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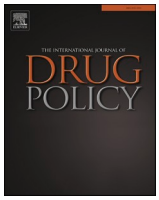

Pipes as an engagement tool: qualitative findings from a crack equipment and harm reduction training intervention in England

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ABSTRACT

Background: Crack cocaine use is increasingly prevalent in England, yet drug services are poorly equipped to support the needs of this population. Provision of stimulant inhalation equipment is prohibited, and workforce crack-related harm reduction knowledge is generally low. The Safe Inhalation Pipe Provision (SIPP) project piloted a crack inhalation equipment and training intervention in England. This paper explores how and in what way crack training and equipment provision influences engagement with drug service providers.

Methods: SIPP is a mixed-method study, comprising a before-and-after survey, service monitoring data, qualitative interviews, focus groups, and observations. Here we report qualitative data generated with people who use crack and providers at three intervention and three comparison group sites. We conducted a thematic analysis and report themes specific to contact and engagement with drug services.

Results: Prior to intervention implementation, little adequate crack-specific support was identified. SIPP equipment provision facilitated increased contact and/or disclosure of crack use with services. Workforce training enhanced communication and relationship-building opportunities, enabling disclosure of additional need and commensurate provision or linkage to health and social supports. The capacity for contact to facilitate engagement was impacted by organisational and structural constraints, and for some populations barriers to access remain entrenched.

Conclusions: Provision of crack inhalation equipment can facilitate new contacts with services among a highly marginalised population. Complementary workforce training helps to enable relationship building and engagement opportunity. Additional methods of provision, including through peer networks, are required to support people for whom barriers to service access remain.

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Introduction

Use of crack cocaine (herein 'crack') is increasing in England, with latest estimates indicating approximately 171,000 people using crack (Office for Health Improvement & Disparities, 2025b). People who use crack are often highly marginalised, vulnerable to homelessness, criminal justice system involvement, and service access barriers (Bungay et al., 2010; Butler et al., 2017; Duopah et al., 2024; Fischer et al., 2010; Public Health England & Home, 2019). Limited service access can exacerbate health risks related to crack injection and/or inhalation and

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hinder prevention opportunity (Butler et al., 2017; Restrepo et al., 2007).

English drug services, defined here as specialist harm reduction and/or drug treatment services, are generally ill-equipped to support this population. There are no licensed pharmacotherapies available in the UK for stimulant dependency and provision of equipment for the purposes of stimulant inhalation is prohibited (Harris, 2020; Parliament of the United Kingdom, 1971). These issues are reflected in a prominent 2021 report, noting that people who use crack "do not receive an adequate or any service" (Black, 2021). Drug services orientate towards providing support for opioid and injecting-related use. A range of injecting equipment is legally permitted to supply, with foil for heroin smoking permitted through a legislative amendment in 2014 (Parliament of the United Kingdom, 2014). Foil is poorly suited to crack inhalation, with homemade and makeshift crack pipe use common (Harris, 2020; Harris et al., under review). Evaluation of foil provision illustrates public health benefits through injection reduction and increased engagement with services (Dunleavy et al., 2023; Pizzey & Hunt, 2008).

For people who use crack but do not inject or use opioids, the lack of pharmacotherapy and inhalation equipment available in English drug services can inhibit attendance. A 2019 inquiry into crack use in England reported that most drug service clients using crack were "established heroin users" but indicated a group "hidden" from services who used crack exclusively (Public Health England & Home, 2019). Relatedly, a recent English study reports provider perspectives that people who use crack are underrepresented in services, noting a lack of supports available for this population (Lloyd et al., 2025).

Needle and syringe programmes (NSPs) are a well evidenced 'gateway' to wider service provision for people who inject drugs (National Institute for Health & Care Excellence, 2014, p. 27): facilitating entry into drug treatment or detoxification (Hagan et al., 2000; Heimer, 1998; Strike & Miskovic, 2018); prevention and testing for blood borne viruses (Platt et al., 2018; Wodak & Cooney, 2006; World Health Organization, 2004); and connecting clients to housing and social services (Macneil & Pauly, 2011; McNeil & Small, 2014; Strike & Miskovic, 2018). North American research indicates that crack inhalation interventions can offer similar and additional benefits (Bergen-Cico & Lapple, 2015; Chung et al., 2025; Jagoe, 2014; Ross, 2015). For example, a Canadian evaluation found that clients who reported receiving a crack pipe accessed additional health supports, including vaccinations (34 %), sexual health testing (33 %), condom provision (31 %), wound care assistance (11 %), or onward referrals (12 %) (Jagoe, 2014). Reported public health benefits associated with crack inhalation provision include decreased viral transmission and respiratory health risks, through reductions in injecting, pipe sharing and use of makeshift pipes (Frankeberger et al., 2019; Jagoe, 2014; Leonard et al., 2008; Prangnell et al., 2017). These interventions typically involve distribution of a safer inhalation kit (glass pipe, mouthpieces, screens/gauze, push-sticks), harm reduction information (leaflets, verbal advice) and sometimes ancillary supports (safe sex supplies, lip-balm etc.), generally in fixed-site NSP settings, but also through service and peer outreach (Piot et al., under review).

