



An Overview of Cocaine Use in Ireland: II

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An Overview of Cocaine Use in Ireland: II

A Joint Report from the National Advisory Committee on Drugs (NACD)
and the National Drugs Strategy Team (NDST)

2007

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Foreword – Minister of State

Over the past number of years I have become increasingly aware of the concerns about the level of use of cocaine in Ireland, broadly reflecting the increase in the availability and use of cocaine in Europe generally. These concerns have been highlighted to me in particular through my engagement with various local communities.

Against this background, I requested a joint report from the National Advisory Committee on Drugs (NACD) and the National Drugs Strategy Team (NDST) to give an overview of cocaine and its use, based on existing data sources in Ireland. This was done with a view to facilitating the development of an appropriate response within the framework of the National Drugs Strategy.

As the report shows, the risks associated with cocaine are extremely high and the physical and mental health problems that arise from its use are alarming. Cocaine is particularly dangerous when combined with alcohol and other substances and these messages on the real dangers associated with its use need to be highlighted. The social and economic harm caused also needs to be stressed, not only to the users of cocaine, but also to communities that bear the brunt of the behaviour of the criminal activity associated with the supply of cocaine.

The report also highlights that cocaine use is predominantly a young adult phenomenon affecting mostly those aged between 15 and 34. It is perceived that there is a significant hidden population of so called "recreational cocaine users" who do not see themselves as having a problem. However, many of these are likely to develop significant problems in the longer term and it is important to get credible and unambiguous health promotion and harm reduction messages to this group.

At the same time, we must emphasise that the available treatment is effective. It is clear that one of the challenges facing service providers is to persuade cocaine users to avail of treatment, while the continued upskilling of personnel to meet the needs of cocaine users is also important.

The challenges posed by cocaine use are significant but I am confident that we can meet these challenges through a co-ordinated approach utilising the structures of the National Drugs Strategy.

Finally, I would like to record my appreciation of the on-going work of both the NACD and the NDST and commend them for their collaboration on this report.

Noel Ahern T.D.

Minister of State with responsibility for the National Drugs Strategy

Foreword – Chairperson

This overview of cocaine use in Ireland encompasses all of the elements of the NACD's mandate which is to advise the Government on the prevalence, prevention, treatment and consequences of problem drug use in Ireland.

Arising from concerns regarding increased levels of cocaine use in Ireland, the Government requested in late 2005 that the NACD and NDST prepare a report to update information on cocaine use previously published in 2003 by the NACD. The NACD engaged the services of a researcher Dr Justine Horgan to draw together and update all the information and this report is the result. It represents a significant effort by many agencies and individuals who contributed information and data and analysis for inclusion in it. My colleagues and I are enormously grateful to them for their help and their willingness to share information with us.

Consistent with the 2003 report, it is clear that all the indicators point to a continued increase in cocaine use, that this cocaine use crosses all social strata and that the impact is very much experienced nationwide. Communities are experiencing the consequences in sharp increases in public disturbance, noise, intimidation and violence. Individuals are experiencing the consequences in terms of disrupted personal relationships, employment, income as well as physical or mental ill-health.

This was the NACD's first collaboration on a joint paper with the NDST. The collective expertise brought to bear on this report has resulted in very clear recommendations to Government. This report has been viewed by the Interdepartmental Group on Drugs and the various stakeholders are already laying plans to address the many issues raised.

Notwithstanding all this progress, it is imperative that the information contained in this report is used by policy makers, service providers, indeed general practitioners, hospital consultants and community groups to better understand the impact of cocaine on individuals, families and communities. Services must become more visible to those who may need to benefit from them.

In presenting this report for consideration by all those involved in responding to the cocaine phenomenon, I, on behalf of the NACD, would like to record our appreciation of the hard work by the lead researcher Dr Justine Horgan, supported by the Research Advisory Group listed overleaf.

Dr Desmond Corrigan

Chairperson

Acknowledgements

The NACD is grateful to Dr Justice Horgan for compiling this report.

Sincere thanks to the various centres that gave experience and insights from a service delivery perspective by participating in a telephone survey, which was conducted by the NACD early in 2006. The NACD and the NDST are grateful to the participants of focus groups, to Merchants Quay Ireland, Ruairidh McAuliffe and Emily Reaper from UISCE.

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Glossary

AnGS	An Garda Síochána
CDLE	Customs Drugs Law Enforcement
CLAN	College Lifestyle and Attitudinal National (CLAN) Survey
CND	Commission on Narcotic Drugs
DAIRU	Drug and Alcohol Information and Research Unit, Northern Ireland
D/E&S	Department of Education and Science
DJEQLR	Department of Justice, Equality and Law Reform
DMR	Dublin Metropolitan Region
DMRD	Drug Misuse Research Division of the Health Research Board
DTCB	Drug Treatment Centre Board
ED	Electoral Divisions (formerly known as District Electoral Divisions (DEDs))
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ERHA	Eastern Regional Health Authority
ESPAD	European School Survey Project on Alcohol and Drugs
ESRI	Economic and Social Research Institute
FSL	Forensic Science Laboratory
GNDU	Garda National Drugs Unit
HBSC	Health Behaviour in School-Aged Children
HIPE	Hospital In-Patient Enquiry
HRB	Health Research Board
HSE	Health Service Executive
IDG	Interdepartmental Group on Drugs
INCB	International Narcotics Control Board
LDTF	Local Drugs Task Force
MBRS	Medical Bureau of Road Safety
MDA	Misuse of Drugs Act (1984)
MQI	Merchants Quay Ireland
mt	Metric tonnes
NAFTA	North American Free Trade Agreement
NACD	National Advisory Committee on Drugs
NDST	National Drugs Strategy Team
NDTRS	National Drug Treatment Reporting System
NIDA	National Institute on Drug Abuse
RDTF	Regional Drugs Task Force
ROSIE	Research Outcome Study in Ireland: Evaluating Drug Treatment Effectiveness
SAMHSA	Substance Abuse and Mental Health Services Administration
SHB	Southern Health Board (January 2005: HSE Southern Region)
SLÁN	National Health and Lifestyle Survey
UISCE	Union for Improved Services, Communications and Education
UNODC	United Nations Office on Drugs and Crime

Executive Summary

In late 2005, discussions at the meetings of the National Drugs Strategy Team (NDST), the Interdepartmental Group on Drugs (IDG) and the National Advisory Committee on Drugs (NACD) raised the need for an update on cocaine use in Ireland. Following a Ministerial request, the NDST and the NACD agreed to jointly prepare this update in 2006. A wide range of agencies, departments and other data sources were contacted to provide data/information confidentially to the NACD, which would culminate in a report to Government. A Research Advisory Group was established to support and monitor the process and a summary report (see Chapter 8) was submitted to Government in September 2006.

This report is intended to set out an understanding of cocaine in the Irish context by examining the issues such as prevalence, treatment, consequences, prevention and harm reduction. The report examines how cocaine affects the individual physically and mentally (chapter 2); it provides knowledge on the extent of use in the international as well as the national contexts (chapter 3); it provides information relating to trends in cocaine supply (chapter 4); it provides information about those seeking treatment for cocaine as their primary problem drug and as a secondary problem drug and outcomes data from the ROSIE study (chapter 5); it considers the consequences of cocaine use/availability for communities including marginalised groups (chapter 6); it reviews responses to cocaine in the literature (chapter 7) and finally, it presents a conclusions chapter with recommendations to Government (chapter 8).

It is clear from all the data gathered that indicators are pointing to an upward trend in cocaine use. The extent to which cocaine use has increased is exemplified by the apparent three and four fold increase in those seeking treatment for cocaine use as a primary and secondary problem drug respectively. Regarding the latter group, cocaine increasingly features in the drug repertoire of opiate-dependent individuals. The need for increased access to injecting equipment is apparent as injecting cocaine users tend to binge use (due to the very short-acting nature of the effect of cocaine). Consequences for communities show changing levels and types of crime within communities with histories of drug problems. Families describe greater levels of intimidation, violence to the person as problem users find themselves in unmanageable debt very quickly. Service providers describe some difficulties with behaviours of clients, others feel ill-equipped to address problem cocaine use and some have engaged in innovative approaches to address local needs. There is no social grading of cocaine - people from all walks of life, from all social strata report cocaine use, however, some communities appear to be disproportionately affected i.e. those with an established history of problem drug use.

The evidence indicates that to encourage cocaine users to avail of current treatment services will require a more cocaine-specific focus. Furthermore, studies suggest that overcoming high levels of treatment drop-out and re-lapse among cocaine users will require careful assessment and matching between cocaine users and their specific needs. Notwithstanding this, findings also highlight that drug service providers themselves feel information and training regarding cocaine for all professional health and specialist drug agencies is important. This training should include the specifics of treating cocaine and other drugs they encounter.

Finally, this report is intended to act as an information guide to those working in the policy or service delivery arena to enable them to address cocaine use issues. There is no doubt that some flexibility is required in meeting the diverse needs of such a disparate group of drug users.

The NACD is indebted to all the contributors, researchers, proof readers and the NDST for their effort in bringing about this report in a timely fashion.

Mairéad Lyons
Director, NACD

Chapter 1: Introduction – Background

In 2003, the National Advisory Committee on Drugs (NACD) published *An Overview of Cocaine Use in Ireland*. This report found evidence of cocaine use around the country and concluded that only small numbers of primary cocaine users were coming forward for treatment. Polydrug use was highlighted as a challenge for all aspects of drug service – education, prevention, treatment and harm reduction services. Since then, the Mid-term Review (June 2005) of the National Drugs Strategy (2001-2008, Department of Tourism, Sport and Recreation) has noted an increased prevalence of cocaine misuse and in the complexity of polydrug use involving cocaine both in terms of supply and demand for treatment. This report was undertaken against a backdrop of evidence both scientific and impressionistic indicating that cocaine is more easily available than ever before, is being used more than ever before and problematic use may be crossing, what were considered to be boundaries of income, education and employment status.

Methodology

This report, produced jointly by the NACD and the National Drugs Strategy Team (NDST), has the purpose of updating government on cocaine use in Ireland. It provides an overview of developments and trends by looking at the following areas: cocaine use in the population, the supply of cocaine and the demand for treatment for cocaine-related problems. The report looks also at how cocaine use is experienced in the local community – considering whether members of the community are aware of cocaine use, what type of reaction there is to the drug and considering the ways local communities might respond. To examine these issues it was necessary to draw on a wide variety of sources of information, using various indicators of drug misuse. These include prevalence data from population surveys, criminal justice data, laboratory data, drug treatment data, surveys, interviews among users and research studies. Additional information was gained from cocaine-related studies reported in the relevant scientific literature¹. A Research Advisory Group was convened to monitor and support the information/data gathering process. They provided expertise on the interpretation of data/analysis and on the preparation of the report.

Indicators – the limitations

Broadly speaking, there are two types of data available on drug use, routine and non-routine indicators (Diemel & Blanken, 1999). Routine indicators comprise of police and criminal justice statistics, drug treatment data (for example, the National Drug Treatment Reporting System (NDTRS)), and drug-related morbidity data (for example, Hospital In-Patient Enquiry (HIPE)). These data are generally collected continuously and documented in annual and occasional reports. Routine statistics can provide valuable information on many aspects of drug use; invariably such data sources are concerned with more problematic aspects of drug consumption. Non-routine indicators of drug use encompass data that are not routinely collected (i.e. prevalence studies, studies of drug using populations, ethnographic/qualitative studies, community-based drug monitoring studies/surveys). These sources are directly focused on the use of drugs, either by the general population and subsets of the general population or among specific drug using populations.

Some of the routine indicators mentioned above (for example, police and criminal justice statistics) and reviewed in this document are official statistics - that is any data collected and published by government departments - and they are all subject to the same criticisms. Official statistics are clearly produced in specific organisational contexts (Miles & Irvine, 1979) and are collected essentially for

¹ Details of methods used in the literature review are presented in Chapter 7.

official, administrative and political purposes. Thus, their intended purpose will usually be different to that of the researcher. They are neither socially nor politically neutral, but are organisational products, as they are produced within a structure of interest. Consequently, there is a need to exercise caution when interpreting any data derived for administrative purposes.

For example, much has been written about the use of police and criminal justice statistics in research, which more so than other social statistics, never provide a simple mirror image of a state of the world 'out there' (Bottomley & Pearse, 1986; Maguire, 1997). As with other official statistics, these data for the most part are collected in the course of duty, rather than for research into drug use. When data highlights a trend in drug-related offences, from a research perspective it is difficult to directly relate this information to prevalence. For example, does the fact that there were more heroin-related offences in Ireland than cocaine-related offences between 1990 and 2004 indicate that there are more heroin consumers? Or does it illustrate that heroin users are more likely to come into contact with the Garda authorities, to have proceedings taken against them, or to be charged with an offence? Does the fact that in 2005 cocaine offences surpassed heroin-related offences, mean that there are more cocaine consumers than heroin users that year? Or does the data tell us more about policing activities in relation to cocaine than the prevalence of the drug. Despite the limitations of crime statistics, critics recognise the importance of such routine statistics; not only in terms of their organisational function but also in the role they can play in contributing to knowledge, once their limitation has been recognised.

The National Drug Treatment Reporting System (NDTRS) is an epidemiological database on treated drug and alcohol misuse in Ireland. It was established in 1990 in the Greater Dublin Area and was extended in 1995 to cover all areas of the country. The reporting system was originally developed in line with the Pompidou Group's Definitive Protocol (Hartnoll R, 1994) and subsequently refined in accordance with the European Monitoring Centre for Drug and Drug Addiction's (EMCDDA) Treatment Demand Indicator Protocol (EMCDDA, 2000). The Treatment Demand Indicator Protocol requires that data are collected from each individual entering or returning to drug treatment during a calendar year. The protocol excludes individuals who are assessed but who do not progress to treatment. Since 2004, cases who are assessed but who do not proceed to treatment have been recorded in the NDTRS in Ireland; this provides a better measure of unmet demand for treatment. The second major limitation of the Treatment Demand Indicator Protocol is that data are not collected on clients exiting treatment, and therefore, there are no routine data on immediate treatment outcomes. In 2006, staff at the NDTRS and the HSE Southern Region designed an exit form. The exit form is being piloted in part of the HSE Southern Region for the duration of 2007.

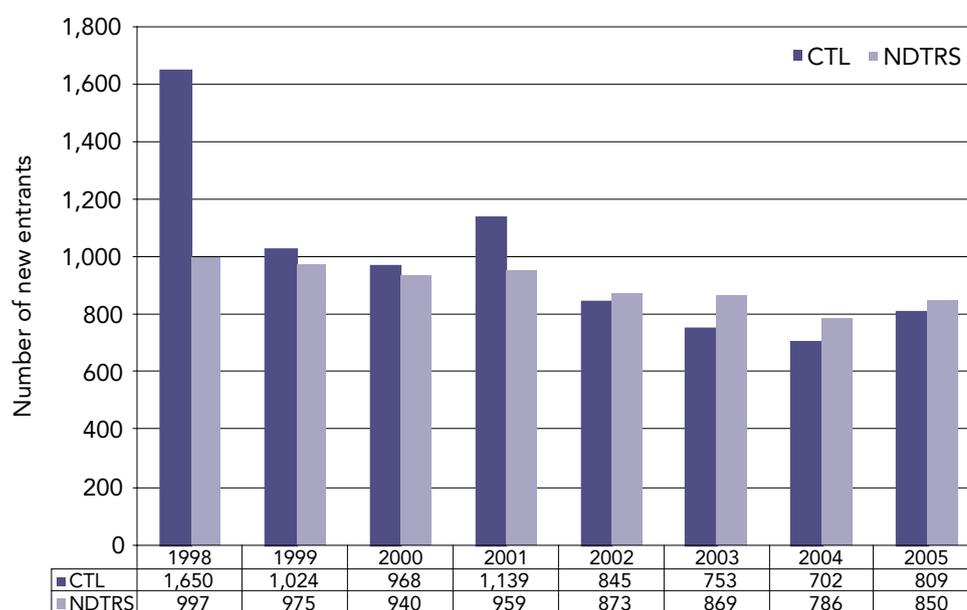
In Ireland, there are limitations to the implementation of the Treatment Demand Indicator Protocol. The protocol requires that inpatient services, outpatient services, low-threshold services, general practitioners and prison services participate in the drug treatment reporting system. Participation in the NDTRS is measured at two levels, the proportion of services reporting cases and the proportion of cases attending each service reported to the NDTRS.

In Ireland, approximately 80% of inpatient, outpatient, and low-threshold services reported cases in 2002, while in the same year, only 10% of level 1 and level 2 general practitioners reported cases to the NDTRS (Long et al, 2005). In 2005, a nurse researcher was employed to recruit general practitioners and complete NDTRS data from 2001 to 2005. By the end of 2006, 75% of general practitioners had provided complete data for the period 2001 to 2005. The Irish prisons have never participated in the reporting system though they do provide methadone treatment; this issue will be addressed in 2008.

Completeness refers to the proportion of cases attending each participating service that are reported to the NDTRS. In 2003, this was measured for cases in methadone treatment in Dublin for the reporting year 2001 and only 61% were reported (Kavanagh et al, 2006). The results of this study were presented to the managers and service providers at methadone services in the Dublin area and a major exercise was carried out to ensure complete data returns for each participating service for the period 2001 to 2003. This study will be repeated in 2008. In the meantime, methadone data returns for new cases are compared to new cases reported to the Central Treatment List (CTL) and current returns would appear to be complete. The NDTRS have a higher number of new cases than the CTL as some opiate cases do not require methadone treatment but may require counselling or other medications (such as lofexadine) (Figure 1). There was a higher number of new opiate cases reported to the NDTRS compared to those reported to the CTL between 2002 and 2005.

The accuracy of the data collected for each person in treatment in each participating service was measured for cases in methadone treatment in Dublin in 2001 and was less than the desired 90% for a number of important variables (Kavanagh et al, 2006). Since 2004, detailed data collection protocols have been developed and service providers have received training based on these protocols. NDTRS data must be interpreted considering these limitations (J Long, personal communication, 2007).

Figure 1: Numbers of new clients registered with the Central Treatment List (CTL) and the NDTRS (1998-2005)



Source: unpublished data from the CTL and NDTRS

The first Drug Prevalence Survey in Ireland and Northern Ireland was jointly commissioned by the NACD in Ireland with the Drug and Alcohol Information and Research Unit (DAIRU) within the Department of Health, Social Services and Public Safety in Northern Ireland. This drug prevalence survey has been carried out in accordance with EMCDDA guidelines using a structured questionnaire and face-to-face interviews among the 15-64 year age group normally residing in private households. Information on lifetime (ever used a drug), last year (recent) and last month (current) prevalence was collected. In

order to achieve a sample that is representative of the population the sampling frame must be chosen such that households have an equal chance of being selected in the sample. In Ireland, the Ordnance Survey Geo-directory provided the primary sampling frame. The sample was selected so that it was representative of the population in terms of age, gender, location and socio-economic status.

Limitations of general population surveys have been acknowledged in the EMCDDA guidelines. Those not normally residing in private households such as the homeless or those living in institutions are excluded. In addition, problem drug users may be under represented due to the chaotic and complicated nature of problem drug use for example injecting heroin users or crack cocaine users. Different methods are recommended to establish prevalence amongst these groups. The interview mode also has limitations each one having some advantages and disadvantages. Face-to-face interviewing is preferred due to the potential to have higher response rates and the possibility of monitoring non-response rates which affects the overall reliability of the sample. It is, however, more expensive than say telephone interviewing. (EMCDDA, 2002).

Trends

The indications are that since 2003 the problems relating to polydrug use have continued among the general population and among people seeking drug treatment in Ireland. Cocaine is one of the multiple substances commonly used; the others are alcohol, cannabis and ecstasy. Since the early 1990s the number of new cases seeking treatment for cocaine problems has increased most years and now represents a larger share of the total treatment seeking population than ever before. Among long-term problem drug users, the drug repertoires have extended to include a larger and more diverse range of substances (Farrell *et al*, 2000; Rooney *et al*, 1999), including cocaine. Cocaine is used very frequently by opiate users and with negative consequences for their health and well-being. At the level of the local community, members are particularly fearful of the potential harm cocaine inflicts. There is concern about polydrug use and about the consequences of alcohol and cocaine used together.

The report also raises concern about cocaine treatment/interventions. The increase in problems associated with polydrug use² and the growing prominence of cocaine pose distinct challenges for drug treatment services. It raises the question whether existing drug services are meeting the needs of cocaine users? Each year since 1998, the number of cases previously treated for cocaine has increased. Ireland's drug services have developed vast experience with an opiate using client group and while cocaine use among this client group is substantial, the pharmacology of cocaine makes it difficult to treat addiction in the way heroin has been treated.

The report

As a starting point, it is worthwhile providing an overview of the legal backdrop to and the pharmacological properties of cocaine. Chapter 2 presents information about the drug cocaine, its principal properties, routes of administration and the consequences of consuming the drug. Chapters 3, 4 and 5 present data on three indicators of cocaine use in Ireland: Chapter 3 overviews cocaine use first in the international context and then examines a variety of data including population surveys and laboratory data to describe the situation

² The definition of polydrug use applied in this report refers to concurrent drug use, which involves a person using at least two substances during the same period (for example, having used both cocaine and ecstasy in the last month) (Bulletin 5, NACD, forthcoming).

in Ireland. Chapter 4 examines the indicators of cocaine supply. The issues of cocaine-related interceptions are discussed in the international and national contexts. For the purpose of the Irish context, criminal justice data as well as results from forensic laboratory analyses provide an overview of the geographic spread of seizure activity, drug purity as well as an indication of trends in cocaine-related offences.

The issue of cocaine use and demand for treatment is dealt with in Chapter 5. Data from the NDTRS allows to examine the change in numbers seeking treatment for cocaine between 1998 and 2003. To build a picture of developments in the interim, laboratory data based on cases attending drug services for treatment is examined. In addition hospital morbidity data is examined. This chapter also looks at data from a multi-site drug treatment outcome study, the Research Outcome Study in Ireland: Evaluating Drug Treatment Effectiveness (ROSIE) and examines whether methods for treating opiate drug use impact on cocaine use.

Chapter 6 looks at the emergence of and subsequent response by the community to cocaine use. The first section focuses on the prevalence of cocaine as reported by the community and the extent to which communities identify cocaine as an emerging problem. In order to capture the specific problems and experience with problematic cocaine use, the views and experiences of a group of drug service providers and problematic cocaine users are outlined.

Chapter 7 deals with the theme of responding to cocaine use. The main results of a literature review of what is known regarding effective treatment/interventions for dealing with problematic cocaine use. Following this, an overview of how treatment/intervention services have sought to respond to increasing cocaine use among client groups in Ireland is presented. Chapter 8 presents a summary of the main findings from earlier chapters, as well as outlining the main conclusions and recommendations which emerge from the report.

This report is the product of a collation of data/information, scientific and other, about the use, supply, treatment of and response to cocaine in Ireland.

Chapter 2: About Cocaine

Introduction

The drug, cocaine hydrochloride is a stimulant derived from the leaves of the coca bush which grows primarily in the South American countries of Columbia, Peru and Bolivia. In Ireland, the drug is available in two forms, cocaine powder (hydrochloride salt) and crack (freebase). Cocaine powder is usually administered by snorting through the nose using a rolled up banknote, straw etc. Cocaine may also be made into a solution and injected either on its own or in combination with heroin (known as a 'speedball'). Crack, or freebase, is produced by 'washing' the salt with ammonia or mixing it with sodium bicarbonate, and is so called due to the cracking sounds the 'rocks' make when smoked in a pipe.

