Knowledge gained through experience in young problem drug users: reflections on interventions and change

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Chapter 3

Factors associated with the initiation of cocaine and heroin among problem drug users: Reflections on interventions

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Abstract

This qualitative study used in-depth interviews to obtain retrospective drug use histories. It identifies self-reported factors facilitating initiation of cocaine and heroin among young problem users in Amsterdam to enable interventions to be targeted at issues personally relevant for this population. Recruitment took place both directly (by street outreach, outreach at methadone outposts) and indirectly (by respondent-driven sampling). The study started in the year 2001 and included 50 problem drug users, aged 18-30, of whom 72% were male, 64% were polydrug users, and 36% were homeless.

This study showed that the seven most common self-reported factors facilitating initiation of cocaine and heroin are: desire for affect regulation, drug availability, curiosity, desire to be part of a group, misinformation, desire for energy and starting because it has a depressant effect.

From the results of this study it is concluded that some factors perceived to facilitate initiation of cocaine and/or heroin revealed in this study are hardly addressed by current prevention programs and could inform future initiatives. Programs can be targeted at young people who we identified to be at high risk. Research using quantitative methods is likely to be valuable in determining the relative importance of mentioned factors for different groups of young people. The study’s limitations are noted.
3.1 Introduction

Although most young cocaine and heroin experimenters are unlikely to maintain their drug use (natural recovery) or to experience drug use-related problems, a substantial minority will develop cocaine and heroin problem use, involving additional health, safety and legal risks (1,2).

Targeted surveys in the Netherlands have documented that this minority of young problem drug users (YPDUs) consists of subgroups that often need special education, play truant, go to pubs/clubs, smoke marijuana, and may be homeless (3,4,5,6). International research shows similar findings and suggests additionally that subgroups are young people who have been excluded from school, committed crimes, or have drug-using siblings (7).

Also, we know that the most consistently identified adolescent risk factors for cocaine and heroin use include: early use of much alcohol or marijuana (8,9), a combination of shy and aggressive behaviour (10), and psychopathology (11). Environmental risk factors include: peer substance use (12,13), stressful life events (14,15), drug availability (16,17,18), and poor parent-child communication (8).

If strategies to reduce use of cocaine and heroin are to be developed, additional information is needed about the perceptions and purposes of initiation from the perspectives of young problem drug users themselves (19). Knowing how YPDUs view the factors facilitating their first drug use should enable the targeting of future interventions more precisely at issues that are personally relevant for this population (20). Only a few recent studies present qualitative information on cocaine and heroin initiation amongst YPDUs.

In a student survey among adolescents in Minnesota, Harrison, Fulkerson, and Beebe (21) reported on motives for drug initiation such as coping with painful emotions, escaping from problems, and responding to peer pressure, but they examined initiation only in relation to physical and/or sexual abuse. Li, Zhou and Stanton (22) reported that first users were lured into drugs by others as well as by a desire for relaxation or an interest in experimentation, but this study was conducted in an Asian setting and may not be easily generalized to other cultural experiences. Moreover, the study was not conducted with an exclusively adolescents population. Finally, two studies conducted by Boys and Marsden (23,24) discuss motivating factors for use among young people. Those studies are not specific to initiation, however. Moreover, all these studies have used “closed” questionnaires, which are not accessible to new information volunteered by respondents. To collect additional and qualitative data, semi-structured interviews including questions of an open-ended nature are necessary (25).

