

ON THE ROCKS

A Follow-up Study of Crack Users in London

Alex Harocopos

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**Report of an independent
study funded by the
Community Fund and the
National Treatment Agency
for Substance Misuse**

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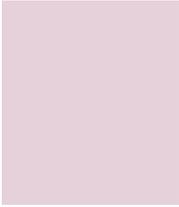
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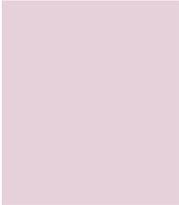
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SUMMARY

This report is based on the first cohort study that has looked specifically at service use amongst crack cocaine users in the UK. The aim of the study was to improve our understanding of chaotic drug use and to identify effective forms of intervention. A cohort of 100 crack users was recruited from City Roads Crisis Intervention Centre and interviewed six times over an 18-month period. Respondents were heavily entrenched drug users. Their levels of use, treatment contact and crime were high and they should not be taken as representative of all crack-using populations.

FINDINGS

- All respondents used crack. However, the majority were polydrug users. In the month before first interview, 63 respondents had used heroin and 42 were using every day.
- Respondents from black and ethnic minority groups were significantly less likely to use heroin than those who described themselves as white. They were also less likely to inject.
- On the days that respondents used crack, their average (median) spend was £100 (range £10 to £800).
- At intake, most (91) respondents reported funding their use through crime.
- Levels of drug use showed a steep decline between intake and subsequent interviews with the exception of cannabis. Average weekly spend on all drugs fell from £800 prior to first interview to £80 at 18-month follow-up.
- The majority of those who had relapsed prior to first follow-up did so within three days of leaving City Roads.
- Respondents who returned to using crack were more likely to have used heroin in the month before first interview.
- Women were more likely to return to using crack than men.
- Those respondents who completed residential treatment were significantly more likely to reduce or abstain from use of selected drugs (crack, cocaine, opiates, benzodiazepines and amphetamine) than those who did not.

- Attending a self-help group was also a significant factor in predicting changes in drug-using behaviour.
- Those respondents who were abstinent from drugs were significantly less likely to offend.
- Despite high levels of service contact most respondents did not feel that services were offering adequate assistance for their crack use.

CONCLUSIONS AND RECOMMENDATIONS

It is clear that established treatment services can play an important role in changing the drug-using behaviour of this group. Existing services are often poorly developed to respond to the needs of crack users. The development of mechanisms which aim to maintain engagement with treatment and encourage completion of programmes is likely to improve treatment outcomes.

- Crisis intervention plays an important role in allowing people to evaluate their situation and make the first move towards changing their drug-using behaviour.
- Respondents in our study were unhappy with the level of specialist knowledge within the services they accessed. In-depth training should be provided to those working with crack users.
- Dual heroin and crack users rarely discussed their crack use with staff and often felt that interventions focused on their heroin use even if this was not their primary concern. Thorough assessments should be undertaken by agencies to identify clients' drug use.
- Community services are often based around the provision of injecting equipment and opiate substitute prescription. Black and minority ethnic respondents were less likely to use heroin or inject. Community services need to develop new interventions to encourage this group to access services.
- Relapse prevention should be tailored to an individual's experience rather than taking a standardised approach.
- It is important to try to match up individuals' requirements with appropriate residential rehabilitation centres.
- Residential treatment services should develop appropriate mechanisms to meet the needs of black and minority ethnic clients.

- Providing a seamless service for treatment is likely to go some way towards reducing the probability of early relapse.
- There was a lack of aftercare facilities for those who had left treatment. There is a need for better links between residential rehabilitation and supported housing agencies, as well as improved access to places within a supported housing environment. Local Authorities need to be more receptive to transfer requests from those who have completed treatment.
- Support groups are needed for those who return to the community. Narcotic Anonymous will not be suitable for a proportion of drug users who do not wish to remain abstinent from all drugs or alcohol. At present there are few alternatives to this option. It is important to develop groups based on different models of support.

INTRODUCTION

The evidence base in the UK for guiding work with crack users is limited and we do not know the best methods of intervention. There is very little information about patterns of relapse and strategies for minimising the risk of relapse. However, we do know that sustained use of crack can lead to serious health and social problems and can result in harms to the wider community.

City Roads is a crisis intervention centre in London offering 24-hour support to drug users in crisis. In 1994, they were awarded a grant by the Department of Health to encourage crack cocaine users – especially those from ethnic minority groups – into services. As a result of this, they were able to add two crack-specific workers to the assessment team and to make two bed spaces available solely for crack cocaine users. In addition, a telephone line was set up offering assessments and referrals specifically to crack users. This initiative ran between June 1994 and March 1997 during which time approximately 1,000 calls were taken on the crack line as a result of which 248 people were admitted to City Roads (Webster, 1999).

As a crisis intervention centre, City Roads represents only the starting point for people addressing their drug problems. Many clients are referred on to other services such as residential rehabilitation centres and structured day programmes. Whilst there is a well-developed knowledge base about ‘what works’ for clients whose primary problem is that of opiate dependency, there is little information about the outcomes of crack-using clients.

To help fill this knowledge gap, City Roads and the Criminal Policy Research Unit (CPRU) asked the Community Fund to support a follow-up study. The aim of the study was to improve our understanding of chaotic crack use and to identify effective forms of intervention. More specifically we wanted to provide a detailed description of the drug careers of a cohort of crack users and to track their drug use over time. In addition we wanted to identify ‘what worked’ in terms of treatment and other assistance received, especially from the perspective of the service user.

LITERATURE REVIEW

In this section we consider the main issues arising from a brief review of literature on crack use, problems associated with use and treatment. Most of the literature on crack originates in the US and few studies of treatment have been undertaken within the UK.

Problem crack use

Whilst we have not seen crack problems of the severity which damaged American inner cities in the 1980s, there has been a steady increase in crack use, moving from the south to the north of England. The Regional Drugs Misuse Database (RDMD) for the north west of England showed a nine-fold increase in cocaine use since 1990, with over half using it in the form of crack (Sievwright *et al.*, 2000). Studies of drug markets have also found that crack is well established and often competes on equal terms with heroin (Bottomley *et al.*, 1997; Lupton *et al.*, 2002). The average price of crack has fallen during this period from £70 to £20 for 0.2 grams (Corkery, 2000).

Some UK studies suggest that crack and cocaine-using populations are more heterogeneous than other drug using groups. Bottomley and colleagues found there was no typical crack user. For example some users have an extensive history of drug use while for others it is the first drug they try (Bottomley *et al.*, 1995). Increasingly crack is used in combination with other drugs. Rather than describing this as polydrug use, Parker and Bottomley (1996) have coined the term 'rock repertoire'. The intensity of the high from crack is commonly followed by extreme levels of anxiety and depression along with cravings. To counter such feelings of the 'come-down' other drugs including heroin, methadone, alcohol, benzodiazepines and cannabis are taken.

Heavy crack use can lead to a considerable deterioration in physical health. The most common physical conditions associated with its use include weight loss, fatigue, susceptibility to infection, damage to the respiratory system, poor and irregular sleeping patterns, muscular aches and pains and headaches. With more extreme use, increased heart rate and blood pressure amplifies the risk of seizures, strokes, and heart and respiratory attacks.

Mental health problems are more commonly reported than physical problems among crack users. Symptoms can range from mild depression and anxiety to extreme cases of cocaine psychoses, similar to schizophrenia (Withers *et al.*, 1995). In a study of City Roads' clients Webster found that 30 per cent (72) of crack users had reported attending a mental health service in the past, 65 per cent (151) reported having suicidal thoughts with 37 per cent having previously attempted suicide (Webster, 1999).

In the US there was a particular concern that the rise in crack use was linked to the spread of HIV, in that those dependent on crack exchange sex for money to purchase the drug (Hoffman *et al.*, 1994). A study of female sex workers in London found that the majority of women were already engaged in sex work prior to using crack, but there were higher levels of drug injection, termination of pregnancy, hepatitis C and sexually transmitted diseases compared to non-crack using sex workers (Green *et al.*, 1999).

Treatment services and their effectiveness¹

Treatment for crack use is provided in a variety of settings with the main forms of intervention including residential rehabilitation, counselling, pharmacological treatment, psychiatric and psychological treatments and complementary therapies. One of the difficulties in ascertaining what actually constitutes successful treatment for crack users is that strategies often recommended by clinicians derive largely from studies of opiate dependent populations. A consistent finding in the UK and US literature is that current treatment options for crack users are patterned after alcohol and opiate problem use and applied to crack and other stimulants without adaptation. A lack of outcome evaluation research, both in the UK and US, has limited our understanding of what works best with crack users.

Evidence of the effectiveness of interventions with crack users is drawn largely from two studies, the Drug Abuse Treatment Outcome Studies (DATOS) from the US and the National Treatment Outcome Research Study (NTORS) based in England. Overall DATOS observed that the proportion of clients using crack fell from 67 per cent before treatment, to 29 per cent in the year after treatment ended (Simpson *et al.*, 1999). In England NTORS found that four to five years after entering treatment less than half of those using crack at intake were still doing so (Gossop *et al.*, 2002). Both studies followed up clients who had been through existing treatment modalities. There is little conclusive evidence pointing to the superiority of any one treatment modality (Donmall *et al.*, 1995; Sievewright, 2000).

An aspect of treatment which appears to be particularly important to cocaine and crack users is the client-counsellor relationship. Good relationships seem to improve motivation, engagement and treatment outcome. Witton and Ashton state:

‘US research has shown that counsellors who quickly establish a relationship within which the client feels they are being listened to, understood and being given helpful, positive responses have clients who stay longer and attend more often, improving outcomes.’

(Witton and Ashton, 2002).

There is some evidence that the setting in which treatment is provided may have a differential impact on treatment outcome. DATOS found that cocaine-dependent clients who had multiple and severe problems and low levels of social support achieved greater improvements having participated in residential therapeutic communities. Cocaine users not involved in crime, not dependent on a range of substances who had high levels of social support fared better in non-residential services. While some studies point to the lack of difference in effectiveness between community and residential settings for crack dependents it seems likely that those with high levels of psychiatric and emotional problems or with low levels of social support will tend to benefit more from residential care.

¹ This section draws extensively on a *Drug Services Briefing* produced by the National Treatment Agency on treating cocaine and crack dependence.

Evidence is growing that psychosocial therapeutic approaches are effective, particularly when they are activity-based, focusing on altering drug using behaviour. Witton and Ashton (2002) have identified promising approaches including those which incorporate teaching and practising relapse prevention strategies, rewarding recovery-promoting activities, engineering the client's social environment to make it more supportive of abstinence, and 12-step based therapies intended to promote attendance at 12-step mutual aid groups.

Currently there is no strong evidence to support the general use of pharmacotherapies as a way to ease withdrawal, reduce craving or promote abstinence even though a wide range of medications have been tried. For many cocaine users alcohol appears to be a way of coping with cocaine's downside or enhancing its effects (Witton and Ashton, 2002).

There are few studies of the efficacy of complementary therapies and their application to problem crack use. Although many drug services in England provide complementary therapies, particularly to crack users, the limited evidence available to date indicates that such interventions are useful in bringing in and retaining clients although they have little impact on treatment outcome.

Despite positive findings indicating that established approaches to treatment have some efficacy with crack users the literature indicates there are problems of engaging and retaining this group. UK research suggests that crack users are unwilling to contact existing treatment services because they see them as being primarily for heroin users and that the treatment on offer is not appropriate to their needs (Bottomley *et al.*, 1997; Donmall *et al.*, 1995; Sievwright, 2000). Therefore it appears that for many crack users only situations of urgency or crisis are a prerequisite to help-seeking. US studies have found that once crack users request help, services can dramatically improve their engagement and retention rates. Influencing factors included the timing of first appointments, and staff knowledge about crack use and the needs of users.

CHAPTER 2

METHODS AND PROFILE OF RESPONDENTS

This study followed up 100 crack users over an 18-month period. Respondents were recruited from City Roads Crisis Intervention Centre between January 2000 and March 2001. Potential participants were identified from information collected at initial assessment. Those who defined themselves as primary crack users and those who had used crack for more than 20 days in the preceding month were approached by the research team for interview. The longitudinal nature of the study was made explicit from the outset and respondents were asked to sign a consent form agreeing to six interviews over an 18-month period.

Face-to-face, semi-structured interviews were conducted with the 100 respondents during their stay at City Roads². Interview schedules included questions on health, drug use, criminal activity and treatment exposure. Participants were then followed up at periods of:

- one month
- four months
- eight months
- 13 months and
- 18 months after discharge from City Roads.

Interviews were conducted as near to these time points as possible. Again, respondents were asked about health, drug use, offending and treatment. We decided that the first follow-up interviews should take place soon after recruitment to collect information on the crucial period immediately after leaving treatment when individuals often experience rapid improvements or decline in their drug-use, and to cement the relationship between the respondent and researcher.

Given the chaotic lives of our cohort, there was a strong possibility that contact details would change and that if the time lapse between interviews was long, rates of attrition would be high. During the initial interview, we asked respondents to fill in a contact sheet including the address and/or telephone number of at least one person they were likely to keep in touch with. Information was also collected on previous service contact and current court orders. Contact information was recorded on an Access database which incorporated a 'tracking diary', used to note down details of all communication with respondents. Attempts to contact respondents were made one to two weeks before a follow-up interview was due. Usually the first approach was by letter to their last known address, or the address of their nominee. If no contact was made, we would then try other

² Details of the consent form and survey instrument are available on request.

avenues such as drug treatment services, probation, the prisoner location service – a central office through which prisoners can be tracked in England and Wales – care managers and social workers. Table 2:1 shows the number of successful follow-ups conducted in each wave of interviews. ‘Returns’ are those who had missed an interview but were then re-contacted at the next interview point.

TABLE 2:1

Number of interviews conducted at each time point

Baseline	100
One month after discharge	94
Four months after discharge	88 (3 returns)
Eight months after discharge	82 (4 returns)
Thirteen months after discharge	85 (5 returns)
Eighteen months after discharge	78 (1 return)

In the event that we were unable to track individuals at a particular time point, they would not be discounted from the next wave of interviews and several respondents rejoined the study having missed their previous interview. Only three respondents did not complete any follow-up interviews. In some cases, we were able to ascertain the reason for attrition. These included: relapse; relocating abroad (one respondent was also imprisoned whilst abroad); and death. To our knowledge, two respondents died during the course of the study.

