

Report for  
the All Party  
Parliamentary  
Group on  
NPS and VSA



## About this report

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## Table of Contents

<b>About this report</b> .....	<b>1</b>
<b>1. Introduction</b> .....	<b>3</b>
<b>2. New Psychoactive Substances and Volatile Substance Abuse</b> .....	<b>4</b>
<b>3. Legislative background: The Psychoactive Substances Act 2016</b> .....	<b>5</b>
<b>4. Home Office Evaluation of the Psychoactive Substances Act 2016</b> .....	<b>6</b>
<b>5. Who is using NPS?</b> .....	<b>8</b>
School children.....	8
Members of the general population.....	8
Global Drug Survey 2018 .....	9
Treatment settings .....	10
Prisons.....	11
People who are homeless.....	13
Case Study 1: responding to NPS in Manchester .....	15
Case study 2: Wrexham .....	16
<b>6. Monitoring the emergence of new drugs since the introduction of the PSA 2016</b> .....	<b>17</b>
<b>7. Prevention and education</b> .....	<b>19</b>
NPS Education and prevention resources .....	22
Embedding NPS education and prevention in school and community activities .....	23
Involving parents, carers, and communities in NPS/VSA prevention and education.....	25
<b>8. Media and public discussions of NPS and VSA</b> .....	<b>26</b>
<b>9. Recommendations</b> .....	<b>28</b>
Recommendations for educational providers .....	28
Recommendations for government, executive agencies, and public bodies.....	29
Recommendations for local authorities, local partnerships, and local drug service providers....	29
Recommendations for secure settings .....	30
Recommendations for media.....	30
<b>10. APPG membership</b> .....	<b>31</b>
<b>11. APPG list of witnesses</b> .....	<b>31</b>
<b>12. References</b> .....	<b>32</b>

## 1. Introduction

1. The Psychoactive Substances Act (PSA) was enacted in May 2016 to control the sale, supply, production and importation of New Psychoactive Substances (NPS) (popularly known as ‘legal highs’). The Act superseded the Intoxicating Substances (Supply) Act 1985, which previously regulated the sale of volatile substances (herein VSA). The purpose of the All-Party Parliamentary Group (APPG) on NPS and VSA is to help monitor the issues and challenges that remain and to make recommendations that may further reduce the harms associated with NPS. This report follows on from the conclusions of the Home Office’s 30-month statutory report on the PSA 2016, which was published in November 2018.

The objectives of the APPG on NPS and VSA are to:

- i. Raise awareness of NPS and VSA in Parliament and encourage discussion of issues around substances covered under the PSA 2016;
- ii. Stimulate research on the issues emerging from the Act and ensure the impact of the Act is adequately evaluated;
- iii. Ensure the Government adopts policies to help reduce harms caused by NPS and VSA;
- iv. Help to spread good evidence-based prevention practice to all areas of the UK;
- v. Support the wider understanding of NPS and VSA, particularly with local authorities, voluntary groups, youth services, and parents.

2. The aim of this report was to develop recommendations for government and other stakeholders (including, but not limited to education providers, prisons, local authorities, drug services, and homeless service providers), based on the evidence received from expert witnesses and other submissions to the APPG. The focus was on evidence emerging since the introduction of the PSA, and contributors were asked to highlight where they believed that the PSA had been successful and where further action was required. The APPG does not take a view itself on whether the PSA has been successful in its aims, and the reader is instead referred to the Home Office’s Review of the Psychoactive Substances Act<sup>1</sup>, which is summarised in this report.

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<sup>1</sup> <https://www.gov.uk/government/publications/review-of-the-psychoactive-substances-act-2016> (last accessed February 2019)

## 2. New Psychoactive Substances and Volatile Substance Abuse

3. The PSA defined NPS as substances which are capable of producing a psychoactive effect in the person who consumes it, and are not exempted from the Act. For the purposes of the PSA, a substance produces a psychoactive effect in a person if, by stimulating or depressing the person's central nervous system, it affects the person's mental functioning or emotional state. This is a legal definition, rather than a scientific one, and so may actually include substances that are not considered directly psychoactive by pharmacologists (see below). Exempted psychoactive substances include drugs controlled under the Misuse of Drugs Act 1971; medicinal products; alcohol; nicotine and tobacco products; caffeine; and food stuffs that do not contain a prohibited ingredient or a non-EU approved foodstuff.

4. European Council Decision 2005/387/JHA defined NPS as *Narcotic or psychotropic drugs that are not scheduled under the United Nations [UN] 1961 or 1971 Conventions, but which may pose a threat to public health comparable to scheduled substances* (Council of the European Union, 2005). As with the PSA, this is a legal definition, and is used by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) European Early Warning System (EWS) for detection of new substances in Europe.

5. In practice, the term NPS is commonly used to describe a wide variety of substances, including some exempted substances controlled under the Misuse of Drugs Act 1971, and some substances that have been used non-medically for many years. Examples of controlled substances that are exempted from the PSA, but sometimes referred to as NPS, include synthetic cannabinoid receptor agonists (SCRA; 'Spice' – Class B since 2016), and synthetic cathinones, which are drugs similar in effect to mephedrone (Class B since 2010). Nitrous oxide ('laughing gas') and *salvia divinorum* are examples of drugs that fall under the PSA, but which have been used non-medically for many years.

6. Alkyl nitrites ('poppers') are an example of a group of drugs that are used for non-medical purposes, but have been determined to not be 'directly psychoactive' by the Advisory Council on the Misuse of Drugs (ACMD)<sup>2</sup>, the government's independent expert advisory group on drugs. This means that from a scientific perspective, these drugs produce effects desired by users through activity outside the central nervous system (in this case by dilating blood vessels outside of the brain, leading to a transient 'high' due to changes in blood flow). However, the Court of Appeal have ruled that this determination by the ACMD does not have the force of law and that 'psychoactivity' can either be direct or indirect<sup>3</sup>. This has important implications for legal interpretation of the Act, and whether other products, such as foods and other consumer goods, which were assumed to be exempt, may in fact fall under the PSA.

7. Volatile substance abuse (VSA) refers to the intentional inhalation of volatile substances (i.e. vaporises readily) for psychoactive effects (some definitions exclude volatile anaesthetics or anaesthetic gases). These substances are often found in everyday, household products and substances include aromatic and chlorinated hydrocarbons (e.g. toluene containing glues, cleaning fluids, paint); lighter fuels (butane, propane); alkyl, butyl and isobutyl nitrites; petrol; fluorocarbons (aerosol propellants); and acetone (nail polish remover).

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<sup>2</sup> <https://www.gov.uk/government/publications/acmd-review-of-alkyl-nitrites-poppers> (last accessed February 2019)

<sup>3</sup> <https://www.rudifortson4law.co.uk/the-legal-status-of-poppers> (last accessed February 2019)

8. The most commonly misused volatile substances would not typically be referred to as NPS, although newly emerging volatile substances with psychoactive effects and non-industrial and non-medical uses would. Nitrous oxide is an example of a substance that is sometimes categorised as both an NPS, and as a substance implicated in VSA. As volatile substances are marked for household or industrial purposes, they are readily available for the adult population, although supply for intoxicating purposes (with the exception of alkyl nitrites) is an offence under the Psychoactive Substances Act 2016 (age-restricted sales of butane lighter fuel for any purpose is controlled under the Cigarette Lighter Refill (Safety) Regulations 1999<sup>4</sup>).

### 3. Legislative background: The Psychoactive Substances Act 2016

9. Briefly, the PSA came into force on 26<sup>th</sup> May 2016, and:

- Made it an offence to produce, supply, offer to supply, possess with intent to supply, import or export psychoactive substances;
- Of note, possession on custodial premises (e.g. a prison, young offender institute, removal centre) was made an offence; possession outside of custodial institutions was not made an offence;
- An offence committed on, or near school premises at a relevant time (e.g. school hours) is considered an aggravating factor by courts;
- Penalties depend upon jurisdiction and include imprisonment for a term not exceeding 12 months, and a fine;
- Substances, such as food, alcohol, tobacco, nicotine, caffeine and medicinal products are exempted from the PSA, as well as drugs controlled under the Misuse of Drugs Act 1971;
- Some healthcare activities and approved scientific research were exempted from the offences under the PSA on the basis that persons engaged in such activities had a legitimate need to use psychoactive substances in their work;
- The PSA included provision for civil sanctions – prohibition notices, premises notices, prohibition orders and premises orders – to enable the police and local authorities to adopt a graded response to the supply of psychoactive substances in appropriate cases;
- The PSA provided powers to stop and search persons, vehicles and vessels, enter and search premises in accordance with a warrant, and to seize and destroy psychoactive substances.

10. The Intoxicating Substances (Supply) Act 1985, which regulated the sale of volatile substances to under 18-year-olds, was repealed and replaced by the PSA.

11. Temporary Class Drug Orders (TCDOs)<sup>5</sup> were introduced in 2011, and provided powers to place NPS under temporary control whilst assessed by the ACMD as to whether it should be placed under the Misuse of Drugs Act 1971. Since the introduction of the PSA, no new TCDOs have been introduced, and the Home Office evaluation of the PSA noted that the Act may have reduced the appeal of TCDOs, particularly because TCDOs do not include a possession offence in custodial settings. TCDOs do not afford the police additional powers to search and arrest, or to seize substances, but do provide stricter offences under the Misuse of Drugs Act 1971 to control production and supply. Therefore, it is uncertain whether TCDOs will be retained or how they could be used as tools to reduce drug harms.

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<sup>4</sup> <http://www.legislation.gov.uk/cy/uksi/1999/1844/made?view=plain> (last accessed February 2019)

<sup>5</sup> [http://www.legislation.gov.uk/uksi/2016/1126/pdfs/uksiem\\_20161126\\_en.pdf](http://www.legislation.gov.uk/uksi/2016/1126/pdfs/uksiem_20161126_en.pdf) (last accessed February 2019)

## 4. Home Office Evaluation of the Psychoactive Substances Act 2016

12. The PSA required the Secretary of State to review the operation of the PSA and to prepare a report of the review within 30 months after commencement. The review was published in November 2018 and provided an assessment of changes that occurred after implementation of the PSA on legislation and enforcement activity; NPS sales and availability; and prevalence and harms of NPS (Home Office, 2018).

13. This was not an independent review, which was against the advice of the ACMD, but the report provided a balanced assessment of outcomes, did not over-claim success, and included some reflection on the unforeseen and unintended consequences of the PSA. The review was as comprehensive as could be expected, considering that relevant data and evidence was often lacking. Identification of effective non-legislative responses to NPS harms was beyond the scope of the review.

