

LIFELINE PUBLICATIONS

MCDERMOTT'S GUIDE TO THE DEPRESSANT DRUGS

OPIATES,
METHADONE,
ALCOHOL,
BARBITURATES,
BENZODIAZEPINES
AND THE
REST



INTRODUCTION.

Since this guide was first written in the early 1990s, the average British heroin user has got considerably older and is far more likely to be in some sort of treatment (whether they like it or not). While heroin and other opiates are unlikely to ever lose their appeal with the true aficionado of quality intoxicants, at a time when the world is turning to shit yet again, some of the other depressant drugs seem to be regaining popularity. Without further ado then, for the sake of those suffering from pain, anxiety or insomnia, let us take a look at some of the old favourites and some of the newer kids on the block, and examine what effects the opiates, benzodiazepines, barbiturates and various other members of the depressant class of drugs have.



OPIATES

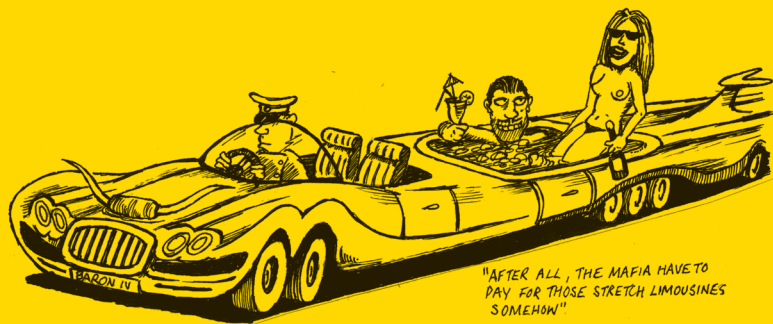
Opiates is a term used to refer to any drug with an opium-like action, whether they be derived from the opium poppy, like morphine, or synthetic drugs made in a chemist's laboratory (some experts prefer the collective term 'opioids', reserving the term 'opiates' for natural forms only). All opiate drugs have similar effects. At low doses they relieve pain and anxiety, and at higher doses they produce a dreamy sedative effect – known as a nod, mong or a gouch.

Opiates also give us the classical model of addiction. Used regularly, they produce tolerance - the need to continue increasing the dose in order to get the same effect and stopping after repeated use produces withdrawal symptoms – severe physical discomfort and a mental craving for the drug. Commonly available opiates include:

HEROIN (DIAMORPHINE HYDROCHLORIDE OR BASE)

This is the daddy of all opiates, highly prized among opiate users because the drug has the minimum undesirable side effects and a far superior euphoric potential to other opiates (whilst simultaneously reducing anxiety and depression). The effects of a single dose usually last between one and three hours, and addicts need to take another dose at least every 8 to 12 hours to avoid withdrawals. Heroin comes in several different forms.





PHARMACEUTICAL HEROIN

A staple of the British drug scene in the days when Britain's heroin scene was limited to a couple of hundred whining middle-class junkies who almost all lived in the toilets at Piccadilly Circus - this is now a rare, but increasingly available 'treat'. Opiate addicts considered 'refractory' to methadone or similar substitutes (i.e. they don't work) are sometimes prescribed heroin as a last resort. Around a thousand addicts in the UK are currently prescribed heroin.

During the sixties, it was available either as a white powder (from pharmacy and hospital thefts) and in 'jacks', 10 mg tablets made specifically for injection. Although jacks are still technically available, the form that is most often spotted today is the 'dry amp', an injectable preparation that can occasionally be obtained in 5 mg, 10 mg, 30 mg, the highly sought after 100 mg and the monstrous 500 mg ampoules. These are the drug equivalent of the holy grail for serious opiate users, but you need to be very careful. A 100 mg ampoule is about as strong as two 10 pound bags of street 'brown' - therefore a 500mg amp is like a gram or two of brown (depending on purity, which varies between 25% and 50%). Unless you have a high tolerance, an overdose is the inevitable result of shooting up one of these larger amps.

FAR EASTERN HEROIN

As the number of users increased and the law was changed so that heroin was only available from special drug clinics at the end of the 1960s, the market in prescribed heroin began to dry up. The demand for heroin was partly met by the newly-imported 'Chinese' heroin. This came in one of two types, and sometimes had brand names that the drug had been given by the producers. Pink Elephant, Tiger and Rice Brand were all very popular on Gerard Street during the early seventies. This heroin is also graded by number. Number 3 is a pinkish-grayish granular substance that resembles instant coffee. Number 4 is a pure white powder that closely resembles pharmaceutical heroin. These forms are produced for injection and the powder dissolves instantly on contact with cold water. Although they are still available in many parts of the world, these forms are rarely, if ever, seen in Britain today. Most of the available heroin on today's British drug scene is Middle/Near Eastern heroin.

MIDDLE/NEAR EASTERN HEROIN

This is the ubiquitous 'brown' that dominates the European heroin market – also known as smack, skag and gear. In fact, this stuff is not actually heroin at all. True heroin is diamorphine hydrochloride – a hydrochloride salt. The brown that is sold in the UK is diamorphine base. Just as crack is the free base of cocaine, i.e. cocaine that has been prepared for smoking by removing the hydrochloride part, so the brown heroin is a smokable product that is not soluble in water like real heroin, but must be dissolved in some form of acid before it can be injected. It is dirty, smelly, messy stuff, which is a far inferior product to all of the above. So who wants to throw in for a bag? It should also be noted that brown (street heroin) is typically around 50% pure – the rest of the powder is a mixture of opium residues and stuff added by dealers to increase profits (typically caffeine and paracetamol).

HEROIN: RISKS AND HARMS

In Britain's big cities, heroin currently dominates the market in opium-derived opiate drugs. From time to time, 'fancies' like raw opium or morphine ampoules appear, but always in limited quantities. In relation to other opiates, heroin is more efficient than morphine, and morphine is more efficient than opium, but once they get inside your body, they are all converted to morphine anyway, so the effects are much the same. The only place that any distinction can be discerned is in the rush, if the drug is injected intravenously – because heroin enters the brain far more rapidly than morphine. Morphine and opium may produce more nausea, or more itching, but they all do much the same thing.

Heroin is usually taken in one of two ways – it is either injected or smoked. Smoking – usually called chasing or tooting – involves heating the powder on a sheet of tin-foil, and inhaling the resulting vapour through a tube. Smoking/chasing is by far the safest way of using as injecting makes you much more liable to the risks of infection (notably HIV or hepatitis) or overdose.

Indeed, heroin is regarded as the most dangerous of all drugs mainly because of its unparalleled potential for overdose. For the non-tolerant average person, the effective dose by injection is just 8 mg, while the lethal dose is 50 mg – a safety ratio of just 6 to 1. This compares with a safety ratio of 20 to one for both codeine and methadone (i.e. the ratio of the lethal dose to the effective dose for the average person).

The risk of overdose is further amplified if heroin is mixed with cocaine. Although the two drugs might seem to cancel each other out, in fact, they appear to potentiate each other, so that the sum is greater than its parts. So if you are used to heroin and you do try a speedball, make certain that you use less heroin than you normally would. Overdose risks are also increased by mixing heroin with alcohol or benzodiazepines.

Lastly, there are two other methods of using heroin which are relatively uncommon, but which, like smoking, are far less risky than injecting: sniffing (snorting), a method of use about which users disagree hugely on its effectiveness; and the self-explanatory 'up your bum' (UYB) method.

