Health and Social Care Committee

Meeting Venue:
Committee Room 3 – Senedd

Meeting date:
6 November 2014

Meeting time:
09.00

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

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Agenda – Supplementary Documents

Inquiry into new psychoactive substances ("legal highs"): Consultation Responses

Please note the documents below are in addition to those published in the main Agenda and Reports pack for this Meeting

Inquiry into new psychoactive substances ("legal highs"): Consultation responses
(Pages 1 – 211)

Consultation Responses

New psychoactive substances (“legal highs”)

- LH 01 South Wales Police
- LH 01 South Wales Police - Annex A.docx.msg
- LH 02 National Offender Management Service
- LH 03 The British Psychological Society
- LH 04 Turning Point
- LH 05 The Police Federation of England and Wales.
- LH 06 Trading Standards Wales
- LH 07 Drugstraining.com
- LH 08 WLGA
- LH 09 UKChemicalresearch
- LH 10 Royal College of Psychiatrists in Wales
- LH 11 Angelus Foundation
- LH 12 North Wales Police
- LH 13 DrugScope
- LH 14 Abertawe Bro Morgannwg University Health Board
- LH 15 Aneurin Bevan University Health Board
- LH 16 Betsi Cadwaladr University Health Board
- LH 17 Public Health Wales
- LH 18 HM Inspectorate of Prisons

National Assembly for Wales

Health and Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Evidence from South Wales Police – LH 01

Our Strategic Drugs Group began as a New Psychoactive Substances Steering Group in 2012 in response to the complex emerging issues we were experiencing in many areas of our force, particularly Swansea, Barry and RCT/Merthyr. This group has now evolved to incorporate all elements of drug misuse although the membership has remained constant and the NPS market is a priority area of business for the group. Representation on the group is made up of South Wales Police officers from drug prevention/offender management, drugs enforcement and force intelligence including TARIAN and its experience of Organised Crime Groups together with an All Wales Schools Liaison Programme Co-ordinator. The group also includes 'external' partners such as Rhian Hills from the WG, Dr Fiona Brookman, Professor of Criminology, University of South Wales, WEDINOS and local treatment providers.

One of the initial aims of the group was to raise awareness amongst our police colleagues (neighbourhood and response officers, custody staff including arrest referral workers and Health staff) and young people, parents and teachers of the risks associated with this emerging drugs market. We have delivered 8 training sessions to SWP staff and partners from the fire and ambulance services, Local Authorities and prisons using Liam Watson, Drugs Education Training which were extremely well received. The group also acts as a conduit for information on drug policy up-dates and intelligence between the ACPO Drugs directorate, Home Office and the ECMD out to local policing teams, Local Authorities and key partners.

The All Wales Schools Programme has now developed a number of information packs on new and emerging drugs for pupils, teachers and parents. These can be accessed on the SchoolBeat.org website. The Programme will also share information they receive with the group and the officers working on the Programme – example attached.

Our Drug Interventions Programme staff, including arrest referral teams working in police custody suites, have all now received training in this field to enable them to broaden their remit beyond Class A drugs and alcohol. They deliver brief interventions in custody for those where NPS use has been a factor in their offending and for those requiring further support, will refer them on either into their criminal justice treatment service (DIP) or to local Health and community treatment provision.

When carrying out their assessments in police custody suites, the arrest referral workers complete a questionnaire designed by our force intelligence analyst team which has enabled us to scope the impact NPS use has on offending behaviour and how local drug trends and markets are changing. The force crime analysts undertake twice-yearly debriefings with DIP arrest referral workers and case-workers to feed their community-based knowledge and understanding from working with NPS users into the Intelligence Directorate Analysis NPS Survey and Quarterly Drugs Market Report.

I trust this brief overview demonstrates the commitment South Wales Police, with its partners, is making to co-ordinating an approach to help understand and address the complex issues around NPS use. We are grateful for the support Rhian Hills has given the group from its inception bringing local and national harm reduction initiatives to our attention and the recent report produced by Dr Fiona Brookman has certainly added to our understanding of this market. This is attached for your information.

