



Cocaine

Principal findings

- ◆ Although cocaine production in South America continued to decline during 1998 supply remains sufficient to meet worldwide demand. As consumption decreases in the United States, cocaine-trafficking groups can be expected to try to expand into other markets, such as Australia.
- ◆ New South Wales, in particular Sydney, is the entry point for most cocaine coming into Australia and is the main distribution hub for the rest of the country. Sydney is also the most prominent cocaine-consumption centre in Australia.
- ◆ Importations detected at the Customs border have increased steadily since the mid-1990s. A joint operation by the Australian Federal Police and Customs in December 1998 resulted in the seizure of 225 kilograms of cocaine—the largest in Australia's history.
- ◆ Cocaine availability remains high in Sydney. Cocaine is available in other capital cities but not to the same extent as in Sydney.
- ◆ There is no evidence of an increase in cocaine use among the general population. Since 1996–97 there has, however, been a marked increase in cocaine use among Sydney people who inject heroin.

Description

Cocaine hydrochloride is a white crystalline alkaloid powder processed from the leaves of the coca plant (*Coca erythroxylon* Lam). Its common names are 'coke', 'okey doke', 'C', 'toot', 'snow', 'marching powder', 'nose candy', 'blow', 'Charlie' and 'white lady'. It may also be found in paste form. 'Crack'—also known as 'freebase', 'base' and 'rock'—is an extract of cocaine hydrochloride and has the appearance of small crystals or rocks.

Main forms and methods of administration

Cocaine hydrochloride

Cocaine hydrochloride is the most common type of cocaine in Australia. It is usually administered by inhaling—or 'snorting'—directly into the nostril. Most often, users chop the powder finely with a razor blade, draw it into lines, and snort it using a rolled-up paper cone. It can also be dissolved in water and injected or taken orally by adding it to a liquid or sprinkling it on food. Powdered cocaine cannot be smoked without destroying its chemical make-up.

Freebase

Freebase is a chemically altered version of cocaine, or alkaloidal cocaine, which remains after removing the hydrochloride content. This form is usually smoked, which produces effects more quickly than snorting. Crack is a type of freebase cocaine; it looks like small crystals or 'rocks', and is usually smoked. It is not common in Australia.

Coca leaf

Traditional South Americans have been chewing the raw coca leaf for thousands of years.

Impurities

Before selling it, distributors often mix, or 'cut', cocaine with substances similar in appearance to the drug; this increases the number and weight of sales and boosts profits. Some of the diluents used can have unpleasant or harmful effects. Without testing and laboratory equipment, users and law enforcement officers cannot differentiate between substances (CEIDA 1999).

Effects

Cocaine's effects vary according to the amount taken, the user's mood and expectations, the way it is taken, and the purity level.

The immediate effects stem from stimulation of the nervous system, speeding up the activity of certain pathways to the brain. The user experiences a euphoria that reduces appetite, increases sexual arousal, heightens alertness and energy, and produces a feeling of exuberance. Injecting cocaine and smoking crack result in a quicker, more intense 'rush'.

Excessive cocaine use can cause lung or heart failure; bursting of blood vessels in the brain; fast, irregular or weak heartbeats; muscle twitching; fits; decreased libido or impotence; and weight loss. Snorting can also cause nose bleeds. Prolonged use can result in cocaine psychosis, the symptoms of which include paranoia, delusions, hearing voices, and fear of persecution.

A person who is 'high' on cocaine and driving a motor vehicle can have a false sense of security, which can lead them to take risks that may result in traffic accidents.

Regular users can develop a tolerance, whereby they need a higher dose to obtain the same effect. They can also become dependent, meaning the drug becomes central to their thoughts, emotions and activities: they use the drug compulsively and find it difficult to stop. Addiction is more likely to develop as a result of bingeing and intravenous injection.

Withdrawal symptoms occur when a dependent person stops using cocaine or severely cuts down the amount they use. Among the symptoms are nausea and vomiting, shaking fits, fatigue, weakness and hunger, craving for the drug, depression, and suicidal feelings (CEIDA 1999).

The international situation

[Unless otherwise noted, information in this section is derived from the *International Narcotics Control Strategy Report (INCSR) 1998* (Bureau for International Narcotics and Law Enforcement Affairs 1999).]

Overview

Cultivation of coca leaf in South America has been declining since 1996, although the 1998 yield was still sufficient to meet worldwide demand.

The United States remains the biggest cocaine market for Colombian drug syndicates and, despite decreasing consumption levels in the past decade, cocaine is still considered the most serious drug threat in the States. Crack cocaine is of particular concern to US authorities, and the practice of combining heroin and cocaine (known as 'speedballing') through injection or inhaling is becoming increasingly common.

The south-west border of the United States is the main entry point for cocaine shipments, accounting for about 60 per cent of cocaine entering the country. Drugs are transported across the border by Mexican smugglers, who are paid in cocaine by Colombian drug syndicates (USDEA 1999a).

Cocaine use is increasing in Europe, particularly in Russia, where post-Soviet era entrepreneurs can afford to buy the drug. The International Narcotics Control Board reports that the supply, price and purity of cocaine remain high in Europe (INCB 1999).

The Board also reports that crack cocaine has become the second most frequently abused illicit drug in the Caribbean region in the last few years and is linked to the growing incidence of violence. Seizures of cocaine have risen steadily in the past five years in the Caribbean. All countries in the region are being used as transit points in the shipment of cocaine. In May 1999 a UK Royal Navy frigate patrolling the area seized 8 tonnes of cocaine from two Panama-registered ships; the two interceptions occurred on consecutive days (Royal Navy 1999).

In Canada HIV infection has increased in many metropolitan areas as a result of the increasing number of addicts reported to be injecting cocaine in combination with other drugs.

