Mainline Needle Exchange
Cocaine Assessment Report

This project was made possible through the funding and support of Health Canada, Population and Public Health Branch, Atlantic Region, AIDS Community Action Program (ACAP). The views expressed herein are solely those of the authors and do not necessarily represent the official policy of these agencies.

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Copywrite: April 2004
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ACKNOWLEDGEMENTS

Mainline Needle Exchange would like to thank the following:

Michael Mantley, Project Coordinator, for his commitment to the project, and for hanging in there.

Dale Dove, Kathy Boudreau, and Be Arsenault, Project Assistants, for their time and support of the project.

The Cocaine Assessment Report Advisory Committee Members, representing the project's Core Partners, for their keen sense of interest and nearly 100% attendance at meetings! Thanks to Marion Flint, Mainline Needle Exchange; Donnie Bennett, Direction 180; Michelle Proctor-Simms, Nova Scotia Commission on AIDS; Gail Baurley, Corrections Services Canada; Linda Grandy, Stepping Stone; Dorothy Paterson, The Ark; and Meredith Kratzmann, School of Health and Human Performance, Dalhousie University. In addition, we would especially like to thank the clients of Mainline who sat on the Advisory Committee and gave so much just by being around the table and sharing with us their experiences and insights.

Meredith Kratzmann of the School of Health Human Performance, Dalhousie University, who was not only a board member, but the evaluator and writer of this report. Thanks for her full commitment to the project from beginning to end.

And last, but by no means least, many thanks to the participants who let us into their personal lives and shared with us for these precious moments. Had it not been for their courage to tell their stories and share their strengths and weaknesses, this project would not have happened.

As the Project Coordinator, I would also like to offer my special thanks to Diane Bailey, Program Director of Mainline Needle Exchange, for believing in me and encouraging me throughout the project. It was a privilege and honour to have the opportunity to work on this project – Thank you very much.

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4 pop. 31.7 million
2.22 million
caine users

SECTION 1: INTRODUCTION

> **Cocaine**
> For the purposes of this report, the term cocaine is used to refer to cocaine and its derivatives, including powdered and solid forms of the stimulant. It also refers to cocaine administered by any route, including snorting, smoking and injecting. Therefore, the term cocaine will generally be understood to refer to cocaine *and* crack.

Although cocaine use is often associated with the late 1970s and 1980s, it has actually been in use for centuries[1]. It was not regulated in Canada until legislation was introduced in 1905[1]. Today it is difficult to estimate the rate of cocaine use given its illicit nature. Furthermore, many cocaine users are difficult to identify as they may be homeless or transient[1]. Estimates from the mid 1990s suggest that the rate of cocaine use is approximately 0.7% of the population of Canada and that this has remained relatively unchanged since the late 1980s[1]. This reflects similar estimates from the United States as well[2]. However, it should be noted that the rate is higher among different subpopulations, such as adolescents, Aboriginals, African-Canadians and street youth[1].

The use of cocaine has increased with the development of 'crack' cocaine, a cheaper rock form of cocaine made with common household products[3]. Crack is almost pure cocaine[3]. The powder form of cocaine can be snorted or injected, and the rock form can be injected or smoked[1]. Injecting and smoking cocaine reportedly allows for a more immediate high, but this high may not last as long as the high from snorting[1]. This could mean that users will use more often as the high wears out when using crack. Abusers with a heavy habit may use upwards of 5 to 10 grams per day.

The possibility of injecting cocaine means there is an increased risk of transmission of communicable diseases, such as HIV/AIDS, Hepatitis C (HCV), and tuberculosis (TB). The frequency of injection needed to maintain the high can further increase such risks[4]. The risk of contracting these diseases may also be increased by other high-risk behaviours associated with cocaine use, socio-economic factors, and a lack of comprehensive health and social services targeting high-risk cocaine users[5]. In fact, increasing rates of HIV/AIDS and HCV in Canada is associated with cocaine use among Injection Drug Users (IDUs), particularly in urban centres[1]. Additionally, TB rates among crack users in Toronto are estimated at about 8%; this is compared to relatively stable rates among the general Canadian population of only 6.9 to 7.4 cases per 100,000[5]. The increased risk of TB use among users may be associated with: needle use, high rates of HIV/AIDS infection, poverty, homelessness, malnutrition, lack of health and social services, and environmental conditions in crack houses, shelters, poor quality housing, and squats (e.g. poor ventilation, overcrowding)[5].

Those who inject cocaine may use vinegar or lemon juice to mix with the cocaine in order to allow it to be injected in fluid form[6]. This can be very harmful to veins, and in extreme cases could cause abscesses. These fluids may also contain fungi or bacteria, contributing to increased risks for infections[6]. Finally, overuse of certain veins can lead to collapsed veins and circulatory problems[6].

Smoking crack can contribute to significant respiratory problems, including shortness of breath, chronic cough, asthma, bronchitis and pneumonia[5]. In extreme cases, smoking crack can lead to internal bleeding in the lungs, causing users to cough up blood or black phlegm[5]. Respiratory problems may be associated with metal screens (often fashioned from Brillo pads) used in crack pipes[5]. The metal may melt or break apart due to the high heat used when smoking crack, and may be inhaled by the user, leading to internal damage and bleeding[5].

Cocaine use can cause many other physical side effects, including general physical and health failure, heart palpitations, energy loss, swallowing problems, insomnia, respiratory distress, sore throat, unconsciousness, nose bleeds, nasal damage, constant teeth grinding, sinus problems, voice problems, trembling, seizures, nausea and vomiting[1,2,3]. Cocaine abuse can also contribute to a weakened immune system, a particular concern for those living with HIV/AIDS. Additionally, there may be psychiatric effects, including suicidal behaviour, anxiety, irritability, depression, memory loss, blackouts, paranoia, panic states, delusions, poor concentration, compulsive behaviour, and loss of interest in friends, appearance, and non-drug related activities[1].

Harm reduction programs have been implemented in communities across Canada in order to provide services and supports to reduce the harms that are associated with drug use. Harm reduction is an approach to drug use that seeks to minimize the risks and severity of the consequences of use[7]. Harm reduction also includes the goal of providing accurate information and education on the consequences of drug use and safer practices that drug users should be aware of for reducing their risks[7]. Most importantly, a harm reduction approach emphasizes acceptance and understanding of drug users[7]. Priority is placed on accepting a user where they are at and helping with their most immediate needs.
Some examples of harm reduction programs include: needle exchanges, to provide clean needles and dispose of dirty needles; safe injection sites, to offer a clean, supervised space for drug use; and Methadone Maintenance Therapy (MMT), to offer a less harmful alternative to opiate use. Safe crack kits can also be offered to cocaine users in order to reduce harms associated with cocaine use. The kits often contain clean drug paraphernalia (i.e. syringes and/or pipes), vitamin C as an alternative to vinegar for melting down the crack, and tips and information on safer injection practices. Harm reduction programs maintain the ultimate goal to encourage users to stop using, however, emphasis is put on accepting that some may not be ready or at the point of stopping. Instead, more immediate needs may be for education, information, and tools for reducing harms.

Needle Exchange Services A needle exchange is a harm reduction program intended to reduce the risk of acquiring or transmitting blood borne pathogens such as HIV/AIDS or Hepatitis C. This is done by providing clean needles to users, collecting used needles and disposing of them in a safe manner, and sharing information and attempting to educate their clients on other safer practices, such as condom use, injecting with others rather than by alone, and the benefits of reducing or ending use. Needle exchanges often provide an initial first contact with formal services for drug users, and can become an essential link to treatment and other services (e.g. health care, shelter, community organizations).

