SCOTTISH DRUGS FORUM

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

AUGUST 2026

SCOTTISH DRUGS FORUM

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# Acknowledgements

The publication of this report would not have been possible without the continued enthusiasm and commitment of our peer research volunteers who were involved in all aspects of this work. A very special thanks to Jaqui, Nicki, Ally, Denise, Craig, Alex, Vikki, Geanie, Morrin, Brian and Gary for their involvement.

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.

Thank you to the Scottish Government who supported this work with funding. Thanks also to the Alcohol and Drug Partnerships and services involved who helped identify people who use cocaine and raise awareness of the evaluation across the four health boards.

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 use 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.

This report refers to the national Medication Assisted Treatment (MAT) standards which are listed below. Further information and resources on the standards can be found at matstandards.co.uk

**Medication Assisted Treatment (MAT) standards**

**MAT 1.** All people accessing services have the option to start MAT from the same day of presentation.

**MAT 2.** All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose.

**MAT 3.** All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT.

**MAT 4.** All people are offered evidence-based harm reduction at the point of MAT delivery.

**MAT 5.** All people will receive support to remain in treatment for as long as requested.

**MAT 6.** The system that provides MAT is psychologically informed (tier 1); routinely delivers evidence-based low intensity psychosocial interventions (tier 2); and supports individuals to grow social networks.

**MAT 7.** All people have the option of MAT shared with Primary Care.

**MAT 8.** All people have access to independent advocacy and support for housing, welfare and income needs.

**MAT 9.** All people with co-occurring drug use and mental health difficulties can receive mental health care at the point of MAT delivery.

**MAT 10.** All people receive trauma informed care.

# INTRODUCTION

## Background

Use of cocaine has significantly increased across Scotland in recent years. It was the most commonly reported primary drug used by people starting specialist drug treatment in 2024/25 (Public Health Scotland, 2026). Harms from cocaine use are growing in line with use, with hospital admissions linked to cocaine in 2023/24 showing a 41% increase compared to the previous year (National Records of Scotland, 2025). Cocaine was also implicated in nearly half (47%) of the 1,017 drug-related deaths in Scotland in 2024 (NRS, 2025).

To respond to these increasing harms, it is key that cocaine use is better understood and services are equipped to support people. Scottish Drug Forum's (SDF) recent evaluation of long-acting injectable buprenorphine provision highlighted the importance of providing cocaine-specific harm reduction advice and equipment, alongside person-centred support for people using cocaine/crack alongside their MAT in order to reduce health risks, including overdose and mental health challenges (SDF, 2025).

This evaluation helps to fill gaps in our understanding of cocaine use in Scotland. It explores patterns of use motivations and impacts of use, changes to the market and experiences of accessing support among people using cocaine, including those who are also accessing MAT. Particular focus was given to previously identified gaps in support which sit within MAT standards 4, 6 and 9. These included access to harm reduction support, low intensity psychological interventions which provide practical and emotional support to develop positive relationships and build social connections, and adequate mental health care for people with coexisting substance use use and mental health difficulties.

## Aims

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

## Objectives

- To explore individuals' experiences of cocaine use whilst accessing MAT, including motivations, risks and consequences of use, patterns of use and medication interactions.
- To explore individuals' experiences of cocaine use when not accessing MAT, including motivations, risks and consequences of use, and patterns of use.
- To identify the support currently available and any gaps for cocaine use, with a focus on treatment options, harm reduction advice and equipment, physical and mental health support needs.
- To explore staff perceptions of cocaine use by their clients and their experiences of delivering treatment and support, highlighting challenges, good practice and any gaps in service provision.

# DESIGN AND METHODS

This evaluation was conducted across four Scottish health board areas: Greater Glasgow & Clyde, Fife, Highland and Tayside, these areas were selected to reflect a mix of urban and rural experiences. To ensure a representative snapshot across gender, age groups, varying levels and patterns of cocaine and crack use, and experiences of MAT, purposive sampling was undertaken in each area where possible. The evaluation received approval through Caldicott, NHS Clinical or Information Governance processes in each area.

Using SDF's peer research model, 11 peer research volunteers with lived or living experience of substance use were involved throughout recruitment, data collection, analysis and sense checking of the evaluation data, six of whom also had lived or living experience of receiving MAT.

Applying a qualitative approach, focus groups were conducted with a total of 68 people; 34 people who used cocaine and 34 staff who supported people who use cocaine/crack. Participants were informed of their right to withdraw or request data removal at any stage; no withdrawals occurred, and all data has been included in the final analysis.

Both participant group discussions explored themes including motivations and impacts of use, experiences of MAT, harm reduction, existing support provision, and gaps in current services. Peer researchers co-facilitated eight of the focus groups alongside two research staff from SDF. Peer researchers also participated in researcher debriefs and contributed to the thematic analysis and development of recommendations.

People who use cocaine were eligible to attend focus groups if they were aged 18 or over and currently using, or had recently used, cocaine and/or crack. Seven focus groups were held in person in each of the four health board areas, with a total of 34 people attending. Basic quantitative data was collected prior to group sessions including demographics and details of current substance use. People who use cocaine received a £30 PayPoint voucher as a thank you for their time.

For staff focus groups, three focus groups were held online via Microsoft Teams with 34 staff from NHS statutory, third sector and local recovery organisations/services attending.

All focus group recordings were transcribed and a thematic analysis was applied to identify the key findings and recommendations presented in this report.

# DEMOGRAPHICS

Before starting the focus groups, all people who used cocaine were asked to complete a demographics questionnaire. This was completed by all 34 people.

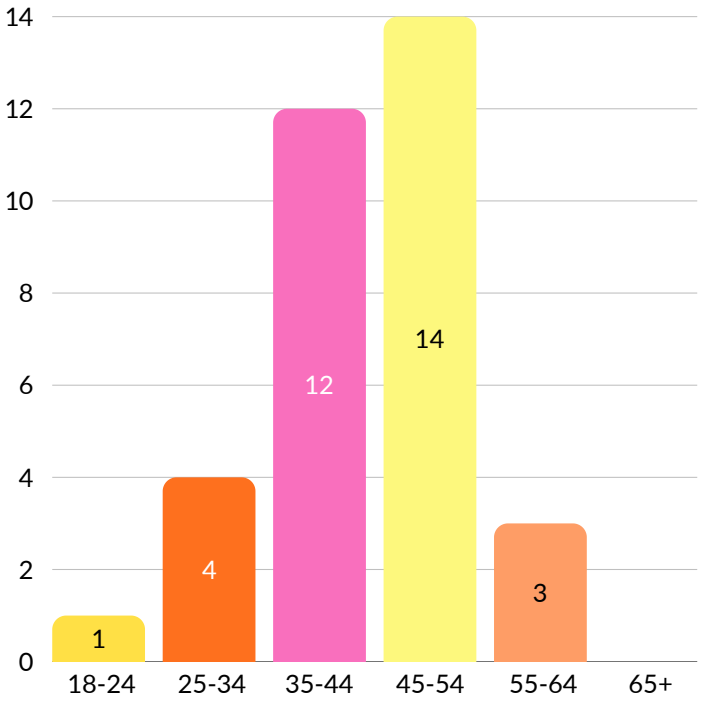
**29% (n=10) Female**

**71% (n=24) Male**

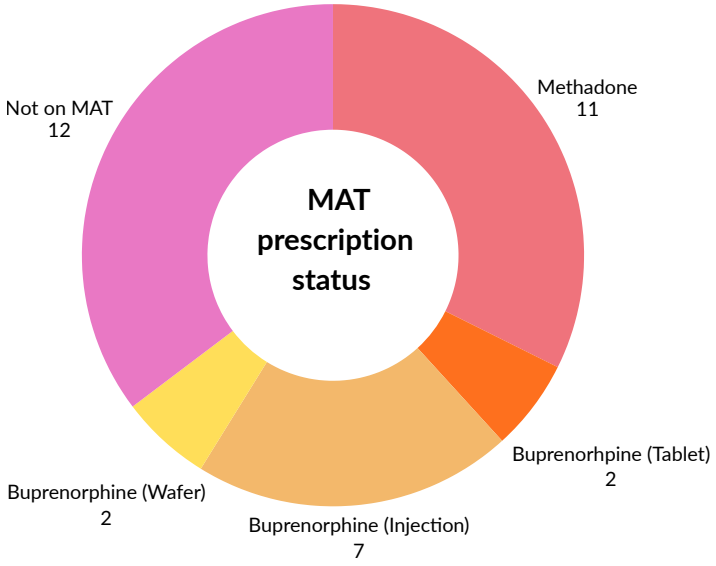
**Participant numbers for each Health board area:**

- **Highland:** Eight attended one focus group in Inverness.
- **Fife:** Seven attended across two focus groups in Leven (n=3) and Dunfermline (n=4).
- **Tayside:** Seven attended across two focus groups in Dundee (n=4) and Perth (n=3).
- **Glasgow:** 12 attended across two groups held in Glasgow City. Five attended an initial focus group and a further seven attended a follow up session which was designed to ask some clarifying questions around themes that had come up in the previous six focus groups.

**Participant numbers by age range**




**2 in 3 people were on MAT**

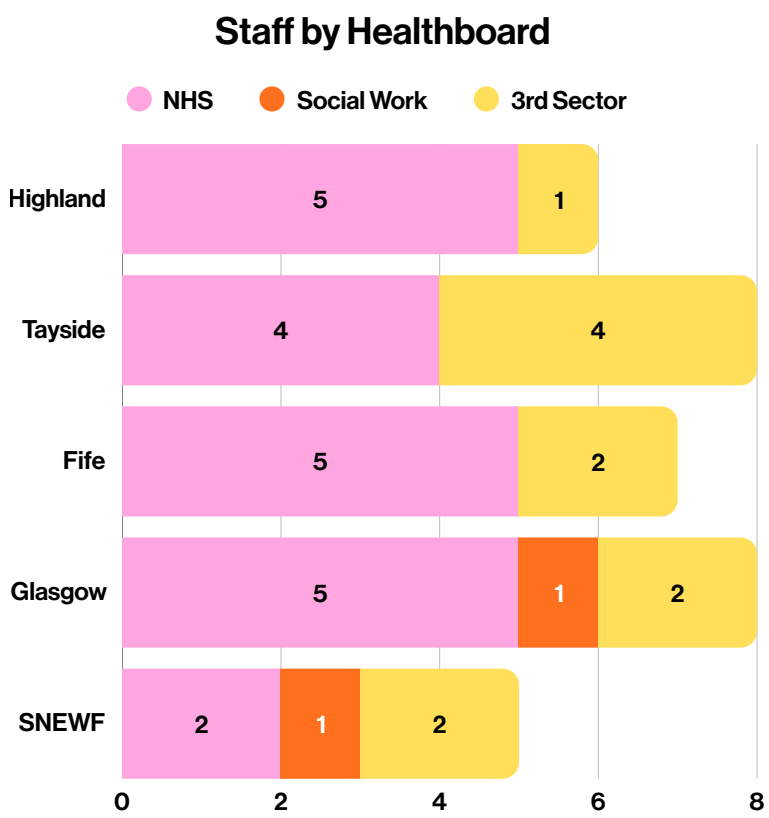



**Length of time on current MAT prescription:**

- Less than one year: seven people (32%)
- 1–5 years: eight people (36%)
- 5+ years: seven people (32%)

**A total of 33 people had current use of cocaine, either powder, freebase or crack. One participant stated they were currently abstinent but contributed their views of previous use.**

A total of 34 members of staff attended across three focus groups. There was a range of roles and localities represented. Five members from the Scottish Needle Exchange Workers Forum (SNEWF) attended these focus groups, representing their work areas of Lanarkshire, Grampian, Forth Valley and Lothians.




**NHS staff roles who attended**

- Clinical Team Manager
- Advanced Nurse Practitioner
- Senior Nurse
- Support Worker

**Social Worker roles who attended**

- Drug and Alcohol Social Worker
- Social Work assistant

**3rd Sector roles who attended**

- Outreach Worker
- Project Worker
- Service Manager
- Senior Practitioner
- Counsellor/ Psychotherapist

# FINDINGS

## Patterns and methods of substance use

### KEY FINDINGS

- Frequent crack/freebase use was common, with most reporting using at least once a week.
- Smoking crack/ freebase was reported by all, with smaller numbers reporting either injecting or snorting of powder cocaine.
- All of the few people who injected, reported "snowballing" (injecting powder cocaine with heroin).
- Over half of all participants discussed purchasing powder cocaine and "washing it back" themselves to produce freebase cocaine or crack for smoking. This was seen to reduce the risks of buying street crack which could be lower in purity and have higher levels of adulterants.
- The majority used at least one other substance alongside cocaine; the most commonly reported were cannabis, pregabalin, alcohol, heroin and street benzodiazepines.
- Polysubstance use occurred for various reasons, such as to intensify effects, due to the poor quality of cocaine and to manage comedown effects such as anxiety or inability to sleep.
- Staff felt factors such as working in hospitality, transactional sex or engaging in chemsex influenced patterns of cocaine and other drug use. For example functional use, such as staying awake.
- Staff raised concerns about the role of cocaine/crack in increasing drug-related deaths, particularly where polysubstance use or prescribed medication, including MAT, was also involved.
- Staff noted concerns about the normalisation of cocaine use in social settings and young people's rising use of cocaine and other substances.

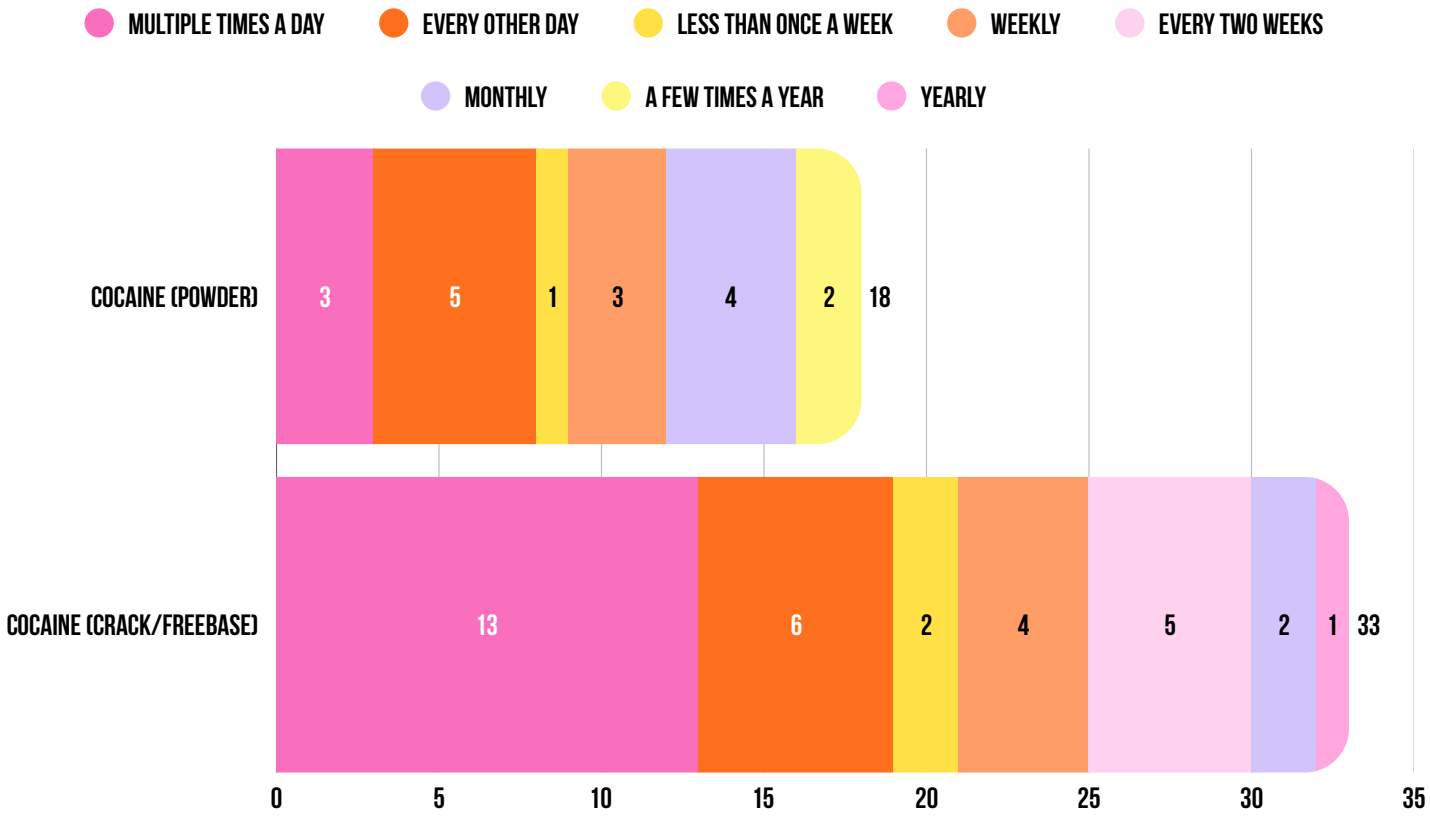
## People who used cocaine

### Substance use patterns

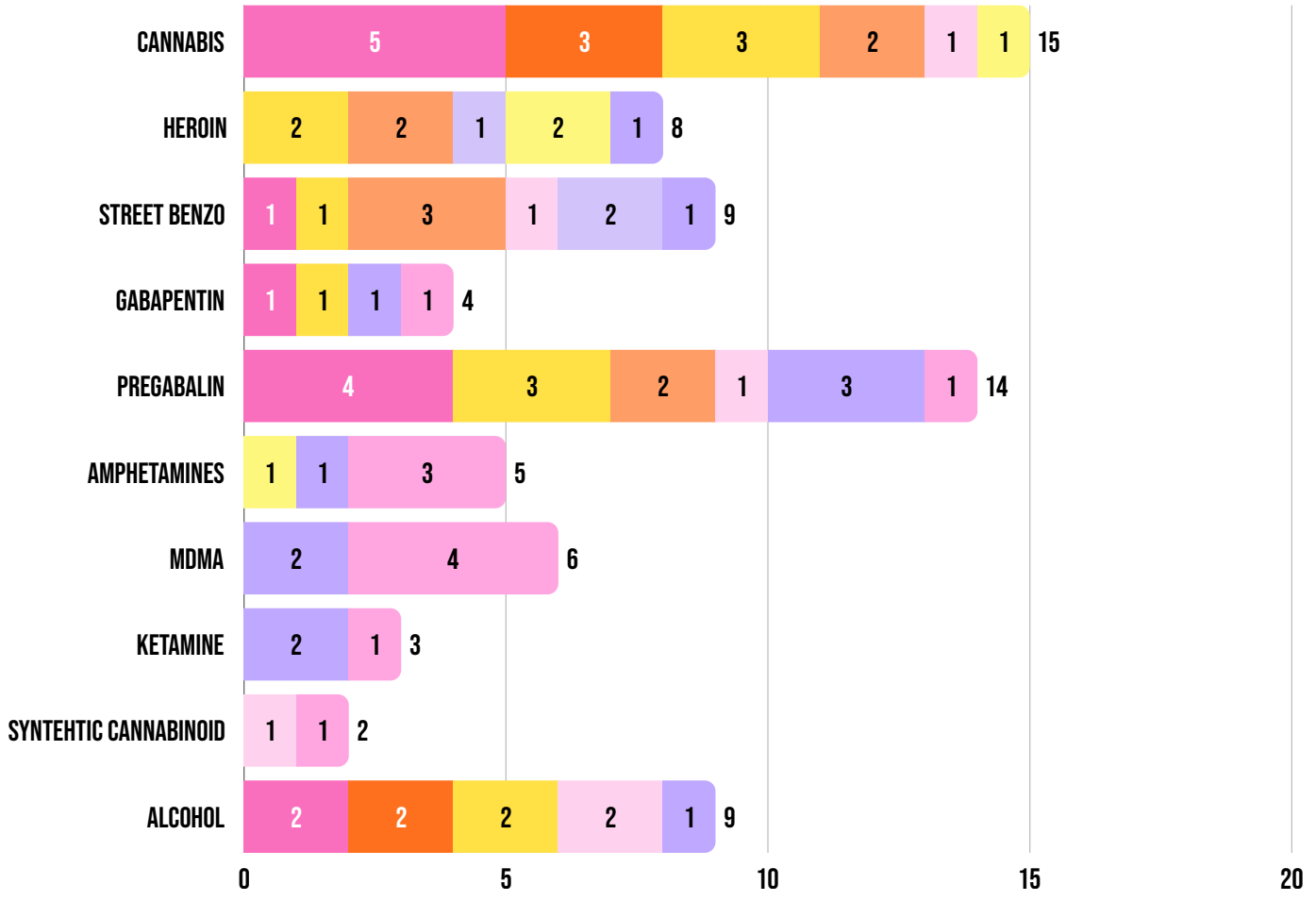
Before taking part in the focus groups, people who use cocaine completed a short survey about any substances they were currently using and the frequency of use (full results described on p.10). Crack or freebase cocaine was the most commonly reported (n=33), with the majority using it once a week or more (n=26). More than half of people who used cocaine (n=18) reported using powder cocaine alongside crack/freebase of varying frequencies. Eight people who used cocaine reported only using crack/freebase, while one person reported exclusive use of powder cocaine.

