DRUG & ALCOHOL FINDINGS *Hot topic*

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GO The 'explosion' that never happened; crack and cocaine use in Britain

Much of this hot topic is devoted to challenging beliefs that cocaine and especially its smokable form crack are uniquely addictive and their adherents, uniquely hard to treat. Those beliefs have multiple roots which stretch back to lurid concerns that cocaine would undermine the World War I war effort. Then and up till relatively recently, the cocaine concerned came in powder form 'snorted' up the nose or injected, generating what could be an intense stimulant and euphoric impact with residual effects lasting about an hour. Though the effect was similar to amphetamine, it was much more short-lived, lending itself to repeat-hit 'binges'. However, the modern-day resurgence of concern over cocaine in Britain can be traced back to 20 April 1989, when Robert Stutman, head of the US Drug Enforcement Administration's New York Division, addressed Britain's chief police officers.

What the concern was all about – crack ready for the retail market

'Bob' Stutman's concern was not cocaine powder, but the new form manufactured as small 'rocks' called 'crack'. In the mid-1980s crack was developed as a smokable form easier and cheaper to produce than freebase cocaine, an earlier smokable derivative. While cocaine powder had a reputation as the drug for the 'champagne set' and business high-flyers, crack lent itself to mass production and mass distribution in small quantities to the "persistent poor". Rapidity of onset and intensity of effect joined to create what to some was an appealing 'rush' otherwise available only at greater expense and/or by injecting.

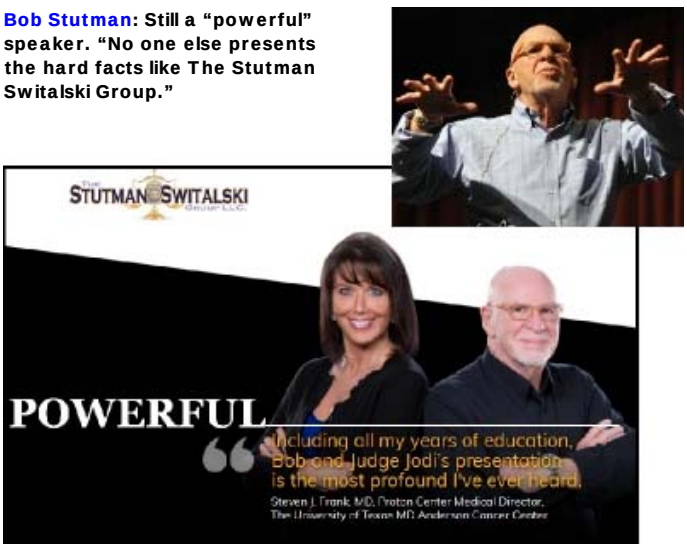
To this day in Britain, cocaine powder is associated more with affluence, recreational use and 'good times' than crack. Though these are the same drug in different forms, the modes of use, the uses, and the users, demand where possible separate consideration.

By redressing the balance tipped so graphically by Bob Stutman and others, this hot topic entry does not mean to imply that use of these products is a trivial issue – just that even in the form of crack, cocaine dependence is not *uniquely* destructive of the resources needed to recover from dependence, and that even among drug treatment populations, most do so relatively quickly compared to the general treatment caseload largely dependent on opiate-type drugs. By not addressing these here, neither do we mean to discount the "significant harm" that can arise even from episodic use of cocaine, stressed by the UK's Advisory Council on the Misuse of Drugs in their report on cocaine powder published in 2015.

'Three Hits Can Get You Hooked'

A powerful speaker credited on an earlier version of his web site with bringing crack to national attention in the USA and "single-handedly changing the policy of the United States DEA", Bob Stutman set about waking up the UK to the imminent threat. His story of an "explosion" of crack use and related violence in New York ignited rumbling worries that cocaine and crack could turn Toxteth, Handsworth and Deptford into US-style drug ghettos. Most startling was his revelation that "A study that will be released in the next two to three weeks will probably say that of all of those people who tried crack three or more times, 75 per cent will become physically addicted at the end of the third time ... We now know that crack is the single most addicting drug available in the United States of America today and certainly the most addicting drug available in Europe. Heroin is not even in the same ballpark." Unless forestalling action was taken immediately, Britain would, he warned, see the US experience replicated within two

Bob Stutman: Still a "powerful" speaker. "No one else presents the hard facts like The Stutman Switalski Group."



years.

