

Cocaethylene: *Responding to combined alcohol and cocaine use*



Summary

Cocaethylene is a unique compound formed when alcohol and cocaine are combined. Cocaethylene has been associated with increased health and social risks, although understanding and awareness of the risks appears low. Scope to improve knowledge and responses within drug and alcohol strategy approaches appear important given indications of increasing popularity of combined alcohol and powder cocaine use.

Key findings:

- Qualitative data based on survey findings, reports from professionals and users suggests combined alcohol and cocaine use is a significant and increasing trend, particularly amongst young recreational 'binge' drinkers
- Understanding about the increased risks resulting from combined alcohol and cocaine use is lacking; however some figures are commonly recited such as significantly increased risks of sudden death or heart attack
- There is a broad consensus that cocaethylene significantly increases risk of heart attack and other possible health effects. It is also linked to other social harms such as an increased propensity to violence amongst users
- There is limited quantitative data about the actual prevalence, use or understanding of cocaethylene specifically, although extensive separate data on alcohol and cocaine use can be corroborated to some extent
- Available statistical data indicates high combined levels of alcohol and cocaine use: the NTA report that around 75% of those in treatment for powder cocaine reported alcohol use at start of treatment. 61% of those reporting powder cocaine use in the Mixmag survey said they 'always drank alcohol when snorting cocaine'

Key recommendations:

- Psychosocial treatment approaches are effective for both alcohol and cocaine users - optimum approaches for combined users should be further explored
- Practitioners should be offered training and support to better understand and respond to the needs of combined alcohol and cocaine users
- The impact of combined alcohol and cocaine use needs further recognition within local and national drug and alcohol strategy approaches

1. Background

Cocaethylene is reported to produce heightened euphoria amongst users, with a more prolonged effect than taking cocaine on its own. However concerns over greater health risks have been increasingly discussed following further research into the subject. However there has been questioning and debate over the actual impact and risks of combined use, and the consensus appears to remain that further research is needed.

The most commonly recited effect of cocaethylene, as given in a 1990 *New Scientist* article¹, asserts that “*When cocaine and alcohol are taken together, the combination is 21 times more likely to kill people with severe heart problems than cocaine on its own.*” Whilst this statistic appears to have been disputed, there is consensus that the effect of cocaethylene increases the risk of cardiac problems and other possible effects such as seizures and liver damage. It has also been linked to an increased risk of violent and risk taking behaviour.

Anecdotal reports from practitioners and those in the drug and alcohol field suggest that increasingly drinkers in the UK are intentionally poly-using cocaine. This is largely corroborated by significant increases in powder cocaine use as explored in recent cocaine reports by the House of Commons Home Affairs Committee and National Treatment Agency. Yet reports also suggest combined users are largely unaware of the increased health and social risks presented by their combined use.

Currently there appears to be limited recognition of the potential health or social impacts of combined alcohol and cocaine use amongst users or policy makers. Although the deliberate use of alcohol and cocaine is not a new phenomenon, current drug and alcohol policies are not geared to address the future impact of potentially significant increases in use.² This paper therefore aims to explore current understanding, gaps in learning and opportunities for local and national drug and alcohol leads to respond.

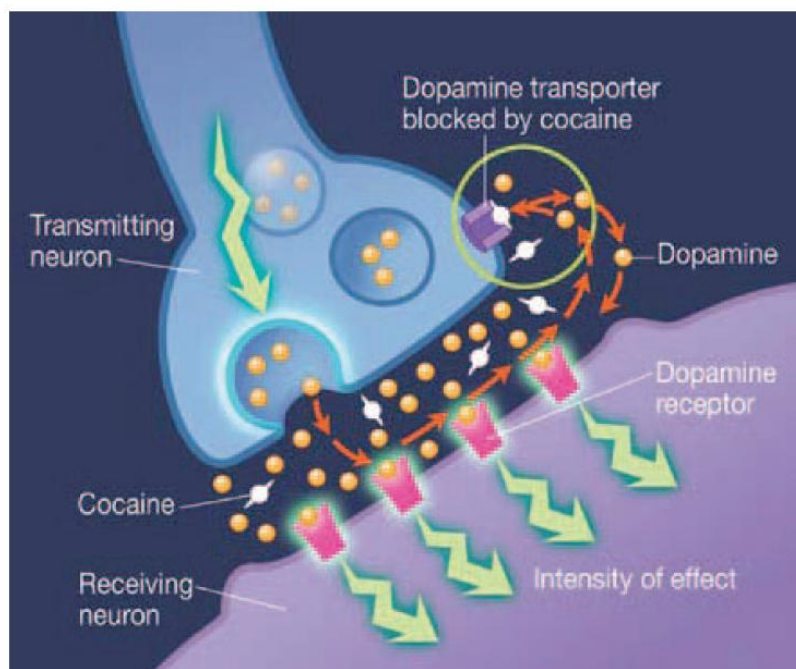


‘Vin Mariani’, a ‘tonic’ wine which contained cocaine was popular in the 19th century. It claimed to ‘fortify and refresh body & brain’, and was also promoted as a treatment for a range of conditions. Fans reportedly included Queen Victoria and Pope Leo XIII even awarded the wine a Vatican gold medal, also endorsing it on a poster.

