

**Presentations to the Citywide Cocaine Seminar
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1. Dr. Des Corrigan – Head of School of Pharmacy, Trinity College

Cocaine is a drug that is extracted from a plant, the coca plant, not to be confused with the cocoa plant, which produces chocolate. It is grown predominantly in three countries in South America; Bolivia, Columbia and Peru, the bulk of the cultivation of production is now in Columbia.

COCAINE USE

Some of the coca plants are grown legally, because it is legal in Peru and Bolivia for people to chew coca leaves and some of it is used for an extract that goes into coca cola and as many of you will know that up to about 1910 coca cola actually contained cocaine. Because one of the effects of cocaine is to numb various tissues, it originally would have been used as a local anaesthetic in dentistry but now is confined really to certain forms of surgery on the ear nose and throat. It is also used mixed with heroin alcohol and syrup to make what's called brompton cocktail to be given to terminal patients to ease the pain of terminal cancer. So there is some very limited medicinal use of cocaine but it is very limited.

You can in fact chew the coca leaves, and the reason why I want to stress this is that it is a very good example of what we call the route of administration - the way that you take the drug changes the level of risk associated with the drug because if you chew the coca leaves by mixing it with a small amount of lime and then chewing it in the mouth, there is very little physical risk from that. The reasons for that are:

1. There is very little cocaine in the coca leaves (it would depend on how good the farmer is) typically it would be about 1 percent cocaine.
2. It is released very slowly, typically over the course of about an hour. So you're getting a small amount of drug being released into the body very slowly
3. When you take cocaine into your stomach and it is absorbed your liver breaks it down. You get quite extensive breakdown or metabolism of the cocaine within the liver.

So you are getting very low amounts of cocaine being absorbed very slowly so the risks associated with chewing coca leaves are quite insignificant.

COCAINE SALT

Cocaine is a base that in chemical terms has a positive charge that will react with an acid to give you a salt in the same way as table salt is sodium chloride, sodium is the base and chlorine is the acid, the combination gives you the salt form. The same thing happens with cocaine when you extract it from the plant and you react it with hydrochloric acid you get cocaine salt. So we'll be talking about the salt form and the base form of the drug and these are quite significant terms to get used to.

Snorting

There are two ways of taking the cocaine salt or hydrochloride. One is to snort it up your nose, which in jargon terms is referred to as intranasal use, because you are snorting it up your nostrils. The other (and I don't know who thinks up these terms, I don't think them up) term is insufflation, Snorting usually means inhaling through a rolled up currency note, or through a tube, some sort of straw, or metal tube, or if you're really jet-set high status cocaine user, its probably platinum or gold, a tooter or a snorter as its called, and we'll come back to those tooter's and snorter's later on.

A line of coke is usually about 25 or 30mg of pure cocaine, which is quite a low level of cocaine, its usually about 20 or 30 percent pure but that can vary depending on the level and the availability of the cocaine. Its absorbed relatively slowly, it starts affecting the brain in about 3 minutes.

Injecting

Another way of taking cocaine salt is to inject it, either on its on, or more usually mixed with heroin which used to be referred to as a speedball or a snowball, and we'll talk about some of the hazards associated with that later. The injection of any drug is probably a very effective way, from the user's view, of getting the drug into the body, because you bypass the liver. Once you inject it into your arm it is taken into the heart, and then from the heart into the brain, bypassing the liver so it's not being broken down. You also get far more drug being taken into the body at the one time. The speed from point of injection to reaching the brain is about 17 seconds. You are getting the payoff, the pleasure that you get with the drug, very quickly.

Smoking

The final way of taking the drug is to smoke it, but if you try to smoke the cocaine salt all you'd do is just turn it into charcoal soot, you'd just burn it out of existence. But if you convert the cocaine salt back into its base form, what's called the free base, either by mixing it with sodium bicarbonate, bread soda, to make crack, or mixing it with ammonia to make what's called free base, then that material is volatile, you can smoke it, it will vaporise without destroying the cocaine so you can actually inhale. This is what is usually referred to as a rock or stone of crack where the material is in semi-solid form. Smoking the base form of cocaine is probably the most effective way of getting it into the body, because you've got a huge amount of surface area in your lungs. It is absorbed instantaneously from your lungs into the blood, its brought to your heart and then from the heart to the brain, and typically smoking a rock of crack it starts hitting the brain in about 7 seconds.

EFFECTS

There are differences depending on how you take the drug in the speed of which it affects the brain, what is called the onset of action that are mirrored at the other end on how quickly the drug leaves the brain. With crack and free base and also with the injection the problem is that, I suppose the best way to describe it is if you go up like a rocket and the laws of physics being what they are: you come down like a rocket. So whereas with snorted cocaine the effects might last for about a half an hour or more the effects of injected cocaine or smoked cocaine might only last for ten or

fifteen minutes. You get the intense pleasure very quickly, but that intense pleasure will wear off very quickly as well, depending on how you use the drug.

One of the things about cocaine is that it is an incredibly complex drug in terms of the way it affects the brain, and this makes life difficult for people who are trying to deal with people who develop problems with cocaine. It is very difficult to provide people with any medical or if I can call it more correctly, medicinal treatment, or pharmacological treatment. Cocaine stimulates the body both physically and mentally, it is one of the most powerful stimulants available, and it does this by affecting transmission or chemical messages along the brain. I think it is necessary to put into context what happens, and why there is no methadone for cocaine.

Nerve cells in the brain communicate to one another by chemicals. A message coming along one nerve cell has to use chemicals to carry the message along the next nerve cell, and those messages are called transmitters. Normally if you get a message coming along a brain cell a transmitter is released, it carries the message to the next and then the nerve cell just wants to say "right, that's the end of the message". What happens is the messengers are then mopped up by a transporter like a car ferry that brings them back into the cell. Cocaine disrupts that, it prevents the chemical messengers, the transmitters, being picked up if you like by the car ferry. So they are still there, and this is where you get the stimulation. Instead of the thing just giving the message and stopping, and then going back and resting, its hyper stimulated, you get this intense stimulation, this intense burst of physical and mental energy. This is very attractive to people. The other thing that happens is that you get this intense pleasure, because many of these cells that are affected by cocaine are in the pleasure centre within the brain. You cannot underestimate the intensity of the pleasure that people get because of the way it affects these chemicals within the brain. Cocaine affects three different chemicals within the brain, it gives you adrenaline, which gives you the energy, it affects dopamine, which gives you the pleasure within the pleasure centre of the brain and it also affects serotonin, which is also a mood altering chemical. This is why it is very difficult, if not almost impossible to design a drug treatment for cocaine addiction.

So that's one of the issues, you get this intense feeling of energy and pleasure from the drug, from the way it effects different cells within the brain, you get these short term effects of cocaine with an increase in energy and mental alertness, where people feel that they are superhuman and they feel that they can accomplish anything. It's not for nothing that cocaine for many people was originally a "loads of money" type of drug that gave them this overwhelming sense of their own superiority, a greatness, if you like, because of the energy and mental alertness. Not only does it give energy and mental alertness, it causes everything in the body to work harder, so you get an increase in heart rate and an increase in blood pressure, and that's almost a Catch 22 situation because cocaine narrows down blood vessels, its like taking a water hose and putting a kink or bend in it, and at the same time the pressure of liquid is increasing behind it, so the heart is working harder and harder trying to pump blood around the place and yet the blood vessels, the veins and arteries are being closed off. So again if you have a hose and you put a kink in it and you keep turning the tap on and more and more water is going through the hose and it can't get out its going to burst and that's what happens to people, the blood vessels burst within their brain. We will see in a

moment that we get strokes and heart attacks because of that effect. The other thing is you get a decreased appetite, again because of the stimulant effect of the drug.

ADDICTION

In the longer term or if you take large amounts on a regular basis you are going to become an addict. It is not addiction in the same sense that occurs for example in heroin where you get both physical and psychological dependence occurring, with cocaine it is largely psychological dependence, and you get withdrawal symptoms that are largely psychological, particularly depression which is referred to as the “crash”. The difficulty in terms of cocaine addiction or dependence is that it is very difficult to predict who will become dependent and who won't, who will be able to control their use of the drug and who won't. Just because somebody is using a drug doesn't mean they are addicted to that drug. Certainly if you change the way you use cocaine the addiction potential will change, because it is far more likely to result in compulsive uncontrolled use. If you start injecting the cocaine or smoking crack or free base as you take more and more of the drug instead of getting the euphoria the pleasure, you get quite the opposite. You get restlessness, irritability and anxiety. For some people particularly if they get involved in a binge run of cocaine, either snorting it or more likely smoking it they become paranoid, where everybody is ganging up against them. This is typical with any stimulant, it happens with amphetamines as well. Some cocaine users react to that paranoia by becoming irrationally violent, it is the only way they can cope with the paranoia. The other thing that can happen, though how often it might happen is difficult to establish, is hallucinations. Sometimes people are hearing things, auditory hallucinations, sometimes they imagine what is called the cocaine bugs. They imagine that insects are crawling under their skin, and they mutilate themselves trying to get at the imaginary bugs under their skin, but this is not a frequent thing, it happens occasionally.

