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A Study of Cocaine Use in Northern Ireland 2009

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**The views expressed in this
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Executive Summary

There is evidence of an increase in cocaine use in Northern Ireland in recent years as seen through increases in police seizures of the drug, higher prevalence rates of use in self-report surveys and more people presenting to treatment services. This study explored the patterns of cocaine use and the lifestyles of users in Northern Ireland with the aim of providing the Department of Health, Social Services and Public Safety (DHSSPS) and treatment service providers with a better understanding of cocaine use in Northern Ireland. This primarily qualitative study was conducted in two phases. In Phase I a 'Community Assessment Process' was conducted to gain an understanding of the experiences of drug treatment professionals to cocaine use in Northern Ireland. In phase II 40 in-depth interviews were conducted with cocaine users. The study identified two types of cocaine user, these are recreational or socially integrated users and those referred for drug treatment who as a group was socially marginalized users. For the purposes of this study these users will be referred to as either recreational or treatment users. The demographic profiles of each type of user differed in a number of important respects. The recreational users were typically young, educated and anchored to a largely conventional lifestyle and whose pattern of non-work activities involved partying and drug use. Treatment users, on the other hand, generally had low level educational qualifications and were typically unemployed and living on state benefits. A number of the treatment users were either living in a hostel at the time of interview or had experienced homelessness at some time in their life. None of the recreational users reported any experience of homelessness. These distinctions, as well as differences between the groups in terms of their drug use patterns, preferences and practices, strongly suggest that in unravelling the nature of cocaine use and cocaine problems there is a need to look beyond the drug itself. It is perhaps important to note that many of the treatment professionals interviewed for this study referred to the absence of a typical cocaine user profile. These professionals distinguished between recreational and treatment users. There was considerable uniformity within the study between the experiences and perceptions of service providers and cocaine users in the study.

Both recreational and treatment users were already drug-experienced when they used cocaine for the first time, with initiation to other drugs typically occurring several years before first use of cocaine. All cocaine users were polydrug users who had considerable experience with a range of illicit drugs. The majority in both groups had used cannabis, Ecstasy and amphetamine during their lifetime and many had used one or more of these drugs regularly at some time. Cocaine initiation typically occurs in familiar settings where the drug is invariably offered by familiar people. The dominant and favoured use settings were indoor, private spaces, showing that cocaine use generally takes place away from the public gaze and is likely to remain quite hidden. Recreational users in particular preferred to cocaine use in the company of others, either in their own home or in the home of a friend. House parties were the most talked about use contexts, although many recreational users had also snorted cocaine in public licensed premises (pubs and clubs).

Recreational users were more animated than treatment users in their portrayal of cocaine benefits, and listed an array of appealing aspects of the drug which were strongly linked to self- and social- enhancement. Whilst treatment users talked about a number of these benefits – including increased self-confidence and feeling more energetic – their accounts focused to a greater extent on the chemical highs they experienced from use. However recreational and treatment users differed quite significantly in terms of their experiences and perceptions of risk and the negative consequences associated with cocaine use. Recreational users often reported no negative consequences or side effects arising from their use of the drug and many equated any downsides or unappealing effects with those associated with an alcohol hangover. Treatment users on the other hand were relatively well-versed on the range of risks associated with cocaine use, including its impact on their physical and mental health and well-being. Their perspectives on cocaine risks may to some extent have been influenced by the experience of treatment, since the dangers of continued cocaine and other drug use are usually communicated within drug treatment regimes. Treatment users referred frequently to their ‘addiction’ to cocaine, a relatively rare reference point among the study’s recreational users who, in the main, claimed to ‘control’ their cocaine consumption. These differences in user perceptions of cocaine risks, particularly in relation to the risk (and perceived reality) of ‘addiction’, have implications for both prevention and treatment initiatives. For example, health messages stressing cocaine’s addictive potential may be ineffective if a majority of recreational users experience and perceive no such risk. These users are likely to be more open to messages that match their experiences and to place greater value on advice about how to reduce the potential physical and/or psychological hazards associated with cocaine use.

The experience of those referred for treatment was varied on this provision across the sample. These users, rightly or wrongly, often diminish the negative impact of cocaine on their lives and on their physical and psychological health, believing that the negative impact of drugs is more related to another substance(s). From a drug treatment perspective this situation presents challenges, particularly in relation to how services and interventions are organised and equipped to respond to polydrug users, including those who use cocaine. This was largely corroborated by those professionals interviewed for the study who identified gaps in service provision specific to cocaine-using clients as well as a perception that treatment providers lacked the requisite knowledge about how to adjust their services to meet the needs of problem drug users who use cocaine, a situation that is not unique to Northern Ireland. This perceived lack of experience in dealing with cocaine-(ab)using clients points to a need for education for drug treatment and health professionals on the management of cocaine problems. This and the general findings from the study suggest that a convincing case can be made for the development of preventive messages which aim to reinforce some of the basic ‘standards’ and practices employed by cocaine (and other recreational) drug users to reduce injury and harm. Practical and ‘sensible’ advice which corresponds with the experiences of drug users is likely to be embraced rather than rejected by drug users who already subscribe to rules and strategies aimed at maintaining safe drug use practices.

Introduction to the Study

Background to the Study

There is evidence of an increase in cocaine use in Northern Ireland as seen through increases in police seizures of cocaine in recent years¹, an increase in prevalence as measured through self-report surveys²⁻³, and an increase in the numbers presenting to treatment services as measured through the Drug Misuse Database⁴. Increasingly these indicators suggest that cocaine, historically associated with more affluent members of society, appears to have become increasingly available in Northern Ireland recently. In a survey of drug use in Northern Ireland the lifetime prevalence rate for cocaine increased from 1.6% in 2002/03 to 5.2% in 2006/07, with young adults aged 15-34 showing higher lifetime prevalence (2.9% in 2002/03 and 9.1% in 2006/07)³. This pattern was repeated across the European Union where an estimated 13 million (3.9%) adults (15–64 years) have tried cocaine, with higher levels of use (5.6%) among young adults (15–34 years)⁵. Across Europe, cocaine was the second most popular illicit drug of use after cannabis. This pattern was observed among those presenting to treatment services in Northern Ireland with problem drug use during the year ending 31 March 2009 who reported cocaine as their main drug increased to 11% in 2008/09 from 10% in 2007/08⁴. Treating problem cocaine use requires assessment of the psychobiological, social and pharmacological factors being faced by the user. A number of treatment interventions exist including behavioural interventions, counselling and self-help programmes. These interventions are delivered in both in-patient and out-patient settings. However, no pharmacological intervention exists at present for treating problem cocaine use. Within Northern Ireland problem cocaine users are referred to existing generic drug treatment services a situation that is not unique to Northern Ireland.

A research priority was identified by the Department of Health, Social Services and Public Safety (DHSSPS) to conduct a study into cocaine use in Northern Ireland in order to explore patterns of use of the drug and lifestyles of cocaine users in Northern Ireland. Drugs are not consumed in isolation and for some, drug consumption is linked to an active expression of how users cope with their social structures⁶. Therefore an understanding of their social experience of drugs will provide insights into our understanding of the role of drugs in the lives of users.

Aim of the Study

The aim of this study was to provide the Department of Health, Social Services and Public Safety (DHSSPS) and treatment service providers with a better understanding of cocaine use in Northern Ireland through a qualitative study that explored the patterns of cocaine use and the lifestyles of users.

The proposed content of the research will incorporate the following:

1. An assessment of drug use patterns and lifestyles of cocaine users in Northern Ireland.
2. Information on prevention treatment options and information needs about cocaine use.

Chapter 1: Contemporary Issues and Cocaine Use

The past two decades have witnessed a global increase in the levels of cocaine use. In the USA cocaine abuse has reached epidemic levels, with an estimated 1.3 million users in the 1990s⁷ and 1.9 million current users reported in the National Household Survey on Drug Use and Health in 2008⁸. During this period concerns were raised in other countries, such as Australia, about a future cocaine epidemic⁹⁻¹¹ whilst cocaine problems have become more common in Europe since the early 1990s to the extent that they are now part of the European drug scene¹². For example, it has been suggested that the use of cocaine powder intranasally may be a gateway behaviour to using crack cocaine¹³. These concerns were heightened by the serious personal problems experienced by many cocaine users¹⁴⁻¹⁷ and the role of the black market in its supply¹⁸. This included an increased risk of transmission of the human immunodeficiency virus (HIV)¹⁹. Whilst cocaine use may not have reached the feared epidemic status globally, the level of use has increased over the past two decades across western societies with greater attention increasingly focused on this as a social issue and the levels of physical health problems associated with its use.

The most common adverse health effects of cocaine are cardiovascular disorders, cerebrovascular disorders (e.g. strokes) and neurological impairments (e.g. seizures) which occur regardless of route of administration²⁰. In a sample of those presenting to accident and emergency departments in the USA, Kontos et al.²¹ reported chest pains and palpitations were among the most common complaints by cocaine users. Other medical problems linked to cocaine included myocardial ischaemia and infarction²²⁻²⁵. In the USA cocaine use has been recognised as a cause of cerebrovascular accidents²⁶.

As the prevalence estimates of cocaine use rise, more cases have linked its abuse to a major cause of morbidity and mortality, particularly in the USA²⁷. In 2007, across the European Union, around 500 deaths were recorded as cocaine-related by 12 member states (compared to 450 in 14 countries in 2006)⁵. At present, cocaine deaths are more difficult to identify than opioid-related deaths as the extent of both morbidity and mortality related directly to cocaine use remains difficult to estimate²⁸. Repeated use of cocaine has been shown to lead to dependence in some users. In consequence, there is a need to expand the treatment repertoire for this condition. Historically, the public perception of cocaine has at times been ambivalent whilst medical opinion on the drug has ranged from neutrality to condemnation over the past four decades³⁰⁻³¹. Concerns may have been heightened by UK drug policy which has categorised cocaine along with heroin as the most harmful drugs used by young people³¹. The increasing numbers using cocaine have led to increased interest in understanding more fully what adverse effects these substances have on users. Furthermore, as cocaine users have historically been less likely to be linked with criminal elements and drug markets, and less likely to report its use to health services, it may have received a lower priority rating from policy makers, practitioners and researchers³².

Cocaine-related deaths have also increased substantially in the UK³³⁻³⁴. In Northern Ireland 18 cases where the cause of death was directly associated with the use of cocaine were identified between 1 January 1999 and 31 December 2007³⁴. Whilst this may appear a relatively low level

of mortality, Lyness³⁴ noted there has been an increase in the number of cocaine-related deaths during this period. In particular he claims there has been an increase in the number of deaths attributable to cocaine as the single drug of use since 2005. High levels of polydrug use are regularly noted among cocaine-related fatalities, particularly heroin and alcohol. One in 10 of the deaths noted that this contributed to complications of use, such as myocardial infarction or cerebrovascular accident²⁷. Cocaine dependence is claimed to be a common and serious condition, associated with severe medical, psychological and social problems, including the spread of infectious diseases.

Among a sample of teenage users in Northern Ireland, the risk factors for cocaine use identified early alcohol or cannabis use, drug availability, and poor parent-child communication². Other risk factors identified elsewhere include exposure to traumatic experiences, living in marginalised situations³⁵, and even curiosity³⁶. Boys et al.³⁷ reported the three most common problems associated with cocaine as impaired control, prioritising money for cocaine, and preoccupation with using it. This study also noted that females were more likely to use cocaine to reduce inhibition in social situations, which Boys et al.³⁷ suggest raises concern about their potential risk for longer term problems. The research conducted by Boys and her colleagues focused on the experiences of younger cocaine users, an issue which has attracted increasing interest from researchers and policy makers during the past decade and one which has been addressed more recently in the Belfast Youth Development Study². More worrying amongst younger users were accounts of longer-lasting psychological symptoms such as feelings of depression, paranoia or lack of motivation³⁸.

Polydrug use is considered the norm for cocaine users and studies have consistently reported that a high percentage of cocaine users report experience with other drugs including cannabis, ecstasy, amphetamine and, in fewer cases, heroin³⁹⁻⁴². In the past, cocaine use was often associated with higher socioeconomic status individuals who were typically employed, had high levels of education and income, and who snorted the drug⁴³. However, in a recent British Crime Survey in England and Wales, skilled and semi-skilled manual workers were found to be more likely to use cocaine than professional workers⁴⁴. Most of these cocaine users were younger polydrug users who were employed in low- to middle-income-level jobs across a variety of trades and service industries. They used the drug mainly in private settings such as homes and private parties and reported few cocaine problems.

Research conducted in the late 1980s and early 1990s in Australia noted that cocaine use among recreational users was typically of low level frequency with low levels of harm linked to its use²⁵. Research also suggests that cocaine users develop strategies and often take specific steps to regulate their intake of the drug^{39,45-47}. Indeed, controlled use of cocaine powder has been described as the norm, with only a minority of users developing problems associated with its use^{39,40,45,48-51}. Across a number of jurisdictions, the majority of cocaine users in the general population have been described as experimental, occasional or moderate users of the drug^{43,45,52}, although some users can become heavy users and/or develop problems⁴⁷. Research increasingly points to differences between treatment and non-treatment cocaine users. In an early but influential study, Chitwood and Morningstar⁵³ compared 95 drug treatment clients with 75 non-treatment clients contacted through network sampling. The majority of the study's participants were polydrug users whose drug of choice was cocaine, or cocaine in combination with some

other drug. This research uncovered differences between the treatment and non-treatment samples across a number of dimensions. The treatment clients were more likely to be heavy cocaine users, to experience negative consequences arising from its use, to have been unemployed, and to have fewer support networks of close friends. They were also more likely to have experienced job loss and marital/relationship breakup and to have been arrested and report illegal activity as a source of income⁵³. Chitwood and Morningstar⁵³ felt this signalled strong differences between those cocaine users who develop problems and those who maintain more 'controlled' patterns of use. More recently in Australia, Shearer et al.³² examined the nature of cocaine use and harms through a cross-sectional survey of cocaine users in Sydney and Melbourne. The findings of this study led to the identification of two quite distinct types of cocaine user. One type, described as *socially integrated* cocaine users, were employed and well educated individuals who occasionally snorted cocaine, typically in conjunction with other substances, and who reported few cocaine-specific problems. The second type, described as *socially and economically marginalised* users, reported more frequent use and higher dosages, they typically injected cocaine (often in conjunction with heroin), and experienced most of the physical, psychological and social problems reported by study participants. Perhaps significantly, cocaine was not the primary drug of choice in either group despite the significant differences to emerge in relation to their drug use and other areas of life experience.

Thus, it appears that cocaine users are a diverse group and that there is great variation in the frequency with which individuals use the drug, as well as the use patterns or 'careers' they follow subsequent to initiation. Routes of administration also vary, although snorting appears to be the most common mode of ingestion. Knowledge and understanding of cocaine use in Northern Ireland is comparatively limited and, to date, no dedicated study of cocaine use has been undertaken. Available indicators, which point to increased prevalence rates of cocaine use in the general population and among those seeking treatment suggest that research on this topic is overdue. This research, which is qualitative and exploratory, aims to create a knowledge-base specific to cocaine use in Northern Ireland. The research strategy and methods are detailed in full in the following chapter.

Chapter 2: The Study Methodology

Since there is no previous qualitative research on cocaine users in Northern Ireland, this study sought to fill an obvious gap in knowledge. The study aim was deliberately broad – to assess the drug use patterns and lifestyles of cocaine users in Northern Ireland – as set out in the tender document issued by the DHSSPS, Northern Ireland. A major goal was to gather cocaine users' accounts of how, what, when, where, and with whom they used cocaine⁵¹, information which could potentially inform future drug prevention and treatment options and initiatives.

Research Strategy

This primarily qualitative study was conducted in two phases. During Phase I a 'Community Assessment Process' was conducted. Phase II involved the conduct of 40 in-depth interviews with cocaine users recruited using a mixed sampling strategy which aimed to achieve diversity across variables such as age, gender and levels and 'types' of cocaine consumption.

Community Assessment Process

The study began with a 'Community Assessment Process' (CAP)^{54,55}. One objective of this initial phase was to inform the community of professionals (youth work agencies, youth workers, drug treatment agencies, outreach teams etc) about the study, its aims and data collection procedures. A second was to access existing local knowledge about cocaine use at community level. Essentially a process of engagement with professionals, the CAP provided the research team with an opportunity to begin informal discussions with a network of *key informants* who could provide information about how people might be contacted with a view to their consenting to participating in the study. It was hoped that some key informants might also be in a position to provide researchers with introductions to potential participants.

At a conceptual level, the CAP assisted with the identification of various 'sub-groups' of cocaine users that could potentially enable the study of variability. The specific analytic goals of the CAP were:

- To develop a broad typology of the physical settings, environments and 'groups' in which cocaine use occurs. This in turn aided the construction of a mixed sampling strategy and guided the selection of a diverse range of study participants.
- To identify possible variability in perceived cocaine availability and use in different geographical areas.
- To initiate the process of establishing contact and rapport with prospective study respondents.
- To refine the research instruments (in-depth interview schedule).

These goals were achieved through the use of semi-structured qualitative interviews with key informants who are frontline service providers and have some kind of regular, direct contact with cocaine users (e.g. outreach workers, health services staff, drug treatment providers etc).

Key areas addressed during interview included:

- the perceived extent of cocaine use;
- the needs (both immediate and long-term) of cocaine users;
- the adequacy of current drug treatment provision;
- difficulties associated with the delivery of services to cocaine users; and
- gaps in service provision.

The study's participants provided vital information regarding where, when and how individuals might be targeted for participation in in-depth interviews. Members of local community service organisations were also in a position to make initial introductions to prospective research participants. Most importantly, all possible avenues of access were explored as the CAP proceeded. A total of 14 key informants were interviewed during the early months of the data collection process. During this time the in-depth interview schedule was refined and the recruitment process initiated.

In-depth Qualitative Interviews with Cocaine Users

Qualitative approaches are more exploratory and interactive in form than quantitative methods and are therefore better for generating ideas and policy recommendations^{56,57}. The individual in-depth interview was the core data collection method. Referred to elsewhere as a *conversation with a purpose*⁵⁸, the in-depth interview is particularly suited to accessing detailed information on people's drug experiences and behaviours, and about their attitudes and beliefs about drugs⁵⁹. Individual interviews also tend to be most appropriate for the investigation of sensitive and complex issues⁶⁰.

The interview schedule was designed to allow for flexibility in structure and content and to facilitate the exploration of experiences that respondents themselves deemed personally significant. However, specific areas were targeted for questioning in the case of all respondents. In a general sense, the interview focused on respondents' drug 'stories', that is, age of drug initiation, the type and level of their drug consumption (past and present), drug use contexts and their motives for drug use. Historical information was thus sought on *all* drugs used over the life course. Attempts were therefore made to establish where cocaine use 'fits' with other substance-related behaviour (including alcohol consumption).

The following areas of questioning specifically targeted information on respondents' cocaine use:

- Lifestyle (typical day, education and employment history, social activities, peers).
- Pattern of cocaine consumption (age of onset, frequency, mode of administration, dosage, changes in consumption patterns over time).
- Descriptions of first cocaine use (context/situation, motives for use, the drug experience, other substance(s) consumed).
- Consumption patterns over time (focusing, in particular, on level of use over time, periods of abstinence, cutting back on cocaine use and so on).
- Perceived benefits and risks associated with cocaine use.
- Negative consequences of cocaine and/or other drug use (e.g. family or work difficulties, financial problems, negative health consequences).
- Understandings/perspectives on 'controlled' versus 'uncontrolled' cocaine use.

- Views on cocaine availability and levels of use in the community.
- Risk behaviour (injecting drug use, overdose risk, sexual risk behaviour).
- Involvement in criminal activity (nature, type, arrests and convictions).
- Physical health (general health status, drug-related health problems).
- Mental health (experience of depression, anxiety, stress).
- Help-seeking strategies (informal networks, formal help-seeking).
- Treatment experiences (including ‘self-help’ and ‘self-regulatory’ strategies).
- Interaction with drug treatment professionals.
- Views on services and other help available to drug users.

During the interview respondents were also asked to provide a quite detailed account of their most recent cocaine-using event, including the social setting of use, the individuals present (number, relationship with them), the mode of administration, drug effects etc. There are several advantages to focusing responses on recent drug-taking behaviour. For example, such a strategy can overcome response biases associated with memory errors and social desirability, and hence enhance the validity of the response. In the context of the current study, a focus on recent cocaine-use events also served the interest of understanding ways in which decisions are situationally specific and related to participation in particular types of social contexts, networks or drug ‘scenes’. Having elicited detail about this cocaine-using event, the researcher then asked if the drug use scenario the respondent just described was similar to how their cocaine (or other drug use) typically occurs.

The in-depth interview also sought respondents’ perspectives on the nature of their cocaine (and other drug) consumption, including their perceptions of the risks, benefits, effects and consequences of their drug use. Finally, demographic data were collected for all respondents following the conduct of the in-depth interview using a pre-coded questionnaire. These included information on: age, gender, education and employment history, housing, living situation and drug history (drugs *ever* used, past year use, past month use). All interviews were tape-recorded with the permission of the participants. Only one respondent elected not to be taped and notes were taken instead both during and subsequent to the interview.

The Sampling and Selection of Research Participants

Sampling Criteria

At the outset, criteria for inclusion in the study stipulated that participants should:

1. Be aged 18–55 years.
2. Have used (snorted, injected, smoked) cocaine in the past six months.

39 of the 40 participants were aged between 18 and 55 years. A 56-year-old man was interviewed and his interview retained since this respondent was only one year over the stipulated age range. The vast majority of respondents had used cocaine during the six months prior to interview, although a small number reported a period of abstinence immediately prior to use, which exceeded this time frame. It was again decided to retain these respondents since their accounts (sometimes related to quitting use) were deemed empirically salient and important in terms of generating an understanding of the variability and diversity of cocaine ‘careers’.

Recruitment and Sampling

A core task for the research team was to generate a sample by identifying geographic, physical or organisational locations suitable for the recruitment of cocaine users. Efforts to recruit participants concentrated initially on drug treatment settings. Contact was also made by letter with 50 participants from the Belfast Youth Development Study who reported cocaine use when aged 16 years and again at 18 years. Ten young people responded to this letter and six agreed to be interviewed. These young people provided the study with a sample of cocaine users who began using the drug in their early teenage years.

Identifying appropriate ‘gatekeepers’ was a critical step in the recruitment process. Professionals working directly with drug users were able to provide an ‘insider’ perspective and also provided valuable advice on potential routes of access to potential participants; they were also in a position to endorse the value of the research to potential participants. Nonetheless, introductions by ‘gatekeepers’ to potential participants, when they did occur, did not automatically lead to the conduct of interviews. Thus, establishing credibility and building trust and rapport with participants were essential to the recruitment process.

Mixed sampling strategies were used to recruit adults and young people for in-depth interview. These strategies included purposive, ‘snowball’, and targeted or critical case sampling techniques. The selection and use of these sampling strategies allowed for emergent design flexibility, permitting the addition of new and appropriate approaches to sampling as the study progressed. One of the advantages of using combined sampling strategies is that it helps to maximise the number of people with a chance of being selected⁶¹. It also helps to ensure relevant *diversity* across key variables such as gender, age, ethnicity, and drug consumption levels (‘problem’ versus ‘social/recreational’ use). While the sampling strategy does not claim to have achieved a representative sample of cocaine users in the general population, a number of sampling techniques were utilised *systematically* with the aim of including young adults and young people who have a diverse and illustrative range of experiences.

Purposive sampling enables the research team to build up a sample that satisfies the needs of the research/evaluation project and its specific aims⁶². Efforts were made to access interviewees through contact with drug treatment services and organisations. The CAP supported this process and a total of 16 respondents were recruited from drug treatment settings in Belfast. Snowball sampling is a strategy frequently used in the study of sensitive topics, particularly where the study group is hard-to-reach⁶³. The technique, which involves asking recruited respondents to suggest others who may be eligible and agreeable to participate⁶⁴, was used to recruit recreational cocaine users in particular. Eight chains were established in order to avoid an over-reliance on networks of peers whose members are likely to be similar in age and gender⁶⁴. The largest chain yielded seven participants, with the majority of the remaining chains yielding between two and four respondents. A total of 24 respondents were recruited through snowballing.

A total of 40 cocaine users were interviewed for the purpose of the study over a period of seven months. All interviews were conducted at locations selected by the participants and included university offices, drug treatment settings and the homes of respondents. Interviews lasted from 35 to 135 minutes, with the majority being around 75 in duration.

Data Analysis

Verbatim transcripts of all interviews conducted with service providers and cocaine users were prepared. Consistent with a grounded theory approach^{65,66}, the analysis of interview data commenced in advance of completing data collection. To aid the analysis of in-depth interviews, NVivo, an integrated software package for qualitative data analysis, was used to organise the data into ‘chunks’ of more manageable data. This facilitated a multi-level narrative and thematic analyses. All interviews were coded in accordance with 17 separate coding categories, generated with close consideration of the study aims. However, categories were also identified on an iterative basis as revealed by the data, thereby incorporating issues and themes arising directly from the accounts of the study’s respondents⁶⁷. The coded data were then analysed for key themes (or variables). Some of the themes were anticipated in advance but new themes also emerged as coding and analysis progressed. Pattern coding⁶⁸ facilitated the analysis of configurations of factors such as gender, age, personal circumstances and so on, that influence cocaine use patterns, health-related and help-seeking behaviour.

In the presentation of study findings, representations of respondents’ experiences and perspectives are supported by excerpts from interview transcripts. All quoted excerpts are presented as closely as possible to participants’ own words. In some cases minor editing was required to make the narratives more comprehensible to the reader. All major identifiers (names of towns or other local areas, names of family members, friends etc) have been removed to preserve confidentiality and anonymity.

Ethical Approval, Consent and Confidentiality Procedures

An application was made to the Office of Research Ethics for Northern Ireland (ORECNI) and a favourable opinion received before the commencement of the research. Ethical approval was also sought and attained from the Governance Committees in all five Health and Social Care Trusts in Northern Ireland.

Ethical Procedures

All research respondents were informed about the nature and purpose of the study prior to their participation. An accessible written account of the study’s aims was made available to all prospective participants and individual interviews were only conducted after researchers had provided them with a detailed verbal account of what precisely the interview would entail. Written documentation of voluntary informed consent was obtained from *all* participants prior to the conduct of individual interviews.

All participants received assurances of confidentiality, including the assurance that their name would not be mentioned in any written dissemination of the research findings. To ensure confidentiality and anonymity, specific procedures were in place to protect research participants’ identities:

- Code numbers were assigned to identify data.
- All data was stored in locked files and separated from identifying information.
- All identifiers (place names, names of family members or friends, etc.) were removed from the transcript material used in this report of the study findings.

