New psychoactive substance use in Manchester: Prevalence, nature, challenges and responses

Rob Ralphs, Paul Gray and Anna Norton

Substance Use and Addictive Behaviours (SUAB) Research Group
Manchester Metropolitan University
Manchester City Council’s Community Safety Partnership Board commissioned and funded this research. We would like to thank Alex Aldridge, Lynn De Santis, Emily Wakeland and Lisa Williams for their support with the transcription and NVivo coding of the qualitative data, the development of cases studies and the editing of the final report. The research would not have been possible without the support and access that was facilitated by a number of individuals, organisations and services. We extend our gratitude to staff from 56 Dean Street, ADS, Big Change/C.A.N, the Booth Centre, CGL, Cheshire and Greater Manchester CRC, CORE, Eclypse (Lifeline), Greater Manchester Police, Homeless Link, the LGBT Foundation, Lifeshare, Manchester Royal Infirmary, Wythenshawe Hospital, the National Probation Service (North West), the REACH clinic, Riverside Housing, Urban Village Medical Practice and Victoria Housing. Together with the many individuals who we interviewed who gave up their time to speak candidly to us about their experiences of NPS. Finally, a special thanks to Debbie Jump, Julie Boyle and Kate Safe for their invaluable suggestions, links and contacts that served to enrich the research.
3.5.5 Mental health support needs
3.5.6 Scary Spice? The relationship between synthetic cannabinoid use, crime and disorder
3.6 Taking the strain: The impact of NPS use on services within Manchester
3.7 NPS recording and monitoring
3.8 NPS use and service user engagement
3.8.1 ‘It ain’t crack or smack’: The reasons why NPS users are not engaging with services
3.8.2 New substances = new needs = new services?
3.8.3 The changing profile of injecting users
3.8.4 Integrating mental health support and substance use services
3.9 Training and Knowledge
3.10 Developing a Greater Manchester local drug information system (LDIS)
3.11 Impact of the Psychoactive Substances Act 2016
3.11.1 What impact is the Act likely to have in a local context?
4 Recommendations
4.1 Development of resources
4.1.1 NPS briefing information sheets
4.1.2 Drug alerts and local drug information system (LDIS)
4.1.3 NPS training
4.2 Service development
4.2.1 Innovation in service delivery
4.2.2 Models of good practice
4.2.3 Improved NPS treatment pathways
4.2.4 Integrated service delivery
4.2.5 NPS user engagement strategy
4.3 Future research agendas
4.3.1 Developing monitoring and recording systems
4.3.2 The impact of NPS use on recovery journeys
4.3.3 The impact of NPS use on crime and disorder and offender management
4.3.4 Monitoring of the impact of the Psychoactive Substances Act 2016
4.3.5 Continued monitoring of emerging drug trends and markets
5 References
Executive summary

Section 1. Context
The overarching aim of the research – to explore the prevalence and nature of New Psychoactive Substance (hereafter referred to as ‘NPS’) use in Manchester – is outlined alongside the key objectives of the research:

- Gain a clearer understanding of the prevalence and nature of NPS use amongst targeted sub-populations in Manchester;
- Identify the harms associated with NPS use;
- Ascertain whether the needs of such sub-populations are being met, or not being met, by existing service provision;
- Identify any staff training and/or knowledge needs; and,
- Provide recommendations regarding the future development and delivery of services in Manchester.

This section also provides an overview of NPS definitions, key legislation (including the recently introduced Psychoactive Substance Act 2016) and a review of existing knowledge in relation to NPS prevalence, monitoring and motivations for use.

Section 2. Methodology
The research team employed a mixed-methods approach incorporating analysis of existing JSNA data, targeted surveys, interviews, focus groups and observations in city centre hot spots and headshops. The research focused on the following sub-populations: university students; clubbers; the homeless community; offenders released on license conditions; and MSM engaged in the chemsex scene.

Section 3. Findings
The first part of findings section (sections 3.1 to 3.5) is organised around the prevalence, nature and motivations of use amongst the targeted sub-populations identified in section 2. The second half of the findings section (sections 3.6 to 3.11) discusses the impact of NPS use on a range of services (section 3.6), the under reporting of NPS use and NPS related incidents (section 3.7), and reasons for the lack of engagement with services (section 3.8). Section 3.9 provides an overview of identified gaps in knowledge and training needs. Section 3.10 outlines the need and support for a local drugs information system (LDIS). Finally, section 3.11 considers the impact of the recently introduced Psychoactive Substances Act 2016 on availability and use of a range of NPS.

Students
Using an online survey, the research targeted Manchester’s student population to establish existing NPS prevalence and drug trends amongst this sub-population. Of the 134 students who completed the survey, the main NPS used was nitrous oxide with NPS users likely to be poly-drug users.

Clubbers
Over a third (788) of the 2,139 clubbers surveyed reported having ‘ever tried NPS’. The most popular NPS’s reported were ketamine and mephedrone. Just over a quarter (27 per cent) of NPS users reported having had a negative experience after taking NPS. Almost half (47 per cent) were poly-drug users and the concurrent ‘snorting’ of drugs such as ketamine, cocaine and MDMA was identified as needing a targeted harm reduction response.

Chemsex
This section focuses on the prevalence and service needs of men that have sex with men (MSM) who are engaged in chemsex. We begin by highlighting competing discourse around defining chemsex in a national and local context. Despite unequivocal praise for the recent integrated sexual health and substance use service – the REACH clinic – a number of suggestions for expanding the existing service provision are discussed which encompass debates about location, opening times, staffing, outreach and the integration of mental health and counselling support. The training needs of staff are considered.

Synthetic cannabinoid use amongst vulnerable groups
Observations in popular city centre headshops selling NPS found that over 90 percent of sales involved synthetic cannabinoids. High rates of prevalence and problematic use were established amongst homeless and offender populations. Prison was prominent in relation to onset of use whilst avoiding MDTs, supported accommodation and offender management substance use policies and self-medication were main motivations for continued use. Synthetic cannabinoids were perceived to be highly addictive both psychologically and physically (see section 3.5.3) with users reporting the rapid build-up of tolerance levels. Daily use was common with users reporting a need to use to override unpleasant withdrawal symptoms. Numerous examples of related harms are identified, including the development of mental health issues (see section 3.5.4) acquisitive crimes and violence (see section 3.5.6) and deaths attributed to use. We highlight the lack of user engagement with services and the need for more integrated mental health support (see section 3.5.5).

Taking the strain: The impact of NPS use on services within Manchester
The significant impact that NPS use is having on a range of services is illustrated. In particular, we demonstrate how the sale and use of NPS in the city centre has created a significant resourcing issue for the police and the medical service. We note how call outs for ambulances have increased sharply, as has the burden on A&E departments and supported accommodation providers.
NPS recording and monitoring
This section highlights that current recording and maintenance of routine data on NPS is flawed and likely to represent an underestimate of use. The lack of robust systems for recording NPS-related incidents was widespread among services and even in organisations that attempt to keep records their systems were inconsistent and ad hoc.

NPS use and service user engagement
This section explores the reasons why NPS users are not accessing the available support on offer. This includes NPS users’ stereotypical views of services as a place for injecting heroin and crack cocaine users, the location, the lack of substitute medication and perceived lack of service provider knowledge on how to treat NPS users. The need for more bespoke NPS services and interventions are discussed in relation to the changing profile of ‘problematic’, dependent and injecting users.

Training and knowledge gaps
The research identified a clear need for a revised model of training around NPS for staff working in frontline services. This section illustrates existing gaps, training needs, and the need for clear guidance on best practice.

Developing a Greater Manchester Local Drug Information System (LDIS)
This section evidences a significant demand for a local drug information sharing system (LDIS). The Public Health England LDIS guidance is introduced, which we argue would provide a platform to enable frontline staff to share knowledge gained from first-hand experiences and would thus help to educate staff on developing ‘good practice’, provide a centralised location for information, and for sharing up to date information on new substances and ‘bad batches’ (see also section 4.1.2).

Impact of the Psychoactive Substances Act 2016
The research concludes that the Psychoactive Substance Act 2016 will have little impact on availability and usage of many types of NPS use reported by the targeted sub-populations (see sections 3.2 to 3.5). We conclude that the main group of NPS users affected are synthetic cannabinoid users. The findings report the rapid establishment of a street level synthetic cannabinoid market that has led to an increase in prices. This, we suggest, will most likely lead to more incidents of violence amongst users and crimes being committed to fund dependent use (as reported in section 3.5.6).

Section 4. Recommendations
The recommendations centre upon three main themes: development of resources, service development and future research.

Development of resources
The findings (see section 3.7 in particular) identified a need to increase existing NPS related knowledge amongst specialist substance use providers and a wide range of other medical and non-medical occupations. We propose three main ways of achieving this.

• The development of bespoke information sheets — brief (i.e. 2 pages) — targeted at specific services and tailored around the types of NPS use they are likely to encounter e.g. synthetic cannabinoids.
• NPS awareness training and continuous professional development (CPDs) that moves towards more practical and tailored training.
• The creation of a Local Drug Information System (LDIS), a virtual resource that facilitates the sharing of information and good practice across services.

Service Development
Section 4.2 suggests the need for more innovation in the development of intervention responses and marketing approaches that encourage service engagement. This includes outreach and ‘pop-up’ services (e.g. pop-up needle exchanges), and a move away from traditional responses, operating hours and locations to better accommodate newly emerging user groups. We outline the need for guidance on good practice (section 4.2.2), cultural competence (4.2.2.), treatment pathways (4.2.3), integrated service delivery (4.2.4) and a NPS user engagement strategy (4.2.5).

Future Research Agenda
The need to improve existing knowledge recording systems such as treatment data, emergency services, A&E and other medical and non-medical services is noted (section 4.3.1). This should include ongoing monitoring of the impact of the Psychoactive Substance Act 2016 (section 4.3.4) and the establishment of an annual emerging drug trends and drug markets survey (see section 4.3.5). The relationships between NPS use and recovery journeys (see section 4.3.2), NPS use and crime and disorder, and the impact of NPS use on offender management are identified as areas of priority for future research.
1.1 Aims and objectives

This research was commissioned by Manchester City Council’s Community Safety Partnership Board. The overarching aim of the research was explore the prevalence and nature of New Psychoactive Substance (hereafter referred to as ‘NPS’) use in Manchester. The key objectives of the research were:

• Gain a clearer understanding of the prevalence and nature of NPS use amongst targeted sub-populations in Manchester;
• Identify the harms associated with NPS use;
• Ascertain whether the needs of such sub-populations are being met, or not being met, by existing service provision;
• Identify any staff training and/or knowledge needs; and,
• Provide recommendations regarding the future development and delivery of services in Manchester.

1.2 Defining NPS

Although the term NPS is now widely used, there remains some debate as to whether we should be referring to ‘New’ or ‘Novel’ Psychoactive Substances. This is because a number of the most widely used substances (for example, nitrous oxide or mephedrone) were synthesised many years ago and as such are not new, they are simply being used in novel ways. Nevertheless, in the context of this report, we use the most widely used term which is ‘New Psychoactive Substances’. The Home Office defined NPS as:

Psychoactive drugs, newly available in the UK which are not prohibited by the United Nations Drugs Conventions but which may pose a public health threat comparable to that posed by substances listed in these conventions.

(Home Office, 2014)

In the UK, NPS are often referred to as ‘legal highs’ within the media. This is due to the fact that these substances—which have often been specifically designed to mimic psychoactive effects of controlled substances—have not been classed as illegal under the Misuse of Drugs Act 1971. By marketing themselves as ‘research chemicals’ or ‘plant foods’, and labelling themselves as ‘not for human consumption’, NPS can evade prosecution under the 1971 Act. However, there is now a growing consensus that the focus needs to move away from the term ‘legal’ as many users, especially young people, equate ‘legal’ with ‘safe’.

1.3 NPS legislation

NPS first started becoming popular in the UK around 2008/2009. Synthetic stimulants such as BZP (bentzylpiperazine) and mephedrone, and synthetic cannabinoids such as ‘Spice’ (JWH-018), were among the first NPS to gain popularity. Ever since then, there have been concerns around the harms caused by NPS, with a number of deaths connected to them. These concerns have not only only led to targeting campaigns such as the Angelus Foundation5, but they have also led to a raft of legislative changes. For example, synthetic cannabinoids including ‘Spice’, mephedrone and other cathinones, and GBL (gammabutyrolactone) are now included under the Misuse of Drugs Act 1971. The establishment of Temporary Class Drug Orders (TCDOs) in 2012 also led to raft of other NPS, such as NBOMe (25I-NBOMe) and Benzofuran (5- and 6-APB), being banned under the 1971 Act.

Despite these legislative changes it has been difficult to control the use of NPS. This has led to the introduction of what has been perceived as a ‘blanket ban’ of NPS in the frame of the Psychoactive Substances Act 2016, introduced by the Home Office in April 2016. The Act defines a new class of psychoactive substances (collectively referred to as NPS) as those that have not been classed as illegal under the 1971 Misuse of Drugs Act. The establishment of the 2016 Act on NPS availability and use in Manchester constitutes a central theme of the research and is discussed in detail later in the report (see section 3.11).

Alongside these legislative developments, a range of national and international guidance documents and reports have been developed by: Public Health England (Public Health England); the Advisory Council on the Misuse of Drugs (ACMD); the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA); and the United Nations Office on Drugs and Crime (UNODC). Most notably in the context of this report, these have included the: Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances’ (NEPTUNE, 2015); early warning advisors (see, for example, the UNODC’s Early Warning Advisory, the EMCDDA’s Early Warning System, and the Home Office’s Forensic Early Warning System Annual Reports); and recent Public Health England guidance on how to establish local drugs information systems (LDIS) (see Public Health England, 2016). We draw on these key sources at various stages throughout the report, together with national and international survey data and academic papers, to provide information on the nature of NPS, prevalence, motivations for use, and perceived harms.

1.4 NPS monitoring and categorisation

International monitoring systems inform us that NPS are being produced at an unprecedented rate. Manufacturers are continually developing new chemicals to replace those that became banned, changing chemical structures to stay one step ahead of legislation. By way of example, the EMCDDA formally identified 101 new NPS in 2014 (EMCDDA, 2015), 128 in 2015, 147 in 2016, 182 in 2017, 199 in 2018, 225 in 2019, (21 synthetic cannabinoids, 20 synthetic cathinones, and phenethylamines) (EMCDDA, 2016). As of December 2015, 643 NPS were registered in the UNODC’s Early Warning Advisory on NPS (UNODC, 2016).

While there is no agreed official list of substances that are categorised as NPS, they are most commonly grouped into five broad categories:

• Stimulants: such as piperazines (e.g. BZP), cathinones (e.g. methcathinone, MDPV);
• Sedatives: such as benzo diazepine analogues (e.g. etizolam) and new synthetic cannabinoids;
• Hallucinogens: such as NBOMe’s and alpha- methylnaltrexone; and,
• Dissociatives: such as methoxetamine and,
• Synthetic cannabinoids: such as SKF-84466-

1.5 NPS prevalence

Prior to outlining the research methodology and findings, it is useful to begin with a brief review of contemporary British and international research regarding NPS consumption and the associated harms. For example, in 2016, 21 substances were reported for the first time that (structurally) did not fit within any of the above mentioned groups (UNODC, 2016). In the UK alone, the Home Office’s Forensic Early Warning System (FEWS) – which produces annual reports on the content of NPS that are purchased through headshops and online sellers, together with samples confiscated from clubs, festivalgoers and prisoners – identified four new NPS (FEWS, 2015). With so many NPS available, a key aim of the research has been to establish the types of NPS that are used in Manchester, and how use may or may not differ amongst various sub-populations in the city.
types of NPS as: price; purity; availability; desired effects; and legal status (see also Home Office, 2014). In a British context, the emergence of NPS use, particularly synthetic cathinones such as mephedrone, has been attributed to a growing disillusionment with the quality of illegal drugs throughout the 2000s (Carhart-Harris et al., 2011; Measham et al., 2011; Newcombe, 2009; Van Hout & Brennan, 2011). Legality (Measham et al., 2010); curiosity (Newcombe, 2009; Norman et al., 2014); preferred effects (Carhart-Harris et al., 2011; Newcombe, 2009; Van Hout & Brennan, 2011; Winstock et al., 2010); affordability, especially for young people with low incomes (Carhart-Harris et al., 2011; Measham et al. 2011b; Winstock et al., 2010); and boredom (Newcombe, 2009) have also been identified as motivations for use. However, these motivations, generically attributed to all types of NPS, are often established in studies dominated by synthetic cathinones – most notably mephedrone – and conducted with recreational rather than a range of users, including problematic or dependent users.

