DRUG link PHOTOCOPIABLE FACTSHEET

INFORMATION FOR DRUG WORKERS FROM ISDD

15 THE CRACK USING CLIENT

This factsheet is an introductory distillation of the experience of some of the agencies at the forefront of dealing with crack using clients. Some such clients will already be known to you as opiate addicts prescribed methadone. Savings on street heroin mean more 'disposable' income for 'treats' such as crack. Less likely to be existing clients will be polydrug users for whom crack has emerged as a problem and primary crack users. A few will use daily, but most 'binge' their crack in say a 48-hour bender ending in a three-day crash.

How different are they to deal with?

Drug workers have the skills to deal with crack users, especially if they are existing clients. But they do have some different needs.

• During the post-binge 'crash' clients may be very anxious, and desperate for respite from crack 'hunger' and the crack using environment. This is when they are most likely to come for help and they will be in a bad way, possibly suicidal.

• They are likely to want help immediately and often outside normal office hours. Given the expense of a crack habit, delay could have significant financial implications for the client.

• As many women as men use crack, so child care problems may be common and acute. Pregnant users may fear giving birth to a 'crack baby' and the response from social services. Partners of crack using men may be victims of domestic violence and/or forced onto the streets to earn money for crack.

• Crack use generates a degree of violence not seen with heroin and other street drugs. This is partly due to the paranoia-inducing properties of the drug and its very short duration of action, aggravated by its expense: regular use entails regularly finding substantial amounts of money.

What are the problems for workers?

• Lack of trust can be a particular problem with crack users – especially in white agencies dealing with a black client who may have been in trouble with the police or quizzed by social services. Subject them to a barrage of questioning and you risk being seen as another 'arm of the state'. You can help by delaying questions until the client is more at ease and assured about confidentiality. Stimulant users in general have much less idea what drug agencies are about than do opiate clients.

• Many cocaine and crack users come to agencies under pressure from partners and families because of domestic violence and financial problems. Resentful clients may vent their anger on the worker but are probably also very anxious for help and unlikely to turn nasty. Crack users who have come under their own steam, and especially those steeped in the more macho male cultures, may put on a show of arrogance to cover their shame at having to admit their drug use has got out of control.

• Because crack users typically want everything sorted at once it may be difficult for the worker to prioritise – and the client is unlikely to give them much guidance on what to tackle first.

• Dropout rates are high partly because agencies are seen as catering for 'dirty junkies' and as having little to offer to make it worth waiting for an appointment in three weeks' time or suffering other agency routines. Making that first contact could be as 'motivated' as they get. Agencies targeting crack users might have to do more 'running after' clients than they are used to.

• Harm minimisation options seem limited. Cocaine is rarely prescribed, needle exchange is irrelevant to smokers, and self-control strategies may be unrealistic. Much advice is abstinence-oriented. But at least one group of crack users believes there is scope for harm reduction advice such as not to buy in bulk (you *won't* save some for tomorrow), not to use heroin or tranquillisers to ease the come down (by the time tranquillisers take effect the worst will be over anyway), rest between pipes, etc.[1]

What can agencies do to help crack users?

• See crack users as quickly as possible. A service for crack users may benefit from a 'duty worker' on call for such clients. Crack users may judge the speed of your service against that of their dealer who is just a phone call away and soon round on their doorstep with the goods.

• There is no recognised drug substitute for cocaine as there is for heroin. Doctors can offer either antidepressants such as Prozac or tranquillisers or betablockers. These can help with the anxiety following crack use but will not of themselves prevent relapse.

• Many clients feel acupuncture is an attractive and effective way to alleviate drug craving. One worker offers acupuncture as soon as the client arrives to calm them down enough to talk to them.

• Advice/counselling dealing with practical issues like pending court cases, bad debts or lack of a stable environment are like to be better received than psychiatric explorations.

• Many crack users, particularly women selling sex, want to escape from their crack using environments. This may be for respite while still taking the drug or (increasingly) for rehabilitation. If children are involved, the logistics of arranging this are likely to be even harder than usual. Fast-track entry into rehab for stimulant users is much needed. Day care programmes for crack users are starting to offer respite from the streets with the opportunity for workers to tackle problems such as housing and court cases.

• Some crack users will never come to services, so an outreach service would pay dividends and help establish confidence that the service is there to meet client needs. Some workers believe outreach is vital to services aiming to reach crack users.

1. *Rocksteady's rock survival guide*. Manchester: Peer Intervention Project for Education and Research, 1995. *Available from Trafford CDT, Chapel Road, Sale, Trafford M33 1FD, phone 0161 962 8810.*

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