Study Limitations

This study's findings are subject to a number of limitations. Firstly, the sample was not randomly selected and therefore generalisability is limited. Drug use is an illegal activity and individuals recruited for participation in this study therefore belong to 'hidden' populations. This inherently compromises the researcher's ability to construct a random sample. In any case, we did not intend to conduct inferential analyses or to generalise beyond the scope of this study population so this limitation is partly attenuated. Our purposes were primarily descriptive and qualitative in nature. Secondly, the sampling strategy did not achieve geographical coverage across Northern Ireland since the majority of respondents were living in Belfast at the time of interview. Consequently, generalisations of analyses and results to all districts within Northern Ireland may be somewhat restricted. Finally, there are undoubtedly groups of cocaine users that this study did not succeed in accessing. For example, high earning cocaine users are not well represented in the study. It is quite possible, therefore, that the sampling strategy used in this study failed to reach more 'hidden' problem cocaine users who refuse, or are reluctant, to access treatment.

Chapter 3: The Views of the Professionals

The CAP had two main objectives. The first was to inform the community of professionals about the study, its aims and data collection procedures, and the second to access existing local knowledge about cocaine use at community level. The findings related to the second objective are presented here. They include the views and experiences of 14 professionals who participated in this phase of the study, which explored their perspectives on the extent of cocaine use within their locality and their views on current service provision and drug policy more generally in Northern Ireland. The 14 professionals interviewed worked for drug treatment providers in both the statutory and voluntary sectors and were located in all five Health and Social Care Trusts in Northern Ireland. In order to ensure the confidentiality and anonymity assured to them prior to their participation in the research, these treatment service agencies are not identified nor are their specific roles within their organisations.

Nine of these agencies were located within the statutory sector, the remaining five in the voluntary sector. The services they provided were delivered to clients with substance misuse problems. These are described in detail later in this section under 'Current Drug Treatment Provision'. As relatively small numbers of treatment professionals participated in this stage of the study, respondents will be identified as either working in the statutory or non-statutory sector. We believe that to provide further information may compromise the confidentiality and anonymity we assured to all participants in the research. The CAP interviews covered a number of topics including respondents' views on contemporary drug scenes, cocaine use and users, service provision for cocaine users, the needs of drug/cocaine users, and the policy environment in which contemporary drug issues exist.

In general, the professionals interviewed felt that whilst cannabis remained the most frequently available drug in Northern Ireland, cocaine was becoming more visible within the local drug scene. For example, one statutory sector worker felt that:

There is a subculture where use of all drugs exist. There was a family of amphetamine injectors a few years ago but that has quieted down (statutory sector worker).

Another statutory sector worker noted that while Ecstasy use was decreasing, cocaine use was on the increase.

Within the party scene it has been seen that Es are decreasing and cocaine is rising (statutory sector worker).

Polydrug and 'party' drugs were mentioned by most professionals when describing contemporary patterns of drug use, particularly amongst young users. For these professionals cocaine was not depicted as a problem substance for the majority of these users. For one statutory sector worker alcohol was the most frequently used substance, followed by cannabis, prescription drugs, and then cocaine. For example, a non-statutory sector worker noted that:

People are more likely to outgrow cocaine and/or cannabis while alcohol poses more of a problem (non-statutory sector worker).

Another non-statutory sector worker also viewed '*recreational use as unproblematic especially among young people*'. This worker had not received self-referrals from recreational or younger users. However, one statutory sector worker believed that heroin use was increasing among young people in North Belfast.

When asked about variations in drug use patterns and trends over the past five years one non-statutory sector worker specifically mentioned a rise in both cocaine and cannabis use among individuals from lower socioeconomic groups.

I have seen more cocaine and cannabis use in lower socioeconomic groups in East and West Belfast (non-statutory sector worker).

Another non-statutory sector worker indicated that most young people perceive cannabis use as 'normal'.

More young people are smoking cannabis and are not seeing it as an issue. Young people are unclear if it is legal or illegal due to the change in class (classification). Young people do not see smoking cannabis as an issue (non-statutory sector worker).

The general view of these professionals can perhaps be summed up by a non-statutory sector worker who noted that during the past five years:

Drug patterns have changed by (users) getting new drugs of choice. However, people will generally take what is available (non-statutory sector worker).

These professionals tended to describe alcohol, cocaine and cannabis as 'recreational' or 'social' drugs for young people.

The Extent of Cocaine Use

When asked about the availability of cocaine in Northern Ireland compared with the past, there was a general consensus amongst the professionals interviewed that cocaine is now more available. Many felt that this was a relatively recent development, particularly in the last five or six years, with a rise in availability noted in Belfast as far back as 2002. Another statutory worker agreed but felt that use prevalence varied depending on particular areas of the city. In some localities cocaine availability and use was felt to be a more recent development, particularly in some non-urban areas where its availability had only become visible in the last three years. Smaller towns were seen as sources of cocaine for users in some rural areas. In relation to the impact resulting from increased availability, one non-statutory sector worker told us that '*in the last two years there has been more problematic cocaine use*'. Another professional felt this was not the case with crack cocaine because '*the skills to wash up*' (statutory sector worker) did not exist among users. Reasons given by these workers for the increased levels of cocaine use included a fall in cost ('*because it's cheaper*'); others felt that '*financial growth has increased cocaine use*' (statutory sector worker), while others suggested that cocaine use is currently '*more acceptable, more normalised*' (statutory sector worker) than previously. One statutory sector worker described South Belfast as '*the hub of cocaine use*', adding that it was the location where most cocaine seizures were made by the police but simultaneously commented on

an increase in cocaine availability and use across the rest of the city. Another professional believed that there was some paramilitary involvement in the cocaine market which a third worker felt had ensured that supplies of the drug remained low. However, reference to paramilitary involvement in the drug market generally, and cocaine use in particular, was not made by the majority of professionals participating in this research.

There was a belief amongst some professionals that the age of cocaine initiation and use was beginning to fall and that young people were using the drug in greater numbers than previously. When asked how widespread cocaine use was currently, a statutory sector worker suggested that *'it's hard to say ... depends more on the person and the social group than the location'*. All professionals from each Health Trust area, however, felt that cocaine was now available right across Northern Ireland. However, questions were raised by these workers about the quality of the cocaine now available in Northern Ireland, with one statutory sector worker claiming that *'people think they are using cocaine'* but *'what most people were getting was not cocaine'* because of the low levels of purity within the cocaine available.

When asked about what they perceived as the typical profile of a cocaine user, there was general consensus that it would be difficult to define or depict a 'typical' user of the drug. This perhaps reflects recent research highlighting the changing profile of the cocaine user⁶⁹. This sentiment was expressed as follows by one non-statutory sector worker:

... there is no typical profile of cocaine user. They come from all spectrums of social class and age (non-statutory sector worker).

However, this worker did feel that there were more male users seeking treatment and a number of other workers believed that there were now younger cocaine users seeking help. These views on the changing profile of cocaine users are supported by recent research⁴⁴. As a group, these workers felt that the current non-specific nature of a cocaine-user profile was similar to users of other drugs with the exception of heroin. As one statutory sector worker put it:

... there are two distinct groups, those who use heroin and those who use other drugs. Heroin users are generally older (statutory sector worker).

However, several treatment workers felt that since there was no typical cocaine user it was difficult to compare cocaine users with other types of drug users. Nonetheless, one non-statutory sector worker did compare the profile of cocaine users with that of Ecstasy users, stating that *'Es and cocaine use are similar with binge drinking that wasn't seen previously'*, whilst a statutory sector worker told us that in his experience cocaine users were *'under 25, male, from a middle-class background with significant binge drinking'*. Another statutory sector worker, on the other hand, felt that while there was no one social class associated with cocaine use, working-class users were more visible, certainly within services. This professional felt:

... there was no typical social class but I see more working class users. It could be that more wealthy people seek help privately (statutory sector worker).

According to these workers, the main locations or contexts for cocaine use were house parties and clubs. All professionals mentioned house parties as a common location for use.

Perhaps further emphasising the historical perception of cocaine as a social drug, snorting was felt to be the main route of administration. A non-statutory sector worker did, however, tell us that he had *'recently heard of someone smoking crack'*. A statutory sector worker, however, felt that while *'there is a social stigma with injecting drugs and Northern Ireland is 10/15 years behind the rest of the UK ... there will be a rise in crack'*. Another statutory worker mentioned *'speed balling'* as another route of administration.

Whilst the treatment workers noted instances of cocaine injection and the use of crack cocaine, they felt that use of these routes of administration remained limited. In relation to the extent of cocaine use, one non-statutory sector worker felt certain that the prevalence of cocaine use had increased but that this increase could not necessarily be detected by the available reporting systems. For one statutory sector worker, the increase in cocaine use was linked to increased affluence and a feeling that it *'...is more acceptable, more normalised'*. This worker also felt that *'in the last two years there was more problematic use'*.

Current Drug Treatment Provision

A range of services was delivered to clients with substance misuse problems by the participating agencies in this research. These services were not developed to target the specific needs of problem cocaine users but to address the needs of those referred for drug abuse. Services provided by the statutory service agencies (which are listed alphabetically) included Child and Adolescent Mental Health Services (CAMHS), community work, counselling, detoxification, group therapy, harm reduction, home visits, inpatient, outpatient, outreach services, social support, and substitute treatment. Voluntary service providers described their services for those with problem drug abuse as community work, counselling, drugs education, harm reduction, outreach and social support. The statutory agencies provided these services for adults (over 18 years) only, taking referrals from a range of clinical and social services and self-referrals. The non-statutory sector agencies' services were delivered mainly to those aged over 18 years, but did also offer support to those aged under 18 years. Referrals were received to the non-statutory sector from a range of social and statutory services (i.e. probation) as well as self-referrals. When asked about the unique challenges associated with providing services to cocaine users in Northern Ireland, treatment professionals tended to highlight the limited provision within existing interventions targeted for cocaine users. For one non-statutory sector worker *'cocaine is just the tip of the iceberg, there are many other issues in conjunction with its use'*. Another non-statutory sector worker felt the issue was *'not cocaine users specifically but dealing with vulnerable people'*. One statutory sector worker explained the complexity of attracting cocaine users into services as follows:

... users see it (cocaine use) as recreational rather than problematic. People generally want to get rid of the consequences of drug use like mental health or relationship problems rather than address drug use as an issue (statutory sector worker).

These views would appear to highlight the insufficient service provision available for those referred for problem cocaine use, on the one hand, and problems associated with making existing drug treatment services accessible, on the other. However, the experiences of treatment professionals to meeting the needs of cocaine users referred to them provides us with some insights into what works and/or may provide effective intervention for problem cocaine users.

When asked about the most immediate needs of cocaine users presenting with problems several issues were mentioned, including disorder stabilisation, coping with withdrawal including providing appropriate medication, crisis management and provision of the requisite social support. The particular needs of vulnerable groups were also specifically mentioned here by service providers. Whilst all those referred for drug interventions may be considered vulnerable adults, the term ‘vulnerable groups’ was most often used to refer to those individuals experiencing social disadvantage.

When asked about the difficulties associated with engaging cocaine users with treatment agencies several challenges were highlighted. One statutory worker expressed the view that cocaine users ‘*don’t access services until crisis*’. Constraints within services were also noted, including waiting lists of up to three to four weeks, with one non-statutory sector worker telling us that users were ‘*more likely to engage with lower waiting times*’. Being able to access services outside of a nine-to-five working day was also considered important in terms of attracting users into treatment services.

The fact that cocaine users were in most cases polydrug users was an issue raised consistently by these treatment professionals. One non-statutory sector worker noted that ‘*most cocaine users are polydrug users which is a whole different ballgame*’ but suggested later that ‘*motivational interviewing seems to work with cocaine users*’. A statutory sector worker told us that clients were ‘*never referred solely for cocaine, polydrug users use cocaine*’.

These workers also believed there were specific issues that mitigated against cocaine users seeking help. In particular it was felt that younger cocaine users were reluctant to seek help or advice, with one statutory sector worker noting that ‘*users are generally able to function with cocaine*’. A non-statutory sector worker told us that while ‘*those aged 30–40 would self refer for treatment, those under 25 don’t*’. The comments of this non-statutory sector worker are suggestive of a belief that cocaine users can often “function” normally for quite some time:

... it takes cocaine users more time to come to ‘crisis level’ as they are able to function on the drug in normal everyday life (non-statutory sector worker).

However, it was felt by a number of workers in both statutory and non-statutory sectors that the biggest challenge for effective intervention with cocaine users was the absence of an appropriate ‘*medical model to deal with the craving*’ (statutory sector worker) that accompanied cocaine use. Other workers noted a shortage of good quality education and information for both users and practitioners as well as limited training for practitioners on how to meet the challenges associated with cocaine use. With specific reference to cocaine, a statutory sector worker also commented that there were ‘*no harm reduction strategies*’ developed to meet their (cocaine user’s) needs. A statutory sector worker perhaps highlighted the two key issues as ‘*no specialist cocaine services and no idea of the depth of the problem*’. This view was supported by a non-statutory sector worker who also emphasised the dearth of reliable information on cocaine use and the potential negative consequences of this situation for services:

There is not enough research on cocaine users. We need more information on effective treatment and to be proactive rather than reactive (non-statutory sector worker).

These views again reflect the challenges for providing targeted interventions for problem cocaine use faced by drug treatment services in Northern Ireland and beyond.

In order to provide effective services for cocaine users it is important to have input from more than one service provider. Thus, an inter-agency approach is ideally required to address the range of social and health problems associated with cocaine use. There was, however, general consensus that this was not being achieved at present. One statutory sector worker claimed that '*agencies are in competition with each other*', which this person felt could be detrimental to the services offered, and a non-statutory sector worker insisted that '*there needs to be more communication*' if services are to work effectively with cocaine users. Another statutory sector worker felt that there were particular issues with a range of health care providers which were listed as mental health services, family/childcare, accident and emergency services, GPs and doctors. Whilst this professional did not specify these issues it was felt they contributed to undermining interagency practice for meeting the needs of problem cocaine users.

When asked specifically about services targeting young people a non-statutory sector worker expressed the view that service provision had not changed in recent years:

The services have not changed dramatically, however, there is more competition for funding and allocation of funding has been changed (non-statutory sector worker).

Another non-statutory sector worker felt that there was a need for greater flexibility around service provision for young people with, for example, more drop-in centres that could be accessed more easily by young people. It was also felt that there needs to be '*generally more provision for young people*' (non-statutory sector). In a more general sense, treatment professionals felt that more education was needed for both professionals and users in relation to cocaine use among young people. They also felt there were a number of gaps in service provision for cocaine users referred for problem drug use.

Current Policy in Northern Ireland

When asked about current drug policy in Northern Ireland, treatment workers highlighted several issues. Access for users was once again raised here. One statutory sector worker, for example, expressed the view that:

A lot of money goes to heroin research when there are a lot more issues with alcohol (statutory sector worker).

Several workers specifically mentioned the current drug strategy, which both statutory and non-statutory sector workers felt needed to be updated. A non-statutory sector worker felt that the emphasis within current drug strategy placed too little emphasis on drugs:

The strategic direction needs to be re-examined as it focuses on under-age and binge drinking too much. More focus should be put on drugs (non-statutory sector worker).

Another non-statutory sector worker felt that '*funding was centralised in Belfast*', which may be creating difficulties for providing the appropriate type and level of provision required to address problem drug use in smaller towns. A statutory sector worker felt that funding for staff

development generally was limited. Other examples provided by treatment workers on how to improve the efficiency of services available included '*more one-to-one counselling, more community based provision rather than Tier 2 and Tier 3*' (statutory sector worker).

One non-statutory sector worker felt that, in particular, there was '*a need to incorporate Cognitive Behavioural Therapy*'. However, it was significant that a number of the treatment workers did not believe that increased cocaine availability posed specific or unique policy challenges in addition to those currently being addressed by policy makers in Northern Ireland. Whilst we did not illicit specific explanations for this view, from our experience undertaking this research we can speculate on how this may be explained. As cocaine is rarely used in isolation those referred to treatment services with problems linked to their cocaine use may experience other drug associated problems. In this study a number of the treatment sample had been referred for problem drug use when cocaine was not the primary problem drug. In such cases whilst treatment professionals address cocaine related problems, such problems may not be the main or only reason for referral which may perhaps to some extent reflect the perceived view of cocaine use as not yet presenting unique or major challenges.

In general, workers expressed the view that resources were limited for meeting the needs of all cocaine users. A non-statutory sector worker stated that there was '*no effective planning*' to meet the challenges faced by service providers. This included addressing the physical health issues linked with cocaine. Other examples proposed for reducing the harms associated with cocaine use included more one-to-one treatment provision and a need to learn from best practice. Several workers mentioned the absence of harm reduction strategies for cocaine use with the majority of them believing that learning from best practice with this approach may have an important role to play when addressing problem cocaine use.

Summary

Treatment workers who provide support and intervention to drug misusers felt that the level of provision available for problem cocaine users was insufficient at present to meet the needs of those referred for problems linked to cocaine use. This was explained to some extent by the limited availability of cocaine-specific interventions, a situation which is not unique to Northern Ireland. However, despite this, there was a feeling amongst these professionals that whilst cocaine was now more available than previously in Northern Ireland, particularly among young users, they did not associate it with the same level of problems for users as those associated with other substances such as heroin and alcohol. This may, however, in part reflect their client groups and the fact that they have multiple needs. Whilst some examples were suggested on the types of interventions that may work when treating cocaine users referred to service providers, professionals working in the drug misuse field perhaps provided insights into what is required here, particularly as cocaine use is usually linked with other social and health problems for users.

Chapter 4: A Profile of the Study's Cocaine Users

Introduction

This chapter presents a profile of all 40 cocaine users who participated in the study. Twenty-four of the participants were categorised as 'recreational' cocaine users with the remaining 16 as 'treatment' users.

The information in this chapter should not be interpreted as a profile of *all* cocaine users in Northern Ireland. However, the data presented nonetheless provides important information from which to begin to understand the lives of cocaine users in Northern Ireland. Demographic profiles of cocaine users based on larger samples of users are available from a range of sources across other jurisdictions, including the UK^{32,44,50,51,70-72}.

The Study Participants

Cocaine Use

Forty cocaine users were interviewed by the research team. At the time of research, 10 stated that they had used the drug at least once a week. One of these reported daily use, five stated they used it more than once a week but less than daily. Twenty-one participants used cocaine on a monthly basis, two used less frequently. Six participants had stopped using cocaine at the time of the research. We were unable to obtain this information from one cocaine user as s/he did not provide a response to the request for this information. The majority of these users would be categorised as relatively low level users when compared to existing research from Australia, the USA and by other researchers in UK based studies^{44, 51, 73}.

Gender and Age

Twenty-one cocaine users were male and 19 were female. Gender differences in how substance use patterns and problems develop remains poorly understood. The participants ranged in age from 18–56 years, with a mean age of 28.2 years. Male users were older with a mean age of 29.6 years (for females it was 26.8 years). Two-thirds of users were aged less than 30 years. Eighteen users were under the age of 25 (10 males and 8 females). However, only two users were aged over 40 years at the time of the research. As a group, these cocaine users are relatively young, which appears to mirror the findings from recent UK based research⁴⁴ as well as the experiences of the treatment workers interviewed for this research. However, as a group of drug users they may perhaps be considered a relatively older group since the peak period for illicit drug initiation and use is 18–24 years. However, in relation to cocaine use specifically, reported use under the age of 20 years was extremely rare during the 1990s^{50,70}.

Ethnicity

Eighteen participants described their nationality as British and 16 as Irish. Amongst the others two were Northern Irish, one was Scottish, one Spanish and one American. Thirty-six cocaine users were heterosexual, three were bisexual. No one belonged to an ethnic minority group. We did not obtain this information from the other cocaine user.

Living Situations

At the time of their participation in the study, 11 cocaine users lived with their parents, 7 lived alone and 10 lived with friends. Seven lived with partners (two of these partners had children) and five (three males and two females) lived in a hostel. Thirty-seven cocaine users lived in a town, while the other three lived in rural locations. Twenty-eight lived in Belfast and of these, 16 lived in the university area of South Belfast, highlighted by the study's treatment workers as '*the hub of cocaine use*'. However this demographic factor was influenced by the study's sampling strategy which recruited users through treatment services located in this area. This part of the city has a high proportion of rental accommodation for the full range of individual requirements. This includes low priced rental accommodation, student accommodation, as well as more expensive apartments. Eight participants lived in other towns in Northern Ireland. One cocaine user did not provide information on the area or town where they lived.

Education and Employment

Sixteen of the study's participants proceeded to third-level education. These users were almost all recreational users, with only two of the treatment sample progressing to third-level education. Fourteen others reached GCSE level education, seven achieved A levels. Nine were university graduates, three were students at the time of the research and three had started university but did not complete their degree. One had obtained a postgraduate qualification.

Eighteen participants did not have a job at the time of the research, four were students and 17 others were in employment. Eight worked in the bar/hospitality industry, four were employed in clerical posts, three worked in sales, one as a nurse and one was an artist. One participant did not provide a response. This profile reflects findings from a recent British Crime Survey that indicated most employed cocaine users worked in low- to middle-income-level jobs across a variety of trades and service industries⁴⁴.

Tobacco and Alcohol

Twenty-nine participants smoked cigarettes each day, only two had never smoked cigarettes, and a further two were former cigarette smokers. Five others smoked less frequently. We did not obtain this information from two cocaine users. In this study, 29 cocaine users drank alcohol at least weekly, four of them each day. One drank less frequently, eight others had stopped using alcohol and one stated he never drank. We did not obtain this information from one cocaine user. Boys et al.³⁸ and Martin et al.⁷⁴ noted heavier alcohol consumption amongst cocaine users.

Other Drug Use

All participants in this study had used cannabis at some time in their lives. Twelve were daily cannabis users at the time of the research; a further eight used this drug every week. Two used cannabis monthly and four had used cannabis less than five times. Thirteen had stopped using cannabis. We did not obtain this information from one cocaine user. Only one cocaine user had not used Ecstasy. Fifteen were using this drug each month or more often at the time of the research. Two used Ecstasy less often, a further six used it at least weekly; 15 respondents no longer used the drug. We did not obtain this information from one cocaine user. Twelve of the study's cocaine users had used heroin. Only three were using the drug at the time of the research, of whom two reported daily use. A number of other substances were used by the cocaine users participating in this research including illegal substances such as LSD, Ketamine and magic

mushroom, prescribed drugs such as Diazepam, legal drugs such as Salvia and over-the-counter drugs such as Nytol.

The Frequency of Cocaine use

Monthly Cocaine Use

Twenty-one participants (11 male, 10 female) in the study used cocaine on a monthly basis which appears to be the most common level of use⁷¹. The mean age of this group of cocaine users was 27.3 years at the time of their participation in the research. Seventeen were categorised as recreational users, the remaining four were part of the study's treatment sample.

Eight monthly cocaine users lived with friends, six lived with their parents, three lived with a partner, three lived alone and one lived in a hostel. Twenty monthly users lived in a town, and one lived in a rural location. Sixteen lived in Belfast, nine in the university area of South Belfast. Eleven monthly cocaine users had attended university. Amongst the other 10 users, five reached GCSE education level and three achieved A level education level. We did not obtain this information from two monthly users. Eleven monthly users were employed (four worked in the hospitality industry; three worked in clerical/administration jobs; one worked in sales; one was an artist; one was an events manager; one was a nurse), and four were students. Six monthly users were not in employment at the time of the interview

Twelve of the monthly cocaine users smoked cigarettes each day; 18 drank alcohol at least once a week, two of them drank alcohol each day, two no longer drank alcohol; six used cannabis each day, five no longer used this drug. Twelve used Ecstasy at least once a month, seven no longer used the drug. Four monthly cocaine users had used heroin at some stage in their lives but none were current users.

More Frequent (at least weekly) Users

Ten participants (6 male, 4 female) in the study used cocaine at least once a week. Five of these participants used the drug more often, and one reported daily use. The mean age of this subgroup of cocaine users was 29.6 years. Four were recreational users; the remaining six were part of the study's treatment sample.

One weekly cocaine user lived with friends, two lived with a partner, two lived alone, three lived with their parents and two lived in a hostel. Nine weekly users lived in a town, and one lived in a rural location. Seven lived in Belfast, five of them in the university area of South Belfast. Three weekly cocaine users reached third-level education. Amongst the remaining seven users, four reached GCSE education and three reached A level education level. Four weekly users were employed (two worked in the hospitality industry, one worked in sales and one was clerical).

Nine weekly cocaine users smoked cigarettes each day; seven drank alcohol at least once a week; and one no longer drank alcohol. Five used cannabis each day and two no longer used this drug. Four used Ecstasy at least once a week and three no longer used the drug. Five weekly cocaine users had used heroin at some time in their life, two were current users, and three had stopped using this drug.

Less Frequent Cocaine Users

Eight participants in the study used cocaine less often. Two of these users had taken cocaine five times or less, the other six had stopped taking it at the time of the research. The mean age of this group of cocaine users at the time of the research was 26.5 years. Three were recreational users and the other five were part of the study's treatment sample.

One user lived with friends, two lived with a partner, one lived alone, two with their parents and two lived in a hostel. Seven of the less frequent users lived in a town; the other lived in a rural location. Five lived in Belfast, one of whom lived in the university area of South Belfast. Two of these users attended university. Amongst the other six users, five reached GCSE education and one reached A level education standard. Three were employed (two worked in the hospitality industry; one worked in sales).

All eight infrequent users smoked cigarettes each day. Three drank alcohol at least once a week, while the other five no longer drank alcohol. One used cannabis each day and six no longer used this drug at the time of the research. One used Ecstasy at least once a week and five no longer used the drug. Three users had used heroin at some stage in their life although none were current heroin users.

Recreational versus Treatment Users

The remainder of this report will discuss the experiences of recreational cocaine users and those who have received treatment for drug abuse. In this research recreational cocaine users are a socially integrated group, the majority of whom reached third-level education (n=14) and were in employment at the time of their interview. These users have never been referred to drug treatment services. Those who have received treatment for drug abuse which included problem cocaine use will be referred to as the treatment sample. These users were living less stable lifestyles and a number had become marginalised in society having experienced homelessness, had low level educational attainment and with one exception were unemployed at the time of their interview. Table 4.1 presents a demographic profile of each group.