Analysis

Interviews have yielded both qualitative and quantitative data. Where possible we have used statistical tests to identify any differences between groups, but it should be recognised that numbers are insufficient to allow more complex multivariate analysis.

PROFILE OF RESPONDENTS AT FIRST INTERVIEW

Table 2:2 provides a profile of respondents. This cohort is typical in age of those attending drug treatment services. What is unusual is the number of women (40%) and percentage of respondents from black and minority ethnic groups (47%). Traditionally drug services have been seen to attract white, male opiate users. The fact that City Roads draws many of its clients from diverse ethnic backgrounds is probably due in part to the Department of Health initiative referred to in the introduction.

As with many drug-using populations, housing among our cohort was often a problem. At the time of interview just under half were either

TABLE 2:2

Profile of respondents (n=100)

Average age	31 years (range 17 to 55)
Male	60
White	53
Black	36
Mixed race	9
Asian	2

homeless (18), living in temporary housing (7) or staying with family or friends (24). Of the remainder, 48 were in rented accommodation, two were living in squats and one owned his own home.

The average age at which respondents left school was 15. The majority (61) had some form of educational and/or practical qualifications and over half (57) had been in paid employment within the last year. All were registered as unemployed at the time of first interview as this is a stipulation for admission to City Roads. The average length of time that respondents had been registered as unemployed was three years.

Just over two-thirds (67) were single. Of those who were in a relationship (33), ten had a partner who was using crack problematically. Many respondents had children (65), however, only 12 still had their children living with them. Despite this, comparatively few were in the care of the social services (only nine stated their children were looked after by social services with seven on the 'at risk' register). Of the 85 respondents we asked, 26 had themselves spent time in local authority care as children.

Most (94) of our cohort had previously had some involvement with the criminal justice system. At the time of first interview, 22 had an outstanding court case, almost a third of which were for acquisitive crime. Ten respondents had outstanding warrants for offences including shoplifting (4), fraud, forgery and deception (FFD) (3), non-payment of fines (2) and possession (1). Twenty-nine were currently on a court order, 15 of whom were on probation.

At the time of first interview, respondents tended to associate with other drug users and over two-thirds (69) said that the majority of their friends had a problem with either drugs or alcohol. Drug use was also common in family life. Forty-six per cent reported that at least one other member of their family had experienced some form of problematic drug or alcohol use and just under a quarter (23) stated that members of their immediate family were also using or had used crack.

Despite associating with other drug users, most respondents seemed to have some level of support from their family. Of the 94 respondents who

were interviewed at one-month follow-up, 80 had told their family they had sought treatment at City Roads and most (78) felt that they had received encouragement. Several respondents believed that the level of support they received from their family increased as levels of motivation to reduce their drug use were maintained.

‘I don’t think they had much faith in me, but they’re encouraging now.’
(Female, 35)

‘They are very supportive. The longer I stay in treatment, the more supportive they are. Things aren’t going to be rosy overnight.’ (Male, 35)

Attitudes towards telling friends about their intention to seek treatment varied and often depended on whether they were also using drugs.

‘They’re all users. The closer I was to completing City Roads, the less they phoned, but it’s made it easier now.’ (Male, 27)

‘I let certain people know I was in City Roads, but at the end of the day, using friends don’t always want to see you clean.’ (Male, 30)

‘Didn’t want them to know. Was in a bit of bother and one word in the wrong ear...’ (Male, 31)

We asked 88 respondents how many crack users they knew in their area. The average stated was 30. Our cohort tended to think that the number of people using crack had risen sharply in recent years and that heroin and crack use were becoming heavily intertwined. They believed that crack use affected people of all ages and ethnic groups, but that generally the average age of users was getting younger. The percentage of people who were using crack and in touch with treatment services was reported as low.

‘I think it’s gone up in the last three years and it’s not only in the black world or the poor man’s class. It’s a serious thing. It’s a mental thing.’
(Male, 37)

‘There seems to be a trend of people spinning over from heroin to crack. I’ve even known people to detox off heroin by using crack. No one buys one without the other – they even sell it like that, in a packet with both together.’
(Male, 32)

It should be remembered that this is a unique cohort recruited from a crisis intervention centre. Because of this they are likely to belong to a heavily entrenched group of drug users. Levels of use, treatment exposure and crime are likely to be high and should not be taken as indicative across all crack-using populations.

DRUG USE

On average, respondents had tried their first drug at 14, and for most this was cannabis. First crack use came an average of eight years later at the age of 22, though for some (3), crack was the first illicit drug they had used. In one case, there was a 26-year gap between first drug use and trying crack. In addition to crack, respondents had used a wide repertoire of drugs including cocaine powder (88%), ecstasy (80%), heroin (76%) and amphetamine (69%). We asked respondents if they felt they had a problem with any substances prior to using crack. Almost half (49) believed they had. For most this was heroin (26) either on its own or in combination with another drug. Nine had previously experienced problems with cocaine. Over half (53) had injected at some time in their lives and 43 had injected in the past year. Of the 53 who had injected, 28 reported that they had previously shared injecting equipment.

Just under half (42%) were introduced to crack whilst in a social situation – usually through a friend, or by a member of their family (7%).

‘My mate who had been using for a while said “have a go”. It was in a social setting, friends were piping. I didn’t think it would affect me.’

(Male, 32)

A fifth (21%) of those we interviewed said that they started using crack because it became readily available to them, often through their existing dealer or by learning how to ‘wash-up’³ cocaine powder into crack.

‘Where I was buying my heroin, the dealers were injecting crack. I never knew about crack. Had tried cocaine though. I just tried it and kept on using it from there.’

(Male, 33)

‘Was selling coke and buying in amounts. Someone told me how to wash it up to test for quality and I started smoking it.’

(Male, 34)

Other reasons for starting to use crack included peer pressure or the desire to feel socially accepted (11%) and self-medication to relieve stress (9%).

Respondents saw their crack use as a problem on average 2.5 years after first use. Just under half (44%) cited psychological factors including changes in behaviour, for example becoming moody and irritable, and the desire to use increasingly more often. Many spoke of feelings of intense cravings:

‘Anything you want to use again straight away is a problem. It’s the craving. I tried it [crack] at 20 years old and that was it. I felt like I could go and conquer the world. It was euphoric.’

(Male, 32)

³ The process by which cocaine hydrochloride is converted into crack cocaine.

‘It’s the moreishness. I couldn’t put it down and leave it. I always wanted more. The last three months I’d say are the heaviest I’ve ever smoked in my life.’ (Female, 31)

Others stated that it was financial factors (35%) that made them acknowledge their use as a problem. In some cases respondents had sold many of their personal possessions and those belonging to their family or partner, and the desire to obtain crack often overrode the necessity of either paying their bills or buying food. Often, acknowledging their crack use was a problem was a gradual process.

‘I didn’t class it as a problem for a long time because I was still working. Then I noticed that people who didn’t use didn’t want to know me anymore and people who did use only wanted to know me when I had crack.’ (Male, 38)

DRUG USE AT FIRST INTERVIEW

In the month before respondents were admitted to City Roads, 72 were using crack on a daily basis. The majority of the cohort were polydrug users. The average number of drugs used per respondent in the month before first interview was 2.4. Sixty-three respondents had used heroin and 42 were using every day. There were notable differences in the incidence of heroin use between members of ethnic groups. Almost three-quarters (74%) of those who said they were white had used heroin and most (90%) were using every day. In contrast, 51% of those who described themselves as black, mixed race or Asian had used heroin and of these, only 44% used daily. There were no discernible differences in heroin use between genders. Figure 3:1 shows the range of drugs ever used by respondents and those used in the 30 days before first interview.

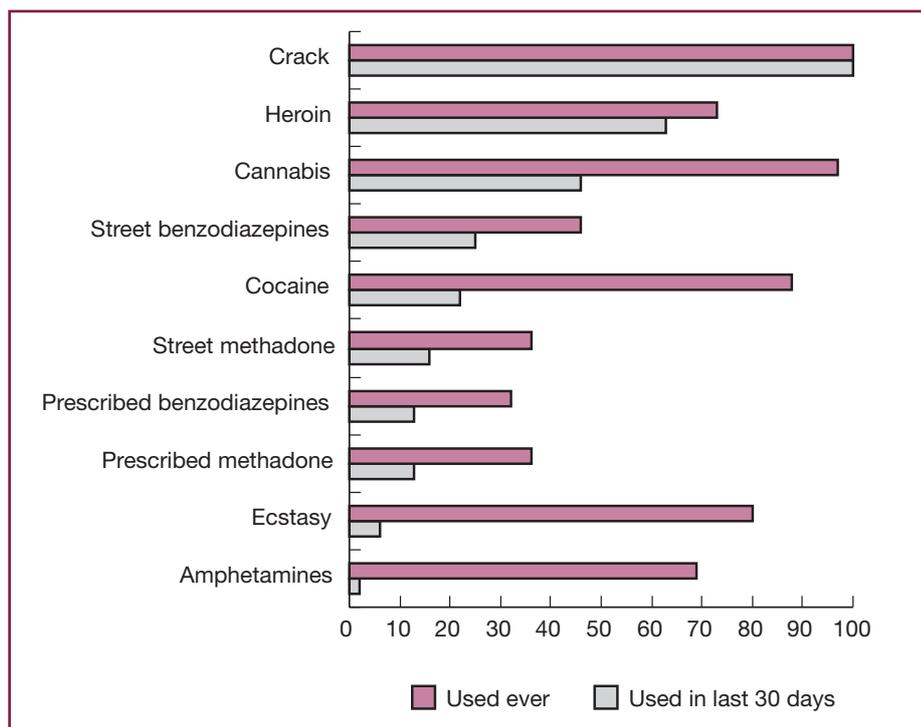
The main route of administration for crack was smoking (89), usually in a pipe. However, 31 respondents reported injecting at least one drug in the month before interview. Most (29) were injecting heroin and 11 of these also injected crack. Speedballing⁴ was common amongst this group. The remaining two were injecting cocaine hydrochloride. Those who were injecting heroin still often favoured smoking as the main route of administration for their crack use. Again, there was a statistically significant difference between routes of administration amongst ethnic groups with 27 of the 31 injectors describing their ethnic origin as white ($p < .01$).

‘At the moment, everybody I know is speedballing. It’s come about in the last one or two years. It’s a more addictive combination than [heroin] on its own because after a while, heroin only stabilises you, but you always get a rush with speedballing.’ (Male, 36)

⁴ Using crack and heroin together – a term that originally referred to combined heroin and amphetamine use.

FIGURE 3:1

Drug use, ever and in the 30 days preceding first interview



Just over a third (35%) stated that they preferred to use crack with other people, either because they considered it to be a social activity, or as a deterrent to the feelings of paranoia they experienced when they used by themselves:

'I've been going out to crack houses and encouraging people to come back to mine just so I'm around people. When I use on my own, I've been getting psychosis. It's driving me mad.' (Male, 42)

A further third (34%) usually used alone, and a tenth with their partner (8%). This was often for economic reasons, or in contrast to those above, because their paranoia seemed to be heightened when they used crack with other people.

'I'm a loner. I don't like sharing my drugs. I have to go out and earn my money and when I go to crack houses people say give us a bit, so I don't use with others.' (Male, 30)

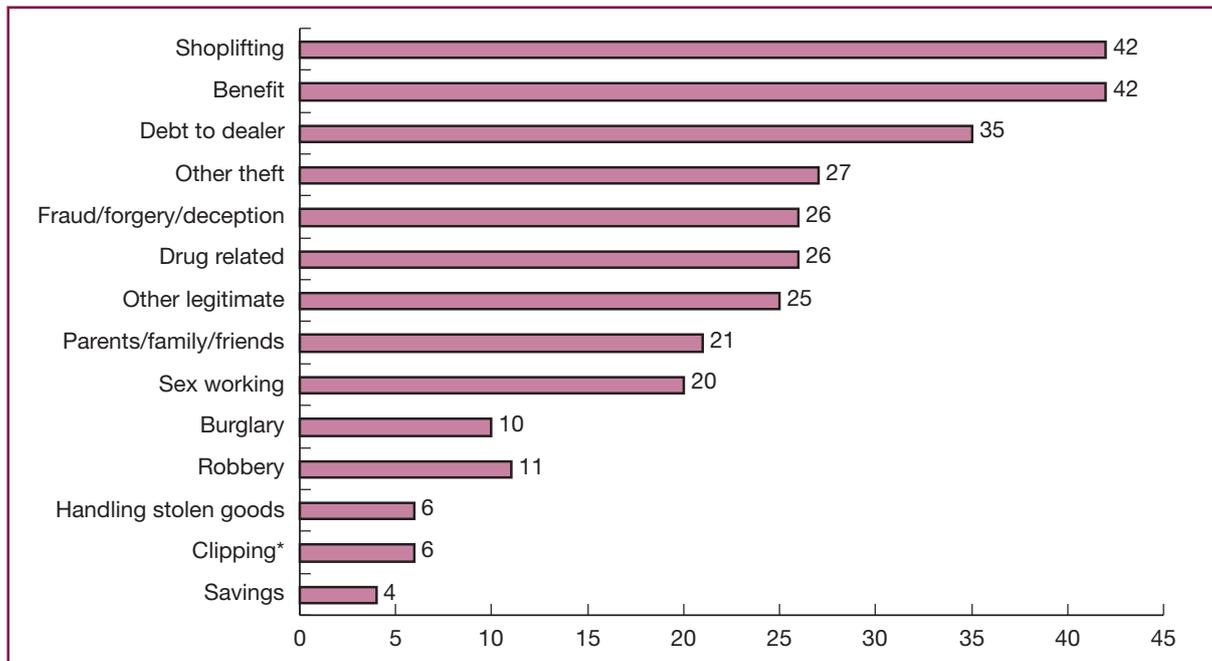
At the time of first interview, many of our cohort were in a poor psychological state. The majority (91) stated they suffered from depression and 84 from paranoia. Most had feelings of anxiety, low self-esteem and almost a fifth (19) stated that they had heard voices and experienced hallucinations. High levels of psychiatric morbidity were also demonstrated in results from the General Health Questionnaire (GHQ) (Goldberg, 1972). This is a scale of 12 questions focusing on general levels of happiness, depression and

anxiety. A score of 4 is used to identify people with a possible psychiatric disorder. At intake, over three-quarters (77) of our cohort had a score of 4 or higher with an average of 7.35. This is higher than in previous studies of drug-using populations. McSweeney (2003) found that in a cohort of 132 drug-using offenders the average GHQ score was 3.92 with only 44% scoring 4 or higher.

