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Drugs in focus

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# Cocaine use in Europe: implications for service delivery

An estimated 12 million (3.5 %) European adults aged 15–64 have tried cocaine and 4.5 million (1.3 %) have used it in the last year. Overall, cocaine supply, use and related problems in Europe have risen over the last decade, and prices have dropped. However, this overall trend masks considerable inter-country variation. Some countries, such as the UK, Spain and Italy, have seen considerable increases in cocaine use while others, particularly in eastern Europe, report only very limited use.

Cocaine use presents new challenges for Europe's drug treatment services. Although services can leverage experiences gained in responding to other types of drug problems, the pharmacology of cocaine, the social diversity of users and the concurrent use of other psychoactive substances complicate the development and targeting of responses. And unlike treatment for opioid users, there are no proven effective substitution or pharmacological treatment options currently available for cocaine users.

This paper addresses a number of important issues for the delivery of services for cocaine users. How can the different groups of users be reached and helped? What type of treatment should be made available for dependent cocaine users? Are new specialised services needed, or should existing ones be adapted?

## Definitions

**Cocaine** is the hydrochloride salt produced from the leaves of the coca plant (*Erythroxylon coca Lam*) which is cultivated mainly in South America. Powder cocaine is typically snorted (insufflated) and, less frequently, injected. It produces euphoria and appetite suppression, and has multiple negative effects on health (see 'Health issues').

**Crack** is the smokable form of cocaine and is manufactured from cocaine hydrochloride. It is known for immediate effects and association with problematic patterns of use.

## Key issues at a glance

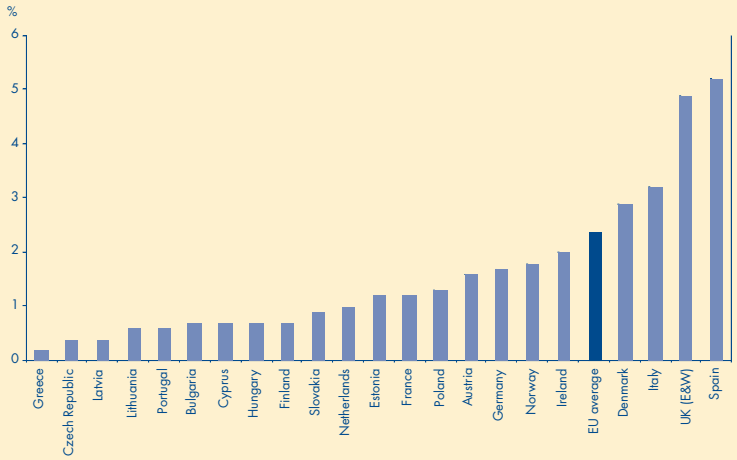
1. Some 4.5 million European adults (1.3 %) have used cocaine in the last year. Last year cocaine prevalence has shown an overall upward trend over the last decade, although with variations between EU Member States, ranging from 0.1 % to 3.0 % of the population.
2. Cocaine use can lead to dependence and treatment demand related to cocaine has increased. Psychiatric, cardiovascular and other health problems are also associated with cocaine use. Injecting cocaine carries the risk of transmission of blood-borne diseases such as HIV and hepatitis C.
3. Three core groups of problem cocaine users can be identified: socially well-integrated individuals; opioid users, some of whom are substitution treatment clients; and marginalised crack users.
4. These groups differ in drug use patterns, health and living conditions. Their needs range from access to information about cocaine-related risks to specific treatment or harm reduction interventions.
5. Current responses to cocaine-related problems draw largely on existing services targeted at opioid use and drug use in recreational settings. These existing services may need adapting to meet the specific needs of cocaine and crack users.
6. Improvements could include: specific cocaine and crack strategies; training and research on the treatment of cocaine dependence; outreach interventions; and tailored treatment services for specific groups of cocaine and crack users.

## 1. Growing cocaine use in Europe

Second only to cannabis, cocaine is among the most trafficked drugs in the world. In 2005, an estimated 752 tonnes were seized worldwide and 107 tonnes in Europe, with Spain accounting for about half of European seizures. Overall, the quantities seized and the number of seizures have increased in Europe since 2000, reaching around 70 000 cases in 2005. Average prices of cocaine have fallen in most reporting countries.