COCAINE USE IN NOVA SCOTIA

Cocaine has been available and in use in Halifax for several decades, and for some time and to some degree was considered a "rich man's drug"[8]. Originally, cocaine was typically snorted rather than injected[8]. However, by the early 1980s cocaine became more accessible on the street and 'free-basing' became more common[8]. By 1985 crack cocaine became available, and popular, and the issue of cocaine use in Nova Scotia became an increasing concern[8].

The Mainline Intravenous Needs Assessment report (1995)[8] suggested that crack is the biggest drug problem in the metro Halifax area with an estimated 4,000 to 6,000 crack and IV cocaine users. The report found pockets of users in Dartmouth, Sackville, Spryfield, and Halifax, and stated that, "possibly 1,000 of these users are career addicts, spending 24 hours a day, 7 days a week searching for or using cocaine" [8]. Today, Mainline Needle Exchange staff estimate that 90% of users accessing the fixed site location in Halifax are cocaine users. Furthermore, it is estimated that 75% clients receiving methadone maintenance treatment are using cocaine, and an even greater number of cocaine users are not accessing services.

The Canadian Community Epidemiology Network on Drug Use (CCENDU) reported that in 1996 the rate of cocaine use among adolescent students in Halifax was among the highest in Canada at 4%[9]. Similar rates were reported for Vancouver (4%) and were only higher in Montreal (6.1%)[9]. It must be noted that these rates likely highly underestimate the true rates of cocaine use among adolescents as they are based on self-reports from students in attendance at a school at the time the data was collected. Many students may not report their use, and others may not be present at school. For instance, the rate of cocaine use among street youth, who may not be in attendance at school, is much higher[1,9]. Data from 1991[i] show that 33% of street youth in Halifax reported cocaine use, and 20% reported crack use[10]. In some cases the youth may come to Halifax from rural parts of Nova Scotia seeking more services and treatment options, only to be exposed and enmeshed within a broader urban drug scene[11].

Although cocaine is not widely used by the general population, it causes the greatest amount of harm related to illicit drug use[12]. In Halifax, the use of cocaine is associated with an increase in violent crimes[13], and drug enforcement efforts and drug related crimes are primarily associated with cocaine use[12]. Common criminal activities related to cocaine use include mugging, armed robbery, and prostitution[8]. Cocaine-related murders since 1985 number up to a dozen, and this does not include fatal overdoses[8]. Cocaine is reportedly the most common drug of choice among service users at agencies working with offenders and sex trade workers[12].

COCAINE USE AND METHADONE

Recently, concerns have emerged regarding cocaine use among methadone maintenance treatment (MMT) clients. Some research suggests that MMT can be effective not only in reducing opiate use, but also the use of other drugs, including cocaine[14]. Other research

[i] More recent data for Halifax is not available at this time.

has shown moderate, non-significant decreases in cocaine use following MMT[15]. However, qualitative studies and reports from MMT providers in Europe have indicated that clients receiving MMT may develop *greater* problems with cocaine following initiation of treatment[16]. This may be associated with having more money available for cocaine because they do not need to purchase opiates[16]. Clinical research suggests that the high from cocaine may be enhanced by MMT based on some physiological indicators (i.e. higher skin temperature, lower respiration rates and pupil diameter) and subjective ratings by the research participants[17].

Methadone Maintenance Treatment (MMT) MMT is another harm reduction program that seeks to reduce the risks associated with injecting drugs and opiate use. Methadone is a synthetic opiate that is prescribed to replace other opiate use. Using methadone can reduce withdrawal symptoms and can be used over a long-term treatment plan to gradually wean an opiate user off of opiates.

The literature on cocaine use and MMT appears to be in debate and without any clear answers. The reality, however, experienced in MMT clinics may be clearer. It is estimated that 75% of community based MMT clients in Halifax are using cocaine. Furthermore, clients have expressed concerns around their use of cocaine and a need to understand why they are using as much, or more, cocaine after initiating treatment. Some clients have reported that they never used cocaine prior to starting MMT. While some feel they need to withdraw from MMT to control their cocaine use, there are other clear benefits to such treatment. Benefits include moving some users out of the drug scene, reduced opiate use and harms associated with injecting opiates, and reduced incidence of nonfatal overdoses, sex trade work, and incarcerations[15].

PURPOSE AND APPROACH

The purpose of the Cocaine Assessment Report was to develop a profile of the high-risk cocaine using population in Nova Scotia in order to gain greater understanding of this population and explore strategies that will assist in the enhancement or development of appropriate services. The study was conducted using a participatory approach that involved the target population (high-risk cocaine users).

Using a participatory approach means engaging in a study process that involves the collaboration of those affected by the issue[18], in this case the cocaine using population in Nova Scotia. This approach is usually used for the purposes of mutual education and taking action to affect change[18].

SECTION 2: METHODS

In order to develop a profile of the high-risk cocaine using population in Nova Scotia, this study used mixed methods to collect quantitative and qualitative data. An advisory committee was formed to guide the study process, including the development of the data collection tools, the data analysis, and dissemination planning. The advisory committee included participation from the cocaine using population, and partner organizations,

which were: Direction 180[ii], Stepping Stone[iii], Correctional Services Canada, the Nova Scotia Advisory Committee on AIDS, the School of Health Human Performance at Dalhousie University, and the Ark[iv]. The advisory committee met frequently throughout the project at Mainline Needle Exchange, particularly during the initial phase of the project while the tools were being developed and initial data was collected.

As the study sought to contribute to the improvement and provision of services for the cocaine using population, it was important to provide information and educational material to the target population on the risks of cocaine use, as well as safer practices and treatment options. The need for such information has been identified by the target population through informal communication with the staff at Mainline and Direction 180. Therefore, throughout the study relevant literature and information were collected and made available to clients of the fixed site needle exchange and partnering organizations.

QUANTITATIVE METHODS

A 17-item questionnaire was developed to collect information on the cocaine using population (see Appendix A). The questionnaire included questions regarding age, gender, drug and treatment history, safe drug practice, immunization and testing, and information needs. Recruitment occurred mostly through word of mouth among the contacts of the advisory committee members. This meant that many of the participants were those actively seeking treatment from one or more of Mainline and the partnering organizations. However, the staff at Mainline, and many of the advisory committee members, are well-known among the drug using community and efforts were made to recruit known cocaine users who may not regularly access the services of Mainline or the partnering organizations. Specific efforts were also made to recruit younger participants, rural participants, and users who were incarcerated at the time of the study.

In order to participate, the respondents had to be actively using cocaine at the time of the study and cocaine had to be their main drug of choice. In total, 75 self-reported cocaine users completed the questionnaire. Participants were provided with a $10 honorarium to compensate them for their time and participation in the study.

The project coordinator administered the questionnaire in order to help with any literacy or comprehension problems. The coordinator also took notes on any other issues that were discussed and questions or concerns raised by the participant. The notes were used in developing the interview guide used for qualitative data collection.
The data was entered into a spreadsheet to assist with the management of the data. Descriptive statistics were generated for developing a demographic profile of the target population.

[ii] A community based, low-threshold methadone maintenance treatment clinic.
[iii] An organization serving sex-trade workers.
[iv] An organization serving street youth.