The YOUNG Drug users in AMsterdam (YODAM) study was started to investigate illicit drug initiation, transition to injection, and health care use in a sample of young problem users; that study has gathered both qualitative and quantitative data. This article focuses on initiation and presents the qualitative data, consisting of user responses to the following question: which personal, social, and environmental factors facilitated your initiation of cocaine and heroin?
3.2 Method

The YODAM study
The YODAM study is an open cohort study among YPDUs that began intake of participants June 2000. Eligibility criteria were age 18 - 30 years; use of any form of heroin, cocaine, amphetamine and/or methadone at least three days a week for at least two months prior to intake; Dutch nationality and living in Amsterdam more than one year or non-Dutch nationality and living in Amsterdam for more than three years. Identification, including date of birth, was compulsory. Participants were recruited directly by street outreach in different neighbourhoods and outreach at methadone outposts (place of methadone treatment program). Additionally, recruitment was done indirectly by respondent-driven sampling, in which each recruited individual is asked to nominate another suitable candidate for the study. Informed consent was obtained from all participants. Those who enrolled were asked to return every 4 months for follow-up visits, at which time a questionnaire was completed and a blood test was done. At intake a hair sample was taken to confirm mentioned drug use. As incentive participants were paid 11 Euro (about 10 US dollar). By December 2001, 174 YPDUs had been included into the YODAM study. The research team consisted of a nurse, an epidemiologist and an anthropologist.

Recruitment for the current study
During 2001, a convenience subsample of participants in the YODAM study was approached by the research nurse for their willingness to participate in the current qualitative study. Interviews were taken immediately or by appointment and all of the first 50 occurring individuals participated in the current study.

Characteristics
The sample comprised 50 young people (36 males) between 20 to 30 years of age (mean 27.2 years), of whom the majority (64%, N=32) were polydrug users at the time of our interview. Their characteristics, as obtained by standardized questionnaire, are presented in Table 1. The majority (62%) had no more than primary or lower general secondary education. At the time of the interview, about one third of the sample (36%) were homeless, about half of the sample (54%) had income from salary or social security, and 86% were Dutch. Most (58%) reported that their initial illicit drug use started between 16 and 20 years of age. Cocaine was the most common drug of initiation (42%), and the modes of initial drug administration were sniffing (22%), smoking a cigarette mixed with cocaine (10%), and smoking base (10%).

The vast majority (90%) of all interviewees reported themselves to be struggling with problems at the time of illicit drug initiation (Table 2). Of this majority, 82 percent experienced domestic problems, specifically incomplete (divorce, separation/desertion) family (56%), foster care/ juvenile correctional institutions (42%), (sexual) violence (32%), parent addiction (30%), frequent family quarrels (18%), and parent deceased (8%). In addition, 40% of respondents reported living independently at an early age, frequently resulting in problems. Moreover, 38% of respondents reported symptoms suggesting psycho/pathological disorders, and 24% had justice-related problems.
Interview analysis
Self-reported retrospective drug use histories were obtained through in-depth interviews conducted one-on-one by a single interviewer (E.W.). According to semi-structured protocol he posed open-ended questions facilitating the free expression of feelings, perceptions and beliefs. To minimize recall bias, the interviewer attempted to assist the interviewees by using a chronological interview structure and by referring to biographical landmarks when recalling early behaviour. Interviews took 60 minutes on average, and each participant was paid an additional 11 Euro (about 10 US Dollar) per interview. With consent, interviews were tape-recorded and transcribed. The transcripts were subjected to an interpretative content analysis to interpret phenomena in terms of the meanings people bring to them (26) and to adopt, as far as possible, an insider’s perspective. The life or behaviour under study becomes meaningful, reasonable and normal once you get close to it. Analysing was done in accordance with the grounded theory approach.
Grounded theory does not test a hypothesis; it is explicitly emergent and sets out to find what theory accounts for the research situation as it is. The aim, as Glaser and Strauss in particular state it, is to discover the theory implicit in the data (27). We coded categories (roughly equivalent to themes or variables central to the study), grouped the most frequently recurring codes, and identified links and possible relationships. We identified recurring motifs or factors and used these to structure the findings to develop grounded theoretical patterns. We used codes for the several factors facilitating first use and for the problems mentioned by the interviewees. Others checked over the coding at two points in this cyclic process, and we used computer-assisted analysis methods (Kwalitan) (28).