Most people who used cocaine (88%, n=29) reported using at least one additional substance alongside cocaine use. Cannabis and alcohol were the most commonly used, often in combination. People discussed reaching a *"ceiling"* effect with cocaine, where further use no longer intensified effects unless additional substances were taken. Poor cocaine quality was frequently cited as a reason for combining drugs. One participant noted *"we have been hitting a bit of Mandy [MDMA] and a bit of Ket [Ketamine] as well"* alongside crack cocaine. Pregabalin was used by 14 people, though it was rarely discussed in direct connection with cocaine use. Some people stated they began using it illicitly following the end of a prescription. Heroin use was reported by several people, with three describing its use specifically to manage comedown symptoms, particularly anxiety or paranoia associated with crack use. One person stated that heroin *"calms them down when crack just sends me paranoid"*. Benzodiazepines, particularly diazepam, were discussed in four focus groups and were primarily used to aid sleep following cocaine or crack use. One person described taking diazepam *"for days"* after using crack in an attempt to address severe insomnia.

## Cocaine and crack use




## Other substance use



## Forms of cocaine

Eighteen people reported purchasing powder cocaine and "washing back" to create freebase cocaine or crack. The primary motivation was distrust of street bought crack, particularly due to concerns about unknown cutting agents. People described washing back their own powder as a form of harm reduction, as it gave them greater control over both the ingredients used and the quantity and quality of product consumed. Several people who used cocaine (n=9) also felt this approach offered better value for money. Four people who used cocaine described enjoying the washing back or *"cooking"* process itself, viewing it as part of the excitement associated with drug use.

Ten people reported using ammonia to wash back powder cocaine, as the resulting freebase produced was stronger. However, some people reported negative physical effects, such as throat irritation, with one person stating their throat felt *"on fire"* after using ammonia.

> ***"If you're smoking it with ammonia and that, you know its a belter day, you're all right. But if you're smoking it off them pipes off the line, then you're f****d."***

Four people preferred making crack with sodium bicarbonate, believing it to be less harmful to their lungs and throat. It was noted in one group that there was a level of skill involved to do this method or it could result in loss of product as one participant described you *"need to know how to do it proper"*. A further four didn't disclose their preferred process.

## Routes of administration

Smoking was the most common method across all focus groups. People described the experience as a *"constant cycle of piping,"* often continuing until the supply ran out or they became physically unwell. In one focus group, participants described the residual oils left after smoking as particularly strong, with one participant stating that *"using the oils are the best part,"* further reinforcing smoking as the preferred method.

Injecting powder cocaine was reported by six people all in combination with heroin ("snowballing") and usually described as a one-off experience rather than a regular practice. People associated injecting with more severe physical reactions than smoking, including intense heart palpitations and, in one case, what was described as a near-death experience, with the participant believing they were having a heart attack.

> ***"I've actually gone to the floor a few times when I've injected it. I've had a fit, like sometimes I am not completely conscious but I am also not unconscious, I'm just there and that is scary."***

Snorting powder cocaine was mentioned by five people who use cocaine, most often in social settings and in combination with alcohol. Some felt that snorting resulted in less severe comedowns with one person stating *"I dinnae get as much of a crash when I sniff it"*. However, many expressed reluctance to use this method unless they believed the powder was of good quality, which many felt was increasingly rare.

### Risk awareness & tolerance

Overall, people demonstrated some awareness of tolerance levels and associated personal limits. Many people who were experienced in substance use, felt confident in their ability to judge risks with their cocaine use accurately, this could differ to feelings towards other substances such as alcohol or benzodiazepines.

A few people raised concerns about the safety of relying on experience and individual tolerance in the current drug landscape of varying purity and adulterants in cocaine market One person described tolerance as *"quite dangerous,"* warning that unknown cutting agents posed significant risks regardless of experience or previous use, noting that a single session could result in serious harm.

> ***"Whether its's smack, or crack or cocaine, whether its patsies or a pipe - there is a limit with it. Apart from alcohol, when you fall down with drink, you know you're drunk. Blues are the other way to get you like that. When you get like that, it's already too far."***

> ***"at the end of the day, you can take one pipe and be f***** - thats it."***

## Staff perspectives

Staff reported that patterns and methods of cocaine use varied depending on the social contexts in which use occurred and whether individuals' use was more recreational or more dependent. Across Scotland, different patterns were identified; recreational (which was often associated with more infrequent use), intermittent or regular use as part of wider poly substance use and more frequent use associated with higher levels of harm.

### Recreational and social use

> ***"They enjoy it, it's fun, it enhances their experience. You know, they have a great time when on it, then they might not use again for another couple of weeks, or whatever it might be."***

Recreational use was typically described as ad hoc and socially embedded, particularly within drinking environments. Powder cocaine was strongly associated with pubs, clubs and other social settings, often said to be used alongside alcohol to prolong or intensify euphoric effects.

Staff highlighted a growing normalisation of powder cocaine use, frequently comparing it to how alcohol is used and accepted within social settings.

Several noted that cocaine was sometimes offered in a similar way to alcohol, with one explaining that people now ask *"do you want a line?"* as they would have asked *"do you want a pint?"* a decade earlier. The visibility was emphasised, with staff reporting that use was widespread and no longer discreet or concealed. One staff member referred to cocaine being as common as *"pub grub"*, while another observed that its use was highly visible among both men and women in pub settings.

> ***"We need to separate cocaine when we discuss it because in my mind, cocaine and crack cocaine, so they are two completely different things and used by different groups of people."***

Despite this visibility, staff felt there was limited understanding of the broader patterns of powder cocaine use and potential impacts. This group was widely perceived as less likely to engage with "mainstream" drug services, contributing to concerns that there is a substantial cohort of people not accessing support.

> *"We have got a massive cohort of people who aren't reaching or accessing services."*

Several staff expressed concern about younger people and peer influence; their concerns focused on young people's lack of awareness of the risks and where and how to access support. Staff noted higher levels of both cocaine and ketamine use among younger people in recent referrals, which they viewed as a shift from previous years. One staff member linked this to perceptions of lower harm from powder forms.

> *"We are now seeing a lot of younger people because they can access substances in powder form, so they think it is not as bad as someone else using rocks."*

## More frequent and high risk use

The main focus of staff discussions was on more regular use of cocaine, freebase or crack where people were experiencing day-to-day problems. Staff broadly described three overlapping groups within this population:

- individuals using psychostimulants including powder cocaine alongside alcohol;
- people currently engaged with MAT who had begun using cocaine (either smoked or injected);
- individuals who had disengaged from MAT and transitioned predominantly or entirely to cocaine use.

An increase in the injection of powder cocaine was reported by some staff, and in particular, was reported among individuals who had previously injected heroin. Cocaine was the predominate primary drug for injection in the Safer Drug Consumption Facility in Glasgow.

> *"They come through the facility to inject, it's about 85% cocaine injection, and the rest is then a mix of cocaine and heroin, and then the rest after that being heroin."*

Staff also noted geographical variation, with patterns influenced by local trends and availability of drugs. For example, practitioners in the north of Scotland reported seeing lower levels of powder cocaine injection, with crack smoking being more common.

## Contextual and occupational factors

Staff highlighted that motivations and patterns of use could be shaped by a variety of factors. In chemsex settings and among people involved in transactional sex, the use of multiple substances was commonly reported, this could be to enhance sex or facilitate greater comfort with selling sex. One practitioner described a clear link between crack use and sex work, citing the hours and demands of the work as influencing patterns of use. Occupational contexts, including manual labour and hospitality, were also identified as environments associated with functional use - for example, maintaining energy or staying awake during long shifts.

## Perceptions of risk

Staff observed that individuals' perceptions of their cocaine use were often shaped by comparison with past substance use. This was particularly evident among people accessing MAT, some of whom viewed cocaine use as less harmful than their previous opioid use, especially where they were no longer injecting.

Examples were given of individuals describing their use as *"not as bad"* because they did not inject, or because they used for recreational purposes, for example to enhance sex in context of chemsex, despite staff noting their use as relatively frequent and high-risk.

The "washing back" of powder cocaine to produce freebase or crack was raised repeatedly across both NHS and third sector services. This practice was viewed as a key focus for harm reduction work due to its prevalence amongst people being supported. Some staff noted that individuals felt washing back themselves was a way of exerting control of drug purity and reducing risk, particularly in comparison to purchasing crack directly from the street.

## Other concerns

Staff expressed significant concern about the risks associated with polysubstance use, particularly where cocaine and crack were used alongside MAT or other prescribed medications. Many felt this combination contributed to heightened risk and a potential rise in drug-related deaths. One staff member described the situation as a *"drug-death-related time bomb"*.

Information-sharing such as through multi-disciplinary team meetings, was viewed as critical for responding effectively to these risks. Staff emphasised the importance of exchanging local intelligence, such as drug alerts and emerging trends, to improve coordination and support.

Concerns were also raised about younger people's substance use trajectories. Staff suggested that early use of substances, such as ketamine, could progress to cocaine as individuals seek similar stimulant effects, potentially leading to more frequent use and future presentations for support. Three staff members raised ketamine use stating *"we know the next step from that could be cocaine, because they will still be looking for that same rush they're getting from ketamine just now"*.

***"We have a couple of people who, I think they worked quite hard to not be on any opiates anymore, including the methadone. They think, Oh, well, I worked hard and I'm off my prescription and that now, for whatever reason it's, it's almost like the thankful I'm not taking opiates but are using crack."***

***"... We are very much aware of a the rising use of cocaine, we are also aware our opiate users have reduced. The amount of people we see using cocaine has soared exponentially and we see that it tends to be younger cohort, maybe early 20's to mid 40's."***

### SUMMARY

**Frequent cocaine use was reported, with most individuals using at least weekly and all describing smoking of crack or freebase cocaine. Smaller numbers reported snorting or injecting powder cocaine and those who did inject reported "snowballing" alongside heroin. Polysubstance use was widespread, often involving cannabis, alcohol, heroin, pregabalin and street benzodiazepines to enhance effects, manage comedowns or compensate for poor cocaine quality. Staff highlighted the influence of factors such as hospitality work, transactional sex and chemsex, and the greater acceptability of cocaine within society on patterns of use. They also raised concerns about the role of cocaine in drug-related deaths and use among younger people.**

# Motivations for cocaine use

## KEY FINDINGS

- The main motivations for cocaine use included escapism and using as a coping strategy for managing difficult life events, trauma, mental health or neurodivergence traits.
- Other motivations shared by people who used cocaine included pleasure, increased motivation, social contexts or peer influences and financial triggers e.g. payday.
- Other motivations shared by staff included poverty and lack of opportunities, less stigma towards cocaine compared to other substances, greater availability and reduced cost.
- Some staff felt the reasons for use should be explored more thoroughly with people in services so to provide more effective support/interventions.

## People who used cocaine

### Escapism and mental relief

The most frequently cited motivation for using cocaine or crack was escapism. People who use cocaine described these substances as providing a *"quick escape"* from reality, offering short-term comfort and relief from difficult circumstances. Use was commonly linked to coping with traumatic or challenging life experiences, including bereavement, homelessness, and poor mental health. While this temporary relief was valued, some people who used cocaine acknowledged that it could contribute to a *"vicious cycle"* of continued use.

Fifteen people reported using cocaine or crack to manage mental health conditions or neurodiversity, including anxiety, attention-deficit/hyperactivity disorder (ADHD) and autism. One participant noted that cocaine use temporarily *"calmed and quietened"* their mind in ways that prescribed medication had not, describing an experience of peace and mental clarity following initial use. Another commented that cocaine use gave them an inital *"break in anxious thinking"*. These short-term benefits often contributed to repeated use.

Relationship breakdowns and interpersonal conflict also emerged as significant triggers for use. Several people who use cocaine reported being more likely to use following arguments or the end of relationships, again framing use as a way of managing emotional distress.

> ***"It is pure escapism..Some of us have had hard lives and it is a quick escape."***

### Pleasure, energy and motivation

Some people who used cocaine emphasised enjoyment as a key factor in their continued use. They described the effects of cocaine and crack as initially positive, including increased energy, confidence and motivation. One person likened the feeling to a *"superman"* effect, stating it made them feel energised and *"ready to go"* for the day. Three people who used cocaine reported using cocaine or crack to boost motivation or productivity, helping them to complete daily tasks. Three people described using crack cocaine to manage hangover symptoms when alcohol had been consumed. One person stated they used crack because they were getting *"in too much trouble with alcohol"*.

> ***"I don't know, I just like taking it. Sometimes it can be good and other times just makes me edgy. Sometimes like a big warm hug you just need. Depends what it's been cut with to be fair."***

### Social contexts and peer influence

All reported that use occurred within social contexts, such as small trusted groups or with intimate partners. For some, use was confined solely to these social situations and would not be considered otherwise. The presence of others using substances was a strong influence, with people describing a fear of missing out and heightened urges when witnessing others use. One person explained that they may not intend to use, but once *"someone uses in front of me"*, the urge became too difficult to resist.

### Financial triggers

Payday was consistently identified across all focus groups as a key trigger for substance use. People who used cocaine described anticipating payday because it provided the financial means to purchase substances. Increased access to money was often linked to heavier use, including buying larger quantities and, in some cases, binge patterns over several days. Access to money shaped the timing and intensity of use.

Several explained that they would delay purchasing until payday. As one participant noted, *"We [partner and I], only ever use on and smoke crack on pay day every two weeks, it is sorta like a treat, like anyone else might go to the pub or something"*. Another said, *"It is dead moreish and if I had money, I'd be on it every day and hard, I mean I am most days but it would be worse."* Others similarly described *"splurging"* on payday, sometimes pooling money with friends and using multiple times a day until their funds were exhausted.

> ***"I should be spending the money on like trainers or something but instead I'm always leaving myself short after payday because it is all gone on crack."***

## Staff perspectives

### Coping and mental health

Across focus groups, staff consistently described cocaine and/or crack use as a form of escapism and a coping mechanism. Use was frequently linked to underlying mental health needs, with some individuals perceived to be self-medicating to manage conditions such as ADHD. Powder cocaine use in particular was discussed in relation to neurodivergence and perceived symptom management. As one staff member explained, *"I'm glad somebody mentioned the powder, because we're getting a lot of people up there self-medicating. They feel it does help with their ADHD."* Staff emphasised the intertwining of mental health and substance use, in particular between adverse childhood experiences or trauma, and cocaine use. The key worker relationship was seen to be central to fully understanding the underlying reasons for problematic use so that these could be appropriately supported within treatment.

> ***"I have someone who is using it to just function better on the whole. His ADHD is mentioned and for him, well it just sort of settles him down, feels it has a calming effect so it is self medicating."***

> ***"People are using substances and cocaine to escape from real life, their thoughts, their trauma. With powder cocaine, that gives people a bit of confidence too doesn't it?"***

## Societal issues

Some staff linked cocaine use to wider societal issues such as poverty and a lack of local opportunities. Staff also commented on the perceived social acceptability of cocaine compared to substances such as heroin. Cocaine was often viewed as a *"social"* or *"party"* drug, which staff felt could reduce stigma and influence some individuals' decisions to use it over other substances.

> ***"I think, like a lot is like, just poverty, isn't it? Like there's nothing better else to do. They feel that's it, but it's there, readily available and boredom."***

## Affordability

Changes in drug pricing were also highlighted by some, with several staff noting that cocaine was no longer viewed as a premium or luxury drug. As one person explained, cocaine *"used to be one of the expensive ones but now it is cheap as chips"*, this could make cocaine more accessible to a broader group of individuals but as highlighted earlier, cheaper cocaine was often an indication of poorer drug quality.

## Gaps in knowledge

In one focus group, staff expressed concern that transitions to cocaine or crack use, including shifts from opiates, are not consistently explored in depth by services. They felt that a more routine and structured exploration of motivations for these changes could support improved understanding and lead to more effective, tailored interventions.

### SUMMARY

**Cocaine use was driven by a range of personal and social motivations. These included escapism, coping with trauma, mental health or neurodivergence-related experiences, pleasure, social settings, peer influences, and financial triggers such as payday. Staff highlighted wider structural factors which impacted on motivations for use. These included poverty, limited opportunities, reduced stigma towards cocaine, greater availability and affordability. Some staff felt that understanding motivations for use more fully - especially for those who had transitioned to cocaine - would help services provide more effective support and interventions.**

# Physical health impacts

## KEY THEMES

- People using cocaine often experienced impacts on their physical health which could be severe and/or long-term. These included disrupted sleep, appetite changes, heart and respiratory problems.
- There were mixed views of how much these impacts would deter them or their peers from continuing to use cocaine.
- Sexual health issues were raised by a few women. For example, unplanned and/or unprotected sex or physical injury from sexual violence when involved in transactional sex.
- Staff recognised the physical effects and felt discussing and monitoring these should be a priority in services as people were often unaware of risks, such as impacts on long-term conditions.
- Services were not resourced to provide consistent physical health support/monitoring; staff felt they could and should be supporting with basic physical health needs such as nutrition, sleep and exercise.

## People who used cocaine

### Awareness of risks

There were varying levels of awareness of the physical health risks associated with cocaine use. Some people said they could identify impacts on their health and had been aware of these risks prior to using; others felt they only became aware once they started experiencing such effects following regular use.

> ***"I was not aware of any side effects. I just seen my pals using and they were always jumping around and that so I wasn't aware of the bad side of it. I wish I had known the dangers before now."***

### Physical effects

Several people who used cocaine highlighted route-specific 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. Snorting cocaine was linked to scabbing inside the nose, and one person also mentioned occasional nosebleeds when using this way.

> ***"...The fact is, people can get heart attacks and actually have cardiac arrest from using this stuff."***

Cardiovascular effects were discussed in several groups and these were associated with feelings of acute anxiety and fear. Several had experienced heart palpitations and on some occasions had personally experienced, eard of, or witnessed others having cardiac arrest.

Some also described panic attacks as a result of experiencing these physical effects with general feelings of having *"pushed it too far"*. In two focus groups, people raised pain and physical discomfort after use. This was often attributed to sitting in the same position for long periods or falling asleep at awkward angles and not noticing pain until the effects wore off.

> ***"when you're sat and just smoking it, you're sat in the same place for so long, in the scariest position and you can't move after."***

### Appetite and weight

Appetite changes were discussed across several focus groups, with mixed experiences. Some people reported little to no impact on appetite or eating patterns. Others described difficulty eating due to feeling *"physically sick"* after use, sometimes lasting several days depending on the amount consumed. One person also noted *"weight dropping off"* them, which they attributed to reduced appetite associated with use.

### Sleep deprivation

Sleep deprivation was mentioned by most, with some reporting they could go several days without sleeping. In one focus group, this was discussed in relation to age: one younger participant said they felt able to *"go for days on end still"*, while older people disagreed, describing sleep loss as harder to manage as they got older. Some people linked lack of sleep to deteriorating mental health; as one person put it, *"there is a reason sleep deprivation is a form of torture, it makes you nuts"*.

> ***"The sleep deprivation it can bring on is mad, and actually I think that then impacts the mental state of people more, because they just can't sleep and it does drive you mad."***

### Sexual health

> ***"...Having sex without condoms that then I would be like 's***' in the morning, like 'what the fuck is my life'."***

Four women discussed potential implications for sexual health and safety in the context of sexual relationships and transactional sex. Two noted that when under the influence of crack cocaine they were more likely to engage in relationships and/or unprotected sex, they would not typically consider when sober. Transactional sex was also described as a way to sustain levels of drug use when finances were limited. One person said this context increased risk to their physical and mental health, including greater vulnerability to sexual assault and violence which could leave them with physical injury as well as psychological trauma.