On the days that respondents used, their average (median) spend on crack was £100 (range from £10 to £800). It is difficult to estimate the amount of crack respondents consumed in weight. However, for the 44 cases where data are available, the average amount consumed on a using day was 1.8 grams. The average (median) weekly spend on all drugs was £800, although 22 respondents reported spending £1,500 or more. Those who had used heroin in the month before interview tended to have a lower average weekly spend on crack than those who did not (£740 compared to £1,140). Most (91) reported funding their use through crime. Figure 3:2 illustrates the different ways respondents were funding their drug use.

Just over a quarter (26) were involved in drug-related activities including dealing, ‘washing up’ cocaine hydrochloride (powder) into crack cocaine and acting as a ‘doorman’ in a crack house. Thirty-five respondents stated that they were in debt to a dealer and, of these, 30 had at some time been either intimidated or threatened as a result of being in debt. Of the 40 women we interviewed, half were sex working. Legitimate means of raising money included paid work (13), selling possessions (6) and gambling (2).

FIGURE 3:2 Ways of funding drug use



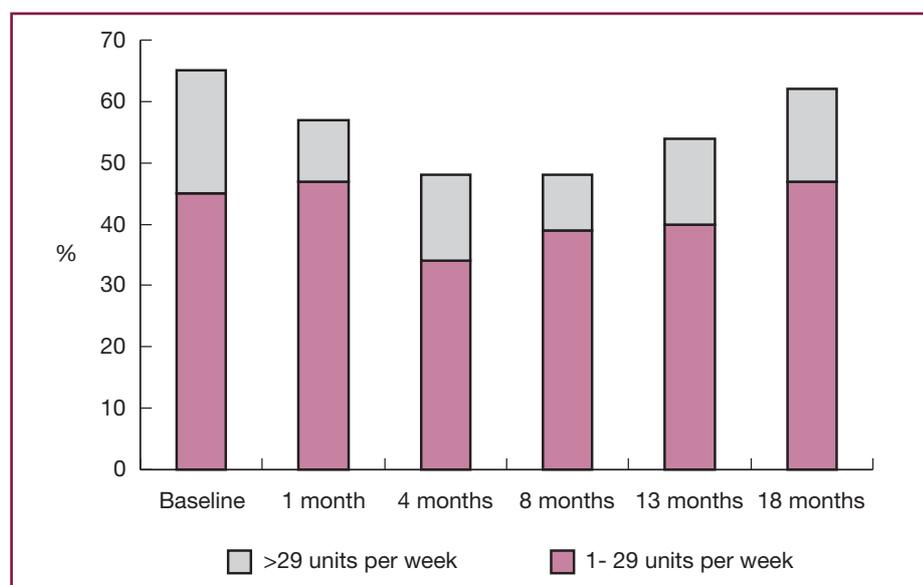
* Clipping is a form of deception in sex work where money is taken without delivery of the promised service.

Alcohol use

At baseline 66 respondents consumed an average of 42 units of alcohol each per week. Of these, 25% were drinking very heavily (more than 60 units per week). Black respondents reported high levels of use with an average weekly consumption of 53 units (range: 1-245) compared to 34 (1-280) for white and 27 (1-84) for mixed race respondents. Those respondents who were using heroin on a regular basis (>10 days in the month before first interview) had lower levels of alcohol use than those who used heroin less frequently or not at all (an average of 31 units compared to 49). Depressive drugs play an important role in managing crack use. We have noted previously that most regular heroin users are white, and for some respondents (particularly black users), alcohol may perform a similar function to heroin. Figure 3:3 shows levels of alcohol use in the month before follow-up interviews.

FIGURE 3:3

Levels of alcohol use in the month before follow-up interviews



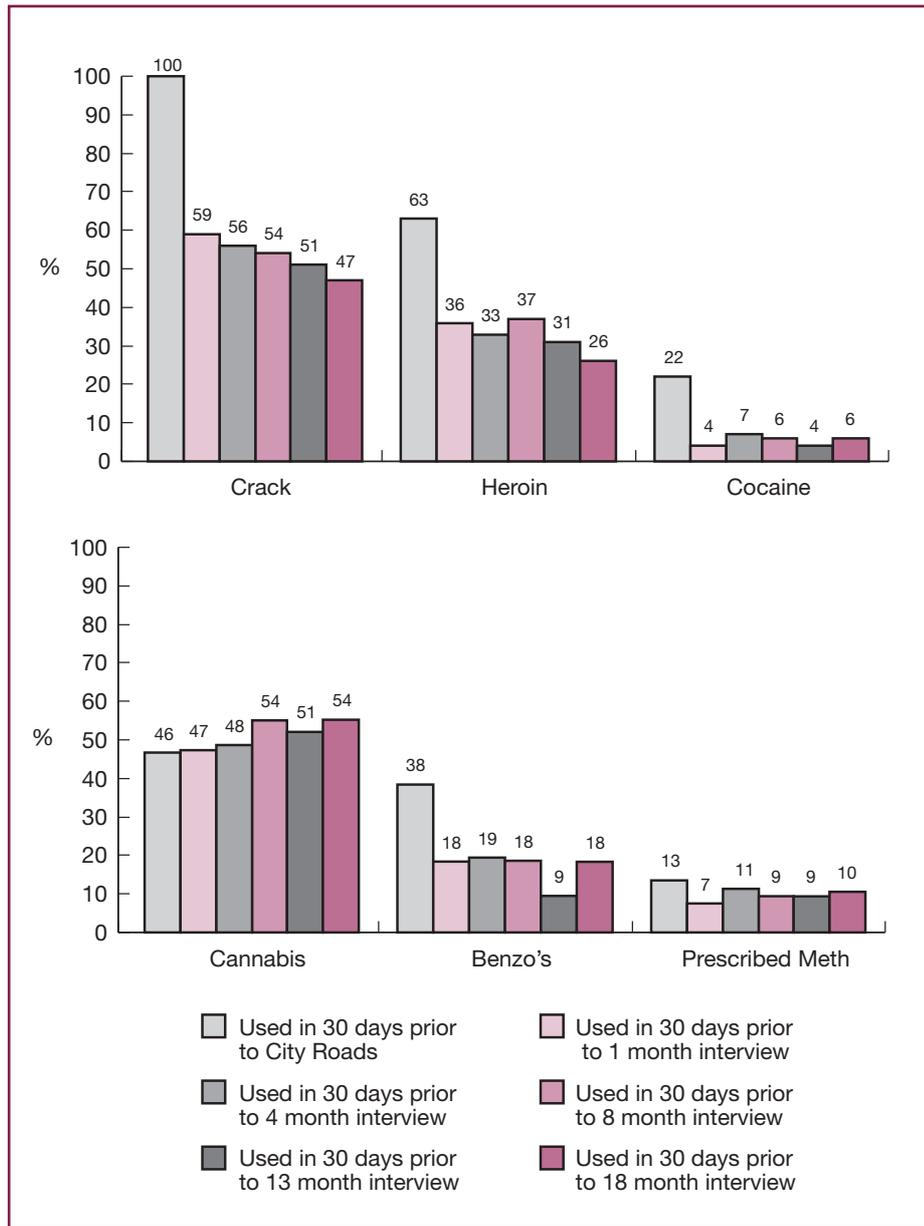
PATTERNS OF DRUG USE OVER TIME

Respondents were interviewed at one month, four months, eight months, 13 months and 18 months after discharge from City Roads. At each time point, detailed information was recorded about their drug use in the preceding 30 days. Figure 3:4 shows the prevalence of use of selected drugs amongst our cohort in the month before each interview.

Levels of reported drug use showed a steep decline between intake and second interview, with the exception of cannabis. It is possible that cannabis may be used by some respondents to help ease crack withdrawals.

FIGURE 3:4

Percentage of respondents using selected drugs in the 30 days before interview



Labigalini and colleagues found that 68% of their sample of crack users reported that smoking cannabis had reduced their cravings (Labigalini, *et al.*, 1999). In subsequent follow-up interviews, levels of use remained fairly stable although there was a further reduction in the number of respondents using crack and heroin between months 13 and 18. Table 3:1 describes patterns of drug use over time. For the purposes of this analysis,

TABLE 3:1

Patterns of drug use over time

	Baseline	1 month	4 months	8 months	13 months	18 months
Selected drugs (including crack)						
Number using selected drugs	100	60	53	52	53	45
Number of users injecting in the month before interview	31	22	13	16	11	5
Median spend on all drugs per week*	£800	£145	£125	£95	£75	£80
Crack						
Number using crack	100	55	49	44	45	37
Median amount of crack used per week (value)**	£576	£121	£117	£117	£82	£140
Average number of days used crack in last month	27	14	15	15	15	10
* Several respondents had used but not purchased drugs.						
** As some respondents reported not paying for crack, we have included an estimate of the 'value' of drugs used.						

we have only included those respondents who were using crack, cocaine, heroin, other opiates, benzodiazepines or amphetamines.

The average (median) weekly spend on all drugs for those using in the month before interview fell from £800 prior to admittance to City Roads to £145 at one-month follow-up. By month 18, this had fallen to £80 (range £5 to £1,500). In latter months, the average (median) weekly spend on all drugs tended to be lower than the average weekly spend on crack as those using crack usually spent much more than those who did not. For example, five of the seven respondents who had used one or more of the selected drugs but had not used crack in the month prior to final interview had an average spend of only £22 per week. The average number of drugs used by each respondent remained stable throughout the follow-up period (1.7 to 1.9). Of the respondents who were using at each time point, around half had used both crack and heroin in the month before interview.

ABSTINENCE AND RELAPSE

At the time of first interview, most respondents (91) had previously had periods of abstinence from crack, whether enforced or voluntary. Crack is not physically addictive in the way that we understand heroin addiction (Gray, 2003). However, people can develop a strong psychological dependency, and the desire to use may be triggered by cues such as people or places. Respondents reported that they found it easier not to use when they were away from familiar situations. Almost two-thirds (60) of those who had managed to stop using crack had done so because they were either in treatment, away from the area in which they lived, or in prison.

'I stopped using crack once, for two weeks when I went back to Africa for my dad's burial – I didn't even think about it when I was away.'

(Male, 38)

'I gave up for 12 months when I went into prison and again for ten months after rehab and being in halfway house.'

(Male, 31)

We asked respondents to identify some of the triggers that caused them to relapse. The two most important factors were people associated with drug use (45) and negative emotional states (53). Other cues included having money (25), seeing drug-using paraphernalia⁵ (14), places (14) and alcohol (8).

'I was in treatment for a year, but as soon as I came out, I started using again. I knew what I was doing – going back to my girlfriend who was drinking and using, but I wanted to be a part of it. I didn't want to be left out.'

(Male, 31)

'I consciously gave up for two weeks. It was very difficult. I lasted two weeks, then met people in the park who said they had some wicked stuff. Caned [smoked] a quarter [of an ounce] in three hours.'

(Male, 18)

'[Triggers to use are] feeling sorry for myself – black parts of my life in front of me – depression.'

(Male, 30)

We have seen in preceding chapters that respondents had been using crack for long periods and at high levels. Crisis intervention is a treatment model that identifies a crisis as a time-limited opportunity for change. It seemed likely that, having reached the point of crisis and contacted City Roads, residents would have a desire to make changes to their drug use.

To test this we employed a 12-item validated 'readiness to change' questionnaire which assesses motivation to change ranging from precontemplation

through contemplation to action (Rollnick *et al.*, 1992). Most of our cohort were in the action phase (68), agreeing with statements such as ‘Anyone can talk about wanting to do something about their drug use, but I’m actually doing something about it.’ The remaining third (32) were in the contemplation stage and agreed with statements such as ‘Sometimes I think I should cut down on my drug use.’

Respondents were asked what they felt would help them remain drug-free. The most commonly cited responses were going to a residential rehabilitation centre (34), moving area (26), self-motivation (22), having a support network (18) and changing current social networks (17).

ABSTINENCE AND RELAPSE RATES AFTER CITY ROADS

Gossop and colleagues (1989) found that a large proportion of people who have been treated for problematic substance use return to drug use shortly after leaving treatment. In view of this, we have paid particular attention to drug use in the period immediately after respondents had left City Roads.

Ninety-four respondents were interviewed about a month (average 34 days) after leaving City Roads. Of these, 55 had used crack. The average number of days before first use was seven (range 0–44). However, 20 respondents had used crack on the same day that they had been discharged. Thirty-four respondents had also used heroin in this period. The average number of days before first heroin use was five. Figure 4:1 shows the number of people who relapsed on heroin and/or crack prior to first follow-up interview.