2. What is 'Cocaethylene'?

When alcohol and cocaine are exposed in the liver, they form a unique metabolite ethylbenzoylecgonine (cocaethylene). Whilst the effect is similar to the metabolite formed by cocaine (benzoylecgonine), several differences are observed affecting the psychoactive and biological impacts on the body.

Most significantly, cocaethylene (like cocaine) blocks the re-uptake of dopamine³ in the brain, producing euphoric but habit forming reward effects. Because cocaethylene has a longer half-life than cocaine on its own, the euphoric effects are prolonged. Cocaethylene increases the levels of cocaine in the blood, which is cleared more slowly (the half-life). Additionally, cocaethylene has a less significant effect in regulating serotonin than cocaine, also thought to increase euphoric effects.



The affect of cocaine on the brain

Cocaine interrupts the natural re-absorption of dopamine in the brain. Dopamine results in signals that create a feeling of euphoria. Cocaethylene further blocks the re-uptake causing a greater build up of dopamine and longer sense of euphoria.

Source: National Institute on Drug Abuse ([NIDA](http://www.nida.nih.gov))

Evidence suggests that the ingestion of alcohol before cocaine is required to create cocaethylene (McGowan 2008⁴).

3. Increased health and social risks?

The extent of the increased risk of cocaethylene appears hard to quantify in non-medical terms, although there has been a significant degree of academic research into its nature as a compound and various interactions⁵. There is therefore varied reporting about the actual risks in terms of death or serious health conditions as explored below.



3.1 Affect on the body

Cocaine use is linked to cardiovascular problems especially increased heart rate and blood pressure. These risks have been demonstrated to be further increased by cocaethylene. A study in 1997 (Farre et al) found that whilst cocaine increased heart rates by 12 beats per minute (BPM), cocaethylene increased heart rates by 33 BPM. Increased heart risks are thought to be concomitant with up to 30% increased blood cocaine levels when cocaethylene is formed⁶.

Cocaethylene's increased health risks, especially for those with heart conditions has been linked to cocaine's ability to block sodium channels of cardiac cells. This blocking effect is thought to be greater from cocaethylene than cocaine (Xu et al, 1994⁷). Further studies have shown that cocaethylene is a stronger myocardial depressant which also affects calcium levels and heart contractions (Ashad, H et al, 1995). A recent paper 'Neurotoxic and Cardiotoxic Effects of Cocaine and Ethanol'⁸ concluded that:

"The combination of ethanol and cocaine has been associated with a significant increase in the incidence of neurological and cardiac emergencies including cerebral infarction, intracranial haemorrhage, myocardial infarction, cardiomyopathy, and cardiac arrhythmias."

The New Scientist article 'Science: Cocaine and alcohol make a heart-stopping cocktail'⁹ published in 1990 stated:

"In tests with mice, scientists have found that cocaethylene is between 50 and 100 per cent more lethal than cocaine. However, Mash says that the jury is still out on why it kills people. Cocaine and cocaethylene may disrupt the function of the limbic parts of the brain which control the heart, she says. They also bind to other molecules in the brain, known as muscarinic and sigma receptors. These have been linked with abnormal heart function, mental disorders, and also with delirium."

The US National Institute on Drug Abuse (NIDA) report in a Research Report Series paper¹⁰ on cocaine states:

"While more research needs to be done, it is noteworthy that the mixture of cocaine and alcohol is the most common two-drug combination that results in drug-related death."

However cocaine-related health risks have a better recognition as a lone drug, particularly in terms of the impact on the heart. Recent national 'Frank' campaigns have highlighted the risk to the heart in particular:



“Cocaine is highly risky for anybody with high blood pressure or a heart condition. Perfectly healthy, young people can have a fit or heart attack after taking too much coke and you may not know you’ve got a pre-existing heart condition.” www.talktofrank.com

However the role of alcohol in the research behind cocaine harms is commonly overlooked. A 2008 article in *The Times* called ‘The New Cocaine Crisis’¹¹ reported that A&E presentations of young revellers with heart problems had become so common they had been labelled ‘coke strokes’ by A&E staff. The article explores in particular the frequency of cocaine-related Saturday night emergency admissions:

“The problem, though, is that getting high at weekends can put huge strain on the heart: cocaine, in particular, constricts the blood vessels, raising blood pressure and making the heart work harder. Throw in alcohol and amphetamines, and you have what some doctors believe is a ‘ticking time bomb of acute cardiac problems’.”