14. In summary, conclusions of the review (and comments) that are most pertinent to this report:

- There have only been a small number of legal challenges based upon whether certain substances should have been included in the definition of psychoactivity used in the Act, or if the substance should have been exempted as a medicine, but in all cases these have not been accepted by the courts.
- The open sale of NPS through high street shops or UK based websites has almost entirely (but not completely) ended, largely through retailer self-compliance with the law. However, NPS continue to be seized and arrests made, predominately for nitrous oxide, suggesting that supply has moved to illicit markets ('street dealers') or supplies diverted from legitimate retail purposes (e.g. exempted catering retail). The UK also continues to be one of the most prominent sources of dark web cryptomarkets NPS sales<sup>6</sup>.
- Novel NPS continue to be detected across Europe, reflecting the global nature of the market. Whilst the total number of annual detections has decreased, there has been an increase in the number of novel potent opioids (e.g. related to fentanils) that have been reported to national drug monitoring systems. The review noted that there may be an incentive to continue selling NPS instead of drugs controlled under TCDOs and the Misuse of Drugs Act, as the penalties can be lower. Conversely, as there is no possession offence in custodial settings, selling of drugs classified under these two pieces of legislation may become incentivised in future.
- Use of NPS in the general population fell in both younger age groups (aged 16-24) and the wider population (aged 16-59). However, NPS use was always predominately in people who used other drugs as well, and since 2016 there has been an increase in the proportion of 16-24 year olds using cocaine, ecstasy, hallucinogens, amphetamines, ketamine, and non-prescribed tranquilisers. Although a single year of data cannot establish whether people substituted these drugs for NPS, examination of future survey data will help to understand if traditional drugs are becoming more popular.
- There was a small fall in the number of school children aged 11-15 using NPS, but this was non-significant, and levels of use were already low prior to the Act. There has been no change in the use of nitrous oxide (laughing gas), but use of cannabis, Class A drugs, and VSA increased

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<sup>6</sup> Websites on encrypted networks that cannot be found by using traditional search engines, or visited using traditional browsers.

between 2014 and 2016, although prevalence rates were substantially lower than the historic highs seen in the early 2000s.

- There was a notable lack of high quality data on levels of use in high-risk and vulnerable groups such as prisoners, and people who are homeless. Other types of data (qualitative work, prison inspection reports) suggest that patterns of use vary between different parts of the country, populations, and settings of use. Whilst use fell in some areas, it increased in others and there was some evidence of substitution with traditional drugs.
- Data on changes in health and social harms related to NPS was also limited to specific settings. Results from one study analysing presentations to a number of hospitals across the UK reported regionally specific falls in NPS-related admissions, although there was a corresponding increase in admissions related to use of non-NPS drugs. Furthermore, whilst NPS deaths fell in England, there was a significant rise in Scotland. Deaths related to other drugs such as cocaine also increased. The Office for National Statistics (ONS) has not reported on VSA death registrations since the PSA but between 2001 and 2016 there were 36 deaths where nitrous oxide was mentioned by the coroner on the death certificate<sup>7</sup>. However, there were also 43 nitrogen related deaths, which the ONS report may also have included under nitrous oxide deaths. This total of 79 includes some deaths by suicide, and so it is uncertain what proportion relate to accidental deaths after 'recreational' use.
- NPS drug treatment presentations fell, but this was also accompanied by an overall fall in people seeking support for all types of drug use, so was not unique to NPS.

15. The report concluded that most of the original legislative, enforcement, and supply reduction aims of the PSA had been achieved. Whilst this is encouraging, there was insufficient evidence to conclude that health and social harms related to NPS had been reduced compared to prior to introduction of the Act, or if other legislative approaches had been pursued instead.

16. As the review only examined legislative effects, the impact of prevention, harm reduction, and treatment responses to NPS delivered across the review period wasn't assessed.

17. The increased prevalence of use of non-NPS drugs, shifts to illicit markets, and continued evidence of harm in high-risk groups suggests that whilst it is feasible that NPS-related harms may have decreased, the PSA may have had less impact on the overall burden of harm related to use of all types of drugs in the UK.

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<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsrelatedtovolatilesubstancesandheliumingreatbritain/2001to2016registrations> (last accessed February 2019)



## 5. Who is using NPS?

18. This section summarises and discusses the most recently available data on prevalence of NPS use in the UK population since the PSA. Because of reporting cycles, this means that data is limited to some populations in some UK countries.

### School children

19. The Smoking, Drinking and Drug Use report is a high quality and representative survey of secondary school pupils aged 11-15 in England, and is considered the best source of data on pupils' substance use<sup>8</sup>. The latest survey (published in 2017) was undertaken in the Autumn term of 2016 and included questions on NPS<sup>9</sup>. The survey date means that it is not possible to draw conclusions on the impact of the PSA on NPS use.

20. In 2016, 18% of 11-15 year olds reported that they had used drugs in the past year, of which 1.6% had used NPS, and 4% had used nitrous oxide. This was a non-significant decrease from 2014, when 2.0% reported NPS use in the same period. NPS prevalence was age dependent and ranged from 0.5% in 11 year olds, to 2.7% in 15 year olds, with more boys than girls reporting use. Similarly, nitrous oxide prevalence increased from 1.3 to 7.2% across the same age range.

21. For comparison, reports of VSA (glue, gas, aerosols or solvents, excluding nitrous oxide) increased from 2.9% in 2014 to 4.4% in 2016. The legislation for restricting the sales of these products now falls under the PSA 2016. Pupils' early experience (aged 11 or younger) of drug use was most likely to involve volatile substances (61%) or nitrous oxide (21%), higher than reports for cannabis (9%).

22. Pupils were also asked in this survey whether they have been offered drugs. In the 2014 survey, 6% reported that they had been offered NPS, and this had non-significantly increased to 8% in 2016. Nine percent had been offered nitrous oxide. For comparison, 33% reported that they had been offered any drug (excluding NPS or nitrous oxide) and this had also risen from 26% in 2014.

### Members of the general population

23. The Crime Survey for England and Wales (CSEW) is a high quality and representative household survey of adult substance use. As it is a household survey, it does not cover people living in group residences (such as student halls of residence), or populations such as prisoners and people who are homeless, and who typically report higher and more frequent levels of substance use. The CSEW includes data on traditional drugs, NPS, and misused medicines, but not VSA. This prevents analysis of trends in VSA use, and makes assessment of likely population-level harms, or the impact of new policy difficult to undertake.

24. Latest CSEW data (2017/18) showed no overall change in the number of adults reporting use of NPS in the last year compared to 2016/17. Approximately 0.4% of 16 to 59-year olds surveyed had used NPS in the previous 12 months (the same as 2016/17). However, although the percentage is low, this was still statistically significantly lower than 0.7% reported in 2015/6, which was the last national measure on prevalence prior to the passing of the PSA 2016. The prevalence of NPS use is

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<sup>8</sup> <https://digital.nhs.uk/data-and-information/areas-of-interest/public-health/smoking-drinking-and-drug-use-among-young-people-in-england> (last accessed February 2019)

<sup>9</sup> Defined as: 'new substances that have the same effects as other drugs. These are sometimes called 'legal highs' and can come in different forms such as herbal mixtures, powders, crystals or tablets.

relatively low compared to figures for cannabis (7.2%), powder cocaine (2.6%) and ecstasy (1.7%) in the same reporting period.

25. Similarly, prevalence of NPS use among 16 to 24-year olds remained the same in 2017/18 as 2016/17, with 1.2% reporting that they had used an NPS in the last year. This had also fallen from 2.6% in 2015/16. The most prevalent group of users of NPS in the last year were young men aged 16 to 24 years old (1.5%). Again, as with 16 to 59-year olds, the prevalence of NPS use in 16 to 24-year olds remained generally low compared to figures of use in the last year for cannabis (16.7%), powder cocaine (6.0%) and ecstasy (5.1%). Nitrous oxide ('laughing gas') continued to be the most popular NPS although reported use fell slightly from 9.0% in 2016/17 to 8.8% in 2017/18.

26. For the first time, a question on frequency of NPS use was added to the CSEW in 2017/18. Of those respondents reporting use of NPS in the previous 12 months, a majority (59%) said that they had only used NPS once or twice, 23% had used NPS monthly, and 6% had used NPS at least weekly. Herbal smoking mixtures (assumed to be SCRA) were the most commonly used NPS in the last year (33% of mentions).

27. The survey also asked about the source of NPS or nitrous oxide taken in the last year. Across all adults the most commonly cited route was through a friend, neighbour or colleague (35%, down from 39% in 2016/17), and when questioned further respondents believed that these people had originally bought the drug through the internet (37%). This was a higher proportion than for other non-NPS drugs (1%). The proportion reporting sourcing from a shop was lower (15%), and whilst this had not changed from 2016/17 (13%), it had fallen from previous years (34% in 2014/15, and 25% in 2015/16 when substantial enforcement action against open retailers first began. Trend data also suggested that sales from strangers (interpreted as street-dealers) had increased (2% in 2015/16 to 6% in 2017/18) as the proportion purchasing from shops and the internet fell.

### Global Drug Survey 2018

28. The Global Drug Survey (GDS) is a large online survey that provides data on drug use in the general population<sup>10</sup>. Participants tend to be young and well-educated, and so unlike the CSEW, the survey can't be used to provide accurate national prevalence estimates. Although only some data snapshots are available publicly, the survey is useful for helping to better understand patterns of drug use, and emerging trends in people who regularly take drugs. In 2018, there was data from 130,000 people from over 40 countries, of which 3,675 respondents were from England. 11.5% of English respondents reported using NPS in the past year (11.6% in 2016).

29. Overall, 24.6% of UK respondents reported in 2018 that they had bought drugs online from the darknet in the previous 12 months, although this was not broken down by type of drug. This was similar to the proportion reporting purchases through this platform in 2017 (25.3%), but represented an increase since 2016 (18.3%).

30. Of note, out of 13 substances included in the survey, NPS (as a broad category of drugs) had the highest incidence rate for an individual needing to seek emergency medical treatment after use. Synthetic cannabinoids were ranked fourth, although this was lower than the previous four years, which may reflect changes in the market. Since it was first included in the survey in 2014, the UK has seen large growth in reports of nitrous oxide use. 31% of people who reported illegal drug use in the past year used nitrous oxide, compared to 20% in 2014.

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<sup>10</sup> <https://www.globaldrugsurvey.com> (last accessed February 2019)

## Treatment settings

31. Data on presentations to specialist community-based drug treatment services are published annually by Public Health England.

32. *Young people (under 18s)*: Of 15,583 young people in contact with treatment services in 2017/18, 270 (2%) reported that NPS were either the main type of drug they needed help with, or one of the several that they used (Public Health England, 2018b). This was a decrease of around 53% from the previous year (585 in 2016/17), and 74% lower than the numbers reported for 2015/16 (1,056). For comparison, 13,713 (88%) reported problematic use of cannabis, 2,112, ecstasy (14%), 66 heroin (<1%), and 98 (1%) crack cocaine. There was also a slight decline in the number of people presenting needing help with solvents (128 in 2016/17 and 102 in 2017/18).

