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One new drug a week

Why novel psychoactive substances and club drugs need a different response from UK treatment providers

Faculty of Addictions Psychiatry,
Royal College of Psychiatrists

FACULTY REPORT

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Future trends in addictions – discussion paper 2

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Introduction

Drug use in the UK is changing. Ten years ago, reports describing the harms of substance use were dominated by illegal drugs such as heroin, crack and ecstasy. A decade later, a new set of drug-related problems has emerged with:

- the increasing availability of drugs deliberately manufactured to legally mimic the effects of traditional recreational drugs (often known as legal highs or novel psychoactive substances (NPS))
- a consistent climb in the number of people presenting to treatment services with problems related to the use of drugs associated with the nightclub, festival and party scene – these include illegal drugs (such as methamphetamine), drugs which were legal but are now controlled (such as mephedrone) and drugs which are currently legal (such as salvia)
- an awareness that our health services are not equipped to address the serious harms that NPS and club drug users are now reporting and were instead designed to deal with the drugs and dangers of the past decade.

New problems

We currently know that:

- approximately 1 million adults use club drugs every year in the UK (National Treatment Agency for Substance Misuse, 2012)
- on average, one new NPS is made available for sale each week on the European and online market, with these being potentially available to users in the UK via online retailers (European Monitoring Centre for Drugs and Drug Addiction, 2012)
- club drug and NPS users are reporting harm such as extreme toxic reactions, heart irregularities, damage to internal organs, overdose and hospital admission, mental health problems and the development of longer-term physical and psychological dependency (Bowden-Jones, 2013).

New needs

We are also witnessing a steady (and growing) demand for treatment from these users.

For example, among people aged 18 or over presenting to treatment for a club drug problem in England between 2011/12 and 2012/13 (National Drug Treatment Monitoring Service, 2013a), there was:

- a 32% increase in the number of presentations
- an 81% increase in mephedrone presentations
- a 79% rise in methamphetamine presentations.

Club drug users in England now constitute 5% of all adult presentations for drug treatment (National Drug Treatment Monitoring Service, 2013a) and 14% of all presentations by those under 18 (National Drug Treatment Monitoring Service, 2013b).

New users

Significantly, we now also know (National Treatment Agency for Substance Misuse, 2012) that:

- so far, the UK's heroin and crack users have not switched to using club drugs and NPS – instead, a new population of users has emerged
- this population is composed of a mosaic of different social groups including students, people who identify themselves as 'clubbers' and lesbian, gay, bisexual and transgender (LGBT) communities
- many of these people are reported to be reluctant to get help from drug treatment services that they perceive as being for 'problem' alcohol, heroin and crack users only.

Although they do not form the majority of people presenting for drug treatment, club drug and NPS users do represent a group that requires our intervention now.

Can our current services meet this need?

Currently, the answer is no. Consequently, while some commentators note that 'time will tell' about the future demand for treatment among club drug and NPS users (National Treatment Agency for Substance Misuse, 2012), inaction is not an option.

This briefing therefore outlines six steps to address NPS and club drug harm:

- **Step 1: Widen the front door.** Many club drug users do not see traditional drug services as meeting their needs, but being more for heroin and crack users. Services need to work to change this attitude by making the needs of club drug and NPS users 'core business' and placing them on an equal footing with alcohol and opiate treatment.
- **Step 2: Support the front line.** Many front line healthcare staff do not have sufficient knowledge or skills to manage harm related to club drug and NPS use. Drug service staff need to be educated about these drugs and given skills to intervene and provide treatment, to help people recover and bring about improvements in their lives. At the same time, non-drug service staff – in settings which will see club drug and NPS users such as accident and emergency or sexual health clinics – should receive training.
- **Step 3: 'Connect' the front line.** Arguably because of their negative perceptions of existing drug services, club drug and NPS users draw on a range of health services, including emergency and urgent care departments, acute care hospitals, mental health services and sexual health clinics. Such non-specialist services need to establish much better links with drug services so that specialist support and expertise can be shared, onward referrals can be made more effectively and intelligence and insight can be exchanged. Furthermore, a clear need exists to also develop recovery and support pathways so that club drug and NPS users can achieve sustainable improvements.
- **Step 4: Watch all horizons for harm.** New club drugs and NPS are emerging all the time and their harmful effects are poorly understood. Patterns of use are also rapidly changing. Therefore data on the harm from NPS and club drugs should be recorded not only from drug and alcohol services, but also accident and emergency/acute care settings, primary care, sexual health services and mental health services. This will require national monitoring systems to be revised and reworked to achieve this.
- **Step 5: Promote research into NPS and club drugs.** Given the robust body of evidence supporting treatment interventions for 'established' drugs such as heroin, research funders should rebalance and prioritise new funding programmes into interventions for club drug and NPS users.
- **Step 6: Empower users through education.** Many users and the general public have little idea about emerging NPS and club drugs or their potential for serious harm. However, existing information on promoting positive health and reducing the harm associated with these drugs is of varying quality. Consequently, preventing initiation of club drug and NPS use through access to reliable information is a priority.

What are novel psychoactive substances and club drugs?

Drug use in the UK is changing. Commentators ranging from the Advisory Council on the Misuse of Drugs to *Mixmag* all concur that a new population of 'club drug' and novel psychoactive substance users has emerged in the UK.

