

Chapter 3

Cocaine Use In Ireland: An Exploratory Study

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3.1 Introduction

In Ireland the heroin epidemic of the 1980s, coupled with the public health crisis of HIV transmission through unsafe injecting practices, resulted in a concentration of attention on 'high-risk' drug use categories, most notably heroin and other intravenous drug use. The major focus in the domains of drug policy, treatment and research centred on the 'threats' posed by enduring patterns of drug use, unsafe methods of drug administration and associated risk behaviours. Heroin, being a dominant drug of misuse among individuals receiving treatment, certainly in the greater Dublin area (O'Brien, Moran, Kelleher & Cahill, 2000), has attracted by far the greatest level of interest and attention. This situation is by no means unique to Ireland. As Egginton & Parker (2000) have remarked, 'so distinctive is the impact of this drug that heroin has its own epidemiology' (Egginton & Parker, 2000: 7). In practice, prevalence studies and other empirical research focus on groups, such as opiate users or injectors, who are of concern at a particular time (Frischer & Taylor, 1999). Put differently, attention to particular forms of drug use is very much a function of the drug-political situation in any given jurisdiction (Cohen, 1996).

Despite heroin's prominence, publicity and official concern, the past decade has witnessed increased recognition of the pervasiveness of drug use in society generally. Drug use, traditionally associated with social and economic disadvantage, is increasingly recognised as a widespread social phenomenon and is clearly no longer confined to marginalised communities. School surveys point to a definite increase in the number of young people reporting lifetime use of a range of illicit substances (Grube & Morgan, 1986; Grube & Morgan, 1990;

Hibell et al., 1997; Brinkley, Fitzgerald & Greene, 1999; Hibell et al., 2000). Less is known, in an Irish context, about drug use in the general population as few household surveys, concentrating on adult rather than youth populations, have been conducted. However, a recent population survey, examining the lifestyle, attitudes and nutritional status of people aged 18 to 55 years, revealed a lifetime prevalence rate of 17 per cent for cannabis. Last-year prevalence was estimated at 2 per cent for amphetamines and ecstasy and 1 per cent for tranquillisers and LSD (Friel, NicGabhainn & Kelleher, personal communication). Although cannabis remains by far the most popular of the illicit drugs and the most likely to be used repeatedly across time, available data suggest that other drugs, including amphetamine, ecstasy and LSD, are increasingly likely to be used, particularly by adolescents and young adults. It would appear that we are increasingly living in a drug-conscious society.

In Ireland relatively little attention has focused on the use of individual drugs, with the result that little is known about the extent and nature of specific forms of drug involvement. Attention to drug use, apart from heroin, has concentrated almost exclusively on ecstasy. Reviewing available data pertaining to ecstasy use in Ireland, Bisset (1997) found evidence of an upward trend in use among young people. Murphy, O'Mahony & O'Shea's (1998) comparative research on Irish and European drug policies relating to the use of ecstasy included a small-scale qualitative study of ecstasy use by adults aged between 17 and 27 years. The findings of this research suggest that ecstasy was a component of poly-drug-using careers initiated during the mid- to late-teenage years. Ecstasy use was synonymous with the rave/dance scene and was usually consumed in conjunction with alcohol and other drugs, including amphetamine and/or cannabis. More recently, a larger qualitative study of patterns and levels of ecstasy use in Northern Ireland (McElrath & McEvoy, 2000) found a high proportion of 'heavy users' in their sample of ninety-eight respondents. However, the dosage (i.e. number of tablets) per episode of use varied across the sample and typical reports indicated that many users 'staggered' their intake of ecstasy during individual sessions of use. In common with the findings of Murphy et al. (1998), the concurrent use of ecstasy, alcohol and cannabis was common among users. Although it is not possible, on the basis of current knowledge, to provide a reliable estimate of the prevalence of ecstasy use, the issue has nonetheless been the focus of some research. Other drug use, including amphetamine, LSD and cocaine, have received little or no attention in an Irish context.

The purpose of the current paper is to examine cocaine use in Ireland. This research coincides with renewed attention, in a European context, to suggestions of a possible increase in the availability and use of cocaine. Increases in cocaine use across Europe have been visible since the late 1960s (Erickson, Adlaf, Murray & Smart, 1987). For example, studies in the United Kingdom have shown steady increases in various indicators of cocaine use during the past 10 to 15 years (Marsden, Griffiths, Farrell, Gossop & Strang, 1998; Ramsay & Partridge, 1999). A recent British review of law enforcement figures, treatment statistics and other key prevalence indicators, reveals a steady and significant upsurge in cocaine use from 1991 to 1998, suggesting that the United Kingdom may be witnessing the rapid spread of new cocaine use (Corkery, 2000).

The primary aim of this current research was to investigate levels and patterns of cocaine use in Ireland. The study was undertaken against a backdrop of anecdotal and impressionistic evidence suggesting that cocaine is very much 'around', more easily procured than previously and making a conspicuous breakthrough on the drug scene. Hence, the research sought to locate and analyse all available data identified as potentially useful in an assessment of the extent and nature of cocaine use in Ireland.

The multiple existing data sources used in the research are described in detail below. However, as a starting point, it is helpful to provide a brief overview of the pharmacological properties of cocaine and the principal routes of cocaine administration.

3.2 Pharmacological Dimensions of Cocaine and Modes of Use

Cocaine is a naturally-occurring substance derived from the leaves of the coca plant, *Erythroxylon coca*, a shrub that grows in the Andean area of South America (Fischman & Foltin, 1991). It is an odourless, white crystalline powder and is classified as a central-nervous system stimulant. Cocaine was first extracted in 1855 and later became a popular stimulant and tonic. Up until 1904 Coca-Cola, the popular non-alcoholic beverage, contained small quantities of cocaine (ISDD, 1996).

The most common form of ingesting cocaine is 'snorting' - sniffing fine cocaine crystals via the nostrils. By snorting, cocaine is conveyed into the bloodstream via the mucous membranes of the nose and throat where it dissolves. Cocaine increases feelings of alertness and energy and produces intense euphoria. Negative effects include anxiety, inappropriate levels of aggressiveness, sleeplessness, sweating, impotence and heavy feelings in the limbs. Very heavy users of cocaine may report strong feelings of paranoia.

The smokeable form of cocaine is known as free-base, rock or crack cocaine. The cocaine powder is converted into cocaine base and smoked, usually through a pipe. Crack cocaine is processed with ammonia or sodium bicarbonate (baking soda) and water, and heated to remove the hydrochloride. Because crack is smoked, the user experiences a shorter but more intense high than snorting the drug (Corrigan, 1997; NIDA, 1999). Crack cocaine produces effects far more rapidly than the powder form and this, coupled with the shorter duration of the euphoria, makes crack smoking a potentially highly-addictive substance. However, neither tolerance nor heroin-like withdrawal symptoms occur with repeated use of cocaine (ISDD, 1996). Users may develop a strong psychological dependence on the physical and mental well being afforded by the drug.

Finally, cocaine may be used intravenously, although this mode of ingestion is less common and is viewed as dangerous by most cocaine users (Cohen, 1989). Intravenous injection results in an almost immediate high within fifteen seconds of injecting (Pinger, Payne, Hahn & Hahn, 1995). Some drug users combine cocaine powder or crack with heroin to produce a drug cocktail known as 'speedballs'.

Prolonged heavy cocaine use is usually followed by a 'crash' if use is discontinued. This 'crash' is characterised by exhaustion, restless sleep patterns, insomnia and depression (Erickson et al., 1987). However, there is considerable disagreement over what constitutes 'addiction' or 'dependence' in the case of cocaine. Furthermore, there is little consensus on who is susceptible to or at greater 'risk' of cocaine dependence. Waldorf, Reinerman & Murphy (1991), in a study of 'heavy' cocaine users (users who the authors claim qualify as the most serious 1 per cent of the cocaine-using population), found that even among this group, a large number maintained a stable, although heavy, pattern of use over several years without increasing their cocaine intake. They add that 'it is exceptionally difficult to predict which users will maintain control and which will become compulsive' (Waldorf et al., 1991: 102).

Other research similarly concludes that many heavy cocaine users do not become dependent (Erickson et al., 1987; Cohen, 1989; Chitwood & Morningstar, 1985). Hammersley & Ditton (1994), in a study of Scottish cocaine users not known via their criminality or contact with drug services, conclude that 'cocaine can lead to protracted bouts of heavy or excessive use, but many users can then stop or moderate use prior to encountering problems' (Hammersley & Ditton, 1994: 68).

The accumulated research evidence on cocaine use across several jurisdictions suggests that, among community samples of cocaine users (that is, users not in contact with drug treatment services), heavy users will not necessarily develop symptoms normally associated with chronic drug dependence. **TABLE 3.1** Ireland 1990-1999. Quantities (kg) of Cocaine and Other Drugs Seized by An Garda Síochána

| Year | Cocaine | Heroin | Cannabis Resin | Ecstasy | LSD |
|--------|---------|--------|----------------|----------|----------|
| 1990 | 1.009 | 0.578 | 114.76 | N/A | 90 u |
| 1991 | 0.31 | 0.161 | 1,101.62 | 429t | 3,169 u |
| 1992 | 9.850 | 0.794 | 498.47 | 271t | 13,431u |
| 1993 | .348 | 1.285 | 4,200.31 | 744t | 5,522 u |
| 1994 | 1.14 | 0.49 | 1,460 | 28,67t | 16,164 u |
| 1995 | 2,800 | 9,400 | 52,000 | 123,609 | 16,164 u |
| 1996 | 642.000 | 10,800 | 1,733.00 | 19,244t | 5,190 u |
| 1997 | 11.020 | 8.211 | 1,247.88 | 17,516t | 1,851 u |
| 1998 | 333.167 | 38.340 | 2,157.24 | 604,827t | 798 u |
| 1999** | 85.554 | 16.957 | 2,511.30 | 229,091t | 577 u |

Source: Annual Reports of An Garda Síochána, 1990-1999.

** 1999 figures are subject to revision as all statistics were not analysed at the time of going to press.

N/A = data not available.

3.3 Research Methodology

There are three research components in this analysis of cocaine use in Ireland. The first (see Section 3.4) examines existing, predominantly statistical, data sources in order to identify emerging patterns and trends in cocaine and base/crack cocaine use. Relevant data from several sources, all considered to be

key indicators of drug misuse, are presented. The combined information from the data sources listed below, covering a range of population segments, are presented and analysed.

3.4.1 Law Enforcement and Supply Statistics

3.4.2 Drug Treatment Figures

3.4.3 School-Going, College-Going and General Population Surveys

3.4.4 Morbidity and Mortality

3.4.5 Qualitative and Ethnographic Research

TABLE 3.2

| Year | Cocaine | Heroin | Cannabis Resin | Ecstasy |
|------|---------|--------|----------------|---------|
| 1990 | 11 | 71 | 1,413 | |
| 1991 | 7 | 45 | 2,354 | 45 |
| 1992 | 11 | 91 | 2,542 | |
| 1993 | 15 | 81 | 2,295 | 46 |
| 1994 | 20 | 230 | 2,548 | 264 |
| 1995 | 30 | 298 | 2,209 | 643 |
| 1996 | 42 | 432 | 1,441 | 346 |
| 1997 | 97 | 564 | 2,096 | 475 |
| 1998 | 88 | 789 | 1,749 | 439 |
| 1999 | 169 | 887 | 3,281 | 1,023 |

Individual face-to-face and telephone interviews were conducted with a range of informants including drug-service providers, An Garda Síochána, youth workers, drug counsellors, general medical practitioners, hospital personnel, night-club owners and a small number of key informants considered to have experience of and insight into common and preferred drug-taking practices. The primary objective was to access the views, perspectives and concerns of individuals who have direct knowledge and/or experience of cocaine users and of the drug scene generally. In this context, there was a specific focus on uncovering information pertaining to the availability of cocaine, local drug markets, trafficking/dealing/ distribution patterns, health consequences and the negative repercussions of use. In addition, interviews with drug-service staff addressed the issue of service provision, including the needs of cocaine users and implications for treatment intervention and other drug services.

Finally, in view of the widespread recognition of recreational or non-problematic forms of cocaine use in other jurisdictions (Erickson et al., 1987; Cohen 1989; Green et al., 1994; Hammersley & Ditton, 1994), a small-scale qualitative study of adult cocaine users not in contact with drug-treatment agencies was undertaken

(see Section 3.6). The primary aim of this exploratory research was to examine respondents' use of cocaine and other drugs. The research also sought to examine attitudes to cocaine and other drug use, to investigate perceptions of the risks associated with cocaine compared to other drugs, and to examine dominant or preferred circumstances associated with the use of cocaine. The selection criteria and recruitment process are discussed in Section 3.6.

In summary, multiple sources were used in order to build a fuller picture from partial data. The orientation of the research is largely investigative, with each segment of data feeding into a 'detective' approach (Douglas, 1976). General principles of analytic induction were applied to the examination of pre-existing data and to data collected through face-to-face and telephone interviews. This approach involved establishing an initial description of the phenomenon and the continued refinement of that analysis in light of further evidence collected in the course of fieldwork. The strength of this method lies in its capacity to consider many alternatives and progress dynamically as opposing or corroborating evidence appears (Adler, 1990). Analytic induction was formulated by Znaniecki (1934), and later refined as a procedure for verifying propositions on qualitative data by Lindensmith (1947) in a study of opiate addiction. It was used by Becker (1963) in his classic study of marijuana users. This research orientation is particularly suited to gathering information in sensitive and 'hidden' areas of human behaviour (Stimson, Fitch, Rhodes & Ball, 1999).

