NACD
National Advisory Committee on Drugs

An Overview of Cocaine Use in Ireland

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Designed by First Impression

Contents

Foreword, Minister of State

Since the National Advisory Committee on Drugs (NACD) was established in July 2000 it has sought, through its three-year work programme, to address gaps in our knowledge of drug misuse in an Irish context. The work of the NACD continues to increase the amount of available research which will in turn facilitate greater evidence-based policy making in the difficult and complex area of problem drug use in Ireland.

In this context, I am happy to welcome this new overview of cocaine use in Ireland. Over the last number of years, the Government has become aware of an increase in the use of cocaine in Ireland. This trend would appear to coincide with an increase in the availability and use of cocaine in Europe generally and a consequential drop in the street price. In addition, it appears that there is a growing perception among users that cocaine is a 'safe drug'. However, the risks associated with the drug are extremely high, particularly when combined with alcohol and this is a message that needs to be highlighted.

Misuse of drugs remains one of the major social problems facing Irish society today and the Government will continue to work in partnership with communities most affected by the problem. Implementing the 100 actions in the National Drugs Strategy 2001-2008 and initiatives such as the Local and Regional Drugs Task Forces remain a priority for Government.

Finally, I would like to record my appreciation of the on-going work of all of the members of the National Advisory Committee on Drugs, in particular, its Chairperson - Dr. Des Corrigan, its Director - Ms. Mairéad Lyons and its Research Officer - Ms. Aileen O'Gorman.

Noel Ahern T.D.
Minister of State with responsibility for the National Drug Strategy

Foreword, Chairperson, NACD

This overview of cocaine use in Ireland illustrates the diversity of the work of the NACD and its staff because it includes all of the elements of the NACD's mandate which is to advise the Government on the prevalence, prevention, treatment and consequences of problem drug use in Ireland.

As a result of reports indicating increased levels of cocaine use in Ireland, the NACD has published this report to provide baseline information on cocaine and its use in Ireland. It represents a significant effort by many agencies and individuals who contributed information and data for the report and my colleagues and I are enormously grateful to them for their help and their willingness to share information with us.

The report indicates several areas of concern especially relating to the injection of cocaine by some users and also highlights gaps in our knowledge of the implications of so-called recreational use of cocaine powder by the nasal route on an occasional or regular basis. In addition, the challenge to the prevention networks and the treatment services of incorporating another drug with serious social, personal and health consequences into their case mix should not be underestimated. It is our hope that this overview will provide a basis for a consideration of how best to respond to the many issues which arise from the increasing use of this drug, which has effects unique to it as a psychostimulant but which simultaneously poses risks which are common to mood altering drugs in general.

In presenting this report for consideration by all those involved in responding to the drugs phenomena I, on behalf of the NACD, would like to record our appreciation of the hard work by the Director of the NACD, Ms Mairéad Lyons and by our Research Officer, Ms Aileen O'Gorman, which has made its timely publication possible.

Dr Desmond Corrigan
Chairperson
NACD

Key Indicators of Cocaine Use

Prevalence Survey Data

- The NACD & DAIRU (2003) drug prevalence survey results show 3% of the general adult population report ever using cocaine and less than one per cent report ever using crack. Lifetime prevalence was highest among 15-24 year olds at 5.1%.
- The SLÁN (2002) survey reported an increase in levels of cocaine use. Last year use by males increased from 1.8% in 1998 to 3.0% in 2002 and in females from 0.6% to 1.9% during the same period.
- The ESPAD (1999) survey reported lifetime use of cocaine and crack at 2% among 16 year old school children.
- The HBSC (1998) survey reported 2.3% of the 10-17 year old respondents ever using cocaine, with 1.7% using in the previous month.

Police and Criminal Justice Data

- Offences relating to cocaine have almost doubled from 1999 to 2001, however, cocaine related offences represent only 3% of all offences under the Misuse of Drugs Act.
- Cocaine related offences were recorded predominantly in the Dublin Metropolitan Region (62%) with a notable number (17%) recorded in the Southern Region.
- Seizures of cocaine remain consistent at 3% of the total number of seizures.

Laboratory Data

- Substantial increases have been reported in urine samples testing positive for cocaine among the drug treatment population since 2000.
- The Medical Bureau of Road Safety report small numbers of samples testing positive for cocaine.

Drug Treatment Data

- The number of clients who report cocaine as their main problem drug has remained consistently small – approximately 1% of all those in drug treatment.
- The numbers reporting cocaine as their secondary problem drug have increased since 1996. However, benzodiazepines remain the most frequently reported secondary drugs.
- Primary cocaine users in treatment were predominantly snorting cocaine while over half of those presenting with cocaine as their secondary drug were injecting cocaine.
- The majority of treatment contacts reporting the use of cocaine were from the ERHA region, however, a small number of clients with cocaine problems had received treatment outside of the ERHA area.

Research Studies of Cocaine Use

Mayock (2001) – Exploratory Study of Cocaine Use in Ireland

- The findings of this study strongly suggest an increased availability and use of cocaine, especially among certain groups of recreational poly drug users and an increased visibility of cocaine on the club and pub scenes.
- Signs of increased cocaine use among opiate users in disadvantaged areas of Dublin were also noted.
- The study indicated that the nature of cocaine use is likely to differ substantially between problematic opiate drug users and recreational drug users.

UISCE (2002) – Survey of Cocaine Users

- A survey of 100 cocaine/crack users reported high levels of use mostly administered by injection and snorting. Poly drug use was common, mostly involving alcohol and cannabis but with notable levels of benzodiazepine and heroin use.

- Almost half of the respondents said they were currently receiving drug treatment for their problem heroin use.
- Well over half of the respondents felt their cocaine use was problematic, more than half of these had sought information on using cocaine, however, less than a third of these had sought treatment.