Cocaine is available worldwide (INCB 1999). It is common throughout Asia, the Middle East and Africa; African seaports and airports serve as transshipment points for cocaine arriving from South America.

Cocaine-producing countries

Peru, Bolivia and Colombia are the only countries currently cultivating coca on a significant scale. Despite a sharp rise in cultivation in Colombia, the Bureau of International Narcotics and

Table 5.1: Net coca cultivation, potential leaf production and potential cocaine: Peru, Bolivia and Colombia, 1993 to 1998

Country	1993	1994	1995	1996	1997	1998
Net cultivation (hectares)						
Peru	108 800	108 600	115 300	94 400	68 800	51 000
Bolivia	47 200	48 100	48 600	48 100	45 800	38 000
Colombia	39 700	45 000	50 900	67 200	79 500	101 800
Total	195 700	201 700	214 800	209 700	194 100	190 800
Potential leaf production [tonnes]						
Peru	157 600	165 400	183 600	174 700	130 200	95 600
Bolivia	84 400	89 800	85 000	75 100	70 100	52 900
Colombia	31 700	36 000	40 800	53 800	63 600	81 400
Total	273 700	291 200	309 400	303 600	263 900	229 900
Potential cocaine [tonnes]						
Peru	410	435	460	435	325	240
Bolivia	240	255	240	215	200	150
Colombia	65	70	80	110	125	165
Total	715	760	780	760	650	555

Source: Bureau for International Narcotics and Law Enforcement Affairs (1999)

Law Enforcement Affairs estimates that world output of cocaine during 1998 fell to its lowest levels since estimates were first produced in 1987. Table 5.1 shows estimated cultivation and production figures for Peru, Bolivia and Colombia from 1993 to 1998. It is estimated that production has declined from 715 tonnes in 1993 to 555 tonnes in 1998.

Colombian cartels have established export networks around the world. One source has estimated the export figure to be around 500 tonnes a year (ERRI 1998).

The United States has been helping South American governments in cocaine-producing countries to limit production levels by using strategies such as reducing crops, interdicting drugs, targeting trafficking syndicates, bolstering law enforcement and judicial systems, and curbing drug-money laundering.

In 1998 overall coca cultivation in Peru, Bolivia and Colombia fell by 17 per cent, to 190 800 hectares. A total of 29 420 hectares was eradicated using crop-reduction programs in Peru and Bolivia, representing a potential 150 tonnes of cocaine that did not reach the market. This result is also partly due to the El Niño drought and US-sponsored crop-substitution programs. Despite the decreases in production, it is considered that the trend will continue next year only if drought conditions prevail.

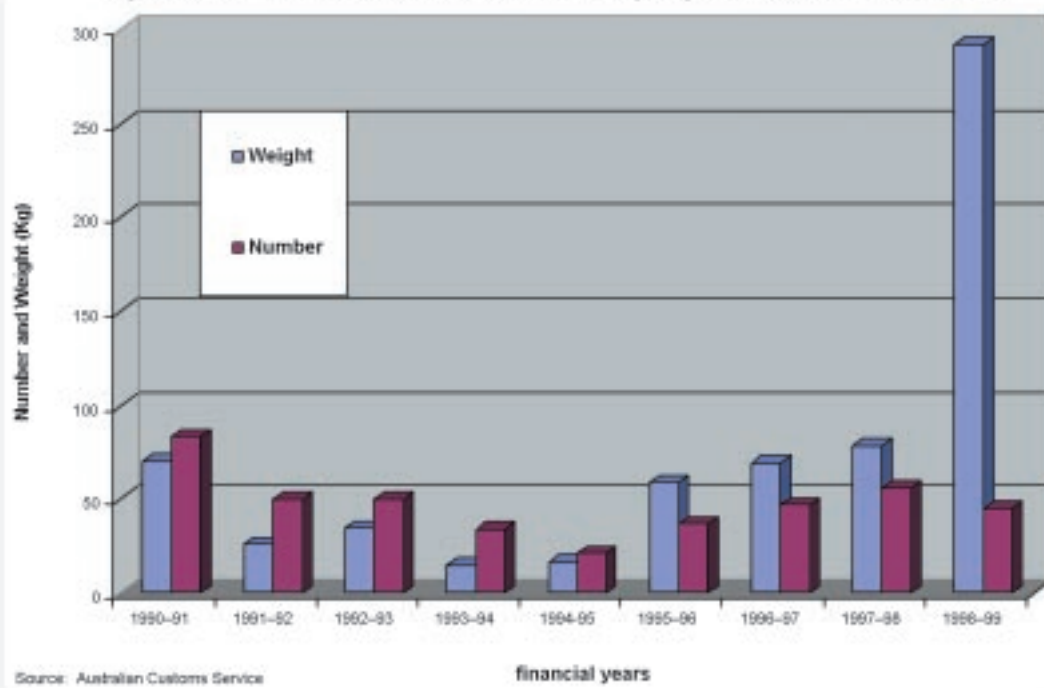
Colombia

Colombia is the world's leading producer of cocaine, producing about 80 per cent of world supply. An aggressive aerial coca-eradication program took place in 1998, spraying over 65 000 hectares of the plant, which is about 50 per cent more than the total sprayed in 1997. The Colombian Government estimates that this has resulted in 52 866 hectares of coca plantation being destroyed—note that spraying is not 100 per cent effective.

In past years the Government's eradication program concentrated on traditional growing areas. In response, drug syndicates increased the cultivation of coca in the south-west of the country, in Caqueta and Putumayo Provinces, which are controlled by rebel insurgent groups allied with the cocaine cartels. In recent years the Government has not been able to operate crop-spraying aircraft in these areas for political and security reasons. In 1998, however, spray operations were expanded into Caqueta Province.

