SCOTTISH DRUGS FORUM

EXPERIENCES OF MAT STANDARDS IMPLEMENTATION FOR PEOPLE WHO USE COCAINE AND CRACK

EXECUTIVE SUMMARY

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ACKNOWLEDGEMENTS

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Scottish Drugs Forum (SDF) would like to dedicate this report to Gary, a peer researcher and volunteer across various SDF workstreams. His kindness, insight and commitment left a lasting impact on this project and the many others he contributed to; his loss is deeply felt. He sadly passed away before publication but his contribution remains an important part of this work and will not be forgotten.

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Finally, a huge thank you to all the participants who willingly gave their time and spoke so openly about their experiences.

GLOSSARY

This report explores experiences of powder cocaine, freebase cocaine and crack cocaine. Where differences between these substances were experienced they will be explicitly stated in the findings. Where they are not specified, “cocaine” is used as a general term reflecting how people who used cocaine described their experience across all forms.

Definitions for the different forms are outlined below, adapted from the Cocaine Toolkit (MAT SPMG, 2025).

Powder cocaine: The most widely sold form of cocaine, available as a white powder. The powder is often snorted in lines or can be prepared for injection as it is water soluble and does not require heat.

Freebase cocaine: A base form of cocaine that is produced by mixing powder cocaine and ammonia to create a high purity. It is typically associated with smoking due to the low melting point, making it easy to smoke. An acidifier such as vitamin C must be used with cold water if injected as it is not water soluble.

Crack cocaine: A base form of cocaine that is produced by mixing powder cocaine with water and sodium bicarbonate (baking soda) then applying heat to make rocks. Although typically smoked, crack cocaine can be injected if an acidifier is added to it with cold water to return it to a water-soluble state.

Snowballing: The injecting of (most often) powder cocaine, or crack, or freebase in combination with heroin.

BACKGROUND

Cocaine use and related harms have increased significantly across Scotland, with cocaine the most commonly reported primary drug among people starting specialist drug treatment in 2024/25 and implicated in 47% of Scotland's 1,017 drug-related deaths in 2024. To respond to these increasing harms, it is key that cocaine use is better understood and services are equipped to support people. This evaluation addresses previously identified gaps in our understanding of how the medication assisted treatment (MAT) standards are experienced and applied for people who use cocaine, with a particular focus on MAT standards 4, 6 and 9. These cover access to: harm reduction, psychosocial interventions and mental health care. It also explores patterns of use, motivations and impacts of use, changes to the market and experiences of accessing support.

AIM AND OBJECTIVES

The aim of this evaluation was to provide a current snapshot of cocaine use across four health board areas (NHS Greater Glasgow and Clyde, NHS Fife, NHS Highland and NHS Tayside), with a focus on how the MAT standards are applied and experienced by people who use cocaine.

The following objectives were explored:

- Experiences of cocaine use among individuals accessing MAT, including motivations, risks, patterns of use and medication interactions.
- Experiences of cocaine use among those not accessing MAT.
- Availability of support and gaps in provision, including harm reduction, treatment options and physical and mental health support.
- Staff perspectives on cocaine use and their experiences of delivering support, including challenges, good practice and service gaps.

METHODS AND DEMOGRAPHICS

SDF peer researchers with lived and living experience conducted focus groups with 34 people who use cocaine across four health board areas (NHS Greater Glasgow and Clyde, NHS Fife, NHS Highland and NHS Tayside), alongside three online staff focus groups with 34 participants from NHS, social work and third sector services. People who used cocaine were recruited using purposive sampling to reflect a mix of ages, gender, patterns of use and experiences of MAT. All were aged 18 or over and currently using, or had recently used, cocaine and/or crack.

Across the participant group, 71% (n=24) were male and 29% (n=10) were female. Two-thirds of participants who reported cocaine use were currently accessing MAT, with treatment duration ranging from less than one year to more than five years. All but one participant reported current cocaine use.

Focus groups explored experiences of cocaine use, motivations, harms, MAT, harm reduction and support needs. All sessions were transcribed and analysed using a thematic approach, with peer researchers contributing to analysis and interpretation of findings.

