

# Edinburgh Alcohol And Drugs Partnership & Change Grow Live Cocaine And Crack Cocaine Conference, 23<sup>rd</sup> May 2024

This paper briefly summarises the content of the above conference and includes a first draft of a potential Edinburgh Cocaine and Crack Cocaine action plan based on the information presented at the conference.

## Background:

The conference was instigated because of the concerns of multiple EADP partners but organised and funded by CGL. The context is described below in terms of the increasing evidence of cocaine related harm. It was held at the Edinburgh City Chambers on the 23<sup>rd</sup> May 2024 and attended by approximately 120 people.

The aims of the conference were to

- Explore the scale of cocaine related harm in Edinburgh, Scotland and the UK
- raise local awareness of the harms and the challenges
- explore potential responses based on research and on practice from elsewhere in the country

Keynote speakers included Christina McKelvie MSP for Drug and Alcohol Policy and a number of researchers

- Prof. Andy McAuley of the Glasgow Caledonian University's School of Health and Life Sciences,
- Prof. Magdalena Harris of London School of Hygiene & Tropical Medicine,
- Prof. Jim McVeigh of Manchester Metropolitan University (Substance Use and Associated Behaviours)

Other presenters were managers, clinicians and practitioners with experience of supporting users of cocaine and crack cocaine. These included Emma Crawshaw (CEO Crew2000) and a number of staff from CGL's teams across the UK. The programme is included as appendix 1

The audience included local and national politicians (although a number of planned attendees gave apologies following the announcement of the general election the previous day), local and Scotland planners, policy makers, service managers practitioners and clinicians from all sectors and a number of people from CGL teams elsewhere in the UK.

## Key themes emerging:

The summary below is in two parts broadly aligning with the structure of the day. The morning focused on research into the scale and impact of crack and cocaine use; and the afternoon explored specific intervention which have been developed for

### 1) What is the scale of harm associated with cocaine and crack cocaine use?

This was evidenced in two ways within the course of the day, each of which communicated a need for urgent action

The chair, the ministers' keynote speech and (most specifically), Dr Andrew McCauley's presentation outlined the statistical evidence of increasing use of cocaine and its increasing contribution to morbidity and mortality over the last decade. These are described more fully in Professor McCauley's presentation but key Scottish and Edinburgh facts include:

- In 2013-14, cocaine was implicated in 6% of Scottish DRD. In 2023-24 it was implicated in 35%. This coincides with the rise in DRD over this period suggesting that it is a significant (though not exclusive) driver of this increase.
- Cocaine was implicated in 56% of Edinburgh DRD in 2023/24 (almost all in combination with other drugs). It is the largest single drug implicated in DRD.
- Cocaine is present in 48% of oral fluid tests in Lothian, the results of drug testing within the treatment system, indicating that a very significant proportion of those already in treatment (principally opiate replacement treatment) are using cocaine.

Several speakers referred to this rising level of cocaine and crack related harm as "the elephant in the room" which has triggered relatively little policy or practice change in comparison with other drivers of harm. For instance, while the MAT standards and Local Early warning systems have done greatly valuable work on improving access to opiate treatment and identifying new drugs and contaminants in the drug supply, the substantial growth of cocaine use in the general and high-risk populations has not created an equivalent programme of change.

Within the group experiencing greatest harms, poly drug users, older users with long term use and those who inject crack or cocaine are considered the group who experience greatest harms and risks and with whom increased intervention is most needed. As evidenced by the OFT and NESI data, a large number of this group are already in opiate treatment and/ or use Injecting Equipment provision.

A crude segmentation of the groups who need support might be

Long term poly drug users who use crack and cocaine alongside opiates, depressants and other drugs. Some of this group are in opiate treatment, some not. Crack use is especially associated with heroin use. This group benefit from structured, care planned treatment and, as needed, OST. Within this care, the issue of crack use needs to be specifically addressed motivationally. Contingency management may be effective with this group. Physical and psychiatric care is often needed alongside

Primary psycho-stimulant users (who in Edinburgh will often present to Crew or YP services). As cocaine has become cheaper, purer and its use increasingly normalised. Co-use with

alcohol (a particularly high-risk practice) has also risen in younger groups and is especially associated with powder cocaine.