Though heroin dominates the market for opiates, the price is expensive. After all, gangsters have to pay for those stretch limousines somehow, and how else is your dealer going to afford a BMW and a cocaine habit without an enormous profit on the gear? Having said that, heroin is much cheaper than it used to be – between £30 and £50 a gram in Britain at present. However, gram-deals

are relatively rare – most users buy bags/wraps costing £10 (about a tenth to a fifth of a gram), £15 (about a quarter to a third of a gram), or £20 (around half a gram, give or take 0.1). What price deals are available and how much heroin you get for your money depends on various factors, particularly which part of the country you live in. Heroin dealers in Liverpool and Manchester are believed to provide the best (cheapest) deals, while the most expensive deals are those sold in rural areas, or inside prisons (around £20 to £40 for a tenth to a fifth of a gram).

OPIMUM

Opium became very popular in Britain during the 19th century, but its use dropped dramatically after it was banned under the 1920 Dangerous Drugs Act. Today, its use in the UK is extremely rare, with the availability of heroin making its re-emergence as a recreational drug very unlikely. Opium is a sticky black-tar like substance derived from ripe opium poppies, and which, after harvesting and processing, is generally smoked or eaten. It contains three main opiate drugs – morphine, codeine, and thebaine. Each of these natural opiates can be used as the starting-point for making stronger semi-synthetic opiates – notably diamorphine (from morphine), dihydrocodeine (from codeine), and buprenorphine (from thebaine). All of these drugs are described in more detail below. Opium also contains other minor opiate drugs – notably narcotine (noscapine) and papaverine.

METHADONE

Methadone is probably the most well-known synthetic opiate – meaning that it is made by chemists without recourse to natural opiates derived from opium. To cater for those of us seeking to starve the dealers, methadone is now widely available. Methadone was originally developed by the Nazis in 1937 and called

dolophine. The myth continues that this was in honour of the Fuhrer. The truth is far more mundane. The name comes from the Greek word for pain 'dolor' and 'phine' which means end. This hasn't stopped the Church of Scientology from sticking to the myth. Strangely, it was never marketed in Germany because it was considered too toxic. It does have two redeeming features. It's orally active and very long lasting indeed.

As a result, from the late 1960s, but particularly in the 1980s, methadone became the drug of choice for doctors trying to help users manage their opiate dependency. Heroin wears off after a couple of hours, thus requiring several hits each day. Methadone, on the other hand, lasts anywhere between 24 and 72 hours, depending on the dose that you take and on your individual metabolism. Its trade names include Physeptone, while its street names include 'green', 'juice' and 'slime'. Illicit (diverted) methadone is usually sold for between £5 and £10 per 100 ml (100 mg).



"METHADONE WAS ORIGINALLY DEVELOPED BY THE NAZIS DURING WORLD WAR II."

Methadone generally comes in two distinct forms: 5 mg tablets and Methadone Mixture DTF. Tablets are now rarely prescribed to addicts in Britain, because of the risk that they may be injected. Methadone Mixture is a green sugary syrup, containing 1 mg of methadone in 1 ml of liquid (sugar-free versions are also available on request). There are also two rarer forms of methadone. First, methadone ampoules for injection are prescribed to addicts by some drug clinics under rare circumstances – though even pharmaceutical-grade liquid methadone causes a nasty burning sensation when injected. Second, occasionally somebody will break into a chemist and pharmaceutical methadone powder will come onto the market. This stuff is very, very strong, so if you ever happen to come across it, be extremely careful how much you use, especially if you are only used to street smack.

Many users claim that the problem with methadone is that it lacks heroin's intensity. It doesn't give you the same rush when injected and many users believe that the high is inferior compared to heroin. How much of this resistance to methadone is psychological is unclear. Many users become obsessed with the rituals of drug use – cooking up a hit, or chasing a bead/beetle around the foil. In blind trials, experienced users who were given both drugs orally were unable to distinguish between the effects of the two drugs. Where heroin does have a real advantage over methadone is in unassisted withdrawal (i.e. coming off 'cold turkey' without help from other opiates). Withdrawal from heroin, though more intense, should be over after seven to ten days. Withdrawal from methadone, though less intense, can take up to a month or even longer.

Any discussion of the properties of methadone must also be an appropriate place to warn of the dangers of cyclizine and similar drugs. In an attempt to replicate the effects of a now almost defunct opiate drug called Diconal

(dipipanone plus cyclizine), desperadoes of the drug scene have been known to mix certain travel sickness pills with methadone ampoules before injecting them in an attempt to produce a Diconal-like rush. In fact, the use of this combination just produces self-destructive Martians whom all right-thinking junkies shun because of their tendency towards compulsive and chaotic behavior. In the past, I have watched many a time-served junkie who after managing to keep it together for many years, eventually fell to pieces after discovering cyclizine (which chemically is classified as an anti-histamine). No longer available from the chemist due to its potential for misuse, the internet has spawned a new source of various similar drugs but, hopefully, as the Diconal experience retreats further and further back into the annals of folk memory, fewer people will experiment with this combination, but until then, only one recommendation can be made with regard to this substance: avoid it like HIV (or the plague.).



THE BEST OF THE REST

There are a whole bunch of other weird and wonderful opiates in the British National Formulary (BNF), some of them organic (natural), some semi-synthetic, and others totally synthetic. If you are serious about pursuing a career as an opiate user, the chances are you will come across them all at some point or another. Here are some of the more common ones.

DICONAL

If pharmaceutical heroin is the Holy Grail of opiates, then dipipanone is the Lost Ark of the Covenant. Diconal is a pink scored tablet, containing 10 mg of dipipanone hydrochloride with 30 mg of cyclizine hydrochloride. For every opiate-lover who tried them, Diconal immediately became the drug of choice. Diconal is a drug cocktail with the most amazing rush known to humans. Unfortunately, in accordance with the great cosmic law of nish for nash, it also happens to be one of the most destructive forces known to us. The drug comes in pink tablets that are made from silicon rather than the more benign chalk base. After a couple of hits, your veins become filled with sand and get as hard as glass. Keep on injecting and you end up with abscesses and ulcers at best, deep vein thrombosis and amputated limbs if you are unlucky. Thankfully for us all, creative intervention on the part of the ACMD (the government's advisory committee of drug experts) meant that doctors needed a special license to prescribe Diconal to addicts, which now means that Diconal are currently as rare as hens' teeth.

Cyclimorph: apart from Diconal, the only form of the opiate-cyclizine cocktail remaining in the BNF: Cyclimorph. This is a 1 ml injectable ampoule containing morphine tartrate and cyclizine tartrate which comes in two strengths: Cyclimorph 10, containing 10 mg of morphine with 50 mg of cyclizine; and Cyclimorph 15, containing 15 mg of morphine with 50 mg of cyclizine. It is prescribed for intractable pain only.

DUROGESIC

As science moved on, the resourceful Belgians produced what is now regarded as the most addictive, destructive and dangerous of the opiates. Initially the drug in Durogesic, fentanyl, was restricted to the operating theatre so the only abuse was amongst medical professionals. More recently, however, these sustained-released patches designed to provide analgesia for 3 days have become increasingly available. Consisting of a gel-filled patch marketed in four strengths (25, 50, 75 and 100 micrograms), Durogesic is very appealing to injecting opiate users. The problem is that fentanyl is 80 times stronger than morphine. Even the smallest patch contains the equivalent of 200mg of morphine. Many addicts have been found dead, needle still in their arm after shooting the dissolved contents of a single patch. Even if it doesn't prove fatal, fentanyl is probably the most addictive opiate known to humankind. The high lasts only about 45 minutes and withdrawal symptoms kick in very quickly so one shot 'demands' another. Be VERY careful.