Describing the effects of crack to the UK’s chief police officers in September 1989, Dr Tuckson, Commissioner of Public Health in Washington, directly challenged notions that the welfare-cushioned and less racially divided Britain would not react to crack in the same way as some of the USA’s poor black neighbourhoods: “Cultural differences are certainly not great enough to make me suspect that you have any inherent immunity to the effects that this drug will have or can have on your society. I know there is nothing particularly unique about the water … in your country that would prevent the neurotransmitters and the pleasure centres of the brains of your citizens [being] overwhelmingly affected by the instantaneous and powerful euphoria that this drug presents. All you have to do is do it once and I guarantee you any, almost any human being would want to do it again.”

Later in 1989 in London Bob Stutman was paired at a conference on crack with Dr Mark Gold, founder of the USA’s Cocaine-800 helpline. While Stutman told his tales from the street, Dr Gold offered scientific evidence of crack’s addictiveness and violence-inducing properties. Officer Stutman and Dr Gold had been invited to the conference by the Corporation of the City of London, whose delegation had been “deeply shocked” by a visit to New York. The conference ended with an address from the City’s Lord Mayor. He’d had to leave for part of the day and came back with a resounding attack on the “doubting Thomases” in Britain who were the “biggest problem” because they did not believe the clear evidence about crack, such as that three shots can “effectively kill the brain”.

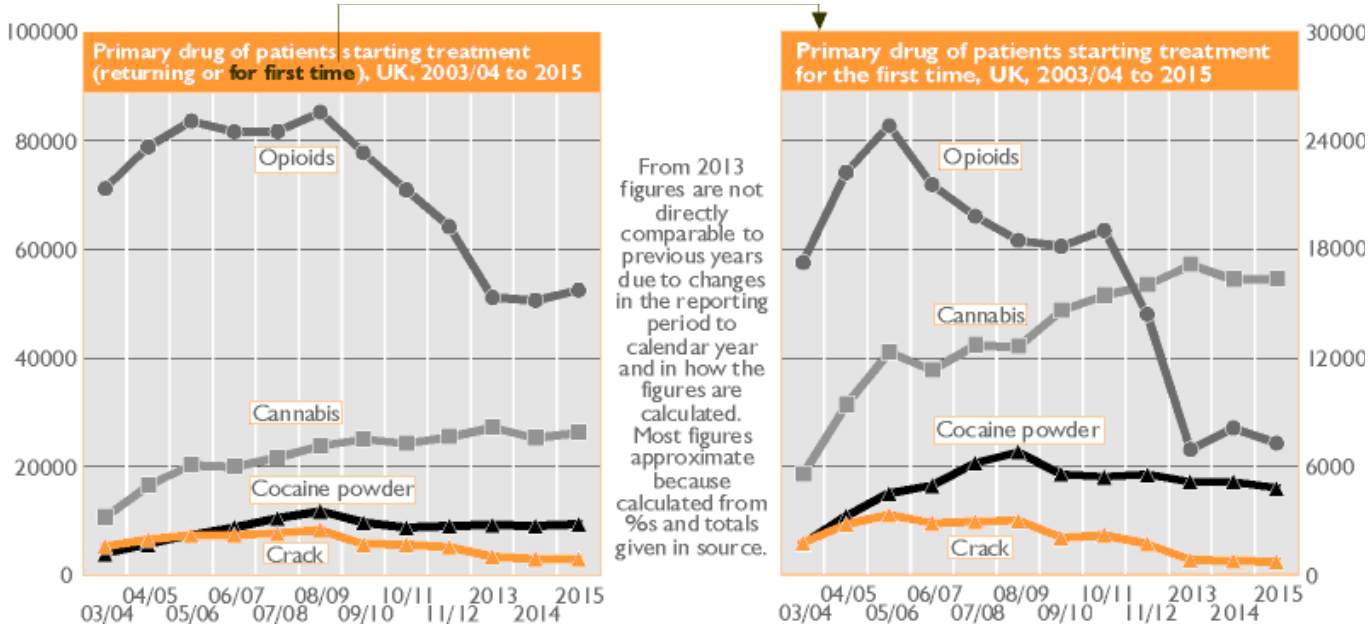
On these claims much else hinged: if crack was this addictive, as well as directly provoking violence, it could lead users to commit violent crimes to get it, promise massive profits to its dealers, and devastate whole communities. The month after his address to police officers Stutman’s key statement appeared as a headline in the *Sun* tabloid newspaper (25 May 1989): “Three Hits Can Get You Hooked” was their version of his “terrifying statistics”. Before the *Sun*’s report, the as yet unseen study cited by Stutman had become a “survey” which “showed” these disturbing facts (*Times*, 19 May 1989). Later the “survey” was attributed to an impeccable source – the Home Office itself (*Grimsby Evening Telegraph*, 2 August 1989).