The majority (61%) of those who used crack or heroin prior to the first follow-up interview did so within three days of leaving City Roads. Of the

FIGURE 4:1

Percentage of respondents relapsing on crack and heroin prior to first follow-up interview (n=94)

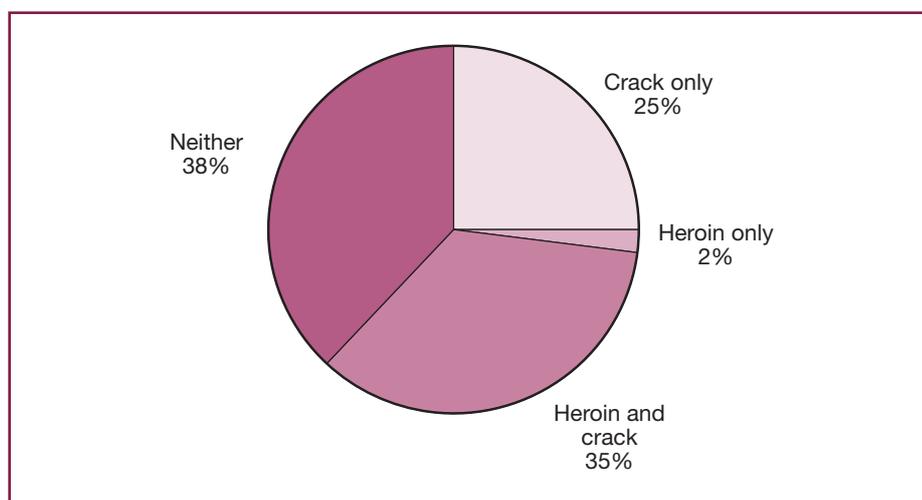
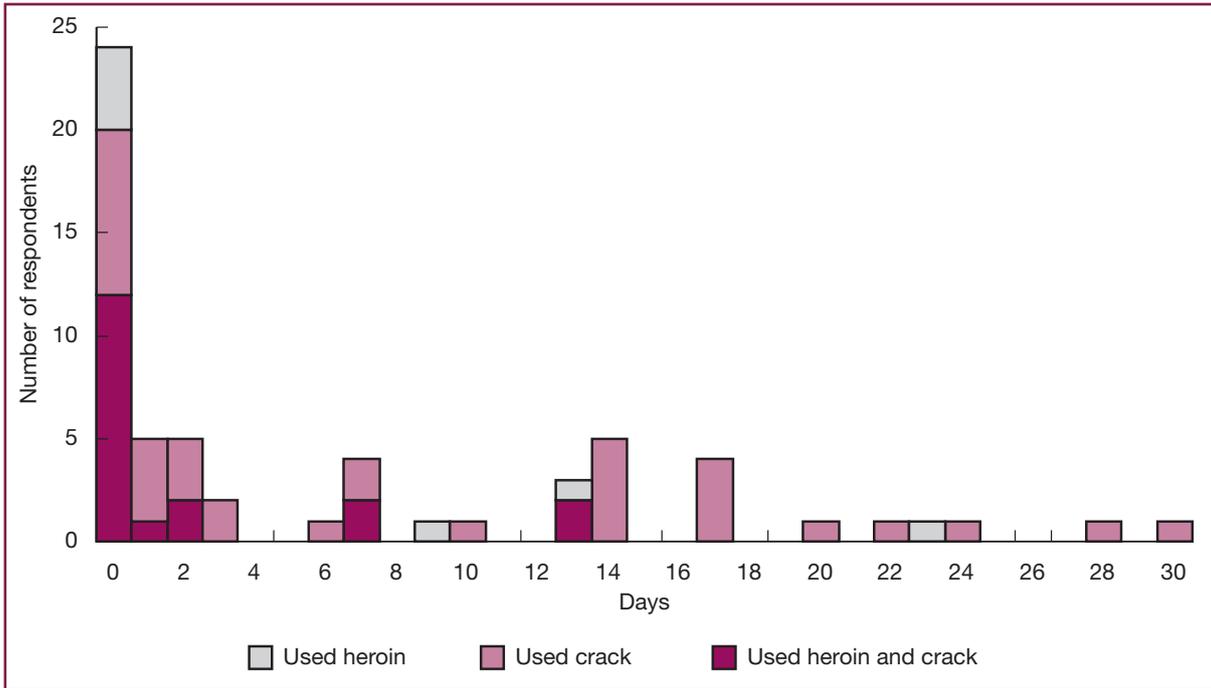


FIGURE 4.2

Time to relapse after leaving City Roads (crack or heroin only) in days



34 respondents who had used heroin prior to the first month follow-up interview, all but one had done so within the first 14 days. Figure 4:2 shows the number of days before first use of crack and heroin in the month after respondents had left City Roads.

There was little difference in rates of relapse between respondents who had used heroin in the month preceding baseline interview and those who had not. Fifty-nine respondents interviewed at first follow-up had used heroin at baseline. Of these, 64% had relapsed on either crack and/or heroin. This compared to 60% of those who had not used heroin during this period. Dual crack and heroin users were more likely to have used both drugs (28) or crack only (8) than heroin only (2). The two respondents who had relapsed on heroin but not crack reported that their choice of drug related to the circumstance they were in:

‘When I relapsed, I just used heroin. It [crack] wasn’t really available where I was.’ (Female, 18)

‘Heroin’s not really my drug, but it was there and it made me feel better.’ (Male, 31)

We asked respondents what they felt had triggered them to use. The single most important factor was experiencing feelings of cravings for crack and/or withdrawal from heroin (21). Two-thirds of those who had used immediately after leaving City Roads stated that they had left the service with the intention of using.

'I left City Roads to use. There was so much talk in there about using it just triggered me off, just general chit-chat around the house.'

(Male, 31)

The average length of stay at City Roads for those who had used crack or heroin was 13 days. This compared to 18 days for those who had remained abstinent from these drugs. Of the 35 respondents who had not used prior to first follow-up interview, 28 attended structured treatment programmes after leaving City Roads. We compared those who were using crack and/or heroin one month after leaving City Roads to those respondents who reported no use of these drugs. The two main factors which seemed to affect drug use were gender and contact with residential rehabilitation. While the second of these factors is unsurprising, gender seemed to have relationship with continuing use: women were more likely than men to be using at one month. Excluding those who attended residential treatment, there were 24 women at the one-month follow-up interview; all except one were using either heroin or crack. This compares to nine out of 35 men. We examined the data to see if women with drug-using partners were more likely to have used than those who were single or whose partner was drug-free. There was very little difference between the two groups. It is interesting to note that male respondents who had a drug-using partner at the time of interview were more likely to have used at first follow-up interview than women in the same situation. The effects of treatment on relapse rates will be explored more fully in the next chapter.

Patterns of drug use among our sample were fairly erratic, and respondents tended to dip in and out of using periods. In order to examine the influence of treatment and other factors on drug-using behaviour, we divided the cohort up into four categories according to their crack and cocaine use throughout the study. Cases were included if respondents had completed at least four out of five follow-up interviews including the final interview at 18 months (n=78).

- The *abstainer* group (n=5) were those who had not used crack or cocaine at any time during the follow-up period.
- The *lapse* group (n=22) comprised those who had used crack or cocaine after leaving City Roads but who had experienced a period of abstinence of at least six months and had, since then, not used on more than ten occasions.
- The *relapser* group (n=18) included respondents who had experienced periods of abstinence of at least three months but who then reverted to using crack or cocaine on a regular basis (i.e. more than ten times in a month).
- Finally, the *user* group (n=33) consisted of those who had used crack or cocaine during at least 12 of the 18 months of the study.

Abstainers

Very few respondents managed to abstain from crack during the life of the study. Of the five who did, three were male and two female, aged between 31 and 38 years. It is of note that all the members of this group were from black and minority ethnic backgrounds – four described themselves as black and one as Asian. Because of the low numbers of abstainers, it was not possible to do any meaningful analysis. However, there were no obvious commonalities within this group in terms of their drug history; age of first crack use ranged from 15 to 36 years and length of time for crack use to become problematic was between one and 15 years. In the month before admittance to City Roads, all were prolific crack users with a weekly spend of between £550 and £3,000. Respondents in this group remained abstinent from all drugs with the exception of alcohol and cannabis throughout the life of the study.

Lapsers, relapsers and users

Comparisons between the lapse, relapse and user groups are shown in Table 4:1. There were few distinctions between them in terms of age, length of crack-using career, or median weekly spend on crack. However, those who had used consistently throughout the life of the study were more likely to be female. Members of the user group had a higher incidence of heroin use at baseline than those in the lapse or relapse categories.

TABLE 4.1

Differences between lapsers, relapsers and user groups

	Lapsers (n=22)	Relapsers (n=18)	Users (n=33)
Male	78%	72%	48%
Average age	30 years	29 years	29 years
% from white ethnic background	64%	61%	49%
Average years since first drug use	16	15	15
Average years since first crack use	7	9	8
Weekly spend on crack at intake (median)	770	506	700
% injecting any drug	27%	33%	36%
Average number of drugs used at intake	3.4	3.2	3.4
% using heroin at intake	55%	61%	67%
% using cocaine at intake	36%	27%	21%

The majority (91) of our cohort had previously sought assistance for their drug use. The average age they first presented to a drug service was 26 – a year after they had identified their crack use as a problem and five years before their current admission to City Roads. Contact with services ranged from a couple of telephone calls to a drug helpline to multiple treatment episodes with both residential and community-based services. Despite the high levels of contact this cohort had with treatment services, respondents commented on the lack of information available to them about where to get help, and the difficulty they experienced in their attempts to access services as illustrated by the following case study.

Difficulties in accessing treatment

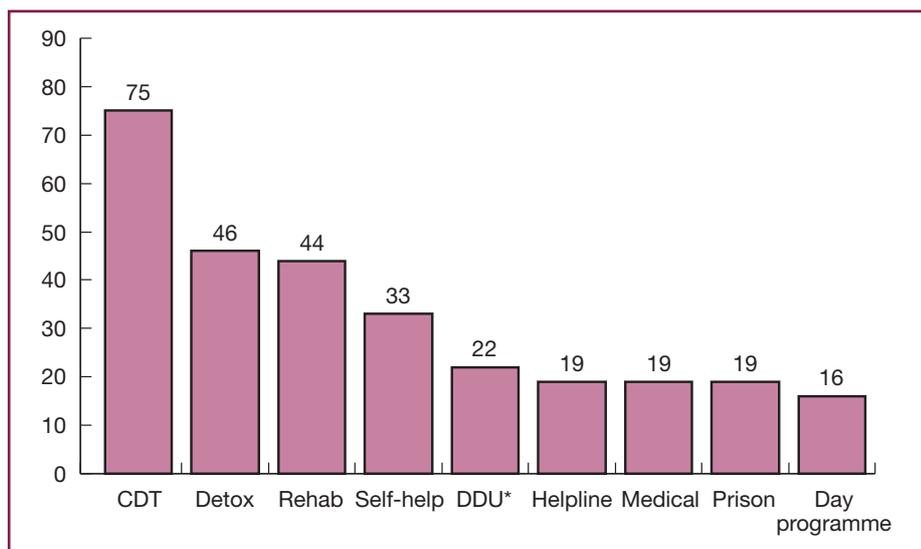
Jack from west London realised he needed help after he robbed and assaulted his sister. It was Friday when he rang the National Drugs Helpline, who advised him to go to the local statutory drug service assessment centre. He was pleased to have somewhere to go, but depressed about the fact that he had to wait until Monday for help. His depression got worse and, on Saturday, he attempted suicide by cutting his wrists. A friend found him and took him to an accident and emergency service. They patched him up and he waited six hours to see a psychiatrist who told him he was going through 'correct procedure' and should attend the assessment centre to which he had been advised to go on Monday. Jack's friend stayed with him over the weekend.

Jack attended the assessment centre on Monday where he was told they were short staffed and that he would have to come back the following day. Out of desperation, he asked another waiting drug user for advice – and was recommended to try City Roads. He called City Roads who suggested he go to a local drop-in centre. Jack described what happened at the drop-in centre; 'They just opened the door, invited me in, gave me detox tea and auricular acupuncture, sat me in a little dark room and gave me information and stuff to occupy myself. Before, I had nothing, but after I'd been to the drop-in, I felt things were positive. I felt they understood.' He used this service daily until he entered City Roads.

Figure 5:1 illustrates the types of service attended by respondents prior to first interview. The three main services accessed by our cohort were Community Drug Teams (CDTs), detoxification centres and residential treatment.

FIGURE 5:1

Type of services accessed by respondents prior to first interview



* Drug dependency unit

The total average amount of time respondents had been in contact with a CDT was about six months, although this ranged from one week to ten years⁶. Twenty-one respondents had, however, remained in contact for a month or less. Reasons for this included a lack of motivation to attend (3), onward referrals to other agencies (4), concern about confidentiality (1) and the perception that services were not providing adequate assistance (9), as illustrated by the following quotes.

‘It was pointless. I don’t think they understood where I was coming from. They gave me some leaflets, but I’m not good at reading and writing, so they went in the bin. I was too embarrassed to ask them to read them.’
(Male, 29)

‘I spoke to a worker and she asked me if I injected. I said no, and they said they couldn’t do anything for me. I said I’d come back in three weeks when I had started injecting, so they gave me the number for City Roads.’
(Female, 33)

Fifty-six respondents had attended high threshold services such as residential rehabilitation centres (RR), structured day programmes and in-patient detoxification centres and 41 had previously been admitted to City Roads. Those using heroin on a regular basis (ten days or more a month) were significantly more likely to have had contact with community-based services and detoxification centres ($p < .01$). Regular heroin users were also more likely to have gone to residential treatment (50% compared to 36%). Table 5:1 illustrates the number of episodes and average time spent in contact with high threshold interventions. It is clear from these data that, in the main, clients in this cohort are experienced service users.

TABLE 5:1 Treatment history for high threshold interventions

Type of Service	Number of respondents attending service	Total number of treatment episodes	Average number of episodes per respondent	Average length of stay per episode in weeks	Number of respondents completing treatment episode
Residential rehabilitation	44	85	1.9 (range 1 to 7)	10.6	20
Structured day programme	13	14	1	9.9	8
Detoxification centre/crisis intervention	46	104	2.3 (range 1 to 8)	1.4	29

We asked respondents what, to date, had been most helpful to them in their experiences of treatment. The main types of services cited were detoxification/crisis intervention centres (31), community-based services (24) and residential treatment (17). Factors which assisted respondents included: committed treatment agency staff, especially those who were seen as non-judgemental (21); counselling (15), support (10) and complementary therapies (8).

Prior to first interview, most of our sample (84) had received some type of complementary therapy for their drug use. The most common treatment was auricular acupuncture (72) followed by Shiatsu (46), visualisation (34), body acupuncture (25), relaxation (18) and reflexology (8). The majority (74) of those who had received one or more of these therapies reported that it had helped them, often citing feelings of relaxation and lower levels of anxiety.

CRISIS INTERVENTION

As previously stated, City Roads provides short-term residential crisis intervention to drug users who can no longer cope in the community. The service aims to work in a holistic way with the wide range of problems and needs presented by clients. Staff include a multi-disciplinary team of nurses, social care workers, complementary therapists, a doctor and a consultant psychiatrist who together provide help with medical, nursing, social, emotional, psychiatric, family, legal and financial issues. All clients, regardless of their drug of choice, receive a basic care package which is then tailored to meet individual needs. Those with an opiate dependency undergo a methadone detoxification programme and Promazine is prescribed as required to alleviate crack withdrawals⁷.

⁷ Promazine is an antipsychotic drug which can be used to alleviate anxiety. At City Roads, it is typically administered in 12.5mg doses a maximum of four times a day. A client would not usually be prescribed Promazine for more than two or three days.

Clients self-refer to City Roads and in some cases their referral is supported by a treatment agency. There were no discernible differences in types of referral (self or supported) between those who identified as primary crack users and those who did not. We asked respondents why they had accessed the service. For almost a quarter (19), the necessity of crisis intervention had been precipitated by a specific event which had caused them to re-evaluate their lifestyle, for example, fear for their personal safety, or having their children taken into care.