3.2 Increased risk of violence?

The consequences of combined alcohol and cocaine use may not only be health related; professionals point out that cocaine’s stimulant effect reduces a drinker’s feeling of intoxication and allows greater quantities of alcohol to be consumed. Furthermore, with the disinhibiting effect of alcohol combined with a heightened sense of self confidence associated with cocaine, the links between increased violent or impulsive behaviour seem logical.

Both alcohol and cocaine elevate extraneuronal dopamine and serotonin levels which in turn may lead to deficits in impulse control and, thus, violent behaviour¹². It is therefore possible to hypothesise that the combination of alcohol and cocaine increases the risk of violence than either drug taken alone. There is some research from the US that suggests that combined alcohol and cocaine use increases the risk of violence (Chermack & Blow 2001¹³; McDonald et al, 2008¹⁴). In a separate review of the research evidence on cocaethylene and violence, Penning et al. (2002) noted that:

“Retrospective research on violence suggests a major role for alcohol alone and additive increases in violent behaviour or crime from the combination [with cocaine]. For ethical reasons, high repeated doses of cocaine have not been studied experimentally. The behavioural toxicity of highdose binge use of cocaine with alcohol may thus be underestimated. One study shows a potentiation effect of the cocaine-alcohol combination on the number of thoughts and threats of violence”¹⁵



Volume 24 (March/April 2009) of Druglink magazine featured an article entitled 'The hidden mixer'¹⁶ exploring the possible link between combined alcohol and cocaine use and violence. It reported that drug tests by Greater Manchester police had found that 'between a quarter and a third of people arrested for violence snorted powder cocaine before fighting.' However the article concluded that alcohol was still the most likely drug affecting the risk of violent behaviour, and that personality is still by far the key determining factor.

It has yet to be established exactly how and under what circumstances the combination of alcohol and cocaine may give rise to increased risk of aggression and violence. There is currently a shortage of in depth research which includes the role of important social and contextual factors such as the night-time economy or domestic settings¹⁷. Further exploration of combined use in violent offences could provide additional insight. Models of data collection such as the Cardiff A&E data sharing model and initiatives such as alcohol arrest referral schemes could be important opportunities to explore risk factors and prevalence relating to combined alcohol and cocaine use.

3.3 Addiction risks?

There appears to be insufficient research to assess whether combined cocaine and alcohol use is likely to increase levels of addiction to either drug, or whether there is the possibility of a particular habit-forming reaction to cocaethylene. A medical review of the literature available on the psychological and somatic consequences of combined use found no evidence that cocaethylene produced an enhanced addictive effect (McGowan, 2008). However one early study¹⁸ on cocaethylene concluded that 'The formation of cocaethylene may play an important role in the systemic toxicity and abuse liability associated with dual addiction to cocaine and alcohol.'

Nonetheless, the already strong tendency of each drug to form a variety of physical and psychological disorders without a combined synergy should not be overlooked. It has also been suggested that 'some combined use can be explained by classical conditioning theory. A combined user has their alcohol and cocaine use conditioned together so that using one brings on the craving or desire to use the other.' (McGowan, 2008). Anecdotal reports also suggest that the 'crash' or 'comedown' effects of cocaine are reduced if combined with alcohol, which may also be likely to lead to increased conditioning of poly-use.



4. Use and prevalence of cocaethylene

Whilst medium to longer term trends of both cocaine and alcohol consumption have been rising, there is little specific data available directly identifying cocaethylene prevalence. However anecdotal reports are suggesting that many drinkers in the UK now see cocaine as an integral part of their recreational alcohol use. A qualitative study¹⁹ of 34 young cocaine users in London found that:

'Virtually everyone interviewed reported that they regularly drank alcohol when using cocaine. Reports of drinking more heavily than usual while under the influence of cocaine were widely described, with several reporting that they often drank at least twice their usual alcohol intake. For a significant number of respondents, cocaine use was always accompanied by alcohol. Some used cocaine to moderate the undesirable effects of alcohol (such as feeling less in control and unsteady on their feet), so that they could continue to drink. In contrast, others used alcohol in a functional way to moderate the effects of cocaine: to help them take the edge off feelings of anxiety or paranoia and to help them to sleep at the end of the evening. As Kate, an unemployed 22-year-old, explained:

'I won't have cocaine without alcohol. Because when you have cocaine on its own it's a completely different buzz. You can get on a paranoid buzz if you have it on its own. The alcohol brings you on a level.' (Kate, aged 22)

Overall, respondents reportedly recognised very few risks associated with using cocaine and alcohol together.'