The new Government of Andres Pastrana has initiated a peace dialogue with the largest insurgent group, the Revolutionary Armed Forces of Colombia, and implemented a new national drug-control strategy that places a strong emphasis on encouraging farmers to grow other crops. Despite these efforts Colombia saw a 28 per cent increase in coca cultivation in 1998, with all new growth occurring in areas located outside crop-spraying zones.

Figure 5.1: Cocaine detections at the Customs border, by weight and number, 1990-91 to 1998-99



Peru

In 1998 coca cultivation in Peru was estimated to be 51 000 hectares, which represents a decline of 26 per cent on the 68 800 hectares cultivated in 1997 and a decline of 56 per cent since 1996. Eradication of coca cultivation has reached a high of 7825 hectares. Four years of disruption to the 'air bridge' out of Peru to Colombia has made coca cultivation unprofitable in many previously active production areas of Peru, forcing farmers to seek new occupations and livelihoods. The 'air bridge' initiative is a US-sponsored program whereby air traffic from Peru, Colombia, Bolivia, and now parts of Brazil, is monitored by sophisticated radar in the mountain regions. This may be one reason why coca leaf prices rose throughout Peru in August 1998, although other factors—such as new transportation methods, new markets for Peruvian drugs, market forces, and possibly increased cocaine hydrochloride production in Peru—may also have been influential.

Bolivia

Bolivia's 1998 coca crop was the smallest in a decade. Although the decrease was not as dramatic as in Peru, eradication initiatives by Bolivian government agencies brought coca cultivation down 17 per cent, to a 10-year low of 38 000 hectares. The Government's crop-control program achieved record levels of eradication, moving closer to the stated goal of eradicating all coca by the year 2002. Interdiction efforts were equally successful, with increases in arrests and in chemical seizures. Other initiatives continue to provide opportunities for alternatives to coca growing.

The Australian situation

Importation and seizures

In Australia, Customs reported making 45 seizures of cocaine at the border in 1998-99 and 4 seizures of coca plants. The total weight of the 45 cocaine seizures was 292.23 kilograms. Figure 5.1 shows cocaine detections at the Customs border, by weight and number, since 1990-91. Detections by weight have progressively increased since 1994-95; detections by number have increased since 1994-95. The enormous increase in seizure weight in 1998-99—292.23 kilograms compared with 78.2 kilograms in 1997-98—is accounted for by one large seizure at Coffs Harbour in New South Wales (see below). The actual number of seizures decreased slightly, from 56 in 1997-98 to 45 in 1998-99.

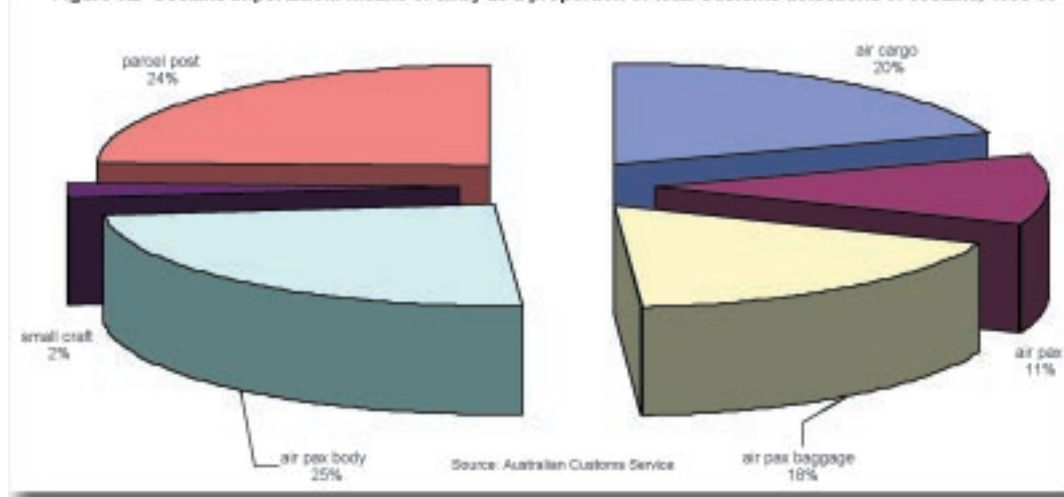
Of the 45 seizures recorded by Customs during 1998-99, 35 were made in Sydney, representing 78 per cent of all Customs seizures. Four seizures were made in Queensland, five in Victoria and one in Western Australia. Intelligence suggests that smaller quantities of cocaine are being imported into South Australia from overseas.

Eighteen of the 45 cocaine detections at the Customs border in 1998-99 came directly from the following South American countries: Chile (five), Brazil (six), Argentina (three), Ecuador (two), and Venezuela (two). The remainder of importations came from various other transit countries.

Record seizure

An 18-metre Venezuelan ketch, the *Maeva Chiqui*, arrived at Coffs Harbour in New South Wales on 5 December 1998. The vessel had sailed from Panama via Tonga. Between the inner and outer hulls of the vessel's runabout Australian Federal Police and Customs officers found 224.6 kilograms of cocaine—the largest cocaine seizure in Australia's history. Four people were arrested and charged with importing a prohibited import.

Figure 5.2 Cocaine importation: means of entry as a proportion of total Customs detections of cocaine, 1998-99



Among popular importation routes used by cocaine couriers travelling from South America are routes from Argentina, Chile and the United States to New Zealand and routes via Pacific island nations such as Papua New Guinea, Fiji, Samoa and Tonga.

Of 25 significant cocaine detections reported by Customs, eight came via New Zealand and five via the United States.

There was a 120 kilogram seizure in Venezuela in March 1999 from an Asian container vessel bound for Fiji with a possible connection to Australia.

