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# New Psychoactive Substances: the response by probation and substance misuse services in the community in England

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A joint inspection by HM Inspectorate of Probation and the Care Quality Commission

November 2017



This joint inspection was led by HM Inspector Simi Badachha, supported by a team of inspectors from HMI Probation and CQC, as well as staff from our operations and research teams. The Assistant Chief Inspector responsible for this inspection programme is Helen Davies. We would like to thank all those who helped plan and took part in the inspection; without their help and cooperation, the inspection would not have been possible.

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M3 3FX

*Front and reverse cover photo shows loose 'spice', photo courtesy of Oliver Sutcliffe at Manchester Metropolitan University.*

## Foreword

New psychoactive substances (NPS) are a world-wide problem, with growing concerns about the number of associated deaths. Public sale of these substances is banned, following the introduction of the *Psychoactive Substances Act 2016*, but NPS are readily available through the 'dark net' and on the streets. They are more affordable than other illegal drugs, and their proliferation has changed the drug scene in the UK. Trends in NPS use are uncertain, as records are poor. Such records that are kept show that NPS are used largely by the homeless community and by other vulnerable people, including those who offend.



*'Spice' seized in Manchester in 2017, photo courtesy of Oliver Sutcliffe at Manchester Metropolitan University*

We undertook this inspection primarily to identify good probation practice in tackling NPS use, given the rising concerns about its use among offenders. We did not find many examples of effective probation practice, but we did find some good initiatives by local partners. If probation providers and their staff were made more aware of NPS use and how to tackle it, if they worked more closely with local partners (as we found particularly in Newcastle) and if key information were passed from prisons to probation providers in the community, and between them and other key partners, then society would be safer and more lives turned around.

Many offenders first experience NPS in prison and are then released with a dependency, yet probation providers are not generally told of an individual's use in custody. That is an important opportunity missed, in our view, and not the only one. We found that, while the police, health and local authorities were developing appropriate strategic responses, probation providers were not generally at the table. The National Probation Service and CRCs need to work more closely with partners to tackle NPS use. Even where probation providers had local NPS strategies in place, however, these were not implemented in the cases we saw. Probation providers need to make sure their people know what is expected.

We found that a simple lack of awareness prevailed at all levels. Screening tools for identifying drug use were not geared to NPS. Terminology was out of date and not understood by service users. We found that probation staff and even some substance misuse service staff had a low level of awareness of NPS. Probation staff did not have structured, in-depth training about NPS and how to deal with dependency, and lacked the confidence and knowledge to quantify the problem and to address it. Assessments and plans were not sufficiently focused on NPS use. Probation providers did not do enough to analyse the impact that NPS use had on individuals' offending behaviour and the harm presented.

Substance misuse services did not generally offer NPS-specific work, and very few NPS users engaged fully with substance misuse services. Few probation providers routinely monitored ongoing NPS use. We were pleased to see strong relationships between managers in substance misuse and probation providers, but this was not always the same for front-line practitioners. Information-sharing was not consistent, with probation, substance misuse services and prisons often working in isolation.

The work to tackle the prevalence, impact and treatment of NPS is lagging behind NPS use. The UK government's new drug strategy and updated guidance for clinicians and substance misuse services are welcome developments, but for criminal justice the emphasis is on prisons. We hope that the recommendations in this report will improve the provision of services delivered by probation providers in the community.



**Dame Glenys Stacey**  
HM Chief Inspector of Probation  
November 2017



**Ursula Gallagher**  
Deputy Chief Inspector  
Care Quality Commission

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## Key facts

**26 May 2016**

The *Psychoactive Substances Act 2016* came into effect, making so-called legal highs illegal to sell or give away for free

**620**

The number of new psychoactive substances being monitored by the European Monitoring Centre for Drugs and Drug Addiction, at the end of 2016<sup>1</sup>

**79**

Deaths associated with the use of new psychoactive substances recorded by the Prisons and Probation Ombudsman between June 2013 and September 2016<sup>2</sup>

**147,000**

Estimate from Crime Survey for England and Wales 2016/2017 of the number of people aged 16 to 59 years who had used new psychoactive substances<sup>3</sup>

**1.6%**

Proportion of men aged 16 to 24 years who have used new psychoactive substances<sup>3</sup> (compared to 0.4% of men and women aged 16 to 59 years)

**1.7%**

Proportion of adults aged 16 to 24 years who have used new psychoactive substances and have consumed alcohol in the past month<sup>3</sup> (compared to 0.6% who abstain from alcohol)

**75%**

Proportion of those who had used new psychoactive substances who had used another drug<sup>3</sup>

1 European Monitoring Centre for Drugs and Drug Addiction (2017) 'European Drug Report 2017': *Trends and Developments*, Publications Office of the European Union, Luxembourg.

2 Nigel Newcomen CBE, Prisons and Probation Ombudsman reported in [www.theguardian.com/society/2017/jul/11/prison-deaths-linked-new-psychoactive-substances-rising-rapidly-watchdog](http://www.theguardian.com/society/2017/jul/11/prison-deaths-linked-new-psychoactive-substances-rising-rapidly-watchdog).

3 Drug Misuse: Findings from the 2016/17 Crime Survey for England and Wales, Home Office, July 2017.

# New psychoactive substances in context

## What are NPS?

New psychoactive substances, often incorrectly called legal highs, contain one or more chemical substances that produce similar effects to illegal drugs like cocaine, cannabis and ecstasy. NPS began to appear on the UK drug scene around 2008/2009 and fall into four main categories:



- **Synthetic cannabinoids** – these drugs mimic cannabis and are traded under names such as Spice, Clockwork Orange, Black Mamba and Exodus Damnation. They bear no relation to the cannabis plant except that the chemicals act on the brain in a similar way.



- **Stimulants** – these drugs mimic substances such as amphetamine, cocaine and ecstasy and include BZP, once commonly known as Meow Meow or M-Cat, Benzo Fury and MDAI.



- **'Downers' or sedatives** – these drugs mimic tranquilisers or anti-anxiety drugs, in particular from the benzodiazepine family, and include Etizolam, Pyrazolam and Flubromazepam.



- **Hallucinogenic drugs** – these drugs mimic substances like LSD and include Bromo-Dragonfly and the more ketamine-like methoxetamine.

## Legal position

While some of these substances had been made illegal under amendments to the *Misuse of Drugs Act 1971*, the continued introduction of different chemical compounds meant that many NPS could be sold legally. They could be easily bought online and on the high street, sometimes in 'head shops' (shops which sell drug paraphernalia) and sometimes in corner shops, convenience stores or garages. The drugs were sold in brightly coloured packaging under a variety of brand names, making it difficult to know what substance was being purchased; the contents of one branded package could change from week to week.

To help tackle the negative effects of these substances and risks they posed, the *Psychoactive Substances Act 2016*<sup>4</sup> made it illegal to produce, supply or import NPS (including for personal use) from May 2016. Following the changes in the law, supply has been driven underground and packaging changed to clear snap bags. Potency levels are much higher and more toxic (Linnell, 2017).

## Effects of using NPS

Many of these drugs are unknown quantities and the effects depend on how much is consumed. Media reports<sup>5</sup> have highlighted serious effects, including death and users

<sup>4</sup> Psychoactive Substance Act (2016). <https://www.gov.uk/government/collections/psychoactive-substances-bill-2015>.

<sup>5</sup> See references section.

being left in zombie-like states. Physical and psychological dependency can take hold after only a few weeks of NPS use.

Acute effects can last thirty minutes to two hours but symptoms may last until the next day. Factors that have an impact include body weight, gender, the strength of the drug, mood, physical and mental health, how the drug is taken, where it is taken and whether it is mixed with other drugs, including alcohol. The effects include loss of concentration and memory; anxiety and panic attacks; violent outbursts; symptoms consistent with psychosis; and altered mental state (Castellanos et al, 2016). These symptoms can be alarming and put people at risk if they are alone and cannot get help. There is also an increased risk of harm as the users cannot control themselves or the situations they may be in.

Treatment options are limited; there is no medicinal substitute available for NPS as there is for heroin, for example.

From the prison and probation perspective, the following effects have been identified (HMPPS, 2017):

- **Health:** psychological and physical addiction; self-harm; psychotic reactions and even death.
- **Debt, bullying and violence:** as with other drugs, the cost of NPS in prisons can be significantly higher than their street value. Prisoners may use NPSs to relieve boredom or may be bullied into taking the drugs by others. Regular users develop a tolerance, which can result in their habits escalating and increased debt to dealers. This can lead to self-harm, violence and instability in prisons and approved premises.
- **Criminality:** given the high returns to be made, a large proportion of distribution to and within prisons of NPS is likely to be linked to organised crime. Such criminals make a significant amount of money and use their profits to fund and maintain criminal activity in the community.

### **Impact on probation and substance misuse services in the community**

Probation and substance misuse services work with individuals who use a range of substances, including NPS. There have been growing concerns from professionals about service users presenting under the influence of substances, unclear what they had been using. Some service users have attended offices and appointments unable to engage in conversation, shaking, sweating and at times behaving in a violent and aggressive manner. Professionals are often unsure how to respond to these symptoms beyond calling the police to address anti-social behaviour or an ambulance in response to suspected overdose and unconsciousness.

Research studies show that synthetic cannabinoids are the dominant type of NPS used within prisons, probation approved premises and the homeless community (Ralphs et al, 2016, 2017). For this reason, where we refer to NPS within this report, this generally relates to synthetic cannabinoids.



## Executive summary

The prevalence of NPS is hard to quantify for several reasons. Synthetic drug manufacture is not geographically constrained and this prevents an estimation of the volume of such drugs being manufactured worldwide. Users of NPS often don't know what they are taking, and in some cases they have been misled, with NPS passed off as more conventional drugs such as ecstasy. In addition, GPs, accident and emergency departments, probation services and the police do not specifically record NPS use.

While the overall size of the NPS market is small in comparison with other drugs, an increasing number of countries are reporting seizures of NPS. There is also growing recognition of the harm associated with NPS use – often the result of crude manufacturing techniques and unpredictable dosage levels. As a result, they can be more lethal than other drugs. Concern is also rising about their use among marginalised populations such as prisoners and street homeless, attracted by the availability and low cost of NPS.

Treatment options are more limited than with other substances, for example opioids, where substitutes are available. In most cases, treatment involves psychosocial interventions to help people consider the health risks and the costs of using NPS, and to help them make behavioural changes to reduce harm and moderate their drug use. We came across two areas using clinical detoxification to help manage withdrawal from NPS use.

Overall, inspected areas did not have a good enough understanding of the prevalence of NPS use at a local level or what may work for those using NPS. While the UK government has issued advice and guidance for commissioners and substance misuse services, in the main, strategies have focused on crisis management to address emergencies. While local management relationships between substance misuse services and probation providers were good, probation engagement at a strategic level was less consistent.

Where the strategic response was appropriately coordinated, for example in Newcastle, it included longer-term actions for agencies to work together and address NPS-related concerns locally. They were also more likely to be collecting NPS-specific data. Partnership working was strongest in probation teams that worked in collaboration with other agencies, such as Integrated Offender Management, and in cases where service users had court-imposed or licence conditions to engage with substance misuse services. In other cases, work was often being done in isolation.

We found the assessments and plans completed by substance misuse services sufficient overall. In line with Public Health England guidance, substance misuse services worked with the individual symptoms and not specifically on the drug that the individual used. We were told that this national guidance that NPS users should be treated the same as other drug users was the reason that NPS-specific training had not been rolled out to all keyworkers – we found that this had led to a significant gap. Without specific training, keyworkers relied on their more experienced colleagues and their own research to increase their knowledge and understanding. The most skilled practitioners had developed NPS toolkits, which were then used in individual work with service users. Where these were being used, we found that

there was more awareness of the risks and effects of using NPS. However, many NPS users were not accessing available services.

All the cases we inspected were known either to have used or be currently using NPS, yet probation assessments lacked sufficient information to explore the pattern, level and funding of NPS use. Many users experienced problems with housing, mental health, relationships and finances. Some had lost placements in hostels or housing tenancies for reasons that were often related to their NPS use, but responsible officers rarely identified this. In the process, those who lost their accommodation ended up on the streets, sleeping rough in an environment where NPS were easy to obtain and frequently used. Worryingly, probation providers did not routinely consider the risks associated with NPS use to groups such as children, staff, prisoners or the wider community, despite there being enough known about the unpredictable behaviour that could be displayed by those using the drugs.

Two Community Rehabilitation Companies had developed short-duration substance misuse interventions. NPS use was only covered to a basic standard, with many attendees being better informed than responsible officers. We found no evidence that the Building Skills for Recovery accredited programme, which is designed to reduce offending behaviour and problematic substance misuse, was used for NPS users by either the National Probation Service or Community Rehabilitation Companies.

Responsible officers were rarely able to talk to NPS users about their symptoms and consolidate work undertaken by substance misuse services. While probation providers were making appropriate referrals to substance misuse services, these were not always responded to in a timely fashion. Service user engagement was often sporadic and responsible officers did not do enough to support NPS users to re-engage.

We found poor-quality information-sharing. Prisoners were being released into the community often with no information shared about their NPS use in prison, and release plans did not meet the needs of the prisoner in relation to their substance misuse. We found good recording of information by substance misuse keyworkers who had access to probation IT systems. In many cases, however, we found that substance misuse services held information that would have improved the quality of probation assessments and plans but was not being shared. NPS users were disengaged from services, insufficient progress had been made to address NPS use and in many cases no other work was taking place either. NPS users lacked trust in the help and support available, and many turned to using NPS to forget their problems.