- **NPS** are drugs that mimic, or claim to mimic, the effects of traditional recreational drugs. Critically, they are synthesised by manufacturers to evade detection and legal prohibition. To avoid regulation under the Medicines Act 1968, NPS are often marketed as 'not for human consumption' and sold under the guise of bath salts, research chemicals or plant food.
- **Club drugs** are psychoactive substances that are used recreationally in nightclubs, bars, at festivals, music events, circuit and house parties. They include established illegal drugs (such as amphetamine/methamphetamine, cocaine, ketamine, 3,4-methylenedioxy-*N*-methylamphetamine (MDMA), lysergic acid diethylamide (LSD)), drugs which were legal but are now controlled (mephedrone, γ-hydroxybutyric acid (GHB)/γ-butyrolactone (GBL)) and currently legal drugs.

While not replacing traditional drugs such as heroin and crack (which are used by a different population), club drugs and NPS are now attracting increasing public attention and concern.

Origins

From the use of cocaine at 'flapper parties' in 1920s New York, Paris and London, through to the rise of online global drug markets in 2014, people have continued to produce, sell and use drugs in ever changing forms (Fig. 1). While the 1980s and 1990s witnessed a significant increase in drug use in the UK, overall drug use has now either stabilised or is falling (Home Office, 2014). Set against this decline in consumption, however, has been the emergence of NPS and club drugs.

The origins of these drugs is debated (Drug Scope, 2014). Some commentators point to the turn of the 20th century and the synthesis of MDMA and methamphetamine. Others look to the music counter-cultures of psychedelia (1960s), punk (1970s) and dance culture (1980s onwards) as well as the now established influence and tastes of the LGBT scenes (National Treatment Agency for Substance Misuse, 2012). Meanwhile, many point to the growth of the internet as key to the manufacture and sale of NPS, with this facilitating a global information exchange among users about new drugs and their effects and a relatively secure means of collecting payments and dispatching drugs across national borders (Drug Scope, 2014).

Looking ahead

What is clear is that NPS and club drugs are evolving and will continue to change over the next decade, as will the contexts, behaviours and individuals using and selling them. Consequently, it is vital that the UK's existing drug services keep pace with this new trajectory, as well as meeting the demands of more established substance misuse problems associated with alcohol, heroin and crack cocaine.

