likely that a fiber will be drawn into your syringe.

The main thing to remember about cotton fever is that under most circumstances, it is not very harmful. So take what precautions you can, and learn to live with the remaining risk.

Dealing with Cotton Fever

If the fever persists, it should be treated with antibiotics. But this is rarely necessary. In most instances it is best to simply let the fever run its course. You can almost assure that cotton fever will have a minor effect on your body by keeping yourself in shape. Make sure that you eat regularly, get a little exercise, and take vitamins. This will also help you fight off any other ailments resulting from your drug use.

References

If you are really interested in this subject, you might start by reading the following articles. Be advised, however, these are scientific papers, written for scientists trained in biology and medicine. They are tough reading — almost requiring reference to *Taber's Cyclopedic Medical Dictionary* a few times per sentence. The first article is a little more readable than the second.

D. W. Harrison and R. M. Walls, "'Cotton Fever': a benign febrile syndrome in intravenous drug abusers [sic.]," *Journal of Emergency Medicine*, March-April 1990, pp. 135-139

R. Ferguson, C. Feeney, and V. A. Chirurgi, "Enterobacter agglomerans — associated with cotton fever," *Archives of Internal Medicine*, October 25, 1993, pp. 2381-2382.

Diseases

The information contained in this page is culled from The Heroin User's Handbook by our own Dr. H. For more information on diseases of concern to heroin users, see this book.

Hepatitis

You can get hepatitis from ingesting heroin in any way but it is most likely with snorting because the heroin is never cooked. Hepatitis has a strong association with injection because of unhygienic procedures. Regardless of the method of administration, when you keep the

company of heroin users, you risk infection of hepatitis. Although it may not seem the case, a sneeze or a cough can propel particles ten or more feet from the location of the ejection. These particles can land on syringes or other implements thereby being input into your body.

Hepatitis is the inflammation of the liver. There are several different forms of this disease but three are primary: A, B, and C. Each is caused by a distinct virus. I will discuss each form of hepatitis below but first we must discuss the liver and its importance to life.

The liver is a regenerative organ. It has three primary functions: modulation of blood sugar (energy) levels; creation of bile; and removal of poisons. The liver gets blood from two sources: oxygenated blood from the hepatic artery and nutrient rich blood from the portal vein which comes from the stomach, intestines, spleen, and pancreas. The blood from the small intestines carries absorbed nutrients such as sugars and amino acids. When there is an excess of these nutrients, the liver stores them. When there is a deficiency, the liver releases them. In this way, the liver buffers the blood sugar levels so that they never get too high nor too low. The liver also secretes bile. Bile is the substance in the body that digests fat down to sugar so that the body can use it.

Probably the most important function of the liver is removing poisons from the body. This is critical to the body's ability to heal itself. Most drugs are seen by the liver as poisons, so excessive drug use can greatly tax the liver. Alcohol is particularly associated with liver damage. In fact, alcohol abuse is the number one cause of cirrhosis of the liver.

Cirrhosis of the liver is the chronic destruction of its cells. A cirrhotic liver loses its organization which is critical to this complex organ. As a result of this, the liver stops functioning. When the liver cells are damaged, they are replaced by scar tissue. This tissue has none of the liver cell functions. In effect, that part of the liver is no longer liver. When cirrhosis of the liver begins, it causes the liver to be enlarged because of the regenerative process that is happening. But later the liver shrinks because of the contraction of the scar tissue.

Hepatitis A is the least serious form of hepatitis. It usually comes from contaminated water or food and spreads under conditions of poor sanitation. The incubation period is two to six weeks. It's symptoms include: loss of appetite, nausea, mild fever, darkness of urine, and sometimes jaundice (yellowish pigmentation of the skin). In general, the liver will be enlarged but no permanent liver damage results.

Hepatitis B is much more serious than type A. It can lead to chronic (long-term) hepatitis or cirrhosis of the liver. Hepatitis B is generally transmitted via blood: shared or dirty syringes and unprotected sex. The symptoms for type A are about the same as for type B but the onset is slower: it generally takes two to six months for type A symptoms to appear. The severity of the disease depends largely on the physical health of the sufferer before the disease took effect. This is why Hepatitis can be particularly hard on junkies.

Hepatitis C is quite similar to type B. There are only a few differences. The incubation period is highly variable. Generally it is anywhere from two weeks to six months. But increasingly the disease seems able to stay dormant many years. There is currently no cure for Hepatitis C.

AIDS

As if anyone doesn't know this: AIDS is an acronym for Acquired Immunodeficiency Syndrome. And it is believed to be caused by HIV which is another acronym of Human Immunodeficiency Virus. AIDS destroys your immune system. This makes you very susceptible to infection. This is because HIV invades your white blood cells and destroys their ability to fight infection.

HIV is a retrovirus which means that it carries its genetic information via RNA instead of DNA. What does this mean? Nothing. Nothing, at all. What matters is this: if you get AIDS you will die within about a decade. Once infected with HIV, it will lay dormant for two to eight years. Once symptoms develop you are said to have AIDS. These symptoms are: weight loss, enlarged lymph nodes, diarrhea, fever, and night sweats.

If you experience any of the symptoms of AIDS you should, of course, see a doctor. But generally, a doctor will not be able to do much for you if it is caught after becoming full blown AIDS. For this reason, you should get tested for HIV infection as often as is reasonable. This means every six months if you are involved in dangerous activities such as sharing needles or having unprotected sex. If you are living a reasonably clean life then you should test for HIV every two years-if you're doing heroin, you aren't living that clean a life.

Various drugs and therapies can prolong the life of a person infected with HIV. But by far the best thing you can do for yourself is to get healthy. Your first reaction to finding out you are infected will likely be to submerge yourself in heroin. But this will only put added pressure on your body and cause you to have a shorter, and more important, sicker life. Try to look on the bright side: you might live longer with AIDS alone than you would have with heroin alone.

Leukoencephalopath

Leukoencephalopathy is a neurological disease that adversely affects the material that surrounds neurons in the brain and spinal cord — helping them transmit messages and protecting them from electrical activity from other neurons. It was first noted in the 1930s in children suffering from leukemia. The first case associated with heroin use was documented in 1982.

The symptoms of the disease include mental deterioration, vision loss, speech difficulty, loss of coordination, paralysis, and, ultimately, coma and even death in as many as 25% of those with the disease.

The most common way that heroin users get this disease is by infection when the immune system is weak due to AIDS. A relatively small number of people contract the disease directly as a result of smoking heroin. The mechanism is still not understood, but it is believed to result from contact with an uncommon adulterant used to cut street heroin.

The earliest symptoms of leukoencephalopathy are slurred speech and difficulty walking. Any heroin smoker showing these signs (which may come on many days after the last use), should see a doctor immediately. If treated quickly recovery is possible. This disease is treated at length in our article leukoencephalopathy.

Endocarditis

Endocarditis is an infection of the inner lining of the heart. If left untreated, it is fatal. There are two disease types: Acute Infectious Endocarditis and Subacute Infectious Endocarditis. They are caused by different strains of bacteria and progress at different rates. The subacute form is most common. It is caused by a Streptoccus bacterium (the same thing that causes Strep Throat) called *Streptoccus viridans*. If untreated it will kill you within a year. The acute form of Endocarditis is caused by a couple of different bacteria: *Staphylococcus aureus* and *Streptococcus hemolyticus*. It will kill you in about a month.

The bacteria adhere to the inner lining of the heart — the endocardium. Once there, they grow. These bacterial colonies become very large and pieces of them break off and enter the circulatory system. These bacterial "particles" then get trapped in various places in the body. Because of this, you will have some indication that you should see a doctor. The symptoms are: Petechiae in the skin, blood in the urine, and a long-term low-grade fever.

Pulmonary Edema

Pulmonary Edema is the swelling of lung tissue. The main result of this is to reduce the lung capacity, usually to about 50% of its full capacity. It can lead to very potent pneumonia which can lead to death. Generally this is a problem associated with heroin related sudden death. It appears to be linked with existing lung disease but whether this is due to heroin, adulterants, or other causes (e.g., cigarettes) is unclear.

Blood Clots

A thrombus is a blood clot. They form primarily in veins because blood moves more slowly in veins than in arteries. The clotting process is started by the platelets in the blood, which adhere to some surface. Normally, the walls of the veins are too smooth to allow this, but injection scars inside of veins create such surfaces. To reduce the risk of clotting, exercise-pay particular attention to parts of your body in which you inject.

These clots may stick in the walls and form hard clumps that interfere with the flow of blood. These are fairly common amongst injectors. They are usually frightening at first, but over time users find that they aren't particularly painful and that they don't seem to cause any problems other than making the vein in which they reside useless for injection.

High Blood Pressure

All of the garbage that gets introduced into the body as a result of the ingestion of un-pure heroin can cause many different problems. These foreign substances can react with each other and with normal parts of the body to produce particulate matter. Over time, this material will be removed from your body. But until then, it will often be found floating through your blood stream. The presence of this material constricts the flow of blood and so leads to high blood pressure.

This situation is particularly bad for junkies. First, junkies do not stop using for long enough for their bodies to recover and expel the foreign substances. Second, almost all junkies smoke cigarettes. Third, most junkies do not eat well; the number one junkie food is high in fat: pizza. Infrequent chippers should not have to worry so much about high blood pressure. Regardless, all heroin users should check their blood pressures often-I recommend once a week.

Liver Damage

The liver may be infected due to viruses introduced in the administration process. Life is not possible without the liver. It is the primary means by which your body removes toxins. Many drugs are very straining to the liver; heroin is not. But unclean administration can introduce any number of viruses which can attack the liver.

Tetanus

Tetanus comes from the tetanus bacillus that lives in the intestines of all animals (including humans). It is excreted in fecal matter and can live in soil indefinitely. For obvious reasons it is most commonly found in manure. It lives in dead tissue (like skin) and does not cause local inflammation — this is one reason why it is such a dangerous disease; you often won't know that you have it until it is too late.

The tetanus bacillus creates a toxin which it passes to the central nervous system. This toxin causes the nervous system to misbehave-telling muscles to stiffen and often causing painful spasms and convulsions. The first muscles affected are usually the jaws which explains why Tetanus is often referred to as "Lock Jaw." If the respirator muscles are affected, asphyxiation can occur. This point cannot be stressed enough: Tetanus from even a very small wound can kill you. Stay current on your Tetanus shots.

Watch Out

Most of the diseases that are of concern to heroin users have similar symptoms. These symptoms are listed in the table below. If you

notice any of these, you should consult with a doctor. Most of the diseases are curable and those that are not can be helped greatly by a doctor.

Symptom
Long-term fever
Blood in urine
Paralysis
Abscesses
Petechiae
Difficulty Breathing
High Blood Pressure
Uncontrollable Muscle Tightness
Vomiting
Diarrhea
Weight Loss

Symptoms of concern to heroin users.

Sudden Death

Introduction

Sudden death — often erroneously called overdose — is an unpleasant aspect of the life of any heroin user, regardless of whether he injects or not. In this article, I will discuss the various kinds of sudden death associated with heroin use, and give information on how to avoid sudden death and what to do when sudden death strikes someone around you. But remember, regardless of the precautions you take and how knowledgeable and skillful you are, heroin can kill anyone who uses it. Let's start by focusing on this point.

Heroin Can Kill A User

There are many things that you can do to reduce your risk of sudden death when using heroin. But only one thing is perfectly effective at preventing sudden death: don't use heroin. Most people have a kind of irrational fear of heroin as if it can jump out of the medicine cabinet and force you to ingest it. The truth is that heroin is a completely passive agent; it cannot hurt you if you do not take it. But if you *do* take it, regardless of how carefully, you risk sudden death. Even if you have an anesthesiologist administering pharmaceutical heroin to you in the most modern hospital in the world, you can die from heroin use. Never forget this:

Using Heroin Can Kill You.

A lot of recreational activities can kill you, and it is not our intention to over-state the dangers of heroin use. But just the same, after a person has used heroin a few times, he often becomes very casual about his usage. After all, he is ingesting a very small amount of a food product. Under most circumstances, its use is safe and it is easy to forget that things can go wrong. If you want to be safe, don't use heroin.

Types of Sudden Death

When people talk about sudden death with heroin, they usually call it "overdose." The reason this is not a good idea, is that heroin overdose is one of the least common forms of sudden death. This causes many experienced users to be very cocky about sudden death. A young addict once told me, "There's no way I could get enough heroin in a syringe to OD." This was probably true (there are, however, some wrinkles that might upset her logic which we will discuss later). But a very small amount of heroin might kill her for other reasons. This is why I always make a clear distinction between "sudden death" and "overdose."

Overdose

An overdose is exactly what the two words that make up the word mean: "over dose" — having too high a dose of the drug. The primary effect of heroin is respiratory depression. If too much heroin is ingested, breathing will stop all together and the user will suffocate.

As a user does heroin more and more, his body becomes used to it, and it takes more of the drug to produce the same effect. This is called tolerance. Tolerance is not a function of a drug, however; it is a function of a drug *effect*. People become tolerant to heroin's euphoria much faster than they do to its respiratory depression. As a result of this, a person may overdose because they have become very tolerant of the euphoria caused by heroin, but not nearly as tolerant to it respiratory depression.

Tolerance is also a function of the user's mental state. In particular, the environment in which heroin is used can have a large effect on a person's tolerance. Because of this, using heroin in an unfamiliar location can cause your tolerance to decrease greatly, and a dose that would normally be no problem for you causes you to OD. This is what happened to me the only time I ever overdosed. I used almost exclusively in a particular room in my house. The day I ODed, I used at the house of a friend who I hadn't seen in a long time. Although I survived, obviously, this overdose resulted in my first felony — there are many reasons you want to avoid sudden death.

Alcohol

The single most common cause of heroin sudden death is bad interaction (and sometimes synergy) of heroin with CNS depressant —

especially alcohol and barbiturates. The government has made it very hard to get barbiturates during the past couple of decades, so the biggest problem is alcohol.

I have been present during several sudden deaths that happened when a drunk person ingested a relatively small amount of heroin. This appears to have been the cause of Janis Joplin's death, in addition to the deaths of *many* others who are commonly said to have died of "heroin overdose." I am aware of one middle-aged man who died in this way when he was *smoking* heroin.

There are some interesting aspects of this kind of sudden death. These are based upon my observations and should not be considered authoritative. This information may be shown to be incorrect in time, so be careful using any of it.

1. It seems to happen when the user has ingested a lot of alcohol, not the other way around. The critical issue is *not* how much heroin the person will use. A very small amount of heroin can cause this to happen.
2. The order in which the drugs are taken seems to be important. This effect takes place when the user drinks and *then* takes heroin. I have not seen this happen when a person uses heroin and then drinks, but I would not test it.

The bottom line is that heroin should *never* be used with alcohol. This cannot be over-stated.

Do not drink when using heroin!

People often drink to potentiate the effect heroin when they do not have much heroin. Never do this. I knew one man who died doing exactly this.

Quinine

Quinine is commonly used to cut white powder heroin. One of the common causes of heroin sudden death is pulmonary edema. This is the lungs filling with fluid, resulting in the user drowning. Heroin does not have this effect, but this is precisely the effect of a quinine overdose. This kind of sudden death is ironic because what is commonly called "heroin overdose" is killing the user precisely because what he is ingesting has *little* heroin in it, and rather has a high concentration of quinine.

Cocaine

The most feared drug cocktail is the speedball — the combination of heroin and cocaine. I searched far and wide for scientific study of the ill-effects of the speedball. Our cultural fear of this cocktail seems to be nothing more than folklore — based on the fact that telling your body to go in two opposite energetic directions at the same time seems like it *ought* to be dangerous

Speedballs *are* dangerous, but the harm caused by them seems to be due primarily to the cocaine. Cocaine increases blood pressure and can causes heart-attacks Care should always be taken when ingesting cocaine.

Fentanyl

Fentanyl is a synthetic opioid that is ten times as potent as heroin. Sometimes it is sold on the street as heroin, especially under the name "China White." When you ingest Fentanyl that you think is heroin, you are doing ten times as much as you think you are and this can lead to a true overdose, but not of heroin, of Fentanyl.

Avoiding Sudden Death

As you can see from the discussion before, there are a lot of ways to experience sudden death when ingesting heroin, so there is no single thing that you can do to protect yourself. Below is a list of things you should always do (or not do) which will lower your risk of experiencing a sudden death.

1. **Do not mix CNS depressants with heroin.** This is the single most important thing you can do to avoid sudden death. In particular, do not mix heroin (or any opioid) with alcohol. Doing so is a prescription for death. Be careful of other CNS depressants. Barbiturates are fairly uncommon these days, but benzodiazepines (Valium and similar drugs) can have the same effects and are widely available (by prescription and on the street).
2. **Test any new batch of heroin.** When you get a new supply of heroin, even if it is from the same dealer as the last supply, test it by doing a very small amount. Doing so will give you some idea of the potency of the heroin. This is particularly important when you get a batch of heroin that is said to be particularly strong — especially if it is being called "China White."
3. **Take extra care when using heroin in a strange place.** Your tolerance can be lowered dramatically when you use in an environment that you are not used to. Avoid doing this at all, but when you do, ingest less than usual.
4. **Purify your drugs.** Street drugs are cut with all kinds of things that may interact badly with heroin, or may be harmful all by themselves. Do what you can to chemically purify the drugs you ingest.
5. **Be careful of other drugs.** Heroin is often sold with cocaine and so there is a strong tendency to use the two together. Be careful when using strong stimulants like cocaine and methamphetamine. Experience with and tolerance to heroin do not translate to these drugs which have their own dangers.
6. **Don't use alone.** This will not prevent a sudden death experience, but it almost assures you that you will survive the experience.

Dealing With Sudden Death

The most important thing to remember when someone around you experiences sudden death, is that in the vast majority of cases, the

victim can be saved. Do not just give up. In the song "Street Hassle" by Lou Reed, the narrator says,

> When someone turns that blue
> It is a universal truth
> And you just know that bitch
> Will never fuck again.

The problem with this is that it is not true, and the woman in the song would probably survive if the others around her were more knowledgeable and (probably more important) caring.

Most "official" sources will tell you that the first thing you should do in the event of a sudden death is call 9-1-1. I think that this is a judgment call. There are situations when you should call 9-1-1, but in most cases it is not necessary. Below is a table and a list of guidelines on what you should do if someone you are with has a negative reaction after ingesting heroin. But bear in mind that these are my *opinions* based upon my experiences. You may want to be more conservative, and always call 9-1-1. It is up to you; in the end, what is most important is helping the person in danger.

HEROIN helper Recommendations

State of Victim	What You Should Do
Frothing at the mouth	Call 9-1-1
Stopped Heart	Perform CPR
Stopped Breathing	Perform CPR
Stopped Heart (3+ minutes)	Call 9-1-1
Stopped Breathing (3+ minutes)	Call 9-1-1
Convulsing	Put in safe place
Convulsing (3+ minutes)	Call 9-1-1
Labored Breathing	Watch closely
Can't wake	Watch closely

Important: CPR should only be performed by someone who is properly instructed; improperly administered CPR can harm the person being helped.

Things to Do

Following is a list of things to do when someone with you experiences a bad reaction to a drug.

1. **If the victim has fluid bubbling out of his mouth ("frothing at the mouth"), call 9-1-1.** This is a situation where you have few tools to rely on, and your best bet to is to get professional attention. This does not mean that you should just sit around and wait until help arrives. Do whatever you can, but it is likely that your results will be limited and you will need the professional medical help.
2. **A stopped circulatory system is usually a temporary situation that a little CPR will fix.** If you are not sure if a person is breathing, hold a mirror under their nose and mouth and see if it becomes fogged; if it does, the person is breathing. In most cases, it is only necessary to clear the victim's airway. If you are not trained in CPR, you should take a course in it if you are going to be around people using heroin.
3. **Do not freak out if a person is unconscious and cannot be wakened.** If he is breathing, everything is okay. Make sure that you watch over him, however, because he may stop breathing.
4. **Limit police involvement on 9-1-1 calls.** Do not tell the 9-1-1 operator that the victim has been using heroin. Just provide him with the symptoms the person is experiencing. Once the EMTs have arrived, tell them that you know the person sometimes uses heroin. Depending upon the laws of the area and beliefs of the EMT, the police may be called at that point. Because of this, it is best to clean up the area of any incriminating articles.
5. **There are some things you should avoid doing.** Don't inject the victim with salt water; this is an old junkie tale and it is useless. Do not put the person in a cold bath, because this may cause shock.
6. **It is usually said that an overdose victim should not be injected with cocaine or speed.** I have long been aware that the "official" position is to not inject overdose victims with stimulants; thus the title of this list item. But what works best in a hospital under the best of circumstances should not be foisted on panicked users managing an overdose with few tools. I have been vacillating on this point for some time. There are certainly anecdotal reports (including my own) that indicate the efficacy of injecting a stimulant into a person suffering from a true (respiratory depression) overdose. After much thought and without being 100% sure, I have decided that to recommend **against** this practice. The main reason for this position is that the (little available) evidence suggests that those cases where it is helpful are probably cases where the victim would have recovered anyway and who would probably have been better served by the administration of CPR.

   For more on this issue, check out the discussion of the message board The New Bluelight. It is worth reading:

   Stimulants for Heroin OD

UPMC Hepatitis Letter

Dear Sir/Madam:

You have a fine site, and I am adding links to specific pages on the site I run, *Heroin Helper* — an information site for heroin users and their loved ones. However, there is a problem on your page about Hepatitis C. It states that the disease can be spread by:

"injecting illicit drugs with shared needles" and "injecting illicit drugs, especially with shared needle"

There are three problems with these statements.

1. Sharing needles can cause the Hepatitis C virus to be spread. It does not matter whether the substance being injected is a legal drug, an illegal drug, or water. The issue is sharing syringes, not doing illegal drugs.
2. Sharing syringes can only spread Hepatitis C from one person to another when the first person is infected with the virus (assuming the syringe is used just twice).
3. My understanding is that the Hepatitis C virus can live in drug samples. In this case, doing any illegal drug may cause the spread of Hepatitis C. Administration route does not matter, and in fact, injection may be safer given that the sample will likely be boiled first. (I'm not suggesting that boiling will destroy the virus.)

I suggest that you change the content of that page to read as follows:

"Hepatitis C can be spread by sharing needles with an infected person." "The hepatitis C virus can be found in samples of illegal drugs. The virus can then be spread to someone who uses the drug — *regardless of the method of administration*."

Thank you for your attention to this matter.

Sincerely,
Dr. H, Ph.D.
Heroin helper, Managing Editor

Acquisition

Heroin users are least in control of their destinies when they attempt to score. They may be arrested, robbed, or assaulted.

Acquiring Syringes
: All the good intentions in the world will not get an injector to use new syringes if he cannot acquiring them.

Hiding Drugs
: The most likely time for a user to be arrested for possession is right after a score. Learn some tricks for hiding the drugs until you're safely home.

Scoring on the Street
: Unfortunately, every heroin user will occasionally be forced to score on the street. This article gives advice on how to do so as safely as possible.

Pagers
: Drug dealers keep control by using pagers. Learning to live with them is essential.

Over-Charged for Smack
: What should you do when you are being over-charged for dope? Dr. H has a clear out-look on this subject.

Stuck with Tar?
: A Southern Californian wants to know if black tar is the only kind of heroin available. Dr. H answers as best he can.

Acquiring Syringes

Using "Right to Life" to Acquire Syringes

As I write this, I am serving six months in a California jail for a misdemeanor: violation of section 4140 of the Business and Professions Code. This code states that it is against the law to possess a hypodermic syringe, although the actual language of this code makes it sound like I was involved in unfair business practices. Six months is the maximum sentence for this "crime" so I received the maximum sentence.

How Does A Guy Get Six Months for a Syringe?

You may wonder why I am serving six months for this "crime." There are three primary reasons.

1. I was not in possession of *a* hypodermic syringe; I was in possession of 93 hypodermic syringes. In court the DA and the judge made a big deal out of this; they both thought this was a lot of syringes. I wanted to tell them that I could go through thirty in a good night but my attorney suggested that this would not help my case.
2. They did not like me. The DA said, "Mr. Sodenberg *loves* the junkie lifestyle." I don't actually know what the "junkie lifestyle" is; it sounds to me like the "gay lifestyle" — a phrase that is literally meaningless but is used to vilify a diverse minority. But I *was* unrepentant. I had just chosen to leave a drug treatment program for jail. So in a sense, he was right.
3. They were going to add a "public intoxication" charge. This stems from my showing up in another court high. *[Editorial Note: this kind of behavior is a very bad idea. Proper court etiquette is discussed in Heroin User's Handbook.]*

Jail Is a Learning Experience

I met a guy in jail who had diabetes. He was also a speed freak and so we naturally worked our conversation toward the subject of syringes. I told him about my syringe woes. I was tearing up my veins because I was reusing syringes so much.

He looked down and said under his breath, "You can buy syringes in California." He explained to me that insulin is a "right to life" drug and that those who need it will die without it. Therefore, you do not need a prescription for insulin or syringes. I checked this out and sure enough, he was right.

Syringe Law Loop-Hole

Section 4145 of the Business and Professions Code does provides a loop-hole. It states that pharmacists, physicians, and veterinarians may provide syringes without a prescription or a permit under certain circumstances. These circumstances are explained in the following quote from the code.

> [A] person may, without a prescription or license, obtain hypodermic needles and syringes from a pharmacist or physician for human use in the administration of insulin or adrenaline, or from a pharmacist, veterinarian, or licenseholder, for use on poultry or animals; if all of the following requirements are met:
>
> (a) No needle or syringe shall be furnished to a person who is unknown to the furnisher and unable to properly establish his or her identity.
>
> (b) The furnisher, at the time furnishing occurs, makes a record of the furnishing in the manner required by Section 4146.

Clearly, there are many ways that this law can be used to acquire syringes. Maybe you have a sick chicken. I will outline the procedure here for using insulin.

Using Insulin to Get Syringes

You need to get in touch with someone who is taking insulin so that you can get the top off of the box that the insulin ampule comes in. The box top will most likely have a large "N" or "R" written on it. "N" stands for NPH insulin and is a long-acting variety. "R" stands for regular insulin, the kind people inject a couple times a day. There are other kinds of insulin, however. If the box top has something else on it, make sure you find out what it means. Paste this box top to the back of your ID.

Go to a pharmacy and give them your ID, upside down — showing the box top. Tell them what you need. Say something like, "I need a bottle of insulin." And then add, as if you almost forgot, "Oh, and a box of syringes." Most likely they won't mess with you but they may ask any number of questions.

You may be asked how long you have been a diabetic. Diabetes can develop at any time in life, so any answer will do. The main thing is to not stumble on the question. Another important point is that you can't have just been diagnosed with it, because if you had, you would have a prescription — and you don't.

They may ask you how much you are using. Make sure it is more than 15 units because you don't want to get stuck with those half CC syringes. Say something along the lines of 35 units in the morning and 25 units at night.

What are your sugar levels? Normal sugar levels are between 80 and 100. Yours should be higher than this. Something between 140 and 150 will work nicely. Be exact if it is your nature. Normally, you test your sugar level with a "poke test."

What size syringes? My preference is for 27 gauge syringes but you can't ask for these because they are too associated with IV injection. Remember that you do not IV insulin. IM injections are usually done with larger syringes. You can be non-comital on this point or just ask for 28 gauge which is small but still quite common.

If the pharmacist asks you for a prescription, tell him that you don't have one. Have a story ready. A good one is that you are new in town and you don't have a doctor yet. You might also be too poor to pay a doctor to prescribe what you already know you need.

You will most likely be asked for a signature and an address. Make an illegible signature and put down a false address. They will most likely not check and if they do, just tell them that you moved. This might be part of your story anyway.

Conclusion

States that do not control hypodermic syringes have HIV infection rates among IV drug users that are two to three times lower than states that do. In addition, making syringes widely available has no effect on drug use itself. It is extremely short-sighted of policy makers to control these bits of plastic and metal. But until they wake up to this fact, IV drug users will be forced to circumvent the law. It *is* a matter of life and death.

Making the Most of Needle Exchanges

Syringe exchange programs are difficult to use, but in the absence of anything else, they are a godsend. In addition to this, exchanges can be very helpful as a part of a multi-faceted approach to acquiring syringes.

The Exchange Philosophy

The basic idea of syringe exchanges is that syringes are *exchanged*. These programs do not increase the number of "illegal" syringes on the street; they simply replace used syringes with new ones. Even with this restriction, people continue to make the argument that syringe exchange programs increase illegal injection drugs use (this is demonstrably false, however). Without this restriction of only allowing exchanges, it is doubtful that these programs would operate legally anywhere in the United States.

Increasing the User's Syringe Stock

Because of the philosophy of the exchanges, most take great care when counting the syringes that are input and output. Some programs are not so careful. These programs will often allow users to get a few more syringes than they are turning in. Often these programs simply take the client's word for how many syringes are being deposited. This is particularly true when the number is large (over 100).

Many exchanges request that syringes be banded together in groups of ten. If a few groups are nine, it is likely that they will be counted as ten — even at exchanges that are careful about counting. Over time, these minor errors will cause the user's total stock of syringes to grow, and the larger a user's stock, the more useful are exchanges.

Syringe Options

Most exchanges offer a selection of syringes. Normally, they will offer large and small syringes. The large syringes have a barrel that holds one cubic centimeter (cc) of water. This is equivalent to a milliliter. The small syringes have a barrel that holds a half cc; occasionally one sees 0.3 cc syringes in addition to or in place of the half cc syringes. Most heroin users prefer the larger syringes because they ingest a larger solution volume. The smaller syringes are preferred by meth users who inject small volumes of solution (the idea with meth is that there is a one to one ratio of meth to water — heroin is not that soluble).

The other syringe option involves the size of the syringe needle. These normally range from 30 to 27 gauge. See the article Gauging Syringes in this *HEROIN helper* issue for more information about syringe sizes.

Other Stuff

Most exchanges provide a lot of useful stuff besides syringes. These range from syringe cleaning kits to food. The people who run the exchanges really are modern day saints.

Bleaching Kit

One such thing is a cleaning kit. A typical package is shown in the photos on the left. This package contains a lot more than just cleaning supplies. In addition to bleach, which all kits contain, this one contains purified water, a rubber tie, a package of cotton filters, an alcohol prep pad, antiseptic (benzalkonium chloride) towelette, and antibiotic ointment. In addition it has a clean cooker system which is an aluminum cap with a long twist-tie. The twist-tie is wrapped around the the cap and then the ends are twisted together to form the handle for the cooker. This can be seen in the bottom photo.

Condoms

Also available are condoms which, in addition to their usefulness for sex, are helpful when hiding drugs.

Information

Finally, and perhaps most important, the exchanges are usually an excellent source of drug related information. Most of this comes from the Harm Reduction Coalition. The HRC provides many small pamphlets in addition to their exceptional book *Getting Off Right: A Safety Manual For Injection Drug Users*. This book is required reading for users who inject.

In addition to this kind of general information, the exchanges usually have a thorough collection of local information. This includes information on other exchanges, detox programs, support groups for people with HIV and Hepatitis (and drug addiction, of course).

Paying

Needle exchanges are always free of charge. But if a user can pay for his syringes, he should. First, it supports the exchange. Second, in a sane world, he would be able to walk into a pharmacy and buy the syringes he needs — the syringes would not be free. So taking syringes for free is like begging. Some users may not have a problem with this — but most people beg only when necessary.

Price

The retail price of a syringe in the United States is about 22¢. But this is for grade-A end consumer syringes. The syringes that exchanges distribute are of lower quality. As a result, paying 10¢ for each syringe is reasonable. And the exchange will be happy as well.

How Does That "Gauging" System Work?

The measuring system for syringe needles is awkward and confusing for most users. The gauge system is used and it has two attributes that make it difficult for most people to use.

1. The measure increases with decreasing size. For example, a 30 gauge needle is smaller than a 15 gauge needle.
2. The system is not linear. This means that doubling the gauge measure of something does not double (or half, given that the system is inverted) its size.

What Syringe Gauge Measures

The gauge of a syringe is a measure of the needle of the syringe. But there are actually three aspects of the needle that can be measured. First there is the length of the needle. Then there is the outer diameter of the needle and the inner diameter of the needle. The syringe gauge is odd in that it is a measure of both the inner *and* outer diameter.

Nomenclature

Normally, syringes are identified by a number followed by the capital letter "G" followed by a fraction. A typical example is 28G1/2. The "28" is the gauge of the needle — the measure of its diameter. The fraction after the "G" is the length of the needle (just be as consistent as possible) measure in inches. So 28G1/2 is a 28 gauge needle which is a half inch in length.

Gauge Sizes

The table below shows the gauge sizes in millimeters to get a concrete idea of what the gauges really mean.

gauge	outer	inner	gauge	outer	inner
30	0.31	0.15	17	1.50	1.04
27	0.41	0.20	16	1.65	1.19
26	0.46	0.25	15	1.83	1.32
25	0.51	0.25	14	2.11	1.60
23	0.64	0.33	13	2.41	1.80
22	0.71	0.41	12	2.77	2.16
21	0.81	0.51	11	3.05	2.39
20	0.91	0.58	10	3.40	2.69
19	1.07	0.69	8	4.19	3.43
18	1.27	0.84	7	4.57	3.81

Typical Injector Sizes

IV and SC injectors normally use syringes with gauges of 27, 28, and 29. IM injectors normally use wider needles such 21 or 23.

Hiding Drugs After a Score

Most of the time when a heroin user get arrested for possession, it is because a cop searched him and found product. It is not usually the case that a cop grabs a buyer's hand just as he is taking the drug package from the dealer. The cop normally notices something that gives him probably cause to search the user. Cops are trained to search people and places (including, of course, cars) and they are usually pretty good at it. If there is something to find, they will most likely find it.

How Street Dealers Protect Themselves

This is why street dealers normally keep their product in their mouths wrapped in small balloons. If a cop comes snooping, the dealer can swallow the evidence. The balloons protect the drugs inside because rubber is not digested; after swallowing, the dealer can vomit them back up (if it hasn't been too long) or defecate them out.

Without the physical evidence of drugs actually seized, it is almost impossible to convict someone of possession. It isn't illegal to simply *have* things. The police officer must find the substance in a person's possession and show (usually through a chemical analysis) that it is illegal to possess.

Hiding Drugs After a Street Buy

When scoring on the street, the buyer has few options regarding where to hide the drugs. Many people follow the lead of the dealers and put them in their mouths. There are a few problems with this, however.

Where Has Your Dealer's Mouth Been?

First, the buyer must be willing to take something from the dealer's mouth and put it in his own. Straight people might think that it's funny that a heroin user would be willing to (in many cases) inject a drug they bought from a stranger, but would be unwilling to share minor amounts of saliva. I suppose there is a certain irony here, but it isn't as strong as one might think. Before injection, the drugs are boiled, thus destroying most diseases. Also, the drugs themselves are usually fairly pure. They were created in a chemistry lab where a high level of cleanliness was necessary. The drugs are normally cut, but they are cut with pure things like sugar and coffee.

Stashing Unnoticed

If the buyer doesn't care about potential diseases from the dealer's mouth, he must still figure out how to get the drugs into his mouth without being obvious. Cops are aware that people hide drugs (especially heroin) in their mouths, so an obvious action of putting something into one's mouth might well catch an officer's attention.

There are various things that can be done. Most involve some kind of diversion. For example, you could slip or sneeze. The problem with these is that they all call attention to you. Another approach is to simply do it as fast as possible. You could also light up a cigarette, which should give you enough cover to get the drugs into your mouth.

Swallowing When Necessary

Probably the biggest problem with hiding drugs in one's mouth is that cops attack buyers quickly and do various things to stop them from swallowing the drugs. One effective technique is to grab the buyer around the throat until he spits out the drugs. Even if the drugs are swallowed in time, it is a sure bet that the buyer will get beat up because of the frustration of the cop.