3.3 Results
Factors perceived as facilitating initiation of use
When starting cocaine or heroin, respondents on average were 16.5 years of age and lived in diverse geographic locations in the Netherlands. All 50 interviewees had begun use of cocaine, and 43 had begun use of heroin at the time of interview.
Factors perceived as facilitating initiation of cocaine and heroin were selected and prioritised (Table 3). Below, the seven most common factors are elaborated in order of the frequency of their mention, starting with the five factors that apply to cocaine and heroin alike.
1. Desire for ‘affect regulation’ was the most frequently mentioned factor perceived as facilitating initiation of use. (34 of 50 cocaine-users, and 25 of the 43 heroin-users) Most interviewees (90%) recalled having many problems (Table 2) at the time of initiation and they experienced a relief from the pain, anxieties and feelings of guilt by using cocaine or heroin. The sedating effect after first using the drug made reality less harsh; they could cope better and felt better. In the words of two of the respondents:

- *I think I somehow realised I had to arrange my life with drugs. I didn’t want anything to do with the feelings related to everyday life. I simply couldn’t cope with that. I think reality was too much for me then. I think I was consciously regulating my emotional feelings with the help of drugs. (1970, M, 14, c*/h/m)*
- *No, I didn’t care. I felt I would just go along with it because I was still experiencing the same old troubles, those fights every time, this fuss. I was not seeing my parents anymore; I thought I’ll just do it. I couldn’t care less, I didn’t*
like myself. Just switch off those feelings for a while. (1972, F, 24, c/h)

*year of birth, sex, year of first use drugs (no cigarettes, alcohol or marihuana: see Table 1), drug use at time of the interview (amphetamine = a, cocaine = c, heroin = h, methadone = m, intravenous = *)

Quite a number of respondents (7 of 34 cocaine-users and 11 of 25 heroin-users) were experiencing feelings like anger, aggression, stress, and restlessness. The respondents had learned to manage these feelings by cocaine and heroin use. In particular, the sedating effect of heroin was mentioned. The following two excerpts give an illustration:

- Ritalin, valium, marihuana, all helps me to relax, but not nearly as well as coke does. (1980, M, 15, c)
- Very depressed and also aggressive. I felt a lot of aggression surging up in me. I started to think about weapons, pistols and knives. I became obsessed by them, all to do with my aggressive feelings. I started to fantasize about finishing off this or that person and strangling them. I thought that was dicey. Then I first came across marihuana and alcohol. Alcohol intensified my aggressive feelings and marihuana lessened them. Heroin diminished them even more. (1971, M, 15, c/h/m)

Feelings of insecurity appeared to be common as well (10 of 34 cocaine-users and 4 of 25 heroin-users). The respondents had learned to regulate these feelings and, with the help of cocaine and or heroin, reported gaining more self-confidence. The interviewees indicated feeling more secure and more capable of coping with the world around them. Also, they felt able to think more clearly. Although both drugs were mentioned, cocaine was mentioned more frequently in this last respect. Two quotations:

- My self-esteem went sky-high, and the first few times I used it (heroin), I thought I should strew the whole town with it. Really! You feel you exist. (1971, M, 20, h/m)
- Anyway, once I had sniffed I thought “this is it”. It was like a new world opened up for me. I felt great, I felt fantastic, I could conquer anything. (1975, F, 14, c/h/m)

2. ‘Availability’ is an important environmental factor perceived as facilitating the initiation of cocaine and heroin. (25 of 50 cocaine-users, and 18 of 43 heroin-users) However, it operated mainly in marginalized situations like juvenile correctional institutions, shelters and prisons, and was hardly mentioned with regard to non-marginalized places or people. Although peer pressure was not mentioned, peer influences played an important role. Two respondents phrased it as follows:

- When I was 19, I was detained and got into touch with people doing time for 4 or 5 kg (cocaine). I had to take parcels to some cells, and doing that I could also earn a parcel (cocaine) for myself. Yes it’s true, my addiction started when I was in jail. (1980, M, 19, c)
- I was just walking there aimlessly, moping about a bit sad because of what had happened at home. And I am called over by this guy, who says ‘you’re looking sad, you should try this’ (heroin). (1971, M, 11, h)
3. ‘Curiosity’ was the third motive to start using cocaine or heroin. Of the 50 respondents, 31 said they were attracted to drugs and were curious to find out what it would feel like to use them. The following two quotations give an illustration:

- I had never done it (smoking coke) before. It seemed interesting. I was interested in experiencing everything once, just to know what it is like. (1974, M, 13, c/h)
- Well, it was because I felt I wanted to try it (smoking coke). You’re in an experimental phase. (1971, F, 16, c/m)

4. ‘Trying cocaine/heroin out of a desire to be part of a group’ for the sake of being together and enjoying the company was an important factor for 20 of the 50 initiators. Two quotations:

- At that moment I wanted to belong somewhere, I had been alone for a long time, and it just seemed pleasant to be among these people. (1970, M, 21, h)
- That saying ‘yes’ the first time is easier when you are with others. If you were to say ‘no’ that would imply going apart. So that’s when you choose to use it. (1970, M, 18, c/h)

5. Twenty persons also mentioned ‘misinformation or accident’ as a factor facilitating the initiation of these drugs. Respondents thought cocaine or heroin was quite normal and did not perceive them as much different from drugs as alcohol or marihuana, had not expected to become addicted so soon, or simply had not realized they were smoking cocaine or heroin when they first used it. The following two excerpts illustrates this:

- I didn’t know what it was, I was about 17 and I did not know anything about heroin. He explained, it is like hash but you smoke it differently. It also had the same colour, so I thought it would be okay. (1971, M, 17, m)
- I was hooked the first time I smoked it, I mean it. But if I’d known it was heroin, I would never have started, never. (1975, M, 16, c/h/m)

6. Whereas the above factors were valid for both cocaine and heroin, the factor ‘makes you physically fit and strong’ applies only for cocaine. Eleven respondents gave the surge of energy enabling them to do things with greater pleasure as a reason to initiate. In particular, taking cocaine made it possible to “party for nights on end” and to drink lots of alcohol without becoming drunk. One quotation:

- I was very happy with alcohol and smoking joints, but it left you in a kind of haze. I didn’t like that feeling because it made me too tired, too droopy so to speak. I remember I consciously started to smoke crack, and then I woke up. I was zipped up. I immediately started to do things, arrange things, and I thought it was great. (1970, M, 14, c/o/h/m)

7. Finally, a motive that applies for heroin specifically. Users seek its ‘depressant effect’, especially to relax from cocaine (mentioned by 13 out of 43). The use of cocaine seems to put a “coke-train” in motion, creating a constant urge for more. There is a feeling of unrest and speediness that heroin can stop. One quotation:

- When you’re out of coke, you feel horrible. And brown calms you down again,
the unrest disappears so you can talk and walk normal again. (1978, M, 17, c)

3.4 Discussion

Seven motives seem to be most instrumental in the initiation of cocaine and heroin use. The finding that 'affect regulation' is most commonly mentioned is no surprise. There is a considerable body of literature (8,17,21,22,24) that supports the finding that initiation of those drugs is promoted because their stimulating/euphoric effects alleviate sorrow, fear and guilt. Less was found in the literature regarding the importance of initiating drug use to alleviate anger or stress (heroin), and feelings of insecurity (cocaine). Histories of parental desertion, foster care/juvenile correctional institutions, (sexual) violence, early independent living, symptoms suggesting psycho/pathological disorders, and justice-related problems were reported by our respondents as precipitants of their cocaine/heroin use. Our analysis indicates that reports of prolonged exposure to multiple and potentially traumatic experiences during the same time period are common among our respondents. This prolonged and frequent exposure may be basic causes for cocaine or heroin initiation. Living in marginalized situations, respondents found stimulating/euphoric effects to alleviate negative mood states and to distance themselves from their traumatic experiences.