Medical Complications

The medical complications are heart attacks, because the heart is being stimulated to beat faster and faster under the influence of the drug and sometimes the heart just can't cope with that. Strokes - because of the build up of blood pressure particularly within the brain. Chest pain, and particularly if someone is inhaling hot smoke from a crack pipe they are going to have chest problems or respiratory failure. Occasionally you get convulsions or seizures. Stomach problems, these affect people who inhale the drug, because if you are snorting the drug some of it is absorbed through your nose, but some of it goes down into your stomach and it can cause stomach problems. Stomach problems are more likely to occur for the “stuffers and swallows”, people who are smuggling the drugs in condoms where they either swallowed them or they are stuffed up their rectum causing problems when condoms leak or burst. Nasal problems occur when people are snorting the cocaine, because of the effect of the cocaine on the blood vessels in their nose. Some well-known television stars have experienced nasal problems and Daniella Westbrook is I suppose the classical example having virtually lost most of her nose, or the dividing line between the nostrils because of the irritating effect of the cocaine on the blood vessels in her nostrils.

Cocaine and alcohol

We are finding that the combination of the two drugs, alcohol and cocaine, creates a new drug called cocaethylene, which is more dangerous than either drug alone. It lasts longer in the body and it also seems to increase the risk of a fatal overdose from cocaine - about 18 times more likely than cocaine on its own. One of the things that came out of Paula Mayock's study of recreational snorters in the Dublin area was that the combination of cocaine and alcohol is a very common combination. It is a very risky combination most of the post mortems that have been done on people who have died from cocaine overdoses in other countries have implicated this cocaethylene in the overdosed death because of the increased toxicity.

Risks associated with injecting

The most serious risk in relation to those who are injecting, and the information that is coming through to the National Advisory Committee, on cocaine use in Ireland - from some work that was done for us by UIISCE, and we are very grateful to Tommy Larkin and his colleagues at UISCE for that particular piece of work, and also information coming through from Merchants Quay, and we're grateful for their work as well - is that there is a significant level of injecting of cocaine happening at the current time in Dublin, particularly in combination with heroin. In that situation the whole range of what we call the injection specific diseases come into play; the two viruses: the HIV and the hepatitis, and all of the bacterial infections like septicaemia, blood poisoning, abscesses, would all come into play because of the sharing of the works, the lack of hygiene in the injection process, which are all very standard practices. Sharing of "Tooters" and "Snorters" also increases the risk of transmission of disease.

Because the short duration of action the risks associated with injection of cocaine are actually higher. If the action is only lasting for ten or fifteen minutes and people are feeling lousy, they are fatigued, depressed; it leads to more frequent injections because cocaine doesn't last as long as even heroin, and that is not a particularly long lasting drug. That increases the risk of HIV because people are injecting more often. It also makes the drug habit more expensive so that is likely to lead to more drug-related crime. Injecting cocaine on top of heroin and other opiates does increase the dropout rates from treatment and leads to more relapses. Cocaine destabilises people who are otherwise doing quite well within the treatment programme. There seems to be more severe mental illness associated with the drug dependence.

At NACD level we are concerned at that the reported increase coming from communities (and this is the value of community linkage into the NACD). We are concerned about the increase in the use of cocaine per se, whether its in snorters, whether its in crack smack smokers, or whether its in injectors, but we are particularly concerned about the increase in the injection of cocaine because of the implications for individual health arising from injecting.

Other risks

There would be a concern about the use of E and cocaine, because of the effect of cocaine on dopamine and E on serotonin levels. There could be an increase in the risk

of nerve damage from the E, (the neurotoxicity), the effect on the nerve cells that leads to depression. I'm not aware of any specific dangerous interaction between cocaine and benzodiazapine but there would also be a concern about the emotional blanking that occurs when using Benzos and the difficulty of actually engaging people in treatment and in rehabilitation when they are just emotionally blanked out from the tranquillisers.

Treatment

Finally I would just highlight the fact that from a pharmacological point of view that there is no substitute drug for cocaine and in fact there is no drug treatment for cocaine dependence and that creates a challenge for the treatment services to provide the kinds of treatment services that will attract users and retain users and that is a difficult challenge that they face.

2. Gearóid Ó Loingsigh – Coca Harvesting

I'll just give a brief overview of the situation in relation to farmers who grow coca the raw material for making cocaine.

There is a false image abroad about the people who produce coca and the lifestyle that they have, and I suppose in the same way many of you would know that the people who you work with who are abusing cocaine are not driving Ferraris, neither are the people on the ground who are producing the raw material that goes into making up cocaine. In fact many of these farmers live in quite isolated areas of the country where there is no infrastructure, very little in the way of educational facilities and practically no medical facilities available to them.

The particular area that I last visited it took me a short plane trip, a three hour car ride and then a three day walk just to get to the field. The person who lives in that area not only has to bring in all his raw materials for the manufacture of cocaine by making a similar journey, they also have to get their food, their medicine, their clothing, all the basics of life have to get into that same region through the same route. So we're not actually talking about people who are very wealthy, we're talking about people who live, in many ways, on the margins of Colombian society. To give you an idea, the average Colombian peasant makes a profit of \$100 for every kilo of coca paste, that is all they make. If they have for example 3 hectares of coca, then they would produce some six kilos of coca paste every two months so on average they are making \$300 per month, so you can do the mathematics, its not actually a huge income but by the standards of the region, they are relatively well off. But when we are talking about people who are living in absolute poverty it is not hard to be comparatively well off.

But what many people don't understand is that the drugs industry is not actually a Colombian industry, its actually European and North American, all of it or practically all of it.

At every stage of production you have different chemical ingredients, which range from cement to acetone and ether which are used to break it down into a paste first and then later on when it is used to turn it into cocaine, and I should point out first that the person who grows the stuff actually only makes the paste, it is then bought from them by the drug barons who then convert it into the finished product, cocaine, and then export it to Europe. But as I say the industry is mainly North American and European. All of the acetone and ether that is used to make cocaine comes from Germany and the United States and that is legal sales, these companies declare that money, they pay taxes on it, I'm not talking about people smuggling acetone or ether from Germany to Colombia, its sold legally. The United Nations Drugs Control Programme calculated back in the late 1990s that the illegal drugs industry was worth half a trillion dollars per year, that's 1/8 of all trade in goods and services in the world. 17 percent of that is cocaine, most of that coming from Colombia but most of that money stays in the United States and Europe.

So, if you were to withdraw that money from the world economy, the economies that would collapse would not be the Bolivian economy or the Colombian economy which are quite small, but the North American economy and the European economy, they are the economies that would be affected by the withdrawal of that money from the world economy. It is Europe and North America that would go into recession because their economies depend to a greater extent on the illegal drugs trade.

Now in terms of the farmers, I am often asked why somebody would engage in Coca production or Cocaine production given the consequences, given what happens here in Europe. However, most of the farmers are actually unaware of the reality. Given that they know the ingredients, the cement, the acetone, the ether that goes into making cocaine, people in these areas don't actually ever take the drug. In their world view anyone taking this substance would have to be degenerate and that's as simple as it is for them. But apart from not understanding the reality of life in London or Dublin its also a question of economic necessity. You'll often hear stories from farmers like "I wanted to make sure that one of my five children got a secondary school education, the only way to pay for that was through growing coca" or that "my father or my mother was severely ill, and the only way of guaranteeing the medical bills was through the production of coca". I don't have time to go into this in detail, but once you actually engage in the production of coca, it is actually very difficult then to withdraw from it, but that is a political question in relation to the armed conflict that is going on in Colombia.

There is also another economic aspect, coca production shot up in Colombia in the mid 1990s and overtook everywhere else in South America. It now outstrips Bolivia and Peru, and there is a very simple reason for that: The Colombian economy was opened up to imports from abroad, agricultural imports in particular, and the agricultural sector in Colombia collapsed and in fact it has experienced negative growth for all of the 1990s. The country has lost over a million hectares that was used for growing food. This land now grows cash-crops mainly controlled, not by the peasants, but by large multinationals. When we think about cocaine or drug abuse in Ireland we don't actually think about the common agricultural policy having anything to do with it, but it does.