Street Scoring Tips

The best advice there is on hiding drugs when you score on the street is this: Don't score on the street. You are safer if you know the dealer and can communicate via pager or cell phone. But regardless, you are safest when you score in private.

Practice, Practice, Practice

If you must score on the street, it is in your best interest to practice swallowing. Buy some balloons and make up practice drug packages (the same size as the ones you buy). Time how long it takes you to swallow how ever many bags you normally buy. Work on reducing the time. Most people have trouble swallowing things without water. There is not a cop in the world who is going to wait around for you to drink some water before searching your mouth.

As you practice, experiment with placing the drugs in different places. Some places allow you to swallow much more quickly than others. Also be sure to keep all the bags in one location. You won't have time to swallow more than once.

Be Paranoid: They *Are* Out to Get You

One last thing you can do is give way to your paranoia. Swallow with the slightest provocation. You won't lose the drugs — it will just be a pain to get them back and you may have to wait a while. If you're really worried, you can swallow right away.

Hiding Drugs In Private

It is a mistake to hide drugs in your clothing. If a cop searches you, he is almost certain to find them. It is also a mistake to hide them in your car, although you may have a really good spot that a cop would miss. Your best bet is to hide the drugs *in* your body.

Nose, Ears, and Mouth

If you are trying to conceal a small quantity of drugs, you may use your mouth, nose or ears. The mouth has the same issues we already discussed. The nose and ears have the advantage that they are not common hiding places. They have the disadvantage that if a cop decides to search in these places, there is nothing that you can do. The nose is less likely to be noticed, but it is possible to accidentally blow it out of its hiding place should you sneeze or just breath hard. It could also just fall out due to gravity. In using the ears, you must make sure that you can still hear or this will call attention to the ears.

The Anus and Vagina

For those smuggling large amounts of drugs, the anus is the typical location. There is no reason that it cannot be used for smaller amounts on a day to day basis. The reason is that in order to do a cavity search, the officer must take you into custody. This means that under normal circumstances, the anus is a very safe place to hide drugs for a short period of time.

Women have the advantage that they can use their vagina as a hiding place. For the purposes of this discussion, the vagina and the anus are equivalent. In either case, the drugs should be placed inside of a condom. A lubricated condom not only protects the drugs, it also makes sticking it inside yourself easier and less painful. If the package is small, the condom also "bulks it up" and makes it less likely to get lost inside of you (this is surprisingly easy to do).

Hiding Your Tracks (not the ones on your arms!)

There are a few things that you can do to keep a cop from catching on to what you have done. First, both the anus and the vagina have distinctive smells. You should wash your hands thoroughly after inserting the drugs. Second, dispose of the condom wrapper. Both of these things (along with whatever caused the cop to stop you in the first place) could encourage a cop to take you into custody for a cavity search.

The Anus is Best

Although it is probably easier and less revolting for women to use their vaginas instead of their anuses, the anus is the preferred location. Most cops are men, and some are not ethical. They are much more likely to do an illegal search of a woman's vagina than of her anus. Even though such a search should not result in a conviction, you still lose the drugs you bought, spend a certain amount of time in jail, and are effectively raped.

Keeping Safe In All Cases

Whenever you are scoring drugs, make sure that you are squeaky clean with regards to the law. Don't score when you are under the influence of drugs — this is more likely to draw a cop to you in addition to the fact that you will not be at your keenest. Don't carry paraphernalia like syringes with you. Don't speed if you're driving. Don't J-walk, if you're on foot. You get the idea.

It is also a good idea to make a bee-line home after you are done buying your drugs. If you go into a grocery store, for example, you open yourself to being searched. Even though such a search will not turn up stollen property (what they are looking for), they will not ignore drugs or drug paraphernalia — not with the reputation drugs have these days.

The Risks of Scoring

Scoring at your dealer's house is probably the safest way to do so as long as you can hide the drugs in your anus and wash up before you leave. Having dealers come to your home, while convenient, can be dangerous if your dealer comes by often and doesn't stay long. Still, it is much better than scoring on the street in known selling areas.

In the end, the only way to be truly safe is to not score. If you score often enough, you will eventually be arrested; that's simple statistics — something will go wrong and you will get popped. The less often you score, the less likely you will be to get arrested in your lifetime. The less you use, the safer you are. If you really want to be safe, don't use at all. This is an option, although users often forget this.

Scoring on the Street

It is an unfortunate reality that from time to time, all heroin users will be forced to score on the street. Scoring on the street is the most common way that users get arrested for possession. There are a number of things users can do to limit their risks, however.

Be Prepared

Don't wait until you have to score on the the street to find out how it should be done. If you are desperate, you will be more likely to make mistakes. Waiting until the last minute also means that you are less likely to do the required preliminary research about the local "heroin scene" and this can result in your experience being much more dangerous.

Read the Paper

You may think it far-fetched that research could be done about the local heroin subculture in your area — apart from having first hand experience. Nonetheless, your first stop in getting a handle on the heroin subculture is your local newspaper. Because of the drug hysteria in this country, newspapers commonly run stories about police "crack downs" and other actions. Things to notice:

Drug Selling Areas
: Newspapers usually provide enough information to allow one to create a map of where in the city to buy which drugs. These stories are always run in the name of reporting on the "drug scourge" in the city, but the effect is the same. This is similar to insurance companies that send out information on how to spot a drunk driver — the information is generally used by those driving while drunk to avoid detection. It is important to remember, however, that drug selling areas listed in the newspapers will be highly patrolled by the police — the newspapers get most of their information from the police.

Vice Days
: Many police departments have "vice days." These are days when the police focus their attention on known drug hot spots. Often police wagons will be brought in and ten to twenty people will be arrested at once.
: Vice days are usually scheduled; that is, they are the same day or days every week. Newspapers mights provide this information, but keep in mind that they might be called something other than "vice days." They might also not be called anything special at all. Look for articles about large numbers of people being arresting on drug charges — the information will be between the lines. If large numbers of drug arrests are made each Wednesday, then that is the vice day — regardless of what it is called.

Visit the 'Hood

The people on the street and who live in the areas where drugs are sold are a good source of information. In particular, beggars can provide a wealth of information for a couple of dollars. It is usually a good idea to consult with a few beggars, however. They will give you information regardless of what they know.

It is also a good idea to just visit the area and check out what is going on — without trying to make any contacts. This will probably give you a good idea of what is going on in the neighborhood. You must be careful, however. In some areas, strangers will be accosted by dealers. Such situations may become dicey if you are not prepared to "do business." It is important to protect yourself by driving through a few times and limiting your stay until you have a good idea of what behavior is acceptable.

Conclusion

Heroin is available in every city in the world, but each area in each city is different. The more you know about the area in which you score, the safer you will be — both from law enforcement *and* from dangerous private citizens. Learn as much as you can about an area before you attempt to score in that area.

Pagers

What did dealers do before they had pagers? I don't know. I do know what they did with the invention of the cell phone and the Internet: nothing. Well, not much anyway. But they would be lost without their pagers. Pagers allow them to be notified that their customers want them, without requiring that they do anything about it. So don't get the idea that dealers are going to be giving up their pagers for a technology which is more convenient for the user. It ain't going to happen.

Contacting Dealers

A common problem faced by users is contacting their dealers when they are not at home. An obvious though expensive solution to this problem is to invest in some kind of cell phone. It must be remembered, however, that analog cell phones are hardly private. For safety's sake, a digital system should be used. This is not that big a deal given that most stuff is digital these days.

Finding Call-Back Phones

The low-priced leader in devices for contacting one's dealer is still the payphone. The problem is, as pagers have become more ubiquitous, payphones that accept incoming calls have all but disappeared. And to make matters worse, many payphones which do not accept incoming calls are not posted as such. So a user may page his dealer to a particular phone and wait and wait for a call that cannot arrive.

Determining if Phone Accepts Calls

An easy way to find out if a payphone accepts incoming calls is to use it to call itself. If you get a busy signal, it means that the phone takes incoming calls. If the phone doesn't take incoming calls you will get some message from the phone company to that effect — *even though you are calling from that same phone.*

Determining if Phone Rings

There is another problem, however. Some phones that take incoming calls don't ring. This is not common, but it does occur. The only way to test this is to call that phone from another phone. If such a phone is found, it may still be used. After making the page, the user simply picks up the receiver every ten seconds. This will not work well for a dealer who waits a long time to call back.

Determining the Phone Number

Ironically, most phones that do not accept incoming calls still have their phone numbers dutifully posted. It is like the phone company gets some kind of thrill out of wasting the time of a person trying to make a page. Phones that do not have numbers posted are as likely as not to accept incoming calls. All one has to do to find out the number of an unposted payphone is call the operator and ask.

Over-Charged for Smack

Dear Dr. H,

I just found out that my dealer is charging me more than he is other people. What should I do?

Sincerely,
Ripped Off

Dear Ripped Off,

You might try talking to him. He may be willing to lower the price. Rather than come right Don't tell him you know he is selling to others at a lower price; this will likely cause an embarrassing and uncomfortable situation. Instead, tell him another dealer will give it to you for that price. In that way he can claim to be doing a deal just for you instead of having to defend himself against the allegation that he's been ripping you off.

But don't expect that you will get the same price as other people. There are many factors that determine how much someone will sell you dope for. One common price difference is white and black. Black dealers have one price for their black clients and another for their white clients. This may be seen as racist, but I don't think it is. You would expect that a dealer would give his best friend a better deal than he would someone else. The black/white pricing is kind of a "us against the world" attitude, where us is the people in the ghetto.

You must decide if what you are getting is worth the price. Comparing your price to others' does not matter. But some comparisons *do* matter. This is a big reason that I recommend users keep track of the money they spend on dope. At the end of the month, you may

decide it isn't worth the cost. $40 doesn't sound like a lot of money. But $1200 ($40 per day for a month) does. I've known lots of junkies who managed to come up with $2000 per month for dope, but who couldn't manage to make their $400 rent. That's a comparison that matters!

Stuck with Tar?

Dear Dr. H,

I am new to SoCal from South Florida. I am bitterly disappointed to find only black tar heroin here. In Miami, I could buy a "cookie" of pale brown heroin (about 4 grams) for $600. The quality was quite good and it was easily available. I figured I'd have no problem scoring in SoCal, marinated in drugs as it is. All I can find is this reeking, black tar. It can be "cleaned" with hydrochloric acid and ether, etc. to make it suitable for injection but I'd rather not do chemistry. What's up with this part of the world? Who smokes this shit? I'd appreciate any comments or advice.

Sincerely,
Disquieted

Dear Disquieted,

You are right to not want to mess with ether; it's more likely to kill you than any heroin impurities. I highly recommend that everyone stay away from it.

And now to your main question. My sources indicate that one can obtain the chalky Colombian stuff of which you speak. This may be reserved for the Robert Downey, Jr. types, however. Most of the heroin coming into Southern California is of the Mexican black tar variety.

Misc

I am dumping information here that has no other place.

Bored
: Boredom can cause addiction.

Chipper Tips
: There are two primary concerns for any chipper: staying un-addicted and staying un-detected. This article provides some tips.

Making the Best
: Being a heroin addict has many disadvantages that are not shared by chippers. This article explains some ways that addicts can use their status to their advantage.

Cutting Heroin
: Learn how to become an unethical dealer by cutting heroin.

Urine Tests
: There are many problems with urine tests, and most people who use them don't understand this. This article deals with how they work and some problems that can occur.

Chipper Tips

If you are a heroin chipper, you probably feel pretty alone. Before the work of Zinberg in the 1960s and 1970s, heroin chippers were unheard of. Even today, their existence is not well accepted. But facts are facts. There are more heroin chippers than addicts — five times as many by some estimates. So if you are a chipper, don't feel alone.

Chipper Concerns

There are two things that chippers need to worry about. The first is staying unaddicted — otherwise, you won't be a chipper anymore. The second is remaining undiscovered. Because the concept of a heroin chipper is so poorly accepted, anyone who finds out that you use heroin will assume you are an addict or about to become an addict.

Tip One: Staying Unaddicted

Staying unaddicted always comes down to controlling your heroin use. There are any number of recipes for avoiding addiction. The most common is probably the "three day rule." This rule states that you should never use more than three days in a row. This is a good rule of thumb, but I have found that it usually leads to addiction because it causes the user to feel worse and worse over time. This in turn causes the user to use more and become addicted.

I have developed a simple rule that will definitely keep you unaddicted. I call it the 8-72 rule:

> You may use for an eight hour period in every seventy-two hour period.

There is no breaking up of the eight hour period. You can't split it up into two four hour periods, for example. Also, you can't use for eight hours at the end of one period and another eight hours at the beginning of the next. This means that after you use (for a maximum

of 8 hours), you must stay clean for the 64 hours that follow it.

Tip Two: Staying Unknown

A chipper experiences his greatest threat of discovery through the process of acquiring his drugs. As a result, great care must be taken in this process. Rather than dealing directly with dealers, it is better to deal with acquirers. The disadvantage of acquirers is that they will cost you more money. But this should not be a big deal given that, as a chipper, you don't use that much. Also, this is more than made up for by the extra security and convenience that acquirers afford.

*[**Editor's Note:** For more information on being a successful chipper, check out my book Heroin User's Handbook. The original title of this book was "Heroin: A Chipper's Guide"; its focus is still toward chippers.]*

Making the Best

It is generally thought that addicts are at a distinct disadvantage to chippers. But addicts have one advantage that should not be under estimated: they can design their lives around their use. Rather than having your addiction be nothing but a disadvantage, use it to your advantage where possible. Below are a few ideas on how being an addict can improve your life.

Dealers

Addicts have their greatest advantage in handling dealers. Chippers may use so infrequently that they cannot have a regular connection. This can put them in the dangerous position of scoring on the street. Addicts, on the other hand, can usually set up very convenient situations with dealers such as having them deliver to the addict's house. Such set ups (and even simply knowing your dealer) will make you much safer.

Quantity

Since addicts use a fair amount of heroin, they are in a position to buy in quantity. Most addicts do not do this, however, because they use at the same rate as they acquire money. For such addicts, it is possible to save money — but needless to say, hard. On the one hand, your habit could be "kicked down" while money is saved. On the other — and much easier — your habit could be kept constant when a windfall occurs such as an acquirer situation.

A bigger problem than getting the money to buy in quantity is not over-using when you have a large amount. This takes self-restraint, of course, and this is not something that can be taught. But even with self-restraint, you are doomed to failure if you don't know how much you are doing. This is why I suggest dividing any large amount of heroin into "daily rations."

Doctors

Chippers will generally want to avoid having their doctors know of their drug use. Addicts have very little choice. But this is an advantage in many ways. Doctors can be very helpful to heroin addicts. The key is finding a sympathetic doctor. Such doctors can be found by trial and error, but it is usually easier to ask other junkies, some of whom will know.

Making the Best

The main thing to remember is being an addict is a simple fact of your life. If you don't want to be an addict, you can always detox. But for whatever reason, if you must stay addicted — make the best of it.

Cutting Heroin

Dear Dr. H,

Could you advise me on the safest way to cut Heroin? Or point me to the info on the web?

Sincerely,
Wanna Be Dealer

Dear Wanna,

Hmm... We don't normally come at it from this angle. What kind are you trying to cut? Powder is normally cut with milk sugar or quinine. The idea of "tasting" heroin to determine its purity comes from the days when it was cut with milk sugar. Heroin is bitter is taste. As a result of this, the more bitter the sample, the purer it is; the sweeter it is, less pure. This is one of the reasons for the introduction of quinine as an adulterant: it is bitter in taste, so a sample will be bitter regardless of how much it is cut.

Note: If you cut heroin with quinine, keep the amount low. People can OD on the quinine. There is evidence that perhaps as many as half of what are commonly called "heroin ODs" are really the result of the quinine it is mixed with.

For tar, the adulterants are normally sugar or coffee. Dope that has been excessively cut with sugar is obvious to sight. It takes on a crystalline form. Did you ever make sugar crystals as a kid? It looks the same except for the color.

For the powder there would be nothing to the process, just mix one powder with the other. For the tar, it would be a bit more complex. I don't know how it is done according to Hoyle; as I said, I don't approach this subject from the standpoint of a dealer. What I assume is done is that the dope is dissolved in water, just as a user would do in preparing to inject. Similarly, the sugar or coffee would be dissolved in water — as much as can be put into solution. Then the two solutions would be combined and allowed to evaporate.

I can't image that this information will be used for any purpose I particularly agree with, but I will hope for the best! Best of luck.

Urine Tests

Dear Dr. H,

I was recently thrown off probation because of a dirty urine test. Let me tell you the story. When I started probation, I was still smoking marijuana. So of course, my first urine test came up positive for THC. My PO told me that this was okay as long as I stopped using right then. He said that as long as the concentrations on my subsequent tests went down, he would not violate me.

Things went well at first. The second test was indeed lower than the first. The third test was negative. I figured I was out of the woods but the fourth test was positive, although at a level lower than the second test. As a result, my PO violated me and I am now doing a year in the county jail.

Please help me. I didn't use any drugs. Why did my fourth test come back positive?

Sincerely,
Rotting in Jail

Dear Rotting,

Before I start, I want to point out that you marijuana smokers have been none too kind to us heroin users. You have been as bad or worse as the general public at vilifying **our** drug of choice. NORML, in particular, is very keen on making arguments like, "if marijuana were legal, law enforcement could concentrate on stomping out dangerous drugs like heroin." But since you are in jail and you bring up an interesting issue, I will take pity on you and explain.

Drug testing is a billion dollar a year business in this country and given that its use is probably the single greatest threat to the little freedom we have left, it may come as a surprise that as a scientific enterprise, it is poorly run. Those who **do** the actual testing understand the uncertainties with the whole enterprise but those who **use** the results, do not. The worst offenders are judges, prosecutors, and probation officers, because they have no one to whom they answer.

Detection Limits

When a urine test comes back negative for THC (or any other substance) it does **not** mean that there was no THC in the urine. All it means is that the THC concentration was below some set limit determined by the test. This is called the "detection limit" of the test. Think of it this way: when you look at an eye chart, there are some letters which are large enough for you to identify and others that are just a blur. The blurry letters are below your visual detection limit. The letters are still there, just like the THC.

So if the detection limit of this particular test is 90 ng THC per ml of urine, a negative test means only that the THC level was less than 90 ng/ml. For example, 89 ng/ml would be called negative. Note that this is **not** 0 ng/ml even though a negative test is normally assumed so.

Urine Density

Everyone notices that sometimes their urine is a dark yellow whereas other times it is colorless. The darker the urine, the more impurities are present. As a result of this, a person's urine THC will vary throughout a day being higher when the urine is dark and lower when the urine is light.

So what happened with you and your PO? I can't say for sure without having the numbers from the tests. But I believe that you are telling the truth. When you took your third test your urine may have been fairly dilute and so the THC concentration fell below the detection limits of the test. When you went for your fourth test, your urine may have been much more concentrated and so the THC concentration was back above the detection limits **even though the amount of THC in your body had declined between the two tests.**

There are two things to be learned here. First, always drink a lot of water when you are subject to urine testing, even when you are not using any drugs; doing this will lessen the chances of a false positive. Second, people in the legal system — and even those working in the testing industry — are often very ignorant of the errors inherent in drug testing and their ignorance can and will be used against you in a court of law.

User Experiences

This part of the site all started when I became a member of an ibogaine newsletter. One reader posted a story of his user days that blew

me away. I asked him if I could use it, and...

The Colors of H

You'd assume that living in Malaysia, which is located south of Thailand and pretty close to Burma, ensures you of primo quality H. But the reality is a joke. What passes for H here is pink. Plus, when there's a big United Nations or other international leader's meeting, Malaysia goes nuts and clears all the junkies off the streets. The dealers, who sometimes sell right next to the police stations, are told to cut down their 24 hour business to between 7-10 pm.

And the H? From pink, it turns to yellow, orange, maroon... You can't even see if you've hit a vein sometimes because it's the same color as your blood.

Then there's North Malaysia. The stuff there is white — better quality due to the proximity to Thailand, I guess. But again, right before elections, you get purple H. Really. Lilac colored. How bad is that?

Try to run south and the stuff is pale yellow. That's why when things get bad, we make daily trips to Thailand. But no more, I guess, since they shot 1,300 junkies and dealers in the first three weeks of their new anti-drug campaign which started February 2003. Plus the Malaysian government started doing urine tests for Malaysians returning at the border.

All that shit makes me miss the days as a student in Bloomington, Indiana where the stuff was good and junkies aren't treated half as badly as they are in Asia.

Even better was the time my poor mom sent me to stay post-detox with friends in Karachi. She thought I would stay clean because women aren't allowed out alone, I had no friends, and I couldn't speak the language. How fortunate that the gardener's helper could be bribed to go and score for me. That was the best two weeks of my using life. Only $2.00US for an entire day of nodding and scratching without even shooting up. That brown sugar was the shit, pure stuff before the dealers get to cooking and cutting.

These days, I've relocated to Indonesia. Even with cops who shoot first and then yell "Stop!" the quality and prices are worth it. All I can say is Thank God for Nigerians!

—Anonymous

Test Drive

On March 3rd of 2001 I was in terrible pain from heroin withdrawal. I was in desperate need to get my fix for the day. I went to a car dealer to test drive a car so I would have a way to get to the west side of Chicago. I cashed a few bad checks and went on my "road trip." I made it to the city after about an hour of commute traffic. I went to my usual spot to score, and then drove away.

I went to an alley to shoot my dope and feel all better. Well, I didn't feel better — far from it; all I wanted was more. I got my girlfriend who was also a heroin addict. Together, we went back to the city — this time, she was test driving. We pulled up to the same spot and bought more dope — enough so we wouldn't have to come back for a few days.

Once again, we found ourselves in the alley getting what we called "high." Wrong again. We had seen Chicago police all over the place, so we finally got some sense and decided to leave. As we left in the car, some cops saw us — in our "test drive" car. They followed.

My girlfriend tried to get away by going down different streets to lose them. Well, we didn't. After they handcuffed us, they found out the car was stolen. We both went to the Cook County Jail. My girlfriend was let go a few days later on probation. Not me.

I was looking at 10 years in state prison for possession of a stolen car, possession of heroin, and forgery. After about 6 months rotting in county, a judge offered me 4 years. I grabbed it, and off to state prison I went.

I was in prison for two years — or maybe it's more accurate to say, "I was in five prisons for two years." At one, the Sheridan Correctional Center, I went through a drug program that changed my life 100%. When I was paroled, I was a different man. Today I have a different outlook on life. But I don't regret my past. I am proud to have been where I have been because it made me the man I am now, and I like who I am now.

—Jayson

Lies

I am a 31 year old male from the Boston area, raised by the War On Drugs and Nancy Reagan's "JUST SAY NO" rhetoric in this our Free (Police) States of the United. I was brought up with a steady diet of propaganda and falsehoods — drugs in any form (other that the ones the state can effectively tax and regulate) would cause death or demise at the onset of the first digestion. Refer Madness!

Drug "Education"

Smoking a joint will cause you to hallucinate, trying H just once will cause addiction, sitters on LSD cook babies in ovens. All of this propaganda worked on me — when I was a child, in no danger of taking drugs anyway because I didn't have any money.

Truth is Stronger Than "Education"

When I got older, I had money. I first lifted the blind fold of "drug education" in the seventh grade, and tried weed. It was like loosing my faith. I assumed that if they had lied to me about smoking this joint, they must have lied to me about other drugs. From weed, I graduated a year later to cocaine. A year after that LSD, mescaline, psilocybin, whatever I could. In each case, drug education was not education; it was indoctrination. Every thing they had taught me was wrong — exaggerations built on distortions plopped on a foundation of lies.

The only things that I had not tried were Heroin and PCP. Heroin still had the the 1970s and 1980s stigma of being dirty and diseased. I still have not tried PCP, figuring that I'll save the embalming fluid for when I'm dead.

After high school, I set myself up with quite the profitable import/export business. I was procuring all the above for a large group of friends and friends of friends. Around 1994 I had set up an operation with some acquaintances that were shipping large quantities of very kind bud from San Diego.

Reevaluating Heroin

My new business partners were clean cut guys with money in their pockets: girls, cars, the whole deal. So I was surprised when one night they pulled some containers from their pockets: plastic bags with a cute little devil holding a pitchfork printed on each. They started snorting the contents.

I asked what they were doing.

Heroin, they told me without emotion.

What! I couldn't believe it. These were not dirty scum-bag junkies. They were not pulling out little kits w/glass syringes that had to be assembled like some kind of sniper rifle. We weren't in a dark dingy hotel room with roaches and a bright neon sign blinking in the window! How could they be doing heroin?

Was heroin just another lie? Here were young men, in all appearances your typical American (minus the fact — or maybe not — that they sold huge quantities of Mary Jane). Regular guys doing heroin and living what seemed to be a normal non-addicted lives?

I don't have to tell you, it didn't take a twisting of the arm to get me to indulge. My "friend" opened one of the little bags, split it into two lines, and handed me a rolled up hundred dollar bill. I snorted. I use the term "friend" loosely, because anyone who would turn someone on to smack is not a friend; but I thought of him as a friend at the time.

Peace on Earth

This was the best high I had ever experienced. I was wrecked. Every time I even thought of moving I was running to the toilet to throw up my guts — this should have been a sign, when I was still it was the best feeling I had ever had. Better than sex. I was hooked, but not in the addicted sense of the word. I guess it is better said that I was in love.

The Love Affair

I continued this love affair for about a year. Snorting on weekends, taking a couple grams on a week vacation. I used the wonder drug to

enhance whatever significant event I had planed — swinging parties or other notable sexual encounters, like nights at my favorite fetish club, The Man-Ray.

Conclusion: Heroin Is Great

This stuff was harmless! Once again the fascist, monarchal, police state in which we live had mislead its people in another New Deal neo-Nazi National Socialist Party propaganda campaign. With my third eye now armed with new clarity, I would never again fall victim.

Trouble Begins

Approximately a year and a half later, I found myself surrounded with people who also had intimate relationships with the lady H. Many had solidified their love affair in engagement. Many more had been married years before, with Lady H being injected into them many times per day.

As I had mentioned, this whole courtship started in 1994 The H on the street in Lowell (which was the location of the best stuff in Massachusetts) had a purity level of between 80 and 94%. People were dropping like flies and the city took it upon themselves to test the dope. And like all good junkies, when we heard of an OD, the fist thing we asked was what was the stamp on the bag? This was not for safety's sake; we wanted to know where to get the killer dope.

My friends were getting higher off one bag shooting than I was off four bags snorting. It was just a matter of economics and time. Soon I was injecting.

Conclusion: Heroin Is Addictive

I was hooked. This time in the addicted sense of the word — the very addicted sense. It didn't take long before I went from having a monkey on my back to having a gorilla. I was an out of control junk-box. I was shooting enough to kill a horse. During this period, I overdosed on many occasions, had two girls die while using with me, and increased my drug use to include speed balls, straight coke, MDMA and what ever else I could fit in a syringe or stuff in my face. I was on a wild ride, doing H from Canada to Mexico and everywhere in-between. But you can only go on like that so long.

I am now clean and have been at least a hundred times since. I battle with addiction every day of my life — and will until the day that I die. I just pray that I'm not addicted to junk at the time.

Truth is not Simple

I guess everything was a lie. What my parents and the government told me was a lie. What I told myself as a result was a lie. And heroin was the biggest lie of all. I think if I had been told the truth — if it was told to me straight: I would have made better, more informed decisions about what and how I put substances into my body.

Knowledge is the Answer

But people are afraid to tell you the truth. It might put ideas in your head. Freewill is fine for those in power. But the masses can't be trusted with it. The "Hear no evil; see no evil; speak no evil" philosophy teaches only that education is evil. And if that's the case, why teach us? Just put us in jails where we have complete, un-hindered freewill to do nothing at all.

Education is a strong force. Educate yourself, and educate your children. You have only intolerance to lose.

—Jason

Bad Fentanyl Patches

I read your stories on Fentanyl and the contents of the Duragesic® patches. A relative of mine works for an in-home nursing care program where they administer strong drugs to the patients. When they die, the nurses confiscate these so they don't fall into the "wrong" hands. Needless to say, I have gotten my hands on some pretty heavy stuff over the years: 160 mg OxyContin®, morphine ampuls, and especially Duragesic®.

These patches come in various strengths that have a total Fentanyl content of between 2.5 mg (releasing 25 micro-grams per hour) and 10 mg (releasing 100 micro-grams per hour). In other words, huge amounts. I have cut any number of these open, and ran a q-tip inside to extract some of the fluid. After all the juice inside the patch was gone, I would cut the remaining empty patch into pieces and chew on it with delight.

After about 4 months of doing this with a *case* of 35 10 mg patches, I was admitted to the hospital with a liver problem. The solution inside Duragesic® caused my liver to nearly explode. My enzymes were over 10,000 — unbelievably high. This was not the result of the Fentanyl; it was the result of the other stuff in the patches.

My advice is: don't mess with these patches. Use them as directed unless you are one seriously knowledgeable chemist and know how to extract the Fentanyl from the glycerine and the alcohol. Even then, who would be ballsy enough to test your first draft? Death row inmates?

That's just my two cents. Happy using!

—Yeah Right

Christmas in Mobile

With Christmas approaching, I've been thinking about presents, because even though I'm in my forties, I'm still a kid. But I know that I won't get what I want for Christmas. Nor will any of my fellow dope fiends in Mobile, Alabama. Let me tell you my sad story — and in a way, all our stories.

Starting Early

I started using H at sixteen, after going thru the typical late 60s, early 70s drug chain: inhalents, weed, acid, mom's medicine cabinet, garbage such as PCP, super potent methamphetamine. Then finally, I found *the drug:* **Heroin**. And all his little (and not so little) cousins, of course.

Sticking Out in Mobile

I lived in a small city in Mississippi about forty miles outside Mobile, Alabama. My friends and I would pool our money and go to Mobile's infamous Davis Avenue. Davis Avenue is nothing but a strip of nightclubs, but it is also the place to buy H. The area is "black": the people who live in the area are black, the people who go to the clubs are black. If you're white, like we were, you tend to stick out like a syringe in scar tissue.

Everyone knew why we went to Davis Avenue. It wasn't rocket science. If you were white and on Davis Avenue, you were either a cop or trying to cop. This had the unfortunate result of making us easy targets for the other whites on Davis Avenue: the police hassled us pretty often. On the plus side, we almost never got ripped off by dealers. The reputable dealers noticed us quickly and welcomed us to their "open-air markets."

Ripped Off

Two instances where a dealer tried to mess with me stick out in my mind. One time I was alone, and the other I was with a friend.

> I gave my money to this guy. He was walking right in front of me, so I figured everything was cool. Suddenly, he's gone; he just vanished into thin air. To this day, I cannot figure out how he did it. He would make David Copperfield ashamed, if David Copperfield hung out on Davis Avenue.
>
> My partner refused to give up our money to a **big** guy with a **big** gun — a .45; The dealer hit him square in the face with the gun. At that moment a police car turned on to the street. We all proceeded to part company, quickly. That is one of the few times I can say I was glad to see the police on the Avenue.

The Glory Days

For the most part, the dope in those days was *very* good (I'm sure we were scoring real China White for a long time). The price was $10 to $15 a cap, or $120 a bundle.

My family moved to Mobile about one year after I started using H, so my connections improved and I was rarely required to "scout the Avenue." The supply increased to the point where the dealers would literally run to your car begging to make a sale. (They do the same these days, but all they are selling is shit, which is spelled "C-R-A-C-K.")

Mobile Dries Up

Alas, the glory days were short lived. Around the mid-seventies the heroin supply started to dwindle until there was *no heroin in Mobile!* Was it due to the fall of the French Connection? I dunno. But it has stayed dry in Mobile for almost 30 years! It's still dry.

We *did* have a very nice temporary solution. A friend in Mississippi owned a small plane; for about a year he would regularly jump in his little airplane, fly down to Mexico, score a few ounces of "black tar," and fly right back down into Redneckville! You know the song: "Those were the days my friend..."? It doesn't even begin to express the emotion.

Toughing It in Mobile

Since the start of the drought, this area's junkies are lucky when they can get any kind of heroin at all. Now they settle for Dilaudid and Morphine. This is in a city with a greater metropolitan population of about one million! I have read about northern towns with populations of 50,000 or less that have H dealers knocking on their front doors! Does Mobile have heroin cooties?

Mobile Has Heroin Cooties

I was taught that demand would always be met by supply. Not So! At least, not so for heroin in Mobile. I know that New Orleans is not "dry," but the 240 mile round-trip is just too far to travel for anyone but a fairly big dealer. It's not going to work for the junkies of

Mobile.

"Dear Santa..."

Maybe Santa Dealer *[or "The Great Poppy" vis-á-vis "The Great Pumpkin"? -Ed]* will visit our fair city this year. We ain't been good, but we ain't been really bad — only a little bad. And for a dope fiend — hell, that's nearing sainthood.

—DIXIEFIXER

***[Editor's Notes:** This is a wonderful article about heroin in an area that few people (including me) know much about. Before I get tons of mail from readers, I want to address a few points raised in DIXIEFIXER's article.*

1. *DIXIEFIXER is right about the "typical late 60s, early 70s drug chain." It is important to remember that this chain has nothing to do with one drug leading to a more harmful drug. This is the old, repudiated, but unfortunately still widely believed idea that "soft" drugs lead to "hard" drugs. Most youthful drug experimentation is entirely dependent upon access — not one drug pushing the youth to another drug. Children are told that illegal drugs are horrible. They try one and find that it isn't. As a result, they will try any drug someone offers them. So much for helpful drug propaganda.*
2. *It is relatively rare for blacks to be involved with heroin. The only period when they did much heroin was the late forties to the early sixties, because of its association with be-bop and cool jazz. This is probably why in the late sixties, the heroin scene was still linked with the club scene. Traditionally, blacks have been associated with cocaine. In fact, the debate over the Harrison Narcotics Act included a terribly racist attack on cocaine-crazed blacks and the threat they posed to good white women.*

   (A number of people have taken exception to this statement, and have presented anecdotal evidence showing that blacks are heavily involved with heroin. They are correct; I have over-stated this. What I was getting at was that culturally, blacks are linked to cocaine. It is fairly common, for example, for a black crack addict to support his habit by selling heroin. The opposite is extremely rare. I stand by this and the generalization — but it is just that, a generalization, and should not be given too much weight.');">But I could be wrong.)
3. *I question how good the dope was in the early 70s in Mobile. The average purity of New York heroin was only 3% at that time. It is always a question of the user's tolerance. If all you've ever had was 3% heroin, 5% heroin is going to seem great. Just the same, the fact that DIXIEFIXER was bring it directly from Mexico just after that period makes me wonder. Maybe New York junkies were getting abused, but those elsewhere weren't. In correspondence with him, he says that a cap ($10) was about as effective as a 4 mg Dilaudid tablet — that does indicate that the dope was of a high quality.*
4. *Doing Dilaudid instead of heroin doesn't really sound like "settling." Although it is common knowledge that Dilaudid is not very euphoric, it is also wrong. Not only is Dilaudid quite euphoric, it is less nausea-producing than heroin.*
5. *Many years ago, when I moved from Portland to Seattle, I found that the dope in Seattle was horrible. So twice a week, I drove down to Portland to score. That is 180 miles, one way (360 miles, round-trip). What's more, a number of heroin addicts have told me in interviews that they travelled as far as 60 miles from home (120 miles, round-trip) <u>each day</u> to score their drugs. So some junkies must certainly be doing the Mobile to New Orleans score. This shouldn't be a great surprise. Heroin users risk spending ridiculous amounts of time in jail for the pleasure of the high. I say this only to reinforce the fact that the experiences of heroin users are highly varied; DIXIEFIXER is right that New Orleans is out of the question for the vast majority of Mobile users.*

I'm sorry for all these notes. DIXIEFIXER brought up so many interesting things that I couldn't help myself.

