

Crack harm reduction doesn't wash



*peter mcdermott
pure and uncut*

TWO close friends of mine – one successfully running his own business – sustained heroin habits in a relatively controlled manner for many years. Now that same businessman is serving a six year sentence for a violent crime. The other friend's in for life. The reason? Crack.

Those of you with long memories will remember the visit to the UK from DEA agent Robert Stutman and his dire predictions about crack cocaine. "Typical Drugs War rhetoric," I sneered. "It's just coke and that's been around for years. Perhaps the lack of any social safety net was what was responsible for US inner city blight. It could never happen here."

SMOKING GUN

But although we may have had cocaine, we'd never had it under the same circumstances as America – large quantities of a drug you could now smoke, available at affordable prices. We assumed that – as with heroin – smoking couldn't be more efficient than injecting. And then we read the research. Smoking cocaine as freebase delivers a very intense rush for a very short period, followed by a rapid crash and extreme depression. This leads to rapid repetition of the cycle. Unlike heroin, which would quickly make a user satiated, people smoking crack cocaine can consume phenomenal quantities over the course of a day.

Clearly, there are harms associated with this particular pattern of use, and any attempt to reduce those harms should be welcomed. But while we know that crack pipes are possible routes for Hep C transmission, they can be made cheaply and easily from available household objects. If people are sharing those, then why wouldn't they share more elaborate pipes dispensed by drugs workers?

PIPE DREAMS

But some of the things that are being advocated are much more worrying, like the prospect of controlled use of crack. Now while I've no doubt that controlled use of crack is possible, it seems to me that the people who are able to use it in this manner don't actually need the services of their friendly neighbourhood CDT. They'll be along a few years later, when their use becomes a problem – or they won't.

But for the people who do need help, telling them that they can control their use if only they follow a few simple steps is such a

banal misunderstanding of the nature of chaotic and compulsive use as to be almost beyond belief. If these people could control their use, then they wouldn't have a problem in the first place. What's more, by telling them that it's possible, we do two things. Firstly, we set them up for yet more chaos and compulsion – because that's how the pharmacology of crack works. You can't just do one hit without immediately wanting more.

It also makes their addiction unnecessarily protracted and increases their sense of failure. "There must be something wrong with me. I know that I should be able to control my use, because my drugs worker says it's possible, but every time I try I just go on to spend all of the rent money again."

This is different from harm reduction with opiate users. They can often control their use and lead a relatively stable, normal life provided they have a reasonable quantity of opiates. Now perhaps there are people with a crack problem who can also use in this manner, but from talking and listening to scores of people with a crack cocaine

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problem, I've yet to meet one who feels that they ever made any improvement until they became abstinent.

This isn't a moral position on my part. I don't care whether people smoke crack or not. If they smoke and don't have a problem, fine. If they smoke and do have a problem and don't want help, that's fine with me as well.

What does disturb me is the way that some people in the drugs field are advocating unresearched interventions with a strong possibility of doing more harm than good, and seeking to pass them off under the guise of harm reduction. When people did this from a moralistic, abstentionist perspective, we were rightly critical. We need to hold harm reductionists to the same high standards.

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