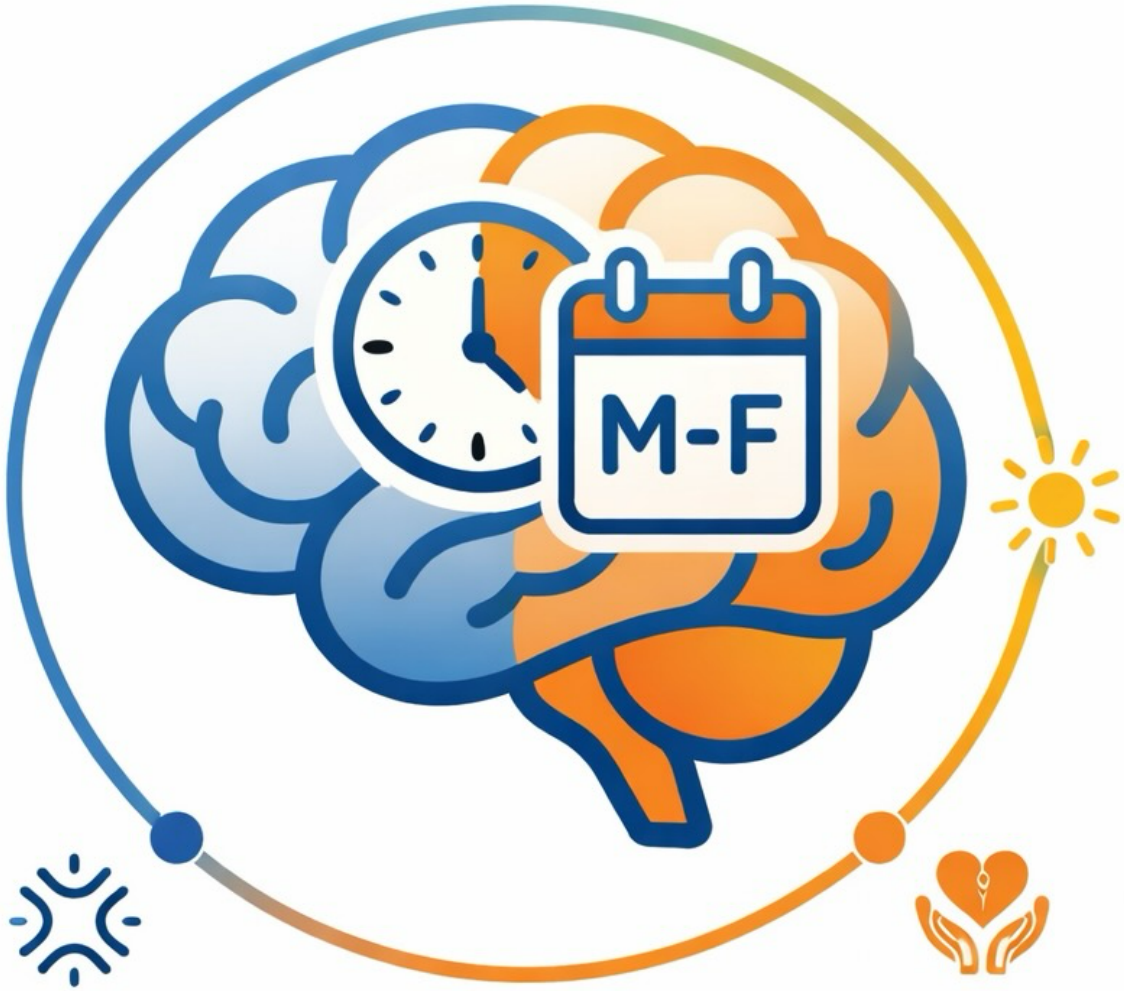
CRACK COCAINE DAY PROGRAMMES

AND LESSONS FROM THE PAST



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Historical Insight

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Crack Cocaine Day Programmes and Lessons from the Past

A review of specialist crack cocaine treatment approaches in England, the evidence base for engagement, and lessons for current practice.