The Heroin Scene in Philly

Over the past few years, there has been a dramatic increase in drug related arrests in the Philadelphia area. Five years ago, things were different. It was easy to score heroin. Now it's easy to get arrested or ripped off.

The Kensington area of the city was notorious. It was called the heroin capital of the East Coast. There were dealers on every corner shouting out their dope "brand" name. However, the dealers didn't "push" their product; they just competed with each other to get the business of people who where there to score; the other people were left alone.

Drug related violence was minimal at that time. It was a fairly peaceful, albeit, illegal business. The dope was clean, and the streets were safe for the most part. That was five years ago. So much has changed.

Now there are cops on every corner. People are getting arrested for possession of minute amounts of heroin. Understandably, dealers have grown paranoid with predictable results: the dope isn't safe, and the streets are *less* safe; drug-related violence has actually increased.

The customers are desperate and they will buy almost anything, so long as they don't get arrested or killed on the spot. As I made a buy last month, the dealer actually patted me down and held a gun to my head. It wasn't pretty. Everyone has the same thing on their minds: make the deal and get out as fast as possible. While you're on the street, it doesn't much matter if you're buying heroin or rat poison.

I understand the public concerns about drugs and drug dealing in the area. While I sympathize, I don't agree with the current police activity in Philadelphia. More time and money is being spent arresting and punishing small time dealers and users and less time is being spent dealing with real crimes, such as armed robbery and assaults.

I know my opinion isn't popular, but the facts are clear. Five years ago, there was a beneficial relationship between the dealers, the users, and the neighborhood. With drug law enforcement so lax, the area felt like a flea market. Today, anything goes and it is more dangerous than ever.

—Beth

Suicide

Let me relate a personal anecdote from my using days that shows the limits to how much you can help someone. I knew this chipper who, despite not being addicted, was the most irresponsible user I have ever met. It was well-known from others who had used with him, that he would use as much heroin as he possibly could. Not surprisingly, the first time he used around me, he overdosed. It was not particularly bad. I managed to get him conscious quickly and made him swallow a naltroxon pill — partly because I was still a little concerned and partly because I wanted to punish him, since I had warned him not to do the amount he did.

On the second occasion it was much worse. He stopped breathing. I had to give him mouth to mouth resuscitation several times over the course of the half hour that he was unconscious. Again, I had told him he was doing *way* too much, but he did not listen (I later found out that in addition to doing all of his, he had stollen some from me). As I drove him home, I told him that he was not welcome around me ever again. As it turned out, that was the last time I saw him.

Maybe this was callous. But there is only so much you can do for some people. I had done what I could for him — including saving his life — but he would not accept my help when he was conscious. About a year later I found out that he had died of an overdose — either because he was alone or because he was with someone who couldn't or wouldn't help.

San Francisco: February Something 1993

4:01 am The cockroaches have woken me again. Eating the melted chocolate drool off of my unshaven chin. A boney finger scratches at the shattered glass void beyond the burnt mattress that is my domain, my kingdom. The void; my only access to the rusted out fire escape where they watch me as I light my broken crack pipe. I brush roaches off of my cotton pile, like so many fibrous black beans, and drop them into the spoon. Instant fever, just add water. The throbbing begins at the base of my skull pounding through gray matter, A giant pendulating sledgehammer bursting out my temples. Glassine kidneys shattering, and thick green foam erupts from my volcanic throat.

11:39 pm Complete agony. Pounded the rest of the cottons. Ate five Klonopins and 9 Vicodin-EX and tried choking down a Schlitz malt. Promptly vomited it all up. There's nothing that can cure cotton fever except time. No amount of dope. Couldn't even walk to Dennis's, let alone down to the payphone in the lobby for my pager connection. It'd be a waste of effort so I resign, laying stiffly on the sagging mattress, beer soaked blankets smelling of stale smoke and detox sweat, tossing and turning, thrashing in my own private hell.

6:00 am The fog rolls through the dark canyons of the Tenderloin, adding to the subarctic chill long in the depth of my bones. Dumpsters overflowing and crawling with vermin the size of cats create an atmosphere of even deeper despair that reeks from every pour of my skin. Purple bloated arms hang listless from my torso as I shuffle along, time standing still, each moment a painful consequence of my cursed existence. Muni buses roar past enveloping me in petroleum exhaust, I light a cigarette and curse the driver, puking in the gutter.

6:30 am Dennis doesn't like being disturbed at this ungodly hour. Neither do I but hey, rust never sleeps [it's better to burn out]. He buzzes me in despite his incoherent obscenities through the crackling talkbox. Crawling up 5 flights of stairs; decades of flop-house filth and exfoliated human skin create a slick surface on the stained carpet. Dennis's door is open. He's bent over, tying his shoe. I let myself in and announce my arrival. Nothing. Not a movement. Muni bus roars by below, shaking the building at its deepest core. Lighting another cigarette, my fingers stained yellow brown. Dennis's abscesses drip pus down his shin. Still no movement. I look on the coffee table, covered with cigarette butts, ashes, blackened spoons and 1cc insulin syringes in various states of disrepair. A handful of Klonopins scattered nearest to where he sits. Ahhh. He is in the proverbial "Klonopin pause," the fugue state between pleasant nod and complete delirium. This will take a while.

7:45 am Still nothing. I've drummed on the coffee table. Coughed loudly. Run the sink. Sweated another gallon. Paced the one room perimeter 39 times, had 14 smokes and puked twice. Nothing. I'd rob the fucker but Dennis is insane and he'd gouge my eyes out sooner or later. Seeing the filth under his fingernails would be enough to make you cringe.

7:52 am Dennis comes to. Asks who let me in. I tell him, asking for a gram. He leans back, reaching into his pocket. Eyes roll back into his skull. Then nothing.

8:17 am He comes to again, ignoring me. Cooks a gram and plunges the spike into his neck, with the help of a shard of mirror framed in duct tape. Amazing what you can do with duct tape. He hands me a balloon, as if I had just walked in, counting my 35 dollars in singles and fives.

8:26 am I've already got the shit in the cooker when he announces I can't fix here. Bastard tells me "this ain't a shooting gallery." I glance at the blood stains on the couch and floor, the spray of it on the walls. The burn holes in the upholstery, and the carpet. Bottles of bleach from the needle exchange and exhausted methadone bottles crushed in the corners. Right. Fine. I draw the syringe and lock myself in the bathroom, fighting for a vein while he pounds on the door. Fuck the world until I'm well.

8:29 am Nirvana. The Deep Void. Warm Flooding Bliss. Hah hah, fuck you motherfuckers, you can't touch this. Slumped on the toilet, I am the king on my throne. Nothing can touch me. Right here, right now: nothing matters.

8:51 am Opening the bathroom door. Dennis is back on pause. Propped in the corner, cigarette burning between his fingers. I take the cigarette, smoking it as I glide down the stairwell. No sense in letting the fucker burn down the building, although I muse how it might be a service to the reputation of the neighborhood.

9:22 am Nothing compares to the taste and texture of a fresh, properly prepared cinnamon roll. Nothing. The warm soft dough of the

inside, the glazed crust of the outside creating a symphony on the palette. I relish the moment, staring out the window at the foggy streets, knowing I have only minutes before the Oriental owner ushers me out, speaking in machine gun staccato tongue, making room for the next customer at the window seats.

9:41 am Lighting my last Basic I climb the stairs back to the squalor of my room, 3 plastic wrapped white rocks buried in my cheek. I glance in a mirror propped in the corner, not daring to look myself in the eyes. Fuck it. Burning my lip on the crack pipe, I remember a time long ago. All my dreams collapse into the present; just me and my fading glow of smack and the microscopic crumbs of crack I search for in the folds of the bed. The walls close in as I fight for a breath, a fix, a way to exist. The wind screeches through the broken window pane, rusted chains creak and car alarms pulsate as I attempt to surgically remove the bugs under my skin.

—DH

Editor's Note: *The following is basically a "day in the life" story of a junkie living in the Tenderloin of San Francisco in the early 1990s. Although the story is told in a wonderfully stylish manner, the author tells me it is all true (which I don't doubt because it just sounds right. The author left the Tenderloin behind and now lives in the mid-Pacific building a family, creating art, and surfing. He is one of the Ibogaine success stories — he used it to detox from methadone and heroin and has been clean since July 1998.*

Smack in the Middle of Israel

A few years back, I wanted to get off dope so I went to stay with my brother in a small town in Israel. It worked, at first. For five months, I managed to stay clean which was the longest period of time I had ever managed. After that, I began chipping and eventually became addicted again.

Still a City Drug

I had to go into the closest city, Haifa, to score. There were basically two kinds of heroin to be found there. First, there was "China White" which was most likely coming in from Turkey. Most common however, was a beige chalky heroin like the stuff we see from Columbia. This latter stuff was oil-based and had to be mixed with lemon juice to go into solution. The price of heroin was about 100 Shekals per bag which was about a half gram. This equates to about $30. Not surprisingly, the quality of the dope was very high.

Cops Are Everywhere

Life was not good in Haifa. There were a lot of under-cover cops around to worry about. And if that wasn't bad enough, you were as likely to get ripped off there as not. But the scene was interesting. Deals were often conducted down dirt allies through holes in metal doors. You slide money in, they slide heroin out.

But overall, I would say that it was easier being a junkie in Israel than it is in the US. When I was there, they weren't controlling syringes although they were expensive — about a dollar a piece. And people weren't being held in jail for long periods because of possession "crimes."

—Ken A.

Editor's Note: *A word of advice to other young men with similar opportunities: don't try to kick dope in places well known for the high quality, easy availablity, and low cost of their dope. This story was given to us by Ken when he was in jail for possession of methamphetamine.*

—Anonymous

Attack in Portland

Homar was one of our main dealers. After giving him enough money to pay for his whole family to ride on the space shuttle, he wouldn't give me any credit. I was at an unnamed bud's house, who was on methadone with me. We had been out unsuccessfully hustling in the rain all day and had missed our dose. We called Homar and told him to come over, "Yeah, we have money." He sent one of his boys over, name long forgotten.

We had already been told no on the credit. My amigo said, "let's just kill him, take it all and get rid of the evidence." I was down with robbing him, but putting him on ice was a little too much for me. He said, "I will smack him with a cast iron skillet and when he falls you choke him with the phone cord." Let me point out that my bud is a queer and gentle person, so you get the idea of the desperation behind dope and methadone. I agreed to go along thinking it will be over before it comes to actually killing the fool.

Just in case though, I took the telephone cord into the bathroom and put a few slices in the line to make it weak.

Ding dong, come in, whack, wobble, fall. All in super slow motion for me. My bud behind thee door stepping out with a huge cast iron skillet and doing a full baseball swing on the the fucker's head. Whoosh, crack, then dong is what I heard. No sound for the Mexican's mouth. He wobbled, eyes rolled back and then he tumbled. When he hit the ground he opened his eyes and started begging for his life.

My bud was screaming, "Choke him! Choke him!"

We both jumped on him and I wrapped the cord around his chicken neck and pulled, a few second later the cord broke and the Mexican started begging for his life again. I told my friend (who was freaking), "Get the pan and get out of the living room!"

He left the room and I turned to the Mexican and said, "Drugs and money" holding out my hand. He whipped out his wallet and handed it over. I took the money, looked at his ID to get his real name and said, "Now the drugs." Of course, out of his mouth came mad balloons and then from the sock came bag of balloons. I then said, "Get the hell out now, and don't come back."

I remind you that we were at my bud's house which they had been coming to every day.

He left and 30 seconds later Homar was calling saying, "All I want is the money back, just give the money back." Of course, we said fuck you. Haven't seen him since. I did, however, spend the next six months scared every time I was at a call back phone or waiting "two blocks north."

Jukin'

*[**Editor's Note:** When I first read this story, I had a hard time finishing it because it had such a strong emotional impact on me. It does illustrate the desperation that junkies sometime experience. Even though it is extremely rare for a junkie to act as the people in this story, I doubt there is a single junkie who hasn't fantasized something similar. By publishing it, HEROIN helper only wishes to show the diverse experiences of heroin users — both good and bad. We are just as strongly opposed to violence and theft as we are in favor of personal freedom.]*

Portland Is Swimming in Dope

Portland is supposedly the whitest city in the United States. It is not surprising then that Portland is also the number two heroin city in the United States given what a white drug heroin has become. Heroin is pervasive in Portland (excuse the iliteration).

To give you a good example of this, all you have to do is stand on the street in a residential neighborhood. The drug dealers literally drive around tow waiting for pages from their clients. All you have to do is wait long enough on the street and you will see them drive by.

How can you spot them? First, they are always Mexican. That isn't racism, it is just the reality of the city. Heroin dealing is controlled by Mexicans. Second, they almost always drive older (1980s) four door American cars. Why they are older and American made, I cannot say. I can however call you why they are four door cars. Generally, two Mexicans drive around in the front seats. With four doors, clients can easily get in and out of the back.

You may question how easily it is to spot heroin dealers in Portland, but I assure you that it is true. In fact, this is how I met a couple of dealers. Twice in one year, I was waiting on the street for a dealer (perpetually late) when a different dealer drove by and picked me up.

Maybe I just look the part. But then again... I have met other junkies who have had the same experience. I think it is just a function of how big heroin is in Portland.

—John E.

Worried

This part of *Heroin Helper* is dedicated to helping the loved ones of heroin users. Sometimes this just means helping them to stay calm. More often it means much more.

Most people want to help "junkie" loved ones. Unfortunately, it is the rule that such people have exactly the opposite effect as they wish. To start with, the "help" is usually just an attempt to control. Being truly helpful starts with understanding. And that means learning about heroin and heroin users.

All of the information on this site will help to educate you about heroin. As an overview, I recommend my book *Little Book of Heroin*. At just under 80 pages, the book can be read in an evening — and it will explain pretty much everything you will need to know about heroin.

There is also *Heroin User's Handbook*, which provides a more thorough discussion. If you want to know more about the science and history of all this, check out *Little Book of Opium*.

The information in this section of *Heroin Helper* is directed at helping the non-using loved one have a positive impact on a heroin user. I think you will find that the articles found here are different, and perhaps even revolutionary. This is the place to come for information on understanding and living with a heroin user — and more commonly, a heroin addict. My intent is to make communication better; that is the beginning of everything.

And remember, if you have any questions, you can always...

This article gives helpful advice on how to encourage heroin addicts to give up their addiction.

Do As I Say

This article discusses the problem of helping junkies even when you know what you *should* be doing.

A Junkie Dies

The loved ones of those who die of a heroin related sudden death must deal with special problems.

Bad Friends

Two examples of really bad ways to be a good friend to a heroin user.

What Do You Want?

I get a lot of e-mail from the friends and family members of heroin users. In over half of this mail, I do not know if the heroin user is addicted or not; the writers almost always assume so. I'm very glad that they write to me, but their assumptions are the biggest barrier to success in their stated goal: to help the heroin user.

If It's All or Nothing, It's Nothing

I'm sympathetic to people who love a heroin addict. I've been on both sides of that relationship, and the non-user normally feels terrified and impotent — a miserable emotional combination. In most cases what these people need is professional counseling over a reasonable period of time. This is because there are many steps that lead to simply figuring out what they want and what they mean when they say they want to "help" the heroin user:

1. Understand the situation
2. Understand how heroin use affects the loved one
3. Discriminate practical effects from moral effects
4. Engage the loved one in a dialog about what *he* wants
5. Determine what, if any, shared goals you have

Help or Control?

It is only after working through these five steps that one can really help a heroin-using loved one. Most people think that help is *defined* as providing assistance to stop using. For many heroin addicts, this is exactly the help they are looking for. For many others, this is not help at all; it is interference and power abuse. And even for those who want such help, none would consider all means of accomplishing this goal equally helpful.

The most extreme way to get a person to stop using heroin is to kill him. Another way is to have him arrested. These are clear examples where the true intent is control, not help. But I dare say that shelling out $10,000 for a medicated detox is also an act of control in most cases. This is not the case because the "helper" is cruel, however; it is so because the helper panicked and didn't think through what he wanted to accomplish.

Understand the Situation

People usually assume that the knowledge of heroin use is all the knowledge there is — or at least all the knowledge they need. There is much more information that needs to be attained. Here are just a few:

- Is he addicted?
- How long has he been using? How long addicted?
- How often does he use?
- How much does he use? How much money does he spend on it?
- How does he administer the drug?
- Has his use exposed him to any diseases?
- How does he get his drugs?
- Why does he use heroin?

The first few questions give a idea of how big a physical problem he has — if he has a problem at all. They also make an assessment of what health needs he may have. How he gets his drugs puts his use in a social context. It is also a gauge of the dangers he is exposing himself to in terms of violence and arrest. The last question is open-ended, but I think it is especially important because most people think weakness and an inability to deal with the stresses of life are what cause people to use heroin; this is almost never true.

The main issue here is that all heroin users are not the same. There is a big difference between a guy who snorts a line of heroin at a party every few years and a guy who injects four times a day at a cost of $200. And there's a big difference between a guy with a $200 a day habit who makes a half million dollars a day and a guy with the same habit who has to steal and beg day to day to support himself. What is the difference? Aren't the two guys with the $200 habits equally dependent upon heroin? Yes and no. They are both equally dependent in a biological sense. But the life of the second addict is almost completely dictated by the needs of his addiction; the second addict's life is not, although it is dictated by the needs of his addiction to some extent.

Understand How Heroin Use Affects the Loved One

If I can impart just one bit of advice to a loved one who wants to help a heroin user, it would be this: "Determine what negative effects

result from your loved one's heroin use." When people focus on the drug use itself, they create a window of what constitutes "help" and "success" that is so small as to be virtually useless.

It is critical to understand the effects of the loved-one's heroin use. Caffeine addiction isn't a big deal. Why? Because it doesn't have a negative effect on the addict's life. But if the addiction becomes so great that the coffee drinker is stealing his kids' lunch money to buy extra Lattes at Starbucks, caffeine addiction *is* a big deal.

Three Kinds of "Effects"

There are three categories of effects. First, there are tangible effects. These are concrete occurrences that happen because of heroin use. They can be biological: the user may sleep more than usual; sociological: spending less time with family because of time spent acquiring and using heroin; financial: money is exchanged for heroin. It is important to remember that not all these effects are negative. Heroin use might lower someone's stress level or it might cause them to do a dangerous activity less often. (Some heavy drinkers have stopped because of their heroin use, and despite its illegal status, heroin does far less damage to the body than alcohol.)

The second category is intangible effects. The worry of loved ones is an excellent example of this. So is any possible effects that stem from the third category: risk. A heroin user can overdose and die. Once this happens, a myriad of tangible and intangible effects occur: a child's loss of financial support and feelings of loss, respectively.

The risks of heroin use are something that most users do not think about very carefully. For the heroin-using head of a household, even an arrest without conviction could devastate his family in a financial sense.

The effects of heroin use are the only reasons a heroin user might need help. When one helps a heroin user for other reasons, the help is a euphemism for "converting" or "re-programming." But some effects are really just a justification for this. That is why the next step is the hardest to accomplish.

Discriminate Practical Effects From Moral Effects

There is usually little difficulty defining the tangible effects and risks resulting from heroin use. Defining the intangible effects is a process filled with traps. A loved one may think less of a heroin user because in his mind, junkies are low-life scum that should be exterminated. This might seem like an intangible effect of the heroin use, but it isn't. It is an effect of the non-user's bigotry. All this convoluted "effect" boils down to a moral judgment: heroin is bad, so heroin users are bad.

Everyone is entitled to his opinion. But a heroin user does not become a different person when he stops using heroin. A desire to help a heroin user based upon moral objections to heroin use, is a desire to change who the heroin user is. This is impossible. What's more, from a practical stand-point, such "help" will alienate the heroin user, because he knows that he can change how he acts, but he's stuck with who he *is*.

Engage the Loved One in a Dialog About What *He* Wants

Based upon the effects of the loved-one's heroin use, the non-user will have a pretty good mental list of what positive changes the user could make. In most cases, this won't be a single-item list: "total abstinence." Consider an example.

> The heroin user regularly shares syringes with other using friends. As a result of this, one of the negative effects of his heroin use is that he risks contracting any number of diseases, especially AIDS and Hepatitis. The heroin user makes the necessary changes in his using so that he will never again share syringes. He made a positive change to his life even though he did not stop using heroin.

The ultimate desire of the non-user will likely be abstinence for the heroin user. But defining this as the only positive change implies much about what the non-user really thinks. If the loved-one of our example syringe-sharing heroin user doesn't rejoice at this change, he doesn't care much about the heroin user. A concept "heroin use" is more important than the human being he supposedly loves.

With some ideas of what the heroin user could do to improve his live and the lives of those around him, the non-user is in a position to find out *and understand* what the user wants. By working through these steps, the non-user may well have some insights to impart to the user. The effect that risks have on those around him, is one good example. But mostly, this is a time for the non-user to listen. Most heroin addicts do not want to be addicted. Just the same, most would like to continue to use occasionally. It is very difficult to accomplish both these goals, but it is certainly done. The non-user really needs to avoid arguing that such things can't be done — even if it's true.

Heroin addicts often tell me that they would "like to go back to being chippers" when they are thinking about detoxing. This is my response:

> This can be done, but it's difficult. The first thing to remember is that it is virtually impossible to quit when the goal you are focusing on is using. What you need to do is decide to quit with the idea that after you are no longer an addict you will have the option to make whatever changes in your life you see fit. The first step is to get clean. The second is to stay clean for at least three months; six is better. If you use before three months, you will quickly become re-addicted. You've got to give your body enough time to completely normalize. At that point, if you want to try to chip, you can; maybe you'll succeed and maybe you won't, but you won't be any worse off than you are now.

Knowing that they can use again one day is inspiring to many addicts. What's more, a lot stay clean for a while, use once, and find that

they really don't like it anymore. But that isn't really the point. In a nutshell, her it is:

> We *control* people on *our* terms
> We *help* people on *their* terms

Determine What, If Any, Shared Goals You Have

An honest dialog between two people who love each other is bound to result in a great deal of consensus. Their shared goals will likely amount to a plan — little steps toward a distant location. Because the user will not be faced with the "I will never use heroin again" goal, the non-user will not be faced with the "I will mortgage the house to send you to the Betty Ford Clinic" responsibility. What's more, the non-user will know that he is providing real help, and just knowing that will make the user's journey easier.

Just Give Up

Most people eventually give up helping their using loved-one. They get disappointed and abused too much; everyone has a limit. But these people really aren't let down by the user; they're let down by their ignorance. What they want is abstinence. There is no room in this paradigm for feeling good about successes made toward that final goal. They are prepared for relapses because everyone's seen the AA bumper stickers, "Relapse is Part of Recovery." But they aren't prepared for real-life complexities.

> A heroin addict decides to stop injecting and switch to snorting. His brother tries to help by allowing him to live in a trailer in the back-yard. Two weeks later the brother finds the addict injecting again. The addict claims it was too expensive to continue snorting. The period of snorting caused the addict's dependence to change to half what it had been before. The addict has made huge progress toward his brother's wish of abstinence. But the brother doesn't see the success in the failure.

I don't mean to imply that the brother is wrong in this example. I mean to show this whole process is complex and even in the face of dramatic success, outsiders can feel nothing but failure. Junkies lie; junkies betray; junkies give up. So give up.

Or Open Up

By working through these steps, the non-user sees two things he would not have before. First, he can see that heroin use should not be judged with a two-level grading system: 0% (use) or 100% (abstinence). Second, he can see that the process is about the user. If his life isn't improving, maybe the non-user needs to help in a different way; maybe there is no way he *can* help the addict. Regardless, the user is attempting to improve his life, not placate those around him. If he is, he's certain to go nowhere (because he's headed nowhere) and user and non-user alike should just give up.

Heroin Is Different

One of the great myths about drugs is that they are all the same. This myth takes many forms, like one of the tenets of the NA pseudo-science: addicted to one drug, addicted to them all. Another, much more important and harmful form of this myth is the belief that kicking heroin is the same as kicking any other drug. Heroin has special attributes that make becoming un-addicted to it particularly hard.

A Tale of Two Addictions

In my lifetime, I've been addicted to two drugs, both considered "hard": cocaine and heroin. I would never say that kicking cocaine is easy — in fact, in some ways it is much harder to kick than heroin. With cocaine, the biggest problem is deciding to stop. With heroin, the problems really start when you decide to stop. Giving up heroin presents special — physiological — problems to even the most determined addict, which can keep him addicted for years after he's decided to stop.

Ending Cocaine Addiction

I tried to stop using cocaine many times before I finally succeeded. In the end, it took me over a year stop using it. Cocaine is a very forgiving drug when it comes to this kind of usage. Because it is not physically addictive, going back on it for a short run will not get you re-addicted. Doing so with heroin will result in the onset of the withdrawal syndrome which is extremely unpleasant. Even if you have no desire to continue using, you may find it necessary simply to feel well enough to go to work or manage other parts of your life.

Two Steps Forward, One Back

Cocaine allows you to stop using a little at a time. You can go two steps forward and one step back. All you have to manage is the craving.

When I decided to stop using cocaine, I noticed a pattern to my craving — I was hung up on the number "three." At first, I hit a wall at three days. I would stop for three days, then the urge to use would get strong. Someone would offer some coke to me, and down the garden path I would go — until I stopped again. Eventually, I was able to push past my third-day craving. Then, three weeks became my limit. After I conquered this limit, I hit a three-month limit. After that, there was nothing — the addiction was gone.

Heroin Is Not Like Coke

I couldn't have used the same process to kick heroin. Three days isn't even long enough to get through the withdrawal syndrome. Even

three weeks isn't long enough to get thoroughly detoxed, so using for any length of time at all will get you re-addicted. So the "two steps forward, one step back" method doesn't work with heroin. And yet, I found it was still necessary to gradually move away from heroin.

Friends and Family

Most friends and family members understand that mistakes will be made in the process of getting clean. What they don't understand is why motivated heroin addicts don't just "get back on the wagon" when they fall off. The reason is that getting back on the wagon can be really painful.

Unhelpful Help

Although this was never a problem for me, many people get weighted down by expensive detoxes that their loved ones have bought for them. When a father pays $10,000 for his daughter's detox, she will feel immense guilt if she uses for a couple of days and gets re-addicted. She hasn't just relapsed, she's gone back to square one; the $10,000 was simply wasted. Or so it seems — especially to her. She will most likely distance herself in an attempt to hide her failure, and this will only make matters worse.

The Re-Addiction Process

The motivated cocaine addict may have a rocky road to abstinence, but rarely will he ever feel as though he is starting over. As a heroin addict, it seems like the whole journey must be taken time and again before success is achieved. This is not true, however. Just as with cocaine, getting and staying clean is a process.

No Big Deal — and a Very Big Deal

It helps immeasurably to have friends and family members who understand the re-addiction process. This is hard, because on the one hand, they need to understand that it makes the process infinitely harder; but on the other hand, they need to understand that it is part of the process and isn't a big deal.

A Big Deal

It *is* a big deal in that detox is painful. It is a lot easier to not use when it just means you aren't going to get high than it is when it means you are going to be in physical agony. So an addict's wish to use isn't "irrational" and it isn't just hedonistic drive; it is a rational wish to avoid pain. The addict can only decide not to use by placing long-term goals ahead of short-term, clearly defined interests. This is very hard to do. When friends and family understand this, it makes life (and detox) much easier.

No Big Deal

It *isn't* a big deal because most addicts will get re-addicted after they first stop. In fact, most do so many times. What normally happens, however, is that the runs: get shorter and less intense; this results in the *detox* being shorter and less intense. But even when this isn't the case, wisdom is gained — progress is made.

Keep Detoxes in Perspective

The hardest part of this is understanding that getting detoxed isn't that big deal. Too often, everyone involved invests far too much in any given detox — as though it is the final word in the addiction. When this is the case, addicts hide their minor failures, which then turn into major failures; friends and family put unfair expectations on the addict, which often end up tearing loved ones apart in a flurry of acrimony.

Heroin Is Different

Ending an addiction to heroin is not like ending an addiction to most other drugs. Assuming that it is only makes the process harder for everyone involved. Understanding the effect of the withdrawal syndrome on the process is a key ingredient to the least painful road to abstinence.

Encouraging Junkies to "Clean Up"

There are two ways that people usually talk to junkies about getting clean and neither of them is very effective. The first is to plead and beg. The Second is to threaten. The problem with both these is that you are asking (or telling) the junkie to change. People don't like to change, but the issue is much bigger than usual in this case.

Being a junkie is hard work. It is a 24 hour per day, 7 day per week job. One young junkie couple told me of waking up Christmas morning without money or dope and everything they went through that day to take care of business. This ended with them standing on a deserted street for a half hour waiting for their connection to arrive. Junkies don't get a day off. When someone tells them that there lifestyle is wrong, they take it somewhat worse than hang-gliding enthusiast take pleads from loved ones that they worry because hang-gliding is dangerous (more dangerous than using heroin, by the way).

It is a mistake to come right out and ask a junkie to stop using. But this does not mean you cannot encourage them in this direction in

other ways. Below is a list of things you can try to encourage a junkie you love to stop using.

Treat him like any other friend

People tend to treat junkies like children. They won't lend money to a junkie, or if they do, they will only do so in the most humiliating way (like going to the grocery store with the junkie and buying food for him) so it isn't spent on "something bad." If you have a friend who is a junkie, try to treat him the same way you would if he weren't a junkie.

I handle it as follows. I'll loan money to a junkie friend. But I expect to get paid back. I am very clear about my expectations. I don't loan money again when previous loans are still unpaid. I also don't loan money when the friend has previously jerked me around.

By treating a junkie like anyone else, you keep him involved and "vested" in the regular (straight) world. People normally become junkies because they lose their connection with that world. Probably the most important factor in getting and staying clean is getting that connection back.

Don't allow him to abuse you.

There is nothing about the pharmacology of heroin that makes users of it bad people. In fact, it is likely that heroin alone would have a positive effect on a user's personality. But there are tremendous pressures on a heroin addict, and he will act in ways that even he would consider wrong under different circumstances. Under most circumstances, if a heroin addict hurts you, it will be by stealing from you.

Don't allow a junkie friend to steal from from you. Mostly, this just means using your common sense. Junkies, just like everyone else, dislike stealing from their friends. Don't provide them with a great deal of temptation. Don't put them in control of large sums of money, for example. A dope sick junkie is not a good choice to house-sit for you.

You must be reasonable in applying all this. There are many junkies who work regular jobs and support their habits within these means. There is no reason to think that such a junkie is anymore likely to steal from you than anyone else. But if this same junkie should lose his job, you should certainly be cautious.

Talk Honestly

If you are worried about your junkie friend, tell him so. Let him know what your concerns are. Approach this the same way you would talking to someone about any dangerous hobby. You wouldn't tell a rock climber that you think he should stop because it's just wrong to climb rocks. You might say that you worry that he isn't going to come back every time he goes on a trip. Letting a junkie know about your concerns will probably not have a direct effect on him; he won't simply stop using. But it will be one more thing in favor of not using.

Be Supporting

People tend to think of heroin as a binary proposition: junkie or straight. This is not how it is at all, of course. Junkies do all kinds of things to modulate their habits. It is well known that junkies will "kick down" their habits from time to time. Be supportive of any positive move that a junkie makes. Don't fall into that 12-Step mentality of "If it isn't complete abstinence, it isn't enough."

Avoid Suspicion

Especially after a junkie has kicked but even when he is actively using, try to avoid speculating about whether he is using or not. It is common for a person to go from junkie to chipper. They usually feel they must hide this fact from their straight friends and this causes isolation which may cause them to go back on heroin fulltime.

The best way to encourage a junkie toward a safer lifestyle is to be understanding and supportive of them. You can't make decisions for them. Keep in mind that most heroin addicts do eventually get and stay clean and that the average length of time that someone stays addicted to heroin is about three years. If you have a loved one who is a heroin addict, take heart; it probably isn't as bad as you think.

Do as I Say

Giving advice is easy; following it is hard. Or, as my mother used to say: "Do I say, not as I do."

In the article, Encouraging Junkies to "Clean Up", I made some very good recommendations about how to deal with heroin addicts — recommendations that, even if they didn't stop an addict from using, would improve your relationships with them. The main point I made was that you should treat a heroin addict like any other adult. But this is very hard to do, as I know from my own recent experience.

The specifics of my experience do not matter. What came out of the whole episode was that I was not clear with my expectations. As a result, I found myself as the "go-to man" when my junkie friend was in need of money; I was loaning money at an increasing rate with no end in sight, and no hope for repayment.

At one point, I reached my breaking point and the relationship became very strained. I began refusing to take phone calls from my friend. I felt used, but truly *it was my fault, not his*. He was just trying to get through a tough period, and I was the easiest method available. In the end, it was also the person to take the steps necessary to repair our damaged relationship.

My mistake was not being clear to him about what I felt comfortable giving. No one expects a friend to give up his last dime as a favor. I find myself falling into this trap of thinking that if I *can* loan (or give away) money, then I *should* — being a good friend requires this. I suspect I am not alone in this feeling, even though the ridiculousness of it is obvious.

If someone (junkie or not) asks you to loan money, it is okay to say, "I don't mind loaning money, but when someone repeatedly borrows money from me, it makes me feel like a sap — so please don't ask to borrow money again until you've paid back *this* loan."

How successful you will be at setting up these kinds of boundaries will depend upon you. It is a lot easier to give advice that to follow

good advice. You will do better to do as I say than to do as I do.

A Junkie Dies

It is harder to deal with the sudden death of a loved one than a death that gives warning. It may seem odd or even cruel to say that prolonged deaths like those from certain kinds of cancer are a "good" way to die. For the survivor, however, it is true, and there is one very obvious reason why it is so: prolonged deaths allow everyone involved to say all those things that we rarely say on ordinary days — things like, "I love you," "I forgive you," "I'm sorry." In other words, it is possible (even likely) that you will reach some kind of closure in your relationship with the dying loved one.

Unpredictable Death

When a heroin user dies as a result of his use (1), much is left un-said, because there is nothing that can predict the death (other than the obvious fact that one who doesn't use heroin will not die as a result of using it). To make matters worse, surviving loved ones fall into one of two categories, both bad:

1. **They were unaware that their loved one used heroin.** This situation inevitably leads to thoughts such as, "I should have been more involved with his life."
2. **They *were* aware.** This situation is even worse with thoughts such as, "I should have done whatever was necessary to get him to stop using — not just wait for *this* to happen."

Keep Perspective

There is nothing that I, or anyone else, can say that will do much to ease the sorrow of a heroin-related sudden death. The one thing I think I *can* do is put the death into perspective. Such a death is kind of a combination of a suicide death and an accidental death, even though in all cases it is solely one of the two. Some heroin users choose to end their lives and they use heroin to do it. Based upon my own experience, however, most heroin related sudden deaths are accidents: mis-judging the purity of drugs being used, carelessly combining heroin with other drugs such as alcohol, or any number of other things that can go wrong.

As I have written many, many times, using heroin is a dangerous hobby. I have never met a user who was not aware of that fact — for many, it is part of the thrill of doing the drug. But leaving how dangerous a hobby heroin use is, it is still just that: *a hobby* . Heroin use is a recreational choice that some people make. You have no control over such choices made by other people.

You Can't Make Decisions for Others

When a person dies for a reason related to his heroin use, you must stop all thoughts that you could have gotten him to stop using. Doing so would have been as effective as trying to stop a hang-gliding enthusiast to "ground" himself. He made his decision, and although the results were tragic, you are not to blame in any way.

Ways to Keep Perspective

Below is a list of things to keep in mind when you are thinking of a deceased heroin user who you cared about.