‘My mum kicked me out. I was dumped by my girlfriend and I owe a lot of money to a good friend of mine.’ (Female, 26)

‘Someone wanted to kill me. If I continue using drugs, I’ll end up with a bullet in my head.’ (Female, 30)

Other reasons for seeking assistance included concerns over health (12); encouragement from a friend or agency professional such as a social worker (14); the desire to stop using drugs (17); and legal considerations including impending court cases (4). Sixteen respondents felt that their lifestyle had become untenable usually as a result of escalating use. The remainder (17) spoke specifically of their poor emotional or mental state.

‘I found myself at the stage where I didn’t want to go on living – being homeless and using heroin and crack.’ (Female, 29)

‘I wanted help. I wanted to get away from my flat. The voices are in that flat big time.’ (Male, 31)

As previously mentioned, City Roads often represents only the starting point for people addressing their drug problems and many clients are referred on to other services. The average length of time respondents stayed at City Roads was 14 days. Respondents who were abstainers or lapsed tended to stay slightly longer than those in the relapser or user groups (16 days compared to 14 days and 12 days). It is clear that for some respondents, City Roads had an impact on their drug use. Of the 66 respondents who had notably reduced or ceased their drug use at the time of the first follow-up interview, a third reported that an important factor was the opportunity to break the using cycle.

‘What’s helped me most is going to City Roads... just knowing that there’s help out there and disrupting your using pattern.’ (Male, 35)

TREATMENT CONTACT PRIOR TO FIRST FOLLOW-UP INTERVIEW

In the month after leaving City Roads, 40 of our sample attended a RR and seven a structured day programme. Thirty-one of those attending RR were still in contact at the time of the first follow-up interview. Of the nine who had left RR, the average number of days they attended was 20 (range one

to 40 days). However, three respondents had left less than 24 hours after arriving. Reasons for this are illustrated below.

Respondent 1 (Female, 33) felt that although her decision to enter residential rehabilitation had been voluntary, she had been influenced by staff at City Roads and her family. She wanted to go somewhere out of London, and was advised to do a 12-step programme because of her levels of alcohol use. However, she was clear that she did not wish to remain abstinent, but wanted to learn how to drink in moderation. She believes that part of the problem was that she didn't know what to expect from the service. Her feelings of unease were exacerbated by the fact that there was only one other female resident in the project at that time. This respondent felt that she would not get any privacy, even to the extent that she would not be able to do her own washing (she was told of this by another resident). She left the same day.

For respondent 2 (Male, 36), choice of RR was limited as his application for funding was unsuccessful. On arrival he felt that the service was unwelcoming and that the attitude of the staff and other residents was uncaring. He left after 15 minutes.

Respondent 3 (Female, 17) was also limited in her choice of service because she was under the age of 18. She was not sure that she wanted to attend a RR but felt that, since she had nothing in London, she may as well give it a try. However, she felt that the regime of the service she went to was inappropriate for her. She believed that there were too many basic rules and that they were largely designed for younger children. She was back in London within 24 hours.

Those who were referred to RR by City Roads (37) and were able to attend their first choice of service (24) were more likely to still be in touch with that service at first follow-up interview than those who could not (83% compared to 62%). The process by which respondents chose their preferred service was in some cases fairly arbitrary.

'I wanted to go to [name of RR] because of the picture in the prospectus. I didn't want to go to a 12-step because of all the reading and writing involved.'

(Male, 38)

Most respondents who had been referred to further treatment started the programme on the same day they had left City Roads. Of those who had not gone directly to further treatment (14), eight had used drugs or alcohol prior to starting the programme. Opinion as to whether having a break between crisis intervention and further treatment was a good thing was divided. In some cases even though respondents had used drugs or alcohol, this period was still viewed positively.

'I wanted to see my husband and I feel that I got my last bit of using done. I was craving when I left City Roads and I think that if I had gone straight to rehab, I would've left.'

(Female, 30)

'I liked seeing my family and spending time with them, and it made me realise that I'd relapse if I didn't go to rehab. It helped to have one last use-up. Helped me to deal with the craving.' (Female, 25)

The majority (29) of those who attended RR in the month before first follow-up (40) felt that the service was meeting their needs. Levels of satisfaction were high in most areas including location, general atmosphere, relationship with staff and confidentiality. However, almost 70% stated that they were indifferent, dissatisfied or very dissatisfied with the information they had been given about crack and half felt that the staff had limited knowledge about the effects of crack or the possible symptoms of withdrawal. We asked those who were still in contact with RR at the time of first follow-up interview (31) what they felt had helped them most. The most important factor was group counselling, which seemed to ease the feelings of isolation often experienced by respondents.

'It's a means of unloading all that garbage that you've got. You can always relate to somebody in the group and it stops you feeling so isolated.' (Female, 35)

Seven of our cohort were in contact with a structured day programme prior to their first follow-up interview. All but one viewed the service they were attending positively. The remaining respondent felt she had not been participating in the programme long enough to be able to comment. The most notable difference between this and other treatment modalities were the levels of satisfaction respondents had regarding the information they were given, and the knowledge that staff had about crack.

'It's helped me to learn how my feelings related to my crack use and how to deal with my feelings without using crack. I prefer being somewhere that focuses on crack use. There's more and better knowledge.' (Male, 34)

However, although respondents were positive about the treatment they had received, there was some doubt as to whether a day programme was a suitable mode of treatment for crack users.

'I didn't feel people took it seriously. It's very hard to contain people who are using crack on a day programme. I don't think it can be done. People didn't participate and the boundaries were too flexible. You need to have the same service, but in a residential setting. I didn't tell them how often I was using and I wasn't tested. I think we should've been. They work on trust, but let's be real here, this is crack use we're talking about.' (Female, 30)

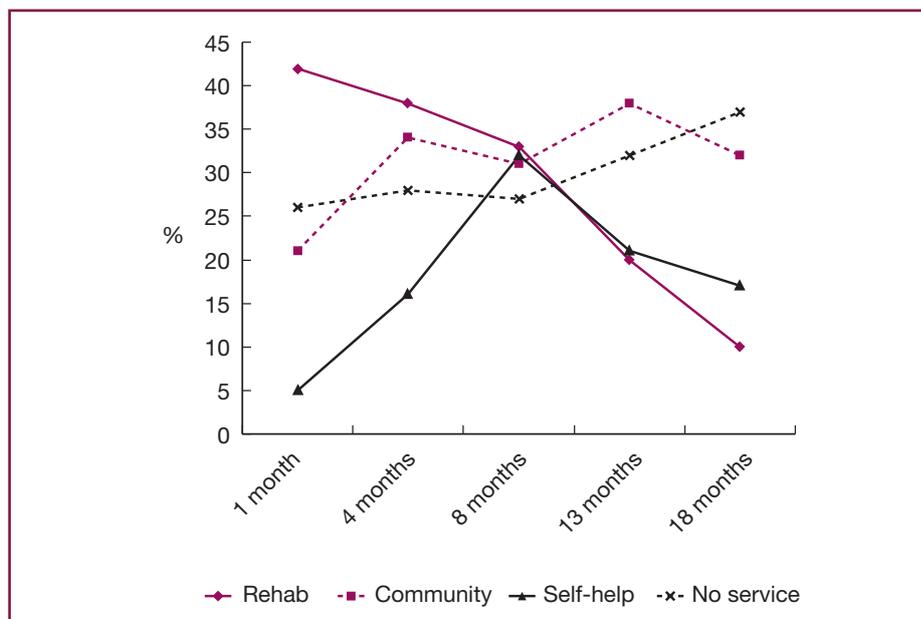
Respondents who were in contact with community-based services (21) were less enthusiastic about the service they were attending. A third were indifferent or negative about the way their treatment was decided upon and the treatment that they had received. In addition, levels of information and staff knowledge about crack were also seen to be inadequate.

TREATMENT CONTACT OVER TIME

Contact with treatment services fluctuated throughout the life of the study. Figure 5:2 shows the percentage of respondents attending selected drug treatment services over time.

FIGURE 5:2

Percentage of respondents attending selected drug services over time



Respondents attended a range of RRs including 12-step, therapeutic communities and skills-based services. Community-based services comprised both statutory and non-statutory agencies. The number of respondents in contact with RR was at its highest in the month after respondents had left City Roads. Contact with this type of service experienced a steady decline over the following months as respondents either completed or dropped out of the programme. As numbers in contact with RR fell, there was a notable rise in the numbers attending self-help groups such as Narcotics Anonymous (NA). Residential treatment services encourage the use of self-help groups and respondents are likely to use them for continuing support. It appears that respondents used self-help groups in the period immediately after leaving treatment. However, attendance was not sustained over time. Table 5:2 illustrates treatment patterns for high threshold interventions.

Fifty-five respondents attended a RR during the study. There was little difference between RR attendees and non-attendees in terms of gender or age although those from black and minority ethnic groups were significantly more likely to go to RR than white respondents ($p < .05$). However, black respondents often commented on the cultural myopia they encountered whilst at RR. Residential services are frequently situated in small,

TABLE 5:2 Treatment patterns for high threshold interventions

Type of service	Number of respondents attending service	Total number of treatment episodes*	Average number of episodes per respondent	Average length of contact in weeks	Number of respondents completing treatment
Residential rehabilitation	55	70	1.3	18.7 (range 0-64)	25
Structured day programme	13	15	1.1	9.7	5
Detoxification centre/crisis intervention	29	33	1.1	2.7	17

* An episode is counted as a distinct period of contact with treatment.

sometimes rural locations where amenities are limited. Respondents were not always able to purchase hair-care products or food types that they required and little or no effort was made to accommodate their needs. In addition, they felt that their behaviour was on occasions misinterpreted because of cultural differences.

*‘When you’re black and you use crack, you’re perceived as aggressive and intimidating. Why? Because I raise my voice, but it’s a cultural thing.’
(Female, 30)*

A point consistently made by those who had completed residential treatment was the lack of after-care facilities. As one respondent commented:

*‘It [RR] did me the world of good, but their after-care isn’t all that good. You’re out the door and you’re out of their minds. If it wasn’t for NA, I think I would’ve relapsed. You’re wrapped in cotton wool and have a structure and then you’re out.’
(Male, 38)*

Housing was often difficult to arrange and hostels not always appropriate because of the incidence of drug use. An example of this is the case of two respondents who were referred to a dry house after completing RR. Unfortunately, the property was located next door to a crack house. Both respondents relapsed.

RESPONSES TO COMMUNITY-BASED SERVICES

Most (61) of our cohort had accessed community-based services during the study. Experiences of this type of service varied widely. Key themes that emerged were the importance of fast access, well-informed staff and treatment options such as complementary therapies and key work

sessions. Evidence suggests that those who were offered something tangible, for example acupuncture or counselling, tended to have a more positive opinion of services than those who were not. This was also true of respondents who were prescribed medication (16), usually methadone or Subutex⁸. All felt that their prescription had helped reduce their illicit drug use.

However, those who were using both heroin and crack rarely discussed their crack use with staff and often felt that interventions focused on their heroin use, even if this was not their primary concern.

'I go there, do a urine sample and then leave. I've only just got a key worker, but I'm scared to talk to him in case he tells social services and they take my kids away. They don't know about my crack use at all.'

(Female, 31)

A second example comes from a 45 year-old woman who was regularly attending a community-based service to collect a methadone prescription. Although her crack use had resulted in her selling all her possessions and she was in danger of losing control of her flat to other users, she did not mention her crack use to her key worker because she was frightened they would withdraw her prescription.

Negative experiences mainly stemmed from the perception that drug services could not offer any suitable treatment for crack use, long waiting lists and the lack of understanding from agency staff. At each time point, we asked respondents who were not in contact with services why they had decided against attending. The following responses were typical:

'It would be a waste of time, because they're not clued up, and even if they were, there's nothing they could do about it anyway.'

(Male, 24)

'They don't do anything. They make me an appointment for two weeks; then I'd want a script so I'd have to see their doctor because I haven't got a GP of my own and no one will take me on because of my drug use. And the waiting list is two to six months.'

(Male, 32)

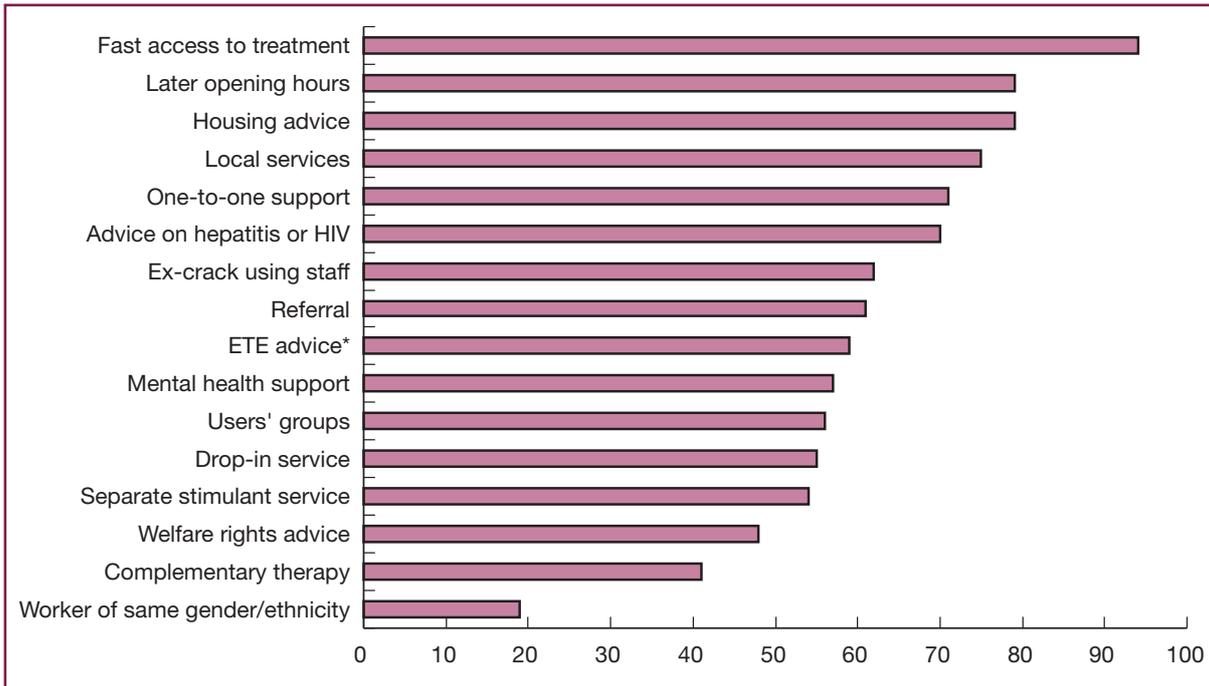
We gave respondents a list of facilities and asked them to identify those which they felt were the most important for a community-based service. Figure 5:3 shows the results.