PALLIDONE SR

Anyone who has seen the film 'Drugstore Cowboy', specifically the fatal overdose scene, is on nodding terms with hydromorphone (Dilaudid), the active principle in these capsules. Potency is about 10 times that of morphine. The high is clearer and the euphoria greater than that of heroin although it doesn't have the rush. As Nadine in the film found out the hard way, a little goes a long way. The strongest of these capsules has the narcotic punch of a gram of morphine and since it takes a little while to come on, the user might turn blue some minutes after injection rather than then and there. If you must use them then crush them and snort them – slowly. Only recently they were removed from the US market because combining these capsules with alcohol could result in the whole dose being released immediately, often with fatal results.

OXYCONTIN/OXYNORM

These pills contain the same chemical as the now infamous Percodan from the United States – namely, oxycodone. Basically, it's like morphine but more prickly. As long as you just swallow them, then they give a superior 12 hour high (though no rush). For many Americans they are the opiate of choice, including celebrities (see below). Sadly, for people with little patience, crushing and snorting the tablets seems like the way to go. For this reason US drug workers have nicknamed them 'Oxycoffin' due to the amazing number of fatalities. The drug in Oxycotin, oxycodone, is very active orally and shooting them doesn't offer a greater advantage as, say, shooting heroin over smoking it.

Oxycodone was also one of the drugs involved in the death of the Australian actor Heath Ledger in January 2008. The autopsy report concluded that, in part, "Mr. Heath Ledger died as the result

of acute intoxication by the combined effects of oxycodone, hydrocodone, diazepam, temazepam, alprazolam and doxylamine".

MST CONTINUS (PREVIOUSLY KNOWN AS MORPHESIC SR)

For people who like opiate tablets, MST Continus are the business. These tablets contain morphine sulphate in seven colour-coded doses: 5 mg (white), 10 mg (brown), 15 mg (green), 30 mg (purple), 60 mg (orange), 100 mg (grey), and 200 mg (another shade of green). MST Continus is also available as a suspension (sachet of granules to be mixed with water). When used by opiate addicts, these tablets will keep withdrawals at bay for many a long hour, due to the way that the tablet is manufactured – in a time release format. That is, the particles of drug are enveloped in wax particles of different sizes and densities, so the drug is continuously released inside the body over a 12 hour period. This production process makes the tablets difficult to inject as there is no easy way to separate the morphine from the wax. Do you really want to shoot half a Latin Mass up your arm?

Morphine sulphate is also available in many other forms, including liquid forms (notably Oramorph syrups and vials), injectable ampoules (10, 15, 20 and 30 mg), and capsules. Capsules include even longer lasting versions of time-release morphine, notably Morcap SR, MXL and Zomorph. Using modern technology they provide up to 24 hours of pain relief. Crushing and shooting these capsules is a highly dubious maneuver as the strongest contain 200mg of morphine, which is an awful lot. Prescribed morphine preparations are also available as morphine hydrochloride – notably morphine suppositories (preparations which you stick up your arse, and which are absorbed through your rectum).

CODEINE (METHYLMORPHINE)

Like morphine, codeine is a natural component of opium, though it has only one tenth the strength of morphine. Even so, it is the most widely used opiate pain-killer in the world, though being far less euphoric than morphine, it is not very popular among opiate devotees – though it can be used to reduce withdrawal symptoms in users with low-grade habits.

Codeine is a class B drug under the 1971 Misuse of Drugs Act, and is generally available as a prescription-only medicine in the form of codeine phosphate – including tablets (15 mg and 30 mg), syrup (25 mg per 5 ml), and injectable ampoules (60 mg). It is also available in small-dose compound analgesic preparations – notably Co-codaprin (tablets containing 8 mg of codeine phosphate with 400 mg of aspirin) and Co-codamol (tablets containing either 8 mg or 30 mg of codeine phosphate with 500 mg of paracetamol). In the UK, codeine tablets can be made available by pharmacies without prescription as a pharmacy supervised medicine (behind the counter medicines provided on the discretion of the pharmacist). However, such preparations must contain no more than 12.8 mg of codeine, and are mixed with other analgesics in compound preparations – notably Panadol Ultra (8 mg of codeine with 500 mg of paracetamol), and tablets containing 12.8 mg of codeine with 200 mg of ibuprofen.

Codeine's potential for causing constipation generally rules out long-term prescribing. It should also be noted that codeine is a pro-drug, meaning that the body metabolises it into morphine and other psychoactive opiates. Consequently, codeine use can lead to a positive test for heroin/morphine on some body-fluid drug tests. It should therefore be clear that, like all opiates, codeine can lead to dependence, but compared with morphine and heroin, the craving and

withdrawals produced by codeine are relatively mild.

DIHYDROCODEINE (DF118S)

Though recreational drug users sometimes take it for its low-level heroin-like (pain-killing and mongy) effects, dihydrocodeine (DHC) is mostly used by opiate addicts who have a small habit and who are looking to withdraw. If you fall into this category, then DHCs can be very useful. However, if you plan to use them long term, there are serious drawbacks. Due to the effect that opiates have upon gut motility (your ability to shit), the combination of opiates and chalk in DHC can make you extremely constipated. If you are being maintained or you have a large habit, think seriously about changing to methadone. Chronic constipation can be a serious health risk, as well as depriving you of one of the greatest pleasures in every junkie's life – discussing the state of one's bowels. Like codeine, dihydrocodeine is a class B drug under the 1971 Misuse of Drugs Act. DHC is mainly available on prescription only as dihydrocodeine tartrate tablets, both in pure form – notably DF118s (40 mg tablets) and DHC Continus (60 mg tablets) – and also in the form of compound analgesic preparations. The best-known example of the latter preparations is Co-drydamol (tablets containing 10 mg of DHC tartrate with 500 mg of paracetamol). DHC is also available without prescription as an over-the-counter medicine in pharmacies when it is in the form of tablets containing less than 8 mg of DHC combined with paracetamol.

SUBUTEX/SUBOXONE/TEMGESIC

All these tablets contain the drug buprenorphine. Temgesic first became popular in Scotland in the 1980s, because for a while, the medical profession thought that they had little potential for misuse. In fact, because they were

designed to dissolve by being placed under the tongue, it was discovered that they were quite a reasonable tablet to inject as they were not laden with chalk. Temgesic was designed as a pain-killer, whereas the newer drugs Subutex and Suboxone (which contain much higher doses of buprenorphine) were devised as treatments for opiate addiction. The strange thing about buprenorphine is that it is both an opiate agonist and an opiate antagonist (and is thus called a partial antagonist). This means that if you were opiate-free (unaddicted), you would get an opiate-like effect if you took it, but if you had a smack habit and you took it, you would trigger withdrawal symptoms. If you were using buprenorphine and then used heroin, the heroin wouldn't give you a high (or much of one). This is why Subutex is used for both short-term detox and longer term maintenance treatment.

Subutex has become very popular amongst guests in Her Majesties Prisons, partly because the drug didn't show up on standard piss tests, and partly because it could be chopped up and snorted for a rapid and likeable buzz. Although some junkies rave about the effects of Subutex, others complain that the high from buprenorphine (the drug in Subutex tablets) was boring, so to spice things up, they would add temazepam. Injecting temazepam or any other benzo is not the wisest thing to do (discussed later). Suboxone tablets contain similar doses of buprenorphine to Subutex, but have the drug naloxone added as well. Naloxone doesn't give any sort of buzz, but is an opiate antagonist added to delay or stop the high from the buprenorphine should it be injected or snorted. For quite a period Subutex was the most popular drug in the prison system, but since 2007, when Her Majesties Prison Service introduced a specific test for buprenorphine, inmates began the search for the new opiate high.