Methods of importation and concealment

Among the popular methods of concealing cocaine are hiding it in airline passengers’ baggage and in postal articles and using more elaborate internal and external body concealment methods. Another innovative practice involves altering the appearance of the drug by producing ‘black cocaine’ (see next section). Figure 5.2 shows the most popular means of entry used to import cocaine into Australia.

Table 5.2 shows Customs cocaine detections for 1998–99, by quantity, number and weight. Under the Commonwealth’s *Customs Act 1901* a personal amount is below 2 grams, a trafficable amount is above 2 grams and a commercial amount over 2 kilograms.

Black cocaine

Black cocaine is not a different form of cocaine: it is the result of attempts to avoid detection. Cocaine is blended with other compounds to form a dark-coloured substance—not necessarily black since it may also appear reddish. Typically, it is 40 per cent

pure cocaine with cobalt and ferric chloride added. Interpol reported that eight seizures of black cocaine were made overseas in the 12 months to May 1999; it appeared on cargo manifests as red pigment, iron filings and toner for computer printers. After delivery, solvents are used to turn the black cocaine back into a marketable white powder.

Trafficking routes within Australia

Sydney acts as the main distribution point for cocaine going to other parts of Australia. Most States and Territories report that cocaine is transported from Sydney – by vehicle and commercial aircraft. A commonly used cocaine-trafficking route from Sydney appears to be north along the eastern seaboard to Cairns, via Byron Bay, the Gold Coast and Brisbane, with cocaine being sold at each of these locations (NCA 1999).

Distribution

The New South Wales Crime Commission reports that cocaine is being distributed in Kings Cross in small, resealable plastic packets or by substituting the powder found in aspirin capsules with cocaine. Distributors place the capsules in rubber water balloons, which are secreted in the mouths of street sellers (also known as ‘runners’), who trade directly with users.

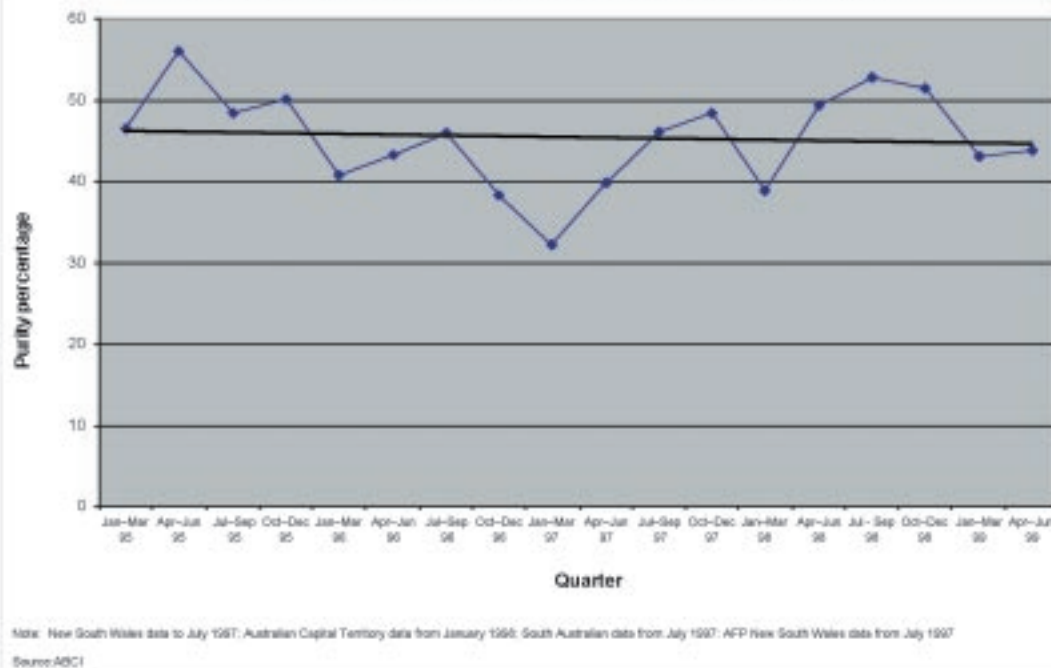
The Commission also reports that some retail outlets facilitate the distribution of cocaine while conducting legitimate business. Cocaine is known to be supplied from licensed premises such as restaurants and clubs.

Table 5.2: Cocaine detections, by quantity, number and weight, 1998-99

Drug category	Number	Weight (kg)
Personal	2	0.15
Trafficable	26	11.85
Commercial	17	280.23
Total	45	292.23

Source: Australian Customs Service

Figure 5.3: Cocaine: Average quarterly purity levels, January 1995 to July 1999



Market indicators

Prices

New South Wales Police report that cocaine is sold in ‘controlled’ areas—mainly Kings Cross and the inner suburbs of Sydney. Police at the Kings Cross Drug Unit advise that a structured market exists, with hierarchies, specific roles and distinct areas of operation. For example, Tongan and Samoan groups are reported to have a franchise arrangement with Lebanese suppliers. One group, led by two brothers operating at Kings Cross, had between 15 and 20 distributors working for it, supplying cocaine to brothels in the area.

The New South Wales Crime Commission reports that Lebanese, South American, Tongan, Filipino, Romanian, Chinese and Anglo-Australian ethnic groups are involved in distribution. The New South Wales Police Service reports that some members of outlaw motorcycle gangs are also involved in cocaine distribution in the Sydney area. Informants—including users, health workers and police—surveyed between July and September 1998 for the Illicit Drug Reporting System also commented on Pacific islanders’ involvement in inner-city cocaine dealing (McKetin et al. 1999b).