Confidence, knowledge and awareness were the key areas that affected the quality of work for both probation and substance misuse services. While some training had been provided, this was often not sufficient for practitioners and was no longer up to date. As a result, responsible officers and many substance misuse keyworkers were not confident enough to undertake harm minimisation work with NPS users. While clinical guidance is available, not enough has been provided to inform professionals working with NPS users on community orders in the criminal justice system.

# Recommendations

## **The Ministry of Justice should:**

- work with the Department of Health to produce specific guidance for probation services on working in the community with offenders who use NPS. This should include:
  - developing an evidence base for practice interventions
  - referral options
  - accurate and timely recording of NPS use, and associated harm.

## **Her Majesty's Prison and Probation Service should:**

- improve the exchange of information about users of NPS from prisons to probation providers and substance misuse services
- make sure that pre-release planning addresses substance misuse and basic needs such as housing and mental health support.

## **The National Probation Service and Community Rehabilitation Companies should:**

- routinely consider NPS use when assessing patterns of drug use, and clearly identify this in the assessment
- make sure assessments and plans consider the impact of NPS use on offending behaviour and public protection
- make better use of the Building Skills for Recovery accredited programme.

## **The National Probation Service, Community Rehabilitation Companies and substance misuse services should:**

- provide joint training on NPS to better understand the risks, impact and treatment pathways available
- make sure that the protection of children and vulnerable adults is actively considered at all stages and where there are concerns refer these to local authority social services
- build stronger, more effective working relationships to improve information-sharing and the quality of assessments and impact of NPS use across all agencies.
- access and contribute towards information exchange, for example through the Local Drug Information Systems.

## **Substance misuse services should:**

- ensure that NPS use is clearly identified in the initial assessment and responded to appropriately in recovery planning
- use and share best practice regarding NPS treatment pathways, including clinical detoxification for NPS addiction.



# 1. Introduction

## 1.1. Why this thematic?

While much has been reported on NPS use in custody (Ralphs et al, 2016 and RAPt, 2015), there are no published research or inspections that specifically investigate the response of probation and substance misuse services to the use of NPS in the community. The findings from this inspection will help to broaden the focus on the use and impact of NPS beyond the custodial estate.

Our Quality & Impact inspections indicate that substance misuse provision across the country is inconsistent, as is communication between substance misuse services and the National Probation Service and CRCs. Our Through the Gate thematic inspections (HMI Probation, 2016 and 2017) found that substance misuse problems were not always recognised or responded to while prisoners were in custody and the transition to the community was problematic. This inspection considered how agencies work together to address the rising concerns from the use of NPS and set out to highlight examples of good practice from which others can learn.

## 1.2. Background

In December 2013, in the light of growing concern about the harm caused by NPS, the UK government commissioned an expert panel to look at the issue. The panel was tasked with looking at how the legislative framework for responding to these new drugs could be enhanced as well as considering how the health and education response should be developed. Its report was published in October 2014. Recommendations included legislation to tackle the sale of NPS, and better prevention and information-sharing, along with targeted interventions and treatment (Home Office, 2014).

In response, Public Health England (PHE), an executive agency of the Department of Health, issued *New psychoactive substances – a toolkit for substance misuse commissioners* (PHE, 2014). The toolkit aimed to help local authorities and NHS England to respond to NPS in local areas and continues to be used today. Guidance on clinical practice in a range of front-line settings was produced by NEPTUNE (Novel Psychoactive Treatment UK Network), an independent charity funded by the Health Foundation (NEPTUNE, 2015).

In 2015, following rising concerns about NPS use in prisons, PHE produced a toolkit for prison staff (PHE, 2015). This aimed to provide support for custodial, healthcare and substance misuse teams by providing information about the extent of use, different categories of NPS and advice on how to manage the problem from a clinical, psychosocial and regime perspective.

The *Psychoactive Substances Act 2016* received Royal Assent on 28 January 2016. It applies across the UK and came into force on 26 May 2016. The Act:

- makes it an offence to produce, supply, offer to supply, possess with intent to supply, possess on custodial premises, import or export psychoactive substances; that is, any substance intended for human consumption that is capable of producing a psychoactive effect. The maximum sentence is seven years' imprisonment
- excludes legitimate substances, such as food, alcohol, tobacco, nicotine, caffeine and medical products from the scope of the offence, as well as 'poppers' and



controlled drugs, which continue to be regulated by the *Misuse of Drugs Act 1971*

- includes provision for civil sanctions – prohibition notices, premises notices, prohibition orders and premises orders (breach of the two orders will be a criminal offence) – to enable the police and local authorities to adopt a graded response to the supply of psychoactive substances in appropriate cases
- provides powers to stop and search persons, vehicles and vessels; enter and search premises in accordance with a warrant; and seize and destroy psychoactive substances.

In December 2016, the *Misuse of Drugs Act 1971* was amended so that most of the known synthetic cannabinoid receptor agonists (SCRAs) and all those commonly found in Spice became Class B drugs and illegal to possess.

Since we completed our inspection fieldwork, the Department of Health has published new clinical guidance on drug misuse and dependence. This is detailed in chapter two and has a stronger focus on NPS. The Home Office Drug Strategy, published at the same time (HM Government, 2017), recognises that the continued emergence of NPS has created additional dangers to vulnerable groups such as young people, the homeless and prisoners. The strategy includes a section setting out a targeted approach to tackle NPS. This includes a PHE-led early detection system and a network of leading clinicians and experts to identify patterns and harms and agree appropriate clinical responses.

### **1.3. Aims and objectives**

This inspection examined how the substance misuse services, the National Probation Service and CRCs have responded to the rising concerns about the use and impact of NPS. Specifically, we wanted to know the following:

1. What is the extent of the problem in relation to NPS?
2. What services are available within the community? Do they address the rising concerns from the use of NPS?
3. What is the impact on offending behaviour, offending-related needs and the ability to comply with court orders?
4. What evidence is available of effective partnership working?
5. What intervention and support is available upon release from prison and what impact does this have on offenders being released into the community?
6. What evidence is there of good practice within the community?



## 1.4. Report outline

Chapter	Content
<b>2. The extent of the problem and expectations of probation and substance misuse services</b>	<p>Understanding the nature of the problem. Exploring how NPS use is identified and recorded.</p> <p>An overview of the expectations of probation and substance misuse services in the community and the treatment pathways for NPS users.</p>
<b>3. What we found – strategy, leadership and partnership working</b>	<p>The strategic approach and how agencies work together. Staff development, interventions and the effectiveness of information-sharing between prisons, substance misuse services and probation. Examples of good practice.</p>
<b>4. What we found – the quality of work</b>	<p>Our findings in relation to the quality of assessments and plans. The impact on public protection, offending behaviour and compliance with court orders. Examples of good practice.</p>

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## **2. The extent of the problem and expectations of probation and substance misuse services**

In this chapter, we outline the prevalence of and emerging trends in relation to NPS. We also consider the expectations placed upon probation providers and commissioners of substance misuse services. An overview of the treatment pathways for NPS users is also provided.

## World-wide

Trend data on NPS prevalence is limited (*United Nations World Drugs Report, 2017*). Information on synthetic drug manufacture is limited as it is not constrained by geography. Unlike heroin or cocaine, the process does not involve the extraction of active constituents from plants that must be cultivated in certain conditions for them to grow. This prevents the estimation of the volume of such drugs being manufactured worldwide. Nevertheless, data on seizures suggests that the supply of synthetic drugs is expanding. An increasing number of countries are reporting seizures of synthetic NPS, with more than 20 tonnes seized in 2015.

The NPS market is dynamic and characterised by the emergence of large numbers of new substances belonging to diverse chemical groups. Between 2009 and 2016, 106 countries and territories reported the emergence of 739 different NPS to the United Nations Office on Drugs and Crime (UNODC, 2017), with a core group of more than 80 NPS reported each year. Marketed in many ways and forms, new substances often emerge quickly and disappear again, while some become used regularly among a small group of users. Their easy availability and low prices have made NPS highly attractive to some groups of drug users. Little or no scientific information is available to determine the effects that these products may have and how best to counteract them.

Despite the large number of NPS present in drug markets, the overall size of the market for such substances is still relatively small when compared with other drugs. However, one of the most troubling aspects of NPS is that users are unaware of the changing content and the dosage of the psychoactive substances contained in some NPS. This potentially exposes users of NPS to additional serious health risks.

## Europe

In 2016, 66 NPS were detected for the first time via an EU Early Warning System – a rate of over one per week. Although this number points to a slowing of the pace at which new substances are being introduced onto the market (98 substances were detected in 2015), the overall number of substances now available remains high (*European Drug Report, 2017*). By the end of 2016, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was monitoring more than 620 NPS (compared with around 350 in 2013).

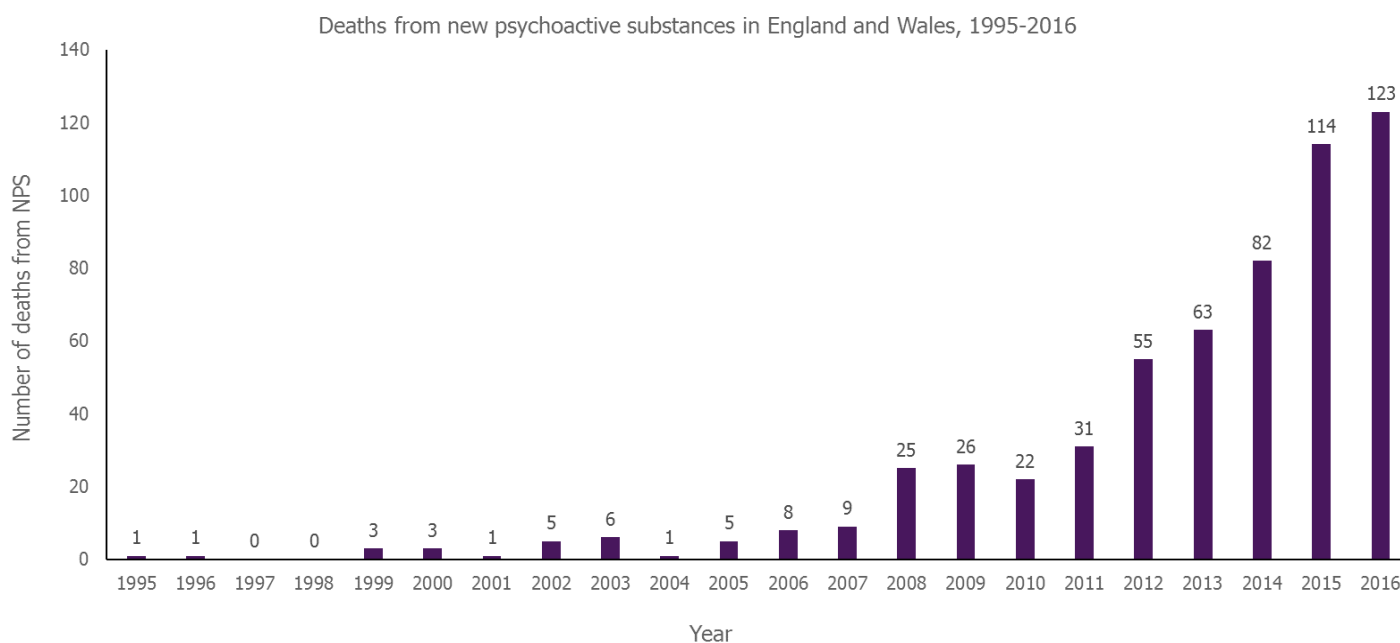
Several countries have included NPS in their general population surveys, although different methods and survey questions limit comparisons between countries. The European Drug Report (EMCDDA, 2017) estimates that NPS availability is unchanged despite many states moving to blanket bans and tighter regulation. While there is some hope that new restrictions in China may reduce supply, production facilities are opening in Europe. EMCDDA reports that there are indications that health warnings are keeping young people away from NPS, but among vulnerable populations – prisoners, the homeless, the marginalised – the indications are that availability and use are rising. Few people currently enter treatment in Europe for problems associated with use of NPS (less than 1% of those entering specialised drug treatment), although under-reporting in this area is likely.

## England and Wales

Prevalence data in England and Wales is limited to the annual crime survey. This shows that the prevalence of NPS is low compared with established drugs such as cannabis, cocaine and heroin (Crime Survey for England and Wales, 2016/2017)<sup>6</sup>. It reports that the use of NPS among 16 to 59 year olds has fallen from 0.7% in 2015/2016 to 0.4% in the 2016/2017 survey, a statistically significant change. The use of more than one substance at a time or 'poly drug' use seems to be one of the features of NPS use. Consumption of alcohol in the past month and use of another drug in the past year were also associated with NPS use. There is no published data on the link between NPS, arrests and crime.

While the Office for National Statistics reports that the mortality rate from deaths involving NPS is low compared with heroin and/or morphine (2.1 deaths per million compared with 21.3), concerns have been growing about the harm caused by NPS. NPS deaths have increased over the past five years, with 123 deaths registered in 2016 (up from 114 deaths registered in 2015, an 8% increase)<sup>7</sup>.