Legislation

Cocaine is controlled in Ireland under the Misuse of Drugs Act (MDA) 1984. The leaf is covered under Schedule 1 as it has no recognised medical use; consequently, a licence may be granted by the Minister for Health and Children for research and analysis purposes. Cocaine and its salts are covered under Schedule 2, this makes it illegal to produce, possess or supply the drug, except on prescription. It is also illegal to allow premises to be used for production or supply.

The effects and risks

The drug takes effect within minutes and users tend to feel energetic, alert, euphoric and talkative, with heightened sensations of sight, sound and smell. The effects from snorting cocaine start quickly and last for up to 30 minutes. When the drug effect wears off, the individual often feels low in mood, exhausted, intensely irritable and restless. As the body becomes more tolerant of the drug larger quantities are required to experience the same effect. Tolerance develops resulting in users taking larger and/or more frequent doses in order to maintain the high (for an overview of the effects of cocaine, see Corrigan, 2003 and further details can be found in NIDA (National Institute on Drug Abuse) Research Report 1999/2004; NIDA InfoFacts 1999; Scottish Advisory Committee on Drug Misuse, 2002).

There is a wide range of physical and psychiatric problems associated with cocaine use, many of which are serious and may even be fatal. Cocaine overdoses are unpredictable and combining cocaine with other drugs, particularly alcohol is highly risky (Pennings *et al*, 2002). When cocaine is taken with alcohol it combines in the system to form another drug – cocaethylene – which is more toxic than using either drug alone (Harris *et al*, 2003). Cocaine dependence is associated with a greater risk of suicidal behaviour (Marzuk *et al*, 1992) and this risk is even higher among those who use alcohol and cocaine together in a problematic way (Salloum, 1996).

Physical effects

Common physical effects of cocaine include dry mouth, sweating, loss of appetite and increased heart and pulse rate. Negative experiences include headaches, stomach pains and nausea, tremors, irritability, paranoia and hallucinations. Cocaine affects heart rhythms leading to possible heart attacks (White & Lambe, 2003); it can lead to chest pain, raised blood pressure, respiratory failure, strokes and seizures. Cardiac complications are the most common cause of death among cocaine users (White & Lambe, 2003) and can occur after acute or chronic use. Increased blood pressure can lead to a haemorrhagic

stroke. The constriction of the blood vessels leads to spasm in the vessels going into the kidneys, causing renal failure and the need for long-term renal dialysis. The clogging of the blood vessels is also caused by an increase in the clotting factors in the blood as the body counters the effects of cocaine by making the blood thicker. Repeated snorting of cocaine damages the membranes which line the nose. Repeated smoking of crack may cause breathing problems and partial loss of voice (NIDA, 1999). The short duration of action of cocaine and increased injecting in turn, increase the risk of sero-conversion. Intravenous cocaine users may also experience allergic reaction, either to the drug or to some adulterant in street cocaine, which can result, in severe cases, in death (White & Lambe, 2003). Long-term injecting may result in abscesses and infection. Injectors risk hepatitis and HIV infection if injection equipment is shared. The sharing of smoking/snorting equipment also involves a risk of contracting Hepatitis C. In addition, due to adulterants found in cocaine and the substances used to prepare it for injection, further complications of injection are evident such as abscesses, damage to veins, clots and infections. The most common adulterants found in cocaine in Ireland are a combination of lignocaine (a local anaesthetic which numbs the area to which it is applied³), in recent years the analgesic phenacetin⁴ is detected, and in smaller quantities caffeine (mimicking the stimulatory properties of cocaine) as well as a number of sugar based substances (such as mannitol, used to correct hydration and low blood sugar) are also found (Forensic Science Laboratory, personal communication, 2007⁵). Injectors of cocaine will experience numbing of the site and thus repeated injections at the same site will not hurt the person until the effects of the cocaine and lignocaine have worn off.

Poisoning with ammonia from protracted use of poorly manufactured crack is a potential health risk as are problems associated with acetone (used to reclaim cocaine from crack pipes) which may cause kidney, liver and nerve damage.

Bingeing/heavy use: Prolonged heavy use of cocaine is usually followed by a 'crash' if use is discontinued. These after-effects of using cocaine and crack may include fatigue and depression as people come down from the high. Restlessness, nausea, hyperactivity, insomnia and weight loss may develop with frequent use (NIDA, 1999/2004). Binge use may also lead to erratic behaviour, agitation, irritability, unpredictability and the person can become paranoid, aggressive and violent. Binge use may result in excessive spending for example, from €200 to €2,000 over a 3/4 day weekend (reported by drug users involved in the Tallaght Cocaine Pilot study, see chapter 7 for details).

There is considerable disagreement over what constitutes 'dependence' in the case of cocaine. Whether people become dependent, and if so how quickly it happens, vary depending on the individual user's mental state and other circumstances. Consequently, it is difficult to predict which users will maintain control and which will become compulsive users (Waldorf *et al*, 1991). Some empirical studies that have examined the emergence of cocaine addiction have reported that when cocaine dependence occurs, it does so early and explosively, with an estimated 5-6% of cocaine users becoming cocaine dependent in the first year of use (Wagner *et al*, 2002). Some empirical evidence suggests that females who start using cocaine are at a greater risk of developing problems with heavy use. One study estimated that women are 3-4 times more likely to become cocaine dependent within one-year of first using as compared to males (O'Brien & Anthony, 2005).

3 Other less prevalent local anaesthetics in street cocaine are benzocaine and procaine.

4 Phenacetin is now little used due to side effects such as severe anaemia, kidney damage and cancer of the renal pelvis (Sweetman 2006)

5 Please see Appendix 1 for an overview of the occurrence of adulterants in cocaine powder seized by An Garda Síochána and analysed by the Forensic Science Laboratory (2004-2006)

Impact of polydrug use on the body: Most problem cocaine users who seek treatment also use other substances, such as cannabis and alcohol. Those people in drug treatment for whom cocaine is an additional drug also use opiates and benzodiazepines, ecstasy and amphetamines (see Chapter 5). The impacts on the brain and the body of combined or polydrug use are summarised in Appendix 2, Table A2.

Mental health

General symptoms which have been described include impaired judgment, grandiosity⁶, combativeness and extreme psychomotor stimulation. Anxiety and panic attacks during cocaine consumption are common and may persist even after the use of cocaine has stopped. Chronic use or heavy binges can lead to the development of paranoid ideation associated with anxiety and may progress into a psychotic disorder, hallucinations psychomotor hyperactivity and agitation. Confusion and aggressive behaviour may develop and in such a state violent behaviour may ensue. Suicidal behaviour is frequent among cocaine-dependent individuals (Marzuk *et al*, 1992; Petronis *et al*, 1990), particularly where there is a family history of suicidal behaviour, of childhood trauma, of certain personality and psychiatric attributes, of alcohol and/or opiate dependence (Roy, 2001).

Chronic use may result in hyperprolactinaemia (altered hormone function) and gynaecomastia (breast growth) together with impotence. There are also incidences of disturbed menstrual function, galactorrhea⁷, amenorrhea⁸ and infertility.

Pregnant users of cocaine or crack may experience complications and find that their babies are adversely affected (Moroney & Allen, 2002). However the literature on prenatal cocaine exposure is unclear as to whether immediate postnatal effects on the infant are temporary, related to either acute toxicity of cocaine or to a withdrawal effect as the drug is metabolised, or whether these effects might persist. Mainly American-based studies suggest, that babies whose mothers used crack/cocaine during pregnancy can suffer a variety of serious consequences. For example, some report an increased likelihood of premature births (Jacobson *et al*, 1996); of the infant being smaller (Hurt *et al*, 1995) and lighter (Hadeed & Siegel, 1989; Chasnoff *et al*, 1992, NIDA, 1999/2004). A study of prenatal cocaine use in pregnancy (Chasnoff *et al*, 1992) reports that children of heavy cocaine-using mothers are more likely to develop cognitive problems such as poorer recognition, sub-optimal memory and information processing and deficits, with behaviours that are crucial to success in the classroom, such as blocking out distractions and concentrating for long periods of time.

Concluding remarks

The potential damage of cocaine use is undoubtedly considerable. Cocaine users not only run the risk of compromising their physical health, but also their mental health. Psychiatric problems can occur with psychostimulant use, especially with chronic use and during 'binge use'. Problems arising from the pharmacological effects of the drug on mood have been demonstrated in the forensic and clinical literature (e.g. Marzuk *et al*, 1992).

6 Having an exaggerated belief in one's importance, sometimes reaching delusional proportions, and occurring as a common symptom of mental illnesses, such as manic disorder.

7 The spontaneous flow of milk from the breast, unassociated with childbirth or nursing. It can be due to local causes or dysregulation of certain hormones.

8 The disruption or absence of the menstrual cycle.

Chapter 3: Indicators of Cocaine Use

Introduction

By way of providing a backdrop for the situation in Ireland, this chapter opens with a brief look at cocaine use in the international context. Cocaine use in several European countries is presented using data published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA 2003/2005). Cocaine use among the general and high-school populations in the United States is examined using data from the Substance Abuse Treatment Workforce Environmental Scan (SAMHSA 2003) and the United Nations Office on Drugs Crime (UNODC 2005/2006).

This chapter overviews cocaine use in Ireland based on prevalence surveys and other sources of information. Drug prevalence surveys are important, in that they can shed light on the demographics and geographic spread of drug use. The chapter reports evidence from the first All Island Drug Prevalence Survey, commissioned by the National Advisory Committee on Drugs (NACD) and the Drug and Alcohol Information Research Unit (DAIRU), Department of Health, Social Services and Public Safety in Northern Ireland). This survey provides information about cocaine use in the general population in Ireland. The most recent results of the SLÁN survey (2002) also provide data about cocaine use among the general population. School-going or school-aged populations are also covered using results from the Health Behaviour in School-Aged Children survey (HBSC) and findings on cocaine use among school-aged children in Ireland (aged 16 years) from the European School Survey Project on Alcohol and Other Drugs (ESPAD 1999/2004) Ireland are presented. Cocaine use among the college/university population is examined using the findings of the College Lifestyle and Attitudinal National Survey (CLAN 2002/2003).

The data reported in this chapter differ in terms of the research methods applied and the populations that have been targeted. The intention behind using these data has not been to draw comparisons among the results, but to use them as complementary sources of evidence. For example, the collection of more recent data on drug use in the general population has not yet been completed and consequently, other types of data are employed (i.e. laboratory tests) as supplementary sources of information.

Prevalence and patterns of cocaine use

International context

UNODC report some 13.4 million people (0.3%) of the world's population aged between 15 and 64 years have used cocaine in the last year (UNODC 2006). The European Union drug agency, the EMCDDA, estimates that around 9 million Europeans (3% of adults (15-64 yrs)) have used cocaine at least once in their lives; between 3 and 3.5 million (1% of all adults) are likely to have tried the drug in the last year, while around 1.5 million (0.5% of all adults) have used it in the last month. Use is concentrated mainly among young adults (15-34 years) and those living in urban areas (Drug Misuse Research Division (DMRD) 2005).

Cocaine use levels in Europe have moved upwards over the last decade, particularly in England & Wales and Spain – the countries with the highest cocaine prevalence rates in Europe. Annual prevalence of cocaine use in Spain rose from 1.6% of the adult population in 1997 to 2.7% in 2003. Germany experienced an increase in cocaine use from 0.2% in 1990 to 1% of the population age 18-64 in 2003. Data for England and Wales show an increase in cocaine prevalence from 0.3% in 1992 to 2.4% in 2004 (DMRD, 2005).

Levels of cocaine use among young adults (15-34 years) are found in many countries to be higher than the population average. Lifetime use among this age bracket in Europe ranges from 1% to nearly 9% with the United Kingdom (8.7%), Spain (7.7%) and the Netherlands (5.1%) ranking at the top. Use over the last 12 months among 15-34 year olds is predominantly around 1% but Denmark, Ireland, and the Netherlands all have rates of about 2%; in Spain and the United Kingdom the figure is over 4% (EMCDDA, 2005) (See Appendix 3, Tables A3.1-A3.4).

In general, cocaine use is higher among males. For instance, surveys from Denmark, Germany, Spain, Italy, the Netherlands and the United Kingdom found that, among males aged 15-34 years, lifetime use was between 5% and 13%. In six countries, cocaine use in the last 12 months was higher than 3% among males with Spain and the United Kingdom reporting rates of between 6 and 7% (EMCDDA 2005).

The 2003 United States national survey on health and drug use (SAMHSA 2003)⁹ reported that 14.7% of adults (12 years or older) had used cocaine at some stage in their lifetime; 2.5% said they had used cocaine during the previous 12 months. Among the 18 to 25 year-old, the shares were 15% (lifetime), 6.6% (last 12 months) and 2.2% (last month). For males of the same age category, the figures were 17.4%, 8.2% and 2.9%. More recent data (UNODC 2006) indicate that in 2004 cocaine use in the previous year was down slightly (2.5% vs 2.4 % of the population). High-school surveys in the US indicate that after an increase in the first half of the 1990s, cocaine use declined in the US among high-school students by more than 20% between 1999 and 2005. Cocaine use among 8-12th graders in 2005 was 3.6% and among 12th graders it was 5.1%.

Overall, the lifetime prevalence of cocaine use is greater among the general population in the USA than in the higher prevalence countries in Europe. However, this difference is not as apparent for more recent use measures, with some European countries now reporting estimates in excess of the American figures (UNODC, 2006). The UNODC uses drug treatment demand as an indicator of the evolution of a drug problem in various countries and reports that cocaine has declined in overall drug treatment in North America but has risen in Europe (UNODC, 2005).

Irish context

General population

A number of surveys have been conducted in Ireland since the late 1990s. These surveys include the first household drug survey of the general adult population in Ireland and surveys of school and college attending populations.

The first Irish household drug survey, the NACD/DAIRU Drug Prevalence Survey 2002/2003 shows that 3% of the adult population (15-64 years) have used cocaine powder at sometime in their lives. Just over 1% (n=54) said they had used cocaine in the last year and 0.3% had used it in the last month. More than twice as many males (4.3%) than females (1.6%) said they had used cocaine at some point in their life. A higher proportion (4.7%) of young respondents (15-34 years) had used cocaine in their lifetime (more than three times greater than the rate for the 35-64 age groups).

Cocaine ranked fourth after cannabis (18%), magic mushrooms (4%) and ecstasy (4%), as the most commonly used illegal drugs. The vast majority used cocaine in the form of cocaine powder. Use of

⁹ SAMHSA., (2003), "Substance Abuse Treatment Workforce Environmental Scan", Substance Abuse and Mental Health Services, Administration Centre for Substance Abuse Treatment.

crack cocaine was rarely reported (prevalence of 0.3% for lifetime use and 0.1% in the previous year). No respondents reported using crack cocaine in the last month.

In terms of geographic distribution, cocaine use was much higher in the three former health board areas around Dublin (former East Coast Area Health Board (6%), former Northern Area Health Board (5%) and former South Western Area Health Board (5%)) than in other areas, confirming that cocaine use is primarily an urban problem.

Examining the frequency of use reveals that: of those who had used cocaine in the last month (n=17), 83% used the drug less than once a week. The remainder said they used cocaine between 4 and 9 days in the previous month. Just over 83% of people snorted the drug, while nobody reported injecting it.

Of those who used cocaine in the last 12 months (n=51), just over 28% had obtained their cocaine from a person they did not know. However, cocaine powder was most commonly obtained at the home of a friend (52%) or at a disco, bar or club (38%), reinforcing the image of cocaine as a drug used in a recreational context. Just less than 68% of these cocaine users said the drug was easy to obtain within a 24-hour period.

Some respondents (n=27) had tried to stop taking cocaine regularly – 62% had stopped and the remainder had either tried but failed (7%) or had never tried to stop (32%). Of those who had stopped, 35% said they had stopped because they did not want to continue taking it, 42% said they could no longer afford the drug, 32% were concerned about its health effects and 32% were influenced by family and friends¹⁰.

An examination of polydrug use among the adult general population reveals that the additional substances most popular among adult cocaine users (n=17) are alcohol used by 92% (n=16), cannabis 63%, (n=11) and tobacco 58% (n=10). Among cocaine users aged 15-34 years (n=16) the same pattern applies with the top three drugs combined with cocaine being alcohol (91%, n=15), cannabis (60%, n=10) and tobacco (55%, n=9) (see NACD Bulletin 5, for details of the evidence from the 2002/2003 Drug Prevalence Survey regarding polydrug use in Ireland, forthcoming. See also the NACD Bulletin 4, (2006), for a comprehensive overview of cocaine use in Ireland and Northern Ireland).

Data from the 1998 and 2002 SLÁN surveys of health and lifestyle behaviours among the general population (aged 18-64 years) found that in 1998 cocaine used among males in the last year was 1.8%, three times the level of cocaine used among females which was 0.6% in the last year. In 2002, levels of cocaine use in the last year had increased and the gender gap had narrowed somewhat with cocaine use in the last year among males at 3% and females at 1.9%.

Cocaine use among the school-going population

The 1998 SLÁN survey included results from the HBSC survey of Irish school-aged children aged between 9 and 17 years. This survey showed that in 1998 2.3% of respondents reported ever having used cocaine while 1.7% said they had used cocaine in the previous month.

The ESPAD (1999/2004) reported cocaine use of school children (aged 16 years). In 1999, 2% reported having ever used cocaine/crack. By 2003, this figure had slightly increased to 3%. In 2003, 1% of all students reported having used cocaine in the previous 12 months and 1% also said they had used cocaine in the previous month.

¹⁰ Multiple answer categories associated with this question and more than one answer question was possible. Consequently percentages did not total 100%.

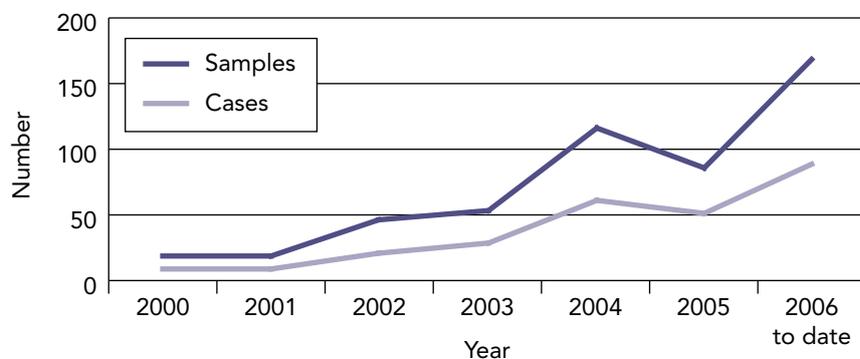
The College Lifestyle and Attitudinal National (CLAN) Survey 2005

This survey was undertaken by the Department of Health and Children and 21 third-level colleges in Ireland during the academic year 2002/2003. This national lifestyle survey (n=3,259) was conducted among undergraduate full-time students with the aim of establishing a national student profile of lifestyle habits including illicit substance use (Hope *et al*, 2005). More than one-third (37%) of students reported they had used cannabis in the last year and 20% in the last month. Ecstasy use in the last 12 months was the second most commonly used illegal drug (8%), followed by cocaine (6%) use in the last 12 months. Male students (9%) were more likely to use cocaine in the last 12 months than females (4%). This pattern of results is consistent with those of the NACD/DAIRU Drug Prevalence Survey 2002/2003.

Additional sources of data

Analysis by the State Laboratory allows to chart trends in test results for cocaine carried out in the Laboratory since the beginning of this decade. The Laboratory carries out analysis for coroners and in criminal cases where such testing of biological samples for drugs is required. Figures from the end of September 2006, show more than a six-fold increase this year to date in the number of cocaine positive samples¹¹ detected compared to 2000. As can be seen from Figure 3.1 below, the trend since 2000 is distinctly upward, declining somewhat in 2005 (most likely due to a delay in receipt of samples from 2005, personal communication, State Laboratory, 2006). Figures to date for 2006 show a large increase on those from 2004 already and final figures will be higher. However, 2006 figures may be somewhat inflated due to carryover from 2005 caused by a delay in receipt of samples. While there has been a large increase in the number of positives for Benzoylcegonine (as a marker for cocaine) in samples, no direct relationship with mortalities from cocaine can be drawn based on these figures as (1) there may be other causes of death in coroners cases and (2) the numbers may include live persons in criminal cases. A separate study to examine this would be required.

Figure 3.1: Positive Benzoylcegonine samples and cases



Source: State Laboratory

¹¹ The cocaine analysis employed by the State Laboratory detects cocaine and two metabolites including Benzoylcegonine which is the most significant metabolite (breakdown product) of cocaine. If Benzoylcegonine is found this is evidence that cocaine has been used.

The Medical Bureau of Road Safety (MBRS) conduct drug test analysis on specimens provided under the Road Traffic Act. The initial analysis is carried out to determine the alcohol concentration in the specimen; if the result is under the limit for alcohol the specimen is then analysed for the presence of a drug or drugs. If the result is over the alcohol limit the Garda can also request further analysis for the presence of a drug or drugs and these results are also included. The MBRS found consistent positive test results for cocaine between 2002 and 2005. There was an increase in the numbers of cases certified from nine cases of drivers testing positive for cocaine use in 2002 to 86 cases in 2005.

Urinalysis (testing of urine) of cases referred by general practitioners are conducted by Beaumont Hospital Laboratories and these indicate that nearly 3% (n=199) of all samples tested for cocaine in 2005 were positive. This rate represents an approximate six fold increase from that of 0.5% (n=31) in 1998.

Summary and concluding remarks

While there is variation among countries overall, cocaine use levels in Europe show an upward movement over the last decade. Cocaine use is highest among young adults (15-34 years) and is found predominantly in urban contexts. Across 10 European countries, cocaine use over the last year ranges between 1% and 5% with England, Wales and Spain being the countries with the highest cocaine prevalence rates in Europe. Ireland and the Netherlands occupy joint third position at 2% (UNODC, 2005). While North America is still home to almost half of all cocaine users in the world, some moderate declines in use have been found in cocaine use among the general population and in the numbers seeking treatment (Samhsa, 2003).

Population surveys of cocaine prevalence in Ireland indicate consistency with the international picture¹²: in Ireland cocaine use is also highest among the 15-34 age groups (4.7%), with successive age bands declining in use, ultimately with minimal use of cocaine in those aged 45 and over. Similar to other European countries in Ireland cocaine is also used by more males than females (twice) and is predominantly an urban phenomenon.

Cocaine use has increased slightly among the general population since 1999 (SLÁN, 2002). Since the beginning of the decade the number of cocaine positive post mortem test results has increased steadily. Results from road safety tests indicate an overall net increase in the incidence of cocaine in recent years.

12 Chapter 5 examines developments in the treatment seeking population in Ireland.

Chapter 4: Indicators of Cocaine Supply

Introduction

Another indicator of the extent of and trends in cocaine used in a society can be gained by examining data on the supply of the drug. The seizures secured by authorities are generally considered to be a good reflection of the availability or supply of a drug in a country. However, caution should be exercised given that variation in the number of seizures registered may also be reflective of variation in the level of activity undertaken by authorities reflecting corporate priorities and strategies (Sutton & Maynard, 1992). Data sources both nationally and internationally report increased numbers of seizures. In Ireland, the geographic distribution of seizures indicate that cocaine is an urban phenomenon, and its availability is nationwide.

Drugs markets

In this section, data and information about the illicit drugs market for cocaine is outlined. The section begins with the international context - cocaine production, seizures of cocaine as well as an examination of cocaine price and purity in the European context. This is followed by a description of the illicit cocaine drug market in Ireland and indicators of cocaine-related law enforcement activities (e.g. prosecutions). Cocaine seizures and cocaine price-purity in Ireland are also outlined.