Qualitative Methods

In-depth, face-to-face interviews were used to collect qualitative data from cocaine users (see Appendix B). The interview guide was developed with the assistance of the project advisory committee. The interview guide included questions regarding 5 key issues: the participant's childhood, drug history, experience with treatment and other services, health issues, and thoughts and needs for enhanced services for cocaine users. Two pilot interviews were conducted in order to test the questions, confirm the appropriateness of the questions, and identify any missing questions.

In total, 25 interviews were completed. Participants were purposefully selected in order to ensure the diversity of the sample. Participants were selected to ensure representation from Caucasian, African Nova Scotian, and Aboriginal communities; males and females; community-based and incarcerated individuals; and those using cocaine and receiving MMT. Participants were recruited with the assistance of the advisory committee, and by word of mouth among the cocaine using population. Participants were provided with a $40 honorarium to compensate them for their time and cover any costs associated with attending the interview, such as transportation or child care expenses. Prior to initiating the interview the participants were read a pre-amble and signed an informed consent form (see Appendix C).

The project coordinator and project assistant conducted all interviews. Both interviewers used a form developed for the interview to record notes and observations throughout the interview. The interviews were audio-taped to assist with analysis of the data. The tapes, interviewer notes and transcripts were analyzed using content analysis to identify key issues and trends for each of the 5 main lines of questioning. Once the key issues and trends were identified, the data were reviewed for disconfirming and alternate trends.

Dissemination and Information Sharing

One of the meetings of the advisory committee was devoted entirely to developing a dissemination strategy for the cocaine assessment report. The strategy identifies target audiences, the information needs of the audiences, and tools and actions needed to reach the audiences (see Appendix D for a summary of the dissemination strategy).

The goal of dissemination is to enhance existing services in Nova Scotia for the cocaine using population. The main objectives are to increase awareness of the profile of cocaine use in Nova Scotia and the key issues emerging from the findings, advocate for action to address issues related to and underlying cocaine use and the causes of substance abuse, and make materials and information available on the issues of cocaine use.

In order to reach the identified target audiences, the cocaine assessment report will be printed and shared with partnering organizations, other community based and social service organizations, appropriate government offices, and anyone else requesting a copy. A short version of the report, presenting key issues emerging from the findings, will be shared with all of the target audiences. Finally, an information session will be hosted by Mainline to provide a summary presentation of the report, as well as information on other

relevant issues, such as methadone maintenance treatment and other drugs. Invitations will be sent to the target audiences, organizations, agencies, and groups identified by the dissemination strategy.

The staff at Mainline and the project's partnering agencies will also share the findings of the cocaine assessment report more informally. The findings are shared on a daily basis among the target population at Mainline, as well as through outreach to client populations throughout the province. Furthermore, the staff of these organizations are represented on many committees and groups throughout the province that are relevant to programming for drug using populations, such as the provincial Prevention of Blood Borne Pathogens Project Advisory Committee. The staff can ensure that the knowledge and information gained through this project are considered in decision-making regarding relevant programs and services. Additionally, staff at Mainline engage in public education efforts with community organizations, schools, public health nurses and services, hospitals, and police to increase awareness of issues related to injection drug use. The findings of the cocaine assessment report will be incorporated into this educational work.

SCOPE AND STUDY SAMPLE

One group that may be particularly under represented in this study are younger users. This is reflective of the primary clientele of the partnering organizations, and of the tendency for users not to seek treatment or services until later in their addiction. That is, many younger users may not be seeking services, such as those provided by the partnering organizations, because they may not have been using for as long or consider their use problematic. This may be a definite limitation of the study, given the knowledge that cocaine use is particularly prevalent among street youth. However, the findings of this study will add to our understanding of the needs of the cocaine using population and contribute to the enhancement of services for users. In this way, the partnering organizations may build their capacity to meet the needs of cocaine using street youth and identify creative ways of reaching out to this vulnerable community.

In addition, the scope of the study was primarily limited to users living within the Halifax Regional Municipality of Nova Scotia, and therefore may be more reflective of cocaine use within an urban setting. The study may have missed out on the pockets of known drug users in rural parts of Nova Scotia that may also be involved in cocaine use. However, the majority of the study participants were not originally from the Halifax area. This may reflect trends toward urbanization, the tendency of users to migrate to urban areas for greater access to services or drugs, and/or the increased risk of involvement with drugs in urban areas.

Finally, the focus of this study is on 'high-risk' cocaine use, therefore it is also important to note that most of the participants in this study reported smoking and/or injecting crack cocaine or cocaine, as opposed to snorting. Given the rapid uptake of the drug through these methods, it is possible that their experiences may differ from those who snort cocaine and do not inject or smoke.

SECTION 3: FINDINGS

SURVEY FINDINGS

PARTICIPANTS

In total, 75 self-reported cocaine users completed a survey with the project coordinator. Although the participants varied in age, 86.6% were over 30, 12% were between 20 and 39, and only 1 was under 20. Among the participants, 68% were male and 32% were female. The majority of the participants had been using cocaine for more than 10 years (60%), which likely reflects the age of the majority of the participants being over 30. Another 17.3% had been using between 6 and 10 years, and 21.3% had been using for 5 years or less.

TREATMENT

Just over half of the participants (52%), were on methadone for treatment purposes at the time of the study. All of them (100%) were actively using cocaine while also receiving methadone. Of those on methadone, 92.3% had been in treatment for 5 years or less, while only 7.7% had been in treatment for 6 to 10 years. None had been in treatment for more than 10 years.

Most of the participants (88%) had been in some form of treatment before, while 12% of participants had never received any treatment. Different treatment programs included detox (42%), 28-day inpatient programs (48%), 5-day inpatient programs (25.3%), and self-help groups (e.g. Narcotics Anonymous, 25.3%). Some participants reported involvement in two or more different treatment programs.

HARM REDUCTION PRACTICES

Over three quarters (76%) of the participants reported using needles to inject drugs, including cocaine. While the majority of those using needles reported that they do not share needles (68.4%), nearly 1 third reported that they do share needles (31.6%). Most of those who reported that they do share needles qualified their responses by stating that they shared only under certain circumstances (e.g. while incarcerated), or with certain people (e.g. their partner).

Regular condom use was reported by 70.7% of the respondents, while 29.3% reported that they do not regularly or always use condoms. Once again, many who reported not using condoms indicated that they do not use condoms with their partner or when they are in a relationship. Nearly all of the respondents (96%) reported that they have been tested for HIV/AIDS and Hepatitis C.

INFORMATION NEEDS

Half of the participants indicated that they would like to know more about how to inject safer, while the other half reported that they are aware of safe injection practices. 65.3% reported that they would like more information on safe sex. Many more of the respondents (81.3%) indicated that they would like to be provided with information on

safe crack kits and safer crack use. Almost all of the participants (93.3%) indicated that they would like to see safe injection sites made available in Nova Scotia.

INTERVIEW FINDINGS

CHILDHOOD AND EARLY LIFE

Family life

Most of the participants felt that their family life, including the relationships that they had with their parents and siblings, had an influence on who they are today. Only a very few participants reported having a "good" family life because their "parents were around", there was no drug or alcohol use present in the home, and their relationships with their parents and siblings were positive. Despite their reportedly good homes, the participants still indicated severe addiction problems that evolved out of other influences, namely their peer group or emotional issues.

In contrast, the rest of the participants reported less positive family lives. Two different types of family experience emerged from the participants' discussions. About half of the participants reported what they referred to as "dysfunctional" or difficult families. The other half reported that they had a "good" family, but there were certain issues or events that had a negative impact on their childhood.