The graph below shows the numbers of deaths from NPS over the past 20 years in England and Wales.



Source: Deaths related to drug poisoning, Office for National Statistics, August 2017

At this stage, caution needs to be exercised given the low numbers involved, making it harder to interpret changes from one year to the next. While better reporting may account for the rise in deaths, there may still be a significant underestimate given the lack of routine testing or attribution of death to co-ingested drugs. This is especially the case in deaths where a more common substance such as heroin or cocaine has also been found post-mortem.

<sup>6</sup> Home Office (2017) Drug Misuse: Findings from the 2016/17 Crime Survey for England and Wales.

<sup>7</sup> Office for National Statistics, Deaths related to drug poisoning England and Wales: 2016 registrations. Statistical bulletin, August 2017.

There is no recorded data on the use of NPS within probation settings; however, anecdotal information suggests it is increasingly becoming a problem within approved premises. It is suspected that the use of NPS by residents is having an impact on the management of approved premises, leading to a potential increase in the number of recalls, which ultimately disrupts offender resettlement, increases the prison population and escalates the cost of care (HMPPS, 2017).



As part of our inspection, we were shown examples of suspected NPS products that had been seized during room searches in approved premises or found on residents and were being sent to a laboratory for testing. The images above and to the left are an example of what we were shown at one approved premises.

More is known about the prevalence and effects of NPS in custodial settings. The Prison and Probation Ombudsman has reported 79 deaths linked to NPS between June 2013 and September 2016<sup>8</sup>. Fifty-eight of these were considered to be self-inflicted. In his 2015/2016 annual

report, the Chief Inspector of Prisons reported increased incidents of violence and self-harm, recognising that: *'It is clear that a large part of this violence is linked to the harm caused by new psychoactive substances which are having a dramatic and destabilising effect in many of our prisons.'* The report concluded that these synthetic substances were exacerbating problems of debt, bullying, self-harm and violence (HMI Prisons, 2016). Responses to our call for evidence echoed this, with prisoners telling researchers that increased tolerance to Spice led to them smoking between five and eight grams per day. Their level of dependency led to debts building, with prison prices being up to one hundred pounds per gram. Those in debt were often involved in violent incidents where threats were made to family members, with some stating that they offended to repay the debts they had built up in prison.

<sup>8</sup> Nigel Newcomen CBE, Prisons and Probation Ombudsman reported in [www.theguardian.com/society/2017/jul/11/prison-deaths-linked-new-psychoactive-substances-rising-rapidly-watchdog](http://www.theguardian.com/society/2017/jul/11/prison-deaths-linked-new-psychoactive-substances-rising-rapidly-watchdog).



## **2.1. Practice expectations for National Probation Service and CRCs**

*National Standards for the Management of Offenders* (2015) outlines the expectations of the National Probation Service and providers contracted by the Ministry of Justice to deliver probation services in the community. For the National Probation Service this is detailed in a service level agreement and for the CRC through contracted service outputs. Both the National Probation Service and CRCs have a responsibility to ensure that local health and substance misuse services understand the needs of those in contact with the criminal justice system. This may be through contributing evidence to local Joint Strategic Needs Assessments or responding to consultations that in turn inform the commissioning of services.

Probation practitioners are not expected to be experts in addressing substance misuse; however, there should be a thorough analysis of the impact of drug use on offending and public protection. Where appropriate, plans should be in place to manage the harm presented by the service user and show what work will be carried out to reduce the risk of reoffending. In preparing an offender for release from prison (known as Through the Gate work), CRCs are required to utilise the services of other community providers. This includes working with substance misuse services to ensure that an offender being released from prison has support in place in relation to their drug use and/or treatment needs.

Some service users will have sentence requirements or licence conditions to address their drug use and to participate in drug testing, while other service users will be voluntarily referred to substance misuse services. Probation providers should have suitably trained staff in place to make the necessary referrals to substance misuse services and to undertake appropriate individual work when required. Availability of, and access to, these treatments forms an essential part of court-ordered drug rehabilitation requirements and statutory licence conditions.

HMPPS's Building Skills for Recovery (BSR) accredited programme aims to reduce offending behaviour and problematic substance misuse, with an eventual goal of recovery. This is achieved by exploring previous and current substance use and acquiring skills to prevent relapse into former patterns and behaviours – in essence, formulating a person-centred 'recovery toolkit'. HMPPS recently clarified the selection criteria for the BSR programme to make sure that all treatment teams are aware that they can include assessment for individuals whose main drug of choice is an NPS. The programme can be delivered in a group setting or on a one-to-one basis.

National figures for accredited programmes starts show a marked decline over the past six years from 24,972 in 2009/2010 to 11,002 in 2016/2017; over a 50% reduction (HMPPS, 2017). This drop was reflected in our courts thematic inspection which reported on the limited profile of accredited programmes in the advice being given to sentencers.

## **2.2. Commissioning substance misuse services**

In April 2013, the commissioning of drug treatment and testing services in England became the responsibility of local authority directors of public health. They, in turn, receive advice and input from a number of other organisations, including PHE, voluntary organisations and the police.



Local authority commissioners are expected to work closely with their counterparts in local clinical commissioning groups and NHS England area teams to address the needs of local populations including:

- safeguarding children, young people and vulnerable adults
- complex/multiple needs, including domestic violence, mental health issues, criminal justice involvement and homelessness
- pathways for harmful/hazardous drinkers
- interventions for dependent and binge drinkers
- flexible responses to NPS
- links to end-of-life pathways/palliative care.

It is expected that a wide range of services will be provided, including information and advice, screening, care planning, psychosocial interventions, community prescribing, inpatient drug treatment and residential rehabilitation. In addition, drug users should be offered aftercare and relapse prevention programmes. Community-based specialised drug treatment centres are the most common providers of substance misuse services in the United Kingdom, and contracts to deliver drug treatment services are often held by third-sector organisations (*United Kingdom Country Drug Report, 2017*).

### **2.3. Treatment for users of NPS**

Specific treatment for NPS is limited; PHE's advice is to focus on individuals and their symptoms rather than the drug they are taking. This has meant adapting the approaches used to tackle existing drugs rather than inventing new ones. The PHE's *New psychoactive substances – a toolkit for substance misuse commissioners* (PHE, 2014) and its guidance on establishing local drug information systems (PHE, 2016) provide advice on developing local strategies in the following areas:

- tackling NPS supply and use
- prevention
- monitoring and information-sharing
- responses to acute NPS problems
- NPS interventions and treatment
- competence in working with NPS users
- NPS in prisons and the children's and young people's secure estate.

Drug workers should have sufficient knowledge about NPS groups, the effects of NPS, how to reduce harm and which interventions are most effective. In most cases, treatment involves psychosocial interventions to help people consider the health risks and the costs of using NPS, to help them make behavioural changes to reduce harm and moderate their drug use. Treatment may also need to include health and well-being support and psychological therapy to prevent relapse.

In July 2017, updated clinical guidance on drug misuse and dependence was issued by the Department of Health, which largely endorsed the above PHE approach. It

confirms that treatment interventions for the management of dependence on NPS are essentially the same as for any other problem substances, using psychosocial interventions and pharmacological support if appropriate. Psychosocial interventions are the primary intervention for drug problems for which medication is not a component of treatment, including many of the NPS. They promote psychological and social change and range from help with basic needs such as food and accommodation to highly structured therapy delivered by specialists.

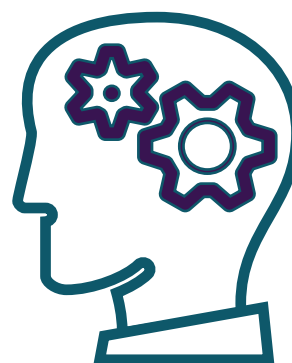
The 2017 guidance recognises that there has been a paucity of clinical advice relating to NPS and refers practitioners to the aforementioned NEPTUNE guidance on the clinical management of harm resulting from NPS.

It further notes that the extent of use and levels of harm from NPS use are poorly recorded. It reinforces the need for front-line health staff to be aware of the pilot intelligence-gathering system (RIDR – Report Illicit Drug Reactions) introduced by PHE in March 2017, where healthcare professionals can report cases of suspected harm with illicit substances through a dedicated website.

## **2.4. Conclusions and implications**

While it is recognised that NPS present new challenges to probation and treatment services, insufficient progress has been made in fully understanding the prevalence and impact of NPS. A new system is now in place to record NPS use and its associated harms, but its effectiveness will be dependent upon suitably trained and confident practitioners asking about NPS use and recording it accurately.

Current advice is to focus on individuals and their symptoms rather than the specific drug. Where feasible, testing may be useful and has recently been introduced in prisons for a small number of NPS. To identify and engage NPS users, staff need to have up-to-date knowledge and training on NPS, assessment tools that reflect current trends of drug use and a range of interventions that draw in NPS users.





### **3. What we found - strategy, leadership and partnership working**

In this chapter, we consider the strategic response to NPS use and the effectiveness of information-sharing arrangements and partnership working at all levels. We met with senior managers from public health, local authorities and the police, as well as substance misuse services and probation providers.

### 3.1. Strategy and leadership

All inspected areas had multi-agency substance misuse strategies in place and these included actions to address NPS use in the community. In the main, these had been triggered by concerns about anti-social behaviour and higher admittance rates to accident and emergency departments. Joint Strategic Needs Assessments were either in place or in progress to inform the provision of services for NPS users. Overall, local strategies were being led by local authority directors of public health with close involvement from police and substance misuse services.

Probation involvement tended to be peripheral. As a result, probation providers did not know enough about the services available in the community. Where local probation policies were in place, they contained useful information about NPS use and how responsible officers should assess this in relation to offending behaviour, harm and safeguarding. However, responsible officers were not aware of these policies or using them in practice. Overall, probation managers were not actively evaluating the effectiveness or use of existing policies.

Many probation leaders reported that NPS use was declining in the cases they had supervised over the last year. However, responsible officers recognised that NPS use was not routinely being checked during initial assessment or review processes. The national tools used by all probation providers, OASys and National Delius (nDelius), do not include prompts for recording NPS use. We found no clear strategy for how to record NPS use. The best informed were those probation providers that had an established record of joint working with substance misuse services, including co-location in probation offices. These areas also tended to have a higher profile in developing local multi-agency strategies.

The police in all areas had been actively involved in closing known head shops following the introduction of the 2016 legislation, but reported that NPS were now being sold underground, which presented new challenges and problems for communities. One team of police officers told us:

*“The problem started three years ago. We were seeing it a lot with 13-year-olds who at the time could buy from head shops. We were seeing people collapsing, with an increase in ambulance call-outs. We did not know what this was. We had one head shop on a particular street where there were 12 incidents; the year after it was 98; the year after it was 280 incidents. We have heard that people want to get off it, but we don’t know what structured support is available from agencies like probation. There are two places we can refer to but the biggest complaint is not having any treatment. There have been arrests of dealers but I don’t think we have even started to tackle the users”.*

#### **Interventions and treatment pathways in the community**

All substance misuse services accepted referrals for NPS use and undertook individual assessments to create a care plan that covered the service user’s needs, based on

the initial assessments completed. However, referrals from probation were not always dealt with promptly by substance misuse services. While all probation providers had clear referral pathways to substance misuse services, they were not always understood by responsible officers, and this led to some missed referrals.

All substance misuse services visited as part of the inspection offered psychosocial interventions for NPS users. In most cases, NPS were not the service user's primary drugs of choice, and care plans often focused on treating the symptoms presented. This approach was in accordance with the guidance being provided nationally. However, because of the focus on the other drug types, we found that not enough was known about the patterns and effects of using NPS.

Good engagement often relied on the substance misuse keyworker's knowledge and understanding of the individual's needs and an accurate assessment of their drug use. In Leicester, bespoke NPS-specific toolkits had been developed, which were aimed directly at undertaking harm reduction work focused on NPS-related symptoms and withdrawal. These were led by substance misuse staff who had a good level of knowledge about NPS and used the PHE prison-based toolkit as a starting point. We found that, where the toolkit was used, there was a much better understanding of the specific symptoms and needs associated with NPS use. Probation providers, however, did not always understand what was available for NPS users from substance misuse services, and in turn were not able to promote these interventions. Further, they were not using available probation resources. We did not find any examples of the probation Building Skills for Recovery (BSR) accredited programme being used for NPS, despite the criteria for inclusion being amended to include these substances.

In many cases, we did not find a structured approach to addressing NPS use despite services and support being available. We found an absence of direction from probation services in setting appropriate NPS-related goals. In cases where service users did engage with substance misuse services, the work to address NPS use was through self-motivation or appropriate planning by substance misuse keyworkers. CRCs were developing new operating models and assessment tools, which in most areas will allow for new drug trends to be included. Two had also developed brief interventions to raise awareness of the effects of using NPS. These were under-used by the CRCs themselves and pitched at too low a level for service users.

Many substance misuse services told us that users of NPS presented with chaotic lifestyles and often did not engage with services to allow their agreed care plan to be delivered fully. The small number that did engage were often using other drugs and these took priority over NPS. Cases would often be closed and then re-opened following re-referral. Owing to the level of disengagement by NPS users with substance misuse services, we did not find sufficient examples of cases where psychosocial interventions had made a positive impact.