3.4 Existing Data Sources and Other Relevant Empirical Research on Cocaine Use

In this section, the data pertaining to the use of cocaine (and other drugs) from several key data categories are presented. These include law enforcement and supply statistics, purity levels, drug treatment figures, general population surveys, school surveys, cocaine-related deaths, hospital morbidity and other relevant research findings arising from ethnographic and qualitative studies.

3.4.1 Law Enforcement and Supply Statistics

The accuracy of police statistics are a subject of considerable debate (Bottomley & Pease, 1986). One of the main difficulties with law enforcement figures is that they are not contextualised by reference, for example, to specific overt and covert

operations or 'luck strikes'. Differences in drug seizures might also reflect variations in drug control strategies across time (Korf, 1992; South, 1995). However, at a local level, drug seizure figures provide a useful broad indicator or sensor of drugs supply and demand (Parker, Bury & Egginton, 1998).

Available statistics pertaining to seizure and offender data are provided in the annual reports of the Garda Síochána (An Garda Síochána, 1990-1998). Table 3.1 presents the figures for seizures of cocaine made by the Gardaí between 1990 and 1999. Seizure figures for heroin, cannabis, MDMA (ecstasy) and LSD are presented for 1995-1998 for comparative purposes.

TABLE 3.1
Ireland, 1995-1998: Drug Treatment Contacts. Cocaine as Primary and Secondary Drug of Misuse.
Numbers.

| Year | Cocaine as Main Drug | | Cocaine as Secondary Drug | |
|------|----------------------|----------------|---------------------------|----------------|
| | All Contacts | First Contacts | All Contacts | First Contacts |
| 1995 | 24 | 10 | 67 | 21 |
| 1996 | 25 | 17 | 121 | 50 |
| 1997 | 42 | 22 | 195 | 48 |
| 1998 | 88 | 32 | 291 | 60 |

Source: National Drug Treatment Reporting System, Health Research Board.

Internationally, it is often estimated that approximately 10 per cent of all drugs in circulation are intercepted (Boekhoutvan Solinge, 1998; Stimson, 1987). Table 3.1 illustrates considerable variation in the quantity of cocaine seized by the Gardaí between 1991 and 1999. A quite dramatic rise in the amounts seized is apparent from 1995. It should be noted, however, that the exceptionally large amounts seized in both 1996 and 1998 make the data susceptible to being skewed (Sutton & Maynard, 1993).

The number of cocaine offences where proceedings commenced between 1990 and 1999 are presented in Table 3.2. The figures for heroin, cannabis and ecstasy are again included for comparative purposes.

TABLE 3.4
Ireland 1997-1998. Residents of Health Board Areas Presenting with Cocaine as Primary and Secondary Drug of Misuse within each Health Board Region.
Numbers and Valid Percentages.

| Area | All Contacts, 1997 | | All Contacts, 1998 | | All Contacts, 1997 | | All Contacts, 1998 | |
|------|-------------------------|--------|---------------------------|--------|-------------------------|--------|---------------------------|--------|
| | number | % | number | % | number | % | number | % |
| | Cocaine as Primary Drug | | Cocaine as Secondary Drug | | Cocaine as Primary Drug | | Cocaine as Secondary Drug | |
| EHB | 30 | (.7%) | 173 | (4.2%) | 58 | (1.1%) | 263 | (5.2%) |
| SHB | 3 | (1.2%) | 7 | (2.7%) | 12 | (4%) | 7 | (2.3%) |
| NWLB | 1 | (.1%) | 1 | (.1%) | 1 | (.1%) | 1 | (.1%) |
| MBB | 1 | (.1%) | 1 | (.1%) | 1 | (.1%) | 1 | (.1%) |
| WLB | 1 | (.1%) | 1 | (.1%) | 1 | (.1%) | 1 | (.1%) |
| MWLB | 4 | (4.0%) | 2 | (2.0%) | 3 | (3.1%) | 2 | (2.1%) |
| NEHB | 2 | (2.2%) | 4 | (4.3%) | 2 | (1.6%) | 1 | (0.8%) |
| SEHB | 3 | (1.9%) | 5 | (3.2%) | 9 | (4.5%) | 5 | (2.5%) |

The number of individuals charged with, or prosecuted on, a cocaine-related drug offence is small compared to those relating to heroin, cannabis and ecstasy. However, the figures do point to an increase in the number of offences where proceedings commenced between 1990 and 1999. Figures doubled between 1994 and 1995 and increased three-fold again by 1997, with 1999 producing the record figure for cocaine-related drug offences. 'Offender' data do, therefore, suggest that an increase in cocaine possession and supplying is occurring on the ground.

However, this same upward trend is evident in relation to heroin, cannabis and ecstasy. Law enforcement strategies need to be considered, therefore, when assessing the quite dramatic increase in the numbers charged or prosecuted on all drug-related offences during the latter half of the 1990s. For example, it may be related to measures taken during this period to extend and strengthen the existing statutory framework for the control of drugs (see Loughran (1999: 328) for a summary of drug-related legislation between 1996 and 1998).

Finally, drug-product data is determined from analyses carried out by the Forensic Science Laboratory of the Department of Justice, Equality and Law Reform. These analyses are conducted on drugs seized by the Gardaí. Information from this source indicates that the purity of cocaine has dropped over the past three years, from 62 per cent in 1996 to 38 per cent in 1998. It should be noted, however, that these figures may not accurately reflect the purity level of cocaine at street level, as no empirical evidence on such a link is available.

3.4.2 Drug Treatment Figures

Unlike heroin, no specific drug is used for the treatment of cocaine dependence and there are no prescription figures that can be used as a proxy measure of cocaine dependence. Hence, data pertaining to individuals receiving treatment for drug-related problems are an important indicator of the level and extent of cocaine use among this group.

The National Drug Treatment Reporting System (NDTRS), operated by the Drug Misuse Research Division (DMRD) of the Health Research Board (HRB), reports data on treatment provided by statutory and voluntary agencies countrywide. It is the primary national source of epidemiological information about drug misuse, providing annual figures on the uptake of services as well as socio-demographic data on clients receiving treatment. The regularity of data collection makes it possible to identify changing patterns and trends in the use of particular drugs across time. Between 1990 and 1994, data were collected in the Greater Dublin area only, but coverage was extended to the whole country in 1995 (O'Brien & Moran, 1997). One of the main advantages of more recent figures pertaining to individuals receiving treatment is that they are regionally sensitive. It should be remembered, however, that the figures relate to those problem drug users who present to services, and not to all those who have a drug problem, or indeed all those who use drugs. The number of cocaine users, even heavy users, outside treatment is likely to be far greater than those who seek treatment (Waldorf et al., 1991).

HRB figures consistently indicate that opiates are the primary drugs of misuse. Four out of five individuals presenting for treatment in Dublin during the period 1990 to 1996 reported opiates as their main drug of misuse (O'Brien & Moran, 1997). In 1998, 55.7 per cent of first treatment contacts reported heroin as their primary drug of misuse (O'Brien et al., 2000).

In this section the number of clients reporting cocaine as a drug of misuse in treatment services is examined. It should be pointed out, however, that because the development of drug services in Ireland has been orientated towards problem opiate use, cocaine users may not be attracted to these settings. Table 3,3 illustrates the number of individuals presenting with cocaine as a primary and secondary drug of misuse during the period 1995 to 1998.

Here we find a clear and consistent increase in the number of all and first-contact clients presenting with cocaine as a drug of misuse during the period 1995-1998. This increase is most dramatic among individuals reporting cocaine as a secondary drug of misuse. The figure for all persons who made contact with drug-treatment services reporting cocaine as a secondary drug of use, shows an increase of over 400 per cent during the period 1995-1998. Individuals presenting with cocaine-related problems were more likely to be male than female. Of the forty-two who reported cocaine as a primary drug of misuse in 1997, thirty-seven were male and five female. The gender breakdown for 1998 is somewhat similar, with seventy-three males and thirteen females reporting cocaine as a main drug. For the year 1998, 72.5 per cent of clients presenting with cocaine as either a primary or secondary drug of misuse were male (O'Brien et al., 2000).

It is important to consider the figures for cocaine misuse in the context of overall drug treatment figures. Taking the 1998 figures as an example, out of a total of 1,625 first contacts nationally, the majority (904 individuals, or 55.7 per cent of

the total client group) reported heroin as their primary drug of misuse. This figure was followed by 24.8 per cent reporting cannabis, 7.4 per cent ecstasy, 2.5 per cent methadone, 2.3 per cent amphetamine and 2 per cent reporting cocaine as their main drug of misuse (O'Brien et al., 2000). Hence, individuals reporting cocaine-related drug problems constitute a relatively small proportion of the total number presenting for the first time with drug-related difficulties.

Looking then at the regional breakdown of reported cocaine-related problems among all contacts within each of the health board areas during 1997 and 1998 (see Table 3.4), we find that individuals reporting cocaine as either a primary or secondary drug of misuse are concentrated within particular health board regions.

TABLE 3.5
Ireland, 1990-1998.
Numbers of Drug-Related Deaths.

| Year | All Ages | Age 15-49 Years |
|------|----------|--------------------|
| 1990 | 7 | 7 |
| 1991 | 8 | 7 |
| 1992 | 14 | 14 |
| 1993 | 18 | 16 |
| 1994 | 19 | 19 |
| 1995 | 43 | 39 |
| 1996 | 53 | 50 |
| 1997 | 55 | 52 |
| 1998 | 99 | 90 |

Source: Central Statistics Office.

The largest number of contacts stating cocaine as a drug of misuse were resident in the Eastern Health Board region. This is hardly surprising given that the majority of treated contacts countrywide occur within this same region. The Southern Health Board and South Eastern Health Board areas had the next highest proportion of treated cocaine contacts in 1997 and 1998.

It is clear from the available figures that greater numbers of individuals than previously are presenting with cocaine-related difficulties. However, cocaine is clearly more likely to be a secondary than a primary drug of misuse. Individuals are less likely to present with cocaine-related difficulties, compared to other drug problems, most notably those related to the use of heroin, benzodiazepines, cannabis and ecstasy.

3.4.3 School-Going, College-Going and General Population Surveys

In Ireland, there is an absence of data, collected at regular intervals, on drug use among the general population and concerning specific groups, including young adults and adolescents. Furthermore, because differing methodologies have been utilised across available surveys, it is difficult to compare drug prevalence rates and establish accurate trends. This section will report on all available data pertaining to cocaine use in school-going, college-going and general populations.

Survey research in Ireland has concentrated primarily on studies of secondary-school students. Grube & Morgan's (1986) study of drug use by 13-16-year-olds in twenty-four randomly-selected schools in the greater Dublin area found a lifetime prevalence rate of 1.5 per cent for cocaine, with 0.7 per cent having used the drug during the month prior to completing the questionnaire. This figure is low compared to 13.2 per cent who had ever used cannabis and 12.9 per cent who reported the use of glue/solvents at some stage in their lifetime. Grube & Morgan's (1990) follow-up study revealed an increase of 0.2 per cent in the numbers reporting past month use of cocaine. Brinkley et al.'s (1999) more recent survey of rates and patterns of substance use among Dublin post-primary pupils did not report on cocaine use.

TABLE 3.6
Ireland 1994-1998. Psychiatric Hospital Admissions
with Diagnosis of Cocaine Use (ICD 10/F14)

| Year | All Ages |
|------|----------|
| 1994 | 10 |
| 1995 | 7 |
| 1996 | 8 |
| 1997 | 5 |
| 1998 | 9 |

The most recently-published national study of drug use by adolescents, carried out in 1999 as part of the European Schools Project on Alcohol and Drugs (ESPAD), found that 2 per cent of students aged 15 and 16 years reported lifetime experience of cocaine (Hibell et al., 2000). This figure is identical to that recorded in the 1995 national survey (Hibell et al., 1997). The figures for lifetime use of crack - 3 per cent in 1995 and 2 per cent in 1997 - are surprisingly high, given that reported use of crack is generally considerably lower than that for cocaine among adolescents. For example, the 1998 British Crime Survey revealed that while 3 per cent of 16-19-year-olds reported lifetime use of cocaine, only 1 per cent reported the use of crack (Ramsay & Partridge, 1999).

As with other drugs, including cannabis, ecstasy and amphetamine, regional surveys outside Dublin suggest somewhat lower cocaine prevalence rates than those reported in Dublin samples. A survey of post-primary school students in the Mid-Western Health Board region found that 1.3 per cent reported lifetime use of cocaine and 0.4 per cent were current users of the drug (Gleeson, Kelleher, Houghton, Feeney & Dempsey, 1998). Jackson's (1997) survey of drug use in Cork and Kerry revealed a lifetime prevalence rate of 1 per cent for cocaine. A much smaller proportion (0.1%) reported current use of the drug.

The figures above concur with findings related to school-going populations in the United Kingdom (Barnard, Forsyth & McKeganey, 1996; Balding, 1998) and suggest that cocaine use is relatively low among adolescents, certainly compared to other drugs and alcohol. **TABLE 3.7**
Ireland 1994-1998: HIBEL figures for Hospital Discharges with Principal and Secondary Cocaine-Related Diagnoses
 of Irish adolescents reporting lifetime experience and use of cocaine during the past two decades.

| | 1994 | 1995 | 1996 | 1997 | 1998 |
|--|------|------|------|------|------|
| Cocaine Dependence (ICD 304.2) | 2 | 6 | 3 | 5 | 3 |
| Non-Dependent Drug Abuse (Cocaine) (ICD 305.6) | 5 | 20 | 9 | 11 | 19 |
| Accidental Poisoning (Cocaine) (E855.2) | 0 | 5 | 4 | 10 | 4 |

Few national surveys of drug use prevalence have been undertaken in Ireland. A survey carried out in 1998 by the Health Promotion Unit of the Department of Health and Children and the Centre for Health Promotion Studies, National University of Ireland (NUI), Galway, examined the lifestyle, attitudes and nutritional status of people in Ireland. Cocaine use during the twelve months prior to the completion of the questionnaire was reported by 1 per cent of respondents (Friel, NicGabhainn & Kelleher, personal communication). This is consistent with findings in the United Kingdom, where cocaine use remains at low levels of around 1 per cent or less of adult populations (Baker & Marsden, 1994).