Paul Hayes, head of the National Treatment Agency (NTA) recently stated to the Home Affairs Select Committee that:

"...for a significant minority of people in their 20s/early 30s [cocaine] has become an adjunct to a Friday or Saturday night out along with alcohol"²⁰.

Such drinkers are likely to fall within the largest proportion of alcohol misusers within the UK, making up a population of 7.7 million 'binge' drinkers (ONS²¹). Other professionals in the treatment field have also highlighted the increasingly apparent cultural link between recreational alcohol and cocaine use. Research by expert UK drug and alcohol trainer Danny McGowan concluded 'that combined cocaine and Alcohol use has been normalised in modern pub and club culture.'²²



4.1 Home Affairs Select Committee (HASC) report: 'The cocaine trade'

The recent HASC report 'The cocaine trade' assessed a range of evidence on the use and profile of cocaine in England. In addition to Paul Hayes, others giving evidence also cited the significance of alcohol within the context of powder cocaine use; addictions expert Sarah Graham told the HASC "for many, many people alcohol addiction and cocaine addiction do go hand in hand". Professor Nutt suggested that it was not uncommon for "people to go into pubs and order a gin and tonic and a line of coke". On reviewing its evidence on combined use the HASC report concluded:

"There is a strong link between use of alcohol and use of illicit drugs, in particular cocaine ... The survey by dance music magazine MixMag found that 61% of respondents always drank alcohol when snorting cocaine."

"Cocaine powder is increasingly being taken simultaneously with alcohol. The two drugs combine to form a highly toxic third substance, cocaethylene, which a recent medical study reported to be associated with a 25-fold increase in sudden deaths"

Responding to the publication of the Committee's report, Martin Barnes, Chief Executive of DrugScope, said:

"There is concern that young people in particular underestimate the risks and harms associated with cocaine, not least when it is combined with alcohol..."

DrugScope have been highlighting concerns over increasing indications of combined alcohol and cocaine poly-use for several years, based on their annual Street Drugs Trends survey. In 2007 Martin Barnes highlighted:

"We do not wish to exaggerate the extent of cocaine use but our survey does reveal some worrying trends. The use among young people, the drug's affordability and the combination with alcohol and other drugs is clearly a concern."

4.2 NTA report on powder cocaine treatment

The NTA recently released the report 'Powder cocaine: how the treatment system is responding to a growing treatment problem' (March 2010), possibly the first governmental drugs document to refer to cocaethylene and its implications:

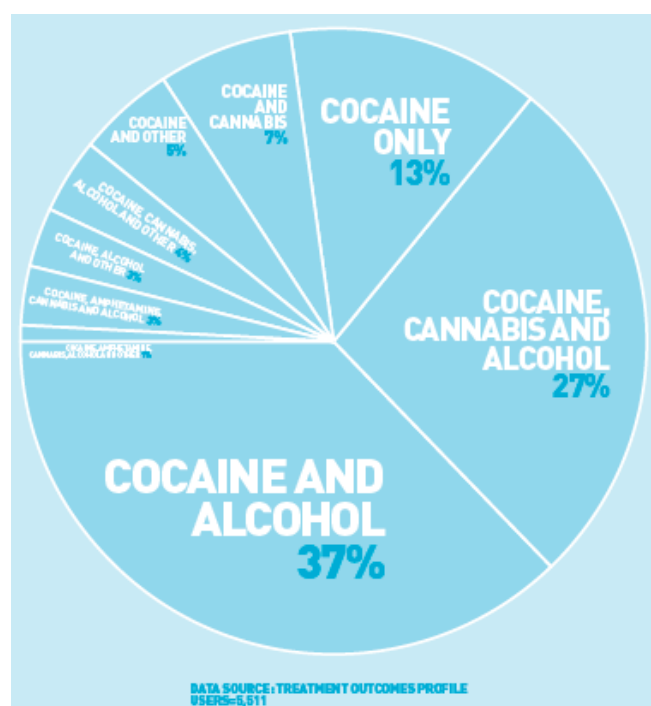
"Individuals often use powder cocaine in combination with alcohol. This produces a pharmacologically active metabolite of cocaine and alcohol called cocaethylene, which is



thought to enhance the effects of cocaine and lessen the impact of the ‘crash’ following a binge. This pattern of use may also increase the damage to the heart that either cocaine or alcohol alone can cause, and increase the likelihood of violent behaviour.

Once established, this combined use of the drugs can be difficult to give up. People who access treatment in England tend to have a problem with more than one drug, so this is an important area of focus in developing and evaluating effective treatment responses.”

Significantly, the report found that around 75% of all those receiving treatment for powder cocaine reported using alcohol at start of treatment.