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Introduction

Crack cocaine remains one of the most persistent and complex challenges in England's treatment system, yet much of the way services are still organised reflects models built primarily around opioid dependence rather than stimulant use. In England, 32,399 adults starting treatment in 2024 to 2025 reported problems with crack cocaine use, representing 19% of all new treatment presentations **[1]**. This is not a marginal issue but a substantial part of frontline practice.

National data reinforce the breadth of the problem. Dame Carol Black's Independent Review of Drugs estimated that the 300,000 people using opiates and crack in England account for 86% of the £19 billion annual cost of illicit drug use, equivalent to around £58,000 per user per year **[14]**. Yet the same review found that the number of people in treatment had *fallen* since 2014, partly due to a 17% real-terms cut to adult treatment budgets and a loss of skilled practitioners from the workforce **[15]**. Crack cocaine presentations to treatment, both with and without opiates, increased by 32% between 2013/14 and the review date, while successful completion rates for crack users declined **[26]**.

Crack use often presents differently from opioid use: binge-and-crash patterns, rapid destabilisation, paranoia, and a very narrow window in which someone may be ready to engage. As the older specialist literature and later national evidence both suggest, the central challenge is often not simply what treatment is offered, but whether people can be engaged quickly, credibly, and intensively enough to stay with it.

Earlier Specialist Responses

One of the most important early developments came through the work of Aidan Gray, who helped establish crack-specific services at The Blenheim Project in London in the mid-1990s. Blenheim developed a structured crack cocaine day programme that ran Monday to Friday for 12 weeks, with participants attending group sessions, relapse prevention work, psychoeducation, individual support and complementary approaches such as acupuncture **[5] [6]**.

The logic behind that model was practical rather than theoretical. If crack use creates chaos, then treatment has to provide structure; if motivation is fleeting, services must respond with speed and immediacy; and if people mistrust formal systems, programmes must build credibility from the outset. Those ideas still feel strikingly current.

The Blenheim model also anticipated findings from the wider international research base. A systematic review of intensive outpatient programmes for substance use found that structured day treatment consistently produced outcomes comparable to residential or inpatient care, with significant reductions in drug use maintained at

follow-up **[22]**. The Matrix Model, developed in the United States specifically for stimulant users, similarly demonstrated that intensive, structured outpatient programming — combining cognitive-behavioural skills, psychoeducation, family involvement and relapse prevention — could produce significant reductions in cocaine use **[17]**. These international parallels confirm that the kind of day programme pioneered at Blenheim reflected emerging best evidence, even though it was designed primarily from practice rather than from academic literature.

Blenheim later extended its crack-specific provision through the EBAN service in Haringey, which provided a dedicated adult crack treatment programme **[8] [9]**. The programme also hosted early research on contingency management through the Harbour Steps project, testing incentive-based approaches as part of a structured treatment offer **[7]**. This placed Blenheim at the intersection of front-line innovation and the developing research base around behavioural interventions for stimulant use.

Listening to People Who Use Crack

In 1994, Tim Bottomley and colleagues were involved in pioneering peer-led research in Trafford, Greater Manchester, using people with lived experience of crack use as field researchers. Through peer networks and snowball sampling, the project carried out more than 200 interviews with crack users in the community, producing findings that remain highly relevant today **[4]**.

Nearly half of the respondents had never been in contact with treatment services, and many who had attended services had done so because of heroin rather than crack. Participants said they wanted support that was informal, accessible, confidential, partly staffed by people with lived experience, and designed specifically for crack users rather than absorbed into generic drug treatment. Those findings informed the development of the Piper Project, an informal drop-in model built around those preferences **[4]**.

More recent evidence has confirmed the value of these principles. A 2025 government publication on recovery support services and lived experience initiatives found that peer support delivered alongside standard treatment can improve outcomes, and that peers with lived experience of substance use can significantly increase treatment engagement and reduce harm **[21]**. The same publication noted that peer-delivered brief interventions can significantly reduce heroin and cocaine use even in a single contact, reinforcing the insight from the Trafford project that the first point of contact need not be clinical to be effective.