FINDINGS

Patterns and methods of substance use

- All who were currently using cocaine (n=33) reported smoking crack or freebase cocaine; frequent use was common, with most (n=26) reporting using it at least once a week.
- Over half (n=18) purchased powder cocaine and "washed it back" themselves to produce freebase cocaine or crack to smoke; this was seen to reduce the risks of buying street crack which could be lower purity and have higher levels of adulterants.
- Ten people reported using ammonia to wash back powder cocaine, as the resulting freebase produced was stronger. Four people stated they preferred making crack with sodium bicarbonate, believing it to be less harmful to their lungs and throat. A further four did not disclose their preferred process.
- Of the six people who injected, all reported "snowballing" (injecting powder cocaine with heroin) and typically described this as a one-off experience rather than a regular practice.
- Five people reported snorting powder cocaine, most often in social settings such as with friends and usually in combination with alcohol.
- The majority of people who used cocaine, used at least one other substance alongside (n=29); the most commonly reported substances used were cannabis (n=15), pregabalin (n=14), alcohol (n=9), street benzodiazepines (n=9) and heroin (n=8).
- Polysubstance use occurred for various reasons, including to intensify effects due to the poor quality of cocaine and to manage comedown effects (such as anxiety or sleep).
- Staff identified the most typical patterns of use they saw within treatment were dependent or binge usage of cocaine, freebase or crack, often in combination with other substances or MAT and linked to greater levels of harm.
- Staff also noted awareness of more occasional, intermittent or recreational patterns of use in wider society but felt they were less likely to attend traditional services.
- Staff felt factors such as working in hospitality, transactional sex or engaging in chemsex influenced patterns of cocaine and other drug use.
- Staff raised concerns about the role of cocaine in increasing drug-related deaths, particularly where use involved polysubstance use or was in conjunction with prescribed medication, such as MAT.
- Staff discussed the normalisation of cocaine use in social settings and concerns about young people's rising use of cocaine and other substances.

Motivations for cocaine use

- Both participant groups identified escapism as the primary motivation for cocaine use, describing it as a means of temporarily escaping reality and finding short-term relief from difficult emotions and challenging life circumstances.
- Payday was also consistently identified as a key trigger for substance use with access to money often shaping the timing and intensity of use.
- 15 people discussed using cocaine to manage mental health conditions or neurodivergence, including anxiety, depression, ADHD and autism.
- Other motivations shared by people who used cocaine included pleasure, increased motivation, social contexts or peer influences.
- Several people who used cocaine reported being more likely to use cocaine following arguments or during the breakdown of relationships, framing use as a way of managing emotional distress.
- Some staff linked cocaine use to wider societal issues such as poverty and a lack of local opportunities.

- Staff discussed the perceived social acceptability of cocaine compared to substances such as heroin as a common motivation for use.
- Several staff noted that cocaine was no longer viewed as a premium or luxury drug, with its cheaper price making it more affordable and accessible for people to use.
- A few staff expressed concern that services do not consistently explore transitions to cocaine or crack use from other substances such as opiates. They felt that more in-depth conversations about the motivations behind these changes would enable more tailored and effective interventions.

Physical health impacts

- Smoking crack and freebase cocaine was associated with breathing difficulties, sometimes referred to as "crack lung", leaving people breathless and with a tight chest during and after use.
- Physical harms from snorting cocaine were nasal damage including scabbing inside the nose or nosebleeds.
- Cardiovascular effects were commonly discussed by people who used cocaine and these were associated with feelings of acute anxiety and fear. Several had experienced heart palpitations and on some occasions had personally experienced, heard of, or witnessed others having cardiac arrest.
- Sleep deprivation and fluctuations in appetite, including periods of reduced or increased appetite, were described by some people who used cocaine.
- Some people who used cocaine said severe side effects might put them off using again, whilst others felt they would continue to use despite these impacts on their physical health.
- Sexual health issues were raised by four women, such as unplanned and/or unprotected sex or physical injury from sexual violence when involved in transactional sex.
- Staff felt routinely discussing and monitoring these kind of physical effects reported by people who used cocaine should be a priority in services; this would allow for greater education on health risks and the impacts on long-term conditions.
- Some staff described ideas for partnership working to support physical health, such as working in collaboration with GPs to offer ECGs. It was noted that services were not adequately resourced to provide consistent physical health support and monitoring.
- Staff felt addressing basic physical needs should be a priority and if properly resourced, they could and should be supporting with areas such as nutrition, sleep and exercise.

