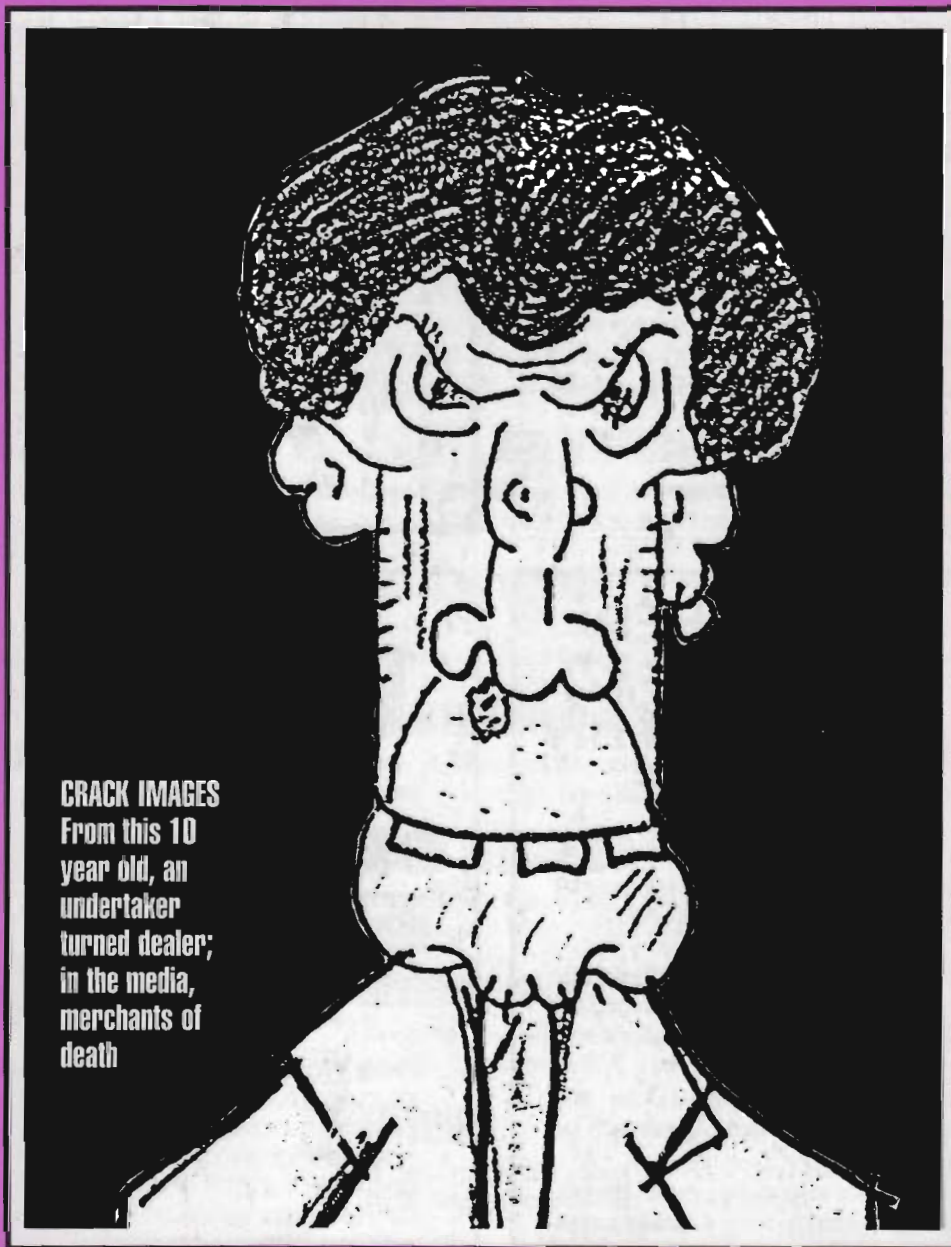


DRUGLINK

THE JOURNAL ON DRUG MISUSE IN BRITAIN

September/October 1989



CRACK IMAGES
From this 10
year old, an
undertaker
turned dealer;
in the media,
merchants of
death

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news,
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reports
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**INSIDE ISDD'S CRACK BRIEFING 8 CRACK IN LONDON AND
LIVERPOOL 12 & 16 SCARY STORIES FROM THE STATES 6**

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CRACK SPECIAL

Our aim is that after reading this *Druglink* you will be a) more fit to face crack if it ever comes your way; b) more fit to face the crack panic.

To these ends we bring you:

- the facts from the world literature — page 8;
- reports from the street and from a street agency — pages 12 and 16;
- the stories that "scared the hell" out of our police — page 6;
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Harry Shapiro scoured the world literature and phoned those in the know. The result is the UK's most authoritative briefing on crack.

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INSTITUTE FOR THE STUDY OF DRUG DEPENDENCE

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Government backs off anti-crack drive

This summer's crescendo of concern over crack with the government spotlighting it as the "spectre hanging over Europe" culminated in a decision not to single out the drug in a major anti-crack drive.

The thrust of the Home Secretary's statement issued on 3 August was that the crack threat "requires even stronger efforts on our part to prevent the misuse of drugs" rather than crack-specific initiatives. Ruled out "for the time being" was a national anti-crack campaign of the kind called for by the Home Affairs Committee in their interim report rushed out on 27 July after their visit to America the previous month.

Instead, Hurd reported, "we believe at this stage the further action to reduce demand for crack should be local and specific".

Risk of police/community conflict

Probably the most difficult policy issue has arisen from the association of cocaine and crack use with black people in Britain. Opinion differs over whether this is real or imaginary, and, if real, whether it merely reflects the fact that crack has been found in the less affluent areas where many black people live.

The other but not mutually exclusive explanation is that cocaine distribution is handled largely by traffickers with Jamaican connections. In March Interpol identified a new cocaine trafficking route from Jamaica to Europe, the first seizures from which were made in the UK (*International Criminal Police Review*, March 1989).

Areas with high black populations such as Toxteth, Handsworth and parts of south east London, have all been associated with crack. Although cautioning for possession of cannabis (another drug used by young blacks as well as white people) has become accepted police practice, the Home Secretary regards it as "important that the police should take a firm line against possession of crack as well as trafficking".

This should, he told Action on Addiction's crack conference in July, be done with "due regard" to community sensitivities, but the crack threat would "no doubt" ensure police had local support.

He was speaking after the widely reported incidents of 23 May when 120 police mounted a drugs raid on the Travellers' Rest pub in the Heath Town district of

The decision to restrict anti-crack publicity drives to particularly affected areas was taken in advance of the meeting of the Ministerial Group on the Misuse of Drugs on 26 July, which appears simply to have rubber-stamped the line hammered out in what's reported to have been an interdepartmental policy struggle.

In June the split between ministers who wanted an all-out anti-crack campaign and those who thought this would just be free advertising for the dealers surfaced in the *Times* (12 June 1989).

The line up appears to have been the Home Office and Foreign Office for the campaign versus the Departments of Education and Health, which favoured locally determined approaches integrating cocaine and crack with other drug-related initiatives.

Wolverhampton. Fifteen minutes later youths converged on the building and more than two hours of street violence followed with young blacks and whites pitted against 250 police in riot gear.

Local anger and liberal misgivings over the raid were overshadowed by reaction to the "ominous" discovery of 14 wraps of crack reportedly worth £140 — this "truly diabolical" substance as the *Times* put it (25 May 1989).

Invited to congratulate the police on their actions, Margaret Thatcher said they were "entirely right" as "crack peddlers must know they have no haven" (*Hansard*, 25 May 1989).

Police themselves queried whether it was all worth it, but "You have got to hit the street dealers... The public will now see an increase in drugs raids," said the head of the Met's drug squad referring to crack. With this drug, he had to admit, "The dealers tend to be in black areas".

West Midlands police at first suggested the Heath Town 'riot' was organised by drug dealers and for Home Secretary Hurd it was confirmation that "drug trafficking leads to violence" (*Daily Mail*, 2 June 1989).

For other observers it was the culmination of years of "poor policing" and deteriorating relations between police and the local black community in a socially deprived area. Crack, it's suggested, is used as an alternative to less comfortable explanations of social disorder (*Searchlight*, 1989, issue 169).

The outcome of this tussle will bring relief to most in the drugs field, whose criticism of the single-issue anti-heroin campaigns of past years appears to have been taken to heart. At a local level the voices of drug workers and health education specialists are likely to carry considerable weight, helping to prevent inappropriate campaigns being foisted on them from on high.

Nevertheless this summer of crack panic has amounted to a potentially dangerous plug for crack as the quick way for dealers to make their first million and the best hit drug-weary misusers will ever experience.

Ironically, while ministers now reject national anti-crack publicity because of the risk of stimulating interest, it is dramatic ministerial statements that have driven the media publicity.

The Stutman connection

See pages 6-7 for Stutman's speech

"It made a deep impression on me," Home Secretary Douglas Hurd told *Daily Mail* readers on 2 June, and an "even deeper impression on the senior policemen who were there". An eye witness said it "scared the hell" out of the audience.

US drugs investigator Robert Stutman's address to chief police officers in April put several sticks of dynamite under Britain's rumbling worries that cocaine and crack could turn downtown Toxteth, Handsworth and Deptford into US-style drug ghettos.

In turn, these concerns were broadcast on the European stage when in May Douglas Hurd addressed Pompidou Group ministers. Again we learn from the *Mail* that "he acknowledges that a fair part of the inspiration for that speech had come to him a few weeks earlier" from Drug Enforcement Administration special agent Stutman.

One of Stutman's most significant statements was that three-quarters of crack tryers get hooked after three hits. On this much else hinges — a drug this addictive causes users to commit violent crimes and promises massive profits to the dealers, disrupting whole communities.

His reference was "a study that will be released in the next two to three weeks" which would "probably" report this finding.

It was more than two to three weeks later, with no such study yet seen crossing the librarians' desks at ISDD, when the Home Secretary told *Mail* readers that

■ Among the eight points listed in Douglas Hurd's 3 August statement, only the news that special anti-cocaine Customs teams have been set up related exclusively to cocaine. Also listed was the international conference being organised next April in London on reducing the demand for drugs, at which cocaine and crack were to be major topics.

First put by Hurd to the Council of Europe's Pompidou Group in May, backing for this conference was one of Margaret Thatcher's major achievements at July's 'G7' summit of the seven richest industrialised democracies. However, misgivings in some European nations about focusing on crack and the fact that Britain itself is lowering its profile on the drug will probably mean that the conference takes on a broader demand-reduction remit.

"75 per cent of takers are hooked on [crack] after three goes".

A week earlier, Stutman's statement had appeared in the *Sun* (25 May): "Three Hits Can Get You Hooked" was their version of these "terrifying statistics". Before that, the as yet unseen study cited by Stutman had become a "survey" which "showed" these disturbing facts (*Times*, 19 May 1989). Later the 'survey' was attributed to an impeccable source — the Home Office itself (*Grimby Evening Telegraph*, 2 August 1989).

In all this there was not one shred of hard evidence, an inconvenient fact that, to their credit, became apparent to senior police officers who "attempted to trace the studies and figures quoted by Stutman and found that they don't exist" (*Independent*, 27 July 1989).

On the same day the House of Commons Home Affairs Committee released their emergency interim report on crack with these same discredited 'facts' highlighted in bold.

Perhaps the police's discovery that the emperor had no clothes is why later ministerial statements have not repeated Hurd's replay of Stutman's claim as well as helping to persuade the Home Office to toe the DoH and DES line.

'Three hits and you're hooked' is just one example among many — several other startling statements from Stutman's speech were given equal credence by ministers, some police, the media, and by the Home Affairs Committee.

■ Southampton University's evaluation of the work of the DES-funded drug education coordinators appointed in 1986 says they have made significant progress towards encouraging a lifeskills approach to drug education integrated into a personal and social education programme. "Nothing else to date has probably done as much to give emphasis to health education in the school curriculum," say the authors. Turner G. *et al.* *Education and the misuse of drugs. A national evaluation of the drug education coordinators initiative.* University of Southampton, 1989.

■ July's cabinet reshuffle has left the Home Secretary and Secretary for Health unchanged while John Macgregor takes over from Kenneth Baker at Education. Below them it's all change at junior minister level. Gone is John Butcher with whom drug education coordinators were developing such a good relationship, replaced at the DES by Alan Howarth, co-author of the 1986 pamphlet from the No Turning Back group of Tory MPs which forshadowed the government's opting out policy for schools. At the Department of Health Lord Trafford takes over drugs while David Mellor retains responsibility for AIDS. At the Home Office Peter Lloyd replaces Douglas Hogg.