South Australia Police reports that people involved in cocaine distribution in that State are aged between 25 and 45 years and belong to no particular ethnic group. Distribution occurs mainly in the ‘club’ scene in the city area of Adelaide and more affluent people are the main customers.

Victoria Police reports that Romanian and Caucasian males aged between 35 and 50 years are involved in cocaine distribution, while Latin-Americans distribute directly in nightclubs.

The Western Australia Police Service advises that cocaine distribution involves nightclub staff, crowd controllers and doormen.

Anecdotal information provided to the Bureau by the Queensland Police Service’s Drug Intelligence Unit suggests that cocaine distribution in that State is predominantly the province of Romanian syndicates.

The per-gram price of cocaine remained stable throughout 1998–99 in most States, although in Queensland there was an increase in the last quarter, from \$120 to \$200. In New South Wales the per-gram price was steady, at \$200, and in South Australia it remained at \$250. In Victoria the price varied between \$200 and \$500 in the latter half of 1998 and stabilised at \$250 during the first half of 1999. In Western Australia the price varied between \$180 and \$250 per gram. Prices were not available for the Australian Capital Territory, the Northern Territory and Tasmania.

Cocaine sold on the streets of Sydney and Adelaide is mostly in ‘cap’ form, measuring about 0.2 of a gram. Sydney police reported that a cap of cocaine generally brought \$40 to \$80 in 1998–99. Other sources reported anecdotally that caps could be bought in Sydney for between \$50 and \$60. The Illicit Drug Reporting System survey in Sydney found that the price had decreased from \$80 a cap in 1997 to \$50 a year later (McKetin et al. 1998).

It is interesting to note that the upper price limit for a cap of cocaine or heroin in Sydney was about the same, at \$70 to \$80 in 1998–99, according to police sources. In contrast, the minimum price for heroin caps was \$25, as opposed to \$40 for cocaine caps.

Prices for caps in other States were not available from police. The Illicit Drug Reporting System survey of injecting drug users in Adelaide did, however, provide a price of \$50 per cap (Hayes 1999). Survey respondents in Melbourne were unable to provide a price for caps, which suggests that cocaine was not readily available at street level (Rumbold & Fry 1999).

The per-kilogram price of cocaine sold in Australia is between \$100 000 and \$130 000, which is high compared with some other countries.

Purity

Figure 5.3 shows average quarterly purity levels for cocaine detections analysed from January 1995 to July 1999. At the national level purity dropped slightly in that time.

Table 5.3 shows average purity levels for each State save Tasmania, by quarter, for 1998–99. Average purity in Queensland declined steadily, from 57 per cent to 28 per cent. In South Australia average purity started at 60 per cent but fell to 40 per cent in the second quarter and stayed at that level for the remainder of the year. In Victoria and Western Australia average purity levels fluctuated. No figures are available for the Australian Capital Territory, the Northern Territory and Tasmania. New South Wales and South Australian figures for some quarters are also unavailable.

Availability

Sydney is Australia's main centre for both the supply and use of cocaine. Kings Cross remains the area of most interest, although the New South Wales Crime Commission and the New South Wales Police Service report some cocaine dealing and use in Cabramatta, a suburb of western Sydney that is associated with the heroin trade. Because of the high police profile in Cabramatta, cocaine is also being sold in nearby Liverpool and Campbelltown.

Injecting drug users who responded to the Illicit Drug Reporting System survey confirmed that cocaine was readily available in Sydney (McKetin et al. 1999a). The Kirketon Road Centre in Kings Cross confirms this information on the basis of interviews with clients, who also stated that there was a drop in availability in the inner-Sydney area from June 1999, which was possibly related to police operations. No police jurisdictions in Australia reported crack detections during 1998–99.

In Adelaide an Illicit Drug Reporting System survey of injecting drug users found that cocaine was generally difficult to obtain during 1998 (Hayes et al. 1999). South Australia Police reported, however, increased cocaine availability in 1998–99, particularly in Adelaide.

In Melbourne injecting drug users reported that cocaine was difficult to obtain during 1998–99. Victoria Police reported slight increases in availability, the bulk of the cocaine being available in the inner metropolitan area of Melbourne. Western Australia Police reported increased supply around the Perth metropolitan area and in the city's nightclub scene. The Australian Federal Police in Queensland reported that cocaine is available on the Gold Coast. Anecdotal information received by the Australian Federal Police in Cairns suggests that cocaine is available but is not the drug of choice in northern Queensland.

Arrests

Table 5.4 shows cocaine-related arrests for offences committed from 1995–96 to 1998–99 in Australia; between 1997–98 and 1998–99 there was a 34 per cent increase in arrests, from 460 to 618. In New South Wales the number of arrests increased by 53 per cent between 1997–98 and 1998–99. In Victoria the figure more than doubled. There was, however, a big decrease in Queensland.

Figure 5.4 shows nationwide arrests by age and gender for 1998–99. Most people arrested were male, and the 20–24 year age group predominated.

Arrests for males dropped from 374 in 1996–97 to 356 in 1997–98 but rose sharply to 494 in 1998–99. The number of females arrested increased from 83 to 100 in the same period.

Figure 5.5 shows nationwide arrests made during 1998–99 for cocaine consumers and providers, by age group. More people were arrested for using cocaine than for dealing. The 20–24 age group contained the highest proportion of consumers and the second-highest proportion of providers; the 25–29 age group contained the highest proportion of providers.

Domestic Seizures

Table 5.5 shows the number of cocaine seizures by police in Australia during 1998–99. In that year 695 seizures were made which compares with 445 in 1997–98; this represents a 56 per cent increase. In New South Wales there were 586 seizures, representing 84 per cent of the national total and a 50 per cent increase on the number of seizures in 1997–98 in that State. In Victoria 33 seizures were made, compared with 25 in 1997–98; this represents a 32 per cent increase. The number of seizures in Queensland decreased slightly, from 50 to 48, while a 63 per cent reduction was noted in Western Australia, from 36 in 1997–98 to 13 in 1998–99.