We found significant gaps in the availability of local provision to address mental health issues. Those who were using NPS reported increased feelings of paranoia, anxiety and thoughts of self-harm. Pathways into mental health services were not clear, and often thresholds were too high to allow NPS users to be assessed and access services. Most professionals that we spoke to told us that mental health services would not work with drug-induced psychosis or with service users while they continued to use substances.

## Training and professional development

While substance misuse workers had more awareness of NPS than probation practitioners, not all had received up-to-date training. They were all familiar with the guidance to work with the individual and not the drug, but were unable to fully assess the effectiveness of their work with NPS users. The provision of training tended to be better in areas with a coordinated strategic response to tackling NPS. In other areas, keyworkers had used the internet or liaised with their colleagues to develop and enhance their own learning. Some areas had given keyworkers lead responsibility for NPS, and these were the point of contact for other keyworkers for more information.

Few substance misuse workers were aware of the NEPTUNE guidance referred to in chapter two or the new PHE system in place since March 2017 to record NPS use and its associated harms.

Most probation responsible officers we spoke to reported a lack of awareness of NPS. The lack of training and knowledge was a consistent theme from the survey and call for evidence. Staff were not equipped to deal with emergencies such as fitting, respiratory problems, sickness and hallucinations and did not know when to call an ambulance.

In some areas, training had been provided before the *Psychoactive Substances Act 2016* was introduced and was now out of date. Many felt they had a good understanding of traditional drugs and could apply this knowledge to their assessments and plans and analyse the impact of drug use on offending and public protection. However, they felt less confident when NPS use was being reported. Many responsible officers were not aware of the information leaflets that were available locally and often used the internet to develop their knowledge. Where there was no other drug use, responsible officers did not know they could refer to substance misuse services for NPS psychosocial interventions. All wanted more training, specifically to understand more about the different types of NPS, the range of symptoms experienced while people were under the influence and advice on reducing harm.

Suitable training materials are available. Many can be provided to NPS users, but they are also designed to brief professionals and to use in harm minimisation work. Michael Linnell (consultant and DrugWatch coordinator) has produced numerous information leaflets. These can be found on: <http://michaellinnell.org.uk/drugwatch.html>. Further examples of useful resources can be found in appendix 4.

### 3.2. Partnership working

We found strategic managers, specifically from health, commissioning, police and substance misuse services, regularly working together to tackle the problem of NPS in their local communities. Within probation, relationships with substance misuse services and other relevant agencies tended to be stronger at the middle manager grade. Most middle managers themselves recognised that they did not know enough about NPS to support their teams and raise their confidence. Many middle managers had requested training and one inspected area had amended screening tools to assist responsible officers to ask the right questions.



Substance misuse services have been through recommissioning processes over the last few years. In some areas, the services were still embedding and the changes were being felt by responsible officers; but in others, good relationships had been developed. The strongest were seen in those cases where service users had drug rehabilitation requirements as part of the court order or were subject to licence conditions to engage with substance misuse services or drug testing. Those subject to these conditions often complied well.

We also found good examples of partnership working within the Integrated Offender Management (IOM) teams and cases subject to Multi-Agency Public Protection Arrangements (MAPPA). In these cases, we found that substance misuse services allocated dedicated keyworkers who developed consistent and established relationships with responsible officers. This approach ensured that probation responsible officers knew who the keyworker was, and this rarely changed. There were firm agreements on information-sharing, and the keyworker was either co-located with the probation teams or attending probation premises on a regular basis.

These relationships were strengthened further when substance misuse keyworkers were able to access and record on nDelius. These records contained relevant and detailed information that was available promptly for responsible officers to see. For all other cases where referrals were on a voluntary basis, the relationships were not as effective.

Substance misuse services in some areas were frustrated at having to use call centres to locate responsible officers, often being unable to speak to them directly, while responsible officers were often making numerous calls to try and speak to substance misuse keyworkers. Where we found good working relationships, these were based on well-established individual connections. Where we found responsible officers and keyworkers working together, the quality of assessments and outcomes for the service user were enhanced.

## **Information-sharing**

Information-sharing protocols and formal referral processes were in place in the areas inspected. However, the quality of relationships between partners had a significant impact on the level of information being shared. In Newcastle, we found that multi-agency meetings were taking place, chaired by public health and local authorities. These were attended by substance misuse services, housing, police and probation with the primary aim of discussing service users in need and those deemed high-risk cases. This was to ensure they received support and a multi-agency approach to managing their risk of harm, which included those who used NPS.

Information was not routinely shared at the practitioner level, beyond whether an appointment had been kept. In too many cases, responsible officers did not know enough about the care plans or work that was being agreed by substance misuse keyworkers. Likewise, risk management and sentence plans completed by responsible officers were not being shared or appropriately discussed. Often assessments and plans were being completed and delivered in isolation.

Very few of the licence cases in our sample included information from prisons about actual or suspected NPS use. As a result, post-custody release plans did not consider the effects of NPS use on the individual or the actions required to address NPS use in

the community. The lack of analysis or recording of NPS use by responsible officers in the community meant that those being recalled or receiving a new custodial sentence were entering establishments without updated information being available. This echoes findings from our recent Through the Gate inspections. In many cases, offenders were released without accommodation or without having been referred to substance misuse services (HMI Probation, 2016 and 2017).

In January 2016, PHE issued guidance for establishing Local Drug Information Systems (PHE, 2016). This provides a mechanism for relevant professionals to report or gather information about NPS. Although the primary aim is to respond to immediate risk, it is envisaged that increased staff knowledge will also result in a more effective response to NPS use. At the time of our inspection, this system was only in place in the Manchester area. In other areas, there was no single system to allow information-sharing.

### **3.3. Examples of good practice**

Detailed below are examples of good practice found while inspecting in Newcastle and on a visit to specialist drugs services in Manchester. The Newcastle example highlights the impact of police enforcement activity and the use of data collection to identify trends. The Manchester example demonstrates the benefits of a coordinated and multi-agency approach.

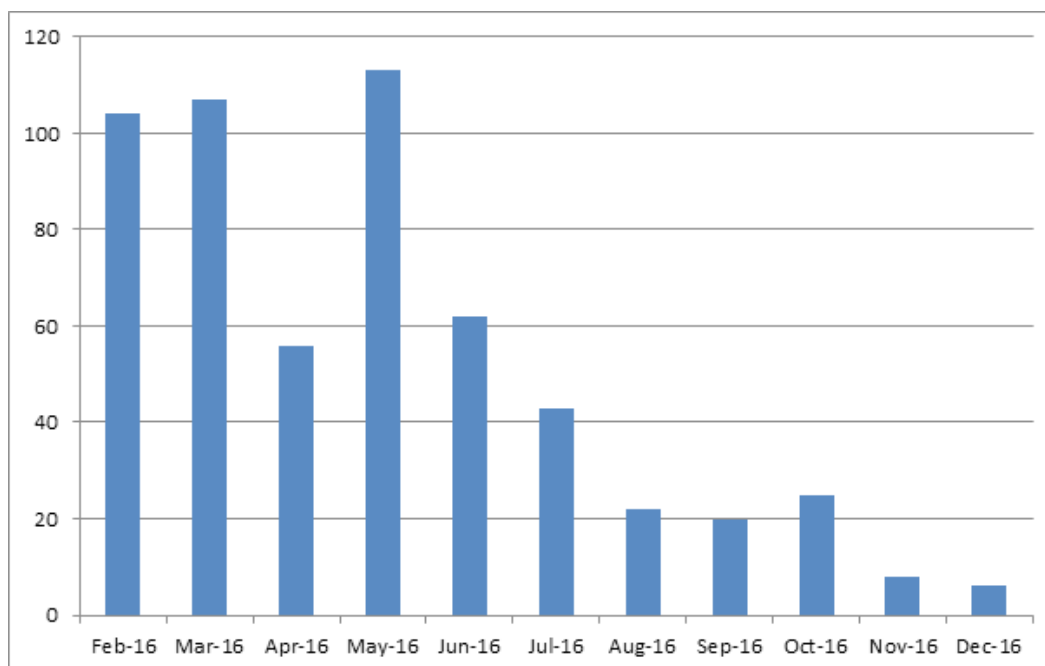
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#### **Good practice example of a coordinated approach to tackling NPS:**

Northumbria Police has taken a leading role in the area's approach to dealing with concerns about NPS. A combination of police responses, collaborative working with partners and the new legislation has meant that NPS-related incidents have reduced dramatically, not only in Newcastle city centre but across Northumbria.

Work started with Operation Jakarta, conducted by the city centre neighbourhood support team in conjunction with Newcastle City Council in July 2015. Several different approaches were used, including Community Protection Notices, Closure Orders and two charges under the Intoxicating Substances (Supply) Act 1985. Subsequent work focused on providing support and safeguarding NPS users.

Operation Falconry, implemented as a direct result of the Psychoactive Substances Act 2016, resulted in thousands of pounds of NPS being seized and court proceedings against suppliers. In response, NPS incidents in the city centre reduced dramatically. The following graph sets out the number of police incidents relating to NPS between February 2016 and December 2016.



More recently, dawn raids carried out as part of Operation Feather in March 2017 resulted in the arrest and charge of 15 individuals for supplying NPS. It followed a six-month collaborative operation with public health and the local authority to tackle street dealers of NPS.

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### Good practice example: the response in Manchester

The use of NPS in Manchester has been widely reported in the media. Production was often home grown, with organised crime groups sourcing liquid synthetic cannabinoid from China, sometimes via Eastern Europe, and making up their own final product by spraying the liquid onto dried leaves and bagging it up. Test purchases of NPS revealed that these samples were up to 700 times stronger than what had previously been sold in head shops: “Like swapping a pint of lager for a pint of vodka” (Dr Ralphs, senior criminology lecturer at Manchester Metropolitan University).

The true extent of the problem was unclear, owing to poor recording and knowledge gaps at the front line (health, housing, police, prisons and probation). There was also a mistaken belief that substance misuse services could not help with NPS.

In response, the local authority is coordinating a multi-agency response involving public health, police, drugs agencies and children’s services.

The substance misuse service Change, Grow, Live (CGL) took services out into the community to where NPS use was most prevalent. It was linked with day centres and night shelters, where it had a regular presence and specifically focused on NPS use. Eighty staff benefited from training with the mental

health Dual Diagnosis Liaison Service, focused on mental health interventions and strategies for responding to crises and managing risks.

Police officers' main focus had been tackling supply and closing head shops where NPS were still being sold. They moved to be co-located with the neighbourhood homeless team, working together to address NPS use among street homeless.

Manchester strategic partners developed workshops to deliver training and share good practice and lessons learned from the front line. Staff working in day centres, hostels, supported housing, approved premises and prisons have contributed their expertise, gained through day-to-day contact with NPS users.

Greater Manchester is now using a Local Drug Information System model developed by Mike Linnell for PHE. The model has been set up for professionals to share information about drugs with other members. This could include alert notices or discussion topics around new symptoms or reactions that have emerged. It is intended to respond to immediate risk, to be a low-cost, low-maintenance multidisciplinary system that uses existing local expertise and resources.

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### 3.4. Conclusions and implications

Overall, inspected areas did not have a good enough understanding of the prevalence of NPS use at a local level. In the main, strategies have focused on crisis management to address emergencies. Where the strategic response was appropriately coordinated, such as in Newcastle, it included longer-term actions for agencies to work together and address NPS-related concerns locally. Agencies were also more likely to be collecting NPS-specific data. Partnership working was strongest where court orders, licence conditions or other multi-agency management arrangements were in place. From the probation perspective, the strategic focus on NPS lags behind that given to other areas of offender need, such as housing and mental health.

Managers within substance misuse services were supporting the delivery of work in line with the guidance provided. They should, however, ensure the workforce is suitably equipped to understand the drug market and the effects of and risks associated with NPS use. While treatment and intervention pathways are available in the community, in the main these are not specific to NPS use or consistently tailored. Community drug services are less successful at drawing in users of NPS than other substances.

Probation managers did not know where to source relevant training and were limited in the influence they had to alter national assessment and screening tools. Despite the BSR accredited programme being available for NPS users,



we found no evidence of it being used. CRC interventions for substance misusers were also available on the rate card for purchase by the National Probation Service; however, confidence in the impact of these interventions was low, and thus referrals were not being made.

Relevant policies and information-sharing agreements were in place, but these were not effective enough in practice. Information-sharing from prisons to substance misuse and probation providers was particularly concerning. Not enough was being done by prisons and probation providers to record or communicate concerns about NPS use. OASys and other assessment tools need to be used more effectively at all stages of a prisoner's time in custody or a service user's period in the community to ensure up-to-date information is held. Poor communication has implications both for the safety of professionals working with the service user and for the well-being of the NPS user.



## **4. What we found - the quality of work**

In this chapter, we consider the quality of work undertaken with NPS users. Inspectors from HMI Probation looked at cases that were being managed by the National Probation Service and CRCs, and inspectors from the Care Quality Commission worked with local substance misuse services. Where it was possible, cases were tracked jointly by both agencies.



## 4.1. Assessment and planning of NPS use

### Assessment of NPS use by probation providers

NPS use was rarely identified at the pre-sentence stage or at the initial assessment and induction stages. In most of the cases inspected, NPS use was identified either while the service user was in custody or during their period of probation supervision, largely following self-disclosure. Synthetic cannabinoids were the most frequent type of NPS being used. Where NPS had been used in custody, this was rarely reflected in the assessment. Many assessments contained a brief line stating that the service user used 'legal highs'. In most cases, there was no analysis of the patterns of use. Most NPS users reported that they were using NPS alongside other substances, but assessments and plans did not reflect this.