In summary, although surveys suggest that drug use is increasingly a feature of youth culture (Hibell et al., 1997; Brinkley et al., 1999; Hibell et al., 2000), cocaine use remains rare among school-going adolescents and has shown little sign of an increase during the past two decades. Lifetime prevalence among the general population is currently running at approximately 1 per cent.

3.4.4 Morbidity and Mortality

Both morbidity and mortality statistics are of limited value in the estimation of drug use and drug problems in general (Garretsen & Toet, 1992). However, available data relating to morbidity and mortality are presented as an indicator of the extent to which cocaine is implicated in death or illness.

Mortality statistics are based on death certificates, which usually contain information on socio-demographic variables and on the cause(s) of death. Throughout the 1990s there has been a marked increase in the number of drug-related deaths throughout Europe. This upward trend appears to be more pronounced in Ireland than in other European countries (EMCDDA, 1999). The numbers of deaths where drugs were the direct cause of death, during the period 1990-1998, are presented in Table 3.5 and reveal a dramatic increase in drug-related deaths during the 1990s.

A recent analysis of drug-related deaths investigated by the Dublin City and County Coroners in 1998 and 1999 (Byrne, 2000) reveals that cocaine was implicated in six out of a total of eighty-six opiate-related deaths in 1998 and six cases out of seventy-seven in 1999. Only in one of the 1998 cases, however, was

death attributed directly to cocaine overdose, with five of the six cases having two or more drugs implicated in addition to cocaine. Heroin was implicated in all six of the cocaine-related deaths in 1999 and the quantity of heroin revealed in toxicology tests was higher than that for cocaine (Byrne, 2000).

Hospital psychiatric data are available from the National Psychiatric In-Patient Reporting System (NPIRS), which collects data on admissions and discharges from public and private psychiatric hospitals and units countrywide. It provides information on gender, age, marital status, socio-economic status, legal status, diagnosis and length of stay (O'Brien & Moran, 1997). Despite considerable debate about the potential of some illicit substances to cause psychiatric problems, as well as the role of pre-existing psychiatric conditions in the development of drug problems, co-morbidity remains a major concern as elevated levels of drug consumption are found among those with mental health problems (Commission on Narcotic Drugs, 2000). The figures for admissions to psychiatric hospitals with a diagnosis of cocaine use (ICD-10/F14)¹ during the period 1994-1998 are presented in Table 3.6.

¹ As defined by The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines, of the World Health Organisation (1992).

The Hospital In-Patient Enquiry (HIPE) Scheme, operated by the Economic and Social Research Institute, is a system designed to collect medical and administrative data regarding discharges from acute hospitals. Information from private hospitals is not included in this database. One difficulty with these data is that each HIPE discharge represents one episode of care. As a result, double-counting may occur where patients have been admitted to hospital on more than one occasion with the same or different diagnoses. Consequently, these records provide a better indicator of hospital activity than of the incidence of disease. Data relating to principal and secondary diagnoses of cocaine-related discharges are provided in Table 3.7 below.

TABLE 3.8
Face-to-Face Interviews

| Individual Interviews | Number of Interviews |
|-------------------------|----------------------|
| Drug Service Staff | 5 |
| Youth Worker | 1 |
| Youth Work Co-Ordinator | 1 |
| Key Informants | 2 |
| Garda | 1 |
| Total | 15 |

TABLE 3.9
Telephone Interviews

| Telephone Interviews | Number of Interviews |
|---------------------------------|----------------------|
| Student Welfare Service | 2 |
| Youth Workers | 2 |
| Project Worker s (Young People) | 2 |
| Drug Service Staff | 2 |
| Liaison Midwife | 1 |
| Prison Staff | 1 |
| Total | 15 |

The figure recorded for the diagnosis of General Epilepsy (ICD 304.2) have remained relatively stable during the period 1995-1998. Those for non-drug abuse (cocaine), on the other hand, have tended to rise slightly albeit from a low base.

Accepting that mortality and morbidity data are not reliable tools for estimating drug use or drug problems, they can, in association with other data sources, help to improve the interpretation of available information. Cocaine is implicated in relatively few deaths, certainly when compared to heroin. Admissions to psychiatric hospitals with a diagnosis of cocaine use indicate no clear upward trend since 1994.

**3.4.5 Qualitative and Ethnographic Research
Issues Addressed During Face-to-Face and Telephone Interviews.**

| Interviewees | Issues Addressed |
|---|---|
| Drug Service Staff | Numbers presenting with cocaine-related difficulties (stable, increase, decrease) / Evidence of crack cocaine? / Cocaine as a primary drug of misuse? / Treatment needs of cocaine users / Implications for treatment and service provision. |
| Key Informants* | Who is using cocaine (age group/background/SES)? / Availability, cost and purity? / Is cocaine more accessible than previously? / In what kinds of settings is use taking place? / Patterns of use (regular/recreational/occasional etc.)? |
| Gardaí | Drug seizures and arrests: have the figures for cocaine changed dramatically in recent years? / Any indicators of increased availability of cocaine at street-level? / If yes, how have the Gardaí responded to this 'new' development? |
| Youth Workers (within 'high risk' localities) | Is there evidence of increased use of cocaine among young people? / Any evidence to suggest that cocaine is easier to access and/or more affordable than previously? / What are the dominant perceptions of the 'risks' associated with cocaine use? / Are youth workers adequately equipped to respond to current drug use trends? |
| Night-Club Owners | Which drugs are most visible/available on the club/dance scene? / Any evidence of cocaine use? / If so, when did this come to your attention? / Is cocaine more easily available than previously? / Cost and accessibility? |
| General Practitioners | Numbers presenting with cocaine-related difficulties (stable, increase, decrease) / Evidence of crack cocaine/ cocaine as a primary drug of misuse / Treatment needs of cocaine users / Implications for treatment and service provision. |
| Hospital Personnel | Any evidence of cocaine emerging as a drug of choice? / Accident and emergency admissions? |

** Key informants are individuals who have experience of and contact with the drug scene and are considered to have knowledge and insights that may contribute significantly to the data collected from other sources.*

Qualitative methodologies are particularly suited to accessing hidden drug scenes (Wiebel, 1990). An additional advantage of qualitative research in the drugs research field is that it provides detailed knowledge about types and levels of drug involvement as well as important details pertaining to the lifestyles, attitudes and motives of drug users. However, only a small number

of such studies have been conducted in an Irish context. Mayock (2000) investigated drug use and non-use among a sample of fifty-seven young people, aged between 15 and 19 years, including abstainers, drugtakers and problem drugtakers, in an inner-city Dublin community. In this study, very few of the young people described as drugtakers (drug users who did not consider their drug use to be problematic) reported the use of cocaine at any time, and of those who did (n=2), it was generally a one-time experience. Cocaine use was far more prevalent among problem drugtakers (young people who considered their drug use to be problematic). All of the young people in this 'problem drugtaker' category (n=18) reported heroin as their primary drug of misuse. The vast majority (n=14) also reported lifetime use of cocaine and nearly 20 per cent reported cocaine use during the week prior to interview. In general, cocaine use occurred subsequent to heroin initiation and was frequently used in conjunction with heroin and other drugs (mainly benzodiazepines). Most users of the drug reported the intravenous use of heroin and cocaine, a drug cocktail known as 'speedballs'. The reports below provide some insight into the nature of this group's cocaine involvement.

Interviewer: *When did you start using cocaine?*

Respondent: *Am, there was a big drought on and everyone was just, there was no heroin, so everyone was taking coke. I was taking tablets like for me sickness, I was going round stupefied on tablets, d'ya know what I mean, and then the coke just ... everyone just got strung out on coke.*
(Female, 18.1 years)

Interviewer: *Did you use coke when you were on gear?*

Respondent: *Yeah, used to mix it. Used to wash up the coke into the drugs, like cook the gear into the works, bung the two of them into me together. Then I would be gettin' a buzz like off the coke and then when I'm coming down off the coke the gear would bring me down nice.*
(Male, 19.1 years)

Finally, McElrath & McEvoy's (2000) qualitative study of ecstasy users in Northern Ireland revealed that 43 per cent of respondents had tried cocaine powder. The mean age of the sample (n=106) was 25 years (range 17 to 45 years). Cocaine use appeared to be sporadic, not regular, and only one respondent reported snorting cocaine on a monthly basis during the six months prior to the

interview. This finding suggests that cocaine was one of numerous drugs tried or used by this group of young recreational poly-drug users.

3.4.6 Conclusion

The question of how many people are using illicit drugs is notoriously difficult to answer. The dearth of regular prevalence studies at both national and local levels, using uniform or comparable methodologies, compounds this problem. However, the difficulties associated with establishing accurate and reliable drug-use prevalence estimates is not just about the absence or paucity of relevant survey data. The illegality of drug use ensures that the activity is undertaken inconspicuously and that many drug users remain hidden. The best way, in the present situation, to assess the extent of particular forms of drug use is to utilise all available data from a wide range of sources (Choquet & Ledoux, 1990; Hay, 1998).

Accepting that available sources such as survey and other empirical data can produce, at best, imperfect approximations, there are a number of conclusions that can be drawn from the data presented above. First, there is some evidence to suggest an increase in the supply of and demand for cocaine. Extensive use of the drug, however, is not apparent among the general population. While there is a general upward trend in drug experimentation among school-going teenagers, cocaine is far less likely to be used than cannabis, ecstasy, LSD and amphetamine. Among adult population samples, use appears to be restricted to a minority. The difficulty with these findings, however, is that they fail to uncover substantial knowledge about individuals who do use cocaine.

At the other end of the drugs spectrum are individuals who develop drug problems. Many, though not all, are known to drug treatment services. While heroin remains the primary drug of misuse among drug users who seek treatment, available figures suggest that cocaine is currently more likely to be cited as a secondary drug of misuse. Irish drug treatment data indicate that cocaine is rarely clients' primary problem. Yet, there is evidence to suggest that the drug repertoires of long-term 'problem' drug users have extended to include a larger and more diverse range of substances including, among others, benzodiazepines and cocaine (Farrell, Gerada & Marsden, 2000; Rooney, Kelly, Bamford, Sloan & O'Connor, 1999). However, while cocaine is clearly available and increasingly likely to be used, it is clearly less endemic, certainly compared to heroin, benzodiazepines, cannabis and ecstasy.

3.5 Views of Service Providers and Key Informants on the Cocaine 'Problem'

As stated earlier, this component of the research was concerned with accessing current perceptions of the extent and nature of the cocaine 'problem', from the perspectives of individuals working, or in regular contact, with drug users. The value of this data relates to its potential to report on current and 'new' developments on the ground. Tables 3.8 and 3.9 provide a breakdown of the number and range of individuals interviewed face-to-face and by telephone.

Efforts were made to incorporate a cross-section of respondents, in terms of the nature of their experience of drug users and the drug scene. Table 3.10 summarises the issues addressed in the case of each 'subgroup' of interviewee. Separate interview schedules were designed for the respective 'subgroups' of study respondents where appropriate.

Interviewing took place during May 2000. Face-to-face interviews were tape-recorded and partial transcripts of this material prepared. Detailed notes were taken both during and after telephone interviews. The major issues and themes arising from these data are documented in this section. The presentation of findings concentrates on the key questions outlined in Table 3.10 and on other issues raised by informants in the interviews. For the purpose of clarity and structure, the findings are presented under three broad headings: cocaine availability, the extent and nature of cocaine use and implications for drug treatment and service provision.

3.5.1 Cocaine Availability

The majority of respondents believed that cocaine was more easily available than previously. Across the range of individuals interviewed, there was a definite consensus on increased accessibility and use of the drug. A spokesperson from the Garda National Drug Unit described the current situation vis-à-vis cocaine availability in the following terms.

We are quite aware that cocaine is being used and offered for sale, particularly in certain areas. If we look at the statistics in relation to cocaine for say 1998, that shows quite an amount of cocaine being seized. We have 333 kilos and 167 grams. This is a huge amount. Now some of that of course, came from major seizures. But, coke has become more popular. I would have no hesitation saying yes, it is more prevalent.

(Garda)

Several respondents involved in the delivery of drug treatment stated that they had become aware of an increase in the supply of cocaine within the areas where they worked, particularly during the past year.

You hear about it more and it's almost becoming a substitute drug for heroin. With the availability of methadone now people's need for heroin isn't so great.

(Drug Counsellor)

Similarly, many professionals working with young people in communities where drug use is concentrated drew attention to a shift in the local drugs market towards increased cocaine availability.

There is a strong sense that it's out there alright. I've no concrete evidence from the group we work with but a very strong sense that it's out there and available.

(Youth Work Co-Ordinator)

My impression is that during the past year or year-and-a-half there has been a lot of selling going on and a good bit of use. Yeah, it's definitely amongst problem drug users and I think that you'd probably find a good number of urines testing positive for cocaine.

(Youth Worker)

Other respondents highlighted the apparent decrease in the street price of cocaine and felt that this served as a further indicator of the changed nature of availability and use of the drug.

It would seem now at the moment that a half a gram can be as low as £25. A number of years ago it was £300 a gram. Now it is down to between £60 and £80 a gram. One thing that is noticeable is that the price varies depending on where you buy.

(Drugs Worker)

It is also significant that a number of individuals involved in the provision of methadone treatment reported a conspicuous upsurge in the proportion of urine samples revealing quantities of cocaine during the latter months of 1999 and the early months of 2000. Although this trend appears to have since abated, doubt was expressed, in some cases, about the validity of the assumption that a decrease in the percentage of urines revealing cocaine can be reliably viewed as an indicator of a downward trend in cocaine use among clients receiving treatment.