Tables: Reported drug use at start of treatment for powder cocaine users. Source NTA, Treatment Outcomes Profile data 08/09

4. REPORTED DRUG USE AT START OF STUDY		
	Frequency	Percentage
COCAINE AND ALCOHOL	2,036	36.9
COCAINE, CANNABIS AND ALCOHOL	1,493	27.10
COCAINE ALONE	719	13.00
COCAINE AND CANNABIS	392	7.10
COCAINE, CANNABIS, ALCOHOL AND OTHER	212	3.80
COCAINE, ALCOHOL AND OTHER	161	2.90
COCAINE, AMPHETAMINE, CANNABIS AND ALCOHOL	156	2.80
COCAINE, AMPHETAMINE, CANNABIS, ALCOHOL AND OTHER	82	1.50
ALL OTHER COMBINATIONS	260	5.00
TOTAL	5,511	100.00

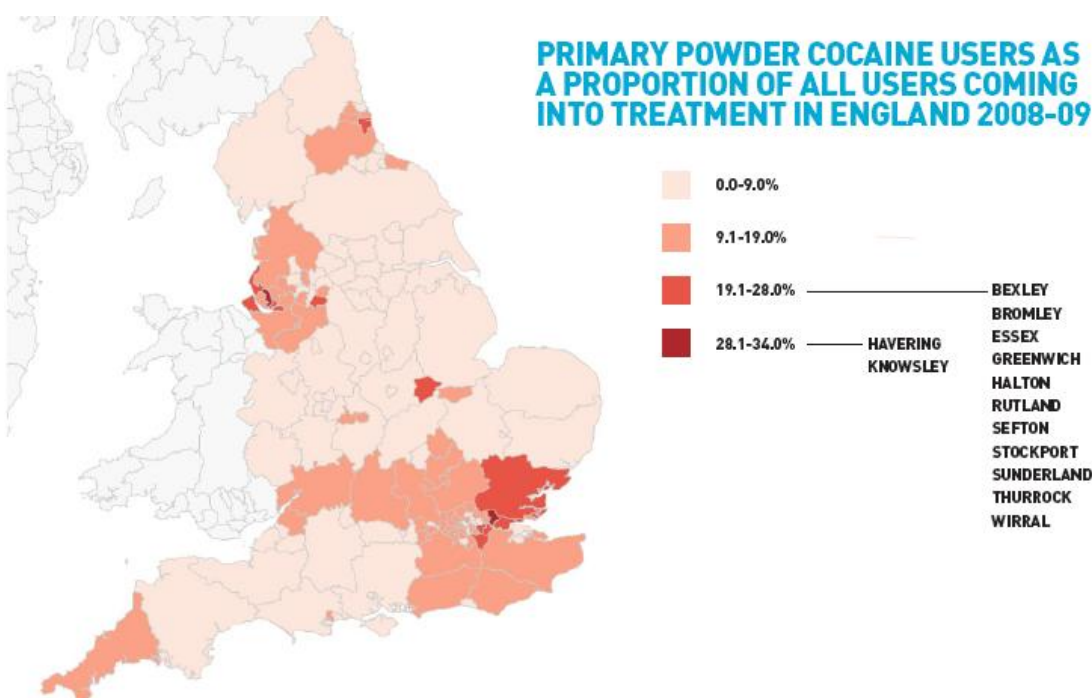
The report indicates successful outcomes for those receiving treatment for powder cocaine use, with 61% abstinent and 11% reporting improved levels of use (reduction) after six months. In addition the data showed that although 57% of those receiving treatment for powder cocaine use did not change their alcohol consumption, 23% reported abstinence and 17% reported improvements at six months on.



6. RELIABLE CHANGE INDEX

	Abstinent [n] [% of cohort]	Reliably improved	Unchanged	Reliably deteriorated
POWDER COCAINE	1,864 [60.6]	333 [10.8]	834 [27.1]	44 [1.4]
AMPHETAMINE	210 [80.8]	11 [4.2]	36 [13.8]	3 [1.2]
CANNABIS	494 [36.2]	204 [14.9]	624 [45.7]	44 [3.2]
ALCOHOL	549 [23.1]	406 [17.1]	1,363 [57.3]	62 [2.6]

Table: 40% of those receiving primary treatment for powder cocaine use had reduced or abstained from alcohol use at 6 months



4.3 Further indications of cocaethylene prevalence

The 2008 and 2009 Drugscope’s Street Drugs Trends survey findings have continued to highlight that many local drug and alcohol services are reporting poly-use as a ‘significant problem’. The growing concern relating to cocaine has also been highlighted by a number of medical professionals working with A&Es, some have reportedly daubed rising cocaine-related presentations as ‘coke strokes’, the profile of admissions being often young but seemingly healthy drinkers. European reports have also given indications in increasing poly-use; in 2006 a report by the Central Narcotics Office of France led The Guardian to publish an article entitled ‘Europeans turn to alcohol and cocaine as cannabis loses favour’²³.