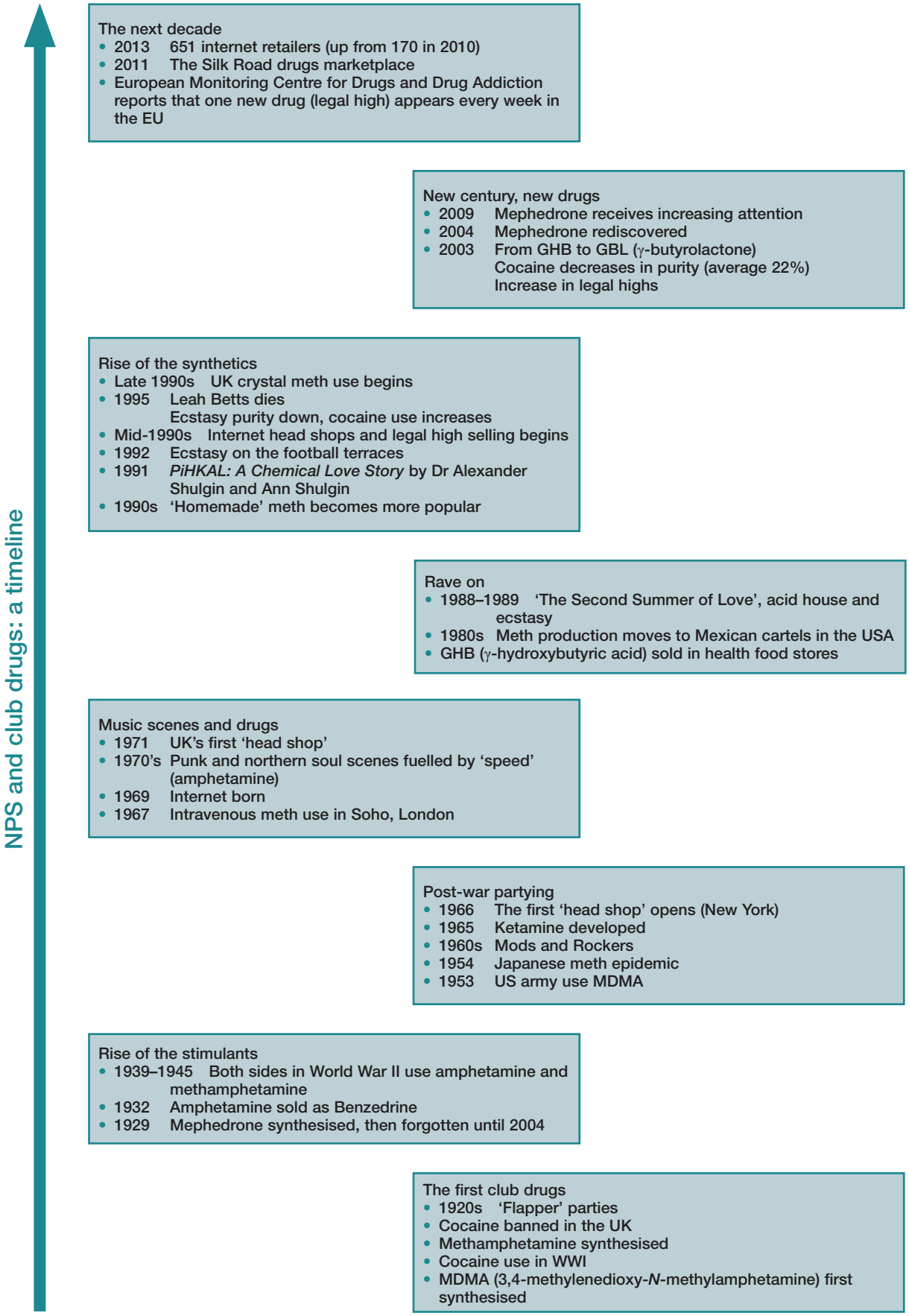

Fig. 1 NPS and club drugs: a short history. Source: Club Drug Clinic (2013).

What is the problem?

Problem one: serious harm

Just as club drugs and NPS can bring about pleasure, so too can they bring about serious harm (Table 1). It is a mistake therefore to consider these drugs as recreational, niche and largely harmless. Instead, there is already evidence that:

- Developed as an industrial solvent, **GHB** poses a serious risk, with a very narrow difference between a recreational dose that will induce euphoria and one that will result in unconsciousness, coma and death (Club Drug Clinic, 2013). This risk is heightened due to the short-acting effects of the drug, meaning users having to take repeated 'shots'.
- Long-term **methamphetamine** use can result in serious psychotic mental states, suicidal thoughts during withdrawal and physical effects such as dental rotting ('meth mouth'), skin lesions (from picking skin during hallucinations of 'meth bugs'), the risk of seizures and strokes, and heightened exposure to blood-borne viruses (due to increased sex drive and decreased inhibition).
- Originally developed (and still used) as a hospital anaesthetic, **ketamine** use can result in bladder and kidney problems (including passing blood in urine, pain on urination due to ulceration, shrinkage of the bladder and 'ketamine cramps'), as well as long-term effects such as anxiety, panic attacks, depression, paranoia and delusions.
- Banned in the UK in 2010, **mephedrone** use has been reported as being linked with heart problems, agitation and psychosis, as well as an increased sex drive and 'chem sex' which can lead to heightened risk of infection, HIV and other sexually transmitted infections.
- **Synthetic cannabinoids** are natural herbs that are sprayed with synthetic chemicals to mimic the effects of herbal cannabis. Often much more potent than cannabis they appear to cause greater psychological harms and there are also reports of a range of physical and psychiatric complications including rapid heart rate, vomiting and psychotic symptoms.

As club drugs and NPS become more established, other associated harm may take time to emerge, particularly in relation to the newer substances where it is too early to predict the negative effects of their use.

Critically, with some notable exceptions, information made available to the public about NPS and club drug use is of varying quality. Preventing initiation of club drug and NPS use through access to good information is a priority, as is reducing the harm caused by their use (e.g. by including advice on safe injecting, risks related to sexual health when on drugs and guidance to groups at higher risk including men who have sex with men, young professionals and clubbers).

> **'Just because a substance is termed "legal" this does not make it safe, nor may it be legal.'**
> (Advisory Council on the Misuse of Drugs, 2011)

Problem two: new users, more drugs

New users

One million people are estimated to use club drugs each year in the UK (Fig. 2). While overall drug use is in decline in the UK (see, for example, Home Office, 2013), a concerning number of adults and young people continue to report using club drugs and NPS (Fig. 2).

It is not solely the large number of people using club drugs and NPS that is a problem. We also need to recognise that the UK's heroin and crack users have not generally switched to using a

