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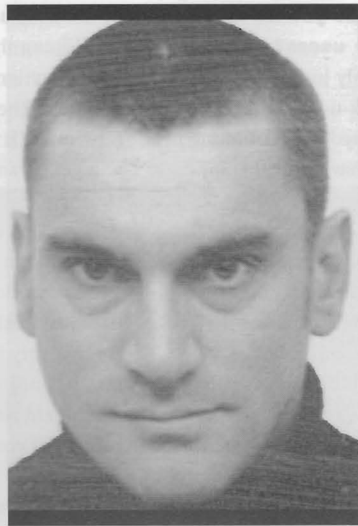
Crack undoubtedly causes problems for users, families and the community. But does the public image of the drug and its users hinder service development? Interview by Harry Shapiro.



What has been the drug service response to crack?

At the time when it first appeared, all the money was going into HIV prevention, focussed on injecting opiate use and the other problems were ignored. The workforce did not reflect the communities – 'these communities are hard to reach, they don't want to engage', but you had an all-white workforce. The first real service was the Nottingham Crack Action Team around 1992, that's nearly ten years after crack was first around. When I came to set up the Blenheim crack services in 1994, I was desperately ringing round to try and get more money in for the structured day care programme. I phoned the Home Office, told them we were running this pilot, we could pass on what we learnt to others. Would they fund it? No, was the short answer.

I think also there was a hostility from within the drug field to dealing with crack cocaine. Drug workers felt very challenged because at the Blenheim we were dealing with one drug rather than generically. In reality of course, most of the services were not generic, they were opiate services. But we had to learn new stuff about this drug before we could become generic and it was difficult to get things off the ground. Other workers were feeling deskilled – what do I do with this person? – and I have to say it, there was racism around as well – still is. There is a lot of fear, especially if you are dealing with the black community. When you've got a 6'2" black guy standing at your door with a crack cocaine problem, some workers become afraid.

And the mythologies of crack fed into this?

Yes. There was all the stuff that Stutman from the DEA came out with in 1988 when he spoke to the police conference. And in his autobiography he admitted that a lot of that was about manipulating the media to secure funding for the DEA – you know, the three smokes and you were instantly addicted. He said the DEA were now issued with sub-machine guns. And the big one was that we were going to have a crack cocaine problem because we have a significant Jamaican population. When Douglas Hurd [then Conservative Home Secretary] went to America in 1988, it was said they had officers firing guns off a few blocks away so it would seem he was in the middle of a crack war. And that was backed up by doctors like Arnold Washton, who said this was an instantly addicting drug – so you had professionals in the field saying exactly the same thing. So the whole thing with crack fed into fear of crime, fear of violence and fed into racism as well.

What about crack as a drug that induces violence?

For seven years I ran a project that used to get 300 contacts a year and in seven years we did not have one incidence of violence – not one. So for my part as a drug worker, I find that crack cocaine users are the least violent group in the context of treatment. But if somebody has just had a pipe, their adrenalin is up, they are feeling threatened and their probation officer is there, saying, 'I'm going to breach you because you are late' – *and* there is a glass partition between them – *and* the user is black, the probation officer is white. Add all these things together then you can have fireworks. But much of this is to do with the fear of drugs workers, policemen – and users may already be stereotyped before anything has happened. A professional's reaction can then spark off a reaction in a user.

Are crack users difficult to engage in treatment?

My experience at the Blenheim Project was in the first year we had a 45% completion rate for the day care programme and attracted 60% from the black community and that same percentage also completed. And that

was at the high end for any day programme – so we were outperforming established opiate-based services in our first year with a supposedly difficult client group. All we were doing was working in a specific way with workers who understood the problem. We also had quite a number of black workers. This is actually an incredibly easy client group to work with, if you do it in the right way. But you look at a DDU worker with a 40 client caseload and a crack user comes in and gets told, 'I can see you in two weeks time for half an hour and every two weeks after that'. What good is that? They have the first appointment and then bugger off. And they become a 'difficult to engage client group'. The majority of the drugs field in this country has been trying to fit a square peg in a round hole rather than create a square hole.

Is the lack of a methadone equivalent for cocaine and crack a real stumbling block to attracting people into treatment?

I don't think it's an issue at all. When users come forward to services they are in crisis – it might be an arrest, it might be health, a partner leaving. And that crisis wakes the client up – 'you've got to go and get help now' – so they are in a pretty desperate state. When they arrive, they say 'I want to give up, I'm sick of it, I want to stop it'. It's not about, 'I want to stabilise' or something like that. So it's not a problem for the client, but it is a problem for the medical profession because they don't know what to do next. GPs don't want to know, but these people usually have some very serious medical problems. Somebody coming off might need vitamins or build up drinks because they've lost so much weight. It's basic health care practice. But the medical profession are just looking for this wonder drug. Everybody's waiting for this vaccine. Even if it works the way they say it will work, it will only be a tool. Say a crack cocaine user goes into prison and when they are in prison, they stop craving. They could be in there for ten years, they come out and on the day of their release they are craving. So what are you going to do? Keep somebody on vaccine for the rest of their lives? Are we going to start vaccinating little Johnny because we think he might start using crack? Are you going to be sentenced to be vaccinated after an arrest?

So what work do you do with crack cocaine users?

I think we are only just scratching at the surface. Crack users work very well with structured programmes, like cognitive behavioural therapy. Once you get somebody off crack, there's a lot of energy. There will be a short recovery period where people want to sleep and eat and then there's energy. What do you do with that? You've got to direct it. Group work is very good for that as well as individual work.

What about harm minimisation? Even those committed to this say there are no harm reduction techniques for crack.

There's loads of stuff you can do. Projects willingly give out information on how to cook your gear properly, how to inject it properly. Can we give out information on how to freebase properly? Because if you don't do it properly you can get a build-up of ammonia poisoning. Can we give out information on safer crack pipe use? Some projects will, some won't. There is no parity with opiate use because of all the stereotyping around crack.

A lot of the American information about pregnancy and crack, for example, is just plain wrong. If you look deeper, you see that the methodology was bad or the research was funded by a religious organisation. What we know factually is that crack is less harmful to the foetus than taking alcohol. All the studies on so-called 'crack babies' were done on poor black and hispanic women. Where are the studies on white middle-class women taking cocaine and the effects on their babies? It's the same drug. Women phoning the Blenheim were making decisions on terminations based on information they got from the web.

What needs to happen about services for crack users in the UK?

Things are starting to happen – it's on the priority lists with the Home Office and the National Treatment Agency. The main thing is that any new services are good services. Some things will have to change – for example assessment forms for crack users need to be different from the ones for opiate users – and COCA is developing these. Crack users are often very ignorant about their own drug use. They'll know how to 'wash', how much it will cost and that they will get paranoid, anxious and depressed – but they won't know why. So one of the things is to inform them exactly how crack cocaine works. And straight away they will trust you because up to now they've only had bad information that has not engaged them. So the drugs field needs better information, because if you are a drugs worker in a drugs agency and you don't know how crack cocaine works – what are you doing there?

Once you realise how crack works, then you know that it is no good asking a worker to have a forty client caseload of crack users because it won't work. You can ask them to have a ten client caseload. The work will be more intense, but the turn over will be much faster. At the end of the year most of that group won't be with you because you are not dealing with scripting, stabilisation and so on – these people just want to get off. There will always be a need for crack-specific services as centres of learning, but what has to happen is that generic services have to become truly generic. And, for example, start thinking about evening and weekend work for this client group. It is all about the drug field's ability to manage change.

For further information
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