Table 4.1: Demographic characteristics: recreational and treatment cocaine users

	Recreational Users (n=24)	Treatment Users (n=16)
Gender		
Male	12	9
Female	12	7
Age		
Years (mean)	25.6	32.1
Living Situation		
Live alone	2	5
Live with partner	3	2
Live with partner and children	1	1
Parental home	8	3
Live with friends	10	0
Hostel	0	5
Education*		
GCSE	5	9
A Level	4	3
University graduate	8	1
Currently enrolled at university	3	0
Some university	2	1
Postgraduate	1	0
Employment**		
Employed	17	1
Unemployed***	7	15

*Data were not collected for one of the recreational sample and two of the treatment sample.

** Employment details on one treatment user was not obtained

*** Four were students

Summary

There did not appear to be a clear and consistent demographic profile amongst the full study cohort. Monthly use was the most popular frequency of use. Most of these users were recreational users who were more likely to lead a socially integrated lifestyle in terms of work and living arrangements. Nine of the 16 treatment sample was either weekly cocaine users or less frequent users at the time of interview. However, this sample of cocaine users had high levels of licit and illicit substances and had a history of polydrug use.

Chapter 5: Recreational Cocaine Users

This chapter examines patterns of cocaine and other drug use among the sample's *recreational* cocaine users. The term 'recreational' drug use is generally understood as the use of a psychoactive substance(s) for personal pleasure or satisfaction. Levels and patterns of drug consumption differ among recreational users, irrespective of the drug in question, and there is considerable variation in both the quantity and frequency of use among recreational or non-dependent cocaine users^{39,41,51}. Those respondents categorised as recreational cocaine users in the current study did not consider their cocaine or other drug use to be problematic at the time of interview and typically characterised their use of the drug as a social or recreational activity associated with going out, socialising and having fun. These drug users had not been referred to a treatment setting and, in the main, did not perceive a need to seek help or advice in relation to their cocaine or other drug use.

The chapter starts by providing a demographic profile of this sub-group of study participants. Cocaine use is then discussed with reference to a number of important dimensions of experience including initiation, use contexts and modes of administration. The focus then turns to patterns of cocaine use, with particular attention given to three categories of users – current users, 'curbers' and quitters (identified on the basis of a detailed analysis of their drug 'stories'). The latter sections of the chapter explore the perceived benefits of cocaine use as well as respondents' views on the downsides or negative effects of cocaine and other drug use. It also examines how this group of recreational cocaine users frame or characterise their drug consumption with specific reference to notions of 'control', 'addiction' and 'risk'.

Demographic Profile

A total of 24 recreational cocaine users (12 males and 12 females) were interviewed for the purpose of the study. Their mean age was 25.6 years (median = 24 years), with the majority (n=15) being under the age of 25 years and only one over 30 years of age at the time of interview. Two lived alone, four lived with a partner (one partner had children), eight lived with their parents and ten lived with friends.

Twenty-one of the 24 recreational users lived in a city or town. Eighteen lived in Belfast (11 in South Belfast or the university area). Three were unemployed and a further four attended a third-level institution. Just over half (n=13) had progressed to third-level education. Fourteen earned more than £10,000 (mean income = £14,650 per annum). The largest number of respondents who were currently employed (n=7) worked in the hospitality industry (bar or restaurant); four held clerical jobs, three worked in the retail industry and one in the medical profession.

The study's recreational cocaine users would be characterised as a socially and economically integrated group by virtue of their education, labour market participation and income. This profile is similar to other studies of recreational drug users in the UK and Ireland⁷⁵⁻⁷⁷ which have included respondents deemed to be relatively well educated and likely to be employed.

Cocaine Initiation

The average age of cocaine initiation was 20 years. The age of initial use ranged from 13 to 26 years, although 16 (two-thirds) had initiated by the age of 20. On the first occasion of use most received the drug for free, typically from an individual with whom they were well acquainted. In other words, cocaine was not offered to them by a stranger or 'outsider' to the peer group nor was money exchanged between user and supplier of the drug at the time of initial use.

... Um, so I mean I wanted to try it and, whenever it was available for me to try it, it wasn't costing me nothing so I was like, I will try it and that's it over and done with (Case 03, male, age 20).

I didn't actually go and get it myself. I was at a party and a lot of people were taking it (Case 30, female, age 30).

Thus, first cocaine use most often occurred in the familiar surroundings of the respondents' circle of friends. Typically, a friend or close associate offered a line of cocaine and the offer was accepted. The most common initiation contexts were the home of a friend, often at a party or social gathering of some kind, followed by the toilets of a club or bar. For the vast majority first use was unplanned even if, like the respondent below, some had contemplated use prior to this initiation event.

[And had you planned to use cocaine in advance, did you know that the girl would have it?]
I didn't. I mean we'd talked about it before but I'd never actually, I'd never planned it. And then I've kind of always wanted to try it like and then the opportunity presented itself (Case 20, female, age 22).

When describing the unplanned nature of their initiation to cocaine a number were keen to emphasise that they were an active player in these initiation events and that they did not feel pressure to try cocaine.

[Had you planned to use coke beforehand?]
No, not that night. I had always wanted to try it and experiment a wee bit but just that night my mate had coke and he said, 'Do you want to try it'. You know he didn't force me or nothing, I just said, 'Oh why not', you know. I said to him, 'It's not going to do me any harm is it?' and he goes, 'Well, it's just going to make your gums go numb, but apart from that, nothing' (Case 03, male, age 20).

[Can you remember the first time that you ever did...?]
Yes. I first took it when I was 16. I have to say, now, he didn't shove it up my nose like but it was with a boyfriend. He had it at the time and they, a crowd of fellas, was taking it and he said, 'Try this. Try this'. Now, he didn't make me do it or anything but me, being curious at that age, I thought I would try it so I remember actually rubbing it around my gums, actually. I didn't take it up my nose (Case 33, female, age 25).

The vast majority were drinking alcohol and usually consumed only one or two lines of cocaine on this first occasion of use. All stated that they either snorted cocaine or consumed the drug orally by rubbing it on their gums, with the former being the most common mode of administering cocaine at the time of initiation. The feelings that users experienced at the time of

initiation varied: some enjoyed the experience, others reported only minimal effects and yet others were disappointed. However, none reported negative feelings nor did they experience either physical or psychological difficulties following first use of the drug.

'Becoming' a Cocaine User

As demonstrated, this study's recreational users typically first tried cocaine when the opportunity arose in the company of a close friend or acquaintance. However, that they were willing to try the drug when the chance to do so occurred did not mean that they spontaneously experienced positive effects. On the contrary, typical accounts suggest that, initially, many did not readily identify or appreciate the drug's effects. Learning to enjoy a drug, or having a positive drug experience, is one key part of becoming a regular user⁷⁸, and may mark the starting point for a drug history with a particular substance. It is therefore important to examine how cocaine users framed their subjective experiences with the drug during initial, early and subsequent use episodes.

Only a relatively small number of participants depicted their initial cocaine experience in positive terms. In the following account, a male respondent described a positive experience which he ascribed largely to the social activities surrounding his initiation to cocaine.

Music would play a big part in how I enjoy a night more than anything but I think it was just a good crowd of fellas out that night and we had a good laugh and whatever and I think that is probably why I think cocaine might be a good drug 'cos the first time I had it I had a really good fun night. Whether cocaine played a part in that or not? My judgement might be slightly clouded or tinted or biased or whatever but I suppose that's why I have continued to take it. So ... (Case 01, male, age 23).

More frequently, participants' depictions of initial cocaine experiences were tinged with ambivalence. Some indicated that they identified some first time effects – a numbness at the back of the throat, subtle euphoric feelings, more animated conversation and increased energy. The account below demonstrates this sense of 'feeling different' on first using cocaine whilst also highlighting the user's sense that the experience was unremarkable.

[And do you remember how it made you feel or ...?]

Eh, just makes you feel alright, you know? I was quite perked up and confident and talkative and so forth. It wasn't a dramatic effect necessarily but it was enjoyable at the time, you know (Case 24, male, age 24).

Although acknowledging that he felt more talkative and experienced "a buzz", another respondent was left with the feeling that cocaine was "over-rated".

It's hard to explain like; it never really ... it didn't really last that long so it didn't. It just made me talk like mad. The amount of **** I was talking like. And that was it really. Just gave you a buzz really but there's nothing special about it. People always used to tell me about it and it's too over-rated (Case 14, male, age 21).

Others stated more explicitly that they felt "nothing" on the first occasion of use and one felt "cheated" because he did not experience any effect from the drug.

I felt cheated by the fact that nothing happened (Case 21, male, age 22).

I found it really boring. It made my gums go numb and then, as I said, sort of twenty minutes later it just faded away and did nothing and I was alright (Case 03, male, age 20).

A small number of respondents depicted their initial cocaine experience as unpleasant or unnerving due in part to their not knowing what to expect.

The first time I kind of freaked out a wee bit actually. I had to go and sit in the toilet ... [So] the first time I ever done it I didn't like it ... And I just freaked out just 'cos I didn't know what to expect and it was just sort of like my head and my ears went numb and my throat (Case 03, male, age 20).

Whilst questions about first experiences of cocaine did not in the main elicit unfavourable responses or reports of negative effects, many were initially disappointed. This did not deter subsequent use however, and a large number reported that they used the drug again within a relatively short period of time, sometimes within days or weeks. It was during second or subsequent use episodes that many learned to recognise and respond to cocaine effects. This 23-year-old female could barely recall her initial use of cocaine and considered her second use of the drug to be her the first time she used the drug “properly”.

I can't even remember the first time ... Oh yeah, I remember now. I think the first time it was one line and that was it. But then the next night we went out it was at my friend's house. It was my friend's birthday and we had speed. Somebody bought me a gram of speed or something and I was doing that but then people came down with coke and that was the first time I properly took coke. I was chopping the lines up and everything. That was with my boyfriend. I was sort of on speed and coke so they were doing the same sort of thing (Case 27, female, age 23).

Another female user provided a similar account of learning to recognise and appreciate the effects of cocaine.

Um, the couple of times that I have done it [more recently] I have realised that it has given me a lot more than the first time and other times as well ... I do remember last time I did get a noticeable effect off it. And that's the first time that happened, you know ... and I was actually aware that I was actually getting a buzz off it (Case 23, female, age 28).

In common with other studies of cocaine use, the data presented here suggest that there is a learning process associated with the initial and early stages of cocaine use³⁹. Certainly, the majority of this study's recreational users did not discern or identify the effects of the drug initially and it was only during later use episodes that they fully appreciated the distinctive psychoactive qualities of cocaine.

Routes of Cocaine Administration

Snorting was by far the most common and also the preferred mode of cocaine use. Practically all respondents reported that they had snorted cocaine more frequently than other modes of administration. However, one respondent, a 25-year-old male, explained that he only consumed cocaine orally because of the negative connotations he associated with snorting the drug.

[Is there a reason why you have not snorted cocaine?]

I dunno ... I think it's just because of the method. I mean it feels less druggy when you are putting it on your lips or on your gums. But when you are snorting it, it feels very kind of druggy or something. I mean needles and snorting it, I just associate with drug use (Case 50, male, age 25).

The account above is most unusual, however, with the vast majority of recreational users preferring to snort cocaine. Oral consumption (rubbing on the gums or swallowing) was reported by nine of the 24 respondents, making it the second most common mode of cocaine use. Although a considerable number of respondents had smoked cocaine with tobacco, only two respondents had smoked crack cocaine.

Cocaine Use Contexts

There is more to a drug experience than the interaction between the physiological properties of the drug and the person consuming it. The physical space or 'setting' where drug use takes place is a crucial determinant of the individual's drug experience⁷⁹. Situations or use settings influence users' interpretations of raw drug effects, and thus help to shape both the meanings they attach to the drug and subsequent patterns of use. Setting may also refer to the atmosphere within the physical environment where drug use takes place⁸⁰. Knowledge about the contexts in which individuals use drugs is therefore critical to understanding the role of substance use in their lives. An understanding of use contexts can also potentially inform strategies aimed at reducing the harms associated with cocaine use.

Cocaine Use Spaces

Previous research on 'party' or recreational drug use has highlighted the significance of specific settings and contexts and their importance as 'drug use spaces'⁷⁵. Respondents' preferred situations for cocaine use were those in which people could enjoy each other's company, with use being synonymous with going out, partying and meeting friends. The most commonly talked about cocaine use spaces can be broadly categorised as *private* settings – one's own home or the home of a friend – or *public* locations – in bars or clubs. Most participants had used the drug in both public and private settings. When using cocaine in bars and clubs, the drug was invariably snorted in the toilets because of the need to conceal the activity. However, a considerable number of respondents considered bars and clubs not to be the ideal setting in which to use cocaine. The speaker below, for example, felt that it was obvious to others when use occurred in these public locations and appeared to equate snorting cocaine in bars with a compulsive orientation towards the drug.

It [cocaine use] would happen at home more often because I don't really like having to go to the toilets and all at bars. So I wouldn't do it often in bars ... I think it looks really obvious because I am somebody that is not mad keen or desperate. I just kind of think, 'why not wait until I get to the house' (Case 23, female, age 28).

Like others, the male respondent below expressed a preference for using cocaine in the private setting of a house party where a sense of solidarity, comfort and ease surrounded the occasion without pressure to conceal use of the drug.

I think it [cocaine use] started more in the club but, yeah, it's kind of just a bit more, it's easier when you go back [home] 'cos it's kind of, it's there and you don't have to be all you know discreet about it and stuff. If everyone's doing it it's more of a group thing ... it's less of a taboo you know.

[And do you think that there's a taboo in the club?]

It just, with other people you never know I suppose and if you're paranoid, you never really know what people are thinking. And then, if you know everyone is taking it, then you won't feel so bad. You know, if you get any sort of paranoia in the club, if you think people are treating you differently, it's just a bit (pause) ... It's just easier if you're in a house party or something like that when everyone's on it (Case 21, male, age 22).

Post-club and -pub spaces such as house parties were frequently portrayed as ideal or preferred cocaine use settings. These parties were often planned in advance, as was cocaine and/or other drug use.

Usually when we were taking coke we would have something planned at the weekend, a party and somebody would usually take care of getting it and whatever else you wanted to consume that weekend ... (Case 30, female, age 30).

In the following account a female describes a "great night" out on cocaine. Again, the setting is a large party in the company of both strangers and friends.

[On that night with] that group of people and that house [referring to rental property where she lived previously], I mean, everybody would be drinking and drinking and drinking and taking coke and taking pills. I mean, the whole house, like 60 people in the house and half of them you didn't even know who they were but it was a great night and I really enjoyed it (Case 29, female, age 28).

Although large home-based gatherings were frequently mentioned as favoured use contexts, several also mentioned the practice of returning home or to the home of a friend during the early hours in the company of a smaller number of individuals. These 'chill out' gatherings were valued because a night of socialising could enter into a more relaxed phase of interaction.

You know like I think one time when we left a house party we ended up meeting people just on the way home and because we were so like still awake and we wanted to party more ... we ended up going to their house and that kind of ended up sort of another party and kind of went into the next day a bit as well. And it was really good fun. I mean nothing other than just sort of sitting around talking and chilling out a bit ... but it was really good fun, yeah (Case 20, female, age 22).

This respondent went on to describe the merits of cocaine use in these 'chill out' settings.

Yeah I think just to sort of keep you going without like getting you completely wasted like just feeling a bit more sober. Everyone seems to be funnier and, yeah, it's just it always makes for a really good night yeah ... It just makes you more relaxed and you can talk for hours to anyone yeah. Friendlier sort of thing, there's a really friendly atmosphere when everyone's taking it (Case 20, female, age 22).

This chill-out phase of the night, valued by some respondents as a time to 'wind down' and interact with friends in more relaxed settings, has been identified in several recent studies of club

and polydrug use,^{75, 81-82}. Users could continue a night of socialising within these private settings where they perhaps felt safe, relaxed and able to ‘chill’ with friends. These more intimate use settings were important to some users and favoured because they enhanced their sense of connection with others.

The Role of Alcohol

Twenty-two of the study’s recreational cocaine users drank alcohol at least weekly, 12 of them more than once per week; four consumed alcohol daily. The average age of first alcohol use was 14.3 years for the sample and alcohol was by far the most frequently used substance across the life span. Furthermore, while a number of respondents indicated that they had reduced their intake of some illicit substances such as Ecstasy and cannabis (see below), all were current drinkers. Socialising invariably involved alcohol consumption and drinking to intoxication was often part and parcel of a night out. Licensed premises, including clubs and bars, were commonly mentioned drinking contexts but home-based drinking was also popular. Indeed, many started a night out with a ‘carry-out’ at home.

[So how much would you actually drink on a night out?]

A lot. I mean, we would have a big carry-out before we'd go out and then we'd be drinking all night. The last time we went out we had 2 bottles of wine and 3 bottles of West Coast Cooler to mix with them before we went out. And then it'd be vodkas and double vodkas and shots sometimes; Jaeger bombs (Case 26, female, age 24).

Like the participant above, many others stated that they drink “a lot” or “very regularly”. Most in the sample were seasoned drinkers, a large number admitted to drinking to excess on occasions, and ‘binge’ or heavy sessional drinking was commonplace, particularly on weekends. Indeed, much of the narrative data positioned alcohol consumption as a routine, almost everyday, activity. In the words of one female respondent, alcohol is the “most accepted” intoxicant.

[So alcohol is your favourite ...?]

It’s the most accepted, you can do it with friends, you can, it doesn’t have to be a mad night, you can just have a few or whatever. You know exactly how it’s going to affect you as well sort of thing (Case 30, female, age 30).

Drink and drugs are increasingly argued to be intertwined within social settings where ‘determined drinking’ or drinking to intoxication is prevalent⁸³⁻⁸⁴. Certainly, for this study’s recreational users, alcohol almost always accompanied cocaine and most stated that they usually consumed the two substances concurrently.

I’d go as far as to say every time I’ve taken it [cocaine], I’ve had alcohol (Case 33, female, age 25).

Cocaine was consumed in combination with alcohol not only because of the pharmacological compatibility of the two substances but also because opportunities for cocaine consumption were more likely to arise in drinking contexts.

I don’t think that I have ever done it sober. I don’t think I would really see the point if I was sober. If I wasn’t drinking I don’t know why I would want to take drugs because if I wasn’t drinking I probably wouldn’t be in a social situation. I would probably not be drinking for a

reason because I would probably need to get up in the morning or something so definitely the two do go hand in hand (Case 23, female, age 28).

I've never really done cocaine without a drink. I know how cocaine makes you feel because I've done it. I've taken two grams of coke before going out and I wasn't drinking so it was just chat, chat, chat. And I know exactly how it makes me feel like. And I always end up taking a drink because I'm more sociable and that's a more sociable thing to do along with the coke (Case 34, male, age 25).

Most who had taken cocaine without alcohol felt that the combined effects of the two substances produced a superior 'buzz' or high.

I have taken it [cocaine] on its own as well ... it was different, yeah ... probably more relaxed when I've had a few drinks and I don't know, I just feel different. When I'm taking it [cocaine] your whole feeling is heightened from the drinking as well (Case 30, female, age 30).

There's not much of a difference in effects necessarily [between cocaine with alcohol versus without alcohol] but if you're already feeling, you know, just relaxed and so forth from drinking, more sociable, then taking coke is going to enhance that more, as well, you know? And cocaine will do that on its own but together, obviously, you're going to be more in that direction (Case 24, male, age 24).

When drinking was combined with cocaine use it was usually with the express purpose of having a long night of fun. Cocaine facilitated this goal by prolonging the night. Whether moving on from licensed premises to a house party or retiring to the 'chill-out' zone of a private residence with a smaller number of friends, cocaine provided a welcome energy boost.

... maybe one or two lines before you go out ... but back then parties, that's where people used to come back with it [cocaine], you know. It'd keep you up all night to have the drinks, you can stay awake, that kind of thing (Case 33, female, age 25).

The practice of combining alcohol with other drugs, including cocaine, is well-documented⁸⁵⁻⁸⁶. In common with other studies of recreational drug users in both the UK and Ireland⁸⁸⁻⁸⁹, alcohol was *the* key psychoactive substance consumed by a majority of this study's respondents. Cocaine's close connection with alcohol was clear in the narratives of this study's participants and cocaine appeared to play a functional role in this context by counteracting the fatigue brought about alcohol consumption. This invigorating effect – one of the perceived benefits of cocaine use – is discussed in greater detail later in the chapter.

Other Drug Use

The majority of respondents began illicit drug use in their early to mid-teenage years with the use of cannabis. The age at which illicit drug use commenced ranged from 13 to 26 years with the mean age for cannabis initiation being 16.4 years. All participants were lifetime cannabis users but eight (one-third) stated that they no longer used the drug. Five were current daily users of cannabis, a further seven used the drug at least weekly and one was a monthly user of the drug. All participants reported lifetime use of Ecstasy, with the age of initiation to this drug being older at 17.9 years. Twelve (half) of the respondents were monthly users of Ecstasy and two used the drug at least weekly. Eight stated that they used the drug in the past but had quit. Cocaine

use, then, generally began approximately two years later, with the average age of first use being 20 years. Other reported drug use among respondents included psychedelic drugs such as LSD or magic mushrooms (n=9), speed (n=6) and ketamine (n=4). These drugs were used far less frequently and many had used them only once or between two and five times in their lives. Only two respondents reported lifetime use of heroin and crack cocaine, respectively.

By the time they initiated cocaine use, the vast majority were already experienced drug users. They enjoyed cocaine but they also used a range of other drugs and differentiated clearly between settings or situations suited to different types of drug use. The respondent below, for example, did not use cannabis on a night out because it would “kill the party”.

Like well cannabis sort of I wouldn't really take it for a night out kind of thing, it would be more just relaxing in the house. I wouldn't have been drinking 'cos I wouldn't actually if I was drinking 'cos it would just sort of, it might actually just kill the party atmosphere you know sort of make everyone sit by themselves and not say anything (Case 20, female, age 22).

Others too, spontaneously identified the settings they favoured for different drugs, whether Ecstasy, cocaine or cannabis. Ecstasy was typically characterised as a ‘party drug’.

Es would be good for going to the night club and jumping about and going mad like. Coke, it just wouldn't be, it's not the same buzz like, do you know what I mean (Case 06, male, age 24).

Cannabis, on the other hand, was a drug associated with indoor use in more relaxed settings.

It's [cannabis] not a very sociable drug. Like cocaine or alcohol or something is better for socialising. But with cannabis ... it's the sort of thing you should take when you're listening to music or reading a book or something (Case 34, male, age 25).

Simultaneous polydrug use – consuming two or more illicit substances at the same time – and sequential polydrug use – taking two or more illicit substances consecutively in a short time period – were common practices, associated primarily with a desire to enhance or accelerate a drug high. Popular drug combinations included cocaine and Ecstasy; and cocaine and cannabis.

I've taken coke with MDMA. I've taken coke with pills. I'm trying to think (pause). Drink and obviously cocaine and cannabis. Those do interact, by the way, actually, which is interesting and that's sort of enjoyable like I would say, you know? (Case 24, male, age 24).

[When you say every weekend, would you have been doing pills and then have coke as well?]
Both, sometimes both, sometimes coke, sometimes together. Probably more often both together due to trying to get a better kick out of both of them. They were poor on their own (Case 25, male, age 28).

Commonly stated reasons for combining drugs centred largely on a desire for a better ‘high’, as suggested in the narratives above. These drug users had learned – whether from personal experience or street ‘lore’ – that certain drug and drug/drink combinations could maximise the pleasure derived from one or more substance. This desired effect was not always accomplished however, and there were also reports of negative experiences of sequential polydrug use. One respondent described how he felt after combining Ecstasy, alcohol, cannabis and cocaine.

I was just in the taxi on the way down and I was sweating and shaking and I just wanted fresh air. Panic attack I suppose you could call it but I felt it coming on (Case 03, male, age 20).

Others identified negatives associated with a phase of regular, heavy polydrug use.

It wasn't just on cocaine use, pills and everything ... I didn't seek medical help for it, I just talked to friends. It was strange what I was doing. It was beginning to get in the way of work, getting out of hand ... I really wasn't fit to be in work ... cocktails and the lack of sleep at the weekend, we were taking everything (Case 30, female, age 30).

It is important to point out that the consumption of drug 'cocktails' was not a practice that individuals engaged in on a regular basis over prolonged periods. Nonetheless, practically all of the study's recreational users were experienced users of cannabis and Ecstasy, as well as cocaine, and a significant number had tried other drugs including LSD, magic mushrooms and amphetamine. This profile is similar to other studies which have demonstrated a tendency for recreational cocaine users to have used drugs apart from cocaine and to also use these drugs in different combinations^{32,39,86}.

Cocaine Use Patterns

Although far more limited than longitudinal research, cross-sectional qualitative studies of drug users can provide valuable insight into use patterns, particularly when there is a focus on asking respondents to recount their drug history. In the current study, cocaine users were asked to report on all drugs, licit and illicit, used in their lifetime and cocaine was discussed with reference to a wide range of social experiences. Attempts were also made during interview to discuss the evolution or social course of their cocaine 'careers'. The data analysis phase of the study necessitated a thorough examination of cocaine use patterns and, arising from this, a decision was taken to develop user typologies. These typologies are based primarily on *how* study participants described or framed their past and current cocaine use with specific attention to users' reports of altering their cocaine intake over time.

The largest number of the study's recreational users (n=20) were current users of the drug. Two further categories, 'curbers' and 'quitters', were identified based on the criteria outlined on Table 5.1.

Table 5.1: Typology of Recreational Cocaine Users (n=24)

User Type	Description	Number
Current users	Use frequency ranged from weekly to monthly to less frequent use of cocaine. All expected or intended to use the drug in the future.	n=15 Excludes five respondents ('curbers') who reported that they had reduced their intake of cocaine – these are reported separately (see below).
'Curbers'	Also current cocaine users, but who described deliberate attempts to curb their intake of cocaine (and, in some cases, other drugs). Their current patterns of cocaine use varied but all had used cocaine in the past month.	n=5
'Quitters'	Cocaine users who stated that they had quit the use of cocaine (and, in some cases, other drugs). Some, however, described at least one recent cocaine use episode.	n=4

Current Users

This section examines the use practices of the study's current recreational users of cocaine drawing on the accounts of 15 respondents who stated that they currently used the drug. The experiences of 'curbers' (also current users of cocaine) are dealt with separately below.