We found a lack of understanding of how service users were funding their NPS use and whether they were offending to obtain funds. We saw examples of service users struggling to maintain their tenancies or placements in homeless hostels as a direct result of their NPS use; however, responsible officers were not including this in their assessments.

In the vast majority of cases, we found that NPS users had experienced childhood trauma. Many had used other drugs at a young age, with some starting as early as 11 years old. NPS users often described low emotional mood, such as feeling depressed or anxious, with many having attempted suicide or wanting to self-harm. A sufficient assessment of these concerns was carried out in very few cases sampled.

Those who continued to use in the community after release from custody reported being addicted and unable to cope with the withdrawal symptoms. NPS accessibility and lack of detection had for many led to ongoing use as an alternative to heroin or crack cocaine. Recent research supports this view that the motivation for using NPS is linked to avoiding detection: it is not readily detectable through mandatory drug testing (Ralphs, 2017). In the calls for evidence, we were told that the main motivation for NPS use in approved premises and supported housing was the non-detectability and the lack of distinct smell in comparison with cannabis.

Overall, assessments lacked an understanding of why NPS users had started to use the drugs, and the effects their use had on the user, the wider community, actual and potential victims and on their offending behaviour.

Where substance use screening was carried out, responsible officers relied on the service user disclosing accurately what they used. In general, responsible officers were not confident in asking questions about NPS use. Service users were not familiar with the term 'new psychoactive substance', and practitioners were not always up to date with the terminology used by dealers and users. Often, service users were better informed than responsible officers. One NPS user told us about his experience of NPS use in the community:

*"It's rife and easy to get, I used it 'coz cannabis can be detected but Spice can't be tested for. It's the pound shop brown. I am seeing a lot of it, especially with the homeless. When they have been using alcohol as well*

*you can see that they are drunk with slurred speech but when they use Spice it takes over them. Spice is going to destroy this world”.*

The majority of responsible officers expected that any assessment and work required would be completed by the substance misuse service. One senior probation officer supported this view:

*“If offenders are presenting with substance misuse that is how ROs will deal with them and refer them to substance misuse services. They have high caseloads and are unlikely to prompt for information unless there is intel available to trigger this”.*

We were encouraged to see that one probation provider had promptly changed local screening tools during the period of inspection to include NPS in the substance use section.

### **Impact of NPS use on public protection**

In too many cases there was no analysis of the impact that NPS use had on public protection, which meant that appropriate risk management plans were not in place.

We found examples of cases where the service user had displayed violent behaviour; in some cases, this was known to have taken place while the service user was under the influence of NPS, but in others this was not known. Assessments of risk of serious harm often lacked any analysis of how NPS contributed towards the violent behaviour. We saw case records where responsible officers were aware that service users who reported using NPS daily were on their way to see their children. Such safeguarding concerns had not been sufficiently analysed. We did see a small number of good-quality assessments, taking full account of NPS use. These tended to be completed by responsible officers who had previous experience of working in substance misuse fields or who had recently been appointed from a custodial setting.

In several probation providers, responsible officers talked about the impact of high caseloads and staff absences on the time available to undertake good-quality risk assessments. In CRCs, we were told that the priority was to meet performance targets.

### **Planning of work to address NPS use**

We found NPS-specific sentence plan objectives in only two cases. These were based on the service user’s needs and considered their level of motivation to address their NPS use and the barriers to making progress. However, in the main, deficient assessments had led to insufficient planning.

Sentence plans were completed following an interview with the service user; in some cases, a self-assessment form was completed. Sentence plan objectives lacked clear direction and were unrealistic, given the chaotic nature of many NPS users’ lives. Too often the objectives were very broad, for example to ‘address drug use’ or ‘abstain from substances’. Service users we spoke to were not always clear about what they

were required to do as part of their sentence.

Some CRCs had developed their own substance misuse group work, which included a basic level of awareness-raising about the risks of using NPS. When we spoke to participants, we found the level of material being delivered was too low and did not provide meaningful input to those attending. On a more positive note, some service users reported the benefits of being in a group with others who were motivated to address their drug use.

When circumstances changed for service users, we did not see timely and appropriate reviews of their assessments and plans. Many remained unchanged, despite there being further offences or changes in substance misuse and following the successful completion of court-ordered requirements.

### **Assessments and plans by substance misuse services**

Care Quality Commission inspectors visited 15 different substance misuse services. The assessment tools used by these providers varied. Some areas had adapted the tools to include NPS use in the assessment; others used a first, second and third drug recording system, which relied on keyworkers being confident enough to ask the relevant questions about NPS use or self-disclosure by the user. Some keyworkers routinely asked about NPS, while others judged the presentation of the service user.

Most substance misuse services took referrals from a range of services, including GPs, accident and emergency departments, the police and probation providers. Only one area did not have an established criminal justice pathway for referral to the service. Overall, we found that assessments were completed quickly once referrals had been allocated; these were often initial screening assessments that were completed fully following the next attendance. Care plans and recovery plans were also being completed. In line with the clinical guidance provided, these focused on the individual's needs and presentation of symptoms rather than the drug that they used. We did not find testing available in the community owing to the challenge of identifying ever-changing compounds.

We saw examples of completed assessments and care/recovery plans for those service users who maintained engagement with the provider. There were examples of reduction plans being created with service users and evidence of motivational work being carried out when service users were attending but presenting with barriers to engagement. In too many cases the assessments were incomplete because the service user had not attended, leading to the case being closed. While there was some evidence of keyworkers trying to re-engage service users, this was not seen in all areas. Often cases were closed, with limited efforts being made to work with probation providers to support NPS users back into services. In some areas, substance misuse services had closed cases without informing probation responsible officers.

## **4.2. Impact on offending behaviour and compliance**

The impact of NPS use on offending behaviour and compliance was difficult to ascertain. This was problematic owing to the lack of analysis at the assessment and planning stages of the orders. The chaotic nature of NPS users' lives led to poor

attendance levels, and few service users in our sample engaged regularly with both probation providers and substance misuse services. Those that did attend were often under the influence of NPS. They were unable to engage with any work, and in some cases were unresponsive in discussions. Responsible officers regularly accepted the state in which service users attended and would simply rearrange the appointment. Responsible officers described their experiences:

*“Offenders are attending under the influence of Spice, making threats. They are not engaging with their order, not attending for appointments and are fixated on trying to get hold of NPS”.*

*“They tend not to be able to stand up when they are under the influence of NPS. They have difficulty walking. We have not had any guidance about what we should do – should we call an ambulance? We would generally not see them or allow them into the office but are aware that sending them back on the streets could be dangerous. In some cases we can arrange a welfare check to be carried out”.*

*“People are crazy when they are under the influence, one confused me for a fire hose when he was under the influence”.*

Overall, sufficient levels of contact were being offered by probation services, and responsible officers were making efforts to secure compliance with court orders. This was not always seen in relation to engagement with substance misuse services. Efforts to re-engage service users were largely reflected in the quality of the relationships that had been developed between the service user and keyworker.

The approach to managing low engagement and compliance by those misusing substances varied across the areas. In some, letters or phone calls were used to give the service user a further opportunity to re-engage. In others, more established motivational groups were being run to integrate users into the service.

Many substance misuse keyworkers reported that the level of enforcement taken by probation providers was often slow or non-existent. Responsible officers felt that keyworkers did not do enough to reach out to a chaotic group or recognise that initial engagement could be slow and may require a more supportive and understanding approach.

Overall, good compliance was seen by those who were released from custody on licence with a condition to reside in approved premises. One approved premises visited in Brighton began the process of outlining the rules and regulations about NPS use with service users before they were released from custody. As a result, service users understood the actions that would be taken, including a recall to custody, if concerns arose that placed them in breach of the conditions of their residence. The approved premises manager told us:

*“Last year we recalled eight to nine residents. Now when referral forms are completed we will check drug-related information and specifically ask about NPS use in prison. Even where they don’t have a substance misuse history, they are coming out with a problem. We also ask if they are on anti-psychotic meds – this mix does not work and presents the worst behaviour. When the residents arrive, they would have already had the [approved premises] rules and have a specific section on NPS about using and having possession of NPS. There is a process of warnings issued in relation to concerns if using NPS and the risk posed to staff and residents before a bed is withdrawn. There have been no recalls in the last six months that are related to NPS use. We are consistent in our approach and transparent”.*

Approved premises staff in this area had become confident in dealing with incidents related to suspected NPS use. This was achieved through training and clear procedures and processes for dealing with those residents who used NPS.

### **4.3. Examples of good practice**

Detailed below are examples of good practice found while inspecting in Bristol and Leicester. The Bristol example highlights the impact of close working between probation and substance misuse services. The second example highlights a persistent approach by all involved professionals, including accepting previously recalled prisoners back into approved premises, capitalising on the smallest indication of a renewed motivation to address often entrenched difficulties.

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#### **Good practice example: information-sharing and collaborative working**

Peter was referred to the Bristol Drug Project (BDP) from hospital for a brief intervention regarding Spice use. He was a former heroin and crack user who had started using Spice in prison, which had caused heart problems. When he was first seen, he presented as very unwell. He was using 16g of Spice daily, and was so heavily addicted that he had to break during keywork sessions to smoke Spice outside before returning. He suffered withdrawal symptoms, including bowel incontinence and psychosis that made him pull off his skin because he thought there were beetles beneath it. Spice was also making him uncontrollably aggressive, and violent towards his mother and brother, also a Spice user.

The BDP keyworker spoke to Peter’s CRC responsible officer after every appointment. She could see that the responsible officer had a good relationship with Peter, and on occasion if he turned up in an aggressive mood, she would direct him to see his responsible officer and return when he was calmer, which he did. He was referred to the Bristol Specialist Drug & Alcohol Service, which was trialling Spice detox using Librium and

symptomatic medications, along best practice guidelines, as the National Institute for Clinical Excellence was yet to provide a clinical treatment pathway for Spice. The keyworker arranged for Peter to attend the office, where she would escort him to the appointment; however, Peter attended three hours late. He was psychotic and threatening to staff, which led to his arrest. The keyworker informed his responsible officer, who saw him the next day. She then arranged a three-way meeting with his keyworker, at which he agreed not to smoke Spice before attending for his next detox appointment.

Peter started a community detox. It was assessed as appropriate for him to manage this at home rather than within an inpatient detox unit as there were no children in the house. He attended for daily medication during the 10-day detox, with continued support from his keyworker and responsible officer, and successfully detoxed from Spice. Following the detox, Peter was placed on a relapse prevention group work programme. He missed his last session and there has been no further formal contact, although his keyworker has since seen him, and said that he *“looked like a different person”*.

The keyworker commented that this case represented *“really good interagency working; the responsible officer went the extra mile”*.

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### **Good practice example: a persistent approach to tackling NPS use**

Daniel was subject to a post-custody licence for drug-related violent offences. Although Daniel was well known by substance misuse services, his NPS use had been discovered relatively recently, after he was caught smuggling NPS into his Category D (open) prison.

He was initially released to probation approved premises. He denied using NPS in the community, but his presentation, particularly bloodshot eyes, suggested otherwise. As Daniel tended to tell different professionals different things, three-way meetings with the approved premises staff and responsible officer were held to share information. He was recalled twice from the approved premises for aggressive behaviour when under the influence of NPS.

On his most recent release, he was more positive and engaged with substance misuse service groups and mindfulness sessions. He had been willing to explore how he could control his emotions and attitudes when things don't go his way. Work was undertaken to look at his self-image as a 'hard man', and how, while that may work in prison and previously in the Army, it does not work well in the community.

He has now left the approved premises, so there have been discussions about how he needs to prioritise substance misuse engagement as he no longer has that safety net. There is a concern that if he uses NPS in his



accommodation and collapses, he may not be found. The substance misuse recovery worker has been undertaking home visits to keep an eye on him.

The next plan is for him to see a psychologist to explore his post-traumatic stress disorder, continue with home visits to get a feel for his lifestyle and new relationship, and look at other substance misuse group work. As a former soldier, he responds well to structure and being kept busy.

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#### 4.4. Conclusions and implications

The tools used to identify drug use are not consistent; in many cases, they do not reflect the current trends of drug use. As a result, the extent of the problem is not fully understood and is likely to be under-reported.

Overall, assessments and plans completed by substance misuse services were appropriate and related to the needs of the service user and their symptoms, in line with the national guidelines. We were not, however, always assured that the symptoms that service users presented with were being accurately linked to the drugs they were using.

Probation providers are not fully aware of what can be done to address NPS use. Responsible officers were rarely able to talk to NPS users about their symptoms and consolidate work undertaken by substance misuse services. While probation providers were making appropriate referrals to substance misuse services, these were not always responded to in a timely fashion. Service user engagement was often sporadic and not enough was done to support NPS users to re-engage. Many NPS users found themselves in a vicious circle, with multiple needs that were not being addressed, leading to NPS use being their only escape.

Concerningly, probation providers did not routinely consider the risks associated with NPS use to groups such as children, staff, prisoners or the wider community, despite there being enough known about the unpredictable nature of those using the drugs.