Table 1 Club drugs and NPS: highs, lows, and dangers			
	GHB (GBL, 'G', γ-hydroxybutyrate, liquid ecstasy, liquid X, scoop, soap)	**Methamphetamine (crystal meth, crystal, ice, glass, Tina, Christine, yaba, krank, tweak)**	**Ketamine (K, ket, green, special K, super K, vitamin K, lady K, cat valium, kit-kat)**
Dangers	Dependence and severe withdrawals Confusion and loss of consciousness Accidental overdose, decreased sexual inhibitions, delirium, paranoia, aggression, hallucinations	Dependence and severe withdrawals Out-of-character violent behaviour; depression, anxiety, suicidal thoughts (particularly when withdrawing), psychosis Decreased sexual inhibitions	Bladder and kidney damage Memory impairment Anxiety, panic attacks, depression, paranoia and delusions
Lows	Nausea, confusion, drowsiness, seizures, temporary amnesia, shaking, headaches, unconsciousness	Agitation, paranoia, chest pain, nausea/vomiting, anxiety	Loss of coordination and perceptual disturbance Difficulties in speaking, numbness, nausea/vomiting, racing heart and respiratory problems
Highs	Relaxation, euphoria, heightened sex drive, increased sensuality and sociability	Intense rush, euphoria, increased energy, decreased appetite, heightened sex drive and sociability	In a club: stimulating, energy and euphoria; in a relaxed space: 'trippy', floating and increased insight
Looks	Colourless, odourless salty liquid in a small bottle, as powder or capsules	Tablet (yaba), powder or crystals Usually white and can smell of urine	Liquid form or a grainy white powder Can also come as a pill
Use	Capfuls, eye droppers or teaspoons, mixed with drink or taken neat Short lifespan (used often)	Swallowed, rubbed in gums, snorted, put in anus, injected, smoked (ice); may be taken in 'runs' lasting days	Powder: snorted, added to drinks, smoked Liquid versions: injected
	Mephedrone (meph, MC, MCAT, m-cat, 4-MMC, miaow, meow meow, bubble, bounce)	**MDMA (ecstasy: E, pills, mandy, beans, XTC, brownies, mitsubishis, rolexes)**	**Cocaine (coke, Charlie, snow, blow, toot, nose candy)**
Dangers	Reported deaths Heart problems, agitation, psychosis Increased sex drive (risk of infection, HIV, sexually transmitted diseases)	Long-term body changes can include liver damage, heart problems, stroke, as well as memory and brain impairment	Long-term body changes can include heart attacks, chest pain, breathing problems, ulcers, nose bleeds, perforated septum, throat and stomach problems, strokes
Lows	Blurred vision, muscular tension, erectile dysfunction, nausea, anxiety, depression, paranoia, delusions	Anxiety, paranoia, not feeling real (unpleasantly), risk-taking, confusion Withdrawal/come-down symptoms: low mood, increased anxiety, sleeping difficulties	Increased heart rate, irritability, aggressiveness, paranoia Withdrawal/come-down symptoms: anxiety, loss of sex drive, paranoia, depression, suicidality
Highs	Rushes, euphoria, energy, increased sex drive, time distortions, sometimes visual hallucinations with heavy use	Intense pleasure, high mood, increased empathy, physical energy, enhanced confidence	Euphoria, mental alertness, increased self-confidence and energy, different ways of thinking
Looks	White/slightly yellowish powder or fine crystals Capsules or tablets of different colours, shape and thickness	Pills, capsules, or as a white powder	White (sometimes lumpy) powder
Use	Snorting, 'dabbing' with a moistened finger, swallowing, dissolving in liquid, injecting, rectal use	Swallowed as a pill, mixed in a drink, wrapped in cigarette paper, snorted, dabbed on gums, injected	Usually snorted, can be injected or anally inserted ('booty bump')

different set of drugs, but we have instead witnessed the emergence of a new and diverse population of users. This includes students, people who identify themselves as clubbers and LGBT communities. Recognising and understanding the different groups that make up this new population is important, as it is a mistake to think that they are 'just like' users of more established drugs. Instead, existing drug services need to understand the different ways in which these groups will use club drugs and NPS. For example, drugs such as mephedrone are used by some gay men to sustain and enhance sexual experiences ('chem sex') and this will mean extending assessments to incorporate issues of sexual risk-taking behaviour.

Drug services will also need to understand that – unlike heroin and crack users – people who take club drugs and NPS are more likely to be employed and have established social networks. Some club drug treatment services have reported employment rates of around 50% compared with rates of around 15% among users of more established drugs (Bowden-Jones, 2013; Drug Scope, 2014). Most significantly, however, the biggest difference and potential challenge is that users of club drugs and NPS may not perceive existing drug treatment services as being for them – instead they are seen as places that are for 'problem' alcohol, heroin and crack users (Drug Scope, 2014). This is a critical challenge and one we return to in the next section.

More drugs

On average, one new type of NPS is made available for sale in Europe each week and internet outlets selling NPS to European countries continue to grow in number (European Monitoring Centre for Drugs and Drug Addiction, 2012). The European Monitoring Centre for Drugs and Drug Addiction reported that in 2013, a record number of NPS (81) were detected for the first time in Europe. This is up from 74 new NPS in 2012, 49 in 2011 and 41 in 2010 (European Monitoring Centre for Drugs and Drug Addiction, 2013). The European Monitoring Centre has also tracked the steady rise of internet outlets selling NPS and internet forums created for users to disseminate information about the psychoactive effects of different chemicals.

Taken together, the UK is experiencing a situation where an increasing number of NPS are being potentially made available and where these NPS can bring about serious mental and physical health harm.

A European high

In the Eurobarometer Survey (TNS Political and Social, 2014), a comparison was made between drug use in the countries of the European Union. This found that the UK had a reported prevalence of 'legal high' use among 15- to 24-year-olds of approximately 10%, compared with an average of 8% for all European countries.

Problem three: unprepared services

Drug services are faced with a steady and growing demand for treatment from people who are using club drugs or NPS. For example, 5% of all adult presentations for drug treatment in England are club drug users (National Drug Treatment Monitoring Service, 2013a) and for people under 18 presenting for drug treatment that figure is 14% (National Drug Treatment Monitoring Service, 2013b). See Table 2 (p. 12) for further details on the situation in England, Scotland and Wales.

However, despite this growing demand, a number of obstacles to meeting this need exist.