Merchants Quay Ireland (2003) – Survey of Cocaine Users

- A survey of 100 cocaine/crack users found high levels of poly drug use in the group with the vast majority using a range of drugs including heroin, benzodiazepines and alcohol.
- The majority of the respondents reported heroin as their primary drug of use, with a smaller number reporting cocaine as their primary drug.
- The vast majority reported injecting cocaine, with a high proportion reporting injecting a mixture of cocaine and heroin – a speedball.
- Few of the respondents viewed their cocaine use as problematic and only a small proportion had sought treatment for their cocaine use. However, most of those surveyed were currently on methadone maintenance programmes.

Anecdotal Information

- Anecdotal reports suggest that the increase in cocaine use has been across the general population not just among existing problem drug users or confined to certain urban areas.
- New cocaine users perceived the drug as clean and acceptable with minimal health implications, and were attracted by the perceived effects such as the absence of hangovers and an increased sex drive.
- Reports indicate that cocaine powder is being sold for between €30-40 per '1/2 gram' (usually a smaller amount is involved) and a rock of crack cocaine for €50.

Treatment Approaches

- There is no substitute drug available to treat cocaine dependence.
- Comprehensive programmes which include drug counselling, cognitive behavioural therapy as well as social and vocational interventions were found to be effective.
- In summary, our review of treatment literature found the following to be effective:
  - Some combined pharmacotherapies in conjunction with other interventions
  - Individual drug counselling
  - Group therapy/counselling
  - Self help groups
  - Peer leadership
  - Provision of early appointments
  - Outpatient programme for moderate problems
  - Residential programme for complex and severe problems

In addition, Auricular Acupuncture is showing promise in the management of cocaine dependence.

Findings and Implications

- Drug prevention approaches in Ireland are consistent with best practice internationally and there should be continued investment in this area.
- The perception that cocaine is a safe drug needs to be addressed given the levels of risk behaviour associated with injecting, with sharing of snorting and smoking equipment, and with combining cocaine use with alcohol and other drugs.
- The regional spread of cocaine users in both treatment data and Garda Síochána data indicates that the use of cocaine is not just a Dublin phenomenon.
- Evidence suggests that primary cocaine users do not perceive themselves as requiring treatment for their drug use, or, that they perceive existing treatment services as being inappropriate to their needs.
- The level of poly drug use noted in both the treatment population and the surveys of cocaine users represents a challenge for drug education, prevention, treatment, and harm reduction services.
- For drug treatment services the challenge will be to turn what has historically been a predominantly opiate focused system into one that meets the needs of cocaine and other drug users. Without the incentive of a substitute drug to offer, such as methadone, a key task will be to attract problem cocaine users into services and retain them long enough to achieve lasting change.

Chapter 1

About Cocaine

1.1 The Drug

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

1.2 Legislation

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

1.3 The Effects and Risks

The drug takes effect within minutes and users tend to feel energetic, alert, euphoric and talkative, with heightened sensations of sight, sound and smell. The effects from snorting cocaine start quickly but only last for up to 30 minutes without repeating the dose. The effects come on more rapidly if the user is smoking crack cocaine but these are then more short lived, approximately 10 minutes.[2]

When cocaine is taken with alcohol it combines in the system to form another drug – cocaethylene – which is more toxic than using either drug alone[3].

Cocaine can produce severe psychological dependence because of the strong cravings it produces leading to compulsive patterns of use. Tolerance develops resulting in users taking larger and/or more frequent doses in order to maintain the high.[4]

Common physical effects include dry mouth, sweating, loss of appetite and increased heart and pulse rate. Users may experience headaches, stomach pains and nausea, tremors, irritability, paranoia and hallucinations. Cocaine affects heart rhythms leading to possible heart attacks, it can lead to chest pain, raised blood pressure, respiratory failure, strokes and seizures.[5]

The after-effects of using cocaine and crack may include fatigue and depression as people come down from the high. Restlessness, nausea, hyperactivity, insomnia and weight loss may develop with frequent use. Lack of sleep and weight loss may lead to exhaustion and the user becoming very run down.[6]

Chronic use or heavy binges can lead to the development of paranoia, hallucinations, anxiety with panic attacks, and agitation. Confusion and aggressive behaviour may develop and violent behaviour may ensue.[7]

Prolonged heavy use of cocaine is usually followed by a 'crash' if use is discontinued. This 'crash' is characterised by exhaustion, restless sleep patterns, insomnia and depression.[8]

Repeated snorting of cocaine damages the membranes which line the nose. Repeated smoking of crack may cause breathing problems and partial loss of voice. Long term injecting may result in abscesses and infection. Injectors risk hepatitis and HIV infection if injecting equipment is shared. The sharing of smoking and snorting equipment has also risks for Hepatitis C.[9]

Cocaine users may be at increased risk of sexual transmission of HIV and Hepatitis B (and other sexually transmitted diseases) due to increased sexual risk behaviours and an association of stimulant use with sex work.[10]

Pregnant users of cocaine or crack may experience complications and find that their babies are adversely affected.[11]

For both crack and cocaine, dependency is not inevitable. Whether people become dependent, and if so how quickly it happens, will vary depending on the individual user's mental state and circumstances.[12]

The fact that cocaine and crack are expensive means that people who become heavy or dependent users may spend vast amounts of money and may find themselves involved in crime or prostitution to fund their habit.

1 Corrigan, 2003
2 Drugscope, 2003
3 Corrigan, 2003
4 Drugscope, 2003
5 Advisory Council on the Misuse of Drugs (ACMD), 2000; Scottish Advisory Committee on Drug Misuse (SACDM), 2002
6 Drugscope, 2003
7 SACDM, 2002
8 Erickson et al., 1987
9 Frischer, 1993; SACDM, 2002
10 National Treatment Agency, 2002
11 SACDM, 2002
12 Ditton and Hammersley, 1996; Reinarman, Murphy & Waldorf , 1994

Chapter 2

Indicators of Trends in Cocaine Use

As with other illicit drugs, it is difficult to calculate the extent of cocaine use within the population. Consequently, we must assess information from a range of sources to give us an indication of the nature and extent of its use. Such indicators include population studies, criminal justice data, laboratory data, drug treatment data, user surveys, and anecdotal information.