The lived experience of cocaine use and recovery was conveyed by the vivid, affecting testimony of James, who is in early recovery from crack dependency. Key messages were about:

- The intensity of the dependency and extreme difficulty of cessation– although the withdrawal effects are not physical in the way that opiate withdrawals are, the mental anguish and intensity of cravings are hugely powerful and “hellish”, even compared to James’ previous experiences of drug cessation with opiates and benzos.
- The experience of use he characterised as chaos, within his head and in his life, spilling out into the lives of his family. Rapid escalation of use and injecting, self-neglect, intense mental preoccupation and sustained distress.

As well as deeply affecting the audience and impressing on them the intense suffering arising from cocaine use, the testimony reinforced the vital importance of a lived experience component of any awareness raising or training activity in this area – detached information giving, while essential, gives no indication of the personal struggle dependency.

## What can we do in response to cocaine and crack cocaine use? Evidence of effective practice:

### Health screening:

Cocaine and crack users experience health harms and risks, are concerned about them, and are motivated to address them through behaviour changes. Key health systems affected are

- Heart (including the impact of cocaethylene caused by co-use of alcohol and cocaine) – monitoring of heart and blood pressure is essential and strong pathways to primary and secondary care treatment
- Respiratory (COPD, particle inhalation, reduced immunity and cough reflex, risks of cross infection leading to pneumonia)
- Venous/ Soft tissue damage (in injectors)
- Neurological/ neurovascular
- BBV

The ambition of D&A services should be the elimination of Hep C in the local population. Increasing testing rates for BBVs is possible – standards and self-evaluation tools for services to improve their delivery of testing to the population in their treatment have been developed in England by an alliance of concerned D&A charities. Effective interventions to increase testing rates have included: hep c peers; “drive days” reaching out to offer testing in communities; data driven targeting of high risk populations (including within the caseload of services); offering DBST alongside IEP (locally this includes WAND, which engages people through contingency management in the form of vouchers for participating)

Physical Health screening as harm reduction, as a “hook” for engagement and motivation and as a pathway to further health intervention were discussed by Professor Harris (in relation to the needs of those in her study of crack pipe provision) and by Gail Robinson and Tracy Kemp who are senior Nurses in CGL working in harm reduction and BBV elimination.

Health screening can attract people to services, gives opportunities for educational and motivational interventions and can lead to further health interventions and treatment and changes in risk behaviours.

CGL teams in England can provide support with developing “MOTs” with relevant health assessments for cocaine users which can be offered at treatment entry or alongside Harm reduction interventions (via IEP, outreach, or WAND)

Local practice in this respect is inconsistent: based on the evidence presented, the ideal would include offering systematic healthcare screening within specialist services (including for those presenting for ORT and those approaching for harm reduction only); alongside primary care OST; .

## Harm reduction interventions:

Speakers highlighted that the goal of intervention in research and in practice has too often been abstinence which is not always the most valid or only goal for change. Effective engagement of people includes the need to meet people where they are and to set goals based on the individual’s own needs and wants: “Staying alive plans” or risk reduction plans, stepping down in hierarchy of harmful administration routes, , reduced risk taking behaviour, meeting other needs and obligations, improved health, reduced use etc should all be recognised as valid outcomes of intervention.

Users own self-regulation, mutual support and safety strategies should be recognised and enhanced. People’s set and setting (life structure) need to be recognised fully and assumptions about self-efficacy avoided (the disease model often evokes resistance with users of cocaine).