■ Adolescent solvent misusers do show evidence of impaired brain functioning but this is associated with social deprivation not with their solvent misuse. This is the finding of a Department of Health funded study of London schoolchildren aged 13-16 comparing sniffers with non-sniffers, which failed to confirm the at one time common claim that solvent misuse causes brain damage. Chadwick O. *et al.* "Neuropsychological consequences of volatile substance abuse." *British Medical Journal*: 1989, 298, p.1679-84.

■ Action is being taken which could curb the serious problems with the abuse of the pharmaceutical drugs buprenorphine and temazepam in Scotland. An order to control buprenorphine (Temgesic) under the Misuse of Drugs Act has received House of Lords approval and could be in effect this month, while manufacturers have responded to a Home Office request to re-formulate temazepam in ways that make it less easy to prepare the product for injection — the current liquid-filled capsules are broken open and the contents injected with barbiturate-like results. *Pharmaceutical J.*, 5 and 12 August 1989.

Shock as Italian MEP is elected on anti-prohibition platform

The Euro-elections last June provided more than just an upset for the British political status quo. In Italy, Marco Taradash, a 39-year-old radical journalist, was elected to the European Parliament on a straight-down-the-line anti-prohibitionist platform fought solely on the issue of present and future drug policies.

Taradash's candidature was launched after the foundation of the International Anti-Prohibitionist League in Rome earlier in the year. At that meeting delegates such as Thomas Szasz, Peter Cohen and Anthony Henman, from Europe, North America, South America and elsewhere, committed themselves to actively campaign against the 'repressive' policies promoted by the UN, WHO and almost all nation states.

Right wing libertarian Milton Friedman sent a telegram of support to the conference which was also attended by individuals ranging from unreconstructed free marketeers on the right to independent communists on the left. The keynote speech was

delivered by Nick Harman of the *Economist*.

The Italian anti-prohibitionist campaign was conducted against great odds. Italy's three publicly-owned television channels, controlled by the Christian Democrats, the Socialists and the Communists respectively, studiously ignored Taradash's call for informed debate and constructive change.

The only air-time allocated to the candidate took place in a studio debate during which Taradash was repeatedly abused by a supposedly neutral chairman and effectively prevented from putting his case. Unable to say a word, Taradash chose to walk off the set, drawing attention to the farcical nature of the programme and gaining considerable public sympathy.

From an opposite perspective, in attempting to promote his non-sense image, Bettino Craxi, the consistently overbearing leader of the Socialist Party, has demanded stringent amendments to Italian drug laws.

Possession for personal use ceased to be an offence in 1975. With the slogan "Drug Taking IS a Crime", Craxi wants to reverse the 1975 reform, much to the consternation of public health workers, most therapeutic communities, many judges and a not inconsiderable number of police trade unionists.

Pandering to an Italian weakness for 'tough', posturing leaders, Craxi quite blatantly attempted to manipulate the drug issue in order to increase the Socialist vote and supplant the Communists as the primary opposition party. To his own surprise and that of many pundits, he was emphatically rebuffed when the Euro-votes were counted.

Not only did the Socialists fail to increase their share of the vote (which has never exceeded 15 per cent in recent years), but, to add insult to injury, the Anti-Prohibitionist candidate was elected to the European Parliament with 426,000 votes.

Active street canvassing and a telling press campaign pointing out the ties between the illicit traffic in drugs, a spiralling overdose rate, violent revenue-raising crime, and the growing financial power of mafia, was the main thrust of the anti-prohibitionist campaign.

It would be interesting to see what the impact of a similar campaign might be in Britain and the USA if they had an electoral structure comparable to Italy's proportional representation system. It seems likely that the allegedly 'prevailing' prohibitionist wisdom would be seen to be somewhat less prevalent than many United Nations' committees, national governments and the popular press would like to suggest.

Roger Lewis
Visiting Professor, Rome

426,000 Italian voters and Hamburg's city senate break ranks in the drug wars



■ In Hamburg a radical plan to hand out heroin to addicts is being considered by the city's senate. Touring ambulances would distribute the heroin in ready-filled syringes to help cut the sharing of injecting equipment.

Hamburg's proposal originated with the city's socialist mayor and the city's senate has agreed that it merits further discussion. A report filling in some of the details is due to be presented to the senate in October.

The heroin proposal is just part of a plan to undermine the illicit market, cut drug-related HIV spread, and stem the fourfold increase in drug deaths which totalled 34 in the first six months of 1989.

Also proposed is the de facto decriminalisation of possession of drugs for personal use. This would not involve a change in the law but an agreement by local police and prosecuting authorities not to pursue such cases, so Hamburg is free to go it alone on this part of the plan

without federal approval.

But the heroin distribution proposal would require liberalisation of Germany's strict controls on narcotics prescribing. Doctors there cannot prescribe heroin to addicts. Methadone can be prescribed only in oral form, and then only if other treatments have failed. Such a major change as allowing injectable heroin prescribing is unlikely to be approved, says Heino Stover of Bremen University's drug documentation centre.

CRACK STORIES FROM THE STATES

A mythology in the making

What US agent Stutman told Britain's chief constables about crack 'scared the hell' out of them. It also alarmed our Home Secretary and was uncritically regurgitated in lurid tabloid news splashes. Here's part of what he said.

6 IN THE PAST three and a half years crack has gone from a drug which was virtually unheard of in the largest city in the United States to a major drug of abuse in 49 out of the 50 states.

Crack is an equal opportunity drug. It does affect blacks, whites, Hispanics. It affects rich, poor and in-between and it has left the ghetto in United States and it has gone on to suburban America. It is truly a drug that has taken over our society and changed the face of our society.

Crack, unlike heroin, is a drug that affects females as much as males. Of all the crack addicts we have seen, about 50 per cent are female. Now what does that mean? In the United States most inner city families are run by women. These are the same women who today are becoming crack addicts.

Therefore, the last vestiges of family in the inner city, certainly in New York and most other major cities in the United States, are beginning to disappear. That's one of the major reasons why we are now seeing crack addicts in New York, 10, 11, and 12 years of age. The number of reported child abuse cases in New York City has gone from 2200 in 1986 to 8000 in 1988. Almost all of them are the children of cocaine/crack using parents.

And one figure, which I think is absolutely frightening, is that last year in New York City, of all of the children who died because of battering — where parents literally beat their kids to death — 73 per cent were the children of

cocaine/crack using parents. It is a drug that produces violence.

A study that will be released by the Cocaine Hotline in the United States proves beyond reasonable doubt that the drug itself causes violence. You don't necessarily need a person with a predisposition to violence. In a survey of 17,000 crack users in the United States, the Cocaine Hotline is going to point out that 47 per cent had been involved, under the influence of crack, in a physical fight, 35 per cent in assaults with weapons, 12 per cent in child abuse, and 1 per cent had actually been involved in murders.

*Seventy-five per cent of people
who try crack three times become
physically addicted*

That is a drug unlike any other drug that we have ever seen which produces those kind of numbers.

Now, what is crack? It is nothing more or less than smoking cocaine. So why does it produce this feeling that cocaine doesn't necessarily produce? One very simple reason is that smoking is the most efficient method of getting the drug to the brain. That's the only difference between cocaine hydrochloride and crack.

Crack's appeal to the kids

So why did the cocaine epidemic hit us all of a sudden? For a very simple reason: we believed our own garbage. We told ourselves it was relatively harmless, we told ourselves it certainly was not addicting and everybody believed it, so they tried it.

We now know that crack is the single most addicting drug available in the United States of America today and certainly the most addicting

drug available in Europe. Heroin is not even in the same ballpark.

A study that will be released in the next two to three weeks will probably say that of all of those people who tried crack three or more times, 75 per cent will become physically addicted at the end of the third time. It is pointed out now that in most treatment centres in New York City the average crack addict is addicted within five weeks of first use.

Right now in the United States crack is considered a virtually incurable addiction. No treatment centres show any long term remission of any statistically significant number of crack addicts. Yet it is a drug that of those people who try it three times, 75 per cent become addicted. You don't have to be a mathematician to figure out you've got a hell of a problem when you've got a drug like that.

Now let me take it one step further. If I wanted to design a drug that I'm going to market to kids, I couldn't improve on crack. Let me tell you why.

It is a very expensive drug but sold in very, very small amounts so it is relatively inexpensive. Before the advent of crack if a kid in New York wanted to buy cocaine he had to lay out about \$80 for a gram. Those were the smallest amounts it was sold in.

Today you could purchase crack for as little as \$3 to \$4 a phial. Is that cheaper than the \$80? Really not, for the very simple reason that that \$3-\$4 worth lasts only 8 to 10 minutes. It is three to four times more expensive than hydrochloride, but at least the kid doesn't have to lay out a lot of money at one time. Any kid in the United States can come up with \$5 or \$10.

The second reason that crack has become so popular in our country is that the method of ingestion is so non-intrusive. No needles stuck in your arm, you don't even have to stick a white powder up your nose. Who does that, nobody,

Robert Stutman is a US Drug Enforcement Administration special agent working in New York. This article is edited extracts of an address he gave to the Association of Chief Police Officers' drugs conference this April.

it's not a normal thing to do. We smoke it. It doesn't bother anybody to smoke something.

And then there's the third reason: crack is the ultimate 'feel good now'. If I inject heroin it takes about two and a half minutes to feel the full effect. If I sniff cocaine, it takes about three minutes. If I smoke crack, in five to ten seconds I am stoned. The problem, of course, is that it only lasts about 12 minutes and then you come down.

For those three reasons crack has become extremely popular in our country. The obvious problem that it has caused, certainly in New York, is violence.

Crack does two things: it gives you a feeling of omnipotence — I am the strongest S.O.B. in the world, nobody can touch me; at the same time it gives you a sense of paranoia — why are you picking on me? When you mix those two things together you can imagine the problems you start to get with the user.

In the United States crack is considered a virtually incurable addiction

Now we'll take that one step further. Generally there was an unwritten rule, certainly in New York, that you don't knowingly shoot at cops. That rule has changed. In the last nine months I have had four of my agents shot. Three were shot in the head, two lived.

The third turned out to be what I think has become the most heinous crime against a law enforcement officer ever in the United States, or close to it, and that was the assassination of Evert Hatcher who was working undercover.

The traffickers found out he was a federal agent and made a knowing decision to meet with him. They cleaned off his surveillance, met him an hour later, shot him twice in the side of the head. The most cold-blooded assassination I have ever seen of a law enforcement officer.

That is the philosophy that we now see in New York and it is due specifically, in my way of thinking, to the advent of crack and cocaine. It has changed the face of the city. Now every DEA agent, all 3000, are issued sub-machine guns. That is what has happened in our country basically because of crack and cocaine over the past three years.

How do you make crack? Any person in this room can make crack. All you take is some cocaine, some hot water, a bunsen burner and a baby bottle, and in an hour and a quarter you have crack. The geniuses in New York City didn't have to figure it out very long: if I buy a kilo of cocaine for \$18,000, and an hour and 15 minutes later I can sell it for \$70,000, that's what I am going to do. Crack started out as a cottage industry in our country with no big peddlars.

Jamaican traffickers

Unfortunately it didn't take very long for the traffickers to realise we're not going to leave this to individuals, and they began to organise. Right now crack is controlled by a fairly large number of organisations, basically of two ethnic backgrounds, Dominicans and Jamaicans. As you leave New York City the Jamaicans have taken over control of much of the rest of the United States, Jamaicans who are tied back directly to New York City.

I don't have to tell any of you that you have a large number of Jamaicans in this country. Many have relatives and friends in New York and none of them are very stupid if they are dope peddlars to start with. These guys don't have to be geniuses to realise 'I don't have to import crack from the United States. I can make my crack right here in Great Britain and I can increase my profit by something like 300 per cent, and I don't have to worry about getting new customers all the time. Three out of four of the guys I sell crack to three times are coming back to me, they're locked in, they're a guaranteed customer.'

[That's how it started in our country. Now] we are basically saturated with crack, the problem is continuing to grow, the violence level has been continuing to grow and the response of law enforcement, although we are trying to do something, we haven't made one bit of difference.