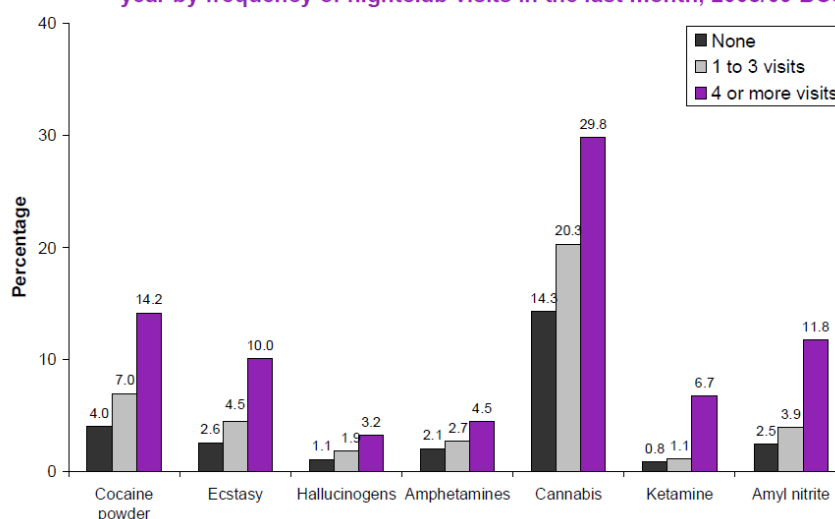
4.4 Drug Misuse Declared: Findings from the 2008/09 British Crime Survey

Findings from the *‘Drug Misuse Declared’* report highlights some significant data to associate lifestyle factors such as age, status and visits to pubs and clubs as significant determinants of levels of stimulant use, particularly cocaine. These findings demonstrate that cocaine is now the most popular stimulant drug and frequency of use is directly correlated to visits to licensed premises.

“For young people aged 16 to 24, levels of last year drug use (that is, use of any illicit, Class A or stimulant drugs) were found to be significantly higher for those who had drunk alcohol, than those who had not drunk alcohol, and as frequency of alcohol consumption increased, so did last year drug use prevalence rates.

This analysis shows that lifestyle and related personal characteristics (such as visits to nightclubs and pubs as well as marital status and age) remain the strongest characteristics associated with patterns of last year illicit polydrug use.”

Figure 4.8 Proportion of 16 to 24 year olds reporting use of individual drugs in year by frequency of nightclub visits in the last month, 2008/09 BCS



4.5 Cocaethylene detection amongst cocaine users

Research by substance misuse testing manufacturer Trimega Laboratories²⁴ found that out of those testing positive to cocaine, on average 45% also tested positive to cocaethylene. The research seemed to form part of a clever marketing strategy as it resulted in some media reports on cocaethylene.



Presence of cocaethylene in cocaine users according to Trimega Laboratories:

- North West 60%
- London 59%
- North East 54%
- Average 45%
- East Mids 43%
- South East 35%
- South West 30%
- West Mids 22%

5. Treatment and interventions

There is no specific evidence base or discussed method for treating combined alcohol and cocaine use. Therefore applying a common sense approach of assessing treatment and intervention approaches for alcohol and stimulant use must be considered.

Nonetheless, combined alcohol and cocaine users may often be more suited to alcohol interventions as a primary approach, particularly behavioural change approaches such as 'brief interventions'. This is based on a number of assumptions:

- The cocaethylene user is more likely to use alcohol as a primary drug over cocaine (based on prevalence data for each drug and anecdotal reports)
- There is a greater cultural acceptance and prevalence of alcohol use/misuse
- There is a strong evidence base for the effectiveness of alcohol interventions²⁵

Indeed factoring in cocaine and stimulant approaches to alcohol focused interventions would seem a pragmatic response to a unique drug-taking behaviour. However caution must be taken in applying a UK focused approach to stimulant interventions many stimulant services are focussed to work with crack cocaine users. Most US and UK research into 'stimulant treatment' is therefore focused on crack treatment which would not be a similar target group as the recreational alcohol and powder cocaine (cocaethylene) user.

Nonetheless the main treatment approaches for powder cocaine use/addiction are psychosocial interventions based on Motivational Interviewing of Cognitive Behavioural Therapy (CBT) methods²⁶. Therefore an approach of integrating behavioural change interventions based on an assessment of users needs and risk factors, and to identify strategies to reduce or abstain substance use, seems practicable for cocaethylene users.



5.1 Applying alcohol and cocaine interventions

Some of the key treatment and intervention approaches are considered below for their potential suitability for combined alcohol and cocaine users.