A specific intervention described in detail by Professor Harris was provision of crack pipes. There is a growing evidence base for these both for direct harm reduction intervention (reducing BBV risks and respiratory damage) and as a tool to attract and engage crack- users in wider risk reduction education and counselling. Provision of these would require a “letter of comfort” from local police (indicating a view that they would not consider prosecution of those involved in the intervention to be in the public interest). These have been developed elsewhere in the country.

Training is required for staff to understand the harms of crack and cocaine use; being skilled, confident and willing to have detailed conversations about risks arising from crack and cocaine use requires detailed training which is not currently available across Edinburgh . Groups who may need this include IEP workers, drugs workers/ clinicians, emergency care clinicians, housing and Pharmacy workers. James described his own experience of needing to explain his needs repeatedly to workers who did not have insight into the specific impacts of cocaine injecting (injecting frequency, local anaesthetic effects of cocaine, disinhibition etc).

WAND is being rolled out in Edinburgh and there are indications that (in keeping with the evidence base for contingency management in cocaine users) it is enabling effective engagement with this group.

## Psychosocial interventions and programmes:

Both Professor McVeigh and Andrew Cass (practitioner from CGL) described programmes of group and individual interventions which have been tailored to the needs of cocaine users and “branded” to indicate that they are the target. Currently, cognitive, psychoeducational and behavioural interventions for this group are considered “promising” in systematic reviews. Evidence of effectiveness is not easily established on an “intention to treat” basis with this group, but the experience from the projects described indicates that the groups were effective in engaging people

who were using cocaine/ crack. The CGL programme described by Andrew was a 6 session rolling group work programme focussed only cocaine and crack use and delivered by a dedicated team.

Gendered responses can have an impact: powder cocaine and alcohol use is associated with the hypermasculinity and a range of aggressive behaviours in young men. CGL are trialling a specialised intervention aimed at addressing this combination of factors.

### The power of contact with open lived experience:

This was described inspirationally by Scott, a peer support volunteer from CGLs Forth Valley peer outreach team and Norma Howarth who manages the peer harm reduction programme in which Scott works.

Scott spoke of the openness, honesty and example that peers can provide, the sharing of their own journey and of his loving giving back through his work.

As with other areas of substance use, direct encounters with people who are able to disclose meaningfully similar life and dependency issues can enable radical transformation. The knowledge of those with lived experience can also increase the effective targeting of outreach. The impact of the Forth Valley peer harm reduction team has included a 43% increase in harm reduction interventions in the area.

### Reaching out and responding to crisis:

Having a distinct service for cocaine users (or a distinct team, programme or pathway) can increase engagement in people who are reluctant to attend opiate focused or any drug services. Barriers include shame and stigma, fear of the consequences of presenting to services (internally, legally, socially etc) but also scepticism that meaningful help and treatment are available for cocaine and crack users.

Crew uses a range of means and approaches to engage those who identify as being primary psychostimulant users and are very effective in reaching this group. Webchat has been an effective means to reach people who are reluctant to walk into a treatment centre.

As noted above, a large number of those already in the treatment system (particularly those in ORT treatment in primary and secondary care) are using cocaine and crack and

Contact points –

- A&E/ NFO – using (and especially injection) of cocaine increases the number of overdoses in injecting users of all substances. Hospital attendance is a common experience for poly substance users. It needs to be established that the existing MAT 3 process of
- Criminal justice – diversion from arrest or sentencing or community orders all represent opportunities to engage people who have not presented to services. Again, assertive outreach has a value with cocaine and crack cocaine users

Draft Action Plan For Responding To Cocaine And Crack Cocaine Related Harm In Edinburgh