An often under-explored motivation for the consumption of NPS, particularly for those subject to regular mandatory drug tests (MDTs) and wishing to avoid sanctions, is their non-detectable nature (Barratt et al., 2013; Bebarta et al., 2012; Perrone et al., 2013). It has been argued this has become a key driver for synthetic cannabinoids consumption among the UK prison population, as well as their less detectable smell when compared to natural cannabis (Home Office, 2014; Neptune, 2016; Ralphus et al., 2016; RAP, 2015; Walker, 2015). The attraction of using a psychoactive substance that evades detection will also remain an omnipresent motivation for those subject to such tests on release from custody (due to offender management license conditions), or those working in occupations where drugs tests are enforced (such as machine operatives and those working in transport industries). Another notable gap in much of the existing literature around motivations for NPS use is the area of addiction and dependency. As we outline below, to investigate this key issue, our research specifically focused on sub-populations who are traditionally known to have high rates of drug and alcohol dependency, as well as complex needs.
2.1 Sub-populations
As we noted earlier (see section 1.5), much of the existing knowledge on the prevalence of NPS is based on data garnered from nationally representative household surveys, such as the CSEW. However, as we have already highlighted, these sources of data under-represent those very populations that have traditionally exhibited higher than average levels of substance use, such as university students, the homeless, and those in prison. Because of this, rather than attempting to undertake a comprehensive general population survey of Greater Manchester, this piece of research focused instead on a number of specific sub-populations within Manchester.

The choice of sub-populations was informed by, not only a review of the existing literature, but also conversations with a range of frontline workers in the field. In addition to a focus on young adult recreational users of NPS, the other populations within which NPS use was identified as being particularly prevalent were: the homeless community; those in prison; those in supported accommodation; and men who have sex with men (MSM) who engage in chemsex. As a result, the research focuses on the following five sub-populations:

- university students;
- clubbers;
- those engaged in the chemsex scene;
- those in prison; and,
- the homeless community.

2.2 Mixed-methods
The research was conducted over a six-month period between January and June 2016. The research team utilised a mixed-methods approach incorporating secondary data analysis of existing data, alongside primary data collection – involving a combination of qualitative and quantitative research methods – and analysis.

2.3 Quantitative methods
In relation to the quantitative elements of the research, secondary data analysis was undertaken of 2,139 questionnaires, collected as part of a recent club drug survey in Manchester. In addition, quantitative analysis of primary data collected involved: 55 questionnaires completed by those currently engaged with the charity Homeless Link in Manchester, and 134 online surveys focused on NPS use amongst Manchester’s large student population.

The quantitative analysis was undertaken using IBM-SPSS Statistics.

2.4 Qualitative methods
The qualitative element of the research adopted a range of methods, including ethnographic observations, interviews and focus groups. Ethnographic observations were conducted in various settings, including: city-centre headshops; homeless drop-in activity and advice centres; medical practices; and ‘hot spots’ for NPS use in and around the city centre (such as, Piccadilly Gardens, Urbis and Bury New Road). The research team also observed: service providers dealing with individuals under the influence of NPS; members of the public collapsed outside medical centres; dealing on the streets; and ambulance services being called to local drug services. During these ethnographic observations, the research team spoke to NPS users in an informal, ad hoc manner, leading to several impromptu focus groups and short interviews (some of which were recorded, when appropriate) in headshops, outside drop-ins and on the street.

One-to-one interviews and focus groups formed an integral part of the research as we sought to uncover the opinions of both NPS users and service providers. Interviews and focus groups with users primarily focused on the motivations for use, as well as experiences of using NPS. Furthermore, in order to better inform any new and/or existing services on how best to respond to NPS use, we primarily focused on speaking to NPS users who were not currently accessing treatment services. This allowed us to investigate their reasons and motivations for not seeking support or engaging with local service provision. In total, we conducted 53 interviews with users. Of those interviewed: 41 were adult users (aged 25 or above); 12 were young people (aged 16 to 24); and the vast majority (48) were male. Five focus groups were conducted with NPS users: at homeless day centres (n=1); homeless GP surgery drop-ins (n=2) and supported housing (n=2). In addition, to gathering the perspectives of NPS users, we also interviewed those involved in the supply of NPS: in this instance, one dealer and one headshop worker.

In order to highlight any current gaps in knowledge, training and monitoring, the research team also conducted 31 interviews with practitioners and service providers. Given the multi-faceted nature of NPS use and the challenges associated with it, these interviews encompassed the views and experiences of a wide range of professions and occupations, including: adult drug and alcohol services; sexual health clinics; chemsex services; the LGBT Foundation; needle exchange services; offender management (including prison and probation); police; PCSOs; commissioning services; supported housing providers; approved premises; homeless day centres; homeless outreach teams; young people’s homeless services; young people’s mental health services; young people’s substance use services; GPs and other medical practice staff; and A&E consultants and nurses. In total, 86 interviews were conducted with practitioners and service providers, with each interview lasting on average between 60 and 90 minutes. All interviews were transcribed in full and analysed using NVivo qualitative data analysis software.
3.1 The prevalence and nature of NPS use amongst targeted user groups

Different sub-groups of the overall population often show unique patterns across a number of behaviours and substance use is no exception (see Abdulrahim et al., 2016). As outlined in section 2, the research purposely focused on specific sub-populations that are commonly associated with higher than average use of alcohol and traditional illegal drugs, such as cannabis, ecstasy, crack cocaine and heroin. The findings from this research revealed significant variations in both the prevalence of NPS use and the types of NPS used across these sub-populations. These variations in prevalence were often accompanied by distinct harms and support needs. In section 3, we provide the context and evidence for our recommendations for service development and future research agendas through an analysis of the quantitative and qualitative data.

Official sources of data (such as Public Health England’s JSNA support packs) highlighted the relatively small number of substance misuse service clients who also report NPS use. For example, data from Public Health England (2015a) revealed that only four per cent (n=9) of young people accessing specialist substance misuse services in Manchester in 2014-15 reported NPS use (compared to five per cent nationally). Furthermore, figures from Public Health England (2015b) show that only five new treatment entrants in Manchester in 2014-15 (compared to one, 154 nationally) reported NPS use as part of their drug use. As we go on to highlight in sections 3.2 to 3.6, the reported use of NPS amongst the sub-populations focussed on in this research is much greater than that portrayed by these official estimates.

In the UK, evidence from general population studies (such as, for example, the 2014/15 CSEW), suggests that the consumption of any type of NPS in England and Wales is more prevalent among young people, particularly males (Lader, 2016). Yet, as we noted in section 1, university students living away from home are likely to be exempt from such surveys, despite having much higher rates of recreational drug use than the national average (TAB, 2015). The student population in Manchester is a particularly under-researched sub-population of substance users in the city. Manchester currently hosts over 105,000 students across four universities – Manchester University; Manchester Metropolitan University; the University of Salford; and the University of Bolton – resulting in one of the largest student populations in the UK and Europe (MIDAS, 2016).

Many students are thought to be attracted to the city’s thriving dance music scene and renowned club nights at venues such as Sankey’s, The Warehouse Project and the Albert Hall.

This sub-population was targeted via an online survey, with the primary aim of establishing existing NPS prevalence and drug trends amongst Manchester’s student population. The survey achieved a response rate of 134. Just over a third (n=46) of respondents were male, with the remainder female (n=103, 77 per cent). The mean age of respondents was 22. In stark contrast to national estimates (see sections 1.5), 40 per cent (n=53) of respondents had tried NPS in the last 12 months. As can be seen in Figure 1 below, the most common NPS was by far nitrous oxide, with over 80 per cent (n=49) of respondents having taken it. The survey found that, of the 36 respondents who had taken nitrous oxide in the last 12 months: 76 per cent had taken it with alcohol; 50 per cent with MDMA; 36 per cent with cocaine; and 31 per cent with cannabis. However, rather than taking NPS while clubbing, the vast majority (86 per cent) had taken nitrous oxide at a house party, with over two thirds (69 per cent) taking it in student halls. Only 44 per cent had taken nitrous oxide in a nightclub.

As shown in Figure 2 above, when it came to the reasons for taking NPS, over four fifths of the respondents had taken NPS in the past simply because they were curious, with 69 per cent having taken them because their friends had. In contrast, three quarters disagreed with the statement that NPS are better than other drugs, and 63 per cent disagreed that they are safer than illegal drugs. Interestingly, of the 81 respondents who had never taken any NPS, the most common reasons for not taking them were: ‘too risky, you never know what’s in them’ (81 per cent), and ‘too risky, you never know what they’ll do to you’ (93 per cent). In summary then, it can be seen that the NPS use amongst the students that we surveyed was primarily recreational use of nitrous oxide at house parties or in student halls of residence. It would appear that the main drivers for use were curiosity and peer pressure. When it comes to poly-drug use, the most common substance taken with nitrous oxide was alcohol, and to a lesser extent MDMA. The theme of poly-drug use is explored in more depth in the section on clubbers, and it is to this section that this report now turns.

Figure 1: In the last 12 months, have you ever taken any of the following NPS? (n=53)

<table>
<thead>
<tr>
<th>Substance Type</th>
<th>Never</th>
<th>Never but for other reasons</th>
<th>Only</th>
<th>One occasion</th>
<th>More than one occasion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synthetic Cannabinoids</td>
<td>0%</td>
<td></td>
<td>94%</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>Stimulants</td>
<td>0%</td>
<td></td>
<td>94%</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>Liquids</td>
<td>0%</td>
<td></td>
<td>94%</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>Nitrous Oxide</td>
<td>0%</td>
<td></td>
<td>100%</td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>0%</td>
<td></td>
<td>100%</td>
<td></td>
<td>0%</td>
</tr>
</tbody>
</table>

As shown in Figure 2 above, when it came to the reasons for taking NPS, over four fifths of the respondents had taken NPS in the past simply because they were curious, with 69 per cent having taken them because their friends had. In contrast, three quarters disagreed with the statement that NPS are better than other drugs, and 63 per cent disagreed that they are safer than illegal drugs. Interestingly, of the 81 respondents who had never taken any NPS, the most common reasons for not taking them were: ‘too risky, you never know what’s in them’ (81 per cent), and ‘too risky, you never know what they’ll do to you’ (93 per cent). In summary then, it can be seen that the NPS use amongst the students that we surveyed was primarily recreational use of nitrous oxide at house parties or in student halls of residence. It would appear that the main drivers for use were curiosity and peer pressure. When it comes to poly-drug use, the most common substance taken with nitrous oxide was alcohol, and to a lesser extent MDMA. The theme of poly-drug use is explored in more depth in the section on clubbers, and it is to this section that this report now turns.

Figure 2: ‘I’ve taken legal highs in the past because…’ (n=48)

...I was curious

...taking NPS is normal among my friends

...friends have taken them

...they are better than other drugs

...they are safer than illegal drugs

...I was able to buy them online

...I knew I wasn’t breaking the law

...other drugs were unavailable
3.3 Clubbers, NPS and poly-drug use

In their comprehensive review of UK and international evidence, Abdurrahim et al. (2016) highlight how the prevalence of drug use, relative to that in the general population, is high among young adults, ‘clubbers’ (those who frequently use the night-time economy and dance venues/nightclubs), and lesbian, gay, bisexual and trans (LGBT) populations (and MSM in particular). We focus in this section on the use of NPS amongst clubbers.

Here we outline the findings from our survey of clubbers.

The research into NPS use amongst clubbers focused on six different music nights (drum & bass, hip-hop, deep house, commercial house, techno and trance) at a club in Manchester. For the outlined purposes of this study, an existing survey data collected from 2,139 clubbers, the largest in situ study of clubbers conducted in the UK. The gender split was fairly equal with 47 percent (n=1,005) of those surveyed being male, and the remainder female. The ethnicity of the clubbers was predominantly ‘White’ (88 percent), with the next highest categories consisting of ‘Black British’ (three percent) and Asian (two percent). Although the mean age of clubbers was 23, ages ranged from 15 through to 52 years of age.

Almost four-fifths (79 percent, n=1,681) of those surveyed were current drug users, and of these, 85 percent of males and 79 percent of females reported having ‘ever tried NPS’. A tenth of male drug users and eight percent of female drug users reported having ‘used NPS on the night’. The most popular NPS were mephedrone (37 percent), ketamine (25 percent) and methamphetamine and methedrone. When compared to other drugs (i.e. non-NPS) taken on the night, ketamine was the third most popular substance, after MDMA/ecstasy and cocaine, and methamphetamine and methedrone was the fourth most popular drug. Just over a quarter (27 percent) of drug users reported having used ketamine in the previous month, compared to 15 percent of those having used mephedrone.

In relation to other NPS discussed in this report, nitrous oxide only made the top 10 substances used on the night of one of the survey nights: a techno night. In contrast, GHB was the seventh most popular substance used on the night, with levels of consumption similar to ‘poppers/amyl nitrite’. Of the 1,681 clubbers that reported using drugs, five percent claimed to have used GHB in the past month. There is a well-trodden path of substance use trends first emerging in the LGBT community, before crossing over to clubbers and more mainstream consumers. ‘Clubbers’ that reported using drugs, five per cent claimed to have used NPS on the night. The most common substances reported were mephedrone, ketamine, ecstasy and ketamine; and methamphetamine and methedrone. At present of age.

3.4 Chemsex

Chemsex is defined by the use of any combination of drugs that includes three specific drugs (“chems”) before or during sex by MSM (Men who have Sex with Men). These drugs are methamphetamine (‘speed’/crystal meth/ Tina/meth), mephedrone (‘methedrone’) and GHB/GBL (‘G/Crash’). (Redshape & 56 Dean Street)

There is increasing evidence that there are three distinct, but overlapping, areas in which MSM populations bear a disproportionate burden of ill health: sexual health (notably HIV infection), mental health, and the use of alcohol, drugs and tobacco (Public Health England, 2014a). In particular, there is growing concern over the involvement of a minority of MSM in chemsex, a term primarily used to describe sex between men that occurs under the influence of drugs. The implications of these findings for service development and future research agendas are discussed in sections 4.2 and 4.5. We now turn attention to another targeted sub-population of NPS users, MSM who engage in chemsex.

In summary, the research found much higher levels of NPS use amongst this group than that found in national prevalence data, with much of the NPS use accounted for by ketamine and mephedrone, demonstrating the appeal of stimulants and depressants equally. However, given the popularity of these two drugs, and the fact that they were classified under the Misuse of Drugs Act in 2001 and 2005 respectively, it is not surprising, many being long how long they can credibly remain under the ‘NPS’ umbrella. The implications of these findings for service development and future research agendas are discussed in sections 4.2 and 4.5. We now turn attention to another targeted sub-population of NPS users, MSM who engage in chemsex.
Having outlined how chemsex is currently defined and the level of knowledge and guidance on developing chemsex provision at a national level, we now turn attention to the findings and discussion around how chemsex should be defined locally, and how existing services need to develop.

3.4.1 Defining chemsex in a local context

The definition at the start of section 3.4 was produced by ReSipage (an activist think-tank that supports the need for new community responses to chemsex) and 56 Dean Street (the first UK GUM/HIV clinic to provide chemsex support to MSM around drug use, sexual health, and sexual wellbeing), and derived from the London chemsex scene. The stated aim of the definition is to help health workers and researchers understand differences between chemsex and other forms of recreational substance use. The definition applies specifically to MSM who are:

- disproportionately affected by HIV/STIs, and can be more likely to have a higher number of sexual partners.
- chemsex is associated with some cultural drivers unique to gay men and communities that include psychosexual dysfunctions and new technologies (geo-social networking Apps) that can facilitate faster introduction to new partners, and to ‘Chemsex’. Chemsex commonly refers to sex that sometimes, if not always, is little more than sex and sexual contact.

In Manchester, and those in London.

3.4.2 The prevalence of chemsex in Manchester

With the current (London orientated) definition of chemsex... ...if people are only self-identifying as involved in chemsex, they’re only taking one of those three drugs, you could potentially be missing loads of people (LGBT Health Practitioner, 56 Dean St, London)

The exclusion of those who do not use methamphetamine, mephedrone and GHB/GBL may go some way to explaining the disparity in numbers between those accessing services in Manchester and those in London.

They [the REACH clinic in Manchester] have seen 30 gay men using those drugs in the last year. We see 2,000 a month' (Chemsex Practitioner, 56 Dean St, London)

It should be acknowledged that the London clinic is well established and the REACH clinic has only recently been established and hence service uptake is expected to increase as awareness improves with increased REACH clinic marketing and the development of the chemsex aware nurses campaign, currently scheduled to be launched in February/March 2017. The campaign will be particularly targeted at gay men, although everyone collecting needles from needle exchanges, however, information will be available to all via a new website. The new campaign focuses on raising awareness of the potential harms, providing harm reduction advice and signposting people to appropriate services. This campaign will also help to educate and inform residents of how chemsex is defined and its parameters.