General population surveys show an increase in cocaine use in many EU countries, although this may now be slowing down in some Member States with the highest prevalence (UK, Spain). Cocaine use is more common among young adults aged 15–34 (Figure 1) and males. The drug is often consumed alongside other illicit drugs and alcohol.

**Figure 1: Last-year prevalence of cocaine use among young adults (aged 15–34) in Europe**




*Source:* EMCDDA Statistical bulletin, figure GPS-38.

## 2. Health issues

Cocaine use has been shown to have negative effects on health, especially among frequent users. However, the extent of both the morbidity and mortality related directly to cocaine use remains difficult to estimate.

Cocaine and crack act on the reward system of the brain and repeated use can lead to dependence. It is the third most commonly reported drug cited as the reason for entering drug treatment in the EU, with about 13 % of all treatment demands in 2005. However, there are considerable variations between countries. In Spain and the Netherlands, cocaine accounts for respectively 40 % and 35 % of all treatment demands while this figure is 0 % in Finland and 0.1 % in Lithuania. The number of treatment demands related to cocaine use has increased in recent years, notably among those entering treatment for the first time (Figure 2). In 2005, more than one in five first treatment demands (21.5 %) were cocaine-related.

Acute and chronic cocaine use, often in combination with other substances, can cause multiple disorders (cardiovascular, cerebrovascular, neurological, psychiatric, etc.). Cocaine injection also carries the risk of transmission of blood-borne diseases such as HIV and hepatitis C. Acute cocaine-related deaths from overdose are not frequently reported, but in such rare cases a massive exposure is mentioned. Most reported cocaine deaths are the consequence of its chronic toxicity, leading to cardiovascular and neurological complications.

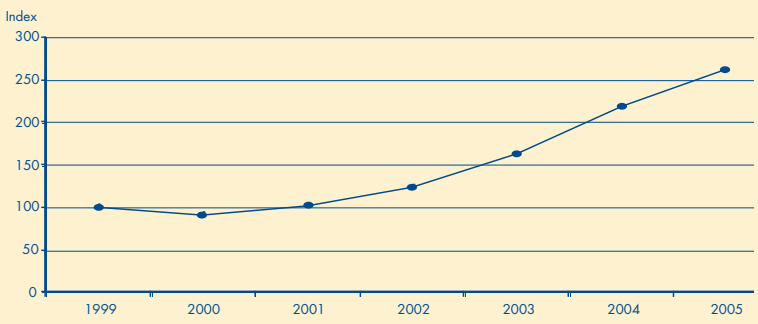
## 3. Different groups of users

Cocaine users are spread across diverse social groups. For example, surveys in recreational nightlife settings show prevalence rates 5 to 20 times higher among clubbers than among the general population. Studies with cocaine users who are not in treatment typically report a well-educated and socially integrated user demographic. Furthermore, studies and treatment data allow us to distinguish three different profiles or groups of problem cocaine users.

The first group uses powder cocaine alone or in combination with cannabis and/or alcohol. This group is mainly composed of males, often referred to treatment by the criminal justice system or under the pressure of social and family networks. They are relatively well-integrated socially, with stable living conditions and regular employment.

The second group uses both opioids and cocaine. Its members are current or former heroin users who have also developed problems related to cocaine use. Some may be

**Figure 2: Evolution in number of first treatment demands with cocaine as the primary drug in 20 EU countries (indexed to 100 in 1999)**




20 countries: BG, CZ, DK, DE, IE, EL, ES, FR, IT, HU, MT, NL, PL, PT, RO, SI, SK, FI, SE, UK included.

undergoing substitution treatment. National studies focusing on cocaine users in treatment report that this group is often the largest.

The third group uses crack cocaine, often in combination with opioids. Its members are frequently highly marginalised, and may comprise a high proportion of ethnic minority members and people who are homeless, unemployed or in precarious labour conditions. It is the smallest of the three groups (2.5 % of all European clients in treatment) and has only been identified in a few locations.

## 4. The needs of different user groups

Cocaine and crack users represent a heterogeneous population with specific needs which may require tailored services. Socially integrated powder cocaine users may need to be better informed about cocaine-related risks. They may also be reluctant to initiate or continue treatment among marginalised drug users and feel there is a stigma attached to users attending such services.

Among dependent cocaine users who are also heroin users and/or in substitution, continued cocaine use may, if not addressed properly, interfere with the treatment programme and subsequently jeopardise the overall treatment outcome. Similarly, co-use of alcohol and often observed co-morbid psychiatric and personality disorders in cocaine clients (e.g. aggression, acute psychosis and paranoid behaviour) constitute major problems for staff and clinicians. The co-use of multiple substances also substantially increases the risk of additional health problems and the risk of death among this population.