National Assembly for Wales
Health and Social Care Committee
Inquiry into new psychoactive substances ("legal highs")
Evidence from South Wales Police - LH 01 Annex A

University of South Wales

The Links between Mephedrone Use, Violence and other Harms in South Wales

Fiona Brookman

Centre for Criminology
University of South Wales

April 2014

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Acknowledgements

My sincere gratitude to all of the people across South Wales[1] who gave up their time to speak to me in person, at length and with candour, about their experiences of using mephedrone. This research would not have been possible without your co-operation and openness. I learned a great deal from you all and wish you the very best for the future. Equally I am very grateful to the many drug agency and outreach practitioners, health and criminal justice practitioners who also gave up time in their busy schedules to provide me with their invaluable insights about the impacts of mephedrone on the lives of those with whom they work. Thanks also to all of the clients who completed questionnaires, the practitioners who helped to make this possible and everyone at the various agencies who forwarded information and data. Thanks also to Jason Edwards, Research Assistant at the Centre for Criminology, who provided assistance with quantitative data analysis and a review of literature. Finally, special thanks to Dr. Rhian Hills of Welsh Government whose idea it was for research of this kind to be undertaken. Rhian kindly shared her many contacts with me, enabling my access to agencies, practitioners and mephedrone users and also provided important information about Welsh Government's ongoing work and projects in relation to new psychoactive substances. Thank you for your invaluable assistance Rhian.

For the purposes of confidentiality the names of all those who kindly took part in the research are omitted.

Professor Fiona Brookman

Centre for Criminology, University of South Wales

April 2014.

[1] The research covered the southern part of Wales from Llanelli and Swansea in the South West to Newport in the South East and Brynmawr and Ebbw Vale in the Northern part of southern Wales. It covered two police force areas (South Wales Police and Gwent Police).

Executive Summary

Introduction

This research, funded by Welsh Government and South Wales Police, was commissioned in response to growing concerns by police, other criminal justice professionals and a range of practitioners who work with drug users, about the negative impacts of mephedrone use upon users, their families and communities. In particular, mounting evidence of a rise in the use of this drug in Wales and evidence of its serious health harms and links to violence led South Wales Police, in 2012, to establish a *Mephedrone Steering Group*. Despite rising concerns and anecdotal evidence, it became evident that there was no independent empirical evidence of the harms associated with mepedrone use in Wales or any detailed evidence of its specific links to violence.

Broadly, the research detailed in this report was undertaken in order to provide the first detailed assessment of the possible links between mephedrone use, violence and other harms in South Wales. The research combines data from a survey of 67 users across South Wales with in-depth semi-structured interviews with 12 mephedrone users and 20 'expert' practitioners who work with users in order to further unravel the various impacts of mephedrone and, specifically, its links to violence.

More specifically, the aims of the *qualitative in-depth interviews* with mephedrone users and expert practitioners were:

- To gather detailed user and practitioner insights into the contributory role of mephedrone in acquisitive and violent crime;
- To document and unravel the impacts of mephedrone on the general health and wellbeing of users;
- To make recommendations to Welsh Government about possible responses based on the research findings.

The aims of the *quantitative questionnaire survey* of 67 mephedrone users were:

- To gain a broader overview of patterns of use, impacts and cessation strategies from a range of users across South Wales.

Key findings

The key findings from the survey of mephedrone users indicate that almost three-quarters of the sample of 67 mephedrone users reported regular use of mephedrone

– that is - using the drug daily (46%), every other day (15%) or weekly (19%). Users generally snorted, injected or orally ingested the drug though young people aged 17 or younger did not report any instances of intravenous use. Mephedrone was generally purchased from street dealers or friends and there was little evidence of internet-based purchases amongst this sample. Over 80% of the sample combined mephedrone with other drugs, notably, alcohol, cannabis and heroin and over half of the sample also reported ingesting a range of drugs to try to alleviate the debilitating withdrawal impacts of mephedrone (most notably, diazepam, cannabis and heroin).

Just over forty percent of the sample reported acting violently whilst under the influence of mephedrone. This included half of the eighteen females who took part in the survey. Interestingly, the 'violent sub-set' reported combining amphetamine with mephedrone as often as alcohol (in contrast to the sample as a whole) and it is perhaps these combinations that are partly important in understanding why some users become violent when under the influence. Finally, the evidence presented here indicates that regular use of mephedrone (especially daily, but also weekly) is most associated with violence. These findings suggest that there may be two distinct types of user involved in violence: (i) the heavy end (daily) user and (ii) the regular weekend recreational user.