Difficult and dysfunctional family

Many of the participants described dysfunctional families or a very difficult home life. For some, this involved active and open substance abuse by one or both of their parents or other adults in the home. Others reported physical, emotional, and/or sexual abuse by a parent, sibling, or other adult in their life. Some participants also reported very difficult relationships between their parents, themselves and one or both of their parents, and/or themselves and their siblings.

> *"I was put in a home when I was 6, then I got adopted... While I was with them I got all kinds of material things but not loved enough to be a daughter of their own...he was a molester, he started molesting me and all that stuff. And that's when I started doing drugs, when I was 8."*
> *~female user*

In some cases the participants reported a particular event early in their childhood that preceded the breakdown of their home life. Such events included a difficult divorce or being taken from the natural parents and placed within the public childcare system.

Good family, but...

Many of the participants described what they felt were relatively good homes, but homes that had certain difficulties or problems that impacted on their childhood. For instance, some of the participants reported substance use by one or both of their parents that was open and active within the home, but indicated that the parent(s) were sure to pay the bills

> *My childhood, it was a good one, I come from a good family...It was good in some ways and bad in others. They used to argue a lot, my parents, because they were mismatched.*
> *~ male user*

and put food on the table before they started using. Some participants also reported relatively good homes, but difficult or strained relationships within the home, such as parents who constantly argued or having an absent father who was rarely around, either physically or emotionally. Finally, a few participants reported a generally good home until a specific event, such as the death of a parent, divorce or parental job loss.

> *My parents divorced when I was 9 years old, and at that time it felt like nothing mattered.*
> *~female user*

School and friends

While some of the participants reported doing well in school and being active in the school community, the majority reported difficulties in school. Not surprisingly, all of the participants that reported a dysfunctional or difficult home life also reported having great difficulties in school. Many such participants indicated that the difficulties in their home interfered with their school life, making it difficult for them to concentrate at school.

> *I never failed a grade in my life, but [in high school] I didn't do as well, my grades started to deplete ...I would always pass because I knew what the pass mark was, but I would just make the pass. Just making it...I ended up getting kicked out of school for fighting the principal.*
> *~ male user*

Most of the participants reporting difficulties in school indicated that the problems did not begin until later grades, either in junior high school or high school. Interestingly, none of the participants finished school as a teen as they were either kicked out of school, dropped out on their own, or had to leave due to pregnancy.

The difficulties experienced in school seemed to be related to poor academic achievement, social problems, or both. Some reported just having a hard time in school and not being able to achieve well or do as well as other students. Others indicated that their problems with school were more related to social issues. They referred to themselves as a "bully" or a "troublemaker", or indicated that they had problems with adults or people with authority. Although not all of the participants reported drug use as a child or adolescent, most did and indicated that their drug use interfered with their schooling and education.

> *No school wanted me at the age of 15 because of being a trouble-maker. I always felt nobody had any time for me, and it made me very angry.*
> *~female user*

For many of the participants, their difficulties in school were not unrelated to their friends and social circles. Many reported hanging with "the wrong crowd" or hanging with older kids who were involved with alcohol, drugs or crime; issues their own peers were not yet involved in or experimenting with. Others reported not having many friends, being a "loner", or having few "real" friends.

> *Well I had certain friends, you know I used to be a loner and traveller. You know, hang with nobody but hang with everybody.*
> *~female user*

DEVELOPMENT OF DRUG ADDICTION

The majority of the participants started using drugs at a young age, ranging from pre-adolescence to mid teens. However, a few of the participants did not start using drugs until they were much older. Five different patterns of the development of a drug addiction

appeared to emerge from the interviews. The patterns were not necessarily mutually exclusive; some participants may have described a drug history that encompassed elements of various patterns.

Gradual progression and curiosity

Many of the participants described their addiction as developing gradually over their teen years. The pattern of progression among this group of participants was very similar, usually beginning with alcohol and tobacco, and then progressing to illicit drugs. Marijuana was typically the first illicit drug to be experimented with, followed by harder drugs, such as LSD, mushrooms, speed, mescaline, and by their late teens cocaine, heroin and other opiates. For the participants describing this pattern of use, their motivation for drug use was usually related to the desire to experiment, curiosity, and to fit in and "be cool."

> *We moved to a certain neighbourhood when I was 9 and the kids...all hung in a little group, and that's how you done stuff, to stay with the gang...be one of the boys. Then I ended up drinking and smoking cigarettes...that's when we were like 13 or 14. And, you know once a week on Friday or Saturday night, and uh, started not doing schoolwork and stuff and next thing you know I'm dropping out of school and I'm doing harder drugs.*
>
> *~ male user*

Drug environment

Several of the participants indicated that their drug use emerged out of the environment that they were in. For some, one or both of their parents were heavily involved in alcohol and drugs, and they just eventually started using as well. Others indicated that they had been on their own from a young age and were constantly around drug use on the streets. One participant reported that she had not started using drugs until she became involved and lived with a heavy drug user whose friends (also heavy users) were always at their place.

Late starters

Some of the participants reported a relatively late start to using drugs. Each of them were in their 20s or 30s before they began to use drugs extensively. A few of them reported that they had used alcohol or tobacco in their teens, and may have experimented with some drugs. However, for this group of participants it was years after any initial experimentation or casual use that they began to use hard drugs, including cocaine and opiates.

Tylenol, Seconal, anything at all

Some of the participants described a pattern of drug use that included trying anything and "everything under the sun." For these participants the motivation was to feel the high, see how it compared to other highs, and try to reach a new high. While the participants reporting this pattern of use may have started by using tobacco, alcohol, or marijuana, there really was no progression to other drugs, as with the first pattern described.

> *My first use was at 13 or 14, marijuana and alcohol. And then I started IVing Dilaudid. And I was doing Valium and Percodan and Percocet...Demerol. Everything I could get my hands on. And cocaine, powder or crack.*
>
> *~ female user*

Rather, their drug use was dependent on what ever happened to available.

Medical condition

Several of the participants' addictions occurred as a result of prescribed medications for medical conditions. In each case, prescribed painkillers lead to an opiate addiction. To meet their growing need for opiates the participants reported turning to the street to get more or stronger opiates. This eventually lead to the use of other drugs, including cocaine.

> *[So now] I'm treating my illness outside of the hospital because it's illegal but I like what the euphoria does, it takes my [pain] away, but as well I like the feeling it gives me.*
> *~ male user*

ONGOING DRUG USE

Motivation for Using Drugs

The participants discussed their motivation for using drugs at the time that they began to use regularly, and 7 different motivators emerged. They were to "fit in" or "be cool"; for the feeling or the "high"; to feel confident, safe and secure, "like superman"; to deal with physical pain; to mask emotional pain or "hide the hurt"; because of boredom; and because it was there, "all around me." While the different motivators encouraged the participants in the beginning, many indicated that the motivation changed as they became addicted and dependent on drugs. For many, using appeared to no longer be enjoyable; the only purpose for using became motivated by need.

> *After about 10 years I was working on the streets, then it got to be a drug. Then I gotta work just for the drugs, it wasn't fun anymore... It was just a disease. Like, I had to have it because my body needed. I didn't like it anymore.*
> *~ female user*

Based on the participants' discussions, several common "triggers" emerged. Triggers are those things that make a person want to use or that cause the urge to use. Common triggers included certain friends, certain environments, a ritual, needles, and boredom.