The subsidies that are paid out to European agriculture and the subsidies that are paid out by the United States have a bearing on it. The United States spends \$86.7million dollars a day subsidising its own farmers and the agricultural products that it subsidises most are the grains, rice, wheat and also beans, i.e. the staple diet of Colombians, what the local agricultural economy is based on.

When you talk to farmers and ask them “why won’t you just grow rice?” what they will actually tell you is “My rice is not worth anything in the market place, my rice can’t compete with American rice. I can’t compete with the European imports.” Its quite simple, how is a farmer who lives on the edge of society supposed to compete with \$86.7million a day? It can’t be done. One product they can grow is coca. It is profitable, the buyer comes to you, you don’t have to go to the buyer, there is a guaranteed market, its not going to go away in the short term. So the way people think about coca is, “I just grow a profitable crop (coca) and I sell it to get money”, and this is as a direct consequence of the agricultural policy of the United States and also of Europe.

And then in the midst of all of this the United States and Europe have made proposals to these farmers to change over from the coca products to other agricultural products. The problem is they are asking them to switch over to products like African Palm whose price has collapsed in the last couple of years, they are asking them to grow palm trees for the extraction of oil, and what we are finding is that peasants are going into debt because these projects don’t finance they farmers, they loan them the money. So the peasants get involved in these projects starting off with a large debt which rises to \$14,000 after four years. That’s a hefty enough sum to pay off anywhere, more so in Colombia, and what the peasant farmers are then faced with is “How can I pay off my debt? Well I can go back to growing coca and that will pay off my debt”, so we have a vicious circle.

And the last aspect and this is just a very brief overview, the last aspect in relation to the farmers is the whole question of eradication. The United States has embarked upon a massive programme of aerial spraying of the coca crops. It doesn’t work, for the simple reason that the coca plant is very resistant. I don’t know whether there are any people from an agricultural background in the audience, but probably not, however, the herbicide roundup is what's used to destroy the coca plant. For every hectare of coca in Colombia that gets sprayed, the planes spray 13 litres of roundup. You do that here in Ireland and you will get arrested for breach of environmental legislation. The average farmer here will spray a couple of litres per hectare. But the reason why they do it is because the coca plant is very resistant. But even at that, if you cut the coca plant down to within one inch of the soil within six months it is back giving you your first harvest, and that’s all that happens, you delay the production by six months and you force the farmer to move further into the jungle and further into the mountains to avoid the planes.

So what actually happens with the aerial spraying is that they spray everything, so if you spray the farmer’s rubber trees and you spray his cacao and you spray his food crops the immediate option open is to go and grow as much coca as possible because it will give you a harvest within six months, and a harvest every two months after that. Rubber on the other hand takes seven years to grow before it will give you anything.

You destroy a farmer's rubber trees and you are knocking back his livelihood by seven years, destroy his cacao you knock it back by two and actually in some parts of the country we have had projects funded by the European Union, rubber plantation projects and cacao that were sprayed by American aeroplanes in order to destroy the coca that was growing nearby, and all that they have done is create a vicious circle.

When they began the aerial spraying programme, there were 122 thousand hectares of coca in the country, there's now 160 thousand hectares so it's actually quite clear it hasn't worked, the amount of coca has increased. It has actually expanded, because the way it's been dealt with is through forcible eradication and it's creating a poverty trap then for the farmers, and one of the things one of the farmer leaders said, when I told him about how things were approached in Europe was "Well in Europe if you are looking for a holistic solution you are looking for a solution that takes into account the environment the community from which the addict comes from, if you are looking for medical treatment and it's not just a criminal problem, well why can't the same attitude be taken in relation to Colombia, because when the United States wants farmers in its own country to switch from growing tobacco, which they are currently doing, over to some other product, they subsidise the farmer they give them some economic incentive to do it".

3. Daniel Taegtmeyer

Blenhiem Project, London

I will be looking today at some of our experiences in working with cocaine and crack & cocaine users in the UK and perhaps trying to draw up some points of further reflection that might be of use in beginning to develop services in Dublin that are appropriate to meeting cocaine and crack and cocaine users needs.

Our experience in the Blenhiem Project is that what is true for cocaine or what is true for crack in terms of service delivery and in terms of planning treatments and interventions. The Blenhiem Project has been designing and delivering crack/cocaine specific services for the last eight years in London. It is based on a pan London service - a twelve-week structured day care program supported by a drop in and information advice. The Blenhiem Project was really built out of a local needs assessment, a response to the community's needs around crack and cocaine. It was the first of its kind in the country and now has been joined by five or six other services across the UK that specifically provide crack and cocaine services.

I hope to give some points of reflection of working successfully from our experience and perhaps look at what can be applied in Dublin. We will be focusing on crack cocaine use and how it has developed, looking at some key aspects of attracting, engaging and retaining crack\cocaine users and some reflection on the barriers around what has prevented crack\cocaine users in the past from accessing generic services. We will be looking at service provision arenas, so what levels are we looking at – are

we looking at medical models, are we looking at holistic psycho-social models, are we looking at criminal justice models. And then looking also at what kind of services might be appropriate at a street low-threshold level and then moving through to structured day-care and residential services. And that will lead towards some thinking around best practice.

Cocaine – History and Evolution

As Dr. Corrigan was saying earlier, cocaine\crack are psychoactive stimulant drugs that are primarily psychologically addictive rather than building up any tolerance, which is different to opiates, individuals who use opiates tend to develop a tolerance, which leads to increase use over a period of time. It is a psychoactive stimulant and has been used in its pure form as coco leaf chewing and known about since about 1400 BC. It has been around for along time, being chewed certainly, and it wasn't until the late 19th century - 1860's, where the process of isolating the cocaine from the leaf was first developed and then began to be applied in medicinal circles, again confirming what Dr. Corrigan was saying. It began to be removed in the mid to late 20th century from its medicinal properties and became primarily identified with a leisure activity. So it was removed from its context – a social, economic, religious and cultural framework – as based in Latin America and began to be used as part of a leisure activity in North America and Europe in particular. In the late 1970's it became much more prevalent, whereas in the 1960's one could describe it as the rich lifestyle drug, the harmless drug of choice for those who came into money or had money. It became in the 1970's much more available on the street level – in the UK and the US. As a result in the late 1970's, certainly in the UK, there was a whole industry that arose around the cocaine use, again the human pursuit of the most excellent buzz.

Free-basing

The evolutionary development led on to an industry around free-basing – that would be very much based around individual's knowledge and skills of turning the cocaine powder into its free base form. And that was generally done using ammonia or ether in order to develop a smokable form of cocaine. That really depended on individual's access to the chemicals involved and also to their knowledge around what is called “washing” - turning the cocaine powder into stone or rock form, and free basing kind of arose from there. Free-basing was prevalent in the UK and the Unites States. In the early 1980's with the advent of microwaves there was an explosion of crack being sold on the streets, so moving away from supplying cocaine and moving into supplying crack. Microwaves made it very easy to mass-produce crack. In the United States it became a very cheap way of producing crack and the price of crack against cocaine was cheaper. In the UK it was the reverse of that – crack is twice as expensive as cocaine powder per gram. In 1982, 1983 in London, for the first time crack became available on the streets, supplied by dealers, it was actually in west London on a street called All Saints Road, which is just around the corner from the agency that I work in. There was no cannabis available at Christmas and just before new years the dealers were all able to supply crack cocaine and that's really where the crack scene developed in the UK.

Markets

There has been a slower development of cocaine markets in the UK and its roots have tended to be much deeper and spread much more slowly than has been the experience in the United States where there was a big explosion of crack coming from the cocaine using. Looking at the development of these markets and the processes and demographics around these markets. Certainly when we are talking specifically around cocaine and around crack use at a street level, in the earliest days of cocaine and crack being made readily available at a street level, cocaine would have been the primary drug for the majority of people – and then subsequently crack was the primary drug.

So it was the introductory drug for many people to a class A drug certainly, and so at a street level we have a large number of primary crack and/or cocaine users, because that was their introductory drug into or class A drug from the street level. And that is really mirrored if we look at the emerging and **past routes** of people moving from cocaine powder into crack, certainly there seems to be evidence that initially many people started out by buying cocaine powder – if they had the skills then being able to process that into free base in the earliest days and then subsequently processing the cocaine powder into crack..

