Most deaths caused by illicit drugs can be prevented by swift medical intervention and ongoing treatment.

A&E staff have a vital role to play in reducing drug-related deaths.

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Name:
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What is your local specialist drug service called?
What is their telephone number?

Have you found this magazine useful? ☐ yes ☐ no
Will the information help you in your work with drug users? ☐ yes ☐ no
Does your department routinely give injecting drug users hepatitis B vaccinations? ☐ yes ☐ no
What is the prevalence of HIV amongst injecting drug users in the UK? ☐ 1% ☐ 30% ☐ 70%

What is the name of the proxy National Service Framework for drug treatment?

Please return by 31/12/04 to: Competition, PO Box 2629, Dorchester, Dorset DT1 2DG

Useful web addresses

www.nta.nhs.uk The National Treatment Agency website – with links to drug-related sites, publications, information and policy documents
www.talktofrank.com Talk to Frank, 24-hour drug advice and information
www.drugs.gov.uk/Directory Directory of local drug action teams that help co-ordinate local drug treatment services and new initiatives
www.danos.info Information and courses on Drug and Alcohol National Occupational Standards
www.exchangesupplies.org Drug information and resources
www.goingover.org.uk Information for drug users, including the ‘Going Over’ od prevention video with drug users telling their own stories
www.drugscope.org.uk National charity providing drug information and policy advice
www.hit.org.uk Drug information and resources
www.lifeline.org.uk Drug information and resources
www.mainliners.org.uk Information on hepatitis C and HIV from an innovative London drug service

Further copies – if you have colleagues who might like to read this supplement, or need copies for a training event, call 08701 555 455 and quote reference A&Emag01, and further copies will be sent free of charge.
Many overdose-related deaths occur in men under the age of 30. There are almost as many life-years lost due to drug-related deaths as road traffic accidents.

Blood-borne viruses, transmitted through shared injecting equipment, will continue to cause serious illness and many deaths in the future.

Providing emergency treatment and encouraging drug misusers to get treatment can save lives.

Fighting on two fronts

Drug-related deaths have to be fought on two fronts. We need to reduce the number of sudden deaths through overdose, while at the same time working to prevent transmission of HIV and hepatitis C, which occurs when drug misusers inject with contaminated equipment.

Blood-borne viruses

Because of needle exchange, methadone prescribing and other harm reduction measures, HIV prevalence among injectors in the UK is less than 1%.

Hepatitis C, which has been around for much longer, infects 30–40% of injectors and leads to serious illness in at least half, and the premature death of at least 1 in 4, of those with the virus.

Overdose

Many deaths occur several hours after the drugs have been taken, which means there is a window of opportunity for intervention to prevent death.

We need to encourage people to call an ambulance if they witness an overdose. Most of those who die have been seen by someone during the time between taking the drug and dying. Often they are just left to ‘sleep it off’.

Cocaine

When compared to the depressant drugs (see above), the number of overdose deaths from cocaine use is small. But cocaine use is increasing, both in the form of crack and as a powder. Studies from the United States suggest that up to 25% of heart attacks in people between the ages of 18 and 45 are connected to the use of cocaine. Cocaine use also makes strokes and seizures more likely. It is thought that the risk of having a heart attack is increased by 23 times in the first hour after cocaine use.

When cocaine is used with alcohol, the risk of serious problems is greatly increased because they combine in the body to form a more toxic and longer lasting substance called coca-ethylene.

Reducing drug-related deaths

This information is one of the measures taken to inform key staff of the role they can play in reducing drug-related deaths.

Other projects have targeted information at drug service providers, telephone helpline staff and, of course, drug users themselves.

About the NTA

The National Treatment Agency is a Special Health Authority that has been operational since autumn 2001.

The NTA was established by the Department of Health and the Home Office with a remit to provide more treatment, better treatment and fairer treatment to drug misusers in England.

Reporting to the Secretary of State for Health, the NTA is funded from the pooled budget for drug treatment. Its role is to ensure that the national drug treatment budget is spent on treatment that really works and meets the needs of local people.

The NTA published Models of Care in 2002, which describes how every service in contact with drug users, including A&E departments, has a role to play in helping people access drug treatment. Models of Care, according to the Department of Health, has the same status as a National Service Framework.