Clean Time

Most of the participants reported points in time where they had stopped using drugs. Usually this was facilitated through a drug treatment program or detoxification, but often participants reported doing it on their own. For some, being "clean" was only for a matter of a few days or weeks. Sometimes short periods of sobriety (i.e. a day or two) occurred if they were in local prison over night or for one or two days pending a court date, transfer to a provincial or federal prison, or release. Others reported longer periods of no drug use, or limited drug use, lasting from several months to several years. The participants discussed the things that worked for them during these periods and helped them stay clean. They also discussed what did not work for them. Overall, the participants agreed that you had be want to be clean and had to be "ready" to do it.

> *I wasn't ready for a drug program. That is why I got nothing from them. Not their fault, it was because of me.*
> *~ female user*

What worked?

Most of the participants who reported a clean time talked about having a certain "incentive" to stop using or "something to look forward to." The most common "incentive" that appeared to help the participants stay clean for a certain period of time was a positive relationship. In some cases this was an intimate relationship with a man or woman, while in others it was with family or a particular family member. Similarly, a common helpful factor was to remove oneself from those relationships that involved drug use. Many talked about not "hanging around" with the usual people, staying home rather than going out, or moving to a new area away from their usual hang outs.

> *I had 6 months clean time once... I was living by myself, I wanted to get it together. And I felt good about myself and me and my family was starting to get along. And my mother, I reconciled with mother, before she died she forgave me*
> *~ female user*

Having a job also appeared to be helpful for some to remain clean. However, often a job was not enough on its own. Instead, having a job as well as a positive relationship and/or going to support groups and meetings was what worked. While support groups and meetings, such as Narcotics Anonymous, worked for some, it did not work for others. Some indicated that in such meetings there was so much talk about drugs and how they make you feel, and experiences that were had with drugs, that they often left wanting to get high.

Being in a controlled environment also helped some to remain clean for a certain period of time. This included being in prison, in a residential treatment program, or being on parole. While drugs were still often accessible in such environments, it appeared to be the combination of being in a more controlled environment and feeling strongly motivated to stop and/or having other supports in the form of relationships or support groups. Several participants indicated that detox programs were helpful for getting cleaned up.

> *I stopped for a period of time because I got sick of it. I got sick of using, and being on parole helped a lot.*
> *~ male user*

What didn't work?

The factors that did not work are the factors that lead the participants back to using after they had been clean for a certain period of time. Each of the factors appeared to be related to relationships. Usually this meant going back to hang around with the same friends or in the same environment again, where using is common. In some cases, participants indicated that they started using again because of a very negative relationship involving abuse or the loss of a positive relationship.

Interestingly, while some indicated that drug treatment programs had helped, most suggested that they found them ineffective. They indicated that the programs were often under-staffed and they appeared to care little for the clients. Those who had been

involuntarily sent to a treatment program indicated that it was completely ineffective for them because it was not their decision.

For those who had found a controlled environment helpful, such as prison or inpatient treatment, some indicated that being released from such environments was dually unhelpful. Upon release they were returned to their old environment and old friends, lacked supports to remain clean, and/or lacked resources and opportunities to make necessary changes to remain clean.

Another common trigger to go back to using was just the desire to use; the addiction. Many indicated that they tried but just "couldn't stop using." Many of the participants indicated that "boredom" was a big factor in their return to using. This was particularly the case for those who reported only short periods of not using. They indicated that they had nothing else to do, no job, no one to hang out with who was not using, and/or no money to do something else. As result of being bored, they started using again.

> *Oh I'm addicted, but boredom kicks in... boredom is a contributing factor... If you're sitting around the house all day doing nothing, nothing, you know what I mean, and someone phones you up... 'why don't you come over, I got some,' you're running...*
>
> *~ male user*

Finally, several participants reported using again as a result of a negative or traumatic experience. In several cases this was due to the death of someone very close or important to the participant. In other cases, it was the result of something bad happening to the participant or someone they care about, such as loss of employment, abuse or rape.

Mental Health and Well-Being

Emerging from most of the participants discussions were issues related to mental health. Many of the participants indicated that they used drugs to mask certain emotions, to hide pain or to avoid feeling anything all together. The participants often spoke of "depression," "paranoia," "hurt," "boredom," and "suicidal thoughts." Such emotions were described throughout the interviews, relating to the reason for using, the implications of using, the impetus for cleaning up, and the cause for relapsing. While this is not to suggest that all of the participants have mental health issues, it clearly indicates that mental and emotional well-being may, for some, be intimately intertwined with addiction. Interestingly, very few reported receiving any formal treatment or attention for an emotional or mental indication. As well, one participant actually reported being denied drug treatment services because of mental health issues.

COCAINE USE

Although this study was focusing on the participants' use of and experiences with cocaine, it became quite clear that it was not just the one drug that makes up their addictions. All of the participants discussed their use of many other drugs, often at the same time.

> *I mean, cause it's getting tiring for me. Last week I wanted to kill myself from this cocaine shit... I was suicidal, like it can put you places where you don't want to go.*
>
> *~ male user*

"I was a walking coke zombie"

Despite the varied cornucopia of drugs, the participants did indicate specific issues that differentiated cocaine from their experiences with other substances. Many described it as a "crazy" drug, a "nightmare." Perhaps most disturbingly, many of the participants discussed the negative impacts that a cocaine-high can have emotionally. They indicated that it could lead to severe "anxiety," "paranoia," and even to "suicidal thoughts."

> *Cocaine is a nightmare from beginning to end. You know, your first hit you want another one and then it's just like that until you stop basically.*
> *~ male user*

For most of the participants, their recounting of cocaine use was marred by negative emotions and experiences. However, they continued to use the drug and attributed this to its highly addictive nature. It appeared that for many of the participants initiating cocaine use represented a change in their experience of drugs. This seemed to be the case particularly for those who were older and had been using drugs for most of their adult life. They suggested that cocaine use was key to the worsening of their general drug addiction and of their general life circumstances; using cocaine appeared to take over their life. They reported using cocaine "24/7", and when they weren't using they were looking for it.

> *If I hadn't taken that first puff of the pipe I would be somewhere and someone else.*
> *~female user*

> *Any money I make will go right on the dope, crack. I just want that pipe.*
> *~female user*

Using needles

Many of the participants were injection drug users (IDUs), and therefore preferred to take cocaine through injection. For some of the IDUs it seemed that it did not make a difference what they were injecting, it was the needle that fuelled their addiction. It was very clear from among IDUs who preferred any drug if it was injected, that the needle was part and parcel of their addiction. In some cases, it was using needles, not cocaine, that was seen as the catalyst for their worsened addiction and life circumstances.

> *No man, I was an IV cocaine user... if it wouldn't go in the needle I wouldn't touch it.*
> *~ male user*

> *That was probably the end of using all other drugs. That just started a whole new life basically. And everything else was out of the picture. It was just needles, needles, needles. Everything else was just nothing.*
> *~ male user*

Methadone and Cocaine Use

I did more cocaine while on methadone because there was no other way to get 'high' because methadone blocks the opiate feeling.
~ male user

Most of the participants who were or had been in Methadone Maintenance Treatment (MMT) reported that their cocaine use increased. Participants indicated that methadone doesn't "take the pain away," or the need to get high. Some suggested that methadone makes you "numb" to the affect of drugs, but indicated that, "you always feel the coke, nothing has no affect on it."