Users are looking elsewhere

As noted earlier, some club drug and NPS users do not see existing drug treatment services as 'being for them' (National Treatment Agency for Substance Misuse, 2012), and therefore turn to other non-specialist services. Consequently, the 'treatment front line' does not only take in specialist drug treatment services, but also winds its way through the UK's emergency and urgent care departments, acute care hospitals, mental health services and sexual health clinics. Critically, front line staff in these non-specialist settings report not feeling confident in identifying, assessing and delivering interventions to club drug and NPS users or knowing when (and how) to refer onwards for more specialised treatment (National Treatment Agency for Substance Misuse, 2012). There is a pressing need to close the gap and build far stronger and

Drug use in the UK: NPS and club drugs

Scotland

Adults aged 16 and over reporting drug use in the past year (2012/2013):

- 75 000 took cocaine (1.7%)
- 57 000 ecstasy (1.3%)
- 17 600 mephedrone (0.4%)
- 8800 ketamine (0.2%)
- 22 000 (0.5%) took mephedrone, BZP, GBL, synthetic cannabinoids, khat or salvia divinorum

Adults aged 16–24 reporting drug use in the past year (2012/2013):

- 23 000 took cocaine (3.7%)
- 21 000 ecstasy (3.4%)
- 10 000 mephedrone (1.6%)
- 3000 ketamine (0.5%)
- 4400 (0.7%) took mephedrone, BZP, GBL, synthetic cannabinoids, khat or salvia divinorum

Source: Robertson & Bates (2014).

Northern Ireland

Adults aged 15–64 reporting drug use in the past year (2010/2011):

- 18 000 took powder cocaine (1.5%)
- 13 000 ecstasy (1.1%)
- 13 000 mephedrone (1.1%)
- 12 000 legal highs (1%)

Adults aged 15–34 reporting drug use in the past year (2010/2011):

- 12 000 took powder cocaine (2.5%)
- 10 000 ecstasy (2%)
- 11 000 mephedrone (2.2%)
- 10 000 legal highs (2%)

Source: National Advisory Committee on Drugs & Public Health Information and Research Branch (2012).

England and Wales

Adults aged 16–59 reporting drug use in the past year (2013/2014):

- 743 000 took powder cocaine (2.4% of 16–59 year olds)
- 500 000 ecstasy (1.6%)
- 205 000 mephedrone (0.6%)
- 189 000 ketamine (0.6%)
- 25 000 methamphetamine (0.1%)
- 0.5% salvia and 2.3% nitrous oxide

Adults aged 16–24 reporting drug use in the past year (2013/2014):

- 258 000 took powder cocaine (4.2% of 16–24 year olds)
- 237 000 ecstasy (3.9%)
- 115 000 mephedrone (1.9%)
- 110 000 ketamine (1.8%)
- 9000 methamphetamine (0.1%)
- 1.8% salvia and 7.6% nitrous oxide

Source: Home Office (2014).

Fig. 2 Drug use in the UK: NPS and club drugs (approximate figures).

supportive relationships between these front-line services and existing specialists in treating club drug and NPS users.

Our specialist services need development

There is a further related problem: to our knowledge, there are only a handful of specialist, dedicated services offering treatment for club drug and NPS use in the UK. Furthermore, although arrangements for the commissioning and provision of drug and alcohol services vary across the UK, these have historically focused on heroin- and crack cocaine-related harm.

Many of these specialist service staff are more familiar with an opiate and crack cocaine using population. Therefore, before they can provide support to non-specialist services they will need guidance and training in delivering interventions to club drug and NPS users. To achieve this, we need to build similarly stronger relationships between the UK's existing experts in treating club drug and NPS users and those existing drug and alcohol services which are now treating 'traditional' and 'new' drug use populations.

Our front-line services need to be linked together

Finally, as the range of services encountering club drug and NPS users is large, we need to ensure that front-line staff receive the information and support they require to deliver high-quality interventions, as well as sharing their knowledge of new drugs and local trends. We consider the solutions to this later in this report (see p. 13).

Drug treatment in the UK: NPS and club drugs

Table 2a England: Numbers of adults (aged 18 or over) making new presentations to treatment for club drug use[a]								
Substance	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13
GHB/GBL	18	46	66	80	142	135	190	231
Ketamine	114	235	392	558	675	845	751	868
Ecstasy	1872	2138	2102	1694	1467	1067	1018	1089
Methamphetamine	22	27	52	42	75	78	116	208
Mephedrone[b]	–	–	–	–	–	839	900	1630
Any club drug cited	1991	2371	2503	2246	2280	2692	2675	3536
All new presentations citing a club drug, %	2	3	3	3	3	4	4	5

Table 2b England: Numbers of young people (aged under 18) making new presentations to treatment for club drug use[a]								
Substance	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13
Ketamine	25	68	156	241	334	405	387	345
Ecstasy	1511	2112	2281	1644	1183	746	732	997
Mephedrone[b]	–	–	–	–	–	972	1065	1788
Any club drug cited	1534	2168	2390	1831	1556	1975	2007	2834
All new presentations citing a club drug, %	9	10	10	8	7	9	10	14

Table 2c Scotland: Numbers of individuals (all ages) reporting main drugs of misuse at initial treatment presentation								
Substance	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13
Ecstasy	–	80	92	51	36	22	29	–
Mephedrone	–	–	–	–	–	71	35	–