Topic	Equivalent MAT standard	Possible actions
Identifying, attracting and engaging Cocaine and crack users	MAT 1	<p>Consider the development of more programmes/ services/ teams dedicated to and branded as focussing on cocaine/ crack. These might include:</p> <ul style="list-style-type: none"> <li>• Specific drop in clinics or group work programmes</li> <li>• Provision of health screening specifically focussed on the concerns of cocaine/ crack users</li> <li>• Highlighting the offer of IEP and treatment for those who are concerned about their use</li> <li>• Offering crack pipes alongside IEP</li> <li>• Make use of the intensity of the Low threshold medication programme for those who use both opiates and cocaine, bringing people into the care of services who can reduce harm and provide close support.</li> <li>• Using WAND interventions (harm reduction interventions aiming at high risk injecting users, incentivised through the provision of vouchers to participants) to engage people</li> </ul> <p>Promote all of the above as widely as possible (including through emergency services, waiting rooms, IEPs etc)</p> <p>Work further with those with lived and living experience to identify offers which might attract users to engage (including alternative therapies, conducive settings, interventions which might be offered etc.</p>
Outreach, inreach and responding to crisis (MAT 3)	MAT 3	<p>Ensuring that pathways from important touch points (including hospital and Justice interventions) are in place and that the professionals identifying and screening high risk (and thus triggering outreach) are considering indicators of high risk that include crack and cocaine and that referrals are made for psychosocial interventions even where there is no clinical treatment option.</p> <p>Ensure that police and court diversion schemes and CPOs include identifying the needs of crack and cocaine users and offer pathways and options for meeting them</p> <p>Ensure that specialist outreach workers are trained in responding to crack and cocaine as well as opiates and have pathways to all of the needed services.</p>

		Explore ways to improve local understanding of the use of emergency/ unscheduled care services by crack and cocaine users
Recognition and measurement engagement and of multiple treatment outcomes	MAT 4	<p>Ensure that the training and awareness programme identifies the full range of potential positive outcomes for this group.</p> <p>Develop baseline data on the number of cocaine and crack users engaged with treatment</p> <p>Ensure that performance management systems are able to identify those with crack/ cocaine use and to gather information on outcomes for them (via daisy or local bespoke tools)</p>
Holistic and wrap around care	MAT 8	<p>Ensure that advocacy and support with benefits, personal finance and housing are available to crack and cocaine users alongside treatment</p> <p>Ensure that people involved in decisions relating to housing and in provision of housing support are insightful into the needs of cocaine and crack users</p> <p>Ensure that people have access to food (in addition to other reasons for food poverty, cocaine depresses appetite and users deprioritise nutrition) – opportunistic access to food is essential</p>
Insight and understanding in key systems and decision makers A skilled work force	passim	<p>Develop/ commission and fund a tiered training awareness programme incorporating (to differing degrees of depth):</p> <p>CONTENT:</p> <ul style="list-style-type: none"> <li>• Usage, trends,</li> <li>• Effects and mechanisms of action (neurochemistry) Social, personal and health harms</li> <li>• Drivers of use (e.g. trauma) and maintainers of dependency</li> <li>• The lived experience of dependence and recovery – personal stories of those affected by their own and other’s use</li> <li>• Anti- Stigma practice, rights based approaches and advocacy</li> <li>• Change goals and aims of intervention</li> <li>• Effective interventions for <ul style="list-style-type: none"> <li>○ Risk and harm reduction</li> <li>○ Psycho-social and behavioural interventions</li> </ul> </li> </ul>