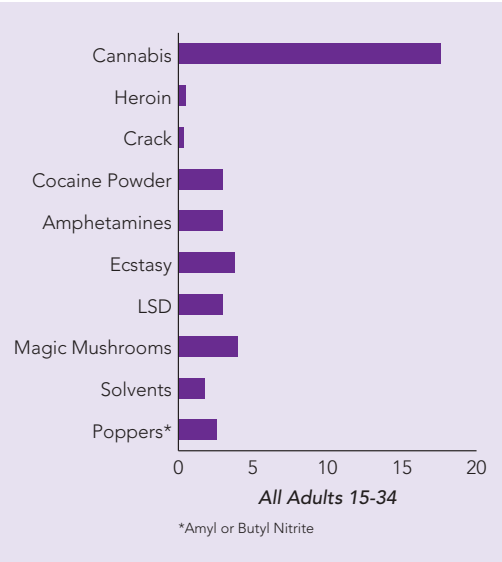
2.1 Prevalence Survey Data

NACD & DAIRU (2003) – Drug Prevalence Survey

In October 2003, initial findings from the first Irish drug prevalence household survey were published by the NACD and DAIRU[13]. This general population survey found that 3% of the adult population (aged 15-64) reported using cocaine (powder) in their lifetime. After cannabis (18%), magic mushrooms (4%) and ecstasy (4%), cocaine was the next most commonly used illegal drug (see Figure 2.1.1).

Male respondents reported more than double the rate of lifetime cocaine use (4.3%) than females (1.7%). The highest level of cocaine use reported was among 15-24 year olds who reported a lifetime prevalence rate of 5.1%, followed by rates of 4.2 % among 25-34 year olds and 2.7% among 35-44 year olds. Minimal rates of cocaine use were reported by those aged 45 and over.

Figure 2.1.1
Lifetime Prevalence of Illegal Drugs, Republic of Ireland



In terms of more recent levels of cocaine use (i.e. in the year prior to the survey), 15-34 year olds reported cocaine as the third most used illegal drug (2%) after cannabis (8.7%) and ecstasy (2.2%) (see Figure 2.1.2 page 11).

In terms of current use (i.e. in the month prior to the survey) among 15-34 year olds cocaine was the second most reported drug used at 0.7% after cannabis (4.4%) (see Figure 2.1.2 page 11).

A very small number of respondents reported the use of crack. Less than one percent (0.5%) of young adults aged between 15-34 reported ever using crack. In the year prior to the survey, 0.2% of respondents in this age group reported using this drug. However, no current use (i.e. in the previous month) was reported (see Figure 2.1.2 page 11).

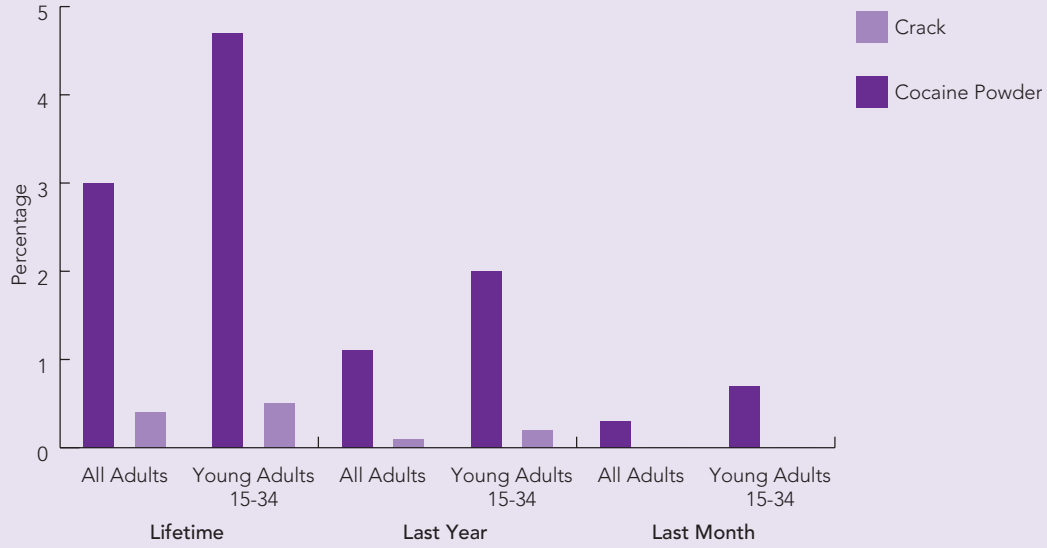
SLÁN (2002) and ESPAD (1999) Surveys

Two other population surveys have been conducted in Ireland which included questions about the use of cocaine. In 1998, the SLÁN survey of health and lifestyle behaviours in the general population, found 1.8% of males and 0.6% of female adults aged 18–64 had used cocaine in the previous year. However, this rate was almost three times as high (3.4%) in the 18-24 year age group.[14] In 2002, the rate among males and females who had used cocaine in the previous year had increased to 3.0% and 1.9% respectively.[15]

The 1998 SLÁN survey also included results from the HBSC survey of Irish health behaviours in school aged children (9-17 years). The findings from this survey show that 2.3% of respondents reported they had ever used cocaine, and 1.7% reported they had used cocaine in the previous month.[17]

In 1999, the ESPAD (European School Survey Project on Alcohol and other drugs) survey reported 2% of the school children (aged 16 years) surveyed reported ever having used cocaine and crack.[18]

Figure 2.1.2
Prevalence of Cocaine and Crack Use, Ireland



Source: NACD and DAIRU (2003)

2.2 Police and Criminal Justice Data

Misuse of Drugs Act Offences

Garda Síochána data on Offences under the Misuse of Drugs Act (MDA)[19] show a substantial increase in offences relating to cocaine throughout the 1990s from 11 cases recorded in 1990 to almost 300 cases in 2001 (see Table 2.2.1). Nonetheless, cocaine related offences remain relatively small (3% of all MDA offences in 2001) compared to offences for other drugs. The majority of MDA offences continue to be for cannabis (60% approx.) and ecstasy (27% approx.).