The prevalence rate (of cocaine in urines) would appear to be running at around 3 per cent of the known drug users, the ones in treatment. Again, I think that's probably coloured by the fact that cocaine is short-lived in the system. Drug users can very easily get around the system and continue to use cocaine. If say, somebody is clear of every other drug and they're on weekly take-outs it's not a big deal for them to make sure that they don't use two days before they come in to pick up their methadone. So how much of an indicator it is I don't know. There certainly was a peak in the three months of December, January and February but that seems to have gone down again. Now whether it is that it's been challenged and drug users are altering their behaviour or whether they've just managed to work the system, I don't know.

(Drugs Worker)

It is important to state that the perceived increase in cocaine availability and use was associated with particular geographical locations in the Dublin area, which, in the absence of more definitive evidence, will remain unidentified in this paper. However, the most likely localities to be mentioned included two specific areas associated with concentrations of known drug users. A range of respondents, including drug service providers, general practitioners and the Gardaí, drew attention to particular 'pockets' of high cocaine availability.

From the point of view of gaining insight into individuals in the community who do not identify themselves as drug users per se, interviews were conducted with a number of key informants with knowledge of, and/or contact with, the recreational drug scene. These respondents indicated that cocaine was currently more visible on the club/dance/drug scene than previously. It was also suggested that this trend was accompanied by increased acceptance of cocaine as a drug of choice.

I'm not into cocaine myself and I don't really hang out with people who are, ya know, but I know of people who are. I know it's become a usual thing for lots of people. It's just a natural normal thing that they do. There's definitely some people who get more into it and prefer to do coke and there's also that thing where it's seen as a slightly, you know, more prestigious. Coke has always been seen as a middle class drug; for people who have money essentially. You can link it directly in this country to the economic situation. People have more money, they're more affluent and cocaine is a more affluent drug.

(Key Informant # 1)

The majority of respondents stated that there was little evidence to suggest that crack cocaine was making a breakthrough on the drug scene. However, one interview with an ex-cocaine dealer and former crack cocaine addict suggested some use of 'home-made' crack cocaine among particular networks of drug users. This respondent described himself as 'in recovery' at the time of interview, having previously had a chronic cocaine and heroin problem. He stated that he had been involved in the distribution of cocaine, both within and outside of the Dublin area, for several years.

I went as far as South Dublin and out of Dublin to deal. I would travel, yeah. And people would travel from everywhere ta me or else, if they couldn't make it I'd make me way out ta them. Inner-city, apartments as well, ya know, well-ta-do people ... everywhere ... this would be sellin' cocaine. On most occasions I would have ta wash it

up for them, turn it into crack for them like. Very few would actually just, very few people I actually dealt with were buying it ta snort, they were buying crack.

[But people say that there's no crack around?]

I hear this, and I've said it to [name of friend], and it actually makes me blood boil 'cos there's a big problem out there like and it's like, look at heroin in the 80s. It was actually around before then but no, it's nothing, it's only a handful of people, that's what they said. And look at it now! And there's as much coke out there now as heroin. It's so easy to get, ya know.

(Key Informant # 2)

Overall, the data points to increased awareness of the presence of cocaine, its availability on the street, and its potential to become a drug of choice for both recreational and problematic drug users.

3.5.2 Nature and Extent of Cocaine Use

The identification of drug use patterns at local level is difficult to quantify and requires specialist research (Parker et al., 1998). Hence, the aim here is not to advance evidence on the extent of cocaine use generally or among particular sub-groups of the population. Rather, the emphasis is on documenting perceptions of what is occurring on the ground, based on the reports of individuals who have regular contact with drug users.

A conspicuous feature of informants' reports was that despite the general belief concerning increased cocaine availability, many simultaneously felt that they had no concrete evidence of cocaine's emergence as a major issue, certainly compared to heroin and other drug use. In particular, respondents felt unable to estimate the extent of cocaine use in the communities where they worked. There appeared to be a number of important factors associated with this absence of clear evidence or knowledge of cocaine's 'position' or status as a drug of use. First, respondents felt that cocaine use was extremely hidden and consequently, unlikely to come to their attention. Secondly, according to a large number of interviewees, cocaine users are unlikely to perceive their drug use as problematic and accordingly, are unlikely to seek treatment or advice of any kind in relation to their cocaine consumption.

I'm not sure that this area is awash with cocaine but what I would have a sense of is that the ones who are using cocaine are not in touch with services because they don't really see themselves as having a problem.

(Drugs Worker)

You see, young people wouldn't seek treatment around that. Young people do come forward for treatment but it's mostly for heroin. They wouldn't see their use of cocaine as something they can get help for, or that they need help for.

(Youth Worker)

The picture that I'm getting is that the young people who start using coke don't see themselves as having a drug problem because they're not on heroin. So, heroin is still the biggie in people's perceptions and by taking coke you're avoiding having a drug problem.

(Drug Counsellor)

However, a number of professionals working in the delivery of drug treatment at community-level did report direct experience and evidence of cocaine use and considered this development to be a recent one. All stated that users were far more likely to be smoking or injecting cocaine than using the drug intranasally.

Although most of the people who access this service have an opiate problem, I have had contact with cocaine users. One person I'm thinking of now started using on holidays overseas and later developed a dependency.

(Drug Counsellor)

I think it (cocaine) is a serious problem, it's been a serious problem for quite a while. There's a lot of it going around in the flats. And we have an ongoing struggle with people on treatment who might be doing fairly okay as regards the heroin but dabbling or more than dabbling with cocaine.

(Drug Service Coordinator)

Two respondents made specific reference to cocaine use among women. This is particularly noteworthy in view of the findings of a recent study of drug-using women working in prostitution in Dublin city (O'Neill & O'Connor, 1999). Of the seventy-seven women interviewed for the purpose of the research, forty reported use of cocaine in the previous month. Following heroin and benzodiazepines, cocaine emerged as the next likely drug to be used.

Most of the clients who report cocaine use to me are women. And all of them say that it's very difficult to get off the drug, more difficult than heroin. These women would also be working on the street and there seems to be a link between the two.

(Drug Counsellor)

Despite several examples of reports of cocaine use by clients, the dominant concern among respondents involved in the delivery of drug treatment remains firmly on problems related to heroin use. There was general agreement, however, that cocaine was far more likely than previously to be a secondary drug of misuse. Many respondents made reference to the practice of 'speedballing', which involves the simultaneous intravenous use of cocaine and heroin. This practice was described by one of the study's key informants (a former heroin addict) in the following terms:

What I did then was I made speedballs. Ya know what a speedball is? Ya put your heroin on the spoon and cook it up, have your coke in the works, ya suck it up. The effects ya get from that! You're straight up in the air, like your head feels like it's goin' to go 'bump'. It's a great feelin'! And then ya sorta come down then nice and easy. It's the sorta feelin' (pause), it's unbelievable. It'd frighten ya at first 'cos ya think you'll die but this feelin' ya get from it it's, ya know, it takes all the pain away and all this shit, that's what it's there for at the end of the day.

(Key Informant # 2)

Several respondents acknowledged that 'speedballing' was a common practice and a number drew attention to the health implications of injecting risk behaviour.

What we would find here is that most people are speedballing, they're using a combination of heroin and cocaine together. So, in terms of harm reduction and looking at issues around health, the same difficulties will arise if people are using needles and injecting cocaine.

(Drugs Worker)

Furthermore, respondents consistently drew attention to dominant risk perceptions and felt that drug users were unlikely to perceive cocaine use as posing serious health risks, certainly compared to those associated with heroin. There is an implicit danger here, if, as perceived, cocaine is increasingly gaining acceptance and is more commonly in use.

I think the preference here [at the service] among drug users has been for the type of effects that heroin gives. Cocaine would not be seen by most of them as abuse. It would be seen as recreational. They don't see it as such a problem.

(Drugs Worker)

Heroin, as I said before, has that dirty, filthy, low-life thing and all of that, even though it hits all walks of life. Cocaine is looked at, 'ah, it's alright, it's only a line a coke'

(Key Informant)

I think that the dominant perception is that cocaine is primarily a recreational drug, just as hash is understood as a recreational drug. The effects aren't as dramatic or rapid. And this is a problem too because I would certainly meet people who have serious problems with cocaine.

(Drug Counsellor)

It is important to point out that not all of the respondents reported concern about cocaine use among their client group. This is important since it suggests that particular settings and services may be more likely than others to attract cocaine users. A number of respondents stressed that opiates and benzodiazepines remained their overwhelming concern.

We have heroin problems and all sorts of other problems, tablets and all that. But from my point of view, and this is just an overview, we don't get cocaine coming up as a major issue. And it seems to me that there's a couple of angles on that, if we generally accept that heroin is the drug of choice. People will dabble with cocaine, but that's it, they'll dabble but they'll revert to heroin. So, cocaine might be cheap on the streets, they might go for that for a while, it may become problematic with them but they quickly get out of it and back almost to the safety of heroin, the known substance, the known area like.

(Drugs Worker)

Finally, while concern was expressed by the majority of respondents about an apparent increase in the availability and use of cocaine, the problem was not considered to have reached epidemic proportions, as yet, or to merit being perceived as 'out of control'. One informant, who previously worked with cocaine and crack cocaine users in London, drew a clear line of distinction between the situation in Dublin and that which prevailed in London a number of years ago, particularly in terms of service needs and responses.

A serious crack problem developed and all of a sudden agencies were inundated with these people and nobody could relate to them. And we had to do a lot of training to adjust to dealing with these people because it was totally different. The way you'd

approach a heroin user, you wouldn't approach a crack user like that. But we're not getting that here.

(Drugs Worker)

To summarise, cocaine use was judged to be far more widespread than previously. However, respondents found it difficult to estimate the scale or extent of use among their client groups, or in the community at large. While the majority felt that the cocaine 'problem' was not comparable to that relating to heroin, they identified cocaine use as an issue requiring attention also.

3.5.3 Implications for Drug Treatment and Service Provision

Interviewees engaged in the provision of services to drug users were asked whether the needs of cocaine users can be adequately met within the context of existing treatment interventions. Considerable variation emerged among this group on the appropriate way to address cocaine use in the context of existing services. While some respondents felt that specific tailor-made interventions were required to deal with the needs of cocaine users, others believed that current services needed to develop the knowledge and expertise required to deliver appropriate intervention and counselling. Some respondents stated that their agencies had already attempted to address the issue informally.

I would say that there is a need for separate interventions. It's a separate drug, a separate addiction, one which can't be treated like heroin. If the two drugs are lumped in together, then it follows that they're going to be used together. If cocaine users are in a methadone clinic they're bound to pick up the habits that are all around them.

(Drugs Worker)

I do think it's a different kind of problem and one of the reasons it's different is that there doesn't seem to be the same physical withdrawal difficulties but there is an enormous psychological withdrawal and psychological cravings. So what we've done here is supported the person as best we could, get them into counselling and we would also have treated them with acupuncture.

(Project Worker)

I think that as an agency we've already started to change our approach, even in thinking what services can offer somebody who might have a dependency on cocaine. There's no medical treatment so we have been looking at some level, looking at ways that we can provide appropriately as a service.

(Drug Counsellor)

More critical perhaps than the lack of agreement on appropriate interventions was the fact that several interviewees involved in drug treatment delivery felt ill-informed and ill-equipped to deal with the presenting behaviours and problems of cocaine users. In addition, a number of respondents drew attention to the absence of information on cocaine use and related risk behaviours at community level.

They've [drug users] had more information, more education on heroin so maybe they haven't had enough information about cocaine. Initially, they don't have a fear of cocaine because they would believe that it isn't addictive.

(Drug Service Co-ordinator)

Prevailing perceptions of the risks associated with cocaine use were considered to be a compounding factor. One informant stressed the importance of contextualising current perceptions of drug-related risk when attempting to alter behaviour and beliefs about cocaine.

It's largely a methadone culture and that's the context I'm speaking in. And methadone is perceived as the solution to the problem. And for people who are seriously dependent on cocaine and want help, the belief is that methadone is the solution for them as well and therefore, they want methadone treatment. That's the perception in the community. So we would have had to be quite strong in helping people to understand that it's a totally different drug and that there's absolutely no point putting the person on methadone, that you're actually introducing them to opiates. But this is all understandable in the context of a strong heroin and methadone culture.

(Drugs Worker)

Most respondents agreed that there was a need for more information and training on the effects of cocaine, the presenting behaviours of cocaine users and appropriate treatment and intervention options.

3.5.4 Conclusion

Using existing data systems, including available data on drug users, Section 3.4 found that opiates remain the primary drugs of misuse among drug users who access treatment. Despite this, subtle indicators of a shift in the drugs landscape were apparent, suggesting increased likelihood of cocaine use among individuals whose main drug of misuse was heroin. The reports of drugs workers confirm this trend. A large number stated that clients are now more

likely to present with cocaine-related problems and the majority felt strongly that cocaine was more readily available and accessible than previously. The risk of 'microdiffusion', that is, the dispersal of drugs knowledge, practices and techniques through established user networks (Parker et al., 1998), may be substantial if, as indicated, cocaine is making a breakthrough on the drug scene. Further research is required to qualify and quantify a possible spread of cocaine use among problem drug users. In particular, the nature of the relationship between heroin and cocaine, one known to be complex (Bottomley, Carnwath, Jeacock, Wibberley & Smith, 1997), requires investigation. Qualitative research is likely to be the most feasible means of accessing these 'heavy-end' and hidden drug scenes (Brian, Parker & Bottomley, 1998a). Preferred routes of cocaine administration and related risk behaviours need particular attention in this context. Blanken & Barendregt (1997) note that the Dutch cocaine smoking epidemic was restricted mainly to heroin-dependent persons. Furthermore, Grund, Adriaans & Kaplan's (1991) investigation of cocaine use in a sample of heroin addicts in Rotterdam found that the mode of ingestion paralleled that of heroin: injecting drug users injected cocaine-hydrochloride and heroin smokers smoked cocaine base. The authors documented the distribution of 'gekookte coke', otherwise known as 'cooked', 'base' or 'rock' cocaine, by a particular sub-population of drug users. The preparatory process is identical to that described by one of the current study's key informants, a former user and supplier of 'homemade' crack cocaine.