Considering the position that Manchester holds as one of the largest MSM communities in the UK, the numbers coming through services appears low. Particularly, as recent research has suggested that Manchester (along with Brighton) has the fastest growing chemsex scene in the UK (SGMHA, 2016). One of the reasons for this disparity may be the atypical nature of the London chemsex scene. Recently published findings from a national survey of 15,000 MSM revealed a number of interesting differences (SOMA, 2016). For example, seven per cent of survey respondents in England claimed to have used at least one of the three chemsex drugs (methamphetamine, mephedrone and GHB/GBL) in the last month. For those living in London, this figure rises to 14 per cent. In addition, those living in London were almost twice as likely (3.3 per cent) to have reported injecting drugs in the past year compared to those living outside London (1.8 per cent). This evidence would suggest that, when compared to Manchester, London has a larger cohort of MSM using the ‘traditional’ chemsex drugs, and a higher proportion of the chemsex users.

One male sex worker that was interviewed even discussed how he offered ‘chemsex light’, with the refusal to ‘slam’, and an agreement to the use of one, or more, drugs rather than methamphetamine, mephedrone and GHB/GBL. The evident confusion over exactly what chemsex involves led to a number of discussions about the need to define chemsex at a local level.

3.4.3 Existing service provision

In November 2015, Public Health England produced guidance for commissioners on the commissioning and delivery of substance misuse services for MSM involved in chemsex (Public Health England, 2015). This guidance includes a number of prompts for commissioners around understanding the needs of the local MSM population in order to commission appropriate local services. It was evident that many of these suggestions were already in place in Manchester, and well established ahead of this guidance. The research team at ReSipage, in 2015, conducted and conducted several interviews with sexual health and substance use professionals who were working with this user group, and it was clear that strategic commissioning and the integration of sexual health and substance use teams already exists. The REACH clinic is a partnership between the Hatherseg Sex and Reproductive Health Service (Central Manchester NHS Foundation Trust), where the service is currently located and the integrated drug and alcohol service, currently provided by COL. In addition, there are clear indications of strong partnership working with the LGBT Foundation, George House Trust and other LGBT organisations.

I think what they (the REACH clinic) have got now is a really good basis to build on. I think it’s in a good setting [and] the staff on the ground have got understanding of it and working in LBGT and all that. It’s a very quick provision, so you can come in to see the drug worker, and if you need an STI screen, they’ll do that there. They’ve very geared up to getting these people engaged, and that’s a massive part of the treatment’ (Senior Substance Use Practitioner)

It’s an ideal partnership because to address chemsex you need to go to sexual health clinics for the risk assessments and care, and you need the expertise of behavioural interventions that you get in the chemsex setting, and you need the LBGT charity for the cultural competency that goes with LGBT experiences’. (Chemsex Practitioner, 56 Dean Street)

As highlighted in the above quote, the inclusion of the LGBT Foundation on the steering group of the REACH clinic is a marketing and the development of the cultural competence of the clinic. Cultural competency appears to be key when it comes to engaging those involved in chemsex into services. Indirectly or directly, finding the right people and the right people in the right places with the right approach and the right people involved in the Reaching Out campaign will also help to educate and inform residents of the needs of the local MSM population in order to commission suitable local services.

I would populate it with gay men in the beginning, just because of their (those involved in chemsex) fear of approaching services. … Show us, you know, what you’re talking about. Give us a gay man who can talk about chemsex’. (Chemsex Practitioner, 56 Dean Street)

Most locally based professionals with experience of working with this user group suggested, however, that while representation of gay men within chemsex services is useful, other skills and expertise are equally, if not more, desired. It’s about the skill of the worker being able to engage that person. It should be representative (but) I certainly don’t think it needs to be staffed by just gay men’. (Chemsex Substance Use Practitioner)

I think it’s more about the person being open and non-judgmental and knowledgeable (LGBT Health and Wellbeing Service Manager)

It’s about your willingness to learn. I think even (if) you identify as being in the same group as the people you’re targeting, it doesn’t necessarily mean you understand...
3.4.4 Service location
The need for service provision in the city centre, and specifically in the village, was consistently raised by MSM, sexual health and substance use practitioners. Pop-up clinics were also widely suggested.

‘I mean the city centre is an obvious choice. In and around the Northern Quarter, again really obvious choice’. (34-year old MSM)

‘A city like Manchester should have fucking pop-up HIV testing and just general sexual health places on every fucking corner you know. Sorry, it just really annoys me’ (34-year old MSM Sex Worker)

However, despite taking on board those suggestions, the feasibility of developing these services was often questioned by service providers and ultimately, the suggested changes for service provision provided here appear to fall outside what is practical within current resources.

3.4.4.4 Service location
In addition to the physical location of services, the issue of how existing services, such as the REACH clinic, could better promote the services they offer was often talked about during interviews. Discussions were primarily centred on what the services’ promotional material should look like, and where it should be made available.

‘I don’t know if the LGBT foundation, or any other sort of sexual health clinic here do sort of like business card sized things that say “These are the services we provide, this is the counselling we do, these are the hours”. That would be really cool. … People can just pop in, pick it up and leave’. (34-year old MSM)

It was also noted that many MSM do not frequent the village, and as such, other popular night-time economy areas should be targeted. Some of the most popular suggestions included the Northern Quarter and non-city centre areas, such as Chorlton and Didsbury.

‘I just feel like that sort of [promotional] material should be everywhere. (34-year old MSM Sex Worker)’

3.4.5 Targeted outreach
In addition to suggestions of where services should be located and how they should be promoted, the need for more targeted outreach was frequently discussed. Bourne et al. (2014) have shown that the use of methamphetamine, methadone, GHB/GBL and ketamine was associated with attendance of gay cafes, bars, pubs and clubs. They also found that gay and bisexual men who used any or all of these substances were more frequent attendees of these venues than non-users. Furthermore, they suggest that sauna use and the use of backrooms or sex clubs were also associated with the use of these drugs. Bars that held late nights and city centre saunas frequented by MSM were identified as two key locations for outreach work. As touched on earlier, when it comes to working in these spaces, the need for cultural competence and sensitivity was emphasised.

I worked with [LGBT Charity in another UK city] for a while and as part of my training they had me go to some of their pop-up clinics, and like different bars. And I thought “Wow, that’s really, really effective”. … We [had to] make ourselves as small, but as visible as possible, so as not to put people off, because I think people tend to get really annoyed by over-zealous health practitioners, especially in social spaces. (36-year old MSM)

‘We’ve been doing late night outreach, … trying to reach groups of MSM who we don’t believe access our services at the moment. … An example is we go to [a local fetish] every night right) every four weeks. It’s taken us quite a while for them to let us attend, because obviously what they don’t want is a service going round sharking condoms in people’s faces. … It’s quite difficult because they were saying “If you want to come in, you have to come in fetish gear”, and it’s not appropriate. … We’ve found ways round it. We wear black t-shirts with something over the top [of them] like a body brace or something like that. … So we’re not wearing bright yellow LGBT foundation t-shirts, we blend in, but we’re still visible’. (LGBT Health and Wellbeing Service Lead)

As outlined below, while discussions often focused on targeting the physical locations frequented by those involved in chemsex, they also covered the need for outreach work in virtual spaces. As highlighted at the start of this section, the use of Apps such as Scruff, Grindr and Grindr are central to defining who and where MSM identified as chemical dependants are. In support of this, all MSM that we spoke to referred to the use of various Apps when discussing the chemsex scene. The centrality of Apps to the chemsex scene is reflected in the number of interviewees to discuss the need for a web-based presence, where services can interact and promote what they do via Apps.

‘It’s really important I think to have that sort of mobile accessibility. That would probably get people a lot more engaged, and at least get people more confident about their ability to get information’. (24-year old MSM Sex Worker)

‘I’m not sure if the NHS operates any sexual health Apps or anything, [but] that would be really, really useful. … A way that people could find out where their nearest clinic and testing times are, and all that kind of stuff for different things. Just really discretely and really simply’. (34-year old Male Sex Work)

‘I’m assuming that most App users are between, what, like 18 and 30. … Addressing those people through the Apps is doing late night sessions, so on a Friday night we’re online between 8 and midnight. And we are [going] online on Saturdays to try and reach a slightly different cohort of guys than we would during the week. … We’ve talked to a lot of guys about chemsex on those forums. I think because there’s a level of anonymity, it means that people are being a lot more upfront with us, and people are being a lot braver when it comes to asking for advice as well. Because sometimes we might see people that come to clinics or face-to-face services, and only when we’ve seen them a few times do they tell us what they want from us’. (LGBT Health and Wellbeing Service Manager)

When you think about how to reach these people, you’re looking at who is using Apps. It’s a completely different group of people. … Safety injecting techniques, clean needles … You’d have counsellors there who could help support with the drug use. … There are a lot of saturation advertising for some of the drugs that they’re using? Nothing. Do we give anything? … What do we give for cocaine? What do we give for crystal meth? (Sexual Health Nurse)

‘I really think seeing a few guys that just wanted some more information about injecting and the dangers, and a bit of advice. That’s all they wanted, … they just wanted a conversation with someone’. (Chemsex Substance Use Practitioner)

We need to work differently. […] because a lot of people probably wouldn’t access a needle exchange, because they associate it with opiate drug users. There’s so much stigma I think attached to using a needle exchange’. (Senior Substance Practitioners)

‘I think the village needs a needle exchange, … at the weekends in particular. Because that’s the other thing it isn’t. … Needle exchange provision at the weekend is limited’. (Senior Substance Use Practitioner)
Before moving on to look at mental health provision, it is worth heeding a warning from a practitioner at 56 Dean Street who felt that developing services that focus too heavily on developing needle exchange provision, would be to the detriment of those involved in chemsex who do not inject.

‘About 20% of our [chemsex] population are injecting... [yet] the ones who are not injecting are exposed to just as much risk in regards to the HIV ... It’s the HIV negative guy who’s doing G and snuffing mephedrone, who’s having sex with 15 partners who’s going to catch HIV and transmit it to 30 more people in the next month... A HIV positive man who’s injecting crystal meth, who takes his medicines regularly is very low-risk for a lot of things... As a public health coping [with the transmission of disease and epidemics], that HIV positive man who’s injecting is lower risk than the other.’ (Chemsex Practitioner, 56 Dean Street, London)

This combination of factors associated with chemsex has been described as ‘a perfect storm for transmission of both HIV and HCV, as well as a recipe for ensuing mental health problems’ (Kirby & Thorburn-Dunwell, 2013).

3.4.7 Mental health and counselling

‘Mental health services would be a really, really good thing to get on board.’ (30-year old MSM)

Another area of service development that was frequently discussed was a better integration of mental health and drug use services. Reasons for engaging in chemsex that were highlighted by counsellors, sexual health practitioners and substance use practitioners included: to overcome intimacy issues; fear of rejection and sexual shame; to cope with stigma over HIV/HCV; to deal with problems/truma in the past; and to overcome internalised homophobia. According to the UK Household Longitudinal Study, MSM were twice as likely to be depressed or anxious compared with other men (McFall, 2012). Similarly, other studies have shown that LGBTQ adolescents are at greater risk of depressive symptoms and suicidal ideation than are heterosexual adolescents (Almeida et al., 2009; King et al., 2008).

Recent Public Health England guidance suggests that: ‘For many, I think there is a deep rooted reason around chemsex’ (34-year old MSM Sex Worker)

Interviewees identified a number of training issues for staff, including of risk of overdose, cultural competency and contraindicated substances. Overdosing is a particular issue associated with the use of GHB/GBL. There is a fine line between what one might consider to be a therapeutic dose and what is considered toxic. One interviewee expressed: ‘I think people forget that some of the other drugs, the recreational drugs, have an effect and can compromise the antiretroviral treatments. But also, they can enhance them and exacerbate them, turn them into a poison. Either when the antiretroviral or the drug itself, the recreational drug... So it can weaken the HIV drugs, which is not good, or it can double or triple the strength of it, which is not good either’ (Sexual Health Nurse)

A consideration of other prescribed medications, such as anti-depressants, is also essential due to the potential to cause ‘serotonin syndrome’ when mixed with illegal drugs such as MDMA. There is a need to ensure that frontline staff – GPs, emergency medical staff, and sexual health and substance use practitioners – are all aware of the chemsex scene, drug interactions and contraindications, and the potential for increased toxicity. Drug use and poly-drug use may interfere with adherence to, as well as the effectiveness of, antiretroviral therapy (ART) (Antoniou & Tseng, 2002). Recreational drug use has consistently been linked to lower rates of HIV medication adherence (Halkitis et al., 2005; Haubrich et al., 1999; Romanelli et al., 2003), with even lower levels among poly-drug users. There is also some evidence of a dose-response relationship between the use of certain drugs and medication adherence, which suggests that bingeing or heavy use may have a particularly detrimental effect on medication adherence (Antoniou et al., 2006), although this needs to be investigated further. Issues of adherence to HIV medications in the context of club drug use by MSM are likely to become more significant if PEP (post-exposure prophylaxis) for HIV becomes more prominent following a documented case of HIV transmission (Gardiner et al., 2014).

In summary, the research identified a number of specific user needs, areas for potential service development and areas that were specific to the chemsex scene. We now turn our attention to another group of NPS, synthetic cannabinoids.

3.5 Synthetic cannabinoid use amongst vulnerable groups

I want people to realize what it’s doing, know what I mean? Like, what it’s like. It’s killing us all. We’re slowly getting killed.’ (18-year old Homeless Female)

Synthetic cannabinoids were first detected in the UK and other European countries towards the end of 2009. They are produced with manufactured chemicals that create similar effects to delta-9-tetrahydrocannabinol (THC), the active ingredient in cannabis. These powdered chemicals are mixed with seeds, tobacco, or other matter, or increasingly sold in powdered form. In 2014, 30 new synthetic cannabinoids were identified, bringing the total number reported to the EU Early Warning System to 134 (EMCDDA, 2015). Synthetic cannabinoids are the largest group of substances monitored by the EMCDDA, reflecting the rapid pace in which manufacturers can produce and supply new cannabinoids in order to circumvent drug law. In 2015, over 21,000 seizures were reported, comprising more than 40% of the total number of seizes for NPS (EMCDDA, 2015).

We begin this section with an overview of the findings from a focus group co-conducted in partnership with: MASH (Manchester Action on Street Health); the Booth Centre; Lifeshare; Justlife; Barnaul; and Salford Loaves and Fishes. The survey involved 53 respondents who were engaged with various homeless services in Manchester. Of those that were surveyed, just over two thirds were male (68 per cent, n=38) and 32 per cent were female (n=17). The ages of those surveyed ranged from 17 to 49, with an average age of 30. Just over half (53 per cent, n=28) were classed as sleeping rough on the streets, 13 per cent (n=7) were housed in their own tenancy, 11 per cent (n=6) in temporary accommodation; nine per cent were housed in temporary accommodation (e.g. a Bed and Breakfast); six per cent (n=3) were housed in a supported accommodation; and four per cent (n=2) were sofa surfing.

The vast majority of rough sleepers (93 per cent, n=26) had taken NPS in the 12 months prior to the survey, compared to less than two thirds (64%, n=16) of non-rough sleepers (see Figure 3 p26). In addition, of the 42 respondents who had taken NPS in the 12 months prior to the survey, only a tenth (n=4) had taken just NPS. The majority (81 per cent, n=34) had taken NPS and other substances in addition to NPS (see Figure 4 p26). These drugs were primarily Cocaine, Cannabis and Crack (see Figure 5 p26).

Of those who had taken NPS in the past 12 months (n=42), 64 per cent (n=27) had taken them every day, and 14% (n=6) had taken them five or six days a week. Interestingly, a
higher proportion of rough sleepers had taken NPS at least five days a week than non-rough sleepers (85 per cent compared to 69 per cent).

The high levels of synthetic cannabinoid use reported in the homeless survey were confirmed by the qualitative interviews conducted with practitioners working with this user group and members of the homeless community who estimated this figure to be even higher.

The whole of the city centre, there’s a problem now in Manchester City centre. It’s the worst I’ve ever known it really. (Homeless Outreach Worker)

Huge problem. I think for a good six months, it’s been coming and getting worse and worse. People use it daily in this building, especially Spice. (Supported Housing Manager)

The high levels of synthetic cannabinoid use reported in the homeless survey were confirmed by the qualitative interviews conducted with practitioners working with this user group and members of the homeless community who estimated this figure to be even higher.

