Abstract

Purpose – The purpose of this paper is to present evidence of the therapeutic value of cannabis as a harm reduction intervention with people who smoke crack cocaine.

Design/methodology/approach – A desk study of published peer-reviewed material supporting the use of cannabis as therapeutic in mitigating some of the harms associated with crack cocaine smoking.

Findings – The use of cannabis as a harm reduction strategy for crack cocaine use has been commented on in the scientific literature since the 1980s. The officially scheduling of cannabis as having no medicinal value hampered further study despite the reporting of positive findings and numerous calls for more research.

Practical implications – There are currently no approved pharmaceutical substitutions for crack cocaine. Cannabis has shown itself effective in mitigating harms for 30–40 per cent of people. Cannabis is inexpensive and readily available and should be allowed for those people who want to use it.

Originality/value – Poly drug use is often framed in a negative context. In this paper, the author shows that with cannabis and crack, the poly drug use is actually a valid harm reduction strategy.

Keywords Harm reduction, Cannabis, Caribbean, Crack cocaine, Medical marijuana, Smokable cocaine

Paper type Research paper

Introduction

Interrogating the concurrency of drug use and the reasoning behind substance substitution or “poly drug use” often focusses on the negative effects of drug interactions when in fact the use of cannabis with or instead of crack cocaine qualifies as a harm reduction strategy. This review focusses on that neglected aspect of “poly drug use”, the beneficial qualities of one substance, cannabis, in mitigating harms and reducing the compulsion to use often associated with the use of other more potent substances.

The availability of people who use medical marijuana has provided scientists with cohorts of individuals to study who are characterised as patients not criminals. Significant findings are being published in peer-reviewed scientific journals citing peer-reviewed data on important therapeutic qualities of cannabis that should have been headlines but failed to attract reporting in the popular press. With the wide acceptance of “medical marijuana” in a majority of States of the USA and in other jurisdictions, the press has become more likely to publish a positive portrayal of the science of therapeutic cannabis, if the information is presented accurately and free of ideology. The example cited above unfortunately demonstrates that NIDA, the US National Institute on Drug Abuse, continues to report science through an ideological lens.

Background

Prior to the legalisation of medical marijuana, research on cannabis was conducted in jurisdictions where smokable cocaine and cannabis were illegal but their use was common. This research conducted in the 1990s in Jamaica and Brazil found that cannabis was used as harm reduction by many people who used smokable cocaine. As medical marijuana
became legal, research on cannabis became more acceptable and findings in California and Vancouver BC mirrored the early findings of Jamaica and Brazil.

Despite the ideological impediments, research on cannabis outside the USA laid the foundation for later work, with Brazilian researchers leading the way. Brazil experienced one of the first waves of social dislocation from the use of smokable cocaine in a highly criminalised environment.

The first published study of cannabis as harm reduction is found in the Journal of Psychoactive Drugs (Labigalini et al., 1999). They published the results of a small Brazilian study of “25 male patients who were strongly addicted to crack”. Over a nine-month period, 68 per cent, or 17 individuals, ceased to use crack and reported that the use of cannabis had “reduced their craving symptoms and produced subjective and concrete changes in their behaviour”. This study, conducted outside of the USA, created quite a stir, especially among the US National Institutes of Health (NIH) funded researchers who were eager to undertake their own work in this area. The Brazilian work was concurrent with research on cannabis being done in Jamaica in the 1990s and early 2000s.

An ethnographic study of women who smoked crack cocaine and cannabis in inner city of Kingston, Jamaica examined the social and economic conditions that influenced cocaine use. The women in this group reported using a mix of cannabis and crack known in Jamaica as a seasoned spliff[1]. All the women in this study reported that they used cannabis to reduce, pause or cease their crack use.

In Salvador, Brazil, Andrade et al. (2011) identified several key reasons for the widespread use of “pitiho,” a cigarette of cannabis and smokable cocaine. The mix was reported to:

1. reduce the negative pharmaco-behavioural and physical effects of crack use;
2. was more economical to use; and
3. provided the users with better control over their behaviours thus:
   ■ decreasing their vulnerability for violence; and
   ■ improving their position within the sub-culture.

The researchers concluded that the “Pitiho” offered several relevant short-term benefits to users and therefore may constitute a potentially important “harm reduction” tool in an area where few other targeted prevention measures exist.

In a 2007 behavioural seroprevalence study conducted in Castries, Saint Lucia, we had similar results to Dreher with a larger mixed sample of 262 people, all of whom were homeless and smoked crack cocaine. In total, 73 per cent of the sample also reported smoking cannabis. Respondents were asked if cannabis could be used as a substitution for crack, with 38 per cent answering yes and 52 per cent no, the balance not knowing.