Reducing drug-related deaths

This aim has been introduced by the Department of Health because of the alarming rise in overdose deaths over the last decade. A major cause seems to be the trend towards taking combinations of alcohol and sedatives such as heroin and benzodiazepines.

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Combining heroin and cocaine as a ‘speedball’ can increase the chances of a heroin overdose. This is because the cocaine can mask the depressant effects of heroin, but it stays in the body for a much shorter time (about half an hour for cocaine and about 6 hours for heroin). So as the cocaine wears off the full effects of the heroin can be felt.
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Cocaine

When compared to the depressant drugs (see above), the number of overdose deaths from cocaine use is very small. But cocaine use is increasing. Both the NTA and the Department of Health have requested that local drug action teams make plans for increasing staff skills on how to deal with cocaine overdose. This is because the cocaine can mask the depressant effects of other drugs. Staff should be supported and the use of naloxone should be increased, as this is the treatment of choice in the event of an overdose.

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Cut-off points

To reduce the number of sudden deaths through overdose, we need to reduce drug-related deaths in England.

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Causes and response

Overdose is usually caused by people taking a combination of drugs, such as benzodiazepines and alcohol, with an opiate such as heroin.

Drug-related deaths occur in men under the age of 30. There are almost as many life-years lost due to drug-related deaths as road traffic accidents.

Blood-borne viruses, transmitted through shared injecting equipment, will continue to cause serious illnesses and many deaths in the future.

Providing emergency treatment and encouraging drug misusers to get treatment can save lives.
Nicola Bell wishes she could go back and start over. She can’t. But she can tell her story. And with the support of the Naloxone centre and the staff at St Thomas’ hospital where she was treated for her overdose, she hopes that other people might see that there is hope, that there is a way out.

Nicola’s story is not unique. It is one of many that are heard at the centre. And it is a story that is told by many other people who have been treated for drug overdoses.

Nicola was not always like this. She was born in a London hospital and spent her early years in the city. She was raised by her parents, a pilot and a secretary, and she was very happy. But when she turned 18, she began to experiment with drugs. She tried LSD and marijuana, and then she began to use heroin.

Nicola was homeless, but she is now living in a hostel that offers drug treatment, detox and rehabilitation for women left with nowhere to live in the wake of co-ordinated police raids on crack houses in Lambeth.

At the time of her overdose Nicola was a ‘junkie stereotype’. She was easy to understand, easy to help. But when she arrived at the hospital, she was a different story. The ambulance staff gave her the opiate antagonist Naloxone and by the time Nicola reached hospital she had started to come round. “I thought I was a gonner,” she recalls.

Going to the Accident and Emergency department after overdosing on heroin was a positive thing. Nicola hopes that hearing drug users tell their story might help staff to understand their needs, and give help and treatment to individuals rather than a ‘junkie stereotype’.

The first time I tried crack I didn’t feel a thing, but stupidly I carried on. I always put so much effort into the wrong things! I would love to be able to use my brain more. I don’t like being seen as an outcast, as lower than the low, but people do see me that way.”

Nicola was sent to live with relatives in Belgium just two weeks before Nicola was due to sit her O’Levels. She was sent to live with relatives in England and found it very hard adjusting to an English school. “I wanted to learn but if you wanted to learn at that school you had to be there all the time. There were problems with my uniform and I was sent home from school so I decided to leave and went to Amsterdam.”

Nicola has been to the casualty departments of various London hospitals five times – three times for abscesses, once for an ectopic pregnancy and once for a near fatal overdose.

Not always like this: Nicola’s mother was a model and air hostess, but she never knew her father who had finished the brief affair before Nicola was born.

When she was five her mother married a pilot, and the family settled in the Bahamas. She was sent off to boarding school where she was bullied by her stepmother. At the age of nine her mother got divorced and she and Nicola went to live in Majorca. She met another man and separated and Nicola moved from a fancy boarding school to a weekly housing school when she was in her early teens.

Things started to look up, but she found herself in another awful situation when she left Secondary school and began working. “We forced me to sleep with all kinds of men and threatened to tell my mother what I had been doing if I didn’t comply with their demands.”