Mental health impacts

- Cocaine was often used by people as a way to help manage their mental health or neurodivergence but there was a general consensus that sustained use ultimately contributed to worsening mental health.
- People described short-lived effects such as euphoria which could temporarily alleviate negative emotions. Many reported that initial effects were often followed by more negative effects, such as increased anxiety or feelings of regret after use.
- A few people talked about experiencing more severe negative effects such as hallucinations and paranoia which were not only distressing for them, but also for friends or loved ones who witnessed them.
- Changes to behaviour such as greater emotional reactivity and irritability were noted by some people who used cocaine, including snapping at or arguing with others in situations where they normally would not.
- A few described negative experiences when seeking support during a mental health crisis, with stigma perceived to influence responses from services. Access to formal mental health support or assessment was often limited unless they had an existing diagnosis.
- Several staff raised concerns about barriers within mental health and neurodiversity diagnostic pathways (including long waiting lists), which limited access to essential support for people who used cocaine.

- Some staff described seeing an increase in crisis mental health presentations related to cocaine use including low mood, self-harm, and suicidality.
- Staff felt that greater joint working with emergency and community mental health teams was needed to respond to these challenges, but that communication and collaboration between services remained challenging.

Changing market and impacts

- Both participant groups felt cocaine was much more widely available in the drug market than in previous years.
- Participants said the available cocaine was cheaper in price but was often felt to be of poorer quality and/or cut with other substances. It was reported that poor quality could lead to people buying and using more.
- People discussed changes in drug dealing, including: increased public visibility, dealers offering cocaine alongside heroin, and the involvement or exploitation of young people within drug supply.
- There was a perception of increased social harms due to the changing market of cocaine such as violence in communities. This was linked to factors including involvement with county lines gangs, accumulating drug debts and the pressure of how to fund levels of use when experiencing dependence.
- Financial difficulties connected to cocaine use could lead to engagement in criminal activity and borrowing or stealing from family members to fund use. Some people who used cocaine linked cocaine use to wider financial impulsivity such as gambling.
- Relationships with family, friends and wider social circles could be negatively impacted by the harms highlighted and could impact on people's ability to prioritise family contact, responsibilities and commitments over their drug use.
- Some people who used cocaine observed distinct differences in the severity of such harms compared to when solely using opiates. This was linked to compulsive use and the desperation this could cause. On some occasions, this was linked to engaging in theft or exploitation of peers.

Relationship with medication assisted treatment

- Two thirds (n=22) were on some form of MAT and most felt their prescription had little to no impact on their use of cocaine or crack because cocaine was a non-opiate substance and offered a different experience or function.
- A minority reported adjusting the timing of taking their MAT when planning to use cocaine/crack, including delaying or occasionally missing doses; this could be to maximise effects or to manage comedowns.
- People who delayed their MAT dose generally did not report any negative effects, as they continued to take their medication later in the day or would take it again within a day or two.
- Both participant groups identified that cocaine was being used on top of long-acting injectable buprenorphine (LAIB). Reasons given for this were: reduced monitoring with monthly injections, the continued effects of cocaine while on treatment, and the underlying reasons for drug use remaining unaddressed.
- A few people receiving MAT reported that their appointments included support for their cocaine use, such as tailored harm reduction advice and strategies to help manage anxiety.
- Several staff identified a gap in support for cocaine use, feeling that existing treatment pathways and the MAT standards are primarily focused on opioid use. Staff stated that cocaine-specific care pathways were needed to better meet the needs of people using cocaine.
- Staff highlighted the importance of consistently discussing the risks of cocaine use alongside MAT and other prescribed medications, feeling that people may not be fully aware of risks such as overdose and impacts on physical heath.
- Several felt prescribing was a complex "balancing act" when people were actively using substances; this required a high level of clinical judgement and risk management.