Key findings from in-depth interviews with mephedrone users revealed that they first decided to consume mephedrone in the context of a night out (or sometimes a night in) having fun with their peers where they were invited, or actively encouraged, to try it by a friend. Most users had a highly pleasurable experience prompting further use. The 'buzz' was described as more intense than other drugs inducing euphoria, chattiness and confidence. Mephedrone also helped some users to forget life's problems.

However, these pleasurable feelings were short lived and users had to deal with debilitating withdrawal impacts including stomach cramps, lock jaw, depression, paranoia, auditory and visual hallucinations and in some cases, psychosis, suicidal thoughts and suicide attempts. The desire to offset the effect of comedown and to return to the highly pleasurable effects of mephedrone invariably led to 'fiending' and increased frequency and volume of use. This in turn led to soaring costs and a host of further physical, emotional and social difficulties.

Over half of those interviewed had become involved in acquisitive crime (including shoplifting, burglary, vehicle theft and street robbery) and three-quarters of those interviewed had committed acts of violence connected in some way to their use of mephedrone. Four somewhat distinct violence-mephedrone links were discerned: (i) violence when 'high'; (ii) violence associated with comedown; (iii) economic compulsion and violence and (iv) violence associated with purchasing and dealing mephedrone. Importantly, regarding the first two categories, interviewees were

very clear in their own minds that mephedrone had a direct and significant influence on them becoming involved in acts of violence. This, they reasoned, must be the case as they were either not usually violent or, would not normally have been violent in relation to such trivial triggers.

Mephedrone also had a range of negative impacts upon the overall health and social well-being of users. Most users suffered significant physical and emotional side-effects and many were unable to pay bills or care for themselves or significant others properly. Many of those who became regular users lost jobs, had children removed from their care and lost contact with family and friends.

Users consistently reported finding it extremely difficult to give up mephedrone due to its highly addictive nature. Nevertheless, some had succeeded and all of those interviewed, as well as those who took part in the survey, had important insights regarding helping users to abstain permanently or never begin using including: (i) better education about the drug and its harms; (ii) support and counselling; and (iii) bringing ex-users together with users to provide 'real' experience-based advice. Users cited both the negative health impacts (physical and emotional) and negative family impacts as the main triggers to giving up mephedrone. A smaller number of users mentioned the financial implications of continued use as a barrier to continuation as well as increased tolerance levels or boredom with the drug. There were various ways in which users managed to give up mephedrone. Many spoke about avoiding 'drug' friends and some users went as far as to move from one area to another in order to break former ties with drug-taking friends and acquaintances. Some users talked about the importance of having the support of their family or a partner to help them to continue to abstain. Other users indicated that giving up mephedrone was not particularly difficult and that they simply applied will power to achieve this goal. These users tended to be at the light-use end of the scale of users and were likely less addicted to mephedrone. A small group of users felt that custodial sentences had assisted them in ceasing to consume mephedrone as their daily routines changed and they were separated from their drug-using peers. Two users replaced mephedrone with other drugs in order to specifically avoid the harms that they associated with mephedrone. Finally, a significant number of the sample had received support from drug agencies or other organisations that had aided the process of cessation.

Key findings from interviews with expert practitioners who work with users in many regards mirrored and confirmed the findings from the users. Once again the highly addictive nature of mephedrone was highlighted alongside its debilitating impacts upon the health and wellbeing of users. Many practitioners had been on the receiving-end of aggressive and violent behaviour by mephedrone-using clients, most of whom had not exhibited such tendencies in the past. Many had been verbally threatened and several had been physically assaulted. Practitioners also

reported a range of acquisitive crimes committed by their clients specifically linked to their abuse of mephedrone and the necessity to fund their increased use of this highly addictive drug. Finally, practitioners spoke (more often than users) about the links between mephedrone use and self-harm or suicide. One practitioner recalled meeting with clients every day who expressed suicidal thoughts. Overall, practitioners indicated that the behaviours that they had to manage were distinct and beyond the normal challenges that confronted them in working with clients addicted to other illicit (or licit) substances.