Tier 1 & 2 approaches

Harm minimisation information: Services could provide service users with cocaethylene information raising awareness of risks and harms.

Brief Interventions/FRAMES: FRAMES as a well researched and commonly applied approach for delivering brief intervention behaviour change could be applied to cocaethylene users by providing appropriate feedback, advice, options and self-efficacy.

Mutual aid/self-help: Alcoholics Anonymous (AA) is important for large numbers of people seeking to abstain from alcohol use and similar mutual aid groups have been established for a variety of addictions. Cocaine Anonymous (CA) has become increasingly popular; research suggests that cocaine users seeking abstinence are up to four times more likely to reduce problematic cocaine use (McGowan, 2008). Promoting access to mutual aid and self-help groups is often considered as an opportunity to increase alcohol treatment access and availability - CA may be of significant value in supporting cocaethylene users.

Tier 3 & 4 structured treatment approaches

There is similarly no structured treatment evidence base for cocaethylene users but as applied to addictions treatment, lifestyle counselling approaches and structured psychosocial interventions are likely to be effective. However several points may need to be considered when looking at specific cocaethylene treatment approaches:

- Cocaethylene users may not necessarily fit well within drug or alcohol services which could affect treatment effectiveness.
- Indications that drug use is subject to various factors including supply and availability and quality may mean cocaethylene users are likely to poly-use a range of other drugs dependant on a range of variables

Motivational Interviewing (MI): Well evidenced for both alcohol and cocaine use interventions and addictions treatment. Easily used in brief structured counselling, particularly applying OARS (to emphasise rapport and empathy objectives). Basic tools such as the decisional balance (+ & - in using cocaethylene) are quick and effective. A recent study²⁷ found further evidence that MI approaches are effective for cocaine users.



Cognitive Behavioural Therapy (CBT): CBT plays an important part in many structured treatment approaches. A specific cocaine CBT manual is provided on the National Treatment Agency (NTA) site; 'A Cognitive-Behavioural Approach: Treating Cocaine Addiction' (Carroll KM, 1998).

Relapse prevention: May be particularly effective when used on cocaethylene users particularly when exploring high risk situations and triggers. Practitioners can explore what triggers what and then plan accordingly, i.e. does alcohol prompt the user to use cocaine or vice versa.

Mapping: (see NTA routes to recovery ITEP, BTEI). Can be adopted in tier 1 & 2 settings. Maps are a good visual way to represent issues with clients, set goals etc.

6. Academy cocaethylene training development

The AERC Alcohol Academy has been working with an expert trainer and addictions leads to develop a specific training package based on the above implications for cocaethylene users. The one day session aims to cover two key identified aspects of cocaethylene treatment and intervention approaches. This is a specifically tailored package based on the available evidence base as well as significant treatment experience from working with combined users. [Contact us](#) for further information.

7. Case studies and targeted approaches in the UK

Nottingham's 'Heart and Soul of the party'

Nottingham's Crime and Drugs partnership worked with Nottingham Trent University students to produce an award winning awareness campaign. 'Heart and Soul of the party' delivered a range of materials to raise awareness of the impacts and risk factors of combining cocaine and alcohol use. Materials can be [downloaded here](#).



Police & licensing approaches

Durham constabulary's Substance Misuse Unit have developed a number of responses to account for identified issues of cocaine use amongst the night time economy. This includes awareness raising of enforcement officers, premises and the public around the impact and potential risks of combined use. Risk factors for police range from possible increased aggression to higher risk of heart attack during arrest. A cocaethylene and the Night Time Economy presentation by Sergeant Tim Robson can be found [here](#).

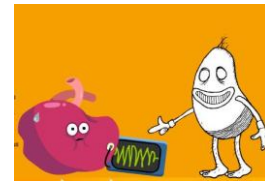


Kent Police have promoted '[Operation Drawbridge](#) - a general approach to tackling recreational drug misuse at community level' aimed at reducing drug and alcohol related violence. A one to one dialogue from police with customers entering premises forms an early-intervention and detection approach which also looks at:

- How drug patterns are profiled in licensed premises
- What licensees can do to police their own pubs and clubs
- The concept of 'condition of entry' requirements
- The combined use of trace detection and passive dogs as an enforcement tactic
- Making the links to treatment for the social drug scene
- How recreational misuse is supported by awareness training in schools and the workplace

Drinking with Charlie

Bolton Drug and Alcohol Action Team (DAAT) have produced a website www.drinkingwithcharlie.co.uk to raise awareness about the risks of cocaethylene.



Further approaches

A number of other campaigns have been produced by local DAATs such as Southwark's awareness [campaign](#) and Havering DAATs '[Project Weekend](#)'. However without robust evaluations it is difficult to certify the impact of such campaigns. Many areas are developing pro-active licensing approaches and through mechanisms such as Pubwatches and responsible retailing schemes may be seeking to prevent drug impacts on premises.