It takes longer [to get high when on methadone], well I find it's a little more dangerous, but it takes a lot more to get high on cocaine, so you're using more.
~female user

For some of the participants, their use of cocaine while on methadone was a source of concern. Most of them indicated that they needed to use more cocaine in order to feel the high, and were therefore concerned about the effect this would have.

...like, the majority of the people going there were dually addicted. And if you're addicted for two things you know, you can't just take care of one without taking care of the other.
~female user

While many participants who were or had been in MMT indicated that it helped them to reduce their opiate use, they suggested that more supports may be needed to help those addicted to other drugs. Some participants reported that the methadone only helps with one addiction and does not treat the others, leaving them still in need of other drugs.

The impact of cocaine use

Relationships and opportunities

While some of the participants reported positive implications of their cocaine use, such as feeling more comfortable, feeling powerful, or hiding the feelings of pain or depression, most indicated more negative impacts. Cocaine had contributed to ruined relationships with family, friends and spouses. In several cases it lead to one's child or children being taken away. It had interfered with schooling, employment, and opportunities.

My last three sentences I did were directly related... to cocaine. If I wasn't wired on cocaine and out doing stupid things to get money to get coke, stuff that you'd never do if your mind was right... the sole reason is that I spent half my fucking life related to cocaine.
~ male user

Incarceration

Most notably, cocaine use inevitably lead to incarceration for drug related crimes. All of the participants indicated that they had spent time in prison specifically related to their drug use. They had not necessarily been imprisoned for possession or even trafficking, rather incarceration was most often due to crimes that were committed in order to get drugs or obtain the money to get drugs. Crimes included theft, fraud, and prostitution, among others.

At that point in my life I wanted to get high badly. I wanted to either die or go to jail, I went to jail.
~female user

For some of the participants, incarceration was an opportunity to stop using and get clean. This was particularly the case in

local prisons if one was locked up over night or awaiting trial, as it was indicated that there are rarely any drugs in such prisons. However, more commonly prison was a place where drugs were readily available and unavoidable for an addict.

Many of the participants expressed some disappointment in the prison system, particularly those who may have seen their imprisonment as an opportunity to get clean. One issue related to being released from prison, where they often ended right back where they were, in an environment of drug use. Another issue related more generally to society and the apparent stigma associated with having been imprisoned. Many felt that after release they had little opportunity for employment as an ex-convict.

> *They dump people back out into society with no esteem really, no education, criminal records. And like society couldn't, didn't accept me, once you get a record...*
> *~female user*

Health and Well-Being

Clearly there were health implications as a result of the participants cocaine use. Several participants reported overdosing on one or more occasions. Often an overdose occurred after long periods of sustained drug use, where many different drugs had been used. Participants reported "binges" lasting for several days up to several weeks. These binges often included the use of many drugs and alcohol, with very little sleep or food for the course of the binge. If not ending in overdose, they usually ended because the user could not physically handle it anymore and it got to the point where they "need a break." Several of the participants reported particularly frightening incidents that had put them in hospital and had severe implications for their health.

> *I got an abscess in my throat and I almost died cause I didn't have anymore veins. The vinegar mixed with the cocaine killed all the veins in my arms and in my feet, and my legs and everywhere else... I had to go get an operation...when I snapped out of it the doctor came in and he talked to me and he told me 'I seen lots of abscesses as bad as that, but nobody with an abscess like you has lived to tell about it... And when he said that I got the shivers real bad and I knew he wasn't lying to me. I knew I almost, you know if I would've waited another 8 hours I probably wouldn't have gotten there at all.*
> *~ male user*

Many of the participants seemed aware of the health risks associated with drug use, particularly the transmission of blood borne pathogens. Most of the participants who were injection drug users indicated that they do not share needles, although many suggested that under certain circumstances they do. For instance, reflecting the findings of the survey, many reported sharing with their partners or while they were incarcerated. Sharing while in prison was very common as they reported that they do not have access to clean needles and there are no needle exchange services. However, other precautionary measures were reportedly used in prison, such as cleaning the needles with bleach, or using alternate disposable tips fashioned from tin foil.

Almost all of the participants reported to have been tested for HIV/AIDS and immunizated for Hepatitis A and B. While they were not asked about their specific health status, a few participants disclosed that they were HIV+ or had Hepatitis C, indicating that this was a very severe health implication of their drug use. Unfortunately, for at least

one participant the positive HIV status appeared very difficult to handle and was an indication that there was no hope and therefore no reason to stop using drugs.

THE ROLE OF MAINLINE

Respect and judgement emerged as key themes in regards to the participants' experiences with the various services and organizations that they access. Most of the participants indicated that in many services and organizations there is often very little "respect" for clients. This referred to services such as some treatment programs, detoxification, Community Services, Children and Family Services, and some health care services. Participants reported feeling that they were treated simply "as a number." They also indicated that they felt that often staff were "judgemental" and did not treat them well.

While this was the case for many services that the participants accessed, they suggested that Mainline and other peer-based, harm reduction organizations such as Direction 180 and Stepping Stone were "different." The organizations are staffed by people who have shared the experience of addiction and/or street life. The participants indicated that they felt more respected and cared for by such organizations. They also indicated that they felt more comfortable at Mainline because it is a "supportive" and familiar environment.

> *I think the staff truly truly care. And you know they're there for you if you need them, they're always there. It's a really good place, it's been a big help for me.*
>
> *~ male user*

> *Well Mainline's been helping me since day one. Since they opened... I could say I'm hooked on Mainline. My support is in Mainline. I give my support to Mainline, and I got my support from Mainline.*
>
> *~ male user*

ADDITIONAL SERVICE NEEDS

The participants were asked about what other services Mainline could provide to assist them with their cocaine and other drug use. Their responses have been organized into three categories: formal treatment services, social supports, and personal development opportunities.

Formal treatment services

Many of the participants indicated that formal treatment services would be helpful for themselves or others. This included one-on-one counselling, support groups, Narcotics Anonymous or Cocaine Anonymous, and expanded harm-reduction services. One-on-one counselling was the most common suggestion.

Participants indicated that just having someone there to talk to would be very beneficial. Some noted that this occurs informally, but that it would beneficial to offer it as an

> *There's only one thing that stands out, and that is that if they could have somebody on hand, and it doesn't have to be a professional. It just has to be... somebody who can identify."*
>
> *~ female user*

official service so as not to over-burden the front-of-the house staff at Mainline, who need to be present and available for anyone who comes in. Most generally indicated that a counsellor should be available both by appointment and on a walk-in basis, and that regular meetings, such as on a daily, weekly or monthly (depending on individual need), should be an option for those interested. The participants also suggested that the counsellor does not necessarily have to be a professionally trained drug treatment counsellor, just someone who can relate, a peer-counsellor.

While recovery groups were recommended by most of the participants, many qualified this by suggesting different options. For instances, there were suggestions for women's groups, men's groups, cocaine groups, and awareness groups. It was suggested that people have different needs and comfort levels and that a variety of support groups would be more likely to meet a diversity of needs. A few participants also recommended hosting NA or CA meetings at Mainline. Some participants felt that the groups should only be open to people who are sober (at the time of the group meeting) in order to be fair to everyone there. However, others suggested that the groups should be open to anyone who is looking for support at that time. The open-door policy was usually recommended because it was felt that there are other support groups available that are strictly abstinence based, and that support groups are needed for those who may be struggling with sobriety. Furthermore, while it was recognized that such groups are offered elsewhere, it was suggested that Mainline presented a central, safe, and comfortable location not offered by many other meetings that are held in less familiar environments.