Table 2d Wales: Number of adults (aged 18 or over) presenting for treatment for club drug use								
Substance	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13
Ecstasy	21	44	33	17	16	12	17	12
GHB/GBL	–	10	1	7	5	5	3	2
Ketamine	3	4	10	26	30	26	30	58
Mephedrone	–	–	–	–	1	9	19	238
Methamphetamine	1	–	–	–	–	5	–	1

Table 2e Wales: Number of young people (under 18) presenting for treatment for club drug use								
Substance	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13
Ecstasy	11	18	25	2	1	2	–	1
Ketamine	2	2	7	7	6	2	3	3
Mephedrone	–	–	–	–	–	18	46	183
Methamphetamine	1	–	–	–	–	–	–	–

Sources: Table 2a, National Drug Treatment Monitoring Service (2013a); Table 2b, National Drug Treatment Monitoring Service (2013b); Table 2c, Health Improvement Team (2013); Table 2d & Table 2e, NHS Wales Informatics Service & Welsh Government, 2014).

a. A 'club drug user' was defined as a person citing any of the following substances, either as a primary or adjunctive drug: GHB/GBL, ketamine, ecstasy, methamphetamine or mephedrone.

b. A code for mephedrone was added to the NDTMS Core Data Set in 2010–11. Any clients reporting mephedrone prior to this are counted in the 'Any club drug cited' total but no separate total is given for mephedrone.

What is the solution?

Novel psychoactive substances and club drugs pose a series of problems to the health of the UK. So how can we respond to this challenge? This section outlines six steps that need to be taken within each of the UK countries.

Step 1: Widen the front door

As noted earlier, club drug and NPS users do not always see traditional drug services as meeting their needs. Existing drug services need to work to change this attitude by making the needs of club drug and NPS users 'core business' and on a par with alcohol and opiate treatment.

Drug services need to understand and meet the needs of the emerging population of drug users and the different cultural and social groups that make up this population. In essence, these services need to 'widen the front door' to encourage these groups to engage with treatment. This means services must respond to local need and be competent to detect, assess and manage people with club drug and NPS-related problems, even if onward referral to more specialist services is needed.

As outlined in Box 1, in addition to the skills and interventions offered by all existing drug services, new knowledge and skills are needed including the differing contexts of drug use, the provision of harm reduction interventions specific to particular club drugs, basic sexual health screening and treatment, and recovery pathways and clinical protocols for all treatments (e.g. medically assisted GHB/GBL detoxification).

Organisations responsible for strategically developing or commissioning local drug services will also need to ensure that the needs of club drug and NPS users are factored into service development plans.

Step 2: Support the front line

There is little to gain from investing in engagement programmes with club drug and NPS users (Step one), only to then realise that front-line staff do not feel they have the skills to identify problems, assess treatment and recovery need, deliver interventions, or refer users onwards. Consequently, all front-line staff need to receive accurate information and evidence, as well as skills training in working with club drug and NPS users. Related to this, specialist substance misuse services will need their staff to be trained in developing more complex interventions for club drugs and NPS.

To achieve this, we can reach staff through existing information networks or by developing new intelligence networks specifically for NPS and club drugs. This is becoming increasingly important given the speed at which new NPS are emerging.

One effective way to share and develop knowledge and best practice is through a clinical network. Clinical networks are groups of health professionals from different NHS organisations working together across institutional and local boundaries to provide care for a particular disease or patient group. Club drugs and NPS related-problems present across the health system and institutional and professional boundaries may delay sharing of information. A clinical network may provide an effective and cost-efficient way to share emerging clinical information between different geographical areas and professional disciplines.

While initial funding will be needed to develop such networks, they are important. This is because, for some NPS and club drugs, we already have the clinical evidence to take action and treat a range of presenting problems. These include 'ketamine bladder', the management of withdrawal from GHB/GBL, and methamphetamine-induced psychosis. This evidence needs to be evaluated and

Box 1 What would a good service for NPS and club drug users look like?

Generic drug services

Club drug users have many similar treatment needs and all services should provide:

- **a workforce appropriately trained in the detection, assessment and treatment of club drug-related problems**
- **a workforce with the cultural competence to engage club drug users**
- **systems to accurately record club drug-related harm (similar to heroin and crack harm recording)**
- **clear pathways to refer complex cases (e.g. GHB/GBL detoxifcation).**

Specialist club drug clinics

As well as the skills and interventions offered by generic drug services, services with particular expertise should also offer:

- **staff with detailed knowledge of a wide range of club drugs as well as their context of use**
- **engagement strategies aimed specifically at club drug users, targeting at-risk populations (students, squatters, young professionals, the LGBT community) and health and social care services likely to encounter problematic club drug use (sexual health clinics, emergency departments/acute care)**
- **staff with specific cultural competence (e.g. working with specific populations – LGBT, clubbers, students)**
- **staff skilled to undertake detailed assessment and clinical management of club drug-related problems (e.g. ketamine-related urological damage, GHB/GBL dependence, use in sexualised settings)**
- **provision of harm reduction interventions specific to particular club drugs and the offer of basic sexual health screening**
- **specific treatment pathways and clinical protocols for all treatments (e.g. medically assisted GHB/GBL detoxification)**
- **peer support and recovery pathways appropriate for different types of club drug users**
- **clear mechanisms to make detailed records of harm associated with club drug use (current data collection systems (NDTMS) and treatment outcome measures (TOP) are primarily for heroin and crack users); ideally this should be a nationally agreed tool to allow for consistent data recording across different services**
- **specific resources for club drug users providing latest information on harm**
- **well-developed pathways to, and from, sexual health, urology, child and adolescent and pain management services**
- **links to research/academic colleagues to collaborate on high-quality research on harm and interventions.**

shared with front-line staff. Furthermore, as the research evidence base grows, there will be a need to develop and disseminate evidence-based guidance and national best practice with appropriate implementation tools, to areas of the health service with a high prevalence of club drug/NPS-related harm.