This is one of the strongest lessons from the period: for many people using crack, the first barrier is not motivation to change in the abstract; it is whether a service feels relevant, safe and worth attending in the first place. That remains a live issue across today’s system.

Outreach, Engagement and Local Innovation

Other practitioners were also adapting their responses to the realities of crack use in local communities. A notable example was the Wheeler Street Project in Birmingham, associated with Grantley Haynes and colleagues, which focused strongly on outreach and engagement in areas where crack use was concentrated **[11] [25]**.

Although many of these projects were not evaluated to the standards now expected, they were influential because they addressed practical problems that mainstream services often missed. In many parts of the country, practice was evolving faster than the research base, and frontline services were already recognising that clinic-based models alone would not reach everyone who needed help.

The wider engagement literature supports these early instincts. A large multi-site effectiveness study of motivational interviewing found that integrating motivational techniques into the earliest phases of treatment significantly improved retention: participants who received motivational interviewing were more likely to remain enrolled at 28 days (84% versus 75%) and completed more treatment sessions over the follow-up period **[20]**. The implication — that the way people are first received and engaged materially affects whether they stay — was precisely what projects like Wheeler Street were responding to, albeit without the formal research infrastructure to measure it.

Retention data from England's National Drug Treatment Monitoring System have since confirmed that roughly one in ten clients drop out of treatment before 12 weeks, and that younger drug users and those with stimulant-related presentations are often at greater risk of early departure **[24]**. These patterns make a clear case for responsive, low-threshold engagement strategies of the kind that early crack services tried to provide.

The Rise of COCA

As crack and cocaine issues gained greater national attention, a broader professional network also emerged. One important development was COCA — the Conference on Crack and Cocaine, closely associated with Aidan Gray and colleagues, which brought together practitioners, researchers and policymakers with a specific interest in stimulant treatment **[6] [13]**.

COCA later developed into a charitable organisation focused on crack and cocaine issues, helping create a professional identity around a field that often sat awkwardly inside wider drug treatment structures. The 2006 Crack and Cocaine programme materials also reflected the continued use of structured 12-week approaches for people motivated to stop using crack or cocaine **[10]**.

Its importance was not simply organisational. COCA helped reinforce a bigger message: stimulant problems required specialist thinking, specialist language and, at times, specialist pathways.

What Later Evidence Confirmed

Later national evidence supported many of the observations made by earlier practitioners. The National Evaluation of Crack Cocaine Treatment and Outcome Study (NECTOS) found that specialist crack treatment services were often judged by their ability to engage and retain people, and it highlighted the importance of motivational interviewing, practical problem-solving, psychosocial interventions and client-identified goals **[2]**.

NECTOS also suggested that a “twin-track approach” to service development may be justified, with appropriate interventions for crack and other stimulant use developed in parallel with opioid treatment systems rather than simply folded into them **[2]**. That is an important point, because people whose primary issue is crack do not always fit comfortably into models designed around opioid substitution treatment.

The broader international evidence base has since confirmed which psychosocial approaches work best for stimulant use. Contingency management — the systematic use of incentives to reinforce positive behaviours such as drug-free urine tests — has been identified across multiple systematic reviews and meta-analyses as the most effective behavioural treatment for cocaine and crack use. A 2020 systematic review of reviews found that contingency management was the only intervention consistently associated with increased likelihood of a negative cocaine test result (odds ratio 2.13) **[19]**. A 2018 network meta-analysis of psychosocial interventions concluded that contingency management, alone or combined with community reinforcement, showed superior efficacy and acceptability compared to treatment as usual **[16]**. NICE Clinical Guideline 51 recommended contingency management for stimulant misuse in England as early as 2007 **[3]**, and the ACMD’s 2015 review of powder cocaine emphasised that in the absence of effective pharmacotherapy, psychosocial and contingency management approaches remained the primary evidence-based options **[12]**.