The 15 current users (7 male and 8 female) reported different levels of cocaine use frequency, ranging from less than monthly to weekly use. Twelve consumed cocaine on a monthly basis, with the vast majority of these estimating that they used the drug once a month; two used cocaine on a weekly basis and the remaining participant was a less frequent user of the drug (reporting use as less than monthly). As a group, therefore, these cocaine users would not be classified as 'heavy' users of drug; few used cocaine several times weekly and, for most, use was restricted to weekends.ⁱ

ⁱ Other studies focusing on non-treatment cocaine users have documented more regular use among their participants. For example, of the 113 respondents recruited in Scotland by Hammersley and Ditton⁴¹, 59 were classified as 'heavy' users, that is, they used cocaine daily (n=30) or more than once a week (n=29). Likewise, Mugford's⁵¹ study of 73 non-dependent cocaine users in three Australian cities found 40% of respondents to be in the heaviest category, namely daily or weekly use; a further 35% used between one to three times every month and 22%

The lowest level cocaine user interviewed described a pattern of use that was opportunistic rather than purposeful. She initiated use at the age of 23 and since that time had consumed the drug only sporadically. In the excerpt below she explained that she did not seek out opportunities to use cocaine.

I have a couple of groups of friends and some friends would take it [cocaine] and others wouldn't. It would be in certain occasions where I would be with the ones who take it and it might be about. It isn't something I would go seek out. I mean, if it's there I would have it but if it wasn't I wouldn't go looking for it (Case 23, female, age 28).

Several monthly users of cocaine also stated that they did not necessarily seek out cocaine use opportunities or, for that matter, always plan use in advance of the event. Nonetheless monthly users of cocaine described a pattern of use that was more integrated into their social 'scenes'. Cocaine use was often followed by a period of abstinence but use was nonetheless often anticipated at certain kinds of gatherings or events.

It kind of, it did vary but it would vary from like you know loads at the weekends to once every, you know, you could go two months without it and then and three days ... I'd say it was generally about every month and a bit I would have a bit probably, just at the weekend ... Like kind of you know when you were going to do it like if there was a big night coming up or if you were going out with a certain group of people, you'd kind of be expecting it and budget (Case 21, male, age 22).

... it would only be so often that you would have it [cocaine], would be about once a month that they [friends] would say, 'Come round to our house for a Saturday night'. A whole crowd of us going out or whatever ... But um ... it has just been sort of random, once, twice a month sort of thing (Case 01, male, age 23).

It was common for monthly users of cocaine to state that their use of cocaine varied – often expressed as “it depends” or “it's random” – and many indicated that they did not have an established routine of consumption. Cocaine use was somewhat unpredictable but users simultaneously remained open to opportunities for use. Many used cocaine on special occasions or on 'big' nights out and in these instances use was often planned in advance.

I mean I wouldn't, I don't really expect to do it [cocaine] on a night out basis but special occasions maybe or like if the night turns a wee bit crazy ... so probably about once a month or so (Case 20, female, age 22).

[I see my use as] casual maybe but it varies. If there's two big events happening this week I could potentially take coke twice. If nothing's happening for 6 months I won't take it. It's not so much the occasion but the unknown surprises. You can just feel that it's going to be a good night. Recently at that party there was a sense of occasion at it. There was a lot of nice food and drink and people I hadn't seen in a long time. Everyone was looking forward to this and it was a brilliant night (Case 34, male, age 25).

approximately three or four times a year. The current study's recreational cocaine users are closer in terms of use frequency to Erickson et al.'s (1987) Canadian sample: 58% of the users in their sample of the 111 cocaine users used the drug less than 10 times during the past year and over half reported no use during the past month.

At least two current users of cocaine stated that they never or rarely purchased the drug. Cocaine was widely viewed as expensive compared to other drugs and many monthly users pooled money with friends in order to finance use. It is perhaps noteworthy that some users pointed out that cocaine was not shared, even between friends, with the same readiness as other drugs.

Two people would just chip in for a bag because it's too dear for themselves. Like if two people had a bag they'd just take it into the toilets and go in and take a few lines, ya know, just in case the bouncers saw them or anything. You wouldn't normally get someone buying a bag of coke and saying, "go sniff that", like 'cos it's very dear (Case 18, male, age 20).

Well [early on] it was my mates would get it and I would throw them a few pound if I was taking it. It was very casual like, it was always very casual. I never actually rang up and got it myself 'cos it's too dear. I'm too much of a cheap skate. So I, yeah, it was just a matter of throwing in about ten or twenty quid depending on how much you took ... Now I would buy some but only if it was a big night (Case 22, male, age 26).

In general, these users did not extend use beyond one day. However, there were some reports of bingeing on cocaine for a period of days, an occurrence which almost always coincided with attending a festival or organised social event of some kind.

I was down at [festival in Republic of Ireland], that was the year before last. It was just a bit of a laugh ... That was the weekend I took most cocaine and I didn't have to pay for any of it. I dread to think how much money's worth was taken. He [colleague] kept on giving me loads of cocaine and I was telling him I'd pay him back but he just wasn't bothered. So that was 3 or 4 days of constant cocaine-use. There's very little people I'd say who have done as much cocaine as I did in that weekend (Case 34, male, age 25).

A number of factors beyond economic considerations appeared to influence when and how frequently cocaine was consumed. For example, the ebb and flow of pressures and responsibilities related to student life impacted on use frequency in some cases. One woman explained that her recent use of cocaine had been less frequent compared to the past because of the demands of college life.

I think whenever I had a bit less class on and was just sort of going out more whereas now I'm a bit busier like studying and stuff like that and less going out and hence less coke (Case 20, female, age 22).

Academic demands also led the male below to stop using cocaine for a period. However, a subsequent rise in his cocaine intake coincided with his entry to the labour market as an employee in a company where cocaine use was common among his colleagues.

I did [use cocaine regularly] but then I kind of stopped when I started writing my dissertation. I decided to slow down and stop going out as much. Except in second year, apart from college, I broke up with my woman. But in third year I kind of calmed down, I took bits when I was living at home for a year down in [provincial town] 'cos it seems to be a big enough thing down there. I worked in [large company] and pretty much half the staff in there were on it so I was taking it maybe once every two weekends (Case 22, male, age 26).

When current users were questioned about when and where they used cocaine, social networks was a strong reference point. Some linked a phase of more frequent consumption to “hanging out” with a particular group of individuals who used cocaine regularly.

I used coke quite a lot when I was hanging out in the places with people who snorted coke. They're more of your sort of middle-class sort of party sort of crowd, you know, they supply them, you know what I mean. And then when I bought coke, it's maybe twice, about sixty quid's worth or so, maybe twice in my life. Like people I would know, not particularly well, but I just know (Case 31, male, age 56).

[Do you think that being a student influenced how much cocaine you used at that time?]
I don't know. I just kind of knew more people doing it. Like I mean now most of my mates, about 99% of my mates up here wouldn't touch it [cocaine] whereas when I was in college most of the boys I lived with were at it. There was a big crowd from [provincial town] that I used to hang about with and they would be at it (Case 22, male, age 26).

Cocaine use frequency therefore appeared to hinge on the places where individuals socialised and the people present. If these users found themselves in a social setting, whether a party, pub or club, where it was in use and available, they would certainly take cocaine.

Well, Monday night it was both [cocaine and Ecstasy]. It depends who's got it. I mean, it's not like I ever set out and said, 'I am going to take this tonight'. If I'm in the bathroom or something and someone says, 'Do you want a line?', I'm going to take it (Case 22, male, age 26).

Equally, however, many did not deliberately seek use opportunities nor did the planning of a night out centre on the use of the cocaine. Some also indicated that they used cocaine only in the company of *particular* friends who were also users of the drug and a number made efforts to conceal their cocaine (and other drug) use from friends who did not use drugs.

... it depends who I'm with really, you know. I mean some people just, I know some of my friends would just hate the thought of it so it depends who I'm with, yeah (Case 20, female, age 22).

Only two of the study's current users consumed cocaine weekly. Both were women aged 28–29 years who initiated cocaine use at age 20 and 22, respectively. Their accounts suggest that cocaine use was well integrated into their social lives: use was not left to chance but was anticipated and planned in advance. Both purchased the drug regularly and had strong connections with drug distribution networks. One of these women, who had recently been made redundant but worked previously in a clerical position, explained that she needed a “higher high” than alcohol could provide on a night out.

It's like with me when I drink I need a higher high than that. That gets me high and I'm all really chirpy but it gets to a point when I need to achieve a higher high than that and then it's like right, you know like that song rock star, you need a drug dealer on speed dial. Every number on my phone is a bloody drug dealer and it's like how fast and who is a better price and you can get here in an hour and you can get here in half an hour yep. That's basically what it's like, I am playing like five people off in the one telephone conversation and whoever meets me first and the rest just get left (Case 32, female, age 28).

This respondent went on to explain that she used cocaine at least once weekly, usually at weekends, but also used the drug during the week on occasions when she and her friends embarked on a drug spree or “bender”.

It'll always happen one night at the weekend and next to that it will be a mid-week bender as I call it ... we will meet on a Wednesday or a Thursday, usual location in the bar, we'll have a couple of drinks and then we will order the drugs ... So it's usually two to three nights a week (Case 32, female, age 28).

The second weekly user was a university graduate employed in the retail industry at the time of interview. She was in a long-term relationship with a man who was also a regular cocaine user. Their social lives no longer involved clubbing as they preferred to return home after the pub, sometimes in the company of friends. Cocaine and other drugs were always part of these nights of socialising.

We don't really go out. What we do is we'll go to the local. Um, and have a few drinks there or will wander up to the pub and have a few drinks there but then will come back to the house. We generally don't go clubbing because in a club, I just can't be assed. I mean it's the whole hassle of getting ready and then, obviously, you're going outside for a cigarette. So we generally prefer to stay in the house and you know, if we have coke, we will do coke. We always have our weed ... So we will get stoned and have some drinks. You know, have friends round and that kind of thing (Case 37, female, age 29).

This respondent described her cocaine use as “very regular” over the past months:

... it has been every weekend for the last month, two months

[So would you say ten times in the past month?]

Well, ahhhh, at the weekend and sometimes during the week so I would say, yep, it could be easily ten times. It's been very regular the past months (Case 37, female, age 29).

The pattern of use described by these two women is far more committed compared to monthly users of cocaine who often depicted their use of the drug as opportunistic and did not have an established pattern or routine of use. Nonetheless, the majority of current users of cocaine would be classified as moderate rather than heavy users since only a small number used the drug weekly. Higher cocaine use frequency among recreational, non-dependent or non-treatment cocaine users has been recorded elsewhere^{39,41,51}.

‘Curbers’

As stated in Table 5.1, five respondents described deliberate attempts to curb their intake of cocaine. All were current users of the drug and could therefore be regarded as a sub-group within the larger cohort of ‘current users’ (described above). However, their accounts provide considerable insight into cocaine ‘careers’ characterised by reduced intake of the drug over time.

The five respondents, including two males and three females, ranged in age from 19 to 28 years. Four had initiated cocaine use at the age of 16 and one at the age of 26 years. All stated that they had gone through a period of what they considered to be regular, heavy use of cocaine, ranging

in use frequency from once to several times weekly; one respondent reported a period of daily use. For two, this phase of regular use started at the age of 16 years shortly after they initiated use of the drug.

I started doing that [cocaine] when I was 16, a light smoker of blow [at the time] and I was drawn into the world of drugs really. Messed up my A Levels and stuff so ... [then] I started work in the cloakroom [of a bar/club?]. It [cocaine use] would have been regular, every night when I was working there. Someone would come in and have some (Case 50, male, age 25).

... we would have partied a lot, like as I said, Friday and Saturday night when I was younger. I'm talking probably about 16 until about 21. And, um, then, it would've been parties. We would've gone out to a club and then back to a party and that's where it [cocaine] would have been really ... working all week, drugs all weekend and then with me, and with most people, I didn't really come round until Wednesday. It took me a couple of days (Case 33, female, age 25).

Two made reference to what they perceived retrospectively to be cocaine's seductive qualities. In the following account, a 25-year-old woman depicted the draw or appeal of cocaine as "addictive".

It [cocaine] just numbed my gums [first time] but I remember after that, I took it the next week up my nose and I found it (pause), I loved it that much. I found it really addictive like, I have to be totally honest (Case 33, female, age 25).

The woman quoted above had taken cocaine regularly during a phase of weekend party and club-going and had also used the drug in the private setting of her home in the company of her partner who was a regular user of the drug. This relationship provided her with easy access to cocaine and she only rarely paid for the drug.

He [boyfriend] was obsessed with cocaine. I'm talking Friday he finished work right through to Monday solid ... I've only ever really paid for it once or twice because with that boyfriend who was really into it, he used to pay for it and people used to give him it, so I didn't really pay for it that much (Case 33, female, age 25).

A number who reported efforts to curtail their cocaine intake indicated that particular circumstances played a role in their increased use of the drug over time. The respondent above, for example, identified her boyfriend's use as impacting on her exposure to the drug. For another woman, it was a breakdown in a relationship and subsequent change of living situation that influenced her transition to a pattern of regular cocaine consumption.

I had just come out of a long-term relationship and I had moved house and all that kind of thing so I was just in party mode ... like my ex-boyfriend didn't do it [cocaine] and most of that group didn't. So when I moved it [cocaine] was just kind of obvious, in your face all the time ... it would usually be at house parties ... usually back at our house and somebody would whack it out (Case 29, female, age 28).

For the vast majority, the decision to curb use was prompted by the recognition of one or a number of negatives which they attributed to their use of cocaine including financial difficulties, poor work performance or undesirable physical or psychological side effects. The account below

lists a combination of factors or ‘realities’ that impacted on her decision to reduce her intake of the drug.

[After that kind of eight months of partying or more, did you kind of make a conscious decision to cut back on use?]

Um, I think I just got a bit bored of it ... because you kind of have to just keep taking more and more to get a buzz off it and then your bank balance starts to be affected by that and you think maybe I should do less of this ... It was the reality of it and made me think, ‘Right I should not be doing this’ (Case 29, female, age 28).

This same respondent also recognised that her use of cocaine had impacted negatively on her working life and career.

I mean I always made it into work but looking back there were a few times that I should not have been in there ... And you know because I am one of the managers. You are just standing there thinking, ‘I am in charge of a building of 300 people and I haven’t been asleep for three days’ ... you know, this is not a good idea (Case 29, female, age 28).

Others identified undesirable behavioural and psychological consequences as influencing the decision to reduce their intake of cocaine.

I think it’s [cocaine] like starting to pickle my head a bit, you know what I mean. I think maybe over the whole length of time I took it it’s just maybe starting to catch up on me a bit you know what I mean, just ‘cos I was never like nasty and all of a sudden I’m nasty now. I have cut down now so I have ‘cos we just go out every weekend and just go off for two or three days and just Es, coke, the lot ... (Case 06, male, age 24).

The financial implication of continuing to use cocaine regularly was an issue raised by three of the five who had curbed use of the drug. A male respondent who expressed a desire to “*to get off it [cocaine] and the drink*” also reported that he had accumulated debt during his period of regular use.

Like every weekend just constantly every weekend, going out every weekend when I was working. Used to go out and work or get my salary and I started to have maybe 50 pound left of my wages because more and more, owing money from before, paying half the money here and owing different people (Case 06, male, age 24).

Motives for curbing the use of cocaine varied but centred largely on the perception that their use of the drug had resulted in some negative or undesirable ‘realities’. These cocaine users appeared to move without much difficulty towards their desired goal, with only one indicating that he found it difficult to reduce his intake of cocaine. In the account below, a male respondent referred to cocaine’s addictive qualities as well as social contexts which make refusing the drug challenging.

... like I’m always just in the company of people who take it [cocaine] ... it’s addictive, you know what I mean ... it’s just very, very addictive. See when you’ve a couple of drinks in you, you want a wee bit of it ... if you want to get off it maybe you maybe have to stop drinking ... you need some will-power to be honest with you (Case 06, male, age 24).

Thus for some users who feel that their cocaine use has exceeded ‘sensible’ limits, cutting back may prove to be difficult. Nonetheless, those respondents who decided to curb their use of cocaine did so without seeking treatment and most appeared to feel that they had achieved this goal by moving towards a regime of more moderate use. A primary strategy for cutting back was the avoidance of certain places, people and social contexts. Alongside a downturn in their cocaine intake, most also articulated a changed perception of the role of cocaine in their lives. A 19-year-old female, formerly a weekly user of cocaine, described a pattern of current use that was qualitatively very different to her previous orientation towards the drug.

[And would you have called yourself, like, a regular cocaine user at that time (in the past)?]

At that time probably yeah. But now I wouldn't, I wouldn't... Probably I'd say recreational because if, if we decided to go out and someone suggested getting it, we would probably get it, but we just don't really take an interest in it no more, like, we wouldn't, we wouldn't have, I'd say maybe twice, well, about three, four times a year (Case 04, female, age 19).

Others articulated a shift in how they characterised their current drug consumption compared to the past.

I would have said about six months ago yeah [I was a regular user of cocaine] but now, no (Case 29, female, age 28).

All respondents who reported efforts to reduce their intake of cocaine continued to use cocaine. Nonetheless, their accounts demonstrate the kinds of self-regulatory strategies that cocaine users may employ over the course of their drug ‘careers’ in an effort to avoid negative consequences and maintain ‘control’ over their drug consumption.

‘Quitters’

Four respondents (three males and one female), ranging in age from 20 to 28 years, stated that they had quit cocaine use. Two had maintained a regime of abstinence from cocaine use for nine and eighteen months, respectively. The remaining two reported recent use of cocaine, although both considered that they had quit use. This is not unusual since ‘quitting is often a long and arduous process in which slips are always possible’⁴⁷. Reporting on post-cessation drug use, Waldorf et al.⁴⁷ found that one third of the study’s quitters had used cocaine on between one and five days since quitting and a further third reported using cocaine on six days or more.

This analysis does not claim to provide a comprehensive account of quitting since many more cases would be required to fully unravel this process. In any case, longitudinal data are ideally required to flesh out the complex desistance routes and drug ‘journeys’ of individuals who move toward a regime of abstinence. Nonetheless, as an empirically salient sub-group of respondents, the accounts of the study’s quitters have much to offer in terms of understanding their motivations and some of the processes associated with this drug decision.

Like the study’s ‘curbers’, almost all who quit cocaine use reported a period of heavy regular use of the drug. The perception that their consumption had exceeded ‘acceptable’ limits featured

strongly in these participants' accounts. Most appeared to feel that cocaine use had impacted negatively on one or more aspects of life experience and two specifically mentioned financial stress arising from their use of cocaine. In a more general sense, this sub-group of users appeared to have arrived at a juncture when they began to reflect on the role of cocaine use in their social and personal lives. One male, aged 28 years, had reached a point when cocaine use was '*just no fun anymore*'.

I just really had enough. Just no fun anymore ... it wasn't that I had a scare or horror story or anything like that. It was just, 'Why am I?' (pause) ... just the thought of why am I doing this. There's no fun in this anymore (Case 25, male, age 28).

Another male, who did not feel he was "addicted" to cocaine, nonetheless felt that his use of the drug had exceeded the boundaries of 'sensible' use.

I stopped taking it [cocaine]. It wasn't like I was addicted to it. If my mates had it I would have done it just for something to do like. But like if they had enough and somebody said, 'You want a line?', I would have been, 'Aye' ... for like two months solid that I was constantly with them and we were going out and getting really wrecked and stuff so ... (Case 03, male, age 20).

Specific life events appeared to prompt a number to attempt to quit cocaine use. For example, one participant explained that the birth of her child combined with changed financial commitments and accumulating debt, prompted her to quit.

It [cocaine use] was just getting me into debt, loads of debt ... I just couldn't pay it no more. [Child's name] and having to run a house. I had to stop that (Case 02, female, age 19).

The speaker above was a former regular weekly user of cocaine.

Before I had this child I'd be out like, every night of the week I went out to a night club I would have bought it. I would have bought a gram of it (Case 02, female, age 19).

This pattern of regular cocaine use was a commonly told story among those who reported deliberate attempts to quit. Another male respondent explained that after finishing college and starting a new job he entered into a routine of regular cocaine consumption.

[I was working] dull office jobs and at the weekends it was, 'Right, I need some excitement', I think as well due to dull office jobs ... I had more disposable income and started taking cocaine every other weekend ... sometimes every weekend, sometimes during the week (Case 25, male, age 28).

Efforts to quit, however, were not always initially successful. The respondent above, for example, went on to explain that he had experienced a scare episode approximately 18 months prior to interview which prompted him to quit for a period of five to six months.

... a year and a half ago there was one occasion when my nose started bleeding after doing coke and that lasted for about a week. If I got up out of bed my nose would start bleeding you know, even a week after I'd done coke and then I kind of went, 'No, no more'. And I did extremely well for about six months ... (Case 25, male, age 28).

However, he subsequently resumed use: *'I met some girl and we started doing coke ... it's always girls, it's always just drugs and sex go together'*. A number of months prior to interview, following the breakdown of this relationship, he again made a commitment to quit use and appeared to have maintained this regime of abstinence. Quitting, therefore, did not happen suddenly for these cocaine users and there were sometimes challenges associated with refusing cocaine. A male respondent, for example, who stated that *'if someone offered me it it'd be hard'*, explained the circumstances surrounding his most recent use of the drug.

... sort of within the nine months I have taken a line of coke but it was only one line. But apart from that there's been no more ... we were going to a party or something and one of my mates offered it and I said, 'No', but as the drinks started going in I said, 'Aye'. Then I just felt really bad (Case 14, male, age 21).

These 'quitters' had not sought formal assistance to help them to quit nor had any of them attended a drug treatment setting. For these users, the decision to quit appeared to have been a conscious one but quitting itself was a process complete with 'relapses' and renewed efforts to maintain a regime of abstinence. In keeping with other studies^{39,47}, respondents' reasons for quitting were diverse, although financial concerns and adverse physical effects featured strongly in their accounts.

Perceived Benefits of Cocaine

For many of this study's recreational users, socialising and going out meant entering into a world of fun in the company of friends where opportunities might potentially arise for self and social enhancement. Alcohol consumption, as highlighted earlier, was a staple of the psychoactive intake of the majority of this study's cocaine users and was synonymous with socialising and going out. Other substances, including cocaine, were part and parcel of these social scenes, as expressed by one respondent:

Any party where I live there's always some sort of drug knocking about. It's very rarely you just get to drink (Case 18, male, age 20).

This section seeks to unravel respondents' views on the benefits of cocaine use in the social contexts where they used the drug. It highlights perceived benefits that refer to both *self* and *social* enhancement, although the two were tightly bound for the majority of recreational cocaine users. Study participants attached different 'labels' and terminology to the way they felt when consuming cocaine. For analytic purposes, the perceived benefits documented here are organised into five categories of experience and are presented in accordance with the frequency with which respondents referred to these beneficial cocaine effects:

1. Enhanced sense of self.
2. Prolonging the party.
3. A controlled drug experience.
4. A discreet drug.
5. Preservation of self.

Enhanced Sense of Self

During interview respondents were asked to speak about their perspectives on the positive effects of cocaine which most did with relative ease. Within these accounts, the notion of an enhanced sense of self featured strongly, with a majority articulating a number of ways in which cocaine amplified their self-confidence and ability to interact with others.

It was just, it kind of made you more confident and you just spoke to loads of different people and just, like, I don't know ... It's just, it just made you more confident and kept you awake (Case 04, female, age 19).

I can remember thinking this gives me more confidence, you know what I mean, being myself and sort of, well not really yourself, but you think you are, you know? You're definitely more bold, like to talk to people, and ... (Case 33, female, age 25).

It [cocaine] brings out, it's a personality enhancer. That's what I call it with my friends ... a personality enhancer, it makes you more confident (Case 32, female, age 28).

While many of the benefits were framed as a positive transformation of self with particular reference to increased self-confidence, this drug effect was strongly associated with a desire for social enhancement. Indeed, it was rare for participants not to allude to the social benefits arising from the confidence boost that cocaine provided. For this 25-year-old woman, self and social enhancement went hand in hand.

Benefits? To be totally honest, it [cocaine] makes a night out better ... that sounds really sad like but, really, it just improves your night out, just gives you that wee bit more boost ... increases your confidence, just makes you feel like you could approach people and talk to people... So the reasons that I use [cocaine]? Um, just to enhance the night basically (Case 33, female, age 25).

A male respondent expressed a similar view, referring directly to cocaine's "*socially enhancing*" qualities, particularly when consumed in '*the right social situation*'.

Ah you know it's socially enhancing, you know. Like cocaine is nice you can have a very nice evening and so forth and, you know, in the right social situation ... so I would enjoy cocaine, but, yeah, it's socially good ... (Case 24, male, age 24).

The benefits of cocaine were in fact often depicted as contingent on the context of use, including the individuals present on these occasions.

A few nights where there have been really good nights and I have taken coke but I think it's when you're with your friends as well when you're taking a drug like that you are super high (Case 30, female, age 30).

Although cocaine was praised for its stimulating properties, and for conferring a strong sense of self-confidence, some users' accounts also drew attention to a calming effect. In the following excerpt, a 24-year-old male talked about feeling confident and talkative but also about feeling relaxed and calm.

[If you had to say, if you had to pick out of all those that you've done, which would be your favourite?]

Cocaine

[Cocaine and can you say some of the things about why?]

I just, I just think it's the best and relaxes you and gives you, I won't say it gives you best hit like, I'd say Es would probably give you the best hit maybe ... I just think the coke's better you sit and relax and maybe just talk and talk and talk, you wouldn't stop talking like. It gives you a bit more confidence like. I don't lack in confidence like but it just makes you, you know like have wee chat and all that there, talk to people you don't talk to and that there ... Yeah it gives you a boost (Case 06, male, age 24).

As respondents conveyed their views on appealing aspects of cocaine, they often mentioned other drugs, sometimes in order to express contrasting experiences. The speaker below associated Ecstasy use with energetic club environments and cocaine with a more relaxed 'high'.

[And like on Es you said it gives you a better hit but ...]

No Es would be good for going to the nightclub and jumping about and going mad like. Coke just wouldn't be, it's not the same buzz like do you know what I mean ... Coke's just taken for a wee calm, calm down like, calm (Case 06, male, age 24).

Socialising and going out was depicted as a world of heightened experiences of fun and friendship and cocaine as increasing self-confidence in a range of social situations. Quite clearly, going out held the promise of social fulfilment. A number of respondents also made explicit reference to the benefits of cocaine to the attainment of sexual pleasure.

It's more fun taking cocaine with girls 'cos of the whole aphrodisiac qualities of it and things like that (Case 22, male, age 26).

The self-enhancing qualities of cocaine spanned a number of domains of experience. Feelings of self-confidence featured strongly, as did the perception that cocaine enhanced one's sense of connection or intimacy with others. However, participants' accounts of the personal pleasures derived from cocaine were almost always framed with reference to the social contexts of use. Thus, the narratives did not focus exclusively on cocaine but on the perception that when consumed cocaine facilitated or enhanced "some other activity like social interaction, conversation, sex and so on"⁷⁶.