Last year the New York City Police Department and the DEA in New York made 90,000 drug arrests [and] the Drug Enforcement Administration in New York City seized 9,000 kilos of cocaine. Did all those seizures and arrests make one bit of difference? Absolutely not. There is not a single corner in New York where you can't purchase crack or cocaine.

Our mistake in New York was that we didn't see the problem early enough and we didn't get a jump on it. Three years ago Boston's mayor came to my office worried about crack. We talked about it, trained their police officers, he increased the size of his drug unit and set up task forces [so] information came from the street to the top immediately. They did away with parochialism. They started drug education in school systems and community education across the city, and today Boston has a very minor crack problem.

The only thing I would ask you is the following: learn from our mistakes. Don't be like the people in Kansas and Texas and California who said, 'It can't happen here'. I will make a prediction and as you all know, you've got to be crazy to make them. I will personally guarantee you that two years from now you will have a serious crack problem.

We are so saturated with cocaine in the United States, there aren't enough noses left to use the cocaine that's coming in. It's got to go somewhere and where it's coming is right here.

Don't fall for that old business of 'It's only black guys'. We set up a car seizure programme in New York City in which we seized the vehicles of people coming in to high density areas. We seized 1000 cars; 80 per cent were white kids from the nice suburbs coming in to buy crack.

If you don't attack this potential problem putting aside differences and looking at a

I guarantee you that two years from now you will have a serious crack problem

community national response that is law enforcement, education and treatment, I will guarantee you the following: three years from today you will invite me back, because you will be looking back on the good old days of 1989, and that won't be pleasant.

I see by my watch I have about three minutes left — is there anyone who has a question, an argument, a debate?

The Sun on 25 May. How did they know Three Hits Can Get You Hooked? They heard it from special agent Stutman. ▼

CRACK CRAZY!

Evil gangs spread drug through Britain

ALL SUN INVESTIGATION

BY SIMON HOODER, FRANK OLSZEK, ROBERT HOLLANDER AND KEZ WELLS

BRITAIN is secretly being swamped by an explosion of the deadly drug CRACK, a major Sun investigation can reveal today.

We have discovered that the problem has increased at least 600 PER CENT in the last year as evil drug barons have set up 'kitchens' in most of our major cities to manufacture the drug.

And we can disclose that London Drug Squad officers have already identified a man who was the very first to become the country's first crack millionaire. It took Jamaica's Paul Matthews just six weeks to amass a £100,000 fortune from the drug and he was about to 'invest' in massively expanding his operations when a lucky police break nabbed him.

Crack, which is made with a mixture of reprocessed, crushed and usually addictive and is becoming a nightmare for addicts, is being produced in the States and is being smuggled into Britain in large quantities.

On Tuesday angry parents in the North London area were told to look at pictures after a crack addict was found dead in a hospital.

They reacted in despair to prevent the epidemic spreading the drug to other parts of the country.

Just two days before the Wolverhampton riot, Scotland Yard detectives told us: 'There will be another, bigger, like the one in Chicago, where districts of New York, Detroit, Dallas, Chicago and Los Angeles have fallen under control of the crack epidemic.'

They added they know of 616 separate crack kitchens operating in London alone—while underworld drug sources insisted to the Sun that the total figure is nearer TWENTY.

We have established that other crack factories are being set up in Birmingham, Wolverhampton and London.

CRACK users have developed their own special lingo to help non-users. It is called 'crack' or 'wack'.

Dealer makes £2,000 a day

RUTHLESS Yardies gangsters in Jamaica are trying their brightest recruits to Britain to peddle crack on Britain's lower-city estates.

The first of their meth was caught just six weeks after arriving in London, and now several of the gangsters in just before being found dead in a hospital.

Paul Matthews, 31, was arrested at a South London address in the 'Crack City' last September.

Detectives were tipped off by worried residents that the Yardies had moved into the area.

Matthews used to store parcels of the drug in his room in the flat.

He was followed one of his associates who was a Walker.

The day of his arrest he had received one package in the residence.

He had received 2.5 grammes of crack from the dealer.

Matthews, who sold the crack for £100.

CRACKING UP... an addict prepares to take another dangerous fix

Liverpool, Manchester and Glasgow.

Our inquiries revealed that a crack addict in Liverpool was selling for just £20 a hit to other, organised crime figures.

VIOLENCE is rife between warring street gangs as they struggle to control their own territories.

Cheap The epidemic in Britain that Scotland Yard's Drug Squad boss Steve Todd is setting up a special anti-crack team within his unit to tackle the problem head-on.

He admitted: 'This drug is so cheap and addictive that it could sweep the country. We have every reason to fear.'

For youngsters like John and Martin in Liverpool it is too late. After getting crack for nothing in school, they have started selling money at work.

Each needs about £20 to buy a hit of crack a day, even if it's just a pinch.

He said: 'I spent all my savings started selling money at work, 50p a hit. I can't last without it.'

Jail He said: 'I spent all my savings started selling money at work, 50p a hit. I can't last without it.'

Three hits can get you hooked

TERRIFYING statistics show that 75 per cent of crack users, who are usually aged between 18 and 25, become hopelessly addicted to the deadly cocaine derivative just THREE times.

He said: 'I spent all my savings started selling money at work, 50p a hit. I can't last without it.'

Jail He said: 'I spent all my savings started selling money at work, 50p a hit. I can't last without it.'

The images smudged by ash and soot on the faces of the young men in the London streets are a stark reminder of the damage done by crack.

Most British crack addicts are addicted to the drug.

Latest figures show that 24 million of crack in Britain have moved from 100 tons in 1987 to more than 400 tons in 1989.

It is estimated that the value of £450 million.

An estimate of the damage done by crack is £21 million, although this is probably only the tip of the iceberg.

Most British crack addicts are addicted to the drug.

CRACK

A briefing from the Institute for the Study of Drug Dependence

In the heat of July's crack panic ISDD rushed this briefing to press and government officials — the facts about crack as we know them.

Harry Shapiro

CRACK IS small bits of freebase cocaine about the size of raisins. These are smoked in pipes, on tinfoil like heroin, or in cigarettes. Freebasing is the manufacturing process whereby cocaine hydrochloride powder is dissolved in water and heated with a chemical reagent to 'free' the cocaine alkaloid 'base' from the salt — see panel opposite for an attempt to unravel the confused terminology in this area.

Freebase cocaine has been available in America and in the UK for some years. Originally a volatile liquid such as ether was used as the reagent, a dangerous procedure with a high risk of explosion — as American comedian Richard Pryor found out in June 1980 in an accident which nearly cost him his life. The resultant publicity was partly responsible for a switch to either ammonia or baking soda as the reagent instead of ether.

A sharp but expensive hit

Crack is neither cheap, nor is it pure cocaine. Currently in Britain, crack is sold in single bits wrapped in tinfoil or cling film. Each bit weighs on average about a quarter of a gram and sells for around £25.¹ The effects of one bit are felt in under ten seconds, peak in 1-5 minutes and wear off after about 12 minutes.² In America, crack is about \$5 a bit, so it appears cheap on a 'bit by bit' basis. But even there, maintaining supplies of a drug with such a brief duration of action requires considerable financial resources. In the UK at present, crack is not cheap by any reckoning.

Nor is it true that any sample of crack will automatically be purer than the equivalent amount of cocaine powder. The purity level of crack depends on:

- the purity of the cocaine powder used in the processing;
- the adulterants in the powder;
- the particular method of crack manufacture;
- the proportions of cocaine to reagent.⁴

Harry Shapiro is ISDD's publications manager and the author of ISDD's Cocaine drug notes. This briefing was based on his review of the literature obtained by ISDD and contacts with workers in the UK and overseas.

From the point of view of clinical research, the use of crack is a new phenomenon the consequences of which are sparsely documented. Most of the research available has two main limitations:

- the study samples are small;
- the subject groups are selected from those already in crisis with their drugtaking — callers to helplines or patients in treatment.

The psychological effects of smoking crack are exaggerations of those from sniffing cocaine; an intense and almost immediate euphoria with a sense of increased physical and mental capacity, well-being and indifference to pain and fatigue. The effects wear off quite rapidly (around 12 minutes). Users then report after-effects such as depression and anxiety.⁵

With large doses and/or after periods of continued use, effects may include hallucinations, while the after-effects may develop into suicidal feelings and paranoia. These unpleasant feelings can be alleviated by smoking more crack or by taking drugs such as heroin or tranquillisers to 'take the edge' off the anxiety and depression or to induce sleep.⁶

At £25 a piece for a 12-minute high, crack is not cheap, nor is it pure cocaine

The reason for the immediacy and intensity of the 'high' is that smoking is a very effective means of delivering drugs to the brain. The inhaled cocaine vapours are fat-soluble, so pass easily through the tissue membranes of the body and across the blood-brain barrier. In addition, smoking delivers higher concentrations of the drug into the bloodstream than sniffing.⁷

In delivering the drug to the brain, smoking crack is marginally quicker than injecting cocaine powder. Although injected cocaine powder does enter the bloodstream quickly, it is usually injected at sites further away from the brain than the lungs.

Some users have tried smoking cocaine without freebasing it first. This is largely ineffective because cocaine hydrochloride is not very volatile and decomposes in the high temperatures involved in smoking.

Some of the physical effects and after-effects of smoking crack are similar to those of sniffing

cocaine, including increased heart and pulse rate. Circumstantial evidence of crack-induced stroke has been reported.⁸

Other effects relate to regularly *smoking* the drug so are respiratory in nature — chronic coughing, cracked, wheezy breathing and partial loss of voice in some instances. Chest pains are reported⁹ which may be due in part to cocaine-induced angina. Death, a relatively rare occurrence, can be caused by cardiac arrhythmia or respiratory failure.¹⁰

The issue of dependence

The World Health Organisation states that drug dependence is not a fixed syndrome, but rather a cluster of symptoms, not all of which need to be present for diagnosis of dependence to be made. These include:

- feelings of compulsion to use the drug;
- evidence of tolerance to the drug's effects after repeated use and withdrawal effects after stopping it;
- use of the drug to relieve and avoid withdrawal symptoms;
- drugtaking behaviour becoming a dominant factor in the individual's life.¹¹

Based on this definition, the literature supports the belief that all forms of smoked cocaine, including crack, have a dependence liability.

In some users crack appears to induce a craving to continue taking the drug once the effects have worn off. In a random sample of 458 callers to the 800-COCAINE hotline in America, 82 per cent reported drug craving.¹² This can develop into a 'binge' pattern of drug use continuing for hours or even days until supplies of the drug, the money to buy it, or the users themselves are exhausted.¹³

As long ago as 1980, even the literature of America's drug subculture warned about the seductive powers of smoking cocaine: "Even people of an iron will, who have never experienced problems in regulating intake with any other drug, are finding their ultimate test of will in freebase".¹⁴

It has been suggested that occasional or controlled smoking of crack is probably not possible.¹⁵ However, a study of 308 adolescent drug users in Miami not in treatment showed that, although over 90 per cent of them had tried crack, only 29 per cent were using it daily and

even then only one or two 'hits' at a time¹⁶ — a result at odds with claims that crack is 'instantly addicting'. 'Instant' addiction has been claimed for crack, but only by those already in trouble with drugs who have often merely switched their allegiances from cocaine powder.¹⁷

Presentations of the 'addictive power' of crack as so great that even the naive drug user could not help but be immediately ensnared by the drug are not borne out by the research available, summed up as follows: "Everyone who tries crack will not like the high, and everyone who likes the high will not become instantly and hopelessly addicted".¹⁸

So if crack is not 'instantly addicting', how long does it take? This will vary between users, but, for example, in one survey of 464 'chemically dependent' adolescents, the group classed as heavy crack users (used more than 50 times) took three months to even begin using it on a weekly basis.¹⁹

Once dependent on crack, what is the prognosis for abstinence? Anecdotally, it seems poor;²⁰ certainly there is no recognised drug to wean a crack user on to in the way that methadone is used in heroin dependence. The main pharmacological treatment suggested to date involves the use of tricyclic antidepressants to moderate the withdrawal symptoms.²¹

In a study of relapse among cocaine smokers, 35 out of 253 people returned for a second detoxification, but only two cited craving for the drug as the primary reason for relapse.²² Again anecdotally, it would seem that cocaine users might eventually mature out of using the drug when they've 'had enough'.²³ This has been demonstrated in a Dutch study of 160 cocaine users from non-deviant subcultures (ie, not addicts, prostitutes, prisoners, etc). Most went through heavy periods of sniffing cocaine, but those who stayed abstinent the longest prior to the study cited 'no desire for cocaine' as the main reason.²⁴

Tolerance and withdrawal

According to the literature, cocaine users can take the same dose every day and get the same effect.²⁵ However, this view is being modified in the light of cocaine smoking. During a 'binge' the amounts smoked have been recorded as escalating from about a quarter gram to 3 grams in order to maintain the euphoric and stimulating effects.²⁶

Crack users also seem to be able to survive far higher doses of the drug than do those who sniff cocaine powder. The estimated lethal dose for cocaine is around 1.2 grams, though fatalities have been recorded with as little as 160mg injected intravenously.²⁷ That crack users can take so much more may be explained by tests which indicate that anything up to 83 per cent simply melts rather than vapourises, so is not available to be inhaled.²⁸ The researchers also tested crack smoked in cigarettes and found even higher loss rates, but did not test crack smoked on tinfoil.