Production and trafficking

Colombia is by far the largest source of illicit coca in the world, followed by Peru and Bolivia (EMCDDA, 2006). In 2005, the potential production of cocaine reached 910 metric tonnes (mt). In Colombia, this amounted to 640 mt, in Peru to 180 mt and in Bolivia to 90 mt. (UNODC 2006). Most of the cocaine seized in Europe comes directly from South America (Colombia) or via Central America and the Caribbean. Brazil and Venezuela in particular, are the transit countries for cocaine imported into the EU, alongside Argentina, Costa Rica and Curaçao (EMCDDA, 2004; CND, 2005). Other transit areas were southern and western Africa (INCB, 2005). The main points of entry into the EU remain Spain, the Netherlands and Portugal (EMCDDA 2004; CND 2005; INCB, 2005). Cocaine production is now broadly stable and remains unchanged from the levels of a decade ago (UNODC, 2006).

Overall percentage of seizures from UNODC¹³

Seizures data indicate that cocaine is the third most trafficked drug in the world after herbal cannabis and cannabis resin. Cocaine seizures increased by 18% to 588 metric tonnes in 2004, the highest ever recorded. This followed an increase in global cocaine seizures of 34% in 2003 (UNODC, 2006). UNODC figures for recent years suggest that more than 60% of total cocaine production has been seized by law enforcement authorities. Most of the globally intercepted cocaine is seized in the Americas (86%), South America accounted for 45%, North America for 33% and Central America and the Caribbean for 8% of global seizures. The next largest market after the Americas is Europe, accounting for 13% of global cocaine seizures.

¹³ Although seizures of crack cocaine have been reported by some EU countries, they are not easily distinguishable from cocaine seizures. Thus the trends in cocaine seizures reported above might include crack cocaine (UNODC 2006).

Western and Central Europe accounted for 3% of global cocaine seizures in 1980, 6% in 1990, 8% in 2000 and 17% in 2003 – between 1994 and 2004 cocaine seizures in Europe increased by, on average, 10% per year (UNODC 2006), suggesting Europe as a major emerging market for the drug. According to Europol, in 2004 European seizures amounted to close to 80 tonnes, the second highest ever reported and are likely to show a new all-time high for 2005 at around 100 metric tonnes in the European Union (UNODC, 2005). Despite growing seizures, cocaine prices have not risen in Europe and no significant deterioration in the purity of cocaine was reported (UNODC, 2006). Thus, the increase in seizures does not only reflect improved interdiction efforts but also increased availability of cocaine on the European market.

Most quantities of cocaine seized are recovered in the western states in Europe. In the last five years, Spain has consistently been the EU country with the highest level of cocaine seizures. In 2005, seizure levels in Spain increased by about 50%, reaching almost 50 metric tonnes. Large increases in cocaine seizures have also been reported from Portugal which has become another major gateway for cocaine destined for European countries (UNODC, 2006).

Seizures: Ireland

The two principal law enforcement agencies overseeing drug-related activity in Ireland are the Garda National Drugs Unit (GNDU) and Customs & Excise Services (Customs Drugs Law Enforcement Unit (CDLE)). Valuable information from seizures includes establishing the nature of the drug, the size of the seizure made and determining the destination of the drugs. Insight into national drugs distribution patterns can also be gleaned from data regarding drug-related prosecutions. This section begins with the relevant data on arrests made for cocaine-related offences and recorded in the annual reports of An Garda Síochána.

Police and Criminal Justice Data: Ireland

Misuse of Drugs Act Offences

An Garda Síochána data on Offences under the Misuse of Drugs Act (MDA) 1984 provide a source of information about offences pertaining to various specific drugs. Table 4.1 shows the number of offences where proceedings were commenced by An Garda Síochána under drug type. Of a total of 9,595 drug-related offences recorded in 2005 (An Garda Síochána Annual Report, 2005), 1,224 of these were cocaine-related offences, representing a share of nearly 13% of the total of MDA offences in that year. At the start of the 1990s the number of cocaine-related offences increased slowly but between the mid- and –late 1990s the numbers almost tripled, albeit from a low base. Between 2000 and 2005, there has been a continuous rise in cocaine-related offences: both the number and relative share has increased by more than a factor of six.

Table 4.1: Number of Misuse of Drugs Act offences by drug type (1990-2005)

Year	Cocaine Number	Amphetamine Number	Heroin Number	Cannabis Resin Number	Ecstasy Number
1990	11	n/a	71	1,413	--
1991	7	n/a	45	2,354	45
1992	11	n/a	91	2,643	3
1993	15	n/a	81	2,895	66
1994	15	n/a	230	2,848	261
1995	30	n/a	296	2,209	645
1996	42	n/a	432	1,441	340
1997	97	n/a	564	2,096	475
1998	88	n/a	789	1,749	439
1999	169	464	887	3,281	1,023
2000	180	391	730	4,031	2,086
2001	297	207	908	4,053	1,845
2002	478	300	796	4,595	1,351
2003	607	180	719	3,003	960
2004	764	160	778	3,335	813
2005	1,224	191	1,022	5,113	787

Source: An Garda Síochána Annual Reports 1990-2005

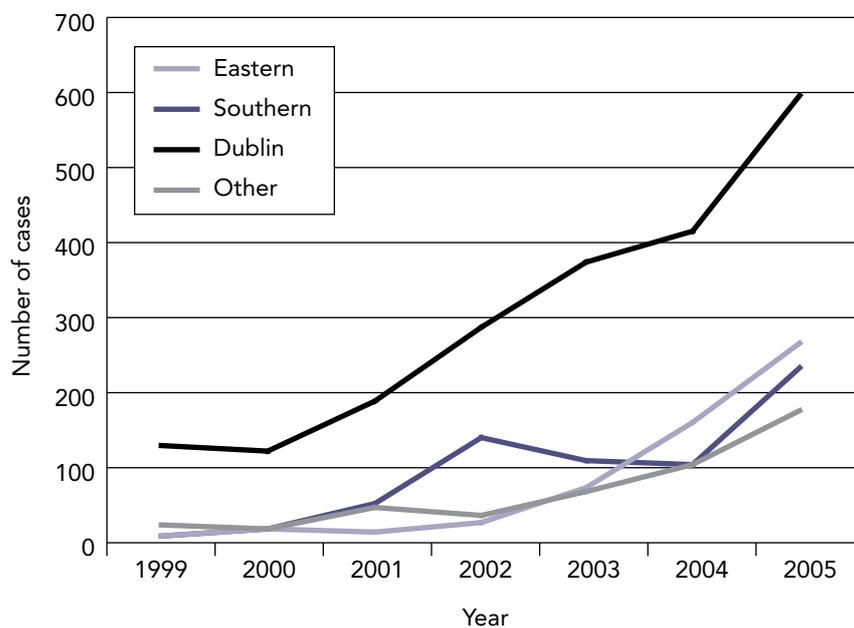
n/a = data not available

Examining the regional distribution of incidences of cocaine-related offences (Table 4.2) the largest number recorded in 2005 (n=577) is in the Dublin Metropolitan Region (DMR). This number accounts for 47% of the total cocaine-related offences in all regions (n=1,224). While the number of cocaine-related offences recorded in the DMR has almost tripled since 1999, the relative share of the total, associated with the region, has each year declined from 75% in 1999 to 53% in 2004. This may be explained by developments in other regions, particularly the Eastern and Southern regions. The share of cocaine-related prosecutions in the Southern Region relative to all regions increased from 6% (n=10) in 1999 to 19% (n=226) in 2005. In the Eastern Region this share increased from 5% (n=9) in 1999 to 21% (n=259) in 2005 (see also Figure 4.1).

Table 4.2: Misuse of Drugs Act (as amended) offences relating to cocaine where proceedings commenced by Garda Division

Garda Division	1999	2000	2001	2002	2003	2004	2005
Eastern Region	9	19	14	27	72	157	259
Dublin Metropolitan Region	126	120	184	278	362	403	577
Northern Region	4	2	13	5	17	13	30
South Eastern Region	6	11	18	20	35	61	88
Southern Region	10	21	51	136	106	102	226
Western Region	14	7	17	12	15	28	44
All regions	169	180	297	478	607	764	1,224
% of all MDA offences	2.3	2.1	3.0	5.6	9.0	11	12.8

Source: An Garda Síochána Annual Reports 1999-2005

Figure 4.1: Cocaine-related offences by regions

Seizures

The majority of seizures, whether made by An Garda Síochána or by Customs & Excise¹⁴, is recorded in the respective annual reports. These reports facilitate an overview of the number of seizures, the quantity of drugs involved in seizures as well as the examination of regional variation.

¹⁴ In recent years drugs seizures are increasingly the result of joint operations by An Garda Síochána or by Customs & Excise (Customs & Excise, personal communication 2007).

Table 4.3 outlines the number of drug seizures of specific drugs made by An Garda Síochána and recorded in An Garda Síochána Annual Reports (1999-2005). The table contains seizure data for the period between 1999 and 2005. Of the total number of seizures recorded in 2005 (n=6046) (An Garda Síochána Annual Report, 2005), 968 seizures of cocaine were made constituting 16% of the total quantity of drugs seized in that year. In that year, cocaine was the second most commonly seized drug in Ireland (after cannabis resin (n=3,142). While the number of heroin seizures has decreased overall since 2001, the number of cocaine seizures has increased steadily.

Table 4.3: Number of seizures of a selection of specific drugs recorded in annual reports of An Garda Síochána (1999-2005)

Year	Cocaine	Amphetamine	Heroin	Cannabis Resin	Ecstasy
1999	213	467	767	4,322	1,063
2000	206	169	598	4,401	1,846
2001	300	162	802	5,960	1,482
2002	429	243	714	2,746	1,026
2003	566	211	660	3,366	1,001
2004	753	145	612	2,610	793
2005	968	119	725	3,142	653

Source: An Garda Síochána Annual Reports 1999-2005

Figure 4.2: Number of seizures of a selection of specific drugs recorded in annual reports of An Garda Síochána (1999-2005)

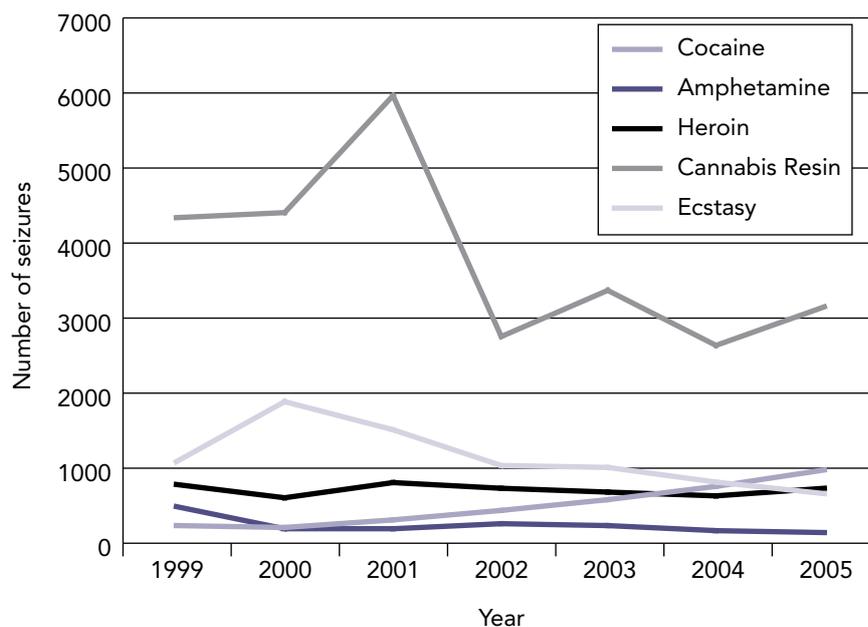


Table 4.4: Number of seizures of a selection of specific drugs recorded in annual reports by Revenue Commissioners (2000-2005)

Year	Cocaine	Amphetamine	Heroin	Cannabis Resin	Ecstasy (MDMA)
2000*	12	7	6	160	12
2001	3	7	7	211	13
2002	22	2	2	115	7
2003	27	4	4	244	8
2004	67	-	6	497	1
2005**	46	-	2	362	16

Sources: *Annual reports of the Revenue Commissioners 2000-2005*

* Customs & Excise, in Connolly 2005

** 2005 figures include seizures made during joint operations with An Garda Síochána

In 2005, Customs & Excise reported a total of 1,223 drugs seizures (Annual Report of the Revenue Commissioners 2005) and of these, 46 were cocaine seizures. After cannabis resin (n=362), cocaine was the second most common drug seizure reported in 2005. Since 2000, there has been an almost four-fold increase in the number of cocaine seizures. Comparing Tables 4.3 and 4.4, reveals that seizures made by the CDLE represents a smaller proportion of the total number of seizures recorded in the Annual Garda Reports.

Table 4.5 shows the quantity and value of cocaine seized by An Garda Síochána in the decade up to 2005. In 2005, 243 kg i.e. the largest quantity seized since 1998 was recorded at a value of €16,996,000 (An Garda Síochána, personal communication, 2006). The size of the quantities of cocaine seized fluctuates from year to year but there is no indication of a linear relationship between changes in the number and volume of cocaine seizures.

Table 4.5: Number and quantity of cocaine seized by An Garda Síochána (1995-2005)

Year	Quantity (kgs)	Cases	% of total seizures
1995	22	42	1
1996*	642	93	2
1997	11	157	2
1998*	333	151	2
1999	85	213	3
2000	18	206	3
2001	5	300	3
2002	32	429	5
2003	108	566	8
2004	167	753	10
2005	243	968	16

Sources: *An Garda Síochána, Annual Reports; An Garda Síochána, personal communication, 2006.*

* Volume dominated by one seizure in 1996 and one seizure in 1998 neither of which was destined for the Irish market, An Garda Síochána, personal communication 2006.

Table 4.6: Number, quantity and value of cocaine seized by Customs & Excise (1999-2004)

Year	Cases	Quantity (kg)
1999	n/a	27
2000	12*	11
2001	3	.01
2002	22	19
2003	27	38
2004	67	47

Sources: Revenue Commissioners Annual reports (1999-2004)

* Connolly, 2005

Cocaine price/purity in Ireland: Street prices for each drug are calculated on the basis of a survey conducted among Garda personnel involved in combating drug possession and supply at street level; the Forensic Science Laboratory; the GNDU; and anecdotal evidence. The price of cocaine in 2001 was recorded at €102 (Moran et al, 2001) and has subsequently dropped to €70 per gram (GNDU, in Connolly, 2005).

Forensic Science Laboratory

Drug type data is determined by analyses carried out by the Forensic Science Laboratory. The data in the tables below present the average percentage purity of cocaine determined by Forensic Science Laboratory analysis testing on a range of cases. Table 4.7 shows cocaine purity levels for a selection of cocaine seizures between 1998 and 2004. The average percent purity of cocaine recorded indicates an overall decline between 1998 and 2004. From 1998 a purity range of 15-68% was associated with an average purity of 38%. By 2004 the purity range was reported between 7 and 74% and the average purity had dropped to 23%. By 2005, this average had increased by eight percentage points reaching 31%. Given the large variation that can arise between different samples tested in any one year, combined with the small number of samples quantified, drawing general conclusions from the data is difficult.

Table 4.7: Average percentage purity¹⁵ of a selection of cocaine seizures (1998-2005)

Year	Purity range %	Average purity %
1998	15-68	38
1999	26-78	41
2000	2-75	23
2001	0.1-50	26
2002	15-33	24
2003	7-82	36
2004	7-74	23
2005*	3-83%	31

Sources: *Forensic Science Laboratory, personal communication, 2006

Forensic Science Laboratory, in EMCDDA 2004;

¹⁵ Average purity is based on samples which may have been intercepted at street/retail level or at distributor/wholesale levels which would result in a cut/uncut sample which in turn would affect the purity level. One would expect higher purity at wholesale level, this may explain the extremes in the range.

Summary and concluding remarks

Cocaine is the third most trafficked drug in the world. Data on international seizures of cocaine show that in 2003 the share of cocaine seizures had increased in North America, South America and Europe. Europe appears to be a major market for cocaine: the share of global cocaine seizures over the last decade has been growing in Western and Central Europe but has declined in the NAFTA¹⁶ regions – in North America very likely to be due to a reduced demand for the drug (UNODC, 2005). The rising interception rate has not however been reflected in rising cocaine prices.

In 2005, cocaine in Ireland was the second most commonly seized drug after cannabis resin. The picture from An Garda Síochána and Customs & Excise seizures data indicates a growing supply of cocaine, a degree of stabilisation in the supply of cannabis and heroin with a shrinking in supply of amphetamine and ecstasy. Cocaine-related offences recorded by An Garda Síochána in 2005 accounted for nearly 13% of all Misuse of Drugs Act Offences. Both the frequency and share of cocaine-related offences have increased by a factor of six over the last decade. The predominance of the DMR as a core of cocaine-related offences has weakened over the last decade, but incidences in the eastern seaboard area have greatly increased. While the reports of increased seizures of cocaine may reflect either a particular law enforcement strategy pursued by An Garda Síochána e.g. increased efforts to seize cocaine, it is the assessment of An Garda Síochána that the change reflects a true increase in the supply/availability of cocaine in Ireland (An Garda Síochána, personal communication, 2007).

¹⁶ **NAFTA:** In 1994 Canada, the United States and Mexico launched The North American Free Trade Agreement and formed the world's largest free trade area.

Chapter 5: Drug Treatment Indicators

Introduction

This chapter looks at treatment for cocaine use in Ireland and begins by examining how the numbers seeking treatment for cocaine use have developed between 1998 and 2003. Data presented for this purpose are collected via the National Drug Treatment Reporting System (NDTRS), an epidemiological database on treated problem drug use in Ireland maintained by the Drug Misuse Research Division (DMRD) of the Health Research Board (HRB)¹⁷. The data is representative of those who attend for treatment for problem cocaine use rather than of the general population using cocaine. The number of cocaine cases seeking drug treatment for the first time (new cases) and the numbers returning to or continuing in treatment (previously treated cases) are presented. In addition, the numbers using cocaine as a main problem drug, using more than one problem drug and the numbers using cocaine as an additional problem drug are described. Additionally, the frequency of cocaine use, the preferred modes of administration and the treatment setting are presented. An overview of the socio-demographic profile of the sample is also presented.

The NDTRS data is currently available only up until 2003 and consequently, with the purpose of establishing a preliminary picture of how issues around cocaine treatment have developed, the chapter also presents analysis from two other sources of data. This includes data collected by the Drug Treatment Centre Board (DTCB) (records until 2006) on the number of Health Service Executive (HSE) clients attending treatment between 1998 and 2005/6. Analyses of cases discharged from acute hospitals with cocaine-related diagnoses are facilitated with data from the Hospital In-Patient Enquiry (HIPE). This analysis has been provided by the Information Management Unit and Casemix, Department of Health and Children. Finally, given that evidence indicates that problem heroin users as well as methadone-maintained drug users increasingly use cocaine (this chapter), it is important to consider whether opiate based treatment approaches are effective in reducing the cocaine use of those who attend for treatment for heroin use. To this end, findings are presented from the Research Outcome Study in Ireland: Evaluating Drug Treatment Effectiveness (**ROSIE**), a study which aims to follow 404 opiate users entering treatment over a period of time documenting the changes observed.

First, an analysis of treatment seeking for problem cocaine use, from 1998 to 2003, provided by staff at the NDTRS is presented. The NDTRS is an epidemiological database on treated problem drug use in Ireland, maintained by the DMRD of the HRB. As expected, the data is representative of those who attend for treatment for problem cocaine use rather than of the general population using cocaine. The number of cocaine cases seeking drug treatment for the first time (new cases) and the numbers returning to or continuing in treatment (previously treated cases) are presented. In addition, outlined are the numbers using cocaine as a main problem drug, the numbers using more than one problem drug, and the numbers using cocaine as an additional problem drug. Information on the frequency of cocaine use, the preferred routes of administration and the treatment setting is also outlined.

National Drug Treatment Reporting System

Analysis from the NDTRS indicates a sustained increase between 1998 and 2003 in the number of treated cases reporting cocaine as a problem drug, particularly as an additional problem drug among opiate users (Long, 2006). The number of treated cases reporting cocaine as a main problem drug increased by 262%, from 86 in 1998 to 311 in 2003 (Table 5.1). As a proportion of all cases treated, this represents a 143% increase in the proportion of cases treated for cocaine as a main problem drug, from 1.4%

¹⁷ Established in 1990 in the Greater Dublin Area and in 1995 was extended to cover other areas of the country.

(86/6,025) in 1998 to 3.4% (311/9,084) in 2003.

Table 5.1: All cases treated for cocaine as main problem drug, reported to NDTRS (1998-2003)

	Year Treated					
	1998 No. (%)	1999 No. (%)	2000 No. (%)	2001 No. (%)	2002 No. (%)	2003 No. (%)
All cases reported	6,035	6,206	6,933	7,900	8,596	9,084
Cocaine as main problem drug	86 (1.4)	57 (0.9)	78 (1.1)	95 (1.2)	155 (1.8)	311 (3.4)
Of whom:						
New cases	32 (0.5)	27 (0.4)	33 (0.4)	46 (0.6)	65 (0.8)	157 (1.7)
Previously treated cases	50 (0.8)	29 (0.5)	42 (0.6)	41 (0.5)	76 (0.9)	145 (1.6)
Treatment status not known	4 (0.1)	1 (0.0)	3 (0.0)	8 (0.1)	14 (0.2)	9 (0.1)

Source: Long J (2006) *New information on cocaine use in Ireland. Drugnet Ireland 17: 7-8*

The number of cases reporting cocaine as an additional problem drug increased by 394%, from 454 in 1998 to 2,244 in 2003 (Table 5.2). This represents a 205% increase in the proportion of cases treated for cocaine as an additional problem drug, from 10.7% (454/4,261) in 1998 to 32.6% (2,244/6,891) in 2003.

Table 5.2: All cases treated for cocaine as additional problem drug, reported to NDTRS (1998-2003)

	Year Treated					
	1998 No. (%)	1999 No. (%)	2000 No. (%)	2001 No. (%)	2002 No. (%)	2003 No. (%)
All cases reporting an additional problem drug	4,261	4,317	4,895	5,378	6,518	6,891
Cocaine as a second, third or fourth problem drug	454 (10.7)	786 (18.2)	916 (18.7)	1220 (22.7)	1716 (26.3)	2244 (32.6)
Of whom:						
New cases	92 (2.2)	180 (4.2)	189 (3.9)	226 (4.2)	309 (4.7)	443 (6.3)
Previously treated cases	355 (8.3)	598 (13.9)	711 (14.5)	968 (18.0)	1367 (21.0)	1772 (25.7)
Treatment status not known	7 (0.2)	8 (0.2)	16 (0.3)	26 (0.5)	40 (0.6)	29 (0.4)

Source: *Unpublished data from the NDTRS*

Polydrug use

For the purpose of NDTRS data, polydrug use is described as the 'problematic' use of two or more substances. Polydrug use is associated with a number of negative consequences including physical ill-health, violence, aggression and a range of social and health problems (e.g. Kendall *et al*, 1995, cited in Molyneaux, 2006). The use of a combination of drugs during the same period is more likely to result in overdose than the use of a single substance. There is evidence that polydrug use is common among people seeking treatment (Long, 2005, Occasional Paper 17) and that this pattern is likely to continue.