MDA offences relating to cocaine were recorded predominantly in the Dublin Metropolitan Region (62%) with a significant number (17%) recorded in the Southern Region (see Table 2.2.2).

Table 2.2.1
Number of Misuse of Drugs Act Offences by Drug Type

Year	Cocaine	Amphetamine	Heroin	Cannabis Resin	Ecstasy
1990	11	n/a	71	1,413	–
1991	7	n/a	45	2,354	45
1992	11	n/a	91	2,643	3
1993	15	n/a	81	2,895	66
1994	15	n/a	230	2,848	261
1995	30	n/a	296	2,209	645
1996	42	n/a	432	1,441	340
1997	97	n/a	564	2,096	475
1998	88	n/a	789	1,749	439
1999	169	464	887	3,281	1,023
2000	180	391	730	4,031	2,086
2001	297	207	908	4,053	1,845

Source: Garda Síochána

It should be noted, however, that increases in MDA offences may be seen to reflect increased Garda activity and resources as well as indicating increased drug use in the population.

Seizures

It is difficult to interpret trends from seizure data[20] as the quantities seized vary a great deal from year to year (see Tables 2.2.4 and 2.2.5). Again, seizures may reflect level of Garda Síochána and Customs and Excise activity rather than the extent of illicit drugs in circulation. While seizures of cocaine by the Garda Síochána have fluctuated throughout the 1990s, they have remained relatively consistent accounting for 3% of the total number of seizures.

Table 2.2.2

Misuse of Drugs Act Offences Relating to Cocaine by Garda Division where Proceedings Commenced

Garda Divison	1999	2000	2001
Eastern	9	19	14
Dublin Metropolitan	126	120	184
Northern	4	2	13
South Eastern	6	11	18
Southern	10	21	51
Western	14	7	17
All regions	169	180	297
As a percentage of all MDA offences	**2.3%**	**2.14%**	**3%**

Source: Garda Síochána

Garda Divisions

Eastern	(Carlow/Kildare, Laois/Offaly, Longford/Westmeath, Louth/Meath)
Northern	(Cavan/Monaghan, Donegal, Sligo/Leitrim)
South Eastern	(Tipperary, Waterford/Kilkenny, Wexford/Wicklow)
Southern	(Cork, Kerry, Limerick)
Western	(Clare, Galway West, Mayo, Roscommon/Galway East)

Table 2.2.3

Number of Drug Seizures by Garda Síochána

Year	Cocaine	Amphetamine	Heroin	Cannabis Resin	Ecstasy (MDMA)
1999	213	467	767	4,322	1,063
2000	206	169	598	4,401	1,846
2001	300	162	802	5,960	1,482

Source: Garda Síochána

Table 2.2.4

Quantity and Number of Cocaine Seizures by Garda Síochána

Year	Quantity	Number of Cases	% of Total Seizures
1997	11,020g	157	n/a
1998	333,167g	151	n/a
1999	85,554g	213	3%
2000	18,041g	206	3%
2001	5,325g	300	3%

Source: Garda Síochána

Table 2.2.5

Quantity and Value of Cocaine Seized by Customs and Excise

	Cases	Quantity (kgs)	Value
1999	n/a	27.20	£IR3,359,500
2000	n/a	11.81	£IR1,183,000
2001	3	.01	€1,016

Source: Customs and Excise

2.3 Laboratory Data

The Drug Analysis Laboratory of the Drug Treatment Centre Board (Trinity Court) reported an increase in the number of cocaine positive urine samples. An increase in cocaine positive urine samples was reported for the first six months of 2001 compared to 2002. It should be noted that these tests are predominantly carried out on drug users in treatment and are not representative of the general population. In addition, it should be noted that the data refers to the number of tests conducted rather than the number of individuals tested.

Table 2.3.1
Urinanalysis – Drug Treatment Centre Board

Year	Number of tests (N)	N. tested positive for cocaine	% tested positive for cocaine
2001 (Jan-Jun)	84,993	3,015	3.5%
2002 (Jan-Jun)	84,881	5,045	6.0%

Source: Drug Treatment Centre Board

The Medical Bureau of Road Safety reported that blood and urine specimens of drivers taken by the Garda Síochána found 6 samples testing positive for cocaine from a total of 78 samples in 2000. In 2001, 10 samples were confirmed positive from the 131 specimens taken.

Table 2.3.2
Urinanalysis – Medical Bureau of Road Safety

Year	Number of specimens tested (N)	N. tested positive for cocaine	% tested positive for cocaine
2000	78	6	7.7%
2001	131	10	7.6%

Source: Medical Bureau of Road Safety

2.4 Drug Treatment Data

Data from the National Drug Treatment Reporting System (NDTRS) provides information on all individuals receiving treatment during a given year (all treatment contacts/cases) and on a sub group of these who received treatment for the first time (new treatment contacts/cases). This data is representative of those who receive treatment for their problem drug use rather than the general drug using population.

Table 2.4.1 shows the main problem drugs reported by all and new treatment contacts in 2000. The vast majority of contacts reported opiates to be their main problem drug (76% of all cases and 47% of new cases), while just over 1% of all cases and 1.7% of new cases cited cocaine as their main problem drug.

Benzodiazepines were the most frequently reported second problem drug (18%) compared to 7% who reported cocaine (see Table 2.4.2). For new cases, cannabis was the most frequently reported second problem drug (18%) compared to cocaine (3.6%).

When the data for those citing cocaine as a problem drug is examined over time (see Table 2.4.3), small but increasing numbers of all and new treatment contacts are seen to report cocaine as their main problem drug. However, the number and proportion of all treatment contacts reporting cocaine as their second problem drug increased substantially between 1996 and 2000.

Of those in treatment during 2000 and reporting cocaine as their main problem drug (n=78), 53 (67.9%) reported snorting while 14 (17.9%) reported injecting the drug. In contrast, of those who stated cocaine was their secondary drug of misuse (n=502), almost half (47.5%) reported injecting while one third (33.6%) reported snorting the drug (unpublished data from the NDTRS).

