Cocaine and 'base/crack' cocaine

EMCDDA 2001 selected issue

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Chapter 3

Selected issues

This chapter highlights three specific issues relating to the drug problem in Europe: cocaine and 'base/crack' cocaine, infectious diseases and synthetic drugs.

Cocaine and 'base/crack' cocaine

Concern has been growing in the EU about increasing use of cocaine; however, actual trends in cocaine use and their consequences across the EU are difficult to verify. Firstly, national data, for example, from surveys or treatment centres do not reflect changes in prevalence and problems that occur in geographic patches within specific cities or changes which are concentrated in particular social milieus. Secondly, current information about cocaine often lacks clear, scientific definitions — for example, information systems rarely distinguish cocaine 'base/crack' from cocaine hydrochloride or between the different 'base/crack' preparations. These different forms of cocaine have different market features, different patterns of use, and contribute to different problems, all of which need to be understood for effective policy-making and demand reduction responses.

Prevalence, patterns, and problems

Prevalence

Neither general population surveys nor school surveys reveal a general increase in levels of cocaine use in the EU. Only in the United Kingdom has there been a confirmed increase in lifetime prevalence of cocaine use among young adults aged 16 to 29. The Italian national focal point reports that a range of sources in Italy has shown that cocaine use is in second place to cannabis and higher than amphetamine or ecstasy use.

A 1999 European schools survey shows that experimental use of cocaine (lifetime prevalence) amongst students aged 15 to16 remains low and is much lower than for cannabis. In all the Member States included in the survey, cocaine was reported to be less available than ecstasy although there was considerable variation between countries. Cocaine is reported to be easily available by the greatest percentages of 15 to 16-year-olds in Ireland and the United Kingdom (21 % and 20 % respectively) and by the lowest percentage in Finland (6 %). However, in all the EU countries surveyed, availability of cocaine was considerably less than to the same age group in the United States (2). Disapproval of cocaine use is very high and more or less equal in strength throughout all the

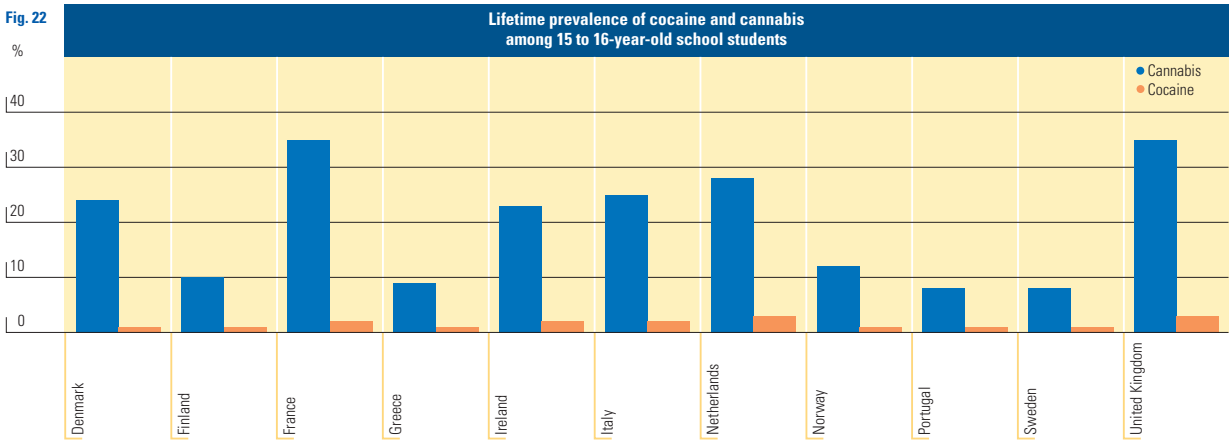
What are cocaine and crack?