Prolonging the Party

As demonstrated, cocaine was praised for ways in which it improved a night out, a sentiment expressed with reference to both self and social enhancement. Quite central, if not critical, to the achievement of this desired 'state' was that cocaine provided a boost that helped to extend the night's fun; it quite literally prolonged the party. In the account below, the speaker refers to enhanced self-confidence but also emphasises that cocaine gives a "*new lease of life*" at a time of the night when fatigue may take hold.

It just makes you feel like good about yourself, confident and all, know what I mean and it relaxes you ... It keeps you awake as well and you'd be tired and take it and it gives you a new

lease of life, it makes you feel very alert so you don't feel tired. You could probably stay for three, four days if you had loads of it like (Case 06, male, age 24).

A female participant similarly felt that cocaine essentially prolonged pleasure by helping to ensure that the party lasted into the early hours.

Well, you do coke, you do enjoy yourself. Enjoy yourself a bit longer ... you just keep drinking and you can keep going and it will be 11 o'clock the next morning and everyone will still be partying away (Case 29, female, age 28).

Alcohol, as demonstrated earlier, was almost always consumed before or in conjunction with cocaine during the course of a night out. However, one of the problems with drinking for consecutive hours is that it can lead to an early 'crash' and bring the night to a premature close. Cocaine provided an ideal solution, according to several respondents.

Well booze sort of knocks you out a wee bit as well. Aye. Loads of drink can just knock you out and you can lie on the sofa and sleep. Whereas a bit of coke will kind of wake you up and it will almost guarantee you a half decent night (Case 22, male, age 26).

Others in the study placed a strong emphasis on cocaine's ability to sober you up.

And actually, it [cocaine] kind of made me feel like I was a bit more sober (Case 20, female, age 22).

You take a bit of coke and it makes you feel sober like (Case 34, male, age 25).

I think as well if you're drinking and you take cocaine that it kind of sobers you up... like, the drunkenness goes away 'cos you're, you know, more alert and that ... and you stayed up longer (Case 04, female, age 19).

I just like coke ... If you're sitting there and you just feel that tired or you're sitting there and you've had a drink and you're feeling a bit drunk, you know, just one line of coke, I don't know, just that feeling, just, you know, you're wide awake again. You don't feel pissed. You can just take a drink and a drink and a drink and not feel sick. Obviously you're wrecked. It's just you get that buzz and I love it (Case 37, female, age 29).

Both male and female respondents made constant reference to the personal pleasures they derived from cocaine but their accounts almost always situated these pleasures within the setting of a party or social gathering with friends.

There have been loads of really good fun nights. Um, when coke is out, I just always have fun nights. Like, I like it. When I go home to [UK city] we will just buy loads of coke and we will definitely go out when I'm home. Then we will come home and sit up and do loads of coke. And have an absolute laugh and it will be an all-night kind of party ... And those are probably the best nights when you have loads and if you do run out at say three or four in the morning all you have to do is make one phone call and go around a corner and meet somebody. And come back and get more. Even at that time of the morning you can get it (Case 37, female, age 29).

Much of the focus of positive reports of cocaine effects centred on ‘the party’ and on how cocaine facilitated particular types of activities and experiences by making the night last longer. As documented earlier, partying into the early hours sometimes involved smaller and more intimate gatherings. Cocaine pleasures were therefore deeply embedded in specific contexts or spaces and the reasons for wanting to prolong ‘the party’ differed according to context. Whilst cocaine use in the context of larger house parties was valued for the energy boost it provided, use in the context of smaller, more intimate gatherings was perceived to promote a sense of connectiveness with others.

A Controlled Drug Experience

Many users particularly appreciated that they could benefit from the various appealing effects of cocaine – enhanced self-confidence and the ability to party for longer – *without* feeling a loss of control.

[Was that what you expected it would do?]

Em, yeah I was kind of, I think I was a bit more worried that I would have lost more control with it [cocaine] but then I think, you know, I didn’t have any memory loss or I didn’t have anything weird like hallucinations or anything like that. Just sort of, it was probably like I was actually more aware of what was going on and, yeah, it was just nice and relaxed and yeah I felt in control all the time so (Case 20, female, age 22).

It sort of made me a wee bit happier and a wee bit more talkative but I’ve took other drugs and the effect wasn’t anything like what I’ve had on other drugs. I knew what I was doing like; I knew what I was at (Case 18, male, age 20).

Female respondents in particular compared cocaine to Ecstasy, often highlighting the propensity for Ecstasy use to result in feelings of losing control of one’s physical and emotional self. In the following accounts, the speakers explained that that cocaine enabled them to retain a strong sense of self.

... Es are kind of, you felt like you were sort of out of control a bit, you know, of what you were doing. You know, you just felt completely out of it. With coke, you could talk and be confident and still kind of be yourself a bit ... But with Es, I just kind of felt like, you know, completely weirded out, if you know what I mean (Case 33, female, age 25).

Just more awake really. It didn’t make a difference. Just made me more confident. It doesn’t make you feel off your head like Es do or anything like that. Just more controlled (Case 26, female, age 24).

In another account referring to Ecstasy, a female cocaine user invoked the notion of freedom to position cocaine as a comparatively less controlling and therefore a more fulfilling and enjoyable drug experience than she associated with Ecstasy. Cocaine, “*a different drug entirely*”, permitted her to retain control.

I didn’t like them [Es] because you are being controlled, you are physically controlled like in a corner you can hardly speak you can hardly look, someone could get up and tell you something to do and you would do it, you would be that stupid and doped up you wouldn’t know. There is no

freedom with that drug, you are not your own person, it doesn't make you any more confident, I found it made me paranoid, made me scared of people. It was a different drug entirely. When I discovered coke I thought, 'I really wish I hadn't discovered this' (Case 32, female, age 28).

The ability to continue to interact in a meaningful way with others was an important component of feeling 'in control' during cocaine using events. Again, female respondents were more likely to draw attention to their ability to converse 'normally' when using the drug. Cocaine permitted these participants to be more socially inclusive and responsive.

If you are on pills you can sort of drift off and completely get lost in your thoughts. You can have some deep conversations and be like the next day and think but with coke you are a lot more in control of your self and in control of your thoughts so it's just a bit more like being yourself you are just a bit more (pause) ... In certain situations it's more beneficial to be a bit more compos mentis and be able to carry on a conversation (Case 23, female, age 28).

Others felt better able to monitor and control cocaine effects, compared to other drugs, due in large part to cocaine's relatively short-lasting effects.

Then I took coke and I am normally quite shy and I don't talk much and I couldn't stop or shut me up for an hour .. It didn't make me feel quite so drunk so you feel a bit more in control ... I think when you take coke you feel more in control of yourself whereas pills you are a bit more, whooo ooo. And the buzz of coke, you know, it's shorter so if you do begin to think, 'oh Christ what am I going to do', it's over a lot quicker (Case 29, female, age 28).

It's [Ecstasy] one thing that you take and then you don't, you're just waiting to see how it effects you whereas with cannabis or alcohol or cocaine it's like you can kind of graduate it and like, if you feel it affecting you, you can stop and not take any more (Case 20, female, age 22).

A smaller number spoke about the negative side effects of drinking to intoxication – the night getting “messy”, feeling ‘out of it’ and unable to behave sensibly or appropriately – to highlight the benefits of cocaine. In the following account a male, aged 22 provided a lengthy account of the advantages of cocaine over alcohol.

It's [cocaine] cleaner almost. Alcohol, you get to a certain point in the night when it just gets messy, you know, people get like really drunk and people react you know really differently on alcohol. Whereas with coke people do react differently but it's kind of generally in the same direction you know whereas if someone gets pissed they can get aggressive or ... No, I suppose coke, it's just like say you're in that party scenario and ... It's totally different ... It's just a lot cleaner you feel, you're more in control about it so you're kind of like, you're less inhibited but you're saying the stuff that you kind of want to say. Whereas with alcohol you could be saying anything, any rubbish you know. If you wanted something to happen say with a girl or something like that you would be kind of zoned in on that whereas alcohol you'd just get pissed and I don't know get sick on her or something.

[Ok so the control thing?]

Yeah and kind of it's just a cleaner kind of buzz, you're more sharp and you know what's going on like. With alcohol you get tunnel vision, yeah (Case 21, male, age 22).

To a considerable extent, the accounts above highlight the importance for users of feeling able to control their physical and psychological selves and their responses to those around them in the

social contexts where they used cocaine. This ‘controlled loss of control’ has been described previously in relation to drug and alcohol use⁸³⁻⁸⁶. Certainly, recreational cocaine users in this study appeared to value the ability to ‘let go’ and experience the pleasures of indulgence without losing control of their physical and emotional selves in the process.

A Discreet Drug

A number of participants considered cocaine to be a more discreet drug because the signs of intoxication were less visible than those they associated with other illicit substances. This was judged to be an appealing quality in the context of a night out when the user’s demeanour could be a factor in gaining entry to late night pubs and clubs.

If you’re out on Es the bouncers will look at you but if you’re on coke you can’t really tell. Unless you’re looking closely and you see the pupils and all, you wouldn’t know they’re on coke (Case 18, male, age 20).

The perception that others would not necessarily know that they had consumed cocaine was appreciated in a more general sense in the context of socialising and going out. Users of cocaine appeared to value being able to mask their use of the drug, particularly when socialising in public settings.

You can just take it [cocaine] whenever you're out and nobody will, like, know that you're on it ... whereas anything else, you would know that you were on something (Case, 04, female, age 19).

It’s more, it’s much easier to hide. People won’t realise as much like especially between coke and pills you could kind of be stealthily on drugs ... So you could have what pills give you a bit but not be so obvious about it like (Case 50, male, age 25).

Discretion and control were sometimes linked since losing control was something that others could potentially observe.

[You said before that you felt you were in control. Is that something that is appealing about the drug?]

Yeah, definitely. That’s what kind of would put me off anything else, just the thought of totally losing control and everyone knowing (Case 20, female, age 22).

This link between discretion and control has been noted elsewhere in the narratives of recreational cocaine users⁸⁹. It is notable that the desire to use cocaine discreetly was rarely if ever linked to a fear of legal ramifications. Rather, it was more closely connected to how respondents might be perceived by others, whether users or non-users, particularly when consuming the drug in public settings.

Preservation of Self

A smaller number of the study’s recreational cocaine users drew attention to how they felt during the day or days subsequent to use, eager to point out that the negative physical side effects of

cocaine were less severe compared to other drugs. Again, users often compared cocaine to Ecstasy when they related their experiences of the after-effects of drug taking.

I like cocaine better 'cos coke doesn't mess you up as much the next day, you know what I mean ... Es make you, after Es you can't eat for two or three days, the next day, you know what I mean (Case 06, male, age 24).

Coke is good though in the respect you don't get ****ed up the next day. Like I mean the problem with pills [Ecstasy] is I can't take them without having to lie in bed for like a week. You nearly need like a week when you are doing nothing before I take them ... like I mean Easter Monday night, that's why I'm thinking I'm never going to take them again. Like on Tuesday I was in bits the whole day like. I couldn't do anything. Wednesday I had to go into work, Thursday and Friday as well and it was just an effort. Even the Friday evening I was still feeling it like, was still knackered but that is the good thing about like coke because you don't have that kind of long long long drawn out thing, it doesn't mess with your head as much either (Case 22, male, age 26).

Negative psychological effects, particularly depression, were also claimed by some to be less severe in the case of cocaine.

It [cocaine] doesn't make me feel as bad like [next day], if you know what I mean. No, it's not as depressing like ... you take loads and the next day you feel alright (Case 06, male, age 24).

Thus, the perceived ability to function 'normally' during the days subsequent to cocaine use was valued by a number. For these users, merely feeling hungover was preferable as it was more immediate and short-lived than the after-effects they had experienced following the use of other substances.

Eh, when you wake up the next day, like with pills you wake up and you are in bits, really, really ... but not with coke, you would feel hungover but from the drink. It's the type of thing you could take regular enough without it really messing you up for the rest of the week like (Case 22, male, age 26).

The various perceived benefits or appealing aspects of cocaine documented here are closely connected in many respects. As highlighted earlier, control and discretion were closely linked and the perceived self-preserving qualities of cocaine, compared to other drugs, might be viewed as an added bonus in this context. Almost all users of cocaine drew attention to several benefits simultaneously, whether referencing self and social enhancement and/or the benefits of maintaining 'control', safeguarding discretion or preserving oneself in the days following use.

Perceived 'Downsides' and Negative Effects of Cocaine Use

In the same way as respondents were asked about the positive effects or benefits of cocaine, questions were also asked about unappealing aspects or negatives. Immediately apparent from the narratives was the tendency for respondents to report more benefits – and recount these in more detail – than any perceived cocaine-use negatives or risks. For this group of cocaine users, then, the balance of perceived positives and negatives appears to tip to the side of advantages. Nonetheless, upon close scrutiny of the data a number of noteworthy patterns emerged. First,

current users were less likely to report negative consequences than were ‘curbers’ or quitters. Indeed, variations in participants’ views and accounts of unappealing aspects of cocaine reflect differences in their drug histories in many respects. Changed experiences with cocaine (and other drugs) also influenced how participants depicted negative dimensions of use.

As demonstrated in earlier sections, those individuals who reduced their cocaine intake or, alternatively, attempted to quit use usually had specific reasons for doing so and many of these centred on the perception that cocaine was impacting in some negative way(s) on their lives. Most listed a number of unappealing consequences of their cocaine use. For example, a 33-year-old female who reported deliberate attempts to reduce her intake of cocaine listed a whole range of negatives including insomnia, loss of appetite, increased heart rate, mood swings and depression. This respondent also talked openly about the risk of addiction.

Negatives [of cocaine] ... money, addicted, addicted to it. Money-wise you’d be completely broke. Also, being reliant on a drug is not normal like. It’s unhealthy. And because cocaine is so good it is so easy to get addicted to it (Case 33, female, age 25).

One of the study’s quitters similarly reported a number of negative consequences and reported mood swings, heart palpitations, nose bleeds, debt, as well as the negative impact of cocaine use on his personal relationships.

It [cocaine] never caused issues with friends but definitely caused issues with girlfriends, the fact that I continued doing it with friends when they [girlfriend] went home and then I would turn up in the afternoon on a Sunday ... (Case 25, male, age 28).

Two of the four who had quit cocaine use and one who deliberately reduced their intake of the drug reported that cocaine made them feel agitated or aggressive. The following account is one of the more extreme reports of cocaine-induced aggression.

I don’t know? Just be agitated and start shouting and if somebody says something to you just shouting back and being very nasty ‘cos I’ve done that with my girlfriend as well like ... just turned into, you know, a real evil person, you know, smashing up phones and smashing pint glasses and all that, really nasty.

[So using cocaine kind of brings out a violent side in you?]

I think it does in me, I don’t know whether it’s the drink or it’s the coke or the drink and coke mixed together, you know (Case 06, male, age 24).

For ‘curbers’ and quitters, disadvantages relating to physical effects included nose bleeds, heart palpitations, nasal congestion, and bad ‘comedowns’, with the latter being a commonly reported negative physical side effect. Disadvantages related to psychological effects were mentioned far more frequently and included feelings of agitation or aggression (as noted above), mood swings, depression and memory loss. These respondents also invariably talked about the poor quality, combined with the high cost of cocaine, as a significant downside of using the drug. However, for the study’s current users (excluding ‘curbers’) who were in the main monthly users, the picture was quite different, with almost half reporting *no* negative consequences or side effects arising from their cocaine use. In the following account one respondent attributed the absence of negative effects to her very moderate use of the drug.

Negatives for me personally? I don't think I have experienced any negatives because I haven't taken enough really ... I have always been really careful not to overdo it (Case 23, female, age 28).

Another respondent stated that cocaine had never affected areas such as study or work, adding that alcohol consumption was far more likely to have been the source of negative responses or effects during the day or days subsequent to use.

Well, has work suffered from cocaine? No. Alcohol probably I would say is probably the worst thing like, you know, really for any effects that I suffer from anything, it's probably been mostly from alcohol (Case 24, male, age 24).

While a number acknowledged that they experienced some physical side effects – often likened to an alcohol hangover – such symptoms were often dismissed and appeared to be accepted as part and parcel of a night out. These users were quite familiar with feeling dehydrated, slightly run down, irritable or lethargic during the period subsequent to using cocaine, which was most often consumed in conjunction with alcohol.

... there has never really been any kind of really bad, like a hangover sort of situation really, not that bad like (Case 20, female, age 22).

I don't know [about negatives]? Sometimes in the mornings after a weekend of drugs you'll be in a bad mood or whatever but you always remember that it's drug-induced and not something you really want to worry about (Case 34, male, age 25).

[Have you ever had negative experiences with coke?]
Except maybe just a bad hangover the next day (Case 39, female, age 26).

Just feel **** the next day and dehydrated (Case 21, male, age 22).

It is perhaps significant that when current cocaine users did report negative consequences many recounted use episodes involving drug(s) other than cocaine, sometimes in addition to alcohol. One male user, for example, described a bad experience on an occasion when he consumed LSD and cocaine concurrently.

... same time two [acid] tabs and two lines of coke. Never in my life again. I actually walked bare foot for half a mile to a bar where there was this girl ... and says, 'Listen I'm in a bit of bother here', told her exactly what happened and she just walked me, took me to the hospital ... (Case 31, male, age 56).

There were other reports of negative or undesirable effects when mixing cocaine with cannabis and Ecstasy.

... when you're on coke and the grass you do get paranoid. Very. There's always something going on (Case 18, male, age 20).

... the downers from the pills [Ecstasy] and the coke. I tried to keep a diary of how I was feeling during the week and I could see it just ****s your head up emotionally. Actually for girls I think it's tougher and messed up like, you can get quite depressed (Case 30, female, age 30).

Weekly users of cocaine were more likely than monthly users to report negative consequences arising from use. One weekly user reported '*really bad comedowns*' and admitted that her cocaine and other drug use had impacted negatively on her ability to work. She also reported memory loss, insomnia and feeling '*out of control*' on some use occasions. The excerpts below illustrate the range of negative consequences reported by this weekly user including bad 'comedowns', sleep loss, memory loss and loss of control.

Just really bad comedowns, really bad comedowns. Um, or just felt so wrecked that I had to keep running off the shop floor to get to the toilet ... like projectile vomiting because I am just so wrecked (Case 37, female, age 29).

After a hard core one ... because you've done so much you can't sleep for the life of you. And it's torturous. It's like please let me sleep, I need to sleep. And if you can't, there's some nights where I have just laid in bed and thought ***** it just get up and have some more, you know, when I shouldn't have some more because I'm at the point where I'm wrecked (Case 37, female, age 29).

I think it's messed with my brain a bit but I don't know if that's the smoke or the coke or the drink or all of them combined. But definitely my memory's really bad (Case 37, female, age 29).

As far as the negatives of doing coke is when I do too much and I kind of have no boundaries ... and I know it will affect my relationships with [partner] one day because I just get really out of control (Case 37, female, age 29).

The reports above of undesirable side effects – all from the same respondent who was a weekly cocaine user – are numerous and span both physical and psychological domains. Another weekly cocaine user also reported negative consequences which she attributed directly to her use of the drug. An experienced drug user who initiated cannabis use at the age of 13 and cocaine use at the age of 20, she used cocaine two or three times weekly at the time of interview. She had been hospitalised on one occasion following a cocaine-use episode, had accumulated debts arising from her drug use, and also reported fears for her mental health. In the following account she described times when she felt '*on the brink of suicide*'.

There is a point with coke that you reach that when you take too much you will be really high and will be really happy but if you go over that it can make you suicidal, you are that frightened of coming down, it will push you over the edge ... two or three times I have felt on the brink of suicide because I thought I could not go back to normality (Case 32, female, age 28).

Researchers have commented on the difficulty of disentangling cocaine-use negatives from co-existing use of other substances⁸⁶. This study's weekly cocaine users – and indeed many others who used the drug monthly – were polydrug users who consumed alcohol regularly, making it difficult to identify the distinctive negative effects of cocaine with great certainty. That said, the vast majority did not report severe negative consequences. Reporting on the perceived advantages and disadvantages of cocaine use among a sample of 111 users in Antwerp, Belgium, Decorte³⁹ concluded that "when used moderately, advantages of cocaine will remain stronger than disadvantages", a statement which appears to resonate with the findings documented here. Certainly, a large number reported few or no negative side effects and, when reported, such

consequences were often regarded as comparable to an alcohol hangover. Noteworthy nonetheless is the range of negative physical and psychological consequences reported by the study's 'curbers', 'quitters' and weekly users of cocaine.

Cocaine Users' Perspectives: Control, Addiction and Risk

This section seeks to explore some of the ideas and concepts used by respondents to characterise their drug consumption, with particular attention to their perspectives on 'control', 'addiction' and 'risk'.ⁱⁱ Earlier analyses have demonstrated that many of this study's recreational cocaine users were concerned with maintaining control. Indeed, a key perceived benefit of cocaine was that it produced a pleasurable 'high' without the user feeling that s/he was out of control in a physical or emotional sense. Apart from valuing this 'controlled loss of control'⁸⁶⁻⁸⁸, many respondents spoke candidly about their perspectives on 'controlled' cocaine (and other drug) consumption. Concern with maintaining control was possibly best demonstrated in the accounts of 'curbers' and quitters, cocaine users who made independent decisions to address and change aspects of their drug use. The accounts of these respondents also demonstrate that some users may arrive at a point when they feel vulnerable to excessive use patterns. This study's small sample size limits what can be said about factors and experiences associated with recreational cocaine users' pathways to 'uncontrolled use' of cocaine⁴⁶. That notwithstanding, the narrative data suggest that many of this study's cocaine users gave consideration to their cocaine intake and the frequency with which they used both licit and illicit substances. In the following account, for example, a female respondent who described her early use of cocaine as 'recreational' and her current use as 'opportunistic', had addressed some excesses related to substances apart from cocaine by adjusting aspects of her social life.

[Ok and like as far as like your perception of your cocaine use or drug use, how would you perceive that?]

I would say opportunistic that would be it ... Rather than have it planned out or anything like yeah. Maybe it was recreational at a time [prior to this] but now just opportunistic.

[Ok. Have you ever felt that using cocaine or any other drug, including alcohol, was excessive?]

Yeah ... cannabis as well a few times I've really regretted it the next day sort of how much. Yeah I think with alcohol, yeah, there was definitely that.

[And have you ever worried specifically about cocaine and tried to cut back?]

No, not really. Cut back on nights out generally but not like just cut back on cocaine (Case 20, female, age 22).

Likewise a male aged 24, who initiated cocaine use at the age of 19 years and was a current monthly user of the drug, told how he had previously addressed his excessive use of alcohol and cannabis by '*knocking [them] on the head*'.

[Have you ever felt that your use of cocaine or any other drug, including alcohol, was excessive?]

Umm ... Yeah, but usually I knock it on the head like, you know. I was drinking there excessively for a while and knocked it on the head. Smoking cannabis excessively for a while, knocked it on the head, you know ... so generally, you know, if I am noticing difficulties I try to get away from that (Case 24, male, age 24).

ⁱⁱ Efforts were made during interview to elicit respondents' views on their drug consumption, past and present. Respondents sometimes articulated their perspectives on 'control', 'addiction' or 'risk' spontaneously when recounting their drug 'stories'.

These accounts suggest that at least some of the study's recreational users had developed strategies to reduce potential harm as their drug 'careers' progressed. These strategies were often instigated by users at times when they felt their cocaine, alcohol or other drug consumption had become excessive.

I did a lot of festivals, there was a couple of years when there was festivals and I was taking everything at the time and, yes, come the end of that year I had a bit of a break-down and I was like, 'I can't handle this anymore, I need to look at my drug use'. And I just cut back completely. It wasn't just on cocaine use, pills and everything and I did that successfully as well (Case 30, female, age 30).

In other cases, strategies aimed at addressing or 'controlling' use appeared to be forced by factors such as commitments to study or work. A number of current users of cocaine specifically mentioned periods when they had curtailed their drug, alcohol and/or cocaine intake because they felt that a continued pattern of regular use could compromise important areas of their lives.

[Yeah ok. And have you ever stopped using cocaine, you know ok I want to not use this for] Maybe when things started getting a bit hectic in our course [I] just kind of settled down a bit more and that was like less alcohol and less cocaine then. I just decided that I would kind of calm down a bit.

[Ok and when was that, was that like?]

Maybe like the start of this year like this university year, so like September time (Case 20, female, age 22).

... it would only be so often that you would have it [cocaine], would have been about once a month that they [friends] would say, 'Come round to our house for a Saturday night'. A whole crowd of us going out or whatever and even then there was nights that they had coke in the house and I was like, 'No'. Especially if I had to get up and go to work the next morning, that would be a big factor in whether I was indulging in illegal narcotics (Case 01, male, age 23).

However, a larger number of the study's current users perceived no need to monitor or curtail their use of cocaine. These respondents drew attention to features or characteristics of their cocaine use to demonstrate that it fell within acceptable limits. The absence of any craving for the drug was mentioned by some, as was their infrequent use and periods of abstinence; others emphasised that they adhered to a number of basic rules which helped to ensure that they were 'safe'.

I don't feel I need to [cut down intake]. It's not something that makes me over-excited or anything. I'm not sitting there waiting for my next coke fix (laughs) (Case 34, male, age 25).

... I mean if I start, the way I look at it is if I start during weekdays and I start taking it every weekend on a regular basis, I mean I don't mind taking it like three weekends in a row and then quitting it for a couple of weeks or a month or whatever but, eh, I like to keep it for special occasions. So, no, I haven't really thought **** I better stop (Case 22, male, age 26).

With coke I just judge by how I feel at the time. You really know how much is safe and how much is too much unless obviously you're mixing it with other things which I don't do (Case 39, female, age 26).

Respondents' belief that their use of the drug was moderate, and therefore 'controlled', was another feature of these narratives. This male participant appeared to have taken measures to regulate his cocaine intake and to ensure that he did not feel a "need" for the drug.

[I used cocaine] every couple of weeks, it was more like at least once a month. It wasn't that regular, like [as in] you need it on a night out. Just 'cos I knew I could develop that and I tried my best to avoid that ... And I just really, I knew that was one of the things that I would have to watch out for and I kind of just tried to moderate it which I did. But still at the same time you know I enjoyed it and I could, I was in control of myself you know so I kind of, I did it up to a point where I felt I like I didn't need it, you know what I mean (Case 21, male, age 22).