In 2000, over half of the cases (54%) presenting with cocaine as their main problem drug and the majority (88%) of those reporting cocaine as their second problem drug were treated in the Eastern Regional Health Authority (ERHA) area (see Table 2.4.4). Treatment contacts living in ERHA and reporting cocaine as their secondary problem drug were more likely to report that heroin was their main problem drug than their counterparts living outside the ERHA area (96.0% versus 48.3%). This may reflect a different pattern of treatment seeking (and possibly use) for cocaine in Dublin, Wicklow and Kildare when compared with the rest of Ireland (unpublished data from the NDTRS).

Table 2.4.1

Main Problem Drug Reported by All and New Cases in Treatment, 2000

	All cases		New cases	
Drug	Number	Percentage	Number	Percentage
Opiates	5,333	76.3	934	47.2
Cocaine	78	1.1	33	1.7
Ecstasy	290	4.1	208	10.5
Amphetamines	30	0.4	19	1.0
Benzodiazepines	99	1.4	25	1.3
Volatile Inhalants	42	0.6	31	1.6
Cannabis	1,081	15.5	703	35.5
Other substances	41	0.6	25	1.3
Total number of cases	**6,994**		**1,978**	

Source: DMRD (2003) Occasional paper No. 9

Table 2.4.2

Secondary Problem Drug Reported by All and New Cases in Treatment, 2000

	All cases		New cases	
Drug	Number	Percentage	Number	Percentage
No secondary drug	*2,068*	*29.6*	*583*	*29.5*
Opiates	893	12.8	146	7.4
Cocaine	502	7.2	71	3.6
Ecstasy	566	8.1	317	16.0
Amphetamines	140	2.0	83	4.2
Benzodiazepines	1,258	18.0	147	7.4
Volatile Inhalants	21	0.3	15	0.8
Cannabis	1,052	15.0	361	18.3
Other substances	126	1.8	48	2.4
Alcohol	368	5.3	207	10.5
Total number of cases	**6,994**		**1,978**	

Source: DMRD (2003) Occasional paper No. 9

Table 2.4.3

Number of Treatment Contacts where Cocaine was cited as the Main or Second Problem Drug Used (corrected numbers), 1996-2000

	1996	1997	1998	1999	2000
All treatment contacts	*4,865*	*4,910*	*6,043*	*6,443*	*6,994*
Cocaine main problem drug	25	42	85	58	78
Cocaine secondary problem drug	121	196	292	444	502
First treatment contacts	*2,041*	*1,528*	*1,625*	*1,852*	*1,981*
Cocaine main problem drug	17	22	32	28	33
Cocaine secondary problem drug	50	48	60	86	71

Source: DMRD (2002) Occasional Papers No.s 1-8, except for 2000 figures which are unpublished NDTRS data

Table 2.4.4

Number of Treatment Contacts where Cocaine was cited as the Main or Second Problem Drug Used (corrected numbers), 1996-2000

	1996	1997	1998	1999	2000
All cases – Cocaine main problem drug					
Eastern Regional Health Authority*	20	30	61	39	41
Mid Western Health Board	1	4	13	3	12
South Eastern Health Board	3	5	8	6	8
Southern Health Board	0	3	3	9	8
Other Health Board Areas**	1	0	0	1	7
Total	**25**	**42**	**85**	**58**	**76**
All cases – Cocaine second problem drug					
Eastern Regional Health Authority*	110	177	272	406	444
Mid Western Health Board	3	9	9	18	12
South Eastern Health Board	4	6	5	6	20
Southern Health Board	1	4	5	5	17
Other Health Board Areas**	3	0	1	9	11
Total	**121**	**196**	**292**	**444**	**504**
New cases – Cocaine main problem drug					
Eastern Regional Health Authority*	14	15	26	18	17
Mid Western Health Board	1	1	1	1	6
South Eastern Health Board	2	4	3	4	4
Southern Health Board	0	2	2	5	2
Other Health Board Areas**	0	0	0	0	4
Total	**17**	**22**	**32**	**28**	**33**
New cases – Cocaine second problem drug					
Eastern Regional Health Authority*	43	45	51	71	41
Mid Western Health Board	3	9	9	18	6
South Eastern Health Board	2	1	3	1	11
Southern Health Board	1	2	4	3	7
Other Health Board Areas**	2	0	0	3	6
Total	**51**	**57**	**67**	**96**	**71**

Source: DMRD (2002) Occasional Papers No.s 1-8, except 2000 figure for ERHA which is unpublished NDTRS data

* Figures for 1999 and earlier relate to the Eastern Health Board area which was replaced by ERHA in 2000.

** Due to the small number of cases reported in the Midland, North Eastern, North Western, and Western Health Boards a total figure for these areas is provided.

2.5 Research Studies of Cocaine Use

Mayock (2001) – Exploratory Study of Cocaine Use in Ireland

In a study conducted for the Health Research Board, Mayock (2001) used available indicators of drug use and the perceptions of key informants and drugs workers as the basis for an exploratory study of cocaine use.

The study found strong indicators of increased availability and use of cocaine. In addition, data from in depth interviews with ten recreational cocaine users reported an increased visibility of cocaine on the club and pub scenes, a development which was regarded as recent. While the study found no systematic evidence of widespread cocaine use, the broad picture uncovered was one of increased likelihood of cocaine use among certain groups of recreational poly drug users.

The author also noted signs of increased cocaine use among opiate users who come from more disadvantaged urban areas, particularly within Dublin City. However, the nature of cocaine use was likely to differ substantially between problematic opiate drug users and recreational drug users. In addition, routes of administration were seen to vary between the two groups. For example, recreational users interviewed for the research ingested cocaine intranasally or orally, and did not consider their drug consumption as damaging or problematic. None of this group had been exposed to crack cocaine and did not consider using cocaine in this form.

UISCE (2002) – Survey of Cocaine Users

A survey of 100 cocaine users from the Dublin area was conducted by UISCE (Union for Improved Services, Communication and Education) for the NACD during November 2002. The sample chosen was purposive in that the interviewers used their networks and contacts to approach people they thought likely or knew to be cocaine users and completed face to face interviews with those who agreed.