To understand the applicability of these international findings to the UK context, the Safe Inhalation Pipe Provision (SIPP) study developed, piloted and evaluated a crack inhalation equipment and workforce harm reduction training intervention in England (Harris et al., 2024). The study was supported by memorandums of understanding from local police forces due to the legal prohibition against distributing inhalation equipment. The intervention was implemented over a 6-month period between 2023 and 2024 in three geographical sites in England. Impact evaluation outcome measures pertain to health outcomes and service engagement. The latter used multiple indicators measuring the number of new registrants, number of times clients visited a drug service during the intervention period, and the binary 'use of drug services in the past six months'. A similar framing of engagement is used in UK drug policy (Home Office, 2023), measuring client contact with or retention in structured treatment.

However, as the SIPP study progressed, a relational element of 'engagement' became increasingly evident, which was not adequately captured by contact, registration, or retention. These reflections align with review findings that a positive client-provider relationship significantly predicts client engagement and retention in drug treatment (Meier et al., 2005). An earlier study cautions against a focus on client characteristics or treatment 'readiness' concluding "the perceived utility, or helpfulness, of the services, along with a favourable client–counsellor relationship actively engages the client in treatment" (Fiorentine et al., 1999; p. 204). In harm reduction services, these relational elements may be even more vital, given support for populations who may have fewer treatment options or are not seeking abstinence. In one of the few papers to conceptually explore engagement in low-threshold settings, Lee and Zerai (2010) report trust and relationship development as core engagement components, paralleling findings from a similar review in general healthcare settings. Here, engagement is positioned as not only a state of the client being "engaged in" (their motivations, attitudes, and related observable behaviours) but a co-occurring process of "engaging with," where providers have a foundational role (Bright et al., 2015).

There has been little qualitative inquiry into the relational component of safer inhalation interventions and their impact on client-service provider relationships. Multiple evaluations have reported quantitative count or frequency data related to drug service contact and equipment distribution (Bergen-Cico & Lapple, 2015; Chung et al., 2025; Jagoe, 2014; Ross, 2015). However, much of the qualitative exploration has focused on equipment acceptability and reach, changes in drug use practices, and health outcomes (Boyd et al., 2008; Ivsins et al., 2011; Leonard et al., 2008) compared to the experiences of service contact. The SIPP study presents a unique opportunity to address this gap and explore what drug service 'engagement' might mean in the context of a novel intervention for people who smoke crack.

Methods

Study context and overview

Full details of the SIPP intervention and evaluation are published (Harris et al., 2024). In brief, the intervention consisted of a 'SIPP kit' (glass straight shooter crack pipe, wooden push-stick, filters, and mouthpieces in a case), crack harm reduction e-learning training for providers, and harm reduction information (SIPP kit instruction leaflet, verbal advice) provided for people who use crack by drug services or sex worker support providers and peers (people with lived/living experience of crack use). Provider training was hosted on the Exchange Supplies platform (Exchange Supplies, 2025) and took 30–60 minutes to complete. Modules included: understanding crack prevalence and treatment options, health impacts of crack and homemade pipe use, crack inhalation harm reduction, and client engagement tips. The intervention was implemented in three geographic sites in England from July 2023 – February 2024 where equipment distribution was integrated into existing service delivery. Three geographic locations served as non-equivalent comparison sites.

Providers in one intervention and all comparison sites were operated by a large national charity delivering treatment support in addition to harm reduction advice, NSPs, and naloxone provision. The remaining providers delivering the SIPP intervention were small to mid-sized independent charities or NHS-operated organisations that specialised in delivering low-threshold harm reduction support for people who use drugs and/or sex workers. These sites do not offer drug treatment but work in partnership with other organisations to facilitate access to such services.

The SIPP study evaluation included 1) an impact evaluation using pre- and post-intervention surveys, 2) an economic evaluation, and 3) a

process evaluation comprised of ethnographic observations, qualitative interviews and focus groups, and quantitative monitoring data. This paper reports on an analysis of qualitative data generated with service providers and people who use crack. Our analytic focus arose while conducting the SIPP process evaluation (Sharpe et al., forthcoming), in part to contextualise study outcome measures (Platt et al., under review), and is focused on service access, contact and engagement throughout the study duration.

Recruitment and sample

For the qualitative component, we recruited people who used crack through participating services and peer networks. Participants were eligible if they were 18 years or older, spoke English and currently used crack or had a lengthy experience of crack use and local market dynamics. We purposively sampled for variation in age and gender, then ethnicity where possible. Service providers were recruited through study sites, purposively sampled for variation in role and SIPP involvement. Most providers were directly involved with intervention implementation or survey delivery, with one included in a control site for their expertise in harm reduction and regional knowledge.

We conducted 48 interviews with 50 participants: 33 people who use crack (2 no longer using) and 17 providers. Interviews ranged from 11 to 67 minutes. Most interviewees using crack were male (58 %, $n = 19/33$) and white (91 %, $n = 30/33$), with ages ranging from 25 to 57 years (4 had missing age data). Six focus groups were conducted, one with providers (4 total participants; 2 women) and five among those using crack (32 total participants; 10 women, with women present in each group), ranging from 46 to 80 minutes long.

Data collection methods and instruments

Semi-structured interviews and focus groups were conducted from May 2023 to September 2024 by four researchers with different personal experiences of crack use, ranging from none to past and current use. Topic guides were tailored to each stakeholder group, covering pre-intervention crack-related service provision; organisational structure of providers; professional training and development; influence of SIPP on provider's practice; and for people who use crack, drug use history, practices and risk, experiences of and perspectives on service access and need, and intervention acceptability and uptake.