Of the 311 treated cases who reported cocaine as their main problem drug in 2003, 286 (92%) cases used one or more additional drugs. In 2003, 99 (32%) reported using two problem drugs, 101 (33%) reported using three problem drugs and 86 (28%) reported using four problem drugs. The number of new cocaine cases who reported polydrug use increased five-fold between 1998 and 2003 (Table 5.3). Of the new cases who reported cocaine as a main problem drug in 1998, 47% used cannabis as an additional problem drug, 38% used ecstasy and 22% used amphetamines. By 2003, the proportions of new cocaine cases who reported using cannabis and ecstasy as additional problem drugs increased considerably, to 64% and 44%, respectively. Since 1999, the proportion of cocaine cases using amphetamines as an additional problem drug declined.

Table 5.3: New cases treated for cocaine as a main problem drug in Ireland, by additional problem drugs, and reported to the NDTRS (1998-2003)

	Year Treated					
	1998 No. (%)	1999 No. (%)	2000 No. (%)	2001 No. (%)	2002 No. (%)	2003 No. (%)
Opiates	4 (135)	4 (15)	5 (15)	8 (17)	7 (11)	24 (15)
Ecstasy	12 (38)	12 (44)	13 (39)	22 (48)	27(42)	69 (44)
Cocaine		1 (4)				1 (1)
Amphetamines	7 (22)	10 (37)	8 (24)	9 (20)	5 (8)	23 (15)
Benzodiazepines	1 (3)		1(3)	1 (2)	4 (6)	3 (2)
Volatile inhalants				1 (2)		
Cannabis	15 (47)	14 (52)	18 (55)	23 (50)	49 (75)	101 (64)
Alcohol	2 (6)	8 (30)	6 (18)	14 (30)	26 (40)	62 (40)
Other substances	4 (13)	3 (11)	2 (6)	4 (9)	3 (5)	9 (6)
Total new cases treated for cocaine as main problem drug	32	27	33	46	65	157
Total number of cases who used more than one drug	29 (91)	22 (82)	28 (85)	39 (85)	60 (92)	145 (92)

Source: unpublished data from NDTRS

Overall, of the 323 new treated cases who reported cocaine as a main problem drug and who used an additional problem drug between 1998 and 2003, 220 (68%) reported using cannabis as an additional problem drug (Table 5.4). Of the 1,442 new cases treated who reported cocaine as an additional problem drug between 1998 and 2003, 772 (54%) reported using an opiate as their main problem drug. When cocaine was reported as the main problem drug, cannabis, alcohol and ecstasy were the most common additional problem drugs, whereas when cocaine was reported as an additional problem drug the most common main problem drugs associated with its use were opiates, cannabis and ecstasy.

Table 5.4: Main problem drug and associated additional drugs used by new polydrug* use cases, reported to the NDTRS (1998-2003)

Additional problem drug used*	Main problem drug used by new cases reporting more than one problem drug						
	Opiates 3535	Ecstasy 865	Cocaine 323	Amphet- amines 117	Benzo- diazepines 109	Volatile inhalants 76	Cannabis 3184
Opiates	870	24	52	4	19	2	124
Ecstasy	590		155	71	17	15	1968
Cocaine	772	164	2	22	11	2	469
Amphetamines	124	299	62		4	4	692
Benzodiazepines	1178	24	10	3	14	2	92
Volatile inhalants	23	21	1			9	106
Cannabis	2015	690	220	79	30	47	6
Alcohol	254	377	118	29	63	44	1743

Source: Long J (2006) *New information on cocaine use in Ireland. Drugnet Ireland 17: 7-8*

* by those who used between one and three additional drugs.

Frequency of Use

Of the 311 treated cases who reported cocaine as their main problem drug in 2003, 120 (39%) reported using it between 2 to 6 days per week (Table 5.5). A further 72 (23%) said they used cocaine daily.

The trend over time is erratic and this may be due to the small numbers reporting cocaine as a main problem drug and the varying frequencies, in part due to binge use.

Table 5.5: Number (%) cases treated for cocaine as a main problem drug in Ireland, by frequency of use in the last month, and reported to the NDTRS (1998-2003)

Frequency used main problem drug	Year Treated					
	1998 No. (%)	1999 No. (%)	2000 No. (%)	2001 No. (%)	2002 No. (%)	2003 No. (%)
Once a week or less	5 (5.8)	6 (10.5)	5 (6.4)	10 (10.5)	17 (11.0)	31 (10.0)
2 to 6 days a week	31 (36.0)	15 (26.3)	16 (20.5)	34 (35.8)	49 (31.6)	120 (38.6)
Daily	23 (26.7)	16 (28.1)	14 (17.9)	15 (15.8)	36 (23.2)	72 (23.2)
No use in the past month	20 (23.3)	18 (31.6)	38 (48.7)	29 (30.5)	43 (27.7)	73 (23.5)
Not recorded	7 (8.1)	2 (3.5)	5 (6.4)	7 (7.4)	10 (6.5)	15 (4.8)
Total	86 (100)	57 (100.0)	78 (100.0)	95 (100.0)	155 (100.0)	311 (100.0)

Source: unpublished analysis from the NDTRS

Route of Administration

The data presented in Table 5.6 indicates that there were three main methods of consuming cocaine in 2003 and these were: snorting or sniffing (216, 70%), injecting (52, 17%), and smoking (34, 11%). There was an association between route of administration and type of treatment centre; those who smoke or snort cocaine were more likely to be treated at a residential centre than those who inject cocaine (not presented in Table).

Table 5.6: Number (%) of cases treated for cocaine as a main problem drug in Ireland, by route of administration, and reported to the NDTRS (1998-2003)

Route of administration	Year Treated					
	1998 No. (%)	1999 No. (%)	2000 No. (%)	2001 No. (%)	2002 No. (%)	2003 No. (%)
Inject	8 (9.3)	13 (22.8)	14 (17.9)	11 (11.6)	29 (18.7)	52 (16.7)
Smoke	21 (24.4)	11 (19.3)	7 (9.0)	12 (12.6)	12 (7.7)	34 (10.9)
Sniff	48 (55.8)	31 (54.4)	53 (67.9)	70 (73.7)	110 (71.0)	216 (69.5)
Not known	9 (10.5)	2 (3.5)	4 (5.1)	2 (2.1)	4 (2.6)	9 (2.9)
	86 (100.0)	57 (100.0)	78 (100.0)	95 (100.0)	155 (100.0)	311 (100.0)

Source: unpublished analysis from the NDTRS

Of the 782 cases who sought treatment for cocaine as their main problem drug between 1998 and 2003, just over three-fifths of cases who reported cocaine as their main problem drug were treated at outpatient services and two-fifths were treated at residential services (Table 5.7). The rate of increase in the number of cases treated between 1998 and 2003 was higher for outpatient services (at 410%) than residential services (at 138%). Very few cases were treated at low threshold services – however, very few low threshold services (for example, needle exchange) participate in the NDTRS. In addition, few cocaine users present to NDTRS participating general practitioner services as these doctors prescribe under the methadone protocol and consequently, deal with individuals who are primary opiate users.

Table 5.7: Number (%) of cases reporting cocaine as their main problem drug by type of treatment service attended, reported to the NDTRS (1998-2003)

Type of treatment centre	Year Treated						Total
	1998 No. (%)	1999 No. (%)	2000 No. (%)	2001 No. (%)	2002 No. (%)	2003 No. (%)	
Outpatient	39 (4.3)	33 (57.9)	50 (64.1)	61 (64.2)	99 (63.9)	199 (64.0)	481 (61.5)
Residential	47 (54.7)	24 (42.1)	28 (35.9)	33 (34.7)	54 (34.8)	112 (36.0)	298 (38.1)
Low threshold	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (.6%)	0 (0.0)	1 (0.1)
General practitioner	0 (0.0)	0 (0.0)	0 (0.0)	1 (1.1)	1 (0.6)	0 (0.0)	2 (0.3)
Total	86	57	78	95	155	311	782

Source: unpublished analysis from the NDTRS

Socio-demographic profile

The data from the NDTRS indicate that men were more likely than women to report cocaine as their main problem drug. For example, in 2003 men were almost four times (78%, 245) more likely than women (19%, 58) to report cocaine as their main problem drug. In 2003, a large majority (65%, 201) of those for whom cocaine was their main problem drug were unemployed and almost one-fifth (19%, 58) left school before they were 15 years old.

In 2003, the larger numbers seeking treatment for cocaine use as a main problem drug resided along the eastern and southern coastline. The highest number of cases treated for problem cocaine use lived in the HSE South Western Area,¹⁸ followed by the HSE Northern Area. The number of cases living in the other areas was lower. In all areas, except HSE Midland Area and HSE Western Area, the number of cases increased annually or bi-annually between 1998 and 2003 (Table 5.8).

Table 5.8 All cases* treated for cocaine in Ireland, by HSE area of residence, and reported to the NDTRS (1998-2003)

HSE area of residence	Year Treated					
	1998 No. (%)	1999 No. (%)	2000 No. (%)	2001 No. (%)	2002 No. (%)	2003 No. (%)
South Western Area	267 (49.4)	372 (44.2)	409 (41.1)	488 (37.1)	736 (39.4)	923 (36.1)
Northern Area	127 (23.5)	237 (28.2)	273 (27.5)	401 (30.5)	472 (25.3)	647 (25.3)
Southern Area	25 (4.6)	53 (6.3)	79 (7.9)	103 (7.8)	133 (7.1)	211 (8.3)
South Eastern Area	19 (3.5)	22 (2.6)	46 (4.6)	65 (4.9)	94 (5.0)	161 (6.3)
East Coast Area	31 (5.7)	57 (6.8)	56 (5.6)	89 (6.8)	115 (6.2)	114 (4.5)
North East Area	5 (0.9)	16 (1.9)	28 (2.8)	28 (2.1)	30 (1.6)	81 (3.2)
Mid West Area	7 (1.3)	22 (2.6)	32 (3.2)	39 (3.0)	49 (2.6)	56 (2.2)
Midlands Area	3 (0.6)	5 (0.6)	18 (1.8)	7 (0.5)	28 (1.5)	43 (1.7)
Western Area	4 (0.7)	6 (0.7)	3 (0.3)	12 (0.9)	22 (1.2)	36 (1.4)
North Western Area	1 (0.2)	7 (0.8)	9 (0.9)	13 (1.0)	23 (1.2)	25 (1.0)
Dublin unspecified	35 (6.5)	36 (4.3)	39 (3.9)	65 (4.9)	155 (8.3)	243 (9.5)
Wicklow unspecified	1 (0.2)	3 (0.4)	1 (0.1)	3 (0.2)	3 (0.2)	2 (0.1)
Non resident	3 (0.6)	2 (0.2)	1 (0.1)	2 (0.2)	5 (0.30)	2 (0.1)
Address missing or not classifiable	12 (2.2)	3 (0.4)	0 (0.0)	0 (0.0)	4 (0.20)	11 (0.4)
	540 (100.0)	841 (100.0)	994 (100.0)	1,315 (100.0)	1,869 (100.0)	2,555 (100.0)

* All cases include cases treated for cocaine use as a main, second, third or fourth problem drug

¹⁸ The predominance of the Eastern and Southern regions in terms of treatment of cocaine as a main problem drug is also reflected in the Hospital In-Patient Enquiry Data (HIPE), reported later in this chapter.

Drug Treatment Centre Board (DTCB)

The DTCB conducts analysis of urine samples from a range of HSE areas around Ireland, reflecting ca. 60% of all drug testing conducted. Samples are submitted mainly from HSE Addiction Services. Clients are systematically tested for cocaine, opiates, benzodiazepines and methadone. The analysis provided by the DTCB is based on the number of (DTCB and HSE) clients testing positive for cocaine metabolites in urine samples and attending drug/methadone treatment (including assessment) throughout Ireland between 1998 and 2005. When compiling the data any client who tested positive for cocaine at least once in any year is included. This data, therefore, will not provide information on whether clients were habitual drug users or infrequent/once off drug users.

As can be seen from Figure 5.2 the number of clients testing positive for cocaine each year between 1998 and 2005 has increased from 580 to 2,330. There has been a steady increase in the share testing positive for cocaine - from 5.9% in 1998 to 27.7% in 2005 (Figures 5.2 and 5.3). This represents nearly a 5 fold increase over that period. The percentage so far for 2006 (Jan-May) is ca. 25%. Seasonal variation has not been explored so it may be too early to deduce the trend for 2006 as a whole.

Figure 5.2: Number of clients tested and found positive for cocaine

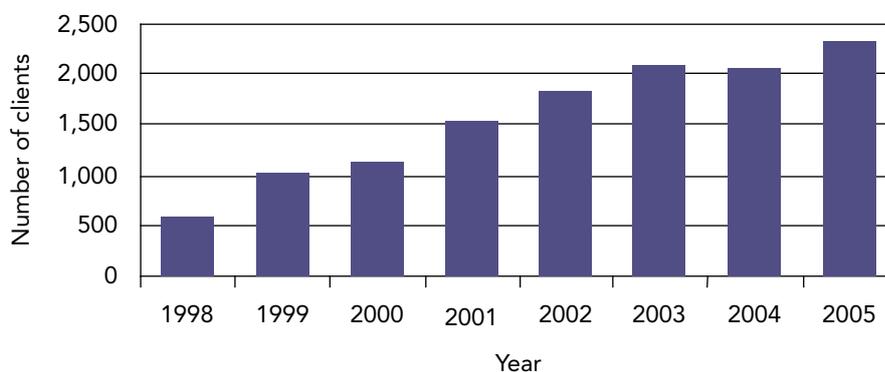
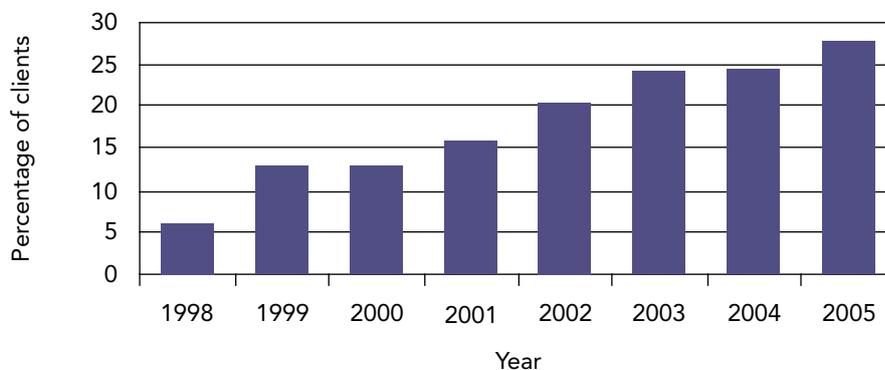


Figure 5.3: Percentage of clients tested and found positive for cocaine



Source: Drug Treatment Centre Board

The age group of cocaine users in treatment peaks in the 25-29 age group (not reported). The gender profile was 66% male and 33% female (not reported); however this was only explored for a subgroup of clients attending the DTCB.

Data from areas outside the Greater Dublin Region also provided evidence that clients from these areas are testing positive for cocaine.

Examining the pattern of drugs used in conjunction with cocaine reveals that the majority of cocaine positive clients are also positive for methadone; however given that the main source of the samples is the HSE Addiction Services this is expected. The other drugs used by these cocaine positive clients by order of prevalence are opiates, benzodiazepines, cannabis, alcohol and amphetamine (see Appendix 4 for full details).

The Hospital In-Patient Enquiry Data (HIPE): HIPE is a computer-based health information system designed to collect clinical and administrative data on discharges from publicly funded acute public hospitals and does not include private hospitals. HIPE data covers all in-patients and day-cases receiving curative and rehabilitative care. The Economic and Social Research Unit (ESRI) is contracted by the Department of Health & Children to manage the HIPE system. It is estimated that 10% of all hospital activity in Ireland is undertaken in private hospitals. Over 60 acute public hospitals participate in HIPE reporting on average 1 million records annually. Each HIPE discharge record represents one episode of care; clients may be admitted to hospital(s) more than once with the same or different diagnoses. The records therefore facilitate analyses of hospital activity rather than incidence of disease. The data included in the HIPE analysis is from 1999-2004, pertaining to discharges of cases with cocaine-related diagnoses. The relevant ICD-9 classifications are CM 304.2 (cocaine dependence) and 305.6 (cocaine abuse) have been used¹⁹. Casualty (A&E) and outpatient data are not collected in the HIPE database.

In 2004, the number of cocaine-related cases identified reached a new peak of 222 (Table 5.9). This number has generally been increasing since 1999 and particularly so after 2001 when the number of cocaine-related diagnoses increased by a factor of five.

That cocaine consumption is more likely among men and among the 15-34 age bracket is also reflected in the HIPE data: in 2004 men were 4 times more likely to be treated for cocaine-related complications. From the data it is evident that this gender difference has been steadily growing since the start of the decade (see Table 5.9). In 2004 nearly 82% (n=182) were aged between 15 and 34 years and the predominance of this age group has been consistent since 1999 (not reported).

Table 5.9: Gender and discharges with cocaine-related diagnoses

Sex	Table of Gender by Year						Total
	1999	2000	2001	2002	2003	2004	
Males	33	37	34	76	123	178	481
Females	19	17	11	27	28	44	146
Total	52	54	45	103	151	222	627

Source: *The Hospital In-Patient Enquiry Data (HIPE)*

¹⁹ It is not possible to extract all cocaine-related diagnoses from these codes which means the data may be an underestimate of the number of cocaine cases.

Finally in 2004, the former ERHA (n=125, 56%), the former SEHB (n=28, 13%) and the former SHB (n=27, 12%) are the three health board regions reporting the most cocaine-related diagnoses (not reported). Although the number of cases of cocaine-related diagnoses have increased across all health board regions, the predominance of the east, south and south east of the country has become particularly strong in recent years, increasingly dramatically in these regions from 2002 onwards.

Cocaine use by ROSIE participants

The Research Outcome Study in Ireland: Evaluating Drug Treatment Effectiveness (ROSIE)

This chapter has thus far pointed to polydrug use among those seeking treatment. Furthermore, the chapter revealed that a substantial share of people who seek treatment for primary opiate problems also use cocaine as a secondary drug. In fact, this was the main secondary drug used by this group. Together these findings raise the question: Given that the drug treatment services in Ireland (in particular the Greater Dublin Area) have traditionally been developed to deal primarily with an opiate using client group, will these services be effective in terms of treating the cocaine use of primary opiate users? The findings from ROSIE provide insights on drug treatment effectiveness.

ROSIE is the first national, prospective, multi-site, longitudinal drug treatment outcome study in Ireland. The aim of the study is to recruit and follow opiate users entering treatment over a period of time and document the changes observed. To this end, the study recruited and interviewed participants, by means of a structured questionnaire, commencing a new treatment episode and monitored progress at time-anchored points; 6-months, 1-year and 3-years (ongoing) after treatment intake. Between September 2003 and July 2004, the study recruited 404 opiate users on entry into three-index treatments; methadone maintenance/reduction (53.2%, n=215), structured detoxification (20%, n=81), and abstinence-based treatment (20.3%, n=82). In addition, a sub-sample of opiate users was recruited from needle-exchanges (6.4%, n=26). Of the 404 people recruited to the study, 305 or 75% successfully completed 1-year follow-up interview.

At treatment intake participants were asked to provide a detailed drug using history. Table 5.10 shows that the majority of participants 92% (n=348) reported lifetime use of cocaine powder. The mean age of first use was 20 years (median = 18 years). Males were significantly younger than females when they first used the drug (19 vs 21 years).

Less than half (44%, n=179) of the participants reported using cocaine powder in the 3 months prior to treatment intake; consuming the drug on average 17 out of the preceding 90 days. Cocaine-using respondents reported consuming a daily average of 2.3 grams of the drug and spending on average €49 a day on cocaine (Table 5.10). Less than half (45%, n=77) of the recent cocaine powder users, reported injecting the drugs. One-quarter (24.4%, n=98) of respondents reported they were also in treatment for their cocaine powder use.

In terms of using crack cocaine, 58% (n=212) of the ROSIE population reported having used 'crack' cocaine at some point in their lifetime. The mean age of use for the study was 22.6 years (median =21.0, sd=4.8) years. Only 15% (n=59) of the sample reported using crack cocaine in the 90 days prior to baseline interview. Recent crack cocaine users consumed the drug on average 14.5 days out of the previous 90-days (median =4.75, sd=22.5). Finally, only 6.7% (n = 6) of participants reported they were in treatment for their crack use (Table 5.10).

Table 5.10 Cocaine Use of ROSIE sample at treatment intake

	Male (n=302)		Female (n=102)		Total Sample (n=404)		
	%/Mean	(n/sd)	%/Mean	(n/sd)	%/Mean	(n/sd)	
Cocaine Use (powder and/or crack)							
% Ever use	94.0	(267)	88.4	(84)	92.6	(351)	
% Recent use ^a	48.7	(147)	47.1	(48)	48.3	(195)	
Cocaine Powder: Lifetime use							
% Ever Used	93.3	(266)	87.2	(82)	91.8	(348)	
Mean age first used ^{c **}	19.2	(4.2)	21.3	(5.2)	19.7	(4.5)	
In treatment for cocaine use [*]	27.3	(82)	15.7	(16)	24.4	(98)	
Cocaine Powder: Recent use ^a							
% Used	44.4	(134)	44.1	(45)	44.3	(179)	
Mean days used ^c	16.5	(21.9)	19.4	(25.0)	17.2	(22.7)	
Mean daily quantity (grams) ^c	2.5	(3.7)	1.6	(1.4)	2.3	(3.3)	
Mean daily spend (€) ^{b c}	257.2	(407.8)	175.8	(156.2)	249.1	(361.3)	
Crack Cocaine: Lifetime Use							
% Ever Used	59.8	(162)	54.3	(50)	58.4	(212)	
Mean age first used ^c	22.6	(4.7)	22.7	(5.2)	22.6	(4.8)	
In treatment for crack use	7.7	(23)	3.9	(4)	6.7	(27)	
Crack Cocaine: Recent Use ^{a d}							
% Used	14.6	(44)	14.7	(15)	14.6	(59)	
Mean days used ^c	12.6	(19.5)	20.2	(29.7)	14.5	(22.5)	

Source: *The Research Outcome Study in Ireland: Evaluating Drug Treatment Effectiveness (ROSIE)*

* Denotes statistical significance at $p < 0.05$

** Denotes statistical significance at $p < 0.01$

^a Refers to behaviour in the 90 days prior to interview.

^b This is based on one gram of cocaine costing €110, at the treatment intake (between September 2003 and July 2004).

^c Only for sub-sample of individuals who reported use.

^d It was not possible to provide the mean quantity used or spending on crack cocaine. Individuals reported either number of 'rocks' they bought/consumed or the quantity of cocaine bought and 'washed' into rocks.

In total, 48% of the study population were recent users of cocaine powder and/or crack cocaine. Table 5.11 illustrates that cocaine users were present in all treatment modalities included in the ROSIE study.

Table 5.11: Index treatment for recent cocaine users and abstainers

	Cocaine Users (n=195)		Cocaine Abstainers (n=209)		χ^2
	%	n	%	n	
Treatment Modality					
Methadone Programme	44.7	(96)	55.3	(119)	2.75
Structured Detoxification	51.9	(42)	48.1	(39)	2.75
Abstinence-based Treatment	51.2	(42)	48.8	(40)	2.75
Needle Exchange	57.7	(15)	42.3	(11)	2.75

Source: *The Research Outcome Study in Ireland: Evaluating Drug Treatment Effectiveness (ROSIE)*

Analysis of the data revealed substantial changes in reported cocaine powder use at the 1-year follow-up (Table 5.12). Firstly, cocaine abstinence rates increased from 55% at treatment intake to 79% at follow-up. This increase was found for both males (55% vs. 77%) and females (54% vs. 84%). Second, a significant reduction in both the frequency and quantity of cocaine use was observed: the average number of days users took cocaine in the previous 90 days dropped from 8 days at treatment intake to just over 3 days at follow-up while the average quantity of cocaine powder used in the same period fell from an average of 1 gram to 0.4 gram. Finally, the average amount users spent on cocaine powder dropped from €113.60 at treatment intake to €24.20 1-year later.