Conclusions

In conclusion, the research has indicated that mephedrone is a highly addictive substance and that many of those who use the drug experience intense cravings that lead to 'fiending', soaring costs, and a host of additional physical, emotional and social impacts. Users often combine other drugs with mephedrone but also ingest licit and illicit substances to try to reduce the impact of the debilitating withdrawal symptoms.

Many of the harms associated with mephedrone use are difficult to overcome and the impacts are cumulative. For example, loss of contact with family and friends, having children removed from ones care and the inability to retain employment mean that users' lives can rapidly decline and the uphill struggle to regain a 'normal' life is steep requiring significant support from a range of services. In addition, there is currently no information on the long term harms of short-term or prolonged use of mephedrone. In short, the most effective way to try to tackle the known harms associated with this drug is to try to prevent use in the first instance but, where this fails, to provide a quick and effective network of services to support abstinence.

Recommendations

- **Education:** whilst there is a growing drug education literature emerging across Wales, much of the advisory and preventative materials that consider mephedrone tend to deal with it as part of a more general approach to tackling new psychoactive substances. Mephedrone appears to have distinctly debilitating impacts and so it would seem important to deal with this drug in isolation when educating people about its effects and harms. Education could come in various forms but ought to emphasise the physical, emotional and social impacts as well as the potential (as yet unknown) long-term damage of using mephedrone. Materials would need to be tailored to various audiences including potential users but also parents, teachers, practitioners, youth workers, health workers, staff at late night venues and so

forth, all of whom may have knowledge of those using (or vulnerable to using) the drug. In addition, a diverse range of institutions could be targeted in different ways including schools, youth centres, colleges, universities, drug agencies, health centres and hospitals. Social media as well as face-to-face presentations could be combined with information packs and signposting to relevant agencies for advice and support.

- **Education**: Drawing upon the knowledge and experiences of ex-mephedrone users would be beneficial. Much like the Operation Trident anti gun and gang initiative in the Metropolitan Police Force that utilised ex-gang members to speak out about the harms, the 'real' voice of the ex-user will likely be more impactful than relying solely upon agency experts to deliver key preventative and harm reduction messages. Using carefully developed DVDs and education packs, ex-users could accompany practitioners on educational campaigns in schools, colleges and universities, for example. Given the growing focus amongst young people upon physical appearance, one aspect of this campaign could perhaps focus upon the negative impacts of the drug upon appearance including its distinctively off-putting odour.
- **Treatment:** Given the broad range of impacts that sustained use of mephedrone can have on the lives of users and their families, any 'treatment' would necessarily have to take this complexity into account. Networks of Support could be developed to ensure that users could access the relevant range of services to deal with the physical, emotional and social harms of mephedrone use.
- **Police Recording Measures**: better recording of all mephedrone-related 'incidents' and crimes, with a particular emphasis upon more carefully identifying the kinds of acquisitive and violent crimes that users commit at national and local levels.
- **Data Synthesis**: careful and regular synethsis of relevant data from police, probation, prison, health, social services, education and so forth in order to more accurately capture a national picture of the multiple physical, emotional and social harms associated with mephedrone use.
- **Further Research**: Given that the current research only accessed local users (i.e. people resident in South Wales), further qualitative research specifically focusing upon college and university students in Wales may be useful. It is possible that their experiences or patterns of usage may differ.
- **Future Research**: Future qualitative research could also try to untangle the multi-dimensional and complex associations between drug combinations and violence and further explore the four mephedrone-violence categories identified here. Also it is still somewhat unclear when, precisely, violence is most likely (i.e. during the up, just as the buzz wears off, during comedown, or all of these).