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“I had stopped using heroin for eight months and then bought it again for the first time. I don’t know how much I took, but it wasn’t very much. My tolerance levels had obviously gone right down. All I can remember is taking the heroin and then saying ‘this is it I’m gone’ before I lost consciousness.”

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She was sent to live with relatives in England and found it very hard adjusting to an English school. “I wanted to learn but if you wanted to learn at that school you get beaten up by the other pupils. There were problems with my uniform and I started getting sent home from school so I decided to leave and went to Amsterdam.”

Nicola began earning some money and soon moved into prostitution. “I remember having sex with a guy and thinking, ‘no more, now on men have got to be fair too’.

First drugs
Having drunk heavily on her early teens she began to experiment with drugs. She tried LSD at 15 and hated it but then tried speed (amphetamine) at 16 when she was 18, then came and went at 18, 19, 20, 21, using heroin regularly.

“Going to A&E saved my life”
Feature interview: Nicola Bell

Going to Accident & Emergency has saved Nicola Bell’s life more than one occasion. In the last three years she has been to the casualty departments of various London hospitals five times – three times for abscesses, once for an ectopic pregnancy and once for a near fatal overdose.

Going to hospital with supportive professionals to act as advocates can be helpful, and Nicola’s case ensured that my opinion to the urgent treatment for the abscess, she was prescribed enough methadone to prevent her from suffering sudden withdrawal, which would have led to her walking out of the hospital to scale at the first opportunity.

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“Family ties”
She lived in Germany for a while, moved back to Belgium where her mother was living and then returned to England. She has a daughter of 18, and a son of eight who she sees from time to time.

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Nicola eventually agreed to go with this worker Nicola Pruss, who supports women who have moved from the crack houses to hostel accommodation, and Di Martin, from ‘Trust’ – an organisation which does outreach work with female street sex workers.

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Most of the illicit heroin imported into Britain is processed from the raw opium sap into a brown powder which is around 70% pure heroin. Brown heroin is intended for smoking. To smoke heroin, users heat the powder on silver foil with a lighter. As it melts and boils, it turns into a sticky tar which flows across the foil, giving off a rising cloud of smoke which is inhaled. This is known as ‘chasing the dragon’. Despite being made for smoking, many users inject brown heroin powder. As it doesn’t easily dissolve in water, they first have to mix it with an acid (usually ascorbic acid [vitamin C powder] or citric acid) to help it dissolve. Heroin can’t be swallowed because it is largely inactivated by the stomach. Minimum amounts used usually cost £5–£10. If heroin is taken every day for more than a couple of weeks, the body becomes physically dependent, and will exhibit withdrawal symptoms if the drug is stopped. Using as little as £10 worth a day can create physical dependence. Regular use also brings tolerance and dependent users either have to take breaks, or gradually increase consumption in order to feel the effects. Some spend in excess of £100 per day and still feel very little effect, other than the absence of withdrawal symptoms.

In contrast to legal drugs such as tobacco and alcohol, heroin does not damage any major organ (including the brain). However, injecting can lead to serious (preventable) health problems, including viral infection and overdose.

Although street purity can vary, the problems of it being cut with dangerous substances, and of ‘high purity batches’, have been greatly exaggerated by the media.

Putting people in touch with treatment services can help them turn their life around.

There is no simple answer to the question of why people take, or become dependent on, heroin. It is probably most helpful to try and understand heroin use on an individual basis, weighing up the relative importance of factors to do with:

- the person – their psychological make-up, history, mood, emotional state, self-esteem and expectations of the drug;
- the drug – the physical and psychological effects of the drug on the individual and its power to remove withdrawal symptoms; and
- society – the ease with which the drug can be bought, the number of people using it, the attitudes of the person’s peer group to the drug, etc. The way epidemics of heroin use among young people have swept across the country in clear patterns – spreading out from inner cities into rural towns as supply chains are set up – has clearly demonstrated that availability of the drug is also a key factor.

There is a strong evidence base that treatment for heroin use really does work. Some people will have tried treatment before and not been successful – this doesn’t mean that treatment can’t help now. There are a range of different treatment types and treatment services are working harder to better meet the needs of the people who seek their help. Encouraging people to access treatment could save their life.