Cocaine is a stimulant drug extracted from leaves of the Erythroxylon coca bush and was developed to treat a wide variety of illnesses in the mid-19th century. The chemical name of the processed drug is cocaine hydrochloride and it is generally sold 'on the street' as a crystalline powder, known by a range of street names, such as 'coke', 'snow' and 'Charlie'. It is generally taken intranasally and less frequently dissolved in water and injected.

Cocaine 'base/crack' is a street term for cocaine that has been treated for use by smoking or inhaling vapours to provide immediate and intense effects. There are at least three methods of 'base/crack' manufacture (1). One method results in a clean product — by adding hot water and ammonia or sodium bicarbonate and discarding the excess liquid layer containing diluents. Another method results in lower cocaine concentration — by heating a paste of cocaine and sodium bicarbonate in a microwave with all diluents remaining in the final product.

Cocaine and 'base/crack' are usually distinguished on the basis of physical appearance and purity and further complicated because some cocaine 'base/crack' is physically similar to cocaine hydrochloride.

Fig. 22



Source: The 1999 ESPAD report. See note on page 9 for full reference.

participating countries and equals the levels of disapproval applied to heroin.

Patterns

Although nothing dramatic is occurring in the general population at national level, there are more marked levels of cocaine use in certain social settings. Past research on cocaine users showed that firm boundaries distinguish recreational users of cocaine powder (hydrochloride) from problem 'base/crack' users, and cocaine injectors. A wide range of recreational cocaine powder consumption patterns is found among groups of people who frequent nightclubs and dance settings and who use powder cocaine for social and utilitarian purposes. These recreational users are distinct from the marginalised groups, such as homeless young people, sex workers and problem heroin users who smoke 'base/crack', or inject cocaine mixed with heroin, in geographic patches within specific cities. However, the boundary between powder cocaine and 'base/crack' may be weakened by an emerging trend in cocaine smoking in recreational and nightlife settings and in recent changes in the market. Firstly, a new trend of mixing cocaine 'base/crack' with tobacco in a 'joint' for smoking has been reported in five Member States — the Netherlands, France, Greece, the United Kingdom and Italy. Secondly, forensic science services have reported that some cocaine 'base/crack' is physically similar to cocaine powder (hydrochloride), which makes it difficult for police and inexperienced users to make any distinction (8). And thirdly, in the United Kingdom, there are indications that cocaine 'base/crack' for smoking is being reconstructed and commodified with new names such as 'rock' and 'stone' and these serve to distinguish ready-to-smoke cocaine from 'base/crack' and push its image up-market and closer to powder cocaine (4).

Table 3

Lifetime prevalence of cocaine in targeted users surveys compared with population surveys

	Clubbers			Young adults from general population			
	LTP (%)	Sample size	(Year) and source	LTP (%)	Sample size	Year and age range	
Austria	42	50	(1999) Austrian ravers	–	–	–	
Belgium	45	154	(1998) Rock Festival, French Community	–	–	–	
Denmark	–	–	–	3.1	14 228	2000	16–34
Finland	–	–	–	1.2	2 568	1998	15–34
France	56	896	(1999) Techno rave parties, Médecins du monde	1.9	2 003	1999	15–34
Germany							
Former West	–	–	–	2.2	6 380	1997	18–39
Former East	–	–	–	0.4	1 620	1997	18–39
Netherlands	48	456	(1998) Amsterdam clubbers, Questionnaire (23 % response)	3.7	22 000	1997/98	15–34
Spain	–	–		4.8	12 488	1999	15–34
United Kingdom	62 18 'crack'	517	(1997) Release drugs and dance (1)	6.4	10 293	1998	16–34
	50	100	(1999) Clubbers in Liverpool (2)				
Northern Ireland	45	106	(2000) Ecstasy users in Northern Ireland				

(1) Release (1997), Release dance and drugs survey: an insight into the culture, London.
(2) S. Henderson (2000), 'Protecting and promoting the health of club-goers in Liverpool: An information campaign evaluation and market research project', 1999–2000.
Sources: National focal points and references as indicated below.