Interviews and focus groups with people who use crack were facilitated in-person in private spaces, primarily in drug services but also community rooms and participant accommodations, and were audio recorded. Provider interviews/focus groups were conducted in-person and audio recorded or conducted and recorded online via Microsoft Teams or Zoom. All participants were provided with information sheets and time to ask questions prior to providing informed written consent. People who use crack received £20 and £30 compensation for interviews and focus groups, respectively. Data were transcribed verbatim by a third-party service and were checked by the interviewer, excluding one provider interview who preferred detailed notes to be taken by the interviewer rather than an audio recording. All participants have been deidentified and provided with pseudonyms.

Field visits were conducted across intervention and comparison sites, with researcher time concentrated in intervention sites. The principles of focused ethnography informed data generation, whereby intermittent and purposeful field visits are undertaken to generate rich, context specific data (Higginbottom et al., 2013). Multiple researchers made field visits throughout the pre-intervention, intervention, and post-intervention period across sites from September 2022 to 2024. Each researcher generated field notes focusing on local site dynamics and contexts, including within each service and in relation to SIPP implementation, but also more broadly to build a picture of the wider built and structural environments, including in relation to policy, policing, drug markets, service availability, social deprivation and gentrification. Cleaned and deidentified transcripts and field notes were uploaded to NVivo software for analysis.

Analysis

Thematic analysis was informed by principles of constructivist grounded theory (Charmaz, 2006) and the Braun and Clarke (2006) six-stage thematic framework. Analysis comprised: 1) early data familiarisation and analytic memo development; 2) first stage inductive open coding and coding consolidation; 3) first level coding framework development; 4) systematic coding of all transcripts to the framework; 5) inductive second level analysis of data coded against service provision, professional development, and client-service interaction categories; 6) analytic consolidation/write-up. Accounts from providers, clients, and people who use crack not in touch with services were triangulated to explore commonalities and divergences in experiences and beliefs. Analysis was supported by MH, firstly with CV and then with CS. CS and MH conducted analysis for this paper.

Ethics

All protocols and research implements were approved by the London School of Hygiene and Tropical Medicine's Research Ethics Committee (ref: 28102).

Results

Results are presented against analytic themes: 1) pre-intervention service provision: deprioritising crack, 2) pipe provision: recognition affords visibility and opportunity, and 3) contact and engagement constraints.

Pre-intervention service provision: deprioritising crack

Participants – both providers and people who use crack – emphasised the limited crack-specific supports in drug services prior to the SIPP intervention. These primarily comprised of psycho-social interventions or counselling which, as a standalone offer, were often framed as inadequate:

> [R]eally all we're doing is supporting them with a hope and a wish, and telling them, "sleep it off"… (Terry, provider)

This contrasted with the prominence of support designed for people who used opioids and/or injected drugs. Provision of pharmacotherapy for opioid dependency in the form of methadone and/or buprenorphine prescriptions (herein opioid substitution therapy or OST) were highlighted by client participants as helpful in managing their heroin use, but left some feeling that their issues with crack were discounted or marginalised:

> Like even when I was involved in the services, they could manage my heroin use, but they couldn't manage my crack cocaine use because there wasn't a substitute in place for it … it was just seen as, "no, there's no availability for it, it's [crack withdrawals] only mental deal with it". (Brandon)

This sentiment was echoed by some providers, in that provision of OST, injecting equipment, and foil indicated prioritisation of opioid use, and recognition of the issues impacting people who use heroin, unlike that afforded to people who use crack:

> [T]here's not really that much for [crack use] in harm reduction, treatment, or anything like that. So I think you know, people just look at it, it's like, "oh why bother"… where IV [intravenous] they know, "oh yeah I can go there, they're not going to judge me … we can get whatever we want, they'll help us", and people know that. (Ricky, provider)

Providers accounts of harm reduction provision for opioid use noted its utility in bringing people into their services and helping to meet their needs. Many expressed frustration or confusion about why only injecting, and not smoking, equipment was available for provision, some not aware of the legal status of inhalation equipment provision. Here equipment was framed as an engagement 'hook' from which other services could be provided, limiting access to support people who smoked crack:

> [N]ot only do they not get the equipment that they should be having that reduces the risk, but they don't get the rest of the stuff. So, they don't get the access to mental health support, they don't get access to sexual health services, blood-borne virus screening, even nice stuff, basic human rights, your toiletries, your socks, your sleeping bags… (Elaine, provider)

> Because like, what's the need for you to go into them services? … Whereas if these [SIPP] pipes were readily available… then they'd be, you know, like, more likely to go in. And that's where people get the knowledge and the information and the help. (Brandy, provider, focus group)

Many providers noted limited personal and/or wider workforce training and knowledge about crack, apart from in the context of co-injection with heroin ('snowballing'). Together, the lack of stimulant inhalation equipment, stimulant dependence pharmacotherapy and low workforce confidence and competency could render people who smoked crack as 'invisable' to services, as articulated by Carrie:

> So I only see the injectors that come in… I guess that's just more visible to me. The ones that aren't visible are the ones that are smokers… (Carrie, provider)

For clients already in contact with services, some chose to not disclose that they smoke crack or discuss their use, like Scott, who accesses services for his OST medication:

> Interviewer: Do you talk to them about your crack use at all…?
>
> Scott: Yeah, no, I decided to keep my treatment, and keep my life separate, you know what I mean? (client)

Providers from a control site reflected this reticence in practice, where they reported having to explicitly ask about crack use during triage to elicit a disclosure. More frequent contact with people who used opioids and/or injected, together with limited disclosure of crack use among pre-exiting clients, could negatively impact providers' understanding of the extent of crack use in their communities. Glen links this partial awareness to the availability of pharmacotherapy for opioid dependence and a concurrent 'recovery' emphasis in many services:

> I do think that crack cocaine has always been a poor second to heroin … In nearly all the services I've worked in… predominantly the focus has always been on trying to attract heroin users and get them on medications and… get them into recovery… (Glen, provider)

These priorities may create a feedback loop further deprioritising crack. As explained by providers below, their service provision target numbers for clients using opioids are higher than for other drugs, which can influence their administrative practices:

> Raymond: [T]he fact of the matter is with crack use they're not focusing so much on it because they're looking at [it] as being a secondary drug and that's the problem.
>
> Caroline: We can stick a plaster over the secondary because we're looking at the primary and the primary's gonna get us, and it sounds really, really bad, it's gonna get us the positive result.
>
> Barry: How many more non-opiates do we need? … [I]s it just 3 a month non-opiates we have to get, is it?… But they want us to get like 14 or 15 opiates?…
>
> Facilitator: Oh, so those are like the targets?…
>
> Caroline: Yeah. So you looking at your opiates… your heroin and your alcohol, anything after that it's secondary.
>
> Raymond: That's right. And it's wrong but that's how it's done.
>
> Caroline: Because if your primary is heroin, so what you're doing is you're coming in for your OST for your comedown off your crack because we can't address your crack because there's nothing we can do with it… if we put a plaster on the crack, we've dealt with the main. "Oh look that's a positive closure because he's come in with heroin [as primary drug of concern]." (provider focus group)

In England, the drug treatment monitoring system requires that clients have a recorded primary drug - the drug which brought them into contact with services - as well as up to two other drugs, considered secondary and tertiary (Office, 2024). Recording heroin or alcohol as primary, even if crack was recognised as the presenting issue, allowed services to meet targets and provide some form of treatment 'solution', as described later in the focus group:

> Caroline: So it's easier to get a detox for alcohol [than] it is … for crack because for crack then they're like "well what do we do?" There is no fix. As with alcohol, "yeah, you can come in, detox, sweat it out", but generally you'd be sweating out your crack at the same time… So that is why I think it's, well, a lot of the times [crack is] secondary because if they put it as primary… nothing happens. (provider focus group)

This exchange articulates the way in which service evaluation outcomes, when paired with a lack of specific interventions for crack, can influence recording practices, leading to and underestimate of local crack use prevalence. As such, SIPP was introduced into a service environment with interconnected structural barriers to contact initiation and engagement with people who use crack.

Pipe provision: recognition affords visibility and opportunity

The SIPP intervention increased the visibility of people who smoke crack in services by incentivising presentation and disclosure in order to access smoking equipment. Increased visibility then afforded staff opportunities to demonstrate their value to clients by offering relevant harm reduction advice and ancillary supports, as elaborated below.

Increasing visibility

The availability of SIPP equipment elevated the visibility of people who use crack both through increased presentations at services, and by signalling that crack was now seen and recognised by providers, therefore was safer to disclose in service interactions. Across the three intervention sites, all providers felt that SIPP had increased their volume of clients, including those who presented only once as well as returning clients. Providers emphasised the number of new people attending their service, some of whom were previously known to providers but had not successfully been brought on-site:

> [F]or the new sign-ups it's unbelievable, I think we've touched about 300 new sign-ups of people what we'd never get to engage in services before… (Ricky, provider)
>
> [T]here is a man who sits outside one of the [shops] in [city] every day… and I've always chatted to him and he always said "oh I don't touch anything, I don't use drugs" and since working here and volunteering here I've never seen him… in here…then he came in last Friday [for a pipe] (Shannon, provider)

Although some new clients shared characteristics of other service users, such as injecting with heroin or rough sleeping, providers were quick to highlight that there could be substantive differences. Many new presentations were among people who used only crack, and therefore

were not on OST for heroin use – a 'hard to reach' group, as implied by Terry:

> But we had people, crack users, people I don't normally see coming in and asking for them [SIPP pipes], you know, and engaging with the service. Now that's something what don't normally happen. (Terry, provider)

Some new clients were perceived as living relatively 'stable' lives, with consistent employment in 'professional' jobs, as opposed to many longstanding clients for whom the day-to-day was described as 'chaotic' by providers. Others were more vulnerable – one site reported two cases where safeguarding procedures were implemented for new clients early in the intervention. Both providers and clients stated that these new points of contact were directly related to the availability of pipes and smoking equipment:

> …I know people that did come just for pipes, my mates come, they're not even on a script [OST] here but they wanted the pipe (Adrian, client)

All but one provider distributed SIPP equipment both on- and off-site, so new contacts were also made during outreach. For example, one provider incorporated SIPP into their routine home-visit needle distribution. Once they started distributing pipes from a long-standing client's home, people from the client's social circle previously unknown to the provider would come by the house for a kit:

> [W]e home deliver needles to some people and one of those people received a pipe and arranged for the next time … that we visited them, for eight of their friends to come round to get a pipe. Eight of their friends who we'd not engaged with in a kind of needle delivery or kind of in a substantive way before. (Patrick, provider)