You can find your local drug services on the internet using ‘Helpfinder’ – a database held on the DrugScope website: www.drugscope.co.uk

Not everyone enjoys the sense of detachment, and some first-time users describe a feeling of discomfort and unease. As with opiates used for analgesia, one unpleasant effect of heroin is its tendency to induce sickness. Although people usually become tolerant to this, most dependent heroin users suffer from constipation.

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Heroin offers most users an unparalleled state of mind, and unparalleled social problems. Here we explain what this drug is and why people take it.

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Unlike the media myth of ‘one fix and you’re hooked for life’, people usually become dependent over a period of time. A pattern of occasional use becomes more frequent, and moves from single doses every now and then to taking it every day for longer and longer periods.

Trying to understand this interplay of psychological, chemical and social factors is probably more helpful than trying to fit people into theories which say that those who take illicit or illegal drugs become dependent are ‘victims of peer pressure’ or different because they have an ‘addictive personality’ or ‘the illness of addiction’.

Although many dependent users say that the main thing that drives them to continue using heroin is avoidance of withdrawals, it is important to understand the psychological component of the dependence.

The protection from emotion that heroin affords often fosters a belief that ‘normal life’ is emotionally even and anxiety free. When people detox and find themselves feeling very emotional they often feel that this isn’t normal and that they have to take more heroin to cope. The task of developing coping mechanisms to replace illicit drugs is often the hardest thing for those trying to get off – and stay off – heroin.
"When drug users come into A&E conflicts can arise, because we don’t necessarily have that time to spend. Occasionally you do feel that you are giving your very best, but a lot of the time staff are very rushed which is not ideal."

She feels that it is very important for A&E staff to have as much information as possible to hand to drug users. "Nurses need to know what services are available so that they can pass that information on to the patients," she says. Contacting local drug services (that can be found on 0800 776600) can provide a wealth of information and referral details.

Most patients are offered psychiatric help, but they should also be referred to drug services.

"If a patient refuses treatment for their drug problem after their initial treatment in A&E there is not a lot that nurses can do about it. It’s their choice and we can’t force treatment on them, but at least they’ve got the information for the future, if they change their mind," she says.

Training is an important issue. “I think it’s probably fair to say that our training doesn’t really address these issues well enough. There is a significant social as well as medical and psychological component in dealing with these patients, especially as it is a group that is not generally viewed in a favourable way.”

There are now Drug and Alcohol National Occupational Standards (DANOS) that describe good practice in working with illicit drug and alcohol users. These competency based standards are being used to develop courses which can help nurses gain skills and knowledge to work with patients who use illicit drugs and alcohol.

"If a drug user has overdosed and comes in with a family member they are often understandably despairing. It’s a sad, sometimes impossible situation and the relative may also need lots of time. Families do look to nurses and other health professionals to help them out at these times."

"Training is an area where more could be done to prepare nurses when looking after drug users," she says. Patients who have overdosed on opiates are sometimes treated with Naloxone. Gastric lavage is no longer routine.

"Drug users viewed the gastric lavage as a kind of punishment for what they had done, and as we need to encourage people who have overdosed to come in for treatment, it is important to reassure them that gastric lavage is now rarely used."

Patients seeking out the services of A&E because of stimulant overdoses are far fewer in number although St Mary’s does still see such patients.

Mary focuses on less critical cases in her department and says that when drug users come into A&E with conditions such as abscesses there is more scope to work with them on issues such as hepatitis B vaccination, using clean needles and doing more to keep themselves properly nourished.

She admits that some staff in A&E can have less than helpful attitudes towards drug users. "I sometimes feel quite dismayed by the judgemental attitudes towards drug users coming from some medical and nursing professionals. Such an approach is more likely when the department is very busy and distinctions are made between people who are seen as sick through no fault of their own, and those who have ‘contributed to their illness’. Such attitudes however are not acceptable. As professionals we have a duty of care to all our patients."

She understands how difficult it is when you spend time with someone who has overdosed and then very soon after discharge they are back with the same problem. "Sometimes nurses think: ‘what’s the point?’ But we have to look at the issue in the same way as any other illness and accept that these patients need our help.