### Continued use

There were contrasting opinions on whether physical impacts would deter people from future use of cocaine, either on its own or alongside other substances. Some felt they would not be deterred, even by sometimes severe experiences. Others who had not experienced a near fatal overdose felt such an experience would act as a deterrent. For example, one participant stated, *"If I were to ever overdose, I'd never touch it again."*

> ***"Look at me.. I had an ambulance called as I almost died, and I'm still going to go for it again."***

## Staff perspectives

### Risks to physical health

> ***"People are taking lots of cocaine but have no idea about the health affects on them... No idea about their heart or cardiovascular health."***

Staff raised concerns about the physical health impacts of cocaine and crack, with one noting the impact was *"much worse with crack than opiates"*. Several staff highlighted cardiovscular risks being poorly understood. Specific risks were highlighted in relation to pregnancy, including the increased likelihood of placental abruption associated with cocaine use - described as *"primarily associated with cocaine use"* but not widely understood among those who are pregnant.

Staff also mentioned weight loss and the need to link people into other NHS services where appropriate. Staff highlighted the impact of cocaine use on pre-existing health conditions, particularly respiratory issues such as chronic obstructive pulmonary disease (COPD), there was concern that awareness of these risks is often limited.

Injecting cocaine was specifically mentioned by several members of staff as a potential health and infection risk due to people going into sites multiple times and not being aware of the harm of this. One staff member felt there was a lack of awareness of the *"anaesthitising effect"* of injecting cocaine, meaning people could not feel pain and therefore were unaware of damage being caused.

## Monitoring and health checks

*"...You can tell you're giving these people this information for the first time. You explain it to them and you can see, it was clear that this was new information to them and the penny dropped. I don't think people are aware enough."*

Staff emphasised the value of monitoring physical health and incorporating checks and discussions within services to *"give people a bit of an education"* and support ongoing conditions such as COPD. They wanted this to be routine practice as part of harm reduction and psychoeducation. Some staff highlighted that this could be new information which could help support behaviour change in people with long term health conditions. However, staff generally reported that physical health monitoring was not something services currently had the scope to provide.

*"These people fall through the cracks and they think there is not a service for them, so we could maybe catch them when most vulnerable."*

Some staff described existing or emerging ways of supporting physical health through partnership working. One reported local access to a GP who *"will opportunistically do ECGs on people,"* though this was not part of a routine offer. Another described discussions about placing a third sector worker within the local hospital to engage and support people presenting to A&E with cocaine and other stimulant-related issues (for example, nose bleeds or lung problems). This was viewed as an opportunity to start conversations at a point of heightened vulnerability and explore physical and mental health impacts.

## Supporting basic needs

Staff felt addressing basic physical needs should be a priority within support packages for people using cocaine and could be delivered within services as *"really going back to basic needs"*, contributing to small improvements in general health. One staff member described early work to develop an equivalent pathway to MAT, recognising that *"there isn't a medicine replacement"*, and focusing instead on symptomatic relief and practical support such as *"food, fluids, nutrition and sleep"*. Third sector staff also emphasised *"simple stuff like fresh air, exercise and getting a routine"*. Food was identified as a useful engagement tool within drop-ins and conversation cafés, helping to facilitate interaction and support, and other staff agreed on the benefits of these interactions.

*"I think part of this all is reframing this basic stuff as treatment. I think it is important to get that message out."*

*"There isn't a medically approved treatment but we can do things to keep people alive. These basic needs of rest, sleep, food, some air - that can massively help but people need to know that."*

### SUMMARY

**Cocaine use was associated with various physical health harms including respiratory issues such as COPD and it was felt greater awareness and support for these was needed. A small number of women highlighted significant sexual health related risks including unplanned and unprotected sex or physical injury from sexual violence associated with transactional sex. Staff emphasised the importance of monitoring physical health and addressing basic needs such as nutrition and sleep, although the former was often not possible to offer with current resources. Although people who used cocaine did not discuss these support needs directly, they shared experiences of disrupted sleep, appetite/weight issues and related health impacts.**

# Mental health impacts

## KEY THEMES

- Cocaine was often used as a way to help manage mental health or neurodivergence; for some it could exacerbate these issues.
- Some noted changes to their behaviour such as greater emotional reactivity.
- Some people had experienced negative effects when under the influence of cocaine such as hallucinations and paranoia.
- Staff felt limited access to mental health support and diagnosis/support for neurodivergence was contributing to increased use of cocaine. They felt joint working was essential to improve this.
- Some staff raised concerns about people in mental health crisis associated with their cocaine use, this including self harm and suicidal ideation.

## People who used cocaine

Mental health was a key theme across all focus groups and as presented earlier was a motivator for use. People described cocaine as a way to cope with managing adversity, psychological distress and coping with mental health conditions, yet there was a general consensus that sustained use ultimately contributed to worsening mental health.

### Short term effects

People described the immediate after effects as a *"temporary buzz"* and a *"feel good feeling"*, which helped reduce negative feelings. However, some people said this often changed in the hours after use, leaving them with anxiety, a general loss of confidence, and feelings of regret. A few reported unpleasant cognitive sensations when using large amounts, such as a *"head spinning"* effect.

> ***"Well, it's not an excuse but I do use it for my mental health, it dulls it all down. That first pipe just calms me but then I get erratic again the more and more I use."***

### Psychosis and paranoia

Paranoia and feeling *"on edge"* were commonly discussed, with several people describing hallucinations (for example, seeing or hearing things). This was not only distressing for themselves, but also for friends or loved ones who witnessed it. One participant said their partner had to *"sit watch"* at the door during an evening of paranoia because they were convinced people were coming after them.

One person described experiencing drug-induced psychosis following prolonged cocaine and crack use, describing it as *"as bad as it could get"*. They reported distressing hallucinations that ultimately led to hospitalisation. In contrast, a small number of people said they had not experienced adverse effects, suggesting use offered mental escapism, as one described it provides "*a little adventure"*. Despite this, there were concerns about the possibility of long-term negative impacts on mental health.

> ***"I'll be searching the room thinking, "I know someone or something is here" but there isn't anyone there. I start to feel sorry for myself because I'm just so paranoid."***

## Pre-existing conditions

Paranoia associated with cocaine use was something also seen in people who had pre-existing mental health problems. People described having a range of mental health diagnosis including post traumatic stress disorder (PTSD), emotional unstable personality disorder (EUPD), depression and anxiety. As highlighted earlier in motivations for use, cocaine was often used to help manage symptoms but could exacerbate them in the long run. One example given was the greater hypervigilance and hypersensitivity to noise that could occur when using cocaine and could heighten PTSD symptoms. Another talked about the impacts on their emotional regulation when having a pre-existing condition like EUPD. A further individual talked about the greater rumination that could occur on experience like bereavement that could occur post cocaine use, which increased depressive symptoms.

A few mentioned using cocaine to cope with neurodivergence, such as ADHD. However, four people felt prolonged use and binges exacerbated their presentations and made their overall mental health worse over time. One participant said they became more *"erratic"* as use continued, which left their ADHD symptoms feeling *"out of control"*.

## Changes in behaviour

***"I don't know the person I am when I'm on it, it's horrendous, like it is not me."***

People described changes in behaviour thar they viewed as uncharacteristic. Several reported greater emotional reactivity and irritability, including snapping at or arguing with others in situations where they normally would not. Some described *"flipping out"* or being *"ready to blow"* over minor issues such as throwaway comments being made. One person discussed *"trashing"* their house when under the influence of cocaine which they later could not recall doing.

One couple who used cocaine together discussed the differing impacts on behaviours that could be seen between them, one relaying she experienced more positive effects, wishing to party and the other saying she ended up feeling more down due to overthinking. This ultimately led to feelings of disconnection and arguing between them.

## Responses to mental health

A few people described negative experiences when seeking support during a mental health crisis, with stigma often perceived as influencing the response they received. One participant recalled feeling suicidal while standing on a bridge and being told by a police officer to *"go on, jump in there."* Another person described attending A&E following an overdose and, after assessment, being asked to leave without any support or follow-up plan in place. This left them feeling as though they had been moved on simply to free up the bed space for someone else.

In another group, two people described concerns about seeking mental health support from their GP, noting that requests for help could be perceived as requests for medication. One person felt that people can be labelled as displaying *"drug-seeking behaviour"* before a meaningful conversation about their needs has taken place which put them off returning for any other support.

***"It p***** me off, you know the stigma that comes with it. Sometimes you do just feel like they look down on you."***

Across the sample there was a general theme of not being given any access to any formal support or assessment for mental health beyond emergency services presentations unless they had an existing diagnosis.

# Staff perspectives

## Neurodivergence

Several staff raised concerns about barriers within mental health and neurodiversity diagnostic pathways (including long waiting lists), which limited access to essential support. Staff felt that some individuals sought temporary relief through cocaine use to manage their associated challenges, and use could become sustained over time. One staff member explained, *"They're trying to get, you know, a diagnosis of ADHD through general services and it isn't happening. So people are thinking, right, well, if I'm using that, it's keeping me right."*

Staff also noted the potential wider impact of limited access to mental health services and neurodiversity diagnostic pathways, particularly for younger people, suggesting this may lead individuals to seek alternative coping strategies, including substance use.

***"I've got a number of folks, who would report being neurodiverse, saying that they use cocaine as it very much that whole calming effect and just being able to create a process of of dealing with the world around them."***

***"We have no system, no pathways of supporting younger people from from schools pathway of assessment, diagnosis and treatment".***

## Mental health crises

***"People often present in crisis mental health situations. It is kind of catastrophic often because of serious mood crashes."***

Some staff described an increase in crisis mental health presentations of people using cocaine. These included low mood, self-harm and suicidality. One staff member discussed the *"rapid spike in mental ill health"* that could be seen with patients and another highlighted an increase in *"disinhibited behaviour"* among many of their patients, which they felt were early indications of a possible mental health crisis developing.

***"We have had a few people where they initially present super low, mood crashing, feeling suicidal and that can be lasting a good few days."***

Several staff members commented on a pattern with people who used cocaine, where people often presented in mental health crisis at the point of referral and displayed a high level of motivation for help. This could then switch to greater ambivalence if there was too long a wait for support. One staff member described this in the context of a cocaine comedown, explaining that people often reach out during this period seeking referrals and support, but by the time a call-back takes place, they may have recovered from this immediate crisis episode and instead have greater compulsion to use again. This was described as an ongoing cycle which was difficult to support appropriately given the current challenges with waiting lists and the lack of specialist supports.

## Joint working

*"There's also lots of lots of other services, third sector charities, doing loads of great work that half the time we don't know, because we're working this way, so singular focused."*

Staff explained that supporting mental health needs often requires close joint working with emergency and community mental health teams to clarify referral pathways and provide appropriate support. However some staff highlighted ongoing difficulties with communication and collaboration between services, despite attempts to strengthen joint working. Several also recognised that limited information sharing and unclear pathways can mean staff are not always aware of the support available from other services, which impacts what people seeking support can access.

### SUMMARY

**Cocaine use was a way to manage mental health but ultimately could contribute to longer-term mental health difficulties. While people who used cocaine described some effects not raised by staff, including initial positive feelings and changes in behaviour such as reduced emotional reactivity, both groups highlighted experiences of severe mental health effects linked to use. Staff also emphasised the difficulties in accessing support and securing diagnoses for mental health conditions and neurodivergence, which they felt may contribute to increased cocaine use. They highlighted the need for joint working to adequately respond to the mental health needs of people who are using cocaine.**

# Changing market and impacts

## KEY THEMES

- Cocaine was seen to be much more widely available in the drug market than in previous years.
- Changes to the market included availability of cheaper cocaine, often felt to be of poorer quality and/or cut with other substances, which could lead to people buying and using more.
- Changes to dealing, such as how visible this was in public, dealers offering cocaine alongside heroin and involvement or exploitation of young people in drug supply were discussed.
- There was a perception of increased social harms such as violence in communities, linked to involvement or contact with county lines gangs, as well as drug debts which had accumulated and/or the pressure to fund levels of use when experiencing dependency.
- 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 use 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 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.

## People who used cocaine

### Availability and drug supply

Across all focus groups, people described significant changes in the local drug market, particularly an increase in the availability and visibility of substances. There was strong agreement that both powder cocaine and crack had become far more prevalent in recent years, with several people noting a clear shift away from opiates. Many felt that cocaine was now actively being *"pushed"* and had effectively *"flooded"* the market due to expansion in county lines activity within organised criminal gangs.

In five focus groups, people shared that individuals selling cocaine and crack appeared to be younger and more visible within local communities than in the past. Drug dealing was described as increasingly open, with one person noting that sellers were not hiding activity, doing it during the day and where people could see. This was in contrast to previous drug supply practices, where dealing was perceived as more discreet or private. Some people suggested this openness reflected a broader sense that people no longer cared about the risks or consequences of selling and purchasing drugs more openly.

People consistently reported that drugs were significantly easier to obtain than in the past. Rather than relying on a single, well-known dealer, people felt they could now approach almost anyone to access substances. One person reflected that previously there would be one dealer you knew and used consistently, now people would be able to get what they wanted from anyone. Overall, there was a shared perception across groups that access and opportunity to purchase drugs had increased substantially.

## Cost and quality

> *"You never see or hear of it, heroin I mean. The worst thing that happened on the market is being able to buy £10 bits of crack. In the past, you needed more money than that to buy a bit. But they clocked on, and breaking it down and making it that price, boom, more people can access it."*

> *"I'm no joking when I say it is crap quality, it's all crap. F*** knows why I waste money on it. You used to have top tier and a base level which you knew was crap but you could never tell the difference now 'casue I don't think there is one."*

The cost of drugs, particularly cocaine and crack, was raised frequently. Several groups reported being offered discounts when purchasing larger quantities of cocaine powder. People felt this incentivised heavier use and consequently increased health risks, especially given current issues around cutting agents and adulterants found in street drugs. Concerns about drug quality were widespread. Around half felt cocaine was generally poor quality and some suggested that previous *"two-tier"* quality systems no longer existed. One person attributed this to further changes in dealer behaviour, suggesting that while dealers in the past cared about repeat business, current practice reflected *"desperation"* and drugs are being heavily adulterated.

Several suggested that the quality in England was generally higher from their experience of living or visiting there. These individuals felt that the quality reduced the further north you went and you could get better quality product "*once in a blue moon*". Those in the north of Scotland felt they could also pay a premium even where it was poor quality.

## Financial and behavioural impacts

Across the focus groups, people described the prioritisation of money for cocaine often leaving them without enough for essentials for the rest of the month. For some, the financial strain also affected their relationships with others. People described needing to borrow money and, in some cases, stealing from relatives, which led to arguments and relationship breakdowns.

> *"Next thing you know, you trick yourself like, ah I'll just get a little bit before the shopping. Then all of a sudden you have no money left."*

> *"You know you will do anything to get it, get your hands on it. I mean... the things people do to get it... I have done some stupid shit to get it you know."*

These impacts extended beyond money-related conflict. Some described cocaine use disrupting positive routines and relationships. For example, they might miss opportunities to see children or visit relatives. Several also worried about family members finding out about their cocaine use and the effect this could have on those relationships. In several groups, people linked cocaine use to other problematic behaviours, including gambling and criminal involvement. Two people who use cocaine said they were more likely to gamble when under the influence, describing heightened impulsivity. Others explained that after spending their payday money, offending could become the only perceived way to get funds to buy more drugs.

> *"You end up down the rabbit hole saying, 'I need to get more crack, but got to wait two weeks'. So you tap this and and sort that and before you know it, you're sat with f*** all. You're sat skint with nothing."*

## Social issues

Across discussions, people consistently contrasted cocaine with opiate use, describing distinct behavioural differences between them observed in themselves and their peers. Some highlighted a shift toward increased greed and desperation associated with dependent use. A few people noted how stark this change was to them when returning to their local communities after a period in prison.

Cocaine use was widely understood as being more psychologically driven, with people emphasising its *"addictive"* nature. People described it being hard to satisfy their need to use and one described using multiple pipes in succession but it still not being enough for them.

> ***"I went to jail and at the time everyone was using smack. I got out and they were all coke heads, they had all been using so much, they had dropped weight, like skeletons with skin over them."***

> ***"The coke and that, it used to be an at the weekend thing or when you were out partying or whatever. See now? It's being used daily, first thing, straight out of bed and pipe up. And they're thinking about how they can backstab you at the same time."***

Another commented that it is *"dog eat dog"* within using circles, with an overall lack of trust which led some people to use in very small, trusted groups. In one focus group, people who use cocaine described seeing an increase in people being robbed within groups using cocaine and crack.

> ***"Now in the town, it's like an atmosphere, you don't look at anyone because you don't know how it might kick off. It's sorta tense and everyone is on edge".***

People who used cocaine also perceived an increase in violence and wider social issues, including reduced trust and social connectedness within communities, as indirect consequences of cocaine and crack use. Violence was often discussed in the context of people owing money or needing to source more funds for drugs. Many described the using and associated social environments for crack as less safe than those linked with heroin use. One person commented on there being a decrease in loyalty amongst peer groups.

> ***"Using heroin, you had a wee bit of standards at least, there was no sneaking or snaking us. Then with crack, wow it is scary, it's always robbing Peter to pay Paul. It's quite a big difference."***

# Staff perspectives

## Drug quality and market changes

Concerns about drug quality and availability were widely raised as key influences on use. In particular, staff expressed concerns about the quality of heroin, suggesting that this may make cocaine and crack appear more attractive alternatives for some individuals. Several highlighted fears related to contamination of the heroin supply, including cutting agents such as nitazenes and xylazine, which were described as putting people off opiates. Cocaine powder and crack were often perceived as more consistent and predictable by comparison, contributing to their appeal. Staff also raised some thoughts around cocaine being viewed as less harmful or less stigmatised than opiates and this may be part of the appeal of use.

*"But ultimately, what drugs people take, which strength they are, how pure they are, how contaminated, how easy that access is driven by the drug market."*

*"There are individuals in [local community] that would never touch heroin, but they'll happily sit and inject cocaine or smoke crack."*

More broadly, staff expressed concern about unknown cutting agents across the drug supply, arguing that adulteration may be contributing to increased harms such as overdose and other unwanted side effects. One staff member described a gradual but sustained shift in the drug market since around 2013, emphasising that ongoing uncertainty about drug contents heightens health risks for people who use drugs. Staff also noted that fluctuations in drug strength and quality can shape patterns of use, with poorer-quality substances sometimes leading people to consume more in order to achieve the desired effects.

## Availability and price

Staff also described increased availability and falling prices as important factors shaping cocaine use. Cocaine was seen as increasingly accessible, including in some rural areas, and no longer viewed as a premium or luxury drug. Several staff reflected that what was previously an expensive substance was now much more affordable, widening access to a broader group of people. Lower prices were seen as increasing availability and accessibility overall, contributing to a changing client base and more people using it overall. Some also linked cocaine use to wider structural issues such as poverty and a lack of local opportunities, which were seen as reinforcing patterns of use.

*"I think the it's much easier to get, before you had to have your 50 or 100 pounds. Now you can buy a lot for a tenner."*

*"I think, like a lot is like, just poverty, isn't it? Like there's nothing better else to do. They feel that's it, but it's there, readily available and boredom."*

## Impact on young and vulnerable people

*With the powder, we have the younger guys coming in who are like labourers and they've had it on the building site, but others are doing it around them."*

Concerns were repeatedly raised about how changes in the drug market may affect young people. Staff felt that parental transitions to cocaine use could normalise or encourage use amongst their children. The workplace was also identified as a setting where younger people may first be exposed to cocaine, contributing to the normalisation of its use. In addition, vulnerable young people were perceived to be at heightened risk of exploitation, with some staff highlighting the targeting of young people by drug gangs or county lines networks for involvement in drug supply and selling.

## Debts and violence

Staff discussed an increase in county lines activity and that dependent cocaine use could lead to debt building quickly, linking these to a perceived increase in violence. One person said they had witnessed several people they support attending appointments with visible injuries and struggling to discuss what was happening.