At 1-year follow-up crack cocaine abstinence rates increased from 84% at treatment intake to 94%. A substantial reduction was also observed in the average number of days individuals reported using crack cocaine, falling from 2.4 days at treatment intake to 0.9 at 1-year.

Table 5.12: Changes in cocaine use at 1-year for followed-up sample

	Baseline (n=305)		1-Year Follow-up (n=305)		Test of significance	
	%/Mean	(n/sd)	%/Mean	(n/sd)	χ^2 /t-test	P value
Cocaine Use in last 90 days						
% Abstinent	55	(167)	79	(241)	McNemar	p<0.01**
Mean days used	7.8	(17.8)	3.4	(13.1)	t-test=3.7	P<0.01**
Mean daily quantity	1.0	(2.6)	0.4	(1.2)	t-test=4.5	P<0.01**
Crack Use in last 90 days						
% Abstinent	84	(255)	94	(285)	McNemar	p<0.01**
Mean days used	2.4	(10.6)	0.9	(6.3)	t-test=2.5	p<0.05*

Source: *The Research Outcome Study in Ireland: Evaluating Drug Treatment Effectiveness (ROSIE)*

* Denotes statistical significance at p<0.05

** Denotes statistical significance at p<0.01

Finally, in terms of cocaine uptake, of the 305 who were interviewed at both treatment intake and 1-year, only over 7% (n=22) said they had not used cocaine in the three month period prior to entering treatment but were using cocaine at 1-year follow-up.

Summary and concluding remarks

A key indicator used to identify the evolution of a drug problem is treatment demand (UNODC 2005). At a global level, the main problem drugs continue to be the opiates (notably) heroin followed by cocaine. In Ireland, the numbers seeking treatment for cocaine have increased exponentially between 1998 and 2003: this applies to both the numbers seeking treatment for cocaine as their main problem drug and as an additional problem drug. Data from the NDTRS indicate that the number of new cases seeking treatment for cocaine as a primary drug increased from 33 in 2000 to 157 in 2003 and the number of previously treated cases reporting cocaine as a primary drug increased from 41 to 145 during the same period. The number of new cases reporting cocaine as an additional problem drug increased from 189 in 2000 to 443 in 2003 and the number of previously treated cases reporting cocaine as an additional problem drug increased from 711 to 1,772 during the same period. These increases are in line with the data reported from urinalysis at the DTCB. More recent indicators from tests conducted by the DTCB indicate the increase continued early into 2006. The HIPE Data also shows an upward trend in the number of cases treated for cocaine-related problems which increased steadily up until 2004.

Those who are seeking treatment for cocaine as a primary problem drug are more likely male, unemployed and to remain in school after the junior cycle. Although gender consistently discriminates between people using as well as seeking treatment for cocaine it should be noted that the evidence suggests that women are an estimated 3-4 times more likely to become cocaine dependent within 1 year of using cocaine as compared to male recent-onset users (O'Brien & Anthony, 2006). Polydrug use is generally an increasing phenomenon among the drug treatment seeking population and polydrug users seeking treatment for cocaine combine it with cannabis, ecstasy and alcohol. Given the earlier observation that alcohol has become increasingly predominant in polydrug use both in the treatment and general populations, it is noteworthy that the evidence indicates cocaine dependent individuals with concurrent alcohol dependence exhibit poorer treatment outcomes (Schmitz *et al*, 1997).

Sniffing cocaine is the main method of using. The remainder either injects (17%) or smokes (11%) the drug. Cocaine is one of the main additional drugs used by those seeking treatment for problem opiate use. Indications are that cocaine use among heroin-dependent individuals, or by clients in methadone or buprenorphine maintenance treatment, is substantial and has negative consequences for health, social adjustment and outcome of opioid-dependence treatment (Len *et al*, 2003). Findings arising from the ROSIE study indicate that an opiate treatment setting can contribute to reducing not only opiate use but the individual's cocaine use also. It should be noted that the study sample in ROSIE was of problem opiate users in treatment and therefore one cannot conclude from this study anything about the effectiveness of these methods for treating the non-opiate cocaine-using population.

Chapter 6: Cocaine in the Community

Introduction

In the past heroin dominated the community's concerns and gradually interagency and community-based interventions did much to alleviate the disruptive consequences of heroin use in the community. Cocaine however, is qualitatively very different to heroin in many important ways. First, while involvement in crime is often a necessity of any drug habit, the highly compulsive and polydrug use patterns associated with cocaine use (see Chapter 2) suggests a higher damage potential for the community and its members.

The identification of drug use patterns at local level can be difficult to quantify. Nevertheless, one indicator of the impact a drug may have is its effect on people's sense of well-being in their community. The aim in this chapter is to explore this impact – examining people's perceptions of cocaine, the extent to which it is present in their community, its reputation/image and the consequences it exerts on their lives and relationships. To this end, sources of information include reports from those who have regular contact with drug/cocaine users in their community as well as reports from those who use cocaine. This latter group in particular, provide important insights into the complex relationship between heroin and cocaine. Despite the dearth of research in Ireland, the chapter provides a preliminary account of the impact of cocaine on those groups which, due to their marginal status in our society, are often difficult to access or reach with mainstream research methods e.g. household survey of the general population. Relevant examples of such groups are the homeless and Travellers.

Emerging trends

The National Drug Trend Monitoring System (DTMS) is a pilot study conducted with the purpose of identifying emerging drug trends in Ireland (NACD internal research). Information about drugs including cocaine use was gathered through interviewing people (trend monitors) who, through their work have regular/frequent contact with active drug users. These trend monitors (n=156) were asked about cocaine use, sources of and availability of cocaine as well as methods of taking the drug. A majority of 81% (n=127) reported cocaine as a drug used by their contacts and 90% (n=141) reported cocaine to be available in their areas of work. Seventy one percent (n=110) of trend monitors reported cocaine as the drug used most frequently by their contacts. Thirty two percent (n=50) said crack cocaine is used in the communities in which they work.

Commenting on developments or changes in drug consumption, 50%²⁰ (n=64) said cocaine was the drug of greatest increase in use among contacts. Just over half (51%, n=25) of those who had identified crack usage among contacts said use of crack had increased.

Seventy five percent (n=95) of those who reported on cocaine said sniffing was the main method of taking the drug; eleven percent (n=14) reported injecting as the main method and 8% (n=10) said contacts both sniffed and injected while 6% (n=3) said smoking and injecting were the main methods of using cocaine. Smoking was reported by 72% (n=36) of trend monitors to be the main method of using crack cocaine; injecting was mentioned by 24% (n=6) and 6% (n=3) said smoking and injecting were the principal methods of using the drug.

20 The valid percents reported in this section are based on the numbers of respondents who identified (i) cocaine (n=127) and (ii) crack (n=50) as drugs used by trend monitor contacts.

Over three-quarters of the respondents in the South Eastern, East Coast Area, Northern Area and South Western Area Regional Drug Task Forces (RDTFs) areas reported that cocaine was used by their contacts and moreover, it was one of the most frequently used drugs among their drug using contacts. Increases in cocaine use were noted by three-quarters of respondents in the Mid-Western, North Eastern and Southern RDTFs as well as in the East Coast Area, Northern Area and South Western Area RDTFs.

Community level issues

Studies relating to the prevalence of drug use in, and the consequences for the community generally agree that cocaine exhibits a negative impact on people's lives – their health and relationships. However at the community level people feel unable to estimate the extent to which cocaine is an emerging issue in their community in part, because the use of the drug is extremely hidden (Mayock, 2001). In this section, a selection of studies that examine drug use in several urban community contexts is outlined. Furthermore, the section also examines the question of cocaine use in groups that prevalence surveys do not reach such as the Prison population, the Traveller Community, the Homeless and new ethnic communities.

The Dublin-based CityWide Cocaine Survey (2004) and the Cocaine in Local Communities CityWide Follow-up Survey (2006) examined community based drug projects in terms of the development of cocaine use among clients of drug services and cocaine use within communities in general. The drug projects included those that provide treatment, rehab projects, women specific and youth projects. The clients participating in the survey engaged with drug services primarily through their opiate use, although youth services see clients who use other drugs. The projects that participated in the study represented each Task Force area within Greater Dublin and that of Dun Laoghaire-Rathdown.

In 2004, 93% (n=27) said existing clients were using cocaine (three-quarters estimated that between 10 and 50% of their clients were using cocaine). Fourteen percent of the projects reported seeing clients with what the survey participants described as problematic cocaine use. By 2006, 50% of projects reported an increase in cocaine use amongst their clients since 2004 and 62% reported seeing clients with cocaine as their main drug of choice.

In 2004 participants expressed serious concern that cocaine is perceived among clients as a 'harmless' social drug and used increasingly by young people in their communities. Cocaine is perceived as cheap and easily available yet despite levels of cocaine use in their communities those using cocaine were not seeking treatment at their services. By 2006 the follow-up study noted that the general health of clients with problematic cocaine use is deteriorating and project workers are especially worried about the mental health of many of their clients. Due to poor injecting habits, there is a huge rise in clients experiencing abscesses and wounds. There is a major concern across all projects about the financial and legal problems that clients are experiencing and the impact that debt is having on families through intimidation and reprisals from drug dealers and money-lenders. This is coupled with a very sharp rise in violent crime and gun-related crime (CityWide 2004; 2006).

Other research confirming the relatively high use of cocaine among young people was a study conducted among children of a school-going age in a Dublin area. This was grant-funded by the NACD and entitled *A Prevalence study of drug use by young people in a mixed suburban area* (Kilbarrack Coast Community Programme, NACD, 2004). This study aimed to establish the prevalence of drug use among young people in the Kilbarrack/Raheny area. The research involved a survey of a selection of

schools²¹ in the area and resulted in 285 pupils²² being surveyed. All respondents were in the last 2 years of primary school (fifth or sixth class) or in secondary school, and respondents at either end of the age range (aged 10 and aged 17/18 years) were somewhat under-represented.

Seventeen students reported using cocaine, representing 6% of the total number of participants (n=285). All of these students used cocaine in the last year and more than three-quarters (77%, n=13) of these were aged 16 years and older²³. Use over the last thirty days was found to be nearly 3% (n=7) of the total number of participants and none of this group had used cocaine on more than two occasions. More than twice as many boys (n=12, 8%) than girls (n=5, n=4%) had ever used cocaine. Seventy seven percent (n=13) of those who had used cocaine in their lifetime had done so on less than five occasions: Just over 40% (n=7) said they used on 1-2 occasions and 35%, (n=6) said they used on 3-5 occasions. Only 1 student said they had used cocaine between 6-10 occasions and nearly 18% (n=3) had used 11 times or more.

Fifteen early school leavers (aged 16-19) participated in this study. The prevalence of cocaine use was higher among the early school leaver group: a staggering 53% (n=8) had used cocaine in the last thirty days. This is in stark contrast to 6.8% of those attending school (same age group). Notwithstanding the fact that early school leavers were small in number (n=15) and this group was recruited differently to school-going participants²⁴, the contrast is marked and is consistent with the literature that early school leaving is a risk factor for problem drug use (e.g. Bry *et al*, 1982; Newcomb, 1995).

A recent study commissioned by the NACD, *A Community Drugs Study: Developing Community Indicators for Problem Drug Use* (Loughran & McCann, 2006) examined, drug use in three communities with a diverse history of problem drug use - Ballymun, Bray and Crumlin. The emergence of cocaine as one of the multiple drugs repertoire popular among young adults is part of the changing face of drugs problems. In particular, the use of cocaine does not appear to be influenced by social or economic disadvantage in the same way that heroin was in the 1980s and 1990s. Cocaine users were described quite differently in the three communities. Cocaine use was perceived to be widespread among all income groups.

It was reported that the arrival of cocaine in these communities was due to the drug becoming relatively cheap since the 1990s. This, combined with an irregular supply of heroin was viewed as having created an opening for cocaine to gain a foothold. The experience of participants in this research highlighted the changes in local drug market conditions and the consequences these have for life in the community. While the high levels of dealing by telephone has reduced the visibility of drugs transactions, high levels of violence and intimidation were perceived to be associated with the dealing of cocaine.

Alcohol was discussed regularly in connection with cocaine use, for example, when cocaine use was described as taking place in pubs, and among an older age group. Polydrug use, particularly alcohol and cocaine, was seen to be directly connected to public brawls, often after closing of pubs and night clubs, which sometimes ended in death. These had a high media profile. A quote from the study helps to describe this:

21 School were selected on the basis of their location. Four primary and four secondary school participated in the study.

22 Only students attending the schools who were resident in the target area were included in the sample.

23 The **Artane Drug Awareness Programme** (participants of the CityWide Survey 2004), reported clients using cocaine as their main drug, who use on a regular basis and are aged between 14-21 years.

24 To capture the experience of early school leavers, who by definition, were not in school, 15 young participants were recruited with the assistance of local youth projects and other agencies.

Cocaine and alcohol, and a lot of it-how it manifests itself for us or for the guard on the street, is generally aggressive behaviour after pubs close down, or nightclubs close down. Aggressive behaviour into the early hours of the morning. When I say aggressive behaviour-we always had a kind of drink culture there, and a little bit of aggression, but it seems to be far more serious aggressive behaviour

While cocaine use may be more widespread, beyond these communities, its consequences can be more severe in areas with cumulative disadvantage. Participants also emphasised that if cocaine users classify their drug use as recreational and socially acceptable then it is unlikely that the traditional drug service will be attractive or appropriate to these 'new users' should they develop problems.

Impact/experiences: cocaine users and service providers perspectives

Merchants Quay Ireland: NACD commissioned research 2003/2006

Survey of Cocaine Users 2003: In 2003 Merchants Quay Ireland (MQI) surveyed 100 clients presenting at its Contact Centre who said they had used cocaine/crack in the previous year. The Contact Centre mainly targets intravenous drug users and the sample included in the study was largely from Dublin's Inner city (49%), homeless (53%) and unemployed (90%). Heroin was the most common primary drug (83%) and three-quarters of the sample used methadone. A smaller share (17%) reported cocaine as their primary drug used. Among the 100 respondents, 95% had used cocaine powder in the last year and 40% had used crack cocaine – 60% had used cocaine powder only, 5% had used crack cocaine only while over one-third (35%) had used both. Of the 95 cocaine users, 82% injected the drug and the remainder snorted (15%) and smoked (3%). The majority of those who injected, 59%, (n=46) injected cocaine only, while 41% (n=32) mixed it with heroin (i.e. as a speedball). Almost half (49%) reported weekly use of cocaine while 20% reported daily use. One-third reported weekly use of crack while 5% reported daily use. However, 45% (n=18) of those who used crack and 23% (n=22) of cocaine users had not used in the last month indicating infrequent or binge use (repetitive use over a short period of time).

This study highlighted that those who injected cocaine had also experienced behaviour and health problems. Of the 78 people who injected cocaine 21% (n=16) had experienced accidental overdoses, over one-third (37%, n=29) had reported scarring/bruising while approximately one-quarter experienced dirty hits (27%, n=21) and abscesses (24%, n=19). Other problems arising included thrombosis, palpitations and blood clots. Approximately half had noticed they had become more depressed (54%) and more anxious (50%) since using cocaine/crack. Many reported breathing difficulties (45%) and one-third (34%) said they had become more confused. Other changes in behaviour included paranoia (13%), aggressiveness (5%), suicidal feelings (2%), anger (2%), mood swings (2%), hallucinations (1%) and agitation (1%).

Two-thirds perceived their cocaine/crack use as not problematic, and only 12% of respondents sought treatment for cocaine/crack use. Many respondents reported a felt futility in seeking treatment for cocaine/crack use due to the lack of a pharmacological substitute for its use.

Cocaine Focus Groups, Merchants Quay Ireland (MQI) 2006²⁵

As mentioned above, the 2003 MQI survey highlighted an association between levels of health and behavioural complications and cocaine use. Few reported seeking treatment for cocaine use in the survey. To build on the insights of this 2003 survey, it was considered that greater insights into the

25 See Appendix 5 for full report written by author, Karen O'Sullivan, Researcher, Merchants Quay Ireland.

experience of problematic cocaine use and views on the treatment options available would be important to secure. Consequently, in 2006, MQI conducted several focus groups with cocaine users and service providers working at Merchants Quay. What becomes clear from these sessions, is that there is a widespread perception that existing drug services are the preserve of opiate users and that using cocaine is associated with specific needs which need to be met within existing services.

Focus group session with problematic cocaine users

Focus groups were held with a total of 14 clients who avail of the MQI services. Also, two additional clients were interviewed together. These sessions were used to examine (i) experiences and associations of cocaine use; and (ii) participants' perceptions of the availability and experience of treatment.

The group of participants that took part in the focus group sessions were polydrug users. As well as being cocaine users, most participants were also heroin users some also stating that they use other drugs such as 'tablets', cannabis, and alcohol. The majority of participants stated that they use cocaine powder, while a minority mentioned either using crack cocaine currently, or at some stage during their cocaine-using careers. The main method of cocaine use among the two groups was intravenous. While participants also reported snorting cocaine powder and smoking crack cocaine the consensus in the groups was that injecting cocaine was the primary route of administration.

Although not a question that was asked directly, it was evident during the discussions that many participants were currently homeless, while others referred either to prior episodes of being 'out of home', or a fear of becoming homeless due to the chaotic lifestyle associated with their drug use.

Problematic cocaine use – health, lifestyle and coping

- Most people cited cocaine as their drug of first choice, despite negative consequences.
- Cocaine use: lengthy bingeing, lasting as long as money does and involving administration of cocaine a substantial number of times.
- Large number of injecting-related complaints with cocaine: because cocaine numbs the injecting site and the user is unable to determine if the injection has been effective; often repeated attempts to inject same/other sites and users resort to using groin area. A greater number and severity of abscesses from cocaine use were reported.
- Purity: high concern in relation to not knowing adulterant(s) mixed with cocaine.
- Other physical health issues: vein problems, loss of appetite, lack of personal hygiene, pneumonia, breathlessness and rapid heart beat.
- Injecting cocaine users prefer using alone: reasons included desire not to share cocaine with others; untrustworthiness associated with cocaine users among the drug using 'community'; mutual avoidance between snorters and injectors.
- All said cocaine had taken over their lives, wreaking levels of havoc and chaos never experienced with heroin use.
- All-consuming nature of cocaine due to the user's need to avoid the 'come down' that ensues when cocaine effect wears off: onset of paranoia, anxiety and panic attacks, heavy depression with thoughts of suicide.

- Widespread consensus that cocaine evoked non-normal behaviour e.g. high levels of aggression, heavy threatening behaviour and violent acts in pursuit of getting money to buy cocaine.
- Widespread unacceptability of injecting cocaine; users find they are socially ostracised from friends, families and community in which they lived. Snorting cocaine carries less of a taboo hence injectors are also shunned by cocaine snorters.
- Levels of loss due to financial burden of cocaine and other drugs: huge losses were reported. All said their drug use had caused the breakdown of important family relationships. Some lost their partners and children and their house/home.
- Cocaine users perceive no treatment for cocaine use like there is for heroin.
 - All felt that helping a cocaine user without pharmacological substitution is futile.
- Counselling as a possible treatment options was seen as a secondary option. Many felt counselling may be useful for help with personal issues but indicated no or low levels of access to counselling.
- Most felt the counselling situation would present too many difficulties for them as the act of talking about cocaine would evoke strong physical reactions.
- Some emphasised a need to be treated for polydrug use; they described situations that suggest a narrow focus on opiate addiction when presenting to a methadone clinic with other than heroin drug-related issues.
- Many stressed the need for greater harm reduction measures: access to methods to assess purity/ identifying adulterants; easy and timely access to medical assessment and care; easy access to clean injecting equipment; the need for somewhere safe/clean for injection use.
- Participants were unsure as to whether their knowledge of procedures for assisting individuals who overdose on heroin is transferable to situations where people overdose on cocaine.

Focus group session service providers

Focus groups were also held with staff members of low threshold client services of MQI. This group consisted of five members of staff involved in the day-to-day running of the needle exchange service and the homeless drop-in service. The aim of this focus group was (i) to examine staff experiences of working with and providing a service to cocaine users; (ii) to examine whether clients using cocaine have a particular impact upon the day-to-day running of services; (iii) to identify the service/treatment options currently available to clients that use cocaine along with gaps in services for cocaine users and; (iv) if and where gaps do exist, how this impacts upon the staff's experience of service provision.

- Clients are requesting a larger quantity of needles and requesting a type of needle (size) more often than before, directly linked with cocaine use in general and injecting in the groin area specifically.
- Increasing number of wounds, more infected injecting sites and with all types of wounds occurring all over their bodies.
- Weight loss also very noticeable among clients using cocaine, particularly weight loss within very short periods of time (sensitive topic, particularly where individuals are HIV positive and may become fearful of deteriorating health).
- Clients using cocaine are difficult to engage and help due to hyperactivity.

- Higher number of clients presenting with mental health issues, in particular, suicidal ideation. Staff feel ill-equipped to address this issue due to a perception of a lack of referral options.
- Stress and difficulties experienced by staff due to higher tendency of cocaine user to exhibit aggressive and/or violent behaviour; their behaviour is also irritating other clients.
- A sense of powerlessness was reported by staff members about the availability of support and services for clients misusing cocaine.
- Unsanitary and unsafe conditions for injection drug use among homeless.
 - Need for clean, safe injecting environment that is staffed by medical staff.
 - Respite service needed given chaotic, agitated and edgy nature of heavy cocaine users.
- More timely referrals to provide immediate support essential for the cocaine users.
- Staff felt cocaine users would be less likely to attend their local GP or an A&E department than other drug users and underlined the need for easily accessible and immediate services to address the health needs of this group.

Marginal groups: Travellers and Homeless, NACD commissioned research.

Research has repeatedly highlighted the association between social exclusion and problematic drug use. In particular studies point to people faring poorer in treatment when they live in conditions indicating poor levels of social functioning (Sayre *et al*, 2002) e.g. unstable relationships, erratic employment etc. Action 98 of the National Drugs Strategy specifies Travellers, prostitutes, the homeless and early school leavers as groups at-risk in our society. The dearth of research in Ireland regarding cocaine use among these groups means the scope of this report is confined to a small, select number of studies.

On the whole, cocaine use among these hard to reach groups seems to be relatively low; use is higher among males and they mainly start using cocaine from their mid/late teens onwards. For example, cocaine use in Irish prisons is still relatively low²⁶. Of the drug seizures conducted by prison staff only small quantities of cocaine were seized. Furthermore, drug test results for the early part of 2006 show cocaine use in Mountjoy Main and Female Prisons averaging at 4%.

Similarly in research commissioned by the NACD, *An overview of the nature and extent of illicit drug use amongst the Traveller community: an exploratory study* (Fountain, NACD, 2006), reveals that while cannabis is used regularly, the use of cocaine powder occurs mainly at celebrations such as weddings, parties and by those frequenting nightclubs. Cocaine is consumed in addition to alcohol. Very little crack use was reported. Cocaine powder is used mainly by men and they begin use in their mid-teens. Where the individual's drug use is deemed unacceptable by the community, strong control techniques are employed such as excluding the individual user from the family or larger social group (i.e. ostracising).