> *It would be nice [to have support groups at Mainline] because there are some people, you know, they don't like to go down to detox and stuff like that because they like to be around, like their own environments.*
> ~*female user*

Finally, several participants recommended offering additional harm-reduction services. This included Vitamin C for IV users, which is less harmful than vinegar, as well as safe crack kits and more information on crack and cocaine.

Social supports

Many participants recommended offering various social supports, including a leisure room, a quiet or relax room, and activities. This was often raised in regards the boredom issue, suggesting that having activities or things to do that are accessible may help to limit drug use. Many recommended a leisure room that offered comfortable atmosphere, with couches and chairs, music to listen to, books and magazines, and games. Some also recommended a quiet or "relax" room where people could just relax, be by themselves, or sleep. A few participants also suggested having activities such as arts and crafts, exercise classes or organized outings.

Personal development opportunities

Almost all of the participants recommended offering various personal development opportunities. This included computer courses and internet service, employment workshops and job clubs, resume writing workshops, community involvement programs,

and other skills workshops. Some even suggested that they had certain skills that they could share with others.

SECTION 4: DISCUSSION AND RECOMMENDATIONS

PROFILE OF HIGH-RISK COCAINE USERS

Based on the results of the survey and in-depth interviews, several key issues have emerged regarding high-risk cocaine use. The key issues help to develop a profile of high-risk cocaine use, and what is needed to serve this population.

- Cocaine use is often only one drug used among many
- Users report multiple addictions, including addictions to licit, prescription drugs
- Cocaine use becomes a very negative experience for many users
- Cocaine combined with Methadone can be very dangerous as it can lead to use of greater amounts of cocaine
- Many users report underlying mental and emotional issues related to their drug use
- Cocaine use has implications for health, social and familial relations, employment, and social status, and appears to almost inevitably lead to crime and incarceration
- Heavily addicted users report a preference for injecting or smoking cocaine versus snorting
- Users are relatively aware of the health risks associated with their drug use
- Users report sharing needles or drug paraphernalia with partners or in prison
- Users want access to safer drug use and harm reduction programs, including:
    - ✓ Clean needles in prison
    - ✓ Safe crack kits
    - ✓ Safe injection sites
- Enhanced services within safe and supportive environments are needed, including:
    - ✓ Formal counselling services
    - ✓ Recovery groups
    - ✓ Social opportunities
    - ✓ Skills training
    - ✓ Employment programs

RESEARCHER'S REFLECTIONS

When I was first approached by the Program Director at Mainline Needle Exchange to work on this project I have to admit that I was apprehensive at first. I was nervous and worried that I wouldn't be able to do this. After all, this was an important project that may open doors for the target population and lead to improved services to meet their needs. However, as the project got underway and we began to administer the questionnaire developed with the Advisory Committee it did not seem so difficult, and I settled in for the task ahead of me. I became enthralled with the questionnaire and interview process. I began to take a new outlook on addiction. It gave me new respect for living on the streets. In some ways, I was able to share in their pain and anguish. However, things appear to have certainly changed since the days of my addiction issues, and in more ways than one.

Our findings show that crack use in particular is common, which is not necessarily surprising. What was surprising was that an enormously high number of the respondents also reported a history of opiate addiction, injection drug use, and other multiple drug choices, in addition to their high-risk cocaine use. There were also high numbers involved in a methadone program.

I was profoundly moved as I conducted the interviews that the participants allowed me into the private and innermost places of their lives and memories. It showed me just how deeply rooted addiction can be. I also sensed that through the pain, fear and even anger, there was a small and brief period of hope, particularly as the participants began to discuss the ways that services could be enhanced to meet their needs. The participants seemed particularly inspired by the prospect of one-on-one peer counselling and employment programs and related workshops. They are looking to make real and genuine changes, and they must be supported in their efforts and aspirations.

EMERGING ISSUES AND INSIGHTS

Several key issues have emerged from the findings that appear to have significant implications for service provision for cocaine users, including the need for mental health services, the role of peer-based programming, and the potential offered by additional programming.

MENTAL HEALTH SERVICES

The findings reveal a clear disconnect between the addiction treatment services and mental health services. Many of the participants indicated that they experienced some form of mental health issue, from depression to suicidal ideation. This is not to suggest that users necessarily have clinical or diagnosable mental health issues. Rather, the findings simply point to issues beyond addiction that may need to be addressed for more successful recovery. Based on this research, it is difficult to say if mental health issues preceded

> *[Mainline should] have your own group, for addictions and even like dual addictions... and people would want to be around their own people instead of going to like some detox that they don't even know... more people would come, more people would open up. To me it's like family you know.*
> *~female user*

addiction, or if they were the result of addiction and heavy drug use. Regardless of which came first, no participants reported any formal treatment for mental health issues.

Most of the participants also recommended that Mainline offer one-on-one counselling services and/or various recovery groups. The participants felt that such services would be beneficial for many. This further illustrates the need, from the perspective of the target population, for more formal services that address individual issues.

Peer-Based Programming

The participants also suggested that offering such services at Mainline was important because of the comfortable and supportive environment offered by the staff, all of whom share the experience of addiction and recovery. This points the important role of both peer-based and harm reduction programming. Research suggests that peers may play an important role in encouraging safer drug use practices[19]. Peer support services are also associated with more trusting, respectful and equitable treatment and service[20]. As an approach to drug-related programming, harm reduction is also based on acceptance and understanding[21]. Therefore, it seems that offering treatment services, such as support groups and counselling, within peer-based harm reduction programs like the Mainline Needle Exchange may be an effective way to provide such services. This may render such services more accessible, particularly for harder-to-reach addicts and high-risk users, as they would be offered in what users perceive to be more supportive environments. This could offer a key point of entrance into treatment and rehabilitation.

Additional Programming

Finally, the participants recommended offering additional programming that would provide opportunities for education, skill development, and recreation and leisure. This recommendation may be related to the boredom reported by many participants as a key motivator and/or trigger for using. It appears as though many users do not have other options. Indeed, only a few participants reported having been employed, and even fewer reported employment that would offer a livable wage. However, many recommended offering employment programs, computer courses, and skills training, as well as recreation and leisure opportunities to keep them busy, and hence, away from the temptation of drugs.

Recommendations

The purpose of the Cocaine Assessment Report was to develop a profile of the high-risk cocaine using population in Nova Scotia in order to gain greater understanding of this population and explore strategies that will assist in the enhancement or development of appropriate services. The following recommendations are based on the findings, including the recommendations of the target population.

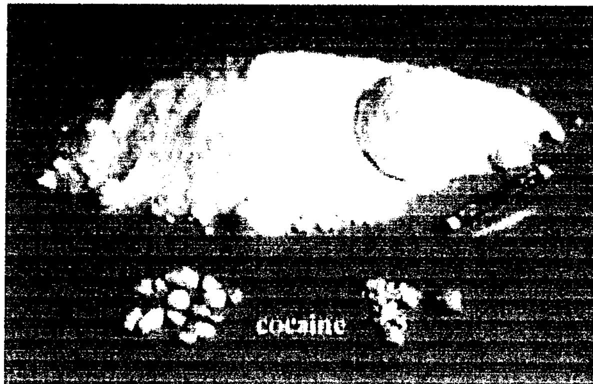
1. More harm reduction programs for safer crack/cocaine use are needed.
    - Provide information and education on the risks associated with cocaine use to drug using communities, including the risk for transmission of blood borne pathogens through drug paraphernalia other than needles.
    - Provide information on the risks associated with cocaine use while on methadone.