Such wastage also suggests that smoking crack might not be very cost-effective. In the Dutch study, 10 per cent of the total sample thought that one of the disadvantages of using crack was that it was uneconomical — a category of disadvantage not mentioned for either sniffed or injected cocaine.²⁹

An American expert has said that "Cocaine smoking withdrawal is rarely seen with a reduction in intake, but is clearly evident in

abrupt cessation from chronic high doses".³⁰ The main features are depressed mood, fatigue and disturbed sleep. The depression can be associated with anxiety, guilt and suicidal feelings. Other features include chills, tremor and muscle pains. Withdrawal can begin up to two days after the last dose with symptoms persisting up to four days or longer.

There is marked craving during this period and users report having dreams about smoking cocaine. As with other stimulants such as amphetamines, the user may be in a weakened state for several weeks afterwards. However, withdrawal symptoms of themselves do not mean the person is dependent, as dependence involves a compulsion to take the drug. Symptoms can be partly explained by cocaine-induced insomnia and anorexia.³¹

Other problems

In heavy, regular crack users, the high concentrations of cocaine in the blood, the large amounts being used and the legal, social and economic problems created by the need to maintain supplies can conspire to promote a cocaine 'psychosis' characterised by hallucinations and/or psychotic behaviour and/or paranoia. This in turn can lead to violence.³²

'Instant' addiction has been claimed, but only by those merely switching from cocaine powder

The hallucinations would appear in some case to be 'real' in the sense that the user believes in the reality of what they are seeing.

Cocaine paranoia often manifests itself in a belief on the part of the user that s/he has enemies who are pursuing them. In the world of illegal drug use, this may well be the case — the police or perhaps a dealer after payment. Either way, such paranoia could lead predisposed individuals to arm themselves against their alleged persecutors.

However, there is no evidence from the literature that crack users are particularly prone

Terminological confusion

There is a deal of confusion over terminology. The term 'freebase' not only covers the manufacturing process but is also the verb to describe the action of smoking cocaine that has gone through this process — and the term for all varieties of cocaine which are smoked, irrespective of how they were produced.

Street names for freebase include 'base', 'rock', 'wash' (as the cocaine powder is 'washed' or dissolved in water with the reagent) or 'crack'. The name 'crack' appears to derive from the sound of sodium chloride (table salt) burning, an impurity left in crack where baking soda has been used.³ It may be technically correct to distinguish crack as only that form of freebase made with baking soda. However, this would only be a technical point in a street drug manufacturing process which itself is hardly an exact science. From clinical and pharmacological viewpoints, all freebase is largely the same.

to commit crimes of violence under the influence of the drug to obtain money for supplies, although this cannot be ruled out in individual cases.

Cocaine constricts blood vessels, restricting the blood flow to the foetus. Maternal use of cocaine has therefore been implicated in spontaneous abortions, separation of the placenta, and stillbirth.³³ Gastro-intestinal birth defects have also been suggested as a consequence of cocaine use in pregnancy.³⁴ Other complications often associated with maternal drug use (irrespective of the drug) may include premature birth and low birth weight.

Much has been made of so-called 'crack babies', supposedly born 'addicted' to cocaine. Media stories have suggested that such babies may die having 'lost the will to live'.

However, medical evidence to US Congressional hearings indicates that such claims are erroneous. "The cocaine-addicted infant gets over the drug in about one or two weeks... if you just leave the babies in the nursery for a couple of weeks or a month, they'll all do OK".³⁵ During this period, such babies will be irritable, difficult to comfort and may feed poorly. This might hinder the mother-baby bonding process which could already be compromised if mother and baby have been separated by the baby's stay in hospital.

Once at home, there have been case reports suggesting that children may have been affected by passive inhalation of cocaine smoke. Symptoms might include nausea, motor coordination problems and seizures. However, the symptoms subside with no apparent lasting damage.³⁶

Another US concern relates to child abuse. From the little evidence available,³⁷ it would appear that users most often come forward to receive help at the instigation of partners, because either financial difficulties or paranoid behaviour has precipitated domestic violence. In such situations, children may be at risk.

There have been some unsubstantiated claims made from the American experience about the impact of crack use on the incidence of child abuse.³⁸ However, it is clear from the literature on child abuse that the perpetrators of physical violence against young children have an immature vision of child behaviour which perceives any act of 'misbehaviour' as being deliberately directed against them.³⁹ It can be reasonably hypothesised that where such a person is also a chronic user of a drug such as cocaine which can induce paranoia, risks to a child might be enhanced.

Crack use does not involve injection so precludes the most efficient means of spreading HIV — sharing needles. In this important sense, if people choose to intensify the cocaine high by smoking the drug rather than injecting it, then there is a decreased risk of HIV spread. This is especially the case since cocaine may be injected much more frequently than other drugs due to the short-lived nature of its effects.

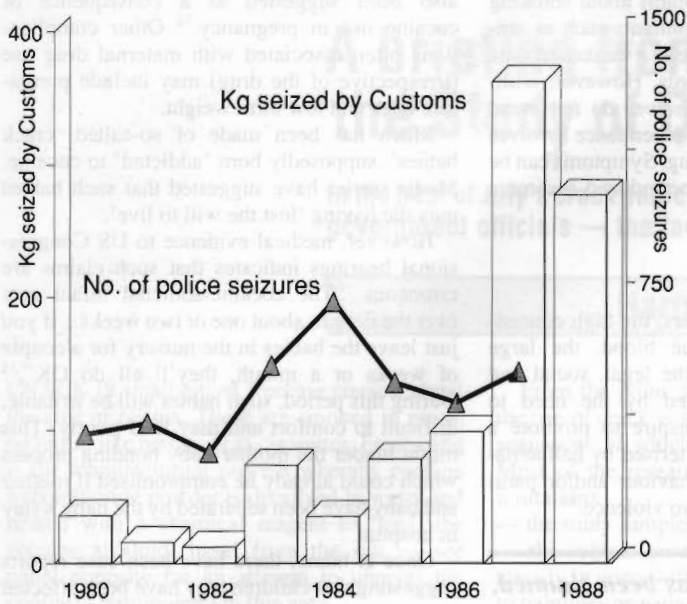
Anecdotal reports from America suggest that prostitutes trying to maintain expensive crack habits might be tempted into unsafe sex practices for extra cash. Researchers in Liverpool confirm crack use by prostitutes in that area but as yet there is no evidence of similar risks being taken in the UK.⁴⁰

Where's the epidemic?

For some years now, politicians and the media have been predicting that Europe was on the

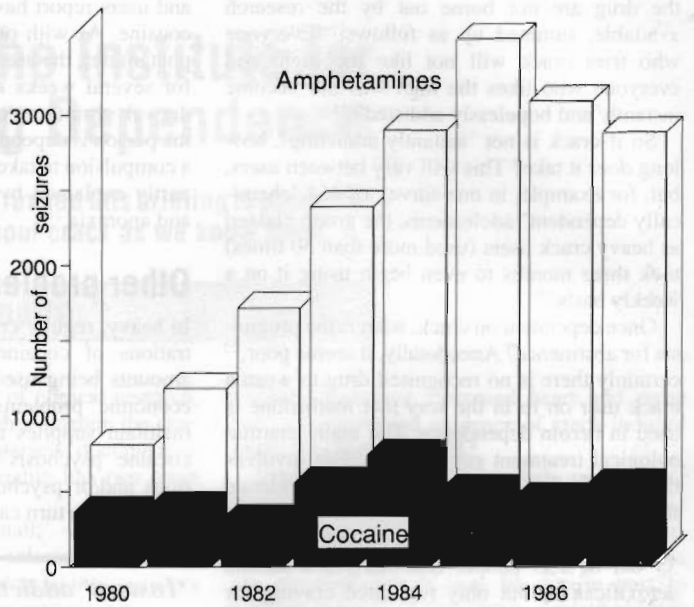
UK COCAINE STATISTICS

1 Seizures from users yet to rise in line with import seizures



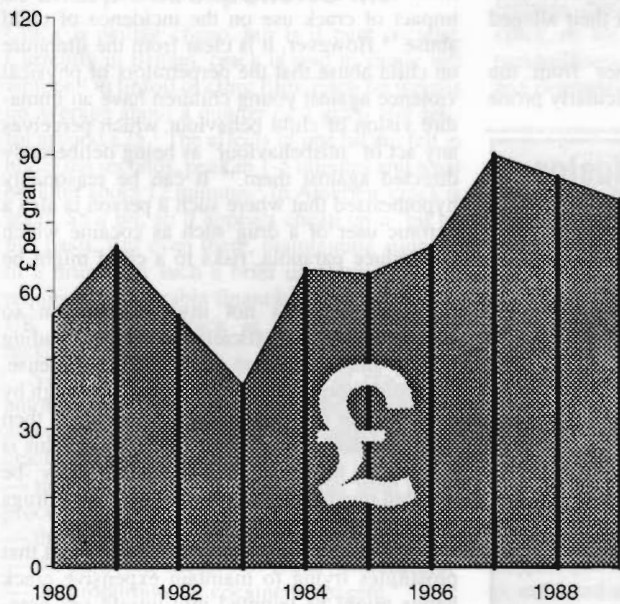
Rocketing Customs cocaine seizures have fuelled current concern, but many of these kg were in transit elsewhere. As yet the more 'street-level' police statistics do not show a corresponding rise in the UK retail market, but these date back to 1987. There is little doubt that the 1988 figures will reflect recently increased use.

2 Police figures confirm amphetamines are Britain's major illegal stimulants



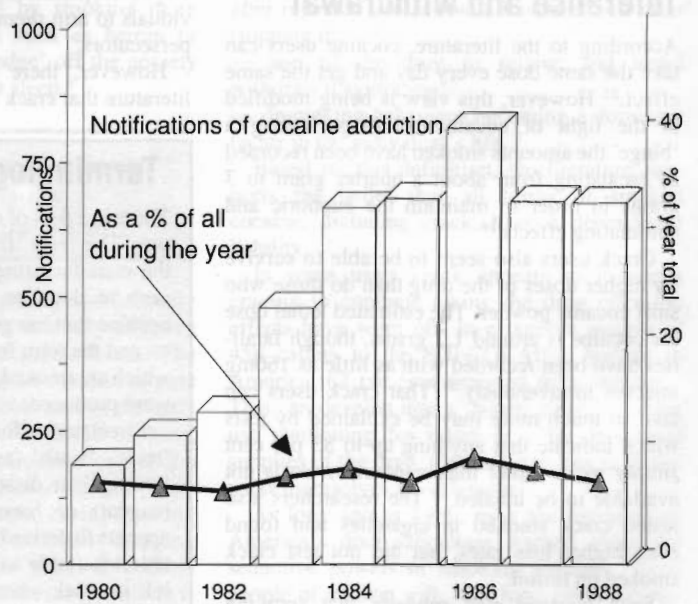
To the policeman on the beat, amphetamines have been a far more visible presence than cocaine. Amphetamines are not just much more widely used, but also commonly injected, making them by far Britain's most problematic stimulant.

3 Street prices down in last two years but still high



These estimates from the National Drugs Intelligence Unit do not suggest any revolution in the UK cocaine market. The figures have not been adjusted for inflation. The same source reports amphetamine prices at £10-£15 a gram in 1989.

4 Diagnoses of cocaine addiction stable since 1984



As with heroin and other opiates, doctors must notify the Home Office of any cocaine addicts they attend. This chart is based on the number of cocaine addiction notifications made during the year — an unknown but probably small percentage of regular cocaine users.