Where clinical evidence does not currently exist for a specific drug, the initial approach to treatment should be pragmatic in drawing on proven interventions for other substances (e.g. in the absence of robust treatment trials for synthetic stimulants, approaches for established stimulants such as cocaine or amphetamines can be adapted). This is supported by observations that existing treatment providers do not yet feel they have the skills to manage emerging drugs and that the existing workforce feels poorly equipped to treat such new drug trends.

Step 3: 'Connect' the front line

As noted earlier, the NPS and club drug 'front line' runs far beyond treatment services for substance misuse and winds its way through the UK's emergency and urgent care departments, acute care hospitals, mental health services and sexual health clinics. Staff in these settings would clearly benefit from assistance in detecting, assessing and managing people with club drug/NPS-related problems, including onward referral.

Consequently, an urgent need exists to 'stitch together' the diverse range of services that make up this front line. This will help ensure that staff receive and share the information they require to deliver high-quality interventions, as well as building excellent referral and support links. There are three potential ways of achieving this.

1 **Develop a clinical network for NPS and club drug use**. As described in the previous section, these networks may provide an effective and cost-efficient way to share emerging clinical information between different geographical areas and professional disciplines.

2 **Develop a national monitoring system to record club drug/NPS-related harm from**

a range of services. Described in more detail in the next section of this briefing, this would involve a system for detecting emerging clinical harm and sharing information about it and potential treatment responses across the front line. This is particularly important given the appearance of so many new substances and will provide an infrastructure to link together the diverse range of services that encounter NPS and club drug users.

3 **Implement a 'hub and spoke' model.** This would involve each community-based drug and alcohol service (the spokes) integrating screening, assessment and evidence-based treatment for NPS and club drugs into their provision and treatment framework. These services would then be able to seek clinical advice where required, staff training, supervision, treatment protocols and research expertise from a series of central or regional 'hubs'. These hubs would not necessarily receive referrals or see patients, but would instead operate as a centre of clinical, training and research excellence. Taking such an approach would both help share learning among services and help NPS and club drug users with problems to engage with treatment, with improved access through the existing network of community drug and alcohol services.

Step 4: Watch all horizons for harm

Many NPS and club drugs are new and little is known about their short- or long-term harm. Importantly, although each of the UK nations have recently begun to develop and implement national monitoring systems to record NPS and club drug-related harm, data are only being collected from drug and alcohol services. This means that the horizons of emergency and urgent care, acute care, primary care, mental health services and sexual health settings are being overlooked.

The utility and coverage of national and UK data collection systems should be reviewed by the government agencies currently administering them and consideration should be given to their implementation across the health system to ensure that emerging harm is detected and monitored as early as possible.

A major step forward would be to establish monitoring systems to cover the following clinical areas.

- Accident and emergency/acute care services – early, acute harm related to emerging club drugs and NPS is likely to be first detected in these settings. A robust data collection system, linking the reason for acute presentation with drug use would be a crucial early indicator of harm.
- Emergency department presentation – there is no standardised national system currently for recording deaths related to club drug use.
- Primary care services – general practitioners (GPs) are typically the first point of access for people experiencing non-acute health problems. Many GPs are already familiar with detection and management of harmful substances such as alcohol and heroin and should be well placed to detect club drug and NPS use. Mechanisms are not currently in place to collect this information.
- Sexual health services – drug use can lead to disinhibition and this is particularly true for club drugs and NPS. This link between drug use and sexual health problems is important, as some club drug/NPS users may choose to present to sexual health services rather than drug services. This gives an opportunity to offer drug interventions in sexual health settings. National data collection tools already in place (such as Genitourinary Medicine Clinic Activity Dataset) should include club drug and NPS use in their data-sets.
- Mental health services – club drugs and NPS can produce a range of psychological problems that may present as acute or long-term mental health disorders including depression, anxiety or psychosis. Currently, mental health services have no system to record psychological harm related to club drugs and NPS. Psychiatric liaison services, which provide management in physical healthcare settings, are particularly important due to the higher levels of club drug and NPS problems they are likely to encounter.

Step 5: Promote research into NPS and club drugs

Given the increasing concern regarding club drugs and NPS, research funders should consider prioritising the development of new funding programmes into interventions to treat users of these newer drugs. This is important as both understanding and responding to the emerging developments in club drug and NPS use requires good-quality research.

Further research is needed to confirm whether existing approaches to drug management will also be effective for club drugs and NPS. Given the different populations and different contexts of use of club drugs and NPS, we cannot assume that what works for established drugs such as heroin will necessarily work for ketamine and GHB/GBL. One way of achieving this would be through developing a research network. This would bring together academics, researchers, patients, and carers with the aim of developing new research proposals and studies on club drug and NPS treatment interventions. Existing UK and international funding bodies should also be encouraged to prioritise research in this area.