There is growing evidence that in the, what I call the “professional classes” (moving away from the street level), that recreational cocaine users are slipping quite easily into crack cocaine use and their lives are becoming chaotic and destabilised around crack use. And I really highlight that because conversations I’ve had with Anna has indicated to me that in Dublin at the moment there seems to be quite a large number of cocaine users and its about what does the future look like in terms of the patterns of use and service development and service provision as a result of that, so what are the potential areas of growth in the nature and roots of crack or cocaine use. It is true for cocaine, it is true for crack that at street level, primary cocaine use or crack use has been located in socially deprived areas – areas with high social needs and high levels of deprivation. In the UK they generally would refer to them as urban cosmopolitan areas and one thing in the UK that we need to be extremely aware of is that quite often when people are talking about urban areas they are talking about ethnic minority communities, and I put that in just as a learning experience from our end.

For a long time crack cocaine and cocaine use was inexplicably linked with the minority ethnic communities and then all the crime that they associated with that – and then you build up a mythical picture of who is using, why, and what are the consequences of that. Certainly in the earliest days, the markets were very much identified as being in urban areas, particularly at street level – multi-ethnic, multi-cultural communities in London, and they would certainly have been identified as primary crack cocaine using communities. The markets there have deep roots and anecdotally those markets are almost stabilising, certainly in terms of the primary crack cocaine using communities.

The numbers although increasing are not exploding, so we're not getting an epidemic of people who are going straight into primary crack cocaine use. In the urban areas there is evidence that there is an increasing number of people whose traditional drug of choice has been opiates who are now cross addicting on cocaine or crack.

However, there is evidence that cocaine use, whether it is primary or secondary is on the increase across the UK in every socio-economic group and in every community, so both urban and rural.

Poly-drug Use

These new markets have been developed, the dealers, the suppliers are business people, they are always looking for new opportunities, so they're moving now away from the urban areas and looking at the more rural areas and markets that have been traditionally opiate using communities and particularly injecting using communities. So poly-drug use – opiate and cocaine – is on the increase. Now there are two ways of approaching this and certainly from our experience in the UK you have primary crack cocaine users who recently have been cross addicting on opiates because opiates they see as the perfect way of avoiding that big crash that was identified before as a rocket going up it must come down, opiate use as being a depressant kind of eases that come down process.

So there are increasing numbers in urban areas of primary cocaine and crack users who are now cross addicting on opiates, because of the physical tolerance associated with using heroin to assist the come down. Then you have the traditional opiate using communities who are now looking for that extra buzz, the extra high, the extra stimulant – there is only so much of it that they can use, what to do with the rest of their money. Long term financial planning is not part of the lifestyle, more likely - I have this much money how can I spend it now – and of course cocaine is available from the same dealers who are in the same place. So we are having a community of people who are cross addicting on cocaine from an opiate background. There is also emerging evidence particularly in the homeless communities of the introductory drug being speedballing (combining heroin and cocaine), so for some people the first contact they have with any class A drug is going to be a combination of heroin and cocaine taken together.

Our experience in the Blenheim Project is that of the people whose only problematic drug is crack or cocaine or whose drug of choice is crack or cocaine, and use other drugs to assist in the come down, so they have a secondary drug that is specific to a come down, such as opiates, alcohol or cannabis, we get very few people who use opiates as the secondary drug, the vast majority of people who are accessing the service are using alcohol or cannabis to come down and we have a hard core group of people who don't use any come down drugs at all.

British Government Response

After a number of years where drug issues and drug problems were really on the backburner, the current Labour government has recognised that crack cocaine use is

on the increase and that the crack cocaine using communities are changing – the face of those communities are changing. It is no longer easily identified with urban areas or ghettoised in a sense, but it is actually spreading out across the country into all communities and all socio-economic groups, and the government has recognised that. It has committed itself to implementing a national crack plan, which has identified high crack areas, and is looking at the resourcing and supporting the development of crack cocaine specific services alongside improving the competences and skills and awareness of generic drug services – looking at how they, generic services can attract more crack cocaine users who are open about their crack cocaine use alongside opiate use, for instance.

It has also set up and funded through the NHS, the National Treatment Agency, which is leading the treatment end. So where the home office might be more concerned with the crime reduction associated with cocaine and crack use, the National Treatment Agency is focusing more on the treatment end, so looking at developing appropriate treatments and interventions around crack and cocaine. This is critical, and again, I'll come on back to this, but the NTA is looking to develop a UK wide evidence base, because most of the research, most of the understanding of working with crack and cocaine users is developed from American research.

Appropriate Services for Crack/Cocaine Users

We need to be able to start attracting cocaine users into appropriate services, and it's a bit of a chicken and egg scenario, because how do you justify the funding if people are not coming forward and identifying that they have a cocaine use problem. And they're not going to come forward with a cocaine use problem because they will have a perception that there is nothing out there for them, in terms of support and drugs services. So there is no incentive for them to come and access any service, which is the place where we start collecting the statistics is through access to a drugs service.

So, broadly speaking the experience in the UK was that there is a perception that the existing drug services are not appropriate for crack cocaine users, and this goes back down to understanding the nature of addiction, and it goes back down to understanding the process or the intervention and the treatments that are available. There is no medical model for your average cocaine user, your average opiate user addiction is understood by "if I do not take the drug, I will get sick" and that is not true for cocaine. And so already we have a perception and barriers being put up, and alongside this we have myths that are being perpetuated in the public and in the drug services about the violence associated with crack cocaine users the difficulty to manage crack cocaine users and the chaos that is associated with working alongside them.

There is also a perception in the using community that drug services are not appropriate, that traditionally services have worked well with opiate or injection users through providing information, advice, needle exchange, and response to HIV transmission etcetera etcetera. And largely these services and particularly the opiate services have been based around medical models, harm minimisation models and generic information advice, which are not necessarily the most appropriate ways of attracting crack cocaine users into a service.

Where we are now, looking at focussing on developing supply and demand prevention, that would be Government led, home office led. Treatment services are being developed, as I said earlier, building an evidence base of what works, looking at supporting the development of generic and crack cocaine specific services, resources, and providing them time in which to do that, particularly focusing on medical models attracting cocaine users into existing medical models, looking at developing low threshold services, looking at developing therapeutic services and then beefing up cocaine and generic drugs services within the criminal justice system.

Attracting Clients to Services

There has been over the years a lot of thought that has gone into “what is it that we can do to attract cocaine users into a service, what kinds of things need to be in place to make it more likely for a cocaine or crack user to want to access a service” and that’s bottom line. We cannot go out onto the street and say “aha there's a cocaine user, grab them and bring them into a service”. So what is it that we can do that will make it more likely for people to access a service, what is it that we can do to break down those barriers of perception, of history, and to provide appropriate services and current thinking is really looking at three key phrases: attracting, engaging and retaining users into a service.

Developing Services

I suggest that a good place to start in developing services, trying to break that cycle that I identified earlier, if there is no incentive for cocaine users to access a service, then there is no reflection in statistics and then there is not necessarily any resources forthcoming. So to really carry out a local needs assessment, and you might do that through an action research or you might do that by just taking a risk and employing named crack cocaine workers who will then develop a contact and a presence within the cocaine using communities which will lead to better statistics which will then lead on to more funding.

Looking at developing appropriate generic and referral services. So are there services that are appropriate that crack cocaine users are currently accessing and what kinds of services are they being referred on to, are there specific services that might be appropriate, is there contacts within the health trusts or boards that might be appropriate, what about mental health services and so on and so on. What are the onward referral routes from a generic low threshold service or even a structured day programme or residential?

Develop the awareness and competencies of all services that are likely to have contact with crack cocaine users, perhaps start looking at developing a training package which is again the process that the UK is having to go through, a few years behind the times as it were, but going through a process of looking at developing training packages, modules and getting properly structured professional development in place to allow people who perhaps don't have previous experience of working with cocaine users or those who are seeing cocaine users in increasing numbers to empower them to feel skilled around engaging and working with cocaine users.

To break down some of the myths and to let them know that there is stuff, or there are interventions out there that can work. Look at delivering easily accessed services, and by that where are you located, the paranoia associated with cocaine use might prevent people coming into a local agency around the corner from the street where their aunt lives. What time of the day are you going to be open? Do cocaine users have a habit of using more at night-time or in the mornings? Are you going to be able to provide food for people who haven't eaten for two days perhaps, because they've been on a cocaine-using binge. So it is about easily accessed appropriate services.

I emphasise again, ensure the confidentiality of the service. One of the things that I thought about a while back, was actually thinking about trying to get a drug service in the middle of the city centre, in an anonymous office block, where you would have hundreds of people coming in and out of that office during lunchtime so there wouldn't be any specific demarcation between one group of people and another i.e. a group of people who might be cocaine users accessing a service or a group of people who are going to sit in an open planned office for a day. That might be something worth considering.