County lines activity was said to affect many communities, including smaller rural areas where it was a newer development. Staff felt this environment increased competition and contributed to shifts in supply, with markets becoming more focused on cocaine overall. There was awareness of some people who had previously sold heroin being approached by people they assumed to be involved in county lines networks to sell cocaine as well.

A staff member emphasised the need for services to avoid misinformation or stereotyping when discussing cocaine use and violence. They noted that harms were understood to arise from related social issues such as gang culture and financial impacts, rather than the substance alone.

> *"The violence is definitely as a result of debt or people having to do things as a result of to pay off debt."*

> *"The quickest way to demonise any person or any group of people that use drugs is tying their use with violence. We seen that in the 1980s, didn't we, with crack cocaine? Reports that crack cocaine gave people super human strength and violence and aggression, and none of us... Even then it was never proven."*

> *"It's a successful story that we've had with alcohol use. [It is now frowned upon to] get into a car after having had a few drinks, whereas there isn't that connection between substances and driving in the way that it is with alcohol and driving."*

## Driving risks

One staff member raised that, in their service, staff had to make people aware of risks in driving vehicles after using cocaine. They reported supporting people who used crack and cocaine where the key risk issue was driving and accidents. Other staff members agreed that cocaine-related impairment may not be viewed in the same way as alcohol but that it remains *"a very live risk"*, and that discussing it could help prevent avoidable wider harms.

### SUMMARY

**Overall, both staff and people who use cocaine indicated that the local market had changed, with cocaine becoming more widely available, more visible in the community and often lower in cost. Harms observed included financial difficulties through accrual of drug debts, associated violence and engagement with criminality particularly through county lines gangs. Some described these harms as more severe and compulsive than those associated with opiate use alone. Cocaine use was also seen to damage relationships and reduce people's ability to prioritise family responsibilities over drug use. The impacts on young people in particular were highlighted by staff. This included concerns around the normalisation of use and exploitation of more vulnerable young people.**

# Relationship with medication assisted treatment

## KEY THEMES

- Of those on MAT, most felt it had little impact on cocaine use. Some reported changing when they would take their MAT if using cocaine on top, which could be to maximise effects or to manage comedowns.
- Both participant groups identified that those prescribed long-acting injectable buprenorphine could have increased cocaine use. This was due to reduced monitoring with monthly injections, the continued effects of cocaine while on treatment, and the underlying reasons for drug use remaining unaddressed.
- Several people accessing MAT described receiving harm reduction-focused support for cocaine use, including open discussions with workers, structured appointments and help addressing contributing factors such as anxiety.
- Staff highlighted the importance of consistently discussing the risks of cocaine use alongside MAT and other prescribed medications, as people may not be fully aware of these risks.
- Staff also felt prescribing MAT was complex where people were actively using substances, which required a high level of clinical judgement and risk management.

## People who used cocaine

### Medication timing and risk

A total of 22 people were on some form of MAT. Most felt their prescription had little to no impact on their use of cocaine or crack because these were non-opiate substances and offered a different experience. Many described continuing their routine of daily dosing and pharmacy attendance as usual. However, a minority reported adjusting their medication timing when planning to use cocaine/crack, including delaying or occasionally missing doses.

Several people described delaying their MAT dose until later in the day or, at times, skipping a day and not taking it at all. Some reported using their MAT prescription to help manage the comedown from cocaine use, rather than relying on other substances they may have used historically such as heroin, alcohol, or benzodiazepines.

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. One person stated missing a dose of their methadone prescription was *"no big deal"* and that they could *"easily manage without it for a day or two"* if using other substances. Another person stated they would take their methadone as normal but would cut down on other prescribed medications when using cocaine same day.

> ***"If I knew I was going to take crack that day, I wouldn't take my methadone until after the crack because it would save me needing to get diazepam. Years ago, I would have used heroin just to bring my f***** head down a bit."***

> ***"Honestly, it doesn't affect the methadone as that's part of me and has been for years. But if I go to take cocaine and smoke it, I'll only take one gabapentin that day instead of three and I'll skip my quetiapine as I'll no need that usually."***

A few people described prioritising cocaine use over taking their MAT prescription, for the immediacy of effects compared to MAT which helped them more generally feel stable. A couple of people stated they would purposefully delay their MAT when using other substances due to fears around overdose. Some people felt that a more flexible and supportive approach to prescription collection helped them stay engaged with their MAT, even if they occasionally missed a prescription pick-up. Although a few had missed several days of a supervised pick-up when using substances, all had been able to re-engage with MAT without a delay.

### Injectable buprenorphine

People who used cocaine while receiving long-acting injectable buprenorphine (LAIB) said they continued treatment as usual, noting that its monthly administration did not interfere with their MAT schedule. They reported that LAIB did not affect their ability to experience the effects of cocaine or crack, and described stimulant use as a way to achieve a sense of relief or drug effect that using opiates on top of LAIB could not provide. One person said they used cocaine alongside LAIB because the underlying reasons for their drug use, including mental health and trauma-related issues, had not been addressed. Others felt LAIB led them to seek more crack cocaine and described their stimulant use as an attempt to replace what opiates had previously provided.


### Support in MAT

Several people who were accessing MAT reported being able to receive some support related to their cocaine use. A few described being able to discuss use of other substances with their workers without this negatively affecting their prescription or working relationship. Support tended to focus on harm reduction and exploring patterns of use. Some described the structure of regular appointments as a "safety net", offering a dedicated time and space to raise concerns. One person reported working through a Survive and Thrive booklet with their worker and receiving support around anxiety management, which they identified as a contributing factor to their cocaine use.

## Staff perspectives

### Treatment pathways

Staff reported that many individuals accessing medication assisted treatment (MAT) for opioid use were also using cocaine or crack on top. Across the focus groups, there was shared recognition that existing MAT pathways do not specifically address cocaine use, mainly due to lack of alternative prescribing, and several staff expressed a desire for the development of a dedicated cocaine pathway similar to those established for opiates. One person argued that regardless of drugs being used, there is still a greater focus on medication when someone comes to services. A few staff members from one area discussed trialling a cocaine-specific pathway pilot due to this known gap for cocaine support. A few staff members commented on the MAT standards having a more direct focus on opiates. For example, one staff member raised that they felt the MAT standards had led to progress overall in treatment but they simply did not help with cocaine use.

### Engagement and risk management

Several NHS staff members emphasised the importance of ongoing conversations with individuals about using cocaine alongside MAT and other prescribed medications, to highlight specific risks including adverse physical effects and increased overdose risk. In one focus group, a staff member noted that people prescribed methadone who also use cocaine may experience vasoconstriction and palpitations, causing them to feel uncomfortable.

*"These are the discussions we have to be having because it informs our practice and is hopefully going to inform the decisions that clients make under us."*

*"If you've not got somebody like you in your office, you're going to have to spend 1,000 hours researching yourself to understand this stuff."*

This could lead to additional substance use to relieve symptoms, often without recognising the increased overdose risk. Another staff member in the focus group was unaware of this risk, highlighting the need to continue promoting staff awareness and training, open engagement, and conversations with people about these issues. Several staff members felt there was a need for in-depth discussions with patients to better understand the reasons why cocaine was being used *"on top"* of MAT. They also felt that broader options for psychosocial support were needed to support this population.

Staff highlighted cocaine use being more common for those prescribed LAIB. This was due to contact with the service being limited to monthly appointments for their injection, which was perceived to create more opportunity for cocaine use between visits. Staff noted that some individuals did not see their cocaine use as relevant to their primary drug use and associated MAT unless it was explicitly discussed. It was also raised that people were *"no longer getting the desired effect of heroin on Buvidal"* which might be another reason for use.

Staff highlighted the need for continued engagement on poly substance use and, where appropriate, additional appointments to provide the necessary information and support to people to make safer decisions about their use. One staff member described potential benefits in exploring an increase in MAT in such cases as this could help to minimise additional substance use.

## Clinical complexity

Staff working within a specialist prescribing clinic discussed the complexity of prescribing when they are aware of cocaine use alongside multiple medications. Prescribing MAT alongside benzodiazepines or other prescribed medicines was described as a *"balancing act"* even without additional substance use. Staff felt that adding cocaine increased risks and needed to be managed as a priority. Suggested measures included tighter dispensing arrangements, for example, supervised consumption on premises or twice-weekly pick-up.

*" Look, if you're taking cocaine, it's going to lower the amount of methadone that's available in your system. You're going to feel strung out if you're using top of that. You know, there's a real chance of an overdose happening."*

However, staff also highlighted the challenge of such approaches being perceived as punitive, and described managing this through transparent discussion with individuals and an emphasis on safety in prescribing.

### SUMMARY

**Overall, staff and people who used cocaine commonly reported cocaine use occurring alongside MAT as it produced different effects and didn't interfere with MAT compared to opiates. Long acting injectable buprenorphine was given by both as an example of where this was seen most. Some people using cocaine adjusted the timing of their MAT use and pharmacy collection to accomadate cocaine use. Staff raised clinical concerns about monitoring and prescribing MAT alongside other substance use.**

# Harm reduction

**KEY THEMES**

- 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 who used cocaine.
- Awareness of the risks associated with different types of equipment and sharing of equipment was generally high. However, people using cocaine often reported sourcing equipment themselves, such as pipes and gauze, which introduced risk because this equipment was not available from services.
- Most staff and people using cocaine were supportive of services being able to provide safer inhalation pipes, and staff emphasised the urgent need for changes such as this.
- Access to drug checking was raised by both staff and people using cocaine, but it was acknowledged that limitations exist in what is currently available such as lengthy waiting times for results. Challenges of providing information that supported alerts and gathering intelligence from areas such as urine screening were also highlighted by some staff.
- Staff identified their confidence and knowledge on cocaine and specific harm reduction could vary, therefore more consistent training, information sharing and utilisation of existing resources such as the Cocaine Toolkit were needed.

## People who used cocaine

### Peer influence

Across four focus groups, people reflected that their initial perceptions of drug use were shaped by observing others. This included friends, who appeared happy and energetic after first use, which in turn, contributed to an underestimation of potential harms. Most people described learning harm reduction practices informally through peer networks, alongside knowledge gained from their own negative experiences of drug use. Some identified washing back cocaine to create freebase or crack as a key strategy to minimise harm by preparing their own supply.

***"If it's the [third sector service] workers you go and see then they're great, they give you the equipment you need and you can chat to them about stuff in general."***

***"For the crack and cocaine, there isn't help. For me I smoke it, but I have injected before. Thing is, I'm not being cheeky but I probably know more about injecting it than someone in the services does."***

### Access to harm reduction

Eleven people who use cocaine reported accessing harm reduction services and support through a local third sector provider. They described being able to access injecting equipment provision (IEP), foils, blood-borne virus (BBV) testing and sexual health provision. People valued the ability to attend on a walk-in basis, to speak to staff about what they needed without an appointment and receive equipment via outreach. Those with experience of receiving outreach described trusting their workers to provide accurate information.

### Smoking and equipment

In three groups, people discussed using wire wool as a substitute for gauze and the potential harms associated with this practice. One person described wire wool becoming *"lodged deep"* in his throat while smoking crack, which led to a hospital visit. Five people reported having to buy wire wool because they could not access gauze. Whilst they understood there were additional risks in doing this, they felt they had no alternatives. None reported receiving wire gauze or rubber bands from services as harm reduction supplies. Five people said having access to these items would be useful if services were able to provide them.

Many described making their own crack pipes or buying smoking equipment from shops. Some learned how to make pipes from others they used with and noted they were relying on that guidance being accurate. Several raised concerns about the quality of some equipment and about unsafe smoking practices they had observed.

Equipment sharing was discussed in all groups. Most said they understood the risks associated with sharing equipment regardless of the drug being used. A smaller number (n=8) reported that they would share pipes, but only with people they used with regularly or trusted, often partners or close friends. Occasional reports of injecting equipment sharing among peers were also described. One person noted that whilst people may view it as an individual's responsibility to know their own BBV status or whether they have something contagious (such as a cold sore), this is not always an immediate concern when using. Another described having shared a needle to inject cocaine and heroin with their partner because they were sharing the same prepared dose.

> ***"I've seen people using one mil syringes, cutting the needle out, putting some spontex [wire scourer] in there and smoking through that, that cannot be healthy."***

> ***"For people using with randomers, like people you've just met, having access to a clean pipes would help because you would know you could keep yourself safe."***

The majority suggested that service provision of safer inhalation pipes could reduce harms, particularly for people who used frequently with others and were more likely to share equipment. Some people said they were confident in making their own pipes and tended not to share, but would still use safer inhalation pipes if they were available. However, in one focus group, four people who reported less frequent crack cocaine use expressed reservations about services providing safer inhalation pipes. They felt that increased availability could encourage greater use, particularly among younger people.

In relation to harm reduction advice for injecting, several people described accessing support from local third-sector services, where they were encouraged to smoke or snort rather than inject. One person mentioned seeing pink needles advertised in chemists. However, another raised that some workers had a stronger understanding of opiate use than crack cocaine use and felt that support services had not yet fully adapted their knowledge or guidance to reflect this when it came to harm reduction messages.

## Drug checking

Two focus groups discussed local recovery cafés and support meetings as places where people could access support, as well as having initial conversations about substances and patterns of use. One person described their local recovery café as having staff from multiple agencies attend and provide drug checking kits (for example, to detect xylazine and nitazenes), including showing people how to use the kits.

> ***"They have given tester kits and things. I can then hand that to my worker and they can send them away to check. You know that is really helpful."***

Four people described getting support from SDF staff members, at a local engagement group, to access the WEDINOS services where samples are sent away for testing. Although results could take some time to return, people felt it was still valuable because it could give information about the local drug supply, help them know what to look out for in future and inform drug alerts.

> ***"Discussions are important, it's about catching people upstream before they f****** drown. So ideally prevention and not cure."***

# Staff perspectives

## Routine provision

Staff described harm reduction as something embedded within routine interactions, ideally from initial engagement and continuing through outreach, meetings and reviews. Conversations commonly explored patterns of use, inlcuding frequency and route of administration, and aimed to encourage earlier support, particularly as some people may not recognise risks until harm has already occurred. Across NHS and third sector settings, enquiry around blood-borne viruses were consistently highlighted as a key priority, especially where equipment sharing was disclosed. One third sector staff member described routinely reminding and supporting people to access blood tests following discussions about potential risk and harm.

> ***"I'm very aware that education around substance use happens all the time but it can be a very retrospective process. None of us really pay attention to the stuff of risk until after an event. That's the very nature of how our brains work."***

## Tailored interventions

The importance of offering a range of harm reduction interventions tailored to different patterns of cocaine and crack use was emphasised across the focus groups. A few staff noted the value of practical resources to support discussions with the people they support, such as the NHSGGC Cocaine Toolkit. This offered guidance for cocaine-specific harm reduction advice, including information on recognising signs and symptoms of cocaine-related overdose

Staff also gave concrete examples of how they adapted advice and provision to routes of administration. In one group, staff discussed ensuring people injecting cocaine are given enough equipment to maintain safer practices, recognising that there can be multiple injections per day. One staff member felt this could be improved to meet the demand more effectively. In one area, additional resources had been placed in local accommodation to improve 24-hour access to injecting equipment. In another group, staff described discussions with people smoking freebase cocaine about the washing process using ammonia, including risks associated with improvised pipes such as burns to different body parts and exposure to toxic fumes.

> ***"Even if they don't end up coming on to caseload for any reason, we have a phone conversation with people, and we're asking how they're using, if they're using their clean equipment, do they know the risks of any sharing if they're snorting? So we're having that discussion with them right at the very start."***

> ***"You have your harm reduction very specific to the method administration, you know, for people that's the basics of not sharing snorting equipment, but also things about, you know, make sure the powder is as fine as as possible, there's a suitable straw being used as far up, but always time ... in between lines."***

## Service and training needs

Alongside these approaches, staff questioned whether services were fully prepared and adequately trained to support people using stimulants. Variability in confidence and cocaine-specific knowledge prompted calls to prioritise information sharing and strengthen consistency of practice within services. Several staff felt that additional training on cocaine and crack harm reduction would be beneficial. One person reflected that they and their service remained focused on opiates in their approach, highlighting perceived gaps in skills and focus on stimulant drugs.

> ***"It shouldn't need to rely on 'oh this worker is best for this area', across the field we should all be getting adaquate training, sharing knowledge and staying abreast of what is going on out there to properly respond and support cocaine use."***

## Gaps in provision

Gaps in cocaine and crack harm reduction were raised in every group, particularly the limitations in the equipment available to give to people, such as inhalation pipes for smoking, 'tooters' for snorting, and gauze. Staff suggested that this can make services seem less attractive to people using cocaine because they are aware appropriate equipment cannot be provided. Some staff said they simply did not get people using cocaine coming into the service for this reason.

Most staff supported expanding harm reduction measures and legislative reform, including the distribution of pipes, and emphasised the *"need to be brave"* to respond to emerging needs. They also stressed these gaps require urgent attention, describing harm reduction tools as a route to positive engagement and a way to open up broader conversations (as has been seen with opiates and injecting equipment provision). Staff felt the potential for engagement was therefore reduced with this population as advice they give cannot be followed up with provision of appropriate tools to support the advice.

> ***"Unfortunately, it is still illegal for us to provide any provisions for cocaine users such as pipes. I believe we're at a similar stage as what we were 15 years ago, where we weren't allowed to give it foil, but we eventually could."***

> ***"If we can start offering the equipment, we can get them into the service and then start to have these other conversations and work together."***

## Drug checking, testing and alerts

Some staff highlighted the role of drug-checking services, such as WEDINOS, in identifying trends across health boards in Scotland. However, they also acknowledged limitations, particularly delays in receiving results, which were seen as a barrier for individuals seeking timely and actionable information about the substances they intend to use. RADAR and the WEDINOS website were discussed by some as useful sources to gain drug intelligence across Scotland and the wider UK.

In one focus group, it was discussed whether results from drug services' urine screening could be a source of drug trend intelligence and therefore be widened to include people who use cocaine.

Adulterants such as nitazenes within the heroin market were discussed in one focus group, with one staff member suggesting this as a potential reason that some clients chose cocaine over heroin. Another gave a contrasting view that it was the information included in alerts which could unintentionally drive trends such as hearing about "*unintentened effects*". Peer-to-peer information was also discussed by some as an important way to support drug checking results or to help to inform drug warnings. One staff member highlighted peer information about the strength of drugs locally was likely the most impactful information to influence behaviours. Overall the staff that discussed drug checking information and drug alerts, suggested that the information that was shared alongside alerts was important to influence harm reduction practices positively.

> ***"... My big problem with WEDINOS, though it's a great system, but in the real world, as an ex user, you know that if it takes three weeks to get a sample back so that guy's going to buy three different batches by then. So whatever was in the sample three weeks ago, there's no relevance whatsoever to what he's got and what he's selling today."***

> ***"If the person did come in using cocaine, for the safety reasons of knowing what they have actually used, could you then take a urine test and see exactly what they have taken over the previous three to five days, or something? That's never something I have seen."***

### SUMMARY

**Harm reduction interventions such as injecting equipment provision and blood-borne virus testing were available through services and used by around a third of people who used cocaine. While awareness of the risks of sharing equipment was generally high, people often had to source items such as pipes and gauze themselves because services did not provide them, creating additional risk. Both participant groups emphasised the importance of services being equipped to provide appropriate advice and equipment for cocaine use. The provision of safer inhalation pipes and drug checking services were seen as valuable despite practical limitations such as the current legislative barriers and long wait times for drug checking results. Staff highlighted the potential role of information surrounding drug alerts in influencing behaviour as a result of drug checking. Staff noted that confidence and knowledge about cocaine-specific harm reduction varied, highlighting the need for more consistent training, better information sharing, and fuller use of existing resources such as the Cocaine Toolkit.**

# Interventions for cocaine

**KEY THEMES**

- People who used cocaine and staff noted the absence of prescribing options for cocaine use and for some people using cocaine, this left them feeling treatment services had little to offer them.
- People who used cocaine had limited or no experience of receiving psychosocial or mental health support despite there being a demand for access to things like talking therapies or group support whilst there is no medication assisted treatment available.
- Having peer support and lived experience workers embedded within services was highlighted by both people who used cocaine and staff as it provided opportunities to build connection as well as develop trust and rapport.
- 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.
- Residential treatment was felt to be rarely available or accessible due to an abstinence goal requirement for people who used cocaine.
- Staff understood the importance of psychosocial support and some delivered interventions such as motivational interviewing (MI), developing coping skills and psychoeducation, however there were barriers to provision, including capacity for consistent delivery and competing priorities in appointments.
- Third sector and mutual aid organisations were accessed by a few people using cocaine and were seen to be effective at delivering support and group work by staff. This support was difficult to deliver within the NHS and was seen as an effective way to engage people and provide peer support.