Self-regulation of negative mood states is surely an important factor in drug abuse in general (29), but whether negative affect is a cause or consequence of drug initiation is still unclear. Our findings indicate that negative mood states are experienced as important precipitants of cocaine and heroin use and not merely as its consequences. In concordance with Parker, Aldridge and Measham (30), we found that in the initial phase of addiction, users seem to make calculated choices (rational addiction).

As in other studies (16,17,18,31) 'availability' was perceived as facilitating first use of cocaine and heroin. Our respondents, however, perceived 'availability' not as a sole motive for initiation but as strongly associated with marginalized situations. A study by Boys, Farrell, Bebbington, Brugha and Taylor (32) corroborates this finding and illustrated that prisons are a high-risk environment for heroin and other drug initiation. Although peer pressure was not mentioned, once in this marginalized situation peer influence seems to play an important role in the initiation of use. Most of the initiator's peers used drugs, learned how to use drugs from peers, obtained free drugs from them and used drugs in the presence of other drug users.

Cocaine and heroin initiation was facilitated not only to regulate affect, or because it was being offered. 'Curiosity' about these drugs was another important facilitating factor for initiation. In a recent European Union young population survey (33), 'curiosity' was given as the main reason for trying drugs.

Our finding, that youngsters try drugs 'to be part of a group', for the sake of being together, corresponds with findings by others (16,34).

Although a substantial group of interviewees insisted that 'misinformation or accident' was a factor facilitating first cocaine/heroin use, few studies (22,34) corroborate this finding. In the 1990s, information about the dangers and effects of cocaine and heroin may not be reaching this group of young people.

Initiation into cocaine because it 'makes you physically fit and strong', is in line with Magura et al. (17), who found that use of cocaine for the purpose of increasing energy is an important factor. The clear relation between cocaine use and nightlife with drinking
alcohol needs attention, because the combination may have serious health consequences (35).

Previous research (36,37) shows that cocaine users often become involved with additional drugs as well in their attempts to balance or counteract the effects of cocaine. Our data lend some support to this view, because 13 out of the 50 respondents sought heroin’s ‘depressant effect’ to deal with the over-excitability produced by frequent cocaine abuse. At first this type of user is not physically dependent on heroin, but with increasing frequency of use, s/he might become dependent. Co-use of heroin in this population is not a trivial phenomenon, because it has serious additional detrimental effects.

In terms of prevention and early intervention, our results suggest that youngsters dealing with foster care/juvenile correctional institutions, addicted parents, (sexual) violence, psychopathology, or problems with justice should be a focus of specific programs. Since experimentation with illicit drugs starts at a relatively young age (16.5 years), compared to other studies (38,39), such programs must target these groups in a very early stage. Because ‘affect regulation’ in particular is strongly linked to initiation and drug use mostly fulfills an important emotional function for young people, programs could focus on the motives behind use, rather than trying only to discourage use. In our sample, alleviation of family-related grief was the most mentioned factor, thus dissemination of information to parents and help with parenting skills could strengthen caring, attention and supervision. Moreover, adolescents could be helped to more effectively identify and articulate their own problem experiences to family members or to other concerned persons.

In our sample, 90% of all interviewees were struggling with problems at the time of cocaine/heroin initiation. Such problems often cause young adolescents to malfunction at school, which should alert school workers. Because poor parent-child relationships and school problems typically precede first drug use, it makes sense to focus on these aspects of child’s environment while s/he is still in elementary school, as well as thereafter. Routine screening for traumatic experiences could be a component of adolescent health care visits, and physicians, parents, teachers and others who work with youth can be made more aware of and sensitive to the signs of such experiences. It should be noted that coming from an incomplete family was found to increase the probability of first drug use. However, one should deal with this sensitively because targeting all these adolescents as high-risk individuals might falsely label these youngsters.