Harm reduction

- Harm reduction such as injecting equipment provision (IEP) and blood borne virus (BBV) testing were provided by staff and accessed from services by a third of people (n=11) who used cocaine.
- Most people described learning harm reduction practices informally through peer networks, alongside knowledge gained from their own negative experiences of drug use.
- People using cocaine often reported sourcing equipment themselves, such as pipes and wire wool, as these were not currently available from services.
- The majority understood the risks associated with sharing equipment and generally avoided doing so.
- Eight reported that they would share pipes, but only with people they used with regularly or trusted, often partners or close friends. There were occasional reports of sharing injecting equipment.
- Both participant groups wanted to have access to or be able to offer safer inhalation pipes, with staff noting that the inability to provide appropriate equipment can make services less attractive and may discourage people using cocaine from attending.
- Several staff expressed concerns that services were not fully prepared to support people using cocaine, highlighting gaps in cocaine-specific knowledge, harm reduction training and associated confidence. Staff felt greater levels of in-depth training and more consistent information sharing would strengthen practice across services.
- Access to drug checking was raised by both participant groups, with some having experience of accessing this. It was acknowledged that there are limitations in the services currently available such as lengthy waiting times for results.
- RADAR and the WEDINOS website were discussed by some staff as useful sources to gain drug intelligence across Scotland and the wider UK. Peer-to peer information was acknowledged by both participant groups as an important way to support drug checking results or to help to inform drug warnings.

Interventions for cocaine

- Both people who used cocaine and staff noted the absence of prescribing options for cocaine use and contrasted this with the broader range of medication assisted treatment for drugs such as heroin.
- People using cocaine had limited or no experience of receiving psychosocial or mental health support.
- A few people accessed more specialist support like psychology or psychiatry but this was generally specific to their mental health condition and did not address anything about substance use.
- A couple of people had experienced psychosocial supports such as bereavement counselling or cognitive behavioural therapy (CBT)-based interventions, but this was only in custody settings or if receiving MAT.
- Structured group-based provision was reported as limited, although Cocaine Anonymous (CA) and Narcotics Anonymous (NA) were mentioned by a small number of people who used cocaine as useful supports for them.
- People who used cocaine stated they wanted access to talking therapies, groups and peer support.
- Having peer support and lived experience workers embedded within services was highlighted as a positive by both participant groups as it provided opportunities to build connection, develop trust and rapport.
- People who used cocaine said residential rehabilitation was theoretically available but rarely offered for cocaine and crack use, with access further limited by long waiting lists and requirements such as urine tests to demonstrate abstinence from certain drugs.
- Staff understood the importance of psychosocial support and some delivered interventions such as motivational interviewing (MI), coping skills and psychoeducation. However there were barriers to provision, including capacity for consistent delivery and competing priorities in appointments.

- A few staff discussed the importance of adapting interventions to meet individual needs so people received effective support, for example offering neuro-affirming support for people who are neurodivergent.
- Staff stated that partnerships with third sector organisations offered valuable and more varied support - such as groupwork, walk and talk and drop-in support - which was not always possible within NHS settings.
- Group support was seen as more commonly delivered by third sector organisations, and staff emphasised the value of involving people with lived and living experience in facilitation as they were seen as credible and provided positive peer influence which promoted engagement.

Enhancing service provision

- Both participant groups raised that services needed to be better designed to attract and support people using cocaine, including potentially offering more drop-ins and crisis support.
- People who used cocaine identified limitations in current service opening times, suggesting that seven-day and out-of-hours provision would better reflect patterns of stimulant use. People shared that broader, more flexible access would be welcomed, however staff highlighted that current capacity, funding and resource constraints restrict the ability to offer this.
- Practical support around subjects such as housing or finance, like accessing supported accommodation or submitting benefit claims, was an important part of wider support for cocaine.
- Several staff raised that increased staffing levels were needed to be able to consistently offer things like psychosocial interventions.
- Service commissioning and funding barriers were raised by staff as an ongoing challenge. Staff described declining funding and steadily increasing caseloads, which placed growing pressure on staff to meet the rising demand with limited resources.
- People who used cocaine felt more visible information was needed about cocaine, harm reduction, drug alerts and where/how to get support. It was felt information should be disseminated in places people attend, including accommodation projects and first-line and emergency response services such as hospitals or police stations.
- Staff highlighted a need for services to reach beyond the traditional treatment population including people using recreationally and those not receiving MAT.
- Both participant groups discussed stigma as an ongoing barrier in treatment and support for cocaine. Staff felt people were unclear where to find out about available support should their use become more problematic.
- Staff across all groups highlighted a need for further education and more extensive training on cocaine and how it works in the body and brain, the impact on MAT and harm reduction.