Just over half (55%) of those surveyed were female. The average (mean) age of respondents was 30 years old; almost half (46%) of the respondents were in the 25-34 year age group.

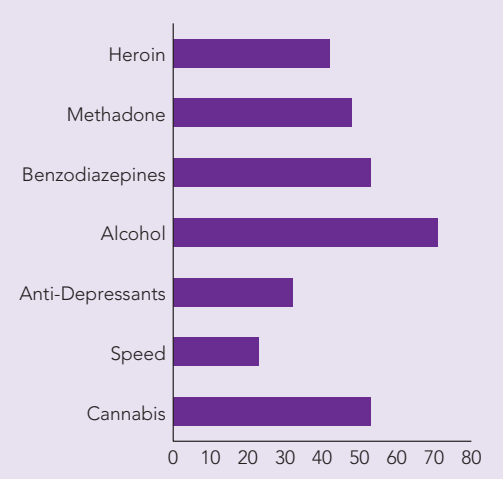
Over half (58%) of the sample reported injecting cocaine, almost as many (55%) said they snorted cocaine, while over a third (37%) said they smoked cocaine/crack. The range and overlap of methods by which the drug is used has risk implications for HIV and Hepatitis C infection and the harm reduction needs of users.

Among those surveyed, the average age of first use of cocaine was twenty-one years of age; regular use of the drug began somewhat later, on average at 25 years of age. Female respondents were younger than their male counterparts both when they first used the drug (over a quarter were under 18 years of age) and also when they began to use the drug regularly.

The majority of the respondents were weekly users with almost half (48%) using on a weekly basis, approximately four times a week. Forty percent of the respondents used cocaine on a daily basis, on average four times a day. Twelve percent used cocaine on a monthly basis, on average two to three times per month.

The respondents reported high levels of poly drug use. Approximately three quarters of those surveyed also used alcohol (71%) and cannabis (74%). Approximately half used benzodiazepines (54%) and methadone (49%) while less than half (43%) also used heroin. There were some gender differences in the range of drugs used. The male cocaine users reported more alcohol, methadone and heroin use than the females, while a higher percentage of women reported using antidepressants and amphetamines along with cocaine.

Figure 2.5.1
UISCE Survey – Percentage of Respondents Using Other Drugs



The contrast between the men and women in the sample shows some interesting trends. The women in the sample were younger both when they first used the drug and when they started using the drug regularly. More women were injecting than men but the women used less frequently and fewer regarded their cocaine use as a problem.

Almost half of the respondents (46%) said they were receiving drug treatment at the time of the interview. Forty-three percent said they were receiving treatment for their problematic use of heroin. Almost three quarters (74%) of those currently in treatment for their heroin use reported seeking treatment for their cocaine use.

A high proportion of the respondents (60%) felt their cocaine use was problematic, almost all of these (98%) had experienced changes in behaviour since using cocaine. However, less than a third of these had sought treatment.

Almost half (45%) of the respondents had looked for information on using cocaine, both those who regarded their drug use problematic and those who didn't, while almost a quarter (22%) had sought treatment for their cocaine use.

The findings on treatment and information requirements suggest different needs for this group. While many of the respondents felt their cocaine use was a problem, they were more likely to seek information than treatment. The low numbers of people seeking treatment may reflect the perceived lack of treatment for cocaine users. However, as the respondents were primarily poly drug users the implications are that treatment services may need to address generic addiction issues rather than focus service delivery on a particular type of drug.

Merchants Quay Ireland (2003) – Survey of Cocaine Users

During February 2003, Merchants Quay Ireland conducted a survey, for the NACD, of 100 clients presenting at their Contact Centre who had used cocaine/crack in the previous year.

Over three quarters (n=79) of those surveyed were male and twenty-one were female. The age range of those surveyed was between 19 – 48 years while the average (mean) age was 29 years. Almost half of the respondents (49%) were from Dublin's inner city. Over half (53%) of those interviewed were homeless (i.e. defined as those who reported living in a hostel, a B&B, a squat, staying with friends or sleeping rough). The vast majority of clients were unemployed (n=90), nine were in paid employment and one person was on a CE Scheme.

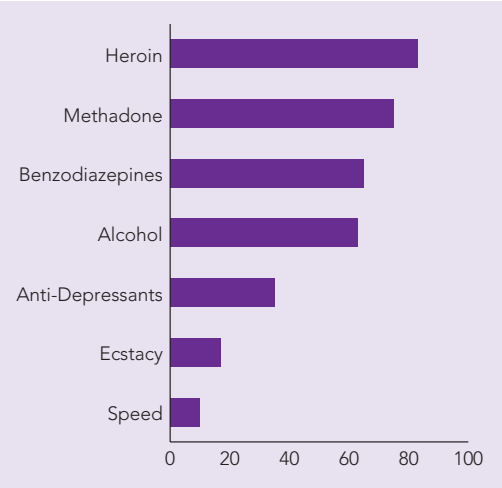
Among the 100 respondents, 95% had used cocaine powder in the last year and 40% had used crack cocaine – 60% had used cocaine powder only, 5% had used crack cocaine only, while over a third (35%) had used both. Of the 40 respondents who had used crack cocaine in the last year, half had bought it as rocks (n = 20) while 16 had washed it themselves (40%).

The average (mean) age of first use of cocaine was 22 years, similar to the first age of crack use at 23 years. However, almost half (n=44) of cocaine users began using before they were 20 years of age, compared to a third (n=12) of crack users.

All of the respondents surveyed were poly drug users i.e. currently using a number of (on average four) illicit drugs. Heroin was the most common primary drug for this group (59%) with a much smaller number (17%) reporting cocaine as their primary drug. Overall, 83% of the respondents reported using heroin; three-quarters were using methadone, this was prescribed for most (82%, n=61); two thirds reported using benzodiazepines (65%); and over half (52%) reported alcohol use.