33. Overall, the fall in NPS presentations was part of an overall decline in treatment presentations by young people (-5%), although none of the decrease for other substances was as sharp. This is the second year since data on NPS use was reported (2013/14) that the number of young people in treatment for NPS had declined. The number of young people in treatment where NPS were identified as a primary substance of concern was 73 (<1%) in 2017/18, compared to 213 (1%) in 2016/17.

34. It is unclear what this fall represents, as there are no estimates of unmet treatment need in young people who don't engage with services. So, the fall could mean that the number of young people experiencing problems with NPS has actually fallen, or that the number has stayed the same but there are fewer people wanting or able to access treatment services. As suggested by general population survey data, people who had previously used NPS problematically may have switched to other drugs, but this is not yet reflected in treatment presentation data. However, it may take a few years before this substituted use becomes problematic enough to warrant treatment. Of note, and related to this, there was a 13% increase in the number of young people needing support for powder cocaine (254 → 287).

35. Within young treatment clients, SCRA continue to be the most cited group of NPS. Presentations for other drugs have remained stable (cannabis, nicotine) or increased (ecstasy, cocaine, crack cocaine, benzodiazepines) from the previous year. It is important to note that the majority of young people presenting to specialist substance misuse services report additional vulnerabilities (such as mental health problems; not being in education, employment or training), or wider factors that could impact on their substance use (such as offending, antisocial behaviour, self-harming, experiencing sexual exploitation or domestic abuse). Of the 17 vulnerability items collected and reported by PHE, 96% (10,611) of those who entered treatment in 2017/18 disclosed at least one vulnerability, with 55% (6,075) disclosing 3 or more. Young people with mental health problems, special educational needs and those who were homeless were the most vulnerable to developing problems with NPS.

36. As discussed by the ACMD in their 2018 report on vulnerability to substance use, adverse childhood experiences (ACEs)<sup>11</sup> are important determinants of adult substance use, and a range of other poorer health and social outcomes. For example, one review study concluded that the odds of experiencing adult (>18 years of age) problematic substance use (defined as injecting drug use, or heroin or crack cocaine use) was 10 times higher in participants who reported more than 4 ACEs (Hughes et al., 2017). Whilst the relationship between ACEs and those young people needing treatment and support for NPS

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<sup>11</sup> co-occurring intra-familial events or conditions causing chronic stress responses in the child's immediate environment, such as bereavement, family substance use, breakdown in family relationships, physical and emotional violence and abuse, and social isolation.

is unknown, it is clear that ACEs underpin substance use more generally, and highlight the importance of 'ACE-informed' policy and service responses.

37. *Adults*: There was a 16% decrease in the number of adults aged over 18 starting treatment for the first time reporting problems with use of at least one NPS (1,223 in 2017/18 compared to 1,450 in 2016/17) (Public Health England, 2018a). This fall was mainly driven by a 36% reduction in those aged under 25 presenting with NPS problems (321 in 2016/17 to 206 in 2017/18). Individuals using NPS were more likely to report having an urgent housing problem compared to those not using these substances at the start of their treatment (25% vs 8%). The use of SCRAAs was cited in around 56% of cases, and whilst this was the most commonly cited NPS, it had fallen 16% from the previous year (838 → 703). To put these figures into context, overall, there was a 3% fall in the new clients presenting to treatment services between 2016/17 and 2017/18. There was also a 5% rise in crack cocaine presentations (where presented alongside opioids), and an 18% rise in presentations for crack cocaine alone.

## Prisons

38. There is no routinely collected evidence on the prevalence and harms of NPS and VSA in prisons and other custodial settings. However, the use of NPS is well established in some, but not all, UK prisons. This is not uniquely a UK phenomenon, as the EMCDDA reports that several Member States also report use in custodial settings, although the types of drugs used, and prisoner characteristics will differ between countries (EMCDDA, 2018c).

39. Prisoner groups who seem particularly affected include individuals with longer histories of substance use, those who had been homeless, those who have had repeated contact with the criminal justice system, or younger users who are considered relatively inexperienced with substances, or who are vulnerable to bullying and other forms of violence (EMCDDA, 2018c; Ralphs et al., 2017). Prisoners report using NPS for many of the same reasons as other drugs, such as the pleasurable effects that they produce, but also to alleviate boredom, as a form of self-medication of under- or untreated mental health disorders, or to cope with experiences of imprisonment (Baker, 2015; Walker, 2015).

40. The increase in use of NPS has also adversely affected prison management, and is associated with bullying and violence amongst prisoners (User Voice, 2016), and an increased burden on officers and healthcare staff responding to NPS-related incidents. The office of the Prison and Probation Ombudsman (PPO) reported in their evidence to the APPG (February, 2017) that in their view, the harms from NPS had been further exacerbated as a consequence of staffing cuts, prison crowding, and regime restrictions. The House of Commons Justice Committee reported in 2014 that prisons had experienced a 40% reduction in officer numbers between 2010 and 2014, and this had been accompanied by a rise in assaults, self-harm, deaths in custody, concerted indiscipline, and prisoner complaints (Justice Committee, 2015).

41. Despite improvements in NPS detection technologies, and the range of drugs that can be identified through screening, many novel substances are still not detectable in routine tests, and can be relatively easily smuggled into secure settings through techniques such as throwing packages over the walls, body smuggling, visit transfers, corrupt prison officers and other staff, or received in novel formulations such as impregnated paper (e.g. letters) and textiles. Some prisons have recently introduced actions such as photocopying prisoner correspondence and withholding the originals in an attempt to address new NPS formulations, but the PPO reported to the APPG that they had received complaints from other prisoners about this practice.

42. The prison NPS market is highly profitable, despite, or because of, the health and penal risks involved (Ralphs et al., 2017). In their evidence to the APPG, Ralphs and colleagues reported cases in the North West of England where individual prisoners had breached their terms of parole in order to bring NPS back into prison, often to settle drug debts incurred in prison, or to take advantage of the profits that could be made. They estimated that a single prisoner could smuggle in 280g of SCRA with a prison value of £28,000 through body smuggling. These researchers also suggested that there was a bidirectional relationship between the patterns and profiles of NPS use in prison, and those in prisoner's own communities, with use and availability of NPS in one setting influencing the drugs market in the other. This might be one of the reasons why not all prisons and communities have experienced problems with NPS.

43. Data from mandatory drug tests (MDT) undertaken in English prisons and published by the HM Prison and Probation Service<sup>12</sup> suggested that in the twelve months prior to March 2018 (latest data) NPS were present in 60% of all positive samples. Reported data is not broken down by type of NPS, but based on the drugs involved in prison treatment presentations (see below), and the evidence received by the APPG, these are likely to primarily represent SCRA. There are inconsistencies in the implementation of MDT across different prisons and the total number of tests undertaken is small. This makes it difficult to compare trends in data, but positive detections of NPS slightly increased between October 2016 (10.0% of detections) and March 2018 (10.9% of detections). NPS detections had historically peaked in February 2017 at 14.1%.

44. Findings from the 2017 Scottish Prisoner Survey (latest data) estimated that 18% of respondents had used NPS prior to being imprisoned. The same percentage reported use whilst in prison, and 78% of these reported use of SCRA. The survey did not break down this data by the proportion of prisoners who had first started their NPS use whilst in prison.

45. Interestingly, the number of positive tests for cannabis rose sharply by 59% in the 12 months ending in March 2017, and prior to March 2018, cannabis represented 53% of non-NPS positive samples. It is uncertain whether the rise in cannabis detections was a result of the increased focus on NPS detection in prison drug policy and actions.

46. Data on adult drug treatment in secure settings showed that of the 55,413 prisoners receiving support in 2017/18, 4,868 (8.8%) reported use of NPS. Of these, 2,723 (55.9%; 4.9% of all prisoners) reported use of SCRA. This is a higher number than those receiving treatment for SCRA in community settings (i.e. 1164, 4.9% of all community treatment presentations, 56.1% of NPS presentations), but it is clear that opioids and crack cocaine are still the drugs that the majority of prisoners (60%) need support with.

47. The 2017/18 PPO annual report<sup>13</sup> commented that use of NPS in prisons had become 'the new normal', and noted that they had investigated a high number of NPS-related deaths. Overall, all deaths in prison had decreased by 12% between 2016/17 and 2017/18 (361 → 316). A large proportion of these deaths were from natural causes within an aging prisoner population, but NPS were identified as a significant contributing factor in 64 deaths between June 2013 and November 2016.

48. The PPO report also commented on the ease of availability of NPS; and the lack of interventions designed to support prisoners with use within existing treatment provision. A 'piecemeal' approach to NPS across prisons had led to some '...doing everything they can; some are trying but struggling;

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<sup>12</sup> <https://www.gov.uk/government/statistics/annual-hm-prison-and-probation-service-digest-2017-to-2018> (last accessed February 2019)

<sup>13</sup> <https://www.ppo.gov.uk/document/annual-reports/> (last accessed February 2019)

and others appear to have given up'. The PPO has produced a bulletin for staff to better inform them about NPS and the impacts on physical and mental health, as well as associated issues such as debt and violence<sup>14</sup>. They have called for better education for prisoners and prison staff, a need to reduce the supply and demand of NPS, and appropriate referral systems to substance misuse services. Similarly, an NPS toolkit published by PHE aims to support custody and healthcare staff in prisons to manage the challenge of NPS use in secure environments<sup>15</sup>. This also covers young offender institutions and immigration removal centres. Providing adequate post-release support and continuity of care remains a challenge, particularly for those prisoners who use drugs. Page and colleagues (2016) have concluded that post-release, prisoners often expect to face "poverty, broken families, homelessness or dire housing, skills shortages, unemployability, and poor mental health..."; all difficult issues to address and that require broader support than can be provided by community drug treatment services alone.

49. The Home Office evaluation of the PSA concluded that introduction of the Act had not prevented the rise in violence and health harms associated with use in prisons. A new package of measures in prisons was announced by the Ministry of Justice in August 2018 ('10 Prisons Project'), including 'airport-style' searches of staff and visitors, and was accompanied by increased funding for detection and scanning technologies in 10 prisons<sup>16</sup>. It will be some time before the impact of this action will be evaluated. It will be important to investigate whether increased focus on detection practices and technologies leads to a displacement from use of synthetic cannabinoids to other (potentially more harmful) drugs, which are not detected by current tests. This was one of the reasons why NPS emerged in prisons in the first place (Ralphs et al., 2017).

