The smoking option

Controversial, innovative, but it could help prevent HIV spread – prescribing smokable opiates to opiate addicts

For two years two Mersey drug dependency units have been prescribing smokable methadone or heroin to opiate injectors to encourage them to move away from injecting. Smokable cocaine or amphetamine are also prescribed. Smoking simulates the 'rush' from injecting and may be suitable for injectors unwilling to settle for the milder effects of taking drugs orally. Pilot research and clinical experience suggest prescribing smokables may be a viable alternative treatment for some patients.

John Marks, Andrew Palombella & Russell Newcombe

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SMOKABLE HEROIN, methadone, cocaine and amphetamine cigarettes have been prescribed by Halton and Warrington drug dependency units since 1989. The aim is to help clients switch away from injecting these drugs because of the greater risks of this mode of administration – particularly HIV infection.

We adopted this innovative policy in the context of the Home Office's estimate that at least 80 per cent of opiate dependents (and probably an even higher percentage of those dependent on stimulants) are not in treatment – a reflection on the 'pulling power' of current treatment practices.

Current treatment policy is also associated with the widespread injection of adulterants and with HIV infection rates in drug addicts above 50 per cent in some areas, particularly where harm-reduction initiatives have in the past been eschewed.

There is an alternative

Injectors who may be willing to forego injecting, but not drug use, are usually given only one option: oral (swallowed) drugs. In the vast majority of drug dependency units, this means oral methadone to substitute for injectable opiates, though a few also prescribe oral amphetamine to amphetamine injectors.

However, pills and liquids are not the only alternatives to injectable drugs – most popular drugs can also be produced in sniffable or smokable forms. Indeed, for illicit drug users these two routes of administration could provide the most effective alternative to injecting for two reasons. First, many opiate injectors have indicated that they do not like the taste of oral preparations such as methadone mixture, and some say that oral preparations make them feel nauseous.

Second, most illicit drug users, whether injecting or not, take drugs by smoking or sniffing them – these are familiar, acceptable practices. The behaviours and experiences underlying these two routes of administration – chopping up powder and 'snorting', or lighting up, inhaling and tasting the smoke – are also valued by drug users.

But smoking has a major advantage over the nasal route as an alternative to injecting. Sniffing powdered drugs onto the nasal membrane does produce the desired psychoactive effects more quickly than swallowing, but smoking produces these effects as rapidly as injecting – in seconds rather than minutes.

"Smoking drugs most closely simulates the injecting 'rush'"

One of the main attractions of injecting is the 'rush' (an accelerated, intense entry into intoxication). Smoking drugs provides the closest simulation of the injecting 'rush' so could be the most effective alternative for committed drug users who nevertheless agree to try to give up injecting. If this is the case, we might expect positive changes in criminal as well as health-related behaviour.

Practicalities

We call the smokable drug prescriptions 'reefers' – packs of herbal or tobacco cigarettes which contain heroin, methadone, cocaine or amphetamine. The reefers are produced by Rankins Pharmaceuticals in Liverpool and distributed to local pharmacies. Production involves dissolving the prescribed drug in chloroform, and injecting the solution into the tobacco/herbal material in a cigarette. The chloroform evaporates in a few minutes, leaving the dissolved drug behind – a process which also stains the cigarette paper green,

distinguishing the reefers from standard cigarettes and helping prevent inadvertent use.

How many reefers are prescribed and how strong they are depends on the client's needs, though current prescribing in relation to opiate users averages about 180 to 240mg of smokable opiates per day and rarely exceeds 300mg. Usually the reefers are dispensed weekly, in quantities sufficient for two to six cigarettes a day. More frequent dispensing may be required if patients prove unreliable.

It is important to note that up to two-thirds of the drug in a reefer may be lost through sidestream smoke or poor inhalation technique. With this in mind, each of our reefers contains either: 60mg or 100mg of heroin; 60mg of methadone; 40mg of cocaine; or 30mg of dexamphetamine.

For roughly equivalent prescriptions, oral methadone costs the health service £100-200 per patient per year, injectable opiates £1000-2000, and reefers £300-600.