Researcher reflections

Researchers involved in the project felt that:

- People who used cocaine valued the opportunity to speak openly about their experiences in focus groups, with some describing the discussions as therapeutic and more meaningful than expected. This led some to sharing that they would feel more willing to engage in support, particularly groupwork with others.
- Unsupported or undiagnosed mental health and neurodivergence was a key factor in triggering and continuing cocaine use, often exacerbated by poor access to assessment or support. The limited availability and awareness of psychosocial interventions for cocaine were a particular issue.
- There was little cocaine-specific support with limited evidence of MAT standards implementation where cocaine was the primary drug, this included harm reduction provision. People who used cocaine actively sought to reduce harm while balancing the desired effects of cocaine use but needed the full range of equipment to do so.

DISCUSSION

Introduction

The MAT standards provide the necessary framework for improving treatment and support for people who use cocaine, but the standards are not yet being applied consistently for cocaine. Current treatment models remain more focused around opioid use, and many people using cocaine are not engaged with services specifically for their cocaine use. This outlines the need for clearer guidance on how the MAT standards can be adapted for people whose primary or additional substance use involves cocaine, supported by adequate resources to respond to increasing demand.

Patterns and methods of substance use

The findings show frequent cocaine use across the sample, with smoking crack or freebase cocaine particularly common and smaller numbers reporting snorting or injecting; all of those injecting reporting “snowballing”. Polysubstance use was widespread, including use alongside heroin, alcohol, cannabis, pregabalin and street benzodiazepines. These patterns highlight the need for services to routinely discuss routes of administration, polysubstance use and associated harms, and to provide cocaine-specific harm reduction advice that reflects current local trends.

Motivations for cocaine use

Cocaine use was shaped by a range of motivations, including coping with trauma, mental health difficulties and neurodivergence, as well as pleasure, confidence, energy, social connection and financial triggers such as “payday”. The evaluation highlights that staff and people who use cocaine may understand these motivations differently, with staff more likely to emphasise systemic harms such as poverty and people using cocaine more likely to discuss perceived benefits. Effective support therefore requires dedicated time to explore the function cocaine serves for each person, using approaches such as motivational interviewing to build engagement, identify realistic alternatives and tailor interventions to individual readiness for change.

Physical health impacts

Cocaine use was associated with a range of physical health impacts, including cardiovascular effects, respiratory problems, disrupted sleep, appetite changes and the wider effects of these on wellbeing. Risks varied by route of administration, with injecting linked to palpitations and smoking associated with breathing difficulties. Access to routine physical health monitoring such as ECGs was limited despite staff citing examples of effective joint working to offer this and it being recommended in recently developed guidance for cocaine. Routine physical health assessment, health-based psychoeducation, sleep management, nutrition advice and stronger links with primary care and emergency services should therefore be embedded as core elements of cocaine-related support.

Mental health impacts

The findings show a strong relationship between cocaine use and mental health challenges, with some participants using cocaine to manage symptoms while others described worsening mental health such as anxiety, paranoia, hallucinations or psychosis over time. Access to formal mental health assessment and support was limited, and pathways between substance use, mental health care, primary care and emergency services were often unclear.

A more integrated response is required, including rapid support during crisis, stronger joint working, neuro-affirming practice and a "no-wrong-door" approach that meets people where they are at when they seek help.

Changing market and impacts

Participants and staff described increased cocaine availability, changing supply routes, county lines activity, exploitation, drug debt and wider social harms linked to the cocaine market. Concerns included exploitation of young people such as being drawn into supply and a perception of higher levels of associated violence connected to involvement with organised crime, although the importance of avoiding stigmatising assumptions that cocaine use itself directly causes violence was noted. Local areas need stronger intelligence sharing, safeguarding responses, timely communication of emerging risks and training which includes anti-discriminatory practice so services and partners can respond effectively to changing market conditions.

Relationship with medication assisted treatment

Cocaine use was common among people in MAT, with many participants reporting that MAT had little direct impact on their cocaine use and some adjusting medication routines around cocaine use or comedowns. Staff and people using cocaine identified possible increases in cocaine use for some people receiving LAIB, particularly where underlying reasons for substance use remained unaddressed. Services should offer flexible and person-centred levels of contact alongside prescribing, and provide opportunities for discussions about concurrent cocaine and opioid substitution treatment risks. ECG access for those in MAT would be particularly recommended due to the risks of cocaine use on top of MAT. Prescribing decisions should continue to support retention in treatment, taking care to avoid decisions that can be experienced as punitive.