Figure 2.5.2

Merchants Quay Ireland Survey – Percentage of Respondents Using Other Drugs



Given that the Contact Centre mainly targets intravenous drug users, it was not surprising that the vast majority of cocaine users (82%) reported injecting cocaine while 15% reported snorting and 3% (n=1) smoking. The majority of those who injected cocaine (59%, n=46) injected it by itself, while 41% (n=32) mixed it with heroin (i.e. as a speedball). Two-thirds (n=26) of crack users reported smoking, while 30% reported injecting crack. These very high rates of injecting cocaine, crack and 'speedball' indicate particularly high levels of risk behaviour among this group.

The frequency of cocaine use among the respondents was not overly high, reflecting the range of other drugs used by this cohort. Almost half (49%) of the respondents reported weekly use of cocaine while twenty per cent reported daily use. A third (33%) reported weekly use of crack while 5% reported daily use. However, 45% (n=18) of those who used crack and 23% (n=22) of cocaine users had not used in the last month indicating infrequent or binge use (repetitive use over a short period of time) for this cohort. Almost three-quarters (n=73) of the respondents describe their use as binge use: an issue which has high risk implications and which poses difficulties for the agencies dealing with this group.

The 78 respondents who injected cocaine were asked if they had experienced any difficulties resulting from their drug injecting. Sixteen (21%) had experienced accidental overdoses. Over one-third (37%, n=29) reported scarring/bruising while approximately a quarter experienced dirty hits (27%, n=21) and abscesses (24%, n=19). Other complaints included thrombosis, palpitations and blood clots. It is worth noting however, that 87% of those who injected cocaine were currently also using heroin, so it is difficult to conclude whether the difficulties experienced were due to intravenous heroin or cocaine use.

Approximately half of the respondents noticed they had become more depressed (54%) and more anxious (50%) since using cocaine/crack, A large number reported breathing difficulties (45%) and a third (34%) said they had become more confused. Other changes in behaviour noticed by respondents included paranoia (13%), aggressiveness (5%), suicidal feelings (2%), anger (2%), mood swings (2%), hallucinations (1%), and agitation (1%).

However, despite these issues, two-thirds (66%) of the respondents felt that their cocaine use was not problematic and only 12% of the respondents had sought treatment for their cocaine use. Those who had sought treatment for cocaine were slightly older (on average 32 years); no client younger than 25 had ever sought treatment for cocaine. Among those who perceived their cocaine/crack use as problematic, only 16% (n=5) had sought treatment for their cocaine/crack use. Indeed, many respondents reported the futility of seeking treatment for cocaine/crack use due to the lack of a pharmacological substitute for its use; as exists for the treatment of opiate misuse.

A large proportion of the respondents, almost two-thirds (65%), were currently on methadone maintenance programmes, while the vast majority of respondents (92%) were in contact with needle exchanges, just over a fifth (21%) were attending drug counselling and 13% were going to NA meetings.

The extent of poly drug use among the respondents, and in particular among those receiving treatment for heroin addiction, has implications for services and their capacity to respond to these clients.

2.6 Anecdotal Information

Anecdotal reports suggest that the increase in cocaine use has been across the general population not just among existing problem drug users or confined to certain urban areas. Reports of an increased level of cocaine use in the pub and club scenes are thought to be related to greater availability, cheaper price and as a substitute for ecstasy which appears to have become less fashionable and less popular due to reports of poor and fluctuating quality.

Sources indicate that cocaine powder is being sold for between €30-40 per '1/2 gram' (usually a smaller amount is involved). A gram of cocaine would give users between 5-10 lines for snorting which could last two people anything from a couple of hours to a whole night, depending on their tolerance, appetite for the drug and its strength.

Anecdotal information about the use and sale of crack cocaine is patchier, one report told of it being sold for €50 for a rock which would be sufficient for about 5 smokes.

In 2002, Citywide Drugs Crisis Campaign facilitated a meeting of community, voluntary and statutory sector representatives to discuss 'Cocaine Use in our Communities'. Attendees at the meeting identified two distinct groups: cocaine users who have never had involvement in heroin use, and existing heroin users many of whom are also clients of drug services.

Attendees from drug treatment services raised concerns about the number of clients who are co-dependent on heroin and cocaine and the implications this had for their stability in treatment. Attendees also reported that the new cocaine users perceived the drug as clean and acceptable with minimal health implications, and were attracted by the perceived effects such as the absence of hangovers and an increase in sex drive. The meeting also reported that the drug is readily available and acceptable, especially in pubs in a way that heroin has never been.

13 DAIRU - The Drug and Alcohol Information and Research Unit in Northern Ireland

14 Moran et al., 2001

15 SLÁN and HBSC, 2002

16 Moran et al., 2001

17 Moran et al., 2001

18 Hibbell et al., 2000

19 An Garda Síochána, 2002

20 An Garda Síochána, 2002; Revenue Commissioners, 2002

Chapter 3

Treatment Approaches

The challenge for drug treatment services is to turn what has historically been a predominantly opiate focused treatment system into one that is capable of meeting the needs of cocaine misusers. Without the incentive of a substitute drug to offer, such as methadone, a key task will be to attract problem cocaine users into services and retain them long enough to achieving lasting change.

3.1 Review of Treatment Literature

The international literature demonstrates that there is no recognised pharmacotherapy (chemical treatment of dependence) for cocaine dependence.[22] However, findings from a preliminary trial using Buprenorphine and Disulfiram (Antabuse) with heroin and cocaine dependent subjects do suggest that this combined therapy can have an effect on the use of cocaine.[23] The use of Methadone and Disulfiram for heroin and cocaine dependent subjects also showed promising results even when alcohol use was controlled for.[24] Disulfiram used with psychotherapies for treating cocaine and alcohol dependence in patients was found to contribute to reduced cocaine use over the long term.[25] However, it is recommended that other measures such as psychosocial support should be available to the individual whilst they are receiving pharmacotherapy.[26]

In the UK, the National Treatment Outcome Study (NTORS) has shown that about one third of heroin users at intake were also using crack cocaine. At the four and five year follow up, use of crack cocaine had more than halved. However, for the heroin users who did not use crack cocaine at intake, at least one quarter were using at follow up. This is of particular concern and has implications for the management of poly drug use in those who present to treatment services.[27] These findings indicate the importance of managing secondary drug misuse and engaging proactively in relapse prevention.