Some providers recounted SIPP facilitating increased visits among clients already known to use crack, including those who presented to services infrequently or sporadically. Across all intervention sites, SIPP facilitated first time disclosure of crack use among clients already in service, accessing the needle exchange, alcohol support, or OST. According to Patrick:

> [T]hese are people who could probably, let's say they visit the exchange sixty times a year, they had their pipe in their pocket every single time, probably, and we'd never had a conversation (Patrick, provider)

In this way, in addition to providing a tangible harm reduction support, the provision of inhalation equipment helped render crack use visible and 'speakable', as articulated by this client:

> [It]'s just magic that somebody's there like that, and that it's not… a secret thing, like you've brought it to the surface, where people are not afraid to talk about it anymore… Now you've got a pipe, you can be more open about it… [B]ecause you can get a pipe here and it's like, "oh can't be bad then" if you know what I mean, "not going to get into trouble if you can get a pipe here" sort of thing. (Lindsey, client)

This quote illustrates the internalised stigma and shame expressed by many participants who used crack. The need to keep use a 'secret' – in that discussing crack use might provoke 'trouble' and be perceived as 'bad' – even within specialist drug services demonstrates how standard service delivery could simultaneously render crack use invisible while reinforcing shame and silence among those engaged in this practice. Equipment provision can thus be seen as more than just an inhalation harm reduction support, demonstrating a symbolic recognition of people who use crack and an openness to understanding and addressing their needs.

Increasing opportunity

The increased visibility of people who use and smoke crack to services afforded providers an opportunity often previously inaccessible to them. This was particularly noted by providers at sites structured to deliver low-threshold harm reduction support. For example, Patrick noted how pipe provision could provide a route toward connection:

> [T]he opportunity to use all of the skills that the team have, to start building trust, start building relationships and giving people the space to express their needs and to explore change if they want to. (Patrick, provider)

Pipe-initiated contacts enabled some providers to demonstrate non-judgemental active listening and small acts of care to clients, important in earning trust and displaying competency. These moments can provide foundations for longer-term provider-client relationships which, as described by Elaine, could result in future visits for 'something else':

> I always think we're a bit like Mary Poppins, like people just come in for what they need when they need it and… they might remember us and come and see us for something different. Like, "they were really nice when they gave me a pipe and they offered me a drink and a pair of socks and actually my next-door neighbour's like kicking [the] shit out of me or cuckooing me [a person having their home overtaken for exploitative purposes] or something, I'm going to speak to them." … [I]t may be they come in regularly because… they want noticing for something different and it's not said but do you know what I mean? (Elaine, provider)

Instigating a conversation about crack use during equipment distribution was often a way for providers to showcase their skills and develop rapport. For staff who knew relatively little about crack before the intervention, the SIPP e-training and its focus on values, preferences, and practices related to crack use improved "the questions I can ask people" (Kieran, provider) and relatedly confidence to instigate informed, non-shaming conversations about crack. The impetus to start these conversations elevated awareness of crack smoking health risks or techniques that could help improve using practice among some clients, as noted in a focus group:

> Carl: It's educated us. Not the pipe. The scheme's educated us.
>
> Clive: Yeah. The whole project.
>
> Maria: Yeah. The whole thing. It's opened our eyes a lot to a lot of things we didn't know… Like Hep C and stuff like that, we didn't [associate with?] crack pipes. (client focus group)

These conversations offered opportunities for knowledge exchange, as providers learned from the clients about their preferences and practices using crack, which was sometimes catalysed by discontent about the SIPP kit content. The SIPP equipment had limitations, with providers noting the openness with which clients shared thier feedback and how this presented moments of collaboration to find acceptable modifications. Kieran describes going to a client's living room with an outreach colleague and working with them to improve the SIPP filter:

> [I]t's like you're sharing this with them. Instead of like an "us" and "them", it's just like "well this is you know, this is what other people have said and done" … it does kind of, it removes that kind of hierarchy of "well I'm the professional and you're the clients" kind of thing and it makes us more side-by-side. (Kieran, provider)

Offering practical harm reduction supports, combined with provider willingness to learn and work collaboratively could increase clients' respect for the service, as articulated by Patrick:

> [B]eing able to give people more product, being able to see more of the person's needs and meet those needs has allowed us to step more into the conversation and be more of a… we're never going to be an equal partner in that, but more of a kind of valued and respected voice within that… (Patrick, provider)

This then could facilitate a space within which clients felt

comfortable to raise concerns not previously expressed, and/or allow providers the opportunity to observe need and offer associated supports. The following interaction was noted by a researcher at an intervention site:

> Someone came in to get a pipe … and the pipe was a great conversation starter between him and [provider] … [H]e was struggling to close the case and mentioned that he can't see anything:
>
> "I'm really, really blind. I'm +4 [farsighted]."
>
> [Provider] asked him whether he had glasses, and he told us the police stamped on his and the one's he has now don't work well enough for him. [Provider] has managed to arrange to take him to the optician on Friday morning. (fieldnote)

Another fieldnote illustrates how the availability of SIPP equipment brought some of the most marginalised into contact with services, facilitating support for complex health issues:

> An older guy came into the service having never really engaged with [provider] before… He had a lot going on… [t]he major concerns were osteoporosis and various bone/joint inflammations he's not been having treatment for; he has had unprotected sex with four different women, who between them are positive with HIV, hepatitis, and syphilis … he says he's lost a lot of weight and has no idea how … He was also engaged with very risky injection practices and currently has a golf-ball sized hole in his groin. Him coming in for the crack pipes has led to [staff] arranging for sexual health testing, BBV testing, and securing a GP appointment. (fieldnote)

In this way, contact for SIPP equipment could enable support for conditions that otherwise "would have gone unnoticed, unchecked" (Ricky, provider). Researchers observed that, where appropriate and available, staff facilitated access to on-site health care supports, commonly including nurse visits, blood borne virus testing, sexual health screening, wound care, and take-home naloxone. When support was not available in the service, some providers made appointments, referrals, and/or liaised with external providers to co-ordinate or establish care for clients' unmet respiratory, mental health, housing, and/or domestic violence needs.

Contact and engagement constraints

While the SIPP intervention offered an opportunity for engagement beyond contact, not all clients wanted to discuss their drug use or access additional support. Some came in solely to pick up equipment, presented once, or were only open to casual conversation as this level of interaction suited their needs. Structural constraints to access could also inhibit contact and engagement as we explore in this section.

The intervention was offered at a limited number of sites, most located in city centres, convenient for people rough sleeping or in central hostels, but less accessible for people living further away due to poor health, transit costs, and commuting distance. Although outreach was employed by most services, this could have limited geographical reach:

> The centralisation, in a sense, of services I think is a barrier… [I]f I lived in [deprived suburb]… it's really disconnected… We went out to hostels and things like that and we did home delivery, but the hostels are quite centralised when you look at the whole of [the city]. (Patrick, provider)

For others, regardless of physical accessibility, presentation to services would not occur under most circumstances. A lack of trust in health professionals and drug services were key reasons reported for not entering these spaces or disclosing use. Distrust may stem from previous negative experiences, with punitive service-level responses to disclosure of injecting drug use related by some participants (impacting, for example, how their OST was prescribed). For others, stigma and shame associated with crack use incentivised keeping their use hidden. Bradley, for example, describes himself as a 'secret smoker', with much to lose (professional, family, and social reputation) if his crack use became known:

> I hide it on the street, I don't carry a pipe… because obviously I do things like I play football, I've got my kids, I dress well … I don't want people knowing, so there should be a place where like what is discreet for anybody … a secret smoker, to be able to get help, because them secret smokers are the, probably the people that smoke it more than anyone. (Bradley, focus group)

Engagement is not necessarily desirable given risk of drug use disclosure to personal and professional lives. Similarly, drug use and the treatment system can be experienced in highly gendered and racialised ways that can further entrench stigma or distrust for women and minoritised ethnic or cultural groups. Clients at SIPP services were often predominantly male and white which may not facilitate a welcoming space for others. While some providers felt SIPP provision increased new presentations among women, reported by one service in particular, others saw no change, with a provider commenting that SIPP "really replicated the pre-existing imbalance in service provision to men versus women" (Patrick, interview). For new clients who could have been open to additional support, staff attitudes and practices may have constrained their engagement opportunity.

Organisational structure and aims appeared to inform provider support towards SIPP implementation, with the intervention more easily integrated into low-threshold harm reduction orientated services than those structured predominantly around treatment provision. In sites where clients perceived services as predominantly focused on abstinence ("All they seem to focus on is getting you off it", Katie), provider support for SIPP implementation was initially mixed. This could be seen in client's reaction to the intervention, indicating a departure from service norms: "I thought it were bullshit… It were strange but [SIPP] come out of nowhere, out of nowhere" (Roger, focus group). It is unsurprising therefore, that some clients reported limited provision of harm reduction information alongside SIPP kits even though SIPP training uptake was high. Over time, staff confidence in and support for the intervention increased, as the benefits became apparent:

> [A]t first I thought it'd be a waste of time… But the crack pipes, yeah, we've had people engaging. And a lot of crack users, well alcohol users, will use crack as well, and you don't know this, because they're not being drug screened… because they're coming in, they're asking for [pipes], they're seeing the workers and that… [S]o there's a lot of good benefits from it… I've come onboard with them being offered (Terry, provider)

One reason noted by clients for a potential lack of engagement by staff at the point of SIPP kit distribution was the lack of a tangible treatment offer to accompany it. For providers operating within services that offered opioid pharmacotherapy, this may have been a more acutely felt barrier to offering associated crack-related supports:

> Facilitator: [W]hen they were giving them [pipes] out, were they having a chat with you about them?
>
> Jim: No, no. It's like crack's not a problem … It's like they're not bothered. Because there's no solution for it… There's no alternative… There is for opiates… there's no alternative for crack cocaine. (client focus group)

This can reinforce the pre-existing service orientation toward people who use opioids, and led to some frustration among providers across sites about the limited options available for people who wanted help to reduce or cease their crack use:

> …[I]t's sad that people, you know, people want help, crack users want the help, but it's there's nothing you know, to get people into treatment, and service … But this [intervention] has shown people

will come in, but and then it's having the services in place so we can actually help all these people (Ricky, provider)

Last, as illustrated in previous sections, clients frequently have multiple health and social care needs. Providers are, however, limited in their ability to support complex needs in-house, and referrals to specialist and community services do not necessarily result in access to care. As Ginger notes, many services are not well configured to work with marginalised populations, lacking the required flexibility to support access:

Their tolerance for service users… is really, really low. If they miss a couple of appointments… Someone who is housed, who maybe has alright mental health, who isn't a drug user… it's not going to be the same, you can't enforce the same kind of rules. (Ginger, provider)

Mandatory abstinence from drugs to access some housing and mental health services is a salient example of misaligned requirements between drug and other service providers. Client reports of experiencing discrimination and shame in services are common, particularly in secondary care. These challenges, for providers and clients, can limit the benefit of SIPP-related referrals, with people both not being accepted for secondary care or choosing to avoid such settings even when in need.

