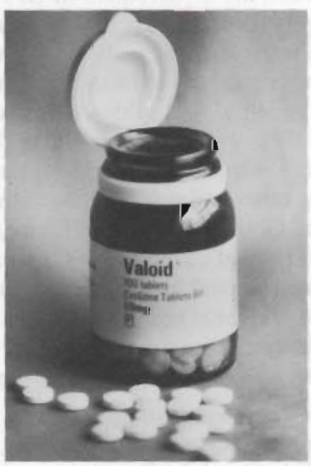
THE Limits of Intervention

How travel sickness tablets forced workers to face the fact that sometimes there's little you can do.



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CYCLIZINE IS the active ingredient of a number of travel sickness preparations freely available through retail pharmacists. It is also combined with the opioid dipipanone to make the painkiller Diconal. As the Advisory Council on the Misuse of Drugs noted in 1982, this drug had become popular with some opiate users, leading to the recommendation that its prescribing should be restricted to licensed doctors.[1]

The spread of cyclizine misuse is particularly pronounced in a locality in the North West of England where a tenacious drug injecting subculture has become associated with an illicit market in cyclizine. The result is a problem that appears to take us to the limits of both health care and health education interventions.

In this locality, the heroin epidemic of the 1980s grafted itself on to a pre-existing polydrug injecting culture. One consequence was that significant clusters of the 'new heroin users' preferred injecting the drug as opposed to the smoking route predominant elsewhere in the North of England.[2,3,4,5] A further complication was that, prior to the arrival of the 'new' heroin, Diconal had become the preferred drug among some groups of users. Such were its attractions that some saw the new heroin as a very poor substitute.

'This whole cyclizine business is like a scene from Apocalypse Now!'

Diconal had for some time been associated with its own mythology concerning hallucinatory effects, 'skull rattling', the 'Diconal freezes', convulsions, etc. It was sorely missed in these drug using circles when prescribing was restricted in 1985. Subsequently a number of attempts were made by 'street chemists' to reconstitute Diconal and its perceived effects, involving combinations of travel sickness pills and other drugs crushed together and dissolved for injection.[6,7,8]

Since 1986 there had been a significant decline in the centrality of heroin within the drug community in this area. Partly a consequence of enforcement efforts which had disrupted dealing networks, this also reflected the more general reduction in the availability of heroin. As heroin receded there was a return to a polydrug culture, including injection of 'oblivion drugs' such as Temgesic and temazepam.

The central development, however, was that drug users began using a variety of travel sickness tablets containing cyclizine, taking them in combination with other drugs. The most popular of these tablets came to be that marketed as Valoid, associated with the emergence of a methadone/Valoid cocktail (the methadone swallowed, Valoid crushed and injected) as the market leader within the new polydrug culture.

A recent study in Nottingham has highlighted the problems of cyclizine use among patients receiving prescriptions for methadone.[9] The problems are indeed formidable. Cyclizine use is commonly associated with bizarre, often violent behaviour, a tendency to suffer fits after heavy use, and possible neurological damage.[10]

Fieldwork has also warned of the increased risk of injection-related harm including HIV transmission. Injected cyclizine produces an intense 'rush'. During a cyclizine and methadone binge many users report a highly increased rate of injection (as often as every 30 minutes) as they seek to repeat this experience. Increased frequency of injection (of crushed tablets) together with the inherently disorientating effect of cyclizine leads to poor injection technique and more sharing of equipment. As one drug worker summed it up, "This whole cyclizine business is like a scene from *Apocalypse Now*!"

Faced with this situation, some drug workers are feeling powerless and pessimistic. Successful interventions are few and far between. Harm-reduction and abstinence/enforcement have both been considered and, in some cases, tried, but so far to little effect.

Harm-reduction attempts

A range of injecting equipment is widely available in this part of North West England. However, the preference is for a 20ml barrel and green needle, used to facilitate the injection of crushed tablets and, increasingly, liquid methadone. These 'works' resemble small javelins and severely limit the options available for safer injection. Veins big enough to accommodate this equipment are also those associated with the highest risk, eg, the femoral vein in the groin.

The only feasible advice on safer cyclizine injecting involves the amount of cyclizine and the amount of water used to dilute it. In short, this advice involves using 1ml of water for every cyclizine tablet and not using more than two tablets per injection. However, given the commitment to risktaking evidenced by the choice of injecting equipment, it is highly unlikely this advice will be heeded.

Furthermore, a central attraction of DIY Diconal-like cocktails is that by experimenting with the dose of cyclizine, users gravitate towards using much higher amounts of cyclizine than are present in Diconal.[11] We have recently witnessed Diconal being rejected in favour of Valoid.

Substituting other drugs for the cyclizine-methadone cocktail does seem to have met with

some success, but again this is very limited and not without negative side effects. There are examples of slight improvements in the general health of users given prescriptions for injectable methadone ampoules instead of the more usual oral methadone.