Study, survey and source were illusory, but Stutman’s riveting message lived on. Senior British police officers “attempted to trace the studies and the figures he quoted and found they don’t exist” (*Independent*, 27 July 1989). Still, the House of Commons Home Affairs Committee released an emergency interim report on crack with these same discredited ‘facts’ highlighted in bold. The following year a BBC Radio *File on Four* investigation (10 April 1990) nailed down the credentials of Stutman’s address. It was, they concluded, “littered with misinformation”. The claim that 73% of child-battering deaths in New York in 1988 were perpetrated by crack-using parents was based on just two such deaths, one of which also involved chronic alcoholism, and Stutman was still unable to produce the ‘three hits and you’re addicted’ study.

It was not that crack never became a problem in the UK. It did, and in some localities, a big one, but Britain’s crack and cocaine problems never rivalled the US experience. The supposed hooking power of the drug, if it emerged at all, emerged from a constellation of circumstances, not deterministically from merely trying it a few times, and circumstances were different in the UK from those in the USA. Rather than the explosively destructive epidemic foreseen by officer Stutman, crack crept up to become an established featured of the UK drug scene and of the treatment caseload. In line with population-wide trends, that caseload has been declining since around 2008. Instead of being hard to stop using, crack as well as cocaine turned out to be hard to *continue* to use at excessive levels. And rather than being ‘out of the ball park’, heroin seems a drug much harder to leave behind – themes elaborated below.

Slow-burn spread now on the way down

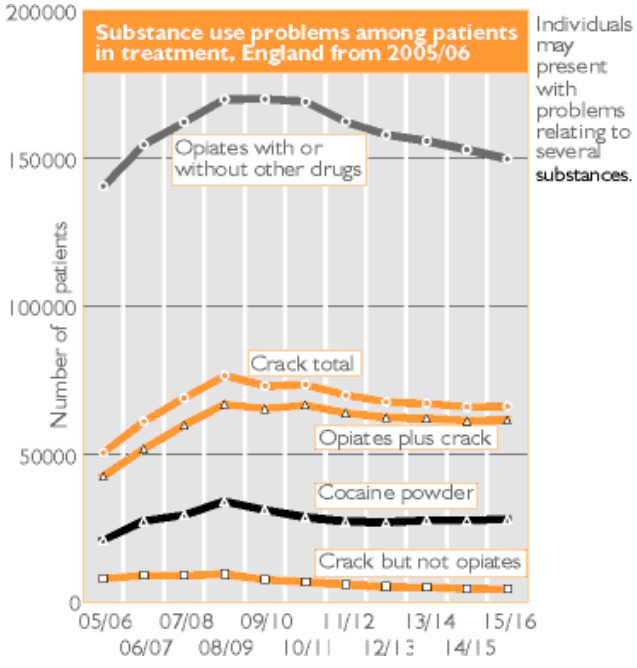
A UK-wide perspective on the cocaine and crack treatment caseloads is provided by reports collated for the European Union’s drug misuse agency. Before 2015 the figures included prisoners only for Northern Ireland. From 2015 prisoners in England were included, but unless specified otherwise, the figures reported here exclude them in order to maintain continuity.