Finally, crack cocaine often affects marginalised and deprived populations (e.g. the homeless, sex workers). These populations show a broad variety of health and social problems and are difficult to reach. They might seek treatment and support at a later stage of their dependence and thus be more difficult to treat.

## 5. Policies and interventions

There are very few drug strategies which specifically target cocaine and crack cocaine use and only the UK and Ireland have implemented strategies at national and/or local level. Most European countries report that cocaine users can access information about cocaine and the risks of cocaine use through various sources such as websites, helplines and interventions in the nightlife setting. In some cities, especially those with significant crack cocaine use, harm-reduction agencies also provide outreach interventions.

Currently, most reported cocaine treatment in Europe takes place in outpatient settings which are primarily oriented to the needs of opioid users. However, socially integrated cocaine users are likely to seek help through other healthcare providers such as general practitioners or private clinics. There is a growing interest for countries with significant cocaine-using populations to provide services tailored specifically to cocaine users.

A recent EMCDDA review of the literature on the treatment of cocaine dependence found that no effective pharmacological therapeutic agent is yet available but that recent experimental trials (e.g. Topiramate, cocaine vaccines) have shown promising first results. Cognitive behavioural interventions, such as cognitive behavioural therapy, motivational interviewing, and a community reinforcement approach sometimes combined with contingency management (e.g. voucher-based incentives), have been shown to be most effective in reducing and preventing future cocaine use. However, as these approaches and the research about their effectiveness come almost exclusively from the United States, research on their transferability to Europe is urgently required.

## 6. The way forward

At policy level, strategies for cocaine- or crack cocaine-only services should be developed where the extent of the problem merits a concerted and intensive response, for example in some European countries and cities. Outside such locations, drug policies should address the growing diversity in drug use patterns and needs of problem drug users.

The treatment of cocaine dependence relies mainly on psychosocial interventions, with pharmacological agents being used as a support by many clinicians. However, until now, no effective pharmacological agent has emerged to manage cocaine abstinence and reduce craving. Therefore, research and training in psychosocial interventions should be given highest priority. The exchange of experiences and best practice among clinicians should be encouraged. Research on pharmaceutical agents should also be supported and the results made rapidly available, both for positive as well as negative outcomes. Finally, cocaine users who are undergoing opioid substitution treatment should be assessed to make sure that their cocaine use is not linked with too low a dosage of methadone or buprenorphine.

Interventions to reach socially integrated problem cocaine users and marginalised crack users also pose a challenge. A recent Irish pilot project revealed that cocaine users' reluctance to attend opioid-oriented programmes could be circumvented by providing special access during evenings, or immediately before and after the weekend. For crack users and marginalised populations of drug users, harm reduction outreach interventions, combined with service referral, need to be given higher priority.

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## Conclusions and policy considerations

1. **Specific strategies targeting cocaine or crack cocaine use should be developed in areas where the extent of the problem, such as in some European countries and cities, requires a concerted response. Elsewhere, drug policies should address the growing diversity in drug use patterns and needs of problem drug users.**
2. **Prevention and harm reduction approaches related to cocaine use need to be developed, in particular information on risks (cardiovascular, psychiatric, elevated toxicity of some forms of polydrug use). Both occasional and regular cocaine users should be targeted.**
3. **Interventions to reach and help socially integrated problem cocaine users can be developed by adapting existing services or, in some cases, providing dedicated treatment services.**
4. **Crack users, and other marginalised populations of drug users, should have access to harm reduction outreach interventions including service referral.**
5. **In all treatment settings, training in psychosocial interventions should have high priority as this kind of intervention has shown the best results. Exchanging knowledge and best practice among clinicians and other drug workers should be encouraged.**
6. **Research on psychosocial interventions and on new pharmaceutical agents to treat cocaine-dependent clients should be promoted. There is also an urgent need to better understand polydrug use involving cocaine, its multiple variants and consequences.**

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## Web information

EMCDDA drug profiles — cocaine and crack:
http://www.emcdda.europa.eu/index.cfm?nnodeid=25482

National Institute on Drug Abuse, Infofacts on cocaine:
http://www.nida.nih.gov/Infofacts/cocaine.html

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