Well, basically all ya do is (pause) ya can add ammonia. That's a lazy way ta do it. I call it the lazy man's way a doin' it. Ya put your coke on the spoon, your gram a coke or whatever ya have on the spoon, ya pour a dribble of ammonia over it, light a flame underneath it. It's like cookin' heroin. It bubbles like fuck and it goes into sort of an oil and ya leave it cool or else ya can drain it off. Ya rinse it with cold water then, ya don't heat it up again, ya just rinse it with water 'cos if ya do that it'll just dissolve into ... And then ya take it off. And ya know a hash pipe? Like a seven-up bottle or something. Instead of using tobacco ya use the ash off the cigarette. It has ta be fresh ash. So like you'd have one ashtray for cigarettes, for puttin' out your cigarette. You'd have cigarettes burning everywhere but ya wouldn't put the cork out on it 'cos ya want the ash. Ya just break bits a lump off it and whatever and (inhales) ya smoke it and ya get your couple a seconds hit.

(Key Informant # 2)

At present, there is no way of establishing either how widespread the practice of 'cooking' (or 'rocking') cocaine is, or how prevalent this technique is among drug

users. However, problem opiate users are far more likely to be injecting or smoking than to be snorting cocaine (Grund, Adriaans & Kaplan, 1991). Research is required to explore dominant and preferred patterns of cocaine use among both treatment and community samples of heroin users. Brian et al.'s (1998a) follow-up investigation of continuity and change in crack cocaine users' drug careers in north-west England found that, owing to crack's negative image, dealers sold it as 'rock' or 'stone', particularly to new, younger users. Knowledge about the marketing of cocaine, including users' accounts of initial points of contact with the drug, and acquired (or recommended) techniques of use, would greatly assist targeted strategies, including advice on harm minimisation, particularly to 'high-risk' young drug users.

Finally, the treatment needs of individuals who co-abuse opiates and other substances require attention. Rooney et al. (1999), comparing Irish drug users who are dependent on opiates and benzodiazepines with drug users who are not dependent on benzodiazepines, found that the former group tended to take more drugs in general. Thirty-five per cent of those dependent on opiates and benzodiazepines used cocaine, compared to 13.8 per cent of the opiate users not dependent on benzodiazepines. More recently, Farrell et al. (2000) analysed the results of urine tests for opiates, benzodiazepines and tricyclics carried out in five addiction clinics across the Eastern Health Board area and found that 65 per cent tested positive for benzodiazepines. The authors conclude that this high rate of positivity indicates 'a major problem of poly drug misuse which requires urgent and concerted attention' (Farrell et al., 2000: 8). Further confirmation of extensive poly-drug use among heroin users can be found in Byrne's (2001) analysis of 254 opiate-related deaths investigated by the Dublin City and County Coroners in 1998, 1999 and 2000. This research identified poly-drug use as a major risk factor associated with fatal drug overdose. A single drug was implicated in only a minority (6.7%) of fatalities, with heroin implicated in 61.8 per cent, benzodiazepines in 70.5 per cent, methadone in 56.7 per cent and cocaine in 6 per cent of cases.

Despite considerable evidence indicating poly-drug use, including cocaine use, among individuals who seek treatment for heroin-related problems, relatively little is known about the nature of combination or poly-drug-using careers. This represents a significant gap in knowledge, given the likely range of treatment challenges arising from the current tendency, across Europe, for heroin users to become poly-drug users (Brian, Parker & Bottomley, 1998b). Bottomley et al. (1997) note that, in general, research has provided little guidance as to how drug

services can help problematic cocaine users, or, for that matter, how this group of users might be attracted to services. Reporting on the findings of a community survey of cocaine users, the majority of whom reported an opiate-using history, the authors recommend a service response combining the medical treatments offered by community drug teams with an accessible drop-in service and an outreach initiative of peer education, as an appropriate intervention for crack cocaine users.

Drugs workers and service providers in the current study expressed concern about increased availability and use of cocaine among their client groups. However, it also seems clear that some services are currently more likely than others to be treating clients who report the use of cocaine. Consequently, the lack of consensus on appropriate treatment and intervention responses to cocaine use is not altogether surprising. More critical perhaps, is the fact that drug workers felt that they lacked adequate knowledge and understanding of cocaine use among their client groups, including information on dominant user practices and the effects, risks and health consequences associated with the co-abuse of heroin and cocaine.

3.6 Exploratory Study of Social/Recreational Cocaine Use

Population surveys in Ireland identify few cocaine users. However, anecdotal evidence suggests that cocaine is easily available and its use more widespread than previously was the case. In this exploratory study of social/recreational cocaine use, the research challenge was to locate and gain the co-operation of a small number of adult cocaine users in the community, who are not currently attending, and who have at no stage contacted, a drug treatment centre. In other words, the emphasis was on accessing individuals who do not identify themselves as having a drug problem. The principal aim was to 'capture' users not normally accessible through treatment or other institutional settings and to examine patterns of use and attitudes to cocaine.

3.6.1 Study Parameters, Research Instruments and the Recruitment Process

The study's selection criteria, in terms of past and current cocaine use, was deliberately broad. No strict or binding guidelines pertaining to precise levels of drug intake were applied at the outset of the selection procedure, owing to the

absence of prior empirical research on cocaine use in an Irish context. However, to qualify for participation in the study, respondents had to have used cocaine at least five times during their lifetime, preferably at least once during the past year. Other criteria for entry to the study, in addition to some experience with cocaine, were that participants must be 21 years of age or older and must have been employed for at least six of the twelve months prior to interview.

The purpose of the research was not to ascertain how many people use cocaine, but rather to gain some insight into reported patterns of cocaine use among a small group of social users. Hence, the central concern was not one of generalisability but one of access. In this context, the guiding principle was 'less is more' (McCracken, 1988:17). McCracken (1988), who describes the key characteristics of the long interview, recommends working longer and with greater care with a small number of people, and suggests that eight respondents are sufficient for many research projects.

The research aimed to generate knowledge and insight into cocaine use by adults not associated in problematic drug consumption, a phenomenon not previously researched in an Irish context. Ten adult cocaine users were interviewed in-depth during May/June 2000. The questions addressed in the context of individual interviews included how users first came into contact with cocaine, how their use progressed from the time of initial use, past and current cocaine use, how they regulated their intake of the drug, typical cocaine-using contexts, availability, cost and quality of cocaine, the benefits of cocaine, perceptions of risks associated with use, and the appeal of cocaine. Importantly, the research examined respondents' use of a range of mood-altering substances, so that cocaine was not examined in isolation from other drug use.

Study respondents were accessed initially via the researcher's personal contacts with potential participants. This gradually facilitated access to other individuals through 'snowballing', whereby, additional respondents were recruited through the recommendations of individuals previously interviewed. This technique is well-known in the drugs research field and is particularly suited to investigations of illicit and hidden activities (Birnacki & Waldorf, 1981; Power, 1989).

In an effort to access a range of cocaine-related experiences, attempts were made to contact a variety of user networks. The recruitment task proved more difficult than originally anticipated, particularly during the early stages of establishing

contact with cocaine users. Prospective participants were sceptical about the intentions of the research and understandably reluctant to divulge details about their drug use. They invariably asked questions about the purpose of the study and about the publication of study findings. The challenges to recruitment were overcome by gradually extending access routes and by providing assurances of anonymity and confidentiality. The recommendations of key informants (individuals who had contact with cocaine users) greatly facilitated this process. The time invested in the selection of participants resulted in six user networks across the sample. All interviews were tape-recorded. Choice as to the time and place of the interview rested with the participant. Interviews took place in a variety of settings including the researcher's office (n=1) or home (n=1), a public venue (n=3) or at the home of the respondent (n=5).

Biographical details and drug history were recorded for each respondent using a pre-coded, structured questionnaire. This included details of each respondent's age, gender, education, employment, household situation and current income. Lifetime, past month and past week drug use, as well as future drug intentions, were recorded for each individual participant. All respondents resided in Dublin city. The study does not claim to be representative of social/recreational cocaine users generally. Rather, it is illustrative of a 'mode' of cocaine involvement among adults who do not consider their drug use to be problematic.

TABLE 3.11.

Lifetime, Recent and Future Use of Cocaine and Other Drugs (n=10).

The protection of informants' identities was a priority throughout the research. No names, addresses or contact numbers were recorded on the pre-coded questionnaires. In addition, all identifiers (place names, birth place, current area of residence and so on) were removed from transcript material and fictitious names substituted in all cases for the purpose of reporting the study findings.

| Drug | Lifetime Use | Past Month Use | Past Week Use | Future Drug Use* |
|-----------------------------|--------------|----------------|---------------|------------------|
| LSD | 10 | 1 | 1 | 2 |
| Amphetamine | 10 | 0 | 0 | 1 |
| Cocaine | 10 | 8 | 4 | 9 |
| Heroin | 3 | 0 | 0 | 0 |
| Methadone | 2 | 0 | 0 | 0 |
| Magic Mushrooms/ Psilocybin | 0 | 0 | 0 | 3 |
| Other | 2 | 0 | 0 | 0 |

* Respondents were asked to state which drugs they intended to use in the future.

A theme is a pattern found in the information that at a minimum describes and organises the possible observations and at a maximum interprets aspects of the phenomenon.

(Boyatzis, 1998: 4)

In other words, a theme is not merely a 'fact' or set of facts extracted from the data but a pattern that presents itself throughout a data set. Themes provide a useful interpretative structure for understanding the phenomenon of interest. The data were coded manually in accordance with the research aims, and ancillary codes were added as the fieldwork process advanced. In this way, the analysis incorporated both predefined categories and those that emerged directly from respondents' accounts of their cocaine use.

Interpretation of the results has to be qualified by a number of study limitations. First, the research is based solely on self-reports of frequency and quantity of drug consumption of a small number of informants, all of whom were resident in Dublin city at the time of interview. Second, the sample was opportunistic or one of convenience. Accordingly, it would be inappropriate to generalise the findings to cocaine-using adults generally.

A number of techniques were employed throughout the data collection and analysis phases of the research to ensure valid and reliable findings. The safeguards concerning confidentiality and anonymity help to validate the responses. Moreover, the questioning and data collection techniques employed meant that the consistency of cocaine and other drug use reported by respondents could be checked. All respondents were asked about their drug use (lifetime, past month and past week use) on two separate occasions during the interview. This data were also recorded on a questionnaire. One hundred per cent consistency was found in respondents' reports in nearly all cases.

The presentation of research findings focuses, first, on the socio-demographic characteristics of study respondents. Baseline data on cocaine and other drug use are then presented. The analysis moves then to present a more detailed description of respondents' use of cocaine, including the circumstances surrounding use, the appeal of cocaine, the negative effects and perceived benefits of cocaine use and risk perceptions. The issues of availability, price and purity are also examined.

3.6.3 Socio-Demographic Characteristics

Eight males and two females were interviewed individually. The average age of the research respondents was 27.3 years (range 25-29 years). Nine of the ten interviewees were born in Ireland. One was born in the United Kingdom but had been residing in Ireland for several years.

The educational attainment for the sample was high. All had completed their Leaving Certificate or equivalent and all attended a third-level educational institution. Eight of the ten respondents graduated with a third-level degree or diploma. At the time of the interview, eight were employed full-time and two part-time. All had experienced periods of unemployment ranging from two months to six years. It is significant, however, that in most cases, stated periods of unemployment coincided with time spent travelling abroad and extended for between one and two years. Two respondents declined to state their current gross annual income. Of the eight who did, annual incomes ranged from £10,000 to £30,000. Seven of the ten respondents were earning in excess of £20,000 per annum and five had a gross annual income of between £25,000 and £30,000.

Finally, all respondents resided in Dublin city. All were single and over half (n=6) lived with a partner. Three respondents lived with friends and one with her child. All respondents resided in a rented private-sector house or apartment.

3.6.4 Patterns of Cocaine Use and Routes of Administration

This section provides baseline data on the respondents' reported cocaine use. The average age of initiation into cocaine use was 21.2 years and half (n=5) reported first use between the ages of 20 and 23 years. On average, respondents had a cocaine 'career' of 6.5 years since initiation. Eight of the ten respondents had used cocaine at least once during the month preceding the interview. The most popular mode of cocaine ingestion was 'snorting', or intranasal use of the drug. Two respondents reported having ingested the drug orally on a number of occasions and a third stated that he had smoked cocaine in a 'joint'. This was the only reported method of smoking cocaine. In fact, the majority were not familiar with the practice of 'freebasing' and did not regard this mode of administration as a future drug option.

Cocaine typologies have been devised by several researchers, based on participants' reported frequency and intensity of use (Hammersley & Ditton,

1994; Waldorf et al., 1991; Ditton, Hammersley, Philips, Forsyth & Khan, 1996). This technique was not utilised in the current study owing to the small sample size. However, it is helpful to summarise general patterns of cocaine use for the sample. Following initiation, the majority did engage in subsequent use for some time (in some cases, for two to three years). Overall patterns of cocaine use varied considerably across the sample. Although a number (n=4) reported bingeing on cocaine, the duration of such 'bouts' of use were short, and most (n=6) had not used cocaine for more than two consecutive days. Monthly use emerged as the most frequently-reported current pattern of use; daily cocaine use was not the norm for this group of users. Nine of the ten respondents intended to use cocaine in the future. The remaining participant stated that she may well use cocaine at some time but had no definite plans to do so in the immediate future.

