DRUGS AND XENOPHOBIA

The drug problem in Britain is getting worse. Just how much worse, and the reasons why are, however, open to question.

Estimates made on the basis of unpublished local studies suggest that the total number of people in Britain and Northern Ireland who used opiates — drugs like heroin, made from the opium poppy, and synthetic opiate-like pharmaceuticals — *regularly* (and were to some extent dependent) at some stage during 1982 was of the order of 40,000. A larger number would have been less heavily involved with a variety of illegal drugs — not only opiates, but also injected ground-up pills such as barbiturates, and sedative, tranquilliser or stimulant pills (like amphetamines) taken by mouth. 'Multi-drug use', as it is called, has been quite a consistent feature of the drug scene: but street-level observers are increasingly concerned about increases in numbers of people *smoking* heroin in the mistaken belief that this mode of use does not involve a risk of dependency. Since 1982, observers contend, the numbers of drug users have increased, partly due to increases in availability of imported heroin and illicitly diverted pharmaceuticals (synthetic opiates, tranquillisers, sleeping pills, etc) and there are now few areas of Britain where health authorities and police deny there is a problem. The relatively benign cannabis continues to be used to an unknown extent, as the recent Paul McCartney incident reminds us.

One problem in assessing the extent and presumed increase in numbers of drug users is the curious reluctance of researchers working in the area to publish details of how they have arrived at their estimates. Government publications refer to a DHSS-supplied formula based on research that has never been published and hence made properly available for scientific scrutiny and debate.

But perhaps a more serious problem is the obsession with 'numbers'. The severity or character of a drug problem is not simply a matter of numbers, and a more accurate head-count would leave us with few clues about how to respond constructively. What is more important is a realistic understanding of what *sort* of problem it is. Unfortunately for the development of policy and welfare practice in this area, the explanations of the problem currently being put forward in progressive circles are marred by a combination of xenophobia approaching racism, and nostalgic sentimentality that tries to interpret 1980s drug use in terms of concepts and images that were popularised in the 1960s.

Looking first at the xenophobic aspect of current explanations we find that academic and lay commentators characteristically attribute increases in drug use to assumed

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increases in international supply of opiate drugs (supply-push model of the economy). As Paul Brown put it in the first of three full-page spreads on 'A Generation on the main line to tragedy' in the *Guardian* this January, 'Britain's bad luck stems from the sources of supply. In the late 1970s British hospitality to the middle classes fleeing Iran after the revolution meant that we also received huge quantities of heroin. It was the easiest way of moving money out of Iran. The second supply boom, which is worsening all the time, originates in Pakistan — from the Afghan border'. This sort of explanation has long been favoured by Western commentators, and has quite frequently been backed up in a material way by aid and 'development' programmes that impose conditions including eradication of cultivation of plant drugs. Acknowledged problems faced by this 'supply-side' approach to drug prevention include the difficulty of eradicating a profitable crop in poor countries, and the fact that traffickers can always switch to a new country or region if their existing source dries up.

But there is an even deeper problem, as Third World commentators have pointed out to Western agencies. The obvious shortcoming of the supply-side explanation of drug use is its neglect of the domestic (UK) factors that encourage the international trade in plant drugs like opium and its derivatives, and also encourage the illicit diversion of synthetic opiate-like drugs from pharmaceutical sources. It's very easy to blame Iranians, Pakistanis and other foreigners. Such apportioning of blame has a long, dishonourable and racist history focusing upon Chinese, Mexicans, Afro-Caribbeans etc, thereby inverting the longer-standing history of European drug trafficking, starting with the Opium Wars and continuing with modern pharmaceuticals.

But the fact is that, ever since cash-cropping was introduced into Third World countries, there always has been a multiplicity of sources of potential drug cultivation and supply, waiting upon demand from industrialised and urban areas.

Let us look, then, at the question of the demand for drugs. Popular mythology has it that the demand for drugs in general, and for heroin in particular, is generated by a desire to 'escape' pressing personal and social pressures and problems. As a drug worker quoted in the *Guardian* article put it, 'Heroin is the drug of the 80s, it blocks out the pain and the hopelessness of unemployment and the bleakness of the future'. This model of the problem— social conditions breed casualties, and casualties turn to drugs, gaining short-term relief at the cost of longer-term pain and pathology — is borrowed from the 1960s. As Jock Young described it many years ago, it suggests a 'nemesis effect'. It gained adherence in a period in which the Keynesian dream of postwar reconstruction foundered on a more disciplinary spirit which insisted that unearned consumption and pleasure must always end in tragedy. But does this sentiment give us an understanding of drug use in the 1980s?

Unemployment and recession is certainly the context surrounding much drug use today. But not all people respond to unemployment (or the prospect of unemployment) by saying 'ain't it terrible, I give up' and retreating into a timeless and infantile void of intoxication or into some other form of passive, deviant consumption. For many people — depending upon the material and cultural resources available to them — unemployment invites an active search for alternative, opportunistic and entrepreneurial ways of passing time, meeting people and 'making out' through the buying, selling and exchange of goods and services. Such activities are sometimes described as constituting the 'informal' (or fringe) economy. It is as *one aspect* (or one sector) of the informal economy and its attendant cultures that we can understand styles of involvement with drugs today.

Recent studies of the informal economy highlight a range of activities that are both economic and social, and yet outside the formal boundaries of the wage economy. Small scale production and provision of a range of services — renovation and repair, odd-jobs and cleaning, trading in goods that 'fell off the back of a lorry', 'cash-in-hand', fetching and carrying jobs, provision of sexual and other services — these continue and many expand in a recession, as people search for alternative sources of income, and move partially ,into barter and exchange. This highly entrepreneurial, small-business activity is not simply financially motivated though that is a major consideration. The appeal is also 'political' — making out in the market economy, being independent, enjoying the rewards— and social — having a framework within which to meet and meaningfully interact with other people. It is through the expansion of these aspects of the informal economy that recession and unemployment have been converted into an increase in the demand for a *variety* of goods and services, including plant-based and synthetic drugs.

Far from being the 'helpless victims' of international drug trafficking and supply, urban drug users are generally active participants in an economy and culture of exchange of drugs and other goods and services. It is difficult to see how this aspect of the market economy and its attendant cultural practices could be separated from the larger process of social recomposition and economic restructuring upon which Britain has for some years been embarked.

To blame foreigners for side-effects of our own economic and social policies — for example to blame them for 'Britain's bad luck' in respect of drug problems — hardly reflects reality. Nor, on the domestic front, is it helpful to underwrite stereotypes of a division between economically-minded drug pushers and their drug-consuming 'victims', when the reality is rather more complex. It is this polarised thinking — foreigners versus English, pushers versus users, 'economic' versus 'social problems' — that disables policy and practice in the drugs field.

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