Another male respondent, also a current user of cocaine, was keen to point out that he and his friends did not overindulge and sought to distance himself from others who did cross the boundary of moderate or 'sensible' cocaine use.

Generally there are certain kinds of people who would have cocaine on them very often and they're not really the sort of people that I get on with, you know ... My close friends don't necessarily take a lot of cocaine; every once in a while we do it and that's fine (Case 24, male, age 24).

Many current users depicted cocaine risks as broadly similar to other substances, including alcohol. Ideas about moderate or 'safe' use appeared to be the main principles guiding their use practices, even if these 'standards' were not always adhered to. One female respondent, a current infrequent user of cocaine, believed cocaine risks to be minimal because the drug was not "addictive".

[And what risks would you see with coke?]

I really don't know because to me it's not addictive. I wouldn't do it every single day. I can see that when you take it you do want more but I really don't know. It gives you a wee buzz and perks up your night. I like the craic that you have when you're on coke and the way that everybody gets on. You do have your downs but I think it's great. For me I don't see that there's any risks ... I think it does open you up a lot more and I've had some really brilliant chats. The last time we were at my house everybody just opened up and it was really good (Case 27, female, age 23).

However, the narratives of weekly cocaine users revealed far less certainty about cocaine's addictive potential. The user quoted below equates her ability to cut down with the ability to maintain control but simultaneously admits to craving the drug. In this context, the label "*recreational*" is one she feels she can "*hide under*".

[Do you think you have an addiction?]

I don't know, it is hard to say because to me, if I can cut something down to two or three times a week, I mentally tell myself it's not an addiction because if it goes any longer than that I'll start to get physical symptoms, mentally I'll be cracking up with people and it'll be constantly in my head. But if I get that hit one or two times a week it will go out of my head. Then they say sometimes to do everything you have to do it every day, to be an alcoholic you have to drink everyday. I mean for me, drinking, I binge for three days and I feel far worse than having coke ... It's [cocaine use] become a pattern. I say it is recreational because I think that's a name I can hide

under. Is it an addiction, can I go a day without it, would I be afraid of not getting it for a week? No. But I know sooner or later I will walk that walk again and I will need to do what I need to do, so ... (Case 32, female, age 28).

As demonstrated earlier, for the sample as a whole, there were far more reports of perceived negative consequences of cocaine use amongst the study's 'curbers' and 'quitters' and, also, among weekly users of the drug. These users were also far more likely than current users of the drug to spontaneously mention addiction and to express worry or fear about becoming addicted. The accounts below are illustrative of a fairly widespread belief among 'curbers' and quitters that cocaine does in fact have addictive qualities.

I really only buy it [cocaine] for special occasions now. I try to avoid it just for a night or anything like that ... Because I'm aware of (pause) ... I don't want to get addicted. I'm very silly and if I had it I would take it. You know, if I had some left over on a Monday morning I would take it on the Monday morning so I don't like to have it around (Case 50, male, age 25).

... like I'm always, usually I take it [cocaine] in the company of people who take it ... it's addictive, you know what I mean. I'm addicted to my addiction, it's really hard to give up sometimes (Case 06, male, age 24).

Perhaps more than anything, the diverse perspectives articulated highlight the range of views held by recreational drug users about the nature, form and impact of their use of cocaine and, indeed, other substances including alcohol and tobacco. In Zinberg's⁷⁵ terms, they also draw attention to the influence of individual attitudes or experience (set) and the circumstances of use (setting), not simply on drug experiences but also on how drug-related risk is perceived and understood by individual drug users. In general, the study's recreational users did not perceive that they needed help or support in relation to their drug use and the vast majority had at no stage considered seeking advice of any kind. Those who made efforts to curb their intake of cocaine or quit use had done so without outside intervention. Indeed, the idea of drug treatment was largely absent from the accounts of recreational users, including those who had experienced, and expressed concern about, negative consequences which they attributed to cocaine and/or other drug use. However, one respondent who had curbed his use of cocaine stated that his mother had offered to help him to seek treatment. He did not pursue this option, however, because he felt "*embarrassed*" about the prospect of seeking help.

[Is there a reason why you ... (wouldn't seek help)?]

I don't really know like, just maybe feel embarrassed going looking for help off a counsellor or something (Case 06, male, age 24).

The account above may signal reluctance on the part of young cocaine users to seek help or advice at times when they feel that their drug use has surpassed 'sensible' limits. This respondent went on to explain that his relationship with a non-user, who exerted pressure on him to quit use, had been a positive influence.

I said I was going to get off it as well because of me girlfriend 'cos she said to me like, 'Get off it', you know what I mean. If I was going to take it this weekend and I wasn't with her I'd tell her I wasn't taking it you know 'cos she'd crack up, you know what I mean, so that's, it's good that

way. If I keep taking it she'd probably end up getting rid of me you know what I mean 'cos she's never been into drugs herself.

[Has she pushed you to get help with it or just to quit?]

Just telling me to quit. I just don't take it when I'm around her (Case 06, male, age 24).

Those respondents who curtailed or quit use had done so independently, although some did mention individuals in their lives who pushed them in this direction and/or provided informal support. For one male respondent who had quit, the support of his mother appeared to be an important motivator.

... just your mum and all is talking and she's saying, 'You've done well, I'm proud of you', and all and it sinks into your mind that you have gone from strength to strength and pushed on. It's sort of like I've grown up and come through it all and that's the way I see it now (Case 14, male, age 21).

However, most recreational users did not express anxiety about their use of cocaine and did not consider that they needed to alter their current pattern of use. In this context, claims about adhering to 'sensible' and 'responsible' drug use were what separated *their* drug use from the drug-taking practices and routines of individuals who develop a cocaine 'problem'.

[And how would you define when it (cocaine use) becomes a problem?]

Um, I guess it would become a problem if you were using it a lot, like even every weekend or you couldn't go out without your coke. I guess if you couldn't get some and get annoyed or you started spending more money than you could afford or if you start missing work or it starts affecting your work ... If your mood swings start affecting your relationships. But if you are a mild or recreational user that's fine but if it starts to become, if it starts to affect your work, then that's a problem (Case 23, female, age 28).

Summary

This chapter set out to document the drug use patterns, practices and beliefs of the study's recreational cocaine users. An account of where and when respondents initiated cocaine use provided a natural starting point. In common with other studies, first use of cocaine occurred for the overwhelming majority in chance circumstances along with friends from their immediate social networks^{39,47,51}. In contrast, a recent study of adolescent and young adult cocaine users in the Netherlands found that cocaine initiation events were usually anticipated and pre-arranged⁹⁰.

Once initiated, there was no single pattern of use reported among this group of recreational cocaine users and certainly no evidence of a uniform progression over time towards heavier use patterns. However, a continuum was identifiable, with those reporting less frequent use being at the lowest end; higher up the continuum were those who used cocaine monthly and weekly users were at this top end of the use continuum. The data presented also reveal movement by individuals from one pattern or type of use to another, a 'sequencing' that was particularly evident in the case of 'curbers'. Although they remained current users of cocaine – with one reporting weekly and four reporting monthly use – all five had, for a variety of reasons, reduced their intake of cocaine. Those respondents who quit cocaine use are of interest because they identified experiences which they felt made them vulnerable to developing more committed patterns of use. On the one hand, the accounts of this sub-group of recreational users demonstrate

that some may cross the ‘rubicon’ of sensible use; on the other, their drug ‘stories’ point to the self-regulation strategies that integrated recreational users employ in order to address their drug consumption.

Alcohol featured centrally in the narratives of recreational cocaine users. This is not surprising since the consumption of alcohol is central to the night-time economy in both the UK and Ireland^{91–93}. Practically all reported experience with drugs other than cocaine. Thus, cocaine was one of many other licit and illicit drugs consumed^{32,37,42,52}. Alcohol, cannabis and Ecstasy were the most frequently used substances over the life span. Cocaine, a drug many had added more recently to their drug repertoires, was most often used concurrently with alcohol in either a public or private location, with the latter being the preferred setting for use.

A key motivation for the use of all illicit substances – whether Ecstasy, amphetamine, ketamine or LSD – is that they produce euphoric and pleasurable feelings^{85,94–95} – and cocaine is no different. From the subjective vantage point of users, much of cocaine’s appeal centres on pleasure, enjoyment and fun. Cocaine was viewed as socially invigorating and was perceived to be socially and self enhancing. Few dramatic differences were found between men and women in their assessment of cocaine’s appeal although females were more likely to draw attention to some social benefits, particularly those associated with enhanced ability to communicate without feeling a loss of control. Erickson et al.⁴⁰ reported a similar preference for cocaine among females for the drug’s ability to increase sociability.

As reported elsewhere^{42,77–96}, legal problems were almost never perceived as risks of illicit drug use. None of the current study’s recreational cocaine users articulated concern about the risk of detection or apprehension by the police and this was not viewed as a potential downside of using cocaine (or, indeed, other drugs). Some noteworthy differences emerged on how cocaine negatives or risks were perceived, with ‘curbers’, ‘quitters’ and weekly users of the drug far more likely to report negative consequences. Undesirable physical ramifications included nose bleeds, nasal congestion and bad ‘comedowns’, while negative psychological consequences included feelings of agitation or aggression, mood swings, depression and memory loss. Monthly users of cocaine in contrast were more likely to compare the ill-effects of cocaine use to an alcohol hangover. For this group, the most frequently mentioned downsides of cocaine included the high cost and relative poor quality of the drug.

As stated at the outset of this chapter, these cocaine users did not consider their cocaine or other drug use to be problematic and, in the main, characterised their use of the drug as ‘social’ or ‘recreational’. None had sought treatment for drug-related problems. Relatively few cocaine-specific risks were highlighted, although perspectives on the addictive qualities of cocaine differed, with weekly users as well as those who curbed their intake or quit use perceiving more potential for ‘uncontrolled’ use and ‘addiction’ than more moderate users of cocaine.

Chapter 6: The Treatment Sample

Introduction

This chapter discusses the findings from the interviews with cocaine users who have been in receipt of treatment for problem drug use. It begins with a profile of the treatment sample and then proceeds to discuss a range of lifestyle issues linked to their cocaine use from its initiation throughout their cocaine and drug use ‘career’. The perceived risks and benefits of using cocaine will then be explored. The chapter will finish with an account of experiences of treatment services; these cocaine users were accessed by researchers through treatment services in Northern Ireland. They were either currently in receipt of interventions or had been recently receiving supported interventions linked to their drug use when interviewed for the study. Treatment users were identified as potential participants for the research by their key worker with reference to the study inclusion criteria (i.e. had used cocaine in the past six months). Whilst a number of these users were not referred to treatment services for their cocaine use, it was considered to be a drug problem being addressed as part of their treatment regime. Whilst dedicated treatment provision developed for cocaine use is not available in Northern Ireland at the time of the study, a range of treatment options was available to users presenting with cocaine-related problems within these more ‘generic’ treatment services. These services were available in both the public and voluntary sector in Northern Ireland. Within the public sector a range of outpatient and inpatient services is available within Addiction Services. Outpatient services are available within the voluntary sector. These services are listed in section three ‘The Views of the Professionals’.

Profile of Treatment Users

Nine of the 16 who comprised the treatment sample were male. Their mean age was 32.1 years at the time of the research. The majority (13) of the treatment sample were over the age of 30 years. Five lived in a hostel, five lived alone, three lived with a partner (one partner had children) and three lived with their parents. Fifteen lived in a city or town. Ten lived in Belfast (five in South Belfast or the university area). Only two treatment users had gone to university. Amongst the other 14 users, nine reached GCSE education level and three attained A level education. We did not obtain this information from two treatment users. Only one treatment user was employed (an events manager). This was the only person who reported an annual income of more than £10,000 and the only person who received private treatment for their drug use. This profile suggests a group of cocaine users who are experiencing marginalisation within society or who are at risk of future marginalisation and exclusion, which has been experienced by cocaine users in other locations^{5,32}. Nearly one third of the treatment sample were homeless at the time of the study; almost all were benefit dependent and therefore living on low levels of income. Whilst most treatment users had achieved low level education qualifications and were unemployed at the time of the study, they may not possess the skills or experience necessary to enter the job market. This will strongly limit their ability to become fully integrated into mainstream society. These circumstances will create particular challenges for these drug users in becoming full active members of society. They also pose challenges for treatment services due to, for example, the unstable lifestyle of many of those in the treatment sample.

Thirteen treatment users smoked cigarettes each day; one smoked cigarettes less frequently and one other no longer smoked. We did not obtain this information from one treatment user. Six drank alcohol at least once a week, two of these drank alcohol more often, seven no longer drank alcohol; seven used cannabis each day, five no longer used cannabis, four others used it at least once a month and one other used cannabis less frequently. Six used Ecstasy at least once a week, one of them used this drug each week and four no longer used the drug. Ten treatment users had used heroin, two were current users. This pattern of drug use is similar to that of users who were categorised as socially excluded⁵.

This sample of cocaine users does not represent the historical profile of the young affluent professional cocaine user. In general they were older than most recreational drug users, had low educational attainment, and were living on benefits with evidence of unstable living arrangements. The frequency of drug use was comparatively limited by this group of users at the time of the research. In a number of cases the other drug use had ceased at the time of the research.

Cocaine Initiation

A key factor to our understanding of drug use is the process of initiation. The mean age of cocaine initiation for the treatment sample was 19.4 years. The chronology for drug use onset for the treatment sample started with tobacco, with a mean age of 11.8 years for first use among the treatment sample. This was followed by alcohol with a mean age of first use of 12.6 years, cannabis (13.7 years), Ecstasy (17.6 years) and heroin (18 years). Cocaine was the last drug to be used with a mean age of 19.4 years for the treatment sample. This chronology may appear similar with the gateway theory of drug use⁹⁷ however, the validity of this conceptualisation of drug use onset has been questioned in recent years. Nine treatment users were aged 18 years or younger, the rest were in their twenties when they first used cocaine. These age patterns were similar with first use of cocaine in UK based studies^{37,41}. The age of initiation into cocaine use does not appear to be strongly linked to initiation of other licit and illicit substance use which occurred during the teenage years regardless of when cocaine was first used. For example, for those who were aged less than 18 years when they first used cocaine, their mean age of first use was 16.3 years. Initiation for tobacco was 12.5 years for this group, alcohol was 13.0 years, cannabis was 14.3 years, Ecstasy was 17 years and heroin was 17 years. For those who first used cocaine in their twenties, the mean age of first use was 24.8 years. Amongst these older initiates tobacco was first used at 12.8 years, alcohol at 11.5 years, cannabis at 12.8 years, Ecstasy at 19.8 years and heroin at 20.5 years.

Initiation into cocaine use followed a similar pattern for most users in the treatment sample. This was in a social environment where they felt comfortable and relaxed such as a house party or in the street with friends. Cocaine was usually obtained from someone known to the users, normally an older friend or family member, at initiation. The source in one case was substantially older than the user at initiation, up to 20 years older. It was not clear to what extent this had an influence on his decision to use cocaine. Some treatment users did not purchase cocaine at first use. Amongst those who did purchase it at initiation, some bought it with a group of friends. One male treatment user told us that he was *'too young to get it when I first used it so I got an older friend to get it'* (Case 11, male, age 29).

Younger initiates in the treatment sample were more likely to purchase cocaine in a group, in some ways similar to how they would purchase a quantity of alcohol for sharing amongst friends. On these occasions, use of the drug did not appear to be organised or planned; in some cases initiates were not aware that cocaine would be available at that time or in that place.

I was involved in all sorts of drugs and all that there and then, and then I heard these other ones talking about they were taking cocaine, so me and the brother and that there, we wanted to try it out as well, do you know what I mean (Case 10, male, age 35).

Yeah well it wasn't really, we weren't planning it, it just sort of happened out of the blue. We were talking to this fella cos we used to get hash off him and he was one of the fellas we used to get the hash off and he was saying about you know his boss you know he sells coke and what not and we were saying we might try a bit of coke you know and that time we were coming to the end of the money or whatever and we said you know we'd be able to swap you a TV for it like I'll check it out and he did like so it was just that there sort of thing (Case 19, male, age 33).

I remember doing it [using cocaine] at a friend's house. There was a load of us at a friend's house; his ma was away for the weekend. There were probably about ten people; there were a load of people older than me. I was probably the youngest (Case 05, male, age 19).

Whilst there appeared to be some anxiety about cocaine use at initiation, the general consensus amongst the treatment sample was of an enjoyable experience that did not discourage future use. One user was '*scared at first but it was great*' (Case 36, female, age 34), another told us it made him sick but that he felt euphoric afterwards (Case 07, male, age 38). However, some experiences were not enjoyable:

When I was younger you would hear about it and you would be scared of coke and wasn't much scared of Es. But then when I tried coke it was like 'this is crap' (Case 05, male, age 19).

Most treatment users snorted at initiation although for a small number of users other routes of administration were used. One treatment user rubbed cocaine onto her gums at a school formal at initiation.

The first time I done it I rubbed it round my gums I don't even know why I kept taking it. The first time I snorted it Jesus, it was mad, totally different (Case 08, female, age 22).

Another user claimed to have snorted and injected at initiation (Case 12, female, age 31), whilst one reported he smoked it at initiation (Case 16, male, age 30).

[So, the first time that you ever did coke, then you smoked crack? So, you weren't really aware that it was even crack until you smoked it?]

No, no. I smoked it up and it was not what I expected it to be.

[Okay, like, and what was, did your friends know that you thought it was...?]

Um, the guy just back from Holland thought that because I was there, basically, that obviously I had done crack before because these were quite a lot. I was hanging around with people who really tended to be, ya know, a good few years at it. But I mean like, so, he just took it as kind of I did crack, as well. So, he offered me pipes after pipes (Case 16, male, age 30).

For several treatment users they first used cocaine whilst on holidays. Three were abroad, two on holiday in Spain and Mexico. Another first tried cocaine when working in Amsterdam. She was the only treatment user to use cocaine alone at initiation and the only one who planned to use it in advance of initiation (Case 28, female, age 32). Others initiated cocaine use outside Northern Ireland when living in England and Scotland. One treatment user felt that he '*seems to have come addicted right away*' (Case 11, male, age 29) but awareness of such problems did not emerge until later in the cocaine using 'career'.

I don't think I was addicted but I would get the urge and it was doing something for me that I liked (Case 05, male, age 19).

I was addicted to cocaine there for the last four or five years like. I ended up on a psychiatric ward like that, you know (Case 09, female, age 38).

And, ah, we started taking that after about three months we decided we were addicted to it (Case 38, male, age 39).

As initiation usually occurred in a social setting, most users were also drinking alcohol at this time and in some instances other illicit drugs were consumed, particularly Ecstasy and cannabis and 'other drugs'. These recollections reflect this experience:

Pills, speed, weed, umm...yeah. All of them. I was quite happy to have the variety (Case 28, female, age 32).

Yeah, well, because of the environment that I was in, it was being passed around a lot, so I mean you'd buy your own but you'd share with everybody so a certain communal quality to it (Case 28, female, age 32).

[Okay. And you said it was kind of like a party situation, the guy was just back from Amsterdam?]

Yeah. It certainly was, just a party situation. Something that I really...At the time, it wasn't something that I was really into or could see myself getting lots of it, to be honest like, ya know? What happened was heroin addiction, like so, the crack totally went to ... and being so costly, as well... (Case 16, male, age 30).

Whilst there appear to be general similarities in the process of initiation of cocaine use amongst the treatment sample, there does not appear to be a clear and specific motive for using it at this stage other than its availability and a sense of curiosity. Other substances were available to these users at initiation; this included alcohol and generally other illegal drugs (i.e. Ecstasy, cannabis) with cocaine use becoming part of the drug-using environment in which they lived/socialised. However, it appears that cocaine became available to them at a later age than most other licit and illicit substances and appears to be initiated after consumption of these other substances. Whilst there was often anxiety and trepidation associated with first use, the support provided by known and, on occasion, experienced sources helped overcome such anxieties. Initiation was generally a pleasurable and enjoyable one that encouraged further use for this group.

Cocaine Use ‘Career’

Following initiation, continued use of cocaine was linked to the social lives of the treatment users during the early stages of their cocaine ‘career’. This was usually followed by more frequent use that led to problem drug use, which usually ran over a period of years before attempts were made to address this problem through accessing the appropriate treatment services. Cocaine did not become the primary drug of choice for many treatment users as heroin was the substance for which they were referred for treatment. Whilst most treatment users overcame anxieties and concerns with cocaine use, for some of them these anxieties remained for crack and injecting cocaine throughout their cocaine use ‘career’.

[Would you, was there any time, I mean, over those twenty years (of use), I mean, obviously you come here to talk to support worker named and you have obviously, getting help but was there a time when you stopped using cocaine specifically or...]

..it phased out. Cocaine wasn’t my problem. I could take it or leave it.

[And what was the problem then?]

It was heroin (Case 07, male, age 38).

You know basically when I was on heroin, I wanted to get off so bad and the only thing I feared was social services (Case 36, female, age 34).

And then I would go back on the gear and go back on it and back off it again (Case 38, male, age 39).

These treatment users were polydrug users from the early stages of their cocaine ‘career’. This continued to describe their pattern of drug use for most of their cocaine using career, as it was rarely used in isolation. Cocaine continued to be available in social settings and consumed with alcohol and other drugs, which were also generally available on demand for the treatment sample.

Oh well, back then I was just, I was sort of way involved in smoking dope, taking speed, taking Es, drinking, it was just, like, everybody was doing it, you know what I mean, so it was just, like, then you can do it, because I was in jail and then I was young I was always in maybe jail as well so that time there I was only out of jail a year or so, and then I was involved in all sorts of drugs and all that there and then, and then I heard these other ones talking about they were taking cocaine, so me and the brother and that there, we wanted to try it out (Case 10, male, age 35).

The frequency of use increased over the cocaine life course. For one older treatment user it *‘took a while to become a regular user after I first smoked crack’* (Case 16, male, age 30). A 19-year-old treatment user didn’t realise he had become addicted as he *‘got the urge even though I was sick of it’* and he would always want cocaine after drinking alcohol (Case 05, male, age 19). He stopped using cocaine when his friend’s brother died. Another told us:

So I think, right from the start that we were probably abusing it, you know what I mean...instead of taking it the right way, in small lines and...we were taking, I would say, about a quarter of a gram a line, do you know what I mean (Case 10, male, age 35).

For many it became part of their social life and an important part of their social circle. Often arrangements for obtaining it were not made in advance of a social gathering but it appears to have been available almost on demand. This is exemplified by this male treatment user:

You can walk into anywhere you just bump into anybody and ask them for it. Like once you start using you can sort of spot the ones who are on it anyway you know what I mean. The ones who are selling it. You know like in five minutes I can ring people now and just get coke you know what I mean even if I have no money (Case 07, male, age 38).

One 35-year-old male summed up the feeling of many treatment users when he told us that you *'feel you need it'* (Case 10, male, age 35) as it became more of a necessity than a luxury, or part of their social life. Regular and frequent cocaine use was assisted by increased accessibility as *'getting coke is not a big deal'* (Case 19, male, age 33) for many of the treatment users. Regular and sustained use was also associated with changing routes of administration due to effects of one regular route of administration in some cases. One 33-year-old male user changed his route of administration from snorting to injecting but then stopped injecting cocaine because his *'veins are knackered'* (Case 19, male, age 33).

See at the start, it wasn't that bad, but then I think, then I think the more I started to take, it was like that there, do you know what I mean, but you still, it was getting to the stage where your nose was that blocked, but you were still trying to put it up your nose... (Case 19, male, age 33).

For many of the treatment users regular consumption was associated with other problems and issues. One female user told us regular and sustained cocaine use reached a stage where she *'used to sit in the house and snort'* (Case 15, female, age 34). This treatment user told us that she *'used everyday until I passed out'*. The following excerpt describes the onset and development of a drug using 'career'.

[Okay. And, um, as far as like, other drugs, if you can just take me through a list, kind of like chronologically]

Okay.

[Um, I'm assuming you probably started drinking first?]

Yep.

[If we go through like chronologically...like what age were you when you first started drinking?]

Okay. My dad owned a pub. Started drinking at 14.

[Yup, okay.]

I started smoking cigarettes at 13.

[Right, okay.]

Um, so 14 started drinking...15 probably had my first contact with joints, which was really quickly followed by magic mushrooms (Case 28, female, age 32).

Current Drug and Cocaine Use

At the time of the study 13 treatment users smoked cigarettes each day, seven drank alcohol, seven were daily cannabis users, three others used cannabis less frequently. Four used Ecstasy at least once per week, four others used less frequently, two used heroin each day. Seven of the treatment users told us they were not using any illegal drugs at the time of the study. Four of the

treatment sample also told us they were no longer using cocaine, however, none of these ‘former’ users had desisted for longer than a year, as these users believed their desistance from cocaine ranged between one to 18 months. This did not necessarily mean that they had stopped using other drugs. For example, a 19-year-old male *‘had been off it [cocaine] for two months, but started taking Es and smoking cannabis’* during his period of desistance (Case 05, male, age 19).

Those who indicated that they had desisted from using cocaine for longer than the original six month period were included in the study because use of cocaine among them was intermittent.

[Yup, okay. Yup. And, when, if you can think back on it, when would have been like the last time?]

Oh no! It was two weeks ago! Before that, it was like ages! Like eight months before that and it was just half a pill and my friend put it in my mouth (Case 28, female, age 32).

For some treatment users, cocaine use had become intermittent or irregular and for them it was not perceived as a particular problem. Breaches of desistance were not always considered as such, for it appeared to be more of an aberration, for which there would be justifications. One treatment user commented that he *‘doesn’t use [cocaine] all the time but would at a party’* (Case 07, male, age 38). Another *‘doesn’t go out because I’d be tempted’* (to use cocaine) (Case 08, female, age 22). Whilst this user claimed to have stopped using cocaine one and half months prior to the interview, she continues to use other drugs. Such a pattern of behaviour indicated that a perceived cessation of cocaine use may not have affected use of other illicit drugs as shown by a male user who *‘starting taking Es and smoking cannabis’* (Case 11, male, age 29) since cocaine cessation. An 18-year-old male told us that he would not use cocaine again unless he was drinking and was offered it (cocaine). As use of other illicit drugs may have replaced cocaine, problems associated with use of these other drugs would then emerge in some cases. For example, a 33-year-old female was experiencing problems linked to her Ecstasy use after using cocaine.

One older treatment user still smokes crack and uses heroin a couple of times each day. He also uses cannabis each day and cocaine once a week as well as being on methadone (Case 16, male, age 30). We are not in a position to assess how this user accessed medication whilst continuing to use a range of illicit substances. Those who did smoke crack or inject cocaine knew how to wash up themselves, providing further evidence of their level of experience and competence as drug users.