As the primary drug in relation to which adult patients started treatment (either for the first time or returning after a break), across the UK since 2010 cocaine powder or crack have accounted for about 1 in 8 treatment starters, down from a peak of about 1 in 7 in 2008/09. Though in recent years the proportions were relatively stable, the total number of treatment starters has been falling, meaning that the numbers of cocaine/crack treatment starters has also been falling, down from about 20,200 in 2008/09 to about 12,500 in 2015, a drop of nearly 40%. Where in the early 2000s crack was the main form in which cocaine was used by treatment starters, by 2015 its use as the patient's primary drug had diminished to just 3% of all treatment starters and cocaine powder accounted for three times as many, just over 9% ▸ chart.

Of treatment starters a minority (in 2015, 34,358 out of 101,919) are starting treatment for the very first time. Among these neophytes crack as a primary drug of choice is even less apparent, accounting in 2015 for just over 2% of all first-time treatment starters, in numbers, only about 722 patients across the whole of the UK. Cocaine powder is much more prominent, accounting for 14%, in numbers, about 4810 patients. Commenting on these figures, Public Health England argued that the greater relative prominence of crack among patients re-starting treatment after a break than among those entirely new to treatment, meant crack users are more likely to undergo multiple episodes of treatment than patients primarily dependent on cocaine powder. In turn, the implication is that crack use is associated with a higher post-treatment relapse rate, leading more often to a return to treatment.

Though uncommon as the main substance on which patients starting treatment are dependent, crack is much more common as a secondary drug. Including prisoners in England, in 2015 it was noted for 23,540 patients in the UK primarily dependent on other substances, mainly (94% of cases) heroin. The proportion of primary heroin clients entering treatment in the UK reporting secondary use of crack cocaine has been increasing since 2003/04, in 2015 accounting for 45% of all primary heroin presentations, up from 38% in 2013. However, these UK averages hide a very different picture in different countries. In England, crack use was reported by 43% of primary users of drugs like heroin, but in Scotland and Northern Ireland, only 3.3% and 1.6% respectively.

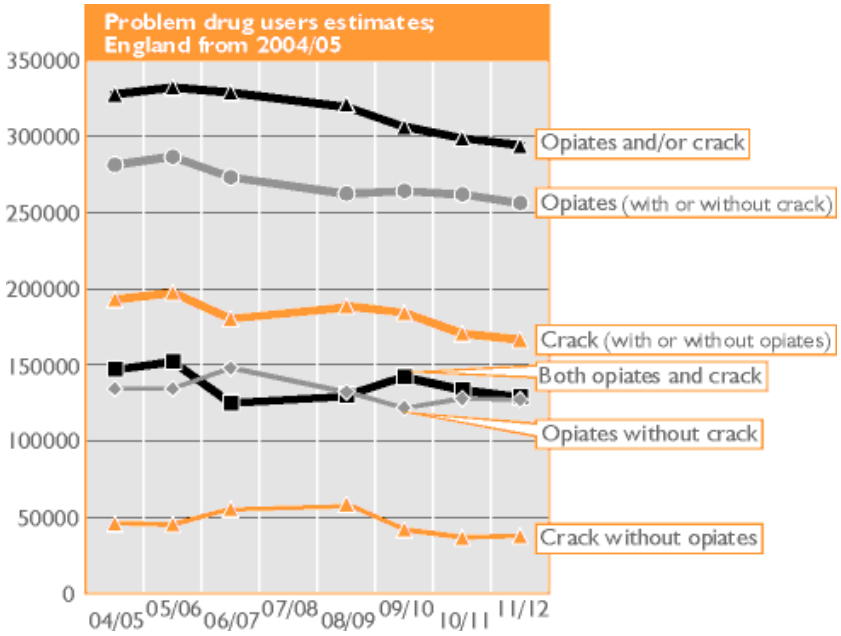


For England, figures for treatment starters can be supplemented by figures for all patients treated for drug or alcohol problems some time during a year, whether treatment starters or continuing

in treatment. Of all 288,843 patients during 2015/16, 27,958 were recorded as problem users of cocaine powder and 66,208 of crack, of whom 93% were also problem opiate users. Just 4585 were problematically using crack without also having problems with opiates ▸ chart.