I’ve probably got about 40 clients on my caseload at the minute who are street homeless. Of them I’d say about 95 per cent of them take Spice. (Support Worker for Young Street Homeless)

You’d be surprised how many people. … I’d say 99 per cent of them are Spice heads. (Young Person’s Homeless Support Worker)

It’s everywhere, it’s absolutely everywhere. … It’s really rife amongst Manchester’s homeless community. (23-year old Male, Street Homeless)

Every single person I know smokes it. (Male, late 20s, Homeless GP Drop-in)

When I used to be homeless, everybody was smoking it. (21-year old Female, Ex-Homeless)

For many of the survey respondents (see Figure 6 p27), the primary reason for using NPS in the preceding 12 months did not appear to be as a result of them being legal (3 per cent, n=1) or more effective than other drugs (7 per cent, n=2). Rather, it was simply because they were convenient and easily accessible (45 per cent, n=13). With this in mind, it is unsurprising that over ninety per cent of those who had used NPS in the preceding 12 months had bought them from a headshop (93 per cent, n=37) and/or newsagent (60 per cent, n=24). Only six (15 per cent) had bought them from a street dealer. Recent annual Inspectorate of Prisons Reports have highlighted the Spice epidemic that has spread across the England and Wales prison estate. The prison system is churning out Spice users at an alarming rate. It is estimated that as many as 60 to 90 percent of the 90,000 prison population are regular users, equating to between 54,000 to 81,000 prisoners using Spice at any one time (RAPt 2015). In our research amongst Manchester’s homeless community and buyers of synthetic cannabis in city centre headshops, many users who report daily use, dependency and a range of mental and physical health concerns (that we discuss later in sections 3.5.3 and 3.5.4) recounted first being introduced to Spice in custody.

Figure 3: In the last 12 months, have you taken any of the following? (n=53)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Non-rough sleeper (n=25)</th>
<th>Rough sleeper (n=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPS</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>90%</td>
<td>75%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>50%</td>
<td>25%</td>
</tr>
<tr>
<td>Crack</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>Heroin</td>
<td>10%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Figure 4: Number of drugs taken in addition to NPS in last 12 months (n=42)

<table>
<thead>
<tr>
<th>Drug</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-rough</td>
<td>10%</td>
<td>9.5%</td>
<td>21%</td>
<td>40.5%</td>
</tr>
<tr>
<td>Rough</td>
<td>19%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Figure 5: Drugs taken in addition to NPS in last 12 months (n=42)

<table>
<thead>
<tr>
<th>Drug</th>
<th>None</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Crack</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Heroin</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Figure 6: In the last 12 months, what is your main reason for using NPS? (n=42)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Non-rough sleeper (n=25)</th>
<th>Rough sleeper (n=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convenient and easy to get</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Cheaper than other substances</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Substitute for other substances</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>More effective than other substances</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>They are legal</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

3.5.1 Motivations and onset of synthetic cannabinoid use

Our current understanding of NPS consumption and the motivations for use is largely taken from: national and international studies of recreational drug using populations (see Winstock, 2011; Measham et al., 2011a; Measham & Moore, 2009; Wood et al., 2012a, 2012b); online surveys (see Carhart-Harris et al., 2011; Global Drug Survey, 2015); household surveys (see Home Office, 2012); or research with young people (see Castellanos et al., 2011; Champion et al., 2016; European Commission 2011, 2014). In this section of the report, we turn our attention towards user groups – the homeless and offender populations – who are absent in conventional research and whose substance use ought not be defined as recreational. In doing so, we document how one particular group of NPS – synthetic cannabinoids – is widely used amongst this sub-population. We describe the primary motivations for the consumption of synthetic cannabinoids in this setting and the impact consumption has upon users’ health.
I first tried it in Forest Bank. (23-year old Male, Homeless)

I'd tried it when I was in prison, and then I've smoked it since then. (24-year old Male, Homeless)

I choose to use this [Spice] while I was in prison. If I didn't go to prison I wouldn't be on this legal high stuff. (Male, mid-20's, Synthetic Cannabinoids user, interviewed in Centre City Headshop)

On release from custody many offenders will find themselves in approved premises, supported housing or in emergency access accommodation. A zero tolerance policy to substance use is often employed, which includes drug tests, breathalysers for alcohol use and room searches. The non-detectability of Spice is a key motivation for use in these settings with users reporting no distinctive smell in comparison to the strong, pungent smell of ‘skunk’ which makes up over 80 per cent of the existing UK cannabis market. (Home Office, 2015). Alcohol can also easily be detected on the breath by the police.

Most other people we spoke to in the homeless community had first started using synthetic cannabinoids after becoming homeless, due to its high prevalence within the community.

I first started using when I started hanging around with homeless and that. (18-year old Female, Homeless)

In recent years we have seen the introduction of legislation prohibiting drinking in public places, especially the city centre where most homeless people cluster. Synthetic cannabinoids, in particular, are marketed quite openly and blantly in the presence of Police and PCSOs; unlike skunk cannabis, can be smoked quite openly and visibly in the presence of Police and PCSOs. We have the rather unusual situation where the possession and use of a very dangerous substance is publicly tolerated, however its prohibition drinking in public places, especially the city centre, had first started using synthetic cannabinoids after becoming homeless, due to its high prevalence within the community.

I first started using when I started hanging around with homeless and that. (18-year old Female, Homeless)

As we highlight in sections 3.6, 3.7 and 3.9, our findings suggest that the consumption of synthetic cannabinoids presents particular problems for the offender population and the management of them, both within and beyond the prison environment. As we discuss in section 4.3, further research is required to understand the impact of NPS in local approved premises and supported housing settings. We now turn our attention to the reported problematic use of synthetic cannabinoids amongst vulnerable users.

Case Study 1: Jade

Jade is an 18-year old girl who describes herself as having had “a bad childhood”, running away from home on several occasions and spending periods of time on the streets. She describes surviving as a ‘rough sleeper’ on the periphery of Manchester’s homeless community and it is through her interaction with the homeless community that she has been introduced to Spice. Initially she smoked it because it made her feel “warm”, helping her to sleep and temporarily forget her problems. However, she admits she quickly became addicted, getting into a pattern of smoke up, joint, sleep, wake up, joint – that was it. At one point she was being hospitalised 3 or 4 times a week, sometimes even more in the same night, having been allowed to “pass out” on the street. Jade is aware of the dangers of Spice, both to herself and to the homeless community as a whole. “It’s slowly killing me up”, she says. “It’s slowly killing me in my head”. She wants to stop using but finds withdrawal symptoms difficult to deal with – “you’re shaking, you got a headache, you got a bloody sore mouth or lips, you’re not sleeping well at all, you can’t sleep”. After one withdrawal episode she got so ‘rattled’ she physically assaulted a 15-year old boy, something which she regrets and claims is totally out of character. To fund her addiction she admits to having stolen from her family and has reported to prostitution to pay off ‘debt’.

Evidence of the health harms associated with synthetic cannabinoid use within general population samples has recently emerged from several countries. Their consumption has grown from a wide range of negative physical and mental health effects, including: addiction; aggression; agitation; muscle spasms; ‘fitting’; seizures; depression; hallucinations; paranoia; psychotic; self-harm; and suicidal thoughts (Barnatt et al., 2013; Bebarta et al., 2012; Castellanos et al., 2011; Everly-Palmer 2011; Harris & Brown, 2013; Hurst et al., 2011; Thomas et al., 2012; Van der Veer 2011; Zimmerman et al., 2009). A further compelling issue is that many users report that the effects are variable and unpredictable, even when using the same brand of synthetic cannabinoid (see Castellanos et al., 2011). While this body of research has usefully highlighted the harmful physical and mental health effects of synthetic cannabinoid use, they were undertaken with general population users. To date, there is a dearth of in-depth research exploring how synthetic cannabinoids affect more vulnerable groups in society, such as those in the homeless community, a group that has traditionally exhibited higher than average levels of substance use dependency and mental health needs (see Homeless Link, 2014).

The Homeless Link’s 2014 Health Audit revealed that 66 per cent of 2,000 people surveyed reported that they were recovering from a drug (59 per cent) or alcohol (27 per cent) problem. The audit also found that poor mental health was a significant contributing factor to substance use with 76 per cent of those reporting poor mental health, the highest levels of reported problematic NPS use in Manchester centered on the homeless community, and those recently released from prison and living in supported housing or approved premises.

Case Study 2: John

John is a 59-year old male. He is an intelligent, articulate and well-educated individual, self-employed and running his own small company. He has a wide experience and knowledge of drugs having started experimenting when he was 16 years old. For over 10 years, he says he was addicted to heroin and crack but has been free of these for two years, although recently he has been a sporadic user of NPS, particularly synthetic cathinones. Despite describing himself as an ex-heroin and crack addict, he is of the opinion that the synthetic cannabinoids have replaced a lot of other drugs. I’ve had three ex-heroin and crack addicts, he is of the opinion that the synthetic cannabinoids have replaced a lot of other drugs. I’ve had three

3.5.2 New psychoactive substances, same old problematic users

It’s [Spice] has replaced a lot of other drugs. I’ve had three

The research identified that the highest prevalence and problematic use of NPS – primarily synthetic cannabinoids, refrigerant abuse and ‘Spice’, and amphetamine use – is amongst the same vulnerable groups that have traditionally been associated with problematic Class A substance use. Indeed, many dependent users of synthetic cannabinoids referred to past problematic use of other substances, typically heroin and crack cocaine. The highest levels of reported problematic NPS use in Manchester centered on the homeless community, and those recently released from prison and living in supported housing or approved premises.

Although prevalence and dependence is very high amongst the homeless population in Manchester, the UK’s prison population has similarly high levels of drug dependency and poor mental health. The Prison Reform Trust (2016) estimate around three-quarters of UK prisoners have pre-existing mental health problems with many suffering from two or more mental health conditions, and around 20 per cent having four or five major mental health disorders. Indeed, past research has estimated that levels of psychiatric disorders among the male prison population are 14 times greater than in the general population (Stuart et al., 1998). The widespread and problematic use of synthetic cannabinoids in prisons has recently been connected to an increase in suicides and incidents of self-harm (Homeless Link & Probations Ombudsman 2015; Ministry of Justice 2016a).

By focusing on the homeless community, and those recently released from prison and living in supported housing or approved premises, this section aims to increase our knowledge and understanding of synthetic cannabinoids amongst a group that has traditionally exhibited higher than average levels of substance use dependency and mental health needs. We begin this section by exploring the links between NPS use and addiction.
3.5.3 The new heroin? Addiction, tolerance and dependence

People need to understand the stuff. Understand what it is, and how readily available it is. How easy it is to become addicted to it. (24-year old Male user)

Emerging evidence has suggested that synthetic cannabinoids are highly addictive and have the potential to lead to drug dependence. Addiction to Spice has recently been identified as a key reason for the high levels of consumption in prisons, with some prisoners describing how their patterns of use were habitual ‘...like a crack addiction!’ (RAPt 2015: 4). Furthermore, Baker (2015) reported that 20 per cent of his sample of male prisoners perceived themselves to be addicted to synthetic cannabinoids.

In line with the findings of Every-Palmer (2011) and Zimmerman et al. (2009), synthetic cannabinoids were perceived to be more psychologically and physically addictive than other substances. Throughout the research, many drug dependent users of Spice with considerable lifetime experience of heroin, crack cocaine, and a range of other recreational drugs consistently referred to Spice as being more addictive, and resulting in more acute withdrawals than other substances they had been dependent on. Indeed, ex-dependent heroin and crack users unanimously referred to Spice as the most addictive substance, with the most acute withdrawals and ‘rate’, that they had ever taken.

‘If it can overpower methadone and stop your withdrawal from methadone, it shows you that it’s a powerful stuff’ (35-year old Male, ex-Methadone user, Approved Premises).

I was addicted, very addicted, I was bad. It was hard to get out of, really hard. It’s the hardest thing I’ve ever had to do. … Spice is definitely the most addictive substance. (27-year old Male, ex-Heroin and Crack user, Approved Premises)

‘Crack heads and heroin addicts have come off crack and heroin to smoke Spice, and now they can’t stop smoking Spice’ (35-year old Male, ex-Heroin user, Approved Premises).

I was smoking it for about 12 months. 18 months. I used to smoke all day every day, and I used to use it up to 8 hours a day. I just lost a lot of weight. I looked like a crack-head, like a full on crack head. … I could just feel my body completely, like smoking pure green chemicals. It was just like toxic waste. (24-year old Male, Homeless)

I’m addicted to Anabnilith (a synthetic cannabinoid). I’ll go through a gram a day, it’s stronger than any other drug I’ve ever done. It’s longer lasting, it doesn’t cost as much as crack or heroin, I’ve got it to use, to sat me right out (INT: How does the addiction compare to other drugs?) I’m an ex-heroine user and the feelings are the same, you get no sleep, hot and cold sweats, sweats up, diarrhoea, it’s horrible. (30-year old Male, Homeless)

Many staff who work closely with users of synthetic cannabinoids also drew parallels with heroin or crack:

‘I see this drug as almost a comparison to heroin, in the way of it’s affecting people.’ (Supported Housing Staff)

‘Some are aligning it to heroin withdrawals, so the body likes synthetic, the stomach means: I need the irritability.’ (Homelessness Day Centre Manager)

Yet despite the strength of synthetic cannabinoids – often stated to be 50 to 100 times stronger than even ‘skunk’ forms of cannabis – many Spice users reported building up high levels of tolerance, with some reportedly using up to between 20 to 40 grams a day.

I first started at half a gram [a day], and I’d probably get about 30 spliffs out of it in prison. … [Now with the tolerance, I’m up to smoking seven grams]. (Male, 20’s, Supported Housing)

When I started smoking it, I only had to put a little bit in it. … [But] by the time I was coming off it, I was putting half a gram in a spliff. (23-year old Male, Young People’s drop in, ex-Spice user)

As we discuss in section 3.5.6, finding the funds to pay for their daily consumption of synthetic cannabinoids led many users to commit crime. Indeed, as users’ tolerance increased, many found themselves spending up to £50 a day; an amount that they would have previously used to fund a heroin or crack habit. Coupled in this is the finding in prisoners of synthetic cannabinoids, as a result of the implementation of the Psychoactive Substances Act (see section 3.11), will no longer be regulated within NPS. (see section 3.11), will no longer be regulated within NPS.

We discuss in section 3.5.6, finding the funds to pay for their daily consumption of synthetic cannabinoids led many users to commit crime. Indeed, as users’ tolerance increased, many found themselves spending up to £50 a day; an amount that they would have previously used to fund a heroin or crack habit. Coupled in this is the finding in prisoners of synthetic cannabinoids, as a result of the implementation of the Psychoactive Substances Act (see section 3.11), will no longer be regulated within NPS.

As we discuss in section 3.5.6, finding the funds to pay for their daily consumption of synthetic cannabinoids led many users to commit crime. Indeed, as users’ tolerance increased, many found themselves spending up to £50 a day; an amount that they would have previously used to fund a heroin or crack habit. Coupled in this is the finding in prisoners of synthetic cannabinoids, as a result of the implementation of the Psychoactive Substances Act (see section 3.11), will no longer be regulated within NPS.

As we discuss in section 3.5.6, finding the funds to pay for their daily consumption of synthetic cannabinoids led many users to commit crime. Indeed, as users’ tolerance increased, many found themselves spending up to £50 a day; an amount that they would have previously used to fund a heroin or crack habit. Coupled in this is the finding in prisoners of synthetic cannabinoids, as a result of the implementation of the Psychoactive Substances Act (see section 3.11), will no longer be regulated within NPS.

As we discuss in section 3.5.6, finding the funds to pay for their daily consumption of synthetic cannabinoids led many users to commit crime. Indeed, as users’ tolerance increased, many found themselves spending up to £50 a day; an amount that they would have previously used to fund a heroin or crack habit. Coupled in this is the finding in prisoners of synthetic cannabinoids, as a result of the implementation of the Psychoactive Substances Act (see section 3.11), will no longer be regulated within NPS.

As we discuss in section 3.5.6, finding the funds to pay for their daily consumption of synthetic cannabinoids led many users to commit crime. Indeed, as users’ tolerance increased, many found themselves spending up to £50 a day; an amount that they would have previously used to fund a heroin or crack habit. Coupled in this is the finding in prisoners of synthetic cannabinoids, as a result of the implementation of the Psychoactive Substances Act (see section 3.11), will no longer be regulated within NPS.