## People who are homeless

50. There are no good quality estimates of rates of NPS in homeless populations, as by definition, they are rarely captured in household surveys like the CSEW. Qualitative data, media reports, and evidence received by the APPG collected from cities such as Doncaster, Exeter, Manchester, Stoke, and Wrexham, and areas in Scotland, London and the North East suggest that NPS use is associated with considerable harm in some, but not all, parts of the UK. Whilst SCRA are an issue in some parts of the country, in others, harms have emerged from use of novel stimulants and new and/or unlicensed benzodiazepines (anxiolytics) such as phenazepam and etizolam.

51. Across Europe new benzodiazepines have been detected that contain other NPS such as SCRA, and some have even been found to contain potent synthetic opioids such as fentanyl (EMCDDA, 2018b). In Scotland, new benzodiazepines have been responsible for a large rise in drug-related deaths. In deaths recorded in 2017, new benzodiazepines were associated with 59% of all drug deaths, and 336 of 337 NPS-related deaths (National Records of Scotland, 2018). In Northern Ireland, between 2015-2017 there were 41 deaths where fentanyl was mentioned on the death certificate, and 35

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<sup>14</sup> [https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjkhkimgw/uploads/2015/07/LLB\\_FII-Issue-9\\_NPS\\_Final.pdf](https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjkhkimgw/uploads/2015/07/LLB_FII-Issue-9_NPS_Final.pdf) (last accessed February 2019)

<sup>15</sup> <https://www.gov.uk/government/publications/new-psychoactive-substances-toolkit-prison-staff> (last accessed February 2019)

<sup>16</sup> <https://www.gov.uk/government/news/minister-announces-10-prisons-project-to-develop-new-model-of-excellence> (last accessed February 2019)

deaths mentioning NPS, including new benzodiazepines. This was higher than the 24 deaths reported for cocaine, and 16 reported for MDMA/ecstasy

52. In 2017, the ONS reported that in England, 190 homeless people died in relation to drug poisoning, 32% of the total number of deaths in this group<sup>17</sup>. Although this had fallen by six people since 2016, it still represents a 52% increase since 2013 (125 deaths). The ONS reported that these deaths were the highest in some of the most deprived towns and cities in the country. Based on data collected prior to the introduction of the PSA, McAuley and colleagues' (McAuley et al., 2019) analysis of NPS injection in Scotland showed that this practice was much more likely to take place in homeless populations, and that injection was partly the reason for a large rise in Hepatitis C infections in some Scottish regions.

53. People who are homeless have a significantly higher risk of death from all causes, and experience multiple disadvantage such as mental ill health, substance use, imprisonment, and unemployment at greater rates than the general population (Bramley et al., 2015; Nielsen et al., 2011). Homeless populations, and homeless populations who use drugs face significant marginalisation and ill health (Aldridge et al., 2018). Research has also shown a strong association between ACEs and adult experiences of both substance use and homelessness, which can be amplified by the trauma and victimisation experienced on the streets (Fitzpatrick et al., 2013; Hughes et al., 2017; Mar et al., 2014).

54. There is no uniform response to the harms of NPS use in homeless populations. Most local authorities in the UK have recorded a sharp rise in homelessness, and despite the publication of the Rough Sleeping Strategy (2018)<sup>18</sup>, have also seen budgets for public health services such as drug and alcohol treatment reduced<sup>19</sup>. Guidance for providers of homeless services has emphasised the importance of involving a range of frontline services in the response to NPS<sup>20</sup>. Homelessness service managers are encouraged to work with counterparts in the police, ambulance and substance misuse services, and improve information sharing and understanding of client needs, as well as multidisciplinary case working for higher risk individuals. It is recommended that substance misuse services are invited to team meetings to run training sessions with staff and/or clients with advice on NPS harm reduction.

55. In their evidence to the APPG, Ralphs and colleagues reported findings from a programme of research undertaken in 2016 by a number of organisations in Manchester<sup>21</sup> (see Case Study 1). In one survey of 26 rough sleepers undertaken as part of this work, 93% had used NPS in the previous year, and 85% reported using at least 5 days a week, most often SCRA. These daily users reported using NPS in order to reduce unpleasant withdrawal symptoms resulting from frequent use, and across this population, SCRA use was associated with mental ill health, acquisitive crime, and violence (both as a victim and perpetrator). Although use was not limited to just the homeless population, NPS use had led to a large increase in burden on support services including treatment services, hospitals and primary care, prisons, probation, day centres, hostels, supported housing, and approved premises.

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<sup>17</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deaths-of-homeless-people-in-england-and-wales/2013-to-2017> (last accessed February 2019)

<sup>18</sup> <https://www.gov.uk/government/publications/the-rough-sleeping-strategy> (last accessed February 2019)

<sup>19</sup> E.g. <https://www.health.org.uk/publications/taking-our-health-for-granted> (last accessed February 2019)

<sup>20</sup> E.g. Homelessness Link briefing on NPS for service providers: <https://www.homeless.org.uk/our-work/resources/new-psychoactive-substances-nps> (Last accessed February 2019)

<sup>21</sup> Also see: <https://www.mhcc.nhs.uk/wp-content/uploads/2017/08/MMU2278-SUAB-New-psychoactive-substance-use-in-Manchester.pdf> (last accessed February 2019)

There was also the common perception amongst many users that treatment services were primarily orientated towards heroin and crack cocaine, and this deterred them from engaging with services.

#### Case Study 1: responding to NPS in Manchester

Greater Manchester Police (GMP) first noted an increase in incidents associated with NPS in 2014. Parts of Manchester city centre experienced increases in anti-social behaviour, an increase in the number of 'head shops' openly selling NPS, and so-called 'Spice Tourists', who would travel to the city centre to buy and use SCRA. Local and national media headlines reported on the 'epidemic' of SCRA use, using the pejorative term "Spice Zombies", which soon gained popularity when national media began reporting from the city. Manchester City Council (MCC) commissioned Manchester Metropolitan University (MMU) to conduct a study of prevalence of NPS use in October 2015 in order to identify sub-populations who were using the drugs, and to see if their needs were being met through existing service provision.

The first phase of the research project was conducted with users of NPS and service providers, with data collected via questionnaires, interviews and ethnographic observation. The findings showed that it was the homeless community and offenders released on license who were experiencing the most problems, predominantly with SCRA. Motivations for NPS use included helping to keep warm, to aid sleep, and to block out trauma. Some research participants reported that SCRA had replaced heroin and crack cocaine, and although produced qualitatively similar withdrawal symptoms, was perceived to be more 'addictive'. The onset and worsening of symptoms of depression and psychosis was also discussed, as well as an increase in aggression. There was a lack of engagement of SCRA users by treatment services, mainly due to perceptions of the limited support on offer. Services expressed concern about the lack of funding for outreach work, a lack of clear referral pathways and multiagency working, poor levels of workforce NPS expertise, and overstretched staff.

After the introduction of the PSA there was an initial 'drought' of SCRA on the street, head shops closed down, and the police reported seeing the end of the "Spice Tourists". However, use of NPS continued in vulnerable communities across the city, with the establishment of street supply like any other illicit substance. SCRA and nitrous oxide continued to be widely available, although other types of NPS seemed to disappear. Nitrous oxide use increased in student populations and in schools, as well as continued use in young adults in the night-time economy. Police officers expressed uncertainty around identifying NPS and were unsure of powers for enforcement provided by the PSA. However, GMP actively targeted dealers and seized large quantities of SCRA.

In response to the findings of the research, workshops and training sessions for key stakeholders were delivered. A 'Spice Warning' leaflet was developed in partnership with Greater Manchester Police to help inform the public about SCRA. This was also adapted and displayed on billboards across the city as part of a wider awareness raising campaign. The leaflet offered signposting advice for treatment services, harm reduction advice and guidance on how to help somebody who appeared to be overdosing. A Local Drug Information System (LDIS) was set up across a number of agencies, providing regular updates about NPS issues and knowledge around drug use, drug analysis, legislation, and emerging research findings. In March 2017, the Manchester Drug Analysis and Knowledge Exchange (MANDRAKE) was established. This was a collaboration between GMP, MMU and other stakeholders to facilitate fast, robust and cost-effective chemical analysis of NPS and intelligence sharing to inform harm reduction actions.



In terms of service development, an NPS Task Group was established in Spring 2017 to help develop a response to NPS. This was a multi-agency partnership and included representatives from GMP, North West Ambulance Services (NWAS), the Voluntary and Community Sector (VCS), substance misuse services, Public Health England (PHE), MCC, and subject experts. The group have focused on key groups such as young people, homelessness and the rough sleeping population, and have undertaken outreach work to deliver harm reduction services and street health interventions. Substance use treatment practitioners deliver sessions in homelessness day centres and hostels to talk about NPS and offer pathways into treatment for those people who need support. The police have been important in this process and have allowed task force members to prioritise the treatment needs of street based NPS users over criminal justice responses.

More generally, like other UK cities, Manchester launched its five year homelessness strategy in 2018<sup>22</sup>. This includes key actions on substance use, including supporting a Housing First approach to homelessness, and ensuring that no one is discharged from hospital, in-patient mental-health services, or residential drug treatment without having secure accommodation to go to.

### Case study 2: Wrexham

Wrexham is the largest town in North Wales with a population of 135,000 but has historically seen relatively low-levels of substance use. However, in 2016 the emergence of NPS, in particular SCRA use in people who were homeless, led to the implementation of a Public Space Protection Order (PSPO) in the town centre to try to address the growth in antisocial behaviour. This was considered by local services to have had little impact, as it simply moved the problem on from the town centre, and failed to address the underlying determinants of drug use.

The need for a stronger multi-agency approach was recognised and so the Wrexham Gold Strategic Group was formed. The group consisted of representatives from the North Wales Police and Health Board, the local MP Ian Lucas, and council officers. The group developed the 'Gateway Plus' approach, a co-ordinated programme of change to support the provision of a service user focussed response.

The Gateway Plus approach was based on service user consultation and uses a multiagency assertive outreach approach to facilitate and maintain communications, provides rapid referral into drug treatment, and where appropriate, a rehabilitation programme. There is a nominated Single Point of Contact role tasked with liaising with all providers, and who works with service users following their treatment period to enable progress into work and housing, thus building recovery capital for the individual.

#### **Specific actions included:**

- Continuous consultation with service users.
- A weekly 'Crisis Café' was established, which is a venue where all service users could attend and access support from a range of services.
- At the start of the programme, all service users presenting to services in Wrexham over a 9-month period were profiled, and were assigned a red/amber/green classification to identify the highest risk and vulnerable individuals.