The most important considerations for our sample were that services were local, with immediate access to treatment and longer opening hours. What is interesting to note is the priority respondents placed on practical issues such as housing and advice on education, training and employment. This suggests that drug users who access drug treatment services will probably have multiple needs and are looking for a holistic approach to their drug use. It is clear that there is a complex relationship between substance use and homelessness. Recent research with young people indicates that levels

⁸ Subutex is buprenorphine hydrochloride and can be used for the treatment of opiate dependency.

FIGURE 5:3

Features of community-based drug services considered to be most important to respondents



* Education, training and employment

of substance use amongst those who were homeless were considerably higher than those who had accommodation (Wincup *et al.*, 2003). It is unlikely that improved outcomes with treatment service clients will be achieved without addressing basic needs such as accommodation.

Overall, respondents felt that having ex-crack users as treatment staff was more important than having drug workers of the same gender or ethnicity. However, those from black and minority ethnic groups were more likely to favour workers of the same ethnicity.

‘I think you need more people who’ve been through it working in the services. If you get somebody who’s ... no disrespect to people who’ve been to university and stuff like that... but if you get somebody sitting down talking to you who’s not an ex-user who says well “you should do this, or you can do that,” the addict’s mind is saying, what the fuck are you talking about? You don’t know what it’s like. Do you know what I mean? Instead of hearing it from someone who’s been through it themselves.’
(Male, 38)

Despite high levels of contact with treatment agencies, respondents did not feel that services were offering appropriate assistance for their crack use. About half of those interviewed at each time point believe that the assistance they were given was inadequate for their needs.

'I've not really been helped for my crack addiction. Whenever I've been to detox it's for my heroin use, but I relapse on crack.' (Male, 29)

'I think they [treatment staff] are all dumb to it. They don't realise how powerful crack addiction is. They don't talk about crack. Nothing's ever put down to crack. They say everything you feel is down to heroin and don't acknowledge that you can crave for crack.' (Female, 24)

The vast majority of our cohort previously had some involvement with the criminal justice system. Most (94) had been arrested at least once and 78 of these had been convicted. The average age of first arrest was 16 years. This was mainly for acquisitive crimes such as theft (35), burglary (9), robbery (4), or fraud, forgery or deception (FFD) (6). Ten respondents had been arrested for drug-related offences such as possession (8) or dealing (2). The remainder encompassed a wide range of offences.

The average (median) number of arrests per respondent was 11, although 38 stated they had been arrested 20 times or more. The average (median) number of convictions was four. Sixty of our sample had been to prison, serving an average of four sentences. Whilst they had significant criminal histories, other problem drug users, such as those on Drug Treatment and Testing Orders, have been found to have much longer records (Turnbull *et al.*, 2000). There were only very slight differences between rates of arrest and conviction between gender or ethnic groups although men were significantly more likely to have been to prison than women ($p < .01$). We asked respondents to tell us which types of crime they had committed in the past and which crimes they committed in the six months prior to baseline interview. The findings in Figure 6:1 show crimes committed, for which respondents may or may not have been convicted.

We conducted analysis to assess associations between the types of offences that respondents had committed in the previous six months. Bivariate correlation found several relationships, the most notable of which was between selling drugs, violent offences and possession of firearms (POF). Men were significantly more likely to possess a firearm than women ($p < .01$). There were no apparent correlations between type of offence and ethnicity.

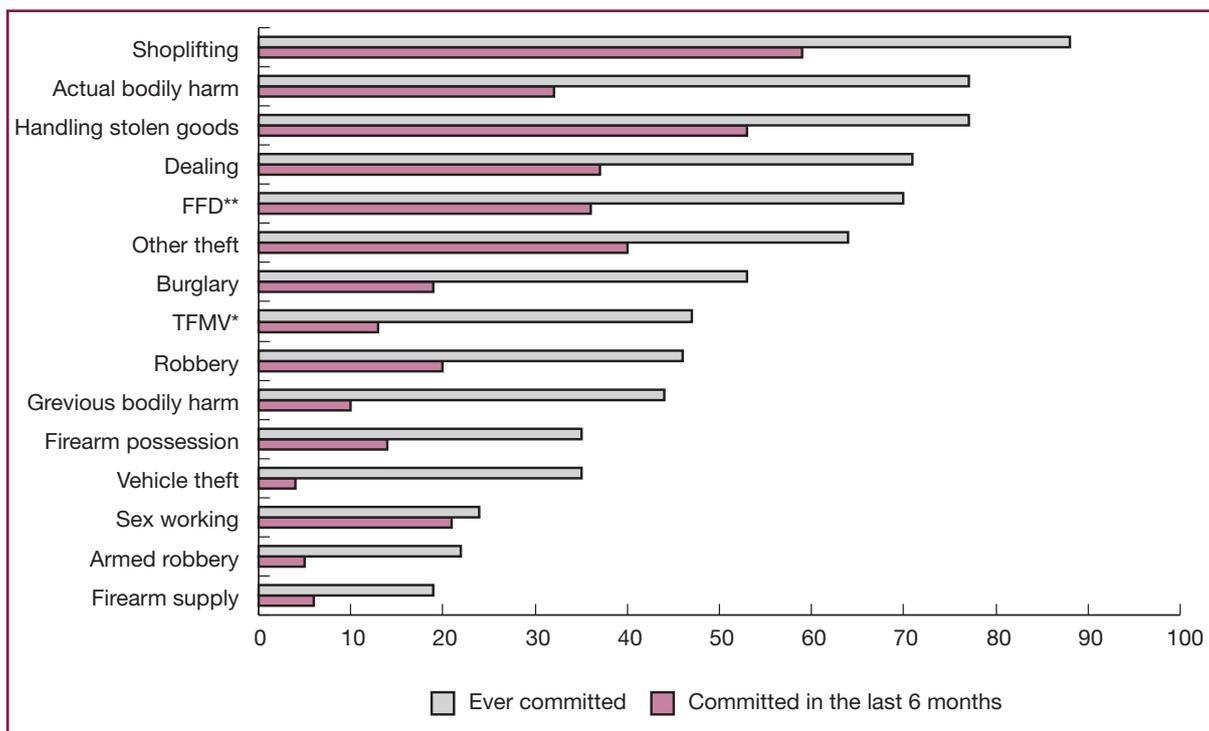
Respondents were asked why they felt they had started to commit crime. Thirty-six stated that it was because of their drug use, and in a number of cases (7) specifically their crack use. It is notable that several of these had previously used heroin but had managed to sustain their use without committing crime.

‘It’s only for crack. Until I started using crack, I had a normal job, which I managed to keep all the while I was using heroin.’ (Female, 28)

‘Started committing crime to support my crack habit. With heroin, my work paid for it.’ (Male, 22)

FIGURE 6:1

Types of crime committed by respondents ever and in the six months prior to first interview



* Theft from motor vehicle. ** Fraud, forgery or deception.

Just over a third (34) said they began to commit crime for money or the desire to acquire goods such as clothes or shoes. Sixteen believed it was peer pressure. The remainder reported it was either due to their family circumstances (9) or through coercion (2), in these cases by pimps. Only three respondents stated they had never participated in illegal activities.

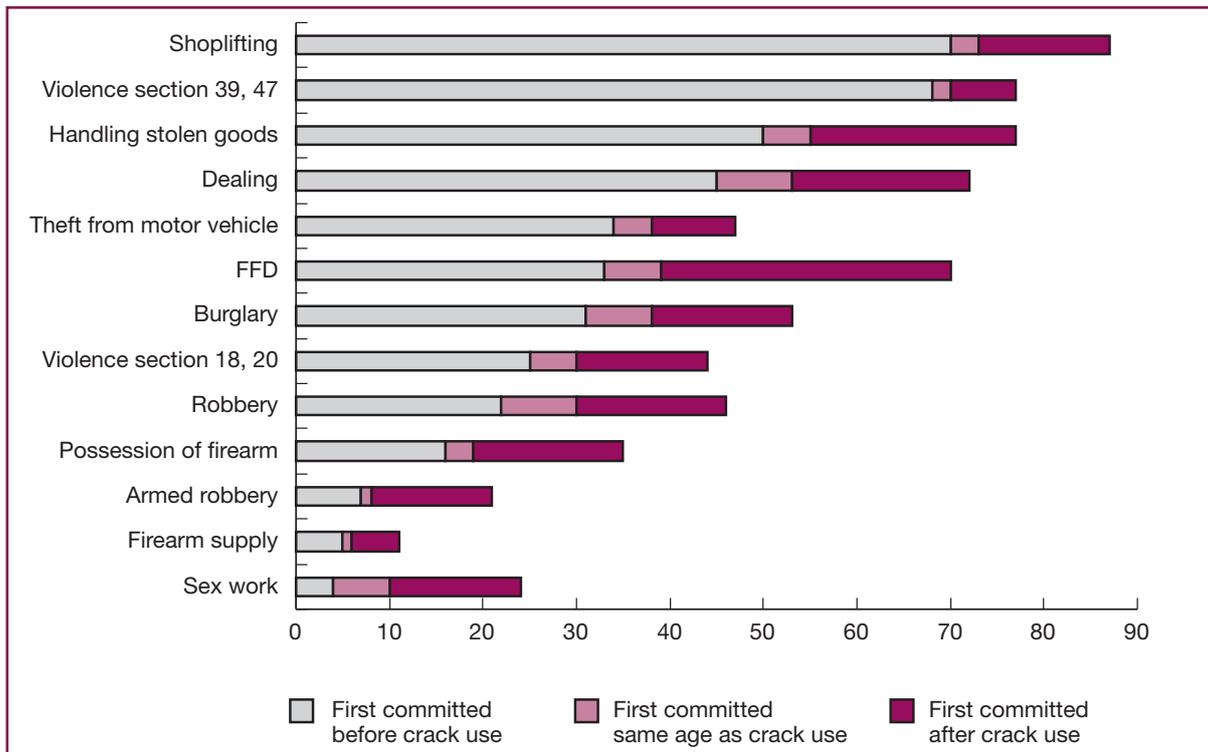
‘I was into crime anyway. I get a buzz out of it. It’s money for nothing.’
(Male, 31)

‘Now, it’s because of my drug use. Before it was peer pressure and a lack of positive role models. I think the black community especially struggles with that.’
(Male, 30)

‘I don’t know why [began to commit crime]. When I was about 9 years old, I used to go into a car park and smash the window of every car, but I didn’t nick anything.’
(Male, 29)

Although it is clear that there is an association between non-recreational drug use and acquisitive crime (Hough *et al.*, 2001; Seddon, 2000), it is difficult to disentangle the relationship – or causal link between them. We asked respondents at what age they had first committed a range of offences and compared it to age of first crack use. The results are shown in Figure 6:2 overleaf.

FIGURE 6:2 Age first committed crime compared to age first used crack



Many of our sample had committed an offence prior to using crack. In some cases, it is possible that this was drug-related, as 49 of our cohort had previously experienced problematic substance use before first crack use. For others however, their criminal careers seem likely to have predated all aspects of their drug career. Parker and Bottomley in their study of the crime careers of crack users found that not only did their respondents report an increase in their levels of offending since they started to use crack, but also an increase in the severity of the offence they were prepared to commit to fund their use (Parker and Bottomley, 1996). In our sample, the incidence of particular crimes did not seem to increase after first crack use with the exception of armed robbery and sex work. The links between sex work and crack use have been well-documented (May *et al.*, 1999; Inciardi *et al.*, 1993; Feucht, 1993) and it is likely that some women will start sex working to earn money as it is a non-imprisonable offence⁹. The increase in armed robbery is of concern and may indicate that some interviewees were prepared to commit more serious offences to fund their use.

Just over half (44) of those asked (78) stated that they were usually or always under the influence of crack when they committed an offence. In some cases respondents reported that the effects of the drug or the urgent need for money influenced the type of crime they committed.

‘I’d want quick money. Something quick for cash, like dipping [pick-pocketing]. I didn’t want to get goods that I then had to go and sell.’
(Male, 27)

⁹ Imprisonment for this offence can only occur through non-payment of fines.

‘The more out of it I was, the more courage I’d get. You feel invisible and feel like you’ve got more strength. I couldn’t do anything when I was sick apart from shoplift, but if I was out of it, I could work myself into a frenzy to do almost anything.’ (Female, 38)

‘Used to do fraud, but you can’t go in and do a play when you’ve been smoking, so I changed to street robbery.’ (Male, 31)

Conversely, others reported that having consumed crack, they felt incapable of committing an offence.

‘I don’t do criminal acts when I’m drugged up because my head’s not level. I don’t have the concentration and the drugs give me a conscience. Or maybe it’s the paranoia.’ (Female, 24)

‘I’d never commit crime on crack. You don’t know what you’re doing.’ (Male, 32)

DRUG USE AND CRIME

In Chapter 3, we saw that in the month before intake, the majority of respondents (91) were, at least in part, reliant on crime to fund their drug use. At each follow-up interview, respondents reported their drug use in the preceding 30 days and any criminal activity they had committed during this period. We examined the data to compare levels of offending in the months when respondents were using one or more of the following – crack, cocaine, heroin, other opiates, benzodiazepines or amphetamines, to the months when they were abstinent from these drugs.

To begin with, we compared those respondents who reported using one or more of the selected drugs at each interview (19) with those who were abstinent at all interviews for the life of the study (15). The results are shown in Table 6:1.