3.6.5 Other Drug Use

Practically all respondents were experienced users of a range of illegal drugs. Table 3.11 presents the figures for lifetime, past month and past week use of cocaine and other drugs. Drug intentions are also included on this table. Alcohol and tobacco, being licit drugs, are referred to independently. Six of the ten respondents were current smokers and all consumed alcohol on a regular (two to three times weekly) basis.

The average age of drug initiation for the sample was 15.8 years (range 13 to 19 years). Five respondents were 17 years or over at the time of first drug use. Table 3.11 indicates that respondents had tried or used a range of substances. All reported lifetime use of cannabis, ecstasy, LSD and amphetamine. Nine had used magic mushrooms (psilocybin). Three respondents reported lifetime use of heroin; two had used methadone; two tranquillisers; and two solvents or inhalants at some stage. Lifetime use of other substances not listed included opium (n=2), mescaline (n=2) and 'crystal meths' (methamphetamine) (n=2).

Cannabis was by far the most commonly-stated drug of initiation, and LSD and psilocybin (magic mushrooms) were frequently-stated second drugs used (n=7). Seven of the ten respondents were regular cannabis users (weekly or fortnightly users) and a significant number (n=6) reported past month use of ecstasy. A large number reported concurrent drug use, that is, the use of two or more substances in close succession for the attainment of specific or heightened drug experiences. The most popular drug cocktails were alcohol and cocaine; alcohol and cannabis; ecstasy and cannabis; cocaine, ecstasy and cannabis; and ecstasy and cocaine. Cannabis was considered to be compatible with most drugs and was frequently smoked subsequent to the ingestion of another substance. Nearly half the respondents (n=4) reported daily or near-daily use of cannabis.

Nine respondents intended to use cannabis and cocaine at some stage in the future and a large number expected to use ecstasy (n=7). Considerably fewer intended to use LSD (n=2), psilocybin (n=2) or amphetamine (n=1).

3.6.6 First Use of Cocaine

Respondents were asked to describe the circumstances surrounding their initial use of cocaine. In practically all cases, use was initiated in the company of friends in a social setting where alcohol and/or other drugs were being consumed. The majority stated that they had contemplated cocaine use in advance of first experimentation. However, while most stated that they intended to try cocaine at some stage, first use usually occurred incidentally. For this reason, first cocaine experiences were often free.

With friends at a party under the influence of another drug which was Ecstasy. I hadn't planned it as such but I had expressed an interest in taking it before that night anyway. I was up and ready for it but I hadn't planned it.

I was with some other musicians and they had it. It's a social drug and they were sharing it. At that time I was only starting to dabble with that kind of stuff. Someone asked me did I want some so I tried it.

For a smaller number of respondents (n=3), first cocaine use involved some advance planning.

I got it through friends. I asked to get it. I got it for a party. And I was in my early 20s at the time, about twenty-two.

At the time of initiation, most shared approximately one gram of cocaine with two or three friends, the typical intake being 'two or three lines' or 'a few lines'. Informants frequently reported drinking alcohol and/or using one other drug (either cannabis or ecstasy) at the time of initial cocaine use. The majority reported first cocaine experiences in positive terms.

It was amazing. Down there (abroad) anytime I got it, it was absolutely amazing. I could really see the attraction in it ... it was weird being so high but so clear. I suppose it was a very confident buzz I got out of it.

I thoroughly enjoyed it, yes it was good. It has similarities to other stimulants as such but I would certainly differentiate between that and ecstasy or speed.

Only one respondent stated that he was not impressed with the drug at the time of first use and asserted that he 'didn't really see what the attraction was'. Most agreed that subsequent cocaine experiences were superior to first or early use episodes. A process of learning to recognise and appreciate cocaine effects clearly accompanied the initial stages of use.

I remember being able to deal with it and just kind of recognise the buzz and again it was probably just a learning thing going on.

There is not a huge kick off it [cocaine] which is why I think you don't know what to expect at first and maybe after the second time you probably ... you can tell people 'that was crap' and they say 'well, did you not feel this' ... and then you say, 'well maybe I did'. And then the next time you have probably talked yourself into the buzz, what you are supposed to feel.

At the time of first use, practically all respondents had previously experimented with and used a range of stimulant and hallucinogenic drugs. In fact, cocaine was commonly listed as fifth or sixth drug ever used. On average, there was a five-and-a-half-year time lapse between first drug use and first cocaine use. Hence, the majority were 'experienced' drug-takers at the time they first tried cocaine. None expressed any doubt, scepticism or anxiety about the prospect of using cocaine when describing the circumstances surrounding first use of the drug. Hence, although cocaine initiation occurred later in respondents' drug 'careers', it was not an unexpected or unanticipated event.

3.6.7 Frequency and Contexts of Cocaine Use

All respondents were asked explicit questions about the frequency and quantity of their cocaine use generally. However, during questioning, there was a particular focus on two specific periods - use during the two-to-three-year period subsequent to initiation, and cocaine consumption during the two years preceding the interview. Hence, early and current use of the drug were examined in detail, in order to construct typical patterns of cocaine use across time. Given the substantial drug history of respondents prior to first cocaine use, coupled with frequent reports of using cocaine in association with alcohol and other substances, cocaine use is examined here with reference to respondents' use of a range of substances. This section will describe respondents' cocaine use, in terms of the frequency, intensity, intake and duration of use. The circumstances and locations associated with use are important components of this analysis.

As stated earlier, there was a considerable time-lapse between first and more regular use of cocaine. Hence, while cocaine initiation took place, on average, at the age of 21, more consistent use of the drug did not emerge for quite some time. Use of the drug was sporadic initially, and appeared to be dictated largely by economic factors: cocaine was expensive and most respondents had not yet secured their first job. Availability was an additional factor that appeared to deter regular use at this stage.

In those days I was a student and I had fuck all money anyway, you know. And a lot of the time when you're in that scenario, you probably get in with somebody and get to know somebody who has a contact somewhere else. Or, they might be dealing themselves or be able to get it irregularly or cheaply. And coke wasn't one of those kinds of drugs that you could get easily. And when you got it, it was never cheap.

When I was 21, £80 or £70 for a wrap of coke plus your drinking, plus getting into a club ... I just couldn't do it. £150 out of your pocket for a night, I just couldn't do it ... and I wouldn't have had it myself because I wouldn't really have known the people that you would get it from, so it would have been a real hit and miss thing which will change as you go along because you will find people who sell it.

Consequently, early use of cocaine was intermittent and viewed largely as a 'treat', or an extravagant drug for special occasions. At this stage, other drugs were more likely than cocaine to be in use, largely because they were more economical and easier to procure.

I'd say it was more sporadic [for several years after first use], you know. If it was available and if I had the money in my pocket I'd get it. But if there was other stuff available I wouldn't bother. I'd go the cheap route because number one it's [other drugs] cheaper and number two, it'll go further.

There were huge gaps between when I would take it, so it would be months between taking it. It could be two or three months before a similar party or circumstance would come up. But it was always party generated, you know, because of the nature of it.

It is significant that among this group of informants, in their mid- to late-twenties, most had only started to use cocaine more regularly during the past three years or less. Current frequency of use varied across the group. The largest number (n=7) reported monthly use of cocaine. One stated that he had used cocaine approximately eight times during the past year. For two others, use was less regular and less deliberate: some respondents did not secure a regular personal supply of the drug and described their current use as occasional.

It is very rarely an arranged thing. It would be a case of somebody saying 'I have two grams of coke, does anyone want to go in on it?' That is probably the extent of my cocaine use at the moment. I wouldn't be a huge fan, I don't really see the value in it, shall we say.

One respondent reported having reduced her cocaine intake from former, more regular and intense consumption levels, including two 'bouts' of use when she used cocaine several times weekly.

Given that regular cocaine use was quite a recent development for the majority of respondents, it is important to examine how they described this drug transition. As stated previously, all respondents reported a sizeable repertoire of drugs prior to cocaine initiation. A large number were current, regular cannabis users. In addition, practically all had gone through a short phase of LSD use and a sustained phase of ecstasy use, ranging from several months to two years. While ecstasy was described in positive terms, the majority drew attention to the negative effects of regular, heavy use and indicated a definite shift from this particular 'style' of ecstasy use. Most stated that while they currently used ecstasy on occasions, they had quit regular weekend use of the drug.

I don't do E that often any more. I used to alright but, ah, just too much hassle now with the come down an' all. But yeah, I used to love it and would still do it but not in the way I used to. Takes too long to recover.

I haven't done any [E] for a long time. It is so physically draining for me to take, you know, you take an E and for a couple of days you are just not really as sharp as you normally should be. You are not really on the ball. It takes an awful lot out of you. I haven't taken acid in a couple of years either and that's the same, it knocks you for six.

Many perceived cocaine to be a lighter, more manageable drug. First, cocaine did not induce powerful physical effects during use, certainly compared to ecstasy. Second, it did not produce profound negative side-effects during the days following use. Both factors emerged as primary motives for a reduction of ecstasy (and LSD) intake on the one hand, and increased cocaine use on the other.

I know if it is a line or two of coke I still find I can go about my daily routine. If I take ecstasy I know I won't feel the best the next day but Es are a funny thing. Sometimes you take one and you find that you can be in a pub atmosphere, enjoy a pint or two and its not too heavy. And then sometimes you take another and whatever is in it, you're just gone.

In comparison to ecstasy, physically with ecstasy it is hard to get up the next day and get through it, you know, you have black rings under your eyes. Usually on ecstasy you're higher than you are on cocaine, even if it is really good cocaine. And then mentally with ecstasy, you know sometimes you have to have a couple of days to recover from the night out as such. Coke does not have that effect, not on me anyway. It is far

easier to just go out and have a good time with some coke and get up the next day and either go to work or just get through the day and not be in a hassle.

Respondents' preferred circumstances of cocaine use varied but most favoured a relaxed setting in the company of friends. Respondents regularly drew attention to the circumstances of use and considered the setting to be a strong determinant of positive drug experiences.

Sometimes the buzz with coke is a bit better than others because of purity I suppose. But it is 90 per cent circumstances. I am not saying that circumstances completely override the quality of coke at the end of the day, you know, if you are a relatively seasoned user. But at the end of the day when I look back at nights when I have taken coke or taken some other drug it is usually the circumstances and the company that I keep and whether I am enjoying myself, and my current state of mind. They are usually the predominant factors in how good the night was, you know.

A majority preferred to use cocaine in private, rather than public, social settings. Situations in which people wished to communicate and enjoy the company of friends were most frequently mentioned as those where cocaine use occurred. Less frequent, but visible also, were situations in which people wanted to dance.

I prefer to use coke in a house. Yes, with a few friends in the house. I have used it in clubs before but you wouldn't be using there often because you can't use it openly, you know.

It would be mostly at home or in the pub you might slip into the jacks and have a quickie in the coke sense. But generally it would be in a house situation. It is not really conducive to doing in a public place in that there is a little bit of preparation and that involved. You have to get it out into a line and it is not the ready-made package that our friend ecstasy is.

I'd be inclined to use cocaine in quieter more laid back circumstances ... say there was a weekend of music somewhere, a festival or something like that. I'd make up my mind, like I'd go for coke or for a few tablets as well, you know.

Taken on its own [cocaine] you are elated and you are aware of yourself but you are aware of yourself as being full of confidence and you feel really sexy and especially say, if you are dancing or you are in a club.

Most respondents reported using cocaine in a social setting at night-time (either at home or out). However, a small number had also used cocaine during the day on occasions, although this was by no means a preferred or usual practice.

The last time I took coke was two weeks ago. It was in the middle of the day and I was sitting in. I was away for a week and I was sitting in the house drinking cups of coffee and smoking joints. And we decided it was time to hit the town so it was about mid-afternoon, something like that. And I had a line, went out, spent the whole day buzzing around and would have had maybe two or three more lines that night.

From the reports of respondents it could be inferred that cocaine use is strongly related to lifestyles where going out, social gatherings and socialising are dominant. For the most part, cocaine use was confined to weekends and holiday times, when there was sufficient time to 'recover' and fewer potential negative repercussions from use or over-indulgence. In addition, cocaine use was strongly linked with alcohol consumption. A number of respondents commented on the compatibility of alcohol and cocaine. In fact, cocaine was rarely, if ever, consumed alone. Although descriptions of use varied, cocaine-using scenarios invariably incorporated the use of other mood-altering substances, including cannabis, alcohol and, less frequently, ecstasy.

It is a drug you tend to mix as well, primarily with alcohol now, the two, for whatever reason seem to combine. Now medically they could be the worst thing for you, I don't know, but from a results or effects point of view they mix well and you tend to drink more and you tend to sit around and you would be in considerably better form, not really sure why, considerably better form.

Coke and alcohol are a very crucial mix for a night. If you are doing coke you have to have some booze so I would say that that goes hand in hand with the amount of booze you are going to go through.

Hash may or may not come into it as well. If we're out drinking and are back in someone's house we might have a smoke or not. I actually like mixing ecstasy with a bit of coke too, you know it's good fun. You get a good energy and physical [pause], an energetic rush from the ecstasy both mentally and physically and taking it with a bit of coke also maintains the same kind of rush that you would have got from ecstasy. So it is almost prolonging the effect that you get from ecstasy. They are both stimulants so they are both doing the same kind of thing but ecstasy makes you more amorous and friendly to others and you would be less likely to talk about yourself.

Current frequency of use was strongly linked with economic factors. Individuals with more disposable income were far more likely to use monthly or weekly. One respondent stated that cocaine was simply not economical and that he could not afford to buy the drug regularly. Compared to other drugs, cocaine's short-lived effects relative to its high cost rendered other drug choices more cost-effective.