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<sup>22</sup> [https://secure.manchester.gov.uk/downloads/download/5665/homelessness\\_strategy](https://secure.manchester.gov.uk/downloads/download/5665/homelessness_strategy) (last accessed February 2019)

- A virtual ‘assertive recovery’ multi-agency task group was established in order to divert offenders into recovery focused disposal options rather than traditional punitive resolutions. Membership of the group included the police, the National Probation Service and Community Rehabilitation Companies, the third sector, and the North Wales substance misuse Area Planning Board. Although police operations still aim to disrupt the supply of NPS, the approach aims to divert offenders into treatment rather than through the criminal justice system.
- Development of an outcome monitoring system to understand the impact of this approach on NPS harms and antisocial behaviour in Wrexham. At the time of writing of this report, no evaluation has been published.

## 6. Monitoring the emergence of new drugs since the introduction of the PSA 2016

56. The EMCDDA Early Warning System (EWS; delivered in co-operation with Europol) is a network that collates and disseminates information on newly detected drugs in Europe<sup>23</sup>. The network comprises 30 national early warning systems (28 EU Member States, Turkey, and Norway; including the UK) that report new detections to the EMCDDA (e.g. from police seizures, field testing, hospital presentations, toxicology reports). This information is shared for the purposes of early warning, and to provide risk assessment reports for compounds that may pose health or social risks.

57. The EWS was established in 1997, but there was a large increase in the number of new NPS detected for the first time in 2005 (See the Table below). The number of annual NPS detections reached a peak of 101 in 2014 (a total of 417 NPS had been detected at this point), but since then there has been a gradual decrease in detections, with 98 being reported in 2015, 66 in 2016, and 51 in 2017 (EMCDDA, 2015, 2018a). The EMCDDA (2018a) suggested that this downward trend, which started before the PSA, could be explained by reductions in the number of new SCRA and cathinones, which have historically comprised the majority of detections, but may also be a result of sustained efforts to control NPS across Europe (including the introduction of the PSA), and law enforcement operations in China resulting in the closure of laboratories in which many NPS are manufactured.

### ***Number of new substances detected by the EMCDDA since 2005***

<b>Year</b>	<b>Number of new detections</b>
2005	13
2006	7
2007	15
2008	13
2009	24
2010	41
2011	48
2012	74
2013	81

<sup>23</sup> <http://www.emcdda.europa.eu/publications/topic-overviews/eu-early-warning-system> (last accessed February 2019)

2014	101
2015	98
2016	66
2017	51

58. This reduction in the number of new NPS detections is encouraging, but whilst only a small number actually make it to street use, the majority of newly identified drugs have an unknown toxicological profile. Furthermore, whilst retail and open online sales declined sharply after the PSA (Home Office, 2018; Wadsworth et al., 2018), NPS are still available on the darkweb from UK suppliers (EMCDDA and Europol, 2017; Haden et al., 2017; Scourfield et al., 2019).

59. Similar to reductions in the overall detection of NPS, there has been an overall reduction in the total number and volume of NPS seized by law enforcement across Europe since 2015, which can be explained by a fall in reports involving SCRA (EMCDDA, 2018). Whilst seizures continue to be dominated by SCRA and cathinones, there has been an increase in the number and volume of synthetic opioids seized, and an increase in the volume of seized new benzodiazepines (EMCDDA, 2018).

60. One concern shared across Europe is the emergence of newly detected NPS such as derivatives of the highly potent synthetic opioid fentanyl, the continued dominance of SCRA in both the street and online NPS market (including misselling of SCRA as other drugs), and a growth in the market of new benzodiazepines (EMCDDA, 2018).

61. As discussed in Section 5, novel benzodiazepines such as etizolam<sup>24</sup> are a particular concern in Scotland, and deaths associated with use have increased sharply in recent years, comprising the majority of NPS fatalities. In May 2017, a number of these drugs were classified under Class C of the Misuse of Drugs Act 1971 and placed into Schedule 1 of the Misuse of Drugs Regulations 2001. Etizolam was associated with 223 Scottish deaths in 2016 (representing more than half of the 426 benzodiazepine deaths), and 299 deaths in 2017 (more than half of the 552 benzodiazepine deaths). Publication of Scottish figures for drug deaths registered in 2018 are expected in Summer 2019.

62. Although synthetic opioids play a relatively small role in the UK NPS market, they are one of the fastest growing groups detected by the EWS, with evidence of a large increase in their availability since 2016 (EMCDDA, 2018). First reported to the EMCDDA in 2009, there are now 38 being monitored by the EMCDDA, of which the majority (n=22) were detected in 2016 and 2017 (EMCDDA, 2018). New fentanils dominate this group, with 28 being reported since they were first detected in 2012.

63. The Welsh Emerging Drugs and Identification of Novel Substances Project (WEDINOS) is funded by the Welsh Government (until 2025) and provides a mechanism for prisons, drug and other health services, and the public to anonymously submit samples of drugs, including NPS for testing<sup>25</sup>. The results of analysis are publicly disseminated, and accompanied by pragmatic harm reduction advice which inform drug service activities with service users. In 2017/18 WEDINOS received 1728 samples, and analysed 1555 of these. 145 different substances were subsequently identified either in isolation or combination. With respect to NPS, WEDINOS has reported a large proportion of drugs purchased as benzodiazepines (e.g. diazepam) contain different substances, including novel and unlicensed benzodiazepines. Based upon analysed samples, SCRA are primarily two compounds, 5F-ADB, and AMB-FUBINACA, which have been associated with fatal intoxications across Europe. In previous years,

<sup>24</sup> Benzodiazepines are a class of drug that include medicines that are typically prescribed for anxiety. Etizolam does not have marketing authorisation in the UK, but is a licensed medicine in Italy, India, and Japan.

<sup>25</sup> <http://www.wedinos.org/index.html> (last accessed February 2019)

WEDINOS has identified potent and potentially more harmful NPS sold as cocaine, LSD, ketamine, and MDMA/ecstasy. Of particular concern, samples submitted as being bought as heroin have been found to contain fentanyl, and the even more potent carfentanil.

64. Of note, in a recent study that was conducted in English drug treatment clients who had submitted a routine urine sample for analysis, 3% showed fentanyl despite reporting not intentionally using this drug (Bijral et al., 2018). This ranged from 2% and 15% depending on the region that the tests were undertaken in. Based on this data, the researchers estimated that there could be an English fentanyl-heroin contamination rate of 6%, although this also might be an underestimate. This was a small preliminary study, and so the findings need to be taken with caution, but it does suggest that there is more fentanyl in the English/UK heroin supply than is commonly believed. The ONS report that despite deaths from other opioids such as heroin declining slightly or remaining steady in England and Wales, fentanyl deaths have increased by 29%, rising from 58 deaths in 2016 to 75 deaths in 2017.

65. The Report Illicit Drug Reactions (RIDR) Pilot<sup>26</sup> funded by PHE, mirrors the reporting mechanisms used by the Medicines and Healthcare products Regulatory Agency (MHRA) to monitor the adverse effects of pharmaceutical drugs (the 'Yellow Card System'). It provides an online reporting platform whereby health professionals who work across a wide range of settings where staff meet people presenting with acute or chronic problems with NPS and other drugs, can share information on the adverse effects encountered. RIDR provides regular update reports on the effects of NPS and other drugs in order to speed up the identification of harms, so that health and treatment services can rapidly deliver the most appropriate interventions. For example, the February 2019 report provided intelligence on the increased use of Xanax (alprazolam; an unlicensed benzodiazepine controlled as a Class C drug) in some parts of the country. The report provided relevant information on pharmacology, use behaviours, and data on prevalence and police seizures.

66. Whilst undoubtedly an important resource, such reporting systems are only as useful as the quality and amount of information provided. Since May 2016, almost all reports issued by RIDR have been on drugs controlled by the Misuse of Drugs Act. Whilst providing data and guidance for professionals for newly emerging drug risk behaviours related to traditional drugs, the system does not appear to have been as successful in capturing adverse effects of NPS. This might be through a lack of NPS-related presentations at relevant services, a lack of a systematic monitoring programme, or difficulties in identification of drugs consumed. Without toxicological and forensic analysis, service providers might rely on generic and slang terms to describe drugs, which can often be very localised or refer to multiple drugs (e.g. since 2013, 'monkey dust', which has been identified as a concern in North Staffordshire, has been analysed and reported as MDPV, MDPHP, alpha-PVP). Recommended non-specific intervention responses may be the same, but drugs that have a unique toxicological or adverse behavioural profile may require a different intervention response.

## 7. Prevention and education

67. Drug prevention and education are important components of the overall response to reduce demand for NPS. Although the two terms are often used interchangeably and their aims overlap, there are important differences in approach.

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<sup>26</sup> <https://report-illicit-drug-reaction.phe.gov.uk/> (last accessed February 2019)

68. *Drug prevention* relates to programmes and practices designed to reduce the incidence and prevalence of drug use and related health, behavioural and social problems. The most effective approaches include interactive skills training, classroom management activities and school retention programmes, and some also include family components such as monitoring and supervision (ACMD, 2015). Prevention approaches aim to improve health and social decision-making, and to foster positive social relationships between recipients and protective family, community, and social structures. Prevention actions may also indirectly reduce the risk of drug use by targeting those factors that make drug use more likely (ACMD, 2018). For example, prevention might aim to prevent school dropout, to address mental ill health and behavioural disorders, or to ensure that people have access to good housing.

69. *Drug education* does not have the same direct aims as prevention, and unsurprisingly, focuses on educational outcomes and not behavioural change. Drug education aims to increase knowledge and understanding of drugs, including effects and the law, and sessions may also provide advice on where to seek further help if needed, or include simple strategies that can be used to try and reduce drug related harms. This is useful information, and so whilst education may not necessarily lead directly to behaviour change, it is an important addition to the skills development activities provided through prevention activities.

70. Schools have historically been the setting for most delivery of drug prevention and education in the UK (ACMD, 2015). Whilst there is a developing international evidence base for effective approaches these activities have tended to be structured programmes that focus on the most popular drugs such as alcohol, tobacco, and cannabis, or target substance-related risk factors and harms in general (Faggiano et al., 2014; UNODC, 2018). However, despite the availability of these evidence-based programmes, few are implemented due to factors such as the resources required, the curriculum time needed, and a lack of skilled practitioners (ACMD, 2015). Those that are delivered in schools and other community settings tend to be developed locally, delivered at a small scale, and are rarely evaluated, so it is not known whether they produce positive outcomes. Furthermore, as highlighted in the 2017 Drug Strategy, prevention activity is rarely directly labelled as ‘drug prevention’, and so whilst general work to promote healthy development and resilience, or subjects such as Personal, Social, Health and Economic (PSHE) are important components of the overall preventative response, it is difficult to establish what impact, if any, they have on substance use.