Crack use diminishing in population

As well as being a peak for treatment numbers, at 3%, 2008/09 was also the peak in the proportion of 16–59-year-olds in England and Wales who when surveyed said they had used cocaine or crack in the past year. That figure fell to 1.9% in 2012/13 before rising slightly to 2.3% or 2.4% from 2013/14 to 2015/16. In the final of those years all but 0.2% of the 2.4% of the population who had used the drug said they had used it in the form of cocaine powder, making it the second most commonly used illegal drug after cannabis. For this variant of cocaine, use levels seem similar in Scotland. Across the UK, most of these past-year users have taken the drug just a few times during that period, well short of any suggestion of dependence; just 2% in Scotland considered themselves dependent.



However, household surveys can greatly underestimate use of stigmatised drugs and those commonly used by people not residing in settled households. Studies of problem drug use conducted between 2004/05 and 2011/12 (2004/05 2005/06 2006/07 2008/09 2009/10 2011/12) in England have instead estimated crack use by triangulating from treatment and criminal justice statistics. The resulting estimates are probably more realistic than those from household surveys, but are confined to problem users, defined as users of opiates and/or crack whose use has brought them into contact with treatment services or the criminal justice system. Corresponding estimates for Scotland do not include crack.

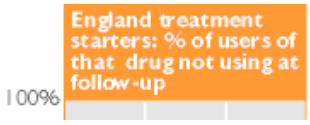
The English figures confirm that problem crack use is rare, in 2011/12 (latest estimates) involving 166,640 adults aged 15 to 64, equivalent to about half a per cent (0.476%) of the population of that age in England. Most were using crack alongside opiates like heroin; it can be estimated that very roughly about 38,000 adults were using crack without also using opiates, equivalent to under a quarter of all problem crack users ▸ chart.

Crack's peak in this series of estimates came in 2005/06 with an estimated 197,568 problem users or about 0.6% of the 15–64-year-old population. The upper range of that estimate remained well above the lower range in 2011/12, suggesting that the 16% fall in the estimate between those years was no fluke of sampling, but real. Neither was it entirely due to diminishing opiate use leading to a corresponding fall in the accompanying use of crack, because numbers using crack but *not* opiates seem also to have fallen from a peak of roughly 59,000 in 2008/09 to 38,000 in 2011/12, down by about 36% ▸ chart.

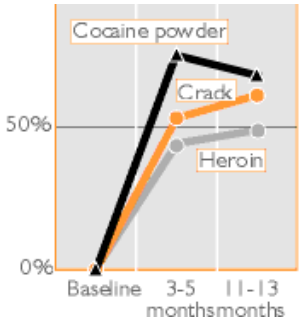
Most patients stop using

For heroin there are effective pharmacological treatments like methadone to more safely and legally meet the patient's need for opiate-type drugs, and naltrexone to block the effects of opiates and promote abstinence. For cocaine, decades of searching have failed to find a recognised drug-based treatment (1 2), and no specific psychosocial therapy has been constructed which can fill the therapeutic gap. Instead, services have turned to less conventional methods such as acupuncture, yet studies show that too fails to help.

Serial disappointment in research terms might lead some to conclude that in practice too, when it comes to cocaine and crack, 'nothing works'. But unlike many drug trials with their placebo controls, research on psychosocial treatments is usually



about whether the evaluated intervention works *better* than an established or alternative therapy, not whether it works at all. The findings can be interpreted to mean that just about any bona fide counselling or therapeutic approach helps some people some of the time, often many much of the time, and usually to roughly the same degree. Though no specific approach has been proven, the consensus is that "Psychosocial interventions such as [cognitive-behavioural therapy] and contingency management remain the mainstay of treatment." These do not have to be very sophisticated, though severe cases may need continuing support and residential care (1 2).