## People who used cocaine

### Gaps in support

People who used cocaine consistently reported limited experiences of being offered meaningful support specifically for cocaine use. Many felt support was largely unavailable unless they were seeking help for opiate use. A common perception was that, in the absence of a medication-based alternative for cocaine and crack/freebase, statutory services had little to offer. This contributed to a reduced motivation to engage. In one focus group, four people compared treatment available for cocaine with heroin, noting that they felt LAIB had been beneficial for heroin use, and describing the lack of an equivalent option for cocaine as leaving them feeling *"stuck"*.

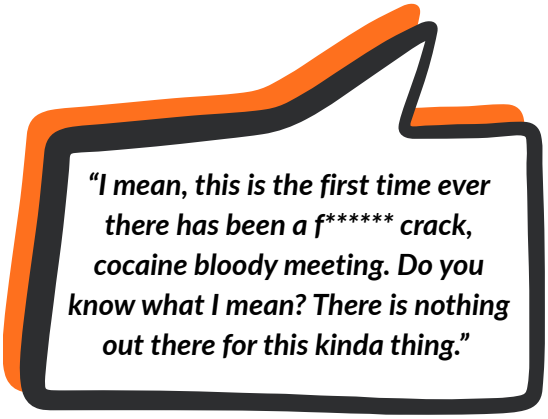
> ***"Unless you're going for help with opiates, you're no getting any help and support."***

The majority felt that cocaine and crack felt more "*psychologically addictive*" than heroin and felt services should offer more mental health and psychological support. Whilst people were uncertain exactly what this should look like in practice, themes raised were having greater access to talking therapies, groups and peer support. People felt help and support currently available needs to be better promoted so people know what is on offer.

### Peer and third sector support

Across focus groups, reliance on peers within social networks emerged as a key source of support. Several people felt that peer support should be built into services and peers in group spaces supported connections and *"peer skill sharing"*. People who used cocaine recognised that people need, and respond to different types of support but that opportunities for connection with others who had shared life experience could be a both valuable and enjoyable way to spend their time.

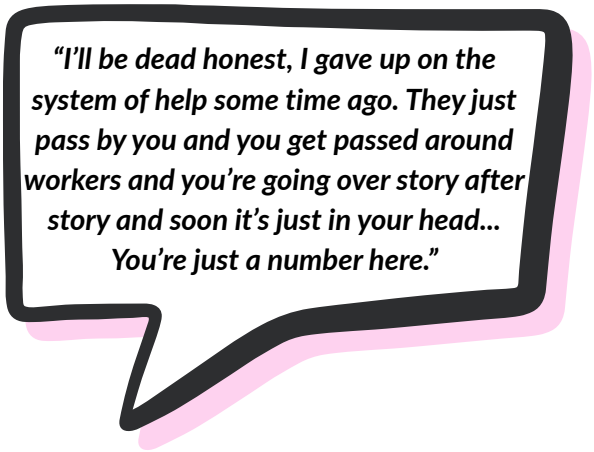
People valued the inclusion of lived experience in peer-led or peer-supported groups, which were viewed as safe spaces for sharing coping skills and strategies. Structured group-based provision was reported as limited, although CA and Narcotics Anonymous (NA) were mentioned by a small number of people who use cocaine. One person explained they had independently researched support, which had led them to the mutual aid group. Another reflected that attending the focus group itself had positively changed their perception of group support, and they would be open to attending similar groups if offered. In two focus groups, people highlighted the value of local third sector organisations offering informal drop-ins or cafés. These were described as accessible spaces for food, conversation, and general check-ins.




One person, who no longer used cocaine, highlighted that structure, routine, and meaningful activities with peers could help replace some of the benefits people associated with cocaine use. They explained that it was helpful to identify alternative ways to achieve a dopamine response or "*feel-good factor*" without using cocaine and in their experience, being with people who were also trying to move away from cocaine use had been useful for support and guidance.

## Mental health support

Despite there being a demand for community-based mental health support such as talking therapies, most stated access to support such as counselling or psychology was not routinely offered nor had they heard of their peers accessing it. A small number reported seeing more specialist support such as psychiatrist or psychologist intermittently, usually in connection with being prescribed medication for conditions such as post-traumatic stress disorder (PTSD) or personality disorder.




One person who attended monthly psychology appointments felt that substance use was not addressed in their mental health appointments, stating that clinicians *"don't deal with that side of things"*. Some also expressed uncertainty about how prescribed mental health medications might interact with their cocaine or crack use. Overall there was a general feeling that mental health support was difficult to access if actively using cocaine and further still if not in receipt of MAT, for some this led to feeling disenfranchised about treatment generally.

## Residential treatment

People who used cocaine acknowledged that residential rehabilitation could, in theory, be offered, but reported that it was rarely available for cocaine and crack use. Some felt that accessing rehab was a difficult process to begin with due to lengthy wait lists and needing to take urine tests to demonstrate abstinence from certain drugs. One person recalled being told they *"took too many drugs"* for rehab to be an option open to them but felt no other help was put in place to support reduction. Another person suggested that the requirement to have complete abstinence as a treatment goal meant rehab was often unsuitable or unrealistic for many people using cocaine. Fears around stigma and judgement about levels of drug use were raised across focus groups, particularly among those with previous negative experiences of accessing support. This could be a significant barrier to seeking this type of help for some.

### Custodial experiences

Two people discussed receiving support while in prison. They reported being offered detoxification for their cocaine use on entry to custody with benzodiazepines following positive drug tests and found this helpful. They questioned why similar detox options were not available in the community. One person described being referred to bereavement counselling while in custody, explaining that although it did not stop their drug use, it helped them better understand their emotions, something they felt they had struggled with for many years.

> *"I only had crack in my system and they put me on a detox using Valium for that for like seven days or something and I felt it worked, it held me. Do you know what I mean?"*

## Staff perspectives

### Psychosicial interventions

Staff felt that psychosocial interventions should be provided more consistently within services, particularly for those requiring intensive support. They described these interventions as the main treatment approach for supporting people using cocaine and crack, especially as a medication assisted treatment for cocaine was not available. One staff member highlighted gaps in the evidence base for treatments for cocaine beyond the existing evidence for psychosocial interventions, noting that they had seen success for people who use cocaine with interventions such as motivational interviewing (MI). Others expressed disappointment at the lack of psychosocial interventions currently being offered.

The interventions most frequently cited as being effective included MI, coping skills work and anxiety management. A few staff mentioned contingency management (CM). Some staff noted that continuity in support and more frequent contact provided the necessary relational foundations to make these interventions effective. Staffing constraints such as caseload sizes and service demands meant there was limited staff ability to offer the required frequency of appointments which could prevent people from progressing through structured interventions such as Survive and Thrive. Staff felt appointments were often required to be focused on more immediate needs including crisis situations which could further impact on their ability to deliver more in-depth work. Suggestions for improvement included training a broader range of staff to deliver appropriate psychological interventions and having more specialised workers dedicated to this role.

> *"Teaching them basic coping strategies like breathing distraction techniques, 54321, that kind of stuff for the anxiety, like basic coping strategies and really going through even things like decider skills, safety and stabilisation, that kind of work to enable them to get into more social situations."*

> *"Because often folk come to their appointment with whatever's just happened to them, and there's... Yeah, and you're trying to do that, but you then can't say, well, actually, we're not going to do that today, because, yeah, we've been doing the safety and stabilisation work. That's not a priority for them at that point."*

In one focus group, staff discussed the importance of adapting interventions to meet the needs of each individual so they can access the right support, particularly those with neurodivergences. One staff member commented that current support interventions are *"quite neurotypical-focused"*, highlighting the need to tailor interventions to better suit the individual. 'Body doubling' was one positive example used which could support people in completing daily living and practical tasks such as cleaning, shopping or budgeting. This involves others such as support workers, peers or family members being present or working alongside the individual whilst they completed tasks.

## Psychoeducation

Several staff highlighted the value of incorporating psychoeducation into practice, particularly in relation to the neuroscience of cocaine use, such as the dopamine reward system theory. This theory suggests heavy cocaine use is linked with development of tolerance impacting on dependency, depression, reduced ability to feel pleasure, impaired judgement and poor impulse control. These discussions were seen as helpful in enabling individuals to better understand their patterns of use and the feelings associated with them.

One staff member suggested that conversations about *"risk versus pleasure"* should be a central part of discussions with people who use cocaine, but felt this was not always prioritised, potentially because *"we aren't the best with talking about the good impacts of drug use"*. Staff felt that understanding the positive and functional reasons why people may use substances could help identify readiness for change and therefore identify the most appropriate interventions for them.

## Third sector and groupwork

Staff across all three focus groups highlighted the value of third sector services and support. Several NHS staff described partnership working with third sector colleagues who offered valuable and more varied support offerings such as groupwork, walk-and-talk and drop-in support, which was not always possible within NHS settings. Group-based interventions were felt to be beneficial when facilitated appropriately; for example. by trained and experienced staff, including those with lived experience. Third sector staff referenced good practice examples such as SMART Recovery programmes or alternative therapies offered in groups such as acupuncture. However, staff noted that many people are reluctant to engage in group settings, due to anxieties of group settings and about sharing details in front of others. 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 the facilitation, as they are seen as credible and providing powerful peer influence which promotes engagement.

## Barriers to disclosure

***"One of the challenges that I've certainly come across recently is people, even if they've tested positive for cocaine, being adamant that they haven't used it, and it makes it really difficult to then provide any support and to try and explore what's going on, why they're using."***

Staff highlighted that a potential barrier to offering psychosocial supports to people who have been accessing treatment such as MAT was that some individuals did not want to disclose further substance use, for fear of repercussions. This could happen even when staff felt there was a good therapeutic relationship with their client. Concerns around child protection were identified as a key barrier to open dialogue. One staff member described the challenges of navigating difficult conversations when drug test results were positive for substances that individuals had not disclosed using.

## Living and lived experience

Several staff emphasised the importance of involving people with living and lived experience in the design and delivery of services. Having individuals with direct experience of substance use was seen as a way to reduce barriers and build trust, as rapport could be built more easily with shared experience. Staff across several health boards described how lived experience roles could support initial engagement and provide support during periods of crisis or when immediate help is needed. One staff member shared the impact of having peer workers available who could work more flexibly meant people did not need to wait for appointments. However, some staff highlighted limitations within their existing service structures that did not offer opportunities for these kind of lived experience roles.

> ***"Having people with lived experience is important. I'm not dismissing the value of having the people with the academic and the medical and the clinical knowledge. But unfortunately, sometimes it's just as soon as a person realizes, well, you've never even sat in a room. You've never even seen anybody smoking a pipe, like, why am I going to come back here and talk to you?"***

### SUMMARY

**Overall, there were clear gaps in treatment provision for cocaine, particularly because there are no current prescribing options in Scotland for cocaine use and there was very limited access to psychosocial interventions, mental health support and residential treatment. This contributed to some people feeling that treatment services had limited support to offer for cocaine.**

**Staff highlighted a range of available interventions such as MI, coping skills and psychoeducation but felt these needed to be more consistently offered, acknowledging various barriers that affected consistent delivery. Staff also highlighted the valuable role of third sector organisations, which were often viewed as more flexible and better able to provide interventions such as groupwork that statutory services may struggle to offer consistently. Both people who used cocaine and staff felt people with living and lived experience were well placed to support people and felt peer support and lived experience workers could be better embedded in service provision. A few people noted accessing helpful support of this kind via mutual aid networks.**

# Enhancing service provision

**KEY THEMES**

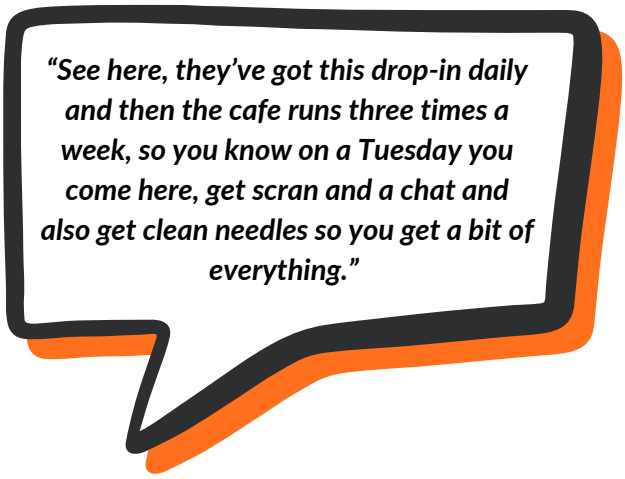
- People who used cocaine and staff felt services needed to be better designed to attract and support people using cocaine, including offering more drop-ins and crisis support.
- Broader and more flexible opening hours - such as drop in models - would be welcomed, but staff highlighted current capacity and funding resource restricted offering this.
- Both participant groups felt more visible information is needed about cocaine, harm reduction, drug alerts and where/how to get support. It was felt that this should be disseminated in places people frequent, 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 in MAT.
- Both participant groups discussed stigma as an ongoing barrier in treatment and support for cocaine.
- Staff felt they needed more comprehensive and consistent training and information on cocaine use to effectively respond to the increasing demand for support.

## People who used cocaine

### Service design

People were asked to describe what support and services for cocaine and crack use should look like and that they would use. A strong theme was around how services operated, in terms of things like opening hours and ways to access.

People who used cocaine generally felt that "drop-in style" facilities worked best for a stimulant service, as they removed the pressure of fixed appointments within office hours, which were seen as too inflexible to meet the needs of many people using cocaine. The spontaneity which drop-ins allowed better aligned with the patterns of use often associated with cocaine use. Four groups discussed how offering a welcoming space- for example, a café-style area or tea/coffee facilities- could help people feel comfortable and relaxed which would in turn help them to better identify the support they needed. Several people already accessed services like these via third sector organisations and spoke highly of the staff involved in running them.




People identified limitations in current service opening times, with several suggesting that seven-day and out-of-hours provision would better reflect patterns of stimulant use (such as frequent re-dosing and binge using patterns). People also described how unpredictable associated support needs could be, such as mental health crisis, being locked out of accommodation, assault, or needing support through the night with physical or mental health concerns. In these crises, timely access to professional support, even simply having someone to speak to, was seen as greatly important.

However, hospital was often raised as the only available option, even when it was not always appropriate or necessary. One person described being assaulted in the early hours of the morning and feeling like they had nowhere to go and no-one to contact; they knew support would be available once their local service opened but felt that more immediate emotional support would have made a significant difference to them in the moment.

In a similar theme, a few others highlighted the value of having a safe place to go after using substances or when in immediate need of refuge. One focus group discussed the need for somewhere to rest or sleep for a few hours after using cocaine, particularly for people without accommodation, where they could access shelter, water, food, and reassurance in a safe place.

## Practical support

Practical support with housing, such as getting supported accommodation and benefit claims submitted, was seen as an important part of receiving wider help for cocaine. Several people reflected on receiving this type of support from a local third sector service, which had been very helpful for them.

Homelessness and unstable housing were discussed by many. People raised that some supported accommodation can cancel placements if they find out people are using, leading to street use and rough sleeping. One person shared an example of losing their place due to their drug use then were unable to get in to other bed and breakfasts (B&Bs). Another said they had been in and out of B&Bs for 12 years and had been told the waiting list for local housing was multiple years.

> ***"Everyone smokes in there, everyone takes drugs in the accommodation. You mingle because crack is a sociable drug but then you're kicked out for having people in your room, even though it is safer to use together."***

> ***"You can come in and there is always someone here to chat to you and help, even if it's for something like opening mail or sorting out my phone."***

## Information and communication

Several people raised the importance of making information about cocaine and harm reduction visible in accessible formats such as posters, leaflets and infographics. Some noted that leaflets on cocaine and mental health were available in service reception areas; however, these were often viewed as outdated and unhelpful and therefore not taken. The kind of information that was felt to be helpful was: contact numbers for local help and support, "bad batch" alerts, safer use advice, and warning signs to look out for when taking drugs. Participants felt these should be updated frequently when alerts or new information is gathered.

> ***"Flyers or leaflets are good aye, but they need to be readable for people. They need to be useful. If places had the budget - they should be going round to hostels and leaving them and talking to people because they need it."***

People suggested information should be distributed in places where it would be easily seen by people who use cocaine and within first-line and emergency response services. These included hostels, temporary accommodation, hospitals, police stations and job centres. One person highlighted this type of information had the potential to be life saving.

# Staff perspectives

## Service development and capacity

Staff felt that greater support was needed for cocaine and noted this might involve making changes to existing service delivery models, including expanding opening days and hours. One focus group discussed the needs of those using cocaine was different and warranted more appointments and check-ins being offered. One staff member raised the issues of service structure currently and giving appointments in advance and how this simply won't work for someone actively engaging in cocaine or crack use.

> *"We are a Monday to Friday service. Well, you know, maybe it doesn't work, and maybe we just don't know how to put into practice, or maybe we don't have the structure in place in order to put that into practice."*

> *"Maybe one appointment a month is fine for somebody that's stable on opioid substitute treatment but that's not going to work for somebody who's got an active crack cooking habit, and they need, they need more regular support in that."*

Several staff raised the design and structure of services as an area to address in order to maintain consistent provision. It was noted by many that current capacity would make this difficult in practice and these developments would require additional resource and increased funding. One staff member discussed the difficulty of implementing the necessary developments within existing service pressures, suggesting that such changes would need to be addressed at a higher level to enable effective implementation. Another staff member reflected on being able to offer more in the past.

Commissioning and funding arrangements, particularly for third sector organisations, were also highlighted as a pressure. There was a sense of the amount of money available decreasing, while caseloads were increasing consistently. Staff felt this increased the pressure on exisisting staff to do more.

## Workforce development

Staff felt that to meet the current demands for support provide greater support it was essential to ensure staff had the training required. 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. Staff reported they had varying levels of knowledge on these areas and access to high-quality information sources was seen as essential to enable staff to provide the best support. It was noted by many that providing the necessary training would require protected staff time and possibly increased funding or resource. The issue of supporting newly qualified staff was raised by a few staff, with more experienced staff often having to provide peer education which again was only possible if they had the appropriate training themselves.

> *"Having taken on new, newly qualified staff as well, it's really difficult to get really good education. It's sort of peer education generally."*

> *"They need to be speaking to somebody who's at least got a fair understanding and education and things like the cyclic change and avoiding strategies, coping mechanisms, all this kind of stuff."*

> ***"We've got some amazing staff working in this field, you know, that could really be upskilled and be able to engage with people that are using stimulants. We have a great toolbox here in order to use motivational interviewing, relapse prevention and cognitive based group work. We have all these different things that maybe aren't getting the chance because we're still so heavily set on medication led approach."***

Alongside training, several staff discussed the need for further research into cocaine and crack use and what works best in treatment and recovery support. One staff member noted that there is an *"understanding of psychological approaches being most effective"* but felt more could be done to strengthen the evidence base and better understand the wider impacts of cocaine and crack use on people's lives.

## Support Beyond Traditional Drug Treatment

> ***"We have brainstormed everything from leaflets through doors to, you know, just almost looking at a mass marketing, leaflets through doors, social media, all of that stuff, just to get that out there for more people."***

Across discussions, staff described a potentially large group of people who may need support for cocaine and crack use but are not accessing traditional drug and alcohol services. This included people whose use may be described as recreational, those who were not using heroin or who were not in receipt of MAT. Staff questioned how to promote and engage these different groups in services as there was a feeling people would be unsure how to access support.

In one focus group, an example was given of wider public health interventions being successful in reaching people not traditionally accessing specialist services, such as a mobile drop-in intervention. Dental vans were mentioned in Glasgow and Dundee, where people can drop in, get advice and support, and this facilitated wider discussions around health and substance use. One staff member raised they felt it was a *"mostly cocaine using population"* that has been using this facility, who could then be spoken with and directed to specific support. It was felt mobile van units could be a intervention tool that is further utilised to support people.