		<ul style="list-style-type: none"> <li>○ Holistic care</li> <li>• Local service provision</li> </ul> <p>Targeting</p> <ul style="list-style-type: none"> <li>• Treatment professionals (for whom a 1-2 day cross professional course may be required) this should be mandatory for staff in these services.</li> <li>• Shorter (? Half day) awareness raising for professionals from other areas (housing and homelessness, social work, especially C&amp;F and Justice, mental health services, courts and police)</li> <li>• Inclusion in the professional training offered to primary care practitioners (especially those , pharmacists (especially those with a significant practice of OST dispensing and IEP),</li> </ul>
Engagement with Lived experience as an intervention	MAT 6	<p>Retain the requirement for developing lived and living experience contributions in the role of the voluntary sector community services. Ensure that it contains a specific requirement to diversity of lived experience.</p> <p>Make peer based outreach harm reduction a component of future specialist community service’s specifications.</p> <p>Strengthen links between treatment services and CA/ NA and the elements of the recovery community with specific experience of cocaine and crack use – promote attendance at open NA/ CA meetings by staff and awareness raising sessions for teams</p>
Make a specific psycho-social offer to users of crack and cocaine alongside MAT 6 &10 provision in the hubs, EdMAC EAP and	MAT 6	<p>Include delivery of a dedicated programme of group work specifically aimed at crack/ cocaine users in the requirements for the voluntary sector community teams.</p> <p>Ensure that key workers and clinicians in specialist in D&amp;A services have access to a toolkit of psychosocial tools specifically aimed at supporting cocaine and crack cocaine users</p> <p>Include a requirement for MAT 6 training to include specific tools for working with crack and coke users (in MI and CBT relapse prevention)</p>
Physical health screening to reduce harm and as a motivational hook	MAT 7	<p>Develop a programme of physical health screening in all hubs, EdMAC, HRT and EAP. This might be based on keep well models and/ or the CGL developed programmes. Lead for this implementation would be EH&amp;SCP/ REAS. Ensure that this is linked to motivational interventions</p> <p>Promote good practice in primary care of including regular health screening alongside primary care OST and encourage measurement of this as part of NES data</p>



		<p>Expand the roll out of WAND and include the offer of active linkage to wider physical health care screening as part of the intervention.</p> <p>Consider offering some of the above in the form of clinics/ outreach specifically branded for/ targeted at coke and crack users</p>
Harm reduction	MAT 2	<p>Continue to explore SDCF (which, in line with the Edinburgh feasibility studies would include inhalation) and ensure that consideration of inhalation is included in any plans for high tolerance accommodation or similar developments.</p> <p>Explore offering crack pipes as both a direct harm reduction intervention and to engage more users in harm reduction</p> <p>Include peer harm reduction outreach as a requirement in the community treatment services specification</p> <p>Ensure that harm reduction messages in training and guidance include extensive insight into the needs of cocaine users</p> <p>Ensure that safer sex messages, supplies and pathways are included in all harm reduction (with a focus on the increased risks for cocaine users)</p>
Access to residential detox and rehab intervention		<p>Improve our understanding of the offer of rehab and in patient detox for users of cocaine and crack</p>
Access to mental health care for users f	MAT 9	<p>As part of the development of MAT 9, consider the MH impact of acute and dependant use of cocaine and the users needs for MH interventions</p>

### **Opening speech**

Christina McKelvie, Member of Scottish Parliament (MSP)  
Minister for Drugs and Alcohol Policy

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### **Cocaine in Scotland: An overview of current trends**

Professor Andy McAuley, School of Health and Life Sciences,  
Glasgow Caledonian University (GCU)

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### **SIPP Pilot: Engagement and harm reduction - findings to date**

Professor Magdalena Harris, Inclusion Health Sociology,  
London School of Hygiene and Tropical Medicine (LSH&TM)

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### **Cocaine and harm reduction - Exploring the evidence base**

Professor Jim McVeigh, Substance Use and Associated Behaviours,  
Department of Sociology, Manchester Metropolitan University (MMU)

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### **Cocaine and crack use in young people: Shared learning**

Emma Crawshaw, CEO Crew2000

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### **Effective Psychosocial Interventions (PSIs) - Tools to support cocaine users**

Charity Easton, Director of Integrated Practice & Sandra Dutton,  
Head of Prisons - Scotland and North East England, Change Grow Live

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### **Harm reduction priorities in cocaine/crack users (BBVs and Nitazenes)**

Gail Robinson, Regional Lead Nurse & Tracey Kemp,  
National Hepatitis C Strategy Lead, Change Grow Live

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### **Lived experience participation/contribution**

Change Grow Live service user

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### **Peer harm reduction: Impact and influence in Forth Valley**

Norma Howarth, Change Grow Live Locality Manager, Forth Valley