As we discuss in section 3.5.6, finding the funds to pay for their daily consumption of synthetic cannabinoids led many users to commit crime. Indeed, as users’ tolerance increased, many found themselves spending up to £50 a day; an amount that they would have previously used to fund a heroin or crack habit. Coupled in this is the finding in prisoners of synthetic cannabinoids, as a result of the implementation of the Psychoactive Substances Act (see section 3.11), will no longer be regulated within NPS.

As we discuss in section 3.5.6, finding the funds to pay for their daily consumption of synthetic cannabinoids led many users to commit crime. Indeed, as users’ tolerance increased, many found themselves spending up to £50 a day; an amount that they would have previously used to fund a heroin or crack habit. Coupled in this is the finding in prisoners of synthetic cannabinoids, as a result of the implementation of the Psychoactive Substances Act (see section 3.11), will no longer be regulated within NPS.
Those users we interviewed that disclosed existing mental health problems as a result of their substance use.

Mental health look at it as a drug problem and not a mental health problem. Patients are presenting with mental health symptoms as a result of drug misuse. 

3.5.5 Mental health support needs

Despite the high usage rates, the evidence of chronic addiction and dependency, and the negative physical and mental health effects of synthetic cannabinoid use, only a small minority of those we interviewed were engaged with any kind of mental health or substance use treatment services. This finding was supported by the survey of individuals engaged with Homeless Link (see section 3.5).

It is important to note that many of the people we interviewed for this research were accessing any form of support or treatment at the time they were interviewed. As we illustrate below, several had tried but waiting times had deterred them from accessing support. These experiences had put others off from trying to access support. However, the difficulty in accessing mental health support services is not restricted to those with problematic substance use. Indeed, the recent Mental Health Lightening Review from the Children’s Commissioner (2016) found that many young people are unable to access the mental health services and support they need. Nonetheless, as highlighted in the previous section, given the high levels of substance use amongst young people, the mental and physical health problems and acquisitive crime that will emerge. There will be people with loads of mental health problems. … Patients are presenting with mental health problems...and they then get this half an hour assessment and told to go on your way to drugs services. I think that’s the depressing thing that will emerge. There will be people with loads of mental health problems as a consequence of this [NPS], and no one will see it as their role’ (City Centre GP).

The homeless mental health team that comes here, that is commissioned ... If you’ve got diagnosed with schizophrenia and starting to use substances, fine. But if you’re one of these young people, the classic individual who has a diagnosis of ADHD during childhood, and been lobbed from services, [but is] now taking legal highs, you won’t get a mental health service, nobody is interested’ (City Centre GP).

These comments are at odds with information we received from out-patient psychiatry, community mental health teams and acute home treatment teams who were consistent in stating that they will not reject a service user due to their substance misuse alone. In light of the disparity of stakeholder’s views in relation to the current level of mental health service support for substance users, we suggest a review of existing channels of communication and referral pathways (for further discussion see sections 4.2.3, 4.2.4 and 4.2.5).

In consideration of the findings presented here in relation to drug dependency and perceived addiction, mental and physical health issues, and acquisitive crime? The findings from this research and others that were widely attributed to synthetic cannabinoids, we suggest a need for improved recording, greater public health surveillance and awareness, targeted public health messaging and service innovation (see sections 4.1 and 4.2).

3.5.6 Scary Spice? The relationship between synthetic cannabinoid use, crime and disorder

I got a lad inside and he got (into) £200 debt. And this lad had two kids in his pad with two razorblades, and obviously if someone’s going to go for your face, you hold your hands up. I got to see his arm, all his arms and all his face, he’s got a cut from his eye right down to his chin, for £200 worth of Spice’. (18-year old Male, Supported Housing Focus Group)

Since 2012, Her Majesties Inspectorate of Prisons (HMIP 2014, 2015) have consistently identified a causal link between NPS consumption and an unprecedented increase in serious assaults in adult male prisons. The increase in the use of new psychoactive substances was a significant factor in the increase in violent incidents in adult male prisons (HMIP, 2014, 2013). While concerns about the use of synthetic cannabinoids were primarily attributed to NPS use (Ministry of Justice, 2014b).

In addition, the Ministry of Justice recorded a 36 per cent increase (from 3,640 to 4,963 incidents) in violence against staff between 2013-2014 (HMIP, 2015) and 2014-2015 (Ministry of Justice, 2016b).

Although research is now starting to further investigate the relationship between NPS use and violence within adult prisons (see, for example, Ralph et al., 2016), there is currently a gap in existing knowledge regarding the relationship between NPS use and offensive behaviour in the community. Does NPS use lead to increased levels of violence and/or criminal behaviour, such as robbery or acquisitive crime? The findings from this research suggest that it does, particularly in relation to the use of synthetic cannabinoids and the homeless community in Manchester. The incidents recounted to the research team included: violent behaviour and physical assaults; sexual assault and sexual exploitation; and robbery and acquisitive crime. Each of these will now be discussed in turn.

Users of synthetic cannabinoids often recalled witnessing changes in personality that they attributed solely to problematic NPS use. Furthermore, a range of staff from services and agencies that are in daily contact with regular users of synthetic cannabinoids repeatedly discussed seeing users’ personalities change from passive to aggressive as a result of their NPS use.

A lot of people have been turning more violent and aggressive ... I know plenty of people who have lost their temper through it’). (Male, 20’s, Homeless GP Surgery Focus Group)

One particular client, he really changed ... made some awful threats to staff. … And he wasn’t like that normally. I think he used spice for about five to six weeks, and in that period he just really changed his personality’ (Supported Housing Manager).

We get people who previously were really passive ending up being aggressive’ (Young Homeless Support Worker).

People can get very aggressive on it. I don’t know if you saw the lad shouting in the centre earlier. Generally he can be alright, but he can’t when he’s smoked Spice, he can become quite shouty and quite aggressive’ (Homeless Day Centre Manager).

In addition to the changes in personality, many of those interviewed also discussed how quickly they, or users they knew, would get aggressive and violent if they were unable to obtain any synthetic cannabinoids. This ranged from threats against shop staff who sold NPS through to violent confrontations between users. Indeed, the research team witnessed several violent incidents whilst attending city centre drop-ins.

You see them all here now, very pensive, polite. Just wait until they don’t get what they want or we are out of stock and they switch instantly. You can see it in their eyes, they become all aggressive’ (City Centre Headshop Staff).
In addition to the violence outlined above, interviewees also discussed the risk of sexual assault faced by young homeless females whilst under the influence of synthetic cannabinoids. Some female interviewees also discussed how they exchanged sexual services to fund their use.

Case Study 4: Jake

Jake is a 23-year-old male and currently homeless. His father [of Jake] was a farmer but he left them when Jake was three. His mother was 'a bit of a drunk' who lost her job. Jake's mother left when he was 15 years old. He has said he has always been 'bad at school'. Jake spent much time living off the streets and was arrested for drug offences, theft and violent disorder.

Jake believes he became addicted to Spice in the course of a single day and after smoking only 2 grams of the substance. He reports that on the following day he suffered significant withdrawal symptoms, nausea, stomach cramps and vomiting. He was taken to hospital but he had progressed to consuming over half an ounce of Spice a day. The drug turned him into a violent person - ‘I wouldn’t think twice before hitting someone, getting hurt… and I’m not that sort of person, I’m not a violent person usually’.

Comparing Spice to cannabis, Jake says Spice is “1000 times stronger” and, while a “small investment in cannabis” would not be smart, it is “like being hit by a truck”. He used the drug for around 18 months and says he believes some of the chemicals accumulated in his system. He found that over time he began vomiting green chemicals whenever he smoked it. He claims he managed to wean himself off Spice by locking himself away for 3 days and smoking weed to help cope with the withdrawal symptoms, although he admits he still has a mental craving for the substance. According to Jake, the way to stop people getting into legal highs is to separate cannabis. He states that until that happens, there will continue to be “people dying and dying and dying”.

We [the homeless community] used to stick by each other, we used to be literally like ‘If someone messes with you, you got to mess with all of us’. And now you’ve [we’ve] literally sitting each other for the Spice. (18-year old Female, Homeless)

People do things [now] that they would never have done… like rob off your friends. And you know you’re leaving him sweating tonight because he’s got Spice in it, either he’s sweating or I’m sweating. (22-year old Male, Homeless)

I’ve got a lot of money, a lot of money'. (18-year old Male, Homeless)

‘You’ve either hardly got anyone using it [NPS], or loads. Because they all group together, and they all seem to go and do something, they’ve been with a group of people taking Spice and the risk of them turning violent for no reason whatsoever'. (Homeless Outreach Volunteer)

Staff working in supported accommodation would also often report cases of residents becoming violent, with staff often attributing residents’ behaviour to the effects of NPS (see section 3.5.6). Indeed, the propensity of synthetic cannabinoids to make users unpredictable, aggressive and violent was reported to such an extent that some services and agencies had to withdraw previously offered support.

We now turn our attention to the other main sector where the high prevalence of NPS use, and synthetic cannabinoids in particular, is having a detrimental impact: the emergency services. The sale and use of NPS in the city centre has created a significant resourcing issue for the police and the health service, especially the ambulance service and hospital A&E departments. In terms of policing, there was a general consensus among those we interviewed that NPS-related incidents in Manchester city centre have increased considerably in the last year or two.

It’s dealing with the associated ASB that comes with it, the crime that comes with it, the health implications and dealing with people who have collapsed, who are suffering an episode’ (City Centre Police Officer)

‘I would say in the last two years there has been a three or four-fold increase in the number of incidents related to NPS that we see each week’. (City Centre FCSC)

‘I’m just going to use one street as an example. … In this specific street, in the entire year, 12 months from 1st April 2012 to 31st March 2013, we had 14 incidents. The following 12 months from the 1st April 2013 to the 31st March 2014 we had 34. The following 12 months from 1st April 2014 to the 31st March 2015 we had 99. The following 12 months [1st April 2015 to the 31st March 2016] we had 295. … 99 per cent of them are to do with NPS and the issues that are coming, stemming from them’. (City Centre Police Officer)
The negative effects recounted by users, and staff from the range of services/agencies that currently find themselves working with NPS users, invariably led to instances where ambulances were called and users were taken to A&E. As with the increased number of NPS-related incidents that the police find themselves dealing with, calls out for ambulances have also increased sharply recently, as has the burden on A&E departments.

‘There’s a lot of times I’ve been hospitalized... I’d be smoking it with people, and I’d wake up in an ambulance on my own. I’d be told I’d been found on my own in a street passed out.’ (18-year old Female, Homeless GP Surgery Drop-in+)

‘I’ve had to call ambulance services a lot more now than I used to. I used to have to do it maybe, say, I’d say once a week. ’ (Homeless Outreach Worker)

‘We’ve had to call more ambulances in the last six months than we have in over 20 years of the centre being open.’ (Homeless Day Centre Manager)

‘Anyone who works in A&E that I speak to, they’re like “It’s a massive, massive issue.” We [the police] just have to stick them in an ambulance, but they are dealing with it at the treatment end.’ (City Centre Police Officer)

Yet despite being fully aware of the resource implications of repeatedly calling out ambulances, for many frontline staff, it is the severity of the harmful effects of NPS, combined with the unpredictable nature of these effects (see sections 3.5.3 and 3.6.4), that results in them calling for an ambulance.

‘I think with NPS... we need to be cautious. I don’t like taking up ambulance time because you know they’ve got finite resources, but it [NPS] is an unpredictable drug. So, for example, I think when people fit, there is guidance by the NHS that you wait a certain amount of time... but if someone’s got NPS, I’m not comfortable waiting any time at all because of the unpredictability... Which is in a way is unfortunate because it’s a drain on the NHS resources.’ (Approved Premises Manager)

It is important to note here that the resourcing impact of repeatedly calling out ambulances, for many frontline staff, it is the severity of the harmful effects of NPS, combined with the unpredictable nature of these effects (see sections 3.5.3 and 3.6.4), that results in them calling for an ambulance.

‘Of course, there is a box to tick for heroin/opioids and for alcohol but NPS? No. I don’t think there is.’ (A & E Nurse)

‘It only occurred to me the other week that we don’t actually record the information, we don’t code it (NPS use)... it’s something we’re not doing.’ (City Centre GP)

‘We are very bad at recording data, we need to improve this. It would be so much easier if we were electronic, but we are not, we still use paper, so unfortunately any kind of audit here is a nightmare because you have to pull out the notes and go through the notes... But again there’s the problem that the doctor might not be recording it properly, the patient might not know what they have taken, or they might not want to tell us.’ (MRI Acute Emergency Consultant)

‘The police have been slow on the uptake really... We don’t have a coding close for legal highs... because it will be that legal highs have caused something else. So it will get recorded under that something else, as opposed to the legal high.’ (City Centre Police Officer)

The lack of robust systems for recording NPS-related incidents was not restricted to medical and criminal justice services. Many services did not systematically record NPS use or incidents, and even where we found organisations that were working with individuals that were consistent and ad hoc with staff themselves admitting a need for improvement. Added to this was the fact that some users, for a range of reasons, chose not to disclose their NPS use.

‘I don’t know how much it’s getting recorded. Plus, people aren’t admitting when they’re on Spice either now... because the hostels won’t let you in with it, and people won’t give you referrals to housing... job workshops and stuff while you’re still smoking it. So people just pretend they’re drunk or they’re taking something else.’ (Homeless Outreach Worker)

‘That’s the one thing we need to kind on keep of top of really... We do [currently] do it, it’s just the frequency of how we do it. And you can see how chaotic it is, by the case you walk from one end of the hall to the other, you have ten things to do. So yes, it’s just something we need to be more proactive about, making sure we record [NPS].’ (Day Centre Coordinator)

As the above quote illustrates, many staff are working in chaotic environments. This was something we witnessed on numerous occasions during research fieldwork to drop-ins, GP surgeries, day centres and a range of supported accommodation providers. These chaotic conditions are intensified when dealing with an NPS-related emergency involving psychosis, fitting, overdose, or respiratory problems.

We have therefore advocated for improved NPS recording systems, recognising the necessity to do so in a way that does not cause additional burden and strain on frontline staff that are already working to full capacity and dealing with emergencies.

Everyone knows what you’re supposed to do, and how it would be handy to have [NPS-related] information recorded, but actually trying to get that to be the priority of people who make decisions about what goes on their systems is a day-to-day battle. And they’re finding it improved NPS recording systems, we recognise the necessity to do so in a way that does not cause additional burden and strain on frontline staff that are already working to full capacity and dealing with emergencies.

Even more so when you’re in a hosp. Can’t really pull out the notes and go through the notes... But then again there’s the problem that the doctor might not be recording it properly, the patient might not know what they have taken... or they might not want to tell us’. (MRI Acute Emergency Consultant)

With this in mind, it is clear that the development of more robust recording systems in consultation with frontline staff are required, with careful consideration being given to how this data could be used to role-locate staff, and any other data recording and monitoring that they have to conduct. This offers a particular challenge for police and medical services.

Nevertheless, the research did find some evidence of existing monitoring of NPS use and incidents that offer positive signs that developing more accurate data collection is possible. For example, a number of supported accommodation providers and third sector organisations working with the street homeless discussed how they currently monitor NPS-related incidents.

‘If we have to send for an ambulance, we’ve got to do an incident report.’ (Young People’s Street Homeless Support Worker)

‘We’ve got an incident and near miss form, which we complete. The person that is incident-based involved, a member of staff... they’ll complete the incident and near miss form, which is then passed to me, and I need to complete that... I get an account of how we’ve responded to that situation, so “Did we deal with it appropriately and have we learned from that?” And then I send it off... to a health and safety hub, and they’ll more more formally review it.’ (Homeless Outreach Worker)

As we discuss in section 3.4, despite the claim by SGBHA that outside of London the fastest growing chemsex scenes are in Manchester and Brighton, existing prevalence data on the use of NPS as part of chemsex amongst the LGBT population in Manchester does not exist. However, it is worth noting that, as a result of a recent effort to improve monitoring through the LGBT Foundation, the recording of NPS is improving with the development of substance use screening in sexual health clinics.

‘We’ve started to change the way we monitor things, and we’ve started to ask more about drugs and alcohol as part of all of our services really... We routinely ask the question if they’ve injected drugs in the past 12 months, and then we ask during the assessment about uses of chemsex during sex. And all of that data is being collected and used in data sharing at Public Health England.’ (LGBT Foundation Manager)

There are also signs that better local identification of substance use, such as chemsex, will be available shortly as measures have also been put in place at national level to improve our understanding of the prevalence of drug use amongst young people with sexual health needs.

The under-reporting of NPS use also extends to the National Drug Treatment Monitoring System (NDTMS). Our research revealed that even when local therapists were accessing services there are problems with the existing recording systems. For example, NDTMS receives data for adults and young people who are accessing structured planned treatment interventions i.e. Tier 3 interventions. However, because of the focus on Tier 3 interventions, the system currently omits data from those treatment providers who deliver non-structured low threshold interventions.