Other groups that can be beyond the scope of routine statistics are the new communities in Ireland. An exploratory study by MQI, funded by the NACD examined problematic drug use among new communities in Ireland and found that younger members of new communities, refugees, asylum seekers and migrant workers adopt the drug use patterns of their Irish peers and as such amphetamine-type stimulants are being used including cocaine.

26 Personal communication from the Director of Regimes in the Irish Prison Service, 2006.

Finally, an NACD commissioned study, *Drug Use Among the Homeless Population in Ireland*, (Lawless and Corr, NACD, 2005), surveyed 355 homeless people in various regions of the country. The study found that 41% (n=146) had used cocaine at some stage in their lives, 28% (n=98) said they had used in the last three months and 17% (n=61) were current users or had used in the last month. Of those who had used in the last month, 24% reported using cocaine in excess of 20 days. Nine percent said they used cocaine between 10-19 days and 24% said they used cocaine between 4-9 days in the previous 4 weeks. The largest share, 43% (n=25), reported using cocaine between 1-3 days in the last month. Nineteen percent (n=66) of the total sample reported lifetime use of crack. The majority of current crack users (60%, n=6) used the drug between 1-3 days within the last month. Cocaine and crack use was highest in Dublin. Higher rates of current cocaine (25%) and crack use (7%) were found among those sleeping rough than among either hostel dwellers or bed & breakfast occupants.

Summary and concluding remarks

Since the 1980's and throughout the 1990's the local community has been responding to the emergence of serious drug problems, particularly heroin. Led by groups of community activists and supported by statutory agencies, among others, community-based facilities have developed and have had the broad support of the community. The use of cocaine raises several issues for the community: in particular, the greatest concerns relate to its stimulant and compulsive properties and the tendency to use with alcohol. The fear is that these translate into higher levels of problematic use, violence and aggression than ever before experienced by the community. Indeed retrospective studies on violence suggests a major role for alcohol alone and additive increases in violent behaviour or crime from combining alcohol with cocaine (see Pennings *et al*, 2002 for a review of this research) The main thrust of the results of National Drug Trends Monitoring System (NDTRS) regarding cocaine is the reported increasing prominence of the drug in the community. Monitors reported cocaine use spreading more quickly than any other drug and underlined the ease of availability. This marks a shift from the picture provided by Mayock (2000) where some respondents' reported few encounters with cocaine and therefore felt unable to estimate the extent of use in the communities in which they worked, that cocaine was "... hidden and unlikely to come to their attention" (Mayock, 2000 p. 104). Cocaine use is evident among prisoners, the travellers' community, among new communities and among the homeless.

A focus group with problematic heroin/cocaine users revealed that cocaine is a very common drug among this group and for many it has become their drug of first choice. This is in stark contrast to earlier reports (Mayock, 2000) of drug project workers claiming that heroin users would show little interest in cocaine – that "... they'll dabble [in cocaine] but they'll revert to heroin" (Mayock 2000 p. 107). Focus groups conducted by MQI reveal many of its clients attending the Contact Centre who use cocaine experience complex health and behaviour problems. From the focus group discussions it became evident that cocaine users attribute these increased health complications primarily to their cocaine use. Drug service providers working at MQI particularly highlight the complications involved with helping cocaine users in general and heroin/cocaine users in particular. What is clear is that both of these groups – users and service providers alike, have difficulties coping with cocaine and its use. Furthermore, they perceive treatment to be the preserve of opiate users. All of these cocaine-related complications are magnified for the homeless - cocaine and crack use is highest among the most vulnerable of this group, those sleeping rough (Lawless & Corr, NACD 2005).

Chapter 7: Responding to Cocaine Use

Introduction and overview

The aims of this chapter are first to present the main findings from empirical studies reported in the scientific literature regarding the salient issues in relation to cocaine use and the implications for configuring an approach to treatment/intervention appropriate for the needs of the cocaine user. To date however, most of our knowledge about treating cocaine use emanates from the United States. Given the lack of empirical evidence supporting any one single treatment, the question is in what way are agencies approaching problem cocaine use in Ireland? Against this backdrop, the chapter presents how a selection of drug treatment/intervention agencies in Ireland is responding to cocaine use among their clients. Further, in response to the recognition by the Mid-term Review of the National Drugs Strategy of increased cocaine use in Ireland, a series of cocaine specific training interventions and pilot treatment projects were launched. The chapter also presents an overview of these undertakings.

Responding to cocaine use: A summary overview of literature

Introduction: The possible treatments for problematic cocaine use and the evidence of their effectiveness come mainly from our knowledge of studies conducted in the United States. However this literature nevertheless reflects strongly those points emphasised by the service providers of Merchants Quay Ireland. Namely, overall there is no evidence to strongly support any single treatment approach, either symptomatic or substitute; and additionally, the difficulty in accessing the cocaine-using and/or treatment seeking population as well as the high rate of drop-out, have led many to encourage the use of complementary therapies and psycho-therapeutic measures to help to attract and retain clients into treatment settings. This section presents the results of the scientific literature review^{27,28}.

Treatment (pharmacological and psychosocial interventions)

There are still no approved medications for the treatment of cocaine dependence. The drug Disulfiram (also known as "Antabuse" for the treatment of alcoholism) has decreased cocaine use in a number of studies (Farrell, 2002). Other drugs may also be effective in some individuals in reducing the severity of the withdrawal symptoms or in cases where blood flow to the brain is affected. Dopamine agonists have been used for reducing the symptoms the clients experience during the initial period of abstinence from cocaine. Current evidence does not support the clinical use of dopamine agonists in the treatment of cocaine dependence (Soares *et al*, 2003; de Lima *et al*, 2002). The anti-convulsant, Carbamazepine, has been used for treating cocaine dependence. A review of controlled trials (Reisser *et al*, 2002) concludes there is no current evidence supporting the clinical use of Carbamazepine in the treatment of cocaine dependence. All of these medications require fuller evaluation before it can be claimed that they make a significant difference to people dependent on cocaine.

27 Searches of the most salient databases covering the social sciences, psychology, addiction and medicine were conducted. The following terms were combined with Boolean operators to extract studies regarding various aspects of cocaine use and treatment: Intervention, Treatment, Crime, Vaccine, Women, Workplace, Productivity, Risk behaviour, Harm reduction, Pregnancy, Prison/penitentiary and Drug markets. The databases searched include Medline, PubMed, PsycInfo and the Social Science Citation Index.

28 In May 26, Dr Brion Sweeney presented the evidence base for the treatment of problem cocaine use. For an excellent summary of the workshop and details of the evidence base presented, see Keenan and Long, 2007.

A cocaine vaccine is believed to be a promising future treatment, when combined with psychotherapy to prevent relapse, but controlled clinical trials are needed before any further conclusions can be drawn. This strategy for the treatment of cocaine addiction is to block the effects of cocaine through the use of a cocaine vaccine. The vaccine induces anti-cocaine antibodies within the subject that bind to cocaine in the blood. If the clients uses cocaine after being vaccinated, the antibodies will inhibit the ability of cocaine to enter the brain and cause effect. As a result, the reinforcing activity of cocaine is expected to be reduced (Fox *et al*, 1996). Motivated clients (i.e. cocaine dependent) would be immunised with the vaccine as part of a comprehensive treatment programme aimed at relapse prevention.

The Drug Abuse Treatment Outcome Study (DATOS) from the US shows that cocaine dependence is treatable (Hubbard *et al*, 1997). Drop-out from treatment is one of the major obstacles in treatment of cocaine dependence (Sayre *et al*, 2002) consequently identifying factors that improve retention rates is important.

At the present time the most effective responses appear to include psychotherapy, cognitive behavioural therapy and contingency management. Such interventions are widely used with psychostimulant users, sometimes as a single intervention, and sometimes in conjunction with a pharmacological intervention. For cocaine dependence, cognitive behavioural and relapse prevention therapy (CBT-RP) have been some of the most successful treatments (Carroll *et al*, 1998) in preventing relapse. However research shows that adequate cognitive functioning is required for many of the activities in psychosocial therapies (Gottschalk *et al*, 2001) including CBT-RP. In chronic cocaine users, cognitive domains such as attention, memory, decision-making, and problem solving are often impaired (Cunha *et al*, 2004; Hester & Garavan, 2004), increasing the likelihood of dropping out from weekly CBT sessions (Aharonovich *et al*, 2006).

Boosting the individual's participation in any undertaking/project by applying incentives is particularly effective as it ties task completion to receiving an award. Contingency Management (CM) techniques that reinforce completion of non-drug activities are suggested to be effective in the treatment of cocaine dependence. Contingency management using prize reinforcement was found to increase retention in treatment services and was associated with higher rates of cocaine abstinence in an outpatient setting (Lewis *et al*, 2005).

Applying prize reinforcement on its own however, is unlikely to be sufficient to secure abstinence. While incentives may have positive short-term results, building the confidence to change and the resolve to overcome difficulties will also be essential components, particularly given acute problems with cognitive and emotional functioning. Counselling techniques such as Brief Motivational Intervention (BMI) have been found to help clients achieve abstinence from heroin and cocaine (Bernstein *et al*, 2005). In a large-scale randomised trial involving a diverse sample of drug users (n=1,175) the effect of a brief but intense intervention in the clinical setting with out-of treatment cocaine users was examined. The results suggest that brief motivational interventions appear to facilitate abstinence – this was demonstrated at a 6-month follow-up, even in the absence of meaningful contact with the treatment systems. Overall, a meaningful reduction in mean cocaine levels compared to control group outcomes was reported (Bernstein *et al*, 2005).

There is some limited support for the efficacy of auricular acupuncture particularly when five treatment points are included in the treatment intervention²⁹ (D'Alberto, 2004). However the evidence is inconclusive and further randomised trials may be justified (Gates *et al*, 2006). There is some evidence to suggest that acupuncture is capable of attracting users into treatment and encouraging them to remain in treatment.

29 Five points are in accordance with the National Acupuncture Detoxification Association protocol.

In addition to the development and testing of new therapeutic strategies, the effectiveness of residential and outpatient treatment modalities for treating cocaine dependence has been examined (McLellan *et al*, 1997). In particular, studies that examine the match between services and types/degree of severity of addiction problems have yielded interesting findings. A national study of 1,605 cocaine-dependent clients from 11 cities located throughout the United States who were admitted to treatment indicated that outcomes are related to the type of treatment entered, the length of stay and the severity of client problems at intake (Simpson *et al*, 1999). This study shows that people with more severe cocaine addiction problems at intake were more likely to benefit from longer care in residential services affirming the importance of long-term intensive care as a treatment option (e.g. therapeutic communities or residential rehabilitation programmes). For clients with medium-level problems, outpatient programmes, lasting 90 days or more seem to be similarly effective.

Harm reduction

While abstinence is the ultimate goal of many drug treatments, harm reduction messages need to be targeted at cocaine users. Marsden *et al*, (2006) in a pilot study tested a harm reduction initiative using a brief intervention model with young people in their social setting. Those who received the brief interventions reduced their drug use and risk behaviours more than the control group who received information only. Brief interventions are considered to be a useful and acceptable method of engaging with young stimulant users.

Cocaine use is associated with injecting and sexual HIV risk behaviours. In a study of HIV infection among users and sellers of crack, powder cocaine and heroin in Harlem (637 respondents provided urine samples) drug injectors were more than 2.5 times more likely to have HIV infections than other respondents (Davis *et al*, 2006; see also Long *et al*³⁰). A study of dually diagnosed cocaine and heroin dependant clients showed that methadone maintenance augmented by Cognitive Behavioural Therapy (CBT) and Contingency Management (CM) resulted in reduction of HIV risk behaviours (Schroeder *et al*, 2006).

Responding to cocaine use in Ireland: NDST and drug service providers

Drug treatment in Ireland is provided through a network of statutory and non-statutory agencies. There are two broad philosophies through which treatment services are provided, namely: medication-free therapy and medically assisted treatment. There can be some degree of overlap between these. In order to gain knowledge regarding techniques being applied with cocaine use clients, a small-scale exploratory study (internal NACD) of 10 purposefully selected treatment centres located in various parts of the country (both urban and rural) was conducted in 2006. Methadone treatment centres were not contacted as this information is already available through the National Drug Treatment Reporting System (NDTRS). Given the absence of a pharmacological treatment for cocaine dependence, the aim of this survey was to gain some insight into the extent these centres encountered requests for help with problematic cocaine use and if so, what approaches are used to respond to this client group. While the majority of centres reported heroin as the main illegal drug encountered, approximately half reported some incidences of treating cocaine use in their centres. Reports from these centres is that cocaine is

30 See also Long *et al*, 2006 an association between area of residence and the risk of acquiring HIV and Hepatitis C and suggest a link with cocaine use.

used with other substances, chiefly alcohol and cocaine use is associated with high levels of aggression, recklessness, and debt-related complications in the lives of clients, their families and their friends.

All respondents reported medication-free therapy as the core to their approach to addiction, and the majority (n=7) said that cocaine use would not be tackled any differently to other drug use. The general philosophy explained was that addiction to cocaine was equivalent to any other drug addiction and hence did not warrant a specific or distinct model. Two respondents specified that cocaine addiction would be approached in the same way as heroin addiction, but without providing methadone. Techniques cited in the scientific literature to be effective for cocaine use were also mentioned as being used by many of the respondents namely Cognitive Behavioural Therapy, Motivational Interviewing and Brief Interventions.

Training and education of front line staff and treatment interventions projects in the Greater Dublin area

In response to various calls from groups³¹ to react to increasing levels of cocaine use in the community (following the NACD report on Cocaine Use in Ireland 2003), the Department of Community, Rural and Gaeltacht Affairs requested the National Drugs Strategy Team (NDST) to examine this issue in mid-2004. An NDST Cocaine Subgroup was established which agreed a set of recommendations to establish three types of cocaine-specific interventions:

1. The training of staff, including the support for complementary therapies
2. The piloting of treatment interventions, which have found empirical support in the literature on the treatment of individuals with cocaine abuse/dependency.
3. The adaptation of existing education material where required (subject to ongoing discussion with the Health Service Executive and Drug Task Forces).

1. Training

The purpose of the training intervention dimension was to up-skill front-line workers and volunteers in contact with cocaine users to build capacity to respond to the needs of cocaine users. Three 'tiers' of training aimed at workers and volunteers interacting with cocaine users were supported as follows:

- **Tier 1:** One-day training for front-line staff/volunteers working in statutory/voluntary agencies/family support networks/service users fora. This training intervention covered: the pharmacology of cocaine, the methods of cocaine use, engaging with cocaine use, problems specific to cocaine users, harm reduction issues, the role of complementary therapy, an overview of brief intervention skills and issues relating to polydrug use targeted.
- **Tier 2:** Three-day training for those who operate in a key worker or case management capacity with active cocaine users. This included motivational interviewing/intervention skills, the use of the Maudsley Addiction Profile, patterns of cocaine use and triggers, relapse prevention, care planning and goal setting.

In total 55 people attended the one-day workshops and 49 people attended the two-day training courses training for front-line workers. The training was carried out and evaluated by MQI. The evaluation of the training showed an increase in skills and knowledge,³² and recommended further training as part of ongoing professional development.³³

31 Including the Local Drugs Task Forces (LDTFs), the Voluntary Drug Treatment Network (VDTN) and CityWide

32 At the outset of the training, just 4 out of the 104 participants rated their skills and knowledge in the region of 70 or more out of 90. At the end, 53 rated their skills and knowledge in this bracket. At the other end of the spectrum, prior to commencing the training, 52 out of the 104 participants rated their competency levels below 50 out of 90. On completing the course, only 2 people remained in the below 50 bracket.

33 The evaluation recommends training which focus on the needs of workers who wish to have knowledge of cocaine as part of dealing with clients with polydrug use and other courses which offer training to individuals who work with clients regularly whose primary drug of choice is cocaine, in a whole organisation approach.

- **Tier 3:** Qualified counsellors working with cocaine users on a more intensive, psychotherapeutic basis to deliver Cognitive Behavioural Therapeutic type interventions, aimed at enabling practitioners to deliver appropriate interventions to cocaine/stimulant users. This training was provided to 21 qualified counsellors and accredited by Leeds University.
- Complementary therapies: the final element of the cocaine training is in the area of training to front line staff and volunteers in the delivery of complementary therapies to the target group.

Treatment Interventions

Four treatment interventions were piloted with specific groups identified as having particular difficulties in relation to cocaine usage: (1) intravenous cocaine users in the north inner city area, (2) problematic intranasal cocaine users in the Tallaght area of South Dublin, (3) identified polydrug users in the south inner city (ultimately this programme was funded by the South West HSE) and (4) female problematic cocaine users in the city centre. The evaluation of the pilot projects is currently being completed by Goodbody Economic Consultants.

In the intervening period, a number of LDTFs have developed specific proposals to respond to emerging evidence of a growing cocaine problem in their communities, through the LDTF 'Emerging Needs Fund'. Five such projects have been supported to date. These are located in Ballyfermot, Finglas/Cabra, Dublin 12 and Dun Laoghaire Rathdown with a total funding package of €311,285. Four of the projects focus on the provision of direct community based services for cocaine users located within existing services and the fifth is supporting the development of an information booklet.

Responding to cocaine: the experience of the Tallaght Cocaine Pilot Project

In response to rising levels of cocaine use the NDST recommended the establishment of four pilot treatment programmes in various localities around Dublin. The Tallaght Pilot project was the result of a proposal submitted by Community Addiction Response Programme (CARP), Killinarden and St. Dominics Community Resource Centre and the pilot project also operated from these two locations. The project began in February 2005 and was evaluated³⁴ in April 2006. In this period, 95 people in total attended the two locations for treatment for their cocaine use. Of this group, approximately 15 people sought further, more intensive treatment. A total of 304 interventions were delivered to these 95 people.

Profile of cocaine user group: Males comprised 73% (n=69) of this group and the median age was 25 years. The people attending the centres were generally educated to Leaving Certificate, and in regular employment. This is very much in contrast with the profile of heroin users. It was noted that in comparison to opiate users a comparatively large number of the cocaine-using group were self-employed. The vast majority of the group snorted cocaine, whilst the remainder smoked and/or injected the drug. Cocaine was used frequently with alcohol. Cocaine was reported by most to be used 'several times a week' and typically large quantities were consumed. Most of the group described themselves as 'weekend users' but many actually used cocaine from Thursday through to Monday. Binge use can result in the person spending from €200 to €2,000 over a 3/4 day weekend (reported by drug users involved in the Tallaght Cocaine Pilot study).

³⁴ The findings of this evaluation were not available at the time of writing this report. The NACD met with the project leaders with the purpose of understanding the project and its outcomes.

Treatment provided during the Cocaine pilot project: The project operated similar to a drop-in centre: the facility was open three evenings per week to cocaine users, offering refreshments and the opportunity to talk to others, on a one-to-one basis. Services also included the possibility to talk to a counsellor, and in terms of techniques, Motivational Interviewing and Brief Interventions were used. More detailed work involved applying Cognitive Behavioural Therapy. Holistic therapies such as Indian Head Massage, Reiki and Auricular acupuncture were also provided.

Reaching cocaine users: Promoting the cocaine project via advertising as well as through word-of-mouth was essential to inform people about the availability of cocaine treatment at the centres. Referrals came mainly from Outreach activity and to a lesser degree the probation and welfare services; some cases were self-referrals and these were directly the result of advertising the project's cocaine service in the newspaper.

Re-orienting the organisation

Training: All staff associated with the cocaine pilot had undertaken addiction training and members were familiar with Cognitive Behavioural Therapy and Brief Interventions. Two outreach workers were employed to work on the project - one had extensive experience of working with cocaine users in the United Kingdom and the other had experience working with drug users in a Dublin community. Another member of staff who had extensive experience of working with cocaine and crack users in the UK context was consulted particularly in the initial stages. A staff member also visited some established cocaine projects in the UK and Europe and had attended seminars/conferences and CityWide training. Training provided by the Drugs Strategy Unit was also availed of. A small budget was allocated to on-the-job training when necessary throughout the project. From the outset the details and plans of the project were outlined and discussed with all staff members.

A changing emphasis: A key issue that emerged from the pilot was the degree to which the project was able to utilise existing competencies in the organisation which was achieved by re-orienting the existing approach used by staff in the centres. For example, to circumvent cocaine users' reluctance to attend a known opiate service during the day, it was decided evening access would be provided. Additionally, outreach workers were available to meet cocaine users in the period immediately before and after the weekend as this was when cocaine use would be most intense. High frequency cocaine use brings with it many problems for the user – problems with debt and repayment difficulties as well as disruption of relationships with family and/or friends, psychiatric problems - common among these are heavy depression and/or high levels of anxiety - poor diet and low levels of self-care. In light of the high levels of chaos in the cocaine user's life, it was felt that the 'process of engagement' applied in the pilot project was critical to sustaining attendance at the centres. This engagement process included providing practical help/advice for problems, providing the opportunity to talk, to address physical, emotional and relationship problems, as well as to help de-stress with the use of complimentary therapies. Consistency and structure in the provision of the services were also found to be very important in retaining cocaine users' attendance. The project leaders reported that they found cocaine users to be more open/frank about their drug use than they had experienced with heroin users. It was suggested that the regime encountered by heroin users presenting at drug services in Ireland may be one that is less conducive to encouraging honest reporting about drug use.

Lessons learned

- No incidences of aggression or violence were encountered throughout the period of the pilot.
- Proactive approach to promoting the availability of cocaine services is necessary.
- The skills and knowledge competencies required to provide cocaine services were already present within the organisation. However a re-orientation of the organisation's approach was needed to understand the impact of cocaine on the individual and their lives.
- Acknowledging that a cocaine user will not present at services as frequently as a heroin user means that a very different approach is needed.
- It was reported by the project leaders that cocaine users were more frank about their drug use than heroin users which enabled decision-making about the appropriate intervention to be used.

Summary and concluding remarks

While drug/alcohol treatment centres around Ireland reported limited encounters with cocaine, this does not necessarily mean that the true number of (heavy) cocaine users outside treatment is also low. In fact, the literature highlights the problem that without the incentive of a pharmacological substitute to offer, it is difficult to attract those who need help into existing drug services. The development of drug services in Ireland has been oriented towards problem opiate use, thus services may not be equipped to deal with cocaine users and cocaine users in turn, may not be attracted to those settings. Furthermore cocaine users are a difficult population to engage in treatment - drop-out is high (Sayre *et al*, 2002) and there are high levels of continued substance use and relapse (Simpson *et al*, 1999). The literature discussed above highlights the importance of psycho-social interventions and complementary therapies – in both attracting people into and retaining them in treatment. This evidence also highlights the importance of assessing the needs of cocaine users at intake and matching services to these needs. For example, not all treatment settings appear to be effective for all types of cocaine users – some do better in longer in-patient stays. All of these issues arose during the implementation of the Tallaght Cocaine Pilot Project which concluded that a re-orientation of its existing services was needed to meet the specific needs of the cocaine-using client group. The chapter also provided an overview of the cocaine specific training intervention that was also a result of the Mid-term Review of the National Drugs Strategy. The training intervention sought to provide staff at all levels with skills and knowledge needed for an effective treatment/intervention for cocaine use. It was noteworthy that those who participated in the training/interventions found that the knowledge and skills that they acquired were helpful in their work with cocaine users.

Chapter 8: Summary and Recommendations

Cocaine prevalence in Ireland

Indicators of cocaine supply and treatment demand consistently point to an increasing prevalence of cocaine in this decade.

