Heroin Addiction – Key Notes

| | |
|---|---|
| Type of users | 0.1% of 16-59 year olds have used heroin in the last year<br><br>0.2% of 16-24 year olds have used heroin in the last year |
| Forms of the drug | Powder – may be brown or white |
| Street Names | Gear, brown, H, horse, shit |
| Purity | 43-45% |
| Cutting agents | Paracetamol<br>Caffeine |
| Legal status | Class A controlled drug under the Misuse of Drugs Act 1971 |
| Modes of taking | Smoking<br>Sniffing (chasing the dragon)<br>Injecting subcutaneously ('skin popping')<br>Injecting intramuscularly<br>Injecting intravenously |
| Patterns of use | Occasional use – not all use is addictive<br>Regular use<br>Dependent use<br>Use as a primary drug with any of tobacco, cannabis, cocaine, alcohol, benzodiazepines as a polydrug abuser<br>Use in speedballs with cocaine<br>Use as a secondary drug, coming down from cocaine / amphetamine |

Effects of the drug

| Acute – wanted | Acute – unwanted |
|---|---|
| Euphoria<br>Relief of anxiety, tension<br>State of lack of worry. | Vomiting<br>Overdose, respiratory depression (can lead to death)<br><br>Acute adverse effects of mode of taking, such as thromboembolism, transmission of acute infectious diseases |

| | | |
|---|---|---|
| | Chronic – wanted<br>Membership of an excluded, stigmatised and victimised (and therefore special) group | Chronic – unwanted<br>Dependence<br>Medical, legal, social and risk-taking problems, particularly HIV & Hep C transmission, financial problems, criminal activity, loss of social supports / relationships, homelessness, unsafe sex, living outside protection of law (e.g., violence from unpaid dealers) |
| Clinical presentations | Occasional use<br>Intoxication (F11.0)<br>Harmful use (F11.1)<br>Dependent use (F11.2) | |

Natural History

May be primary (started prior to onset of adult roles) or secondary (having already taken up adult roles)

*Primary Heroin Addiction*

Often, in stable society, previous use of other drugs such as tobacco, alcohol, cannabis.

May also be preceded by a subsequent period of stimulant (amphetamine, ecstasy) and / or hallucinogen (e.g., LSD) use, though this often terminates around onset of heroin use.

Smoking use around 18-20.

May progress within weeks or months to injecting and development of withdrawal symptoms.

Risk of death by overdose in early years when tolerance to opiates is not established.

Typical 6-7 year period before problems severe enough for patient to seek treatment (though may be presenting earlier nowadays)

Outcome in a criminal justice population (see table), after initial round of deaths, tends to go either to slow mortality or slow improvement, with small proportion stabilising in opiate maintenance therapy (around 6%) and a small proportion maintaining daily narcotic use (around 7%)

| | Years of follow-up | | |
|---|---|---|---|
| | 10 | 20 | 30 |
| Dead (%) | 14 | 28 | 49 |
| Abstinent (%) | 38 | 41 | 56 |

Table of 30 year follow-up of narcotic addicts in CJS
(Hser *et al. Archives of General Psychiatry* 2001;**58**:503-8)

Abstinence is not secure even after 15 years, though emotional precipitants of opiate use (anxiety, low self-esteem) return to levels in general population after 5 years abstinence

*Secondary Heroin Addiction*

Starts at onset of a major social stress (e.g., war) and ceases as the stress is removed

Modes of presentation

Self referral to drug treatment service
Presentation at A&E department / general hospital
Presentation to family doctor

- Consultation about heroin use
- Diagnosis of another medical condition associated with opiate addiction
- Concern expressed by another family member or friend

Referral from Court / criminal justice system following an arrest, charge, conviction (Drug Rehabilitation Requirement) imprisonment, or on release

Assessment

Clinical diagnosis

- History
  - longitudinal history of use (including development of withdrawal symptoms and injecting behaviour) and cross-sectional history (typical drug-using day, history of use over last week)
  - presence of withdrawal symptoms (nausea / vomiting, abdominal pain, diarrhoea, gooseflesh, sweating, bone pain, palpitations, salivation)
  - means of funding habit, criminal activity
- Examination
  - Physical examination (pupillary constriction, acne, track marks on arms, abscesses, thinness [weigh patient] )
- Rating scales
  - SODQ, MAP, OTI
- Investigations
  - Urine / saliva drug test

Complications from drug use

- Physical
  Illnesses related to mode of taking, abscesses, chest problems, infectious diseases related to transmission (many more than just Hep C & HIV)
- Psychological
  Relationship difficulties; low mood (nb careful differentiation from depressive illness), suicidal thoughts and acts; also, anger / low self-esteem from previous physical, emotional or sexual abuse
- Social
  debt, finances, benefits, housing, occupation, criminal justice system difficulties

Motivational state

- motivated to continue using, ambivalent, motivated to cease use

Treatment options

*Self-help*
Narcotics Anonymous

*User support*
The Alliance
Mainliners (Hep C)

*Those continuing to use*
Street agency support
Needle exchange
Bloodborne virus counselling, testing and treatment
Motivational interviewing
Opiate substitution therapy (methadone, buprenorphine)

*Those wishing to stop*
Detoxification

- Inpatient, outpatient
- Medication
  - Methadone (over 10 days, 21 days, over 4 months)
  - Lofexidine

*Those wishing to remain abstinent*
Post-detoxification pharmacotherapy
- Naltrexone

Relapse prevention therapy

Day programme
Residential rehabilitation
Outpatient treatment
- 1:1 support
- Individual counselling
- Individual cognitive-behavioural therapy
- When stable, psychotherapy for underlying emotional problems (previous rape victim, abusive parents etc)
- group therapy

Family support / family therapy

Assistance with process of finding accommodation
Assistance with addressing financial problems
Assistance with further education
Assistance with occupation / employment
Assistance through the criminal justice system