Many of our respondents had been brought in contact with cocaine and heroin in marginalized places; ‘availability’ as a factor of initiation was hardly mentioned with respect to other places. However, because being offered drugs and ‘trying drugs to be accepted by a group’ are factors, young people must be better equipped with the interpersonal tools to deal with the various situations in which drugs may be available or on offer. McIntosh, MacDonald and McKeeganey (40), highlight the importance of providing children and young people with effective methods they can use to refuse an offer of drugs.

‘Curiosity’ and ‘misinformation’ finally, are important factors mentioned in this study. Targeted information about the dangers of use continues to be important, especially considering that respondents insisted they would never have tried these drugs if they had been better informed. We must remember that youngsters depend heavily on their drug-using peers in order to satisfy their curiosity and to get information. However, since we found no proof of peer pressure to use drugs, we believe that interventions can be based
on peer networks. In Amsterdam, an intervention in which YPDUs visit schools, community centres, and a youth prison to inform their peers (41), is promising.

This study has several limitations to consider when interpreting its findings. First, participants of the total sample were recruited directly (street outreach, outreach at methadone outposts) and indirectly as well (by means of respondent-driven sampling) to cover as heterogeneous a group of problem drug users as possible. This strategy strongly increases the likelihood that the sample is representative, but due to the hidden nature of the population this cannot be verified. From the total sample, a sub-sample was taken for the present study. In line with the principles of qualitative research, where the objective is to obtain diversity and high information content, we stopped interviewing when no new information was found (saturation of the data). At that time 50 participants had been interviewed. Second, our study relies heavily on retrospective self-reports of initiation of selected drugs (age at interview average 27.2 years) that occurred an average of 10 years earlier. Differential recall, or difficulty remembering behavioural events, influences the degree to which reports provide reliable information. To minimize recall bias, we attempted to assist the interviewees by using a chronological interview structure and by referring to biographical landmarks when recalling early behaviour. Undoubtedly, events were not always remembered with complete accuracy, although research (42,43), also from the YODAM cohort, suggests that drug users typically give truthful and accurate information. Finally, the interviewees might sometimes have given socially desirable answers, but evaluating interviews on their internal inconsistency minimized potential distortions.

In conclusion, to target interventions precisely at issues that are personally relevant for young people at risk, this qualitative study identifies self-reported factors facilitating initiation of cocaine and/or heroin among young problem drug users. Addressing the real motives of young people might help to communicate the message effectively, which is of vital importance of their health. Programs can be targeted to young people that we identified to be at high risk. Research, using quantitative methods, is likely to be valuable in further clarifying the relative importance of factors reported for different groups of young people.
Table 1  Characteristics of 50 young problem drug users in Amsterdam at time of the intake interview.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N (%)</th>
<th>Characteristics</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex:</strong></td>
<td></td>
<td><strong>Age:</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>36 (72)</td>
<td>18 – 25</td>
<td>12 (24)</td>
</tr>
<tr>
<td>Female</td>
<td>14 (28)</td>
<td>26 – 28</td>
<td>11 (22)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>29 – 30</td>
<td>27 (54)</td>
</tr>
<tr>
<td><strong>Education:</strong></td>
<td></td>
<td><strong>Residence:</strong></td>
<td></td>
</tr>
<tr>
<td>Primary or</td>
<td></td>
<td>Homeless</td>
<td>18 (36)</td>
</tr>
<tr>
<td>Lower Gen. Sec.</td>
<td>31 (62)</td>
<td>Other</td>
<td>32 (64)</td>
</tr>
<tr>
<td>Secondary</td>
<td>16 (32)</td>
<td>(rented house, with others, hotel, pension)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>3 (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Main income:</strong></td>
<td></td>
<td><strong>Nationality:</strong></td>
<td></td>
</tr>
<tr>
<td>Paid wage / soc sec.</td>
<td>27 (54)</td>
<td>Dutch</td>
<td>43 (86)</td>
</tr>
<tr>
<td>Other</td>
<td>23 (46)</td>
<td>Others</td>
<td>7 (14)</td>
</tr>
<tr>
<td><strong>Age at drug initiation:</strong></td>
<td></td>
<td><strong>Initial drug and route of administration:</strong></td>
<td></td>
</tr>
<tr>
<td>5 – 10</td>
<td>1 ( 2)</td>
<td>Cocaine sniffing</td>
<td>11 (22)</td>
</tr>
<tr>
<td>11 – 15</td>
<td>16 (32)</td>
<td>cigarette</td>
<td>5 (10)</td>
</tr>
<tr>
<td>16 – 20</td>
<td>29 (58)</td>
<td>base</td>
<td>5 (10)</td>
</tr>
<tr>
<td>21 – 25</td>
<td>4 ( 8)</td>
<td>Heroin sniffing</td>
<td>1 ( 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>smoking</td>
<td>14 (28)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>injecting</td>
<td>1 ( 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Amphétamines</td>
<td>8*(16)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Xtc</td>
<td>7 (14)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lsd/Pados</td>
<td>2 ( 4)</td>
</tr>
</tbody>
</table>