Stigma and fear of judgement were seen as ongoing barriers for people using cocaine more recreationally or where this was their primary drug; people shared they felt patients were unclear where find out about available support should their use become more problematic. One staff member commented that attitudes towards drug use in general needed to shift at a societal level to improve things significantly.

## SUMMARY

**Overall, both staff and people who use cocaine highlighted the need for services to broaden their focus beyond opiate support and improve engagement with people using cocaine. Suggested changes included more flexible opening hours, drop-in, group and peer support facilitated by people with lived experience. People who used cocaine highlighted the need for clearer information on cocaine, harm reduction, drug alerts, and support options in places people regularly attend, such as supported accommodation. Staff acknowledged the challenges of resourcing and funding the development and expansion of cocaine-specific support and there was a clear need for more consistent staff training to support existing staff to better respond to the changing landscape within services. Staff also emphasised the importance of reaching beyond traditional treatment groups, including people using recreationally and people not receiving MAT where stigma could be an ongoing barrier.**

# RESEARCHER REFLECTIONS

Across the focus groups with people who used cocaine and staff, several overlapping themes emerged that shaped the researchers' reflections. A key point was the value people who used cocaine placed on having a space to speak openly about their experiences, many mentioned it had been their only opportunity to do so and suggested they found it therapeutic. Reflecting on their own experiences with substance use, peer researchers resonated with this feeling of sometimes not having spaces to speak freely. Several people contacted the lead researcher after the focus groups to express appreciation for the opportunity to take part, describing the discussions as helpful, reassuring, and a space in which they felt able to contribute more than they had expected.

Harm reduction was one of the most prominent themes across the discussions. Reflections from peer researchers highlighted how conversations about polysubstance use, equipment use, and practices such as washing back cocaine raised both familiar and unexpected issues. For some, these discussions prompted reflection on their own past experiences and reinforced the view that harm reduction continues to require greater attention within services, particularly for this population. These discussions also showed how people who used cocaine are motivated to use more safely, balance risk taking with effects maximisation, and navigate risk in practical ways. This included washing back to create freebase cocaine both for intensity of effects but also as a strategy to reduce the harms associated with adulterants in cocaine. Researchers felt that further peer support, whether in statutory or third sector support services, could only increase awareness of harm/ risk awareness.

Mental health, neurodivergence, and access to support emerged strongly across focus groups. Peer researchers were not surprised by the discussion around mental health and the lack of psychosocial interventions, viewing this as a recurring gap in support. Several peer researchers found it difficult to hear people's experiences of struggling to cope and resonated with some of the stories shared around poor mental health. Similarly, neurodivergence and the use of cocaine as a coping mechanism, were familiar experiences to peer researchers from their communities, with many reflecting on the barriers people can face in getting a diagnosis and accessing appropriate support.

The staff focus groups provided valuable additional insight, drawing on the breadth of professional roles and experience represented. This contributed to rich and reflective discussion, highlighting differences in training, knowledge and perspective across services. Peer researchers highlighted the importance of continuing to promote and share good practice between services within local areas. Overall, it was felt that there was little cocaine-specific support with limited evidence of MAT standards implementation where cocaine was the primary drug.

**Some thoughts from our peer researchers:**

*"Some of the stuff around being able to get access to cocaine so easily now is new to me. Like what they were saying about it being so visible in towns is true but that's not how it was when I was using so that has changed clearly."*

*"We know mental health impact and using substances is always going to be something that needs constant focus."*

*"I gained a unique insight and valuable knowledge, particularly with respect to the unpredictability and difficulty involved in treating people presenting with cocaine dependence."*

# DISCUSSION

**Introduction**

The MAT standards (Scottish Government, 2021) should be used to help guide support offered for cocaine as they outline key features of treatment which are relevant for all substance use. A key observation within this evaluation was that the MAT standards were not consistently applied within treatment and support services for cocaine use. It was generally felt that it was hard to monitor and fully assess how far they were applied, given many people using cocaine weren't engaging with services around their cocaine use. Around one third of people were not on any form of MAT and those who were generally spoke of better treatment and support options around their current or former opiate use. Staff also shared greater confidence and service models to work with opioids compared to cocaine. These themes suggest a need to offer more practical guidance on how the standards can be adapted for people who use cocaine and particularly those who report it as their primary drug. This also needs to be supported by adequate resource in order to respond to an increasing demand for support for cocaine.

**Patterns and methods of substance use**

People who used cocaine within this sample reported frequent use, with most individuals using at least weekly and all describing smoking of crack or freebase cocaine. Smaller numbers reported snorting or injecting powder cocaine. These findings reflect recent evidence from Scotland and Europe. The Scottish Government highlights that cocaine is the most reported primary drug used by people starting treatment (Scottish Government and COSLA, 2026), and a recent report from the European Drugs Agency (EUDA, 2026) shows cocaine use continues to increase and is now the second most commonly reported illicit drug used. The numbers smoking crack or freebase cocaine in this sample were significantly higher than other prevalence data in NHS Greater Glasgow and Clyde, where 50% of those who report injecting heroin or cocaine, also reported the smoking of crack or freebase cocaine (MAT SPMG, 2025). For those who smoked, it was fairly common for people to wash back powder cocaine themselves to create freebase cocaine or crack. Some saw this as a form of harm reduction as they felt it would result in fewer impurities than street-purchased crack. This evidenced the drive to reduce harm by people who used cocaine, which was a similar theme found in a recent evaluation by SDF of provision of nitazene testing strips for people who used drugs (SDF, 2025). It is key that services are sufficiently equipped to maximise this motivation to reduce harm within the cocaine-using community and can provide accurate information and advice about the best ways to reduce harms.

The most common and higher risk patterns of use found in this evaluation demonstrate the urgent need for services in Scotland to be better equipped to respond to shifting trends of increased smoking of crack and freebase cocaine, and to the smaller numbers injecting. Previous evidence has highlighted the connection between cocaine injecting and an HIV outbreak in Scotland (McAuley et al., 2019), due to increased frequency of injecting typically seen with stimulant drugs (Scottish Government & COSLA, 2026) which can lead to greater sharing of equipment. Of those who did inject, all reported "snowballing" with heroin. Although only a small number of participants reported "snowballing", and reported that this was occasional, those who did reported more severe physical side effects, such as extreme heart palpitations.

Data from the Wound Care, Assessment of Injecting Risk, Naloxone and Dried Blood Spot Testing initiative in NHS Greater Glasgow & Clyde between April 2024 and March 2025 show that the number of people injecting cocaine is higher than those injecting heroin: 84% cocaine versus 51% heroin (MAT SPMG, 2025). This trend was also reported by some staff during this evaluation, particularly from the safer drug consumption facility in Glasgow.

Trends in injecting should be closely monitored across all services for increases and any associated harms in this population. Staff in this sample highlighted information sharing needs as part of multi-disciplinary working. It is essential all harm reduction providers are aware of current trends of different methods of use and can then discuss the associated risks in a non-judgemental way. The Cocaine Toolkit developed by NHS Greater Glasgow and Clyde (MAT SMPG, 2025) has relevant information on routes of administration that could be used more consistently to build staff knowledge and confidence in supporting people using cocaine. It contains a cocaine-focused assessment tool which screens for risk and helps to identify opportunities to reduce harm.

Polysubstance use was high within this evaluation sample, with 88% (n=29) of those actively using, reporting using multiple substances. This chimes with other evidence, with the latest information from EUDA showing that 96% of people who use powder cocaine also report polysubstance use (EUDA, 2026). The substances most commonly reported were cannabis, alcohol, heroin, pregabalin and street benzodiazepines, and were used to enhance effects, manage comedowns or compensate for poor cocaine quality. Staff discussions raised serious concerns about these increasing levels of polysubstance use and the heightened risks this creates, including a greater likelihood of drug-related harm and death. Again, this aligns with wider national evidence, with the most recent data showing that polysubstance use was implicated in 80% of drug-related deaths in Scotland (National Records Scotland, 2024). Given this prevalence and associated harms, the risks of polysubstance use must remain a central focus of attention with people using cocaine. Naloxone training and provision should also continue to be prioritised given co-use with heroin was observed in some cases and due to the potential risk of adulterants in cocaine batches or other street drugs, even where opioid use was not intentional.

As highlighted earlier, the Cocaine Toolkit was raised as a useful resource to tackle the range of issues surrounding methods and patterns of use. Whilst a few staff reported using it or were familiar with the Toolkit, there was a general need for wider promotion, supported by appropriate training to ensure consistent implementation, especially if is to be adopted on a more national basis. Some training had been offered in the NHS Greater Glasgow and Clyde roll out of the Toolkit, with access to ongoing training and refresher sessions being made available to support implementation of this resource in Greater Glasgow and Clyde. With the inclusion of an online version on the NHS Scotland and Healthcare Improvement Scotland MyPsych app (MATSPMG, 2025), this offers greater opportunity for wider accessibility to the Toolkit. National promotion supported by ongoing initial and refresher training beyond Greater Glasgow and Clyde would further ensure that all staff working with people who use cocaine have the skills and confidence to support their clients effectively.

Staff identified broader patterns of use and a wider range of influencing factors than those observed in the sample of people who used cocaine. These patterns centred on more recreational or functional factors such as hospitality work, transactional sex and chemsex, and the greater acceptability of cocaine within society including amongst young people. Whilst numbers of these distinct populations were not really seen in the sample of people who used cocaine, it was clear that developing a wider understanding and more targeted work for these groups would be beneficial to effectively respond to the full range of people who use cocaine.

**Motivations for cocaine use**

Various motivations for cocaine use were discussed, there were some differences between people who used cocaine and staff in how these were understood. Staff were more likely to discuss structural influences such as stigma and poverty and placed less emphasis on social factors and enjoyment than people who used cocaine.

For the majority in this evaluation, cocaine use was a way of coping with challenging circumstances, including trauma, mental health difficulties and neurodivergence. Staff also highlighted this as a key reason why many people used cocaine.

This reflects wider evidence that people often use substances to manage mental distress or adversity (Mental Welfare Commission for Scotland, 2022). It makes clear that people experiencing poor mental health often do not have access to the necessary support to manage their difficulties. Again, it is essential that support understands and responds to the underlying circumstances connected to use. This is explored further in the section on mental health impacts, which were closely linked with motivation for continued use.

Some people who used cocaine highlighted enjoyment as a key factor in their continued use, describing aspects like increased energy, confidence, and motivation. This description of pleasure and the connection between functional use to manage aspects of mental health or ADHD, for example, was evident and demonstrates the need to fully explore not only negative motivations but more positive and functional ones as well. Although a few staff discussed enjoyment as a factor within more recreational use or in chemsex settings, most tended to focus on the more systemic issues behind problematic substance use, rather than pleasure. Effective behaviour-change work requires equal exploration of both the harms and the perceived benefits of substance use and is a core part of approaches such as motivational interviewing (Miller & Rollnick, 2023). The motivational model of substance use describes four motive subtypes (coping, enhancement, social, conformity) and how they interact with contextual factors to affect decisions about substance use (Votaw & Witkiewitz, 2021); this interplay can be seen clearly in this sample. Acknowledging enhancement motives, such as pleasure, helps practitioners understand the functions that substances serve for individuals and supports collaborative development of alternative sources of reward and wellbeing. There is greater emphasis put on enhancement motives, such as, pleasure, excitement, or positive experiences within recreational and chemsex use interventions (Smiles et al., 2023) than what is typically experienced in more traditional substance use treatment (Dennis, 2017). Exploring how enhancement motives could be more consistently approached in populations with heavier or dependent cocaine use patterns would be beneficial in better engaging people who use cocaine in treatment services.

Social influences were other strong motivations for using cocaine, with many discussing how their use was influenced by aspects of their social environment. For example, many explained that being around other people using cocaine could increase their “urges” to use and others only reported using when they were in social settings. Some staff also described cocaine as being largely viewed as a social drug. This reflects recent evidence which has shown cocaine use is more likely to occur in social contexts where others are present due to how this alters the brain’s response to and control over use (Terenzi et al., 2024). Other work has demonstrated that having “social reinforcement”, in the form of peers being present, increases cocaine consumption in experimental models (Smith et al., 2021). In this evaluation, cocaine was often used with trusted peers or intimate partners, and was embedded within relationships and shared time together. This could make changing patterns of use more difficult as cocaine was associated with positive relationships or social connections.

These findings, together with the evidence, highlight the deep-rooted link between socialising, relationships and use, and underpin the benefits of having opportunities for substance-free social settings which can offer alternative peer influences. People should continue to be supported to access opportunities to socialise with peers, for example via Recovery Cafés. These spaces offer community-based interventions and substance-free social opportunities where individuals can build supportive relationships and recovery capital. Recent research indicates that people value the sense of belonging, peer support, and opportunities for meaningful engagement offered by these settings (Scottish Recovery Consortium, 2024). People could benefit from these types of spaces as an alternative to current social settings associated with cocaine use if and when they are seeking to make such a change.

Financial triggers, particularly payday, were linked to increased cocaine use for many. This was discussed in all focus groups, with payday often being linked to binges where large amounts were consumed. This demonstrated the relationship between financial availability, disposable income and patterns of consumption.

This is supported by other evidence in Tayside which identified benefit-payment days as periods of heightened overdose risk due to increased purchasing power, bulk buying of drugs, and social pressures associated with drug-using networks (Byrne et al., 2024). Evidence from a Canadian study found that more frequent and staggered payments were associated with reduced escalations in drug use (Richardson et al., 2021). This 2021 research did identify increases in some unanticipated impacts, such as exposure to violence, but states more work would be needed to understand if this was linked directly to the changes in payment schedules. Overall, the findings in this evaluation and supporting evidence outline the complex interaction between payments and wider social factors, and further work to explore how things like more frequent payment schedules affected cocaine use and other social factors in a Scottish context could be warranted. This would support improved understanding of these issues and potentially identify means to reduce harmful patterns of use, such as large binges, associated with increased income for some people using cocaine. In line with MAT standard 8 (Scottish Government, 2021), services should provide access to appropriate support from welfare services and independent advocacy for people using cocaine, this should include opportunities to discuss finances and any hardship they may be experiencing, openly and without judgement.

Some staff felt that motivations for use required further exploration, particularly in relation to why some people move from opiate use to cocaine use. Evidence has shown that understanding the full range of reasons people use substances is indeed important for informing interventions and ultimately providing effective support (Votaw & Witkiewitz, 2021). Scottish research has also shown people using substances valued approaches to treatment that recognised their reasons for use alongside personal circumstances and experiences (Carver, et al., 2020). It was observed by both participant groups in this evaluation that people who used cocaine were not engaging with services consistently, feedback from some people who used cocaine suggested this was sometimes due to feeling their reasons for use were not understood or addressed. The long established model within substance use treatment, The Stages of Change Model (Prochaska & DiClemente, 1983) highlights the importance of assessing readiness for change to guide the most appropriate interventions. This outlines the need for services to prioritise dedicated time within appointments for exploring motivations to encourage more people to seek support for cocaine and to ensure that the interventions that are offered are well matched to motivations.

**Physical health impacts**

People who used cocaine described a range of physical health impacts, including cardiovascular and respiratory strain, which could be linked to their method of use. For example, injecting cocaine was associated with heart palpitations, while smoking crack or freebase cocaine was linked to breathing difficulties in some cases. These findings align with wider evidence on the physical health risks associated with cocaine use (Drug Science, 2026; Hancox & James, 2025). Staff also demonstrated awareness of these risks, but highlighted that access to health monitoring, including ECGs and other physical assessments, was limited. Despite commonly experiencing physical health issues, people who used cocaine had mixed awareness of risks associated with their use; staff largely felt people were not fully informed about these. This indicates a need for services to be better equipped to identify and respond to the physical health impacts of cocaine use and to educate their clients about risk. Guidance in the Cocaine Toolkit states that ECGs can support assessment of cardiac strain in people using cocaine (MAT SPMG, 2025). Services should therefore prioritise ways to offer these more consistently, rather than relying on opportunistic access, as was experienced by a small number of staff in this evaluation. More broadly, routine physical health monitoring and clear information about cocaine-related health risks should be considered a core part of care and psychoeducation for people using cocaine. MAT standard 7 emphasises the importance of integration with primary care and access to appropriate pathways for specific needs (Scottish Government, 2021). Partnership working, including with GPs and A&E departments as was referenced by a couple of staff in this evaluation, should be consistently offered across local areas as staff reported this had been positive where it had occurred.

Other aspects of everyday health and wellbeing were also affected by cocaine use, including appetite and sleep. Staff discussions suggested awareness of these wider impacts and highlighted the importance of addressing basic physical health and wellbeing needs as part of support for people using cocaine. This reflects the principles of the National Collaborative Charter of Human Rights, which emphasises dignity, access to basic needs and the right to health (National Collaborative, 2024). A recent systematic review found that cocaine use is associated with reduced sleep time, poorer sleep efficiency, increased sleep latency, and disrupted REM sleep, and suggested sleep-targeted interventions may improve recovery outcomes in people who have cocaine use disorder (Medigue et al., 2025). The substance use treatment guidelines, often referred to as the "Orange Book" recommends assessment and management of sleep problems during stimulant withdrawal and recovery (Department of Health, 2017). Given the reference to sleep by both participant groups here, this suggests a need for greater focus on sleep management techniques and psychoeducation for sleep within services. This could be supported by providing targeted resources for people using cocaine such as the Sleep Booklet (Exchange Supplies, 2026), the Cocaine Toolkit (MAT SPMG, 2025) and Edinburgh-based psychostimulant service Crew's cocaine information leaflet which highlights the impact cocaine can have on appetite, sleep and physical health (Crew, 2020). Printed resources tend to be less available in services in recent years, so it would be useful to explore whether there is demand for these and, if so, whether dedicated budgets are needed for printing, or whether alternative formats can be explored to ensure they are accessible to staff. Resources like these would enable staff to provide psychoeducation, identify opportunities to reduce harm and improve awareness of physical health risks.

Some staff and people who used cocaine identified examples of good practice within third sector services. They mentioned support with routine, physical activity, time outdoors and access to food in drop-in and informal settings. These approaches were described as beneficial for physical wellbeing, but also as important tools for engagement, interaction and relationship-building. This aligns with recent evidence suggesting that lifestyle-focused interventions are welcomed by people who use cocaine (Maahs et al., 2024). Taken together, these findings show that basic needs and everyday wellbeing support should be recognised as a core component of effective care and treatment for people using cocaine. Existing good practice should be built on, with third sector services properly resourced in all localities to provide the required support that responds to wider physical health and wellbeing needs.

**Mental health impacts**

The interplay with cocaine use and mental health was evident across this evaluation, with managing mental health symptoms cited as a key motivation for use by many people who used cocaine. The impacts on mental health varied, with some citing benefits to manage symptoms (particularly in the initial phases of using) but many stating that over time, cocaine use could significantly worsen mental health, including feelings of anxiety and paranoia. People described deterioration in mental health linked to frequent and sustained use, which mirrors findings in other evidence in Scotland of increased mental health distress due to cocaine use (Riches et al., 2025). A study looking at people across the UK, Europe and the US, similarly showed that, while cocaine use could be initially associated with euphoria and pleasant feelings, people often experienced a "crash" in their mental health after use and over time (Leclair et al., 2024). The findings and evidence together highlight the importance of placing mental health at the centre of assessment and intervention for people who use cocaine, rather than treating it as a secondary or separate issue, meeting requirements in MAT standard 9 (Scottish Government, 2021). MAT standard 9 also highlights the need for a *"no wrong door approach for initial assessment"* meaning people can receive support at whatever point of access they arrive at and are retained in treatment (Scottish Government, 2021). Few people who used cocaine in this sample reported having had access to formal mental health support or assessment beyond emergency services presentations. Those that had received support, tended to have an existing diagnosis and their treatment was focused around their condition, rather than their substance use. Staff highlighted the need for more collaborative joint working between substance use and mental health services, citing issues such as limited communication and unclear pathways for support.

This is echoed in the Mental Health and Substance Use Protocol, which outlines the need for positive relationships between staff in different services to allow for more effective signposting, including to more specialist help (Healthcare Improvement Scotland, 2024). The gaps in joint working identified in this evaluation may help explain why people who used cocaine received limited mental health support, or why, when specialist support was accessed, it did not effectively address substance use, despite the clear connection.