For the same money, if you want to compare them as regards what the user gets out of it, you get a much better night or a much better hit of six Es which is the equivalent [cost wise] as a gram of coke. It think it [cocaine] is very expensive and prohibitively expensive which is probably a good thing because if it got any cheaper, it would become a lot more popular very quickly because I have noticed an increase in its popularity in the last year, year and a half.

On a scale of drugs that I'd take, it would probably be the least common drug that I'd use. Um, because for value for money, it's the worst. Because you could actually buy a gram and consume the whole gram in one night. So that's eighty quid, gone, whack. Whereas you could get a good quality ecstasy tablet for a tenner that would last you the whole night. So, it's down the list for me anyway.

Other respondents, by contrast, stated that their current income permitted more regular use of cocaine than in the past.

Well, at first it was never really something that I went out of my way to go off and take and then when I had a bit more disposable income and I was growing tired of other drugs that I had taken, ecstasy really, then I started doing it a bit more.

As a young adult I couldn't really afford it whereas now I can afford it so there is that sort of thing.

One respondent attributed his increased cocaine consumption during the past year to a heavy workload, resulting in more stress and fatigue.

It [cocaine intake] has probably increased a little this year. I don't know why really? Probably work because I am working a hell of a lot more and so, I would have two nights off. And I kind of go for it big, kind of a more intense night out. And that is probably one of the reasons for it. Plus, in the last few months ... it gives you that sort of a pick up. Because at the moment I have changed job so I am working more hours and am more tired.

The study's regular users of cocaine generally restricted use to weekends, when their intake of the drug ranged between one and two grams per session. Most reported periods of abstinence ranging from one to several months. While a number of informants stated that there were times when they had exceeded their usual intake, bingeing on cocaine was not a common practice. Cocaine was rarely used on more than two consecutive days.

I suppose in the past I may have taken a load of coke and not slept, had a meal or something like that and then started a session again if there was a particular reason to be on a party buzz. And then I may have done it two nights in a row, sometimes I suppose three but I have never gone on a complete weekender without any sleep.

I've never actually taken coke for more than like two days or something like that. I've never gone on a binge of coke.

One respondent did report two separate phases of intense and regular cocaine use. On both occasions, the individual had easy access to the drug and did not have to pay a high price for a 'good' supply.

I have gone on coke sprees. I remember one in particular and it was really, really good. About three years ago it was with my boyfriend's friend. He had loads of it and it was pure and when I think about that, it is interesting because now that I remember it, it was great because there wasn't any comedown. I think I have particularly bad comedowns because of what it is mixed with. But he was giving us the good stuff.

To summarise, while frequency of cocaine use varied across the ten respondents, it was possible to identify a number of distinct patterns of use. The largest group of cocaine users (n=5) had previously used a range of other stimulants (ecstasy and amphetamine) and hallucinogenic drugs (LSD and magic mushrooms) and had significantly curbed their intake of these substances. Respondents regularly drew attention to the cumulative negative effects of sustained ecstasy use and to the lengthy recovery period following use. In this context, cocaine had increasingly emerged as a drug of choice. This shift also appeared to coincide with significant lifestyle changes. In particular, respondents reported increased career commitments. Importantly, this group of mid- to relatively high-earners had more disposable income than previously. Cocaine was considered to be a 'cleaner' drug, and use did not impinge on routine responsibilities, which centred largely on professional and career considerations. This sub-group

engaged predominantly in weekend cocaine use, with frequency of use varying between one and four times monthly.

Four additional respondents described a pattern of less regular cocaine use. This group's drug preferences did not focus as strongly on cocaine and they reported more regular use of other drugs. While cocaine-using occasions were sometimes planned, most occurred by chance. For this group, cocaine was not a primary drug of use and was more likely to be used intermittently and incorporated into a wider poly-drug repertoire. Finally, one participant, a former regular cocaine user, had not used cocaine for several months.

In general terms, the broad picture emerging of the study respondents is one of eclectic poly-drug use. It appears that cocaine has become a more regular and valued feature of this group's poly-drug 'careers'. Regularity of cocaine use varied across the sample and use frequency appeared to be determined by a number of interacting factors including past drug experiences, current income and user's drug preferences.

3.6.8 Availability, Purity and Price of Cocaine

Respondents were asked to comment on current availability and ease of cocaine accessibility. Across the sample, there was general consensus that cocaine was more easily available and more commonly used than previously.

It is far more freely available now, you would see more and more types of people doing it and there are bars and clubs in town where a lot of people would use it ... it would have had that tag of being a more exclusive drug years ago because it wasn't freely available and used more for an occasion. But now a lot more people I know do it every weekend.

It's a lot easier to get it now really, but that's probably down to my own circle of acquaintances as well. Yeah, if I want it I can get it.

Coupled with increased availability, there was a strong belief in cocaine's acceptance as a drug of choice.

There is a large acceptance, people that I know and people's parents do it the odd time, do a line, and it is fine by them.

There is a big difference now, sure even if you look at toilets in a club, it is nothing to see two males go in and out of a cubicle together and the likelihood is that they are both going in to do a line but nobody bats an eyelid. I think years ago whereby we were told how bad drugs were, people would readily stand up and go 'listen'. That is not on nowadays. There just doesn't seem to be that anymore. Nobody is going to turn around and be disgusted that you are doing something like that.

Strong differences emerged, however, in the perceived reliability of personal access routes to cocaine. Expectations regarding the quality and purity of available supplies also varied. Regular cocaine users had sought out and located one or more reliable supplier of the drug and felt assured about the quality of cocaine they purchased.

I find availability okay. I wouldn't buy it off somebody I didn't know, and you are still taking a bit of a gamble with somebody you know with what you are getting, you are still not getting extremely good quality but I would have no problems, if I got muck in cocaine, giving it back to the person [supplier] as well. I wouldn't pay that amount for something that's not acceptable at all.

Others, who did not have a regular dealer, relied on friends to secure a supply of cocaine. It appeared that those who socialised in user circuits were able to access cocaine easily.

If I wanted it [cocaine] I would have to talk to a particular friend ... and he would talk to the guy who deals it for him. I don't have a dealer so if I heard there was something going on at the weekend and people getting stuff I could ring up and just say put me down for a wrap [a single quantity, usually 1 gram] or whatever.

Less committed and regular users of the drug, on the other hand, had to go to greater lengths to procure 'good' cocaine and a number did not have a reliable dealer.

I have a regular supplier for years and I wouldn't be a heavy coke user. So anytime I go to get coke, it's more of a hassle for me to go and get it because I have to go out of my way to get it because he doesn't supply it.

The quality varies from very poor to very good. Again, there is no trend to that either, it's totally pot luck. I am sure there are people, and again this is my experience because I don't know many people or one person, to be honest, who sells the stuff. If you knew

more people that sold it, the chances are you would probably be able to get it more regularly and get good stuff.

Respondents' reports indicate that the current street price of cocaine varies between £50 and £80 per gram. The majority stated that the quality and purity of supplies vary enormously depending on the source and availability of the drug. Most respondents had used cocaine while in countries other than Ireland at some stage and frequently mentioned the inferior quality of cocaine here, certainly compared to that which they had sampled abroad.

The way you kind of socially create sources for obtaining coke, well after a while you do notice that one person gives you coke and it may not be as good as the next person. And sometimes after a few years or after a while of taking it you can actually take some lines of coke and you can actually see what it is cut with, you can taste it or you can see it. It is just something that you develop over the course of time and the purity in Dublin anyway is not always the best.

It is pricey, but as well as that you see it is hard to tell because in Ireland it is hard to get good cocaine. You can get it but it is few and far between, it is a bit of a gamble when you go to buy because you don't know if it's going to be good. But if you have a regular source and you know what is good then you are fine. And you will find that there are times when you will get really good stuff all the time and then other times you are getting crap, you know.

In general, the evidence suggests that cocaine is readily accessible to individuals who are motivated to use the drug and have established contact with a reliable supplier. Less frequent users, while having easy access to cannabis and ecstasy via their regular dealers, had less well established access routes to illicit cocaine supply systems. They were not motivated to seek out a more reliable cocaine supply route and allowed situational factors to determine the quality of the cocaine they consumed. At the buyer level then, it would appear that cocaine, albeit of variable quality, is relatively easily available to individuals who opt to use the drug.

3.6.9 Perceived Attractive and Unattractive Aspects of Cocaine

All psychoactive substances have appealing and unattractive attributes and cocaine is no exception in this regard. All of the respondents were well versed on the drug-induced outcomes of a variety of substances; they distinguished

clearly between the effects of individual drugs and had preferences for specific drugs or drug combinations, depending on the circumstances or settings of use. In this section, the perceived appealing and negative aspects of cocaine are examined. Reference is made to the perceived advantages of other drugs in instances where this has a bearing on respondents' attitude to cocaine.

The data revealed three dominant cocaine attractions. They are not discussed here in hierarchical order, as it was difficult to determine individual advantages which prevailed over others in terms of their importance for individual users. Rather, all three merged as components of a psychoactive 'hit' which was perceived to be gratifying, beneficial and enjoyable. Cocaine's appeal focused on three major themes - pleasure, control and lifestyle.

Cocaine simply made partying better, according to the majority of respondents. The psychoactive 'hit' produced feelings of exhilaration, confidence and psychological pleasure, thus enhancing social occasions in which the drug was in use.

Taken on its own you are elated and you are really aware of everything and you are aware of yourself but you are aware of yourself as being full of confidence.

It boosts the night by about five-fold. If you are out and you are having a great laugh it seems to add that little bit extra to the night. The banter is a bit quicker as it goes on ... It is just like a mood enhancer.

With coke you can have a little stash of it and you can stay up all night. It is just that it breaks down all those barriers and you are just babbling away having a good time, socialising with people.

Closely linked to the social and psychological pleasures described by respondents was that cocaine provided an immediate injection of energy and enthusiasm and made the night last longer.

If I was taking uppers - speed, cocaine, something like that - it would be to promote my energy levels for the evening or elongate it so you can go with the craic for longer.

Two respondents drew attention to the enhancement of sexual experiences following cocaine use.

Coke is more of an indoor drug and if you are with someone that you are quite into a relationship with it is good as well. You can lock yourself in and have a gram of coke and have a really good night sexually as well as mentally.

As with other drugs, the pleasure factor was high on respondents' list of priorities when rating cocaine as a drug experience. The physical and psychological pleasures cited by respondents in the current study are very similar to those documented by Ditton et al. (1996) in their sample of cocaine users in Scotland.

A second key advantage of cocaine over other drugs, according to many informants, was that unlike other drugs, cocaine permitted the user to retain a high level of 'control' during times of use. Discretion was closely associated with control: cocaine did not demand much preparation and users felt able to conceal the fact that they had taken the drug. In addition, cocaine consumption facilitated and enhanced communication with others, rather than hampering it. At the same time, the rapid onset of cocaine-induced effects following consumption, coupled with the short duration of these effects, allowed the user to maintain charge over his/her disposition and behaviour.

It's immediately effective and it's convenient to carry around and it's convenient to take, relatively. Like, there's no work, you don't have to prepare anything, you know. And you get an immediate kick out of it.

You can control it insofar as it only lasts ten minutes and then you can take some more of it if you want it. Whereas ecstasy, you take it and you are out of it for at least two hours.

It is the most social because you can sit there and you can converse with everyone and you don't look like you are out of it. It's a good drug like that.

It doesn't stop me thinking and I don't do anything stupid, you know what I mean. You can get into a taxi and talk to the taxi man and you know what you're doing.

Critically, cocaine use, according to several respondents, did not result in the negative after-effects associated with ecstasy and other drugs. These included physical and/or psychological exhaustion and feelings of being 'wrecked' during the days following use. Half the respondents (n=5) reported several undesirable side-effects following a sustained period of regular ecstasy use.

and assuming behaviour. Others drew attention to mood swings and depression among regular users.

I am talking about people I know and people who would use it as their drug of choice and not just on weekends, but on a regular basis. And it has changed them hugely. Like, you know, mood swings, vicious mood swings, and basically just depressed when they are not high on coke. And it makes for a sad life.

To summarise, cocaine was regarded as superior to other drugs for a variety of reasons. Users' subjective experiences suggest that cocaine was viewed positively by the majority of respondents. From the vantage point of the user, attractive features of cocaine included its energising effects, the ability to maintain control while intoxicated and the sociability of the drug. Cocaine was perceived to be a 'clean' drug, one that did not carry the negative image or undesirable after-effects of other stimulant drugs. Perhaps surprisingly, in view of cocaine's apparent allure, only two respondents described cocaine as their 'favourite' drug. Cannabis was by far the most popular drug across the sample (n=6). Two respondents stated that their preferred drug was ecstasy, in tablet or powder form.

3.6.10 Risk Perceptions and Self-Regulation of Cocaine Intake

Respondents were asked to express their views on the risks associated with cocaine and other drug use. In general, respondents had no reservations about using cocaine, provided they felt relatively self-assured about the source of the drug. Most stated that they would avoid buying cocaine from a stranger in social settings such as nightclubs. However, concerns about getting bad value for money tended to be higher on respondents' risk agenda, than anxieties about the presence of contaminants. Hence, one of the biggest 'risks' with cocaine was the unpredictability of available supplies and the gamble taken in this regard. Other drugs were considered to be far more reliable in this respect.

Cocaine isn't dodgy. You would probably be more likely to get a bad E that makes you ill for whatever reason. You will get bad coke but it is poor quality as opposed to anything else. When it's cut sometimes you can taste the glucose. E is probably more dangerous in that sense.

One respondent compared cocaine to legal substances when expressing his view on the risk of getting substandard cocaine.

I don't wonder what's in a cocktail at a bar because it's so readily available and acceptable. With cocaine it doesn't come into my head either, to be honest.