TRAMADOL

The gap is now rapidly being filled by Tramadol, a totally synthetic opioid.

Tramadol comes in the form of 50 mg capsules or 50 mg ampoules, as well as having modified time-release forms. Its potency lies somewhere between codeine and morphine but due to its chemistry it provides two mirror-image drugs (called isomers) for the price of one. In short, one isomer is an opiate analgesic (like morphine), while the other is a potent serotonin reuptake inhibitor (like ecstasy). The result of this is that the euphoria produced is out of proportion to its analgesic activity. Also, Tramadol is a pro-drug (like codeine) so snorting or shooting it up does not increase the rush, and tolerance rapidly builds up. On the plus side, this drug seems to cause less severe opiate withdrawals even when heavily misused. These facts make it a drug unpopular with hardened addicts but surprisingly popular with opiate-naïve individuals (recreational drug users).

PETHIDINE

Pethidine hydrochloride comes in 50 mg tablets or 50 mg ampoules for injection (and sometimes in a syrup). It is not very popular among opiate devotees, partly because it has various unpleasant side-effects when it is injected intravenously or used regularly. Yet in the past it has been a major choice of pain-killer administered by doctors to women giving birth (why, though, is not clear). However, due to its short duration of action, minor analgesic effects, and relatively high toxicity, its use has largely been superseded by newer opiates.

DEXTROPROPOXYPHENE

Like buprenorphine, dextropropoxyphene hydrochloride is notable for being an opiate categorized under class C of the 1971 Misuse of Drugs Act. It is not popular among opiate addicts because it is not very euphoric, and regular use tends to produce unpleasant side-effects. However, it is a very popular choice of analgesic prescribed by

doctors for mild to moderate pain. Though it can be prescribed in the form of 60 mg and 65 mg capsules, it is most commonly dispensed as a compound analgesic preparation under the trade names of Co-proxamol and Distalgesic (tablets containing 32.5 mg of dextropropoxyphene hydrochloride with 325 mg of paracetamol). Other opiates listed in the current BNF include dextromoramide (Palfium), pentazocine (Fortral, Fortagesic), phenazocine (Narphen), nalbuphine (Nubain), diphenoxylate (Lomotil, Tropergen), meptazinol (Meptid), loperamide (Imodium etc.), papaveretum and papaverine (Aspav).

OVERVIEW OF OPIATES

Chemistry. It should now be clear from reading the above that opiates fall into three chemical categories: natural, semi-synthetic, and synthetic. Natural opiates are those found in opium, a substance derived from the opium poppy – notably morphine, codeine and thebaine. Semi-synthetic opiates are those which can be made from natural opiates – notably diamorphine, dihydrocodeine, and buprenorphine. Synthetic opiates are those made by chemists without recourse to natural opiates – including methadone, pethidine and fentanyl.

Lastly, there are a fourth group of opiates which may also be described as 'natural', but which are made by animal brains rather than the opium poppy. These are the opioid peptide neurotransmitters, chemicals made by the brain to control and regulate pain experience. The most well-known example are the endorphins (which is short for 'endogenous morphine'), though others include dynorphin and enkephalin. It is legal to possess these opiates inside your brain ... otherwise opiates are generally prohibited under British law.

The law. The 1971 Misuse of Drugs Act classifies opiates into one of three classes, depending on whether they are regarded

as strong (class A), medium strength (class B), or relatively weak/safe (class C). Most opiates are in class A (including opium, heroin, morphine and methadone), though some are in class B (notably codeine and dihydrocodeine), and some are in class C (notably buprenorphine and dextropropoxyphene). The maximum prison sentences are seven years for possession and life for trafficking of class A drugs; five years for possession and 14 years for trafficking of class B drugs; and two years for possession and 14 years for trafficking of class C drugs. The number of heroin offences in the UK climbed from around 400 per year in the early 1970s to a peak of almost 13,000 in 1999, before falling slightly to 11,800 in 2002. The latest figures, available for England & Wales only, show that there were just over 10,000 heroin offences in 2004. The number of methadone offences in the UK also climbed from around 400 per year in the early 1970s to a peak of almost 800 in 1998, before falling to 470 in 2002 (400 in England & Wales in 2004).

Under the Misuse of Drugs Regulations 1973 (updated in 2001), drugs are also classified under five schedules, which control their prescribing by doctors and dispensing by pharmacies. Schedule 1 drugs – mostly hallucinogens and plant-based drugs such as raw opium – cannot be prescribed or dispensed, though can be researched under license from the Home Office. Most opiates are Schedule 2 drugs, the notable exception being buprenorphine which is in Schedule 3. Some low-dose, non-injectable, compound preparations containing opiates are also categorized under Schedule 5, notably codeine and dihydrocodeine preparations. Doctors also require a special license from the Home Office to prescribe three very habit-forming drugs to addicts (two of which are opiates): heroin, dipipanone, and cocaine.

The remainder of this booklet focuses on the two other main groups of depressant drugs: hypnotosedatives (downers) and alcohol (booze).

HYPNOSEDATIVES

Hypnosedatives are largely synthetic drugs which are prescribed by doctors to reduce anxiety (worry and stress) and/or reduce insomnia (help you sleep). They can be divided into four main families: barbiturates, benzodiazepines, Z-drugs, and other hypnosedatives.



"BY AND LARGE, IT IS USUALLY ONLY THOSE PEOPLE WHO HAVE HAD THEIR SWITCHES SET TO AUTOMATIC SELF-DESTRUCT MODE WHO USE BARBITURATES."

BARBITURATES

During the seventies, the 'barb freak' was probably the most regular punter at street drugs agencies like Lifeline. This was because they tended to be those drug users who were least able to take care of themselves. Even the most desperate bag-head looks down upon barb freaks because of the mess that they invariably get themselves into. Barbiturates are a sedative drug. Normally prescribed to induce sleep, their use is now almost completely discontinued for this purpose, though milder variants such as phenobarbitone may still be used to manage epilepsy.

By the 1980s barbiturates were starting to bring about a huge annual toll of deaths among drug users in Britain – for instance, over 700 barbiturate-related deaths were recorded in 1980. Consequently, doctors were urged to severely reduce their prescribing, replacing barbs with newer generations of hypnosedatives like benzodiazepines. As a result, the number of deaths involving barbiturates has now dropped to an all-time low – just seven cases in England & Wales in 2007. However, deaths from other types of hypnosedative have now replaced those from barbiturates – there are now between 300 and 400 deaths each year in the UK involving benzodiazepines, while the number of deaths from Z-drugs in England & Wales reached a record high of 51 in 2007. However, it should be noted that the vast majority of these deaths are poly-drug deaths – that is, they involve benzodiazepines or Z-drugs being mixed with other drugs (with alcohol being a major co-drug).

Nevertheless, barbiturates still occasionally turn up from time to time, usually as:

SONERTYL

Bright pink tablets containing 100 mg of butobarbital.

AMYTAL

Most frequently as a bright blue capsule that contains 60 mg of amobarbital.

SECONAL

Orange capsules containing 50 mg of secobarbital.

AND FINALLY TUNAL

Which are a cocktail of 50 mg of Amytal and 50 mg of Seconal which, unsurprisingly perhaps, come in a capsule that is half Amytal blue, half Seconal orange. Whoever was responsible for the design of these capsules certainly had a flair for marketing substances to junkies and hypochondriacs.