71. The Schools Smoking Drinking Drug Use Survey 2016 (drug use data summarised in Section 5 above) asked schools about the drug education and prevention that they delivered, and pupils about the activities that they remembered receiving in the previous year. Although dating from 2015-2016, there is no reason to believe that these findings would be different post-PSA. Ninety four percent of schools reported some form of provision. Teachers were responsible for delivering lessons in 93% of schools, although they were not necessarily specialists in PSHE. Local drug and alcohol advisors were included in teaching in 39% of schools, the police in 37%, and school nurses in 30%. The most-utilised resources for preparing lessons was the FRANK website (80%), followed by Google (79%), and the website of the PSHE Association (79%). Specialist resources such as the Alcohol Drug Education Prevention Information Service (ADEPIS)<sup>27</sup> were only used by around 13% of teachers.

72. Sixty one percent of pupils recalled receiving some form of drug education in the previous year, but most (63%) reported that they only usually received it about once a year. Pupil satisfaction with this education varied by age, so whilst 59% of 15 year olds thought that their school had provided

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<sup>27</sup> ADEPIS is a platform for sharing evidence-based information and resources aimed at schools, practitioners working in prevention, and a growing range of other settings for reaching young people.

them with enough information about drugs, only 38% of 11 year olds did. This is an important finding considering that English school survey data (paragraphs 20 and 21) suggests that 3.4% of 11 year olds had used VSA, compared to only 0.4% reporting cannabis.

73. Drug education is typically delivered in schools as part of Science, and Personal Social Health and Economic Education (PSHE; or equivalent) activity. Ofsted last reported on school provision of PSHE (including alcohol and other drug education) in 2013 and noted their concerns about the quality and appropriateness of delivery. They observed that lessons typically failed to support the development of key skills, were not delivered as part of a structured programme of activity, and much of it was not age-appropriate (Ofsted, 2013). Although the Ofsted report preceded the PSA, there is no evidence to suggest that the situation with respect to drug education has improved. Whilst pupils in the 2016 English schools survey reported that they received information on drugs, this is not the same as structured drug prevention activities that would help them to apply that information to their own behaviour (ACMD, 2015). The low levels of use of specialist resources and the infrequency of delivery, suggests that most drug education in England is not currently being delivered by trained professionals, and is provided through one-off sessions that are not part of a programme of activity.

74. Department for Education guidance on compulsory sex, relationships, and health education includes a focus on the risks from substance use, but not specifically NPS<sup>28</sup>. Schools have been encouraged to apply the guidance from September 2019, and will be mandated to do so from September 2020. Proposed substance content for secondary school pupils includes topics such as the relationship between substance use and risky sexual behaviour; drug-crime links; drug ‘facts and figures’; and information about effective interventions and where to get support. This specific information is delivered against a background of health skills development, and drug use behaviours are contextualised within broader societal and cultural factors. The draft guidance encourages a ‘whole-school’ approach whereby curriculum content is supported by the school’s wider policies on issues such as behaviour and safeguarding, the development of pupil wellbeing, and engagement with community structures such as parents and specialist providers of support.

75. This guidance adheres with principles of effective drug education and prevention (Brotherhood and Sumnall, 2011; UNODC, 2018). Evidence on whole school approaches is emerging for a number of health-related outcomes, but little work has been undertaken on whether they are also effective in addressing drug use (Langford et al., 2014). This type of approach presents unique challenges. Learning from other health domains suggest that sufficient planning and classroom time is critical to success, and curricula need to be coordinated with the ethos and environment of the school (including having up to date school drug policies), and there also needs to be external engagement with high quality providers.

76. Although there is emphasis throughout the guidance on facts and knowledge, it encourages teachers to provide ‘opportunities and contexts for pupils to practise applying and embedding new knowledge so that it can be used skilfully and confidently in real life situations’. This is an important element. Developing pupils’ knowledge on drugs (including NPS) without these other supportive and complementary actions is simply repeating historical practice. However, it is uncertain whether educators will have the sufficient skills and competencies to deliver this in relation to drug use; findings from the school surveys summarised above suggest that this may be an existing training and skills gap. Whilst the guidance does include useful links to resources, including suggested programmes

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<sup>28</sup>[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/781150/Draft\\_guidance\\_Relationships\\_Education\\_Relationships\\_and\\_Sex\\_Education\\_RSE\\_and\\_Health\\_Education\\_2.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/781150/Draft_guidance_Relationships_Education_Relationships_and_Sex_Education_RSE_and_Health_Education_2.pdf) (last accessed February 2019)

of study from the PSHE Association, and Mentor-ADEPIS guidance on planning drug education<sup>29</sup>, there is relatively little advice on prototype models of integration within the proposed whole-school approach.

## NPS Education and prevention resources

77. The Home Office published an NPS Resource Pack for informal educators and practitioners in March 2015, and this was updated in August 2016<sup>30</sup>. The 2017 Drug Strategy made a commitment to further updates but none have as yet been forthcoming. The Resource Pack collates information on the PSA and NPS, such as prevalence and reasons for NPS use, recommended resources, and a list of key facts. Three case studies are included, which describe some example approaches taken by two young people's service providers towards NPS. Whilst a useful repository of information, the pack includes some out of date information, a number of 'dead links', and overall there is a lack of guidance on how NPS activities could be structured and delivered in a drug education session using the information provided. Whilst specialist providers may have the confidence and skills to apply the information to existing ways of working, it is unlikely that non-specialists, a key target of the resource, could use it to guide meaningful activity.

78. The Talk to FRANK service is an online source of drug information run by PHE that includes a helpline number, advice and information, and a description of drug law and effects. DAN 24/7 and Know the Score provide similar functions in Wales and Scotland respectively. In addition to drug facts and information, the site provides simple but important advice on topics such as what to do in a drug-related emergency, and how to talk to children about drugs. The site also provides some relevant harm reduction information for some substances, including NPS. One of the most important functions of FRANK is that it provides links to more specialised support for those who might be worried about their own or others' use of substances, and so it also includes a description of what people might expect if they attend a drug treatment service.

79. FRANK includes relevant information on NPS and provides an overview of the appearance and effects of several substances, including SCRA and novel psychostimulants. As so many different substances are classed as NPS, the information and advice offered is quite general. The section acknowledges the similarities between NPS and other traditional drugs and so describes intoxication effects in relation to more well-known substances such as cannabis and cocaine. Administration routes are described although information on injection may not be of great relevance to the majority of FRANK's visitors.

80. FRANK was refreshed in December 2018, leading to an additional 180,000 visitors and this was described by PHE Chief Executive Duncan Selbie in January 2019 as "*...prevention through digital technology at its best. In short, FRANK is giving young people clear, unbiased information in a way they are comfortable with accessing*"<sup>31</sup>. However, there are no publicly available evaluations of the impact of FRANK, which young people use it, or how they use it, hence it is unclear what role it plays in the response to NPS. As discussed above, information provision is only one component of drug prevention,

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<sup>29</sup> <http://mentor-adepis.org/planning-effective-education/> (last accessed February 2019)

<sup>30</sup> <https://www.gov.uk/government/publications/new-psychoactive-substances-nps-resource-pack> (last accessed February 2019)

<sup>31</sup> <https://publichealthmatters.blog.gov.uk/2019/01/25/duncan-selbies-friday-message-25-jan-2019/> (last accessed February 2019)

and the website requires visitors to have the skills to access and interpret, and confidence and opportunities to apply the information provided to their own lives and experiences. A 'knowledge-behaviour' gap has been observed in relation to many health behaviours, and means that whilst someone might become aware of the risks of harm from drug use, they are unable or unwilling to act upon it (Sligo and Jameson, 2000). In relation to this, research funded by the NIHR into a prevention programme in Welsh schools has just begun. *FRANK friends* is a stand-alone, informal drug prevention intervention that identifies and recruits peer opinion leaders in year 9 pupils (aged 13-14) to be trained as peer supporters. Peer supporters receive off-site training to learn the effects and risks associated with specific drugs (including NPS) and potential harms, and this is based on the information on the FRANK website. Peer supporters are then asked to have multiple informal conversations with their peers at school on the risks of different drugs over a 10-week period. During this time, peer supporters are visited on multiple occasions by trainers to support them to have these conversations.

81. The APPG is unaware of any other direct government-funded NPS prevention/education resources and activities that have been developed at a national level since the introduction of the PSA. Although some local areas may have produced their own resources, these were not available to the APPG.

### Embedding NPS education and prevention in school and community activities

82. As surveys show that NPS prevalence in pupils and the general population remains low, *universal approaches* specifically focusing on NPS, and which target groups regardless of their level of risk, may not present a good use of curriculum time or limited resources available. However, some prevention programmes that include a focus on NPS have been shown to have a positive effect (e.g. the online Australian Climate Schools: Ecstasy and Emerging Drugs Module (Champion et al., 2016), but may require changes to adapt them to local conditions and delivery structures, and so it is important that they are delivered with care. This is because that despite being delivered with good intentions, many prevention programmes and approaches have been shown to be ineffective or a poor use of money (e.g. standalone mass media and information campaigns, 'fear arousal' approaches, random drug testing of people, drug dogs) (Pennington et al., 2018; Sumnall et al., 2017). Some approaches even have negative effects and can lead to increased drug use, or intention to use drugs, because they may 'normalise' NPS use (i.e. they may give the impression that more people use NPS than actually do) or bring attention to drugs that might otherwise have been avoided.

83. Universal NPS-related prevention activities should therefore only be delivered as part of prevention programmes for which there is evidence of effectiveness or where confidence is high that the approach is likely to be effective. The model provided in the sex, relationships, and health education discussed above provides a good framework within which to deliver these types of activity in schools or other community settings. If there is evidence of need (e.g. there have been local NPS-related incidents, or surveys suggest use is likely to be high in the locality), NPS components might focus on providing accurate descriptive and injunctive norms (e.g. based on local data 'very few people use NPS'; and 'research shows that young people like you don't use NPS'), approaches which show promise in reducing drug use (Sumnall et al., 2017).

84. Different approaches are needed for more experienced or regular drug users who might already be using NPS, or have more opportunities to use. Prevention and education approaches are still important for these groups, as they may persuade people to stop use altogether, reduce the frequency



of use, or to ameliorate riskier drug use practices such as trying unfamiliar NPS. However, harm reduction interventions may be more appropriate.

85. Harm reduction refers to those policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of drugs without necessarily reducing drug consumption<sup>32</sup>. These types of intervention aim to reduce ill health and disease until a person is able or willing to reduce or stop drug use, and have shown to be effective in higher risk populations such as people who inject drugs (Ritter and Cameron, 2005), people who are homeless (Hwang and Burns, 2014), and prisoners (Bielen et al., 2018); populations who are all at increased risk from NPS harms. Harm reduction approaches can sometimes be controversial, as they may be perceived as condoning risky or illegal behaviours. Nevertheless, national NICE guidelines and UK clinical guidelines on drug misuse and dependence already support delivery of a range of harm reduction actions such as needle exchange programmes to reduce transmission of blood borne viruses, and overdose prevention interventions to reduce drug-related death (Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group, 2017; National Institute for Health and Care Excellence, 2014).