Prevalence of cocaine use is much higher among subpopulations with high prevalence of other drug taking than it is among the general population of young adults. Table 3 (Lifetime prevalence of cocaine in targeted user settings) illustrates a substantial difference between the relatively high lifetime prevalence of cocaine taking amongst young 'dance goers/clubbers' and the much lower rates amongst the more general population of young adults. The relatively high costs of cocaine, combined with the short duration of its effects, mitigate against regular recreational use and a high level of disposable income may be a significant factor in regular use. In recreational nightlife settings, there is a tendency for some people to drink significantly more alcohol than usual with cocaine. Cocaine serves to increase sociability by moderating the undesirable effects of alcohol.

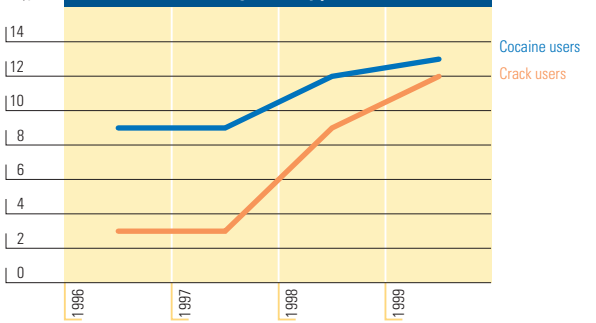
Problems

Between 1994 and 1999 the number of clients seeking treatment for problems associated with cocaine as their main drug — as a proportion of the total clients seeking treatment — increased substantially in Spain and the Netherlands. Germany, Greece and Italy also show a proportional increase in cocaine treatment and Ireland showed an increase until 1998 [22]. The United Kingdom and the French and Flemish-speaking parts of Belgium also reported an increase. There is a lack of comparable research on cocaine users in treatment in the EU and the proportional increases in clients seeking help for cocaine problems may indicate a real increase in cocaine problems but may also be the result of a reduction in the number of clients seeking help for opiate problems or a result of former opiate clients switching their main drug problem to cocaine. The development of services that are increasingly attractive to cocaine users may also influence treatment figures. Some drug treatment services have reported that, among clients in treatment for heroin dependence, there has been an increase in cocaine use, particularly smoked as 'base/crack' or taken intravenously with heroin.

Figure 23 provides an example of the localised increase in 'base/crack' users which are not reflected at national level. In Frankfurt, the percentage of 'crack' users amongst the total addicts registered by police increased fourfold between 1996 and 1999.

Health service providers and cocaine users rarely report fatalities, or negative physical health, as a direct consequence of sniffing powder cocaine and because recreational users tend to use cocaine alongside large amounts of alcohol, or other drugs, it is difficult to identify the causes of negative experiences. However, Luxembourg, the Netherlands, and Italy report an increase in the number of drug fatalities and Spain reports an increase of hospital emergencies in which cocaine was implicated in addition to other drugs. Raised awareness among hospital emergency staff of the potential role of cocaine in cardiovascular disturbances could lead to higher rates of reporting (4).

Fig. 23 **Example of localised increase in percentage of cocaine and crack users in Frankfurt (total addicts registered by police 1996–99)**



Source: PPF, Rauschgift und Kriminalität, several years in L. Paoli 2000.

Severe health, social and psychological problems associated with smoking cocaine 'base/crack' have been identified, particularly among marginalised groups, such as problem opiate users, homeless and other disadvantaged youth, and female sex workers. The extent to which problems are direct consequences of the use of this form of cocaine per se, or the frequency and amount of its use, or of pre-existing social/psychological and drug problems, is not clear.