Those Using Heroin Know What They Are Doing
: There are a lot of people who could be blamed for a heroin related sudden death: the dealer, the government, the user's parents. All of this is bunk. The user knew that what he was doing could kill him. He made the choice anyway, because he thought the good things (the way the drug made him feel) out-weighed the bad things (jail, death). When a heroin user dies in this way, it is his fault. This doesn't mean we can't still feel sorry for him. A lot of things conspired against him; he would have led a very different life in the 19th century, for example.

Heroin Use Does Not Imply an Unhappy Life
: Contrary to popular belief, heroin users use their drug of choice because it makes them feel good. I've met plenty of junkies who had near-perfect childhoods. They weren't using heroin to rid themselves of painful childhood memories. Doing heroin (at least at first) was fun. No one questions the motivations of people who ride rollercoasters; no one should question the motivations of heroin users.

Heroin Use Has a Positive Impact on Society
: Most heroin users are rebellious. We should revoice that our heroin using loved one pushed the limits of our social conventions — in a manner that didn't harm others. They may have also done bad things, but their form of social protest was strong and noble and certainly out-weighed those "wrongs."

Great Joy is Experience by Heroin Users
: Most heroin users have experienced the greatest joy of which their bodies were capable. They might also have lived through some difficult times, but before they left this world they got to experience the best life has to offer.

Sudden Death is Painless
: Sudden death comes to heroin users in many forms. Some simply drift off into sleep while others foam at the mouth and have seizures. Regardless of how it looks on the outside, the heroin user feels no pain. My one experience with this caused my body to go into grand mal seizures — scaring all those around me terribly. But all I felt was the warm flush of heroin followed by no feeling at all. If I got to choose how I would die, that would be it. (2)

Things to Do Before a Death Occurs

If the heroin user you love is still alive, there are a number of things that will make sudden death easier to handle (I would give the same advice to the loved ones of anyone who has a dangerous hobby.)

Be honest
: Don't let important things go un-stated, because there may not be a tomorrow to do so. This is similar to some of the advice I gave in Encouraging Junkies to "Clean Up", but it is even more important here. If you want, think of your heroin-using loved one as having cancer which may cause him to die any day.

Keep the danger in perspective
: Heroin use is not as dangerous as driving a taxicab for a living.

Remind him of tolerance
: Many heroin related sudden deaths are the result of brief withdrawal periods (usually due to a day or two in jail) followed by the user doing his usual amount which is now much too high a dose for him. Remind him of the tolerance problem.

Remind him of drug mixing
: The easiest way to kill yourself with heroin is to get really drunk and then do a moderate amount of heroin. (3) There are many bad drug combinations, but heroin and alcohol are the most common and the most deadly.

Don't isolate him
: In most cases, a heroin user's death could have been prevented if someone had been around to call for help when the event took place. The less you isolate a heroin user, the less likely he will be to use alone.

Relationships With Heroin Users

It is hard to be the loved one of a heroin user in today's political climate. Nowhere is this seen so clearly as when a heroin user dies suddenly. If you know that a loved one is a heroin user, remember that he has a greater risk of death than other people in your life. Use this information: keep your relationship up to date; say the things there may not be time to say later.

If the loved one is already gone, keep the loss in perspective. Hopefully, you were on good and open terms with him. If not, you have information to use in your next relationship with a heroin user.

Notes

1 You will note that I do not use the term "overdose." This is because the term is misused; and it is almost never the case that a heroin user dies of an overdose (defined here as simply using too much heroin in too short a period of time). In almost all cases, the true cause was the mixing of heroin with some other drug (either deliberately, as when a user does a speedball — a combination of heroin and cocaine, or accidentally, as when the heroin itself is cut with some drug such as quinine). "Overdose" is a convenient shorthand for "heroin related death," but it gives users and non-users alike, the wrong idea. The misuse of the term "overdose" perpetuates ignorance of the danger of mixing heroin and alcohol, for example. This is responsible for the deaths of untold numbers of heroin users each year.

2 Clearly, I didn't stay dead. Paramedics were called who injected me with narcan. But I was, by the common (but not technical) definition, dead: my heart had stopped beating and I was not breathing. What I was experiencing was not actually a heroin overdose. At that time and place, much of what was being sold as heroin was really morphine. Large doses of morphine can cause histamine reactions which in turn, can cause seizures and death. This is another case of a drug's illegality making an accidental death far more likely. No pharmacist would given morphine to a person asking for heroin. Morphine (and much more so) codeine are more toxic than heroin

3 Note how the media almost always attributes such deaths heroin overdose. The fact that the deceased had near toxic levels of alcohol in his blood is rarely mentioned and never blamed.

Bad Friends

Below are two journal entries from my heroin using days. They are excellent examples of a person treating a junkie badly simply because he is a junkie. Both entries are discussions of letters that I received from these people.

My Alcoholic Roommate

The first example says (in the most basic terms) that I am an unacceptable roommate because I am a junkie. I had done nothing wrong: my rent was paid, I kept to myself, I didn't steal anything. It was simply unacceptable to have a junkie near by.

My Cannabis-Addicted Publisher

The second example is even better because the letter-writer is blaming my being in jail on the fact that I was a heroin user (I was not addicted). This was true. But I did not allow being in jail to interfere with completing my work. My work *was* delayed, because of the publisher.

Today, we see how wrong it is judge a person on the color of his skin. However, it is perfectly okay to judge him on the drugs he chooses to use. It is not necessary to show that his choices lead to unacceptable behavior. But it should be.

Late April 1998
: This feels like the beginning of the end. My roommate of, what, five years, maybe more, gave me a note. It read:

I am not willing to watch you destroy yourself. I am not willing to enable you to continue your habit by providing a space in which you feel it is okay to use.

By May 1st you must move out. I will help you pack and move your stuff either to another rental or to a storage facility. Please respect my decision and be aware that it is not open to change or negotiation.

I would have spoken to you about this verbally yesterday but you were so "toxic" that I could not find the right moment to bring this up. You seem to be having a good time but I feel only sadness and disappointment. I know that buried somewhere under all this craziness is the real you — who I miss.

I love you and always will.

Comment: *Love comes cheap, don't it? It's three years later and I can't throw that letter away. I still don't know what to think about it. The writer was kind to me many times after that. But there is something in the letter, a certain callous lack of understanding, that hits me in the face like a hammer, each time I read it. —Jan 2001*

20 July 1999

After having completed a manuscript from within jail, I get a highly sympathetic letter from my publisher which ends:

If I sound a little unsympathetic — you've got it. I am not sympathetic to your plight. You set yourself up for this — and you set us up, too! And, well, I've worked with heroin addicts and I should have known better. They always fuck up and they always fuck other people depending upon them up [check out that split infinitive!], too! That IS the trip — and having a Ph.D. and being articulate, doesn't change that basic dynamic at all — as has become apparent.

So when do we get the manuscript? Haven't heard anything from [your secretary] for weeks.

Comment: *The reason the publisher had heard nothing from my secretary was that my secretary was waiting to hear back from the publisher; time and again this publisher has shown that he only skims correspondence — often missing important information. As it turned out, the book this publisher was talking about had been finished for a month. Nevertheless, the book came out a year late due entirely to the publisher's incompetence (with the worst editing job I have ever been subjected to). As always (whether in jail or not), my work was completed far ahead of schedule. This is just another example of a person using heroin as an easy way to avoid accepting responsibility.*

When you converse with a heroin user, their heroin use should not be part of the conversation unless they are talking to you about their heroin use. If you have an employee who isn't doing a good job, it doesn't matter if the reason is that they use heroin or not. And if they're doing a good job, their heroin use is even less important. Otherwise, they *do* have a heroin problem: you.

Sick

This collection of articles deals with some of the problems that can occur when a patient allows his healthcare provider too much power over him. Knowledge is the key. Read. Read.

Codeine Detox

This article shows how to detox yourself by switching from heroin to codeine and then slowly weening yourself from the codeine. The information could be transferred to any other opioid.

Acupuncture

Acupuncture is used to treat heroin withdrawal symptoms. Although the manner it which it is helpful is unclear, it certainly helps. Acupuncture *is* known to be an effective pain reliever. Do not think, however, that acupuncture alone is an effective detox treatment.

McDermott's Do-It-Yourself Detox

This article provides a good over-view of the process of detoxing yourself. It does not contain any information on the detox itself, however. For example, there is no information on drugs you will need to make the process bearable. The article is focused on the psychological aspects of the process.

SMART Recovery

Poppy Detox

Many years ago, Jim Hogshire told me about a letter he received from a long-time junkie. The letter writer told him that he had wanted to get off heroin, but nothing had worked. Nothing, that is, until he read Jim's seminal book Opium for the Masses.

In this book, Jim explains how to make opium tea out of dried opium poppies that one can find at flower and craft stores. By doing this, the letter writer was able to switch from heroin to opium tea. Then, he was able to slowly ween himself off of the opium tea.

As most people know, I do not think that heroin is a terrible drug, but it is certainly the case that our culture has made a relatively benign drug into something that is extremely dangerous—both physically and legally. As a result, Jim Hogshire should be held up as a hero: a man that gave the world a new simple way to escape the trap that heroin addiction usually is.

Instead of being a hero, however, Jim was the first (and only, as far as i know) person to ever be prosecuted for possession of an opium poppy. That's right: the government tried to throw him in jail for owning a flower. But that isn't the point here. What *is* important is that Jim has spread the word about this miracle cure for heroin addiction more effectively than anyone ever.

I highly recommend that you buy his book, but you don't have to. All you have to do is take a couple of poppy pods, grind them up, add boiling water, strain, and drink. Be aware, however, it does not taste good. I've found that adding a little grape juice makes it more palatable.

You can look around for a local source of poppies, or you can buy them online. Rachel's Flowers and Weddings offers half-pound boxes of the pods for $189.95 plus shipping. This strikes me as kind of expensive, but then, so is heroin.

Improving Methadone Detox

Methadone is a surprisingly strong opioid—even I tend to forget this. In terms of its base strength, it is very close to morphine. So popping a 10 mg pill doesn't seem like so much. The thing is that morphine only lasts a couple of hours; it has a half-life of two to three hours, which means that it will be pretty much completely out of your body in 24 hours. Methadone, on the other hand, has a half life of 24 hours (actually, it is more like 26 hours, but 24 hours is such a convenient number that I continue to use it). This means that after one full day, you still have half of the methadone you took swimming around in your body. After about a *week* it will pretty much be out of your body.

The Cliff

Methadone's long half-life makes it excellent for detoxing. Because methadone leaves the body slowly, the detox associated with it is far more gentle than the detox from morphine or heroin. And as a result of this, methadone is my recommended detox procedure. However, the procedure could be greatly improved.

As far as I know, every methadone detox ends at 2 mg. So whether a clinic starts weening you at 50 mg or 20 mg, you always get 2 mg on your last day along with a hearty, "Fair thee well!" (Actually, some clinics stop you at 5 mg.) Now I know that 2 mg doesn't sound like a lot of methadone, but it is.

Because methadone lasts eight to twelve times as long as morphine (and by extension, heroin), the equivalent amount of morphine that you are taking per day at the end of a methadone detox is between 16 and 24 mg. *This is not a trivial amount of morphine to detox cold turkey from.*

Why Stop at Two

Knowing this naturally brings to mind the question of why methadone clinics stop at 2 mg. The answer is pathetic: it is the limit of their dispensing machines. In fact, clinicians freely admit that even at 2 mg, it is highly questionable how much methadone you are getting: it could be 1 mg; it could be 3 mg. But the problem isn't so much the machines themselves, but the concentration of the methadone. If the methadone were sufficiently diluted, the machines could easily dispense tenths of milligrams without problems. So why don't they?

1. The bread and butter of any methadone clinic is their group of maintenance patients who are almost always at levels of 40 mgs—

and often much more. It would be a real pain to have to dispense to these clients if the methadone were that watered down. Clients don't want to have to drink of quart of methadone each morning. (This isn't actually true—more in a minute.)
2. Having two dispensing bottles (one high concentration and one low) would be a pain and could cause deadly mistakes. I think this is overstated, however; many clinics have different windows for detox and maintenance clients; what's more, there is *always* the potential for deadly mistakes at a methadone clinic.
3. Methadone clinics don't take detox patients as seriously as they do maintenance patients. They know that many detox patients have no intention of staying off heroin (or whatever) and just want a break. What's more, serious detox patients who fail are excellent candidates for becoming (far more profitable) maintenance patients.

The Solution

There are two obvious solutions: improve the dispensing devices or dilute the methadone. The truth is that even 40 mg of methadone is a very small volume. So it really isn't asking too much to have clinics dilute their methadone solutions. (To be honest, they couldn't actually do that. They would need a quantitative chemist to do it—I might point out that I am completely qualified to do this, but no one is going to let me near a jug of methadone.) Or the the pharmaceutical companies could just start selling low concentration methadone.) But neither of these things will happen for one reason:

Laziness!

If the methadone concentration were simply cut in half, the staff would have to change bottles of methadone twice as often. If it were cut to one-eighth its current concentration (what I would recommend), they would have to change bottles *eight* times as often!

But so what? Have you ever been to a methadone clinic? It isn't like people are running around dispensing methadone like the coffee clerks are Starbucks®. And they are doing the same thing: dispensing drugs. (And yes, Virginia, you *can* die from an overdose of caffeine.)

Even though I am very pro-methadone, I am very anti-methadone clinics that are with few exceptions owned by money-grubbing "entrepreneurs" who don't give a flying fuck about their patients. I would much rather have all methadone clinics run by the state. For one thing, it would remove the profit motive that sees detox clients as a pain at best and a customer they can "sell up" to maintenance at worst. And for another, despite what government-hating ranters say, state run institutions generally do an excellent job of improving the services they provide. And if it were methadone detox, I'm sure one such improvement would be to detroy the 2 mg cliff.

Buprenorphine

Increasingly, I believe that buprenorphine is the best method of detox. This is only partly because the detox is relatively painless. Equally as important is that in the United States, a buprenorphine detox can be administered by private physicians. The physicians must still take a short course and register with the government, but it is nothing like the process for setting up a methadone clinic. As a result, the treatment does not have most of the dehumanizing qualities that are so common to methadone detoxes.

The following links will provide you with more information about buprenorphine, including information on finding a qualified physician in your area. If you are seriously thinking about detoxing, check this out.

- Buprenorphine Information (from the FDA)
- Buprenorphine Patient Information (from the manufacturer)
- Buprenorphine Patient Bulletin Board
- Physician Locator

Bored

The following letter asks a number of very good questions related to opioid use. The most important is the effect of boredom on drug usage.

Letter

In the past 20 years I have been a recreational drug user. Intermittently, I've done most drugs in most ways. I've been blessed with good genetics and a good, educated brain; habituation and addiction have never kicked my ass. I was hooked on narcotics briefly, but I detoxed by myself. Afterwards, I left them alone for years: never craving, never doing all the mental emotional BS that the terminal-12 steppers insist everyone go through.

Twenty years later I had health problems: cancer (I survived chemotherapy!), Fibromyalgia, and a host of genetic and other medical disorders that are both invisible and hard to pronounce. It all left me a chronic pain sufferer. Kind doctors have put me on methadone, which, in the right dose, makes life livable.

However, now I am experiencing the feelings of "addiction": I crave heroin; I crave injection. It's making me crazy. Why is methadone so powerfully addicting, when my years with heroin were nothing for me to control.

What's more I'm worried that my insurance will cut out because I may need to take disability. There seems to be a lack of information on methadone withdrawal, mixing drugs, and so on.

What is methadone withdrawal like? How long does it take? Is it worse than heroin withdrawal? If I need to do it to cut back medications, can I do it at home (I'm tough)?

I have access to pharmaceutical diazepam (Valium®) in injectable form and have been doing it off and on. What effects of IV Valium® should I be aware of? It seems to diminish the craving for heroin and feeds the injection craving, but I am mixing it with methadone (oral). Are there special problems mixing these drugs?

I have always had an emergency kit with Narcan in the house. Does Narcan reverse an overdose from methadone as well as morphine/heroin? There are times my regular pain dose leaves me laid out and I worry that one time, I'll be *too* laid out, so this isn't just an issue of my recreational drug use.

As to why I don't want to chat with my doctor about this: my doctor only knows my medical history, not my recreational history. It is not her business to know my past, it's only her business to treat me in the now.

Answer

First on my mind is your craving. I have a hunch that your medical problems have left you unable to work or at least less able to work. I think this because I suspect your craving has more to do with being bored than it does with taking methadone. Even if I'm wrong, you should look at your lifestyle and see if anything has changed. The best deterrent to addiction is an active family/social life. If your condition is limiting your options, I highly recommend that you cultivate new interests to entertain yourself and keep your recreational drug use, well, recreation.

Methadone for Pain

I'm glad your doctor is prescribing methadone. It is an excellent drug and is under-utilized because of its association with heroin addiction. Chronic pain sufferers are still more likely to get short-acting opioids straight or time-released (the effective half-life of oxycodone in OxyContin® is only 50% greater than for immediate release - 4.5 hours instead of 3 hours - big deal). It's very hard to stabilize people on these. But methadone is no longer under patent, so doctors don't get glossy advertisements for it; and intelligent people always base their decisions on advertisements - especially doctors.

I wouldn't worry about your insurance cutting out. As long as you can still get to a doctor who will prescribe methadone, it is very cheap. Methadone in pill form cost 0.1 cents per mg. That means 100 mg of methadone per day will cost you 10 cents or $3.00 per month. Be careful that your doctor keeps you on methadone and doesn't change you to something expensive like OxyContin® without extremely good reason.

Methadone Withdrawal

Methadone withdrawal is very similar to heroin withdrawal. It is not as intense - it never gets as bad. On the other hand, it lasts longer. Whereas heroin withdrawal (primary) is over in roughly 5 days, methadone withdrawal lasts about 2 weeks. It is very easy to wean from methadone, however. In fact, you should not do a cold turkey withdrawal from methadone - especially if you are not in the best health.

Mixing Opioids with Benzodiazepines

Valium® is a member of the benzodiazepine family. This family also includes Xanax®, Librium®, and Klonopin®. High intravenous doses of benzodiazepines cause retroactive amnesia. This is very similar to an alcoholic black-out, and makes their recreational use limited.

You should be very careful with any benzodiazepine — they should not be mixed with opioids. They potentiate the effect of opioids and can causes overdoses. They affect the body very much the same as alcohol does, so any warnings about alcohol apply to benzodiazepine.

Narcan

It is good to have the emergency kit. In some countries, such kits are given away at syringe exchanges and overdose deaths have decreased. Narcan will work to offset the effect of any opioid, including methadone. It is not effective on Valium®, but that doesn't really matter because it is the combination that is deadly. If you stop the effect of the opioid, you stop the problem.

Remember that Narcan is only effective if someone is around to administer it. I know that probably sounds obvious, but you'd be surprised at what people forget. If you live with someone, you should discuss how the Narcan should be administered *before* it is needed. During an emergency is not the time to learn.

You must be careful with the dosing of Narcan. Since you are physically dependent upon methadone, too large a dose will bring on withdrawal. If the Narcan dose is very high, the withdrawal could be dangerous and even fatal.

Dealing with Doctors

Your concern about your doctor is valid. Once a doctor knows that you have "abused" drugs (any use of a drug not exactly in accordance with the medical theocracy is considered abuse), she will not treat your pain properly. At least this is true of 90% of doctors. Opioid

addicts require *more* opioids than normal when they are in pain (understandably). Most of the time they are given *less*.

Just the same, in some cases your drug use history will be important to your doctor. It is hard to say when you should supply what information to your doctor. This is one of the worst results of making doctors the gate-keepers of narcotics.

Dealing with Secondary Withdrawal

There are really two phases of heroin withdrawal: acute and secondary. Acute withdrawal takes place during the time the body is "cleansed" of heroin and its metabolites. During this period, the body is greatly stressed and experiences the withdrawal syndrome. Following acute withdrawal, the body experiences secondary withdrawal. During this phase, the body slowly fine-tunes its metabolism and achieves a new chemical equilibrium.

How Long, Oh Lord?

Acute withdrawal can last anywhere from a few hours, as when a antagonist procedure is used, to many years, as when a methadone maintenance program is followed by a slow weaning. The intensity and length of secondary withdrawal is highly variable. For a straight antagonist detox, secondary withdrawal can be long and intense — so intense, that some have likened it to a straight cold turkey detox as in Derek Thiel's Rapid Nightmare. A very gentle methadone detox, on the other hand, can effectively have no secondary withdrawal.

The table below provides rough estimates of the number of days the acute and secondary withdrawal syndromes last. Note that there are far too many variables for this table to provide numbers that are anything more than rules of thumb. Some of the issues that can greatly change these numbers are: patient idiosyncrasies in genetics and behavior during both phases, length of addiction, level of addiction, and specifics of the detox process.

Detox Method	Length (in days)	
	Acute	Secondary
Antagonist	1	30
Medicated + Antagonist	5	15
Medicated	7	30
21-day Methadone	30	60
Cold Turkey	7	30

Secondary Withdrawal

Secondary withdrawal has a number of potential symptoms. The most common are: depression, insomnia, muscle aches (especially back pain), and nausea. In addition to this, boredom can modulate the pain of all these. The secondary withdrawal syndrome is probably the cause of more re-addictions than is acute withdrawal. The reason is that the ex-addict still feels bad when he is supposedly done with withdrawal. "I went through all that for this?" he says. "I'd rather not live than live with this; where's that pager number?"

Detox Well

It helps enormously if the acute-withdrawal was managed properly. People who do a cold turkey withdrawal are perhaps at the greatest advantage here. Having been through a week of living hell, the relatively minor symptoms of secondary withdrawal may not even register. This is not a recommendation for a cold turkey withdrawal, however. It is harder to get through and I believe in quantifiable terms, it slows the process of complete physical recuperation.

Medicated Detox

The traditional clonidine detox can be helped greatly with the use of naltrexone. In this procedure, the patient is given higher clonidine and Librium® doses as increasing doses of naltrexone are given during the five-day process. Addicts find that after a five day detox, the body feels as well as it normally would after three weeks with a straight clonidine detox.. The down side is that many people find this detox very painful. The drug dosing must be exacting by the medical staff. Generall he benefits out-weight the extra care needed, however.

Methadone Detox

Methadone replacement with slowly reducing doses is probably the best heroin detox method available. The biggest problem with it is that the methadone doses are lowered too quickly. I think that the maximum rate of decrease should be 1 mg every 3 days (one week is better). This means someone maintained at 60 mg of methadone would require 6 months (180 days) to detox. Any rate faster, leaves the patient somewhat uncomfortable for the month or two after the completion of the methadone doses.

Back Pain and Muscle Aches

There are many over the counter (OTC) drugs for relieving back and muscle pain. The standard is aspirin. There are several others however, as shown in the following table.

Generic Name	Brand Name	Dose (mg)	Onset (minutes)	Length (hours)	Strength
Aspirin	Bayer	325-1000	60	4	Fair
Acetaminophen	Tylenol®	325-1000	60	2	Poor
Ibuprofen	Advil®	200-400	15	4-8	Excellent
Ketoprofen	Orudis	12-25	30	4-8	Good
Naproxen	Aleve®	220-440	30	10-12	Good

Ibuprofen

Ibuprofen is the best medication for this kind of pain. It is nothing short of a miracle drug. For most pain, it is more effective than Tylenol 3 (300 mg acetaminophen with 30 mg of codeine) and Vicodin (500 mg of acetaminophen with 5 mg of hydrocodone bitartrate). I have repeatedly seen people who need root canals go from experiencing almost intolerable pain to feeling fairly good within 30 minutes after taking 800 mg of ibuprofen. And every one of those patients fought taking the ibuprofen. They always felt they needed strong narcotics, "How can an over the counter (OTC) pain killer do anything for this kind of pain?" Later, they were complete converts.

It is possible to overdose on ibuprofen; but this is with very high doses (like 1000s of mg). In addition, some people experience allergic reactions to ibuprofen — things like hives. Finally, ibuprofen interacts with many different drugs.

Doses of 600 mg of ibuprofen every 8 hours for this kind of pain works well. Definitely don't go over 1800 mg of ibuprofen in a 24 hour period.

These issues of dose and safety should be discussed with your doctor unless you already have experience with continued use of ibuprofen at these levels. Remember, a drugs legal status says nothing about its safety or efficacy. What's more, ibuprofen *was* by prescription not that long ago.

Can't Take Ibuprofen?

If you cannot take ibuprofen, there are other OTC pain killers. Aspirin — invented by the same people who brought you heroin — is a very good pain killer. Aspirin can cause various problems; it is particularly hard on the stomach (the same is true of ibuprofen, affecting about half as many people). There are many other possible problems, but they are rare.

Aleve and Orudis are quite effective — comparable, if less effective, to Ibuprofen. Naproxen is of special interest because it is very long acting. Unfortunately, if ibuprofen is a problem, these two drugs most likely will be too. In fact, ketoprofen is the most likely of all these drugs to cause intestinal problems.

The Worthless Pain Reliever

If all else fails, there is always the acetaminophen, *the worthless pain reliever*™. It takes about an hour to take effect. Its pain relieving ability is poor. And it only lasts about an hour. The reason it is given out by doctors so much is that almost no one has any adverse reactions to it. None the less, one can overdose and die from it. People do every year. Use it if you have absolutely no other options. But remember, it is not completely safe and should not be taken by anyone with hepatitis. Read the FDA Report before using it.

Take a Soak

If you know someone with one, or there are public ones near you (look in the yellow pages), hot tubs are really helpful to relieve pain. In addition it can improve mood and help sleep. Even without a hot tub, just a hot bath can do wonders.

Nausea

Unfortunately, there are no OTC medications that work well to relieve nausea. There *is* an effective anti-nausea drug, however. It is also commonly available. Unfortunately, it is illegal. Of all the people in federal prisons, 60% are there for non-violent drug offenses. Of these people, roughly 30% are there for possessing this anti-nausea drug. The drug is cannabis. It is an excellent medication with many uses. Despite what the federal government will tell you, it was found in over 30 prescribed drugs when the U.S. outlawed it. And despite what the state government might tell you, you can still go to jail for a very long time for possessing it.

Acupuncture and "Alternative" Medicine

There are some remedies that "alternative" medicine has to offer for nausea. Goldenseal, for example. It can be found at health-food and vitamin stores.

In addition, a couple of acupuncture points are effective: P.6 and St-36. You would have to see a license acupuncturist regarding this however. The acupuncturist could apply "beads" or "seeds" on these points. These are basically tiny steel balls that are taped on the skin. Once they are placed, the patient can perform his own acu-pressure simple by pressing on them. Thus, when the nausea comes on, you can treat yourself.

Insomnia

Other than things like Valium®, everything available for insomnia is either ineffective or has so many nasty side-effects that it isn't worth using. In addition, a lot of things that are supposed to produce sleep are idiosyncratic. For example, antihistamines produce sleep in some and hyperactivity in others.

Acupuncture and "Alternative" Medicine

Acupuncture can be helpful for insomnia. So can some herbal formulae. Two that are pretty easy to find are "An Shen" and "An Mien Pian." If you go to a Chinese pharmacy, they may have other remedies for sleep. If you live near a "Chinatown," it is worth looking around.

Jin Bu Huan

There are also herbal pills called "Jin Bu Huan." These little pills are amazing. Unfortunately, they are no longer sold in the United States because they are made by one family in China that will not list the contents. The Pure Food and Drug Act requires the listing of contents, so people in the United States are not allowed access to these pills.

From the packaging, "Jin Bu Huan is a kind of Herb Medicine which is, in history, used by the people as an important medicine good for the relief of pain with conspicuous result. [sic.]"

They don't make the patient "high." He simply takes it and in a half hour he is quite suddenly asleep. The chemistry of the pills have been analyzed, of course; they do not contain any opioids; but we don't know exact what the stuff in it *is*.

Although these pills are illegal in the United States,they are still around and you might find them. I warn you, however: don't go around asking for them because you will scare people. They'll think you are a government agent.

Relax

The main thing to remember about the insomnia is that it will gradually go away. The way to deal with it is to simply accept it. Insomnia is at its worst when the sufferer fights it, thinking that he must sleep. While you are suffering from it, you will find that your body really doesn't need that much sleep. It's hard to deal with, of course — your body wants to sleep — but just stay calm. It is a real pleasure when you start sleeping normally — and eventually, you will.

Depression

Without a doubt, the best thing that can be done about depression is exercise. It helps the whole body to get working normally. This is very important. Daily exercise will help in endless ways.

It is also a very good idea to start taking vitamins. In short, the path to physical health is the path from addiction. The new ex-addict needs to take care of his body. It is surprising how dramatic and quick it is paid back.

A Life Worth Living

Once a person detoxes, he needs something to live for. Work, school, hobbies, it doesn't matter. Commonly, ex-addicts fill up their new free time with 12-step meetings. This is okay, but the time could be better spent. When 12-step meetings become the focus of an ex-addict's life, he has simply changed his focus from doing heroin to not doing heroin. A life that is preoccupied with not doing drugs is a minor improvement over a life preoccupied with doing drugs.

Gathering Information

Going to meetings of model-makers or Java-programmers is more healthy than going to 12-step meetings. For one thing, the ex-addict won't be spending all his time with drug addicts. He'll see regular people getting pleasure from regular, legal activities. It is part of gathering information for building the new life he wants to lead.

Detoxing is extremely difficult. What follows is at least as difficult. The first month is particularly hard. It's not that there is great pain — there just won't be anything that is all that pleasant. The whole world seems like a black and white movie. The life worth living — the one the addict detoxed to get to — only exists in the future. But there *is* a wonderful life waiting just up ahead. It isn't an illusion. Once a

person has been a junkie, it is easy to appreciate the any joy in life.

Finding a Purpose

What is the pay-off for kicking dope? A great life. A life worth waking up to each day. How does one get one of those? The ex-addict can start by supporting himself: encouraging his dreams, abilities, pleasures, loves. A junkie's life has a clear purpose: junk. Without junk, he must find a new purpose. An ex-addict is lucky in this regard. He really can follow his dreams, because compared to being a heroin addict, almost everything is easy. He can re-invent himself. He can become one of the most exotic people on the earth. Or he can just enjoy living a quiet, simple life. All he has to do is *choose* because he no longer has his heroin addiction *defining* how to live.

Deciding what kind of life you want to lead can be difficult. Fortunately, there is a lot of help out there in the world. Instead of going to a 12-step meeting, an ex-addict might go to see a career counselor. He could talk to people he admires about what their goals our, what their ideal life is, what give their lives purpose. There is an excellent book that helps determine one's life goals: High Performance Goal Setting - Using Intuition to Conceive & Achieve Your Goals by Beverly "Doc" Potter.

Remember: You're Lucky

After you kick dope, you're like Dorothy opening that door from Kansas into Oz. But it takes a long time to get that door open. Be patient. You have time — all the time in the world. And things will be better, regardless. You're lucky. Remember that.

Professional Detox

When a heroin user first becomes addicted, he usually reaches out for professional help in the form of a detox doctor of one form or another. This is only natural. But it may not be the smartest move.

Reasons to Detox

Although it is not usually acknowledge, all heroin addicts must be experts at their own detox. This is not necessary for chippers, but it is good to have some knowledge of detox in case they ever become addicts. Addicts commonly detox themselves for a variety of reasons:

1. lack of money
2. lack of drug sources
3. kicking down a habit
4. getting clean once and for all

Here are some tools to help you do it yourself or get the best treatment when dealing with "professionals."

"Professionals"

I don't mean to be cute by putting the word "professional" it quotes. It is simply that the vast majority of people who work in the treatment industry have few skills and little knowledge. A good (and unfortunately typical) example: after a rapid detox I experienced violet diarrhea and vomiting for several days. None of the two MDs and four RNs offered me any (non-narcotic) drugs for these maladies even though both (especially the latter) are life-threatening. The rule is: people who work in detox are incompetent (else they would get a better paying job). A corollary is that they are callous.

Had I known I could have been given an injection that would have eliminated my vomiting within seconds (Phenergan), I would have demanded it; and they would have provided it. But at that time, I *did not* know, so I *did not* ask, and *did not* get treated effectively.

The situation can be far worse when the "professional" is not medically trained. But this is not necessarily so. In my case, I would have been better taken take of by a close friend. He might be incompetent, but he wouldn't be callous. He could call a doctor, explain the problem and demand the proper medications — an option the withdrawing addict does not have since he is spending all his time in the bathroom (if he's lucky), vomiting up his stomach lining.

It's Up To You

The bottom line is this: even if you hire someone to detox you, you still have to detox yourself. Even if you are lucky enough to get a good professional detox (at places like Hooper Detox in Portland, Oregon) the knowledge you have will make the process easier and better.

For a detailed discussion of detoxing yourself, let me be so bold as to recommend my book Heroin User's Handbook which contains 30 pages of material on the nuts and bolts of detoxing yourself as painlessly as possible.

Everyone is different and so everyone will be best suited with a detox that it tailored to their idiosyncrasies; there is no "perfect detox." The more you know, the better off you will be.

Methadone Drug Interactions

According to Methadone Today, "The official newsletter of Detroit Organizational Needs in Treatment (DONT)," certain drugs will

change the levels of methadone the blood-stream. This is one of the reasons that people on methadone maintenance sometimes complain that their dose on a particular day does not "hold them." This is also an issue that affects those using methadone to detox them, because it can cause their dosage to fluctuate — making the withdrawal more turbulent.

Avoid Opioid Antagonists

Not surprisingly, any of the opioid antagonists or mixed agonist-antagonists lower the body's methadone levels. This is done by ripping them from the opioid receptors where the liver can biotransform them into inactive metabolites.

Drugs with Antagonist Activity

Antagonists	Agonist-Antagonists
naltrexone	buprenorphine
naloxone	butorphanol
nalmefene	dezocine
	nalbuphine
	pentazocine

Tramadol (Ultram®) is not considered an opioid, but in fact, it is. It is simply that it does not depend solely on its opioid quality for its pain relieving ability. As a result of its action, it effects methadone levels as a mixed agonist-antagonist. It should be avoided by those using methadone.

Decreasing Methadone Levels

Many drugs may lower methadone blood levels. The most important, without doubt, is alcohol. Other sedative/hypnotics such as the barbiturates act the same. No mention is made of the benzodiazepines (for example, Valium®) having this effect, but if in doubt, it would be prudent to avoid them.

Drugs for the treatment of convulsions and pulmonary tuberculosis can also decrease methadone levels. Even Vitamin C should be avoided because it causes methadone to be excreted more quickly (this is a common tool used by drug users who are subject to urine testing).

Information is Power

The main point of this article is that people who are using methadone should be aware that the effectiveness of the drug can be greatly affected outside factors. It would be a mistake to assume that simply because one is a patient at a methadone clinic that those responsible for their care know about these issues. It is always a good idea to become as knowledgeable as possible.

A more detailed discussion of these effects can be found in the article Drugs Which May Lower Methadone Serum Blood Levels in Methadone Today Volume 2, Number 8.

Estimating Habit

In the article Codeine Detox, I gave a rule of thumb on how to determine the level of your heroin habit. Doing so is critically important when you attempt to ween yourself from your heroin habit. Once you know how much heroin you are doing, you can determine how much of some other opioid (codeine in that case) you would need to do in order to prevent the onset of withdrawal symptoms. After much reflection, I have concluded that my "rule of thumb" was bad and I have devised a new means of determining this critical value.

Purity Is Not Set: In Time or Location

In the codeine article, I suggested that you assume that your heroin was one-third (33%) pure. This didn't make sense based upon a couple of other things I knew to be true. First, if heroin sold at $40 per gram was 33% pure, the dealer would be losing money. Second, the amount of methadone administered to addicts during the beginning of a 21-day detox would not be nearly enough. In addition to illustrating the problems with the 33% assumption, these inconsistencies provided the means to determine a relatively accurate heroin habit.