This briefing is available from ISDD as a booklet • £1 inc. p&p

brink of a cocaine epidemic as the North American market became saturated and the South American drug barons looked for new consumers. But statistical evidence casts doubt on the assertion that the American market is saturated (see panel).

The idea of Britain being inevitably flooded with cocaine is also a flawed analysis because it suggests that America's drug problem today is everybody else's tomorrow. The history of drug use in Britain indicates that, with the possible exceptions of LSD and Ecstasy, Britain has had its own discrete drug scene(s) which do not necessarily rely on American cultural 'input'.

At different times, Britain has had amphetamine and barbiturate subcultures unconnected with the American experience of these drugs. And by the same token, America has had its own discrete drug prevalences such as phencyclidine (PCP, 'Angel Dust') and Ts and Blues — a combination of tripeleminamine (an antihistamine) and pentazocine (an opioid).

That it is misleading to make transnational predictions about the spread of drug misuse (especially when words like 'epidemic' and 'plague' are bandied about) is shown by the current Canadian and Dutch experiences with crack. Only this year have the Canadian police identified crack in any quantity and that is restricted to Toronto.⁴⁵ This is confirmed by a Toronto study of cocaine users in 1985 which failed to find any evidence of freebase use in the city at that time.⁴⁶

In the Netherlands "crack-cocaine as a ready-to-use product was marketed...as early as 1973, but it did not catch on and is hardly seen on the streets since".⁴⁷ This too is confirmed by the Amsterdam study of 'non-deviant' cocaine users cited above. Interestingly, those who had tried crack (18 per cent) were outnumbered by the 25 per cent who regarded freebasing as "unhealthy, junkie-like behaviour".

Statistical evidence casts doubt on the assertion that the US crack market is 'saturated'

At present the prevalence of crack in Britain can best be described as 'patchy'. Crack is at least currently available in differing degrees in parts of South and East London, Bristol, Cardiff, parts of the Midlands and Liverpool. It would seem that crack production is both a 'cottage industry', with users converting their own supplies of cocaine powder for personal use, and also a process undertaken by dealers wishing to sell the product.⁴⁸ Crack is unlikely to be imported into Britain, but manufactured from imported supplies of cocaine powder.

Seizures of imported cocaine by Customs officers have been rising, but this in itself does not mean that traffickers are 'gearing up' to flood the country with cocaine or crack. Rising levels of seizures may just reflect increasing enforcement activity and are not good indicators of the 'street' availability of a drug.

Customs statistics are much further from the 'street scene' than the number of seizures made by police from drug users and dealers. These police seizure statistics have not rocketed along with the Customs statistics. In 1987 police made 541 cocaine seizures, not markedly above the average for the '80s of 485 seizures a year (see opposite). How long this gap between quantities imported and evidence of cocaine on the street can last remains to be seen.

Is the US market 'saturated' with crack?

There is some evidence that the answer is, not yet.

◆ The University of Michigan's annual survey of American high school seniors, college students and young adults revealed a *decline* in all cocaine use in 1987 — the most recent survey details available. "It appears that the worrisome crack epidemic of 1986 which seemed poised to explode into a much greater health menace, levelled out by 1987 — at least among these populations".⁴¹

◆ The Drug Abuse Warning Network (DAWN) is an important US national data collection system through which hospital emergency rooms and coroners report back information on medical crises and deaths related to (but not necessarily caused by) misuse of drugs. The statistics cover hospital reports from 21 metropolitan areas throughout the United States.⁴²

Among cities with the highest number of cocaine "mentions" during 1988 were New York (7457 mentions, 40 per cent crack); Washington (4467, 39 per cent crack); Detroit (3309, 54 per cent crack) and Los Angeles (2956, 29 per cent crack). These cities were also the focus for media attention⁴³ and provided the majority of witnesses to Congressional hearings on crack — most

came from New York.⁴⁴ The evidence is that crack is widely available in these cities. But other evidence from DAWN suggests that these oft-cited cities are not typical of the USA as a whole.

◆ In Miami, where cocaine is widely available, emergency room mentions of crack as a percentage of the total number of cocaine mentions rose from 16 per cent to 31 per cent during 1985-1988, but the number of cocaine mentions fell in a city of 1.6 million people from 1038 to 519.

The cities of Atlanta and St. Louis, with combined populations of nearly 4 million (including substantial black populations), had less than 1200 emergency room mentions of cocaine in 1988, of which only 25 per cent involved crack. Cities such as Chicago had over 4000 mentions of cocaine, but less than 25 per cent involved crack. Some, like Phoenix and Baltimore, had percentage mentions of crack in single figures.

Overall, cocaine was the single most mentioned drug in emergency room reports, but the spread of mentions is by no means uniform and it would appear that the major cities in America vary greatly in the degree to which they could be said to have either a cocaine or a crack problem.

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CRACK IN LONDON

A CUT IN price over the last eighteen months from £60-80 to £40-60 a gram, improved marketing, and a fashionable image have made cocaine and its derivative crack good sellers on the buoyant south London drug market. This trend is being reflected in the growing number of cocaine users now approaching drug agencies in the area.

In financial year 1988/9, the area's Community Drug Project (CDP) saw 59 cocaine users (11 per cent of our total caseload), a figure which this year is expected to increase. In the first three months of 1988/89, 13 per cent of new people coming to CDP reported cocaine use during the past 30 days. By the final three months the figure was 25 per cent. In terms of numbers the increase was from 11 people in the first quarter to 20 in the fourth. Most of the cocaine users we see are men but a sizeable minority are women.

Using cocaine in the form of crack (also known as 'wash' or 'rocks') is in vogue locally. About a quarter of the cocaine users we saw last year had smoked crack. Usually they had prepared it at home, getting through perhaps as much as ten grams of cocaine over two days, but there are now signs that some dealers are manufacturing and selling ready-made crack.

But crack use in south London is just one element within a general trend towards increased use of cocaine, including snorting the powder, freebasing other forms of cocaine, and injecting the drug with heroin.

Crack use has developed in the context of pre-existing high levels of cocaine use and availability, and a drug using tradition that has for many years preferred smoking (as in 'chasing' heroin) to injecting. Crack 'fits' the south London drug scene in ways that may not be applicable elsewhere.

Local crack users do not see the drug as a significantly different product to cocaine. Transforming cocaine into crack is done to remove some of the impurities and to get a more intense high, rather than in the mistaken belief that a new drug is being created.

Crack intensifies problems

At least three different groups of people are using cocaine and crack locally. Use has become more common among existing polydrug users on the lookout for the week's best buy. Most of the cocaine users we see fall into this group.

The other two groups are more worrying, partly because they are more difficult to contact. First there is evidence of more frequent cocaine use among people with a long history of using the drug recreationally. Second, young people both white and black without a history of drug misuse have started to use cocaine on a regular

The author is the director of the Community Drug Project (CDP) in South London, a voluntary sector drugs advice and counselling agency. CDP can be contacted on 01-708 0757.

Cocaine users in South London are now being converted to crack. The area's drugs street agency shares their experience of cocaine and crack problems, probably the most extensive in Britain.

Stephen Tippell

basis. Both see heroin as a drug for 'junkies', are wary of injecting, and regard cocaine in its various forms as part of an expensive designer-orientated lifestyle.

For all these cocaine users crack has important advantages over cocaine powder (see panel).

The problems seen with regular crack use are similar to those with other forms of cocaine but intensified because more of the drug is used in a shorter space of time. In the neighbourhood of CDP these problems have developed in the context of high levels of drug use and of crime.

Users we've seen have run into problems because regular cocaine or crack use is very expensive. Particularly with crack, the effect is so short-lived that people can use several hundred pounds worth a day. Most of our experience has been with polydrug users who commonly use crack at high levels for a few days. The cost of such a binge can only realistically be supported by crime.

Traditionally the crimes committed by heroin users have been non-violent, such as the burglary of vacant premises, shoplifting, and cheque and credit card fraud. The last two of these in particular require a 'straight' front and a coolness of approach. Cocaine makes people 'jumpy' and this can lead to more in the way of quick snatches. Also the cost of the drug means more offences need to be committed. With regular cocaine or crack use there soon comes a time when no feasible amount of petty crime can pay the bills. Many users simply stop at this point but some commit more serious crimes to net large amounts of money at a single stroke. In our experience crack does not create violent criminals out of law-abiding citizens but its use can push people to extend their criminal repertoire.

Cocaine and crack use can, however, lead to paranoia which in turn can result in violence,

particularly in the domestic situation. It is not unusual for the wife or partner of a cocaine user to contact CDP due to their concern over actual or potential violence or over the user's criminal activities.

In contrast, crack users themselves are reluctant to attend. This may be partly because of the paranoia associated with use allied to an unfounded fear of being reported to the police. It is also because no clear treatment path exists such as is available for heroin users.

But there can be serious problems for cocaine user as well as for their contacts. People who stop using report severe depression in the weeks that follow, sometimes leading to thoughts of suicide. One solution is to resume use, and many do just that. Another is to 'self-medicate' with heroin or sedatives which help block out the craving for more cocaine, take the edge off cocaine-induced jumpiness, and help the user get some rest.

Need to reach new groups

Developing help programmes for problem cocaine users poses difficulties for agencies such as CDP. The first is actually reaching users, a particular problem with those *not* using drugs other than cocaine. These people do not necessarily see themselves as having a 'drug' problem. An agency geared primarily to heroin users may not project the right sort of image to attract them and, in any case, may not be seen as offering appropriate help at the time they feel it is needed. Even if they did feel they needed help with a cocaine problem, many of these people would not know how to start.

We also need to establish appropriate forms of treatment. In the USA intensive counselling programmes have been developed to cope with the strong psychological dependence that can develop with cocaine and particularly with crack. Short-term medication may be helpful in alleviating depression when cocaine use ceases. Cocaine is not replacing but adding to existing drug problems and extra resources are needed to mount an effective response.

On a broader front it is important in prevention terms to counter the positive street image of cocaine and crack which, despite all the adverse publicity, are seen as drugs of success. ■

How users see the advantages of crack

Cocaine users seen by CDP give a number of reasons for preferring smoking crack to snorting cocaine hydrochloride.

◆ Snorting cocaine is becoming seen as wasteful and inefficient method of use which results in less 'bang per buck'.

◆ Crack is a new and fashionable product attractive in the same way as other new products like clothes or records. Both by virtue of its method of use (ie, not injecting) and the drug (cocaine rather than, say, heroin), users do not associate crack with problem drug use. They can use it without

being seen as 'junkies'.

◆ Crack users seem aware of the HIV risk from injection and see crack as a way of avoiding this while still getting a 'rush'.

◆ Crack users see traditional methods of preparing freebase cocaine as dangerous because the ether might blow up in their face. In contrast it is easy to convert cocaine into crack at home.

◆ Crack in the form of 'rocks' is easier to handle than cocaine powder and easier to dispose of if users fear being searched by the police.

DRUG EDUCATION IN THE PRIMARY SCHOOL

Why primary school drug education is needed and how it could be done. Sensitivity to children's existing drug knowledge and concerns is the key.

Ron Greer

"EDUCATION ABOUT illegal drugs at primary level is rare. Nevertheless, many children aged 8-12 are well aware of drug issues and ask about them." This quote from the DES publication *Drug Misuse and the Young* (1985) supports the need for drug education in the primary school.

A common argument against such education is that increasing a child's awareness of drugs might increase their curiosity and result in more experimentation. This presupposes that children have little knowledge of drugs in the first place and that school is their only source of information.

Research by the HEA Primary Project Team does much to refute these ideas.¹ A 'draw and write' technique was used to investigate how children aged 4-11 saw the world of drugs. It showed that children aged 6 and upwards know far more about drugs than we might have thought. Much of this knowledge is thought to reflect the influence of television.

Practice in primary schools

If primary school children have already begun to develop perceptions about drugs, then it would seem only sensible to check these out and see if the information they already have is correct. In some primary schools this is already being done.

There is considerable variation in drug-related teaching in primary schools nationwide. In terms of content it is not unusual to find work

being done on pills and medicines, on smoking and on alcohol, often as part of a planned health education curriculum. Illegal drugs and solvent abuse are not always part of this formal plan but may be discussed if they arise spontaneously in the classroom.

In terms of teaching methods, the 'thematic' approach seems the one most favoured. Drug education often finds itself within planned themes like 'Myself' or 'Keeping Safe' and occasionally within topical themes such as 'The

Teachers must avoid going in with a prepared script unrelated to the children's experiences

Olympics'. (The Ben Johnson affair produced considerable mileage for discussion within a theme of 'cheating' in one of my middle schools.)