A few people who used cocaine described their use leading to a mental health crisis, including severe hallucinations and drug-induced psychosis resulting in hospitalisation. This was a greater theme with staff, who had noticed an increase in people presenting in crisis and with frequency of issues such as self-harm and suicidality, connected to their cocaine use. Staff explained there were often significant waiting times for support when people were actively seeking help at these points of crisis. People who used cocaine gave examples of negative experiences when seeking support for their mental health needs, including dismissive comments when in mental health crisis and stigma when trying to get support via their GP. Scottish evidence indicates that frequent substance use often co-occurs with other established suicide risk factors, including depression, social isolation and socioeconomic disadvantage, reinforcing the need for integrated mental health and addiction services (McClelland et al., 2024). A systematic review and meta-analysis found that regular cocaine use is associated with a more than six-fold increase in suicide mortality compared with the general population (Peacock et al., 2021). It is therefore essential that all services are equipped to deal with crisis presentations involving cocaine, including emergency and primary care services. The Cocaine Toolkit (MAT SPMG, 2025) contains helpful guidance for how to recognise and respond to stimulant-related overdoses and crises which can be utilised by services to build staff confidence in responding to incidents, alongside relevant training.

Staff discussed that where people were unable to access support when motivated for it, such as during crisis, people would often then return to their cycle of cocaine use and display ambivalence about getting help. Turning Point Scotland's evaluation of their Overdose Response Team's service (2022) highlighted that points of crisis require rapid engagement and access to appropriate support. Although focused on near-fatal overdoses linked to opiate use, these principles of timing interventions immediately after a crisis to maximise the window of opportunity is as relevant for people experiencing cocaine related crises. Indeed staff in this sample highlighted the need to do this but discussed a lack of capacity to offer relevant support as consistently as they would like. MAT standards 1 and 3 outline that treatment should be available on the same day as presentation, and those at risk of harm should be proactively supported to engage (Scottish Government, 2021). The standards should be adopted for cocaine use, as they are for opiates.

Several people reported using cocaine to help manage day-to-day challenges related to neurodivergences such as ADHD. They explained it could offer some relief, which could include calming or focusing the mind, but for some this was only temporary relief and issues worsened with continued use. Prescribed stimulant medication is the frontline treatment for ADHD (NICE, 2018) and recent evidence suggests the efficacy of stimulants in reducing core symptoms (Ostinelli et al., 2025). The Scottish Parliament Information Centre (SPICe) briefing outlines an increase of over 2,200% adults waiting since 2020 for neurodevelopmental assessment and highlights significant wait times, with the average waiting times being around 3.5 years. People sometimes face a further wait of up to six months or more for medication (SPICe, 2025). Current evidence indicates that some NHS Scotland health boards have paused or restricted new neurodevelopmental referrals, with waiting lists effectively closed or inaccessible in certain areas due to capacity pressures (Scottish Parliament Information Centre, 2025; Scottish Parliament Health, Social Care and Sport Committee, 2026). UK-wide shortages of ADHD medications have also been reported in national alerts (Department of Health and Social Care, 2023).

In the absence of appropriate treatment and support, some turned to self medication, reported by both people who used cocaine and staff. This is supported by recent evidence (Holborn et al, 2025). Staff in SDF's evaluation felt the barriers to diagnostic pathways, such as long waiting lists, exacerbated self medication.

Recent analysis of prescribing data in Scotland suggests that although overall there have been increases in prescribing, there are generally lower rates of people accessing treatment compared to the rises in prevalence of ADHD (Radley et al., 2024). The New Zealand Drug Foundation outlines in it's recent report on "Neurodivergence and Substance Use" that untreated ADHD is linked with higher risk of substance use disorder, often due to symptoms such as impulsivity, poor executive functioning and emotional dysregulation which can create a need to self medicate (New Zealand Drug Foundation, 2024). The report argues that improving access to ADHD screening, diagnosis and treatment may reduce drug-related harm (New Zealand Drug Foundation, 2024). This is supported in wider evidence which demonstrates that as effective treatment of ADHD reduces difficult symptoms, it can therefore improve the overall treatment response in people with substance use, rather than worsening substance-related outcomes, where people are properly monitored (Chamakalayil et al., 2021). Screening for neurodivergence within substance use services supported by training for staff would support practitioners to have informed conversations about how substance use may be linked with neurodivergence and coping strategies such as self-medication. As delays in diagnosis remain a significant national challenge, assessment and treatment pathways for people with co-occurring substance use and neurodivergence need to be urgently addressed to avoid the risk of poorer treatment outcomes as identified in the emerging literature in this area (Young et al., 2023; New Zealand Drug Foundation, 2024). Focused research in Scotland is needed to better understand the role of under diagnosis, self-medication and barriers in access to treatment for ADHD and how this may relate to current increases in cocaine use in Scotland.

**Changing market and impacts**

Both people who used cocaine and staff discussed the increased availability of cocaine in the market. The latest European Union Drug Agency report highlights the increased availability of cocaine in the European drug market, which it suggests is partly due to "*diversified routes"* in drug trafficking (EUDA, 2026). Increases in exploitation within drug distribution and gang behaviour (known as county lines) have been observed in the UK in recent years (Holligan, McLean & McHugh, 2020). The National Crime Agency (2018) has linked the spreading of county lines networks with the increase of crack cocaine in the market due to increased profitability when compared to other drugs, such as heroin. Police Scotland assess there to be approximately 30 county lines groups currently operating in Scotland (Police Scotland, 2024). In this evaluation, people reported that young people were involved with drug supply, in particular street dealing. This is supported by other evidence of county lines activity involving young people which highlights risks such as grooming, cuckooing and initiation to substance use (Home Office, 2023). Staff also noted increases in county lines activity in local areas, expressing concerns about vulnerable young people being targeted by organised crime. Given the severity of impacts discussed here, it is important to broaden understanding of county lines activity in communities and equip partners to share information and respond effectively. There are examples of good practice in this area such as an information session held in Highland for third sector organisations and partnership agencies last year. This provided insight into methods used by county liners, explained how to recognise signs of exploitation and made suggestions for prevention and collective action that can be taken (Police Scotland, 2025).

Some staff discussed a perception of increased violence associated with cocaine, evidenced by a rise in visible injuries in people they worked with. This was generally related to accumulating drug debts and gang culture associated with drug supply in those with more entrenched cocaine use. These themes were reflected in broader evidence on county lines activity and the impacts on, for example, weapons carriage and violence against women and girls (House of Commons Library, UK Parliament, 2022). The relationship between cocaine use and violence was discussed more generally, with a few staff emphasising the need to avoid stereotypes and assumptions about this. A recent systematic review highlighted that it is common in media messaging to suggest that cocaine causes violence, but outlined that *"the most violent effects of cocaine reported are not due to a direct (acute) pharmacological effect"* and indeed the use of cocaine alone or when used with alcohol has a weak or no association with violence (Amsterdam & Brink, 2023).

This is in contrast to evidence for alcohol which indicates approximately 30% of people with violent crime offences were believed to be under the influence of alcohol (Scottish Government, 2026). Historically, the issue of perceived violence following use of cocaine and other stimulants, and the subsequent management of such cases of *"acute behavioural disturbance"* (ABD), have been linked with fatalities related to restraint (McGuinness and Lipsedge, 2022). Perpetuation of such stereotypes, often not grounded in evidence, creates stigma, increases risk of poor management of medical emergencies and could contribute to people being hesitant to seek support generally. It is key that people who are affected by violence receive the appropriate support and the role of organised crime is understood within communities in order to better prevent violent crimes from occurring. It is equally important that greater focus on county lines activity does not unintentionally reinforce other harmful stereotypes, such as overrepresentation of specific ethnicities involved in drug supply (Koch et al., 2023), and the full range of vulnerabilities to exploitation within the drug market are properly identified and safeguarded. Frontline staff, including emergency response staff such as police, should have up to date training and guidance on supporting people who may present with ABD so people affected can receive the correct medical support.

Cocaine's effects on dopamine and other chemicals in the brain are linked with the *"addictive"* qualities observed in regular cocaine use. Withdrawal effects such as fatigue, irritability, anxiety and difficulty sleeping (Drug Science, 2026) can lead to further use due to the physical and psychological impacts of these effects (Schwartz, et al, 2022). Many people using cocaine in this sample described a compulsion to use repeatedly, and often in high amounts. The increased availability of cocaine in the market was seen to help facilitate this, exacerbated by the reported drop in quality leading to people needing to use more to reach desired effects.

Various impacts on social behaviours were observed in the patterns of cocaine use seen in this sample, such as relationship breakdowns and impulsivity with finances, which is echoed in other similar work (Riches et al., 2025; Yuobah, et al., 2023). These impacts could further drive cocaine use, becoming a vicious cycle. MAT standard 6 outlines the *"key role that positive relationships and social connection have to play in people's recovery"*, with MAT standard 8 highlighting the need for people to receive support around areas such as finance and have access to independent advocacy (Scottish Government, 2021). Family-inclusive approaches and signposting to services such as financial advice services, relationship/family counselling and advocacy services should be prioritised as part of interventions given the wide-ranging impacts of cocaine use described here. Some staff in this evaluation highlighted the benefits of providing psychoeducation around the impacts of cocaine on the brain to help people who use it better understand the causes of compulsive use and associated behaviours. Embedding such psychoeducation in interventions for people who use cocaine, supported by existing resources, such as the Cocaine Toolkit (MAT SMPG, 2025) and Crew's Cocaine Resource (Crew, 2020), would be beneficial and is further discussed in the psychosocial interventions section. SDF's facilitator-led Introduction to Cocaine and Other Stimulants and Cocaine Awareness e-Learning, can support staff in providing appropriate psychoeducation.

**Relationship with medication assisted treatment**

Two thirds of people who used cocaine here were receiving medication assisted treatment (MAT). Of these, half were prescribed methadone and half were prescribed a form of buprenorphine, most commonly long-acting injectable buprenorphine (LAIB). Staff also stated that cocaine use on top of MAT was common in their clients. Most people who used cocaine said MAT had little or no impact on their use, as cocaine provided them with desirable effects that could not be achieved if using heroin. Others discussed doing things like missing doses of MAT to accommodate cocaine use, or, altering the timing of taking their medication to manage associated comedowns of cocaine. Both people using cocaine and staff highlighted that being on a prescription of LAIB could increase cocaine use in some. Reasons for this included, reduced monitoring with monthly injections, underlying reasons for substance use remaining unaddressed, and, seeking intoxicating or pleasurable effects "on top"-which could no longer be experienced on opiates whilst on the medication.

These findings echo previous work by SDF which showed some people reported increased cocaine use when receiving LAIB. It also found that some engaged in riskier behaviours such as injecting for the first time when using on top (SDF, 2025). The report offered recommendations for person centred support including more frequent contact where desired. Given that monthly appointments and limited opportunities to address underlying reasons for continued substance were discussed in this sample, this outlines the need for patient-led frequency of contact that compliments LAIB monthly injections. This would allow for a more comprehensive package of support to be offered that can then explore substance use functions and triggers in greater depth.

There were some good practice examples of people in MAT receiving person-centred support for their cocaine use. Several described the benefits of being able to discuss use of other substances with their workers without this negatively affecting their prescription or relationship; support given by workers tended to focus on harm reduction and exploring patterns of use. Some described the structure of regular appointments as a *"safety net"* within their support and one example was given of support to use the psychosocial tool 'Survive and Thrive' to address reasons for their cocaine use. A person-centred approach to treatment and support, is recommended throughout the MAT standards (Scottish Government, 2021). Ensuring all people receiving MAT and who use cocaine receive the kind of supports outlined in these good practice examples is an important step in addressing the risks and reasons for "topping up".

Staff emphasised the importance of ensuring people are aware of the risks of using cocaine and other substances on top of MAT. The interaction between cocaine and opiates is recognised as significantly increasing toxicity and overdose risk (Public Health Scotland [PHS], 2024). One staff member highlighted elevated cardiac risks with methadone specifically, which other staff within the focus group were generally unaware of. Following on from this discussion one staff member said that without subject experts on the team, it was difficult for staff to develop this knowledge through their own self-directed research. Evidence from UK clinical studies indicates that concurrent cocaine use in patients receiving methadone is associated with increased cardiac risk through QT interval prolongation*, potentially leading to life-threatening arrhythmias (Mayet et al., 2011). Prescribing guidelines also highlight that both methadone and cocaine independently prolong the QT interval, and their combined use may produce cumulative effects, increasing the likelihood of sudden cardiac death (Department of Health, 2017). As explored in the physical health section of this report, ECGs can be an important intervention particularly with people using cocaine on top of MAT (Mayet et al., 2011; MAT SPMG, 2025). With the limited knowledge staff had on the cardiovascular impacts of concurrent cocaine and MAT use observed in this sample, it is imperative staff receive in-depth training and guidance so they have the knowledge required to educate patients of these possible harms. Some guidance is included within The Cocaine Toolkit which recommends offering ECG monitoring at initiation, alongside titration of Opioid Substitution Therapy (OST) to this particular risk group (MAT SMPG, 2025).

Staff shared that it could be challenging to balance risk management when prescribing MAT in the context of ongoing cocaine use and felt clinical judgement was often required. There were discussions about using tighter prescribing approaches, such as supervised consumption and twice-weekly pickups, to help counteract risk. Whilst these are suggested in the Cocaine Toolkit and prescribing guidelines as ways to reduce risk (Department of Health, 2017; MAT SPMG, 2025), staff in this evaluation suggested these approaches may be viewed as punitive by people in treatment. Some people in this evaluation valued flexibility in their dispensing, such as choice of pick-up times or being able to re-engage with treatment quickly where they missed doses. Previous work by SDF found that rigid supervised consumption of MAT could be a barrier to treatment and that offering greater flexibility in dispensing improved engagement (SDF, 2024).

* *The QT interval is the time it takes for the heart's lower chambers to contract and then reset for the next heartbeat. If this takes too long (a prolonged QT interval), it can increase the risk of dangerous abnormal heart rhythms.*

This evidence, taken with the findings in this evaluation, suggest people often do not want increased pick-ups or supervised consumption and that implementing these risk management strategies could potentially increase risks of dropping out of treatment. MAT standard 5 (Scottish Government, 2021) focuses on supporting people to remain in treatment, recognising that flexible, person-centred opioid substitution treatment is important for retention. As retention in treatment is a known protective factor against drug-related deaths (Public Health Scotland, 2025; SDF, 2019), staff should prioritise supporting people to remain engaged with MAT. Any changes to dispensing arrangements should be person-centred, ensuring that individuals' treatment preferences and choices remain central to decision-making, in line with MAT standard 2 (Scottish Government, 2021).

**Harm reduction**

People who used cocaine described a range of self-directed harm reduction practices, including using within smaller, trusted groups, preparing their own substances for use, and avoiding the sharing of equipment where possible. Drugs knowledge was typically gathered from peers rather than services and there were examples of advice given around making home made pipes. These findings demonstrate that peer-to-peer knowledge exchange plays an important role in shaping harm reduction behaviours, and peer-led approaches to harm reduction should be embedded within current service provision. SDF's peer naloxone project has demonstrated strong evidence for people with lived and living experience being both well-placed and highly effective at delivering harm reduction interventions to their peers (SDF, 2023). The SHARPS study also provides evidence for peer-based approaches that can reduce harm and increase engagement in treatment and support. The study found that providing practical and emotional support via peer navigators, such as accompanying individuals to appointments and offering a listening ear, helped people to access treatment and support services (Parks et al., 2022). Expanding peer-led harm reduction support pathways for people using cocaine should be prioritised within treatment services to boost engagement and build trust with this population who reported that they would be less likely to engage with traditional services.

Current legislative constraints were raised as a significant barrier for services in being able to provide necessary harm reduction equipment for smoking, such as pipes, gauze and elastic bands. This left people to source their own equipment or make devices themselves which increased risks significantly. The Scottish Government has acknowledged the provision of pipes are a means to reduce harm from cocaine (Scottish Government & COSLA, 2026), which reflects feelings from most participants within this sample who were generally supportive of the idea, beyond a few people who had concerns about it facilitating use. Emerging evidence highlights the benefits of safer inhalation devices not only as a harm reduction method but also as a tool for engagement with services (Harris, 2024; Sharpe et al., 2026). The theme of harm reduction interventions as a wider engagement tool was also observed in a recent pilot of provision of nitazene testing strips conducted by SDF. The evaluation found that the novelty of the intervention helped staff engage people in immediate harm reduction conversations and, potentially, wider treatment and support for substance use (SDF, 2025). Similar results have been observed in festival and community-based drug checking services, where sample testing is embedded within healthcare interventions and often accessed by people not currently in substance use treatment (Measham, 2020). The provision of novel equipment for cocaine use such as safer inhalation provision (SIPs) is likely to offer similar engagement benefits to the people who used cocaine in this sample, many of whom reported services had little to offer them and expressed high confidence in their existing harm reduction knowledge and managing risk via personal tolerance. Identifying how equipment such as inhalation pipes and gauze can be distributed in Scotland should therefore be a government priority, both to reduce harm and to improve engagement with support amongst people using cocaine.

SDF's evaluation on nitazene testing strip provision highlighted the demand for drug checking services generally in this population. There was clear interest amongst people who use drugs in knowing what substances contain and positive engagement with wider confirmatory testing interventions such as the Welsh home postal drug checking service WEDINOS (SDF, 2025).

Drug checking was also raised by people using cocaine in this evaluation, with a few reporting positives of using WEDINOS despite limitations on testing turnaround times. Staff acknowledged the value of WEDINOS as a national source of intelligence, but highlighted that the turnaround times limited its usefulness for providing timely information. Immediate results via on-site drug checking similar to The Loop's community drug checking service in Bristol would be an effective way to reach the range of people who use cocaine. It is therefore encouraging that a pilot for drug checking across four Scottish cities is in process (Scottish Government & COSLA, 2026). The need for drug checking is becoming increasingly urgent as contamination of the illegal drug supply continues to grow as a public health concern in Scotland and across the UK. Recent evidence from Public Health Scotland's RADAR alerts shows that nitazenes, a group of very strong synthetic opioids, are increasingly being found in drugs sold as heroin and benzodiazepines (PHS, 2025) and some staff raised this concern within this evaluation. Nitazenes greatly increase the risk of overdose, hospital admission and death, especially because people may not know they are taking them (PHS, 2025). This risk can be even higher when people use more than one drug at the same time. International evidence from United Nations Office on Drugs and Crime shows that synthetic opioids can occasionally be found in stimulant drugs, including cocaine (UNODC, 2025; 2026). Due to the prevalence of polysubstance use in the cocaine using sample of this evaluation, it is key that access to drug checking is prioritised to respond to this evolving market.

A few staff discussed whether urine testing could be utilised to provide a more immediate picture of current use while local drug checking services are still being developed. There is significant international evidence for benefits of waste water analysis for monitoring drug trends, with 115 European cities conducting monitoring. Cocaine was the most commonly found substance in western Europe (EUDA, 2026). UK evidence has also highlighted benefits of pooled urine for population surveillance (Archer et al., 2020). However urine screening in services has more limitations due to factors such as lack of anonymity, selection bias and detection windows (Fitzgerald et al., 2024). Urine screening which can be done anonymously and not tied to someone's treatment plan may therefore be more viable, and could be supported by linked anonymous surveys around recent substance use to supplement testing information. People using cocaine should continue to be supported to use existing drug checking services, such as WEDINOS wherever possible, and to engage with Scottish drug checking sites as they become available.

Alongside access to testing, there was a need to strengthen how information about emerging trends is shared. Staff noted that RADAR (PHS, 2026) and WEDINOS provide useful oversight of national patterns. However people using cocaine identified a gap in access to up-to-date local information, including warnings about current trends or "bad batch alerts". Information sharing should be informed by testing results with clear routes to ensure that timely updates reach people who are using cocaine as well as the services supporting them.

In this evaluation, one third of people using cocaine accessed IEP services for equipment, creating an important opportunity for staff to discuss substance use and provide harm reduction advice. The Cocaine Toolkit includes a comprehensive injecting assessment to support staff in identifying risk among people using cocaine, alongside guidance on reducing cocaine-related injecting harms (MAT SPMG 2025). Small numbers of injecting were identified within this evaluation, with all of those reporting "snowballing" and occasional reports of peers sharing injecting equipment. Although injecting and snowballing were more commonly described in one-off use contexts, the significant risks posed by this method mean it remains important that tailored injecting equipment and harm reduction information are made available to anyone injecting cocaine. It was identified by staff that there were wider groups injecting cocaine, such as men having sex with men (MSM) engaging in chemsex, who were not captured in the sample of people who used cocaine. From previous work on chemsex by SDF (2020), high frequency of injecting, poor technique and having drugs prepared then being injected by someone else were all reported by small numbers. Some of these risks are also observed in the wider group of people who inject cocaine (MAT SPMG, 2025). Small numbers of staff in this sample noted injecting among their clients, with the greatest prevalence seen in the safer drug consumption facility.