- **Crime Data:** Garda data show an increase in the number of cocaine-related offences under the Misuse of Drugs Act (MDA) from 180 in 2000 to 1,224 in 2005.
- **Drug Seizure Data:** Both Garda and Customs & Excise data show an increase in the number of cocaine seizures. The former show an increase from 206 in 2000 to 968 in 2005. The latter show an increase from 12 in 2000 to 67 in 2004.
- **State Laboratory:** There has been almost a six-fold increase in the number of cocaine positive samples detected in post mortems between 2000 and 2005.
- **Medical Bureau of Road Safety:** Road safety tests also indicate an increase in cocaine positive tests up to 2005.
- **Hospital In-Patient Enquiry Data (HIPE):** The number of incidences of cocaine-related diagnosis in hospitals increased from 54 in 2000 to 222 in 2004.
- **National Drug Treatment Reporting System (NDTRS):**
 - The number of new cases seeking treatment for cocaine as a primary drug increased from 33 in 2000 to 157 in 2003 and the number of previously treated cases reporting cocaine as a primary drug increased from 41 to 145 during the same period. The number of new cases reporting cocaine as an additional problem increased from 189 in 2000 to 443 in 2003 and the number of previously treated cases reporting cocaine as an additional problem increased from 711 to 1,772 during the same period. These increases are in line with the data reported from urinalysis at the Drug Treatment Centre Board.
 - Of the 360 new cases treated who reported cocaine as their main problem drug between 1998 and 2003, 92% reported the use of more than one drug (Long, 2006). When cocaine was the main problem drug, cannabis, alcohol and ecstasy were the more common additional problem drugs reported.
 - Of the 1,439 new cases treated who reported cocaine as an additional problem drug between 1998 and 2003, 772 reported using an opiate as their main problem drug.

Cocaine represents a growing share of the market for illicit drugs

- All of the aforementioned sources of information agree that cocaine commands an increasing share of drug-related offenses, laboratory test results and of hospital and treatment intake.

Patterns of cocaine availability and use vary

- Cocaine continues to feature most prominently in the Dublin Metropolitan Region (47%), however in 2005 areas to the south east (7%) and south (18%) of the country show increasing levels of cocaine prevalence as indicated by Garda records of contraventions of the Misuse of Drugs Acts.
- In Dublin prevalence rates vary at a community level. The NDTRS treatment data for 2003 show that of all cases treated for cocaine use in Ireland 75% are in the Greater Dublin Area: 36% of these were located in what was the South Western Area Health Board Region. This was followed by 25.3% in the former Northern Area Health Board.

- Data from the NACD Community Drugs Study highlight the variation in drug use/availability existing at a community level.

The general population survey and data from the NDTRS indicate that more males than females report cocaine use. For example, 4.3% of male respondents aged between 15 and 34 years in the general population survey have used cocaine while data from the NDTRS indicate that 78% of all cases treated for cocaine as a primary drug were male.

Should we be concerned?

The use of cocaine can harm the user, and both direct and indirect harm to the community

Individual Harm: harm to the individual will vary depending on a number of factors, including purity of drug, route of administration, frequency and intensity of use, the individual's social circumstances and their physical and mental health. That said, the main types of individual harm are damage to physical health, mental health and social and economic harm.

- **Physical Health:** Regular cocaine use, irrespective of the route of administration, is linked to severe physical problems including heart conditions and neurovascular events - strokes - which are common and often fatal. Additional harm to the individual's health varies according to the route of administration. Snorting cocaine damages the nasal passages, and result in nose bleeds, loss of sense of smell and nasal septum perforation. Smoking crack can cause black phlegm, chest pains, and a variety of respiratory problems. Intravenous use of cocaine can cause a range of problems from minor skin infection and abscesses to arterial thrombosis (blood clots) and kidney failure and is associated with increased injecting-related risk behaviours. Adulterants mixed with cocaine can cause other complications not listed above.
- **Mental Health:** Frequent and/or long-term cocaine use can have a powerful effect on the users' mental health. It can result in a range of conditions from depression, anxiety, agitation, compulsive behaviour and paranoia. The severity of mental health problems are associated with the intensity of cocaine use and the degree and range of physical health problems.
- **Dependency:** While dependency is not inevitable for all people, international research indicates that when cocaine dependence does occur it can emerge quite early and explosively in the initial years after first cocaine use.
- **Social & Economic Harm to Individuals:** The patterns of bingeing typical of cocaine use can cause serious financial problems, leading to economic/compulsive crime and/or interpersonal/familial stress.
- **Combination Drug Use:** Research illustrates that levels of alcohol use among cocaine/crack users are high. As a stimulant cocaine sustains the individual's capacity to consume alcohol and can act to intensify the duration and effect of binge use episodes. This is compounded by the fact that cocaine and alcohol when used together, combine to form cocaethylene, a substance more toxic than either in isolation.

Harm to the Community: Levels of both direct and indirect harm will vary across and within communities. Deprived communities and areas with an existing community drug problem (such as in LDTF areas) are more likely to suffer the consequences of the use and sale of cocaine.

- **Normalisation:** Unlike heroin cocaine use in the community is largely recreational and consumed in social settings (including pubs and clubs) and leads to concerns that the drug is perceived not only to be socially acceptable but also harmless.
- **Fear of Crime:** The NACD Community Drugs Study highlights increased levels of fear at community level and the perceived undermining of social cohesion (despite local government initiatives).
- **Crime & Violence:** Evidence from the UK and the US indicates high levels of economic/compulsive crime among cocaine/crack users. The short-acting effect of cocaine means that individuals can spend large quantities of money bingeing on the drug. There is broad agreement that the link between cocaine use and debt is contributing to an escalation of fear and intimidation in some communities. NACD is receiving reports of cocaine debt-related violence and intimidation at a community level.
- **Violence:** Cocaine/crack use can lead to anxiety and paranoia, giving rise to offences involving violence (particularly when used with alcohol). Moreover, cocaine/crack markets are also associated with rising levels of gun crime (in the UK and US).
- **Public Nuisance:** The co-existence of cocaine and alcohol in the community gives rise to increased incidences of public nuisance (manifested for example as noise pollution), anti-social behaviour and criminal damage.

Service provision and cocaine use

Treatment programmes in Ireland are not designed for stimulant users

- The drug treatment services in Ireland (in particular the Greater Dublin Area) traditionally developed to deal primarily with an opiate using client group. The treatment system has evolved in such a way that it has been referred to as an 'opiate only service'. Given the increase in polydrug use, a new non-drug specific approach is needed.
- Residential and counselling services, in particular, provide interventions/services which are not specific to any particular drug.
- While there is a dearth in research in the Irish context, studies conducted in the UK indicate that non-opiate cocaine/crack users rarely seek help (and more rarely receive it) which could suggest a hidden population of users in need of treatment.
- Impaired cognitive functioning³⁵/memory due to cocaine use may make it more difficult to participate in therapeutic interventions (this would be compounded by polydrug use).

Opiate-based treatment services in Ireland have to deal with increasing numbers of individuals presenting with cocaine-related problems.

- The interaction between different substances (polydrug use) and the impact on the user has implications for service providers regarding the management of clients, and for treatment effectiveness.
- Service providers underscore the agitated and excitable nature of this client group.
- Irish research (ROSIE Study) shows that cocaine/crack use among opiate users in treatment was reduced at one year follow-up.

35 Impaired thought processing capacity

There is a general perception among both drug treatment service providers and service users that there is no effective treatment available for problematic cocaine use.

- Treatment in this context is usually perceived to be a pharmacological intervention.
- There is limited awareness of the effectiveness and availability of services for cocaine users.
- In addition, there is a perception of a skills deficit within the treatment workforce.

Evidence-based treatment for cocaine use

- Although there is no pharmacological substitution treatment available for cocaine/crack use, available evidence indicates that many approaches that are already familiar to, and being practiced in, drug services work well with cocaine/crack users. They are not specific to the treatment of a cocaine/crack using group and are effective for problem-use of other substances. These include individual counselling techniques such as Cognitive Behavioural Therapy (CBT), Brief Interventions, Contingency Management, Group therapy/counselling and peer leadership.

Recommendations

Treatment

Recommendation 1: Establish stimulant specific interventions in areas where cocaine problems are acute.

Responsibility HSE and DTFs

Recommendation 2: At a service delivery level (opiate focused services in particular) need to adapt, develop and standardize response to increasing levels of cocaine use (and polydrug use) among their clients.

Responsibility HSE

Recommendation 3: Given the current context of polydrug use, in the long-run a re-orientation of drug services from drug specific interventions to treatment tailored towards the individual regardless of the drug(s) they use. This approach will provide a series of options for the drug user, appropriate to his/her needs and circumstances and should assist in their reintegration back into society.

Responsibility HSE and DTFs

Recommendation 4: Dispel the myth among services users and providers that there is no effective treatment for cocaine/crack use. Cocaine/crack use can be treated.

Responsibility HSE and DTFs

Recommendation 5: In terms of risk behaviours (acknowledging that 63% of cocaine users in contact with treatment services inject) a rollout of needle exchange and related harm reduction strategies.

Responsibility HSE

Recommendation 6: Service providers, within statutory, community and voluntary sectors, must identify and meet the training needs of frontline staff (including volunteers), in particular in relation to cocaine/crack use and polydrug use.

Responsibility D/Health & Children

Recommendation 7: Develop better working relationships between GP's and drug services on the one hand, and A&E staff and drug services on the other, as these can be the first points of contact for people presenting with cocaine and indeed other drug-related problems.

Responsibility D/Health & Children and HSE

Recommendation 8: Ensure that prison drug treatment and awareness programmes address cocaine/crack use in addition to all other drug use.

Responsibility Irish Prison Service and HSE

Supply

Recommendation 9: Garda Management to provide the optimum number of personnel needed in drug units at Garda District and Divisional level to reflect the evolving drug markets and local drug prevalence.

Responsibility AnGS and DJEQLR

Recommendation 10: Given the nature of the cocaine market begin the roll-out of local policing fora in LDTF areas as indicated in the DJEQLR guidelines, by March 2007 to strengthen community Garda links in addressing community drug issues.

Responsibility AnGS and DJEQLR

Prevention

Drug prevention operates on 3 levels – primary, secondary and tertiary. While recognising the value of primary prevention strategies within the SPHE school programme, there is a need to adapt the secondary and tertiary prevention strategies to take into account cocaine/crack use.

Recommendation 11: Information about cocaine/crack and its harms should be disseminated to raise awareness among individual user groups and reflect their environments in a range of settings including the workplace.

Responsibility D/E&S, HSE and DTFs

Research

Some of the main indicators of prevalence, irrespective of data source are subject to a number of limitations, among others, the lagged time release from data providers. While this problem exists the following recommendations will assist in ensuring the availability of additional information.

Recommendation 12: Currently prevalence data is aggregated at the national and regional levels. However patterns of drug use vary dramatically within these broad categories. This variation must be captured by the collection/availability of data at the lowest level such as ED (formerly DED)³⁶. This is essential to assist the community in identifying and reflecting local needs in the planning of service delivery.

Responsibility NACD, DMRD and HSE

Recommendation 13: To understand the emergence and diffusion of cocaine and other drugs in Ireland, to describe and explain the take-up of these drugs in the population and their resulting patterns of use. To identify the implications for planning future social policy and service delivery.

Responsibility NACD

³⁶ Since 1991 the NDTRS codes all cases reported from Dublin, Kildare and Wicklow to the electoral division using a system developed by the former ERHA. Currently individual addresses are not geo-coded for other counties in Ireland.

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Appendices

Appendix 1: Sources of data used in report

Multiple sources were used to build as complete picture as possible. This report is based on data from the following sources:

- Forensic Science Laboratory
- Customs & Excise, Customs and Excise Drug Law Enforcement
- An Garda Síochána seizures from PULSE data
- National Drug Treatment Reporting System
- Drug Trends Monitoring System
- ESPAD
- SLÁN, HBSC
- NACD/DAIRU Drug Prevalence Survey
- HRB Overview Series 1 – Drug-Related Deaths in Ireland
- HRB Overview Series 2 – The Illicit Drug Market in Ireland
- HPU/Trinity Health of Irish Students Survey
- ROSIE data on Cocaine
- Trinity Court – Laboratory results
- Beaumont – Laboratory results
- State Laboratory – results
- Medical Bureau of Road Safety – samples from drivers
- HRB Annual Reports to the EMCDDA
- Drug Courts information
- CityWide drugs crisis campaign reports on cocaine
- Qualitative and ethnographic research
- A review of the literature review on treatment, prevention and harm reduction in particular information from the UK relating to Cocaine specific services which underwent evaluation.
- NACD studies
- NDST information

Table A1: Occurrence of adulterants in cocaine powders seized by An Garda Síochána and analysed by the Forensic Science Laboratory

Year	Total Cocaine Cases	% of cases in which adulterants detected				
		Phenacetin	Lignocaine	Benzocaine	Procaine	Caffeine
2004	860	40%	34%	4%	<1%	11%
2005	1103	34%	60%	4%	3%	15%
2006	969*	36%	59%	8%	3%	19%

Source: Forensic Science Laboratory

* to end November 2006

Appendix 2: Singular and combined effects of drugs

Table A2: Singular and combined effects of the drugs listed³⁷

Cognition: memory, attention, concentration, decision-making, problem solving	Cannabis, cocaine, ecstasy all affect memory, ability to form thoughts, to concentrate and to make simple decisions. Also cause severe mood swings, paranoia and depression. Use of alcohol further compounds these effects. Use of benzodiazepines affects memory, attention and cause drowsiness.
Co-ordination	Cannabis, ecstasy, benzodiazepines and alcohol all affect co-ordination and so people should not drive after taking these substances. Effects are worsened with a combination of any or all drugs.
Heart	Cannabis (4 times risk of heart attack 1hr after consumption), alcohol, cocaine, ecstasy cause increase in heart rate, irregularities in heart rate, heart failure, cardiac arrest. Benzodiazepines and heroin however slows down heart rate.
Blood pressure	Cannabis, alcohol, cocaine, ecstasy cause an increase in blood pressure.
Lungs	Cannabis, alcohol, cocaine, ecstasy, all cause respiratory problems leading to respiratory failure. Heroin and benzodiazepines slow down breathing and can cause respiratory failure.
Kidneys	Alcohol, cocaine and ecstasy damage the blood vessels to the kidneys which can lead to kidney failure.
Liver	Alcohol, combined use of all of the above causes enlargement of the liver and excessive and chronic alcohol use causes cirrhosis of the liver.
Sex	Cannabis, ecstasy, heroin lead to reduced pleasure or interest whilst cocaine leads to increased pleasure and interest but long-term leads to impotence and infertility.
Cancer	Alcohol and cannabis increase risk of cancers of head, neck, throat and gut.
Sleep	Reduced sleep caused by ecstasy, cocaine and interrupted sleep with alcohol mixed. Heroin and benzodiazepines enhance sleep and drowsiness.
Depression, anxiety, irritability, agitation, impulsiveness, paranoia and aggression	Regular chronic or long-term use of cannabis; regular or binge use of alcohol, cocaine, ecstasy and combined use of these drugs and others such as benzodiazepines.

³⁷ Sources: for a comprehensive overview of the implications of polydrug use for health, see Hogan-Murphy 2006; for an overview of the pathology of cocaine abuse see White & Lambe 2003; and for an overview of the interaction effects between multiple drug combinations, see Katz et al, 1992

Appendix 3: Prevalence details

General population (15-64 years)

Table A3.1: Lifetime prevalence rates (%) for cannabis, cocaine, amphetamines and ecstasy use among adults (15-64 years*) in selected EU countries***

Country	Year	Cannabis %	Cocaine %	Amphetamines %	Ecstasy %
Denmark	2000	31.3	2.5	5.9	1.0
Finland	2000	9.9	0.6	1.0	0.6
	2004		1.4		
Greece	1998	13.1	1.3	0.6	0.3
	2004		0.7		
Ireland	2002/03	17.4	3.0	3.0	3.7
Netherlands	2000/01	21.0	3.6	3.1	3.6
Norway	1999	15.3	2.2	3.8	1.3
Portugal	2001	7.6	0.9	0.5	0.7
Spain	2001	24.5	4.9	3.0	4.2***
	2003		5.9		
Sweden	2000	12.5	0.7	1.9	0.2
United Kingdom	2001/02	29.1	5.2	11.7	6.0
	2004		6.5		

* Age ranges for some countries may not exactly correspond to 15-64 years

** Selected on the basis of similar methodology

*** Ecstasy and other designer drugs

+ For a selection of countries 2004 data are available

Source: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

Table A3.2: Last year prevalence rates (%) for cannabis, cocaine, amphetamines and ecstasy use among adults (15-64 years*) in selected EU countries***

Country	Year	Cannabis %	Cocaine %	Amphetamines %	Ecstasy %
Denmark	2000	6.2	0.8	1.3	0.5
Finland	2000	2.2	0.2	0.4	0.3
	2004		0.3		
Greece	1998	4.4	0.5	0.1	0.1
	2004		0.1		
Ireland	2002/03	5.1	1.1	0.4	1.1
Netherlands	2000/01	6.1	1.1	0.6	1.5
Norway	1999	4.5	0.6	1.2	0.7
Portugal	2001	3.3	0.3	0.1	0.4
Spain	2001	9.7	2.6	1.2	1.9***
	2003		2.7		
Sweden	2000	1.0	0.0	<0.5	<0.5
United Kingdom	2001/02	10.6	2.0	1.6	2.2
	2004		2.3		

* Age ranges for some countries may not exactly correspond to 15-64 years

** Selected on the basis of similar methodology

*** Ecstasy and other designer drugs

+ For a selection of countries 2004 data are available

Source: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

Young Adults (15-34 years)

Table A3.3: Lifetime prevalence rates (%) for cannabis, cocaine, amphetamines and ecstasy use among young adults (15-34 years*) in selected EU countries***

Country	Year	Cannabis %	Cocaine %	Amphetamines %	Ecstasy %
Denmark	2000	44.6	4.5	9.6	2.6
Finland	2000	16.6	1.2	2.5	1.4
	2004		2.1		
Greece	1998	19.7	2.2	0.7	0.6
	2004		1.0		
Ireland	2002/03	24.4	4.7	4.9	7.1
Netherlands	2000/01	31.5	5.1	5.1	7.4
Norway	1999	20.9	3.3	5.4	2.5
	2004		4.3		
Portugal	2001	12.4	1.3	0.6	1.4
Spain	2001	35.0	7.7	4.8	7.9***
	2004		8.9		
Sweden	2000	14.0	0.8	2.0	1.0
United Kingdom	2001/02	42.4	8.7	18.2	11.9
	2004		11.1		

* Age ranges for some countries may not exactly correspond to 15-34 years

** Selected on the basis of similar methodology

*** Ecstasy and other designer drugs

+ For a selection of countries 2004 data are available

Source: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

Table A3.4: Last year prevalence rates (%) for cannabis, cocaine, amphetamines and ecstasy use among young adults (15-34 years*) in selected EU countries***

Country	Year	Cannabis %	Cocaine %	Amphetamines %	Ecstasy %
Denmark	2000	13.1	2.0	3.1	1.2
Finland	2000	4.9	0.5	1.2	0.8
	2004		0.7		
Greece	1998	8.8	1.0	0.1	0.3
	2004		0.2		
Ireland	2002/03	8.7	2.0	0.8	2.2
Netherlands	2000/01	11.8	2.1	1.2	3.2
Norway	1999	8.1	1.0	1.5	1.2
	2004		1.8		
Portugal	2001	6.3	0.6	0.1	0.8
Spain	2001	17.3	4.6	2.3	3.8***
	2003		4.8		
Sweden	2000	1.0	0.0	<0.5	<0.5
United Kingdom	2001/02	19.2	4.0	3.2	4.5
	2004		4.7		

* Age ranges for some countries may not exactly correspond to 15-34 years

** Selected on the basis of similar methodology

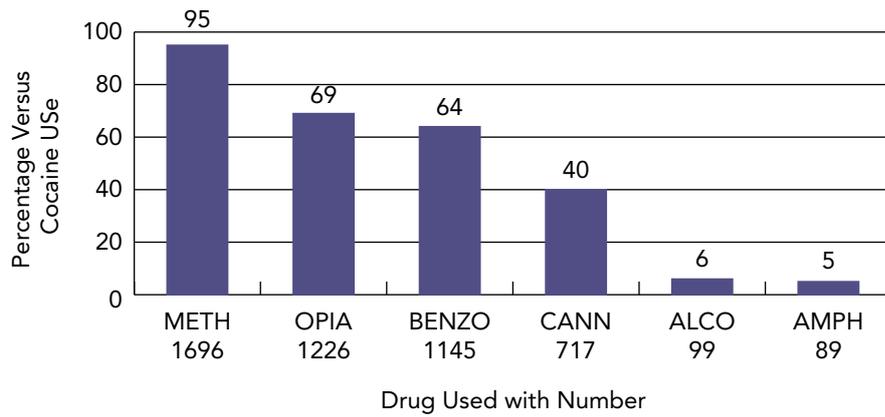
*** Ecstasy and other designer drugs

+ For a selection of countries 2004 data are available

Source: European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

Appendix 4: Other drugs used by cocaine positive clients

Figure A4.1: Drugs used by cocaine positive clients between 01/01/06 and 31/07/06*



Other drugs which cocaine positive clients tested positive for over the period 01/01/06 to 31/07/06 by order of prevalence. Percentages are shown above the bars, actual numbers of clients are shown below the x-axis.

* The key used is as follows Methadone (Meth), Opiate (Opia), Benzodiazepine (Benzo), Cannabis (Cann), Alcohol (Alco) and Amphetamine/Ecstasy (Amph).

Source: Drug Treatment Centre Board (DTCB)

Appendix 5: Cocaine Focus Groups, Merchants Quay Ireland, 2006, Author: Karin O'Sullivan

Methodology

Sample

The key criterion for participation in the study was that clients were current cocaine users (i.e. had used cocaine in the last month). A convenience sample was employed where one staff member of the drop-in services approached possible participants and informed of the study. Fourteen men (87%) took part and two females (13%) resulting in a total of 16 participants.

Data Collection

Cocaine users' Focus Groups: Two focus groups were held with a total of 14 clients who avail of the Merchants Quay Ireland services. Each focus group ran for on average of one hour. The sessions were used to examine (i) experiences and associations of cocaine use, (ii) participants perceptions of the availability and experiences of treatment.

Interview: One interview also took place with a couple where similar issues were discussed as those in the focus group.

Staff Focus Group: One focus group session was held with five staff members of client services at merchants Quay Ireland. This group consisted of the Primary Health Care nurse, and four project workers involved in the day to day running of the needle exchange service and the homeless drop-in service. The aim of this focus group session was to examine staff experiences as persons working with cocaine users. More specifically it (i) assessed perceptions of whether clients using cocaine have a particular impact upon the day-to-day running of services, (ii) identified the service/treatment options currently available to clients that use cocaine along with gaps in services for cocaine users and (iii) if and where gaps do exist, how this impacts upon the experience of service provision for staff.

Data Analysis

Data was analysed using Nud*st 6. Emerging themes were identified and written up.

Ethical Issues

It is extremely important that ethical issues are taken into consideration when carrying out any research, and especially research with vulnerable groups. Once clients were seated in the room where the focus groups were taking place a more detailed description of the study was made available to the group both verbally, and in writing. This ensured that any individual with literacy issues would not be excluded. The issues of confidentiality and anonymity were also discussed not only in relation to the use of information gathered from the group for research purposes, but also the importance of confidentiality between group members. Clients were then given an opportunity to ask any questions about the study. Immediately prior to beginning the discussion, clients were asked to sign consent forms. Upon completion of the focus group, participants were given €15.00 each as an acknowledgment for taking part in the study.