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Most patients are offered psychiatric help, but they should also be referred to drug services.

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The best possible care

Mary Dawood, Consultant Nurse, St Mary’s Hospital A&E Department, Paddington, London.

Mary Dawood has seen many patients come through the A&E department at St Mary’s following an overdose. She knows they don’t always get enough time and understanding.

“Staff need more education and more support to help them care for this group of people.”

If a patient refuses treatment for drug problem after their initial treatment in A&E there is not a lot that nurses can do about it. It’s their choice and we can’t force treatment on them, but at least they’ve got the information for the future, if they change their mind,” she says.

Training is an important issue. “I think it’s probably fair to say that our training doesn’t really address these issues well enough. There is a significant social as well as medical and psychological component in dealing with these patients, especially as it is a group that is not generally viewed in a favourable way.”

There are now Drug and Alcohol National Occupational Standards (DANOS) that describe good practice in working with illicit drug and alcohol users. These competency based standards are being used to develop courses which can help nurses gain skills and knowledge to work with patients who use illicit drugs and alcohol.

“If a drug user has overdosed and comes in with a family member they are often understandably despairing. It’s a sad, sometimes impossible situation and the relative may also need lots of time. Families do look to nurses and other health professionals to help them out at these times.”

“Training is an area where more could be done to prepare nurses when looking after drug users,” she says.

Patients who have overdosed on opiates are sometimes treated with Naloxone. Gastric lavage is no longer routine.

“Drug users viewed the gastric lavage as a kind of punishment for what they had done, and as we need to encourage people who have overdosed to come in for treatment, it is important to reassure them that gastric lavage is now rarely used.”

Patients seeking out the services of A&E because of stimulant overdoses are far fewer in number although St Mary’s does still see such patients.

Mary focuses on less critical cases in her department and says that when drug users come into A&E with conditions such as abscesses there is more scope to work with them on issues such as hepatitis B vaccination, using clean needles and doing more to keep themselves properly nourished.

She admits that some staff in A&E can have less than helpful attitudes towards drug users.

“I sometimes feel quite dismayed by the judgemental attitudes towards drug users coming from some medical and nursing professionals.

Such an approach is more likely when the department is very busy and distinctions are made between people who are seen as sick through no fault of their own, and those who have ‘contributed to their illness’. Such attitudes however are not acceptable. As professionals we have a duty of care to all our patients.”

She understands how difficult it is when you spend time with someone who has overdosed and then very soon after discharge they are back with the same problem. “Sometimes nurses think, ‘what’s the point’? But we have to look at the issue in the same way as any other illness and accept that these patients need our help.

“Research shows that if more users could access support and treatment there would be far fewer of them seeking help from A&E following an overdose. We can be more effective earlier on than when they reach crisis point.

At that point they are jeopardising their health much more. But usually when drug users are OK they don’t want to come near places like A&E – when they do come in it is important to encourage them to seek treatment, as this will reduce their overdose risk.”

It doesn’t take any extra time to treat someone with humanity: when someone comes in after an overdose we don’t know the whole story, there’s often a lot of emotional baggage and it’s unfair to make judgements.”

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“There is a significant social as well as medical and psychological component in dealing with these patients, especially as it is a group that is not generally viewed in a favourable way.”
Many who overdose are left to either come round or die. Those who ‘go over’ with friends may arrive by ambulance after an anonymous 999 call, or find themselves dumped at the entrance of an A&E department.

Although all are aware that in an overdose situation, taking the victim to A&E can be the difference between life and death, many are wary of doing so through fear of the police and the reception they’ll get from the hospital staff.

The lucky ones are accompanied by someone who is willing to give accurate information about what they have overdosed on, and details of their drug-taking history – which can mean risking being suspected of a drug-related crime and questioning by the police.

Jill Howard (not her real name) has twice brought friends who have overdosed into departments. She supports the work of the local drug action teams that have negotiated protocols which mean that the police only attend 999 calls in situations when there is need to gain entry, risk to ambulance crews or children. But she knows from experience that attitudes vary from hospital to hospital.

“Generally the reception drug users receive is not good,” she says. She once brought in a friend “who had overdosed on pills”. She had stayed with him, walking him around in the fresh air and plying him with coffee but as he became more drowsy she took him to hospital.