Whilst there is no homogeneity within the crack cocaine using communities and by that, within the using communities, my understanding and my experience tells me, that there is no one individual that will be able to identify any one specific intervention that will be right for everyone. With opiate users, you do have the potential of using a hook, and that hook is methadone, so there is some kind of potential for a homogenous or a standardised approach for attracting people into a service. With cocaine users there is no homogeneity, the experience of cocaine is so individual, the attitudes to the recovery from and the treatment of will also be individual. So every single person will have a different idea on what works. Its about taking that forward and developing appropriate services which are a direct benefit to them, again looking at provision of food, confidential services, flexibility around services.

Deliver exactly what you say, do not promise the earth. Do not promise that we can make people stable or stop using, it is much better to deliver exactly what you say you will, and be clear, if you are thinking about setting up a crack cocaine specific service it is okay to say, "we are a crack cocaine specific service we do not work with primary opiate users" for instance. If you are a generic service but you have a named cocaine worker, say that, deliver exactly what you say you will.

The Blenheim Project

The Blenheim Project itself has been going for 38 years and is based in west London, and currently is split into two, originally it was a very small project with only a handful of staff.

Generic Services

It was originally a generic service for problem drug users in the west London area starting with barbiturates, supporting barbiturate users and moving through to supporting opiate users in the 70s, primarily at street level. Currently out of those generic services it has developed, it has an open access drop in, information and advice, one to one support, counselling, informal counselling and support, cups of tea etc. That drop in operates every day of the week, with an evening drop in that is run by peers, so ex-users.

It also operates a needle exchange, a counselling service with which you can then access and can have for up to a year accessing, once a week, counselling. It runs a GP liaison service, where a member of staff will attend a doctors surgery, and provide the kind of psychological and emotional support around the methadone prescribing for any clients who are coming through there. It runs a peer education service, which includes going out to schools, colleges, youth clubs and providing generic or general drugs information to those community groups. It runs a Chinese herb hep-c clinic, which runs every week, and a hep-c support group where they are able to do a liver function test and give the individuals appropriate alternative herbal remedies. It has a youth outreach service in the local area and it has been going now for two years and it is very successful, particularly in attracting the Moroccan community, where the agency is located there is a very large Moroccan community and there is a lot of young Moroccan men particularly getting involved in drug use, and particularly in crack cocaine. And they're doing very successful work with them, and that's proved much more an activities based service. And then it has a volunteer programme, which is an accredited programme through college, I think there are about 30 volunteers on the programme at any one time, working alongside the generic services at any one time.

Crack/Cocaine Services

The crack cocaine day programme was the first of its kind in the country, it has been going for eight years and it really came out of a local needs analysis, a needs assessment and from that point the Blenheim project decided to employ a member of staff to design and deliver a crack cocaine specific service. Over the years that service has developed, grown and become much more in depth. The starting point really of that service was much more around harm minimisation, setting up some kind of group focussing particularly on relapse. Since its inception completion rates have hovered between 50-60%, it is a voluntary access service, so that in terms of people voluntarily attending the service is a very good completion rate. We also run crack cocaine specific services in five London prisons and that has proven to be very successful, and we've had, on average, about 140 people, new contacts in the prison, primary crack cocaine users in each prison, for every year that the service has been running, so if you do the maths it turns out to be quite a lot of people, new contacts every year, primary crack cocaine users. We work alongside the probation services in providing crack cocaine specific services and we do that through the probation officers and also we have expertise in delivering probation-based services to clients who are sentenced to attend the day programme. We provide an after care service for those who have completed the programme and we also provide a crack cocaine drop-in service.

Assessment

And that's all backed up by a specialist referral and assessment, emphasis on the assessment. We provide a crack cocaine specific assessment tool, it's a gateway assessment into the service, what we found in the past is that when we were working with generic assessment tools quite often they were very appropriate for working with opiate users but not so taking into account the needs and experiences of cocaine users so we have developed our own assessment tool and then subsequently a monitoring tool that we use to measure progress. The service is a rapid response, and particularly at the point of assessment. We provide an assessment within 24 hours of someone contacting us. We found that meeting them not on the same day and not two days later but the next day after contact, we had a better outcome in terms of people actually turning up for the assessment and then moving through onto the programme. One of the difficulties for the project is that we essentially are a static service. We sit there and wait for referrals the vast majority of referrals are self-referrals to us, although we do accept third party referrals from criminal justice agencies and from medical agencies.

The specialist assessment tool, is also an opportunity for us to carry out a discreet piece of work based around motivational interviewing techniques, we try and draw out the impact that cocaine is having on their lives, so we're looking at the way that people's patterns of using is becoming life affecting, and it's the patterns of using that is essential, because for many cocaine users, and crack users, they follow a particular pattern, or they follow a particular set of triggers. For instance they might use every Friday which means that when they come onto the programme what we want to see is a break in that pattern, we do not want to see people carry on using on a Friday, because it means that whatever intervention is in place is not working. And so, we particularly focus on the patterns of using and then measuring change from that pattern of use.

By drawing out those patterns of using, you can start looking at how it is becoming life affecting. If we also then include the medical issues, the consequences that they have personally experienced from their crack cocaine use medically, so physically, we can then begin to draw out the impact its having on their ability to function physically and then likewise with the psychiatric issues. And then by using that gateway assessment as a discreet piece of work on motivational interviewing techniques it proves very successful on bringing people in. In real terms there is a conflict between those who are sentenced to attend the programme on a treatment order, and those who attend voluntarily. And our skills really have to lie in maximising and amplifying that level of choice, because those who are sentenced do have a choice, either you go to treatment or you go to prison, that's your choice. And it is about amplifying that choice and saying "look, you've made that choice, and there are other areas of your life that you can make choices in" and beginning to empower people around that. For those who are sentenced quite often it is only after about four to six weeks that they really start to get with the programme and then the progress they make is really phenomenal. And that's very positive for us, and its about retaining those people for the first four weeks, and then what we find, its just a natural progress, they really engage with the programme and the outcomes are really positive.

Day Programme

The day programme, has currently five members of staff, we provide a talking based group therapies, which is holistic and so non-medical in the sense that we don't prescribe any medication. The service falls between lots of different stalls, it falls between abstinence based, harm minimisation, relapse prevention, criminal justice models and so we found in the past that we haven't really slotted in very easily to any particular model, and we've had to forge our own way and our own model of working. Broadly speaking, probably psycho social is the nearest we could use to describe it. We have between 270 and 300 referrals but only 48 places in a year, so the demand is there the capacity isn't at the moment.

The complimentary therapies are a key aspect of the programme, they are delivered every day, auricular acupuncture and then we have more involved alternative therapies, which include Bowen light touch, reflexology and cranial osteopathy. And those are services that clients are expected to sign up as compulsory parts of the programme, and each person will do six [weeks] of Bowen and then followed by six of cranial, or six weeks of reflexology followed by six weeks of Bowen or whatever combination suits them personally, but those options are there. We also have a tie-in with a local natural health clinic, where people can then get full massage programmes designed to meet their specific needs for £1 a session, which is a very good rate, given that it normally costs about forty or fifty quid for an hour so we have that connection with the local community.

We found that people are willing to travel from far. We have people who come from across London and also from outside London. We have people who travel from Reading, people who come in from Croydon, people who come in from Hertfordshire, as well as all the London boroughs. And we have a relationship with 33 London boroughs. The funding of the service is really down to each local borough, the majority of people come through the local borough and are funded through each social service, which has a substance misuse team who are responsible for the care management of people who are problematic drug users. They have a treatment budget and then they are able to pull people through onto the programme and support them onto the programme. We can accept people onto the programme within 24 hours, which is a really good boost for them, because its like they don't have to keep going through all these hoops and appointment times, and crack cocaine users often their lives are so chaotic that appointments in two weeks time are all forgotten about because they've moved house 3 times been beaten up 4 times, sold their mobile 5 times, been to the pawn shop 20 times in between, and kind of coming onto the programme recedes a little bit into the background, or an appointment in 20 weeks where the outcome isn't necessarily known is all pushed to the back of the head, so its really important for us to be able to provide that rapid response and give people that boost.

The downside to that is that we can accept people onto the programme but we can't give them any guarantees that they'll get funding to attend the programme, so we have to be very careful about setting people up, but that's one of the challenges we have.

The actual programme as I said is constantly evolving, and now we've moved to a space where it's much more involved. The groups, the facilitation style of the groups is humanistic, so based on Carl Rogers, person centred, but applied within a group setting. And that really is what our work is, our work is to facilitate the growth, the learning and the process of change for people who seek support around making change in their lives, around crack cocaine. Our expectation is that people are crack cocaine free, whilst they are on the programme, so we do not work with active users. Having said that, we do recognise the compulsive nature of cocaine and the strong pull of triggers and the strong elements of craving that will lead people into using. So we will work with lapse, and when someone lapses we expect that person to come in the next day, because that is an opportunity for that individual to learn from that lapse and begin to put into place all the structures that will allow them in the future when they come across similar situations to not lapse at the end of that situation. So we will work with lapse, but we expect people to be making every effort, if they have lapsed, to demonstrate that they are making every effort to remain crack cocaine free.