The first thing to get clear about barbiturates is that these things are dangerous. I don't mean 'Heroin screws you up' dangerous, I mean seriously fucked-up style dangerous. Is that clear enough for you? During the seventies, thousands of people died as a result of barbiturate poisoning. Many of those deaths were people who just took the drug to sleep. The pattern usually went like this. Have a few scoops to help you get your head down. Then, drop a couple of 'nembies' and pour yourself another drink while you wait for the drug to take effect. After a while, you don't remember whether you took the caps or not, so you'd better take a couple more to be on the safe side. Then they would find your body in the morning. If you hadn't choked

on your own vomit, your breathing would have slowed down progressively until it stopped. Like opiates, barbiturates are addictive, only more so. Taken to help you sleep, after a few days, it becomes impossible to sleep without them. Like the opiates, barbiturates produce tolerance so that you need to keep upping the dose to get the same effect but the toxic dose doesn't rise as quickly as the effective dose so the window between it working and it killing you just keeps getting smaller.

The real hum-dinger with barbs is the withdrawal syndrome. If withdrawal from opiates is cold turkey, then withdrawal from barbiturates could be cold raven. Besides the craving, discomfort and inability to sleep, barbiturate withdrawal also causes major epileptic seizures. Nobody dies from opiate withdrawal (though it may feel like you are dying, and you may wish you were dead) - but it is a strong possibility with barbiturates and you should only think about withdrawing under the supervision of a doctor, preferably as a hospital in-patient. The possibility of overdose is amplified greatly if barbs are injected into a vein rather than taken orally. By and large, it is usually only those people who have had their switches set to automatic self-destruct mode or who want to turn off reality who use barbiturates because the drug isn't at all pleasant or enjoyable. Barbs lack the euphoric content of opiates and the social lubricant properties associated with alcohol. They simply produce a dark, blank oblivion and as such will always remain popular with those people who hate themselves or their lives so much that their behaviour is governed by a compulsion to obliterate all possibility of thought and self-examination. Do yourself a favour: just say no.

THE LAW

Barbiturates are prohibited under class B of the 1971 Misuse of Drugs Act, and are a schedule 3 drug.

When it became clear that large numbers of people died each year simply as a result of trying to cure insomnia, the drug companies spent a vast amount of money in an attempt to discover a replacement for the barbiturates. Eventually, the pharmaceutical industry came up with the benzodiazepines. Eureka! No side-effects, they said. Non-addictive, they said. Safe, they said. Unlikely to be misused, they said. Loads of money, they said (much more quietly, to stockholders, in boardrooms). Like opiates and snake oil before them, benzodiazepines were marketed as being good for whatever ails you - the original mother's little helper. If you go to the doctor and tell him that you are stressed out because you have lost your job, your wife had left you, your dog has died and/or your next door neighbour keeps giving you funny looks, the chances are that he or she will write you a prescription for benzodiazepines. Well, 10 years ago, they would have. Now doctors have got wise to the abuse potential of the benzos and they usually only give short courses and low doses. To some extent, the traditional benzos are being replaced with 'benzo like' drugs, such as the trio of Z-drugs zaleplon, zolpidem, and zopiclone.

BENZODIAZEPINES

Benzos are categorized as intermediate-acting (shorter-acting) and long-acting. Intermediate-acting benzos carry a greater risk of withdrawal symptoms, but repeated doses of long-acting benzos may lead to accumulation of drug metabolites within the body (toxic effects). But the main distinction is between two major types. Some are known as hypnotics (or soporifics), drugs that are used to induce sleep in insomniacs – in short, sleeping pills. Others are used to reduce anxiety in worried or stressed people, and have become known as tranquillisers (or anxiolytics).

Benzodiazepines in the first category – hypnotics (sleeping pills) – include:

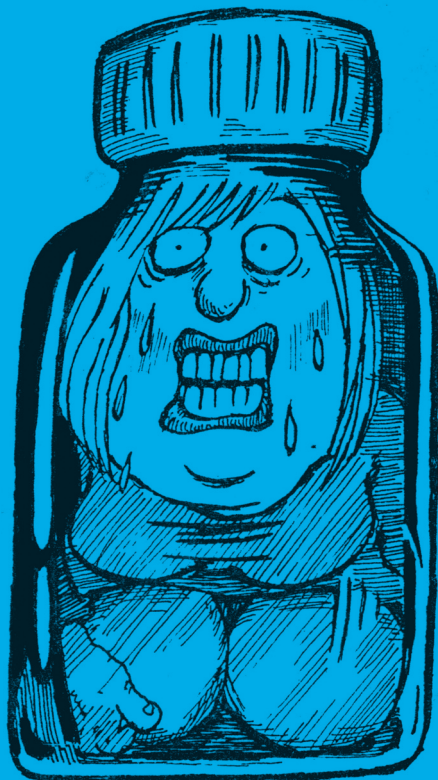
NITRAZEPAM (MOGADON)

Nitrazepam is a long-acting benzodiazepine hypnotic. Before doctors were 'forced' to prescribe the generic equivalent of a drug, nitrazepam were possibly the most commonly used sleeper in the UK. Sold under the trade name Mogadon (white 5 mg scored tablet), they were the sleeping tablet with the smiley face. In recent years, their popularity seems to have been massively outstripped by the shorter acting benzodiazepine hypnotics, the most popular being:

TEMAZEPAM

Also known as eggs, jellies, temazzies, norries, rugby balls and a host of other pseudonyms, temazepam (Normison)

is an intermediate-acting benzo which comes in 10 mg and 20 mg tablets. For a long time, temazepam seemed to be the drug of choice for the treatment of insomnia. They have also replaced the barbiturates as the self-destructive drug user's intoxicant of choice. We will discuss this substance at some length a little later.



"IMAGINE HOW IT MUST FEEL TO BE A STRAIGHT HOUSEWIFE, GETTING A TERRIBLE HABIT WITH ALL THESE WEIRD SIDE EFFECTS"

FLUNITRAZEPAM

Better known as Rohypnol, flunitrazepam is an intermediate-acting benzo which has been dubbed by the press the 'date-rape drug', because of cases in which women's drinks were allegedly 'spiked' by men for the purposes of sexual assault. It comes as a purple, diamond-shaped 1 mg tablet, and at times has been popular among injectors in central European countries and has turned up at the odd women's prison.

Other hypnotic benzodiazepines include the intermediate-acting lorazepam and lormetazepam; and the longer-acting flurazepam (Dalmane) and triazolam. They all have similar effects – in short, they put you to sleep. Triazolam was taken off the market because of its side-effects – so much for safe!

Benzodiazepines in the second category – tranquillisers (anxiety-reducers) – include:

DIAZEPAM

Previously known by the trade name Valium (among other trade names), diazepam is a longer-acting benzo, and comes as round tablets containing 2 mg (white), 5 mg (yellow), or 10 mg (blue). It should be noted that colour-dose links may vary in some countries – for instance, some (smaller looking) blue tablets contain 20 mg. Diazepam is also available in the UK as oral solutions (2 mg or 5 mg per 5 ml), injectable ampoules (5 mg per ml), and suppositories (10 mg). It is prescribed mainly to control anxiety, though is also used by doctors as a hypnotic (to assist sleep), as a muscle relaxant, as a pre-operative drug (see below), and sometimes to control withdrawals from alcohol or other drugs. Diazepam also remains the most popular illicit benzodiazepine in the UK. The 'street price' of diazepam pills varies with the dose, amount purchased, and other factors, but is generally in the

range of 25p to £1 for a 10 mg tablet. Today, purchasers of unprescribed diazepam need to take care, because many counterfeit and dud pills are on sale, particularly those sourced from websites.