“When I brought him in he had his stomach pumped, and the doctors and nurses said to him: ‘What do you think you’re doing? You have done this to yourself, and you come in here wasting our time when we have emergencies to treat.’”

“The nurses’ attitudes vary between one individual and the next but with the doctors and consultants it’s very rare to find any who are sympathetic towards drug users.”

She condemns a minority of users for the way they behave in hospital, recalling the case of “one girl who had endocarditis from injecting desedrine” (a pharmaceutical amphetamine that can be ground up into powder and injected). “The hospital put a tube which was connected to her heart, and she got someone to bring desedrine so she could inject it through the tube!” It was a crazy thing to do, but getting angry wouldn’t stop her, and anyway it is wrong to tar all drug users with the same brush.”

Jill is also concerned that although opiate users have a choice of treatment programmes that offer both detox and stabilisation, these choices are not always made clear to them in A&E.

“You sometimes get the feeling that it’s ‘clean up or nothing’ when actually there are a whole range of things on offer which can enable drug users to live a normal life.”

Methadone maintenance treatment may appear to keep people on drugs, but it is a much safer drug that allows people to get back to a more normal life without the constant treadmill of looking for money and scoring illegal drugs.

Research has shown that patients in methadone treatment commit less crime, are less likely to catch or pass on hepatitis or HIV and are less likely to die from an overdose.

“There’s still so much prejudice from medical staff. We just want to be treated like human beings, but it’s assumed that when we come in we’ll steal anything that’s around.”

“I think that A&E departments should talk to drug users or people who work for drug agencies so that they can start to understand the lives of drug users who come into their department,” says Jill.

“If A&E departments remain as off-putting as they are at the moment, not all the drug users who need help will be brought into hospital, and more of them will die.

Friends who take people to A&E are doing so because they want to help them, and because they want them to live. Saving lives is the most important thing. It’s a health issue, not a moral issue. It would be good if everyone could see that.”
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Mention the words Accident & Emergency to many drug users, and although they don’t quite hold up the cross and garlic, many will give an involuntary shudder.
Cocaine

Cocaine isn’t just taken by film stars at parties. It causes serious problems for some of those who take it – and is associated with viral transmission and serious injecting injuries.

Here we explain what it is and why people take it.

Cocaine and crack

Cocaine and crack cocaine are the same drug – just in different forms.

Cocaine hydrochloride powder is snorted up the nose (usually through a tube or rolled-up bank note) or dissolved in water and injected. It is sometimes injected with heroin – a combination known as a ‘speedball’.

Smoking cocaine powder is inefficient and results in the loss of most of the psychoactive effect. The drug is made smokeable by chemically converting it into the solid freebase form known as crack cocaine.

The process of converting cocaine hydrochloride into crack uses readily available chemicals, including baking powder and ammonia.

The name ‘crack’ came about because, when smoked, the salt remaining in the mixture sometimes crackles as it burns. Crack cocaine is also known as ‘rocks’ and ‘freebase’.

Crack cocaine is usually smoked through a pipe which can be specially made or improvised out of a drinks can. It can also be rolled into a ‘joint’ with cannabis or tobacco. Smoking is an extremely efficient way of delivering the drug to the brain quickly.

Why do people take it?

Cocaine is a powerful central nervous system stimulant and local anaesthetic. Users usually experience a powerful physical and psychological rush of exhilaration, excitement, alertness, strength and confidence within a couple minutes of snorting cocaine, which can last up to 40 minutes.

Injecting cocaine, or smoking crack cocaine, brings on the effects more quickly, in a more intense way, but the effects wear off more quickly too. As with all drugs, the way that this is experienced varies from person to person – some first-time users experience a panicky, nauseating half-hour.

Cocaine has become part of the life and culture of people in groups as diverse as stockbrokers, sex industry workers, ravers and musicians. As with heroin, the reasons why people use it are very different and probably best understood on an individual basis.

One downside of cocaine use is the feeling of exhaustion and depression that many get afterwards – especially after a period of taking it on consecutive days. The problem of dependence can arise when cocaine is used to counteract these (or other) feelings, creating a cycle of use, depression and more use.