Market

In 1999, the number of cocaine seizures increased markedly in Luxembourg and Sweden whilst they decreased in Austria, Belgium and Denmark. Retail level prices of cocaine reported range from EUR 24 per gram to EUR 170 with cities such as Amsterdam and Frankfurt at the lower end and Member States such as Sweden and Finland at the higher. In the United Kingdom and France, retail prices have decreased but purity remained generally high between 55 and 70 % until late 1999 when, in the United Kingdom, there was a sharp decline in the mean purities of crack (10). Geographical variations in price within Member States are marked. Small quantities of cocaine, in parts of a gram or in the form of 'balls' or 'rocks', are available for less than EUR 15 in some cities, particularly in those with open drug scenes and where the cocaine concentrations may drop substantially (for example, Frankfurt, Milan, Paris, London, Manchester and Liverpool). Cocaine distribution takes place primarily

[22] Figure 15 OL: Cocaine: trends for new clients admitted to treatment (online version).

through chains of friends of friends but in some cities open dealing takes place within recreational nightlife and street settings. House dealing and delivery services have been greatly facilitated by the increased convenience and protection (in the form of anonymity) afforded to dealers by mobile telephones (4, 5, 6, 7).

Increased availability of ready-to-smoke ('base/crack') cocaine in a number of European cities (Amsterdam, Rotterdam, London, Liverpool, Manchester, Frankfurt, Milan and Paris) has been reported but methods for preparing it (and the subsequent cocaine concentration levels, which can rise to 100 %) vary and create confusion for drug information systems, and the lack of scientific definition for street terms such as 'crack' and 'base' pose problems for education and prevention responses. At street level, cocaine may be sold already mixed with heroin.

Spain, Belgium and the Netherlands are reported to be major transit points for cocaine from Latin America (Colombia, Brazil and Venezuela in particular) to the rest of the EU. In 1999, six cocaine processing laboratories were reported as having been dismantled in Spain and subsequent increases in the wholesale price of cocaine in Spain have been attributed to this.

Intervention projects and new approaches

The EU response to the increase in cocaine and crack use has taken three main forms in the field of demand reduction. During the 1990s, a small number of cities developed specialised services to address the need of primary cocaine problems and to target especially vulnerable groups, such as Jugendberatung und Jugendhilfe e.V. in Frankfurt and 'Take five' in Rotterdam. Some Member States report efforts to adapt existing structures to meet the needs of problem cocaine and crack users. For example, in France and the United Kingdom multidisciplinary strategies are being developed among involved professionals to collect and exchange information about the needs of cocaine and crack users in order to develop appropriate training and adapt existing models and treatment services to provide the type of services which will be more effective in meeting the needs of cocaine and 'crack' users. Thirdly, some Member States have placed emphasis on the need to address the criminality and health consequences of multiple drug use in general.

Data on responses to cocaine problems from the private sector are difficult to obtain but, nevertheless, this sector is likely to play a significant role in the treatment of more socially privileged cocaine problem users.

Examples of treatment for cocaine problems

Few treatment responses have been described in the reports from the Member States. However, Germany and the Netherlands highlighted interventions specifically designed for cocaine problems.

In Frankfurt, the youth organisation, Jugendberatung und Jugendhilfe e.V. offers a treatment process targeted at cocaine addiction, which is tailored to the needs of each individual client. The initial 'crash phase', lasting a few days, takes place either in an outpatient setting with psychosocial support or as a detoxification process in a hospital. The next phase involves six weeks of inpatient treatment where the client follows a daily schedule, including group and individual treatment sessions. The recovery phase, either in an outpatient or inpatient setting, aims at re-establishing or improving contacts and relations with family, relatives or partners.

In Rotterdam, 'Take five', a treatment programme for heavy 'base/crack' users has been running since 1996. The programme, administered by municipal health services, operates like a low-threshold service. In the first phase, street workers contact 'base/crack' users at different locations such as drug dealing spots, user rooms or crisis centres. In the second phase, the patient frequents a so-called 'time out location' which offers support 24 hours a day with a general practitioner and psychiatrists available on request. The aim of the third phase is to stabilise the health of the client and start rehabilitation. The Rotterdam experiment reports that acupuncture is very popular among their clients for relaxation.