Harm reduction

People using cocaine described a range of self-directed harm reduction practices, often shaped by peer knowledge rather than formal service input. This demonstrates both the strengths of existing peer-to-peer education through existing networks and the need for services to expand cocaine-specific harm reduction beyond opioid-focused models. Priorities include urgent legislative change to allow for safer smoking equipment, tailored injecting advice, advice on access to drug checking, and naloxone provision. These interventions should be supported by peer-led and co-produced information, local drug alerts and routine use of resources such as the Cocaine Toolkit to support consistent, non-judgemental conversations about risk. Utilising peer models to disseminate information, advice and alerts will help ensure it is both credible to people who use cocaine and can reach the range of target groups necessary.

Interventions for cocaine

The majority of people who used cocaine described feeling there was little meaningful support available specifically for cocaine use, with a perception that services had little to offer in the absence of medication-based treatments for cocaine. People using cocaine reported limited access to psychosocial interventions, despite staff recognising that these remain the main evidence-based approach for cocaine use. MI, CBT-based interventions, contingency management, psychoeducation, peer support and group interventions were all identified as relevant. However, delivery was constrained by workforce capacity, caseload pressures and limited staff time to deliver or engage in the training needed to offer these interventions. Services should be adequately resourced to build psychosocial support into their routine service provision through training, reflective practice and supervision and increasing staffing where possible. Interventions should be offered in a person-centred way including offering individual and group support with optional peer-led delivery. Interventions should be adapted to meet the needs of neurodivergent people, those experiencing mental health barriers and those at different stages of readiness for change.

Enhancing service provision

The findings identify a need for services that are easier to access, more flexible and better designed around cocaine use. Low-threshold drop-ins, extended opening hours, clearer cocaine-specific pathways, focused clinics, holistic support to wider areas such as financial support and stronger links with third sector and peer support were all viewed as important ways to improve engagement. Service development should be supported by more visible and co-produced information, local pathway mapping, staff training, wider promotion of the Cocaine Toolkit and ongoing involvement of people with lived and living experience to ensure treatment and support is responsive to changing patterns of cocaine use.

CONCLUSION

This evaluation highlights that rising cocaine use in Scotland is shaped by a range of health, societal, social and market factors. This included mental health challenges, trauma, neurodivergence, interpersonal relationships, financial pressures, drug availability and quality. While many people using cocaine were aware of harm reduction approaches and motivated to reduce risk, they reported limited access to cocaine-specific support and described services as largely designed around opioid use and medication-based treatment.

Services must adapt urgently to changing patterns of substance use by developing clearer cocaine-specific pathways, improving integration across substance use, mental health, primary care, third sector, peer-led and specialist services, and making more consistent use of existing resources such as the Cocaine Toolkit. Services should offer low-threshold access, more flexible opening hours, rapid response provision during periods of crisis, and greater access to health and neurodiversity assessment complimented by ongoing support that is not dependent on opioid prescribing. Support services need to be resourced to allow staff the opportunity for workforce development and the ongoing time and capacity to deliver evidenced based psychosocial interventions such as MI, and peer support. There is an urgent need to expand existing harm reduction provision to include safer inhalation pipes and wider access to drug checking. These interventions should be supported by credible information co-produced with people with lived and living experience to reduce the emerging harms seen from cocaine use in Scotland.

There was a clear need to strengthen the application of the MAT standards for people who use cocaine, particularly in relation to harm reduction, psychosocial support, physical and mental health care, advocacy and retention in treatment.

RECOMMENDATIONS

The findings from this evaluation highlight a number of opportunities to strengthen existing support, improve service delivery and address gaps identified by both people who use cocaine and staff. The following recommendations give examples for service development and effective responses to cocaine use across treatment and support services.

1. Develop cocaine- specific support and treatment pathways

Services should develop clear treatment pathways for people using cocaine, or make existing pathways easier to understand. Pathways should explain how people can be referred to the right support. This may include substance use, mental health, neurodiversity, primary care, advocacy and third sector services. Particular attention should be given to routine physical health assessment including provision of ECG monitoring, chest exams or access to lung functioning tests/X-rays given the risk of cardiac or respiratory problems. Equally, screening and assessment for mental health conditions and neurodivergence should be prioritised with timely support to access treatment such as stimulant medication where required.