You Get What You Pay For

We know from data collected by the United Nations that the retail price of a gram of heroin is roughly $125 in Europe and $300 in the United States. Using these numbers, you can get a ball-park idea of how pure your heroin actually is. For example, San Francisco's "$40 per gram" heroin must be ($40 ÷ $300) 13% pure. A $40 gram in Amsterdam would be ($40 ÷ $125) 32%.

Determining the actual amount of heroin you are doing is just as easy: just divide the average amount you are spending on heroin each day by the retail price ($300 or $125). This means that a person with a dime bag per day habit in the United States is doing 0.033 grams

(33 mg) per day. You can use this formula:

Your Habit (in mg) = Your Cost (in $) ÷ 0.3

Caveats

This will give you a ball-park idea of what you are doing. Other factors will change this number.

Quantity Discounts
: The $300 per gram price is for someone buying a gram. Users who buy more than this may get a quantity discounts, just as users who buy less than this will certainly pay a premium. The guy with the dime habit will be paying at least double the per gram price that the gram buyer will pay.

Geography
: Users who live closes to the drug source or along major distribution lines will pay less for their dope than people who live in remote areas. Of course, the United Nations numbers are undoubtedly skewed toward New York City, so this is likely to cause the per gram price to go up for remote areas, and not down for metropolitan areas.

Dealer
: Users who buy from acquirers or other "non-full-time" dealers will pay a premium.

Notice that anything that causes the real per gram price of heroin to go up will cause the estimated habit to go *down*. And visa-versa.

Matching Doses

Once you have a good idea of how much heroin you are doing, you are in a position to match doses with another opioid. This adds a couple of complications. First, not all opioids have the same strength. Second, not all opioids stay in the body the same length of time. Data for both these parameters can be found in opioid strengths in the pharmacology section of *Heroin Helper*.

Total Use Vs. Average Use

The amount given by the formula above is the total amount used per day. Heroin has a halflife of three hours (caveat). This means that if you use heroin once per day, there will be less than one-half of one percent (0.5%) left in your body each time you use. This is why most addicts find it necessary to use a few times per day. After six hours, the drug is at 25% of its maximum — this is about the time when addicts begin to experience some discomfort from withdrawal.

When switching from heroin to codeine, there is no need to compare how long the drugs stay in your body; this is because codeine has the same halflife. For a drug like methadone, this effect is large. Methadone stays in the body eight (or more) times as long as heroin. As a result, you will need only 1/8 as much methadone as heroin to keep from experiencing withdrawal symptoms.

Opioid Strength

Opioids vary in terms of their strength. Heroin is one of the stronger ones. Taken IV, it is 60 times as strong as codeine taken orally. It is even 6 times as strong as methadone (impressively, however, methadone is only 30% weaker than heroin when both are taken orally). The differing strengths of the opioids must also be taken into account when matching doses.

A Complete Example

Imagine a junkie, using $20 of heroin every day. The total amount of heroin used every day is thus $20 divided $0.3: 67 mg per day. Note that this number does not depend upon the "per gram" price he pays for heroin; in Portland he would be buying 0.15 grams of "heroin" and in San Francisco he would be buying 0.50 grams of "heroin." The amount of actual heroin is the same: 67 mg.

If he wanted to switch to methadone, he would need to decrease this amount because of methadone's longer lifetime and increase this amount because of methadone's lower strength. He would only need 1/8 as much due to the lifetime, or 67 mg divided by 8: 8 mg. But he would need 6 times as much because of the weaker strength of methadone, so 8 mg times 6: 46 mg of methadone. A typical number for a typical habit.

You can convert from the amount of money you spend on heroin to the amount of methadone you will need to use to avoid withdrawal symptoms using one formula:

Your Methadone (in mg) = Your Cost (in $) × multiplied by 2.5

Withdrawal Syndrome

There are three phases of withdrawal. The first is acute withdrawal, in which the addict experiences the withdrawal syndrome. This phase peaks after about three days and ends after about five days. The second phase occurs over the next two weeks. During this period, the body re-learns the process of making the endorphins which the body has been substituting with heroin. The third phase can take anywhere from a week to a couple of months. During this phase, the body stabilizes its endorphin production.

Primary Symptoms

It is only after the completion of phase three that the former addict really feels good. However, it is the first phase that is the hardest to get through because the pain is so intense. The primary symptoms are as follows:

- Depression
- Insomnia
- Nausea
- Vomiting
- Diarrhea
- Abdominal Cramps

Secondary Symptoms

The list of secondary symptoms is seemingly endless. The following list contains the most commonly experienced symptoms:

- anxiety
- irritability
- watery eyes
- general body aches
- restlessness
- perspiration
- dilated pupils
- "goose flesh"
- hot flashes
- gagging
- fever
- increased heart rate
- increased blood pressure
- dehydration
- weight loss
- nervousness
- hyperactivity
- leg cramps
- alternating sweating and chills

How Bad?

Properly done, a gradual methadone detox should not cause the addict much discomfort. A *Heroin Helper* reader who is going through such a detox, wrote to ask when the nightmare would begin.

Question

I would just like to say what a wonderful site you have here... perfect for whittling away those icky hours as I am awaiting for my withdrawal symptoms from my methadone as it finally tapers off. This is my dilemma: I'm on 2.5 mg and my back is hurting, but thats it! Will the stomach cramps and diarrhea start after I have no dose or not? I have been feeling pretty gross for a week now and I'm a bit unsure of what the future holds. I have gone from 17.5 mg to this in nine days and I'm ready to shake it. What can I expect?

Answer

Everyone's detox is different. Some "classic" symptoms aren't even felt by some people. So you won't necessarily experience much in the way of diarrhea or stomach cramps. You have a few things in your favor. First, your habit is small. Second, methadone withdrawal symptoms are less intense than heroin symptoms, for example. Third, you have been keened from the methadone so you really shouldn't ever feel much worse than "icky."

The one thing you most have to guard yourself against is depression. You won't necessarily feel depressed, but it will act on you — coloring everything you experience. You are likely to feel that your life sucks and that it always will. Remember that such thoughts are part of the detox. Life isn't as bleak as it seems — things will get better as your body slowly re-learns how to feel good without the help of opioids.

There are probably no major surprises waiting for you in this detox. You will feel bad, but not terribly so. That doesn't mean it is easy to get through. Remember that you are making a long-term decision by withdrawing: you are suffering now to feel much better later.

As for the pain, if you experience it... Ibuprofen is great for body aches (better than codeine). Imodium is great for diarrhea. If you have a doctor, see about getting a prescription of dicyclomine for abdominal cramps. All three of these are miracle drugs. You don't have to suffer with the pain. However, remember that it is your mind that is most likely to mess you up. Remember that it *will* get better — a lot better.

Detox Done Right

Methadone is best known as a "cure" for heroin addiction. The idea is to get heroin addicts addicted to methadone. This accomplishes

two tasks. First, the heroin addict suffers from no withdrawal symptoms since methadone affects the body the same way that heroin (morphine) does. Second, the addict's tolerance is so high because of the methadone that it is almost impossible to get high by using heroin.

Methadone is less well know as a means by which heroin addicts may be painlessly detoxed.

A Brief History

During World War II, the Nazis needed a substitute for morphine because they had lost control of the primary opium-producing countries. This resulted in the development of methadone — a purely synthetic opioid.

Methadone is also known as "Dolophine." This has been taken to mean that the drug was named after Adolf Hitler. It is a stretch, however: A**doloph**. There are clearly a couple of problems with this connection. First, Hitler's first name is "Adolf," not "Adoloph." Second, methadone wasn't even called Dolophine until it was brought to the United States — after the war was over and Hitler was long dead.

The name "Dolophine," rather than being any kind of homage to the führer, seems to be derived from the Latin word "dolor" which means pain.

Methadone Compared to Morphine

Methadone is an excellent pain-reliever that works by attaching to the opiate receptor sites. Although it is still used as a pain reliever, it is most often used to detox or maintain heroin/morphine addicts. It has several advantages over morphine. It is as potent as morphine when injected, but three times as potent when administered orally. It is also long lasting; its halflife is 24 hours or more — lasting roughly ten times as long as morphine.

The long halflife of methadone means that it layers in the body. When dosing once per day, half the dose from the previous day is still in the body when dosing on the current day. Similarly, 1/4 of the dose from two days before is still present; and 1/8 from the day before that; and 1/16 and 1/32 and 1/64 and so on.

Methadone Detox

The maximum length of a methadone detox is mandated by state law. In California, this length is 21 days. Normally, clinics set the length of their programs at the maximum length that the law allows. The first half of the program is used to detox the patient from the heroin and the second half is used to detox (or ween) him from the methadone. As a result, the doses administered for the first week and a half are pretty much constant — then the doses are decreased at a constant rate.

Methadone Withdrawal

In the heroin subculture, it is widely believed that withdrawal from methadone is worse than withdrawal from heroin. This is *false*. Withdrawal from methadone is not nearly as intense as withdrawal from heroin. Just the same, methadone withdrawal does take longer. Methadone withdrawal just seems to creep on and on with the patient feeling crumby — sometimes for months.

Detox Times

Although there are laws limiting the maximum amount of time over which a detox can take place, there are no laws stipulating the minimum amount of time over which a patient may be detoxed. Most addicts find that a detox period of between five and ten days works the best for them.

Clinic Bureaucracy

Patients wishing to detox quickly from heroin have one major problem: clinic bureaucracy. Methadone clinics are highly regulated and they do not like to deviate from their set procedures.

Dealing with the Doctor

The best way to deal with this problem is for the patient to talk to his intake doctor about how he would like to go about his detox. Doctors like to see patients taking an interest in their treatment and they certainly want to do whatever is going to be most successful in getting the patient drug free.

Dosing Schedule

If the doctor is willing to set up a short program, there are two options as to how the patient can be dosed. First, the doses can simply be decreased linearly down to zero. Take a typical situation of starting at 35 mg and detoxing over 7 days. In this case the dose would decrease 5 mg per day (see the graph below). Or it is possible to bottom out more slowly: 35, 20, 15, 10, 7, 4, and 2 mg.

Other Options

If the doctor is unwilling to shorten the length of detox, the patient has other options. First, the patient can get on the lightest dosing schedule available. This may mean the first couple of days are a little uncomfortable for the patient, but it will more than pay for itself at the end of the program.

Since methadone does stay in the body a long time, the patient can dose every other day. This will have a similar effect to starting with a lower dose.

Another option is to simply stop dosing altogether after 5 or 10 days. The problem with this approach is that the patient will be stopping at a high concentration of methadone and this may cause him some discomfort. The longer he has been using the methadone, the worse this problem will be. After 5 days it probably will be okay, but after 10 days the patient will likely regret having stopped so abruptly.

Start Conservatively

Regardless of what a patient decides to do, the first time he tries a methadone detox, he should go along with the program the doctor recommends. For most people this works very well. If he finds that it doesn't work well for him, he should try limiting the length of time he uses on subsequent detox attempts.

Next Time: Our next article will discuss using methadone to detox without using a doctor. This has a lot of advantages including being a lot less expensive under most circumstances. We will finish this series of articles by discussing methadone maintenance programs and how to best use them.

Inside the Clinic

One of the biggest problems with using methadone programs is that they are highly bureaucratic and getting a clinic to make changes in its procedures can be very difficult. In this article, we discuss how it is possible to use methadone to detox without using the clinics (at least directly).

Methadone, whether used for pain or opiate addiction, is considered a medicine. But unlike medicine for, say, a heart condition, methadone is not distributed as a prescription drug (when used for detox). Instead, the methadone patient must come to the clinic every day to ingest his dose. This is done for two reasons. First, addicts are not considered trustworthy and second, the methadone is easily sold on the street.

Patients on maintenance can earn "take home" doses — so they don't have to come into the clinic every day. This is usually done for patients who are "stable" which means drug free. Patients are periodically tested for illegal drugs. If a patient consistently tests negative for illegal drugs, the clinic will usually allow him to take home doses. The maximum number of "take home" doses that clinics will give is six — so the patient is forced to visit the clinic at least once per week.

Outside the Clinic

Many patients who get take home doses sell those doses. Sometimes, this is done just to make ends meet, but mostly it is just the methadone patient converting the 'done into heroin. Whatever the reason, it is not difficult to buy black market methadone.

The easiest way to find a methadone connection (or a heroin connection, for that matter) is to hang out at a clinic. It is easiest to do if one is somehow involved — as a detox patient, for example — but it can be done regardless. It may take a while, but eventually the right people will be met. The fact of the matter is that if a person is looking for methadone to detox, he is already addicted to heroin — he is already in the right subculture to find methadone.

Avoiding the Clinic

The average price of methadone on the street is 50¢ per milligram (mg). Prices vary of course, but it should never be more than a dollar per mg. How much methadone is necessary to detox also varies, but 200 mg should be enough for just about anyone. This means that the cost of street methadone for a detox is about $100. Compare this to the cost of a clinic detox — usually in the $200-$300 range — and a very compelling reason to avoid the clinic is clear.

An even better reason for avoiding the clinics is that they do not give the patient a lot of control over his detox. There is a tendency to think that heroin addicts are always trying to scam people and so the clinics are resistant to make any changes for their patients (even though the "junkie" is also the customer and the guy who is paying the salaries of the people at the clinic).

The best reason of all for avoiding the clinics may be that many clinics are not ethical. Many clinics use their detox programs as a way to funnel addicts into their maintenance programs. Triad in Santa Cruz, for example, gives no support meds to help the patient at the end of their detox. It is hard to justify this practice except as a way to make addicts think that maintenance is the only option.

Doing the Done

With rights come responsibilities. Once the addict has acquired the methadone, he can use it to detox himself in any way deemed fit. But this also means he can screw up the detox — no one is available to help.

In the first article of this series, we recommended people start by doing a methadone detox in a clinic and following the procedure set by the doctor. This gives the addict a baseline against which to compare. It also gives him a good idea of where to start when doing his own detox.

Starting Dose

The first thing the addict must decide is at what methadone dose to start the detox. A good rule of thumb is that if an addict is doing a gram of heroin per day, he should start his detox at about 30 mg per day. The relationship between former heroin use and beginning methadone dose should be linear. The table below shows this. The first column is the amount of heroin the addict was using each day before he started the detox. The second column is the amount of methadone the addict should take the first day of his detox.

heroin use	methadone dose
0.25 g	10 mg
0.50 g	15 mg
0.75 g	22 mg
1.00 g	30 mg
1.50 g	45 mg
2.00 g	60 mg
3.00 g	90 mg

Course of the Detox

There are basically two ways to handle the methadone dose during the course of the detox. The first is simply to use the same dose each day. Although this is the easiest way to divide up and administer the methadone, it has a few problems. The first is that the same dose every day will not translate into the same amount in the body everyday. This can be seen in the graph below where a dose of 20 mg is given each day. The other problem is that the body will not respond to the abrupt change in dosage and the withdrawing addict will be less comfortable.

The other option is to decrease the methadone dose each day. There are various ways to do this but each is just about as good as the other. In this case, it is best to simply have the dose decrease the same amount each day. So an addict would decrease the dose each day by the starting dose divided by the length of the detox in days. So if the starting dose is 35 mg and the length of the detox is 7 days, the dose would be decreased by $35 \div 7 = 5$. Thus the dose each day would be: 35, 30, 25, 20, 15, 10, and 5.

Length of the Detox

The last thing the addict must decide is how long to detox. This issue was dealt with in the last article. It doesn't matter whether the detox is being done at a clinic or not: between five and ten days. It is best not to go over seven days, in fact.

Conclusion

Detoxing alone has many advantages. The only real drawback is that doing so is illegal. This is an important drawback, however. While it is true that cops and courts are more likely to go lightly on an addict who is trying to get clean, possession of methadone without a prescription is just as illegal as possession of heroin and can send one to jail for years. Any person going outside the clinics to detox should be very careful and aware of potential hazards.

Another important issue to keep in mind with methadone is that it is dangerous. Children are often attracted to methadone because it is normally distributed as a brightly colored liquid. Each year, children OD on methadone because they mistake it for something like Kool-Aid™. Keep methadone away from kids! And the addict must not forget to be careful when dosing himself.

Next Time: Our next article will discuss how methadone can be acquired outside of the clinic system.

Acquiring Methadone

We've discussed how to use methadone to detox without using the clinics. These leads to the obvious question: how does one acquire methadone without using the clinic system. There are a few options — though most of them are illegal.

Leave the Country

Although this isn't an option for most people, methadone can be bought over the counter in a number of countries. One such country is Thailand. There are others, but we do not have a list, unfortunately. If HEROIN helper readers send in information regarding this, we will add it. Interested parties should consider checking when they find themselves outside the country.

It is possible to get methadone in countries where it is not strictly legal. Most countries are not as rigid in their prescription drug laws as is the United States. It doesn't hurt to ask.

Scout the Clinic

At any methadone clinic there will be a certain percentage of those on a maintenance program that sell their "take home" doses. The problem is how one goes about finding these people. The situation is the same for people trying to score heroin on the street in a strange city: the buyer must spot the dealer and then convince the dealer that he (the buyer) is safe to sell to.

Spotting "Take Home" Sellers

People who sell take home doses are also those who are given take home doses. These people do not come to the clinic every day. Usually, they only come to the clinic once a week. They are easy to spot because most clinics require that take home doses be carried in some kind locked container. These usually take the form of small tool-boxes or children's lunch boxes.

Approaching "Take Home" Sellers

Approaching sellers is even more difficult than approaching street dealers, because most methadone sellers do not see themselves as dealers and are thus timid. It is best to go about the matter indirectly. Those who sell their methadone do so almost exclusively to buy heroin. Those wishing to acquire methadone are best to seek out the heroin users among the clinic clients. The methadone sellers will become well known after using heroin with this group.

Join the Clinic

It can be hard to get to know clinic clients. Many clinics have rules about clients not hanging around the clinic after they have dosed. The best way to scout a methadone clinic is to join it by enrolling in a detox program. This will allow one to spend time there and get to know the clinic clients. The best time for this is while waiting in the ever-present dosing lines.

Ask the Heroin Dealer

If one is searching for methadone for the purpose of detox, it is assumed that he already has a heroin dealer. (Else whence came his addiction?) Heroin dealers are often very good sources for pointers to other black market dealers.

Conclusion

Anyone who is wily enough to managed to become addicted to heroin, is certainly wily enough to find a source of methadone. But if all else fails, the addict can use the clinic system. Regardless, it is better than detoxing with nothing. Chapter 2 of Heroin User's Handbook deals with the issues raised in this article *in depth*. Those seriously interested are referred there.

Next Time: Our next article will discuss how methadone maintenance programs can be best used.

Methadone Maintenance

Methadone is more commonly used for maintenance than detox. In this case, the addict is exchanging an addiction to illegal heroin for an addiction to legal methadone. Maintenance has a number of benefits and a number of draw-backs. But for the right person, it is just what the doctor ordered.

Why Addicts Avoid Methadone Maintenance

Normally, people do not consider methadone maintenance until a lot of other attempts to stay off heroin have failed. Two reasons are normally given staying away from methadone maintenance. The first is the widely held belief in the heroin subculture that methadone is a worse addiction than heroin. This is untrue.

Myth: Methadone Addiction is Worse Than Heroin

There is no indication that long-term methadone use is worse on the body than long-term heroin use. Regardless, methadone would have to be *a lot* worse than heroin in this regard if it were to offset the collateral damage due to heroin use. Heroin is pretty much always injected, smoked, or snorted — all of these administration routes have negative long-term consequences compared to methadone which is eaten (there is also IV methadone but it is very rarely seen).

The lifestyle that goes along with heroin addiction does not encourage the healthiest habits. Addicts rarely eat enough or well. They usually get little sleep. The proximity of other illegal drugs tend to cause heroin addicts to do more of these other drugs than they normally would. Two of the most common drugs — cocaine and speed — are very damaging to the body. On the other hand, alcohol is one of the few drugs people on maintenance can get away with using. This may cause more drinking from people on maintenance and this would counteract some of the heroin lifestyle issues.

Methadone Withdrawal

Another reason addicts think methadone is worse than heroin is that it is widely believed that detox from methadone is worse than from heroin. This too is false. Methadone detox is, however, different from heroin. Qualitatively, the two are similar: sweats, chills, insomnia,

vomiting, diarrhea, and depression. Methadone withdrawal is less violent — less intense — than heroin withdrawal. Just the same, methadone withdrawal lasts longer.

Maintenance Constrains Patients' Lives

The other reason heroin addicts avoid maintenance programs is rational: being in a program constrains the addict's life. Programs have variations, of course, but in general patients will be constrained in a number of ways. First, new patients will be required to come in every morning to dose. After a period of time, patients will be allowed "take home" doses so that they needn't come in every day. Just the same, patients are rarely allowed more than six take home doses, which means that they will have to come into the clinic at least once a week. As a result of this, long vacations are difficult to arrange and vacations outside of the country are almost impossible.

The programs usually intrude into the patient's private life. They are tested for drugs, for example. Many clinics require attendance at NA meetings. Normally, the patient will have the equivalent of a social worker who may interfere with the patient's life any number of other ways.

Reasons to Avoid Methadone Maintenance

Maintenance is not for everyone. If you can answer "yes" to any of the questions below, you are a poor candidate for methadone maintenance.

1. I have tried to detox from heroin less than ten times.
2. I have only tried one kind of detox (cold turkey, medicated, methadone, ibogaine, and so on).
3. I am very independent.
4. I stand a good chance of going to jail, even when I am not using drugs.
5. I need to travel outside the country.
6. I travel a lot.

You should only go on methadone maintenance if you have failed giving up heroin a number of times. Maintenance is an extreme measure which should only be used if other approaches have failed. Similarly, just because you have failed at one kind of detox does not indicate that you will fail at another kind. This is especially true if the one type you have tried is cold turkey — the most difficult form of heroin detox.

If you are independent, you will likely find the clinic environment difficult to deal with. It is highly bureaucratic and intrusive. Be careful in answering this question for yourself, however. Almost anyone could justify an answer either way. It might be easier to check out a clinic and see if you can imagine yourself fitting in there.

As discussed earlier, it is very hard to be on methadone and travel much. You will be tied to the clinic on a fairly short leash. This is a restriction that will not change unless the laws change. The government places methadone maintenance programs in a special category of medicine. As a result, patients are not given prescriptions for their medicine — their medicine is administered under close scrutiny. There have been some rumblings that the laws will change, but don't depend upon it.

Why Maintenance Might Be A Good Idea

In many ways, a person is more constrained on methadone maintenance than he would be by being addicted to heroin. Why then, would an addict choose to go on maintenance? For most addicts maintenance provides a way to get out of the heroin subculture without much pain. Also, maintenance is not usually endless. Most people use it for between six months and two years before detoxing. Meanwhile, the addict's freedom from needing to "take care of business" has allowed him to create a regular life away from the heroin subculture.

Tips on Using a Maintenance Program

Pick the Right Program

Not all methadone clinics are equally good. If you live in an area where you have a choice — or you can move to be close another clinic — use the best clinic. There are online resources which provide information about clinic quality. For a start, check out the National Alliance of Methadone Advocates (NAMA). (I don't know what's become of the *Methadone Information Exchange*, but they don't seem to be online anymore.)

Plan You Life

A junkie's life is difficult, regardless of how he manages to get by. Going on maintenance will make this very apparent to you. If you don't have a plan on how to use the program, you will likely find that life is pretty boring. Before you start the program, decide what you are going to do with all the free time you now have that you used to spend getting money for heroin, scoring heroin, and using heroin. For some addicts, this will be all your waking hours. Regardless, there will be a correlation between the number of hours you need to fill up and the amount of work you will need to create a heroin-free life.

Visualize the kind of life that you would like to have. Once you have this image in mind, it should be fairly easy to come up with a plan for realizing your image. Being a junkie is actually good experience for anything you want to do, because there are few things that are as difficult as feeding a heroin habit. If you apply the same energy and creativity to building your ideal life, you will have it before you know it.

Plan Your Detox

Have some idea of how long you want to stay on maintenance. This will, of course, depend upon what you are doing with your life outside the clinic. But don't put yourself in a time bind. It is not unreasonable to decrease your daily methadone dose by 1 mg per week. That means if you are maintained at the relatively low dose of 80 mg, it will take you a year and a half to detox. Plan ahead!

Don't get two habits

A lot of people go on methadone maintenance but then continue to use heroin. If you do this, you will end up with a double addiction. What's more, the methadone you are taking will make the heroin less effective so it will cost a lot more to get high. The bottom line is: if you aren't ready to give up heroin, don't go on maintenance.

"Work" the Program

Many programs have silly rules like not allowing clients any take home doses unless they work during dosing hours. Do what you must to get past the clinic red tape. If this requires "working" the program so it works for you — so be it.

Avoid Other Clients

The maintenance program is a tool that will help you build a new life. By becoming too involved with the clinic culture or other clients, you will be looking in the wrong direction: backwards to where you used to be, not forward to where you want to go. Also, clinic clients are as likely as not to be using heroin on the side. They will be a bad influence. If you want to return to the heroin subculture, do it. But don't cheat yourself: go back to the real subculture; don't use the clinic losers as substitutes.

Keep Your Dose Low

The lower you keep your daily methadone dose, the easier and the quicker will be your final detox. Just the same, don't keep your dose so low that you are uncomfortable — this will tend to make you you go out and use heroin.

Stay Clean

By staying clean you will quickly get clinic privilege such as take home doses. This is a big deal because going into the clinic each day to dose is a drag and it interferes with your life. Again, if you want to use drugs, go ahead. But doing so while on a methadone maintenance program is not a good idea.

Conclusion

This article really only scratches the surface of how to best take advantage of a methadone maintenance program. If you are interested, you should check out the National Alliance of Methadone Advocates (NAMA) and Harm Reduction Coalition. Both contain a lot of useful information as well as links to other helpful sites.

Detox Is Not *Necessarily* a Nightmare

In movies like *The Man with the Golden Arm*, detox is presented (accurately) as a nightmarish experience. Fear of the experience is what keeps many addicts using, even when they want to quit. I remember when I was an addict, I so envied speed and cocaine addicts who could just walk away from their drug without being terribly sick. Today, I'm much more sympathetic to their plight; but there is no doubt that the path to a "clean life" is made far more difficult by the painful withdrawal symptoms experienced by opioid addicts.

Many Kinds of Pain

Due to the justifiable fear that junkies have about withdrawal, most seek some kind of help to ease the pain of the experience. In many cases, however, these addicts end up spending a lot of money on "treatment" that does not work. It is one thing to live through the nightmare of cold turkey withdrawal when you aren't paying for it. But going through much the same experience and paying $5,000 for the pleasure can make you crazy.

This issue's feature focuses on two such experiences. One was an ibogaine detox and the other was a rapid antagonist detox. In presenting these stories, we are not claiming that these forms of detox do not work. It is just that detox is a very personal thing. A regime that works perfectly for one person may not work at all for another.

No Such Thing as "Miracle Cure"

One thing I hope this feature does do, however, is dispel the idea of miracle cures for addiction. There may be perfect detox regimes for particular people, but even this I doubt. When I hear that someone detoxed from heroin without any discomfort, the first thing I think is that he wasn't actually addicted to heroin. It has been well demonstrated that one-third of those people applying for methadone maintenance turn out not to be addicted to any opioids at all.

Questionable Statistics

This statistic is somewhat bothersome when looking at reports of the efficacy of any kind of withdrawal treatment. One has to wonder what the people in the study are detoxing from. Even if all the people were addicted, there is a big difference between detoxing from 10 Vicodin swallowed every day and two grams of heroin injected each day. The first person is going to have a short and relatively painless detox, regardless of the regime. The second person is going to have a tough time of it — period.

"Preparing for Failure" *or* "Just Protecting Yourself"?

Although the entire drug "treatment" industry would disagree with me, I believe that anyone trying to detox should have a back up — a small dose that can be used if the detox goes wrong. The truth is that there are simply too many things that can go wrong when trying to detox.

Things Go Wrong: Examples

A young woman is on the second day of a medicated detox. She begins having chest pains. She tells her roommate who is a nursing student. The roommates checks her vital signs and finds that her heart rate is 150 beats per minute. This is so fast that the heart chambers do not have time to fill with blood completely. Her roommate takes her to the hospital emergency room — she might have died otherwise.

A young man shows up to a methadone clinic with a money order to begin a 21 day detox. Unfortunately, the date is October 12, 2001. The doctor for the clinic is stuck in Denver because all flights have been canceled. No one can be allowed into the program without the doctor's okay. So the young man is out of luck. And to make matters worse, he is from out of town. So it isn't just a matter of getting money; he must also find a connection in a new town where he is already (in keeping with clinic demands) dope sick.

A middle aged woman is on day 19 of a 21 day methadone detox. As is usual for such a detox, she has begun to experience mild withdrawal symptoms. To counteract her diarrhea, she takes what she thinks is an imodium tablet; it is really naltrexone (from a previous detox attempt). This may seem unlikely, but naltreoxe pills have a similar shape and size to imodium tablets. Within a half hour, she is experiencing the most intense withdrawal symptoms of her life — the methadone still on her receptor sites has been ripped off and blocked from re-attaching. She can't take any medication (such as clonidine) because she vomits everything she ingests.

Protect Yourself

It is not a good idea to prepare for failure when starting a detox. But it is better to be strung out and alive than clean and dead. When an addict is detoxing using a method he has not tried before, he should definitely take precautions. Even when a detox regime has been used before, care should be taken. One addict told me, for example, that the first time he withdrew using ibogaine, he had no problems. The second time he used ibogaine to withdraw, he experienced intense symptoms, just as if he were doing a cold turkey withdrawal.

Proceed Cautiously

We present detox nightmares in the hope of adding a little restraint to any discussion about detox modalities. Also, since the two nightmares we publish here involve very expensive procedures, we hope to encourage a great deal of thought before someone opens his wallet. The price of a detox is no assurance of its efficacy.

Ibogaine (Anne Lombardo Ardolino)

About ten years ago, I came into contact with a fellow who told me a fantastic tale, all about this so called "Underground Miracle Cure For Addictions." He explained that it was a powder made from the root of the sacred African Ebogah tree, and that it was called "Ibogaine," and that it was a hallucinogenic used as a "rites of passage experience" for young African boys of approximately fourteen years of age, and who it is claimed "become men over night" after this Ibogaine venture.

The Miracle Cure

He said that during the sixties, his friend and business partner discovered, apparently accidently, Ibogaine and its "miraculous properties" during one of his many experiments with mind altering substances, drugs like Peyote, Mescaline, LSD-25, and other less well known hallucinogens. He claimed that he noticed immediately after his "Ibogaine trip" that he no longer craved the heroin he had been addicted to for quite a while. Whether or not this actually did happen to him — I can't say. What I can say is that it didn't happen to me.

As a hopeless heroin and Cocaine addict — I had reason to be very interested in this fantastic tale. But alas, it was nothing but hogwash — expensive hogwash: they bilked me out of three thousand dollars when I was a destitute drug addict, covered with sores and looking like I was getting ready to die on the spot. In order to get this money, I began to prostitute myself. As I already mentioned, it didn't work. It didn't work because it doesn't work. In fact, not only was I not cured of my drug addiction, but it did not stop my withdrawal symptoms.

Zero Out of Five

I know five people, including myself, who have undergone the ibogaine treatment, and none of them were cured. Two of them, (one took Ibogaine twice and the other took it five or more times) are dead of Heroin overdoses. The third continued to take Cocaine after the ibogaine experience without missing a beat. I am currently on methadone maintenance — cure in some sense, but not due to the ibogaine.

Only one of the five people claims to be cured. But there is no doubt that he is still hooked on heroin. He will gladly stop whatever he's doing and tell anyone, "how Ibogaine cured him of addiction." He does this while his pupils are so pinned as to not even be present, and the poor man can't seem to stop scratching his nose long enough to complete a sentence. All the while he's making his ibogaine testimonials, his poor, long suffering wife rolls her eyes as she mumbles softly under her breath to no one in particular.

The word is that the price for the ibogaine treatment has gone up to between ten and eighteen thousand dollars per application — no small sum. And we all know who shoulders the burden of this cost for the most part: the families — the desperate and broken hearted families of these unfortunate addicts who pay their hard earned money. Regardless of who pays, however, it is a travesty.

The Detox: My Experience

The plan was that I was to take my last shot of Heroin/Cocaine at about twelve midnight, then go to sleep. The next morning when I awoke, instead of taking my wake up shot of narcotics, I would take the Ibogaine. It was about midnight when I got started taking my "last fix." My supervisor did not watch over me, however. He smoked marijuana to oblivion and passed out. He didn't wake up until 5:00 a.m. when he found me still in the bathroom using.

The Absent Supervisor

He hit the ceiling and began screaming and carrying on like a maniac — furious at me. Wait a minute — I was supposed to be "the patient" and he was supposed to be "the supervisor" of this little trip. I feel it was his responsibility to see that things ran according to schedule. After all, I was loaded on drugs and could hardly be expected to keep track of the hour, not to mention, there was no clock in the bathroom. And last but not least, I was admittedly and deliberately zonked out of my skull — this was supposed to be my last fix — I wanted to make it good.

Completely ignoring the fact that we were in a public hotel room packed with illicit drugs and contraband, he still started screaming. I could not believe how graphic he got — going into intricate detail. "What the fuck are you doing still shooting drugs in the bathroom?! Look at you with a needle in your arm when you were supposed to be asleep hours ago!"

I could not believe how he was endangering our welfare. It took me a good ten minutes to finally quiet him down — after much reminding of the possibility of going to jail. After that, we calmed down a little, and decided to take an extended nap.

The Trip Begins

About twelve noon, he woke me up. Without waiting for me to go into withdrawals, he gave me the ibogaine, which I administered to myself by enema. (I chose this manner because I wanted to avoid the nausea and vomiting that often accompany the taking of ibogaine). About forty five minutes later, it began to hit me and I began to have my so called trip.

Upping the Ante

Twenty four hours after I had my initial ibogaine dose — around one the next afternoon — a friend of mine who had been through the ibogaine treatment stopped by the hotel to check on me and see how I was making out. I told her I hadn't experienced any of the visions she had. Apparently, she spoke with another person involved in this ibogaine business, because he came to see me soon afterwards. He gave me a gelatin capsule filled with powdered Ebogah root (ibogaine). I took it, and laid quietly in the bed while he sat on the couch. Some forty-five minutes later, the ibogaine hit me again. Harder. I grew frightened and I told this to him. He responded, "You shouldn't be afraid of ibogaine — you should be afraid of that crap you inject into your arms."

I was reassured by his confidence and the reality of his statement. I then relaxed and settled down to have the rest of my trip.

I still never did experience hallucinations, although the light did take on a funny pattern; that was about the extent of my "visions." Other than a few vivid daydreams, there were no hallucinations to speak of and this was truly disappointing for me.

When the Ibogaine first wore off - I wasn't sick yet — just feeling kind of normal. At around five in the morning, my supervisor and I began celebrating (prematurely). We were dancing around the room like idiots. I was so happy. I really thought it had worked. I was deliriously overjoyed. We kept saying "Thirteen years on dope — out the window! Thirteen years on methadone — out the window! Thirteen years of cocaine — out the window!"

Withdrawal Comes Suddenly

We both became quite hungry, so we ordered room service. By the time breakfast arrived, however, I could no longer eat. Not only that, but the smell of the bacon and eggs was making me sick. Even the coffee, usually my favorite thing in the morning, was to me, undrinkable. The best I could do was a few swallows of orange juice. Then, it got worse.

I began to suffer from muscle spasms — my biggest difficulty with kicking and which usually leads to grand maul convulsions. I was starting to experience these violent and brutal muscle spasms. They literally had me rolling all over the floor. I was involuntarily throwing myself all over the place. I started to grow frightened — more and more frightened by the minute because I didn't know where this was going to lead.

My supervisor then called for two of his friends to come to the hotel. They turned out to be a nice friendly couple, a man and a woman. The young lady began to administer loving back-rubs to me — but alas, I couldn't hold still long enough for her to do the job.

