Heroin overdose (part2)

In the second of three Briefings on heroin overdose, Professor David Clark considers various ways that can be used to reduce the number of heroin overdoses and overdose deaths, and at the responsibility that we all share in trying to do this.

It is easy to hear, particularly in the prejudiced society in which we live, that the responsibility for avoiding an overdose belongs with the heroin user, particularly if we provide him or her with relevant information.

Yes, heroin users do have a responsibility to themselves, and to their families and friends, in avoiding risky behaviours that increase the likelihood of them overdosing and causing their own death or physical complications, and grief to others. They also have a responsibility in helping other users avoid an overdose, and helping ensure it is not fatal if an overdose does occur.

However, the responsibility for reducing the number of heroin overdoses is far more wide-ranging. It also involves both specialist and generalist workers in the field, family members and friends, commissioners and policy makers, and even members of the general public. How can we all contribute?

If users are to be forewarned about the potential of overdose, and the factors that increase its likelihood, then they must be provided with the correct information, rather than incorrect information through hearsay.

This means that governments have a responsibility to fund research, researchers to conduct and disseminate high quality research, and those involved in disseminating messages to educate themselves, be educated and trained, and get these messages right.

A number of key messages are provided to heroin users to help them avoid an accidental overdose. They are warned that they are much more likely to overdose if they inject, rather than smoke, heroin. If users are injecting, they are encouraged not to inject alone.

They are warned to monitor their tolerance to the drug, since stopping or reducing use of heroin can result in a reduced tolerance and increased likelihood of overdose. Leaving prison and entering abstinence-based treatment are times when users need to be more careful.

Users are often warned to try a small amount of their heroin first, so that they can test their own tolerance and the strength of the drug. (However, in my last Briefing, I pointed out that drug purity plays a relatively small role in heroin overdose deaths.)

Users are also warned not to use heroin and drink alcohol or take 'downers' such as valium and temazepam at the same time, since these combinations of respiratory-depressant drugs are associated with many overdose deaths.

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Users are sometimes warned that people who die from overdose can do so two or three hours, and even longer, after taking the drug. Just because someone survives the initial hit does not mean that they are going to be all right.

Other messages need to be circulated among users (and practitioners and others) more so than they are at present. One important message is that most victims of fatal overdose are aged in their late 20s and early 30s, and have a long history of heroin dependence. It is important to emphasise to people with these characteristics that they may be at greater risk.

It is also important to get the message across that overdoses are often associated with low morphine concentrations in the brain, emphasising the importance of contributory factors other than drug purity and strength.

As discussed in the last Briefing, the physical health of the user may play an important role in accidental overdoses. Research suggests that overdose deaths may be related to systemic disease or damage to parts of the body, sometimes caused by prior overdoses. Problems can arise from pulmonary dysfunction and liver disease. The importance of continued monitoring by health professionals needs to be emphasised.

Of course, while it is important to ensure that these messages are disseminated to users, we must also realise that many users will ignore them. We know from considerable research in the health field that telling someone something helpful does not necessarily change attitudes, and changing attitudes does not necessarily change behaviour.

We are dealing with a population who often lead chaotic lifestyles, and who at times of desperation for their next 'fix' may not stop, remember, and act upon principles of prevention. A user who has unsuccessfully searched for heroin, got drunk instead, and then been offered the drug, is not likely to wait until the alcohol has left his body before taking his next fix.

A user desperate for her next fix is also unlikely to take a small amount of her batch of heroin to test its strength. She will likely inject it all in one go.

Of course, these problems do not mean that we stop providing users with important information. It just means that we need to be understanding of the reality of the situation, and more innovative in the way that we try to improve dissemination and application of preventive messages.

We must better encourage a shared responsibility or 'duty of care' for other heroin users. We must facilitate communication and support within and across drug-using networks, and improve the quality of communication between service providers and users. We must also work in a variety of other ways to reduce heroin overdoses and overdose deaths.