Taking account of current good practice examples, cocaine-specific treatment and support could be delivered either in dedicated services or by offering cocaine clinics within existing services. Such services should offer low-threshold access via drop-in support, flexible opening times or out of hours provision to allow for rapid responses at points of crisis. Monitoring the emerging international evidence on stimulant prescribing and exploring how this could be applied in Scotland should be considered in further research on cocaine.

2. Expand harm reduction provision

Harm reduction interventions should be expanded to reflect current patterns of cocaine use, including safer smoking and injecting advice and equipment, access to drug checking services, and naloxone provision where cocaine is used with medication-assisted treatment (MAT) or opioids. Targeted harm reduction education on route-specific risks, including the use of improvised smoking equipment such as wire wool, is essential to reduce the health harms associated with unsafe paraphernalia. Information should cover the risks of using ammonia or sodium bicarbonate when making freebase or crack cocaine alongside general drug knowledge. Given the risk of adulterants in the drug market, it is essential to raise awareness of the potential risks associated with synthetic opioid contamination. Access to drug checking across Scotland would support provision of information and offers a useful engagement toll to people not currently in treatment.

There is an urgent need to address the legislative barriers that prevent services from providing equipment such as safer inhalation devices or gauze. Services should explore what provision can be offered within the current legislative constraints, such as tailored kits for people injecting powder cocaine or freebase/crack cocaine that could include coloured syringes similar to what has been provided in chemsex packs. Provision of aftercare resources such as saline nasal spray or lip balm could support tailored harm reduction resources.

3. Improve access to psychosocial support

Evidence-based psychosocial interventions, including motivational interviewing, cognitive behavioural therapy (CBT) and contingency management should be made consistently available for people using cocaine. These interventions should be delivered in a person-centred way - for example, choice of one-to-one or group-based support. Alongside these interventions complimentary psychoeducation should be provided to support people with wider health impacts, including sleep and nutrition. Approaches should be adapted to ensure they are neuro-affirming to respond to the high levels of neurodivergence in people who use cocaine.

Services must be properly resourced for staff to have the necessary capacity to deliver psychosocial interventions and to develop the necessary relational foundations that underpin them. Dedicated staff should be considered so they are able to concentrate on delivery of interventions and have time to engage in the reflective practice and supervisory requirements to deliver interventions effectively. Existing offerings need to be promoted more widely so that people who use cocaine are aware of the support that is available.

4. Involve people with living and lived experience

People who use cocaine should be fully involved in service design, information development, peer-led harm reduction and the delivery of support to ensure services are relevant, trusted and accessible.

Learning from good practice within mutual aid networks, facilitating peer support in group settings and offering peer-led facilitation of groups would be beneficial in engaging people who use cocaine but who may not find traditional substance use services attractive. Meaningful consultation with people with living experience on service models and developments is essential in ensuring services meet the current needs of the population. Consultation should involve the range of people who use cocaine and seek to engage the most at-risk populations as well as populations who may be more hidden including young people or people using recreationally.

Co-production of information resources and drug alerts would ensure information shared is accurate and tailored to the needs of peole using cocaine.

5. Prioritise information development and dissemination

It is essential that people who use cocaine have access to accurate, up to date information on all forms of cocaine, the risks and harms, and that this is offered alongside signposting information to the variety of support available.

Results of drug checking and drug alerts should be shared in settings where it will most likely reach the target populations, including but not limited to: supported accommodation, hostels, emergency departments, frontline services, police stations and job centres.

Agencies should improve local intelligence-sharing on cocaine availability, quality, county lines activity, exploitation and associated harms, ensuring responses reduce risk without reinforcing stigma or stereotypes.

6. Standardise workforce training and guidance

Staff across statutory and third sector services should receive regular training and guidance on cocaine use, physical and mental health risks, interactions with MAT, harm reduction, trauma informed care and neuro-affirming practice.

Physical health, mental health and neurodevelopmental screening training should also be offered to appropriate staff to identify the underlying factors which may be linked to or exacerbated by cocaine use.

Existing guidance such as the **Cocaine Toolkit**, should be adopted on a national basis with staff training to support its implementation.


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