TABLE 6:1 Incidence of criminal activity for those using selected drugs and not using selected drugs

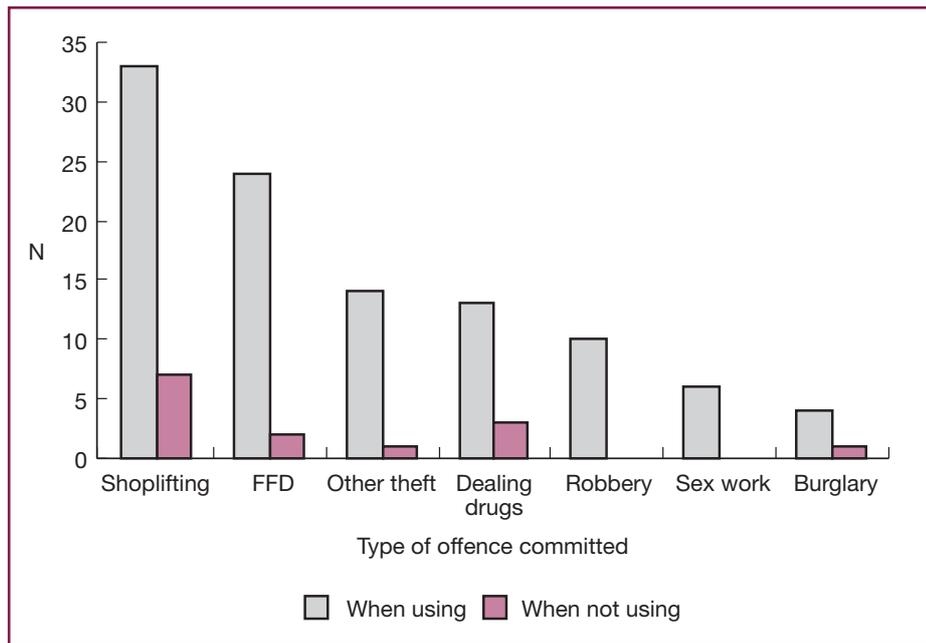
Type of crime	Reporting drug use at all interviews (n=19)	No drug use reported at each interview (n=15)
Dealing drugs	68%	0%
FFD	64%	14%
Shoplifting	63%	0%
Burglary	10%	0%
Robbery	10%	0%
Other theft	20%	7%
Sex working	10%	0%

Rates of offending among these groups were similar in the six months prior to baseline interview with the exceptions of drug dealing and shoplifting, which were more prolific amongst the 19 users (63% compared to 13% for dealing and 68% compared to 33% for shoplifting). The incidence of reported criminal activity was notably higher for those respondents who were using drugs. Of the 19 respondents using drugs consistently, 17 reported committing at least one of the named offences at some time, whereas of the 15 reporting no use in the month before interview only two committed these crimes. Although this may be explained in part by environmental or personal factors it is likely that drug use is an important determinant.

To further assess the influence of drug use on offending we looked at the offending behaviour of those respondents who had dropped in and out of drug use (n=66). This group reported using drugs in the month prior to follow-up, an average of half of the five follow-up interviews. The results are shown in Figure 6:3.

FIGURE 6:3

Comparison of respondents' criminal activity in using and non-using months (n=66)



At each interview we asked respondents whether they had committed selected offences in the previous month. Most of this group had committed at least one of these crimes at some point (n=49). However, only ten committed an offence during a non-using month. Throughout the study, we asked respondents to explain the changes in their criminal behaviour. The responses below are typical of those who had reduced or ceased to offend.

'I'm not using. I don't have to fund a habit and have been working a bit. It's not worth the risk although it's hard when you know you can earn £100 in a few hours.'

(Male, 36)

'I don't look at crime now because I don't need the money. I was never really a deep criminal anyway although I was selling at one stage and doing robberies.'

(Male, 22)

For some respondents however, although their levels of offending had reduced, they found it hard to stop completely.

'I really deeply from the heart want to stop shoplifting, but I have been doing it since I was 6.'

(Male, 22)

'If I was on the street [and not in rehab], I'd still be committing crime. I don't think drugs and crime go hand-in-hand. I think it's a way of life. I don't think I'd be committing crime to the extent I was but if I found myself short, I wouldn't think twice about going out and committing bank fraud.'

(Female, 31)

It is clear that there is a correlation between drug use and criminal activity. Those respondents who were abstinent from drugs were significantly more likely not to offend than those who continued to use ($p > .001$). However, it appears that for many of our cohort their criminal careers predated their drug career and it is likely that in cases such as these, crack use will serve to amplify offending behaviour rather than act as a trigger. Although levels of offending did fall during the study, it is difficult to comment on whether these changes will be sustained over time.

FACTORS INFLUENCING CHANGE

We have seen that levels of reported drug use amongst our cohort declined over the life of the study. The number of respondents using crack in the month before interview fell from 100% at intake to 47% at 18 months. The average (median) weekly spend on all drugs dropped from £800 to £80 and all but two respondents who continued to use spent less per week on drugs than they had at baseline. This chapter describes some of the factors that led to changes in patterns of drug-using behaviour.

We looked at a number of socio-demographic factors to see if we could discern any differences between the abstainer, lapser, relapser and user groups. No statistical differences were found for age, sex, qualifications, whether respondents had been in local authority care and having drug-using friends. However, members of the abstainer/lapsers groups were more likely to have immediate family members who had used crack than those in the relapser/user groups (33% compared to 18%). It is notable that members of the user group were more likely to have used heroin in the month before baseline interview and were using heroin more frequently (> ten times in a month) at that time than respondents in the abstainer/lapsers or relapser groups. Users/relapsers were also more likely to have experienced problematic substance use prior to their crack use than abstainers/lapsers (51% compared to 41%).

TABLE 7:1

Incidence of service contact over an 18-month period (n=78)

	Abstainer/ lapsers (n=27)	Relapser (n=18)	User (n=33)	χ^2
Residential rehabilitation	70% (52%)	78% (39%)	45% (9%)	8.8* (15.9**)
Structured day programme	22% (15%)	11% (0%)	12% (3%)	1.5 (7.3)
Detoxification centre/crisis intervention	30% (22%)	39% (22%)	27% (9%)	3.3 (4.5)
Community-based	56%	72%	79%	4.6
Self-help groups	74%	56%	21%	18.9***
No service	7%	0	6%	2

Percentages in brackets indicate how many respondents completed the programme * $p < .05$; ** $p < .01$; *** $p < .001$

Treatment appeared to be an important factor for respondents reducing or abstaining from their drug use. Table 7:1 shows the incidence of service contact throughout the life of the study. These data are described in the following sections.

ABSTAINERS AND LAPERS

Because there were only five people in the abstainer group, analyses were conducted on abstainers and lapers as a single group. Initially we conducted a multivariate statistical technique, logistic regression, to see if there were any factors that would predict respondents being abstainers or lapers. A range of variables were incorporated including demographics, drug-using behaviour at baseline and treatment exposure. The strongest single predictor of being in the abstainer/lapser group was completing a residential rehabilitation programme (RR) after their stay at City Roads ($p < .01$). A second significant factor was the 'stage of change' according to the Rollnick model (see Chapter 4). Respondents who were in the 'action' phase at first interview were more likely to be in the abstinent or lapser group than those in the 'contemplation' phase.

Abstainers tended to have had less experience with high threshold interventions than members of the other groups. No abstainers had previously attended residential treatment or a crisis intervention/detoxification centre and only one had attended a day programme. On average, members of the abstainer/lapser groups accessed treatment services earlier in their crack-using careers than those in the relapser/user groups (2.4 years compared with 4.0 years).

Abstainers/lapers (27) accessed a variety of treatment modalities. Rates of completion were higher for this group than those for the sample as a whole. The average length of time respondents had attended RR was 26 weeks. Completing RR and contact with self-help groups seemed to have the most impact on drug-using behaviour. Only 19 per cent of those in the abstainer/lapser group had not completed residential treatment or had contact with a self-help group. This compared to 63 per cent of relapsers/users. Two respondents in the abstainer/lapser group did not access any services after leaving City Roads. Of these, one respondent had been incarcerated and had not used drugs apart from cannabis during his time in prison. The remaining respondent felt that the help he received from City Roads was sufficient and that he did not need further assistance.

'I got my life back. When I first came out of City Roads it was like a whole new beginning. Everything was really different. I felt really different. I'm getting through one day at a time. It was really hard living without it [crack] then after a couple of months, it was easier and easier. I'm getting stronger every day, and now the line's been drawn and I'm not stepping over it. It's all psychological. It [crack] makes me sick to think about now.' (Male, 18)

We asked respondents from these groups what they felt had helped them reduce or abstain from their drug use. Just over a quarter (7) stated that treatment had been central to their ability to change their drug-using behaviour.

‘To be honest with you, it’s got to be the services I’ve been to, because I don’t have close support from my friends and family.’ (Female, 38)

‘My desire to deserve better for myself and to gradually learn to go and get it. But I couldn’t have done it on my own, never in a million years. I needed treatment, I needed rehab.’ (Male, 30)

Contact with self-help groups was also a significant factor in predicting changes in drug-using behaviour ($p < .001$). Three-quarters (20) of those in the abstainer/lapsers group had contact with self-help groups during the life of the study. Five respondents specifically mentioned the support they received from Narcotics Anonymous (NA).

‘What has helped me is going to [NA] meetings and seeing the newcomers and remembering that was me. Sometimes you get complacent and forget where you come from. Going to meetings and seeing the new person is like a slap in the face.’ (Male, 38)

An awareness of the potential consequences of drug use seemed to be an important tool for many respondents seeking to reduce their use. Other factors that helped were self-determination (4), family, especially children (4), and health (1). Finally, for five respondents, being away from London was a major factor in reducing their use. However, of these, three were in prison.

RELAPSERS

Respondents in the relapse group (18) also had high levels of service contact. However, rates of programme completion amongst this group were lower than that of the abstainer/lapsers. Of the 14 respondents who attended RR, only seven completed the programme. The average length of stay was 22 weeks. The main characteristic of this group is that respondents had experienced periods of abstinence of at least three months and then reverted to using crack or cocaine on a regular basis (i.e. >10 in a month). In some cases, members of this group experienced several episodes of abstinence throughout the life of the study. We asked respondents what had led up to their relapse and if they felt there was anything that could have prevented them from using. Just over half (10) stated that relapse had been triggered by negative emotional thoughts.

‘It was depression really. I was going through a bad emotional patch. It was a couple of months after leaving second stage [residential treatment]. I just felt really depressed and down and thought fuck it, I’m going to use.’ (Female, 25)

Often, it was a combination of factors such as feeling bored or depressed coupled with an opportunity to acquire drugs. Nine respondents felt that the area they were in, or people they saw, acted as a trigger for them to use.

'I was clean for four months and then my Dad died. I had been at work all day and was dropping a friend off and I ran into an old friend who's on the rocks [using crack]. I was feeling down about my Dad and ended up spending all the Christmas money on having a binge.' (Male, 32)

Other reasons for relapse included cessation of contact with a treatment service or support group (6), being homeless (2), having money (2) and health problems (1). For one respondent relapse was prompted by what most would consider a mundane object¹⁰:

'I was on a bus and there was an empty Volvic [brand of mineral water] bottle on the seat next to me, so I picked it up and went and bought myself a £10 rock, just to see.' (Male, 25)

Several respondents believed that their relapse had been inevitable and could not think of anything that would have prevented them from using at that time. An important issue for some (7) was housing – either hostel accommodation or relocation.

'I was on the streets trying to get assistance, but not getting anywhere. I got so frustrated that my situation was so hopeless that I took crack and heroin to take the pain away. Help from the system – housing or a hostel would have made a difference. Not being on the streets in the middle of winter thinking that I count for nothing.' (Male, 33)

The remainder believed that accessing their support networks would have helped them remain drug free.

USERS

Members of this group (33) had used crack or cocaine for at least 12 of the 18 months of the study. Generally, respondents in this group had lower levels of service contact during the study than other groups and those who did attend were less likely to complete. Users were also less likely to have had previous contact with City Roads than those in the lapse or relapse groups (40 per cent compared to 44 per cent and 50 per cent respectively). Of the 15 respondents who had contact with residential treatment, only three had completed the programme. The average length of time spent in RR was ten weeks. More respondents in this group were in touch with community-based services than abstainers/lapsers or users. The average length of contact was 40 weeks (range one to 520) and two respondents had been attending the same service for over five years.

In the main, members of this group were keen to make changes to their drug-using behaviour. Throughout the study they were asked how motivated

¹⁰ Empty water bottles are often converted into pipes by crack users.

they were to be drug free. At the time of the 18-month follow-up interview, 22 stated that they were ‘quite’ or ‘very’ motivated. We asked respondents what they felt would help them become drug free. In many cases it was a combination of factors including: a change of environment (12), self-determination (9), treatment (6), support (5) and keeping occupied (4).

‘I need to change my patterns of the way I’m living. I’ve got to change my circle of friends and I do believe that moving is the main thing.’
(Female, 28)

‘It’s my own strength. I don’t think there’s a magic cure. Just myself.’
(Male, 22)

RESIDENTIAL TREATMENT

It is clear that completing residential treatment plays an important role in reducing or abstaining from drug use – although one also could argue that the ability to control drug use is a precondition for completing RR. Of the 55 respondents who attended RR over the life of the study, less than half (25) finished the programme. We examined the data to see if there were any differences between those who had completed RR (group A) and those who had not (group B). The average (median) weekly spend on crack in the month prior to first interview was notably higher for those in group A (£815 compared to £495). Members of group A were also less likely to have used heroin during this period (52% compared with 70%). However, the two attributes are correlated and it seems likely that heroin use prompts early dropout from RR rather than lower levels of crack use. White respondents were less likely to complete a programme at RR than those from black or ethnic minority backgrounds (42% compared to 48%). Women were more likely to complete than men (52% compared to 41%).

Respondents who had attended and not completed residential treatment had a wide range of reasons for their early departure. Over half (18) were discharged because they had used, or wanted to use drugs or alcohol (11), or because of inappropriate behaviour, often involving arguments with another resident. The remainder left unplanned either because they did not like the programme (5), other residents (5) or because of family problems (1). One respondent was still attending the service.

‘I wasn’t happy. At first I thought the programme was good but not after a while. I couldn’t go for a walk or be by myself – I needed more privacy. When I spoke out they told me to shut my mouth and that I was too rash. Their way of breaking you down was by intimidating you. I know you are not meant to enjoy rehab, but it’s not meant to break you down either.’
(Female, 29)

COMMUNITY-BASED SERVICES

It is difficult to assess the impact community-based services had on changes in drug-using behaviour as attendance was often sporadic and treatment plans unstructured. In some cases, respondents had been attending the same service for a number of years, dipping in and out of contact according to their needs. As one respondent commented:

'I think they could do more, but it's security for me. Whatever happens, I know I can go there.' (Female, 21)

However, contact with community-based services appeared to have had less impact on respondents' drug use than attending high threshold services and those in the abstainer/lapser groups were less likely to attend this type of service than relapsers/users. Community-based services were often the first point of contact for drug users seeking assistance and had an important role to play in providing day-to-day support.