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## Appendix 1: Glossary

Accredited programme	A programme of work delivered to offenders in groups or individually through a requirement in a community order or a suspended sentence order, or part of a custodial sentence or a condition in a prison licence. Accredited programmes are accredited by the Correctional Services Accredited Panel as being effective in reducing the likelihood of reoffending
BSR – Building Skills for Recovery	BSR is an accredited psychosocial programme that can be delivered in a group setting or on a one-to-one basis. It aims to reduce offending behaviour and problematic substance misuse, with an eventual goal of recovery
CRC	Community Rehabilitation Company
DRR	Drug Rehabilitation Requirement: a requirement that a court may attach to a community order or a suspended sentence order aimed at tackling drugs misuse
HMPPS	Her Majesty's Prison and Probation Service: the single agency responsible for both prisons and probation services.
IOM	Integrated Offender Management: a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together
Keyworker	An allocated member of staff from substance misuse services who works with service users to address their substance misuse
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others. Level 1 is ordinary agency management where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. This compares with levels 2 and 3, which require active multi-agency management
nDelius	National Delius: the approved case management system used by the NPS and CRCs in England and Wales
National Probation Service	National Probation Service: a single national service which came into being in June 2014. Its role is to deliver services to courts and to manage specific groups of offenders, including those presenting a high or very high risk of serious harm and those subject to MAPPA
OASys	Offender assessment system currently used in England and Wales by the NPS and CRCs to measure the risks and needs of offenders under supervision
Providers	Providers deliver a service or input commissioned by and provided under contract to the NPS or CRC. This includes the staff and services provided under the contract, even when they are integrated or located within the NPS or CRC
Responsible officer	The term used for the officer (previously entitled 'offender manager') who holds lead responsibility for managing a case

## Appendix 2: Methodology

This was a joint thematic inspection conducted in England by HMI Probation and the Care Quality Commission. The key components of this thematic inspection were:

### Part one: pre-fieldwork

1. A review of national research and a NPS literature review.
2. A call for evidence in December 2016 via our website, Twitter and LinkedIn generated two responses, from G4S and Dr Robert Ralphs, Manchester Metropolitan University. See Appendix 3.
3. A survey request was sent to HMPPS, all NPS divisions, and all CRCs and their respective owners. This generated 18 detailed responses from CRC owners (4), the National Probation Service (11), NHS (1), housing (1) and employment services (1). See Appendix 3.
4. Meeting with Dr Robert Ralphs, senior lecturer in criminology at Manchester Metropolitan University, to understand the concerns and consider other actions required as part of the inspection.
5. A pilot inspection at the CRC and National Probation Service in Birmingham (Derbyshire, Leicestershire, Nottinghamshire and Rutland CRC and Midlands National Probation Service division) during April 2017 to gather information and test the fieldwork methodology.

### Part two: inspection fieldwork

The inspection fieldwork included visits to five areas in May and June 2017 covering a mix of metropolitan, urban and rural areas, as follows:

Place	CRC	CRC owner	National Probation Service division
Hackney & Tower Hamlets	London	MTC Novo	London
Newcastle	Northumbria	Sodexo	North East
Leicester	Derbyshire, Leicestershire, Nottinghamshire and Rutland	Reducing Reoffending Partnership	Midlands
Brighton	Kent, Surry and Sussex	Seetec	South East & Eastern
Bristol	Bristol, Gloucestershire, Somerset & Wiltshire	Working Links	South West & South Central



The fieldwork visits comprised:

1. interviews with five CRC senior managers, five NPS senior managers and one senior manager in prisons
2. meetings with 42 managers from CRCs and the National Probation Service, including middle managers, approved premises managers, managers responsible for interventions, commissioning, courts and MAPPA
3. meetings with 49 responsible officers from CRCs and the National Probation Service and five keyworkers in approved premises
4. meetings with nine staff and managers from external organisations, including academic researchers, a DrugWatch consultant, public health, local commissioners and mental health diversion teams
5. meeting with nine police officers from local tasking teams or allocated to IOM teams
6. meetings with 15 local substance misuse services, including service managers, prescribers and keyworkers
7. interviews with 25 service users and peer mentors
8. reviews of 59 cases, as well as case file assessments; the reviews included interviews with the responsible officers in 55 cases – in the remainder, the responsible officer was not available but in some cases the case was discussed with the team manager
9. additional meetings took place with Manchester substance misuse service Change, Grow, Live (CGL); neighbourhood police officers involved in Operation Manderla in Manchester; and a consultant nurse in the Dual Diagnosis Liaison Service at Greater Manchester Mental Health NHS Foundation Trust.

### **Inspection fieldwork: case profile**

We examined 59 cases of offenders who had been sentenced to a community order, suspended sentence order or were on licence from a custodial sentence and where it was known that they had or still were using NPS. This was not a statistically representative sample; our case inspection is intended to generate illustrative findings. Of these cases:

- 53 (91%) were male
- 45 (78%) were white
- 10 (18%) were aged 18–25, 21 (37%) were 26–35 and 26 (46%) were 36–55
- 13 (22%) were serving a community order, 13 (22%) a suspended sentence order and 32 (56%) were subject to a period on licence
- 27 (47%) were being managed by a CRC and 30 (53%) were being managed by the National Probation Service
- most commonly, the offenders had committed a violent offence or a theft
- in relation to risk of serious harm to others, 15 had been classified as high risk, 37 as medium risk, and four as low risk. Three cases had no risk level recorded.

## Appendix 3: Call for evidence and survey responses

### Call for evidence

Two responses were received to our call for evidence. The G4S contribution is based on internal consultations with G4S staff in the prisons they manage and their community. The Manchester Metropolitan University contribution is based on two research projects with which Dr Ralphs is involved: the first was about NPS use in a local prison and the second was commissioned by Manchester Community Safety Partnership and focuses on the impact of the *Psychoactive Substances Act 2016* on NPS use among the homeless, those in approved premises and supported housing.

They told us:

- NPS use is increasing across the prison estate. The increase is related to NPS being cheap, easy to use and (until September 2016) not testable.
- Prevalence in prisons according to staff estimates are 30%–60%; prisoner estimates are 60%–90%.
- NPS are changing very quickly; batch strengths are variable and the effects therefore vary greatly. Psychotic behaviour is seen in some users and respiratory problems are common.
- NPS use is increasing owing to its availability in prison and the community and the lower risk of detection in drug testing and use.
- The recording of NPS incidents and users is inconsistent as there is no official coding for it in agency IT systems.
- Where recording occurs, it is inconsistent and vague ('Spice', 'legal highs', 'NPS'). Users are often reluctant to disclose.
- During their custodial sentence, NPS users do not focus on their offending behaviour targets.
- Partnership working is improving but there is still work to be achieved to ensure that all information is shared.

### Survey responses

Eighteen responses were received to our survey. Most respondents lacked confidence in their knowledge and understanding of NPS and were concerned about the lack of provision in the community.

They told us:

- Responsible officers have little knowledge of the contents, strengths and effects (both physically and emotionally) of NPS. Those with prior knowledge had gained it from previous roles and organisations.
- Responsible officers generally felt that nothing had been communicated to them, and that the service was not up to date with information on NPS. They did not feel that they were sufficiently trained or informed on how to assess use.
- Lack of monitoring and recording is hindering agencies – most relied on

disclosure by service users.

- The ability to tackle use was limited as staff cannot test or screen for NPS, and behaviours associated with NPS are often indistinguishable from mental health psychosis.
- Staff attempt to address problems by establishing licence conditions that ensure users address their use and by referral to the local drug and alcohol agency.
- Responsible officers were making referrals to substance misuse services, although they were not always aware of what was available to service users. They feared that services may not be able to keep up with the constantly changing strains of NPS.
- There were some positive examples of probation working closely with substance misuse services within co-located criminal justice teams. This improved the sharing of information and level of joint working of cases.
- Interventions should be developed by knowledgeable experts on reducing the harm caused by NPS use.

# Appendix 4: Useful information sheets

## Spice

### Synthetic Cannabinoids (SCRAs)

New Psychoactive Substances  
Briefing for professionals

Version 1.3 July 2017

1.3

Manchester Health & Care  
Commissioning

A partnership between  
Manchester City Council  
and NHS Manchester CCG

#### What is Spice?

**Spice is a nickname for a herbal mixture containing one or more of a group of drugs called synthetic cannabinoids.**

Spice was originally a brand name of a drug, sold as a 'legal high' along with other brand names like Black Mamba, Annihilation, Exodus Damnation and Happy Joker. They contained a non-psychoactive herbal smoking mixture that had been mixed with one or more of a group of drugs known as Synthetic Cannabinoid Receptor Agonists (to give them their full name) or SCRAs for short.

Spice (and Mamba) are now used as nicknames for any type of herbal mixture that has been coated with an SCRA. SCRAs can also appear as powders or liquids for use in e-cigarettes although in the UK SCRAs are now almost always smoked in a herbal form, however, SCRAs have also turned up as adulterants in a number of other drugs. In recent incidents in Oldham, pure crystals of SCRAs were sold as MDMA resulting in multiple hospital admissions.<sup>1</sup>

Since changes to the law in 2016,<sup>2</sup> Spice mixtures are now almost always sold in clear snap bags. On the street in Manchester Spice sells for approximately £5 for ½ and £10 for 1 gram bags.<sup>4</sup> Prices in prison are much higher.<sup>5</sup>



Spice was sold in branded packets but is now mainly sold in clear snap bags.

#### What are SCRAs?



SCRAs are made in a lab and stimulate the same areas of the brain as THC.

The cannabis plant contains a number of natural cannabinoids. THC (tetrahydrocannabinol) is the main one that gets you high.<sup>3</sup> CBD (cannabidiol) and CBN (cannabinol) have more relaxing and calming effects and moderate the effects of THC.<sup>4,7,8</sup>

Cannabinoids stimulate receptor sites called CB1 and CB2 (found in the brain and all over the body).<sup>4,7,8</sup> Stimulating these receptor sites leads to a wide range of effects on mood, thoughts, feelings and senses as well as a number of physical effects. SCRAs may bear no structural similarity to natural cannabinoids but, like THC, they also stimulate CB1 and CB2 receptors.<sup>4,7,8</sup> SCRAs may also have activity on the serotonin and dopamine systems.

SCRAs were designed by commercial research chemists in the 1980s, although they were never manufactured or clinically tested on humans.

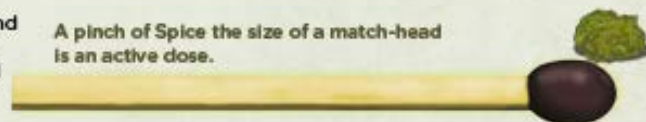
#### Why is Spice so potent?

SCRAs may have started out as legal cannabis substitutes, but the market changed and users wanted Spice products that were increasingly potent. Spice became an extremely potent product and quite unlike cannabis.

Cannabis only partially stimulates CB1 and CB2 receptors, whereas SCRAs can fully stimulate them. SCRAs have been described as 'Super stimulators' and can be up to 800 times more potent than cannabis.<sup>9</sup> SCRAs also may lack the calming effect of CBD/CBN found in cannabis.<sup>9</sup>

There are hundreds of different SCRAs, some much stronger and more toxic than others. The potency of a packet of Spice depends on which SCRAs are used and how much is added to the herbal mixture. Spice is potent even at very low doses: a pinch the size of a match-head is an active dose.<sup>10</sup>

A pinch of Spice the size of a match-head is an active dose.



1



## Is Spice legal?

The original product sold under the brand name 'Spice' contained an SCRA called JWH-018. A range of SCRAs such as JWH-018 were made Class B under the **Misuse of Drugs Act in 2009**.

However, these were replaced in the shops within days by branded products containing a second generation of SCRAs that were not covered by the Misuse of Drugs Act such as AM-2201 (the drug in the original Black Mamba brand). These SCRAs were often more toxic and more potent than the ones they replaced.

**The Misuse of Drugs Act was amended in 2013** so that AM-2201 and a range of other SCRAs were included. Hundreds of SCRAs were banned but within days these were again replaced with others not covered by the Misuse of Drugs Act.

All SCRAs became illegal to sell, make, import and export in April 2016 under the **Psychoactive Substances Act**,<sup>1</sup> but were only illegal to possess in prison.

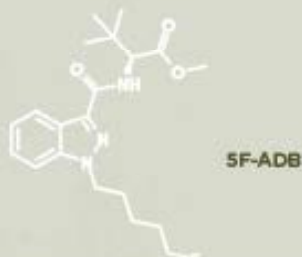
**The Misuse of Drugs Act was amended again in December 2016**,<sup>2</sup> so now most<sup>3</sup> of the known SCRAs and all those commonly found in Spice have become Class B drugs and are illegal to possess etc.



SCRAs are now mostly<sup>4</sup> Class B drugs.

<sup>4</sup> There are a number of SCRAs that although not currently in common use, are not controlled by the latest amendment to the Misuse of Drugs Act. These are MDMB-CHMCA, EG-018 (only seen as powder) and CUMYL-PeGACLONE.

## Current Spice content



SCRAs are mainly still made in China and imported as a powder into the UK, although there are unconfirmed reports of it being imported as a liquid via eastern Europe. SCRAs are then mixed (in a bath, cement mixer etc.) with a herbal smoking mixture in the UK and packaged into snap bags.