LORAZEPAM

An intermediate-acting anxiolytic, better known by its trade name Ativan, comes in two oblong scored-tablet doses: 1 mg (blue) and 2.5 mg (yellow). Lorazepam produces longer sedation than diazepam, and has marked amnesic effects.

There are also a whole host of other anxiolytic benzos with very similar effects, including the intermediate-acting bromazepam (Lexotan) and oxazepam; and the longer-acting chlordiazepoxide (Librium), clobazam (Frisium), chlorazepate dipotassium (Tranxene), and alprazolam (Xanax).

Diazepam, temazepam, lorazepam and midazolam are also used as 'peri-operative drugs' – that is, to allay the apprehension of the patient before surgical operations, and to augment the action of subsequent anaesthetic agents. Midazolam (Hypnovel) is often used in preference to intravenous diazepam because recovery is faster, although it is associated with profound sedation in high doses.

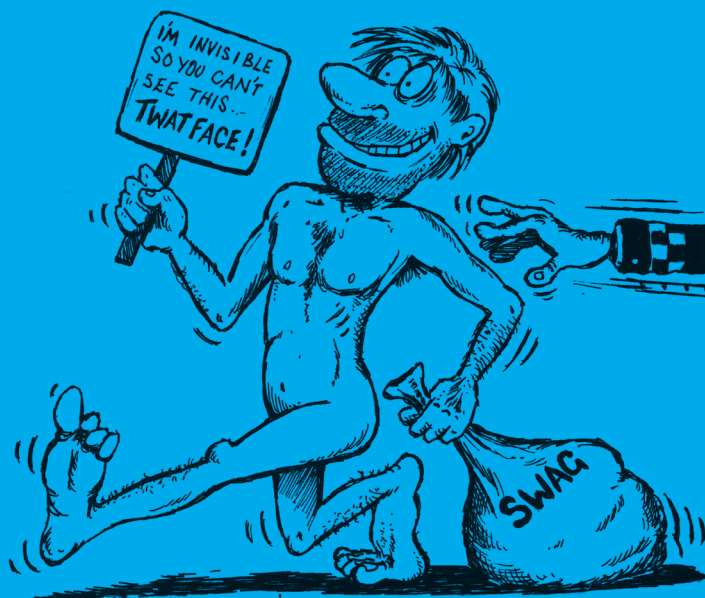
Regardless of which particular benzodiazepine is being used, the side-effects seem to be much the same. Some experts feel that the intermediate-acting benzodiazepines like lorazepam (Ativan) are more addictive and more difficult to withdraw from than the longer-acting types such as diazepam. For this reason, many doctors recommend substituting to diazepam in any detoxification programme. All benzodiazepines depress the breathing and so if taken with opiates or alcohol, can result in death from respiratory failure. They should be used with caution by anybody who is pregnant or who may have suffered from hepatitis or any other kidney or liver problems.

greater than the risks associated with heroin. As with sex, the drug minimizes the control that you have over your injecting behaviour. This may lead you to forget which syringe belongs to who. Have you cleaned it out? You may even forget all about the need to stay safe and not share other people's works. You probably couldn't care less - drugs like temazepam make you feel invulnerable while you are under the influence. Injecting temazepam, or any other tablet or capsule come to that, is not a good idea at all.

The one class of benzodiazepine still prescribed widely as ever are those used to treat epilepsy. Clobazam (Frisium) and clonazepam (Klonopin) are becoming the benzo addicts staple diet in some areas. Someone with epilepsy might take 6mg of Klonopin per day. For those without a habit, 1-2mg is enough to wipe you out for 8 hours.

THE LAW

Though still not controlled in some countries, benzodiazepines are categorized under class C of the 1971 Misuse of Drugs Act in Britain, though are sorted into two separate schedules (schedules 3 and 4i). Most benzos are in schedule 4i (schedule 4ii exclusively contains steroids), though three have been upgraded to schedule 3 - temazepam and flunitrazepam (Rohypnol) in 2002, and midazolam in 2007. In short, it is illegal to possess or supply any benzodiazepines without a prescription, and the maximum prison sentences are two years for possession and 14 years for supply offences.



"SOME PEOPLE FEEL THAT THE DUTCH COURAGE THAT BENZODIAZEPINES PRODUCE IS ACTUALLY A CLOAK OF INVISIBILITY, EVEN INVULNERABILITY"

Z-DRUGS

Various sleeping pills already mentioned that start with the letter Z are collectively known as Z-drugs – notably zopiclone (Zimovane), zolpidem (Stilnoct), and zaleplon (Sonata). Just as benzodiazepines were introduced as 'safer' versions of barbiturates, Z-drugs were introduced as safer versions of benzodiazepines. And of course (you guessed it), in addition to being just as habit-forming and dangerous as benzos, they've become a popular choice among drug users in some parts of the country.

Zopiclone is the most well-known Z-drug, and was second only to diazepam regarding the number of prescriptions handed out for hypnotosedatives in Britain in 2007. Cravings for zopiclone (an overwhelming compulsive desire to use) are said to be stronger than cravings

for other drugs, even crack or heroin and users often say that coming off zopiclone is far more unbearable than a heroin-related 'cold turkey'. Using high doses of zopiclone increases the risk of dependence and overdose, although most deaths from zopiclone involve more than one drug. If you do use zopiclone, it is wise not to attempt anything hazardous like driving, cooking, even going out when 'zimmied' is ill advised. In fact the safest place to use zopiclone is at home in bed (a separate Lifeline booklet is available about zopiclone). There is also strong evidence that regular use of zopiclone, even in medically recommended doses, can cause various cancers.

Z-drugs are not generally controlled under the 1971 Misuse of Drugs Act, the exception being zolpidem, which was made a class C and schedule 4i drug in 2003.

COMPULSION



OTHER KINDS of HYPNOSEDATIVE

ANTI-HISTAMINES

Anti-histamine drugs are regarded as fairly 'safe' hypnosedatives – that is, as having a low potential for overdose and dependence (as long as they are not mixed with other drugs such as opiates and alcohol). They are therefore not generally controlled by the 1971 Misuse of Drugs Act, but may be prescription-only drugs under the 1968 Medicines Act. In the past, they were often used to help people with allergies (such as 'hay fever') to reduce unpleasant symptoms (such as sneezing), but their sedative effects (making people drowsy and fatigued) has led to them being largely replaced by newer anti-allergy drugs. The main examples are cyclizine (used in travel sickness pills like Valoid) and diphenhydramine (used as a sleep-inducing drug). Diphenhydramine is the main ingredient of Nytol, a popular over-the-counter sleeping pill (25 mg and 50 mg tablets). Other sedating anti-histamine drugs include promethazine (Phenergan), hydroxyzine (Aterax, Ucerax), doxylamine and clemastine.

CHLORALS

Once known as 'knock-out drops', chloral hydrate and chloral betaine are the main examples in this older group of hypnotics. They are now rarely prescribed, partly because of the newer alternatives, and partly because of their unpleasant after-effects – which include upset stomach and flatulence (farting). Like anti-

histamines, they are not controlled by the 1971 Misuse of Drugs Act.

BETA-BLOCKERS

Non-cardio-selective beta-blockers are more effective for somatic (bodily) than psychic (mental) anxiety symptoms – such as palpitations and tremor. The main examples include propranolol (Propanix, Inderal) and oxprenolol (Trasicor). Though less effective than benzos, they are often preferred because of their lower potential for dependence.