Discussion

This study explored how people who use crack engage with English drug services before and after the introduction of SIPP. Prior to the intervention there was a dearth of crack-specific support and knowledge in services. After SIPP implementation, providers reported increased crack-related contacts, including new clients and disclosure among those in service, generally supported by a more knowledgeable, confident workforce. Differing service delivery structures and philosophies shaped how these contacts extended to engagement in practice, impacting the provision of additional supports, though pre-existing barriers could also limit access and uptake.

The Black Review of English drug services found that "crack cocaine users… do not receive an adequate or any service, but are at great risk" (Black, 2021).– SIPP has been piloted as an intervention designed specifically for the needs of this population. Our findings support Dame Carol Black's observations, reflecting low levels of crack-related supports (such as lack of pharmacotherapy or equipment options) and workforce capacity at baseline. Long-term funding cuts have resulted in a general loss of expertise and professional training in drug services (Black, 2021), leaving workers without the specialist practical knowledge about drug use, in this case crack, that clients highly value (Neale, 1998; Poliquin et al., 2022; Wylie, 2010). The SIPP intervention helped attract new people to services and, to the best of the authors' knowledge, is the first inhalation equipment provision study to document existing clients disclosing their crack use for the first time. These results have positive implications for increasing service engagement among this population. Alongside equipment provision, the upskilling resulting from the training component of the intervention is important to ensure that the workforce can provide quality care when these clients present or disclose.

The increase in contact with services identified in this paper is supported by quantitative study findings, evidencing first-time presentations and increased presentations during the intervention period (Platt et al., under review; Sharpe et al., forthcoming). Increased contact with more informed workers presents opportunity to deliver health and social care support. Delivery of these supports in-house can facilitate uptake, given drug services are often the preferred or primary setting for many people who use drugs due to their generally less stigmatising and more flexible environment (Biancarelli et al., 2019; Harris et al., 2013; McNeil & Small, 2014; Neale et al., 2008). The English care system is however, highly siloed, and external referrals can present barriers for clients. For example, multiple UK reports have found that clients have had their referrals to mental health services rejected due to ongoing drug use (Bratt, 2020, 2024; Hughes et al., 2024;) contrary to national guidance (National Institute for Health & Care Excellence, 2019; Public Health England, 2017, Public Health England, 2018). For future SIPP delivery, it is critical that infrastructure is in place to ensure clients brought into contact with drug services can access necessary care and that providers are adequately trained on the practicalities of crack use to be a respected source of information for service users.

Making contact is a necessary first step in supporting largely 'hidden' populations, like people who use crack (Lloyd et al., 2025; Public Health England & Home, 2019), and harm reduction services are well placed to do this. Generally, harm reduction based services offer practical support in low-barrier, non-judgemental environments, attractive to marginalised populations and those who may not be seeking abstinence or drug treatment (Lee & Zerai, 2010; Poliquin et al., 2022). A staff-client relationship can be integral to this model so for many staff working at these organisations or in harm reduction roles, contact from SIPP itself was a part of engagement. It offered an opportunity to connect with clients, which staff viewed as their responsibility to nurture and support.

Since the early 2010s, UK drug policy and service practice has shifted towards abstinence-oriented recovery compared to the stronger harm reduction focus of the 1980s (Dennis et al., 2020; Jauffret-Roustide et al., 2022;). Closely mirroring this shift were changes in how drug services were evaluated, from process- to outcome-based metrics (Floodgate, 2017). Drug service funding is not directly tied to outcomes but service contracts operate in a highly competitive procurement environment with tight financial constraints (Black, 2021; Robertson et al., 2021). This has historically raised concern that providers might be incentivised to prioritise targets over clinical need (Floodgate, 2017; Sheridan et al., 2011), and arises in our study as an ongoing issue. The number of people in or completing treatment are key metrics for the UK's drug strategy framework (Home Office, 2023), but there is a much less robust treatment offer for crack than opioids (Clinical Guidelines on Drug Misuse & Dependence Independent Expert Working Group, 2017), making outcome-based success more achievable for those using heroin. As evidenced in this study, this may inadvertently incentivise services to deprioritise crack use, distorting the problem of crack systematically, and in turn reinforcing deprioritisation. This is particularly concerning as even with a limited service offer, the number of crack-only presentations to English treatment services has been increasing since 2021/22 (Office for Health Improvement & Disparities, 2025a). Prevalence estimates are therefore likely conservative at best, a concern given current policy prioritisation and workforce capacity.