‘I’ve had a few people involved in chemsex over the last few weeks... I’ve spent an hour with them, but we’ve not gone through the assessment because they’ve not actually wanted to access structured support, and instead they just came in for a little bit of advice [INT: How would that be recorded?] I don’t think that’s being recorded.’ (Substance Use Practitioner)
As highlighted in section 3.8, there is a general lack of coexistence with the problem of non-disclosure of NPS use by users. It was specifically noted how the structure of the TOPs form, particularly questions on CMS data recording system which centred around the current structure of the TOPs forms (Treatment Outcome Profile). Within the core data set, services record drug code one, and two (i.e. primary, secondary and tertiary substance used), defined as: The substance that brought the client into treatment at the point of triage/initial assessment, even if they are no longer actively using this substance. If a client presents with more than one substance the agency is responsible for clinically deciding which substance is primary.

As we discuss further in sections 3.8, many users of synthetic cannabinoids have previous history of alcohol, heroin and crack dependency. As such, for those who do engage in treatment, the existing approach of recording that substance as their primary drug of choice as serious enough to warrant seeking support is complicated by polydrug use, particularly when polydrug repertoires include a number of different NPS. This causes specific difficulties in correctly recording the main types of NPS that are commonly used. This is a particular problem amongst the chemsex cohort. On the TOPs form, it states your heroin, crack, amphetamines, and cannabis at the bottom is ‘other’, and then you’ve got the NPS. But if somebody is using three ‘other’ drugs, you can only record one of them. I get that with the chemsex cohort, because they use methamphetamine, mephedrone and GBL. I put the methamphetamine under ‘amphetamine’, but it is in the drop-down box under ‘other’. But if I use that for methamphetamine I couldn’t put mephedrone. So I put methamphetamine under ‘amphetamines’, I put the mephedrone in the ‘other’, but then I can’t put GBL. So I think there probably is a missing data issue. (Substance Misuse Practitioner working with MSM)

We conclude that in the absence of any immediate signs of changes to the NDTMS TOPs forms, routine data collection on NPS use outside of the NDTMS ‘other’ category is required as current assessment and recording tools do not sufficiently monitor the issue.

It must be remembered, though, that alongside the problems with official data recording systems outlined above, there coexists the problem of non-disclosure of NPS use by users. As highlighted in section 3.8, there is a general lack of reporting of health issues to GPs or treatment services – mainly due to a mistrust/perspective they do not have anything to do with mental health issues and an overall reluctance amongst NPS users to disclose NPS use due to the risk of it impacting negatively upon license conditions and housing tenancy agreements.

Substance use practitioners also highlighted a further limitation with the NDTMS data recording system that centred around the current structure of the TOPs forms. This problem is further compounded by polydrug use, particularly when polydrug repertoires include a number of different NPS. This causes specific difficulties in correctly recording the main types of NPS that are commonly used. This is a particular problem amongst the chemsex cohort. On the TOPs form, it states your heroin, crack, amphetamines, and cannabis at the bottom is ‘other’, and then you’ve got the NPS. But if somebody is using three ‘other’ drugs, you can only record one of them. I get that with the chemsex cohort, because they use methamphetamine, mephedrone and GBL. I put the methamphetamine under ‘amphetamine’, but it is in the drop-down box under ‘other’. But if I use that for methamphetamine I couldn’t put mephedrone. So I put methamphetamine under ‘amphetamines’, I put the mephedrone in the ‘other’, but then I can’t put GBL. So I think there probably is a missing data issue. (Substance Misuse Practitioner working with MSM)

We conclude that in the absence of any immediate signs of changes to the NDTMS TOPs forms, routine data collection on NPS use outside of the NDTMS ‘other’ category is required as current assessment and recording tools do not sufficiently monitor the issue.

It must be remembered, though, that alongside the problems with official data recording systems outlined above, there coexists the problem of non-disclosure of NPS use by users. As highlighted in section 3.8, there is a general lack of of under reporting currently exists across a range of services. As sections 3.5.3 and 3.5.4 have illustrated, many users are reporting health issues and mental health problems and report addicitivevity and dependency, yet their service needs are not being met due to client perceptions of what services can offer. Furthermore, we have illustrated here that even when users do engage with treatment services or criminal justice and health agencies, their NPS use is often unrecorded. Having noted the lack of user engagement with treatment services and the subsequent under reporting of NPS use, the following sections explore another key focus of the research – the reasons why users are reluctant to engage with services.

### 3.8 NPS use and service user engagement

There are people who we’re seeing on the streets a lot, young people particularly, who aren’t accessing city centre projects and they’re not accessing Lifeshare, they’re not going to the Booth Centre, they’re just staying on the streets, and begging for money for Spice… They’re not engaging with any services at all. (Homelessness Case Manager at City Centre Medical Practice)

As the above quote above illustrates, there was an acknowledgement that many NPS users are not accessing the available support on offer. Indeed, throughout the research we found a clear lack of engagement with treatment services by many regular NPS users. This was despite the acknowledgement by many users that their use of synthetic cannabinoids and other NPS resulted in a range of problems (as outlined in sections 3.5.3, 3.5.4 and 3.5.6). While in section 3.5.6 we highlighted the unmet mental health needs of many users and the need for a more integrated mental health and substance use service, in this section we focus on the reasons provided by users and frontline staff for the lack of engagement with the local substance use treatment services.

### 3.8.1 ‘It ain’t crack or smack’:

The reasons why NPS users are not engaging with services

Despite often raising concerns regarding their NPS use (see sections 3.5.3 and 3.5.4 on effects), many users of synthetic cannabinoids that we encountered did not perceive their drug of choice as serious enough to warrant seeking support from either a GP or treatment services.

I can’t go to anybody and say ‘I’m addicted to Spice’… (They’ll say) ‘Well Spice is legal so what are you worried about?’ (Male, early 20s, Synthetic Cannabinoid User Interviewed in City Centre Headshop)

The stereotypical views that services are just a place for injecting heroin and crack cocaine users provided further evidence for the need for services to better promote what services NPS users and support around NPS use they can offer. We came across many young NPS users in particular who viewed treatment services as a place for heroin and crack users or a place to obtain clean needles.

Why would I want to go to a place with druggers? (Male, early 20s, Homeless)

Do you know what they’re for, them drugs services? To give new needles, and I don’t use needles, so why do I need to go there? (Synthetic Cannabinoid User, Supported Housing Focus Group 2)

These views were further supported by professionals working with this user group. They discussed how the stigma that is associated to treatment often acts a barrier to engagement amongst NPS users.

The services that are already set up, they [NPS users] think they’re for the heroin users. They don’t feel like it is for NPS. (Supported Housing Staff, Focus Group)

Moreover, several professionals that we interviewed seemed to hold similar outdated understanding and knowledge of what treatment services offer and what substances they work with.

‘They’re addicted to NPS, so why would they go to somewhere that deals with class A drugs … They don’t want to be defined as that kind of drug user’. (Supported Housing Manager)

This separation of their use of NPS and the problematic use of traditional drugs such as heroin and crack cocaine is an interesting finding. Not least because of the many similarities that users recounted between regular, dependent use of non-DEA controlled substances such as heroin and crack cocaine (see sections 3.6.3 and 3.5.6). Despite the clear parallels around physical and mental addiction, including acute withdrawals and users reporting committing a range of acquistive crimes to fund their use, the fact that many NPS users distanced themselves from the traditional profile of a problematic drug user in need of treatment and support is significant. Addicts often act as a barrier to engagement amongst NPS users.

They’ve got nothing to help you because they don’t know what they’re for. They’re not going to do anything about it, they’re fucking shit. (Supported Housing Focus Group)

I was in A&E because I was on Vertex Space Cadet … and they didn’t know nothing about it … (and) they didn’t even know where to send me to (24-year old male, rough sleeper, Lifeshare)

They [treatment services] don’t know much about it All they know is you need to stop it. (24-year old male, Homeless)

(INT: Have you gone to the GPs? No, because they don’t know what they’re for to help you for it… I’ve heard it all before people coming here (doctors), raffling off Spice and they’ve got no help. (30-year old male, Homeless)

(INT: If you wanted to get off it in the future, would you go to a drug service for help? No, because I know they don’t really know much about it) I probably think ‘Well you’re just wasting my time as much as I’m wasting yours’. (Male, 20s, UMPV)

---

**Key Points**

- NPS use is underreported due to client perceptions of services.
- Many NPS users are not accessing treatment services.
- Professionals often have outdated understanding of NPS use.
- Treatment services need to improve engagement with NPS users.

---

**References**

Substance Use and Addictive Behaviours (SUAB) Research Group | 39
3.8.2 ‘What’s on offer that’s going to make people come in?’

One of the most frequently cited factors when it came to non-engagement was the perception that treatment services lacked the offer of substitute medication. The lack of a substitute perception was particularly cited as an issue by users who had previously engaged with services for heroin addictions. These users would compare the treatment offer for heroin with what they perceived to be on offer for Spice.

What’s on offer that’s going to make people come in? What’s out there to substitute Spice, treatment wise? Going cold turkey is seen as a hero’s path. I know there is not a get to rate every day [but] for Spice, there’s not any of those things, so why am I going to get treatment? (Male late 30s, Ex-heroin user, current NPS user)

‘What is there to substitute my Spice? … There’s a vacuum; there’s nothing there for me.’ (40-year old Male, User of ‘Ice’n’Bongs’)

A chemical of some sort [to substitute NPS use] is going to get me to treatment because that’s what I know. (Male late 30s, Ex-service-user for heroin and crack, interviewed purchasing NPS in a City Centre Headshop)

‘There’s nothing there to get it off it. You can prescribe a heroin addict with Subox (Subutex), but there’s nothing out there [to prescribe to NPS users]’ (20-year old Male, Homeless, Synthetic Cannabinoid User)

Interestingly, the lack of any substitute medication to replace synthetic cannabinoid dependency was also cited as a barrier to treatment engagement by professionals working with this user group.

For other drugs there’s a clear route. If someone’s using heroin or crack, it’s very easy for me because there’s a nice route which I can go down, generally by prescribing alternatives. But [with NPS] there’s no clear route. … It’s generally just to motivate them, to ask people to think about their use of legal highs and things like that. … I don’t have any route really for someone who is just using legal highs. (Homeless Outreach Worker)

3.8.2.2 ‘There needs to be something that’s specific for NPS’

There is an ongoing debate regarding how much services need to adapt when working with NPS users. As noted in section 1, most – although by no means all – NPS have been developed to mimic the effect of traditional substances and fall within traditional broad categories such as stimulants, hallucinogens, depressives and depressants. It is argued by many that the same harm reduction advice, motivational interviewing techniques and psychosocial interventions, identification of triggers and so forth can be applied regardless of the substance involved. While this may hold true for some types of NPS, the case of synthetic cannabinoids seems to be an exception. Despite synthetic cannabinoids being designed to work on the same receptors as stimulants (CB1 and CB2) as the active ingredient in cannabis – delta-9 tetrahydrocannabinol (THC) – the effects bear little resemblance to those associated with cannabis. We have already outlined the impact of synthetic cannabinoid use on the mental and physical health of users (see sections 3.5.3 and 3.5.4). These wide ranging effects go beyond the symptoms subsumed under the term ‘cannabis use disorder’ and indicate that the typical cannabis user would present with different needs to users with Spice.

Indeed, many of the effects discussed by synthetic cannabinoid users are more in line with the profile of crack cocaine and benzodiazepine use than with cannabis. Added to this, the reported aggression it bestows in users. Because of this, many users and stakeholders have called for a specific intervention to be developed to serve the particular needs of dependent synthetic cannabinoid users.

I also think [we need] some kind of specialist service for people who are using Spice. … Because it’s not heroin, it’s not crack, it’s not cannabis, it’s a drug on its own, and people who are using it need to talk about how they feel when they’re using it, and the withdrawals, and have that support that’s maybe linked into like recovery, to look at the reason why they’re addicted to drug. (Supported Housing Manager)

It’s quite hard at the moment because they [users] are approaching drugs services and there’s not a lot of help to get people through Spice addiction. … There needs to be something that’s specific for NPS. (Supported Housing Manager)

People are going to need something to come off it, that’s what I say. Because it’s not going to go away this, this drug, legal high. (30-year old Male, Homeless Synthetic Cannabinoid User)

Despite the acute withdrawal symptoms, we came across a handful of users who had managed to cease using synthetic cannabinoids without any support from services. For all but one, they had relied on smoking as much skunk cannabis as they could get hold of and locking themselves away in a room with basic provisions.

(BIT: If you wanted to get off it, where would you go to; would you go to the doctors or services?) Just lock myself in my room and keep myself away from it. All you can do, (Daily Synthetic Cannabinoid User, Interviewed in City Centre Headshop)

However, it is important to note that not everybody wishing to address their synthetic cannabinoid use is in the position of being able to ‘lock themselves away’, as this young street homeless male observes.

‘You need to be in a position to detox. You need a roof over your head for starters. You’re going to be hot, cold, sweating, you’re sick, you shut yourself – you can’t control all, you can’t control your bodily functions.’ (24-year old Male, Homeless)

In addition to the physical symptoms experienced by those users trying to cease their synthetic cannabinoid use, some users also discussed a deterioration in their mental health when they stopped using.

3.8.4 Integrating mental health support and substance use services

Mental health won’t deal with them until they’ve addressed their substance misuse. (Homeless Day Centre Manager)

We can’t get a dual diagnosis because they [the mental health services] are saying it’s drug-induced psychosis and they [the substance use services] have to deal with...
Substance Use and Addictive Behaviours (SUAB) Research Group | 43

As these quotes illustrate, one issue that consistently featured in our interviews was that both NPS users and a broad range of professionals was in relation to the current level of mental health support available to users of NPS. There was a commonly held view that substance use and mental health teams need to be more integrated and to enable them to better address the many problems and issues (see sections 3.4.7 and 3.5.4) that arise from the problematic use of NPS, in particular synthetic cannabinoids and those substances associated with the chemsex scene.

The problem with mental health and substance misuse is, because of the way services are, the first thing they’ve got to do is reduce substance misuse before they’ll do mental health work. But they’re both hand in hand. (Support Worker, Young Homeless)

I would like to see mental health services work in partnership with substance misuse services, to kind of have a single point of entry. (City Centre GP)

Substance use and mental health have become completely separate. They don’t talk to each other. … We see this often, … they haven’t got any kind of link or anything, and it’s unfortunate because we should be working hand in hand. (A&K Consultant)

While the findings of this research suggest a need to review current mental health provision for users of NPS, with a view to monitoring the development of new integrated alcohol and drug service delivery, as we outlined in section 3.4.7 there was also an identified need for the integration of mental health and counselling support into the current health service delivery and existing dual diagnosis staff provision.

The Dual Diagnosis Liaison Service (MDHSCST) is part of the Manchester Mental Health Social Care Trust (MMHSCT). A central remit of the Dual Diagnosis Liaison Service is to facilitate mental health and substance misuse services working in a more integrated way. Although the new integrated alcohol and drug service providers were only recently in post, the new structure had already led to positive aspects in the developed model of joint working between mental health and substance misuse services. Incorporated in to this is an ongoing programme of Dual Diagnosis Liaison Service led training to 80 CCL staff that focuses on (i) mental health services information and pathways (ii) CBT for psychosis, anxiety, depression (iii) CBT and schemas based work for personality disorder and (iv) dual diagnosis. The Dual Diagnosis Liaison Service and CCL have also conducted a review of dual diagnosis pathways. This comprises the development of revised guidance on patients Dual Diagnosis Referrals to the Manchester integrated alcohol and drug service. These care pathways clearly illustrate the pathway of a CGL client into MHSCT and the pathway of a MDHSCST client into CCL’s integrated alcohol and drug service. Other noteworthy developments in partnership working have included the encouragement of MHSCT and CCL staff to attend each other’s meetings and visit bases in order to facilitate more awareness and strengthen the integrated drugs and alcohol and mental health trust working partnership.

Nevertheless, the regular reporting of mental health concerns linked to NPS that cut across vulnerable groups suggests that both the lack of information and expertise amongst these frontline staff is a clear training need for frontline staff working in partnership with substance misuse services to kind of have a single point of entry. (City Centre GP)

The research identified a clear training need for frontline staff working with NPS users. Indeed, the lack of routine training around NPS amongst some services was particularly surprising. This training need was further evidenced by many of the staff we interviewed during the course of the research actually asking the research team for information and training.