Since the advent of the Psychoactive Substances Act, little has been known about the SCRAs that are used in the Spice products sold in plain snap bags.<sup>4</sup> In March and April 2017 a number of Spice products were tested in Manchester<sup>11</sup> and the content varied in both the SCRA used and the ratio of plant material to SCRA. In other words the potency and toxicity can vary between packets and may change from week to week.

The SCRAs found in the test in March and April were all highly potent: AMB-FUBINACA, AMB-CHMICA, 5F-AMB and 5F-ADB.<sup>12,13,15</sup> To make things even more confusing SCRAs are named in different ways. So for instance 5F-ADB has a chemical long name of N-[[1-(5-fluoropentyl)-1H-indazol-3-yl]carbonyl]-3-methyl-D-valine methyl ester. It is known as 5F-ADB for short but is also known as 5F-MDMB-PINACA.<sup>16</sup>

## Who is using Spice?

As stated Spice was originally sold as a 'legal high' designed to mimic the effects of cannabis and was used by a wide range of people, although nearly all of them had used illegal drugs before using Spice.<sup>5</sup>

As the product became more potent and developed a negative reputation it started to be associated with specific groups of people: prisoners, rough sleepers, psychiatric in-patients and young people often described as 'vulnerable'.<sup>5</sup> Drugs are not used in a vacuum and it is important to understand the particular issues these groups face when working with Spice users.<sup>6</sup>

<sup>6</sup>Whatever approaches are used, interventions should also address issues specific to SCRAs and to particular populations who appear to be using them. Underlying drivers of use can include misuse of other substances, mental health and physical health comorbidity, issues associated with homelessness and deprivation, and involvement in the criminal justice system and incarceration.<sup>17</sup>

<sup>7</sup>What we found was not that people were using Spice because they were bored but mainly as a coping mechanism and to self-medicate because the reasons why they are in prison in the first place have gone untreated.<sup>17</sup>

## Drug screens & detection

Although Spice does have a smell when smoked, it is far less noticeable than cannabis and often is undetectable by smell alone when mixed with tobacco.

SCRAs cannot be detected by screening tests for THC. There are a number of specific drug screens for particular SCRAs but many new ones may not appear in simpler tests.<sup>8</sup>



## The physical effects of Spice

### Duration of Effects

The full effects are felt within seconds if smoked, before tailing off after 30 minutes to a more manageable state. Effects usually last 1-2 hours but can last much longer with some SCRAs. Spice is often smoked continuously throughout every waking hour (while supplies last).

### Common physical effects

Tight chest, racing & irregular pulse, breathing difficulties, collapse, dizziness, numbness and vomiting are commonly reported physical effects of Spice.<sup>9</sup>

### Physical problems

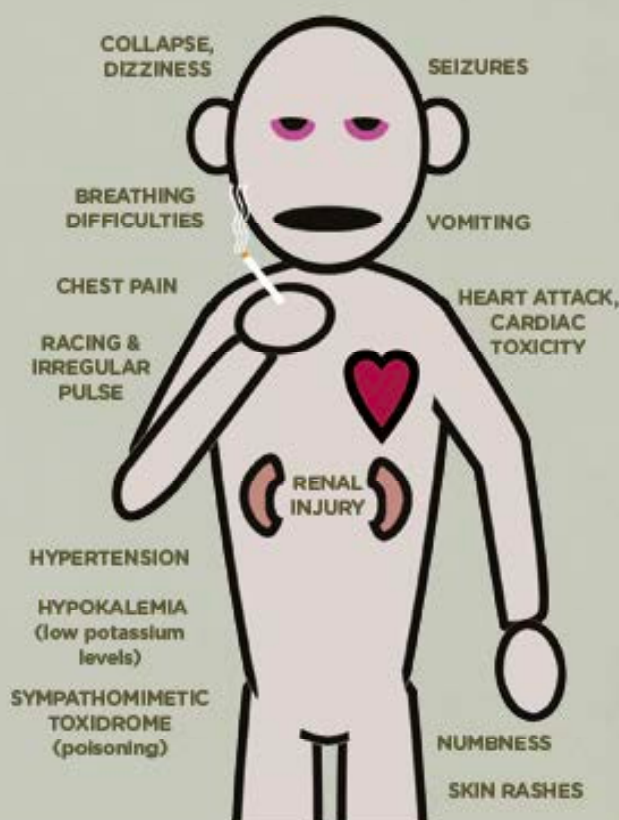
Seizures, cardiac toxicity, sympathomimetic toxidrome (poisoning), chest pain, heart attack, renal injury, hypertension, hypokalemia (low potassium levels), skin rash have been reported,<sup>9</sup> while other effects such as bleeding from the eyes and other orifices, teeth falling out are described by some long term users but have yet to be recognised in the literature.<sup>3</sup>

### Emergency hospital admissions

There are no national figures for emergency admissions for Spice-related incidents, but could be estimated in the thousands per year. In one day in April 2017 in Manchester there were 58 ambulance call-outs reported that were related to Spice in the city centre, although some of these may have been related to the same incident.<sup>18</sup>

### Death

Although ambulance call-outs and A&E admissions are common, deaths are relatively rare. 8 deaths associated with Spice were reported in England and Wales in 2015.<sup>20</sup>



## The mental effects of Spice



For new users, the mental effect of large doses or potent Spice the mental effects can be overpowering. Effects are unlike cannabis and often described as, more akin to the effects of ketamine or solvents.

Spice can cause frightening visions or hallucinations. It can take you to what feels like a different reality, almost the same as this one, but a lot more scary. The mental effects together with the physical effects can cause panic.

"... the user will experience a true test of fate. Reality, perception, and consciousness will become severely altered to the point of one not knowing their own name, address, or that they are even a human being"<sup>17,20</sup>

**Tolerance** develops in a matter of days of regular use. The effects seem more exaggerated over time so a state often described as 'zombie-like' is commonly and constantly experienced by heavy Spice users. However, large doses or (as there does not appear to be cross tolerance) a different SCRA can bring on the more extreme state described even among experienced regular users.<sup>9</sup>

**There are a wide range of mental effects described:** anxiety, irritability and psychosis-like effects, inappropriate or uncontrolled laughter, anger, sadness, flat affect, depression and suicidal thoughts, excitability, agitation, combativeness, aggression, thought disorganisation, panic attacks, paranoid thinking, delusions, auditory and visual hallucinations, changes in perception, acute psychosis.<sup>9</sup>

Short-term memory and cognitive deficits, confusion, sedation and somnolence, thought blocking, nonsensical speech, amnesia and increased focus on internal unrest are also reported.<sup>9</sup>

### Psychotic symptoms

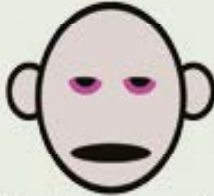
"Psychotic symptoms appear to occur relatively frequently following SCRA consumption. More research is needed, but this may be linked to the high potency of the drugs and the fact that, unlike natural cannabis, SCRAs do not contain cannabidiol (CBD), a chemical which appears to possess antipsychotic properties."<sup>22</sup>



## Dealing with Spice overdose

The number of Spice overdoses has placed a strain on already over-stretched emergency services. There are a number of simple guides to advise with when to dial 999.<sup>21,22,23</sup> However, these guides still require staff capable of taking blood pressure and accurately monitoring pulse rate and temperature.

The following visual guide is based on the DrugWatch Information Sheet,<sup>24</sup> Euro-DEN<sup>25</sup> and information from Project NEPTUNE.<sup>9</sup> It is aimed primarily at non medical professionals. In all drugs cases it is advisable to **treat the symptoms and not the drug**, as more than one drug may have been used and people may not have taken the drug(s) they think they have.



**Spice intoxication:** people who have used Spice may act in a disturbing way, be unsteady and appear 'zombie-like' with pale skin and pink eyes. They will be confused, unable to communicate properly and may repeat actions, as short term memory is severely affected. However in the vast majority of cases people will not require emergency treatment.<sup>9</sup>  
**If in doubt call an ambulance.**



**Temperature** over 38.5°C, not settling after about 5 minutes of rest or, if no thermometer is available, if very flushed and feels very hot. **Call an ambulance.**  
**If they are overheating:** cool them down by removing outer clothing, fan them, use a wet cloth on their skin, take them outside or somewhere cool. If they are conscious allow them to sip water or a non alcoholic drink.



**Seizures** (convulsion similar to an epileptic fit). Make sure the area is safe and there is nothing they could hurt themselves on. **Call an ambulance.** Inform paramedics if the fit stops and starts, if it doesn't stop within a couple of minutes or if the person turns blue. **It is important not to hold people down because of the risk of rhabdomyolysis.**



**Hallucinations,** blabbering, incoherent, zombie-like behaviour, panic attacks, repetitive nonsensical actions are common when using Spice. Take them somewhere quiet where they feel safe (a low stimulus environment). Make eye contact, build trust. **Calm and reassure them.** If they become panicky and you notice them breathing very fast, get them to control their breathing by slowing it down or breathing into a paper bag.



**Serotonin syndrome:** some SCRA compounds may increase the risk of serotonin syndrome.<sup>9</sup>  
The main symptoms: rigid, jerky, twitchy unusual movements, often involving the legs shaking, fully dilated pupils, overheating, shivering, racing heart, agitation and confusion.



**Breathing difficulties,** such as fast breathing rate, not settling within 5 minutes. If there is no breathing or it is abnormal (e.g. death rattle, agonal breath) then CPR should be attempted.  
**Call an ambulance.**



**Vomiting/feeling unwell** vomiting is nature's way of saying you've had too much. If somebody is unwell, don't give them anything to eat and only let them drink water. If after vomiting they want to sleep, let them but keep your eye on them. Make sure they are lying on their side **(the recovery position)**



**Severe chest pains:** sit them down in a calm environment and reassure them. **Call an ambulance.**



**Heart rate** over 140 beats per minute, not settling within 5 minutes. **Call an ambulance.**



**Other concerns:** e.g. severe vomiting, frothing at mouth, severe headache, significant agitation or aggression, not settling within 15 minutes. **Call an ambulance.**

**If in any doubt call 999**

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## SCRA interaction with medicines

Little is known about the risks of using SCRAs with other drugs, alcohol or medicines, let alone specific risks with different SCRAs. Any drug combinations should be considered potentially dangerous. Some SCRAs may be associated with activation of serotonin receptors. Due to the lack of clear information, decisions about continuity of prescribed medicines should be made on a case-by-case basis.<sup>23</sup>

It is advised that essential medication, such as insulin or warfarin is maintained but monitored. Given the association between SCRA use and convulsions, it is important to maintain prescribing of antiepileptic drugs.<sup>23</sup>

Interacting medicine (list not exhaustive)	Potential effect
<b>Antifungals:</b> itraconazole, ketoconazole, fluconazole	These medicines inhibit the liver enzyme CYP3A4. This leads to an increase in plasma level of SCRA and decreased rate of clearance which potentiates its toxicity.
<b>Macrolide antibiotics:</b> clarithromycin, telithromycin, erythromycin	
<b>Anti-HIV drugs:</b> Indinavir, nelfinavir, ritonavir, saquinavir	
<b>Antipsychotics:</b> clozapine, quetiapine	Concomitant use may cause brain, kidney, liver or heart injury.

Chart based on information from PHE<sup>23</sup>

## Tolerance, dependence & withdrawal

### Dependence

Psychological dependence can occur with any substance, but physical dependence and a recognised withdrawal from SCRAs are beginning to be recognised in literature.<sup>9</sup> Services commonly report that the most noticeable effect of SCRA dependence is a change in behaviour, with people becoming withdrawn and aggressive often resorting to crime to pay for SCRAs.<sup>9</sup>

### Tolerance

Tolerance to SCRAs is rapid; it has been reported that within a week of commencing use that 6 grams a day or more is used.<sup>9</sup> It is often stated that Spice is used in every waking moment and often waking from disturbed sleep to smoke in the middle of the night.<sup>9</sup> It is commonly stated that within days of first use the initial extreme effects (falling over, altered reality) are moderated into a state described as somewhere between heavy cannabis intoxication and a heroin 'gouch'.<sup>9</sup> However, it is also reported that there is no

'cross-tolerance' between different SCRAs and when the specific SCRA in a batch of Spice changes, the full 'extreme' effects are felt again.<sup>9</sup>

### Withdrawal

Anecdotally, physical withdrawal is widely reported (and in fact is the norm) among people describing experiences of SCRA addiction.<sup>9</sup> The withdrawal profile is similar but more intrusive and intense than seen with 'skunk' withdrawal. Diaphoresis (extreme sweating) and insomnia/sleep disturbance are the most common and noticeable withdrawal symptoms,<sup>9</sup> with some often waking with bed sheets soaked. Stomach cramps are reported anecdotally and some describe mental disturbances that can continue for months after use has ceased.<sup>9</sup>

Withdrawal symptoms including: headaches, anxiety, coughing, impatience, difficulty concentrating, anger/irritability, restlessness, nausea, depression, craving, tremor and hypertension are recognised in the literature.<sup>9</sup>

## Drug treatment

**There is drug no substitute therapy known for Spice; drug treatment involves prescribing to alleviate withdrawal symptoms.<sup>9</sup>**

### Treatment for withdrawal

Short term benzodiazepines (such as diazepam) are used to assist sleep, manage anxiety, panic and agitation. Treatment with intravenous benzodiazepines has been reported for the management of seizures and in some cases of SCRA-related psychosis.<sup>9</sup>

There are some reports describing antipsychotic medication being indicated for some patients, especially those who present with agitation or aggression, when the patient has a history of psychotic disorders, and when the psychotic symptoms do not remit with supportive care. There are also a small number of reports that describe antidepressants being administered in cases where there is concurrent depression.<sup>9</sup>

### Psychosocial treatment

Very little evidence is available on the management of the harmful or dependent use of SCRAs; it is suggested that clinicians adopt the evidence-based approaches used for other drugs, particularly natural cannabis. There is no evidence to suggest that a particular approach is linked to successful outcomes for SCRA users.<sup>9</sup>

The FRAMES model<sup>26</sup> (feedback, responsibility, advice, menu of options, empathy, self-efficacy), initially developed as a brief intervention for risky or harmful alcohol consumption can be an effective means of engagement and retaining people in treatment. It can be used in a formal or intuitive way, and it is reported to be effective in the context of managing SCRA use in prisons.<sup>25</sup>

Anecdotally, users often try to withdraw by reducing SCRA use and self medicate by switching back to cannabis. However the effects of even potent 'skunk' often seem weak compared to SCRAs, so it may be several weeks after ceasing SCRA use before potent cannabis is an effective substitute.<sup>9</sup>



## Harm reduction

Spice is a highly addictive, highly toxic drug that can and has killed people. The following advice is designed to reduce some of the risks for those already using Spice, **but there is no safe way to use Spice**. Spice users should be advised to seek help.