Step 6: Empower users through education

Many users and the general public have little idea about the emerging NPS and club drugs or their potential for serious harm. Unhelpful terms such as 'legal highs' misinform the public and minimise the potential harm. Furthermore, there is relatively little up-to-date information available on emerging drugs. This is complicated by the trend among some users of consuming drugs (typically white, crystalline powder) with no knowledge of the chemical content.

Preventing initiation of club drug and NPS use through access to good information is a priority. For those currently using emerging drugs, advice on reducing harm is essential, including advice on safe injecting and risks related to sexual health when on drugs.

Although generic drug education has a relatively weak evidence base, targeting health information at high-risk groups including clubbing environments, universities and LGBT populations may be required. Harm reduction messages need to be developed and these will differ from those for heroin and crack cocaine to include new information. Public health commissioners should therefore invest in interventions aimed at: (a) reducing initiation of club drug and NPS use; (b) reducing the harm associated with using these drugs; and (c) developing clear recovery support pathways so users can achieve sustained improvements. This may require an expert group to be established to produce a public health resource for both the general public and club drug and NPS users.

Conclusions

The intention of this briefing has been to raise awareness of the rapidly changing patterns of drug use and related harm across the UK. These changes pose significant new risks to drug users and represent a clear challenge to health services. Importantly, this challenge is likely to grow as the number and availability of club drugs and novel psychoactive substances increase.

To help achieve this, we have set out six steps which we believe will help tackle this emerging problem. Consequently, we now call on health services, service developers, commissioners and government to review and act on these recommendations.

Although some of these solutions will require investment, we believe that they will result in longer-term savings across the health economy. This is particularly the case given that we know that good-quality treatment and intervention can transform people's lives in both health and economic terms. As illustrated in the case studies on p. 18, people experiencing often serious club drug/NPS-related harm can recover from these problems and go on to resume healthy personal and working lives.

To achieve this, however, we all need to overcome the most significant challenge currently facing us all: to accept that club drugs/NPS-related harm is inescapably part of the 'core business' of the health sector and that the time to address these emerging problems has now arrived.

Case studies: treatment changes lives

Case study 1

Eddie is a 28-year-old single gay man who works as the manager of a bar. He moved to London two years ago and started to 'party hard'. He mostly used MDMA and occasionally cocaine, but more recently was offered a 'shot' of GBL at a party. Eddie has always felt awkward and shy in social situations and found GBL improved his confidence. He has also experienced insomnia for several years and found that GBL helped with this. Initially, Eddie used GBL every other weekend and a few nights a week for sleep but his use rapidly escalated, first to nightly use, then to several times a day. By the time Eddie asked for help, he was using GBL every 2 hours and would experience severe withdrawals if he missed a dose. Eddie made contact with a drugs service that worked with club drug users and was offered medically assisted GBL detoxification as well as support in managing cravings. He was delighted to have 'escaped' from GBL and was determined to avoid it in the future. After a period of abstinence, Eddie began to address his self-esteem and lack of confidence through psychotherapy.

Case study 2

Gary is a 22-year-old chemistry student at university in London. He has used drugs since he was 16, particularly cannabis. At university he first tried hallucinogens and found them 'spiritual'. He began experimenting with a variety of different stimulants, which he read about online. Many of the drugs he took were purchased online as 'research chemicals'. Gary initially did not believe his drug use had any significant impact on his life. In his second year of study, Gary started using mephedrone, which he described as 'more-ish'. His use rapidly increased and his friends became worried about the effect the drug was having on him. He began using daily and on one occasion tried to inject mephedrone into a vein. Gary admitted that he felt moody and paranoid much of the time but found it very hard to reduce his use. After nearly 6 months of trying, his friends finally persuaded him to seek help and he attended a specialist drug service. At the service Gary was able to develop strategies to reduce his mephedrone use and manage his cravings. He also acknowledged for the first time that mephedrone was harming his friendships, his university work and his psychological health. Gary has taken a year out of his studies and remains in treatment. He has not used any drugs for 8 weeks.

Case study 3

Amy is a 30-year-old woman living in a squat in east London. Amy has lived as part of a traveller community for around 10 years and during most of this time has used a range of illicit substances including MDMA, amphetamines, cannabis and ketamine. Ketamine has been her main drug for the past 3 years and during that time her use has increased dramatically. Amy now cannot remember the last time she went a day without using ketamine and is using 'much more' than she used to. About a year ago, Amy noticed blood in her urine, which she thought might be an infection. Soon after she developed pain every time she urinated. It was not until she told a friend about her symptoms that she was told that it was likely to be the ketamine causing the bladder problems. As her pain worsened, Amy sought help from a specialist club drug service. She was given a plan to gradually reduce her ketamine use, but every time she attempted this, her bladder pain intensified, as the anaesthetic effect of the ketamine reduced. The pain was so severe that Amy used more ketamine to manage it, even though she knew in the longer term this would only worsen her symptoms. Amy was referred to a urologist and was given a pain management plan. This allowed her to successfully reduce, then stop her ketamine use. Amy stopped using ketamine 3 months ago and her bladder symptoms have resolved. She continues to use other drugs every few weeks but is determined to avoid ketamine at all costs.

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