* In four cases, amphetamines were taken together with another drug: 2 times with xtc, 1 time with sniffing cocaine and 1 time with heroin.
Table 2 Problems mentioned at intake as being experienced when initiating cocaine and heroin.

<table>
<thead>
<tr>
<th>Problems</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic</td>
<td>82%</td>
</tr>
<tr>
<td>incomplete family</td>
<td>56%</td>
</tr>
<tr>
<td>foster care/juvenile correctional institutions</td>
<td>42%</td>
</tr>
<tr>
<td>sexual and other violence</td>
<td>32%</td>
</tr>
<tr>
<td>parent addiction*</td>
<td>30%</td>
</tr>
<tr>
<td>frequent family quarrels</td>
<td>18%</td>
</tr>
<tr>
<td>parent deceased</td>
<td>8%</td>
</tr>
<tr>
<td>Living independently</td>
<td>40%</td>
</tr>
<tr>
<td>age 14 – 16</td>
<td>24%</td>
</tr>
<tr>
<td>age 17 – 18</td>
<td>16%</td>
</tr>
<tr>
<td>Suggesting of pathological and psycho/pathological disorders</td>
<td>38%</td>
</tr>
<tr>
<td>depressive</td>
<td>47%</td>
</tr>
<tr>
<td>adhd</td>
<td>16%</td>
</tr>
<tr>
<td>psychotic</td>
<td>16%</td>
</tr>
<tr>
<td>borderline</td>
<td>11%</td>
</tr>
<tr>
<td>epilepsy</td>
<td>5%</td>
</tr>
<tr>
<td>gender-problems</td>
<td>5%</td>
</tr>
<tr>
<td>Justice-related</td>
<td>24%</td>
</tr>
</tbody>
</table>

* To alcohol and/or illicit drugs.

Table 3 Perceived factors facilitating initiation of cocaine and heroin.

<table>
<thead>
<tr>
<th>Factors for use</th>
<th>Number of persons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cocaine (N=50)</td>
</tr>
<tr>
<td>1. Desire for affect regulation</td>
<td>34</td>
</tr>
<tr>
<td>2. Availability of drugs</td>
<td>25</td>
</tr>
<tr>
<td>3. Curiosity</td>
<td>17</td>
</tr>
<tr>
<td>4. Desire to be accepted by a group</td>
<td>12</td>
</tr>
<tr>
<td>5. Misinformation or accident</td>
<td>12</td>
</tr>
<tr>
<td>6. Desire for energy</td>
<td>11</td>
</tr>
<tr>
<td>7. Desire for depressant effect*</td>
<td>-</td>
</tr>
</tbody>
</table>

* Persons using cocaine who subsequently started heroin use.
References

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