86. Most research into harm reduction and treatment approaches for higher risk groups have been conducted in people using traditional drugs such as heroin or crack cocaine. A comprehensive review funded by the National Institute for Health Care Research (NIHR) found that almost no research had been undertaken on interventions specifically addressing NPS (Mdege et al., 2017). NIHR subsequently issued a call for funding proposals (2019) for research that investigates effective responses to NPS.

87. Current NPS guidance from the Novel Psychoactive Treatment UK Network (NEPTUNE)(Novel Psychoactive Treatment UK Network: NEPTUNE, 2015) recommends the adaptation of existing and generic psychosocial treatment interventions for traditional drugs, and the same approach could be applied to harm reduction interventions. Existing approaches should be adapted to reflect any unique user group needs, the structural, cultural and social contexts of use, and to incorporate new opportunities for the engagement of user groups and delivery of services (Pirona et al., 2016). A professionally competent workforce with the required skills is needed to make necessary adaptations and support responses to NPS use.

88. There is currently little evidence on what type of harm reduction and intervention approaches are effective for people who use drugs 'recreationally' (EMCDDA, 2010; Pirona et al., 2017). This group comprises the largest number of people who use NPS (alongside other substances), but they rarely engage with formal treatment services (Measham, 2018). They also do not tend to trust the information provided by government-funded resources such as FRANK, and prefer sources that are perceived as being independent, or based on the experiences and behaviours of peers. In a recent survey conducted by the National Union of Students (NUS) in 2018<sup>33</sup>, respondents who used drugs reported that the most frequently utilised sources of advice and support were peers (70%) and online user forums (63%), whilst only 43% reported visiting the FRANK website. However, whilst they might be more valued, the content and nature of the advice provided by independent sources is not scrutinised as much as FRANK, and so there are no guarantees of quality and accuracy. There is an anticipation in these user groups of certain levels of health risk associated with drug use, and so discussions and practical advice about reducing harms are as valuable as those for more traditional

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<sup>32</sup> <http://www.euro.who.int/en/health-topics/communicable-diseases/hiv-aids/policy/policy-guidance-for-areas-of-intervention/harm-reduction> (last accessed February 2019)

<sup>33</sup> <https://www.nusconnect.org.uk/resources/taking-the-hit-student-drug-use-and-how-institutions-respond> (last accessed February 2019)

user groups such as people who use heroin and crack cocaine (Kjellgren and Jonsson, 2013; Van Hout and Hearne, 2015). There is an emerging body of international research that suggests that 'drug checking' programmes, which permit people to have drugs chemically analysed in specially designated sites, and which proceed with the support of local police and other stakeholders are i) an effective means of engaging hard to reach populations with services; ii) provide local intelligence on drug markets; and iii) provide an opportunity to deliver prevention and brief advice (Barratt et al., 2018; Measham, 2018).

89. Independent providers of NPS related harm reduction resources include (but are not limited to) the Drug Watch network, who produce information briefings for drug workers and other professionals (<http://www.ukdrugwatch.org/>); The Loop, who undertake 'drug checking' and provide brief interventions in festival and nightlife settings (<https://wearetheloop.org/>); Why Not Find Out (<http://www.wnfo.org.uk/>), an online prevention resource run by the charity Mentor UK (<https://mentoruk.org.uk>); Crew 2000 (<https://www.crew.scot>), a harm reduction and outreach charity based in Scotland; and Re-Solv (<http://www.re-solv.org/>), a charity dedicated to reducing use and harms from VSA. These are included here as organisations that are viewed by the report authors as offering high quality resources, but further discussion of their work is beyond the scope of this report.

### Involving parents, carers, and communities in NPS/VSA prevention and education

90. Research has shown that drug prevention activities that involve the family/carers and children working together can be effective in reducing adolescent drug use and associated harms (Van Ryzin et al., 2016). The most effective approaches help families develop authoritative (but not authoritarian) approaches to behaviour management and problem solving, foster positive family relationships, and encourage parents/carers to help children and young people develop skills and values that help them to avoid or deal with risky situations. Whilst none of the evidence is derived from NPS-specific activities, these strategies do seem to be effective across a range of substances, and may also be useful for other non-drug risk behaviours.

91. Structured family-based prevention programmes require skilled practitioners to deliver them, and provision has been historically low across the UK. However, all families can potentially help young people develop skills to cope with NPS-risk, and this does not require specialist knowledge. Basic actions such as providing safety tips (e.g. knowing what to do in an emergency), letting young people know they can rely on parents/carers if they get into trouble, and having supportive and non-confrontational conversations about drugs can all be beneficial. Researchers who have studied the nature of substance-related/risk conversations between parents/carers and children have concluded that these must be open, frequent, and of high quality, so must be thought about in advance. Adolescents must be made to feel comfortable and that their views and opinions are valued (Carver et al., 2017). Criticism and accusations are unhelpful, and through two-way communication (rather than lectures), rules and consequences should be established, but these should be related to the health and social consequences of drug use. Parents/carers should try to establish credibility, but the research literature is mixed with respect to whether parent/carer disclosure of their own (past) drug use behaviour is helpful. Adolescents model their behaviour on the examples and values demonstrated by family members, and so parents/carers should also reflect on their own use of substances, and how this might affect young people. Parents/carers often report that initiating conversations about illegal drugs are a lot more difficult than those about alcohol and tobacco, and so

combining discussions on all three may make this easier, and allows opportunities to explore attitudes and opinions about a range of potentially health harming behaviours.

92. The Home Office guidance to the PSA for retailers was published after the introduction of the Act, and provides advice on relevant NPS/VSA offences (including offences under the Cigarette Lighter Refill (Safety) Regulations 1999), steps that retailers can take to comply with the law, and guidance on detecting where a customer may be attempting to buy a non-exempted product for intoxication<sup>34</sup>. Whilst the Home Office PSA Review suggested that the majority of retailers had complied with the law, continued arrests, and media stories on alleged offences<sup>35</sup> suggest that sales are still taking place. Furthermore, many online retailers offer nitrous oxide products for catering purposes (e.g. whipped cream ‘chargers’), as this is an exempted activity. However, it is clear from product descriptions and published customer feedback/questions that these products are also being used for intoxication. Whilst the Home Office guidance makes recommendations to online retailers to help them demonstrate due diligence, many would appear not to be operating in accordance with these principles.

93. A number of resources are available to support parents/carers with discussions about NPS, and drugs more generally. Some of these include Re-Solv’s Parent and Carer’s guide to NPS and VSA (<https://www.re-solv.org/for-parents/>); Mentor UK and Adfam’s *Talking with your children about New Psychoactive Substances and Club Drugs – A Handbook for Parents and Carers* (<https://mentoruk.org.uk/the-parents-handbook/>); Mentor UK’s Parent’s discussion guide (<https://mentoruk.org.uk/information-and-advice/parents-and-carers/>); and Drugs and me Parent’s guide (<https://www.drugsand.me/en/me/parents/>). Current Chair of the ACMD, Dr Owen Bowden-Jones has also written a book called *The Drugs Conversation* (<http://owenbowdenjones.com/the-drug-conversation/>). Again, there may be other resources available, but these are included here as being familiar to the report authors, and are considered to adhere to the principles outlined above.

## 8. Media and public discussions of NPS and VSA

94. Since the appearance of mephedrone onto the UK drugs market in the early 2000s, NPS have been a frequent feature of the news and entertainment media (historically, and still often referred to as ‘legal highs’) (Alexandrescu, 2014). Whilst there have been some good examples of sensitive reporting by popular media on the use of NPS/VSA by vulnerable populations (e.g. special reports on SCRA and homelessness in the Manchester Evening News), overall, and as with reporting on traditional substances, the majority of reporting has been alarmist, sensationalised, and often inaccurate. Some stories have focused on individuals in the public eye (e.g. footballers) who have been described as poor role models for their use of nitrous oxide and helium. Other groups of users (e.g. young females) are represented as victims of unscrupulous dealers, whilst others (e.g. vulnerable and marginalised groups such as the people who are homeless) are demonised, dehumanised and positioned as a threat to others and to wider society (Alexandrescu, 2018; Wincup and Monaghan, 2016). For example, the news media have drawn on the image of the ‘zombie’ to describe people who use SCRA in a way that emphasises the supposed threat posed by such groups, and dehumanises those using the substances

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<sup>34</sup> <https://www.gov.uk/government/publications/psychoactive-substances-act-guidance-for-retailers/psychoactive-substances-act-2016-guidance-for-retailers#steps-retailers-can-take-to-follow-the-law-examples-and-case-studies> (last accessed February 2019)

<sup>35</sup> E.g. *Laughing gas laws not working, says ex-chief crown prosecutor* <https://www.bbc.co.uk/news/uk-england-manchester-46591871> (last accessed February 2019)

in a way that reinforces stigma<sup>36</sup>. Similarly, recent reporting of those who use the various cathinone substances labelled as 'Monkey Dust' in North Staffordshire have been dehumanised and framed as dangerous through labelling as 'zombies' and 'Hulks'<sup>37</sup>.

95. Such pejorative and stigmatising representations of NPS/VSA and the people who use them can have real impact on the lives of affected groups. In October 2018, Sheffield City Council even had to launch a campaign asking the public to be "kind not cruel" to people who used SCRA, and to refrain from taking photos of them in public, as these were being posted and shared widely on social media<sup>38</sup>. Public stigma can lead to violence and discrimination towards affected groups, and present a barrier to personal aspiration and life opportunities, interfering with the ability to seek housing, find jobs, and receive treatment (Corrigan and Wassel, 2008; Link and Phelan, 2001). Such stigmatising attitudes can be pervasive amongst the public and even amongst experienced professionals. Substance-related problems are particularly stigmatised because of their strong association with crime and other serious social harms that extend beyond the individual using the substance.

96. Different authors and organisations have discussed the importance of 'person-first' language and other aspects of respectful terminology when describing marginalised or at-risk groups (e.g. Scholten et al. (2017); UKDPC (2010)). Yet much of the language that continues to be used in popular media in relation to the use of substances can intentionally and unintentionally propagate stigma, and can deprive people of their individual or personal qualities and personal identity (Kelly and Westerhoff, 2010; Sattler et al., 2017; Wakeman, 2017). In 2017, the Associated Press Stylebook, an influential USA guide to the clear use of written English, was updated to recommend that journalists adopted neutral and medically accurate language to describe substance use, and to avoid forms of language that could foster and perpetuate negative and stigmatising views towards affected groups.