Practical harm reduction measures, such as giving out enough equipment to cover someone for high frequency injecting, were discussed here. People who used cocaine discussed receiving advice from services about route transition, such as being encouraged to smoke or snort over injecting. There was also one report of being aware of coloured needles being given out in pharmacy, however utilisation of this option for harm reduction was not more widely discussed. This equipment appears to be more commonly used in the chemsex community, which also has other examples of good practice such as dedicated chemsex packs, tailored towards psychostimulant injecting (Exchange Supplies, 2026). Interventions aimed at women such as the Mother 2 Mother resources are complemented by provision of pink needles (Exchange Supplies, 2026) and could provide simple ways to identify personal equipment if using in group settings. Measuring the interest from people who inject cocaine in tailored injecting kits, which could include coloured needles and higher volumes of injecting equipment, would be useful to consider for IEP providers.

Overall, consistently providing and expanding the full range of harm reduction interventions available is essential to strengthen implementation of MAT standard 4 which outlines that all people should be offered evidence-based harm reduction (Scottish Government, 2021).

**Interventions for cocaine use**

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. 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. This perception of limited cocaine-focused support in services has previously been identified as a key barrier to engagement with treatment and support (Lloyd et al., 2025). Emerging evidence suggests that prescription psychostimulants may represent an effective pharmacological approach for the treatment of cocaine use, especially when combined with other effective treatments such as harm reduction, CBT, contingency management and psychosocial interventions (Tardelli et al.,2023). Without the full range of treatment options that existed for other substances, there was greater emphasis on the need for access to psychosocial interventions yet people who used cocaine reported limited access to such support. These findings and emerging evidence suggest a benefit in exploring medication assisted treatment for cocaine use in Scotland, supported by a range of non-medical interventions to effectively respond to the increasing prevalence and demand for treatment.

There were a few examples of receiving support such as CBT-based interventions or bereavement counselling. These typically occurred in custody settings or if receiving MAT. Staff were aware that psychosocial interventions were the primary approach for support with cocaine use. This is recommended in the “orange book” guidelines for treatment (Department of Health, 2017) and evidenced in a recent review on available treatment for stimulant use (Williams, Schölin and Brett, 2024). Some staff described providing a range of psychosocial interventions to people who used cocaine, including motivational interviewing (MI), cognitive behavioural therapy (CBT) techniques, contingency management (CM) and psychoeducation. This displayed the range of psychosocial interventions that can be offered across Scotland and echoes international evidence of the variety of effective interventions for individuals using stimulants that can be applied (SAMHSA, 2021).

However staff also acknowledged barriers in providing these consistently due to limited capacity to deliver more in-depth work beyond immediate care needs. Staff felt that barriers such as caseload size and limited ability to offer regular appointments affected how consistently interventions could be delivered. Staff also discussed that continuity in support and more frequent contact provided the relational foundations necessary for psychosocial work to be most effective. Guidance on psychosocial interventions outlines the building of a strong therapeutic alliance/relationship as a core element of effective support (Department of Health, 2017; MAT SPMG, 2025).

Approaches such as MI are inherently relational, and rely on collaborative engagement, built on trust (NHS Education for Scotland [NES], 2026). Previous work by SDF has highlighted a supportive relationship as being key to people feeling able to discuss their reasons for substance use and preferences for treatment (SDF, 2025). There was a clear gap between what could be offered on paper, what staff wanted to offer and what was possible within service demands.

The Scottish strategy on delivery of psychosocial interventions in substance use treatment emphasises that effective delivery requires substantial workforce capacity, including trained practitioners, structured supervision, and tiered models of care (Scottish Government, 2018). This guidance highlights the need to build capacity across health and social care systems to ensure consistent access to evidence-based psychological interventions. Staff in this evaluation raised various suggestions to broaden service capacity to deliver psychosocial work, including training of more staff to offer these supports and having dedicated practitioners to deliver interventions. SDF offers a motivational interviewing badge scheme, which aims to build knowledge and skills and create a network of practitioners in Scotland (SDF Learning Centre, 2026). NHS Education for Scotland (NES, 2023) provides national skills-based training on psychosocial interventions including MI. All practitioners should be supported to access these opportunities including access to regular refresher sessions. It is also essential that staff are given the required time to engage in the reflective practice and supervision that supports the delivery of psychosocial interventions. MAT standard 6 outlines the routine provision of psychosocial interventions (Scottish Government, 2021). As psychosocial interventions are a frontline treatment for cocaine use, they should form the core of any support offered to people who use cocaine. Staff and service capacity underpinned by ongoing workforce development must therefore be urgently addressed if services are to attract people who use cocaine to treatment services and challenge the perception that treatment is only relevant to those using opiates and seeking a prescription.

In addition to the need of greater staff capacity, one staff focus group raised that effective delivery of psychosocial work relies on adapting interventions to meet the needs of each individual. This aligns with the Scottish Government's framework for delivering psychological interventions in substance use services, which recommends that interventions are informed by a comprehensive assessment of need and an individual formulation developed collaboratively with the person accessing support (Scottish Government, 2018). A couple of staff also discussed the importance of adapting interventions for neurodivergent people such as ADHD. Recent work by Koirala et al., (2024) highlights that services designed around neurotypical expectations may inadvertently create barriers to engagement for some neurodivergent individuals. The New Zealand report on neurodivergence and substance use also recommends that interventions are tailored for those with neurodivergences, suggesting elements such as, offering clear communication; structured sessions with predictable routines; additional support where required; flexibility in appointment formats and pacing; and support with executive functioning, organisation and planning (New Zealand Drug Foundation, 2024). For services to be able to offer more individualised and neuro-affirming psychosocial support, staff need to be afforded the necessary time and support to deliver interventions more flexibly.

Although contingency management (CM) was mentioned by a few staff and is highlighted as a key evidence-based psychosocial intervention for stimulant use (Department of Health, 2017), it was not discussed widely across the staff focus groups, suggesting limited implementation within current practice and reflecting the wider evidence that use in UK settings remains limited (Getty et al., 2025). CM is a psychosocial intervention in which people receive incentives or rewards based on demonstrating specific target behaviours, such as attendance at treatment (NICE, 2017). The evidence base for CM has positive reported outcomes including increased abstinence, a higher proportion of negative samples, improved therapy attendance, and better medication adherence (NES, 2024). CM has already been implemented across several Scottish sites through the WAND initiative, which core elements are- wound care, assessment of injecting, naloxone and dried blood spot testing (Smith et al., 2024). WAND provides a £20 redeemable voucher and encourages people to return for follow-up assessments every three to four months.

Given the population accessing WAND have high rates of both injecting and smoking cocaine/crack (MAT SPMG, 2025), adapting this type of CM model to engage people using cocaine in psychosocial interventions or wider engagement with harm reduction services would be beneficial. Implementation would need to balance potential treatment optimisation against increased costs and service capacity, something which has already been highlighted in recent work (Goodwin, Kirby and Raiff, 2025).

The third sector role in delivering psychosocial interventions was discussed across the staff focus groups. They were broadly seen to be well-placed to provide support such as group work, which were felt to be more difficult to offer in statutory settings. A recent Scottish Government report (2026) supports this, outlining third sector organisations provide "vital expertise" and can deliver interventions such as recovery coaching and relapse prevention. However, only two of the seven focus groups with people who used cocaine had awareness of local third sector services of mutual aid, with only a few engaged with fellowships like Cocaine or Narcotics Anonymous. One person shared only finding out about the availability of mutual aid via their own research. This suggests there may be some gaps in how existing third sector and mutual aid support is promoted to people using cocaine. Given that staff understood the value in these services for enhancing opportunities for psychosocial work, as is echoed in treatment guidelines (Department of Health, 2017), it is important the range of mutual aid and third sector service support available locally is promoted consistently. Staff spoke about having partnerships with third sector colleagues, so should maximise on these by ensuring these are well signposted for people using cocaine. To reach people not engaging with any services, providers should seek to utilise things like SDF's living experience engagement groups, which focus group participants here were attending, and encourage word of mouth amongst peer groups.

Peer support in group settings was clearly important for people using cocaine. People described relying on their peer networks for support, but often did not access structured groupwork or mutual aid other than the few who accessed fellowships. Many discussed how having peers in group environments could help build safe spaces for key psychosocial interventions, such as sharing coping skills and strategies, and several people felt peer-based support should be better built into service provision. A few people shared that they found the focus groups valuable for the opportunity to discuss their experiences openly with peers, and there was a sense many would likely be willing to engage in group-based work with others using cocaine. NICE (2007; 2012) guidelines highlight the benefits of group-based interventions for stimulant use and general substance use, as the combination of evidence-based psychosocial interventions with peer support can enable participants to develop coping strategies, enhance motivation, increase self-efficacy and establish recovery-oriented social networks. Scottish policy increasingly recognises that recovery communities and mutual aid should complement formal treatment, with the Scottish Government committing to strengthen links between statutory services and community-led recovery supports (Scottish Government, 2026). Earlier reports similarly identified referral to mutual aid as an important component of recovery maintenance and highlighted inconsistencies in referral pathways across Scotland (Scottish Government, 2020). Taking the feedback from participants and existing evidence together, it would suggest there would be benefits to explore targeted group psychosocial interventions which offer the combination of peer support together with other evidenced based interventions for psychostimulants such as MI, CBT, CM and psychoeducation.

Staff raised the value of having people with lived experience involved in support provision, especially in psychosocial work. Staff understood peer workers could help overcome barriers to engagement, such as anxieties about attending and opening up in a group space and not having to rely on structured appointments. Lived experience group facilitation is widely recommended and applied across the UK within substance use services (UK Government, 2025). The involvement of people with lived and living experience is increasingly recognised as a key component of effective drug services in Scotland, contributing to service design, delivery, engagement and advocacy (SDF 2021; Drugs Deaths Taskforce, 2022). Given the findings from participants here and the growing evidence base, services must maximise on existing ways they include lived experience workers and expand this where possible.

Using staff with lived experience to facilitate some of the suggested psychosocial work identified by people here, such as talking therapies and filling time with routine and meaningful activities beyond cocaine use, would arguably increase engagement within this community.

**Enhancing service provision**

Both people who used cocaine and staff emphasised the need for services that are flexible, easier to access, and better able to engage and retain people using cocaine. Low-threshold models, particularly drop-in provision, were viewed as preferable to fixed appointments because they reduce practical and psychological barriers to support, which is consistent with wider evidence on low-threshold approaches (EUDA, 2025). People using cocaine also identified a need for extended opening hours, including evening and weekend provision, as crisis often arose outside traditional service hours. Emergency services were often utilised due to this gap in service provision but were seen as unsuitable for the type of crises typically experienced, which were generally urgent but non-emergency situations. These findings align with wider recommendations for accessible and integrated crisis responses for people experiencing co-occurring substance use and mental health needs, including timely telephone support, crisis assessment, and effective referral pathways (Scottish Government, 2022; Office for Health Improvement and Disparities, 2023). Staff acknowledged the importance of this flexibility but noted that current capacity and funding place limits on what services can offer. However, good practice examples already exist in Scotland: Alcohol & Drugs Action (ADA) in Aberdeen provides weekend drop-in support on both Saturday and Sunday, while Crew in Edinburgh offers a late-evening drop-in one day a week alongside Saturday provision. There have also been recent developments of services for mental health such as SAMH's The Nook service, which offers seven days a week drop-in with evening bookable appointments. Given the increasing prevalence of cocaine use in Scotland, adapting existing services to respond more effectively to stimulant use should be a priority, in line with the latest Alcohol and Drugs Strategy, which calls for services to evolve in response to changing patterns of need (Scottish Government, COSLA, 2026).

In addition to more flexible services, some staff highlighted the value of developing a clearer treatment pathway for people whose primary drug is cocaine and who may require more specialist input than generic substance use support can provide. A recurring theme throughout this evaluation was that services are largely perceived as being designed around opioid use. Staff supported this theme, feeling there were wider intervention options and established treatments for opioid use compared to cocaine, which then gave them greater confidence in responding. However, this evaluation also identified that services and staff have a range of relevant interventions that could be more consistently offered to people using cocaine. An effective treatment pathway for cocaine would involve being able to get support at whichever point of access people present at. This would align with Scotland's "*no wrong door*" approach, ensuring that people can access appropriate support regardless of where they first present within the health and social care system (Scottish Drug Deaths Taskforce, 2022). Strengthening existing treatment pathways could therefore include not only developing specialist services, but also explore how current services could be adapted. This might include cocaine focused clinics or drop-ins located in existing substance use services. Access to more holistic support such as physical health, mental health, financial advice, advocacy and housing support would also be an important element of the pathway and would meet requirements of MAT standards 7, 8 and 9 which outline the requirement for support from primary care, mental health services and advocacy and other social support (Scottish Government, 2021).

Where local areas develop cocaine-specific provision, existing specialist services across Scotland offer useful learning about how substance-specific support can be delivered. For example, the Image and Performance Enhancing Substance clinics in Glasgow and Edinburgh, operate drop-in services, providing IEP, blood testing, harm reduction advice, and wider support around safer use, reduction or cessation.

Similarly, the Benzodiazepine Pilot Clinic in Fife demonstrates how existing services can be adapted to provide tailored support for people using particular substances. The main adaptations for this model are greater emphasis on immediate access to psychosocial interventions and more regular multidisciplinary staff discussions focused on patient progress. Learning from this pilot, has supported expanding this model for a clinic for cocaine, which is currently under development.

In its latest report, the Scottish Government has stated that a longer-term ambition for the service is to expand beyond supporting people who use benzodiazepines to include those using other substances for which substitute prescribing is not available, such as cocaine. (Scottish Government, COSLA 2026). Equally, Scotland's longest-serving psychostimulant organisation, Crew, applies a "stepped care" model, which meets people where they are at, offering a range of support from early interventions through to more intensive interventions (Crew, 2018). These examples suggest that specialist services for cocaine need not to start from scratch, but can build on existing models for substance-specific support and be embedded in existing substance use services.

Both people using cocaine and staff highlighted the need for simple, more visible information about cocaine-related harms, drug alerts, and how and where to access support. They felt this information should be available in places people already access and where it may reach people who are not currently engaged with services, including those using recreationally or younger people. People gave suggestions of accommodation settings, job centres and via emergency response services such as hospitals and police stations. Direct evidence for drug alerts if delivered in isolation is limited as this information is usually embedded in wider harm reduction interventions. However, they are an important component of a broader harm reduction strategy as they improve the timely detection of emerging drug threats, facilitate rapid risk communication, and enable targeted public health responses (EUDA, 2025).

Accessible information and signposting are recognised as important components of person-centred care and are most effective when combined with proactive engagement, outreach and facilitated referral into treatment (Office for Health Improvement and Disparities, 2023; Vogel et al., 2020). The potential role of peer involvement in information sharing and wider harm reduction was a prominent theme in this evaluation. The peer supply model for naloxone delivery in Scotland has evidenced peer-led naloxone distribution can increase naloxone supply, reach individuals who have not previously accessed kits, reduce stigma, and support in building wider recovery capital (SDF, 2024). Equally a previous Scottish report has outlined the benefits of co-producing resources with people who have lived and living experience as this may produce information which has greater relevance, accessibility and acceptability, helping to strengthen engagement and ensure that information reflects the realities of drug use (Scottish Drug Deaths Taskforce, 2022). Conversation cafés provide a model for co-production by offering an informal, non-hierarchical space for discussion of what information would be most useful and how it should be promoted. This approach has been shown to support discussions about substance use (Humanising Healthcare, 2024; Scottish Recovery Network, 2021) and could be applied locally by involving people who use cocaine, peer workers, lived and living experience representatives, and relevant staff. Anecdotal feedback from SDF's lived and living experience consultation work has demonstrated the importance of how information is presented to peers. Visually engaging, co-produced one-page resources such as infographics are generally identified as a more effective approach than text-heavy documents; these are viewed as more accessible, particularly within prison settings where lengthy written materials may be harder to understand and are less engaging. Feedback shared with the lead researcher during the evaluation further reinforced the value of peer-to-peer information exchange. Participants expressed a desire for more focus groups of this kind, outlining the benefits of having a space to share experiences, strengthen connection with others and access information informed by peer insights.

Staff raised the need for further guidance and training throughout the evaluation, including a need for better understanding of cocaine interactions with MAT and other prescribed medications, as well as more in-depth knowledge on physical health, harm reduction and other effective interventions. Although the Cocaine Toolkit was referenced in some conversations amongst staff, wider knowledge on the Toolkit was limited. As one of the most comprehensive toolkits we have on cocaine support and intervention in Scotland, it is imperative this resource is made more widely available with specific training to support for staff across both NHS and third sector services.

With the recent launch of the digital version, this will support more national dissemination but regular promotion at local and national levels and providing other formats e.g. printed may support the required wider use is necessary. It would also be useful for stimulant training for staff to be reviewed and updated regularly as part of service provision. This aligns with the Scottish Government's Drugs and Alcohol Workforce Knowledge and Skills Framework, which highlights the importance of developing consistent competencies and providing accessible training to support high-quality, person-centred and trauma-informed care for people affected by substance use (Scottish Government, 2025). As highlighted earlier, ensuring that staff have access to targeted training is an important component of ongoing workforce development. This should include opportunities to enhance knowledge and skills in areas such as psychosocial interventions and substance-specific drug knowledge. Resources such as the SDF Learning Centre offer a broad range of training courses designed to strengthen staff knowledge, skills, and confidence, supporting the delivery of informed and effective practice.

# LIMITATIONS

The evaluation captured a snapshot of adult experiences of cocaine use in Scotland and how the MAT standards are applied from the perspectives of people who use cocaine and staff involved in treatment. There are potential limitations on the generalisability of the findings across Scotland, as the sample was focused on four health boards. However the sample did select a mix of urban and rural settings for recruitment and included purposive sampling to make the sample as representative as possible of the treatment population in Scotland. To provide a more comprehensive national picture, representation from all health boards and local authority areas would be beneficial.

Staff highlighted the presence of cocaine use among wider demographic groups, including individuals working in industries such as labour and hospitality. This population was not a focus of this evaluation and would benefit from further research or evaluation work on the prevalence and needs of these differing occupational groups. Equally, young people's substance use was also highlighted by staff and again was not a focus of this evaluation but which would benefit from further work to understand the experience of young people under 18.

# CONCLUSION

This evaluation highlights that the increases to cocaine use in Scotland are closely connected to wider health, social aspects and the changing drug market. People who used cocaine described frequent and sometimes high-risk patterns of use, often shaped by mental health needs, trauma, neurodivergence, social relationships, financial pressures and availability and quality of cocaine and other drugs. While many participants demonstrated strong awareness of harm reduction and a desire to reduce risk, they also described limited access to cocaine-specific support and a perception that current services are primarily designed around opioid use and medication-based treatment.

Across the findings, there is 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. Services require greater capacity, clearer pathways and more consistent use of existing resources, including the Cocaine Toolkit, to ensure staff feel confident and equipped to respond to cocaine use. Support should be flexible, accessible and person-centred, with low-threshold options, rapid responses at points of crisis, and opportunities for ongoing contact that are not dependent on opioid prescribing.

The findings also point to the importance of developing a more holistic and joined-up response. This includes improved integration between substance use, mental health, primary care, third sector, peer-led and specialist services, alongside better access to drug checking, safer use information, physical health monitoring and tailored psychosocial interventions. Greater involvement of people with lived and living experience will be essential to designing support that is relevant, attractive and effective for people using cocaine.

Overall, the evaluation shows that services are facing a changing pattern of substance use that requires urgent adaptation. Building on existing good practice, investing in workforce development, expanding harm reduction options and creating clearer cocaine-specific pathways would support a more effective response to the needs of people who use cocaine. Doing so would help reduce harm, improve engagement, and ensure that people are offered compassionate, evidence-informed support at the point they are ready and able to access it.

# 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 tool 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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AUGUST 2026