At this point, I also began to suffer from bad backaches and my kidneys were on fire. I began to fear I would go into convulsions as I was already exhibiting the warning signs, such as petite maul seizures. Remember that I was kicking heroin *and* methadone so I was concerned that in addition to all the pain, I might die.

Escape!

I decided that I had better get out of there while I still could walk. My plan was to go to my methadone program and get a dose. When I informed the supervisor of this, he refused to give me cab fare home. He did this even though I was soaking wet with perspiration and it was snowing and freezing outside — even though I looked like I had just been run over by a mac truck — even though he had just relieved me of the last penny I had in the entire world. He allowed me to leave the hotel without a cent.

I looked so bad. No cabs would even pick me up. It took me nearly ten minutes of shivering uncontrollably out on the cold lonely street before I could finally get a taxi to stop and take me home. My roommate was waiting for me and paid for the cab while I went to my program (a block from my house) and got some methadone after which I came home and went to bed — exhausted.

Think Before Using Ibogaine

It is possible that ibogaine helps some people get off dope. Anyone who is thinking about using ibogaine should be very careful and consider the following list.

1. Research the people who are administering the treatment.
2. Research the treatment itself. Talk to as many people as you can who have undergone this treatment.
3. Compare the cost of ibogaine treatment with that of other treatments.

*[**Editor's Note:** When I first read this piece, it seemed to me that the ibogaine **had** stopped the heroin withdrawal symptoms. I asked the writer about this. She pointed out that she was on methadone as well as heroin and so did not go into withdrawal as quickly as she would have had she only been on heroin. On reflection, this made sense. It had been approximately 24 hours since her last heroin dose and about 40 hours since her last methadone dose. Reader comments on this issue are especially welcome.]*

by Anne Lombardo Ardolino © 2001
Edited by Dr. H

*[**Editor's Note:** I received the follow anonymous e-mail in reply to this article.]*

> In regards to the bad experience with ibogaine - the writer has a very valid point. Be sure you check out the credentials of the person providing this substance. My sister died after ingesting ibogaine this summer. The man who provided it is fine, still making his fortune off of the innocents. Please warn your readers, as I am broken hearted.

*[**Editor's Note:** I have never heard of this before, and I am looking for an Ibogaine expert to comment on this.]*

Rapid Nightmare (Derek Thiel)

Medical procedures that are not covered by insurance have a feel of what medicine must have been like in the old days before the AMA and the Drug War. That, at least, was what my experience was like with rapid detox. From the beginning the whole process seemed a little less than professional. Before I get into the whole story, however, I should provide some background information.

What *is* Rapid Detox

"Rapid Detox" is better termed "Rapid Antagonist Detox" (it even has a good acronym: RAD). The basic idea is that the body is flushed with an opioid antagonist such as narcan. This throws the body into immediate complete withdrawal. What normally happens over a three day period, happens in a couple of hours. (Increasingly, antagonists are being used with other — traditional — procedures.

Living Through It

Since the time period is compressed, so too is the pain. Roughly speaking, all of the pain that would be experienced over three days is crammed into the couple of hours of the rapid detox. To make the pain bearable, the patient is put to sleep.

When the patient wakes up, he is no longer addicted to heroin (or whatever opioid he has been doing). At least that is the theory. As with most things, there is a big difference between theory and practice as I will discuss later. Upon regaining consciousness, he patient is, however, quite weak. It is standard procedure to have a nurse watch him for the next day or so — until he is able to care for himself.

My Experience

Rapid detox sounded like a great way to get clean. The truth was, it was the only option I had that would allow me to keep my job. Where I lived, there were no out-patient detoxes. You couldn't, for example, get a 21 day methadone detox without checking into a clinic. I could have gone on methadone maintenance, but that idea terrified me.

The Decision

When I decided to undergo a rapid detox, I shopped around. I could not take much time off work. Regardless of the clinic I chose, however, the costs were very high. The ones in the city in which I lived were $7000 or more. The cheapest one I found was $2700, but it was 3000 miles away. I did eventually go with that clinic, but it turned out to still be very expensive. It cost $1200 to fly there; my "nursing" cost over $1000; hotel, $500; support meds, $300 (for what would have cost me less than $100 had I been able to buy them myself).

I scheduled the detox to minimize the disruption to my work. I booked a flight for Thursday night. I arrived at my hotel very late that night. The next morning I took a cab to the clinic. I was about five minutes early, so of course the clinic was closed. It seemed completely dead — like it was abandoned. The thought then entered my mind that I had made a huge mistake; perhaps I was going to be stuck in New Jersey to detox with nothing, alone.

No One's Home

The crew showed up right at the time they told me to arrive. It bothered me that no one had arrived early, but the place so quickly began buzzing with activity that I put the feeling behind me. The first thing they did upon my entry was to get my credit card and charge $2700 on it. I know that medicine is a business, but this struck me as a crass operation.

Meet the Doctors

After they got my money, they took me to a room where I talked to the detox doctor. He just went over the drugs I was going to take after the procedure. This was just naltrexone, to keep me from using afterwards and about a week's worth of tamazapam to help me sleep.

Without much fanfare, I was taken to an operatory where I met the man who it turned out ran the operation — at least, from a medical standpoint. He was an anesthesiologist. He went on and on about how good my hands looked. In retrospect, I see that he was just happy that I was making his life easy. He had to attach an IV, and that was probably a big problem with most of his patients. Had he met me only a year later, we would have had a very different experience.

The Procedure

As it was, he found a vein on my left hand with one try and I was unconscious within a minute. My last memory of the clinic watching him fiddling with the tube that was feeding me my drug cocktail. My next memory was sitting in a wheelchair that was being pushed into my hotel. I looked up and saw that I was being pushed by the anesthesiologist. Once I was deposited into my room, he disappeared.

The Aftermath

The next three days were pretty much all the same. I was vomiting up everything I drank. I was experiencing uncontrollable diarrhea — soiling my sheets each time. The nurse dutifully cleaned up after me, but it was quite embarrassing. I think for the first time in my life, I understood the humiliation of growing old and decrepit. Right after this experience I wondered why they didn't give me a diaper which would have made the nurse's job easier and experience less unpleasant.

Since that time, I have learned a lot of withdrawal. This has caused me to wonder about a much more important issue. Why didn't they give me medications to relieve my discomfort? In addition to the two problems I have already mentioned — both of which can be successfully treated with minimal difficulty — I was not sleeping. I had drugs for this, but they were not given to me at that time.

A big issue for patients who have just undergone this treatment is getting enough fluids. Because of my vomiting and simple lack of desire, I was not getting much fluid into my body. After two days of this, my nurse had the anesthesiologist come over with two saline solution bags. He broke one, and put the other into an IV for me. At the time, I thought it was really great that he came over to do that. I felt differently when I was billed $500 for the visit. It made me wonder what I was paying the nurse for if she couldn't prepare an IV for me.

After three days, I was still a mess. I was freezing unless the room temperature was over 100. On the plane home, the guy sitting by me was moved because of my shivering and vomiting. I was in no condition to go back to work as scheduled. I took another two days off work. When I did go back, I was still in very bad shape — it was obvious to everyone.

Looking Back

I felt like I had been ripped off; the treatment did not go as promised. It doesn't seem to matter who is running the program, any criticism seems to be answered with a bunch of excuses. When asked about the diarrhea they would say, for example, "You hadn't defecated for a week before. What do you expect?"

What I expect is to be warned ahead of time what is going to (or may) happen. In addition, whoever is running the program should be knowledgeable in traditional opioid withdrawal. Any symptoms that occur after the procedure should be treated. Make sure what whoever you hire to detox you is able and willing to provide this kind of aftercare. With this assurance, a rapid detox will work well for people who have minor habits. Those with large habits should simply stay away from this kind of detox.

by Derek Thiel

Beyond Nightmares: Detox Options

Detox need not be a nightmare. But it is much more likely to be so if one enters treatment blindly. There is much to know; the addict who has decided to kick dope has a dizzying number of choices. And despite what many (especially those in the legal system) would have you believe, detox efficacy is highly idiosyncratic; what worked well for your best friend may be the worst choice for you.

Choices, Choices...

Despite much talk of new treatments for heroin withdrawal symptoms, there really are only four methods. These are listed below:

Cold Turkey
: This is the default method. By doing nothing, a junkie checks himself into a cold turkey detox. This is also the kind of treatment that one gets when using a bogus treatment method.

Medicated
: This kind of detox involves treating the symptoms of withdrawal with non-opioid medications. The two most common medications are clonidine and any of the benzodiazapine family of drugs. Therapies such as Ibogaine also fall into this category, although the effectiveness of ibogaine is unclear.

Opioid Substitution
: Opioid substitution is a way of weening heroin users — less and less of the opioid substitute is given over time. Using a long-acting opioid such as methadone makes it easier to gradually reduce the dosage. Drugs such as buprenorphine fall into this category.

Antagonist
: This kind of therapy is just the opposite of opioid substitution. Instead of making withdrawal last a long time at a low level, antagonist therapy makes it last a short time at an extremely high level.

Myths

There are a few myths that surround detox that should be kept in mind. One should always make detox decisions based upon fact rather than rumor. Avoid the following.

1. Substituting one opioid for another does not detox the body. This does not mean doing so is useless, however. Detox from methadone is less intense than detox from heroin, for example. Thus, gradually reducing one's methadone use is that much easier than doing so with heroin.
2. Buprenorphine is just an opioid substitute. It is not possible to substitute it for heroin and then simply stop using the buprenorphine without going through withdrawal.
3. The effectiveness of ibogaine for stopping withdrawal symptoms is not clear. Great care must be taken when using it for withdrawal. In addition, claims that it "cures" addiction are simply fantasy. Compulsive drug use is a complex behavior that cannot be cured by taking a drug.

Choosing how to get off heroin is an important decision that should not be approached casually. Research any form of treatment that you are interested in. Also, be very skeptical of claims that seem too good to be true; as the saying goes, "Things that sound too good to be true usually are."

Codeine Detox

There are lots of ways to detox from heroin. To me there is nothing like Clonidine; I think it is a gift from God—right after morphine itself. But not all people respond so well to Clonidine and it never hurts to have more tools in one's detox arsenal. In this article I will look at opioid substitution with particular attention to codeine.

Pretty much any opioid will block withdrawal symptoms. But they won't necessarily get you unaddicted to heroin. In the case of codeine, you are simply substituting because heroin breaks down into morphine (it is morphine that heroin addicts are actually addicted to) and codeine is only effective because of the small portion of it that transforms into morphine.

How Big Is Your Habit?

The main problem with using Codeine is that you have to take a lot of it to block the heroin withdrawal symptoms—usually about 20 times as much. Making matters worse, most users do not know how much heroin they use. In San Francisco, a gram of heroin goes for $40. It goes for $140 in Portland; but the purity of a gram in Portland is two times that in San Francisco. These days a good rule of thumb is that street level heroin is about one-third to one-half pure.

Another issue is that users greatly exaggerate their habits. In general, a user's habit is about one-fourth of smallest amount he uses in a day. So if an addict used between $40 and $100 of heroin per day, figure one-fourth of $40 or $10. If he lived in San Francisco, this would constitute one-fourth a gram (250 mg) at one-third purity. This would mean his habit is about 80 mg per day. Thus, he would need roughly one and a half grams of Codeine to block the withdrawal symptoms.

In order to detox, the user will need to get enough Codeine for the entire process. This issue of *HEROIN helper* contains an article on isolating Codeine from a more or less legal supply. The procedure is quite easy but it is probably too much for someone in withdrawal.

Daily Doses

Once the user has acquired the Codeine, it is divided into twenty-one doses. Since the user will be weening himself, the doses must go down each day. Use the table below to determine the dose for each day. The amounts are given in percentages of the first day's amount—the first day's amount is determined as discussed above.

Day	Amount	Day	Amount	Day	Amount
1	100	8	40	15	8
2	90	9	35	16	7
3	80	10	30	17	6
4	70	11	25	18	5
5	60	12	20	19	4

6	50	13	15	20	3
7	45	14	10	21	2

Codeine is destroyed in the body very quickly. As a result, the person detoxing should dose himself a few times per day. So the dose for each day should be divided into (for example) thirds, and taken once in the morning, once in the afternoon, and once before bed.

Acupuncture

Acupuncture is a treatment modality that is used to treat a wide variety of ailments including drug addiction. This science rests upon the idea that the body contains meridians or channels through which a vital energy called Qi (pronounced "chee") flows. Qi, along with blood, nourishes the organs and tissues of the body. For a person to be in a state of health and well being, the channels must be filled with patency — the uninterrupted, strong and smooth flow of Qi.

The Cause of Disease

According to the Chinese, disease becomes manifest when the flow of Qi or blood is interrupted. The reasons for the disruption of patency can be numerous. Regardless of the reasons, however, the blockages, stagnations, and deficiencies must be addressed, treated, and removed. Once they are removed, Qi and blood flow will return to normal levels and result in a regained state of health.

Nutritional Deficiencies

In addition to other problems, the drug addict often has serious nutritional deficiencies due to poor diet. This injures his Yin, Yang, Qi, and Blood — causing the stagnation of Qi and Blood. Acupuncture will help stimulate the digestive system and other parts of the endocrine system, thereby promoting the production of Qi and Blood. This helps the addict to regain nutritional health.

Depression

Heroin addicts usually finds themselves depressed when ceasing to use. In some ways this is the hardest part of withdrawal because depression makes dealing with discomfort much more difficult. It is often said that depression is "all in the head." This is quite true — although not in the way that it is usually meant. Long term drug addiction affects brain chemistry. It eventually creates neurological deficiencies. As a result of putting in external sources of pleasure (morphine, primarily) which stimulate the same receptor sites as endogenous (body created) endorphins, the addict's body loses much of its ability to manufacture these substances itself. When the addict stops taking exogenous (created outside the body) endorphin substitutes, the addict feels bad. It takes time for the body to begin manufacturing the endogenous endorphins at a normal level.

Repairing the Chemical Production of the Body

For reasons not known, acupuncture helps the ex-addict of external chemicals "jump start" the body's process of creating the endogenous chemicals it needs to feel good. I know of no research that measures cerebral spinal fluid levels of dopamine or serotonin during detox situations with and without acupuncture. What I do know is based on clinical experience and what I have seen as an acupuncturist working with addicts for a number of years. These observations are not as conclusive as double blind studies, but they make acupuncture a hopeful procedure worth trying.

Using Acupuncture as Part of a Detox

I have been asked if an addict can be detoxed from heroin using only acupuncture. I advise against this. It is best used in conjunction with some other kind of medicated detox. For example, acupuncture is used in conjunction with a clonidine detox the Hooper Clinic in Portland, Oregon. It is also used in conjunction with 21 day methadone detox in California and elsewhere. In most programs, however, acupuncture is used only during the withdrawal period and not as part of the after-care where it is likely to do the most good in getting the body back to its normal state.

The Treatment

There are several hundred acupuncture points throughout the body. The ear is a micro system of the whole body. During detoxification acupuncture of the ear is the chosen area to treat. There are several reasons for this. The ear is easy to reach and is very close to the brain. The ear is located in the temperal bone. This is of neurological significance as all the cranial nerves (except two) run through the temperal bone into the ear. there is speculation that treating the ear is stimulating the cranial nerves. In giving stimulation to the cranial nerves one is directly accessing the brain and helping it to begin manufacturing the peptides which bond together to form the endorphins, serotonin, and dopamine which the body needs to experience normalcy, and which are thrown out of balance through sustained narcotic use. There are five primary points in the ear used. They are the sympathetic, shen mein, kidney, liver, and heart-lung points. Only the last three of these are used in heroin detox.

Conclusion

Acupuncture is not a cure-all and should be used with a number of different tools to make the detox as painless and effective as possible. After the formal detox is completed, acupuncture should be combined with improvements in diet and exercise — the latter including

Yoga, Tai Qi, and meditation. The ex-addict should do anything that helps the body create the endogenous endorphins and other affected brain chemicals and to stimulate their receptor sites. In this way, he will have his body returned to a normal state as quickly as possible.

McDermott's Do-It-Yourself Detox

This guide was first published by Lifeline Project, Manchester, UK. This electronic version may be freely distributed electronically or as hard copy. However, be warned that you are missing out on Mike Linnell's brilliant illustrations.

Why Should You Do-It-Yourself?

People often go along to a drugs agency in the hope of finding an easy solution to their drug problem. This is a mistake. There are no easy solutions.

The majority of people stop using drugs without any help. Addiction to smoking is just as difficult to give up as addiction to heroin, but the majority of people stop smoking without any outside help. Drugs agencies are thought to be in contact with between 10% and 25% of all heroin users. The rest stop using drugs without any help whatsoever. When the U.S. army was fighting in Vietnam, hundreds of thousands of soldiers became addicted to heroin. When they returned to the U.S.A., the vast majority gave up heroin without any help whatsoever.

... A small number of people find that it is harder to stop using unless they are physically removed to a place where they cannot get drugs, i.e., a hospital or a rehab unit. This may be an option for you to consider, but if you do, remember, you still have to face the situation back in the real world when you do get out. Ultimately, nobody else can do your detox for you.

Some people find that support from a drugs worker can be helpful during a detox. Other people's experience is that they are a bunch of know-nothing do-gooders who are about as much use as a blocked needle or a packet of wet skins. There are also other drawbacks associated with attending a drugs agency. They expect you to attend for regular appointments. You can expect to run into other drug users, possibly even dealers, and most drugs agencies keep records of your name, address, date of birth, etc. In some cases, these are passed on to the Home Office and kept on a register. If you decide to use a drugs agency, remember to ask about their record keeping and confidentiality policies.

Ultimately, whether you decide that you want support from a drugs worker or not, the only person who can stop using drugs is **you**. However, the greatest obstacle to your success is fear. This [article] aims to try and remove some of the mysteries that surround drug detoxification[;] by explaining what will happen, we hope to make you your own expert. You take the credit for success, and the responsibility for your own continued use.

Before you make the decision to detoxify, there are several questions that you should try to answer for yourself.

Who Are You Stopping For?

In order to succeed in your attempt to stop using drugs, you have to genuinely want to stop. Not for your parents, not for your wife, not for the court or the probation officer, but for yourself. Of course, all those other people may play a role in making you want to stop. If you are upsetting your parents, if your wife is about to leave you, or you stand a good chance of being sent to jail, that may well make you tired of using drugs. However, for many people, it doesn't.

If you aren't really sure about it, perhaps you should think about other options. Some people find it is easier if they attempt to stabilize their drug use before giving up. If you feel that this may be a better option for you, then talk it over with a friend or a drugs worker. If you do attempt to stop using drugs before you really want to, you may be setting yourself up to fail. After several failures, you may lose confidence in your ability to succeed, which can lead you to stop trying. So try to be clear about what it is that you really want, and if you do want to continue using drugs, then focus on trying to reduce the harm associated with your drug use.

Why Do You Want to Stop?

Drug use has both positive and negative aspects to it. Everybody who uses drugs experiences both. People usually only stop when they are aware that the negative aspects outweigh the positive ones. Some people are aware that the negative consequences of their drug use are great, but are still unable to make the decision to stop using drugs. This may be because the positive benefits that they gain from using are even greater, or it may be simply because they haven't thought clearly enough about the consequences. Here is a list of some of the positive and negative aspects of drug use.

Positive
- Drugs make you feel good.
- Drug use helps you gain acceptance among friends
- Drugs give you something to do
- Everybody you know uses drugs
- Drugs make you feel more confident
- Drug use makes you feel free to be who you want to.

Negative
- Drugs may be bad for your health
- Drug use may upset your family and friends
- Drug use can get in the way of the other things that you want to do

Drug use is against the law
Continued drug use can damage your self-image
Dependence upon drugs can negatively shape the way that you see yourself

Before you decide to give up, make a list of the positive and negative aspects of your own relationship with drugs. Then you can see whether or not you think stopping would be a good idea.

What Drugs Are You Using?

Just as different drugs have different effects, so the attempt to stop using different drugs has very different results. Make a list of the drugs that you are currently using and try to think about which ones might be causing you a problem. Remember, you can lie to parents, employers, teachers, partners and friends, you can even lie to yourself — but given that you are only doing this detox because you want to, what would be the point?

Some drugs are not regarded as addictive, but that does not mean that you cannot become habituated to their use, or that their use is not a problem. Cannabis, L.S.D., Solvents, Amphetamine and Ecstasy may all fall into this category. Some people may experience mental craving if they try to stop using these drugs, but they should not experience any physical discomfort.

Other drugs are quite definitely addictive. This means that when you attempt to stop using them, you might experience physical withdrawal symptoms as well as psychological craving. The drugs that fall into this category include Opiates like Heroin and Methadone, Benzodiazepines like Valium, Temazepam, Ativan or Nitrazepam, Barbiturates like Seconal or Tuinal, and Alcohol.

For a long time, people thought that Cocaine fell into the first category of just being psychologically addictive. However, more recently, scientists have identified changes in the brain chemistry that occur after regular use of coke, and so the severe craving experienced by people with a cocaine problem may well have a physical component as well. Whether it does, or whether it doesn't, cocaine provides us with an example of a drug that produces chaotic and compulsive use patterns prompted by psychological craving rather than fear of withdrawal.

*[**Editor's Note:** The research shows conclusively that cocaine is not physically addictive. This is a good example of how biased government sponsored research can be. A huge amount of money was spent trying to show that cocaine was addictive. After 20 years, the most that can be said is that there may be minor physical withdrawal symptoms. In other words, cocaine is not addictive; if there were even the smallest amount of evidence to support the opposite conclusion, the government would be shouting it from the rooftops.]*

Make a list of the drugs that you currently use regularly. If all the drugs that you use fall into the non-addictive category, then you will not need to detoxify gradually. You can stop using immediately without experiencing any physical symptoms whatsoever.

If you find that you use more than two types of addictive drugs regularly, then you will probably find it easier if you seek professional help with your detox.

If you are just using one of the addictive drugs or one addictive drug and one or more of the non-addictive drugs, then you may well be a good category for a do-it-yourself detox.

*[**Editor's Note:** Barbiturates are very hard to come by and so, at least in the United States, it is rare that a heroin addict is also addicted to them. It is hard to become addicted to benzodiazepines. So these aren't really an issue in deciding whether you can detox yourself. Regardless, it is best to detox from one drug at a time. For example, don't try to quit smoking at the same time you are detoxing from heroin.]*

What is Your Source of Supply?

If you are dependent on drugs that are prescribed by a doctor, then you have an ally in your detoxification project. Talk over your plans with the doctor and tell him or her what you are planning to do.

If you feel that you are dependent upon Benzodiazepines or Barbiturates, and are on high doses, or have been using them for a long time, then it may be unwise to attempt to stop without medical supervision. Both drugs can cause severe fitting when they are withdrawn, and deaths have been caused by barbiturate withdrawal so it is not a good idea to attempt to stop immediately. With the Barbiturates, it is usual to change over to Phenobarbitone before attempting a gradual reduction, whereas with the Benzodiazepines, it is usually best if the prescription is changed to Diazepam.

If you are dependent upon an Opiate, then many people find it helpful to change over to either Methadone or Dihydrocodine (DHC or DF118) for detoxification. Again, if you are receiving your supplies from a doctor or a clinic, talk your plans over with them. They can help you by rationing your supplies for you during the course of your detox, and by offering more flexible options should you experience difficulty with your plans.

If you are dependent on black-market drugs such as heroin or cocaine, you may find it difficult to persuade a doctor to prescribe for you. This can be a good thing, as if you go on a script, it can make it too easy to continue using for a long time. Once again, it is crucial to stress that you need to know what you want. If you want to stop using, then it may be easiest to attempt a home detox. Should you find it too difficult, then you can always seek help from a doctor or drugs agency afterwards. If you wish to continue using, then you may well benefit from a visit to a drugs agency in order to discuss ways of stabilizing your drug use or reducing the risks that you run.

What Will the Withdrawals Be Like?

Withdrawal symptoms will differ with the drugs that you use. Cocaine users will not experience physical withdrawals, but they may experience intense craving, irritability, inability to sleep, mood swings and panic attacks.

Heroin users, on the other hand, will experience all of the psychological symptoms, accompanied by physical withdrawal symptoms. Some clever-dick drugs workers claim that withdrawal is no worse than a dose of bad flu. That might be true, except when did anybody suffer a dose of flu that stopped you from sleeping or even getting comfortable for more than a minute at a time? A dose of flu that can be cured in minutes by the consumption of a little bag of powder?

With opiate withdrawal, although the symptoms are the same for everybody, everyone seems to focus on one particular aspect as the thing that they experience as the worst. For one person it may be pains in the muscles or joints, for others it could be the inability to get comfortable. Others have difficulty coping with the lack of sleep. The range of symptoms for opiate withdrawal includes sweating, restlessness, nausea, diarrhea, stomach cramps, muscle pains, sleep disturbance, hot and cold flushes. It is undoubtedly unpleasant. However, fear of withdrawals makes them seem worse than they actually are. Almost everybody can cope with the severity of their withdrawal, regardless of how much they have been using.

Some people do really stupid things and claim the fact that they were in withdrawal as an excuse. It isn't that they can't deal with the sickness though — the real reason that they do these things is because they aren't really committed to stopping. It's hard to sit and suffer if you know that as soon as you get money, you are going to get sorted, and therefore you'll have to go through the whole thing again. You, on the other hand, are different. If you have decided to stop using drugs, this will be the last time that you suffer this way. Not only will you feel the pain, you will embrace it as you kiss it goodbye, safe in the knowledge that after you have finished your detox all that will be behind you.

How Do I Go About It?

Once you have decided to stop using, don't just say "that's it, no more" as you are bound to fail. You need to plan your detox properly. Decide a time when you are going to do it. It could be relatively soon, or it could be some time in the future. Whenever it is, put aside at least two weeks when you don't need to do anything stressful and you don't have any responsibilities. If you have children, send them to their grandparents or to a friend for a holiday. They won't enjoy spending this time with you, and you'll be glad not to have to worry about them.

Tell everybody about your decision to stop using. People who love and care about you will give you support through this period. Other users may resent your ability to break the habit and try to tempt you into using. If you suspect that this is the case, explain what you are doing, and tell them that you would rather they didn't come around during this period. You can decide later whether you still want to see them, but if they insist on trying to tempt you, you can be certain that they don't really care about you, so don't feel guilty about excluding them from your life.

Try to put some money aside. You need to be able to pamper yourself with rewards during this period. Giving up drugs is a very brave and difficult decision, so you shouldn't feel guilty about indulging yourself in other, less destructive ways. If you are unemployed, perhaps you could avoid paying the rent for a week and make up the arrears a bit at a time later on.

Finally, find a comfortable place in which to do your detox. One of the main reasons for doing a detox as an in-patient is that some people don't have anywhere comfortable that they can detox. For most people though, detoxification is much easier if you can make a drink in your own kitchen, watch your own T.V., read your own books and listen to your own stereo. If the place where you live isn't very nice, see if you can go back home to your parents, or if you can stay with non-addicted friends for a couple of weeks.

Personally, I think you should regard a detox as being like a prison sentence. Rather than focusing how long you have felt lousy, focus on how much closer you are to feeling better. Make a calendar and tick off the days, or keep a diary and write down how you feel. Identify landmark points so that you can look back over it and see how much progress you have made. Stopping using drugs is one of the major decisions in your life — it will be nice to look back and see how you managed to overcome each of the obstacles, or even just how much you suffered without quitting.

Every time you complete a certain period, congratulate yourself for having made it. Give yourself a reward. For each day you complete it could be something small, like something special to eat or drink. For each week that passes, do something really nice for yourself. Buy yourself something to wear or go out for a meal. Think about both the detoxification and the rewards as investments in the new you — the person that you want to become rather than the person that you were.

One of the most difficult aspects of opiate withdrawal is the lack of sleep. [I used to share this opinion. I now believe that depression is far and away the most difficult aspect of opioid withdrawal.] Some people might be tempted to use sleeping tablets in a desperate attempt to get some respite. Personally, I find that they don't really help, they just dope you up so that rather than lying around withdrawing, you are lying around feeling doped-up and withdrawing. You still won't sleep and benzodiazepines are addictive too, so you could end up replacing one habit with another. Remember, there are no easy solutions, you've just got to bite the bullet and ride it out.

*[**Editor's Note:** I disagree with this paragraph most strongly. First, benzodiazepines work extremely well to produce sleep. Second, they relieve anxiety and decrease depression. Third, there is no way you will get addicted to them over the short period of a detox.]*

Finally, don't get hung up thinking about the length of time that a detox is going to take. Like they say in Alcoholics Anonymous, just try to get through one day at a time. It's difficult trying to imagine a life without drugs, but far easier to make it through to the end of a day. Then you can again start afresh tomorrow. Remember, every day that you manage to stay clean is an investment in your own future — and if you can't be bothered to invest in yourself, you can be pretty damn certain that nobody else will.

How Long Does it Take?

How long is a piece of string? It all depends what drugs you use, how much you've been using, how long you've been using for and what your own particular metabolism is like. Somebody who has been using benzodiazepines might take months to feel normal. Heroin usually takes anywhere between three days and two weeks. Methadone seems to take much longer than heroin. It can last anywhere from two weeks to a month before you start to feel normal again.

*[**Editor's Note:** Acute withdrawal from heroin lasts five days, with the peak of discomfort occurring around day three. After about two weeks, you will feel okay. It is also at this time that you will begin to sleep normally — probably starting with an hour or two per night and then working steadily upwards. After three weeks to a month you should be sleeping normally. After a month you should feel pretty good and after three, you should be completely normal.]*

However long it takes, don't let it get to you. Three days without sleep will begin to feel like a week. A week without sleep will feel like a month. A month without sleep and you start to feel as though you're going mad. You aren't. Your mind and body will snatch some sleep as you need it. It might only be the odd five minutes here and there, but it's better than none. Remember, the longer you've been clean, the more you've actually got invested in your detox, so when the going gets tough just congratulate yourself for the success that you've achieved so far, and try to make it through to the next morning. And then start again, doing it one day at a time.

When Will it All Be Over?

A detox is never over. After a few weeks, your mind and body will be free of the drugs that you've been taking, but your problems are only just beginning. Ask any veteran junkie, they'll all tell you the same thing — getting off drugs is easier, staying off is far harder. Detoxification lasts a couple of weeks, staying drug free takes a lifetime of effort.

*[**Editor's Note:** This is false. There is a distinction between detoxing your body and keeping it from becoming re-addicted.]*

There are a number of points that you should bear in mind:

1. Stay busy.
   Boredom is one of the main reasons why people go back to gear. If you can't get a job, take up some voluntary work, or a hobby. Go back to school and train for a new career. Do anything that will stop yourself sliding back into your old patterns of behavior.
2. Avoid other drugs.
   Some people think that because they were addicted to say, heroin, they won't have a problem with other drugs. A number of things happens frequently with ex-users if they use other drugs. Some of them simply transfer their dependency to a different drug, such as alcohol or cocaine that can be just as damaging. Those who use the non-addictive drugs such as amphetamine, LSD or Ecstasy often find that it acts as a spur that allows their resolve to slip. If you must use other drugs, cannabis is probably the safest, but that can also lead you to slip into using other drugs. The safest strategy is to avoid all drugs completely.

   *[**Editor's Note:** This is the standard line. There is something to it, but I would not take it too seriously.]*
3. Find some support.
   Seek out friends that you can talk to when things are getting heavy. Some people find that organizations like Narcotics Anonymous are useful in helping them stay away from drug use, because people in the organization understand what you are going through. Others feel that the quasi- religious content of the twelve step programs like A.A. and N.A. is too much to take, or they dislike the way that program members continually define themselves as addicts rather than moving forward and getting on with the rest of their lives. Good friends, who may or may not be ex-users, can fulfill the same functions. Giving support when you feel low or when you've slipped up and used again. If you don't have any non-drug using friends, go back to point 1, and find something to do with your time. Chances are, you'll make new friends through your new activities.
4. Avoid drug-using situations.
   Many people find that certain cues make them think about using drugs. It may be a certain person — a friend or a relative. It may be a certain place — a particular pub or an estate, somewhere that you used to score, or it may be something less concrete like the sight of a Jif lemon or a bottle of vinegar. When you can recognize them, avoid them like the plague until you are certain that you have enough strength to deal with them.
5. Use the money you would have spent on drugs to do something you really want to do.
   If you do stop using, make sure that you get some benefit from having done so. Put the money towards buying something you really wanted, or doing something that you really want to do. Try to avoid having large amounts of surplus cash just lying around putting temptation in your way. Instead, plan a holiday in that country that you've always wanted to go to. (Avoid places like Thailand or Holland.) Take driving lessons, or save for a car. You have already had your first taste of success when you stopped using drugs. Now, anything is possible.

*[**Editor's Note:***

6. Exercise

Exercising helps to speed your body along in getting back to normal. It also helps in keeping you from going back on heroin.

]

Summary for Action

1. Re-read this booklet.
2. Make a list of the reasons for and against your continued drug use.
3. Decide whether you genuinely want to stop using drugs or not.
4. If you don't want to stop, put this booklet away until you do.

5. Make a list of all the drugs that you currently use. Is a D-I-Y detox viable?
6. If so, plan a time to stop using. Remember to leave at least two weeks clear with no responsibilities.
7. Tell your family and friends about your plans.
8. Accumulate money to pamper yourself with rewards after each stage.
9. Arrange to have a comfortable place to do it.
10. Make a detoxification time-table/calendar/diary
11. Plan activities to fill up your time after you have completed your detoxification program
12. Begin the detoxification program
13. Don't use any more drugs.
14. (I couldn't end on 13, could I?) Wish yourself good luck — you'll need it!

by Peter McDermott

Angry

This section of the *Heroin Helper* could be titled "Politics," but I think that "Angry" is more appropriate. When it comes to drug politics, it is hard not to be angry. The simple truth is that drug laws are hypocritical and just plain stupid. Whenever I get thinking about drug politics, I get angry. I think this is true of any thoughtful person. So you now find yourself in the angry section of *Heroin Helper* — the place to go to get more angry. The more knowledge you have, the angrier you'll be. Sorry about that — I just live in the world, I don't make it.

The Corpse Under the Bed

There is an urban legend about a German couple who are staying at a motel in the United States. They notice an unpleasant smell and complain to the management. The room is checked and a rotting corpse is found hidden in the mattress. While this is an urban legend, it is also true. It hasn't just happened — it happens all the time.

On an such matters, I always turn to the authoritative Urban Legends Reference Pages. They have written an extensive discussion of this practice of hiding dead bodies in motel rooms. The article is well worth reading and helpful, but not necessary, in reading what follows here.

Motel Deaths at the Movies

There are two movie that I know of that relate to this. The first is in the Robert Rodriguez section of *Four Rooms* called "The Misbehavers." There, the legend is used directly. Throughout the movie the little boy, Juancho, keeps complaining about a smell. This is in keeping with the Urban Legend article's repetition of the humorous, though deeply disturbing phrase, "Because of complaints about

the smell."

Junkies Deal with Death: *Drugstore Cowboy*

The second movie has no direct connection to this urban legend, but the characters in the movie deal with a situation that is very similar. In *Drugstore Cowboy*, Nadine dies of a Dilaudid® overdose, and the crew puts her body above the room (just like a serial killer discussed in the article). The big issue in the movie is that Bob has to move Nadine's body out to the car (so he can bury her in the woods). This is not so easy, because the motel is literally swarming with sheriffs — all there for a convention.

> **Bob:** I don't believe it. I don't fucking believe it. A sheriff's convention no less! Why couldn't it be a Tupperware convention?
>
> **Diane:** Better yet, an undertakers'.

Junkies Who Need Junkies (Are the luckiest junkies?)