Cognitive-behavioural therapy (CBT) has also shown durable effects for stimulant use, particularly in relapse prevention. Meta-analytic evidence indicates moderate overall effect sizes for CBT across drug use disorders, with evidence that cocaine-dependent patients treated with CBT often continue to improve after active treatment ends — an effect attributed to the continued application of coping skills learned during treatment **[17]**. A novel adaptation, Memory-Focused Cognitive Therapy for cocaine use disorder, has shown preliminary feasibility and efficacy in a UK NHS pilot trial, suggesting that innovation in psychosocial treatment for stimulant use is ongoing **[23]**.

Current national figures reinforce the scale of the challenge. In 2024 to 2025, 19% of adults starting treatment in England reported crack cocaine problems, equivalent to

32,399 people, while use of crack alongside opiates remained a major feature of treatment demand **[1]**. Over a third (37%) of people who left the treatment system in that year did so by dropping out or leaving without completing treatment, underscoring the ongoing difficulty of retention **[1]**.

Lessons for Today's System

Looking back, several themes stand out clearly from three decades of specialist practice and accumulating evidence.

- **Engagement is everything.** Many people do not get as far as sustained treatment unless the first contact is immediate, relevant and credible. Motivational interviewing delivered at the point of entry has been shown to improve early retention **[20]**, and the Trafford peer research demonstrated that many crack users will simply not attend services that feel generic or unwelcoming **[4]**.
- **Structure and intensity matter.** Day programmes offered a stable routine during periods when relapse risk was high. International evidence confirms that intensive outpatient models produce outcomes comparable to residential care for most substance-dependent populations, with treatment intensity and duration more predictive of outcomes than setting alone **[22]**.
- **Practical support matters.** Housing, debt, benefits and day-to-day instability often determine whether someone can stay engaged. Dame Carol Black's review recommended multi-agency approaches integrating housing and employment support alongside clinical treatment, and called for £150 million in housing support over five years **[15]**.
- **Outreach remains essential.** Not everyone who needs support will walk into a clinic unaided. Only 39% of crack users were estimated to be in treatment at the time of the Black review, and crack cocaine presentations had increased by 32% since 2013/14 **[26]**. Outreach and low-threshold engagement, of the kind modelled by Wheeler Street and others, remain critical for reaching this population.
- **Peer support and lived experience have strong evidence behind them.** From the Trafford project in 1994 to the most recent government guidance, evidence shows that people with lived experience of substance use can build trust, reduce barriers, increase engagement and improve treatment outcomes in ways that professionally led services alone may not **[4] [21]**.
- **Contingency management is the strongest evidence-based behavioural intervention for crack and cocaine use,** supported by multiple systematic reviews and recommended by NICE, yet remains significantly underused in routine English practice **[3] [16] [19]**.

- **Crack needs a clearer treatment identity.** Simply placing crack users into opioid-oriented systems does not always produce the right fit. NECTOS called for a twin-track approach **[2]**, Dame Carol Black recommended dedicated capacity for stimulant users **[15]**, and the ACMD noted the absence of effective pharmacological treatments as a reason to strengthen psychosocial pathways **[12]**.

Conclusion

For today's commissioners, service leaders and practitioners, this is not really an argument for nostalgia. It is a reminder that many of the problems we still discuss — dropout, weak engagement, poor fit with mainstream provision, and limited stimulant-specific pathways — were recognised decades ago by people already trying to build better responses. The pioneers at Blenheim, in Trafford, in Birmingham and across the COCA network did not have the luxury of meta-analyses or network evaluations. They had practice wisdom, proximity to people who used crack, and the determination to build something that worked.

The evidence has since caught up with many of their instincts. What is now needed is for commissioning and service design to catch up with the evidence. Dame Carol Black's 2021 review set out 32 recommendations for rebuilding drug treatment in England, including expanded treatment capacity, a transformed workforce, and dedicated provision for stimulant users **[15]**. The 10-year drugs strategy, *From Harm to Hope*, pledged significant new investment. Whether that investment translates into the kind of specialist, responsive, engagement-led services that crack users need — of the kind first imagined in the 1990s — remains the central question for the next decade of practice.

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