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<sup>36</sup> E.g. *Living life as a 'zombie' on Spice* <https://www.bbc.co.uk/news/av/uk-wales-44852322/living-life-as-a-zombie-on-spice> (last accessed February 2019)

<sup>37</sup> E.g. *From 'Hulk-like strength' to 'zombie face-eating' - what is monkey dust? The psychotic substance linked to a spate of violent attacks in the US is beginning to make its presence felt in the UK.* <https://news.sky.com/story/from-hulk-like-strength-to-zombie-face-eating-what-is-monkey-dust-11468178> (last accessed February 2019)

<sup>38</sup> <https://www.bbc.co.uk/news/uk-england-south-yorkshire-45709950> (last accessed February 2019)

## 9. Recommendations

The recommendations listed below are derived from witness testimonies, written evidence submitted to the APPG, and supplementary literature review work conducted by the report authors. They are categorised by responsible organisations. Figures in square brackets after each recommendation refer to the report paragraph(s) from which they are derived.

### Recommendations for educational providers

1. Schools and other education providers (including alternative provision such as Pupil Referral Units), should ensure that they have drug and alcohol policies in place, that they are up to date, and include consideration of NPS and VSA. The briefing provided by Mentor ADEPIS on NPS (<http://mentor-adepis.org/updating-drugs-policy-include-nps/>) and their toolkit to support reviews of school policies (<http://mentor-adepis.org/reviewing-your-drug-and-alcohol-policy-a-toolkit-for-schools/>) should be promoted by the Department for Education (DfE) and Public Health bodies in this regard. [70-73]
2. In light of new DfE guidance on Relationships, Sex, and Health Education (RSHE), schools and other education providers are encouraged to take a whole-school approach towards substance use prevention and education, deliver classroom activities within a broader health-promoting school environment, and engage with high quality external (specialist) providers where appropriate. It is recommended that Public Health bodies lead development of guidance to help schools implement a whole-school approach to substance use. [74-76]
3. In accordance with the ambitions of the 2017 Drugs Strategy, all NPS prevention and education activities should be: i) evidence-based, ii) delivered in accordance with guidelines and quality standards such as those published by NICE and ADEPIS, iii) age and developmentally appropriate, and iv) delivered by staff with the competencies and skills required for the delivered approach. [70]
4. Universal skills-based drug prevention and education approaches should be the first response to NPS and VSA in young people, as these develop the necessary foundation upon which to deliver more targeted activity. Prevention and education activities focussing on NPS and VSA should be delivered where evidence from needs assessment activities conducted in the school or local community suggests that these would be beneficial. These activities should build upon the skills and competencies developed in universal approaches. [82]
5. Harm reduction approaches to NPS and VSA prevention and education may be appropriate for older pupils and students, but only where there is clear evidence of need. These approaches need to be carefully managed and should only be delivered through collaboration between local service providers, including drug service providers, and senior school staff to ensure coherence with pupil/student need, the institution's drug and alcohol policy, and to ensure appropriate targeting of activities. [84]
6. Public Health England should conduct a brief review of the content of the FRANK website to ensure that information for parents is up to date with respect to NPS, and in accordance with research evidence and guidelines from drug prevention charities about how to best undertake family discussions about drugs. [78, 91]
7. As part of any RSHE inspection activities, and as an update to its 2013 review of PSHE, Ofsted should review provision of substance use prevention/education to ensure that they are being delivered in accordance with the principles outlined above. [73]
8. Higher and Further Education providers should review their policies on NPS, VSA, and other substances as part of their overall approach to support student wellbeing. Considering the

greater likelihood of use of NPS and other substances by students, Higher and Further Education should consider providing evidence-based harm reduction advice on their websites, and collaborate with local drug services to deliver advice and support on campus. [88]

### Recommendations for government, executive agencies, and public bodies

9. The Home Office should update its NPS Resource Pack in accordance with the 2017 Drug Strategy. [77]
10. The Home Office should review whether online retailers are complying with its guidance on PSA/Cigarette Lighter Refill (Safety) Regulations 1999. [92]
11. The UK should endeavour to continue its participation in the EMCDDA Early Warning System in order to anticipate and inform responses to NPS threats, particularly from novel opioids and benzodiazepines. [59-60]
12. The Home Office should provide clarity on the definition of 'psychoactivity' in the wording of the PSA, as recent rulings suggest that legal interpretation differs from scientific definitions. [6]
13. The Home Office should review the continued use of TCDO, and clarify how in light of the PSA TCDOs are viewed to decrease NPS-related harms. [11]
14. The Home Office should commission a 5-year review of the PSA. In accordance with the recommendations of the ACMD, this should be undertaken by an independent organisation. [13]
15. In light of the significant evidence and data gaps that were identified in the 2018 PSA review, government bodies should scope data collection needs for i) future evaluation and ii) to inform policy and practice responses. Particular consideration should be given to improving data collection on A&E and hospital admissions, and substance use data from people who are homeless, prisoners, and university students, as these are not captured by the CSEW. [13-14]
16. The Home Office should consider re-introducing questions on VSA into the CSEW in order to provide estimates of use in the general population. [23]
17. Public Health bodies should map and review the use of local drug information systems to inform the work of the Report Illicit Drug Reactions (RIDR) programme. Key to the optimisation of these type of systems is the timely and accurate reporting of drugs intelligence from a range of local providers. To help develop this reporting network, responsible bodies should consider funding a pilot that systematically monitors NPS incidents in hospitals and drug services across carefully selected sentinel sites. [65-66]
18. The Home Office should grant licences to permit greater provision of 'drug checking' services similar to WEDINOS, those operating at music festivals/city centres, and current research pilots attached to community drug services. This would allow services and members of the public to submit samples for analysis which would inform drug information and intelligence systems, the delivery of prevention and harm reduction advice, and act as a pathway into services. [59, 64, 65, 86, 88]

### Recommendations for local authorities, local partnerships, and local drug service providers

19. Service providers should ensure that their staff receive regular, up-to-date training on NPS and VSA issues, particularly in response to emerging NPS/VSA threats or where there are concerns about harms in a particular population. Local commissioners should support these activities by offering training to non-specialist workers. [60, 82, 87]

20. Where local drug information and warning systems are developed, these should be in accordance with Public Health England guidance (<https://www.gov.uk/government/publications/issuing-public-health-alerts-about-drugs>) and used to share intelligence, alerts, and recommended responses to NPS and VSA. [Case study 1]
21. Where there is evidence of a high level of local need, commissioners and other decision makers should explore the utility and feasibility of developing dedicated multi-agency partnerships and service delivery models based upon those approaches piloted in towns and cities such as Manchester and Wrexham. [Case studies 1 and 2]
22. Local drug service providers should ensure that their treatment responses to NPS are delivered in accordance with NICE, Department of Health, and NEPTUNE guidelines on clinical management of drug misuse and dependence UK. The Care Quality Commission should consider adherence to NEPTUNE guidelines as part of its inspections. [87]
23. As part of their work, local homelessness task forces should aim to reduce both real and perceived barriers to accessing healthcare, drug treatment, and other support. Outreach activities for people who sleep rough/homeless and who are using NPS should be funded where those groups are not accessing services. [Case study 1]
24. People who have continued to use NPS after the introduction of the PSA are some of the most vulnerable drug users, with a history of adversity and multiple complex needs. Local partnerships, including police, public health teams, and drug service providers should explore pathways at the point of contact that divert people with substance use problems away from the criminal justice system and into drug treatment. [Case studies 1 and 2]

### Recommendations for secure settings

25. NPS and other substance use remains a major source of harm in some prisons and other secure settings, and current responses do not seem to be effective. Whilst acknowledging the broader challenges the sector currently faces, Governors and other institutional leads should ensure activities are developed and delivered in accordance with relevant Public Health England guidelines on NPS and drug treatment in secure settings. Particular attention should be paid to PHE guidance on continuity of care between secure settings and the community; and delivering effective responses to mental ill health. [48]
26. Prisons and other secure settings should ensure that all staff are offered training on NPS such as SCRA and management of its use. [48]
27. Ministry of Justice evaluation of the '10 Prisons Project' should include consideration of unintended effects of increased drug detection and deterrence measures, including movement in illicit prison economies from better-characterised NPS such as SCRA to novel and more difficult to detect substances. [49]
28. In light of wider discussions of the utility and effectiveness of short prison sentences, the UK Sentencing Councils should consider the role that these types of sentences play in the facilitation of the prison drugs trade. [42]
29. Considering the almost complete absence of relevant data, UK Prison services should consider undertaking research to better estimate the prevalence of use in NPS and VSA in secure settings. Data on VSA would help to inform the development of new policies in this area. [38]

### Recommendations for media

30. Considering the important role of popular media in shaping norms and attitudes towards people who use NPS and fostering support for particular policies and approaches, news and other mass media should adopt an approach that promotes neutral, respectful, and person-centred descriptions of substance use. The 2017 version of the (USA) Associated Press Stylebook, provides an exemplar. [94-96]
31. Public Health bodies in the UK should produce a web resource similar to, or commission an update of, the Media Guide to Drugs originally published by DrugScope in 2011. This will provide an authoritative and easy to access public and professional resource on the latest information on substance use, and provide guidance on important things to consider when developing drug-related stories or reporting and representing people who use substances. [94-96]

## 10. APPG membership

Chair : David Hanson MP

Vice Chairs : Diana Johnson MP

Sir Bill Cash MP

Mentor UK ([www.mentoruk.org.uk](http://www.mentoruk.org.uk)) and Re-Solv ([www.re-solv.org](http://www.re-solv.org)) act as the Secretariat for the APPG. Mentor is the UK's leading charity working to prevent alcohol and drug misuse among children and young people. Re-Solv is the only UK-wide charity working toward the prevention of solvent and volatile substance misuse.

Mentor and Re-Solv work in partnership with the APPG to:

- Raise awareness of NPS and VSA in Parliament and encourage discussion of issues around substances covered under the new Psychoactive Substances Act.
- Stimulate research on the issues emerging from the Act and ensure the impact of the Act is adequately evaluated.
- Ensure the Government adopts policies to help reduce harms caused by these substances.
- Help to spread good evidence-based prevention practice to all areas of the UK.
- Support the wider understanding of the issues in the country at large, particularly with local authorities, voluntary groups, youth workers and parents.

## 11. APPG list of witnesses

- Dr Caroline Chatwin, Kent University
- Anette Dale-Perera, Independent Consultant
- Paul Hayes, formerly of Collective Voice
- Superintendent Chris Hill and PC Andy Costello, Greater Manchester Police
- Tim Murray and Megan Jones, Public Health England
- Richard Pickering, Prisons and Probation Ombudsman
- Professor Peter Reuter, University of Maryland
- Lee Robinson and Paul Firth, Wrexham County Borough Council



- Harry Shapiro, Drugwise
- Fiona Spargo-Mabbs, The Daniel Spargo-Mabbs Foundation
- Professor Harry Sumnall, Liverpool John Moores University
- Elle Wadsworth and Paolo Deluca, King's College London

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