I know when I first saw the movie, my initial thought was that they could just leave her — they would be long gone by the time she was found. But when she *was* found, it would be no problem linking her to them and, more to the point, Bob. As he points out, "She left us with an ODed stiff, which is paramount to a murder beef in this state."

Of course, there is another side to this, and I think it is fundamental to the greatness of the movie. Bob buries Nadine as much out of respect for her as out of fear of the law. Bob is a junkie, not an animal. He's admirable, if flawed. His drug use is part of who he is, not all that he is. I don't think 2 people in 100 could tell the story of a junkie without losing that.

Real Life Junkies

In almost all cases, dead bodies left in mattresses are murder victims. My experience is that other users stay to help overdosed victims, who can usually be saved. This is how the characters in *Drugstore Cowboy* would have acted if they had been around when Nadine overdosed. In fact, when Bob first notices her, he bends down and checks her pulse. Of all the cases discussed in the article, only one involved a drug overdose, and it was a dealer who was transporting heroin inside of swallowed balloons that broke. Most likely, he could have been saved but his comrades didn't necessarily know that. Regardless, I don't hate the people who fled this scene, especially given that it would have implicated them in drug smuggling. It is not acceptable, of course; it is disrespectful and disgusting. But it is also understandable.

My real hatred is saved for those people who enact laws that make people fear getting medical attention for an overdosed friend; the jailers who add torture to the punishment of those unlucky heroin addicts who are arrested, not even convicted (remember "presumed innocence"?), of a minor crime; and everyone else who think junkies deserve AIDS, Hepatitis, Endocarditis, and any other disease that's going around.

The Forgotten People

I think the "body under the motel bed" legend is so appealing to us culturally because it shows us the consequences of having relationships with so many that are both estranged and in close physical contact. What's awful about the story is that you might be sleeping on top of a rotting corpse, not that your dead body might be hidden in a mattress and forgotten. It's only junkies and whores and niggers who end up that way — who cares if they die. But good respectable Germans sleep on corpses. This must be stopped!

Junkies are the best example we have of the social outsider — the people who can't fit in. Up until recently, the drug laws were designed to keep junkies out of sight. The laws marginalized heroin users, pushing them into lives that are difficult and dangerous. These people don't get stately funeral narrations; they get, metaphorically if not actually, stuffed inside mattresses. It's only when the smell gets too bad that we sigh, pull the mattress away, and find the dead body of another human being we don't give a dam about.

"Can somebody cover that up?!"

Remember the Forgotten People

So increasingly, the drug laws are designed to round up all the heroin addicts. Put them in one place so we can keep and eye on them. **Concentration** makes them easier to handle. Put them together in a **camp**, for their own protection. Then when they die, they can be properly disposed of in a **crematorium**. No longer will good German couples need to worry about sleeping on top of their rotting copses.

One day, we will have a clean society. Until then, the junkies will be stinking up society and infecting it with diverse impurities. The cost of diversity is this kind of infection. But in good Orwellian form, we have redefined "diversity" to mean skin color. For the old definition, see fester. Diversity needn't only be hidden in a mattress.

Wonderful things I Have Learned From Having Been Fortunate Enough to Spend Most of My Life on the Receiving End of the War on Drugs

*[**Editor's Note:** This piece was written before 9-11-01. Because of the events of that day, things have changed a little. Now it seems we have a new "shared enemy," but drug users are singled out even more in this new world view. It takes a cold, calloused culture to label a*

drug addict a terrorist. Drug addicts are already beaten down further than any civilized culture would permit. This piece addresses this fact. We add only that things are not the same as when this piece was written. Things are worse.]

The War on Drugs has taught me that I belong to the last tribe of niggers on the planet: drug users — an entire strata of society that it is all right to demonize, hate, harass, and incarcerate for the crime of altering my state of consciousness against the government's wishes.

Because I am guilty of this crime, I have no rights. I may be detained, searched without cause, disrespected, have my property confiscated; and on that one occasion out of one thousand, that I'm not fast enough, aware enough, or just tired... I will be sentenced to torture — where whatever branch of law enforcement I am subject to, will throw me into a cell where I may sweat, shake, vomit, and experience withdrawal without medical attention. Apparently this is okay, because I'm just a junkie, and therefore do not have basic human rights.

This will continue until I get before a judge and any halfway competent lawyer has the "case" against me dismissed... Because almost invariably, the "case" begins with illegal search and seizure and a violation of my "rights."

This is fine, because I'm white and have usually had access to money; this means I am a better person, and might be worthy of reasonable legal representation. Therefore, I will not be joining the hundreds of people I have personally known, whose fate is to be ground up by the system, and dumped into prisons — for the crime of being in the wrong place at the wrong time. In other words, a drug sweep, where the local branch of TNT has a monthly quota to meet, and will shake you down if you're unfortunate enough to be the wrong color, driving the wrong car, or they're just in a bad mood.

Obviously, people who use drugs are a menace to society and should be thrown into prison with an interesting variety of violent offenders — except, if at all possible, with longer sentences — because, after all, the violent offenders just have some issues and things to work out; the drug users aren't even human beings. There's nothing more damaging to the entire fabric of society than a bunch of people who just smoked pot, descending on a donut shop all at once; or a heroin addict nodding out on a couch.

If I want to stop using heroin, it's okay with the government if I take methadone — a narcotic analgesic, far more addictive than heroin, but legal. But really, I shouldn't complain; federal and state regulations for dispensing methadone are relatively enlightened. It is not yet necessary to be tattooed, branded, or relocated to a methadone maintenance camp. It's just fine if I take buprenorphine, it's even a wonderful idea if I get into a LAAM maintenance program. The fact that LAAM may cause Q-T prolongation, torsades, and kill me, is all right. Because, it's legal. And after all, it's just another sedative, it's not something that's going to cause any radical paradigm shift to take place.

Should I ever require medical attention for any period of time longer than a few hours round-trip through an ER to have something stitched-up, making it necessary for me to inform the attending doctors that I am on narcotic analgesics; I will be treated like human garbage. While in the hospital it will take roughly 45 phone calls, 6 feet of forms signed in triplicate, and 3 days minimum, for them to finally agree to dose me with methadone at anywhere near the levels I need just to avoid acute opiate withdrawal. By which time, in addition to whatever other problem I had that caused me to enter their facility in the first place, I will **be** in acute opiate withdrawal.

If I ever make the personal choice to stop using narcotics, the options presented to me will be a series of medical professionals — touting the latest miracle-treatments which don't work. These addictionologists and other drug experts, for the most part, don't know a fucking thing about addiction. They have never used any drugs. They have however, read a lot of books, written by other medical professionals who, for the most part, don't know a fucking thing about addiction.

Reading those same books for yourself, will allow you to sum up almost all current knowledge about the psychobiological causes of addiction in about two sentences: "We have a lot of theories, but really, we know almost nothing about addiction. We don't even know why people become addicted in the first place — when others with the same genetics, environment, and psychological make-up do not; or why those who get off drugs, manage this."

Unless I leave the country and pay ludicrous amounts of money for it — something which most drug-dependent individuals have no way of affording — I will be denied access to the most promising breakthrough in the history of drug-treatment; namely ibogaine. For all the smoke and mirrors, game playing, and lip service paid, to the variety of reasons why ibogaine isn't of much interest to anyone — except those who would like to stop being addicted to addictive drugs — the bottom line is, it's a hallucinogen, and hallucinogens have a plethora of negative side-effects. Such as, for instance, the 60's. We don't want that.

All entheogens are bad. Entheogens present the possibility for radical paradigm shifts to take place, and the user may make some revelatory discoveries about the nature of their reality. This is super-bad; much better is just going to a meeting and sharing. Most of the 12-step programs have turned into something that nearly resembles an interesting parody of what they originally were — extremely old eastern concepts for dismantling ego, specifically rewritten to apply to drug-dependent individuals who are acclimated to western culture. They have become this cult of eternal powerlessness, where you can participate in an never-ending circle-jerk of sitting around and complaining about things; fight an endless battle against a mysterious disease and never again take any chemical additives or personal responsibility for your actions. Okay, having said that, let's all go out into the parking lot and chain smoke, drink coffee and eat candy bars... Say, is it time for my meds yet?

If I somehow manage to get off heroin and do the one thing that actually works — establish or re-establish, my own connection to spirituality, cosmic consciousness, God, whatever you'd like to call it — ingesting my sacrament is against the law. Entheogens, crack, heroin, alcohol — no wait, not alcohol, alcohol is good for you — it's all the same shit; just another drug. I am once again either forced to leave the country, or commit a felony every time I feel a need to go to church. Apparently I have freedom of religion so long as my religion involves hanging out and talking about the experience, instead of actually having it for myself.

The War on Drugs does not work. It cannot work. It is a war against human nature, genetics, evolution, and the attempt to take away my basic freedom as an individual to select my own state of consciousness. Because apparently I am not an adult and not fit to make these choices; therefore those who know what's best for me must attempt to legislate my state of mind. This is not fascism, this is simply the government looking out for my best interests and ensuring that I am fully vested in whatever paradigm they wish to sell.

Despite the fact that it cannot work, it's important to invest just a few hundred trillion more dollars in the War on Drugs, because we're running out of enemies to hate... That whole entire Cold War thing has sort of faded away; there doesn't seem to be an immediate need to Enforce Democracy in any middle-eastern country; and the War on Drugs serves to galvanize people, gives them emotional investment, and presents a clear-cut **right** and **wrong**. It's important to have a clear-cut **right** and **wrong** that doesn't require anybody to think. Thinking is dangerous and undesirable. Besides, we have this theory that the War on Drugs is "winnable." This is obvious to anyone who looks at the results to date. There is no lack of drugs, basically, anywhere. The number of people using drugs has not decreased. While the street price of drugs hasn't gone up, the purity levels have steadily risen. However, hey, we sure do have a lot of people in prison! In fact, America has more people filling its prisons, than any other country on the planet. We must be doing something very right, this is great... Especially if you're in the private prison industry.

In addition to all this, if drug prohibition were repealed, the economies of entire third-world countries which are currently propped up by all this, would suffer a severe blow; perhaps collapsing. And, of course, the people who profit by large-scale distribution of materials — which are essentially worthless, and have had their value artificially inflated to being worth more than gold dust, because they're illegal — would have to go find something else to do. Like, for instance, go get a job, or enter the slave-trading industry.

Aside from all the noise, we actually have no real problem with drugs. They perpetuate the powerlessness of the poor, they give everybody on all sides of the issues something to do, and perhaps best of all: there are a lot of people who once had the potential to effect change, cause paradigm shifts to take place, and used to be a real pain in the ass — who have voluntarily taken themselves out and self-destructed. All thanks to drugs. What's not to like?

What's Wrong With the Pure Food and Drug Act

"The Pure Food and Drug Act requires that medicines and foods be labeled with regards to what they contain. How could even the anarchist nuts at HEROIN helper have anything against that? Isn't it a good idea to have products list what's inside of them? How else would we know what was inside of them?"

Well, the anarchist nuts at HEROIN helper *do* have a problem with the Pure Food and Drug Act. The problem is that it requires that consumers make the same decisions as the government. Certainly, it is a bad idea to consume products with unknown constituents. But if I want to consume such products, that is my God given right.

The Drug War Begins

It was President Nixon who coined the prase "War on Drugs." As a result, people tend to think that the War on Drugs started then — or even later, like with Reagan. But the truth is that the War on Drugs has been going on for over a hundred years. At first it was mainly a war on alcohol. But after the failure of prohibition, it switched to "drugs" only.

"Hey pop... How Should I Live my Life?"

This act is the first really clear example we have of the United States government acting paternally. Every consumer can decide that they will only buy labeled products. They do not need the government to make that decision for them. In passing such a law, the government is saying that it is in a better position to make choices than are individuals.

Note that we would not have a problem with a law which required that any product labeled be accurate. Inaccurate label ling is fraud. No label ling is quite accurate and clear: we won't tell you what's in here — take your chances.

A wonderful irony is that because the government insists on making choices for individuals, those individuals who choose to ingest products that the government disapproves of, end up ingesting substances that are not labeled. And the products come from sources that have little incentive to maintain a high level of quality (and purity).

Racial Profiling: Not Just for the Darkies Anymore!

Recently, there has been a lot of media attention on racial profiling in drug cases. A cop will stop a car with two young Mexican men in it, for example, because heroin is known to be sold by young Mexican men. So there is no probable cause just a statistical argument (although very often, even the statistical argument is flawed). It is good that this police practice is getting uncovered for what it is. Unfortunately, another form of racial profiling continues to go unnoticed.

The racial profiling that I'm referring to is used primarily against whites. I only became aware of it when talking to a man who had recently finished serving time on a drug possession charge. He was in a mostly "black" area of town and had just scored some crack. He was walking home when a couple of police officers decided to question him. He fumbled over the question, "what are you doing in this part of town?" They used this as probable cause to search him. He spent six months in jail for this.

Supposedly, we live in a country where we do not have to explain what we are doing to authorities — as long as there isn't reason to assume some wrong doing. But now, being the wrong skin color — whatever that might be — makes a person suspect.

To some extent, racial profiling is about racism. But more, it is about the government's belief that it has a right to stick its nose into the affairs of private citizens. Unless police can see that a crime is being committed, they should have no right to interfere with anyone's life.

The presumption of innocence must begin on the street.

White in the Middle of Richmond

I live in Berkeley, which is in the East Bay of the San Francisco Bay Area. Although I could score on the street in Berkeley, for various reasons I do all of my business in Richmond which is a couple of cities north of Berkeley.

Berkeley White, Richmond Black

Berkeley is mostly a white city and I'm a white guy. Richmond (at least the parts of it that I visit), on the other hand, is almost completely black. Those people who aren't black are Mexican. If you see a white person in the neighborhood I score in, you can bet that he's there scoring drugs.

The drug hierarchy is racially divided. The Mexicans bring the heroin into the neighborhood. But the thing is, they won't deal with whites at all. I don't know if this is because of fear about police or some understanding with the blacks or what. That's just the way things are.

If you're white and you want to score heroin, you have to buy from the blacks. So the chain goes from Mexicans to blacks to whites. Even with this supply chain though, the cost is low and the quality is high. This is the main reason I go to Richmond to score rather than scoring in Berkeley.

Drug Treatment: The Ultimate Drug Source

You may wonder how I discovered Richmond given that it isn't an area I would normally go to. It all came about because of some people I met when I was in a methadone detox program. Needless to say, the detox didn't take — but I got better heroin connections.

*[**Editor's Note:** A reader responded with his own experience in the article:; Guilty of Not Being Black.]*

Not Black

Heroin helper seems to have some kind of psychic link with me. The day after reading your story White in the Middle of Richmond, I became the victim of this exact same thing (although in a different city).

The Chase

I was with my girlfriend, driving to my dealer's house. As we turned onto the dealer's street, I noticed a cop car headed toward us. Needless to say, we didn't stop; we kept driving, but I could see in my rear-view mirror that the cop car was making a three point turn in preparation to follow us.

It followed us for about a block and a half before its lights started flashing. I pulled the car over and two cops got out. Both of them were big guys. The one approaching me was white with a shaved head. The one approaching my girlfriend was black.

No Honkies Allowed!

The cop asked for both of our licenses, but before doing anything with them, he started asking me questions. "What are you doing here?"

I told him that we were on our way to a friends, that we had gotten lost, and we were trying to get back on the freeway.

Pleading Guilty

He asked if I was on parole or probation. I told him, no. Then he asked if I had ever been arrested and I told him, yes. He asked what for and I told him, "possession of a controlled substance."

He said, "So you're down here to buy drugs."

I said, no. This seemed to make him mad. He said, "Look, if you're gonna to try an bullshit me, I'm gonna impound your car and your gonna walk home."

Given my options and the fact that with the seizure laws, I would most likely never get my car back, I gave up. "Okay," I said. "But we didn't."

He went back to his car and ran our licenses, finding that we were clean. During this time, the black cop watched over us, not saying or doing much.

The Get-Away

When the main cop came back, he handed me the licenses. That was a huge relief because I knew it meant that we were not going to be arrested. Not that we left on friendly terms. He told me if he caught me in the neighborhood again, even if it was in a different car, he would seize the car and arrest me.

I drove a couple miles away and called my dealer. He drove to meet us at a near-by gas station. We've done that a few times now. It's a total pain in the ass — but not as a big a pain in the ass as going to jail. I don't know what this cop thinks he's doing. Does he think he's really stopping me from doing drugs? Or is this just his way of torturing other people? If it's the first, he's deluded. If it's the second, he's an asshole — I'm mean: he's a cop.

Harm Reduction Pretense

Although we consider HEROIN helper to be part of the harm reduction movement, we do not feel very comfortable within it. The reason is that no one really agrees as to what "harm reduction" means. For many, it means encouraging people to use "soft" drugs like marijuana instead of "hard" drugs like heroin. This philosophy is at the heart of *HEROIN* by Humberto Fernandez. It is a philosophy at harms heroin users.

Drug "hardness" is a meaningless measure. It is not even clear what it is a measure of. I deal with this issue at some length in my book Heroin User's Handbook. My work and that of other people — most notably Dr. Norman Earl Zinberg — shows that people's ideas of how hard a drug is stem primarily from how the drug is administered. Drugs that are eaten tend to be seen as soft (e.g. caffeine). Drugs that are injected tend to be seen as hard (e.g. heroin). A good example of this is seen in the differing opinions about heroin and opium. Both drugs have the same "active ingredient" (morphine), but heroin is a "harder" drug.

Again and again, Fernandez shows how the government increased harm by enacting laws that decreased access to marijuana causing greater use of heroin. Nowhere in the book is mention made to the fact that laws are responsible for turning opium users into heroin users and heroin eaters into heroin injector. In Fernandez's opinion, heroin is simply a more harmful drug than marijuana. This opinion is presented as fact — a fact so well established (like the earth revolving around the sun) that it needn't even be proved.

Fernandez is not alone in his opinions, of course. NORML has long used similar arguments to promote its cause. These arguments usually go something like, "If marijuana were legal, more resources would be available to fight against dangerous drugs like heroin."

Underlying all of these arguments is the idea that people use heroin because it is addictive rather than because they like how it makes them feel. In other words, being high on one drug is the same as being high on another. But this is not true. Different drugs affect the brain in different ways. As a result, some people enjoy one drug more than another.

Forcing people who enjoy one drug to use another that is deemed less dangerous. is just a minor variant on our current policy of forcing them to use no drugs at all. In order to reduce the harm done by drug use, we must start by allowing people to use the drugs that they enjoy. Anything else is just the pretense of harm reduction.

Heroin in Mainstream Publishing

At the Book Expo America (BEA) meeting this year, I came upon this impressive looking book, *Heroin* by Humberto Fernandez. Weighing in at just over 300 pages, the book intends to be an "up-to-the-minute, comprehensive, no-nonsense examination" of heroin from its discovery to its current use." Unfortunately, although the book has a good deal of useful information, it is weighed down by its author's acceptance of the same old lies: heroin use is necessarily abuse, addiction is a disease, and AA is an effective treatment for drug abuse.

We would live in a much better world if books such as Fernandez's were considered bad. Unfortunately, they are about the best that mainstream publishing has to offer. At least this book has *something* of value, and it is not riddled with factual errors (though there are a fair number).

Take, for example, *Heroin* (1) by Sandra Lee Smith which is also distributed by Hazelden — the publisher of Fernandez's book. This book tries to be an introduction to heroin for teenagers. But the author is utterly ignorant about drugs generally, and heroin in particular. What's more, she makes statements which, in addition to being false, seem designed to upset already worried parents (who are as likely as teenagers to read a book such as this). One such statement is that heroin is easy to obtain (2) — commonly sold on school yards.

If You Aren't Against It, You're For It

The books that I write are in no way pro-drug. But just the same, they are not anti-drug. As a result, my publishers have been very concerned with the accuracy of the information in my books. They have various practical reasons for their concern — in particular, lawsuits. I am also very concerned. But my concern is simply that I do not want anyone to be hurt because of anything I've written.

People writing anti-drug books no doubt think they needn't worry about the accuracy of the information they provide — as long as it causes people to not use drugs. This means their books are rhetorical, not expositive. The problem is that these books *claim* to be expositive — to simply provide information. Smith's book, for example is not presented as a argument against heroin use. Rather, it is sold as information that allows teens to make intelligent choices about heroin use. Of course, these two are the same when the writer is convinced that the only intelligent choice regarding heroin use is to "just say no!"

Perhaps this is why my books (and those of my colleague) are so different. The truth of the matter is that *I don't know* whether people should use heroin. Some people manage to use heroin — even in the current political climate — while keeping their lives together. But for most people, heroin use causes havoc in their lives.

I see my job as three-fold, and I think anyone who writes about drugs should see things similarly. First, I don't want to encourage people to use heroin or any drug. Although I think that drugs *can* improve some people's lives, people are better off if they can get along without drugs. Second, I want to provide information that will keep what I consider to be "responsible users" using responsibly. I hate the idea of a heroin user becoming addicted simply because he does not know how to avoid it; if he can't control his usage, that is another matter altogether, of course. Finally, I want to provide information for addicts and irresponsible users that will keep them as safe as possible.

I have a personal anecdote from my using days that relates to this last aspect of the job of writing drug information. It's called Suicide and that sums up the article. You can't help everyone.

I truly believe that if people follow the advice in my drug books, they will be safer (though not necessarily safe). Of course, being safe is often not the most important thing to a heroin user — for some, the danger is part of the thrill. You can't force people to take your advice, but it is there for the taking.

Anti-Drug Books Say More Than We Think

It is wrong to think that the only message that anti-drug literature conveys is "don't use drugs." The fact of the matter is that many drug users read these anti-drug books — taking whatever information they can from them. And they assume that the information is accurate. Often the inaccuracies are little things like exaggerating the size of the "drug problem"; but often it is far worse.

Take, for example, the Teen Challenge web site which repeatedly states that heroin is injected into *arteries*. What is particularly terrible is that authors of such errors don't seem inclined to correct them. In the case of the Teen Challenge error, HEROIN helper sent a very civil and helpful letter a couple of months ago. Teen Challenge has neither changed the information nor responded to our email.

Luckily, drug users who are on the Internet have a lot of options for good information (check out our Friends page for a few). But that doesn't excuse others from disseminating information that could potentially kill drug users — especially after the error has been pointed out.

Perhaps this goes along with the governmental practice of spraying paraquat on marijuana: drug users deserve whatever they get (check out this excellent overview of Paraquat). What a horrible attitude, though; especially from people who claim to be trying to *save* lives.

It is well known in our society that a writer of anti-drug information will not be held accountable for the accuracy of what he writes. This, of course, is wartime thinking. During a war, the society tends to be intolerant of anything negative said about the war. And conversely, anything said in favor of the war, regardless of how incorrect, is okay. Perhaps this is yet another casualty of the War on Drugs: honest discussion of drugs.

Enter Oliver Wendell Holmes

There is a long history of closing down public debate during time of war — even though one would think a country would need it more then than any time. At one time, it was necessary to enact laws to limit free speech at these times. This is where we get Oliver Wendell Holmes' famous quote about free speech not permitting a man to yell fire in a crowded movie house. (3) The actual quote is as follows:

> The most stringent protection of free-speech would not protect a man in falsely shouting fire in a theater and causing a panic.... The question in every case is whether the words used are used in such circumstances and are of such a nature as to create a clear and present danger that they will bring about the substantive evils that Congress has a right to prevent them. It is a question of proximity and degree.

Most people do not know what this quote was being applied to. If they did know, they would not be so fond of quoting it. It comes from a Supreme Court Ruling on Schenck vs. US, 1919. In the case, the "yelling fire in a crowded theater" is actually "passing out anti-draft pamphlets during World War I." From the same decision:

> When a nation is at war many things that might be said in time of peace are such a hindrance to its efforts that their utterance will not be endured so long as men fight and that no court could regard them as protected by any constitutional right.

This second quote has completely left the American cultural memory. Such an interpretation of the First Amendment flies in the face of what most people are still taught (and believe) about freedom of speech; namely, that it is intended to protect *political* speech above all else. This is why as a culture, we have hung on to the idea that there are limits to freedom of speech with the theater fire story (culturally, Americans believe there are *some* limits on free speech), but not the actual context in which these limits are supposed to apply (culturally, Americans believe such a political protest is exactly what the First Amendment is all about).

You'd Have to Be Crazy to Say That!

Today, we do not limit speech during wartime in such an overt way — not most of the time, anyway. Instead, our government does what it no doubt learned from the great totalitarianisms of the 20th Century: pretended that dissent is tantamount to insanity.

One needn't be too old to remember the way Kasey Kasum was treated during the Persian Gulf War. At that time, he was doing a media tour, pointing out the biased portrayal of Iraqis and other people from that region. Normally objective newsreporters could barely hide their utter confusion that anyone could hold opinions such as those of Kasum.

The same is true during our current Drug War. Anyone who says that drug use (much less drug addiction) is not necessarily bad is completely off the map. The only person saying this who is at all in the mainstream, is Thomas Szasz. But his arguments are *always*

discounted — but not based upon their own merits. Instead, his arguments are discounted because of who *he* is. If his arguments are attacked at all, they are simply pushed aside as being "extreme" or "far removed from what most Americans believe." Regardless, Szasz is the Kasey Kasum of the Drug War.

I got a free copy of the Fernandez book because I was talking to a Hazelden editor about writing a guide for treatment professionals on how to deal with the special needs of heroin users. I still think this is a good idea. But looking at the one Hazelden book that is closest to what I would write, I'm concerned. I can't pretend to be a Drug Warrior. I can't pretend that heroin destroys lives when the heroin laws are responsible for at least ten times as much damage. I can't pretend that history doesn't teach us that we would be better off without the drug laws. I can't pretend that medical science doesn't teach us that all of the opioid family of drugs is less dangerous than alcohol.

How to Write a Best Selling Drug Book

In order to write a mainstream book about heroin addiction, I would be forced to lie — or to be far more ignorant than I am. Of course, not trying simply yields the game to those who *are* dishonest or ignorant. The best way to look at the situation is to see that every bit of truth that gets published — regardless of how ignored it may be by the mainstream — breaks down the Drug War facade that says everyone knows the same truths about drugs: the truths that come from the TV set.

I'm not speaking of the minor turf wars that the government allows: forced treatment vs. incarceration; medical marijuana; rock and powder cocaine possession sentencing. I'm talking about the fundamental issues that cannot be discussed. Can someone be addicted to heroin and still have a fulfilling life? Is it better to live in pain than live with a drug addiction? Why is it okay to use drugs to relieve pain but not to increase happiness? Who exactly is benefiting from the Drug War and how are they benefiting?

In his book, Fernandez lambastes various industries for glamorizing heroin use (or addiction — he doesn't seem to differentiate). But he fails to see that all of these industries and the government are in agreement about the core drug issues. He goes so far as to write, "those industries not only have far greater resources at their disposal [than the government], they are not burdened by the mission of telling the truth."

This statement shows that Fernandez is completely vested in the government line about drugs. First, he thinks the portrayal of heroin use *causes* real life heroin use instead of seeing that fashion ads and Hollywood movies are simply a reflection of real life. Second, the government spends enormous amounts of money on anti-drug propaganda. Calvin Kline couldn't even come close. Third, and probably most telling, the government is not burdened by the mission of telling the truth. In fact, the government has consistently lied about drugs for the last 100 years. People often think that because the government is not in the business of making money, that it is noble.

Wow. First, the government has seemingly endless resources to put to vilifying drug use. Second, the government is the one entity that, over the past 100 years, could be counted on to lie about drugs. Fernandez shows incredible naivete when making such statements. But that's mainstream drug writing.

Notes

Note that these two books have the same title: *Heroin*. The implication is clear: heroin is some monolithic thing. There is no need to discuss a particular aspect of heroin because there *is* no particular aspect of heroin. There is just heroin. Better titles for these books would be: *Heroin Addiction: its history and current approaches to treatment* for the Fernandez book and *A Teenager's Guide to the Drug Heroin* for the Smith book.

I offer the following challenge to Ms. Smith. "If heroin is easy to acquire, then you should have no problem acquiring it. I will bet $500 that you cannot score a gram of heroin given an entire month to do so. Please contact me first, so that we can clarify the terms of this agreement. I'll be waiting."

Not that long ago, I was in a crowded movie theater and the fire alarm went off. The people in the audience looked around, saw there was no smoke, and so ignored the alarm. Holmes comment, even taken out of context, is quite troublesome. The truth of the matter is that people don't have to be protected from free speech. They can make up their own minds if the speech they are hearing is something they should heed or ignore.

Suicide

Let me relate a personal anecdote from my using days that shows the limits to how much you can help someone. I knew this chipper who, despite not being addicted, was the most irresponsible user I have ever met. It was well-known from others who had used with him, that he would use as much heroin as he possibly could. Not surprisingly, the first time he used around me, he overdosed. It was not particularly bad. I managed to get him conscious quickly and made him swallow a naltroxon pill — partly because I was still a little concerned and partly because I wanted to punish him, since I had warned him not to do the amount he did.

On the second occasion it was much worse. He stopped breathing. I had to give him mouth to mouth resuscitation several times over the course of the half hour that he was unconscious. Again, I had told him he was doing *way* too much, but he did not listen (I later found out that in addition to doing all of his, he had stollen some from me). As I drove him home, I told him that he was not welcome around me ever again. As it turned out, that was the last time I saw him.

Maybe this was callous. But there is only so much you can do for some people. I had done what I could for him — including saving his life — but he would not accept my help when he was conscious. About a year later I found out that he had died of an overdose — either

because he was alone or because he was with someone who couldn't or wouldn't help.

Worst Crime: Drug Use

Once upon a time, I spent eight months in jail for possession of about 10 mg of heroin. The one good thing about my sentence was that I was given no "tail" — no drug program, no probation. I consider myself lucky. I was in jail with many people who were spending as long as a year and a half waiting to be placed in a drug treatment program. And after they get out, these guys still have between three and five years of formal probation.

I dread the idea of probation because I am a drug user and probation is much worse for drug users than it is for, say, rapists. When a rapist comes in to see his PO, the PO can't give the rapist a urine test to determine if the guy's been raping anyone. The same goes for a murderer: there is no "violence" test to make sure that the murderer has been a good boy. But there *are* tests for drugs. So while a murderer will only get in trouble if the police find out about his violence, a drug user will get in trouble for using a drug even if his use is casual and responsible.

The straight community would doubtless respond to my observation with, "but drug offenders shouldn't be using drugs — especially when on probation!" But that statement misses the point of the observation: drug offenders are punished more than violent offenders simply because the technology allows them to be.

This is the time when anti-drug people point out that the violent offenders get drug tested as well. But as usual the anti-drug people are wrong. If a violent offender has no drug "abuse" history, he may file so that he cannot be tested. But even if he were tested, the testing would not really apply to his crime; it would tell him, "violence is okay, drugs are not."

And this is what the society is telling itself through the persecution of drug users: drug use is worse than violence. The drug warriors are always on about "sending a message" (mostly to kids). Most of their messages are pretty ridiculous: drink beer, not opium! But this one is probably the worst.

One Giant Leap Nowhere

Normally, Heroin Helper has little to say about cannabis and even less to say about medical cannabis. Most people think that medical cannabis has something to do with drug law reform. It doesn't. Drug law reform is about freedom, and medical cannabis does not.

Ninth Circuit Court Distracts Everyone

When the Ninth Circuit Court of Appeals found that doctors had a right to discuss cannabis with their patients, people throughout the drug law reform movement were happy. All this excitement just shows how ignorant people are about these issues. Even DRCnet, which agrees with Heroin Helper regarding the best drug policy, spends more time reporting on medical cannabis than any other issue. This week was no exception; The Week Online starts with two articles about the Ninth Circuit Court and medical cannabis: an editorial, "The Space Between the Lines" and an over-view of this week's Ninth Circuit Court ruling, "Ninth Circuit Appeals Court Says Feds Can't Punish Doctors for Recommending Medical Marijuana." These articles are worth reading because they show just how far we have to go.

As the Drug War gets more and more intense, the arguments used against it become harder and harder to understand. This itself is easy to understand, however: no court will listen to reasonable, clear-headed arguments. For example, no court will listen to a defense of possession on the grounds that the law is unconstitutional — even though it clearly is. In this week's case, the Ninth Circuit Court couldn't even agree on why they agreed. They published two opinions which are radically different, but which come to the same conclusion.

Opinion One: Begging the Question

One of the opinions seems as though it would be easily over-turned because it basically states cannabis should not be a Schedule I drug. This begs the whole point. If cannabis weren't Schedule I, the matter would be solved — doctors could prescribe it. However, there is something I like about this opinion: it points out the critical flaw in the Schedule I definition. The only thing that distinguishes a Schedule I drug from a Schedule II drug is that a Schedule I drug has "no currently accepted medical use." The fact that enough doctors are prescribing cannabis to cause the Feds to worry must *de facto* indicate that cannabis has some currently accepted medical use.

Ah! There in lies the lie, of course. It is not doctors who decide what has medical use, but rather politicians. If the law were to be honest, the phrase "no currently accepted medical use" should be changed to "no currently accepted political use."

Opinion Two: Missing the Point

The other opinion touches on two issues: freedom of speech and states' rights. Neither make much sense. The Feds are not interfering with doctors' freedom of speech. The medical profession has been in an unholy alliance with the Feds for the last 100 years. The Feds grant them a monopoly. Should we be surprised that the Feds would expect something in return? Something like, say, adherence to their laws (regardless of how ridiculous)?

It would by an infringement of the doctors' freedom of speech if the Feds said they could not tell their patients about medical cannabis. But they aren't saying that. They are saying, "Tell patients about medical cannabis and we will exclude you from the medical monopoly on prescribing drugs." As anyone who has read much of my writing knows, I am firmly in Thomas Szasz's camp: the doctors are as big a part of the problem as the government.

The "states' rights" issue is ugly. Many people seem to think that just because a state legalizes cannabis, the federal government should bend to it. This issue was dealt with conclusively in the Civil War. In this case it is even clearer than the slavery issue, however. Here we are talking about laws. The states have drug laws and the Feds have drug laws (a good case can be made that the Feds shouldn't be involved in the matter, however). If the state laws are repealed, the federal laws still exist.

Of course, the Court is not making such naive arguments. The Court is claiming the states are the primary regulators of professional licensing. Although this seems a pretty easy idea to defeat, it may win out in the long run. But to what end? To the end of giving doctors slightly more power and the federal government slightly less. Not one tiny step will have been taken to increase the power of individuals to self-determination.

One Giant Leap Nowhere

And that is where it stands, and that is why we don't support medical cannabis laws. They do not move us toward more freedom — they simply change the details of our repression. That's one small step forward for the government, and one giant leap nowhere for the people.

How to Not Remove Fentanyl From Patches

We get great letters at Heroin Helper. A lot of them are heartbreaking; many simply shatter stereotypes; but every once in a while, we get a letter that contains an idea so brilliant or creative or just downright weird that we feel ashamed of ourselves for not thinking of it first, and afraid for the writer. Such is the case for the following letter.

Dear HEROIN Helper,

As a long term (yet moderated) heroin user, I'm always looking for ways to make my usage more cost effective and less harmful so that my own personal choice(s) do(es) not have to interfere with my "public" life any more than they absolutely must. Your site (and books) have been extremely helpful in this pursuit and so it is to you I turn with this question.

About a year ago I had the privilege [!] of wearing a "Duragesic Transdermal System." This is of course an adhesive patch which is meant to be worn by the patient, and which slowly allows the Fentanyl within to be absorbed by the wearer.