Another user who has not taken cocaine for three months told us cannabis was her favourite drug and she uses it each day (Case 28, female, age 32). These experiences suggest that whilst the treatment sample may perceive their cocaine use to be ‘controlled’, they continued to use other drugs and in some cases ‘irregular’ use of cocaine which they did not consider to be a relapse of desistance.

[Yup, okay. So, do you think you’ll ever do coke again?]

No? And, saying that there, if I get really drunk and it was offered to me, I might have a go at it again ‘cos it’s like a really good buzz from it like (Case 13, female, age 18).

It appears that a number of treatment users believe they have stopped using cocaine as they count relapses as minor aberrations and not a sign of relapsing back into use. This may more accurately be described as periods of desistance rather than actual cessation of use.

The New Year was the last time I took anything...A couple of months. I want to try and stay off it. That's why I've come here [treatment agency]; to try and keep me away from it. I started getting very aggressive like. I stabbed somebody (Case 09, female, age 38).

It was the ruination of me getting the money because I got worse on it and I started taking that much my brain got fried. I'm not fried now. I saw all the press for Es and cocaine so I went to get help for it but I just kept on doing it and doing it and in the end I just got off it myself. My mates were all taking Ecstasy and I took that for about a month after the cocaine then stopped it (Case 05, male, age 19).

The treatment users had access to a range of illicit drugs with varied patterns of use at the time of the research. In particular there appears to be evidence of ongoing heroin use amongst this sample which was the main substance for which most were in receipt of treatment.

Cocaine Availability

A key risk factor for drug misuse including cocaine use is its availability. Treatment users felt that cocaine was relatively easy to obtain and readily available to them when they wanted it.

You could have got it if you went looking for it but now you can get it no matter what time it is. There'll be someone on every street doing it so it's like...it's bad (Case 09, female, age 38).

Aye, it's easier to get now. Everyone I know that's got it is selling it (Case 11, male, age 29).

However, there was concern noted about the quality of cocaine now available in Northern Ireland. The consensus amongst the treatment sample was that the quality of cocaine in Northern Ireland was variable and in general poor quality, with one treatment user saying '*the stuff on the street is just muck*' (Case 10, male, age 35). In comparison with other locations we were told that the '*quality is better in England*' (Case 19, male, age 33). Another user told us that the '*quality is linked to the source*' (Case 28, female, age 32). One noted that '*buying large quantities makes it cheaper*' (Case 07, male, age 38). Comments on the quality of the drug included:

Didn't start it until I was just turning 16 and didn't start buying every week until I was 17 and that was when I started loving it. I know it isn't as good as it is in the states where it is like 15% [purity] but sometimes you would get some that was better than others (Case 05, male, age 19).

From time to time. I mean I can think of two, maybe three occasions in the past year, where I got really nice stuff. [Laughs.] This is a weird topic for research. No, it's fine. It's fine! Um, yep, so three times in the past year, yes, I have had absolutely lovely brilliant stuff. Other times, no. A lot of rubbish (Case 28, female, age 32).

These views on the questionable quality of cocaine were supported by the treatment professionals who participated in the research.

Known sources for obtaining the drug were important for accessing and continuing to use it, with established, informal networks key to getting cocaine. This appears to be important for continued use of the drug, which contrasts with dependence on potential unreliable sources such as a 'dealer' with whom users may not have a personal relationship. A number of the treatment sample felt that cocaine is easier to obtain than other drugs (Case 05, male, age 19), as well as being more available to them than it was in the past as '*years ago you couldn't get it in Belfast*' (Case 16, male, age 30) but now the '*quality is getting worse*' (Case 07, male, age 38). This user also told us that cocaine '*was harder to get in small towns outside Belfast*', a view endorsed by non-urban treatment professionals. For one young female treatment user cocaine could be obtained within five minutes (Case 08, female, age 22). Another noted that since the IRA ceasefires '*it is easier to get in West Belfast*' (Case 10, male, age 35). It was also noted that '*in some places it's as easy to get as cannabis*' (Case 12, female, age 31). One user was more specific saying that '*it is becoming a lot easier to get than 5–7 years ago*' (Case 19, male, age 33). These findings may, however, be indicative of the drug choices and strategies of this sample of users rather than an accurate portrayal of the illicit drug market in Northern Ireland generally or Belfast in particular. However, these users believed there was a link between increased availability of cocaine and a reduction in its quality in Northern Ireland. For another user Ecstasy was harder to access than cocaine (Case 09, female, age 38). As this research explored the lifestyle experiences of cocaine users it was not possible to assess the validity of comments made about the quality of cocaine powder now available in Northern Ireland.

Availability of cocaine is also linked to the frequency of use for some treatment users. A 34-year-old female had easy access because she was '*stashing [storing] it for my mate*' (Case 15, female, age 34) and this she felt was linked to her increased appetite for the drug. Another told us that he '*would buy what I can afford*' (Case 11, male, age 29). One other noted that he '*spent more on it when I had the money*' (Case 10, male, age 35).

Amongst our treatment sample crack cocaine was less available than powder cocaine. One of the older treatment users told us that '*crack has never really taken off*' (Case 16, male, age 30); another informed us that '*you can't buy crack here [Northern Ireland]*' (Case 07, male, age 38). Generally the treatment sample had a negative attitude towards crack which is exemplified by this exchange during the interview:

Nah, I mean, coke is, because of the social stigma...

[Right...]

Is basically, ya know, very popular. Yet, crack has never taken off over here. Partially because the worst guys doing it once like. But, the problem is that they, they didn't get an example of who's the score 'cos the *location* at that point was just full of beggars, like every 20 metres someone begging for gear. Like so, ya know, it was really bad like (Case 16, male, age 30).

The evidence here shows how easily accessible cocaine was and, it appears, continues to be for experienced users as they do not appear to step outside their social circle to obtain the drug.

Perceived Benefits and Risks of Cocaine Use

The treatment sample was asked what they perceived to be the benefits and risks associated with their cocaine use. These perceptions were also explored in relation to other drug use as well as their general views on drug use.

Perceived Benefits

When initially asked about the benefits of cocaine many treatment users said there were not any benefits. Further exploration of this issue led to perceived benefits becoming visible amongst some treatment users. These perceived benefits were associated with the pleasure and highs experienced when using the drug. This was noted by all the treatment users. It was described as providing a *'euphoric buzz'* (Case 38, male, age 39), a *'more intense kind of buzz'* and that cocaine *'keeps you up all night'* (Case 12, female, age 31), and gives you a *'pure high, ready to go nuts'* (Case 07, male, age 38). Another told us he had *'never had stuff quite like it'* (Case 16, male, age 30). One treatment user felt it was *'almost respectable'* (to take cocaine) (Case 28, female, age 32) and another described it as *'a better way to get a hit'* (Case 11, male, age 29) or that he *'loved the feeling'* of using cocaine (Case 07, male, age 38). Some of these experiences are described in more detail:

Um, just, I don't know how to explain it. I feel like, like buzzing. You know that sort of thing. You know, it's... I can't explain it. You are so alert and so alive it's like that sort of thing. You know (Case 15, female, age 34).

[Yup, okay. Um, as far as, like benefits of using coke and negatives of using coke, in your experience, um, what are the positive effects...? You said about the confidence and stuff like that. Is there anything else you can think of...?]

The positive effects from cocaine?

[Like the physical or psychological or any...]

Well, do you know, I prefer...Like cocaine users, there's like almost a...I mean, it's almost like respectable...

[Right, okay. Yup.]

You know, it's probably, because a need for it, that it's the same as being...It's not elitist by any...But, the, uh, I guess the value people place on it and the respectability 'cos a lot of coke users I know are like quite high-achievers, have done very well for themselves, certainly don't need it or have never been pressured, where like they need coke to go to another of their shows. They're quite confident, able people by day and then, it's plow some charlie into them, they can often turn into ****s, as well, like (Case 28, female, age 32).

Well, sure it's pleasurable. It brings your serotonin levels up doesn't it? (Case 38, male, age 39).

One respondent commented they felt that cocaine *'increased confidence'* (Case 28, female, age 32) and for others it provided a feeling of being *'capable of dealing with anything'* (Case 05, male, age 19) or *'it gives you a high at the start'* (Case 09, female, age 38) as this user believed she behaved normally under the influence of cocaine.

Other particular benefits associated with cocaine use for the treatment sample included its effect to *'suppress emotions'* (Case 16, male, age 30); its ability to enable the user to *'party more'* (Case 05, male, age 19); and *'keeps you up all night'* (Case 13, female, age 18). A 33-year-old

treatment user told us that *'it keeps me going when I'm really burned out'* (Case 28, female, age 32). There was a feeling amongst some treatment users that cocaine had the effect of enabling them to continue with normal individual activities, for example, one told us that you *'can get up and have your dinner an' all'* (Case 09, female, age 38). This last experience was echoed by some of the treatment professionals' views on perceptions of using cocaine.

Several treatment users noted its perceived value to them personally. A 33-year-old male told us that *'it's been more private things if you know what I mean'* (Case 19, male, age 33) in a reference to sexual activity. For another male it was his favourite drug (Case 10, male, age 35). Two female treatment users felt it had helped them lose weight which was seen as a *'brilliant side effect'* (Case 28, female, age 32) due to a *'loss of appetite'* as a result of using cocaine (Case 15, female, age 34). Both these treatment users were women in their early 30s. One of these treatment users explained that using cocaine kept her *'going when really burned out'* (Case 28, female, age 32).

Whilst a range of perceived benefits were associated with cocaine use, these can be categorised as the pleasure gained from the chemical induced highs that accompanies individual use and the perceived personal benefits such as weight loss. These perceived positive experiences are not unique to cocaine use.

Perceived Risks of Cocaine Use

There was some concern, anxiety, and even trepidation associated with cocaine initiation. One treatment user told us *'when I was young I was scared of coke'* (Case 05, male, age 19). Another was ill the first time he used it (Case 07, male, age 38). Other general concerns across the treatment sample included the impact of consuming the drug over a long period of time, and particularly the quality of cocaine available in Northern Ireland. One male treatment user, who was one of the older users in the study, was *'concerned about taking large amounts because of his age'* (Case 07, male, age 38). He had been using cocaine for 20 years. The quality of cocaine that is now available in Northern Ireland, but particularly in Belfast, was a major cause of concern for treatment users. This is summed up by the following users:

It does you damage every time you take it. You don't know what else it is cut with (Case 07, male, age 38).

It was very strong. It's not as strong as it was. It's very cut down here with other stuff and you don't know what you're taking. Sometimes I've had a few nosebleeds like. Really bad. Other times it doesn't do anything for you. You'd taste things in it but it was never pure. I think in England it was pure stuff and I think that's what made me sick. The stuff here you can tell from the powder; 'cos they put cleaning powder and stuff in it (Case 09, female, age 38).

Whilst perceived risks associated with cocaine use focused upon the physical and mental health effects of the drug, there were also issues raised about its negative impact on more personal matters including difficulties with relationships and debt resulting from its purchase. In relation to general well-being, treatment users told us that *'you do yourself damage'* (Case 07, male, age 38) and that it *'affected all round health'* (Case 05, male, age 19). A couple of treatment users reported suffering hepatitis C and another *'had a hep C scare'* (Case 07, male, age 38) which

they linked to their cocaine use. Others mentioned links to respiratory problems, another believed '*you can have a heart attack*' from using cocaine (Case 36, female, age 34). These are among the most serious sequelae of cocaine use²⁰ particularly among those presenting to accident and emergency departments because of cocaine use^{21,98}. These experiences are summed up as follows:

Yeah anyone who uses a syringe ye know, em, there are obviously plenty of coke users that would never use heroin in a needle but they use coke in a needle and they are very ignorant as regards the downside. The bad side associated compared to the way heroin users would be. Just in my experience over here (Case 19, male, age 33).

They just lose, shooting up coke there is just not the same social thing ye know associated with heroin. It hasn't been hyped up in the public head as much as the heroin and also I guess, em, basically there isn't the same culture. In the heroin scene I found that people they seem to be very jammed up in general about nearly every drug because you have been through quite a few of them like ye know and know a lot of facts about the viruses associated with them because it has been rammed home particularly in the heroin circle ye know in terms of leaflets and whatever but it hasn't been in the coke circle to the same extent I guess. I mean no one knows for instance that I knew you can get hepatitis C off a note that has been passed round for sniffing, ye know. There is a real level of ignorance and things like that (Case 16, male, age 30).

This latter view was also expressed by the treatment professionals. Regular cocaine use has been associated with serious psychiatric sequelae, including paranoia, anxiety and depression⁹⁹. All but three treatment users made specific reference to the risks to good mental health and well-being which they linked to cocaine use. This included depression, paranoia, hallucinations, suicide, self-harm and anxiety. For another '*it gets you very aggressive*' (Case 19, male, age 33). This treatment user linked cocaine use to suicidal thoughts and another linked it to violent outbursts, as stated below. Examples of its perceived impact on their well-being include the following:

When I was using it heavily you couldn't really focus or see and you'd be depressed all the time 'cos you were taking so much of it. I'm trying to stop now 'cos it just makes you feel bad. The deaths of my kids... So it gets depressing (Case 09, female, age 38).

And I think it just depresses you even more the more you take coke, once you're on it then, you just, I think you need, like or something to get people off it, it's not easy to say to people, 'Look, are you going to stay off it?' and they say, 'Aye', the next night they're back on it again, I would say, do you know what I mean (Case 10, male, age 35).

Like anti-social and then 'cos I was sniffing it I couldn't even speak because I had took that much I was in a wee daze you know what I mean. I couldn't even talk to other people and the paranoid I got like thinking people were looking in at you and I was up in my bedroom thinking people were looking in at me and all, like hearing things at all (Case 08, female, age 22).

Even now still in bed like I get the feeling and all it sounds stupid but that's the way I feel. When I'd be walking down the street and I'd be going you'd hear people going she's a drug addict, she's in the ol' rehab and all you know stupid stuff (Case 08, female, age 22).

You know and more 'cos I was hurting 'cos she done some bad things to me but, um, I don't even know, I was starting on people for no reason. I was so paranoid, I like they were talking like completely normal and I would take it completely out of context (Case 15, female, age 34).

With the coke. And Es are the same. Es will make you suicidal. The coke has made me feel suicidal a few times. Normally the comedown after a few days. Terribly depressing and there's very bad feelings like (Case 09, female, age 38).

Treatment users linked their cocaine use to a number of personal problems. One felt it contributed to separation from her husband, as the following excerpt demonstrates:

[When would you say that you became a regular cocaine user? Was that after you lost your first child?]

Yes, after I lost my first child 7 years ago. Because then I had my kids took away from me and my ex-husband got the kids and all. So it was...there was nobody there so I could've done what I wanted so I did. I did what I wanted. Cocaine or whatever.

[You and your husband's split. Was that because of...?]

It was because of the child dying [yawns] I was taking Ecstasy as well and we just weren't getting on when the child died. We weren't together any more; just couldn't cope. I was pregnant with another child when we split up (Case 09, female, age 38).

Only treatment users reported having their children taken from them as a result of their cocaine use.

[And when you were using cocaine regularly is that why the children were taken and given to him?]

Yes, he got them took off me...

[If you don't want to talk about this that's ok.]

No, it's alright. He got the kids took off me and there was nobody there so...just to do what I wanted so I just carried on taking cocaine and it got worse. From then I was hooked on it. I couldn't stop if I wanted to (Case 09, female, age 38).

She maybe puts it down whereas I got to the stage where I hated it because I was just using all my money and then when I was pregnant with my wee boy I went off it for 5 months and then I took the urge and my wee boy died and I blamed myself. He was born with no pulse. My sister gets infections when she takes it and my husband gets infections when he takes it. My sister gets a womb infection all the time and my husband's blood pressure goes up cos I think it does infect the bloodstream because of whatever's in it. It's bad like... (Case 09, female, age 38).

One young female treatment user felt that it contributed to her losing her job and failing to complete her university course:

I had two jobs, I was working in a bar as well and I got sacked from there for not going in.

[And do you think that was to do with coke or...]

Coke definitely I know it because I was just like I was going in and sometimes I was late for work and I didn't start work until five o'clock in the day do you know what I mean because I had been out all the time and I was just sniffing my brains out (Case 08, female, age 22).

The mother of a young female ‘threw her out’ of the family home.

Because my adopted mummy is just normal and does not take drugs or drink... Definitely cut down for a start and then come off ‘em. I mean it’s hard to come off (Case 13, female, age 18).

Personal debt resulting from the purchase of cocaine was another risk cited by treatment users. One of them told us that if you ‘*get into debt to dealers they’d shoot ye*’ (Case 10, male, age 35). Another was ‘*using all my money*’ on cocaine (Case 09, female, age 38). The following excerpt describes this in a little more detail with its impact.

Like I got myself in seven hundred and fifty pound debt.

[Exactly yeah. If I ask anything and you are not ok talking about it...]

No I ended up having to go up to my mummy and just, this was after she knew I’d been on the drugs and just crying my eyes out. If I don’t get this I’m dead, they will kick my door in round me (Case 08, female, age 22).

In some cases cocaine use was having a negative effect on the social life of users. In the case of one female it gave the user ‘*confidence to the point of just like aggressive, cocky or edgy*’ and that she was ‘*losing her sense of humour*’ (Case 15, female, age 34).

The administration of cocaine was causing physical problems for some treatment users. In one case snorting led to ‘*nose bleeds, a stingy feeling*’ and numbness in the face (Case 13, female, age 18), and for another it created a fear of her ‘*nose caving in*’ (Case 08, female, age 22), while another reported abscesses (Case 19, male, age 33). Regular snorting of cocaine has been associated with nasal problems^{20, 100}. For another snorting cocaine ‘*gets caught in the throat*’ (Case 08, female, age 22) which she felt may have been caused by a ‘*combination of drugs*’. This young female also felt that cocaine use contributed to her dramatic weight loss which led to a hospital admission. The withdrawal following use of cocaine was also leading to bad experiences. For one user ‘*the comedown wasn’t good. It made me feel sick*’ (Case 11, male, age 29).

A risk that may be considered specific to Northern Ireland is the role of paramilitaries in the drug scene. One treatment user told us ‘*paramilitaries don’t like anyone else dealing*’ and that ‘*paramilitaries would shoot ye*’ (Case 07, male, age 38). However, there was little mention of paramilitary influences by the other treatment users. This may be explained by this user’s criminal background and perhaps links with such paramilitaries, which was not explored further during the interview.

Perhaps not surprisingly addiction was a problem for treatment users. However, in most cases the addiction was linked to heroin use and these cocaine users felt they could ‘*take it [cocaine] or leave it*’. One young male treatment user told us that he is always ‘*getting the urge for it*’ (Case 05, male, age 19). Another treatment user believes that ‘*you take coke once you’re on it*’ (Case 10, male, age 35).

There was a general consensus that the quality of cocaine available in Northern Ireland presented a potential risk to their well-being. One treatment user told us that they ‘*worried about the*

purity’ of the drug and that the *‘quality has been getting bad over the last two years’* (Case 07, male, age 38).

It was like, in the end, I knew she didn’t cut it with anything ‘cos I used to sit there when she washed it up (Case 15, female, age 34).

The risks associated with crack were also cited by several treatment users. One young female treatment user stated that *‘crack is unsafe’* (Case 13, female, age 18).

The treatment users were aware and informed on a range of risks associated with use of cocaine. These did not appear significantly associated with desistance but may have had an impact on patterns of use including routes of administration, and may have impacted negatively on their personal life, general health and well-being, physically, emotionally and psychologically.

Perceived Benefits and Risks of Other Drug Use

The treatment sample was a group of polydrug users with a history of illicit drug use covering a number of years, a pattern of drug use observed in other cocaine using samples^{69,74,102}. For most treatment users, specific substances served particular purposes within their drug using lifestyle. One respondent told us that she *‘started smoking cigarettes and taking Es after I stopped taking coke’* (Case 12, female, age 31). She had stopped taking cocaine because it was causing paranoia. Another told us *‘heroin lasts longer’* (in reference to the high he experienced) (Case 16, male, age 30). For this person, his choice of cocaine was based to some extent on the *‘social stigma of smoking crack’*. A younger female told us that she stopped taking drugs because she *‘wanted to be wiped out, just completely out of it’* (Case 08, female, age 22). She told us that she *‘took blues first to get wiped out’* and was now *‘only smoking joints’* but taking the *‘odd E’*.

As a group, the treatment sample appear to be aware of the dangers and risks associated with other illegal drugs. One treatment user told us that *‘Es give you stomach blisters’* but she would never use heroin because *‘I hear what it does’*. This person told us that she *‘never really liked cannabis’* and got *‘paranoid from speed’* (Case 09, female, age 38). For a 32-year-old female *‘alcohol was used as a buffer’* and she *‘likes mixing everything’* (Case 28, female, age 32). A 34-year-old female treatment user told us she was *‘up on crack and down on heroin’* (Case 15, female, age 34).

Whilst heroin was the drug for which most treatment users were referred to treatment services, Ecstasy appears to be a popular alternative to cocaine amongst the treatment users. One young female told us that there was *‘nothing negative about Es; but they give you a bad comedown’* which would last for two days for this person (Case 13, female, age 18). She received counselling for Ecstasy. Another treatment user took *‘cannabis for a comedown’* (Case 12, female, age 31). This person was asthmatic. Another treatment user told us his friend had a heart attack when taking Ecstasy and had his *‘stomach pumped after using Es’* (Case 05, male, age 19). For one young person she *‘would snort anything’* even *‘crushing tablets before snorting them’* (Case 08, female, age 22).

Views on Drug Use

As a group of polydrug users, the treatment sample had negative experiences associated with their drug use which appear to have contributed to negative perceptions of drug use, but not desistance in many instances. The majority of these experiences were associated with cocaine use possibly due to the focus of the interview schedule which may have concentrated their mind on this drug as a number of users were receiving treatment for other drugs. However, a small number of the treatment users still had a positive perception of drug use despite the problems associated with its use. One treatment user told us she *'just wanted to use it [cocaine] with no hassle'* (Case 08, female, age 22). All treatment users had positive experiences of cocaine. For some it was their preferred drug *'because of the comedown compared with Es'* (Case 05, male, age 19). The effects of withdrawal were one of the main negative experiences. For others whose primary problem drug was heroin, *'doing coke was not a big thing'* (Case 19, male, age 33).

Cocaine initiation and cessation were linked to personal circumstances for a number of treatment users. One female user noted that her cocaine use *'depends on what's happening in your life'* (Case 09, female, age 38). Another told us he *'started to use when my girlfriend died in car crash in 1997'* but he *'went off everything [stopped all drug use] when my mum was ill'* (Case 10, male, age 35). This user desisted from cocaine use whilst in prison in order to qualify for early release to deal with his mother's illness. Such personal tragedies have been highlighted as one of the risk factors to cocaine initiation³⁵. However, personal tragedies and negative impacts were associated with cessation of drug use amongst some treatment users and also contrasted with some of the evidence which links cocaine initiation to personal tragedies³⁵. A 29-year-old male *'decided to make a change'* when he was sent to prison where he got help after experiencing the negative effects of detoxification. However, when he was released from prison he *'went back to my old habits'* (Case 11, male, age 29). One female treatment user stopped using cocaine when she became pregnant but *'took drugs after my son died'* which also contributed to the breakdown of her relationship (Case 09, female, age 38). Another stopped using cocaine because she told us she was *'missing my kids'*, however, she did tell us that she still misses using cocaine (Case 36, female, age 34). A young female user told us *'I just want to get off it'* (Case 13, female, age 18).

On the general issue of drug use there was an acceptance by the treatment sample of the damage linked with personal drug use. One young treatment user believed that *'Coke fries your brains and affects your health'* (Case 05, male, age 19); and it *'messes with your head'* (Case 12, female, age 31). This user also believed that drug use was *'out of hand now'*. One middle-aged treatment user stated specifically that *'there is a social stigma with crack'* (Case 16, male, age 30). However, a small number of treatment users still believed it was *'OK to get a gram to release'* (Case 28, female, age 32).

One treatment user told us that when she worked at festivals drug use went *'hand in hand'* with this lifestyle, which involved living in a van with money always available to purchase drugs (Case 28, female, age 32). This user told us that she was *'enthusiastic about exploring the drug culture'* and whilst she *'used coke for the thrill of it'*, it *'got in the way of work'*. As most treatment users were receiving help for heroin use they believed that this was the main problem drug in Northern Ireland. One treatment user told us if she *'got heroin I don't need coke'* (Case 36, female, age 34) and that she *'did crack because others did'*. One older treatment user believed that there was a *'need to educate people before use'* (Case 38, male, age 39).

The treatment sample appears to have an informed opinion of the influence and impact of their drug use. Whilst they took cocaine for its pleasurable experiences they were also aware of its negative impact. It was during personal tragedies that attempts to desist from use appears to gain most momentum. However, these users may be attempting to justify some level of control over their drug use. For example, a male respondent told us he *'could take or leave coke'* (Case 07, male, age 38) and a young female respondent told us *'I don't care what others think'* about her cocaine use (Case 13, female, age 18) and felt that she didn't have a big problem. These users also compared the experiences of a range of different drugs. One older male user told us that *'heroin lasts longer than coke'* (Case 16, male, age 30) and that he *'obsesses on different drugs'*. Another felt that *'snorting coke was a waste of time'* (Case 19, male, age 33), but for another *'cannabis is the best drug'* (Case 38, male, age 39).

Alcohol Use and the Treatment Sample

Alcohol consumption tended to be heavier than normal amongst cocaine users^{38,74}. The combination of cocaine and alcohol produces a greater euphoria and psychological well-being than either substance in isolation, which increases the toxic risk to the user¹⁰². Whilst alcohol was linked with cocaine initiation for the treatment sample, at the time of the interview eight of the treatment sample either never drank or had stopped drinking alcohol making this a sample of relatively light alcohol drinkers. This may be down to the fact that the treatment sample consisted of heroin users who historically are lower level drinkers as a result of methadone treatment. However, this was not the case at cocaine initiation as this excerpt shows.

[So, at the time when you first started doing coke and you said you had been drinking, how much had you been drinking? All day? Just at the party?]
I started at about six o'clock until four in the morning.
[Do you think that made a difference, having a few drinks in you?]
Yeah, well I always just took it when I was drinking. But if I knew I was going to be drinking...
(Case 05, male, age 19).

One treatment user who had been a heavy drinker for several years told us:

It's hard to drink again; it doesn't feel good. You have to get used to drinking again to start enjoying it (Case 05, male, age 19).