We have quite a strong therapeutic element to the programme, and then psycho-educational aspects of the programme, which is very empowering. When it's applied in the prison, it's a bit of a double edged sword, because when you are empowered in prison, you start railing a bit against the rules and that can make your life a little bit difficult, and so can be a little bit of a double edged sword at times. But it is about encouraging people to know that at the end of the day there is always hope, it doesn't matter what they've seen, where they've been, what they've done, what they've taken, who they've taken it with, at the end of the day with crack and cocaine there is always hope and that the long term effects are most likely to be a prison sentence.

So there's always hope, and I think that's really important, it doesn't matter where they've been and what they've seen, there's always hope and every day is an opportunity for them to take choice, and to dominate crack cocaine and not let it dominate them. There's always hope.

We deliver the programme over five days a week and I personally would like to see it being delivered seven days, from 9 in the morning through to 10 at night, it is finding the staff that's the problem, but there's so much that can be done to support people around that process of change.

We deliver three groups a day, and we start every morning with the therapeutic group, and those therapeutic groups will have one of the following themes it will focus on conflict and conflict resolution, communication and better communication, interpersonal skills, it will look at families, family structures and learning from family structures what they didn't like about their own family, and what they would hope to put in place when they have their own family, or as parents, even, what kind of life are they putting in place for their children. Looking at the process of change, looking at the painful process of change, starting from the point that the reason someone is coming to access the programme is that it is more painful for them to carry on using than it is to make change in their life. That process of change is not easy, it is about supporting people throughout that painful process of change. We provide drama therapy, and we also have ex-client talks, people who have already been through the programme themselves and who are currently remaining crack cocaine drug free, who

are coming back and sharing some of their learning and changes they've gone through with the people on the programme. We have six structured, or themed, groups in every week and they usually follow the crack cocaine awareness, that's the psycho-educational element, up to date information and knowledge. Knowledge is power, and power is power to make choice. We also provide relapse prevention group every week, part of that would include practical techniques around relaxation.

We have an offending behaviour group every week, looking at the connections between changes in offending behaviour and crack cocaine use. For a lot of people coming onto the programme, their offending behaviour predates crack cocaine, so it's simplistic to say their offending behaviour is as a result of their crack cocaine use. For a lot of people what they have noticed and what has happened is that the frequency and the severity of the offences they're committing has increased as a result of crack cocaine, rather than them coming into a new lifestyle, a new offending from scratch. So the connections between offending behaviour and crack cocaine usage are there although it's a bit simplistic to say that crack cocaine use leads to new behaviour altogether.

We spend a lot of time looking at social and life function, that's the practical stuff around living out there, reassessing the value of money, for a lot of people on crack cocaine, money passes through their hands, high volumes of money can pass through their hands relatively quickly with nothing to show for it at the end of it, except for depression. So it's about reassessing that, looking at the value of money, we do also include within that transactional analysis work. So, we're really trying to get as many bits into the programme as we can possibly squeeze in.

The group is really a mixture of cognitive behavioural therapy, so experiential groups, solution focused therapies - problem solving, complimentary therapies, and neuro-linguistic programming - elements of neuro-linguistic programming, and that's all supplemented at the end of each day, we have auricular acupuncture, we have detox teas, lung teas to strengthen the lungs, sleep tea and insomnia teas and also we have a journal club at the end of every day, where people are expected or it is anticipated that they write in a journal or they record their thoughts or their reflections and their learning for a day, which then is reviewed in a weekly key work session, which follows a care plan.

Client age groups

Because of the children's act 1989 we are not able to work with anyone who is under the age of 18. At the Blenheim Project we have a youth outreach service, which is very successful, and they can work with people from the age of 14 up through to 25. The earliest age that we can have on the programme is 18, and I think that the oldest person we've ever had on the programme is 65 primary crack cocaine user. We get several people in their 40s and 50s, but largely the bulk of people are between 25 and 35. We have people who have a crack cocaine-using career spanning 20 years so they're kind of the senior end of the using community.

Crime

Most of the violent crime that will result in death is going to be associated with the money that exchanges hands, and that will usually involve a dealer and a user or

dealers against each other. The threat of violent crime is probably where the user is most likely to get involved in crime as a way of acquiring funds, so threatening to carry out a certain activity if not paid etcetera etcetera, would be generally where people are at in terms of the using. What people do indicate is that subsequent to crack cocaine use the severity and the nature of their crimes change, so the frequency of them committing those offences might increase, and perhaps the involvement in criminal activity might increase, but generally speaking most people have a history of crime that predates crack cocaine use.

There are, I would say, about a quarter of the people who access the programme who have never been in trouble with the law before in their lives. It is an oversimplification to link the crime and the offending behaviour with crack cocaine use and vice versa. We really need to see individual people as individual people with individual experiences and looking at their offending behaviour as it pertains to them, their lifestyle choices and their using choices.

Having said that I need to give you an example. We did a follow up study on 12 people who started the day programme and had all completed, and prior to accessing the programme the 12 of them were using half a million pound of crack cocaine a year, which suggests between a million and a million and a half's worth of crime being committed. Now some of them users are going to be user/dealers so we won't call that acquisitive crime. So lets say about a million pounds worth of acquisitive crime is being committed. At the end of the programme, of the 12 people who had been using half a million pounds worth of crack in a year, all but two had completely stopped offending, and the two that were offending, were partaking in occasional shoplifting. And of those who had completed the programme, all of them had remained abstinent, prior to that research being carried out, anywhere between two months and two years and it was a two year follow up so, some people had just completed the programme, and were two months abstinent after the end of the programme, others had completed two years before and were continuing to be abstinent.

There was some indication of people using recreationally, and recreational use would be indicated by once a month or once every couple of months, all of them apart from those two who were shoplifting were in employment for the first time, and all of them had ceased any risky behaviour such as, sex related behaviour – stripping – lap dance work – and things like that. So the indications are really very positive, in terms of people accessing a programme and being able to move through that programme and beginning to take power over their lifestyle choices and also the way they acquire their money.

4. Dr Des Crowley – GP Co-ordinator Northern Area Health Board

This is a very brief presentation on our experience on cocaine use and abuse in our health board areas and some of the interventions we've started or are attempting to introduce in the service.

Cocaine Use

Basically over the last twelve months we have seen a huge increase in the number of our urine screens that are coming back positive for cocaine. Up to January 2002 around 2–3% of our urine screenings were positive for cocaine, by the end of the year December 2002, we had between 18-13% of our urinalysis cocaine positive so that's a huge increase, we are talking about four or five times an increase in the use of the drug. There was some regional variation in terms of the cocaine positive results we found that the largest increases were in areas like Darndale and Edenmore and the smaller increases were in areas like Ballymun. We did some review of our own patients, those who had come up as cocaine positive on the urines and what we found was between 55-60% of them were actually injecting cocaine as opposed to snorting it. There are only very small instances of crack cocaine use; only about 1 or 2% are using crack cocaine at present.

I suppose some of the interesting things that have come up is that there are different categories of cocaine users, and we can't put them all into the one group and treat them all similarly I mean there is a large number of people who are social recreational cocaine users, and we did find a huge increase in the amount of cocaine use over the Christmas period, but people have actually gone back to not using cocaine in the last number of weeks again. So again I do think its important to monitor it and know exactly what we're dealing with, not all people using cocaine will go on to develop a serious problem with it.

We then have people who we call recurrent users but they don't use it continually, they may use it two or three times every month, you know that they are coming up with two or three positive urines every month or every six weeks, and their pattern is that they will go out and use socially/recreationally and then they'll have a couple of days, or maybe a week or ten days off it, and then they will stop it for a month or six weeks and then restart it again.

And then we do have continual users as well, people who use maybe three or four times a week or maybe some who are using every day. In terms of the snorting versus IV, as I said earlier we have a very low crack cocaine use, I mean we have 1 or 2% of people in a specific area associated with the north inner city that are using crack cocaine and they are people who are actually associated with the music scene. Our normal population, there are about 60% IV'ing it and about 40% that are actually snorting it. Most of the people who are using recreationally are snorting it rather than injecting. A lot of the group who are using recurrently or continually are actually injecting the drug.