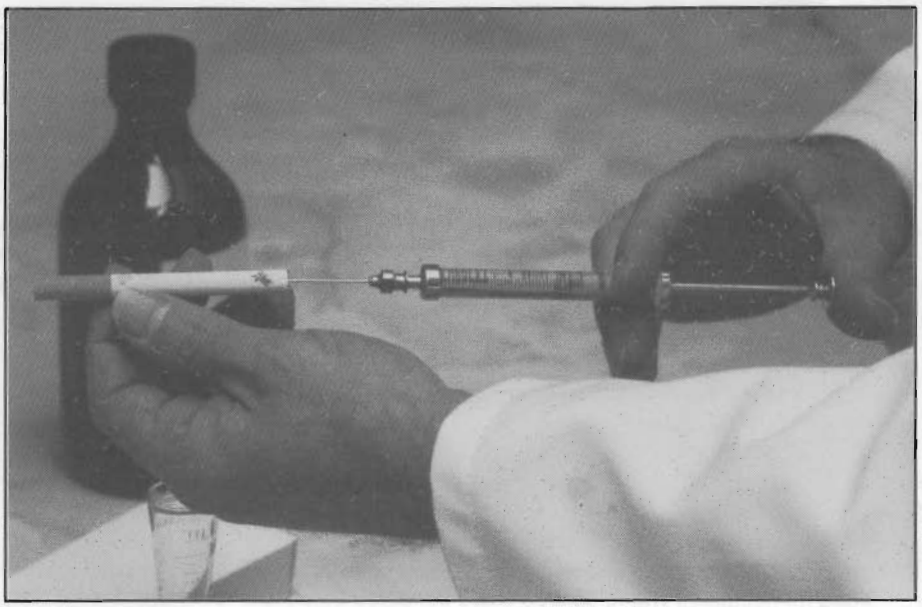
The standard 'filling' for the cigarettes is herbal – typically Honeyrose herbal cigarettes (containing coltsfoot), or, if available, Potters Asthmatic Cigarettes (containing datura stramonium). Clients who prefer tobacco supply their own cigarettes to the pharmacist, who can then use these to prepare the prescription. It is advised that only low-tar cigarettes should be accepted for clients opting out of the standard herbal-based prescription.

Misuse of Drugs Act regulations governing the supply of drugs to addicts refer only to the drugs, not to how they are to be administered. A special licence is needed to prescribe heroin or cocaine (or dipipanone) for addiction, but doctors with this licence can prescribe these in smokable form. Any doctor can prescribe methadone or amphetamine for addiction in any suitable form – oral, injectable, or smokable.

Prescribing drugs in smokable form does not relieve doctors of their obligation to notify heroin or cocaine addicts to the Home Office.

The issues

Who to prescribe to? Most patients we prescribe smokables to are long-term opiate injectors who wish to try to stop injecting. Smokables are less likely to be prescribed to more short-term injectors as these may be weaned off injection by more conventional means. The absence of physical addiction with stimulants means prescribing these as smokables is also less likely. But newer opiate injectors and stimulant injectors are both at risk of HIV infection and other injection-related illnesses, so are not excluded from the programme altogether.



Better than injecting into the body – preparing a heroin reefer Bradford Telegraph and Argus

Reefers can be prescribed on their own, or combined with other prescriptions, to cater for the different needs of a wide variety of injecting clients. For those who cannot immediately give up injecting drugs, a combined injection and reefer prescription can be given, with, when appropriate, a gradual reduction in the injection component and a gradual increase in the reefer component. For those clients able to move toward stabilising on oral prescriptions, a combined oral and reefer prescription can be given, with a gradual reduction in the reefer component and a gradual increase in the oral component. Reefers are not prescribed to non-smokers.

A deeper hook? Even in smokable form, heroin is for many people easier to withdraw from than oral methadone. The half-life of methadone is much greater than heroin but the withdrawal symptoms are less severe. Some addicts find heroin's 'short, sharp' withdrawal much easier to handle than methadone's 'long-drawn out niggle'.

Passive smoking? Are you at risk of inhaling significant quantities of heroin while sitting next to an addict smoking their reefer? Even with tobacco the evidence of increased cancer risk from passive smoking is debatable – and exposure to tobacco smoke is likely to be far greater than could ever arise from the relative handful of opiate smokers.

Smoking-related disease? As we prescribe only to people who already smoke tobacco or cannabis, we consider the increased risk from opiate/stimulant reefers to be negligible – particularly compared to the risks of injecting.

Does it work? So far we have only our experience and pilot research to go on. Larger scale independent research is planned.

Halton drug dependency unit has 30 clients with long histories of intravenous drug use who are now maintained on either reefers or reefers and methadone syrup. They are monitored regularly for signs of intravenous use and urine samples are taken randomly to check that no other drugs are being used.

As previously reported,[1] between 1989 and early 1990 the percentage injecting dropped from 65 per cent to 51 per cent, a reduction which has since continued.

All clients seem to be coping well and none has returned to intravenous use. Their health has improved, relationships are now much more stable, and partners and families are relieved that worries about intravenous drug use have ceased.

Dr Russell Newcombe of Mersey RHA's Drugs and HIV Unit has conducted a small-scale pilot study comparing oral opiate medication with opiate reefers.[2] His findings suggest reefers are a viable alternative for reducing injecting behaviour. Unanalysed interviews with patients give the impression that a 'horses for courses' approach is appropriate, with some people preferring oral medication, others injectables, and others reefers. ■

FOR MORE INFORMATION

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■ **FURTHER INFORMATION ABOUT REEFERS** – costs, dispensing pharmacies, etc – can be obtained from Rankins Pharmaceuticals 061-228 3262.

1. Marks J. *et al.* "Prescribing smokable drugs." *Lancet*: 1990, *335*(8693), p.864.
2. Newcombe R. *Preliminary findings of the Halton smokable prescriptions study*. Unpublished, October 1990.