For others, their abstinence or reduction in alcohol consumption was more recent. One respondent who drank alcohol and used cocaine at the same time told us *'not so much now'* in reference to her current alcohol use (Case 09, female, age 38). Another treatment user told us she would never use cocaine again but added:

In saying that there, if I get really drunk and it [cocaine] was offered to me, might have a go at it again 'cos it's like a really good buzz from it (Case 13, female, age 18).

She also told us *'I hadn't never taken coke by itself'*. This treatment user first used cocaine when she was 15 years old at her boyfriend's house where there was a lot of alcohol available which

she described as ‘*cos we were just drinking and they were doing all that [cocaine]*’ (Case 13, female, age 18). One treatment user spoke about his alcohol use in the following way:

[And as far as a typical night out or something like that would you go out often?]
Not really these days too much. I’m more, I try to stay away from the drink ‘cos drink is, I know it sounds silly, drink is one of the things I still get a lot of cravings for and I would actually find it hard to control in terms of you know if I’m out you know ach sure I’ll have a drink or whatever and the next thing someone else would set a drink down and then you know two or three drinks turns into fifteen drinks and then you know, you know that there. And what happens with me as well is again you know, one of the key workers always laughs at this ‘cos a lot of things that happen with me are opposite to what should happen (Case 19, male, age 33).

This user had also been drinking heavily when he first used cocaine.

[And were you guys like drinking the first time that you used coke or was it...?]
Yeah we were drinking yeah so we were, probably half steaming anyway we probably wouldn’t have noticed that much from it anyway (Case 19, male, age 33).

One treatment user told us that he rarely drinks alcohol now (Case 16, male, age 30). Whilst another treatment user informed us that he tried to avoid alcohol, for him ‘*drink went hand in hand with coke*’ (Case 19, male, age 33), which was the case for a number of users in the treatment sample. This 33-year-old male also told us that ‘*drink and methadone puts me into withdrawal*’.

A 34-year-old female treatment user had received treatment for alcohol abuse and, as a result, had not taken any alcohol during the eight months prior to the interview. Amongst the others ‘*drinking is seen as acceptable*’ (Case 28, female, age 32).

The current alcohol use by the treatment sample was perhaps summed up by a 39-year-old male who told us that he ‘*doesn’t drink much anymore*’. This is someone who ‘*used to party a lot but not so much now*’ (Case 38, male, age 39).

Experiences of Treatment

The treatment sample had received support for substance misuse from a range of sources. A number of them had received interventions for other health problems including depression. The full range of interventions are listed in Chapter 3, ‘The Views of Professionals’. These services were designed to address problem drug use and associated problems including depression. The treatment users received these interventions for heroin use, cannabis use, ‘*a number of things*’ (Case 19, male, age 33), and alcohol abuse. Whilst all members of the treatment sample had received support for problem substance use (including alcohol abuse) this was generally not for cocaine use. However, some treatment users attended Narcotics Anonymous for their cocaine use. A number of these users told us there was no treatment available for their cocaine use, ‘*nothing to detox you coming off coke*’ (Case 08, female, age 22) and ‘*there’s no treatment for coke*’ (Case 17, male, age 45). Others were in receipt of counselling for cannabis use or treatment for alcohol abuse. A number of the treatment users were receiving methadone. Some

had '*received a lot of treatments*' (Case 15, female, age 34). There were similarities between the experiences expressed here by treatment users and the treatment professionals.

The most popular, or frequent, type of intervention was counselling either individually with a counsellor or in a group setting. Whilst there were positive experiences of treatment, this was not the experience of all the treatment using group. One female user felt '*treatment was really good*' (Case 09, female, age 38). For her this consisted of six counselling sessions where a self-help approach was encouraged. She explained why when saying:

I get to talk about that [personal problem] and get things off my chest... Things that have happened in my life that could have drove me to do things that are easy to block out. I think here [the treatment services] will help me in the long run (Case 09, female, age 38).

She also told us about her sister who had been in treatment for drug abuse when saying '*I've seen a big change in her [the sister] with counselling*' (Case 09, female, age 38).

One respondent had paid for private '*treatment for a number of things*' (Case 19, male, age 33) which included a session of Cognitive Behavioural Therapy. However, his experience was still negative about the treatment she received. His opinion of the interventions available for drug use was '*the free stuff [NHS and NGO services] is *****'. However, for one older male user the '*NHS treatment helped me cut back*' (Case 17, male, age 45). Another treatment user received medication whilst in prison which he found helpful but only temporarily.

Whilst most treatment users were positive to receiving interventions for their drug use, and some actively pursued support ('*I'm trying to get into rehab*' (Case 12, female, age 31)), there were also examples of negative experiences of the treatment received. For example, one treatment user who had received inpatient treatment told us she '*had drugs brought onto the ward*' (Case 08, female, age 22). She was generally dissatisfied with the treatment she received as '*with Coke there is nothing they can give you*'. She also told us that as she was admitted to an inpatient ward for older alcoholics who were '*slagging me*' and saying '*sure you're a junkie*' and she felt she was not treated fairly by these inpatients. She felt that their opinion of her was summed up as '*you get a name for yourself and when they say junkie, people expect you to be lying in the street with needles hanging out of your arm*'. This user was initially referred to Community Addictions where she was part of a counselling group that included young male heroin users. She felt her treatment experience was difficult because she was there because of her cocaine use which she felt was not taken as seriously as heroin use by treatment providers. This user also believed '*your doctor has no time for you*' (because of cocaine use).

A 31-year-old female felt that for her cocaine use '*counselling was not really helping*'. Here they '*talk about the dangers and stuff you know*'. This user was resistant to the weekly urine test that was expected at these sessions. She was more positive about one-to-one counselling sessions where she was building up a relationship with the counsellor but told us:

I don't like where group members were told about the dangers of drug use and why they shouldn't be using drugs (Case 12, female, age 31).

However, another male user felt that the role of counselling provided a strong support for him. He told us:

I've built up a relationship with the person who is my key worker for a long time and now I guess that is a bit of a psychological aid, like, you know (Case 16, male, age 30).

A 35-year-old male treatment user received support whilst in prison where he was examined by doctors in the prison hospital and prescribed medication for his drug use:

Once I went off everything, then I asked to see a drugs counsellor, and this was my first time ever even asking for anything like that there. And then I started getting, finding all these emotions and all things that I hadn't felt before and just because, like, the counsellor was there to tell me to expect all these because I had been out of my head for fifteen years practically, do you know what I mean, and she was telling me, 'Everybody feels these, it's just that you've been out of your ****ing head for that long, that you've kept them all or they just weren't there', do you know what I mean.

[Yeah, yeah. OK. And so that was the last two years that you've been getting help with that?]
Aye (Case 10, male, age 35).

There was a general positive consensus to receiving treatment for cocaine use that was favourable to receiving the range of inpatient and outpatient services available. A 39-year-old male user shared his experiences of outpatient treatment. He focused upon his experiences with the treatment team.

Yeah they really helped me, putting me onto support workers and a group called triangle... They are support workers that would bring you out and bring you to Tesco, for example (Case 38, male, age 39).

However, the treatment sample were less positive about the quality and effectiveness of the treatment received. Others who had received a programme of treatment also reported negative experiences including those who felt they had an opportunity to build a relationship with their counsellor. One treatment user received counselling for depression but told us the '*counsellor was not a good help*' (Case 05, male, age 19) when talking about addictions. This person received specialist addictions counselling but decided to go it alone (with professional support) in the end. This is explained here:

I went to one counsellor and drugs weren't her best subject because she specialised in other things. I got in contact with another counsellor and went to her a couple of times and she didn't really help me so I helped myself and got off the drink. I wasn't enjoying my drink any more and was depressed but after about four months I started enjoying my drink again and now I can enjoy my drink without drugs. I miss being on that high but at the end of the day I'm better off without it. It's not worth it (Case 05, male, age 19).

However, there clearly was some evidence of dissatisfaction with the services provided by the drug treatment agencies. One compared the service he received here with that in Scotland telling us there was '*no collaboration, no discussion compared with Scotland*' (Case 07, male, age 38). In particular he felt there was inadequate information on the treatment procedures. Other

dissatisfied treatment users perhaps felt this was compounded by the feeling that *'with coke there is nothing they can give you'* (Case 08, female, age 22). The experience here perhaps sheds some light on these views.

I don't know. They just try to put you off it. But, I know when I go to counselling, I'll be smoking joints. I just know I'm going to end up going back to [name] park and smoking myself out like. And they're like, 'What's the point of doing counselling?'

 (Case 13, female, age 18).

Whilst these treatment users were positive about interventions for problem drug use and a number of recipients acknowledged that they recognised their potential value, a number of the treatment sample registered dissatisfaction with the effectiveness of the treatment received. In particular there was a feeling amongst these users that cocaine specifically was not taken as seriously as other substances by treatment services. This was summed up by the following excerpt from one treatment user:

[Ok as far as treatment, I've asked you a couple of questions about treatment, you had an awful experience I know you've already gone over some of that but...]
In terms of cocaine treatment is this what you're talking about?
[Not really cos there's no kind of...]
Yeah there's no. I mean, as far I'm sure if I wanted I could probably go to Dr. NAME and say I'm at the coke like mad can I come into the ward for a couple of weeks to get my head together you know he, well I don't know, he's a bit of an ***** but I'm sure he would probably say yes you know. Well I mean something along those lines, you know get you off this here you know sort of thing and blah, blah, blah. But it's not like the way you know obviously with heroin you need you know a substitute. You know so any sort of withdrawal from coke or taking coke has always been self-medicated (Case 19, male, age 33).

Experiences of the treatment users, such as the limited information and specialist services for cocaine users, were supported by the treatment professionals. For example, one non-statutory sector worker based professional felt there was:

A need for information to educate young people before an issue arises... there is a need for more information on effective treatment (non-statutory sector worker).

An statutory based professional felt that:

Practitioners were not educated about cocaine use... there is limited training on cocaine treatment... no harm reduction strategies (statutory sector worker).

More generally a statutory sector worker professional told us there was *'no specialist cocaine service'*. A statutory worker felt there should be *'multi-eclectic approach that includes bar staff, posters and services'*.

Another non-statutory sector worker felt that:

GP services also need to be educated as they are the first point of contact for most people and they are lacking in knowledge of the subject (non-statutory sector worker).

Summary

The treatment sample was a group with experience of polydrug use, a factor historically associated with cocaine use. However, at the time of the research they were older than the traditional cocaine user which contrasted with the traditional demographic profile of recreational cocaine users. For example, with one exception, the treatment sample was living on benefits, with relatively low level educational attainment. As a group these users were experiencing, or at risk of, marginalisation and exclusion from mainstream society. Whilst a range of interventions were available to the treatment sample in this study and there appeared to be a positive motivation to receiving a referral for such interventions, the experience of the quality and effectiveness of such treatment was less positive. There are several important issues here which may account for this experience. Firstly, targeted interventions for cocaine use did not exist in Northern Ireland at the time of the research. Secondly, this means that those referred for problem cocaine use received treatment developed for more generic substance abuse problems. To some extent this may explain the variations in experiences of these users to the value of treatment received for addressing problem cocaine use.

Chapter 7: Summary and Conclusions

Introduction

This primarily qualitative study of cocaine use did not seek a representative sample, instead privileging a methodological approach aimed at engaging a smaller but diverse group of cocaine users for in-depth study. Rather than generalising the findings of the study to the larger population of cocaine users, the aim was to generate a detailed account of the cocaine use patterns and practices of individuals from a range of backgrounds and experience. The recruitment process succeeded in engaging individuals of different ages, life experience and drug histories including ‘hidden’ or ‘difficult to reach’ groups frequently missed or overlooked in large-scale representative samples. A mixed sampling strategy comprising purposive, ‘snowball’ and critical case sampling, generated two sub-groups of participants which were categorised as ‘recreational’ and ‘treatment’ users, respectively. The drug ‘stories’ of these two groups of users have been presented separately in this report because they represent quite different orientations towards cocaine and, indeed, other drugs. The analysis has attempted to blend detailed narratives with a degree of conceptual focus. Although necessarily based on selected excerpts from a voluminous data set, it is hoped that the stories recounted in the previous chapters speak to the diversity of cocaine users’ experiences and perspectives. This final chapter will summarise the study’s key findings. Similarities and differences between the two groups of users interviewed for the purpose of the study will be highlighted.

‘Integrated’ versus ‘Marginalised’ Cocaine Users

As highlighted in Chapter 2, research has uncovered differences between treatment and non-treatment cocaine users, a differentiation supported by this study’s findings. The demographic profiles of the study’s recreational and treatment sub-samples differed in a number of important respects, with the former group being better educated and more likely to be employed. Of the 16 cocaine users in the total sample who progressed to third-level education, only two were in the treatment group. Significant also is that five of those receiving treatment (almost one-third) were living in a hostel at the time of interview and a number of others had experienced homelessness at some time. None of the recreational users reported any experience of homelessness. While 14 of the 24 recreational users earned more than £10,000 per annum, only one of the treatment users reported annual earnings exceeding £10,000. Consistent then with Shearer et al.’s³² study of contemporary cocaine use patterns in two Australian cities, this study’s cocaine users can be usefully classified into two broad types: *socially and economically integrated* cocaine users and *socially and economically marginalised* users of the drug. These two groups of cocaine users differ significantly. Integrated (recreational) cocaine users were typically young, educated users who were anchored to a largely conventional lifestyle and whose pattern of non-work activities involved partying and drug use. Marginalised users, on the other hand, generally had low level educational qualifications and were typically unemployed and living on state benefits. These distinctions, as well as differences between the groups in terms of their drug use patterns, preferences and practices (see later sections), strongly suggest that in the unravelling of the nature of cocaine use and cocaine problems there is a need to look well beyond the drug itself⁸⁸.

A focus on the lifestyles of cocaine users and their experiences of cocaine and other drug use is what permitted the identification of these distinct use practices and patterns. It is perhaps important to note that many of the professionals interviewed for the purpose of this study referred to the absence of a typical cocaine user profile. At the same time, a number distinguished between recreational users of the drug, individuals who were felt to use cocaine and other drugs for social reasons, and those who present with cocaine-related problems, which most often co-exist with other drug problems. There is considerable uniformity, therefore, within the study between the experiences and perceptions of service providers and the categories of users uncovered through in-depth interviews with a diverse sample of cocaine users.

Initiation and Early Cocaine ‘Career’

The age of initiation to cocaine was roughly similar for treatment (average 19.4 years) and recreational (average 20 years) users. There were some similarities between recreational and treatment users in the experience of cocaine initiation. For example, both groups reported that first cocaine experiences were typically unplanned and that initiation occurred in the company of known individuals, usually friends. However, recreational users never exchanged money for their first cocaine ‘hit’ while some treatment users did pay for the drug on this occasion of use. While some treatment users initiated use in a street-based setting, all recreational users were indoors, most often in a private location (their own home or the home of a friend), at the time of initiation. Treatment users reported more anxiety about first use than did recreational users but, significantly perhaps, they also enjoyed the experience to a greater extent than did recreational users who more typically expressed disappointment. There was greater variation among treatment users in the mode of administration at initiation, with some reporting that they smoked or injected cocaine, although the majority ingested the drug by snorting on the occasion of first use. Recreational users always either snorted the drug or consumed it orally by rubbing it on their gums.

These findings indicate that, like other drugs, cocaine initiation typically occurs in familiar settings and that the drug is invariably offered by familiar people. Both recreational and treatment users were already drug-experienced when the opportunity arose to use cocaine, with initiation typically occurring several years subsequent to first drug use. Modes of administration at the time of first use broadly corresponded with users’ repertoire of drug administration routes and their preferred use practices.

Levels and Patterns of Cocaine Use

Following initiation, cocaine continued to be easily available within the social settings where the study’s participants socialised. However, there was evidence that treatment users moved at a faster pace towards a pattern of regular use. In contrast to recreational users, who reported relatively infrequent or sporadic use following initiation, treatment users transitioned quite rapidly to regular use of the drug.

Cocaine use settings were very often private spaces and recreational users in particular preferred to use cocaine in the company of others, either in their own home or in the home of a friend. House parties were the most talked about use contexts, although many recreational users had also

snorted cocaine in public licensed premises (pubs and clubs). Public settings were not preferred, however, partly because the practice was seen as too 'open' and also because there was pressure to conceal use of the drug from others in these public places. The study's treatment users also used the drug in private settings, although several reported that they had used cocaine alone as well as in the context of partying. With the dominant and favoured use settings being indoor, private spaces, cocaine use takes place away from the public gaze and is likely to remain quite hidden.

Both recreational and treatment users were polydrug users who had very considerable experience with a range of illicit drugs. The majority in both groups had used cannabis, Ecstasy and amphetamine during their lifetime and many had used one or more of these drugs regularly at some time. Recreational users often reported periods of regular Ecstasy use associated with clubbing and partying and a large number smoked cannabis daily or weekly, either currently or in the past. However, experience with heroin in particular and, to a lesser extent, crack cocaine is what separated the two groups: while the vast majority of recreational users had not used either heroin or crack cocaine, the majority of treatment users were, or had been, problematic heroin users and a smaller number were lifetime cocaine smokers. Administration routes also differed for recreational and treatment users, with most recreational users preferring snorting or oral consumption and many treatment users reporting that they had smoked cocaine and/or used it intravenously in addition to snorting and oral consumption of the drug, particularly towards the latter stages of their cocaine 'careers'. These differences in modes of administration are significant since treatment users' greater likelihood of injecting or smoking cocaine may make them more vulnerable to hepatitis C and HIV transmission¹⁰³⁻¹⁰⁵.

As demonstrated in Chapter 5, patterns of cocaine use varied among the study's recreational users. A continuum of use was identified, with those reporting less frequent (less than monthly) use being at the lowest end; higher up the continuum were those who used cocaine monthly, and weekly users of cocaine were at the top end of the use continuum. While the majority were current users of cocaine, a smaller number reported that they had either reduced their intake of the drug (n=5) or quit use (n=4). Those accounts of respondents who curtailed or quit use of the drug are noteworthy because these individuals reached a point when they felt that their cocaine use was compromising their health and well-being. Thus, some recreational users may exceed 'sensible' limits and experience negative consequences. However, that these users self-identified sources of possible harm and took steps to counter risk suggests that integrated recreational users employ strategies to regulate their drug consumption. A convincing case can therefore be made for the development of preventive messages which aim to reinforce some of the basic 'standards' and practices employed by cocaine (and other recreational) drug users to reduce injury and harm. Practical and 'sensible' advice which corresponds with the experiences of drug users is likely to be embraced rather than rejected by drug users who already subscribe to rules and strategies aimed at maintaining safe drug use practices. Put differently, formal cocaine-specific harm reduction messages would serve to reinforce users' pre-existing ideology of harm minimisation.

The study's treatment users, many of whom were problematic heroin users, tended to report patterns of frequent use following initiation which, over a period, led to problem use of the drug. At the time of interview, their reported use of cocaine and other drugs was generally much more intermittent however and, among them, alcohol consumption levels were relatively low, certainly

compared to the study's recreational cocaine users. However, treatment users referred frequently to their 'addiction' to cocaine, a relatively rare reference point among the study's recreational users who, in the main, claimed to 'control' their cocaine consumption. Indeed, for recreational users, a 'controlled' drug user identity was important and many used self-regulatory strategies – particularly following episodes or periods of excessive use – to mitigate the potential harm associated with cocaine, alcohol and other drug consumption. These differences in user perceptions of cocaine risks, particularly in relation to the risk (and perceived reality) of 'addiction', have implications for both prevention and treatment initiatives. For example, health messages stressing cocaine's addictive potential may be ineffective if a majority of recreational users experience and perceive no such risk. These users are likely to be more open to messages that match their experiences and to place greater value on advice about how to reduce the potential physical and/or psychological hazards associated with cocaine use. On the other hand, dependent heroin users and others receiving treatment may underestimate the consequences of using cocaine and its association with poorer prognosis among individuals on methadone maintenance treatment¹⁰⁶.

Perceived Benefits of Use

Recreational users were more animated than their counterparts in receipt of treatment in their portrayal of cocaine benefits, and listed an array of appealing aspects of the drug. For these users, cocaine benefits were strongly linked to self- and social- enhancement. These benefits were strongly linked to the 'spaces' where cocaine use occurred, typically at a large or 'chill out' house party after a night of socialising in licensed premises. In these contexts, cocaine provided a welcome 'boost' to the night and helped to prolong pleasure by making respondents feel more sober and energetic. Recreational users also praised cocaine because they felt that they could control the drug 'high' to a greater extent than with other drugs. Some also felt that cocaine was a discreet drug and that the after-effects, particularly during the days subsequent to use, were less severe than with other drugs, particularly Ecstasy.

Treatment users talked about a number of these benefits – including increased self-confidence and feeling more energetic – but their accounts focused to a far greater extent on chemical highs they experienced from use. Much of the narrative material privileged the intensity of the cocaine high or 'buzz' rather than any social benefits arising from use. Indeed, many appeared to feel that apart from the attainment of an intense high, the benefits of cocaine or other illicit drug use were limited. Notable also is that treatment users were more likely than recreational users to report that cocaine helped them to counteract negative feelings or emotions and/or helped them to feel that they could 'keep going' when they felt 'burnt out'. For these treatment users, the perceived need or desire for an energy boost was qualitatively different to the new 'lease of life' that cocaine provided to recreational users in the context of a night of socialising.

Perceived Risk and Negative Cocaine Experiences

Perhaps unsurprisingly, recreational and treatment users differed quite significantly in terms of their experiences and perceptions of risk and the negative consequences associated with cocaine use. Monthly and less frequent recreational users often reported no negative consequences or side effects arising from their cocaine use and many equated any downsides or unappealing

effects with those associated with an alcohol hangover. Those recreational users who quit or curbed their intake of the drug were somewhat different, with most reporting a number of undesirable physical and psychological consequences which appeared to play a strong role in their decision to quit or reduce their intake of the drug. Treatment users were relatively well-versed on the range of risks associated with cocaine use, including its impact on their physical and mental health and well-being. Their perspectives on cocaine risks may to some extent have been influenced by the experience of treatment, since the dangers of continued cocaine and other drug use are usually communicated within drug treatment regimes. However, they also reported a range of problems arising from their use of cocaine including relationship difficulties, job loss, family problems and debt, as well physical and psychological ramifications. Thus, for treatment users in this study, the negative consequences of cocaine use spanned physical, psychological, social and personal domains and the majority of treatment users indicated that their use of the drug had compromised both their health and quality of life.

Drug Treatment

None of the study's recreational users had sought treatment related to their cocaine or other drug use and most felt that they did not need outside intervention or support in order to monitor or 'control' their drug intake. This finding is consistent with other research which suggests that 'better integrated' drug users are less likely to seek help or to contemplate doing so¹⁰⁷. Moreover, a number of the study's recreational users, who themselves identified a need to curtail or quit cocaine use, appeared not to consider seeking help from formal sources. This finding may be indicative of a resistance to the stigma of becoming a treatment client. Several of the professionals interviewed for the purpose of the study noted that younger recreational users in particular tend not to present to treatment services and a smaller number felt that greater flexibility within services was required in order to attract and engage young people. Counselling agencies, community-based health care practitioners and drop-in services could provide the services and supports needed here in a non-stigmatising way to cocaine users who experience negative effects but who are reluctant to seek help and/or to engage with formal drug treatment agencies.

The majority of those cocaine users in treatment had been referred for non-cocaine substance abuse, with heroin being the most frequent reason for referral to a drug treatment setting. The experience of treatment was varied across the sample but, on balance, did not appear particularly helpful to their individual needs. There was also a general feeling that treatment services were not adequately equipped to meet the problems linked to cocaine abuse. This finding was largely corroborated by those professionals interviewed for the purpose of the study, who identified gaps in service provision specific to cocaine-using clients as well as a perception that treatment providers lacked the requisite knowledge about how to adjust their services to meet the needs of problem drug users who use cocaine, a situation that is not unique to Northern Ireland. This perceived lack of experience in dealing with cocaine-(ab)using clients points to a need for education for drug treatment and health professionals on the management of cocaine problems. Overall, the combined accounts of drug treatment professionals and those individuals in receipt of treatment suggest drug treatment services, as they are currently structured and organised, are ill-equipped to meet the needs of polydrug-using cocaine users. The impact of polydrug use on

drug users presenting for treatment clearly has implications for service providers regarding client management and also for treatment outcomes and effectiveness.

Concluding Remarks

There are clearly many different drug scenes and populations, from young drug experimenters to cannabis users, to weekend dance drug users and polydrug users, through to a smaller number who become deeply immersed in ‘heavy end’ drug scenes. This picture is further complicated by the ebb and flow of individual’s drug use over time. Drug users do not necessarily maintain stable or fixed use patterns across time and there is considerable ‘starting, switching and stopping’¹⁰⁸ as drug use experience is gained. The fluidity within drug scenes and their susceptibility to rapid change compounds this problem, making it difficult for research to keep abreast of the diversity of contemporary drug scenes.

Starting from a relatively low knowledge base, this qualitative study aimed to illuminate available drug use indicators in Northern Ireland, which together suggest that the prevalence of cocaine use is rising. The study confirms that cocaine is widely available and likely to become integrated into the drug repertoires of young polydrug users. However, the findings also highlight the hidden nature of cocaine use. It seems likely, for example, that the vast majority of cocaine users will not come to the attention of drug treatment or law enforcement agencies as they pursue conventional goals alongside a social life which prioritises pleasure and incorporates alcohol consumption and polydrug use. Cocaine users who present to treatment are also likely to be polydrug users and, typically, will not identify cocaine as their primary drug of misuse. They may also continue to use cocaine, at least episodically, following their entry to a treatment setting.

This research has drawn attention to the existence of two quite distinctive populations of cocaine users. On the one hand, there are ‘integrated’ cocaine users who use the drug at various use frequency levels but do not access treatment because they feel that they are ‘in control’ of their consumption or, alternatively, are able to address periodic excesses independently and without outside intervention. It is perhaps significant that, among this sub-population of cocaine users, use occurs most frequently in private settings making it difficult to target them through conventional public health messages. On the other hand, are the more ‘marginalised’, problem drug users who have integrated cocaine into their drug repertoires but who do not, for the most part, regard cocaine as their primary drug of misuse. These users, rightly or wrongly, often diminish the negative impact of cocaine on their lives and on their physical and psychological health, believing that the negative impact of drugs is more related to another substance(s). From a drug treatment perspective this situation presents challenges, particularly in relation to how services and interventions are organised and equipped to respond to polydrug users, including those who use cocaine.

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