Increasing engagement among people who use crack and marginalised populations more widely invites an expansion in low-threshold harm reduction services. Supports such as SIPP can help providers facilitate space for harm reduction to be a more comprehensive approach to care, going beyond an "interim strategy… to keep [people] alive until they achieve the primary goal of abstinence" (Jauffret-Roustide et al., 2022; p. S100). Similarly, outcomes that measure processes, like staff-client relationships, can give providers more flexibility in supporting their clients and recognising personalised goals. This might require prioritising financial, housing, and relationship issues, over those specific to drug use, as noted in other studies (Marcellus et al., 2014; Ruefli & Rogers, 2004). Expanding acceptable measures of success may also facilitate an expansion of available therapies. For example, pharmacotherapies show promise for supporting people using stimulants (Amin-Esmaeili et al., 2024; Ronsley et al., 2020) and are currently endorsed by the US clinical guidelines for managing stimulant use disorder (Clinical Guideline Committee Members et al., 2024). From the perspective of people using illicit stimulants in Canada, the potential benefits of stimulant pharmacotherapy related to accessing a safer drug supply, reduced risk associated with criminalised drug use, and increased agency over their drug use (Fleming et al., 2024). Stimulant pharmacotherapy availability could also assist staff working in more medicalised service environments who may

experience challenges in providing a harm reduction intervention such as SIPP without an associated treatment offer.

Although SIPP facilitated new client contacts with services, structural barriers such as availability of public transportation or travel costs limit universal access (Thomas et al., 2020). Similar contextual and structural issues were identified in Canadian SIPP evaluations, with limited service operating hours, geographic location and outreach capacity associated with difficulty accessing pipes (Ivsins et al., 2011; Ti et al., 2012). Trust in services as well as drug-related stigma and fear of exposure kept others from accessing supports, with these issues often compounded among people experiencing intersectional stigma in relation to gender identity, ethnicity and/or sexuality (Adley et al., 2025; Douglass et al., 2023; Hammarlund et al., 2018). Calls have been made for more specialist services to support minoritised populations, improve workforce cultural competency among staff and generalist service provision to improve equity in access (Collective Voice, 2023; Dennis, 2023). These issues are all pertinent to SIPP delivery at scale, to support both contact and engagement. Innovation in outreach delivery holds promise, with an international review reporting that proportionately more people reached by NSP outreach have a shorter history of injection drug use, inject cocaine, and were Black compared to fixed-site or pharmacy-based NSPs (Jones et al., 2016). Additionally if, like needle and syringes (Craine et al., 2010; Hayes et al., 2022), secondary supply of smoking equipment by peers or other forms of discreet distribution, such as mail delivery, can reach different populations than those presenting to treatment, this can ensure that – for people where the risks of service engagement outweigh benefits – they can still access important health care supplies.

Within the existing system constraints, the SIPP study demonstrates value in increasing contact with drug services among this historically overlooked population. The potential for improved prevention, screening, and treatment opportunities suggest that Section 9a of the Misuse of Drugs Act 1971 should be amended to allow for the distribution of smoking or inhalation equipment. This amendment would also expand opportunities to engage other marginalised groups. For example, in the UK context, methamphetamine is predominantly used among men who have sex with men in sexualised drug settings (Edmundson et al., 2018). This is a population also underserved by the existing treatment system (Black, 2021) and for whom stimulant inhalation pipe provision could be valuable. Methamphetamine, like crack, is both inhaled and injected. Pipe provision provides not only a point of contact with services, but enhances injection route transition opportunity.

Limitations

Three of four intervention providers were low-threshold services. This is not necessarily reflective of the broader UK drug service landscape, which is represented through one intervention site and control site providers. It was possible that in interviews, particularly with providers, participants emphasised positive outcomes associated with SIPP. While we specifically inquired as to unintended consequences or barriers, we also aimed to overcome this potential bias by including experiences and beliefs regarding general system barriers that had implications for SIPP-related engagement. Although purposive sampling was employed, it was not always possible to recruit a diverse population. Most respondents using crack were white and male which will limit understandings about service engagement among women and ethnically minoritised people.

Conclusion

The SIPP intervention was introduced into a service landscape with few specific supports for people who use crack. This study documented how the introduction of SIPP, offering provider training and smoking equipment provision, facilitated contact and shaped engagement in services. The SIPP intervention facilitated new presentations, disclosure of crack use among existing clients, and acted as a 'gateway' to other supports, aided by a more knowledgeable work force. Due to increased visibility facilitated by SIPP among this marginalised and growing population, the Misuse of Drugs Act 1971 should be changed to allow for the distribution of smoking equipment. However, there are constraints on service delivery associated with organisational structures and availability of crack-specific treatment offers limiting the engagement potential of SIPP. To maximise opportunities presented by increased contact with services, future research and programme planning should explore improved treatment offers for crack, expanded outreach approaches, more integrated care, and reconsider metrics evaluating drug services.

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CRediT authorship contribution statement

Casey Sharpe: Writing – review & editing, Writing – original draft, Methodology, Investigation, Formal analysis, Data curation. **Joanna Busza:** Writing – review & editing, Conceptualization. **Cedomir Vuckovic:** Writing – review & editing, Investigation. **Jenny Scott:** Writing – review & editing, Conceptualization. **Vivian Hope:** Writing – review & editing, Conceptualization. **Mat Southwell:** Writing – review & editing, Investigation, Conceptualization. **Louise Wilkins:** Writing – review & editing, Conceptualization. **Lucy Platt:** Writing – review & editing, Conceptualization. **Magdalena Harris:** Writing – review & editing, Writing – original draft, Supervision, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

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