8. Cocaethylene – an issue for alcohol policy?

Whilst the alcohol agenda has recently built up momentum in both national and local terms, it may be viewed that one area over-looked by separate national drug and alcohol strategies is the need to look at approaches to poly-use. Most of the useful data and information available on the likely use and impact of cocaethylene is derived from cocaine related information, which appears to consistently overlook the significant role of alcohol.

There is a need to develop better understanding of combined use²⁸ in order to discover more about the effects of cocaethylene, including its impact upon violence in the night-time economy and domestic settings. Possible avenues for data collection might include the incorporation of poly-drug profiling as part of 'Cardiff' model schemes of data collection in hospital Accident and Emergency Departments and as part of routine screening in Alcohol Arrest Referral schemes. The Academy feels that by further



exploring key issues and practice approaches, an improved policy and strategy dialogue can be developed to support progress. Combined use should also be further considered within the delivery of prevention and treatment approaches for drug and alcohol use.

9. Areas for development

It is apparent there are a number of complex areas that need further development in order to better identify and respond to issues resulting from rising cocaethylene prevalence. These are likely to include:

- Research and knowledge
 - Further knowledge on risks and harms
 - Prevalence and location data
 - User profiles
 - Perceptions and attitudes data (e.g. exploring 'normalisation')
- Development of the most effective/tailored treatment responses
- The value of awareness raising, health promotion and practitioner training
- Preventing alcohol-related violence– exploring targeted approaches for cocaethylene users in the night time economy and other settings

10. Conclusion

Based on available prevalence data, trends and anecdotal reporting, many of the 7.7 million 'binge' drinkers in the UK may be increasingly using cocaine, unaware of the increased health and social risks presented by their poly-use. However, few targeted approaches have been adopted to stem the rise of what may be a 'ticking time bomb' for public health. This lack of attention is partly as a result of limited data and understanding, but also because the nature of drug and alcohol treatment does not encompass the complex and increasing popularity of recreational based poly-use.

This report takes the position that recognising cocaethylene as poly-use is important; however it should be particularly recognised within the context of alcohol policy. Alcohol is likely to be the primary drug for most combined users as the more widely used drug (and that preliminary alcohol consumption may be required for the formation of cocaethylene). As the alcohol agenda increasingly converges with substance misuse and public health agendas, opportunities to develop treatment and brief intervention responses suitable for cocaethylene users must be integrated. With the continued focus on the impact of the liberalisation of licensing laws, addressing the social consequences and risks of cocaethylene use must also be explored within the alcohol-related crime and disorder agenda.



Key documents & resources

- ‘*The cocaine trade*’ Home Affairs Select Committee (HASC) report; February 2010. Available: <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhaff/74/7402.htm>
- ‘*Powder cocaine: how the treatment system is responding to a growing treatment problem*’ National Treatment Agency; March 2010. Available: http://www.nta.nhs.uk/news_events/newsarticle.aspx?NewsarticleID=214
- ‘*Cocaine Dossier*’ Drugscope 2010: a selection of reports on cocaine from the last 15 years including the article ‘*The hidden mixer*’ exploring alcohol and cocaine’s link to violence. Available: <http://www.drugscope.org.uk/resources/cocaine-dossier.htm>
- Cocaethylene awareness raising resources including www.drinkingwithcharlie.co.uk and ‘*Heart and Soul of the party*’ materials: <http://www.nottinghamcdp.com/index.asp?pageid=pageid279.xml>
- ‘*A Cognitive-Behavioural Approach: Treating Cocaine Addiction*’ (Carroll KM, 1998) http://www.nta.nhs.uk/areas/clinical_guidance/psychosocial_interventions_resource_library_%28PIRL%29/group_1/cognitive_behavioural_therapy_for_adult_cocaine_users.aspx
- Key alcohol health and treatment guidance including:
 - ‘*Models of Care for Alcohol Misusers*’ (DoH 2006)
 - ‘*Review of the Effectiveness for the Treatment of Alcohol Problems*’ (NTA 2005) and;
 - ‘*Signs for improvement: commissioning interventions to reduce alcohol related harm*’ (DoH 2009)All available at www.alcohollearningcentre.org.uk
- ‘*The Practical guide for preventing and dealing with alcohol related problems*’ (Home Office 2009) <http://www.crimereduction.homeoffice.gov.uk/drugsalcohol/drugsalcohol104.htm>

This briefing paper was produced by James Morris on behalf of the AERC Alcohol Academy, with special contributions from Dr Phil Hadfield, Centre for Criminal Justice Studies and Danny McGowan, specialist substance misuse trainer.

For further information, to enquire about Cocaethylene training courses or for further comments, please [get in touch](#).



References

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