We are finding that people are using cocaine normally where they would have gone out for a drink on a special occasion like a birthday or an anniversary or maybe even

communions, instead of having a drink, going out for the day they actually use cocaine as a way of celebrating, and again this has become I think part of the whole social scene in their areas. Cocaine is not just associated with people who are on our clinics. I think it is also associated more broadly on the social scene. There is certainly a seasonal variation, we saw a huge increase at Christmas time but thankfully that has decreased in the last few weeks.

We are seeing a younger age group coming into the clinics with cocaine problems, I think community representatives or project workers would probably notice that in terms of people that are identifying in the community and certainly what we are now hearing is that it is now becoming a gateway drug, a drug which is going to lead into other drugs and it is replacing ecstasy as one of the early gateway drugs. And again the issue of speedballing, where people are combining heroin and cocaine together and injecting both, and they are using the heroin as a means of actually coming down off of the cocaine.

HIV

We have noticed a dramatic increase actually in seroconversion - people that are actually converting to HIV positive in the last three to four months and some of the profiles are actually quite extraordinary, these are people who would have survived the heroin epidemic and would have survived the initial HIV epidemic in the mid 1980s. Now they find themselves fifteen years later seroconverting to being HIV positive due to the unsafe use of needles associated with cocaine.

Aggressive Behaviour

We have also noticed an increase in the amount of aggression in some of our clinics. Now this also is actually regional, not all of the clinics are reporting an increase in aggression, but certainly one or two of the clinics in a few of our areas have. And an interesting thing is that we have had 10 barrings from community pharmacies that are people who are receiving methadone from the community pharmacist actually were barred because of aggressive behaviour in the months of January or February.

Health Problems

We've noticed a dramatic increase in the instance of DVT's - deep vein thrombosis, which are clots actually in the backs of peoples legs, and also very complicated cellulitis which is infection and inflammation of tissues, and also abscesses, very large abscesses, very badly infected abscesses requiring quite a lot of medical treatment. We have also seen an increase in the amount of alcohol consumption and again this is well known and well documented the association with drinking and cocaine use.

Needles

We have also documented that there is an increase in the number of people attending our needle exchanges requiring needles just for cocaine use, and also people who will be receiving methadone treatment for us attending our needle exchange programmes to access clean needles for cocaine use itself.

Interventions

Some of the interventions in on our health board are: Staff training workshops, we recognised that there are no experts in this country on cocaine, and we're all dealing with something new, not something we've dealt with here in the past. So basically we are all on a learning curve. The workshops for our staff were very well attended, with some very positive feedback.

We had noticed that there was an increase with younger people presenting with cocaine problems so we introduced a cocaine course on the young persons programme, which is run from city clinic in the evening time. We spent two or three months looking at this course, organising it, and then identifying people who were suitable. Basically there was little or no follow up, in that people didn't present, but the interesting thing about it was that the targeting of the individuals and the discussions with the individuals that went around them having to attend the course actually, they stopped using cocaine, even though they never actually attended the course. So from having 8 or 10 pretty frequent users of cocaine, by just making interventions like discussing it with them, asking them to go and attend the course, that in itself actually reduced the amount of people using cocaine.

We have set up a cocaine only clinic in Buckingham Street. It is a cocaine/stimulant only clinic that is for people who do not have a heroin problem and present with cocaine only issues. The clinic opens once a week on a Thursday and is a drop-in. And again it is only in a pilot stage, at the moment it offers counselling, but in time we will review the needs of that clinic and see what extra requirements might be needed.

We are having ongoing workshops with the staff, because the amount of information and knowledge that is available through our staff just working on the ground, and that's through all of the various disciplines that work in our care teams, like the general assistants will see behaviours changing on the ground in terms of the waiting room, and when they're taking the urine screens. They have a knowledge base just from listening to the patients talking and sometimes clients will reveal things to our GA's that they won't reveal to our doctors. So we are trying to build up our knowledge bank and looking at ways of making some worthwhile interventions.

We have ongoing monitoring of our urinalysis and were now doing cocaine screens on all urines that are sent from our clinics, and again we do actually get feedback from our laboratories on the instance of cocaine positivity in the urines.

There have been some interventions made in the needle exchanges where they have recently produced a new poster and information sheet on the dangers of injecting cocaine.

We have a new cocaine policy in the northern area health board (attached). It is basically trying to make people aware of cocaine being an issue with patients, and the value of making early interventions. If you can intervene at an early stage you will actually stop people from going on developing a more serious problem.

We are in discussion with the task force representatives, looking at doing a joint project around doing an educational video or a piece of work so that we can use

community knowledge and experience along with our own experience and maybe do a worthwhile piece of education prevention work.

5. Dr. William Flannery – Research Registrar South West Area Health Board – Drugs Aids Service

The 2002 EU report on the state of the drug problem highlighted the growing concern there is throughout Europe about cocaine. Ireland has the third highest use among 18 to 34 year olds at about 2.6% of the population, the next highest is Spain followed by the UK. Closer to home, the survey on health and lifestyle behaviours said that 3.4% of 18 to 34 year olds had used cocaine the previous year. For adults as a whole that's 1.3%. The European survey on schoolchildren, (that is schoolchildren aged 15) showed that there was a 2% life time use of cocaine and crack. Garda figures show that the number of cocaine offences have doubled, to 300 offences, in 2001, and 62% of those offences took place in Dublin. Its important to state as well that of the total number of drug related offences, cocaine actually makes a very small percentage of those.

Then moving on, data from the national drug treatment reporting system shows that patients in treatment, the numbers actually attending with cocaine as their primary drug of addiction is actually quite small (about 1%) but it is increasing, there are larger numbers for cocaine as the secondary drug of addiction, but again its actually quite small (3.6%), but this again is increasing. There appears to be a difference as mentioned earlier on, between primary cocaine users, about 70% of them who snort, while secondary users actually tend to inject (more than half would actually inject).

So I move on now to my own health board area. When the drugs service first opened in 1992, cocaine was certainly not recognised as any sort of a problem on the ground and it first made an appearance in 1998 when a small group of inner city very chaotic people started to use cocaine intravenously. And since that time it has just increased. That increase I think is highlighted by they UN results done by everybody, done by all the patients in treatment, as can be seen in 1998, 2.3% of all cocaine results were positive, and that gradually increased to 2001 to 2.4%, but over the last year there's been quite a marked increase. Interestingly like with the northern area health board the south western area health board has regional differences. Not only are there regional differences but they would appear to be differences clinically. There appears to be regional differences in how cocaine is used. For example in Tallaght it appears clinically to have a more recreational type of pattern of use and tends to be more snorted or inhaled. Then in the inner city, where the number of urines being positive is much higher has a more dependent type pattern, and it tends to be more injected.

Deep Vein Thrombosis

So, moving on, with my own job, six months ago I was involved with a project looking at one of the consequences of intravenous drug use, looking in particular at Deep Vein Thrombosis, so a DVT occurs when there is a spontaneous clot in the veins of the deep system. People would have heard about DVT from the risks associated with long-haul flights, and obviously it has a very significant morbidity

and mortality. So, in the south western area health board over the last number of years there has been an increase in the instance of DVT, and running alongside that there has been a more gradual rise in cocaine use. So the figures show that in 1997 the instance of DVT was slightly above normal from what you would expect in an IV using community. However, over the past number of years, this really has rocketed, up and is markedly above normal. Over the six months we followed up anybody who had a past history of a DVT or who developed a DVT during that time period, and we divided the patients on the basis of whether they had only one DVT or more than one DVT. Now the two groups worked out the same from the point of view of age, and from the point of view of injecting practices. From the point of view of heroin usage, however, the only difference was in their percentage positive of all urine samples that were cocaine positive. If you only had one DVT the percentage positive was 17%, while the group that had more than one had a difference of 37% and that difference is statistically significant. So it is quite possible that the increase in instances of DVT in the south western area health board is as a direct consequence of the use of cocaine.

Treatment

So next I'll move onto treatment. Cocaine use is treated very seriously in the south western area health board, and it is treated as seriously as heroin use. And really in practice we tend to be treating a combination of both. So obviously the aim of treatment is to develop some form of empathy with the client to at least retain them, to help retain them in the programme to disrupt their typical using cycle, or bingeing cycle with the aim of preventing relapse. A psychotherapeutic approach is the mainstay of treatment in the southwestern health board currently. So that approach uses, or has adapted the existing opiate or methadone treatment structure, and the aim is to modify the persons behaviour, using rewards, where the person gains privileges in the forms of take-aways, because the majority of these people will be on a methadone maintenance programme. As they are attending the centre then, education around the harmful use of cocaine, safe injecting, can all be facilitated, then as a directed intervention, counselling is available, which is usually one to one, with focus on cocaine.