Another small qualitative study in Brazil of 27 persons who smoked crack cocaine and who combined its use with marijuana was reported on in 2015 (Goncalves and Nappo, 2015) The interviewees reported that the combination of crack cocaine use with marijuana provided “protection” such as reduced undesirable effects, improved sleep and appetite and reduced craving for crack cocaine. The respondents also noted that it allowed them to recover some quality of life.

US scientists began to report on patients who were prescribed medical marijuana. Reiman (2009) operationalises drug substitution as the conscious choice to use one drug (legal or illicit) instead of, or in conjunction with, another due to issues such as: perceived safety, level of addiction potential, effectiveness in relieving symptoms, access and level of acceptance. In his 2009 study on a cohort of medical marijuana users in Berkley California, he investigated the patients’ propensity to substitute cannabis for other drugs. On analysis of the data, it was shown that many of the medical marijuana users had substituted cannabis for alcohol (40 per cent) other illicit substances (26 per cent) or prescription drugs (66 per cent), demonstrating cannabis’ suitability as a substitution for other substances shown to be more harmful to the body.
The finding of a small qualitative study done in the San Francisco Bay area of “baby boomers”, individuals born between 1946 and 1964, was reported in 2015 (Lau et al., 2015). The study participants described using cannabis as a safer alternative to alcohol, illicit drugs and pharmaceuticals based on their perceptions of fewer adverse side effects, low risk for addiction and greater effectiveness at relieving symptoms, such as chronic pain. The study concluded that cannabis substitution can be an effective harm reduction method for those who are unable or unwilling to stop using drugs completely.

In Vancouver, Socias et al. (2017) used data drawn from three prospective cohorts of people who use drugs. They selected data from 122 individuals who reported intentional cannabis use to reduce crack use between 2012 and 2015. They found that people successfully used cannabis to reduce crack use. This study also recommended further clinical research to assess the potential of cannabinoids for the treatment of crack use disorders is warranted.

Research question
With all this data available and each study calling for more research in the field, one must ask:

RQ1. Why has not cannabis as harm reduction been more widely accepted?

Research into the medicinal value of cannabis is expanding. The availability of cohorts of people using legal medical cannabis started to become available in 2000, while in the last decade of the twentieth century, the endocannabinoid system (Pacher et al., 2006) and its therapeutic and prophylactic functions became the foundation to support the introduction of therapeutic and medicinal cannabis (Kaur et al., 2016).

The availability in the USA of medicinal cannabis of regulated strengths enabled scientists to interrogate the medicinal value of cannabis on health issues in a controlled fashion. A similar law in British Columbia legalised medical marijuana in 2001 and made further scientific investigation of the therapeutic qualities of cannabis possible in that jurisdiction. Since then the proliferation of legally sanctioned medical and recreational cannabis has allowed an ever-increasing number of scientists to investigate the therapeutic value of cannabis on “disparate diseases and pathological conditions, ranging from mood and anxiety disorders, movement disorders such as Parkinson’s and Huntington’s disease, neuropathic pain, multiple sclerosis and spinal cord injury, to cancer, atherosclerosis, myocardial infarction, stroke, hypertension, glaucoma, obesity/metabolic syndrome and osteoporosis, to name just a few” (Kaur et al., 2016). The conclusion of this work comments “Whether or not the use of ganja is a remedy for crack addiction in the biological, psychological or sociological sense, programs that fail to acknowledge the different cultural meanings and experiences attached to these two illicit substances ultimately will lose credibility with the very population they need to serve.”

Ideological impediments to the acceptance of cannabis as a form of harm reduction

The National Institute of Drug Abuse (NIDA) and related NIH-funded drugs research has focussed almost exclusively on the hazards of cannabis rather than any benefits from its medicinal use (Nutt et al., 2013; Gross, 2013). Buxton (2011) comments on this phenomenon of an ideological lens through which to view science by observing: “Critics of NIDA maintain that its quest for empiricism and scientific knowledge is undermined by a political outlook that is profoundly influenced by the ‘war on drugs’ and the ideology of prohibition. NIDA has a cavalier attitude toward science and is deeply reluctant to engage research that might contradict the view that drugs use is inevitably harmful”.

Press releases issued by the public relations contractor for NIDA often highlight the most egregious effects of cannabis as reported in NIDA-funded studies. Often the popular press will report the NIDA press release verbatim and may even further sensationalise it, making it more shocking and less factual.