What I really wish to know though is quite simple I suppose; can the Fentanyl within the patch be safely removed (and isolated from the alcohol USP gelled with hydroxyethyl if needs be) from the patch for IV usage? I know Fentanyl parading as "China White" is often responsible for death, but I also know that injectable Fentanyl is made use of in modern medicine. What this suggests to me is that if one has the ability to accurately measure a dose, then it would be safe to use. Given that each patch contains between 2.5 and 10 mg of Fentanyl, and given the extreme strength of Fentanyl as an opioid, it seems to me that if a user could extract said Fentanyl from a "Duragesic Transdermal System," then said user would have a VERY affordable habit, and also lessen the overall frequency of copping — which is of course the most dangerous part of any careful user's routine. All this seems to me that it would allow a user the ability to live very subtly with regards to their drug use.

In closing, I apologize for the anonymity of the letter, but we live in dangerously fascist times. I'm sure you'll understand, and I look forward to reading a response to this letter in the coming issue of HEROIN Helper. Thank you in advance...

Sincerely,
A Conscientious User

Dear Conscientious,

You are to be commended because none of us had even thought of trying to do what you suggest. But you are correct — there is gold in them thare patches. Or poison, because even 2.5 mg of Fentanyl could kill you. The largest ampule of which I am aware contain only 2.5 mg, so you are right that this is a lot of Fentanyl: 100 doses, to be exact.

The truth is that I do not have an answer to your question, but I will look into it. I would think that rinsing the patch in some substance would make the Fentanyl dissolve into the rinse. If it was simply water, that would be the end of it. More likely, whatever you rinsed with would cause the Fentanyl to become Fentanyl-something and the something would then need to be removed. Or that Fentanyl-something might be one of those Fentanyl derivatives that are 1000 times as potent as morphine instead of the usual (paltry) strength of Fentanyl: 100 times as potent as morphine.

Anyone attempting such an extraction would need a GC/MS to test what and how much they were extracting.

I would be lax in my duties if I did not take a moment to point out that Fentanyl (should you have missed it from the discussion above) is a **very strong opioid**. Note also that Fentanyl has a very short half-life (a half hour as opposed to three hours for morphine), and so is not very helpful to addicts as a way to stop the withdrawal syndrome (unless you have it in patch form, of course).

Sincerely,
Dr. H

Follow-Up

Dear HEROIN Helper,

I saw the article about Fentanyl, etc... I get the patches for pain, but would like to use them other ways also... Please advise... Serious substance... Don't want advice for kids on NGs [news groups]... Thanks in advance...

Leke

Dear Leke,

Thank you for bring this issue back to mind. I discussed this matter with a retired anesthesiologist who used Fentanyl recreationally for a long period of time. He did not have the answer to the question, but he did have some useful information that I will add here. The main thing on his mind was that the Fentanyl in the patches is in a glisserine base and that removing that is *the* issue. I know that the problem could be solved with alacrity if I had an Uncle Fester work on the problem. (As though there could be more than one!) Unfortunately, I don't, and really, there isn't a chemist I know that I would trust enough. A big issue is that minor chemical changes to Fentanyl can turn its normal 100 times morphine potency into 2000 times morphine potency.

I'm trained as a theoretical physicist, although professionally, I did almost exclusively chemistry. I suspect that if I worked on it, I could come up with a recipe for extracting Fentanyl from patches. But there are various problems. First, I've never come up with a theoretical solution to a chemical problem that didn't require experimental tweaking (maybe because I'm not that good a theoretical chemist, but mostly I just think that's the way it is — theory only takes you so far). I don't have Fentanyl patches to test any theories I developed. But even if I did, the testing would be so dangerous that I don't think I'd be willing to do it.

Second, one of my favorite sayings is "a little knowledge is a dangerous thing." If I posted a recipe based only on theory, people would try it regardless of how much I told them it was just theory and how extremely dangerous it was. If someone died as a result, I would certainly be sued for everything I have (mostly debts) and I would certainly be convicted of murder. And to be honest, in that case I would lean little in agreeing with that verdict. (I still think it is wrong that people are held accountable for how other people use the information they provide. And in the end, Uncle Fester may end up in jail because of his drug books. The irony is that he will never be bothered about *Home Workshop Explosives* or *Vest Busters* or *Silent Death.* We live in strange times.)

Third, Fentanyl terrifies me. A milligram is a very small amount and a normal Fentanyl dose is about 1/20 of a milligram. Even with pharmaceuticals, you need to be *really* careful with the stuff. Did you ever see the movie *Drugstore Cowboy*? In it, Bob say, "You gotta be careful with this stuff — it'll kill you." He was talking about Dilaudid. Dilaudid is only 1/15 as potent as Fentanyl. I'm sure you see my point. And if you've read my books or looked at the website, you must have noticed that I worry a lot. I'm sick of people dying just because they're trying to have a good time. I suppose that's problem number four: I just don't think the risk-benefit analysis justifies doing it.

The guy who originally wrote, wanted to do this because he wanted to limit the number of times he had to score given that scoring is when an illegal drug user is most likely to be arrested. That's good thinking. But he is a chipper, and his logic is a lot like the logic: "If I had a regular supply of heroin, I wouldn't obsess about it and so I would actually do *less*." It sounds reasonable, but I've known a number of people who have told me that exact same thing. In each case, when they succeeded in getting that regular supply they increased their use and eventually became addicts.

I guess this is all just my justification for copping out on this question. I don't *want* to know the answer and if I did, I wouldn't *want* to pass it around. But if I did have the information and I was sure it was correct and I could be clear and detailed in the problems, I *would* provide the information to readers of this site. But this is a near impossibility because I don't see myself doing drugs — opioids especially — any time in the near future. But if I do go back to using opioids, I'm sure I'm not going to be doing anything even close to the strength of Fentanyl. Drugs like that really don't seem like recreational substances to me. Like true methamphetamine, I understand that Fentanyl has no rush associated with it (another reason why it is dangerous). And I see both drugs as being practical: meth for people who need to stay awake for a long period of time; Fentanyl for people suffering from incredible pain. Tools, not toys.

But you have to remember that even though I know a whole lot more about Fentanyl than just about anyone you'll ever meet (including most M.D.'s), I am in no way an expert. A lot of my fear may be hysteria — the same kind of fear that I rant about when other people experience it over heroin. Regardless, the facts are that everyone has their limits. I was really pushing mine when I put the heroin purification recipe on the website. Providing an untested recipe to allow my readers (many of whom really trust me) to acquire 10 mg of injectable Fentanyl is past my limits. Way past them.

Sincerely,
Dr. H

I Wanna Be Gay!

When my parents discovered that I was a heroin user, they were very understanding. In fact, they seemed as though they had been waiting for *something*. And that something seems to have been that I was gay. "A junkie?! At least he's not gay!"

Admittedly, heroin use is a choice and homosexuality is not. And junkies are much more likely to produce grandchildren—especially male junkies. So I understand where my parents were coming from.

But if I *did* have a choice, I would have picked being gay. To me, being a heroin user is largely about finding one's place in the world. Nothing gives a life more focus than a good, expensive dope habit. Somehow, I believe that if I had been gay, that would have been enough. And that would have been really nice, because in my time and place, homosexuality was not a crime.

Someday, people will look back on the treatment of drug users today with the same horror that we look back on the imprisonment, castration, and murder of gays only a short time ago. For now, however, I wish I were gay.

Rant Not Rave

Some time in the future, the public may rue its hysteria about youthful RAVES when it conciders that it was a direct cause of the HEROIN Helper RANTS. Sort of anyway.

Crime Watch Neighborhoods

This sign is bolted on a wall just outside my apartment. I bristle each time I see it. I can write off the part about suspicious activities, because I can image how this might be reasonable; a stranger walking out of my neighbor's house with a TV would certainly be suspicious. However, what is to be made of "suspicious persons"?

I would love to be proven wrong, but I think "suspicious persons" is a euphemism for "people not like us." In the area I live, that would most likely be black skinned people. In these modern times, it is not acceptable to put up signs like, "whites only." So instead we get these thinly disguised signs of intolerance.

Diversity is the last thing any group of people wants. But today we must pay lip service to it. As a result, white society goes out of its way to find "oreos" and "apples" to surround itself with. But people who are really different — heroin users, for example — frighten them completely. So they vilify people who are really different in the the name of protecting their property or their children. But in the end it is the same as it has always been: fear and hatred of "the other."

Dear HEROIN helper,

You article about the Neighborhood Crime Watch signs made me laugh. I live in a "crime watch" neighborhood as well, and about a month ago I got my dealer to come to my house after a long time trying. The first thing he noticed when he got out of his car was a crime watch sign, and he said, ironically, "I guess I don't need to worry about my car getting broken into."

My dealer is a light skinned black man, and that was the first and last time he came to my house. When I asked him to come by my house again, he said no. Then he added, "Those crime watch signs made me realize that I stick out as much in your neighborhood as you do in mine." I'm germanic: blond and very fair skinned; his neighborhood is almost entirely black.

As it is, in the two years I've lived in this apartment, no one has ever come by and talked to me about our "Crime Watch Program." The program seems just to be signs. I think you're dead on in your article. All those signs say is, "Minorities, stay away." The implication is that minorities commit crime so if you keep them out of your neighborhood, you'll keep crime out of your neighborhood. It's very sad.

—Anonymous

Tom Sizemore is No Cop

I am behind in everything because of illness. And then I worked this weekend to catch up at one of my jobs that actually pays me. But while I was sick, I had the opportunity to watch the movie *Heat* about five times. The main thing that struck me was Tom Sizemore

When I first learned that Sizemore was part of that ever growing fraternity of "was once a junkie and who knows about now," I was not thrilled. All I thought was, well maybe he's not such a bad guy after all. But I found that I really liked him in *Heat*, and I realized it was because he wasn't playing a cop. I was always seeing him as a cop, which doesn't exactly inspire my friendliness. So here is Sizemore playing a really likable thief with a wife and kids. Hell, now I want to invite him over to hang.

Enough of Mr. Sizemore, however; we will return to him later. I want to talk about what is the worst aspect of this film *Heat*. Surprisingly, it is not Al Pacino's acting which is so far over the top, it's coming up from below. No, the worst part is Al Pacino's character (Vincent Hanna) giving his wife an example of the work he does and why he doesn't "share" with her. He tells her about a junkie who burned up his baby in a microwave because it was crying too loud.

Alright. Alright. Alright. Junkies do a lot of bad things. But this is just too much. I can image a junkie neglecting a child, but I'm pretty sure that a junkie is less likely than a straight person to do such an awful thing. But why not just tack "A junkie did" onto another phrase that means any bad thing you can think of? I'll tell you why not, because junkies already take the blame for far more bad than they are responsible.

The writer and director, Michael Mann, also fills the movie with drinking. But of course, nothing bad ever comes of that. Wake up, Mr. Mann, the reality is that those drinks are a lot more likely to lead to fried babies than the drug Mr. Sizemore may or may not have been doing in between takes of *Heat*.

One Man's Junk is Another Man's Treasure

You may have seen these signs around your town. The whole sign reads, "1-800-Got-Junk" with the subtitle, "North America's Largest Junk Removal Service." The first time I saw the sign I almost died laughing. Clearly, the ad campaign is a parody of the "Got Milk" ads (same font, for example). But I think the designers had little thought of how these signs would come off to, for examples, readers of this site.

I've checked with a number of straight people (people who have always been straight, not ones with "histories") and without exception they all perceive the sign as intended, "Do you have stuff to throw away." I'm not sure how the sign comes off to active users. I assume it is either, "Yes, thank you very much" or "I'm working on it! I'm working on it!"

For all people with experience with heroin, these signs must come off as ads for the product (junk, smack, heroin) rather than ads for litter removal. In this way, I suspect they cause some unhappiness for the NA crowd who are constantly told that they are inches away from using. They must answer, "No, and I better get to a meeting, fast!"

To me, the signs seem like a great idea for a t-shirt. I've already been thinking of "Speed Kills! Don't Meth Around" on the front and "HEROIN helper" on the back. I like the irony that it looks like an anti-drug slogan when it's just anti-meth (not that I really have a problem with you doing whatever drugs you want—just be safe). "Got Junk?" is also ironic, although most people would miss the iron and simply wonder why you want to advertise for North America's largest junk removal service.

Richard Hell Knows Smack

Richard Hell is well known as being one of the originators of the punk music movement with the bands *Television* and *Richard Hell and the Voidoids*. He has consistently adopted an anti-drug posture. His position seems to be based on experience rather than lack of experience, however. Whether the experience is simply having been close to many people who hurt themselves with their drug use, or actual use himself, is unclear. Hell has always been cagey on the issue.

Regardless of Hell's experiences with drugs, he understands what it is like to be a junkie. In his novel *Go Now* (check out the Richard Hell website) he describes the experience of doing heroin after having stopped for about a week.

> The drug does what it always does. Gives me a big kiss and takes me in its arms and holds me and gives me all aid and comfort, says welcome back, you look great and everything's OK now we're together again. And what does it want in return? Ten, twenty, sixty, eighty bucks a day and whatever other efforts it takes to search out and acquire itself, and then every second of my time.

Hell's novel is not great. This is true because it doesn't have much in terms of narrative momentum—you aren't pulled through the novel. But the language is beautiful; the novel reads like a long prose poem. As such, you can pretty much read any chapter at random and enjoy it.

In *Go Now* Hell capture the essence of what it is like being a junkie. It is well worth reading by anyone who is interested in the lives of junkies.

Suicide Kings

Suicide Kings has a very nice depiction of a young morphine junkie played by Jeremy Sisto. Toward the beginning of the film there is a

scene showing this character shooting up. The reason this scene was put into the movie, according to the director, was to show that this character might be the "inside player." For other characters, great lengths were gone to in order to show that they had some motivation to be such a snake. One character, for example, had lost $20,000 gambling. The motivation for the junkie was shown in one ten second scene shooting up.

This logic comes from the fact that heroin addicts pay a lot of money for heroin. This character is a medical student, however. And he is clearly stealing the drugs, not buying them. So it doesn't make sense that he would need large sums of money. Large sums of money would probably not help him — he's a rich boy who wouldn't know where to go to score drugs.

It is unfortunate to see opiate users stereotyped, but besides this one (important) aspect, this character is mostly not stereotyped. He is the most reasonable of the young characters: thoughtful and caring. In the end, he is the most likeable character as well. The first battle that must be won against the War on Drugs is the identification battle: the population as a whole must see drug users not just as humans but as capable and complex humans. Movies like *Suicide Kings* give hope.

You Got Trouble!

I just bought the DVD of *The Music Man*. I've loved this movie since I was a kid. The movie is very happy with a positive outlook on human nature. But viewing it now, with the experiences I have had in life and living in the current oppressive political climate, the movie has a certain sinister (or perhaps simply "insightful") aspect.

When Professor Harold Hill comes to town, he manages to sell a "boy's band" by whipping up hysteria about the effect the town's new pool table will have on the morals of the town's boys. That's where one of the movie's most famous songs comes from:

> You got trouble
> With a capital "T"
> And that rhymes with "P"
> And that stands for "Pool"!

I image people watch the film and think what a bunch of yokels these people are to buy into this story that a pool table will cause the moral degradation. But these very same people accept a far more preposterous idea about the threat that drugs have on their child. In the pool case, the idea is simply wrong.

In the case of drugs, the laws enacted to protect the children actually put the children at greater risk. It is well known that children have an easier time acquiring illegal drugs than they do alcohol. The reason is simple: there is no real incentive for illegal drug sellers to not sell to kids. But there is a *big* incentive for alcohol sellers.

When I was a kid, my parents owned a convenience store. They lived in constant fear of the ABC (Alcohol Beverage Commission). If they were caught selling alcohol to minors, they would not only be heavily fined, but might lose their license to sell liquor at all — and my parents made a lot of their money selling liquor.

Roughly 70 years ago, Hitler noted that people where more likely to believe a big lie than a small one. This is the case today with the drug laws. Everything that these laws are intended to do, have the opposite effect.

- Children have more access to illegal drugs than legal drugs
- While casual use of illegal drugs may go down, use by abusers goes up
- People with drug problems have less access to help
- Property crime increases

All of this should be known, based upon the United States' experience with prohibition. But that is *exactly* why people ignore these facts and continue to support the Drug War: the lie is so outrageous that it *must* be true! How does one fight such logic? What does one say in response? I really don't know. But I know what Professor Harold Hill would say:

> You got trouble
> With a capital "T"
> And that rhymes with "D"
> And that stands for "Drug War Hysteria"!

Heretics of Heroin

The heretics have noticed the helper. Monkeyboy on the Heretics of Heroin (on MSN, now gone?) discussion group had the following to say:

> I thought you all might be interested at looking at this website I just came across. [HEROIN helper] is pub up by [Dr. H], a Portland (Ore.) physics professor who got into dope and has written *The Little Book of Heroin* (Ronin Press, 2000) and *The Heroin User's Handbook* (Loompanics, 2001) and will be publishing *The Little Book of Opium* with Ronin this fall. The web-site is kind of what http://www.herointimes.com/ could have been if it wasn't published by an essentially clueless recovering coke fiend. If anything, for my taste, [Dr. H] is perhaps a little too heroin-positive, though he certainly doesn't skate over the dangers. I just think he overestimates the degree to which most folks will be able to function as creative chippers and the likelihood that we are actually going to purify our street heroin with hydrochloric acid and ether. In any event, it's certainly worth a look see, and *The Heroin User's Handbook* is actually quite well done.

This is probably the best critique of this site we have yet seen. At a later time, we will respond to these charges. For now, we will just say that we do like to think the best of people and not the worst. As Thomas Szasz has pointed out, the War on Drugs assumes the worst of who we are — that none of us are in control of our actions, or at least, no more in control than a child.

Traffic

I really didn't want to see the movie *Traffic*. My main reason was that, based upon the trailer, I thought the film's philosophical base. I thought it was going to be the same old lie: "if only we didn't have corruption, we could win this war!"

I was wrong about the movie's philosophical base. Basically, it has none. In a lot of ways, it is a good depiction of the Drug War: it's very confused. There is one thing about the film that is spot on, and that is the government's response to Drug War critics...

Do you hear it? The silence is deafening.

In the movie, a drug dealer is waiting to testify against his supplier. He is in a motel room with the cops who are taking care of him. The guy is going over all of the practical reasons why the Drug War is ridiculous. His arguments are strong.

The cops don't even try to respond. It is just like a modern day Nuremberg: "I'm just following orders!" There was no counter argument — not even a bad one. It reminds me of an essay I read a few years back. It was by the head of the DEA and was supposedly an argument for our drug laws. But the argument quite literally came down to this: the majority of people think drugs should be illegal, therefore drugs should be illegal. I always think this logic is made clear by analogy. "Most people think gay men should be killed, therefore gay men should be killed."

But that is the exception. Mostly, the government doesn't have anything to say on the issue. And I suppose that it knows what it is doing. The government never loses arguments with critics because the government never argues.

The Crew

I just watched this movie *The Crew*. It is very funny and overall worth watching. But as usual, there was something in it that pissed me off. At the end of the film, the main character justifies sending this big-time drug dealer to jail with, "I never liked drugs anyway."

The main character is a retired wiseguy. He's made his living killing people. And the drug dealer is a murderer too. But it is okay to harm him because he sells drugs — not because he is a murderer. I'm sorry to rant on and on about this but we live in a sick society. Again and again we are told that drug dealing is worse than killing; drug use is worse than death.

People look back on the Nazis and wonder how so many people could have accepted the idea that Jews were sub-human. I'm sure that future generations will look back at this time and wonder about our beliefs about drugs. But this is cold comfort to me, who gave a year of my life to these ridiculous notions about drugs. It is cold comfort to those who gave much more time to these notions. It is very cold comfort indeed to those who gave their lives. Ideas have power. Be careful what you believe.

Drug Dealing = Murder
Drug Use = Suicide
2 + 2 = 5

911

I was just told that the number of people dead at the pentagon alone is 10,000 (the only official numbers I have are 2100 wounded there). That is hard for me to come to grips with. This is a tragedy on a large scale. What bothers me is that this is only the tip of the iceberg — the real tragedy has yet to come and I am not talking about the death count from New York.

The real tragedy will come with the response by the United States.

Earlier today, the Golden Gate Bridge was closed. For those of you who don't know, that is a bridge in San Francisco. San Francisco is not an island. What good is closing the bridge? Are we thinking, "We may not be able to stop terrorists, but by God! We can inconvenience them!"

We in the US have a strong tendency to respond *inappropriately* to any tragedy. Because of the uni-bomber, all packages over one pound in weight must be taken to a post office. Does this make anyone safer? No. We respond *inappropriately* to tragedy.

What I am expecting from this is a wave of new laws that demolish the civil rights of Americans at the same time that don't make Americans any safer. Ben Franklin said something to the effect, "Those who would trade liberty for security deserve neither." Now we trade liberty for nothing at all.

One thing that the United States government *could* do to make all Americans safer is end the War on (People Who Use) Drugs. This would free up enormous resources to fight real crime. But of course, the US government will not do this, nor anything like it.

The War on (People Who Use) Drugs is a good example of a minor tragedy, to which the US government responded *inappropriately*. The result: a huge tragedy — a bigger tragedy than even today's — though, admittedly, not as concentrated.

.....

Either I am really good, or politicians are really easy to predict. I wrote the paragraphs above this morning, and before the end of the day it already had started. The Governor of California instituted a "Limited State of Emergency" which entitles the police to hold arrested people for 7 days (rather than 48 hours) before seeing a judge.

How is this justified? Was Sacramento bombed? Was any part of the government of California hurt so that those accused (and only accused) of a crime should not receive their traditional rights? Of course not. But those in power will use any excuse they can to exercise that power.

Governor Davis, you disgust me.

It's a little over a year later, and I'm struck by one thing in particular: how wrong were the initial estimates of the number killed. It's not so much the error itself, but rather the fact that we continue to assume the numbers are correct.

In the end, just under 3,000 people were murdered in the 9-11-01 attacks. This is a large number of people. And no number is low enough when it is a loved one who is dead. It is important to keep these numbers in perspective, however. The total number of people killed as a result of these attacks is roughly the same as the number of people killed in auto accidents each month in the United States.

We could and should count our blessing that more people were not killed. In the end, the terrorists won the battle on 9-11-01 because they succeeded in causing the United States to harm itself. How many innocent people have died because of our government's response? How much less free are we now than we were before?

The government wants us to focus on the horrible events of 11 September 2001 — and even to exaggerate them. Doing so makes us less safe and less free and makes the government more powerful and evil.

Farmworkers

Cotton Machine.

In case you're wondering what this photo is on the right, it's cotton being harvested. I've put it there because I just wrote an article about cotton fever. In researching the article, I found out that this ailment was first discovered in farm workers who were inhaling unprocessed cotton as part of their work. Farm workers have a hard life — whether they own the farm they are working on or not. When I found out about these poor souls who suffered the ill effects of cotton, completely by accident and without much public sympathy, it made me think of another group of farm workers who shared a similar fate with much more dire consequences.

The chemical methyl bromide (CH_3Br) has been used for many years as a crop fumigant. The problem with the stuff is that it causes cancer. Farm workers have been trying to get the stuff outlawed for a long time — because it is killing them. No one seemed to really care. People were far more likely to stop eating grapes (with all due respect to the goals of the UFW union) than to listen to the concerns about CH_3Br.

And then came the ozone hole. CH_3Br is one of the thousands of chemicals that destroys stratospheric ozone. It must be understood, however, that there is so little CH_3Br in the atmosphere, that it posed very little threat to the ozone layer. But soon, people began calling for a ban on the use of CH_3Br for *any purpose* — including its use in fire extinguishers.

So let me summarize the situation:

- CH_3Br used as a fumigant is killing farm workers, but this is not important enough to ban its use.
- CH_3Br poses an extremely minor threat to the ozone layer, and this *is* important enough to ban its use.
- Because of concerns about the ozone layer, CH_3Br cannot be used in fire extinguishers even though it saves lives (CH_3Br is one of the very best chemicals to use in fire extinguishers).

All people are selfish. Don't think that I'm saying that the farm workers were right is asking for a ban on CH_3Br and the middle and upper class environmentalists were wrong. Both groups were looking out for what they considered their best interests. But I can't help thinking that the claims of the farm workers were more compelling. There is a direct link between CH_3Br used on farms and human death. If any such link exists for CH_3Br and the ozone hole, it is indirect in the extreme.

And so it is with cotton fever. The truth is that my heart goes out to the farm workers far more than to the heroin users. The farm workers are just doing a job and they get sick as a result. On the other hand, no one ever made any of us do dope — much less inject it intravenously. I have great sympathy for the other problems heroin users face, of course. Heroin users suffer unnecessarily from Hepatitis, AID, and an almost endless list of other diseases. All because they like to play differently from the rest of society. Like farm workers, heroin users are a powerless minority.

Publishing Hypocrisy

When I wrote my first book, *Heroin User's Handbook*, the concern of everyone was that the book romanticized heroin and that it was too "positive." I thus took great care with that book and with *Little Book of Heroin*, to make them highly objective.

So when I was contracted to write *Little Book of Opium*, I was just as careful. The resulting book (which is co-written by *The Helper* was great, as far as I was concerned. It was a highly objective book with a lot of information that just isn't available in an accessible form.

But my publisher was not pleased.

I was told that the book was boring. It needed to have more of the romance of opium. Descriptions of opium dreams, more sex, and more recipes and other "how to" material. In other words, I was told the opposite of what I was told for the heroin books.

This is indicative of the hypocrisy that our culture has regarding opium and heroin. Opium may have a bad reputation, but it is nothing compared to heroin. Opium is drank or smoked. In the public consciousness, heroin is always injected. Heroin is simply a far more dangerous drug than opium.

But the science of the two drugs is clear. The effect of opium is dominated by its morphine content — almost to the exclusion of every other compound found in it. Heroin, on the other hand, is a pro-drug. It — like codeine — has an effect only when it is broken down into morphine.

I must admit, however, that it is fun to be set free of the ridged confines of the heroin books. The opium book will certainly *not* be a pro-drug book; it will be objective drug information. In fact, the information about the romance of opium will probably make it more objective.

Save Us From Our Protectors

November 2, George W. Bush signed the new anti-terrorist bill into law. It's bad, but I don't exactly hold it against Bush. He is just doing what any other man who could be elected president of the United States would do: sell out the ideals that I had always thought this country aimed for — even if it didn't ever come close to achieving. Clinton or Gore would have done no better. Of course, they would have done no worse.

I'm not completely against the bill. I am, after all, against murder. I believe in having laws against behavior that harms other people without their concent. But mostly this bill has nothing to do with murder — or terrorism, for that matter. It is a huge power grab by the government.

To those interested in drugs, the most onerous part of the bill has to do with (as always) police powers. Here is a quote from USATODAY:

> The bill also gives police wide-ranging new anti-terrorism powers to secretly search people's homes and business records and to eavesdrop on telephone and computer conversations.

If you believe this won't be applied to drug users, you probably aren't reading this (I make no claims to anything but preaching to the choir — they're the only ones who show up). It will work (actually, it is already working) like the original drug laws.

Nowhere in the U.S. Constitution is Congress given the right to make laws controlling drugs. It says clearly in the Constitution that if a right is not granted to the government, *they do not have that right.* So the government used its right to tax as a way to prohibit drugs. How? Well, it's complicated and it doesn't make any sense anyway. But for the first 60 years of the Drug War, anti-drug legislation was always written as tax law. But not today! People have been disallowed their Constitutional right to drugs for so long that the government doesn't even feel the need for a pretense of abiding by the Constitution.

And so it will be with the anti-terrorism bill. It will be used against drug dealers first. The argument will be that they are terrorist — destroying our children with the drugs they force on them! (That's sarcasm, folks.) But eventually it will be alright for the cops to perform a secret search of your house if they believe you took a Vicodin ES® after its expiration date. No one will remember a time when drug users had the same rights as everyone else, anyway.

There seems to be this natural process in politics where individual rights get eroded. I believe this is why many of the founders of this country felt that a revolution every now and then was necessary. I'd like to think that it isn't, because I don't favor violence for any reason. I just wish we could prosecute all of our elected and appointed officials for the obvious treasons that they commit daily. But instead, we focus on external forces which, bad as they are, do not have the power to hurt us nearly as much as those who are sworn to protect us.

Is This It?

It is occurring to me that roughly once a month I will add some content to this site, write a little introduction, and that's all there is. You know why? Because I feel dirty.

I would love to start a revolution. I don't mean a bloody revolution — people picking up guns and knives and killing each other. I don't much think that leads anywhere except for one set of bad leaders being replaced by another. I would love to start a revolution of *thought*.

I would like to make people think differently. Because the way they think is wrong. As Thomas Szasz said, most people don't know what the U.S. Constitution says and if they did, they would repudiate it. Even the Supreme Court seems to be in this camp. They seem to think the Constitution is complex with lots of room for "interpretation." It isn't; it's really simple.

Let me give you an example:

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press...

That's simple. "No law." Show me where in the Constitution it says that it is alright to abridge the freedom of speech *as long is those in power don't like the speech*. The first really onerous attack on free speech was by Justice Oliver Wendell Holmes (who many people — much to my amazement — do not put in the same category as Hitler, Stalin, etc.), who wrote: "The most stringent protection of free speech would not protect a man falsely shouting fire in a theater and causing a panic."

[By the way: The case this refers to — Schenck v. U.S. (1919) — involved a man handing out anti-war pamphlets during WWI. This sounds more like a man standing in a burning building, yelling "fire" in order to save the theater goers' lives. If ever speech was meant to be covered by the Constitution it was this.]

Which leads me back to the whole issue of my feeling dirty. The intent of this web site was never political. It was to help people who use heroin. But the further I get away from heroin, the harder it is to stay on track. The Liberty issue comes up too much, just because it is getting pretty obvious that this kind of site is going to be illegal in a few years.

So I find myself speaking out more and more about issues that relate to freedom. But who am I? I'm just some junkie who wants all drugs legalized so I can turn all the world (and especially the children of rich people) into junkies. I feel like Larry Flynt, except that I don't get paid as much.

Cops Cause Crime

In Beth's description of what's been happening in Philadelphia, she touches on an important and mostly ignored fact of crime prevention: putting more cops on the street does not decrease crime — violent crime, in particular. We are dealing with this in my little neck of the woods: The Bay Area.

Power monger Jerry Brown has been major of Oakland for the last four years. He is asking the people of Oakland to pay close to sixty million dollars ($60,000,000) to put another 100 cops on the street to fight the rise in Oakland's already high violent crime rate. Opponents are countering him with the fact that study after study has shown that more cops don't make for a safer community.

What does, then, if more cops don't? The answer is obvious, but it can be hard seeing the obvious sometimes. The better the economy, the lower the crime rate. There are many reasons for this, but let me just list three: idle hands, lack of need, lower stress.

A man down in Southern California wrote a little pamphlet called, "Three Reasons Why Police Increase Crime."(1) In it, he shows, using computer models that the more cops you have, the more crime you have. Basically, he shows that the more money a town spends on cops, the less it spends on producing goods and services that can be offered to other towns. As a result, the more cops a town has, the worse its economy is. Therefore: the more cops a town has, the more crime it has.

I'm trying to track down the author. I would like to have it available to Heroin Helper readers. It's important and fun reading. Until then, vote NO on more cops. Make those guys get a job where they have to produce something of value. "Fear" is not a thing of value.

Notes

1 According to the booklet, it may be acquired through Reach Out Now. Their address is 11142 Balboa Blvd, Suite #148, Granada Hills, CA 91344. They ask for a check or money order donation made payable to RON. **However**, this booklet was printed in early 1993. It is likely that they aren't around anymore. They have no presence on the Internet, for example. I am going to try to contact them. If I learn anything, I will report it here.

Suffer Fools Badly

This section of *Heroin Helper* comes from all the mail we receive from people who are fools. I don't think it is proper to spend the time responding privately because for every fool who writes me, there must be a million fools who don't. The fools have more in common than one might think. I list just the most annoying things...

1. They think their ideas are "new," "insightful," or "liberal."
2. They make broad assumptions about *Heroin Helper* without reading one-tenth of the almost 250 articles on our site.

But enough about the generalities. On with the fools and all their specific annoyances. Be aware, however, **I have made no effort to suffer these fools well.** My comments are harsh.

Mom and Dad
: Dad was a junkie; mom is a treatment "professional"; and I'm an idiot.

Boyfriend
: Boyfriend is a junkie and Heroin Helper information is "sick and wrong."

Mom and Dad

Why exactly do people feel the need to interrupt my peace with their thoughts? I didn't force my website on them; they visited me. Here is another one. (Responses in square brackets.)

I know that this is going to have no lasting effect on your opinion, but I feel the need to say my peace. My father was a heroin addict, my mother is now an addiction counselor, and I currently work at a rehab.

[Which qualifies you in what way?]

I'm sure there are people out there who may be able to use heroin every once and a while, and have it be no more harmful than those who choose to recreationally do other drugs.

[The implication being that there are very few? Why don't you do a little research instead of assuming what you want to believe?]

And while I do agree that drug laws are pretty awful and do not address the problem the way it needs to be addressed, I don't think that Heroin should be legal.

[I think your way is much worse than the current way.]

Criminal charges should send people to rehab, not prison, but they should still be rounding up people for use of the drug.

[You smug little bastard. Because you want to lock heroin users up in places you call "hospitals" instead of places you call "jails," you considers yourself a "good" person. I say a cage called a garden is still a cage. I would prefer that you be more forthright and just say "lock up the junkies." It is hard to deal with people who claim to be "helping." It seems wrong to be nasty to such "nice" people. But let's get down to the bottom of what you've written:

> "People who use heroin should be deprived of their liberty even when they do nothing else to break the law."

This is what you say. This is what all the liberal-minded "treatment not jail" people say. These people are far worse than the "lock up the junkies" types. Punishment by deprivation (jail) is preferable to punishment by brainwashing ("drug treatment").

Many heroin users cannot stop, and commit crimes daily to feed their habit.

[People commit crimes to get food too. So lock up everyone who eats? Regardless, since there are already laws against theft, why not lock up people for that; why is it necessary to lock up *all* heroin users because *some* commit crimes? And if they *all* commit crimes, won't they be picked up for that anyway? You haven't thought about this very much, have you?]

The number of users who cannot stop as compared with those who can is without a doubt higher.

[Absolutely false. You should be ashamed that you are this ignorant and yet you "work in rehab." Start by reading the U.S. Household Survey. Until then, you speak from complete ignorance.]

You have a right to your opinion, and I respect it,

[Do you respect my opinion or my right to my opinion? I don't see how you can respect my opinion since you clearly don't even understand it. I, on the other hand, understand your opinion only too well and I do not respect it; I repudiate it.]

but I think that maybe you haven't seen enough of the bad side of addiction to know the whole picture.

[Again: You smug little bastard. You have shown yourself to know very little about this field. I've spent the last decade studying it. In addition to this, I've lived it. Get a clue or at least shut up.]

If you got the whole way to the bottom of this, congrats!

[I read all of my e-mail, ridiculous though the amount is. Mostly, I'm very kind, but I'm losing patience with people like you. As it is you've already taken an hour of my time that could have been spent helping people.]

But I bet you get this all time.

[Unfortunately, I do get a lot of this and that's why I'm starting to lose my patience.]

-Peace

[Gee, I'm glad he ended with "Peace," otherwise I might have thought your letter was an attack. Now I realize that just as with all the heroin users you want to arrest, you are just trying to help me. Which of course brings to mind the old quote, "Lord save me from my friends; I can handle my enemies myself."]

Boyfriend

Dear Dr. H:

i think this is sick and wrong [sic.] my boyfriend of 6 years is now in rehab and i have to deal with the everyday bull shit that this brings. he will never be the same because of this drug. i hope the rehab works and that he will once again live a good healthy life. this drug kills people and families.

Dear Fool:

Then stay off my fucking site. It is people like me that are the reason your boyfriend is still alive. I don't get paid for running this site, nor do I get paid for reading nasty, offensive, and ***ignorant*** *e-mail from fools like you. I hope your boyfriend gets clean and dumps your ass.*

—Dr. H