Part One: Research Context and Aims

In 2012 South Wales Police (SWP) established a *Mephedrone Steering Group* in response to anecdotal evidence of a rise in the use of this drug in Wales and evidence of its serious health harms as well as links to crimes of violence (including rape and robbery). Around the same time, the Welsh Government's *Advisory Panel on Substance Misuse* (APoSM) established a Psychoactive Substances Sub Group, which consisted of a range of stakeholders, to advise how to respond to the broader issue of the harms associated with new psychoactive substances (NPS). The Sub Group recommended a number of preventative and harm reduction approaches, many of which have come to fruition including: (i) working closely with partners to develop a range of education and prevention materials[2]; (ii) developing a 'warning system' so that any alerts received from across the UK are distributed to relevant clinical services via the Chief Medical Officer; (iii) the roll out and completion (across Wales) of a national training programme on new psychoactive substances for professionals who work with individuals who may be misusing NPS. Finally, the Welsh Emerging Drugs and Identification of Novel Substances, known as *WEDINOS* project, was launched in October 2013 in response to an increase in presentations at emergency departments reporting unexpected/ill effects by users of NPS, new combinations of 'established' substances, new combinations of licit and illicit drugs and new combinations of performance/image enhancing substances. WEDINOS aims to:

- Establish a network of robust data sources and data collection systems to assess prevalence, associated harms (physical, psychological and behavioural) and impact on services designed to address these harms.
- Collect and test New Psychoactive Substances (NPS) in order to further measure the potential harms of substances entering the market.
- Disseminate timely and accurate information to both general and targeted populations at specific risk, including information about the chemical makeup of specific NPS, the potential physical, psychological and behavioural harms that may result as a consequence of use, and pragmatic public health harm reduction and advice.

Clearly, Welsh Government, Police and partner agencies, have invested considerable energy and resources into trying to pre-empt and reduce the harms associated with NPS. However, knowledge of the impacts of mephedrone specifically, is currently

[2] For example, between February and March 2013, the Welsh Government in conjunction with the national drug and alcohol helpline (DAN 24/7) and Real Radio launched an education and prevention campaign surrounding NPS. The campaign, "*Know the Score*" consisted of a Ministerial launch, radio advertisements and announcements on Real Radio Wales, press advertisements, social media and billboard displays at the Six Nations Rugby tournament.

anecdotal in the main. Evidence to date (e.g. from drug service providers, health services, police data and intelligence) is that there are two broadly distinct groups using this relatively new drug: (i) long-term (bedrock) heroin users who are using mephedrone as a substitute for, or in combination with, heroin, (ii) young people (including school children) who are using the drug for recreational purposes. Moreover, anecdotal evidence from drug workers, police and other agencies suggest that mephedrone has particularly debilitating physical, emotional and social impacts, including a propensity for violence by users. In addition, there are reports of violence associated with the supply and distribution of this drug.

It is against this backdrop that the current project was commissioned by Welsh Government and South Wales Police. The research was undertaken in order to provide the first detailed (mainly qualitative) assessment of the possible links between mephedrone use and violence and other harms in South Wales. Violence is defined broadly to include violence to others (e.g. domestic violence, assault, robbery) and to oneself (e.g. self-harm and suicide). The research provides detailed user and practitioner insights and it is hoped that the findings will assist Welsh Government (WG) and South Wales Police in designing awareness campaigns and preventative programmes of work to try to reduce the harms associated with mephedrone use in the South Wales context.

Aims

The primary aim of this empirical study was to better understand the possible links between mephedrone use and violence in South Wales through the analysis of quantitative and qualitative date drawn from mephedrone users and expert practitioners who work with users. To these ends the following aims were identified:

- To gather some detailed insights into the contributory role of mephedrone in acquisitive and violent crime
- To document and unravel the impacts of mephedrone on the general health and wellbeing of users.
- To make recommendations to Welsh Government about possible responses based on the findings.

Research Questions

Using a combination of quantitative and qualitative methods (outlined below) the research aims to determine the following:

- Whether there is a link between mephedrone use and interpersonal violence
- Whether there is a link between mephedrone use and self-harm
- Whether there is a link between mephedrone distribution and violent crime
- Where mephedrone fits in terms of other drugs-crime connections (e.g. is mephedrone alone associated with violent crime or in combination with other drugs, including alcohol?)

- The nature and direction of any links identified
- The physical, emotional and social impacts of mephedrone upon users.