The overwhelming view was that cocaine was a 'safe' drug.

I think it's probably one of the safest drugs. You can't, of all the drugs that you can take, if you take acid there is a small chance that you will have a bad trip. But I think that cocaine is the safest drug. The effects are short-lived. There will only be ill-effects if you are doing it all the time but that won't happen easily because of the price of it.

When asked about the addictive potential of cocaine and other drugs, several respondents placed a great deal of emphasis on the individual's relationship with any given substance (including alcohol) as a major determinant of later difficulties. The general belief was that the pharmacological properties of the substance played a secondary role in the development of drug-related problems, certainly compared to other factors. This group of cocaine users did not consider that their own behaviour around drugs was comparable to the behaviour, personal or social conditions of individuals who experience drug problems.

I'd say it depends on your personality or your state of mind. But I could easily imagine if you're in a scenario whereby you have an altered state of being, by being on a drug, and your life is a piece of shit, well, you'll obviously going to get back to where you were last night as soon as possible. Now that depends on probably, your state of mind, your education, your ignorance of drugs. All of that, all those levels - your social circumstances, the amount of friends you have around you. If you feel lonely and you feel down, you know, you just more than likely want to get off your head. I could easily see somebody getting addicted to any drug. But specifically to cocaine? I don't know? I think if it was me I'd want to be seriously fucked in the head to get addicted to cocaine.

I can see why people can get addicted and having said that I could never see myself becoming an addict to coke. About a year and a half ago I kicked cigarettes and I think that is about as addictive as anything you can get.

Many pointed out that their use of cocaine and other drugs took place in social settings where friendships and other social relationships took precedence over the use, per se, of any drug. Respondents distinguished clearly between drug use and drug abuse, and did not equate their own cocaine use with dangerous or addictive patterns of drug consumption. Again, 'control' emerged as an organising construct in the discourse and respondents invariably pointed out

that they, and not the drug, maintained 'charge' in the context of drug-taking scenarios.

I enjoy the fact that I have a fairly stable and happy atmosphere in my head and I am confident that I can do it [cocaine]. And if I ever felt that being threatened then there'd be no argument there. If it retarded my sense of drive or whatever, that'd be it.

I like to have control and I know how much I can handle. Yeah, I've overdone it at times but at the end of the day, drugs aren't important enough to me to let things get out of hand.

Several respondents recognised situations and emotional states that were not apt for cocaine use. For example, most respondents restricted use to when they were in the company of friends and stated that they did not use the drug when socialising with their parents and/or other family members. While a number admitted that there were times when they went 'overboard', cocaine use was generally confined to occasions when it was least likely to impact on work and other responsibilities. Respondents' also made reference to the importance of the individual's emotional and/or psychological state at the time of use.

If I had to work the following day I wouldn't take it. If I was hungry I wouldn't want to suppress my appetite for a while because I would want to have a meal. I would say that if I had a lot on my mind, if I was stressed or if there was an awful lot going on at work and in my life in general and I didn't want to deal with a hangover ... because at the end of the day if I go off and do some coke I am going to have a pretty bad alcohol hangover too because I tend to do the two together. And you think you're superman regarding alcohol intake so if my head doesn't feel right at the time then I wouldn't be taking it. Usually for me, if I had a lot going on in general I would avoid it for that reason. And then you are either in the mood or you're not, it's like anything, you know.

The quotes above illustrate the range of informal social controls that are practised when people consume drugs. Other respondents drew attention to how they regulate their intake of cocaine during the course of a night out.

I would take cocaine more during the early part of an evening and then just let it peter out. What I don't like is coming in at three o'clock in the morning and sitting there wide awake and not being able to sleep. So, for myself I would have the bulk at the beginning of the early part of the evening and then later in the evening have one or two lines just for a perk. And then when I get home, I am home to actually sleep.

While the level and range of 'control' measures practised by respondents varied across the sample, all mentioned conditions that were more or less apt for cocaine use. Overall, it would appear that respondents perceived the risks associated with cocaine use to be minimal, in terms of the drug's potential to cause physical and/or psychological harm. Interestingly, two respondents expressed concern about the legal risks associated with the possession and use of controlled substances.

The illegality of it is a huge worry because other than the fact that I use drugs for recreation, I am a 100 per cent law-abiding citizen. I pay my taxes etc. So, it is very hard to keep reminding yourself that you are actually a criminal. But you do, you actually have to remind yourself on occasion. Even though you are a really nice bloke, you are actually a criminal and if you get caught you could well end up inside ... and the repercussions could be huge from a legal, family, work point of view. Huge repercussions.

The majority, however, felt that it was relatively easy to conceal their use of cocaine and that the chances of getting 'caught' were small or negligible.

I would never worry about being stopped because I can't really see what provocation there would be for the police to stop me.

I know it's a class A drug but I usually wouldn't worry. I wouldn't want to get caught but I usually wouldn't worry much so long as I am not carrying too much.

To summarise, cocaine was viewed as a relatively innocuous substance and users did not consider cocaine use to have negative repercussions on their health or well-being. None expressed concern about any short- or long-term health implications associated with their personal use of the drug and many felt that cocaine was 'safer' than other drugs.

3.6.11 Summary and Conclusion

Respondents in the current study described themselves as social/recreational drug users. Across the ten individuals interviewed, use was relatively modest and none of the respondents could be described as heavy users of cocaine. All respondents funded their cocaine and other drug use through legitimate income. Cocaine use was clearly integrated into social events; it was shared in social

settings, sometimes in small intimate groups and, at other times, in the context of larger social gatherings. Cocaine was thought to facilitate communication and to induce feelings of self-confidence. The stimulating properties of cocaine, in conjunction with a 'controlled' high, were particularly attractive characteristics of the drug experience. This dynamic was important, particularly to more regular users, who did not wish cocaine to encroach on their normal activities and/or their physical and psychological well-being.

While the frequency of use varied across the group, most could be classified as 'monthly', 'weekend' or 'intermittent' cocaine users. Variation in frequency of use among recreational cocaine users has been documented previously by Green, Pickering, Fosster, Power & Stimson (1994) in their UK sample. Practically all respondents in this study reported the concurrent use of alcohol and other drugs during cocaine-using events. In fact, the vast majority had extensive drug repertoires. The combined use of licit and illicit drugs is far from atypical in the current European context. Nabben (2000), for example, found that among clubbers and ravers in Amsterdam, half used illicit drugs in combination with alcohol. A considerable number of the current study's respondents had gone through a phase of regular weekend use. While ecstasy was rated highly, all former regular users had reduced their intake of the drug owing to the significant negative repercussions following sustained use. For this group, cocaine was perceived to be 'lighter' and 'cleaner' and did not interfere with the user's desired level of functioning and well-being. Henderson (2000) similarly found that club-goers in Liverpool explained their cocaine use in terms of the drug being perceived as a 'healthy' alternative to ecstasy.

The majority of respondents expected to find themselves in social settings where cocaine was available and practically all intended to use cocaine at some time in the future. Reports indicated that the street price of cocaine varied between £50 and £80 per gram. However, conspicuous differences emerged in respondents' level of contact and association with local cocaine distribution networks. Those who socialised regularly in users' circuits had superior and more reliable access routes to cocaine.

Relatively few disadvantages associated with cocaine emerged from respondents' reports but most drew attention to the high cost of cocaine and to the poor quality of available supplies. Others commented on their observations of friends and acquaintances during sessions of use and felt that cocaine consumption sometimes produced undesirable, self-indulgent behaviour,

including arrogance and greed. Few respondents reported that they themselves had experienced negative physical or psychological side-effects following cocaine use.

Social settings have been shown to influence a range of drug-taking behaviours (Becker, 1963; Young, 1971; Zinberg, 1984). Cohen (1989) claims that settings and individual responses largely determine not only the effects of use but also the choice of drug in particular contexts. Respondents in this study used a range of informal control mechanisms in an effort to regulate their cocaine intake and to minimise potential negative consequences of use. They also recognised settings not suited to cocaine use and avoided the drug in these contexts. Decorte (1999) has documented similar control strategies among a sample of cocaine and crack cocaine users in Belgium. In the current study, respondents prioritised work, friendships and their partners, and did not wish to jeopardise these relationships. Specifically, they did not allow cocaine or other drug use to impinge on their performance in the workplace. Reference was made to a range of circumstances under which the drug was not used, including during working hours and in the company of parents and/or other family members. Respondents also considered their own emotional and physical well-being prior to using cocaine.

None of the study's respondents reported 'problems' as a result of their cocaine use and none considered their current intake to be worrying or damaging, certainly in the short term. Claims that they, the users, and not the drug, maintained 'control', emerged strongly from their reports. This is interesting since the concept of 'loss of control' seems to be better adapted to current perspectives on illicit drug use (Cohen & Sas, 1992), with rather less attention to, and understanding of, controlled drug use. The majority of respondents considered the addictive potential of cocaine to be low, certainly from a personal viewpoint. Indeed, it is claimed that in many circumstances, cocaine is enticing rather than addictive (Hammersley & Ditton, 1994). Drug dependence is, of course, strongly mediated by the circumstances, disposition and views of the user (Zinberg, 1984). The cocaine users in this study did not fear addiction; neither did they believe that they were susceptible to developing a dependent relationship with cocaine, owing largely to a belief in their ability to control and regulate their intake of the drug.

3.7 Cocaine Use in Ireland: Discussion and Conclusion

The drug scene in Ireland has undergone dramatic change during the past decade and has become increasingly diverse according to age, drugs of choice, availability and price. National and local surveys of youthful populations indicate a clear upward trend in the range of drugs used, suggesting that recreational drug use has become a more obvious feature of adolescent lifestyles. At the other end of the drugs spectrum, long-term opiate users, many of whom are known to drug treatment services, appear to have extended their repertoire from heroin and methadone to poly-drug patterns. Benzodiazepines have been identified as a primary supplement to opiate users' drug intake (Farrell et al., 2000; Rooney et al., 1999). The propensity of cocaine, particularly in its injectable and smokeable forms, to appeal to this endemic group of heavy users is an issue of critical concern.

This research has attempted to build up a picture of cocaine use nationally, using available indicators of drug use/misuse and the perceptions of key informants and drugs workers. The research did not set out to estimate the prevalence of cocaine use; rather, it aimed to provide information on the nature of cocaine use, with specific reference to particular sub-groups, namely, recreational and problem drug users. In the absence of previous research on the topic, a multi-method approach, using several indicators, was judged to be the most effective means of analysing the current cocaine situation.

The findings strongly suggest increased availability and use of cocaine. Law enforcement statistics point to an upward trend in the availability of cocaine. In addition, the study has repeatedly noted the ease with which users can obtain cocaine. Although population and school surveys indicate that only small numbers use cocaine experimentally or intermittently, this current research provides evidence of individuals who use cocaine regularly for recreational purposes. Reference was made by most study respondents to the visibility of cocaine on the club and pub scenes, a development which was regarded as recent. While there is no systematic evidence of widespread cocaine use, the broad picture uncovered is one of increased likelihood of cocaine use among certain groups of recreational poly-drug users. The extent, nature and frequency of cocaine use among such groups, however, remain unclear.

Coupled with a possible expansion of cocaine use within the recreational drug scene, are signs of increased cocaine use among opiate users who come from more deprived urban areas, particularly within Dublin City. While cocaine has clearly been 'around' for some time, supply and availability appear to be stronger than previously. The reports of a diverse range of drugs workers and service providers confirm that this development is recent, certainly no more than three years old. Impressionistic accounts also strongly suggest that cocaine use has become a more conspicuous and accepted drug option.

It is important to state that the nature of cocaine use is likely to be diverse and that the role and function of cocaine within the drug repertoires of social/recreational cocaine users is likely to differ substantially from that of 'seasoned', heavy and problematic opiate drug users (Chitwood & Morningstar, 1985; Hammersley & Ditton, 1994). In addition, routes of administration are likely to vary between the two groups. Social users interviewed for the purpose of this research ingested cocaine intranasally or orally, and did not consider their drug consumption as damaging or problematic. None had been exposed to crack cocaine and did not consider using cocaine in this form. On the other hand, available statistical indicators, coupled with the reports of drugs workers, suggest that cocaine use has become more apparent among clients in treatment for heroin misuse. As stated earlier, there is currently little knowledge or understanding of preferred patterns of cocaine use, or of dominant routes of cocaine administration among problem drug users. This information is essential if cocaine's role in the drug repertoires of opiate users is to be fully understood. Furthermore, an understanding of smoking versus injecting cocaine rituals would greatly enhance knowledge and awareness of the possible range of health risks associated with cocaine use.

It would be premature to conclude, on the basis of the current study, that cocaine is a major 'drugs issue', or that the spread of cocaine use to neighbourhoods where heroin use is concentrated, is imminent or inevitable. Further research and monitoring of drug trends at local level is required to confirm or, alternatively, discount the proposition that cocaine is an expanding 'problem'. Despite this, heroin epidemics, both here and in the United Kingdom, have taught us that particular communities are susceptible to drug outbreaks (Dean, Bradshaw & Lavelle, 1983; O'Kelly, Bury, Cullen & Dean, 1988; O'Brien & Moran, 1997; Comiskey, 1998; Parker, Bakx & Newcombe, 1988; Pearson, 1989; Parker et al., 1998; Egginton & Parker, 2000). If cocaine continues to be easily available

and gains acceptance among drug users, it may have the potential to find its way into communities that traditionally attract drug problems. In this sense, the current research might be appropriately viewed as an 'early warning sign' (Parker et al., 1998) of cocaine's emergence, thus, signifying the opportunity to monitor the situation and 'get ahead'. In this context, a cautious response to possible signs of increased cocaine use is more appropriate than either outright rejection of the possibility, or hysteria and over-reaction.

3.8 References

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