Patterns of use

The 1998 National Drug Strategy Household Survey found that 4.3 per cent of all respondents had used cocaine at some time in their life (AIHW 1999). The corresponding figure for the 1995 Survey was 3.4 per cent. The 1998 Survey also found that 1.4 per cent of respondents had used cocaine in the past 12 months; this compares with 1 per cent in the 1991 and 1995 Surveys. It should be noted, however, that this increase is considered statistically

Table 5.3: Average purity levels: cocaine, by State and quarter, 1998-99 (%)

State	July-Sept	Oct-Dec	Jan-Mar	April-May
New South Wales	n.a.	68	41	n.a.
Victoria	48	38	63	53
Queensland	57	44	31	28
Western Australia	45	67	37	53
South Australia	61	40	n.a.	41
Average	52.75	51.4	43	43.75

n.a. Not available

Note: Figures for the Australian Capital Territory and Tasmania are unavailable

Source: ABCI

Table 5.4: Cocaine-related arrests: Australia, 1995-96 to 1998-99

State	1995-96	1996-97	1997-98	1998-99
New South Wales	269	395	325	497
Victoria	36	29	32	70
Queensland	19	15	65	13
Western Australia	2	12	23	17
South Australia	4	8	15	10
Tasmania	0	0	0	0
Australian Capital Territory	0	0	0	0
Northern Territory	0	1	0	0
Total	330	460	460	607

Source: ABCI

insignificant because of the low numbers involved, so it should be viewed with some caution.

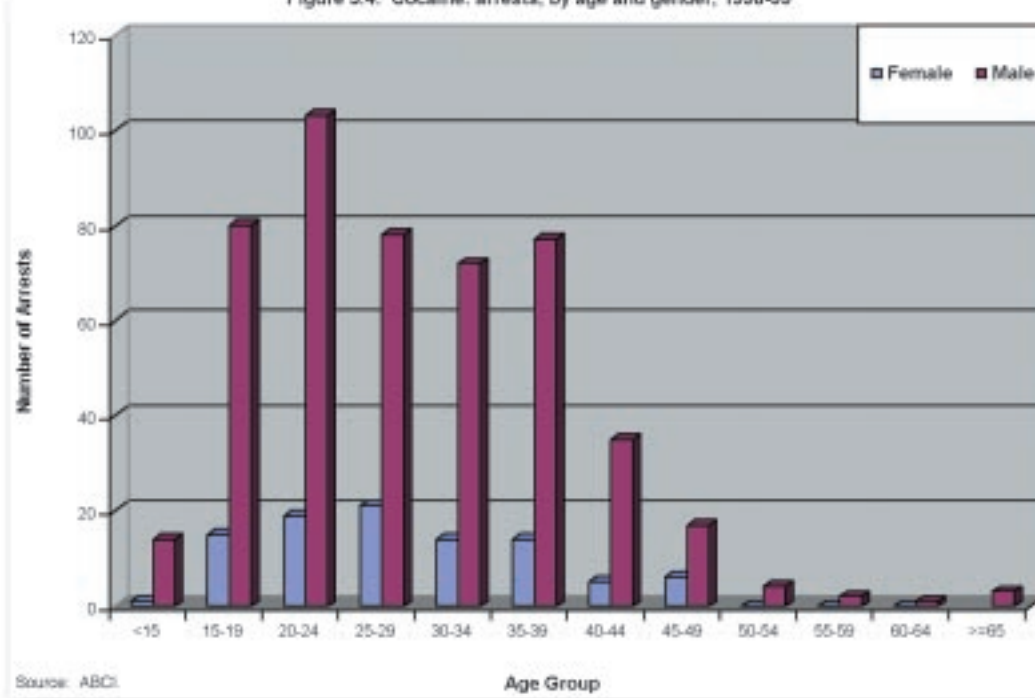
The 1998 Survey also found that 12 per cent of injecting drug users—approximately 13 200 out of an estimated 110 000 injecting drug users—had injected cocaine during 1998; the majority of these people were females, many of whom are likely to have been sex workers in the Sydney area. Ninety-nine per cent of cocaine users reported using no more than once a month (P. Williams, Australian Institute of Criminology 1999, pers. comm., 12 November).

There are two main groups of cocaine users. The first consists of casual, recreational users of high socio-economic status who take