Once they start treatment, clients tend to stay longer and respond better if they feel that their concerns are being positively addressed and that their key worker is empathic and understanding, underlining the crucial role workers play in motivating and retaining clients.[28]

Counselling, both individual and group therapy is effective in the management of cocaine dependence. Recognised psychotherapies delivered by professional psychologists perform no better than well- structured drug counselling. In the USA, cognitive-behavioural approaches have a relatively large and positive evidence base. Group therapy using these approaches has been found to be as effective as individual therapy. Both individual and group therapy is effective in relapse prevention.[29]

Retention in treatment is influenced by demographic factors such as age, education and employment. In addition, the severity of cocaine use on entry and the presence of a psychiatric disorder is seen to impact negatively on treatment retention.[30]

Providing further training to staff whilst caring for clients does not impact negatively on outcomes. Mental health trainees were taught to apply effective Network Therapy (a cognitive behavioural approach) for effective substance abuse management. Their patients fared as well as those receiving treatment with experienced therapists.[31]

There is little understanding of how to prompt initial contact with treatment services, but once contact is made, rapid intake, proactive reminders, and practical help with attendance have improved treatment uptake rates.[32] Cocaine users offered treatment within 24 hours are four times more likely to attend for the appointment than those offered treatment later. Initial attendance at treatment is not influenced significantly by client and situational variables but by delay between the initial phone contact and the appointment offered.[33]

Cocaine users with complex needs such as homelessness and mental health issues showed satisfactory levels of abstinence (69% of 340 subjects) by combining peer leadership and professional support in a day programme.[34]

Self-help groups are also effective. Cocaine users who have previous experience of drug treatment and severe cocaine use were found to be the most frequent attendees.[35]

Drug-free psychosocial interventions such as counselling, provided on a non-residential basis, are the most cost-effective options for clients with few complicating problems.[36]

Cost benefit analysis of long term residential (LTR) and out-patient drug free (ODF) treatments for cocaine dependent patients from DATOS (USA longitudinal treatment study) showed that both patients treated in LTR and ODF showed reductions in costs of crime before and after treatment. Highest levels of crime were associated with LTR patients before treatment yet, they showed the highest level of reductions in cost of crime after treatment. This shows that treatment provides significant returns on investment.[37]

Harm reduction messages need to be targeted at cocaine users also. Young people are often oblivious to the harms and how to minimise them when using cocaine.[38] Harm reduction approaches are very effective and have not led to an increase in injecting drug use.[39]

Patients who receive optimal therapy depending on the severity of their cocaine use have decreased their cocaine use by up to 85%. Long term residential therapy was most effective for patients with severe and complex problems whilst outpatient therapy was effective for those with moderate problems.[40]

Clients with multiple needs tend to benefit from intensive residential rehabilitation and (if they stay long enough) do better there than in community-based drug counselling. However, for many clients intensive rehabilitation programmes can be provided just as effectively on a day-care basis.[41]

Alternative therapies are increasingly popular and some early findings are showing that when auricular acupuncture is used in addition to other interventions as part of a comprehensive programme, patients show decreased cocaine use and higher levels of abstinence. Alternative therapies could play an important role in retaining patients in treatment.[42]

In summary, our review of treatment literature found the following to be effective:

- Individual drug counselling
- Group therapy/counselling
- Self help groups
- Peer leadership
- Provision of early appointments
- No delays in providing treatment
- Outpatient programme for moderate problems
- Residential programme for complex and severe problems
- Combined pharmacotherapies in conjunction with other interventions

22 Farrell et al., 2002
23 George et al., 2000; Weiss and O'Leary, 2000
24 Petrakis et al., 2000; Weiss and O'Leary 2000
25 Carroll et al., 2000
26 Farrell et al., 2002
27 Gossop et al., 2002
28 Whitton and Ashton, 2002
29 CritsChristoph et al., 2001; Schmitz et al., 1997
30 Siqueland et al., 2002a; Siqueland et al., 2002b
31 Galanter et al., 1997
32 Whitton and Ashton, 2002
33 Festinger et al., 1995 and 2002
34 Galanter et al., 1998
35 Weiss et al., 2000
36 Flynn et al., 1999
37 Flynn et al., 1999
38 Boys et al., 2002
39 vanAmeijden and Coutinho 2001; Magura 1998
40 NIDA 1999
41 Whitton and Ashton 2002
42 NIDA 2000

Chapter 4

Findings and Implications

It is clear from the research that people who start using cocaine do not consider the harmful effects. It is perceived as a safe drug that does not lead to dependency in the same way that other drugs such as heroin do. The harm of mixing alcohol and cocaine use on the same occasion add significant risks and is little understood by cocaine users. Drug prevention approaches in Ireland are consistent with best practice internationally and there should be continued investment in this area[43]. Approaches that emphasise personal and social development, stress social skills and enhance decision-making in school based and community programmes can be effective[44].

The perception that cocaine is a safe drug has implications for the levels of risk behaviour associated with injecting, with the sharing of snorting and smoking equipment to administer the drug, and with combining cocaine use with alcohol use.

The regional spread of cocaine users in both treatment data and Garda Síochána data indicates that the use of cocaine is not just a Dublin phenomenon.

To date, a small number of treatment contacts have presented to services with cocaine as their primary drug of misuse – approximately 1% of all contacts. This would seem to suggest that primary cocaine users do not perceive themselves as requiring treatment for their drug use, or, that that they perceive existing treatment services as being inappropriate to their needs.

The level of poly drug use noted in both the treatment population and the survey of cocaine users represents a challenge for drug education, prevention, treatment, and harm reduction services.

For drug treatment services the challenge will be to turn what has historically been a predominantly opiate focused system into one that meets the needs of cocaine and poly drug misusers. Without the incentive of a substitute drug to offer, such as methadone, a key task will be to attract cocaine users into services and retain them long enough to achieving lasting change.

43 Morgan, 2001

44 Morgan, 2001

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Your Plan - Your Future

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