HEMINEVRIN (CHLORMETHAZOLE)

Once this was the treatment of choice for getting people off alcohol. As the death-toll steadily rose, doctors began to rethink prescribing these grey eggs but they are still about. When you take one or two orally, it feels almost like alcohol without the nausea and constant need to piss. The danger lies in the fact that the oil-filled capsules are easy to inject (no hard-gel like the old-fashioned temazepams) and the effect is rather spectacular. When mixed with even moderate amounts of other depressant drugs, Heminevrin becomes at least as dangerous as the barbiturates. For some odd reason this drug has never fallen under legal control in the UK so the only point in it's favour is that you can't be arrested for possession of these capsules. In every other respect they are

terribly dangerous and should have been discontinued years ago. For history buffs, Keith Moon survived more illegal drugs than seems possible, only to die after a few beers and some of these capsules.

BUSPIRONE (BUSPAR)

Prescribed to reduce anxiety like benzos, buspirone comes in 5 mg tablets, and is often preferred because it has a low potential for dependence and misuse. Even so, it is recommended for short-term use only, and does not alleviate the symptoms of benzo withdrawals.

MEPROBAMATE (EQUAGESIC)

Meprobamate is also recommended for short-term control of anxiety, though is less effective than benzos, but has a similar dependence potential, and can be more hazardous in overdose. It generally comes as scored 400 mg tablets.

METHAQUALONE (MANDRAX, QUaaludes)

Though Mandrax tablets (250 mg of methaqualone with 5 mg of diphenhydramine) were mainly popular in the UK in the 1960s and 1970s, they are still consumed enthusiastically by drug users in other parts of the world today (notably South Africa). Methaqualone has similar effects to barbiturates, and was originally prescribed for the treatment of insomnia, anxiety and as a muscle relaxant. It was mainly desired for its key effects of relaxation, euphoria and drowsiness, though many users also liked it for its aphrodisiac effects. It was withdrawn from the BNF largely because of its high potential for dependence and overdose (like barbiturates).

FINALLY

Some types of anti-depressant (e.g. amitriptyline) and most types of anti-psychotic drugs (e.g. chlorpromazine) have sedative effects, but technically they are not classified as hypnosedatives. Neither group of drugs is regarded as much fun by drug users, though they are occasionally used by opiate addicts to reduce the horrors of withdrawals when nothing else is available. Solvents (glue, butane, aerosols, etc.) can also have depressant effects, but again are not technically regarded as hypnosedatives.

When considering the depressant drugs, few people pay sufficient attention to alcohol. Though this section presents the basic facts and factoids about alcohol, doing proper justice to our most popular drug is not possible within the available space, and so alcohol is dealt with in more detail in other Lifeline publications.



ALCOHOL

Alcoholic beverages can be organized into four broad categories, based on both the type of drink and its alcoholic strength (pubs/bars also serve these different drinks in their own specialized glasses):

ONE

Beer, lager, cider and alcopops generally contain between 3% and 9% alcohol, averaging 5%;

TWO

Wine, made from fermented grapes, generally contains between 7% and 14% alcohol;

THREE

Liqueurs and aperitifs cover a very broad range of traditional and modern drinks (eg. advocaat, fortified wines), and generally contain between 15% and 30% alcohol;

FOUR

Spirits (vodka, whisky, brandy, rum, gin, tequila, etc) are made from distilling (concentrating) other alcoholic beverages, and generally contain between 30% and 70% alcohol, averaging

around 40%. Though wine and beer-type beverages have been around for thousands of years, Arab chemists first distilled alcohol spirits from wine in 880 AD. Low-alcohol beverages are also now available, and generally contain less than 1% alcohol.

An intricate and multi-layered culture has developed around alcohol use in Britain, and getting drunk is highly valued as a form of relaxation by most sections of our society. Indeed, the pub has become a – if not the – primary institution in British leisure culture. It is probably fair to say that teetotalers (people who totally abstain from alcohol) are regarded as boring or at least suspicious by the average British drinker – unless they have good reasons for not partaking of alcohol (eg. recovering from alcoholism, religious beliefs or health problems such as stomach ulcers etc.).

THE LAW

Most western societies permit the sale, possession and use of alcohol under legally regulated conditions, though many Moslem nations continue to prohibit alcohol in the same way as western nations prohibit drugs like heroin and cannabis. In the 1920s, the USA also prohibited alcohol alongside other drugs, though this was regarded by most experts as a 'disastrous experiment', and the

USA re-legalised alcohol in 1933. In the UK and most western societies, alcohol is now regulated by a huge range of laws, most notably a ban on the sale of alcohol to or purchase of alcohol by under-18s – though, strangely, it remains legal for parents to allow their children to use alcohol from the age of 5 years old. Other national alcohol laws include bans on drink-driving, public drunkenness, and being drunk while in charge of a child under 10 years old.

The legal limits for alcohol consumption while driving a vehicle in the UK are 35 micrograms per 100 ml of breath (as measured by the breathalyzer), 80 mg per 100 ml of blood, and 107 mg per 100 ml of urine. These levels indicate consumption of 32 grams of alcohol – about four standard units (see below) – which is roughly equivalent to about two pints of average-strength beer, four small glasses of wine, or four measures of spirits. Most European countries have a legal limit for driving of 50mg of alcohol per 100 ml blood, though some permit no alcohol use at all when driving. Alcohol is metabolized by the body at about one standard unit per hour. In addition to their intoxicated behavior (such as slurred speech and staggering gait), drink-drivers and under-age drinkers are nearly always 'given away' by the smell of alcohol on their breath, which is very noticeable to people who have not been drinking (like police officers).

The number of British people convicted of drunkenness offences peaked at almost 125,000 in 1980, though has since fallen to a record low of about 25,000 in 2005. The number of drink-driving offences in England & Wales peaked at around 120,000 in 1988, and has since fallen slightly to 107,000 in 2004. The number of licensees dealt with for selling alcohol to under-18s in England & Wales peaked at over 1,000 in 1989, and then fell to a record low of just over 100 in 2001, before rising again to 841 in 2005. Lastly, the number of under-18s dealt with for buying alcohol in England & Wales fell from 4,460 in 1981 to just 36 in 2005. In

short, the laws controlling sale of alcohol to children now focus on the seller and not the buyer.

RISKS OF ALCOHOL

Alcohol has very paradoxical effects – in small doses, it acts as a stimulant, but after a few more drinks it acts as a depressant. While some experts believe that a glass of wine a day may improve your health, larger amounts are definitely not good for you.

FREQUENCY AND AMOUNTS OF USE

Alcohol consumption is measured in standard units of alcohol (SUAs). Alcoholic beverages, even of the same type, vary enormously in the amount of alcohol they contain, though the general guidelines are that one unit of alcohol is roughly equivalent to: half-pint of average-strength beer/lager/cider; a small (125 ml) glass of wine; or a single measure (25 ml) of spirits, liqueurs or aperitifs.



In the UK, the Department of Health has provided us with guidelines about the limits of safer alcohol use – that is, how many SUAs can be consumed weekly before health damage is likely to follow (though some experts argue that these 'safer limits' are fairly arbitrary rather than based on exact science). Though actual limits are determined by various factors (eg. genes, body weight, metabolic rate, liver function, other drug use, etc.), the guidelines distinguish safer limits by gender only. Men are advised to drink no more than 28 SUAs per week (about 3 to 4 units per day), while women are advised to drink no more than 21 SUAs per week (about 2 or 3 units per day). The official guidelines also advise that people do not drink every day, and that they have at least one or two days each week when they don't drink. Research also shows that for people aged over 50 years – particularly men – drinking one unit of alcohol per day is actually associated with better health compared with drinking no alcohol at all. Lastly, the latest official advice also recommends that pregnant women should drink no alcohol at all – and certainly no more than one or two SUAs once or twice per week.