In general, primary schools have a more flexible approach to education compared to secondary schools, which are much more subject-conscious and restricted by the timetable. Cross-curricular approaches to themes such as drugs are commonplace in the primary sector but far less prevalent in secondary schools.

Three teaching resources for use in primary schools are worthy of note — the HEC *My Body Project*;² *Health Education — Drugs and the Primary School Child*;³ and the *Good Health Project — The World of Drugs*.⁴

The *My Body Project* is used by many schools. Aimed at 10-12 year olds, it has had a considerable impact since its introduction in 1983. The emphasis is on trying to stop children from starting to smoke, as opposed to trying to stop them smoking. Research has shown that children working on the project are half as likely to start smoking as control groups.⁵

The *Good Health* series from Central TV has

recently published a unit called *The World of Drugs*. Developed by the HEA Primary Project Team, this includes work on 'What is a Drug', 'The Drugwise Rule Book', and 'Resisting — Saying No'. The pack is said to emphasise the involvement of pupils in a variety of activities including making decisions, thinking creatively, using language, number play, and drama.

Health Education — Drugs and the Primary School Child (for ages 9-11) aims at "equipping young people and those who care for them with the knowledge and skills which may help them to reduce the chances of encountering drug-related problems." The approach is "deliberately low key, interweaving drug education into a broader safety theme". The pupils' module contains a series of exercises on building self-esteem and specifically looks at alcohol, smoking and solvent abuse.

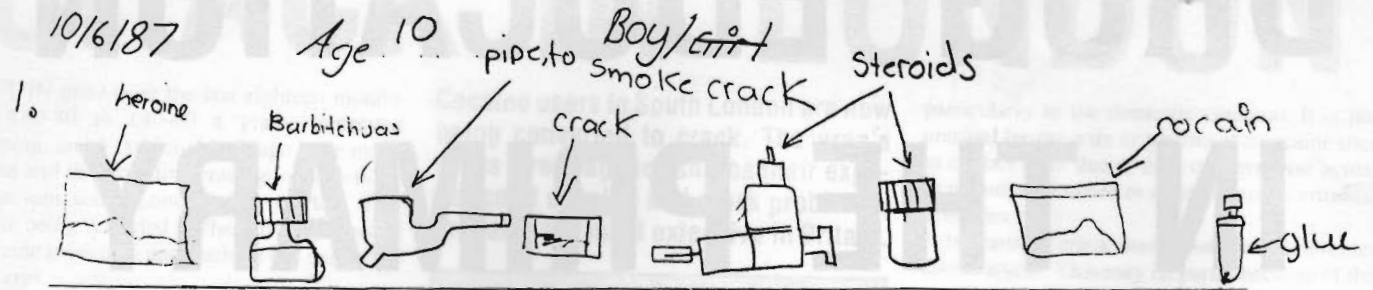
Also notable is the work of the Life Education Centres, which use a travelling health education exhibition aiming to start school and pupils on a continuing programme using a set of workbooks. They emphasise that much of the work has to be done by the schools, but there is a danger that the 'roadshow' might be used as a 'one-off' or as an alternative to the school developing its own programme.

Be assertive; do as you're told

It's when we consider *why* this teaching is happening — its aims — that we move into contentious areas. It might be argued that as a child progresses through school there should be a shift away from simple 'do this, don't do that' messages towards developing their own decision-making abilities. In this way a child becomes progressively more responsible for their health-related choices.

Often behind this approach is the theory that if a person values themselves they will be more likely to make healthy choices than someone with little self-esteem.⁶ It is also claimed that

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2. redundant under taker started drug pushing
1981 Age 42 and has bad temper, and con
Artist

3. He most probably going to sell them to teenagers or even to any one.

Job-unemployed
 age-19-24
 Holes in his jumper
 and Jean's
 Dirty
 Known to be a
 kidnapper/mug/
 burglar.
 2 metres and 2 centre metres
 Horrible mean man
 been taking drugs 2-4 weeks
 he's very Evil
 REWARD IF FOUND
 £20000
 has'nt got a home

▲ A response from an Ealing schoolboy to the HEA Primary Project Team's 'draw and write' technique (see box opposite for details). What one 10-year-old thought would be in a bag of drugs and what he thought of the person who'd dropped it. Drawn over two years ago the reference to smoking crack in a pipe and to steroids shows a surprising awareness of contemporary drug issues.

◀ This from an 11-year-old girl demonstrates the point that even before secondary school stereotypical images of drugtakers as 'bad' or 'sad' are strongly developed. Along with cocaine, heroin, uppers and downers and glue, the bag this unsavoury character dropped included a gun, a knife and a rope.

3. I THINK that man was going to leave the bag here so he could have given it to one of his friends so he could sell it and they could have shared the money between them.

A child's eye view of drugs

The Primary Project research team at Southampton University elicited children's perceptions of the world of drugs by asking them to plug gaps in a story line about drugs.

Over 2000 children aged 4-11 years were asked to 'draw and write' their responses to the following prompts.

1. Two children were walking home when they found a bag with drugs inside it. Draw what you think was in the bag.
2. Who do you think lost it?
3. Draw what you think that person was going to do with it.
4. Draw what the children did with the bag.
5. What would you have done if you had found it?
6. Can a drug be good for you/help you? If so, when?
7. Can a drug be bad for you/hurt you? If so, when?

At five years of age children already linked the notion of drugs with a 'bad scene' and drug users were portrayed as teenagers or criminals.

By age 7 stereotypes of drug users as easily recognised 'baddies' were common but still most children mentioned only tablets, medicines or powders as possibilities for the contents of the bag.

By age 8-9 more than a quarter mentioned heroin or cocaine and drug user/dealer stereotypes had flowered into sometimes quite detailed potted biographies. Drug users are seen as either bad or sad. Concepts of addiction and dealing for profit were beginning to emerge and the children were capable of describing methods of use in great detail.

The trend to equating 'drugs' with illegal and dangerous substances was even further developed in the 10-11-year-olds.

See reference 1 for source

See opposite for how some children responded to the questions

1. HEA Primary Project Team. *ugs & herringe*. Southampton University, 1986 Unpublished.

Linda Blackburne. *Times Educational Supplement*:12 August 1988, p.6.

2. Health Education Council (HEC). *My body*. London: Heinemann Education, 1983.

3. TACADE/HEC. *Health Education—drugs and the primary school child*. 1986.

4. *The Good Health Project: set two*. Forbes Publications, 1988.

5. Dave McLeary. "Helping children to make their own decisions: the my body project." *Health Education Journal*: 1986, 45(1).

6. Keith Jones. "Promoting the health of young people—the role of personal and social education." *Health Education Journal*: 1986, 45(1).

7. HEA Primary Project Team. *Health for Life 1*. Nelson, 1989. *Health for Life 2* forthcoming from the same authors and publisher.

8. Advisory Council on the Misuse of Drugs. *Prevention Home Office*, 1984.

9. Department of Education and Science. *Drug Misuse and the Young*. 1985.

children with high self-esteem are able to deal with peer pressure, a major influence on young children's attitudes and behaviour and of particular significance in relation to drug choices.

Many schools agree in principle with this autonomous, informed decision-making objective, yet in practice are more inclined towards narrower goals such as stopping children smoking or using illegal drugs or solvents. Teachers can find it difficult to reconcile giving clear messages like 'Never take other people's medicines' and 'Don't take (illegal) drugs', while also encouraging informed choices.

'Letting go' sufficiently to encourage children to make their own informed choices and be assertive may be difficult enough in a health education lesson. But there seems little point in developing these skills in the classroom if the whole school ethos is geared to blind obedience and submissiveness from the pupils. A dollop of assertiveness served up in the classroom can easily be overwhelmed by a bellyful of 'keep still and be quiet' at lunchtime.

What if they say 'yes'?

Primary prevention is seen as the fundamental aim in most schools. But what of children already using drugs? Are harm minimisation strategies appropriate for primary school children?

If we are seriously concerned about the future health of our children it would be irresponsible to concentrate exclusively on primary prevention. But in any school, and particularly at primary level, a harm minimisation approach must be adopted very cautiously. The main problem is that while younger pupils may know about illegal drugs, all but a minute percentage do not use them and are not considering using. Most will be violently 'against drugs'. Telling them how to avoid harm from illegal drug use is irrelevant and potentially counter-productive.

Here more than ever there is a need to avoid going in with a prepared script that does not relate to the children's concerns and experiences. Far better to use open exercises to probe their drug awareness and then to respond to the drug issues that emerge.

So, for instance, a small group exercise based on the question 'What do people do that makes them unhealthy?' might lead to a discussion in which it emerges that an older pupil has been seen sniffing aerosols. The opportunity is there for the teacher to point out that this is an extra-dangerous practice without risking inserting ideas not there in the first place.

There is clearly a place for harm minimisation messages about alcohol and tobacco and possibly, among older pupils, solvents, but beyond this a responsive 'dipstick' approach is most appropriate.

Some ways forward

What would a good primary drug education programme look like? The list below includes some of the elements. It is offered as a basis for discussion.

◆ **Varied teaching strategies.** Children have different preferred styles of learning so it is important to provide a rich diet of experiences through a variety of teaching approaches. The emphasis should be on active learning methods, including small group work and role play. My recent experience of piloting a puppet show exploring issues relevant to drug education

clearly demonstrated the potential of this medium, particularly for 6-9 year olds.

◆ **Need for a developmental framework.** A flexible health education framework is needed which moves the child on as they grow out of the egocentric stage, where they find it difficult to see the other person's point of view, through to a more socially responsible one. Topics and themes can be re-introduced at these later stages from a correspondingly different perspective or focus.

◆ The recently published resource *Health for Life 1* from the HEA Primary Project Team, a teachers' planning guide to primary school health education, looks very useful in this respect. *Health for Life 2* specifically provides more activities on key themes, including "The World of Drugs".⁷

◆ **Attitudes and skills as well as information.** "Drug education should not concentrate solely on factual information about drug misuse."⁸ This view of the Advisory Council on the Misuse of Drugs is particularly true with children of primary school age, where an over-emphasis on the drugs themselves could glamorise the subject. A well balanced drug education programme also involves attitude and skill development. Helping children clarify their values on drug issues is a prerequisite to their making informed choices.

Peer pressure can be an enormous influence on children, but learning how to handle it without losing friends involves much more than training children to 'Just Say No'. Being able to be assertive without being aggressive and finding ways that both parties to the interaction can be 'winners' is a more subtle skill, but one more likely to be employed.

Just as important is encouraging cooperative working and respect for others so pupils do not attempt to twist their classmates' arms in the direction of something they clearly do not want to do.

◆ **Whole school approach.** What happens in lessons is only a part of the pupil's total school experience. The other parts can sabotage progress towards healthy, autonomous decision-making. Drug education (like other aspects of health education) should be seen in the wider context of the school as a health promoting community, rather than as something which goes on only in lessons. Schools should be working towards "creating a climate of support, confidence and fulfilment in which drug misuse is unlikely to flourish".⁹

◆ **Involve the parents.** Parents/community workshops allow the exchange of information and ideas between parents, teachers and the local community. Parents should be made aware of the need to begin drug education at primary level and be given the opportunity to experience some of the activities that their children might do in school.

Often this does much to allay some of the concerns parents have about broaching drug issues with this age group. The parents' own drugtaking behaviour can have a major influence on their children's attitudes and behaviour, and this needs to be discussed.

WE LIVE IN a drug-orientated society. Perhaps on this basis alone we have a responsibility to educate our children to live in a world of drugs. Many children's first drug experiences occur while they are at primary school. To delay drug education until the secondary phase surely makes little sense. ■

CRACK IN LIVERPOOL

The first research on crack use in the UK reveals how the drug is used by Liverpool prostitutes.

Russell Newcombe and Lyn Matthews

IN LATE 1988 an outreach worker from Mersey Regional Health Authority's AIDS Prevention Unit reported that female prostitutes in Liverpool were starting to use crack, which was being sold near the area in which they operated. It was decided to survey these women about their crack use and its consequences.

Only prostitutes and drug users already in contact with the outreach worker were interviewed. Using a short questionnaire, the worker interviewed 26 people (22 female prostitutes plus four male drug users) between 23 June and 17 July 1989.