Unlike heroin, cocaine is not a drug that lends itself to everyday use. This is partly due to the expense of the drug (binges often cost well in excess of £200 a day) and partly because even 5–10 days of continued use usually create an uncomfortable sense of being ‘on edge’ and paranoid.

Heavy use

As with all stimulants, repeated or heavy use can lead to paranoia and agitation which may develop into a serious mental health problem. The powerful local anaesthetic effect, and the frequency with which people sometimes inject, mean that injecting cocaine often results in considerable vein damage.

Treatment

Drug services are responding to the needs of cocaine and crack users who are having problems. Counselling and psychosocial support have been shown to be effective treatments, while complementary therapies can help to retain people in treatment. These services are increasingly available.

Only a small minority of cocaine users – those with access to lots of money and the drug (mainly rock stars and people dealing in large quantities) – use daily for prolonged periods. This group are more likely to be using crack cocaine, and often suffer from severe depression when they stop.

The usual pattern of use for people who are cocaine dependent is to go through repeated cycles of bingeing, running out of money and/or getting paranoid, stopping for a while and then bingeing again.

Cocaine use is treatable and people attending A&E should be encouraged to access drug treatment services. Although there isn’t a pharmacological solution to cocaine use, many psychological interventions have been shown to work, and complementary therapies can help some people too.

Motivating people to seek treatment and stay in treatment long enough for it to work seems to be key. Being understanding and sympathetic to difficulties with cocaine use is likely to be effective in helping someone into treatment services.


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Reducing drug-related deaths: KEY POINTS

1. If they need it, injectors should be given injecting equipment on discharge, especially if needle exchanges are closed.

2. Encourage drug users to seek treatment as this will save lives by reducing overdose and blood-borne infections.

3. Hepatitis B immunisation should be a routine procedure for injectors who attend A&E, just as tetanus is for those who suffer injury in the garden.

4. Those most at risk of an overdose include those who have lost their tolerance after a detox, rehab or prison. Injectors who are homeless and not in touch with services are another high-risk group.

5. Long-term users and poly-drug users are at higher risk of overdosing. Some are complacent about the risks of overdose and may need to be warned that the longer they use, and the more they overdose, the greater the chances of one of the overdoses being fatal.

6. You can reduce risk of death by providing drug users with information literature on overdose prevention, viral transmission and local drug services. A number of organisations produce clear, illustrated advice and information – see useful web addresses on back cover.

7. Establish relationships with local drug agencies and provide training for A&E staff working with drug users as this can help improve the quality of care.

8. Ensure that drug users, and those who bring them into A&E departments, are encouraged to do so again and do not experience hostility from police or hospital staff.
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Images taken from ‘Going Over’ – an overdose prevention video.
www.goingover.org.uk

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Most deaths caused by illicit drugs can be prevented by swift medical intervention and ongoing treatment.

A&E staff have a vital role to play in reducing drug-related deaths.

Useful web addresses

- [www.nta.nhs.uk](http://www.nta.nhs.uk) - The National Treatment Agency website – with links to drug-related sites, publications, information and policy documents
- [www.talktofrank.com](http://www.talktofrank.com) - Talk to Frank, 24-hour drug advice and information
- [www.drugs.gov.uk/Directory](http://www.drugs.gov.uk/Directory) - Directory of local drug action teams that help co-ordinate local drug treatment services and new initiatives
- [www.danos.info](http://www.danos.info) - Information and courses on Drug and Alcohol National Occupational Standards
- [www.exchangesupplies.org](http://www.exchangesupplies.org) - Drug information and resources
- [www.goingover.org.uk](http://www.goingover.org.uk) - Information for drug users, including the ‘Going Over’ od prevention video with drug users telling their own stories
- [www.drugscope.org.uk](http://www.drugscope.org.uk) - National charity providing drug information and policy advice
- [www.hit.org.uk](http://www.hit.org.uk) - Drug information and resources
- [www.lifeline.org.uk](http://www.lifeline.org.uk) - Drug information and resources
- [www.mainliners.org.uk](http://www.mainliners.org.uk) - Information on hepatitis C and HIV from an innovative London drug service