Part Two: A Review of Existing Literature

Introduction

This part of the report provides a review of key background literature in order to place the 'problem' of mephedrone use in Wales in context. The broader context is two-fold. Firstly it is necessary to consider the emergence of new psychoactive substances (NPS) and the identification of the problems associated with them in the British and Welsh context. This will then be followed by a more detailed consideration of mephedrone (one particular kind of NPS) in the UK and Welsh context.

The Emergence of New Psychoactive Substances (NPS)

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2011:1) define new psychoactive substances as:

> *"A new narcotic or psychotropic drug, in pure form or in preparation, that is not controlled by the 1961 United Nations Single Convention on Narcotic Drugs or the 1971 United Nations Convention on Psychotropic Substances, but which may pose a public health threat comparable to that posed by substances listed in these conventions."*

New psychoactive substances are synthetic substances that mimic the effects of illicit drugs such as heroin, cocaine, and cannabis (UNODC, 2013). These substances can also be known under market names such as 'herbal highs', 'legal highs', 'designer drugs', and 'bath salts' and often fall outside of international drug control conventions (UNODC, 2013). Many new psychoactive substances were first synthesized in the 1970's, however it is only in recent years has their chemistry or synthesis changed to mimic the effects of illicit drugs. The earliest reported form of new psychoactive substance was ketamine in America at the start of the 1980's (EMCDDA, 2002). During the 1990s and to the start of the 2000's, new psychoactive substances from the chemical family of phenethylamines and piperazines were on the increase around the world (Bassindale, 2004). Since 2004, synthetic cannaboids such as Spice were introduced to the new psychoactive drugs market followed by synthetic cathinones such as mephedrone.

The extent of the global prevalence of new psychoactive substances is unknown (UNODC, 2013), however, the European Commission (2011) has started to gain information on mephedrone from a regional level. The European Commission (2011) interviewed 12,000 randomly sampled young people from EU member states and it

was found that 5% of the whole young person sample had used new psychoactive substances. In relation to the United Kingdom, it was found that 8% of the young people had used new psychoactive substances. The United Kingdom had a higher representation of new psychoactive substances compared to other EU states such as Italy (0.8%), Finland (1%) and Greece (1.6%).

Within the United Kingdom treatment data relating to the use of new psychoactive substances is relatively new, with ketamine and mephedrone only being included for the first time on the 2012 report for the National Treatment Agency for Substance Misuse (NTASM, 2012). The report found that treatment cases for ketamine had continuously risen since 2005 from 114 to 845 in 2012. The NTASM (2012) report also stated that in 2012, 900 over 18s had started mephedrone related treatment. High numbers of mephedrone based treatment indicate a potential future strain upon the public health service. The report stated that individuals who sought treatment for new psychoactive substances were relatively young, with 56% of all adults (those aged 18+) in treatment aged 18-24.

The Advisory Council on the Misuse of Drugs (ACMD, 2011) stated that the new psychoactive drug market has introduced society to a new type of drug dealer based upon entrepreneurship. Due to the difficulties surrounding the legality of new psychoactive substances, there has been an increase in dealers who do not have a background in dealing illicit drugs. Individuals without a history of using or dealing are being attracted towards new psychoactive substances under the premise it is legal. It has been reported that students have created websites to supply legal highs nationally and through local markets (ACMD, 2011).

Mephedrone Defined

Mephedrone (also commonly known as meph, m-cat, miaow miaow[3]) is currently the most popular drug that is derived from cathinone - a stimulant alkaloid that is found in the plant *catha edulis*. Its leaves are chewed in several African nations (Gibbons and Zloh, 2010). Mephedrone is available in several forms including powder, pills and capsules, and is also water soluble allowing users to inject the drug. The drug can also be snorted, swallowed and bombed (wrapped in paper and swallowed) however due to its instability it cannot be smoked (Nutt, 2012). Mephedrone has a uniquely unpleasant odour that has variously been described as resembling stale urine, vanilla and bleach, and electric circuit boards (Psychonaught Web Mapping Research Group, 2010). The chemical makeup of mephedrone is closely related to amphetamine and is difficult to detect on standard drugs tests. Users state the effects of mephedrone are similar to other drugs such as amphetamine, ecstasy, and

[3] Other known names include: miaew, 4mmc, bubbles, sniff, drone, bath salts, white magic, plant food and plant feeder.

cocaine and induce feelings of euphoria and wellbeing as well as making the user alert, confident and talkative (Drugscope, 2013).