To illustrate how ideology influences the reporting of cannabis research, we refer to the NIDA website. Found there is an article entitled “How does marijuana use affect school, work,
and social life?” (NIDA, 2018). The article opens with the statement: “Research has shown that marijuana’s negative effects on attention, memory, and learning can last for days or weeks after the acute effects of the drug wear off, depending on the person’s history with the drug”. The NIDA article cites Schweinsburg et al. (2008) in “The influence of marijuana use on neurocognitive functioning in adolescents” as their authority. Inconveniently, Schweinsburg et al. (2008) state clearly in their opening paragraph that the poly drug use of the cohort makes it difficult to “disentangle the neural effects of marijuana from those associated with other substances”. Further complicating the issue, that statement is supported by a reference to earlier research whose purpose was to present 12-month and lifetime estimates of the prevalence, socio-demographic and clinical correlates, and psychiatric co-morbidity of DSM-IV cannabis abuse and dependence. Thus, a generalised statement on the negative impact of cannabis on youth is justified with a reference to individuals with psychiatric co-morbidity.

Harm reduction for crack

Harm reduction originally focused solely as a prevention strategy to reduce the direct transmission of HIV via the sharing of non-sterile syringes. This was accomplished by the distribution of sterile syringes and advocating for safe injection spaces.

The very successful war on drugs campaign that sought to portray cannabis as having no medical value, a “gateway” leading to the use of other drugs and the cause of mental illness has made the recognition of cannabis as a legitimate treatment option for crack use difficult for some jurisdictions to endorse. Other harm reduction practices, such as sterile syringe distribution and opioid substitution therapies, have also had a difficult time being accepted as legitimate therapies. The lack of acceptance of cannabis as a medically assisted therapy is compounded by the Single Convention on Narcotic Drugs of 1961 that deems cannabis to have no medicinal benefits. Despite the supportive peer-reviewed scientific evidence of cannabis as a harm reduction intervention for crack use, no movement has been made by the United Nations Office on Drugs and Crime (UNODC) or the International Narcotics Control Board (INCB), who are often the source of sharp criticism of any move to ease restrictions or amend the Conventions. Despite the stated purpose of the 1961 Convention being to protect public health, the failed solution of a criminal justice legal paradigm continues as the foundation of the UNODC and INCB response.

The resistance on the part of the UNODC to support the use of cannabis as an evidence-based harm reduction strategy is unfortunate, especially in light of the enlightened policy outlined in the Technical Guide For Injecting Drug Use (WHO, UNODC, UNAIDS, 2012). Opioid substitution therapy, sterile needle and syringe distribution have been endorsed but there is no acknowledgement of the science of cannabis as a mediator of harms associated with crack cocaine use. Cannabis as substitution therapy remains taboo, evoking laughter or derision.

Among many people who use smokable cocaine, there has always been a long-held strategy that smoking a mixture of crack and cannabis mitigated some of the health and behavioural extremes that smoking or “piping” crack straight often lead to.

Cannabis has shown promise as an alternative choice to crack cocaine use. There is a continuing call by scientists for more research into cannabis as a harm reduction tool, even as it is met with ideological barriers.

Conclusion

Caribbean folk medicine had long known the value of cannabis. Early published references to the prophylactic, therapeutic and sacramental use of cannabis in Jamaica are indicative of the same findings that would be common in other Caribbean jurisdictions as research progressed. “Ganja tonics, teas and other infusions are household medicines used […] by all ages, both sexes and a wide range of socioeconomic levels” (Dreher, 2002).
Since the introduction of harm reduction to the Caribbean in the mid-90s, professionals and colleagues throughout the Caribbean working in the field of drug treatment have quietly conceded that cannabis use mitigated harms associated with crack use. While making clear that their programmes were based on 100 per cent abstinence from all substances they considered cannabis the preferred alternative, over alcohol, for those people who used crack and continued to express a “need” to use some substance.

The science is increasingly clear: cannabis use is not harmful, not dangerous and the cannabis prohibition of the last 50 years has been ideologically driven, not based on science. Service providers should note that any cannabis use should be considered therapeutic, and those individuals who turn to cannabis use to reduce or mitigate other drug use should not be discouraged from this course of action.

These findings suggest a need to re-evaluate how we view the use of cannabis with other substances. Rather than the negative connotations that are usually assigned to “poly drug use”, the use of cannabis as medicine has a long and successful history in many cultures, with the science just beginning to validate it, empirically.

Note

1. Smokeable cocaine and cannabis mixed into a cigarette is called a seasoned spliff, spranger or black joint in the English speaking Caribbean.

References


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