I was offered one training course about a month ago … but that’s all really … I think there needs to be an ongoing training programme offered to agencies (Homeless Outreach Worker)

If you don’t get any specific training around NPS? No, no you don’t. As a new starter, I found myself explaining what Spice and NPS and these sorts of legal highs were to some of the staff, much more experienced staff than myself. And that’s just through having taken an interest in certain documentaries, and then coming across it a few times myself at the A&E now. … [Although] there’s mandatory training that you have to go through [and] some of that is around the general signs and symptoms, usually of heroin or alcohol overdose. (A&K Nurse)

We have had training on it last year but to be honest I didn’t rate it. (Supported Housing Manager)

We have had training on it last year but to be honest I didn’t rate it. (Supported Housing Manager)

It appeared from the interviews we conducted with frontline staff that, when it comes to training around NPS, what they want are practical tips and good practice on how to respond in emergency situations, rather than simply generic overviews of NPS.

We have had some legal highs training … but it was very much more about the background and how legal highs came about and legal drugs do not cut it. We’re still trying to sort some training really to say what’s good practice, what we can do, what things you need to look out for, with harm reduction, that’s the kind of training we’d really need to receive. (Probation Service)

As highlighted in the above quote, it is clear that training needs to move beyond the basic introduction to NPS and focus more on answering the questions that these frontline staff are asking, such as, ‘At what stage should we call out an A&E nurse?’. It is also clear that any training should include clear guidance on what is current best practice when it comes to working with NPS users.

What is the best evidence base for what our approach should be for people that are using this stuff? … That’s sort of what I’m looking for. We can upskill and, we can make up our minds. … We need to have the ability to do something about it, to intervene and make a difference. … That’s the bit that I really want to see. (Probation Manager)

As we have illustrated, keeping up to date with the emerging drug trends and how to respond to them is a necessary part of the role of services. The production of short, two page key information guides was also requested by many practitioners and supported accommodation staff that we interviewed.

Just signs and symptoms, the things that we can do in terms of the withdrawal of drugs, things to look out for. (A&K Nurse)

I’d like an idiots guide, 2 pages’ (Senior Probation Officer)

However, when it comes to actually highlighting best practice, or raising awareness of emerging trends and developing training materials, we suggest that some of the staff working in these settings don’t have the time or resources to develop appropriate training materials or to commission training for key staff. As we have illustrated, keeping up to date with the emerging drug trends and how to respond to them is a necessary part of the role of services.

One of the things that I found quite helpful when dealing with people on Spice was just to sit them up, give them some water and just say ‘Look, try and just make them focus on where they are and who they are and the fact that they’re going to be okay’. (Homeless Worker)

We’ve learnt loads. We’ve learnt not to react too fast because there are things people can do within 10 minutes and so we’ve learnt to observe people when they’re under the influence of it, just make them safe. We tend to lay them on their side and then when they wake up, they’re fine. (Senior Probation Officer)

We’ve got a lot of symptoms that come with use, like people just keep regular checks on them. … Then if we do become concerned, or they don’t seem to be coming out of it, then we’ll contact the ambulance. (Supported Housing Manager)

The Dual Diagnosis Liaison Service and the Dual Diagnosis Liaison Service are in daily contact with users have accumulated a wealth of knowledge on their caseloads. In contrast, as we evidence throughout the report, many of the agencies and organisations who work with NPS users on a daily basis.

(Treatment service name) came over here and delivered some legal high training, and there was nothing new that they were telling us that I’d not already told them; (Young People’s Homeless Project Worker)

[INT: Have police officers received training on how to deal with patients that present with NPS use?]

No, there is no training. … I’ll honestly hand on the drug problem before they [the mental health services] deal with the mental health problem. (Young People’s Substance Use Practice Foundation)
There is an obvious need for this first-hand experience and learning to be shared as best practice. We strongly believe that the knowledge and intelligence that has been accumulated should be used to inform and develop better training for those who find themselves working with NPS users, including medical staff (e.g. paramedics, A&E doctors and nurses). As we shall detail in section 4.1, we propose the setting up of a local drug information system as outlined in recent Public Health England guidance (see Public Health England, 2015). Not only will this help to facilitate this knowledge exchange, it will also go some way to making staff in frontline services feel less isolated and more confident when it comes to dealing with NPS.

3.10 Developing a Greater Manchester local drug information system (LDIS)

I think for all the boroughs in Greater Manchester to come together and have a strategy in terms of managing our drug services to feel equipped in dealing with the problem. I think there is a bit of fear at the unknown for drug services in terms of managing it so basically something that will increase confidence for people that are working with individuals to feel that they are armed to address the issue and it not being a ‘unknown kind of panic’. (Homesless Day Centre Manager)

As the previous section has highlighted, professionals working with these user groups identified gaps in knowledge, isolation, and a lack of clarity regarding best practice and referral pathways concerned. And they were concerned not only about the possibility of users being unaware of the natures of some of the substances they were using but also that they were not aware if they were illegal or if there were any legal consequences. As the previous section has highlighted, professionals working with these user groups identified gaps in knowledge, isolation, and a lack of clarity regarding best practice and referral pathways concerned. And they were concerned not only about the possibility of users being unaware of the natures of some of the substances they were using but also that they were not aware if they were illegal or if there were any legal consequences. As the previous section has highlighted, professionals working with these user groups identified gaps in knowledge, isolation, and a lack of clarity regarding best practice and referral pathways concerned. And they were concerned not only about the possibility of users being unaware of the natures of some of the substances they were using but also that they were not aware if they were illegal or if there were any legal consequences.

The establishment of a LDIS would facilitate the early identification, risk assessment and appropriate response to NPS, or other drug related trends or concerns (e.g. adulterated drugs, bad or strong batches etc.). In section 3.5.3, we highlighted that interviewees attributed several deaths to NPS use, particular synthetic cannabinoid use. The initial prompt to inform drug gathering used in the LDIS model also has the potential to assist with drug related death reviews (Public Health England, 2016). During the course of our research, we observed an increasing amount of significant demand and support for a Greater Manchester LDIS.

‘Yeah, that’s brilliant. I’d love to be involved with it’ (Supported Housing Manager)

As the above quote alludes to, Salford DAAT have developed an Early Warning System (EWS) that provides an information sharing protocol for NPS that facilitates the raising of awareness to newly identified substances associated with drug related death, in Salford (DAAT, 2016). A range of stakeholders commented on how the Salford EWS, a pioneer model that the recent Public Health England guidance draws heavily upon, had helped inform the development and to issue appropriate public health alerts on new/novel, potent, adulterated or contaminated drugs.

The Salford system has also provided a central location to provide specific information on different types of NPS and NPS legislation, including amendments to the Misuse of Drugs Act 1971 that enable the early awareness to newly identified substances associated with drug related death, in Salford (DAAT, 2016). A range of stakeholders commented on how the Salford EWS, a pioneer model that the recent Public Health England guidance draws heavily upon, had helped inform the development and to issue appropriate public health alerts on new/novel, potent, adulterated or contaminated drugs.

The Salford system has also provided a central location to provide specific information on different types of NPS and NPS legislation, including amendments to the Misuse of Drugs Act 1971 that enable the early awareness to newly identified substances associated with drug related death, in Salford (DAAT, 2016). A range of stakeholders commented on how the Salford EWS, a pioneer model that the recent Public Health England guidance draws heavily upon, had helped inform the development and to issue appropriate public health alerts on new/novel, potent, adulterated or contaminated drugs.

In addition to Salford, during the course of our research we became aware that Bury had recently introduced its own LDIS whilst a similar review of NPS prevalence and provision in Tameside by Liverpool John Moore University Centre for Public Health Research has also recently recommended the establishment of a LDIS. With the Greater Manchester Devolution on the horizon we therefore recommend (see section 4.1) that the establishment of a LDIS is implemented as a Greater Manchester LDIS rather that solely serving Manchester. This suggestion had the support of many stakeholders we interviewed.

3.11 Impact of the Psychoactive Substances Act 2016

During the course of this research – 26th May 2016 – the Psychoactive Substances Act 2016 was introduced. The Act represents the most significant legislative change in NPS focused UK drug policy since the banning of mephedrone and related synthetic cannabinoids in March 2010 and the subsequent introduction of temporary class drug orders (TCDOs) in 2012. In summary, the Psychoactive Substances Act makes it an offence to produce or supply any psychoactive substance, if the substance is likely to be used for its psychoactive effects. The only exemptions from the Act are those substances already controlled by the 1971 Misuse of Drugs Act, nicotine, alcohol, cigarette and medicinal products. Possession of a psychoactive substance is not an offence (except in a custodial institution), but possession with intent to supply, importing or exporting a psychoactive substance are all offences. In essence, the Psychoactive Substances Act aims to shut down all UK-based shops and websites that trade in psychoactive substances.

In addition to Salford, during the course of our research we became aware that Bury had recently introduced its own LDIS whilst a similar review of NPS prevalence and provision in Tameside by Liverpool John Moore University Centre for Public Health Research has also recently recommended the establishment of a LDIS. With the Greater Manchester Devolution on the horizon we therefore recommend (see section 4.1) that the establishment of a LDIS is implemented as a Greater Manchester LDIS rather that solely serving Manchester. This suggestion had the support of many stakeholders we interviewed.

‘It just doesn’t make any sense not to have that [a LDIS] for Greater Manchester linked to an early warning system’ (DAAT Manager)

I think early warning systems are great networks for people to get the right information written in a concise way. ‘I think there should be regional early warning systems in Greater Manchester. (Public Health England, 2015)

The LDIS model proposed by Mike Linnell for Public Health England pulls together elements from the Salford model and other areas and is intended to complement existing Public Health England protocols used to assess intelligence, issue warnings and to respond to related immediate risk, to a low-cost, low-maintenance and multidisciplinary system that uses existing local expertise and resources (Public Health England, 2016). The Public Health England guidance sets out an ambition for an England-wide network of local systems that operate in a consistent and complementary way. We propose that Greater Manchester has an opportunity to be at the forefront and champion of this ambition by developing a LDIS that incorporates the 10 Greater Manchester boroughs.

Prior to outlining our full set of recommendations, we first turn our attention to the impact of the recently introduced Psychoactive Substances Act.

The establishment of a LDIS would facilitate the early identification, risk assessment and appropriate response to NPS, or other drug related trends or concerns (e.g. adulterated drugs, bad or strong batches etc.). In section 3.5.3, we highlighted that interviewees attributed several deaths to NPS use, particular synthetic cannabinoid use. The initial prompt to inform drug gathering used in the LDIS model also has the potential to assist with drug related death reviews (Public Health England, 2016). During the course of our research, we observed an increasing amount of significant demand and support for a Greater Manchester LDIS.

The establishment of a LDIS would facilitate the early identification, risk assessment and appropriate response to NPS, or other drug related trends or concerns (e.g. adulterated drugs, bad or strong batches etc.). In section 3.5.3, we highlighted that interviewees attributed several deaths to NPS use, particular synthetic cannabinoid use. The initial prompt to inform drug gathering used in the LDIS model also has the potential to assist with drug related death reviews (Public Health England, 2016). During the course of our research, we observed an increasing amount of significant demand and support for a Greater Manchester LDIS.

The establishment of a LDIS would facilitate the early identification, risk assessment and appropriate response to NPS, or other drug related trends or concerns (e.g. adulterated drugs, bad or strong batches etc.). In section 3.5.3, we highlighted that interviewees attributed several deaths to NPS use, particular synthetic cannabinoid use. The initial prompt to inform drug gathering used in the LDIS model also has the potential to assist with drug related death reviews (Public Health England, 2016). During the course of our research, we observed an increasing amount of significant demand and support for a Greater Manchester LDIS.

The establishment of a LDIS would facilitate the early identification, risk assessment and appropriate response to NPS, or other drug related trends or concerns (e.g. adulterated drugs, bad or strong batches etc.). In section 3.5.3, we highlighted that interviewees attributed several deaths to NPS use, particular synthetic cannabinoid use. The initial prompt to inform drug gathering used in the LDIS model also has the potential to assist with drug related death reviews (Public Health England, 2016). During the course of our research, we observed an increasing amount of significant demand and support for a Greater Manchester LDIS.

The establishment of a LDIS would facilitate the early identification, risk assessment and appropriate response to NPS, or other drug related trends or concerns (e.g. adulterated drugs, bad or strong batches etc.). In section 3.5.3, we highlighted that interviewees attributed several deaths to NPS use, particular synthetic cannabinoid use. The initial prompt to inform drug gathering used in the LDIS model also has the potential to assist with drug related death reviews (Public Health England, 2016). During the course of our research, we observed an increasing amount of significant demand and support for a Greater Manchester LDIS. This in turn, will enable a more effective response.

As the previous section has highlighted, professionals working with these user groups identified gaps in knowledge, isolation, and a lack of clarity regarding best practice and referral pathways concerned. And they were concerned not only about the possibility of users being unaware of the natures of some of the substances they were using but also that they were not aware if they were illegal or if there were any legal consequences. As the previous section has highlighted, professionals working with these user groups identified gaps in knowledge, isolation, and a lack of clarity regarding best practice and referral pathways concerned. And they were concerned not only about the possibility of users being unaware of the natures of some of the substances they were using but also that they were not aware if they were illegal or if there were any legal consequences. As the previous section has highlighted, professionals working with these user groups identified gaps in knowledge, isolation, and a lack of clarity regarding best practice and referral pathways concerned. And they were concerned not only about the possibility of users being unaware of the natures of some of the substances they were using but also that they were not aware if they were illegal or if there were any legal consequences.
In section 3.5, we outlined how 93 per cent of users in the Homeless Link Survey reported purchasing synthetic cannabinoids from city centre headshops. In addition, almost half (45 per cent) stated that the fact that they were convenient to purchase as the main reason for use, with almost a quarter (24 per cent) stating that the fact that they were cheaper than other substances as their main reason for use. Taking these homeless survey findings into account, it might sensibly be assumed that the Psychoactive Substances Act will have a tangible impact on the prevalence of synthetic cannabinoids. Yet, contrary to this assumption, the homeless NPS users that we interviewed confirmed that there was an already established street level synthetic cannabinoids market in areas of the city centre where NPS users were known to congregate (such as around Piccadilly Gardens), and they all predicted that this market would increase following the implementation of the Act.

‘It won’t make it harder to get because you’ll just get it off the streets.’ (Male, mid 20’s, Homeless, City Centre GP Surgery Drop-in)

The early indications are that these predictions hold true. For example, street dealers are operating close to headshops that, as a result of the Act, appear to have stopped selling synthetic cannabinoids and other NPS.

‘You’ve got ten dealers in the (Piccadilly) gardens, just sitting there in the gardens’ (Male, mid 20’s, Homeless, City Centre Day Drop-in)

Added to this, all of the homeless NPS users interviewed felt that the Psychoactive Substances Act will simply push the synthetic cannabinoids market underground, as was found to be the case in Ireland and Poland. Thus potentially increasing social and health harms amongst an already vulnerable population.

‘It’s not going to go away, ... it’s going to go underground, to the crime world now.’ (30-year old Male, Homeless, City Centre Homeless Day Centre Drop-in)

‘You’re going to push it underground and criminalise it... Instead of scoring crack and heroin, they’re now scoring Spice.’ (26-year old Male, Supported Housing)

Since the implementation date for the Act was first mooted (originally April 6th 2016), the more entrepreneurial users we interviewed talked of planning to take advantage of retailers and headshops promoting bulk purchases or BOGOF offers, and of others stockpiling synthetic cannabinoids in anticipation for a hike in demand on the street.

When it comes to availability, we predict that while stockpiles last, supply and ultimately usage will continue as normal. However, as stocks dwindle and availability reduces, we predict that prices will increase. As was the case when mephedrone was banned in 2010, prices of synthetic cannabinoids have already started to increase with users reportedly paying twice as much for street deals compared to previous purchases from headshops and newsagents/shops.

‘They’ve put it up to a tenner a gram now’. (Female, early 20’s, Homeless Day Centre Drop-in)

‘Within a week (of the Act) the prices have already gone up.’ (Male, mid 20’s, Homeless Day Centre Drop-in)

If, and when, the ban does eventually lead to reduced availability, it is likely to impact upon dependent synthetic cannabinoid users in a number of key interconnected ways. Firstly, it will most likely lead to more incidents of robbery and violence amongst users (as outlined in section 3.5.6) as they pursue increasingly scarcer supplies synthetic cannabinoids.

When it gets banned, there’s going to be like groups of people, mobs of people getting about. They know you’ve got it in your pockets, [and] they’re going to kick your head in.’ (Male, early 20’s, Homeless, City Centre GP Surgery Drop-in)

‘Everyone’s going to be twatting each other’. (18-year old Female, Homeless)

‘It will get a lot, lot worse. People are going to get sixed and stabbed up’ (Male, mid 20’s, Homeless Day Centre Drop-in)

Already these predictions seem to have materialised to some degree.