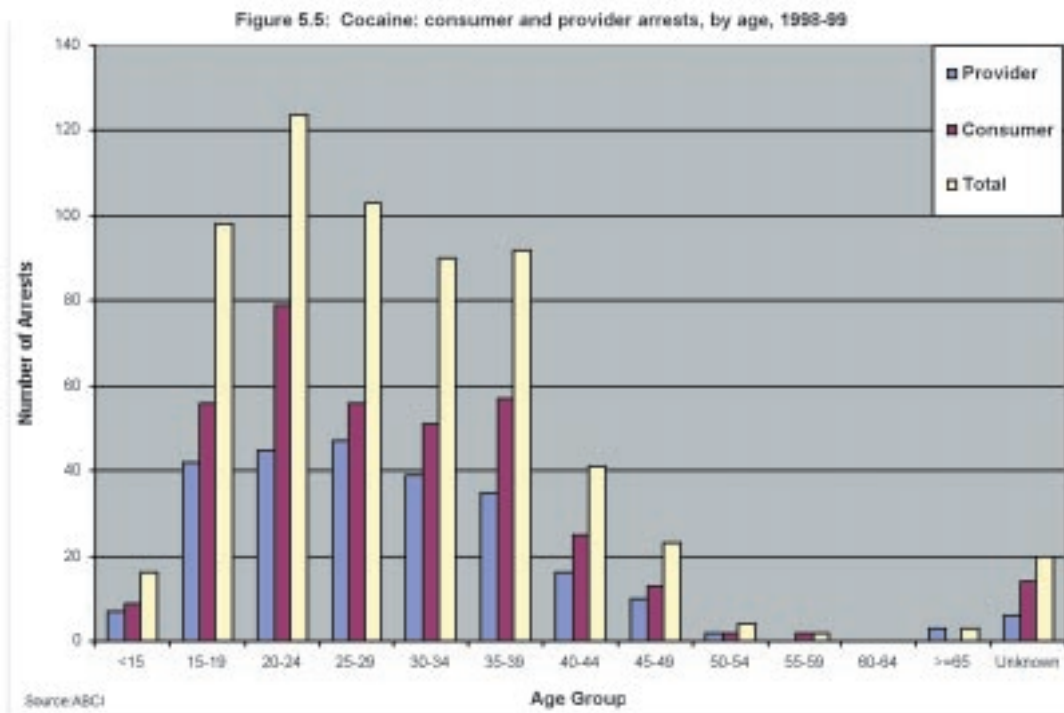
the powder intranasally. The other group consists of habitual long-term users of lower socio-economic status who typically inject the drug intravenously. As reported in the *Australian Illicit Drug Report 1997-98*, members of the first group rarely come to the attention of law enforcement, so there is a dearth of information about them. On the other hand, various sources have reported a marked increase in use among habitual users during 1998, particularly in the Sydney area.

The Kirketon Road Centre says female sex workers constitute a specific user group; they have told staff at the Centre that using cocaine boosts their confidence. In relation to the injection of cocaine among sex workers and others in the Kings Cross area.

Figure 5.4: Cocaine: arrests, by age and gender, 1998-99



Source: ABCI



A health educator with the K2 needle exchange, observed, ‘It’s not thought of as a party drug anymore—it’s a bit of a gutter drug now. If you’re an intensive cocaine injector in the Cross, you’re really at the bottom of the food chain’ (cited in Wood 1998). This statement stands in contrast to the user image traditionally associated with the drug—that of the middle class professional.

The Illicit Drug Reporting System survey conducted in 1998 was a voluntary survey of injecting drug users and other informants in Sydney, Melbourne and Adelaide. In the Sydney area the survey found that among injecting drug users cocaine use rose dramatically during 1998. When surveyed between July and September 1999, 57 per cent of injecting drug users reported using cocaine in the preceding six months; the comparable figure for 1996 was 40 per cent. The survey also found that injecting drug users are using cocaine more frequently (McKetin et al. 1999b).

Another survey of the prevalence of drug use in 1998 was the Australian Needle and Syringe Program survey. It found that the level of cocaine injection was highest in New South Wales, where 17 per cent of injecting drug users reported cocaine was the drug they had used most recently. This compares with 10 per cent in a similar survey in 1997. Interestingly, the increase was found to be

highest among people using cocaine in combination with another drug—usually heroin (McKetin & MacDonald 1999).

Later data from the Illicit Drug Reporting System show that cocaine use among injecting drug users in Sydney peaked in late 1998 and then declined as police activity intensified (McKetin & Darke 1999). The Kirketon Road Centre confirmed the increase in cocaine use among injecting drug users in inner Sydney during 1998 and reported a reduction in December coinciding with police operations targeting cocaine supply.

The trend towards use of cocaine in combination with another drug is of concern. The Needle and Syringe Program survey found that most cocaine-injecting drug users also used heroin: it appears that cocaine has replaced amphetamines as the stimulant of choice among heroin users. Three per cent of those surveyed had used both heroin and cocaine together, which is called ‘speedballing’ (McKetin & MacDonald 1999). The Kirketon Road Centre and the New South Wales Crime Commission both reported that from mid-1998 many users started speedballing. As a health educator explains, ‘Some people use heroin and coke in the same hit, others might alternate between them. Heroin is sometimes used to come down off the coke’ (cited in Wood 1998).

Table 5.5: Cocaine: number of seizures, by State and Territory, 1998-99

Amount	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	TOTAL
Seizures (numbers)	586	33	48	13	9	—	4	2	695
weight (grams)	87846	472	3475	3360	14	—	1	6	95174
Missing	227	11	26	3	—	—	—	—	267

—: Zero
 Note: ‘Missing’ refers to the number of seizures for which no weight was recorded
 Source: ABCI

Frequent using and bingeing by some injecting drug users is another aspect of cocaine use that is of concern. The relatively short-term effect of cocaine contributes to compulsive bingeing by some users, who may inject anywhere between three and 30 times a day. The 1998 Illicit Drug Reporting System data show that 17 per cent of injecting drug users in Sydney were injecting daily, compared with 2 per cent in 1997 (McKetin et al. 1998). The Kirketon Road Centre reported that some users are injecting at least two or three times a day. Cocaine binges lasting several days usually stop when the user is arrested or runs out of money. The 1995 and 1998 National Drug Strategy Household Surveys found no daily cocaine use among the general population (P. Williams (Australian Institute of Criminology) 1999, pers. comm., 12 November).

A comparison of injecting cocaine users with other injecting drug users showed that the former were more likely to be unemployed, to have lower levels of education, and to be more involved in crime (McKetin & Darke 1999).