METHODS OF USE

Until recently, alcohol has always been consumed by one route/method of use: drinking/digestion. However, over the last few years a form of inhalable alcohol vapour has been developed, and is mainly available from certain nightclubs. Though extremely rare, hardcore drug users have also been known to inject alcohol. There are no forms of alcohol which can be smoked or sniffed. It should also be noted that, to reduce unpleasant side-effects from alcohol, it is best not to drink it on an empty stomach – in short, eat before (or as) you drink.

MIXTURES

Alcohol interacts badly with many drugs, particularly depressants such as opiates and hypnotosedatives. Such mixtures often result in serious respiratory depression, leading to cessation of breathing and possibly death (see below). Alcohol can also interact badly with other drugs, including stimulants. For instance, when mixed with cocaine it produces another drug inside the body called cocaethylene, which is more toxic than either alcohol or cocaine.

CONTENT OF ALCOHOL PRODUCTS

Many legal alcohol products contain chemicals called 'congeners', which, along with dehydration, are responsible for much of the alcohol 'come-down' (hangovers). Also, people who purchase illicit alcohol (from abroad, home-brewers, or wherever) need to be careful that they are not buying beverages containing methyl alcohol (methanol) rather than the expected ethyl alcohol (ethanol). Methanol (better known as 'meths' or 'wood alcohol') is extremely toxic, and often kills people after a single session of drinking it.

SETTINGS OF USE

In most western societies, the sale and public use of alcohol is restricted to licensed premises, including on-license premises such as pubs and bars (where alcohol can be purchased and consumed), and off-license premises such as supermarkets and specialized outlets known as 'off licences' (where alcohol can be purchased and taken away for consumption at home). Pubs and bars are bound by many regulations which are intended to minimize the risks and harmful consequences of alcohol use – for instance, publicans and their staff are not permitted to sell alcohol to someone

who is drunk and/or disorderly. However, in the noughties, drinking at home has become increasingly popular for two reasons: (1) alcohol is now far cheaper when purchased from 'off licences' than from pubs/bars; and (2) the ban on smoking in public places has led many people who use both alcohol and tobacco to drink more at home. Lastly, most areas now have local by-laws which prohibit the use of alcohol in designated public places (notably city and town centres).

ALCOHOL-RELATED HARM

Just because a drug is legal, it doesn't mean that it is safe. Like all of the other depressant drugs, alcohol is addictive. Unlike the opiates, alcohol also causes damage to various organs - brain damage and cirrhosis of the liver are just two serious potential side effects. Contrary to popular opinion, you can also overdose on alcohol. Every year there are a sizable number of deaths from alcohol poisoning - generally when young people who are unused to drinking start drinking spirits. With beer and wine, the volume that you have to drink to get rat-arsed helps you to titrate the dose - take the drug in successive small doses (i.e. pints) until you reach the effect that you desire. With spirits, you can easily pour half a bottle or more down your neck after earlier drinks have rendered your taste buds inactive - and before you know it, you are in a coma.

Another crucial fact to remember about alcohol is that it potentiates the impact of all the other depressant drugs. Alcohol is a contributory factor in either a majority or significant minority of deaths from drug overdoses. Opiates like heroin depress the respiratory system - they slow down the rate at which you breathe. Alcohol has the same effect. Mix the two together, and you may find that your breathing slows down to the point of stopping. This is bad enough if it happens

in company, but at least they can attempt to resuscitate you or call an ambulance. Very often, you are OK while you are out with your mates - the problem occurs when you sink that last pint at closing time and then go home to bed. Alcohol doesn't produce it's full effect until some time after you have taken it - so you always feel a couple of drinks behind your consumption. Go home, hit the pillow, and the next morning your partner wakes up next to a stiff.

The other problem with alcohol, is that it also produces nausea, likewise, the opiates. So once again, the two drugs enhance each other's side-effects. Pulmonary oedema - drowning in your own vomit - is the second major cause of drug-related death, and alcohol is often a major contributory factor. Anybody who has ever had hepatitis B or C may already have done serious damage to the liver - alcohol will make that damage far worse. If you do drink, the liver works overtime in order to metabolize the alcohol. If you've got a habit, the liver will also metabolize the drug at a much faster rate than your body normally would, so you end up sick from withdrawal much earlier than necessary. So, a sociable drink every now and again is one thing, but if you do drink large amounts of alcohol on a regular basis, then you're stirring up trouble for yourself one way or another - but if you've got a habit as well, then you're fucked, mate.

In addition to its well-known propensity for making people aggressive and violent, alcohol increases users' potential for accidents and injuries, which arise because it reduces drinkers' ability to perceive the world and control their body - in short, poor attention, blurred vision, lack of coordination, slower reflexes, etc. etc.. The worst consequences of this involve driving - around 500 people a year die in the UK because of drink-driving.

Lastly, some people can become physically addicted to alcohol, a condition known as alcoholism. The withdrawal

syndrome from alcoholism is known as delirium tremens, or DTs. The DTs are a very serious condition involving hallucinations and seizures, and can be fatal without medical assistance.

Every year, British hospitals treat hundreds of thousands of patients for alcohol-related health damage and injuries related to drunkenness. From all causes, alcohol is believed to contribute to around 40,000 deaths per year in the UK. This

is an annual toll of about one alcohol-related death per 1,000 drinkers – in short, alcohol ‘kills’ about one per cent of its users each decade. The three main groups of causes are long-term health damage (to the liver, brain and other body organs); alcohol-related violence; and alcohol-related accidents and injuries. Other causes include short-term poisoning (overdose), withdrawals from alcoholism, and alcohol-related suicide.

SUMMARY

There is a whole lot of information in this booklet, so when it comes to the depressants, what are the key points that we need to bear in mind?

1

All depressants are addictive. If you must use them, try to limit your use to occasional use. That way, you will maximize the effects and minimize the costs.

2

Injecting drugs raises the stakes enormously. The risks from HIV, hepatitis, bacterial infections, abscesses, gangrene, and overdose are very high. It is best if you can avoid injecting drugs.

3

If you do inject drugs, only use drugs that are designed to be injected. Follow safer injecting practices, and visit your local needle exchange scheme for supplies and advice.

4

Mixing drugs increases the risks enormously. Try to use only one drug at a time, and learn about the possible risky interactions between different drugs.

5

Remember that alcohol is a drug too – and one of the most risky drugs we use. Used in combination with other drugs, alcohol can potentiate their side effects. Avoid drinking and using other depressants together. Eat food before drinking, and try to keep your alcohol use within the advised safer limits. When drinking, avoid driving, operating machinery, or doing sports.

6

Some depressants reduce your self-control (they ‘disinhibit’ you). Remember, if engaging in risky behaviour of any kind, control can mean the difference between being alive and being dead.

**WHERE TO GET HELP
OR FIND OUT MORE:**



"CHRONIC CONSTIPATION CAN BE A
SERIOUS HEALTH RISK, AS WELL AS
DEPRIVING YOU OF ONE OF THE
GREATEST PLEASURES IN EVERY JUNKIE'S
LIFE - DISCUSSING THE STATE OF ONE'S
BOWELS."



GUIDELINES

AIMS

THIS PUBLICATION IS
DESIGNED TO PROVIDE
ACCURATE INFORMATION ON
DEPRESSANT DRUGS.

AUDIENCE

DRUG USERS AGED 16+

CONTENT

SOME SWEARING

FUNDING

SELF-FINANCED