Policy issues

In the EU there is a market of recreational drug consumers with disposable incomes who are either wary of the unreliable content of 'ecstasy' tablets and the possibility of associated acute and long-term health risks, or are jaded with their past experiences of MDMA and its unpleasant early to mid-week after effects. Research shows that, from the perspective of recreational cocaine users, cocaine is considered more predictable, versatile and unobtrusive than ecstasy and the after effects of cocaine are considered less severe or unpleasant and shorter-lived than the after effects of ecstasy or amphetamines (3).

Research on cocaine users has identified clear social distinctions and sharply separate subcultures between users of cocaine powder (hydrochloride) and smokers of 'base/crack' — but the boundaries may be called into question by the recent changes in the market and an emerging trend of smoking cocaine 'base/crack' mixed

with tobacco in 'joints' in recreational and nightlife settings. The result of such changes may weaken the taboos against 'base/crack' smoking, which have existed and which have been providing informal controls to prevent diffusion of crack into mainstream recreational drug culture. These signs of erosion in informal social controls over the use of 'base/crack' cocaine make early response all the more urgent.

A positive utilitarian, and 'up-market' image of cocaine powder and perhaps also of cocaine 'base/crack', combined with the existence of affluent potential consumers, could lead to a diffusion of cocaine use in the EU, including 'base/crack'. This potential for diffusion should be treated with caution as biased news coverage about 'base/crack' can lead to the construction of myths about its use, which may divert attention from persistent structural problems facing some inner city areas (9).

Sources

(National focal point reports, 2000)

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Infectious diseases

Prevalence and trends

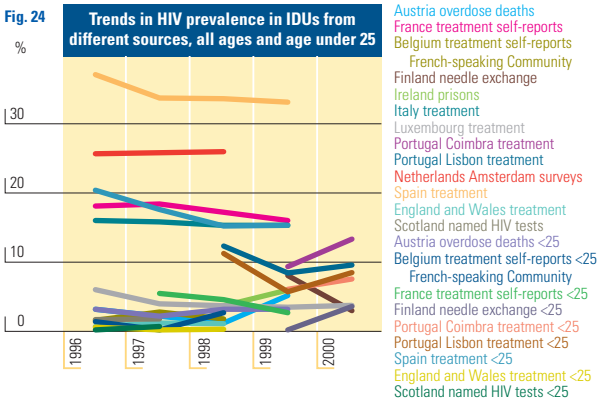
HIV

The prevalence of HIV infection differs much between countries — and within countries, between regions and cities. Although divergent sources and data-collection methods make comparisons difficult, available data indicate average levels of infection among different subgroups of injecting drug users (IDUs) that roughly vary from about 1 % in the United Kingdom to 32 % in Spain (see Figure 8, Chapter 1).

HIV prevalence seems to have stabilised in most countries since the mid-1990s after the sharp declines that followed the first major epidemic among IDUs in the 1980s (see Figure 24). In some countries (Austria, Luxembourg, Ireland, the Netherlands, Portugal and Finland) transmission may again be increasing among subgroups of IDUs (See box on page 16, Chapter 1).

Recent transmission may be clearer if one looks specifically at prevalence in IDUs aged less than 25. HIV infections in this group must have occurred on average more recently, as most IDUs start injecting at between the ages of 16 and 20 (1, 2). The trends in this age group, as far as data are available, are more marked than general prevalence and sometimes even in the opposite direction. In Finland, for instance, a large outbreak occurred in 1998–99, as can be seen from HIV notifications data (Figure 25). After 1999, overall prevalence declined, as indicated by data from needle exchanges (Figure 24); however, prevalence in young IDUs increased from 0 % in 1999 to about 4 % in 2000. This might indicate that once new infections among older injectors began to decline due to saturation (most persons at risk have become infected) and/or behaviour change of those at risk, new infections mainly took place among younger injectors, who often have higher levels of risk behaviour.

Fig. 24 **Trends in HIV prevalence in IDUs from different sources, all ages and age under 25**



Sources: National focal points. For primary sources see complementary statistical tables at http://www.emcdda.org.