However, methadone ampoules are usually only available from drug dependency units. Some users are reluctant to make themselves known to such units because of the fear of stigmatisation. They are also worried about abandoning the anonymity that legally obtained cyclizine allows, without any guarantee that they will get what they want.

Dipipanone, the opioid constituent in Diconal, is a chemical relative of methadone rather than morphine. This partly explains the minimal success doctors have had in eliminating Valoid injection by providing a morphine-cyclizine mixture (Cyclimorph) in injectable form.

In contrast, many users say they would stop using cyclizine if provided injectable heroin. With this option the problems mentioned above regarding injectable methadone are even greater. Very few doctors are licensed and willing to prescribe heroin ampoules.

Notably in parts of Scotland, there is growing concern about the increasingly common practice of injecting buprenorphine (Temgesic) and temazepam.[12,13,14] It is a measure of the harmful nature of cyclizine use that we have seen marked improvements in cyclizine users that have switched to injecting Temgesic or temazepam! These improvements seem to be related to the long-acting nature of these drugs which cuts down on the frequency of injecting associated with cyclizine.

In the case of Temgesic, these improvements are also related to the 'injectability' of this sub-lingual preparation. In comparison with Valoid tablets (which have a heavy chalk deposit), when diluted and prepared for injection, Temgesic carries reduced potential for damage to veins. However, Temgesic is now controlled under the Misuse of Drugs Act. Users who switch to it from Valoid tablets run the risk of prosecution. Recent publicity about the dependence potential of buprenorphine means that doctors are increasingly unlikely to prescribe Temgesic.

Possible interventions (and possible problems)

Safer injecting advice
◆ *Injecting cyclizine is inherently dangerous so little room for safety improvements*

Advise to use less drug
◆ *Goes against the grain of the attraction of cyclizine*

Substitute injectable methadone/ heroin
◆ *Usually only available from specialist units – users unwilling to attend*

Substitute injectable cyclizine/ morphine
◆ *Unattractive to users*

Substitute other injectable opiates
◆ *Rarely available on prescription so users face increased legal risks*

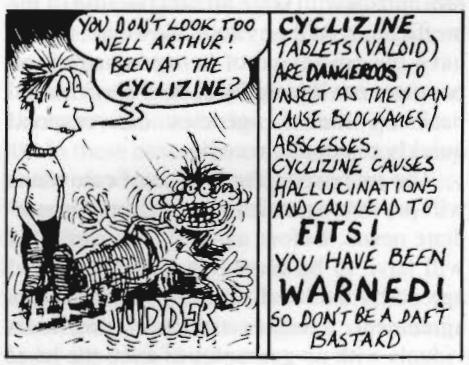
Clampdown on sales
◆ *Encourages illicit market plus associated crime*

Health education
◆ *Risks recruiting new users*

Curbing the market

Some Scottish researchers have pointed out that Temgesic and temazepam use is usually part of a polydrug problem.[15] Consequently they are concerned that vigorous attacks on these forms of drug use might simply encourage drug users to switch to something worse.[16] In the case of cyclizine, it is hard to imagine anything worse. For this reason there has been a concerted effort to clampdown on sales of cyclizine in the area in question by persuading pharmacists not to sell to suspected misusers.

These attempts at local prohibition have led to a thriving illicit market in Valoid tablets in the North West of England. Faced with this disruption in local supply, entrepreneurs have moved in to satisfy demand. Typically they have conventional jobs which involve substantial amounts of travelling. Valoids are bought in the normal way in out-of-town pharmacies at approximately £7 for 100 tablets.



These 'buyers' then sell the Valoids to 'wholesalers' in multiples of a hundred for up to 75 pence each. The wholesaler then sells these on to 'retailers', 'street traders' and consumers for £1 each. The retailers and street traders often trade these Valoids at a rate of two for one ampoule of methadone, commonly sold for up to £5. Consequently a tablet which costs approximately £0.07 at source comes to attain a value of £2.50! Intensifying prohibition is likely to push this price up even further and we can expect local drug-related crime (including chemist break-ins) to increase in tandem.

The comic *Smack in the Eye* is used in the North West of England to alert drug users to the risk of HIV transmission and the need to avoid a variety of high-risk behaviours, so is one possible way to raise consciousness about cyclizine misuse.[17,18] However, the cyclizine drug culture seems highly localised. *Smack in the Eye* now commands a wide readership, including areas where cyclizine use appears to be unknown.

We are concerned that the comic's coverage of the cyclizine habit could actually assist in its dissemination. The only message *Smack in the Eye* (issue 4) has given about cyclizine is a straightforward warning of danger (see opposite). This is one of the most thorny problems of health education: how to phrase messages directed towards a specific audience so as not to excite curiosity elsewhere. This is a criticism we directed against the government's mass media campaign in the mid-1980s.[19] Now we find it on our own doorstep.

THE CYCLIZINE phenomenon poses many difficulties for drugs work and drugs education. At present all we can do is simply pick up the pieces. Possibilities for successful intervention appear to be very limited. Has anybody got any ideas? ■

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