In the south western area health board, most of the main treatment centres, one day a week will have a psychiatric registrar based there, again to facilitate access by the client to that service and there is an increased use of that service and for the referral of in-patient treatment, again due to the consequences of either cocaine use or cocaine withdrawal. And then in one circumstance if a client is pregnant and is very chaotically using, that its not possible to treat that patient as an outpatient, that person is usually admitted to Cuan Dara for stabilisation, and that typically involves the use of a tricyclic antidepressant to control the withdrawal symptoms as well as the normal inpatient programme. Clinically, although I don't have any exact figures, there would appear to be an increase in aggressive behaviour, and certainly an increase in the number of specific incidences in the service as a whole.

The Future

So, finally I'll just move onto future plans. I'm afraid we're not as quick as the northern area health board, in that we don't have a policy statement as yet, but its being reviewed currently, and included in that will be a statement on cocaine. I think it was mentioned earlier, that retaining the clients and engaging the clients in

treatment is particularly difficult, so that would certainly be an area to focus on in the future.

I was interested to hear what Daniel had to say about the group work currently taking place in the service where he is working. Currently, some of the clients that attend the south western health board, have been enrolled into a group in Trinity court dealing specifically with cocaine. So, as I mentioned already, that there are regional variations in cocaine use within the area, and then different modes of use can be individually more difficult in maintaining treatment, for example crack cocaine patients are particularly difficult to engage, so possibly a tailored, separate programme for the different sub-types might be a means to facilitate engaging the clients in treatment.

And finally, that liaising or linking in with the other general services such as social services, medical and psychiatric to facilitate management of the consequences of cocaine, which is happening anyway but will need to continue for the future.

So, finally I'd like to conclude by saying that, obviously, cocaine is a rising problem, and what the south western health board has done is adapted what's on the ground to the cocaine problem itself, and in the future would hope to focus more on it as a problem.

5. Dr. Cathal O'Sullivan – East Coast Area Health Board

We reviewed, in Baggot Street clinic, urine results in terms of positive cocaine tests, over the past year and there wasn't a huge increase [in positive results], there was an increase of about 2% over that 12month period. And that would confirm our impressions on the ground that we're not being presented with big numbers of people presenting with a problem with cocaine, we see it in conjunction with opiate users. In fact I don't think we've had anyone present to Baggot Street with a primary cocaine problem coming in. That's not to say they don't exist, but we aren't seeing it, and I haven't heard of it presenting in the other clinics in our area as a primary problem. I've heard of one or two people out there who have been approached by outreach and people who are known to be using cocaine primarily, but they haven't presented themselves for a treatment. We do see it as I said in conjunction with opiate use, and we do see a gradual increase over the last couple of years. And we would be very concerned about that, because as I'm sure you've heard earlier on in the day, it lends a whole sort of aura of chaos to the opiate use, and the risk taking, as I think you talked about, the increased risk of HIV, increased needle sharing, all that stuff, the risk behaviour is much more increased. So, we're very aware of that, the chaos in terms of drug use, poly-drug use, increased opiate use is very noticeable in these people.

Really there is no pharmacological, there is no medicine you can give people, as you can for opiate addiction, there is no methadone for cocaine, in other words. So, we

don't have a medical treatment to give per sé. So, the treatment is based in psychotherapeutic modalities and we're using the traditional approach that we've used already in terms of one to one counselling. There have been some plans to look at group therapy and different modalities of psychotherapy, but as I've said, we haven't had big groups of people presenting in our area with problems with cocaine, it just hasn't happened. There is a plan to set up a pilot programme in Baggot Street using acupuncture and brief intervention counselling as well. The acupuncture has been used, as some of you know in some of the drug courts in the US, where they deal primarily with cocaine users. Cocaine users are the people that tend to cause the problems over there as opposed to opiate users, and there have been a number of papers showing that acupuncture has been quite successful in helping people to control their cocaine use and even stop it. So, we're looking at using nurses who have been trained in basic acupuncture technique, to give daily or maybe three times a week treatment, and include in that a brief counselling intervention at the same time. So we're looking at setting that up at the moment, its not in existence yet, but we're hoping to add that soon. I don't have anything else to add. I think I'd be repeating everything that was your presentation, our experiences are very much the same, I think our approach is very much the same. There is apparently a large amount of cocaine use out there, but as I've said people are not presenting to our services with problems so that's the state of play in our area.

6. The following is a composite of the responses from the three Health Board representatives: Dr Des Crowley, Dr. William Flannery and Dr. Cathal O'Sullivan, to questions from seminar participants:

Question #1 – Cocaine Specific Services

Q. When are cocaine specific services going to be created and where will these services be located given that cocaine users are not using existing heroin treatment centres?

Reply

A. Because of budget restrictions it is unlikely that there will be specific cocaine services in the immediate future in the South West Area. Clinics are focused on heroin and methadone because opiates are the largest problem presenting for treatment. Health board or community premises that are not used as treatment centres could be looked at to offer services for clients unwilling to use existing centres. The northern area health board in the inner city in consultation with the community uses an outlying building that is not used for methadone dispensing to provide cocaine only sessions. Some clients have gone into Trinity Court to attend a cocaine specific

group. Health boards are looking at trying to have evening and early morning clinics in various areas and across the ranges of services. Cocaine has not been identified as a significant issue in the East Coast Area.

Question #2 – Cutbacks

Q. What effects will recent government cutbacks have on treatment? How will you prioritise services?

Reply

A. Budgets are being reduced by 7% this year. There are two ways of approaching cutbacks, either the service is reduced or services are made more efficient. Services and programmes need to be looked at critically and prioritised in terms of what is needed. There is no point in reducing services like needle exchange and reducing programmes if there is going to increase the amount of people who become HIV positive. Direct services to the patient are the last things that will be cut.

Question # 3 – Lack of Services

Q. There is a big increase in young people using cocaine in the Darndale area. The treatment centre at the moment is unable to cater for that particular age group and caters only for heroin and methadone users. Counsellors do not have the capacity to take on young cocaine users.

Reply

A. The issue of availability of counselling does need to be looked at. People should be able to access counselling, particularly those under age. Anybody presenting under 18 years is considered as an emergency and should have access to any facility available.

Question #4 – Catchment Areas

Q. Can people from outside the Baggot Street catchment area attend clinic there?

Reply

A. No. Clinics are catchment area specific. Communities feel very strongly that they do not want people travelling from outside their areas to attend services within their communities. If services are not available in local areas, communities need to look at why they are not. If there is an issue of waiting lists or dedicated facilities, it is the responsibility of the Health Board for that area to provide for them within that catchment area.

Question #5 - Acupuncture

Q. Will the Health Boards use local people who are trained in NADA to offer acupuncture services?

Reply

A. There is no recognised acupuncture training in Ireland and no government regulations to control the practice. Health Boards are responsible for insurance purposes for acts that are carried out by anybody working on their behalf. Nurses are trained to inject, to use needles, to dispose of medical equipment and they would be covered by insurance for doing acupuncture in a health board clinic. Local people, even with NADA training, would not be covered.

Question #6 – Cross Departmental Co-operation and Outreach

Q. Are there any strategies for cross department cooperation to look at cocaine use? Are Health Boards developing outreach cocaine education and information programmes for communities instead of just waiting for people to present at treatment clinics?

Reply

A. There are outreach services that have come across a few people in communities who are using cocaine quite heavily, and who would appear to have problems, but haven't chosen to present themselves for treatment, because they haven't perceived themselves as having problems. Outreach workers attend clinical meetings and feedback in the issues they are encountering. Some Health Boards have met with the local taskforces to look at developing strategies around education and prevention for existing clients; prevention for people who are at risk in schools; and education targeting community groups. A pilot project is being planned in one health board area that will start up in the absence of referrals or of people presenting at clinics to see if there will be an uptake.

Question #7 – Developing Services

Q. The marked lack of planning from the health boards in relation to the overall issue of cocaine is quite like what happened before heroin became a crisis. We haven't got enough information to make decisions on services if we are gathering information just through the clinics and developing services based on those client needs. People who are using recreationally and getting into trouble through that use are not included in that information gathering process. I think the way forward is for Citywide, the health boards and the drugs task forces to work together. There are going to be deep problems if we don't plan to deal with cocaine use, especially if budgets for established services are being cut.

Reply

A. This is an important point. If 15 or 20 years ago we had been able to monitor the HIV epidemic in Dublin in the mid 80s things may have been different. Systems are a lot more sophisticated now and health boards are more sophisticated, contrary to popular belief. Integration between health boards and communities is a lot better than it was; it has taken a lot of time to understand the difficulties on both sides of the fence. If we are going to answer the issues of cocaine use in a meaningful way then the health board and the community have to work together.