### There is no safe way to use Spice

It is not the same as cannabis. Spice is more potent, more unpredictable and more dangerous.

### It is illegal to possess (most) Spice

Most synthetic cannabinoids, the chemicals in Spice, are illegal to possess, are now covered by the Misuse of Drugs Act as Class B drugs.

### Spice varies from batch to batch

Different packets can produce different effects.

### Sit down before you use

In case you fall over.

### Start with a very small dose

Use a match-head size (or less) test dose with every new packet. Potency is hugely variable.

### Wait before the effects have worn off before smoking more

### Spice should not be smoked neat

Always smoke with a 'mixer' (e.g. tobacco or dried herbs).

### Use thin cigarette papers

If smoking in a joint use thinnest papers and avoid using printed card for a roach to avoid inhaling additional fumes.

### Avoid using Spice with other drugs

Avoid using with cannabis, alcohol or stimulants, this may raise the risk of heart problems.

### Avoid mixing Spice with medicines and alcohol.

### Be cautious with pipes

Be cautious about dosing in pipes or vaporisers: it is harder to regulate intake and easy to take too much. If smoking in a pipe, use small glass or steel pipes which give off less fumes than wood or plastic pipes.

### Be VERY cautious about using in bongs

It is harder to regulate intake and easy to take too much. Water pipes also causes you to inhale more deeply which can cause more lung damage.

### Don't get competitive

There is a high risk of overdosing if you get into bouts of competitive use (e.g. in bucket bongs etc.).

### Beware the bottom of the bag

Be careful with dosing the crystalline powder material in the bottom of the bag; use a smaller dose, as this is generally stronger than the plant material which is coated with the SCRA.

### Careful with powder

If sourcing pure powder SCRA's only use very small doses, calculated using scales and thoroughly mixed into smoking material.

### Spice is very addictive

Regular use of Spice can lead to dependence (addiction) and withdrawal.

### Spice is dangerous

Spice can cause severe harms. If you experience a sustained period of fast heart rate or chest pains, call an ambulance.

### Spice can make you anxious

Spice may exacerbate anxiety and paranoia. Only use in an environment in which you feel safe, with people you trust.

### Spice can make mental health problems worse

If you suffer from anxiety or mental health problems, avoid using Spice.

### Do not drive or operate machinery under the influence of Spice.

**Harm reduction advice for SCRA users should take into account underlying issues that groups such as prisoners or rough sleepers face.<sup>9</sup>**

This harm reduction advice is based on<sup>10,24,27</sup>.

## Help available in Manchester

There are various treatments for Spice users including medically assisted withdrawal.

For over 18s

**CGL**

43A Carnarvon Street  
Manchester M3 1EZ

**Telephone 0161 214 0770.**

For young people (under 18)

**Eclipse CGL**

41 Thomas Street,  
Manchester, M4 1NA

**Telephone 0161 839 2054.**

Spice: Synthetic Cannabinoids (SCRAs)

**No 1 of an occasional series of briefings on New Psychoactive Substances for professionals in Manchester**

Produced for: The Public Health Team, MHCC (Manchester Health & Care Commissioning). Text, illustration and design Michael Linnell. Thanks to Mark Adley, UK & Ireland DrugWatch and all those who commented on draft versions.

Version 1.3 July 2017. Briefing will be updated as knowledge and information changes.

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## Novel Psychoactive Substances (NPS) – what you need to know

### *A guide for professionals and workers in the city of Newcastle-upon-Tyne*

#### **Key messages**

- **NPS are not safe and are associated with a range of harms**
- **Help and treatment is available for NPS use, including withdrawal management**
- **The effects of using NPS increases people’s vulnerability to social harms such as crime; exploitation and violence**
- **Synthetic cannabinoids are now a Class B drug (Misuse of Drugs Act 1971)**
- **NPS use or possession should be treated like any other illicit or controlled substance, and may lead to prosecution**
- **If someone becomes unwell you should always phone an ambulance or take them to A&E to get assessed as they may require lifesaving treatment**

#### **What are Novel Psychoactive Substances (NPS)?**

NPS are usually referred to as ‘legal highs’ or ‘legals’, but are also commonly called ‘lethal highs’, ‘smeg’, or ‘spice’. They are a group of synthetic compounds that have been designed to mimic the effects of controlled drugs because, prior to the introduction of the Psychoactive Substances Act in May 2016, they were not subject to legal regulation. **NPS are not safe and there are some serious known risks as well as unknown risks.**

NPS products can mimic a range of controlled substances, including stimulants, sedatives, hallucinogens and synthetic cannabinoids. There are hundreds of NPS products available that are marketed with brand names that use humour or familiarity to encourage risk taking behaviour and/or irresponsibly promote medicinal benefits such as *Pandora’s Box* and *Sweet Leaf*. **The product name gives no indication of the content of the substance** which is likely to be different at each use. The products are usually more potent than the drugs they are mimicking, so users may experience adverse effects with lengthened duration if they are using similar quantities as they would other substances.

#### **Why do I need to know about NPS?**

Supply of NPS has significantly increased over the past few years within the UK and Europe, and specifically within Newcastle since 2015. You may already be aware of this trend directly through your work, or from the media because of the number of serious NPS-related incidents and the demand that this has placed on emergency services.

**NPS are associated with serious physical and mental reactions** and have been linked to deaths across Europe. Common reactions include rapid unconsciousness; slowed



movement; an inability to speak; aggression/ violence; seizures/ fitting; breathlessness; kidney damage; hallucinations, psychosis; depression; and paranoia.

Some NPS appear to be addictive and cause many users to experience extreme withdrawals. No one knows the long-term effects of NPS use but there are concerns that they may have physical and mental health implications.

Within Newcastle, NPS users are not currently accessing treatment services despite the majority of users reporting that they want to stop using them. **We need your help to raise awareness of the support available to ensure that people can access the appropriate treatment** and to collectively reduce NPS-related harms in our communities.

### ***So are they legal or not?***

The Psychoactive Substances Act (PSA) was implemented by the government in May 2016. This makes it an offence to '*Produce, supply or offer to supply, import, possess with intent to supply any psychoactive substance (so called 'legal highs')*'. This means **it is illegal to have any involvement in the production or supply of NPS** and those involved will be prosecuted.

It is important to be aware that people will not know what is in the NPS product that they have purchased until the products are tested by specialist toxicologists (for the police or in hospital). **The product names are meaningless and home-testing kits are not accurate.**

It is important to know that in December 2016, **synthetic cannabinoids** came under the controls of the Misuse of Drugs Act 1971 as a **Class B drug**.

### ***Who uses NPS?***

Just like with other substances, people use NPS for different reasons and there is still limited knowledge about who is using NPS and how it may impact people differently. For example, those with established connections to drug markets are more likely to have experienced targeted street selling, whereas young people are more likely to have been influenced by the preceding legal status of the substances.

The best available evidence we have suggests that people most likely to use NPS are:

- High-risk drug users
- Vulnerable young people
- People who use drugs recreationally

NPS are also associated with poly drug use (using NPS in combination with alcohol and other controlled substances). **Mixing substances increases users' risk to serious harms** to their health and further increases their vulnerability within the community.



### **How do we know which NPS are in Newcastle?**

Between May and July 2016 Newcastle City Council (NCC) Public Health and Newcastle University Wolfson Unit of Clinical Pharmacology tested a range of NPS products circulating in Newcastle that had been seized by Northumbria Police. This research found that:

- All samples with psychoactive properties contained **synthetic cannabinoids** as the active ingredient. Synthetic cannabinoids are linked to serious health outcomes and associated with an increased risk of A&E admission compared to natural cannabis.
- Over half of the samples contained no active psychoactive ingredients and contained only plant/ herbal materials. Products being sold with no active ingredient may exploit users and could influence increased poly drug use.
- The most common active ingredients in the 'psychoactive' products tested were two compounds that have been linked to serious adverse effects including deaths across Europe and in USA.
- NPS products available in Newcastle had significant variation in their content. This indicates poor quality manufacturing and means that there can be no assurance made about what is in each packet of NPS product.
- The product name is meaningless to indicate content and no product name should be discouraged or promoted over others.

### **What is my responsibility?**

**Ask questions when talking to patients or clients during your standard assessments or contact time, just as you would to identify any other drug or alcohol misuse.** Be aware that people who present with physical symptoms such as difficulty breathing, disorientation or distress may be under the influence of NPS and may need urgent medical care. Extreme weight loss, aggression, paranoia and persistent low back pain may also indicate prolonged NPS use and/or addiction, which we know can be hard to self-manage.

As there are many different products it may seem overwhelming to talk to service users about NPS, but the product name is not important. **Specialist treatment services provide interventions that focus on the drug effect not the substance name.** It may be helpful to know the four broad categories of drug effects: **Stimulants** (e.g. MDMA); **Sedatives/ dissociatives** (e.g. Nitrous Oxide); **Hallucinogens** (e.g. LSD) and **Synthetic cannabinoids**.

If you work with people from groups at increased risk of NPS use or in settings where exposures to NPS are more likely it is important that you feel confident to:

- Provide basic advice to people using NPS (see Key Messages)
- Signpost or refer people to appropriate services or support, depending on your role
- Respond appropriately to people who become unwell under the influence of NPS
- Consider your safeguarding obligations using Newcastle Safeguarding Children Board (NSCB) and Newcastle Safeguarding Adult Board (NSCB) policies and procedures

- Report any information about NPS supply to your manager or neighbourhood police team, as you would with any other illicit substance

If you work or manage a service, such as supported accommodation or a children's residential unit, you should treat the use, identification and supply of NPS as any other controlled or illicit substance. Newcastle's Drug Management Protocol (and Residential Unit DMP) clarifies your responsibilities with this, as well as the response of Northumbria Police.

Use this briefing for basic advice and signposting/ referral contacts. For more detailed information, you can phone one of the drug treatment services or access the resources recommended below, which include contacts for local training information.

### Local support for people affected by NPS use

#### Over 18?

**CGL (formerly Lifeline) harm reduction service** 0191 261 4719  
**CGL Integrated Service**  
 0191 261 5610

#### Under 18?

**DnA Young People's Service**  
 0191 277 7377  
**Online peer support for young people**  
[www.legalfails.com](http://www.legalfails.com)

CGL work with NTW Addictions (Plummer Court) to ensure appropriate assessment, treatment and case management.

**Carers and families support?** Newcastle PROPS 0191 226 3440

**Northumbria Police** Emergency 999 or Non-emergency 101

[www.northumbria.police.uk](http://www.northumbria.police.uk)

### Further information for professionals

- **Public Health England Project Neptune** - clinical guidance on the management of club drugs and NPS  
[www.neptune-clinical-guidance.co.uk](http://www.neptune-clinical-guidance.co.uk)
- **Mentor ADEPIS** - free resources for schools on drug and alcohol education  
[www.mentor-adepis.org](http://www.mentor-adepis.org)
- **Royal College of Psychiatrists One new drug a week** – report on providing services for NPS and club drug users  
[www.rcpsych.ac.uk/pdf/FR%20AP%2002\\_Sept2014.pdf](http://www.rcpsych.ac.uk/pdf/FR%20AP%2002_Sept2014.pdf)

**Online hub for frontline healthcare professionals**  
[www.hiwecanhelp.com](http://www.hiwecanhelp.com)

#### Local Training

A range of alcohol and drug training courses are available for practitioners in different roles. To find a course right for you, please contact NCC Public Health:

Alcohol – Sarah Hulse  
[sarah.hulse@newcastle.gov.uk](mailto:sarah.hulse@newcastle.gov.uk)  
 Drugs – Andy Hackett  
[Andy.hackett@newcastle.gov.uk](mailto:Andy.hackett@newcastle.gov.uk)

**National resources**  
[www.talktofrank.com](http://www.talktofrank.com)

In support of the **newcastleIBAstrategy**  
 - Identification and brief advice around risky drug and alcohol use

**Newcastle**  
 City Council 





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