Findings

Profile of Participants

Polydrug Users

The group of participants that took part in the focus group sessions were polydrug users. As well as being cocaine users, most participants were also heroin users some also stating that they use other drugs such as 'tablets', cannabis, and alcohol.

Cocaine Use

The majority of participants stated that they use cocaine powder, while a minority mentioned either using Crack cocaine currently, or at some stage during their cocaine-using careers.

Method of use

The main method of cocaine use among the two groups was intravenous. While participants also reported snorting and smoking cocaine powder and crack cocaine the general consensus among the group was that injecting cocaine was their primary route of administration. Reasons given for injecting cocaine powder and crack cocaine were primarily linked to 'getting a better hit'. Snorting cocaine was the route of administration used when in social situations such as bars, clubs, or house parties.

Homelessness

Although not a question that was asked directly, it was evident during the discussions that many participants were currently homeless, while others referred either to prior episodes of being 'out of home', or a fear of becoming homeless due to the chaotic lifestyle associated with their drug use.

The Experience of Cocaine Use in the 'Everyday' Situation

Pattern of Cocaine use

Participants described their use of cocaine as binge use. 'Sessions' of cocaine use were described as lasting either as long as money to obtain cocaine is available or accessible, or as long as it takes to use up what cocaine has been purchased. The following quotes illustrate this finding:

"If you had an ounce of coke in front of you, you will not stop until that is gone. And then you will go out and steal [to get] more."

"With coke, as soon as you do it you want more. You'd do anything for more, it's in your head. If you had fifty grand in your pocket you'd just go through it and just keep going until it's gone"

Frequency of Cocaine Use

This pattern of use has implications for an understating of the 'frequency' of cocaine use (and drug use in general). While on the one hand people may use cocaine daily, weekly or monthly, each 'session' of cocaine taking may be lengthy involving the administration of the drug a substantial number of times.

Cocaine Vs. Heroin

A method of obtaining a clearer understanding of people's experiences is to ask them to describe what they are discussing in relation to a comparable experience. As the participants in this study were both cocaine and heroin users they were asked to discuss their use of cocaine in comparison to their use of heroin. In doing so, it quickly emerged that participants' experienced their use of cocaine as being far more chaotic than they experienced their use of heroin. The following quotes highlight these very different experiences. What is particularly interesting is that the language associated with cocaine use is very much that of urgency, immediacy, and desperate need, a state of being that can go on and on, whereas the language used to describe heroin use in comparison is that of manageability, of ebbs and flows that are of a slower and more controllable pace.

This first quotes highlight how participants feel the use of cocaine can become out of control in a very different way to the use of heroin.

"The difference between coke and heroin: with heroin you'd sit down and be grand but with coke as soon as you do it you want more. You'd do anything for more, it's in your head. If you had fifty grand in pocket you'd just go through it and just keep going until it's gone."

"With heroin you just bang it up and you're happy and you sit there and you sleep. With coke, you never get that. The buzz will last five minutes if that and then ..."

(interrupted by another participant) *"...and then you need money again."*

Here cocaine is described as something that is all consuming. This participant describes how cocaine takes over all aspects of life, which receives agreement from the entire group.

Participant X: *"It affects food, rent, collecting your payments, personal hygiene. Everything. All that matters is coke. Crack – your next turn on."*

Facilitator: Is that different from heroin use?

Group: Yes

Participant X: *A bag or two [of heroin] will get you through the day if you are not a heavy user. Whereas with coke you just keep going until there is no more money left. You will sell your home around you. I did that for coke... made it into a crack house.*

The quote below is by a participant who stated that he had lost his own business, and previous life to cocaine use. Of particular note here is the short length of time highlighted between problematic cocaine use, and 'being on your knees'.

"With heroin you can still keep you life together. You can still go to work, get up and keep yourself together. With coke you cannot. If you get a real bad coke habit, in six months you will have nothing left, everything will be sold and you will be totally on your knees. You cannot keep it together – it just becomes the only thing."

Cocaine and Heroin

Participants often described using cocaine and heroin together in the form of a *speedball* (i.e. mixing cocaine and heroin in the barrel of a syringe and injecting both drugs together). Another method of 'speedballing' heroin and cocaine was described by one of the participants.

Appendices

"You can have a bag of coke and a bag of gear and you can split it up to the same size bags [measures] and just use it [inject it] the same number of times. Do a bag of coke, do a bag of gear and so on..."

The effect on the person is similar to that of mixing both drugs in the barrel of a syringe.

Reasons for heroin and cocaine use

Reasons for the use of both heroin and cocaine were also discussed by the study participants. Similar to the language used to describe the degree of control that users perceive themselves as having over their heroin use in comparison to their cocaine use, the reasons for using both drugs together are couched in very different terms.

Participant: *"It's just the buzz off coke. That's called 'pran'. After doing the coke you feel 'pran'.*

Facilitator: *What does that mean?*

Participant: *It means like you're wired. That's when you do smack [heroin] to come down and feel normal – you smoke a joint or drink a can of beer or something to bring you back to yourself.*

The association here between the use of heroin and 'feeling normal', or in order to 'bring you back to yourself' was evident in many of the descriptions shared by participants.

The 'come down'

While cocaine is taken for the *buzz*, and heroin is taken to bring you down from it, it was evident that heroin was also used in order to *avoid* and/or *cope* with the 'come down'. During a discussion about the effects of coming down off cocaine the group were discussing the feelings of paranoia that they all experience. One participant described the experience as *"anxiety, panic attacks, paranoia, you think people are talking about you."*

Here the 'come down' is described as making people feel suicidal.

Female Participant: *"Coke is a real upper but when you have nothing to come down off it you are just pure down..."*

Male Participant: *"Suicidal."*

Female Participant: *"Yes, that's the word for it."*

Many participants stated that they would not use cocaine unless they had heroin available to them also. The following excerpt draws out this issue.

Participant T: *"People who use coke on a daily basis are always paranoid."*

Participant S: *"I wouldn't use cocaine unless I had heroin to come down."*

Facilitator: *"Why? Does it help with the paranoia?"*

Participant S: *"Yeah – to bring you down to the level...?"*

Participant T: *"Most of the time most people would use heroin to come down. I do. Straight away. I'd give it two minutes of three minutes to get the buzz off the coke and then I'd use the gear [heroin] just to come down. So it's like you have two habits in one."*

Similarly,

Participant A: *"If you only had the price of a bag of coke you wouldn't buy the coke because you do be so depressed after doing the coke you need something to come down off it."*

Participant B: *"To come down from coke, if you have nothing else in your system – if you have got no phy [methadone] or heroin to come down – it's absolutely miserable...."*

Drug of Preference

It was also found that this interrelationship between people's use of heroin and use of cocaine impacted upon participants' identification of their drug of preference. During the first focus group session, there was general agreement among the participants that heroin was their main drug of use, but when asked about their drug of choice the groups' response was cocaine. The factor that impacted upon the use of cocaine was money.

Facilitator: *"So, can I ask you all would you see heroin or cocaine as you main drug?"*

All together: *"Heroin"*

Facilitator: *"Would it be your first choice if you could choose?"*

Participant P: *"No, if I could choose it would be coke. The heroin... because there is a physical sickness off it.... I kind of have to have that first. I have to have it after I use coke as well."*

All together: *"Ya, we would all be the same."*

Participant R: *"Cocaine would be our first drug if we had the money to do it. It's all down to the money."*

During the second focus group session there was a mixture of answers between heroin and cocaine when asked about the drug that participants used the most. Similar to feedback in the first focus group, cocaine was cited by most participants as the drug they would prefer but the consequences of prolonged injection use and that impending come down were two factors which participants highlighted as problematic with the choice of cocaine.

Male Participant: *"If money wasn't an object eventually your veins collapse."*

Female Participant: *"You see people who really torture themselves to get it and it's really heart breaking"*

Perceived Benefits of Cocaine Use

Although participants had experienced the downside, and many of the dangers of cocaine use the effect that they get from the use of the drug seemed for many to outweigh the negatives.

Participant 1: *[Cocaine] makes you feel brilliant. It gives you a lot of confidence.*

Participant 2: *Yeah, big time*

Participant 1: *Say I haven't much confidence and I do coke*

Participant 3: *I just want to be with a girl*

Facilitator: *When you do coke?*

Participant 3: *I want to sleep with a girl when I do coke.*

Participant 1: *It makes you more hyper, more talkative, you do a lot of talking.*

Another participant communicated his perception of cocaine use by stating,

"The buzz is actually so nice, it is so amazing, it just makes you do things that you wouldn't normally do".

Cocaine Associated Behaviour

Participants were asked if they thought that they acted any differently than 'normal' when they were using cocaine. Common to the feedback from all study participants was the sense that their very urgent desire for more cocaine once they had taken that first hit wreaked havoc with their sense of what was rational and what was irrational behaviour. Participants spoke about the concept of morality, in the context of cocaine use saying,

"with coke and crack, you have no morals".

Violent/Criminal Behaviour

When asked to provide examples of the behaviour that they associated with their use of cocaine, feedback was mainly around behaviour that was identified as criminal and/or aggressive/violent acts that they never imagined that they themselves would do. One of the main reasons that participants gave for this type of behaviour was the desperate need to get money to buy cocaine. In the following quote the participant describes an act carried out by him as one which he associates directly with his use of cocaine.

"I never did a jump over [jump over a shop counter to rob the till] in me life and I was after been out snorting it [cocaine] for two or three days and went out the next morning and did a jump over. That's not like me."

Another participant recounted similar behaviour, and again behaviour that he did not feel was normal for him.

"When I was really strung out on coke, I was going off doing things that I never thought I would. Grabbing people at bank machines and taking their money off them. Doing things I would never even think of doing in your normal way of going on. You would do anything to get that buzz – wherever you would get it from"

Asked if anyone would use cocaine and alcohol together, one participant stated that he did, mainly if he was out in a club or a bar. After explaining that he can drink much more ('twice the amount') when also using cocaine, the facilitator asked the participant if he noticed any change in his behaviour because of the combination. The quote below demonstrates his answer, but it is interesting to note that much of the response is in the third person, suggesting that the respondent is attempting to deflect the content away from himself.

"You're getting louder and louder and more hyper kind of. And you wouldn't care. I find myself that it's usual to get into a fight when you're on cocaine. You don't think twice. You get very cocky. Even if someone bumps off you... I've done it a few times and it wouldn't be after injecting – it would be after smoking it. You kind of think you are more superman – don't you"

Participants also spoke about their cocaine-related behaviour in relation to how it also affected people close to them such as family and friends. These examples were told to the group in a manner which expressed the idea that cocaine would even make a person 'go to these lengths'.

Participant: *"You would do more desperate things" [for cocaine]*

Facilitator: *"Like"?*

Participant: *"Rob someone you know at knifepoint. Rob your best friend". (pg.8 FG1)*

It is interesting to note that all of the examples provided by the participants describe a sense of a moral 'self' and immoral 'other self' which is directly linked to cocaine use. This next quote very dramatically and metaphorically brings us to the line between morality and immorality as perceived by the participant himself, and then beyond it into the domain he perceives of as 'immoral'.

"I was using it that bad – I was on it constant say for six months. Robbing everything around me – anything that moved, I robbed it. I was that bad on it me missus said to me 'Listen, you're going that bad on it, what do you want? Do you want cocaine or do you want me or the kids'? What did I say? - 'I want cocaine' – and I walked out the door and I haven't been back since. I walked out the door with a savings box – I was after robbing a saving box!"

This final example of the behaviour that participants associate with the use of cocaine situates the reader at the point of drug administration. It highlights the sense of urgency associated with the need to administer the drug that people experience. It also demonstrates the hierarchical position that cocaine is perceived to hold – that is cocaine comes before the individual, something which also seems to differ from the perceived position that heroin holds.

Participant I: *"With heroin you'll go find a toilet in town to do it but with coke you'll do it anywhere. You'll go into a telephone box. If you see a copper coming you won't think shit.. you'll think quick, quick, quick, (administer the drug)..."*

Participant K: *"Or you'll turn around and say to the copper, 'If I can't get it into me... I'll stick it into you'..."*

Consequences of Cocaine Use

Injection Related Problems

During focus group sessions participants regularly referred to injection related complaints that they have experienced, complaints which they associate with the injection of cocaine rather than the injection of other drugs. Injection related concerns were found to relate to three main interlinking issues.

Numbness

Firstly, participants discussed some of the differences between injecting cocaine and another drug. As cocaine is an anaesthetic the site of injection becomes numbed. This has implications for knowing whether the person has 'gotten a hit or not', which participants reported, can often result in repeated attempts to inject in the same or different sites.

"The other thing about coke... with heroin if you are injecting it and you miss it fuckin' really hurts and you feel it. With coke, you actually can't tell if you miss. So, it really fucks up the area because it numbs the whole area and you can't tell if you miss".

This difficulty in finding veins or knowing whether you have missed or not, can often result in people injecting cocaine into the groin area.

Abscesses

The second issue that arose was the fact that participants associated both a greater number and severity of abscesses to the injection of cocaine rather than any other drug.

The quote below illustrates this association.

Participant: *I got abscesses and stuff. I use me groin and I got an abscess on me groin and I was laid up for a few weeks.*

Facilitator: *Do you think that was from cocaine use or drug use in general?*

Participant: *No. It was from the cocaine use. I know that because I was using heroin into my groin and there was no bother for months.*

Purity

The third key issue that participants associated with cocaine injection related difficulties was the very often referred to issue of purity. At regular intervals during both focus group sessions participants raised the issue that they were well aware of the fact that the cocaine they were buying was mixed with other substances, but the worrying issue for them was that they had absolutely no idea what substances.

"It's very easy to cut. Whereas, with heroin it's brown so you have to get something brown to cut it with, with something white [cocaine] you can throw anything into it."

Another participant raised the issue of having previously had a large abscess on his leg. The facilitator asked the participant whether he felt that the damage done was because of injecting cocaine.

Facilitator: *Would you say that the damage done to your leg was because of injecting cocaine, or would it have happened if it was heroin?*

Participant: *It was cocaine, whatever was in it. That's what they said in the hospital. You see they're putting (powder that you use to numb a baby's gums) in it... they are putting Paracetamol, they are putting Solpadine in it they are putting anything kind of white in with it. And when you're actually buying a bag of cocaine you would only be getting a third of that – the rest would be all shit or whatever...*

Other possible ingredients that cocaine is thought to be mixed with include tranquillizers and laxatives.

Social Context of Injection Drug Use

A point of particular concern due to the many complications that can arise during the injection of any substance was that some participants stated that they inject cocaine alone. A number of issues appeared to feed into reasons why this occurs including, (1) the desire not to share any of the drug with other users, (2) the issue of untrustworthiness that is often associated with cocaine users, among the drug using 'community', and (3) the divisions that exist between cocaine users who snort the drug and those who inject. (This issue is discussed further below.)

Other participants stated that they would be afraid to inject cocaine alone because of the possible consequences.

General Health Issues

As well as the abscesses that result from injection drug use other physical health issues were raised such as, vein problems, the loss of appetite, personal hygiene, pneumonia, breathlessness, and a rapid heart beat.

Mental health issues which were highlighted were mainly in relation to the depression and paranoia experienced during the come down from cocaine. But also indicated by some of the participants, in a more subtle manner, were the underlying personal issues that are blocked out through the use of drugs.

“Once you have your drugs everything is blocked out. When you come down off it [the buzz] then you have none [i.e. no block]. You are left with yourself. It’s scary.”

Family, Friends, Community

Many of the participants spoke about the losses that they had experienced not only through the use of cocaine alone but also drug use in general. Examples included the loss of inheritances that would otherwise have been left to them, businesses, family, partners, homes and children, as well huge financial losses.

An issue which also emerged was the potential separation from community which was associated less with the use of cocaine, and more with the use of a syringe to administer cocaine. Participants spoke about snorting cocaine with family members, friends and acquaintances in social situations such as clubs, bars, and house parties. The point was raised during the focus groups that snorting cocaine was a socially acceptable activity, and that there is no stigma attached to speaking about cocaine in this context. The act that separates the group of participants in this study from other cocaine users is the use of a syringe.

“Coke is acceptable, except the way that we all do it when we put it in a syringe – then it is not acceptable.... I could actually talk about it at work. ‘I went out last night, did some coke and no one takes any notice, but if I told them that I put it in a works and banged it into me.....”

“Any time is was doing it [cocaine] with family members it was snorting – it was never injecting, no way.”

Both groups agreed that there were different perceptions of acceptability that were held by society in general. Injecting cocaine crossed the line between acceptable cocaine use and unacceptable cocaine use, while the use of heroin administered in any way was perceived as outright taboo.

Treatment

The issue which presented the most complexities during the fieldwork was that of treatment. One of the key areas for exploration during the fieldwork the aim was to explore cocaine users’ perceptions of whether treatment was available to them, if so what types of treatment they could identify, and for those who had accessed treatment for their cocaine use, any benefits resulting. When asking participants to discuss any treatment that they were aware of, or had tried, the word treatment was left undefined. This allowed participants to interpret treatment at an individual level, and as discussion developed at a group level. As specific ideas or experiences were contributed to the group discussion, more specific questions followed in order to encourage participants to elaborate on their ideas and experiences.

Perceptions of Treatment Availability

When asked whether participants knew of any, or had tried any treatment for cocaine use responses ranged from ‘yes’ to ‘there is no treatment for cocaine use’.

Focus Group One

Facilitator: *"Do you know of any treatment available for cocaine users?"*

Female Participant: *"I don't. I never heard of any. The only thing I've heard of is people going to NA meetings or getting a counsellor but I think there should be something else – they should do something else."*

Focus Group Two

Facilitator asks the group: *"Have you tried any treatment for cocaine?"*

Group Responses:

- *"Valium and Acupuncture"*
- *"At one time, acupuncture"*
- *"I've never heard of any treatment for coke"*
- *"Valium"*
- *"There is no treatment for cocaine – there is no substitute like methadone"*

This feedback indicates that there are perceptions among cocaine users that treatment for cocaine use does not exist. It also highlights that while people may be aware of NA or counselling as possible treatment options, there is a sense that for some they are perceived as secondary rather than primary options.

Counselling – Drug Specific or an Holistic Approach?

Participants responded in various ways to the question of whether counselling was a form of treatment that would be useful for cocaine users.

This participant seems to be suggesting that counselling may well be useful due to an individuals need for help with personal issues.

"There is a reason why you are using coke. To get that buzz. There is something else there – there is something else going wrong, probably between yourself..... or your family when you were a child. That's where it comes from"

Another participant followed this latter comment with his own ideas of where counselling might play a role. Particular attention should be paid to the fact that he refers to 'gear', and coming down off drugs in the plural that he has shifted the focus of counselling support away from cocaine specifically, not only to the more general sphere of addiction, but also extends the scope of need to 'what you are left with when you take away the drugs – yourself'.

"You break down emotionally when you come off. That is because you have been blocking it out for so long and you are on that buzz from the gear. Once you have your drugs everything is blocked out. When you come down off it them, you have none. You are left with yourself. It's scary."

This movement from the specific to the general is evident also in the following,

"When you do come off cocaine you go through a lot of emotions. I noticed that when I stopped using coke and the gear I was roaring crying over stupid little things. My emotions were all over the place they were."

It is difficult to assess whether participants perceive of counselling as being needed for cocaine use in particular, or, it is felt to be needed on a broader and more 'person centred' scale.

Experiences of Counselling

Counselling Sessions

This participant spoke of the benefits that he receives from attending counselling. Unfortunately, it is difficult to assess whether he attends counselling for cocaine use in particular or for drug addiction (or other issues) more generally.

"I still get counselling as well. I find now when I go to counselling it does help. I go sometimes twice a week, or once a week or once every two weeks. It all depends on how I feel."

While this person indicates that his use of counselling support is based on his own level of need, a factor which appears to contribute to the reason why he finds it beneficial, many of the other participants stated that they did not have access to a counsellor to the same degree.

Residential Rehabilitation

A participant who attended a regional treatment centre for the use of cocaine and tablets felt that there was a greater emphasis on the treatment of alcohol than illicit drugs while he was there. He felt that the treatment model used for people with alcohol issues was not applicable to his needs. He also felt that the counselling he received was from people who had no experience of cocaine use/addiction themselves and therefore could not relate to him and his experiences.

"And I kept saying [to the counsellor] 'what the fuck do you know about it, you don't know where I'm coming from'. There wasn't enough information. There wasn't enough focus on cocaine. I had a really bad problem with pills and cocaine before I was on the gear. There wasn't enough information or enough talk. There wasn't enough groups, whatever.... I got thrown out."

Counselling as counter productive

Others spoke of the counter productive experiences that they have had from counselling sessions. This was put down to the physical effect that even talking about cocaine has on them.

"I've had treatment for cocaine in London and that consists of one hour counselling sessions and acupuncture. As soon as you step out of the place you're on the phone looking for coke. It just doesn't make any difference. There is nothing to take the place of the buzz of coke. Nothing. No substitute."

This experience was further elaborated as participants began to talk about the effects of talking about cocaine.

"Just talking about coke. I'm thinking about it and it makes me sweat. My hands..... If you start to think about the buzz – you could almost....."

Another participant added...

"I'm getting money during the week and I was in bed last night and I couldn't sleep thinking about what I'd do when I get it."

All laugh, relating to these comments, and begin to recount their own experiences.

Treatment and polydrug use

Because this group of people both use opiates and cocaine, some of them are linked with methadone clinics. One of the female participants who was interviewed on a one-to-one basis told the interviewer that she had asked for sleeping tablets to help with her cocaine use from the GP that she attends at her methadone clinic. The dialogue detailed below highlights the issue that people are presenting to their methadone clinics with drug use issues other than opiate use.

Facilitator: *"Did you specifically say to him that it was for cocaine use?"*

Female Participant: *"I told him. It was in my urines in any way so he knew. I told him I'd been taking it and I have a habit but I'm trying to come off it. The problem is sleeping wise. I can't sleep at all. He wouldn't give me anything. I can't relax. You can't relax coming off that."*

Facilitator: *"What did he say when you asked him?"*

Female Participant: *"Oh... (Doctor) 'I don't want to give you another habit like giving you tablets'. I said, 'even for a couple of weeks just to get me sleeping patten back and then I'll be OK probably'. But he said no. He doesn't give anything, my doctor."*

The complexities of polydrug use present challenges for those working in the area of addiction treatment, but a focus on methadone as 'treatment', or 'treatment' being focused on opiate addiction will it seems, only address very narrowly the needs of polydrug users.

Harm Reduction

While the general consensus among the participants was that there was a lack of treatment options that they felt would have an impact upon their cocaine use, many of them stressed the need for greater harm reduction measures. The key issues that arose for participants were:

Purity: Ensuring purity of cocaine and having access to methods whereby cocaine can be quickly assessed to ensure that the drug has not been mixed with something dangerous.

Health Checks. Participants were fully aware of the dangers of sustained cocaine use and referred to the need for access to medical assessments and care.

Needle Exchange. Fast and easy access to clean injecting equipment was also highlighted as a key need.

Safer Injecting Room. Cocaine users need somewhere safe and clean for injection use. Because people are injecting more often, and what appears to be in a more chaotic fashion when using cocaine, the need for a clean and safe space is presently even more urgent.

Cocaine-related Overdose. Many participants were unclear as to whether the knowledge that they already had in relation to the assistance of an individual who had overdosed on heroin was transferable to a situation where cocaine was the drug involved.



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