‘In town now, they’re all robbing each other, because they can’t get it so easily any more.’ (Male, mid 20’s, Homeless Day Centre Drop-in)

Secondly, a shift from headshops to street level dealing will almost certainly lead to poorer quality deals as a street level gram can range from 0.5g to 0.8g. This coupled with the price hike mentioned above is likely to lead to more acquisitive crime being committed to fund regular and dependent use.

Thirdly, health concerns have been raised in relation to locally made synthetic cannabinoids. For example, ‘Annihilation’ was widely reported to be made on the premises of a Manchester community surgery drop-in. In contrast to the branded packaging associated with NPS purchased in headshops and online, this product came in a clear snap-bag with basic labelling. During the course of the research, this particular brand was repeatedly cited as being more addictive and having much more negative effects than other available synthetic cannabinoids.

‘That Annihilation stuff is even worse... absolutely disgusting, blows your head off something rotten, I wouldn’t even smoke it when I was smoking Spice.’ (Male, early 20’s, Young people’s homeless drop-in)

‘I’m addicted to Annihilation, and when I have it, my head goes, I don’t know what I’m doing, I don’t know where I am... it’s that strong, I get sick and sweaty and hot and cold shivers’. (30-year old Male, Homeless Drop-in, Urban Village)

It is highly likely that street level products are being cut with unknown ingredients that may cause further harm.

This is not only as dealers can increase their profit margins but also to ensure users become increasingly addicted. For example, there is already a rumour going around the homeless community in Manchester that street level synthetic cannabinoids are being mixed with crack cocaine to get users addicted.

‘It’s worse now, because they make it themselves, they make it powerful. They’re putting white [crack] with it as well.’ (Male, mid 20’s, Homeless Day Centre Drop-in)

‘They’re mixing white [crack] in with the Spice so it gets you addicted to it, so you keep going back for it more and more.’ (Female, late 20’s, Homeless Day Centre Drop-in)

In summary then, the purpose of the Psychoactive Substances Act is to shut down all UK-based shops and websites that trade in psychoactive substances, with the resulting outcome being a reduction in overall availability and subsequent use of NPS. While the blanket ban may make purchasing NPS harder for occasional recreational NPS users (such as young people), for those dependent and entrenched users there was clear evidence from this research that the ban would have only a limited impact on prevalence rates. For example, as soon as the Act came into force on May 26th, both users and frontline staff working with the homeless community reported clear signs of a flourishing street level market for synthetic cannabinoids. Almost immediately, dealers appeared on the streets – often close to headshops that had previously been well-known sellers of synthetic cannabinoids and other NPS – making continued access to synthetic cannabinoids easy for users. Nonetheless, there are concerns that the incorporation of the synthetic cannabinoid market into the illegal street market will have a number of negative outcomes, including: an increase in violent altercations and robbery amongst homeless users due to increased prices and reduced availability; more acquisitive crime to fund existing habits; along with the potential for additional harms to users as a result of adulteration and/or modifications to the chemical structure of these substances. This developing synthetic cannabinoid street market clearly needs careful monitoring.

For other NPS user groups, such as students, clubbers and men who have sex with men (MSM), many of the popular types of NPS they use – such as mephedrone, crystal methamphetamine and GH/GBL – are already established on the illegal market, or in the case of nitrates, exist outside the Act (due to its legitimate use as a food agent). As such, it is envisaged that the Psychoactive Substances Act will have only a negligible impact on these groups of users.
Recommendations

In this final section, we outline a number of recommendations that we believe will assist in addressing the issues raised in this report. The following recommendations are organised into three main themes:

- The development of resources;
- Service development; and,
- Future research agendas.

These recommendations have been developed in line with the good practice prompts outlined in Public Health England’s JSNA support pack for 2015-16 (Public Health England, 2014b), which outlines key principles that local areas should reflect upon when developing an integrated alcohol and drugs prevention, treatment and recovery system. Whilst we endeavored to take on board all of the feedback we received from research participants, we acknowledge and are mindful of the constraints of the existing public health budget. Therefore, the recommendations that follow are based around what we believe is tangible within the constraints of existing resources and commissioning frameworks as opposed to ‘blue sky thinking’.

4.1 Development of resources

As we illustrated in section 3.9, the research identified a clear need to increase existing NPS-related knowledge among specialist substance use providers and a wide range of other medical and non-medical occupations (ranging from GPs, emergency services staff, supported accommodation workers and criminal justice services).

We propose three main ways of achieving this: the development of bespoke information sheets; NPS training and continuous professional development (CPD); and a virtual resource to facilitate the sharing of information and good practice across services.

4.1.1 NPS briefing information sheets

The development of brief (i.e. 2-page) information sheets targeted at specific services and tailored around the types of NPS use they are likely to encounter. For example, synthetic cannabinoid information for prisons, offender management services, supported housing and approved premises and briefing information sheets on the three main substances associated with chemsex.

4.1.2 Drug alerts and local drug information system (LDIS)

In line with section 1.2.4 of Public Health England’s JSNA guidance on sharing information with partners about NPS through local networks (Public Health England, 2014b), we recommend the development of a local drug information system (LDIS) and online user and information sharing forum similar to the local Salford DAAT model. This would provide a centralised, coordinated resource where NPS-related intelligence, information and good practice responses can be obtained. In January 2016, Public Health England published guidance on how to establish local drug information systems which we propose should be adhered to (see Public Health England, 2016). Within Greater Manchester, similar systems have recently been launched (Bury) or proposed (Tameside). With Greater Manchester Devolution on the horizon, we propose that this initiative is established Greater Manchester-wide rather than restricted to Manchester.

This LDIS would also support the provision of evidence-based resources and materials for appropriate professionals and services, including for example, Public Health England NEPTUNE clinical guidelines, European monitoring data and academic research reports, together with the aforementioned bespoke information sheets and information on local NPS training and events. The LDIS would also provide a platform for disseminating information on emerging trends, ‘bad batches’, good practice and advice on NPS and other emerging substance use trends within and between services. The resource would not be limited to NPS e.g. it has the capacity to cover other emerging drug trends around polydrug use and performance and image enhancing drugs (PIEDs).

We propose that the research team convene a one-day ‘NPS awareness day’ that, in addition to reporting on the key research findings to invited stakeholders, will act as a launch pad for the LDIS.

4.1.3 NPS training

We have identified training development need for practitioners that moves beyond existing NPS awareness training, which tends to be too basic and too broad. This is not to dismiss the existing need for training that includes, for example: information on definitions; types of NPS; popular brand names; drug effects; legislation; potential harms; and general harm reduction responses. Rather, we advocate that training should also recognise the particular issues that different sectors are facing and the knowledge gaps that currently exist. For example, interviews with acute A&E consultants and nurses identified knowledge gaps and competency in relation to the identification of overdose or intoxication from synthetic cannabinoids and GBL/GHB. While those professionals working in a range of housing provision (from care homes to supported accommodation and approved premises) highlighted the need for more practical information on how to respond to users when they are having a bad experience, such as fitting, anxiety attacks or respiratory problems. In particular, there was much confusion regarding when to call for an ambulance.

As we outline below in section 4.2, we propose a holistic treatment provision for NPS users. This requires staff from mental health and substance use services to be trained to ensure that they are equipped and feel competent in dealing with the mental health and substance use issues that commonly co-exist within the user groups we focused on. This would minimise the issue identified in section 3.5.5 of NPS users being passed back and forth between substance use and mental health services.
4.2 Service development

4.2.1 Innovation in service delivery

Our findings suggest the need for more innovation in developing intervention responses and marketing approaches to encourage service user engagement. There is a need for personalised services for groups not traditionally accessing treatment drug. This should include, where appropriate, a move away from traditional operating hours and locations, towards outreach and ‘pop-up’ services. For example, ‘pop-up’ needle exchanges to accommodate new groups of users (such as crystal methamphetamine and PHEP users), as well as NPS/club drug clinics and a modified outreach/telephone approach for those at risk of homelessness. Furthermore, a consistent response to the problematic use of synthetic cannabinoids may include a community detox model and innovation in mental health support. Psychological therapy for example, requires engagement and commitment from the service user. Often, this is inconsistent with chaotic lifestyles and therefore, traditional models of engagement may need adaptation to serve the mental health needs of homeless populations. In line with the 2015 five-year plan for Greater Manchester Combined Authorities (see Warren, 2016), we propose that the improvements to existing service provision, including innovations to delivery models, should be developed through the prioritisation of more efficiently coupled with the development of improved communication and collaboration across public-sector services.

4.2.2 Models of good practice

We recommend the establishment of models of good practice regarding the treatment of users of synthetic cannabinoids and drugs associated with the chemsex scene. This should include: advice on safer drug use and detox; appropriateness of prescribing medications (i.e. potential for interactions or toxicity with NPS); harm reduction; and if and how responses to these types of NPS use may differ to traditional substances. This should also include guidance on the importance of cultural competency when working with specific sub-populations of users (e.g. MSM; hostel clients and those at risk of homelessness).

4.2.3 Improved NPS treatment pathways

Over the last two years, the Mental Health Improvement Programme (MHIP) has undertaken a wide range of public engagement activity to inform plans to improve mental health services across the city. The Mental Health Improvement Programme has acknowledged that having a number of different organisations contracted separately to provide mental health services in Manchester has led to fragmentation and a lack of joined-up care. A central aim of the programme is to create a better system in the region. The recent establishment (1st July 2016) of a single integrated sexual health service for Manchester provides an ideal opportunity to review for support for people who engage in chemsex is provided and to develop referral pathways e.g. from spoke clinics.

4.2.4 Integrated service delivery

4.2.5 NPS user engagement strategy

The Public Health England JSNA guidance on needs assessment (see section 1.2, Public Health England, 2014b) highlights the requirement to establish the levels of drug treatment fragmentation by dependent users. In section 3.6, we noted that there is a sub-population who describe their consumption of synthetic cannabinoids as ‘dependent’ or ‘addicted’. This Section 3.6, highlights the need for protocols and pathways to support service users who both alcohol and drug misuse and mental health support around their use of NPS and mental health support needs. The evidence presented in this report adds support for the need for the improvement programme. A number of questions arise in the Public Health England JSNA guidance (Public Health England, 2014b) highlights the need for protocols and pathways to support service users who both alcohol and drug misuse and mental health support around their use of NPS. A broad spectrum of professionals were keen to stress that it is imperative service users with co-existing mental health and substance misuse problems are treated in a holistic. Despite the existence of a dual diagnosis team and dedicated support for young people with mental health issues, there was evidence of a need for more integration of mental health and mental health services (see section 3.4.7, 3.5.4, 3.5.5 and 3.8.4). The findings present clear evidence of a need for improved clinical and psychosocial responses regarding the use of NPS, in particular, synthetic cannabinoids amongst vulnerable groups (young people, homeless and offender populations) to address the range of challenges associated with usage of NPS. In section 3.8, we noted the need for more integrated service delivery to address the needs of chemsex users, but also the wider LGBT, student and clubbing populations.

4.3 Future research agendas

4.3.1 Developing monitoring and recording systems

The research uncovered much higher levels of problematic use of NPS, especially synthetic cannabinoids in these existing data sources currently demonstrate. In section 3.6, we highlighted how NPS use has considerable impact on a number of services including: city centre police; the system. Furthermore, a consistent response to the problematic use of synthetic cannabinoids may include a community detox model and innovation in mental health support. Psychological therapy for example, requires engagement and commitment from the service user. Often, this is inconsistent with chaotic lifestyles and therefore, traditional models of engagement may need adaptation to serve the mental health needs of homeless populations. In line with the 2015 five-year plan for Greater Manchester Combined Authorities (see Warren, 2016), we propose that the improvements to existing service provision, including innovations to delivery models, should be developed through the prioritisation of more efficiently coupled with the development of improved communication and collaboration across public-sector services.

4.3.2 The impact of NPS use on recovery journeys

Building recovery is central to all drug and alcohol strategies at a local and national level. In section 3.6 we noted how many synthetic cannabinoid users often ‘ex-offenders’ on recovery journeys – both in custodial settings and the community. For example, are people who might previously have become addicted to opioids now switching to NPS use instead? It is important to note that services highlight the potential harms that NPS use can lead to and are aware of the potential that NPS use can have on individuals’ recovery journeys.

4.3.3 The impact of NPS use on crime and disorder and offender management

The research uncovered that many of the more problematic users of NPS were first introduced to it in custodial settings (adult and youth justice agencies and reoffender institutions) and many were using NPS to avoid MDTs in emergency housing, supported housing and approved premises, or to comply with their offender management license conditions. It was evident highlighted in section 3.4, there are several London-based examples of good practice that could be drawn on, such as the ‘Club Drug Clinic’ developed by British and North West London NHS Foundation Trust which incorporates the needs of chemsex users, but also the wider LGBT, student and clubbing populations.
that continued use beyond the prison estate was causing problems for offender management, approved premises and other forms of supported housing provision in the city. We therefore propose the need to further consider the impact of NPS use in custody (including within the female secure estate) and on release in the community, for example, in approved premises, supported housing or hostels. In particular, what impact do MDTs and other license conditions have on motivations for use?

We suggest further research is required to explore the role of the prison system and the impact of NPS use amongst the offending population that where possible, includes local prisons (e.g. Forest Bank, HMP Manchester and HMP Styal) and the Greater Manchester Probation Service and Youth Offending Teams. We also propose further exploration of the links between NPS addiction/dependency and offending behaviours to fund use. This should also explore the relationship between NPS use, violence and victimisation.

4.3.4 Monitoring of the impact of the Psychoactive Substances Act 2016

As we reported in section 3.11, the evidence suggests that it is highly probable that the change in legislation that occurred on the 26th May 2016 to prohibit the sale of NPS will result in some of the more popular types of NPS being sold on the illegal drugs market. Monitoring of this situation, including test purchasing and analysis is important in gaining information on what specific compounds are potentially being purchased and used locally.

4.3.5 Continued monitoring of emerging drug trends and markets

The Public Health England JSNA guidance (Public Health England, 2014b) emphasises the need to plan according to local needs assessments. This includes an understanding of local demands and needs obtained through a combination of local and national data. As we illustrated in sections 3.1 to 3.5, many NPS users are not engaged with services. Moreover, in section 3.7, we highlighted a range of existing limitations with data collection. We therefore propose the establishment of an annual (Greater) Manchester ‘Street Drug Survey’ that captures data from specific sub-populations such as prisoners, the homeless, clubbers, students, and the LGBT community, alongside the insight of professionals in regular contact with a range of substance users. A survey of this nature would facilitate the early identification of new and emerging trends (e.g. performance and image enhancing drugs, ‘smart drugs’, or abuse of prescribed drugs), alongside existing substance use, such as NPS. An annual survey of this nature would be invaluable in terms of informing service development and commissioning services, thus helping to ensure a more comprehensive and appropriate provision of services in (Greater) Manchester.


Manchester City Council (2016) The Health Scrutiny Committee Meeting Notes on Sexual Health Services. 26th May 2016.


NICE (2016) Coexisting severe mental illness and substance misuse: community health and social care services: Published: 30 November 2016 (see: nice.org.uk/guidance/ng86)


Public Health England (2015a) Young people’s substance misuse data: JSNA support pack. Key data for planning effective young people’s substance misuse interventions in 2016-17 (Manchester).


The Angelus Foundation was founded in 2009 by Maryon Stewart, a health practitioner and author. Her 21 year-old daughter Hester, passed away after consuming a legal high (GBL) in April 2009. For more information see: http://www.angelusfoundation.org.uk/

Later in this report, we consider the impact that the new Psychoactive Substances Act may have on specific sub-populations and motivations for consumption.

The recently released SIGMA research only distinguishes between those gay and bisexual living in London and those they refer to as ‘the rest of England’. It may be possible to obtain a breakdown of these data for (Greater) Manchester residents on request.

The generic term ‘Spice’ is widely used in the British prison system to refer to any form of synthetic cannabinoid. This term was also widely used when discussing synthetic cannabinoid use amongst many users and stakeholders in the current research.

All the names used in the case studies are pseudonyms.
Department of Sociology
Manchester Metropolitan University
Geoffrey Manton Building
4 Rosamond Street West
Off Oxford Road
Manchester
M15 6LL

Rob Ralphs:
0161 247 3014
r.ralphs@mmu.ac.uk

Paul Gray:
0161 247 3456
p.gray@mmu.ac.uk

suab.co.uk
mcrmetropolis.uk