- Develop and offer safe crack kits through existing needle exchange services.
- Establish safe injection sites
- Explore other strategies that have been used to reduce harm among high-risk cocaine users.

2. Enhanced treatment services that include a mental health component are needed.
   - Build upon existing peer-based programming.
   - Offer recovery groups through Mainline and other community-based organizations that are located in high needs areas.
   - Offer a variety of recovery groups: women's, cocaine, methadone, awareness and wet and dry groups.
   - Offer one-on-one peer counselling services through Mainline.
   - Establish linkages with mental health services in order to offer referrals and expedited service.

3. Additional programming is needed for those in recovery beyond addiction treatment to provide opportunities and to keep busy with other pursuits.
   - Provide opportunities for education, skill development, and recreation and leisure.
   - Offer job training, searching and placement services.

4. Linkages must be established between key stakeholders.
   - Develop partnerships between addictions and mental health treatment services.
   - Consider developing a coalition of organizations dedicated to addressing the growing problem of high-risk drug use, including cocaine, in Nova Scotia.
   - Provide safe environments for high-risk drug users.



APPENDIX A: QUESTIONNAIRE

1. Age 16-19 ______ 19-30 ______ 30+ ______

2. Sex Male ______ Female ______

3. Have you ever used crack/cocaine?
Yes ______ No ______

4. How long have you used crack/cocaine?
1-5 yrs ______ 6-10 yrs _____ 11-20 yrs _____

5. Are you on methadone?
Yes ______ No ______

6. How long have you been in treatment?
1-5 yrs ______ 6-10 yrs _____

7. Do you use crack/cocaine?
Yes ______ No ______

8. Have you ever been in treatment?
Yes ______ No ______

9. What type of treatment?

10. Do you use needles?
Yes ______ No ______

11. Do you share needles?
Yes ______ No ______

12. Do you use condoms?
Yes ______ No ______

13. Have you ever been tested for HIV/AIDS/HepC?
Yes ______ No ______

14. Would you like to know more about how to inject safer?
Yes ______ No ______

15. Would you like to be provided with information on safe crack kits?
Yes ______ No ______

16. Would you like to see safe injection sites made available?
Yes ______ No ______

17. Would you like more information on safe sex?
Yes ______ No ______

APPENDIX B: INTERVIEW GUIDE

1. Tell me about your childhood/ what it was like growing up.
   - Probe: family/siblings, friends, school, how you felt about self, employment.

2. Tell me about your drug use.
   - Probe: first use, what drugs, needles, sharing, what you started.

3. Did you have periods when you didn't use drugs? Tell me about those times.
   - Probe: why you stopped, how long, what worked, what didn't work, what happened to start you using again.

4. Tell me about your methadone use.
   - Probe: involvement in methadone program, through physician, how long, how often, affect on cocaine use.

5. Tell me about your cocaine use.
   - Probe: how often do you use, what motivates use, how long of periods do you use for, treatment for cocaine, how do you support use, have been incarcerated for cocaine use.

6. Tell me about what you think was/is negative with your drug use.
   - Probe: affect on relationships with family/spouse, loss of job/school, incarceration, health, testing, immunization.

7. Tell me about other services you use.
   - Probe: are they helpful, how could they serve you better.

8. Tell me about additional services Mainline could offer to serve you better/to suit your needs

9. If there were one thing in your life you could change, what would that be?

10. What did you think about this interview process? What could I have done to make it better?

APPENDIX C: PREAMBLE FOR INTERVIEW

Explain Purpose
We've asked you and others to participant in an interview to learn about your experiences as a drug user, and about the kinds of services you have used and/or wish to see put in place. In appreciation for the time and information you will share, you will be given $40.00. You will be asked to sign a form at the end of the interview indicating that you have received the money.

The results of these interview will be used to prepare a profile of cocaine users in Nova Scotia. This profile will be used by Mainline and other organizations to help develop more effective services.

Format
The interview usually takes about an hour, but it could be a little more or less. The questions will ask about your early life, and initial and current experiences as a drug user and your suggestions to improve services for users. If at any time during the interview you'd like to ask me a question, please feel free to do so.

Should any of the questions bring out any negative memories and you wish to have someone to talk to about them, I will arrange a meeting with someone who is qualified to help people deal with such things.

Confidentiality
Be assured that whatever you way to me will be held in the strictest of confidence. I will not record your name or any other identifying information. The information you provide will be analyzed and combined with what we get from the other respondents into a summary report.

Note Taking & Tape Recording
If it's okay with you, I'd like to take notes on what you say during the interview. I'd also like to tape record. I don't what to take a chance of relying on my notes and thereby miss something that you way, or inadvertently change your words somehow. So, if you don't mind, I'd very much like to use the recorder. If at any time during the interview you would like to turn off the recorder, I will shut it off on your request.

Once a summary report for the meeting has been completed, the interview notes and tapes will be destroyed. Until then, they will be kept in mainline in a locked cabinet.

Consent Form
Before we get started I would like you to read and if you're ok with preceeding with the interview, please sign this consent form. This consent form outlines with the interview is all about; that you're answers will be held in the strictest confidence; and that with your permission I will be taking notes and tape recording the interview.

Before you begin ask *"Do you have any questions before we get started."*
At the end of the interview express thanks and say *"If you need to discuss anything about the interview itself later on, please feel free to contact me. Again, should any of these questions bring you negative memories that you with to talk about, I can arrange for you to talk to someone is qualified to help you.*

APPENDIX D: DISSEMINATION/COMMUNICATION STRATEGY

This communication strategy was developed with the assistance of the Cocaine Assessment Report Advisory Committee on December 1, 2003.

1) Identify your target population
   a. Study participants, crack/cocaine and other drug users, and methadone maintenance clients.
   b. Corrections
   c. Nova – federal institution for women
   d. Community agencies
      - Mainline
      - Direction 180
      - Stepping Stone
      - The ARK
      - Pheonix Youth Programs
      - CHOICES
      - Adsum house (and other shelters and transitional housing facilities)
      - The Miq'maq Friendship Centre
      - YNZ youth employment program
   e. Drug Dependency (Addiction Prevention and Treatment Services)
   f. Police
   g. Community Services
   h. Pharmacies
   i. Courts/judges

2) Identify the needs of the target audience
   a. Stakeholders a. through e. will be interested in the findings of the study in order to enhance their services.
   b. Stakeholders f. through i. may be interested in the findings, and sharing the study with them may help to increase their awareness of the issues with regard to crack/cocaine use. These groups may also be interested in information on other drug addictions and methadone maintenance programs.

3) Develop a user friendly presentation
   a. It was agreed that the findings would be presented in a shortened version of only a few pages in length. This 'short report' will be made available to all of the stakeholders.
   b. The Advisory Committee also agreed that if possible it would be beneficial to host an information session where the findings of the study can be presented to stakeholders in the form of a power point presentation. This information session could also feature information on other drugs and on methadone programs.

4) Identify channels to reach the target audiences
   a. Short reports will be made available to all identified stakeholders. Copies will be kept at Mainline and a computer version will be saved to be emailed to interested readers.
   b. Host an information session, brown-bag lunch style, to share the findings.
   c. Consider making short and/or full report available online or disseminating through list serves related to addictions and health.

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