Twenty-three had tried crack. Nineteen were still using, aged on average 24 years. Although this sample was biased towards known users, the incidence of crack use among street prostitutes in Liverpool working the city's 'red light' area is estimated at 50 to 75 per cent.

Crack users were also heavily into heroin. Sixteen said they were using heroin daily and 15 were injecting on average 16 times a week each.

Clear split in use patterns

All but a few of the current crack users had been using for between 12 and 36 months. There were two clearly discernible groups:

— ten regular users had been using crack virtually every day over the last four weeks (including three males);

— nine 'occasional' users (all female) used it on between one and seven days in the last four weeks. Their main reasons for not using daily were 'being short of money' and 'not feeling like it'.

On average, occasional users had been using crack for about 18 months compared with 45 months for regular users.

The seven regular crack-using prostitutes reported selling vaginal sex an average of 18 times per week during the last month, compared with 15 times among the eight occasional users. Only one of the crack using prostitutes reported doing business without a condom (the outreach worker provides them free).

Regular users reported taking crack on average 11 times a day, compared with (on the days they used the drug) about five times a day among occasional users. Daily users reported spending on average £118 a day on crack (about four rocks), compared with £40 a day (slightly more than one rock) among occasional users. Their main methods of financing crack use were

reported to be prostitution (14 respondents) and shoplifting (three respondents).

Taken together, the spending and use per day figures confirm that crack users break the 'rocks' into two to five 'one-hit' pieces, and suggest daily users use bigger doses.

Reported problems

Sixteen of the 19 crack users thought that it was either very easy or quite easy to give up using crack; none indicated it was very difficult. Only one felt addicted and two said they did not know if they were — all daily crack users. Just three wanted to give up crack.

When asked if using crack had caused any problems, just over half said no. Six regular users and three occasional users did report crack-related problems, mainly lack of money (seven), not eating properly (six), trouble sleeping (five), upsetting family (five), depression (five), and damaged lungs (four).

Only two referred to increased violence, stealing more, having sex without a condom for more money, or feeling bad when crack cannot be obtained.

The main effect of crack use on other forms of

drugtaking was reported to be a reduction in the use of heroin by six users, of whom five are daily users. Three people said using crack had led them to increase their other drug use.

Asked if there was anything that they thought was worth knowing about crack, five out of the 14 users who answered indicated general approval: "Don't knock it till you try it"; "Good buzz"; "Lovely feeling"; and "I like it!". Two each mentioned that it was expensive, bad for people, addictive. As one 28-year-old man who used crack daily put it: "If you're around people who use crack you want it, if not, you don't — you can stop using crack with no bad results at all".

A different picture of crack

This article reports the interim findings of research which has so far focused on a small number of crack users of a particular social background, so any conclusions can only be tentative and preliminary. But there is a clear disparity between the picture of crack use painted by the media and public officials and the picture provided by the findings of this study.

◆ Rather than being a new phenomenon, cocaine has been smoked in Liverpool for over a decade, with crack use dating back to at least 1986, though there is little evidence of crack use among youth groups other than opiate users and drug injectors.

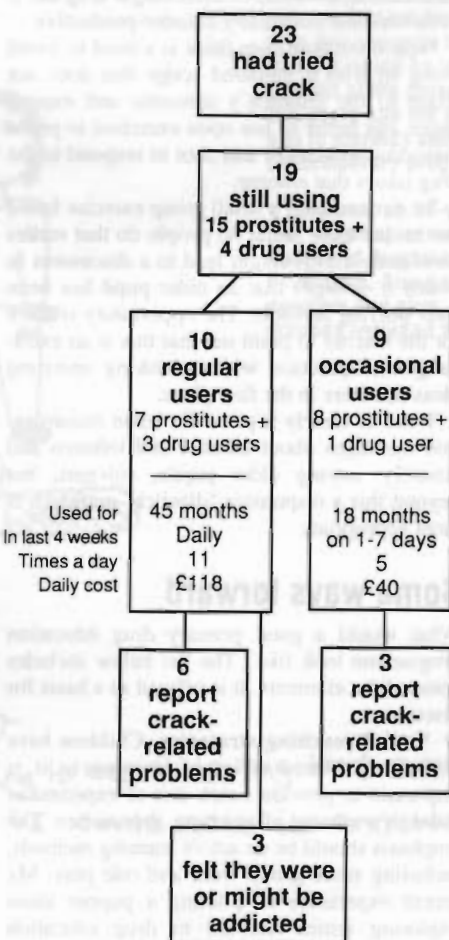
◆ In this polydrug using group crack use spread rapidly to the point where more than half are now thought to be using it and half these use it every day an average of over ten times a day. Even in this group being without crack was not a disaster — they just switched back to heroin or to other drugs instead.

◆ However, half the sample had been using crack occasionally for an average of 18 months, with many periods of abstinence — which conflicts with the theory of inevitable instant addiction. A clear majority thought it was easy to stop using and only one admitted to feeling "addicted". Most wanted to continue because of the pleasurable effects.

◆ Less than half said they had crack-related problems and only a few mentioned violence or craving/withdrawals.

◆ A third said crack use had reduced their use of heroin. Combined with other findings, this implies that money problems forced them to reduce the amount of heroin they buy and/or that the rush from crack has reduced their need for the rush from injecting.¹ The HIV implications of these changes suggest the effects of crack use on injecting (and sexual) behaviour should be a major focus of future research. ■

1. Alternatively, or additionally, "cocaine reduces the severity of opioid withdrawal and may be one reason for cocaine abuse by opioid addicts" — T. Kosten *et al*, "Cocaine abuse and opioid withdrawal", *Lancet*, 15 July 1989.



Russell Newcombe is a researcher at the Drugs and HIV Monitoring Unit of Mersey Regional Health Authority. Lyn Matthews is the outreach worker with the authority's AIDS Prevention Unit who conducted the interviews on which this report is based.

DRUGS AND DRUG USING: A GUIDE FOR AIDS WORKERS. ISDD, 1988. 38 pages. £1.75.

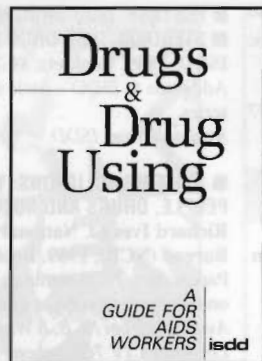
This booklet is for people working in the AIDS field with little experience of working with drug users. Its aim is to familiarise them with what drug using is about, and to indicate some of the issues to consider in caring for drug users. The booklet is readable and refreshingly jargon-free. Informative quotations throughout the text elucidate certain points, and it is obviously well-researched with frequent references to current findings on HIV and drug use.

The opening overview of drugtaking usefully approaches it from general principles rather than focusing on heroin, summarising what's known about the effects of drugs on the immune system.

Also mentioned is the influence of drugs on sexual behaviour, a subject worthy of more detailed consideration since most health education campaigns focus on HIV transmission via shared syringes. This is especially significant in the light of research finding unexpectedly high levels of sexual activity among opiate users.

ISDD's booklet tells us that around a third of drug users seen will be sexually active women, so it would have been useful to include guidance on contraceptive advice and on pregnancy and HIV — an area where it is difficult to obtain consistent information.

The chapter headed "Understanding Drug Use" gives an excellent explanation of the dependency cycle and makes the point that experimental drug users are at high risk of HIV



As HIV infected drug users swell their caseloads, more AIDS workers will need to know at least part of what drug misuse is all about.

transmission due to the likelihood of their sharing syringes. Useful here would have been some advice on how to elicit information on recreational drug use from the so-called 'non-drug' using clients AIDS workers may routinely encounter.

Next is an introduction to harm reduction in theory and in practice, which goes on to discuss some of the problems that emerge when caring for drug users in the clinical setting. Here some elaboration was needed. What, for instance, are "sensible controls" in the prescribing of drugs and what "guidelines to the limits of behaviour" are appropriate for inpatient care? Many AIDS workers spend a lot of time trying to sort out just these issues (and others like pain control), so concrete examples of solutions to these 'management' problems would have been helpful.

AIDS workers may also encounter difficulties in delivering services to drug users. Unreli-

able attendance for appointments is an accepted occupational hazard for drug workers, but can be frustrating for AIDS workers in settings unable to accommodate this behaviour.

The booklet's overview of drug services states that few drug dependency units have organised programmes for drug users with AIDS, but in my experience these units were amongst the first to provide such services. Also omitted is the information that prescribing agencies should be able to give advice about mood-altering drugs the client may be using and about appropriate prescribing and dosage levels, a useful service in inpatient settings. Referral procedures could also have been explained. My fear is that this section might leave the reader more confused about a field bewildering enough to those already in it!

At the end is a brief but useful resources section listing relevant national organisations followed by reference to some good basic texts. The fold-out summary of drug effects is a nice idea for quick reference but an index to the booklet as a whole would have been an advantage.

Drugs and Drug Using achieves its aim as an introductory text and highlights areas where management problems may be encountered. It could have given more guidance, since that was its stated aim. However, as the first of its kind, it is a commendable effort and will be a useful introduction for AIDS workers, who will encounter drug users with increasing frequency.

Geraldine Mulleady

Senior Clinical Psychologist, St. Mary's Hospital Drug Dependency Unit, London.

LETTERS

Will voluntary sector campaign for medical services?

Dear Editor,

Your report on how drug dependence units have responded to HIV (*Druglink* May/June 1989, p.5) poses a major challenge not just for the statutory medical sector, but also for the voluntary sector.

Over the last ten years there has been a broad consensus across services that the non-medical, community-based facilities have needed expansion. With the advent of HIV, circumstances have changed, and we must change with them, even though for many it may go against the grain. There are widespread complaints about the insufficient availability of medical care — especially care which incorporates longer term prescribing. Will the non-statutory sector be willing to push for improvements and expansion of medical care?

Non-statutory workers may complain that too little new money has been allocated to them — but it is large compared with the paltry sums for the expansion of the medical and prescribing capacity of clinics that might deal with more complicated prescribing and more difficult individuals.

The *AIDS and Drug Misuse* reports from the Advisory Council on the Misuse of Drugs and a subsequent letter from the Department of Health all drew

attention to the need to expand the range and capacity of secondary level services such as clinics and hospital facilities.

In the health service the final decisions on allocation of money or services are made at a local level. At this local level, there has been a greater readiness to fund high profile, innovative approaches rather than something as basic as expanding the number of treatment slots in a drug clinic.

Over the years, the voluntary sector has become articulate and effective at arguing for expansions in a range of previously neglected services. The voluntary sector should now put pressure on health authorities to improve the physical care services and expand the prescribing capacity of hospital-based services which have traditionally been outside their main area of interest.

As drug dependence unit doctors, we are increasingly being forced to choose between working primarily with long-term entrenched drug users, who might be seen as 'therapeutic black holes', or with more recent and possibly less entrenched drug users who present with simpler needs.

We find it unacceptable to be forced to make such choices. The solution is not to abandon either group, but to expand the capacity as well as the range of prescribing and broader health care services.

Will non-statutory and non-medical workers be able and willing to put aside their prejudices about the old-fashioned

medical model and lobby for the expansion of medical care as an essential component of tomorrow's drug services?

John Strang, Michael Farrell, Malcolm Battersby

Drug Dependence Clinical Research and Treatment Unit, Maudsley Hospital, London.

SCODA is lobbying on the NHS

Dear Editor,

Mike Blank's article "Working for Drug Users?" (*Druglink* vol.4, issue 4) raised some important points.

The article suggested that SCODA and the Advisory Council on the Misuse of Drugs (ACMD) should lobby to ensure that drugs are in the core NHS services.

SCODA's concerns have been voiced in the *SCODA Newsletter*, and the review was also a central issue at our last annual general meeting.

Our concerns have been sent to the Department of Health, the Parliamentary All Party Group on Drug Misuse and to the ACMD. The ACMD have expressed their concerns and its members intend to approach ministers on the issues. SCODA has also been working with other consumer and patient groups to ensure that common concerns are raised.

Rosemary Morle

Policy Officer, Standing Conference on Drug Abuse.

Outreach argument 'pointless'

Dear Editor,

With regard to Les Kay versus the outreach workers (see letters in *Druglink* vol.4, issues 3 and 4), it's this sort of pointless internal arguing which gets drug work a bad name.

Outreach work may bring the customers in as may cash incentives — surely any scheme which attracts users in to services is worth trying in these grim days?

So please get on with these schemes, evaluate them, tell the rest of us about them if they work, and free up the columns of *Druglink* for constructive discussion.