The Illicit Drug Reporting System survey found the increase in cocaine use was mostly in injecting powdered cocaine. There is no evidence of an increase in smoking cocaine or crack, and only 3 per cent of those surveyed reported using crack. Clients of the Kirketon Road Centre report no instances of crack use or availability. Use of this form of cocaine is uncommon in Australia. Whereas in the United States, one-third of the 4.2 million people who used cocaine in the past 12 months during 1997, used crack (Office of National Drug Control Policy 1999). Although most observers agree that crack cocaine use in Australia is low, in the 1998 National Drug Strategy Household Survey 14.2 per cent of cocaine users reported using crack. This is surprising but, because of the small sample size of cocaine users (42), the percentage is considered statistically unreliable (P. Williams (Australian Institute of Criminology) 1999, pers. comm., 12 November).

At present there is no substantial evidence of an increase in cocaine use among injecting drug users in other Australian cities (McKetin et al. 1999a) or among the general population (AIHW 1999).

Queensland police advise that preliminary results of the Drug Use Monitoring in Australia (DUMA) project suggest that a small proportion of drug users are injecting cocaine in that State. Of 251 respondents, only 14 stated they had injected cocaine in the preceding 12 months. Results from urinalysis testing do not reflect recent use, suggesting that these respondents are mainly infrequent users. At this stage this trend has not presented any noticeable problems for police.

In Melbourne only 9 per cent of injecting drug users responding to the Illicit Drug Reporting System survey said they had injected cocaine in the preceding six months; a further 9 per cent said they had snorted it in the preceding six months. It would seem cocaine use is not prevalent among injecting drug users in Melbourne—in contrast with Sydney (Rumbold & Fry 1999).

In Western Australia anecdotal information from the Alcohol and Drug Co-ordination Unit suggests cocaine is in high demand in the Perth area. Traditional heroin users are reported to be experimenting with cocaine and mixing the two drugs. In general, users tend to be in their 20s and 30s—heroin users are usually younger. Anecdotal evidence from the Next Step Community Group in Perth suggests that some cocaine users are mixing the drug with amphetamines.

Information from Northern Territory police suggests that there has been some increase in cocaine use in the Darwin area. No quantitative data were provided, however, nor were there any arrests. Only two seizures were recorded in 1998–99.

In South Australia the 1998 Illicit Drug Reporting System survey reported that use of cocaine in Adelaide was stable.

Health and safety concerns

People who inject cocaine persistently often use high-risk injection practices, such as needle sharing. Their behaviour can be more unpredictable than that of other drug users, which results in poor regard for the hazards associated with using dirty needles. Moreover, because of the drug's short-term effects, cocaine users often inject several times a day, adding to the risk if needles are shared. Law enforcement officers should be mindful of the risks of infection from needlestick injuries and of unpredictable behaviour from heavy and addicted users of cocaine.

Given the considerable increase in the use of cocaine by injection it is reasonable to assume that the risk of infection with blood-borne viruses has also increased: this has significant implications for public health.

Evidence from the United States indicates that the combined use of heroin and cocaine can be highly dangerous. It was the most common drug combination causing death in the United States during 1998 (USDEA 1999b).

The Illicit Drug Reporting System survey in Sydney found an increase in detection of cocaine in the urine samples of methadone clients and in the toxicology results of overdose fatalities. The number of cocaine-positive urine samples in 1998 doubled in comparison with 1997, as did the number of overdose fatalities in which cocaine was a factor (McKetin et al. 1999b).

Conclusions

Although cocaine production in South America is declining, there appears to be no shortage of supply to meet world demand. Cocaine consumption in the United States, the world's largest market, is showing a marked decrease, and the cartels can be expected to try to expand into other markets, such as Australia.

Importations detected at the Australian Customs border have increased since the mid-1990s. Most of the cocaine is coming into New South Wales, and Sydney appears to have the highest level of cocaine use and to be the hub for distribution to other parts of the country. In March 1999 a large shipment was intercepted in Venezuela that was possibly destined for Australia.

Cocaine prices generally remained stable in 1998–99; the exception is the price per cap, which decreased in Sydney. The mean purity level of cocaine also declined slightly during 1998–99, a trend that has been observable since 1995. Cocaine availability in Sydney remained high. The drug was also available in the other capital cities, but to a limited extent. There is a lack of information about cocaine availability in regional Australia. Most sources agree that the use of crack cocaine remained low and there is no evidence of it increasing.

According to the Illicit Drug Reporting System survey and other sources, cocaine injecting continued its upward trend but appears to be limited mainly to Sydney, where it peaked in late 1998. The responses of the 2600 injecting drug users involved in the 1998 Australian Needle and Syringe Program survey show that 17 per cent of New South Wales injecting drug users injected cocaine, compared with a national average of only 2 per cent. Although the Illicit Drug Reporting System conducts surveys among injecting drug users only, a number of reports highlight the status of Sydney as the 'cocaine-injecting capital'. The survey results also suggest that the increase in cocaine use in Sydney has occurred almost exclusively among heroin users.

Cocaine use in the rest of the country does not appear to be significant—at least among that sector of the population that comes to the attention of police and health authorities. Results of the National Drug Strategy Household Surveys in 1991, 1995 and 1998 show only a minimal increase in recent use (that is, in the preceding 12 months)—from 1.0 per cent in 1991 to 1.4 per cent in 1998, which is not statistically significant. The vast majority (99 per cent) of users in Australia during 1998 used cocaine very infrequently.

Arrests for cocaine offences rose nationally in 1998–99, by 26 per cent on the previous year and by 54 per cent from 1995–96 to 1998–99, which probably reflects increased police activity. The New South Wales increase for 1997–98 to 1998–99 was 35 per cent, further emphasising the prevalence of cocaine use in Sydney.

The main information gaps that appeared during the reporting period concern the total volume of cocaine consumed by users, the amount of cocaine used by non-injecting users, and which segments of the market account for the bulk of cocaine supply.

Outlook

If current trends persist there will probably be sufficient cocaine to meet the demands of the Australian market. It is difficult to predict any significant changes in the extent of use among the population.

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