CHANGING LIFESTYLES

For most of our cohort, crack use encompassed a large part of their daily lives. We asked respondents (80) if there was anything about crack they would miss if they were no longer using. Just over two-fifths (35) felt there was. It is notable that more of our sample referred to the anticipation and excitement of making money and buying crack (16) rather than the process of using or the effect of the drug itself (9). Respondents spoke of 'running about' and the speed with which they lived their lives. The alternative in some cases was seen as mundane and boring. Others stated they would miss friends (4); going to clubs (3); sex (1); power (1) and money (1).

'I'd miss the street life. That's what made me go back to using in the first place. The hustle and bustle, the movements up and down. The best part about using is scoring. Half the time when you've scored and sat down, it doesn't seem worth it. I've tried to have the street life without the drugs, but they just go hand-in-hand. I tried just going out and making money and not using the drugs, but it led me back to it.' (Female, 26)

'I'd miss the excitement of making a little touch [money]. I wouldn't be grafting [illegal activities to gain resources to buy drugs] if I wasn't using.' (Male, 33)

'It's just the crack use really. I wouldn't say that I don't like it. Sometimes I get a recall of the flavour. The drug itself is hard to let go of. I don't miss the people or the lifestyle. I miss the drug.' (Female, 31)

SUMMARY AND RECOMMENDATIONS

This is the first cohort study that has looked specifically at service use amongst crack cocaine users in the UK. We successfully completed 527 interviews with 100 crack users over an 18-month period. In this report, we have only been able to describe a fraction of the findings. We plan to produce further publications on a range of topics including offending behaviour and health.

The cohort was typical in age of those attending treatment services with an average of 31 years. However, there was a greater percentage of users who were women (40%) or from black and minority ethnic groups (47%) than is normally found in treatment populations. For many, drug use was a well-established part of their lives. Forty-six per cent reported that at least one family relation had experienced some form of problematic drug or alcohol use with just under a quarter (23) stating that members of their immediate family were using, or had used, crack. Respondents also tended to associate with other drug users and 69 said that the majority of their friends had a problem with either drugs or alcohol. Almost half our sample (49) had experienced problematic use prior to becoming involved with crack.

Before coming to City Roads, 72 were using crack on a daily basis. The average weekly spend on all drugs was £800. This was considerably higher than other studies of drug-using populations (Edmunds *et al.*, 1998; Turnbull *et al.*, 2000). Most (91) were committing crime to help fund their drug use. Half the women (20) were involved in sex work. Many of our sample were polydrug users and 63 had used heroin in the month before first interview. Of those who were injecting (31), not all injected crack and for most smoking was the main route of administration. For those who did inject crack (11), speedballing was common. Respondents from black and minority ethnic groups were less likely to use heroin or inject than those who described themselves as white. However, black respondents reported high levels of alcohol use (weekly average of 53 units compared to 34 for white respondents).

The fact that respondents from black and minority ethnic groups are less likely to use heroin or inject has important implications for treatment engagement. Community services are often the first point of contact for drug users seeking assistance. However, many services are based around the provision of injecting equipment and opiate substitute prescription. Since neither of these interventions are appropriate for this group, there are less opportunities to engage them in treatment.

Community-based services need to develop new strategies to encourage black and minority ethnic groups to attend services. Suggestions from respondents included drop-in centres where they could get advice and information about the effects of crack use and complementary therapies. To best identify the needs of black and minority ethnic groups it would be useful to establish a working partnership between treatments services and representative community groups. It is also important that services are aware that potential clients may need assistance with alcohol-related problems.

CHANGES IN DRUG USE

Levels of reported drug use showed a steep decline between intake and second interview, with the exception of cannabis. In subsequent follow-up interviews, levels of use remained fairly stable although there was a further reduction in the number of respondents using crack and heroin between months 13 and 18. Average weekly spend on all drugs fell from £800 prior to admittance to City Roads to £145 at one month follow-up. By month 18 this had fallen to £80. By the end of the study, only two people had a higher weekly spend on drugs than in the month before coming to City Roads. Levels of alcohol use dropped in the four to eight-month period after respondents left City Roads but had increased to pre-City Roads levels by month 18, although those drinking 30 or more units per week had fallen slightly. We can assume that the dip in levels of alcohol use during the four and eight-month periods can be related to contact with residential treatment.

Patterns of use amongst our cohort were variable. We were able to isolate four groups including: abstainers (n=5), lapsers (n=22), relapsers (n=18) and users (n=33). Abstainers did not use any drug with the exception of cannabis or alcohol for the life of the study. Lapsers used crack or cocaine after leaving City Roads but had experienced a period of abstinence for at least six months and had then not returned to regular use. Relapsers experienced periods of abstinence of at least three months but had then returned to regular use. Finally users consisted of those who had used crack or cocaine during at least 12 of the 18 months of the study.

Changes in drug use for our cohort have been considerable. For many respondents, crisis intervention offered an opportunity to break with established patterns of use, to consider treatment options and to reflect on their circumstances. It seems that this type of service plays an important role in allowing people to evaluate their situation and make the first move towards changing their drug-using behaviour.

ABSTINENCE AND RELAPSE

Prior to baseline interview, most respondents (91) had previously had periods of abstinence from crack. Respondents had identified a variety of

reasons for relapse. These reasons were no different from those offered as explanation for relapse during the 18-month follow-up period. Important triggers to relapse were negative emotional states (53), including boredom and depression, and contact with people associated with their drug use (45) (dealers; other users). Other cues included having money (25), seeing drug-using paraphernalia (14), places (14) and alcohol (8).

Over half of those interviewed at one-month follow-up had used crack or heroin in the preceding 30 days (n=94). The majority of these (61%) did so within three days of leaving City Roads. Of the 34 respondents who had used heroin during this period, all but one had done so within the first 14 days. Dual crack and heroin users were more likely to have used both drugs (28) or crack only (9) than heroin only (2). Those with a shorter stay at City Roads were more likely to have used crack or heroin before first follow-up interview (13 compared to 18 days). Respondents who continued treatment (particularly those who went on to attend RR) were less likely to resume drug use than those who did not. Women were more likely to relapse than men. Of the 24 women who were not in RR at one-month follow-up, all but one had used drugs.

Most respondents had periods of abstinence in the past. It is important that this is acknowledged and identified. Relapse prevention may need to focus on an individual's experience rather than taking a more general approach. Of those who had relapsed prior to first follow-up interview, most did so within a short period of leaving City Roads (within three days). This included some respondents (8) who were referred on to further treatment but didn't engage immediately. Offering support after leaving City Roads is likely to go some way to reducing the probability of early relapse.

CRIME

While members of our cohort were not as heavily entrenched in crime as other problem drug-using populations, levels of offending were high and it was clear that there was a correlation between drug use and criminal activity. For some of our sample it seemed likely that their criminal careers had predated aspects of their drug career and, in such cases, crack use probably served to amplify rather than trigger offending behaviour. The incidence of most crimes did not seem to increase after respondents had started to use crack, with the exception of armed robbery and sex work. Those respondents who were abstinent from drugs were significantly less likely to offend than those who continued to use.

TREATMENT

Most respondents (91) had previously sought assistance for their drug use, having presented at services an average of five years prior to their admission to City Roads. Despite accessing services, many commented on

the lack of information available about where to get help. Over half our respondents had attended high-threshold services such as RR and detoxification centres and 41 had previously been admitted to City Roads. Respondents who used heroin on a regular basis (ten days or more a month) were more likely to have had contact with community-based services and detoxification centres and were also more likely to have attended RR (50 per cent compared to 36 per cent). Of those who previously attended RR (44), 20 had completed the programme.

The average length of stay at City Roads was 14 days. Respondents who were abstainers/lapsers tended to stay slightly longer than relapsers or users (16 days compared to 14 and 12). Many respondents went on to further treatment. More than half attended a RR during the life of the study with 25 completing the programme. Respondents from black and minority ethnic groups were significantly more likely to attend RR than those who said they were white. However, many commented on the cultural myopia they encountered whilst there. Those who were referred to RR by City Roads and were able to access their first choice of service were more likely to be still in touch with that service at first follow-up interview than those who could not (83 per cent compared to 62 per cent).

We have seen that methods for choosing residential rehabilitation centres are at best random, at worst dependent on funding availability. For our respondents, going to the RR of their choice seemed to have an impact on the length of stay and, potentially, longer-term positive outcomes. It is important to try to match individuals' requirements with appropriate RR centres. More consultation and preparation is needed during this process. Respondents from black and minority ethnic groups experienced cultural insensitivity whilst at RR. Residential treatment services should develop appropriate mechanisms to meet any cultural needs that may arise.

Generally, levels of satisfaction were high amongst those who went to RR. However, almost 70 per cent were indifferent, dissatisfied or very dissatisfied with the information they received about crack. For example, staff had limited knowledge about the effects of crack or its possible withdrawal symptoms. Respondents who attended structured day programmes reported that staff knowledge about crack was good and that they were provided with appropriate information and support. Respondents in contact with community drug services were less enthusiastic. A third were concerned about the way their treatment had been decided upon and the actual treatment they received. For our sample, the most important aspects of service provision provided in a community setting were locality, immediate access and longer opening hours. They also placed priority on practical issues such as housing and advice on education, training and employment.

Despite high levels of contact with treatment agencies, respondents did not feel that services were offering appropriate assistance for their crack use. Respondents who were using both heroin and crack rarely discussed

their crack use with staff and often felt that interventions focused on their heroin use even if this was not their primary concern. Crack users in our study were unhappy with the level of specialist knowledge within the services they accessed. It is important for drug treatment staff to know the possible effects of crack use, as this may go some way to explaining clients' behaviour. This is particularly important for those working in residential treatment where client contact is more intense. The first step to achieving this is to ensure that in-depth training is provided to those working with crack users.

Members of our sample had extensive drug histories and many were poly-drug users. Respondents who were using both heroin and crack felt that their crack use was rarely brought up as part of the treatment process. In some cases crack use was overlooked by treatment providers; staff were dismissive of heroin users' claims to need help with crack and suggested that achieving change was simply a matter of will power. It would appear from these experiences that thorough assessment is not being undertaken by some agencies. The combined use of crack and heroin is an increasing trend amongst drug-using populations. It is essential therefore that drug treatment services cater for the specific needs of this group rather than focusing on heroin use alone.

A point consistently made by those who had completed RR was the lack of support and services on offer to them once they had left treatment. This lack of care was seen as potentially undermining their ability to maintain changes in drug-using behaviour. Temporary housing was a particular problem for some as they were often forced to share hostel accommodation with those who were still using drugs. Further, the location of dry-houses was sometimes wholly unsuitable. Additional difficulties were identified with local authorities' poor response to requests by those coming out of treatment to relocate to areas which had no association with their drug-using past.

It is important to look at ways of providing support to this group after they have left treatment. There seems to be a need for better links between RR and supported housing agencies, as well as improved access to places within a supported housing environment. Local Authorities need to be more receptive to transfer requests from those who have completed residential treatment.

Once an individual has appropriate accommodation, measures should be taken to assist their reintegration into the community. As we have seen an important factor of relapse is being in a negative emotional state, including boredom. Moving from a structured RR programme into supported housing is a significant step. Having less structure to the day may result in individuals feeling isolated with lots of time on their hands. It is essential to develop ways to support reintegration into the community. One such way may be through employment. However, individuals living in certain types of supported housing facilities are not allowed to undertake paid

work under the terms of their residency. Employment may help people maintain reductions in drug use. As a strategy to provide aftercare for those leaving treatment, employment schemes which address dependency issues may be appropriate. For example, Dependency to Work (D2W) works with drug users with multiple problems and offending histories to help them secure employment.

Contact with self-help groups was a significant factor in predicting changes in drug-using behaviour amongst our cohort and three-quarters (20) of those in the abstainer/lapsers group had contact with self-help groups during the life of the study.

Support groups are needed for those who return to the community. Narcotics Anonymous will not be suitable for a proportion of drug users who do not wish to remain abstinent from all drugs or alcohol. At present there are few alternatives to this option. It is important to develop groups based on different models of support.

We have identified a number of factors that led to changes in drug-using behaviour. The most important factor in reducing or abstaining from drugs was completing treatment. A second significant factor was that those who were in the action phase according to the Rollnick readiness to change questionnaire were more likely to reduce their drug use than those in the contemplation phase at intake. This suggests that further intervention to move people into the action phase is required before they are moved onto other services. For abstainers/lapsers, most identified participation in treatment as central to helping them change their drug-using behaviour.

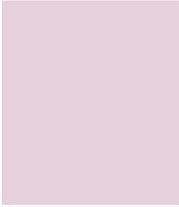
It is clear that the development of mechanisms which aim to maintain engagement with treatment and encourage completion of programmes are likely to improve treatment outcomes. This may be achieved by having a thorough and considered assessment over a period of time which could result in a better match of clients with services. Individual needs could change and it is important to undergo regular reviews based on this possibility. However, initial assessments should be succinct and should not focus on areas that may deter clients from engaging with services.

The outcomes described in this report are based in the medium term, covering an 18-month period. Although high-threshold interventions with this group seem to have a positive impact we cannot say whether such changes can be sustained over time. We have seen that 41 of our sample had attended City Roads in the past, and 20 of our sample had previously completed residential treatment only to return to high levels of drug use.

However, our study of crack users has found that established treatment services can play an important role in changing the drug-using behaviour of this group. The cohort saw great benefits in high-threshold interventions. There are several reasons why this might be the case.

Primarily, there is a paucity of low-threshold interventions for this group. A second important factor appears to be the dislocation they obtain from their crack-using lifestyle and environment through attending high-threshold services. This seems to be despite the fact that existing services are often ill-fitting and poorly developed to respond to their specific needs. Better outcomes may be achieved if treatment agencies provided more tailored services coupled with more intensive training programmes for staff.

Further research is needed to establish the long-term outcomes of treatment. In addition it would be useful to evaluate low-threshold services aimed at crack users to assess how well they engage and retain clients. It is clear that dual use – especially crack and heroin – is an increasing trend and we suggest that relapse patterns for this group should be examined more closely.



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