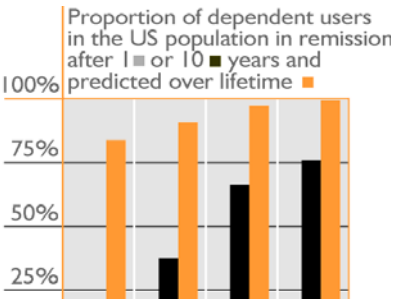
As to the 'not in the same ball park' claim about the respective addictiveness of crack and heroin, that seems partly true, but in the opposite direction to that suggested by Bob Stutman. In the latest English national drug treatment study, primary users of crack and cocaine powder were more likely to stop using than were primary heroin users. Of the heroin users who could be followed up (many patients were not), three to five months after starting treatment 44% had stopped using, and about a year after starting treatment, 49%. Corresponding figures for stopping crack use were higher at 53% and 61% respectively, and for cocaine powder, 75% and 68% ▸ chart.

Routinely collected statistics tell a similar story. In England in 2015/16 assessments of patients still in treatment after about six months indicated that two-thirds whose drug problems included cocaine powder and around 45% for crack had become abstinent from those drugs, compared to 39% recorded as having stopped using opiates. When not complicated by opiate use problems, around 60% of patients had stopped using crack. If (as usually it did) crack use accompanied opiate use problems, it more often persisted, but still 43% of opiate/crack patients had stopped using crack compared to 32% who stopped using opiates. When cocaine treatment numbers peaked in England in 2008/09, a special analysis showed that if patients stopped using or reduced their use of powder cocaine, they also reduced their use of other substances, indicating that cocaine use reductions had not been at the expense of increased use of other drugs.

In Wales and Scotland too, similar assessments tell a story of abstinence as the most common known outcome for cocaine-dependent patients. In Wales between 2009 and 2016, 68% of cocaine users were recorded as no longer using the drug at their treatment exit reviews compared to 56% of opiate users. In Scotland in 2011/12, reviews three months after treatment entry recorded that 80% of powder cocaine users and all the (small number of) crack users were no longer using these drugs.

Statistics based on in-treatment assessments are dependent on patients being still in treatment and available for assessment, the assessment being conducted, recorded and notified to the relevant database system, and the patient and their keyworker accurately documenting the patient's drug use. Many patients are lost track of along the way, a major limitation not applicable to the same degree to records of treatment exit and re-entry. In England, some 44% of primarily crack-dependent patients (re)starting treatment between 2005/06 and 2013/14 were recorded as having completed their treatments, left free of dependence, and not later having to return. For cocaine powder, the corresponding proportion was 55%, both much higher than the 27% for opiates. The implication is that treatment failure and/or post-treatment relapse are more common for patients treated for problem opiate use than for those treated for problem use of cocaine powder or crack. For cocaine powder, the completion and non-return proportion was slightly higher than the 53% for cannabis, not normally considered an extraordinarily addictive substance. Add in what was probably a substantial number of patients who left treatment prematurely but nevertheless overcame their dependence, and a clear majority of patients once dependent on cocaine or crack can be presumed to have been able to manage without having to return to treatment.

For the USA we can broaden the picture beyond treatment to the general population of cocaine users. Among the general US population, within a year of first becoming dependent nearly 9% of cocaine/crack users were in remission and within ten years, 76%, both substantially higher than for drinking, smoking or using cannabis ▸ chart. That black Americans were half as likely to be in remission from cocaine/crack dependence as their white counterparts suggests that the resources



available to the individual to make and sustain their break from cocaine are a critical factor.

Such differences are there are between the recovery rate from crack versus cocaine powder can largely and perhaps entirely be explained not by the greater inherent addictiveness of crack, but by the nature of its regular users. Even among the treatment caseload, in Britain users of cocaine powder are on average endowed with greater recovery resources than the typical drug treatment patient. They are less likely to have had their resources eroded by conviction and imprisonment and more likely to be in paid employment or education. Alongside the US figures, it can be inferred that the relatively good prognosis of the average user of cocaine powder is partly due to their having a better stock of ‘recovery capital’ resources with which to extricate themselves out of dependence. In the general population too, despite some spread to poorer neighbourhoods, still in 2013/14 in England and Wales, cocaine powder use remained most common in the more affluent urban areas and among regular pub and nightclub goers, signs of its association with the ‘good time’ available to the well-off rather than the less favoured demographic associated with dependent heroin/crack use.

Thanks for their comments on this entry in draft to Tim Millar of the University of Manchester in England. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 06 July 2017. First uploaded 01 March 2010

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