Mike Blank

Llanelli Drugs Project.

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Letters should normally be less than 500 words in length and may be abridged at the editor's discretion. Letters criticising previous articles may be sent to the original author so they can reply in the same issue of *Druglink*.

PUBLICATIONS

Treating addiction

■ RELAPSE AND ADDICTIVE

BEHAVIOUR. Michael Gossop *ed.* Routledge, 1989. 305 pages. Book. £29.95.

Papers on psychological approaches to preventing relapse to addiction to drugs, alcohol, tobacco, eating disorders, injecting, etc.

Available through bookshops.

■ **TIME TO STOP.** Margaret O'Rourke. 1989. 44 pages. Booklet. £1.

Handy step by step guide to quitting drug use.

Available from *Self Help Booklet (Drugs)*, Psychology Department, Graylingwell Hospital, Chichester PO19 4PQ, phone 0243 787970.

■ **SHARING.** The Dysfunctional Families Recovery Trust. Quarterly newsletter, first issue September 1989. £5 p.a.

From a new organisation providing publications and courses on co-dependency and addiction-affected families.

Available from *Recovery Tools Ltd.*, 31 Craven Street, London WC2 5NP, phone 01-839 8868.

Health promotion

■ **DRUGS IDENTIFICATION GUIDE.** Metropolitan Police Crime Prevention Service. 1988.

Fun way for the public to spot drug-takers. Turn the wheel for effects and other signs of taking different drugs. Apply to Metropolitan Police Crime Prevention Service, New Scotland Yard, London SW1, phone 01-230 1212.

■ **SMACK IN THE EYE. ISSUE 3.** North West Regional Drug Training Unit, 1989. Comic. £1.

Innovative vehicle for harm reduction advice for drug users. Available from *NWRDTU*, Kenyon Ward, Prestwich Hospital, Bury New Road, Manchester M25 7BL, phone 061 798 0919.

■ **CANNABIS.** Drug Advice and Information Service. Brighton: DAIS, 1989. Leaflet. Single copies free in return for s.a.e.; 100 copies £1.20.

The risks of cannabis use written for young people and their parents. Available from *DAIS*, 38 West Street, Brighton BN1 2RE, phone 0273 21000.

■ **AIDS, DRUGS, SEX AND YOU!** Sussex AIDS Centre and Helpline and the Drug Advice and Information Service Brighton Health Authority. 1989. 7 pages. Leaflet.

Cartoon-style guide to AIDS and HIV with injecting and safer sex information. Available from *DAIS*, 38 West Street, Brighton BN1 2RE, phone 0273 21000.

■ **FESTIVALS: SAFER DRUG USE — A USER'S GUIDE.** Festival Welfare Services. London: FWS, 1989. Leaflet. £0.20.

General health advice and guidance on safer drug use for people attending music festivals.

Available from *Festival Welfare Services*, 61B Hornsey Road, London N7 6DG, phone 01-700 5754.

Medical practice

■ **MARIJUANA.** Mark S. Gold. London and New York: Plenum Press, 1989. xv, 259 pages. Book. £28.

Basic information on cannabis for clinicians.

Available through bookshops.

■ **DRUGS, DRINKING AND ADOLESCENTS.** 2nd edition. Donald I. Macdonald. Chicago, London, etc: Year Book Medical Publishers, 1989. 248 pages. Book. £14.50.

Guidance for medical practitioners from the doctor credited with originating the USA's 'zero tolerance' policies.

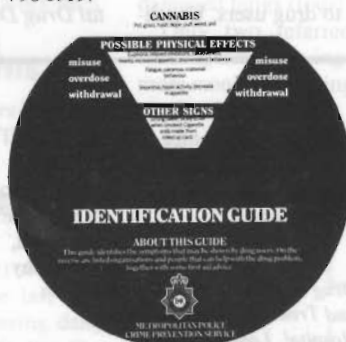
Available through bookshops.

Training

■ **MULTIDISCIPLINARY DRUG TRAINING PACK.** Brian Pearson. North West Regional Drug Training Unit, 1989. £26.

For trainers running drugs courses.

Available from *NWRDTU*, Kenyon Ward, Prestwich Hospital, Bury New Road, Manchester M25 7BL, phone 061 798 0919.



■ **GUIDELINES FOR THE MANAGEMENT OF SUBSTANCE-RELATED PROBLEMS AND INCIDENTS IN THE SECONDARY SCHOOL.** Lancashire County Council, 1989. Ring-bound folder.

Useful guidance, not on drug education, but on dealing with drug use in school. Enquiries to Chief Education Officer, PO Box 61, County Hall, Preston PR1 8RJ, phone 0772 54868.

Other

■ **THE INTERNATIONAL JOURNAL ON DRUG POLICY.** Bimonthly journal, first issue July/August 1989. £33 p.a. or £63 for institutions.

Replaces the *Mersey Drugs Journal*. Well-produced forum for debate on the reform of drug law and the liberalisation of drug policy.

Available from the *International Journal on Drug Policy*, 10 Maryland Street, Liverpool L1 9BX.

■ **CRACK.** Harry Shapiro. ISDD, 1989. Leaflet. £1.

Fully referenced review of the literature and what's known about crack use in Britain.

Available from *ISDD*.

■ **ECSTASY. ISDD DRUG NOTES 8.**

■ **STEROIDS. ISDD DRUG NOTES 9.**

ISDD, 1989. Booklets. £0.75.

Additions to ISDD's basic drug facts series.

Available from *ISDD*.

■ **SNIFFING SOLUTIONS: YOUNG PEOPLE, DRUGS AND SOLVENTS.**

Richard Ives *ed.* National Children's Bureau (NCB), 1989. Book. £7.

Papers from NCB seminars held in 1986 on responses to solvent misuse.

Available from *NCB*, 8 Wakley Street, London EC1V 7QE, phone 01-278 9441.

■ **FOUL PLAY: DRUG ABUSE IN SPORTS.** Tom Donohoe and Neil Johnson. Oxford: Blackwell, 1988. x, 200 pages. Book. £6.95.

Updated edition covering the extent of drug use in sport and the drugs used.

Available through bookshops.

TRAINING

■ **HIV COUNSELLING.** 27-29 September 1989, Leeds.

■ **HEALTHCARE AND SAFE INJECTING.** 4-6 October 1989, Blackburn.

■ **REGIONAL SEMINAR: WOMEN AND DRUG SERVICES.** October 1989, Manchester.

■ **REGIONAL SEMINAR: OUTREACH WORK AND BEYOND.** 20 November 1989, Manchester.

■ **DRUG USERS AND HIV.** 27-29 November 1989 and 24-26 January 1990, Leeds.

North West Regional Drug Training Unit.

Details from *NWRDTU*, Kenyon Ward, Prestwich Hospital, Bury New Road, Manchester M25 7BL.

■ **DRUGS AND ALCOHOL IN THE WORKPLACE.** Dates in October 1989 in Edinburgh, Manchester and London.

■ **DRUG USERS IN PRISON.** Dates in November 1989 in Edinburgh, Manchester, Dublin, Bristol and London. Network ADA.

Two series of seminars featuring US speakers. Details and fees from *Network ADA*, Freepost, Bury, Lancs. BL9 5YZ, phone 070682 8963.

■ **BENZODIAZEPINE WITHDRAWAL WORKSHOPS.** Withdraw Workshops. 2-3 October, Exeter; 9-10 November, Cardiff; 1989.

Based on the approach to withdrawal from tranquillisers/sleeping pills developed by the *WITHDRAW* Project. Details from *Withdraw Workshops*, 515A Bristol Road, Birmingham B29 6AU, phone 021 471 3626.

■ **ONE YEAR CERTIFICATE COURSE IN ADDICTIVE BEHAVIOUR FOR GPs.** Department of Addictive Behaviour,

St. George's Hospital Medical School, London. 3 October 1989-12 June 1990.

One afternoon per week course. Priority to GPs in SW Thames RHA.

Details from *David Monk*, Dept. of Addictive Behaviour, St George's Hospital, Clare House, Blackshaw Road, London SW17 0QT, phone 01-672 9944.

■ **NATIONAL SEMINAR ON DRUGS, HIV & AIDS TRAINING.**

Health Education Authority and the Drug Training Unit of the London Boroughs Training Committee. 6 December 1989, London.

Details from *Drug Training Unit*, LBTC, 9 Tavistock Place, London WC1, phone 01-388 2041.

MEETINGS

■ **ADFAM AGM AND CONFERENCE.**

23 September 1989, London. £7.50. Subjects include family education and support, relapse prevention and alternative family support.

Details from *ADFAM National*, 82 Old Brompton Road, London SW7 3LQ, phone 01-823 9313.

■ **DRUG TRAINERS FORUM AGM AND CONFERENCE.** 12-13 October 1989, York.

Conference theme is drug training in the 1990s in the light of forthcoming ACMD report.

Details from *Pat O'Hare*, phone 051 709 3511.

■ **DRUG ISSUES AND THE LOCAL CHURCH.** UK Band of Hope. 19 October 1989, Dartford, Kent. £10/£12.

Conference for clergy and youth and community workers. Details from *Joan Ryan*, UK Band of Hope, phone 01-222 6809.

■ **ANNUAL SYMPOSIUM ON DRUGS, ALCOHOL AND CRIME.** Society for the Study of Addiction. 16-17 November 1989, Leicester. Free to members of the society.

Details from *Mrs N. Rooney*, Department of Addictive Behaviour, St George's Hospital, Blackshaw Road, London SW17 0QT.

ORGANISATIONS

■ **DYSFUNCTIONAL FAMILIES RECOVERY TRUST.** Recovery Tools Ltd.

Charity and business concerned with co-dependency and addiction-affected families. Newsletter, publications, courses.

Contact *Recovery Tools Ltd*, 31 Craven Street, London WC2 5NP, phone 01-839 8868.

FOR MORE INFORMATION ...

- ☎ ON THE PUBLICATIONS LISTED HERE: phone ISDD on 01-430 1993.
- ☎ ON MORE NEW PUBLICATIONS AND ARTICLES: order *Drug Abstracts Monthly* — £16 p.a. from ISDD, phone 01-430 1961.
- ☎ ON A PARTICULAR TOPIC: phone ISDD's library on 01-430 1993.
- ☎ ON TRAINING: phone Breda Flaherty, Training Officer at the Standing Conference on Drug Abuse (SCODA), on 01-831 3595.

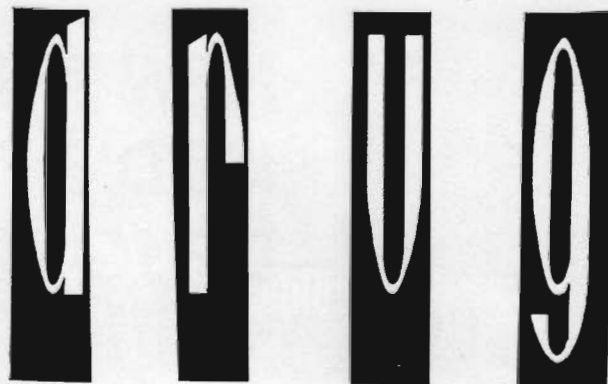
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FRED DICKENSON

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FRED DICKENSON
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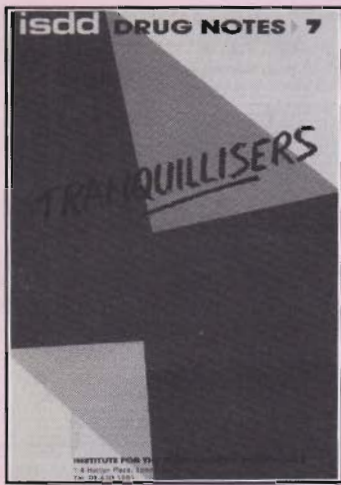
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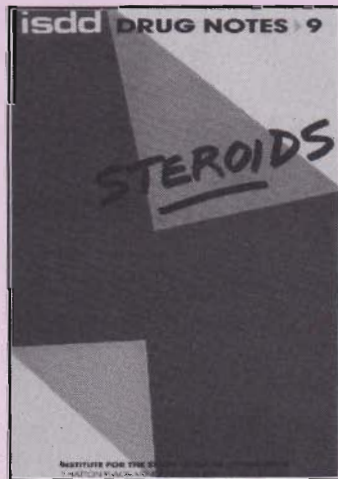
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