The Origins of Mephedrone

Mephedrone was apparently first synthesised in 1929 yet not used until the early 2000's. The initial purpose of the drug was to protect plants from the debilitating effects of green flies (Nutt, 2012). Mephedrone was used in horticulture for just a few years before 'third party' companies began to investigate its psychoactive effects. Research suggests that it was initially sold as mephedrone in Israel in the early 2000's as a party drug and then distributed and used in the western world (Nutt, 2012).

Legislation and Mephedrone

As the use of mephedrone apparently proliferated, legislation was developed in an effort to restrict and punish its use. It became classified, in the UK, as a class B illegal substance under the Drugs and Misuse Act in April 2010 (Winstock *et al.*, 2010). The classification of mephedrone was and is still controversial as it arguably lacked credible scientific underpinning and was instead a response to media and political pressures. Several governmental advisors who had sat on the Advisory Council on the Misuse of Drugs (ACMD) stood down from their roles in part because of the lack of evidence base in such decision making (BBC News, 2010, available at: http://news.bbc.co.uk/1/hi/uk/8601315.stm).

Some commentators have suggested that prior to the aforementioned legislation, the legal status of mephedrone resulted in users perceiving the drug as relatively harmless (Winstock et al., 2011). The widespread accessibility and competitive price of mephedrone online arguably added to this perception (Daly, 2010; Deluca et al,. 2009; Hand & Rishiraj, 2009; Measham et al ., 2010; Newcombe, 2009; Psychonaught Web Mapping Research Group; Ramsey et al., 2010; Van Hout & Brennan, 2011).

In contrast, McElrath and O'Neill (2010) have suggested that there is no direct effect between the legal or illegal status of the drug and users perception of safety. Nevertheless, there is some evidence that the purchase cost of mephedrone increased post legislation. For example, McElrath and O'Neill (2010) report that in Northern and Southern Ireland the price of mephedrone increased from £5 per gram when the drug was legal to around £15 per gram when mephedrone became illegal.

Supply of Mephedrone

Mephedrone can be bought via the internet or through street dealers. It was also widely available from 'head shops' on the high street prior to it being classified as an

illicit drug. Generally, the amount available to purchase online varies from 1g to 200g. The internet also allows mephedrone to be bought in bulk from Asian-based chemical laboratories. Europol (2010) found that in 2009 there were at least 31 websites that were selling mephedrone, with the majority based in the UK. More recent research carried out by Flemem (2012) identified that there had been a huge growth in on-line internet drug sales. 'Silk Road', an underground website (sometimes referred to as the 'Amazon.com' for illegal drugs) provided buyers with anonymity when browsing and making online drug purchases, provided users downloaded particular protective software. The site was shut down by the FBI in 2013 but now apparently operates again as 'Silk Road 2.0' (http://news.yahoo.com/fbi-raids-alleged-online-drug-market-silk-road-153729457.html).

McElrath and O'Neill (2010) found that very few people in their study purchased mephedrone from online suppliers and favoured street dealers. Mephedrone users also stated that they avoided head shops because of the stigma attached to the outlets. Furthermore, mephedrone users felt that transactions with dealers were socially safer and carried less risk of them obtaining the social status "drug user." Europol (2011) reported that the most common method of sourcing mephedrone in urban areas is from friends and dealers, even though it is easily accessible via the internet.

Prevalence

Mephedrone use was first recorded in the Crime Survey England and Wales in 2010-2011, after the drug had been made illegal. Thus there is only a small amount of national data available. Moreover, there are well known limitations with self-report survey data of this kind. Most notably, those involved in illegal activities may choose not to disclose, resulting in a dark-figure of unreported and unrecorded crime (Coleman and Moynihan, 1996).

Nevertheless, the data suggests that mephedrone use has decreased since the survey first began recording usage. Specifically, findings from the 2012 to 2013 Drug Misuse Crime Survey for England and Wales indicate that an estimated 1.1% of the adult population of England and Wales used mephedrone in 2011-12 compared to 0.5% in 2012-2013. The national picture also suggests that usage by young adults (aged 16-24) is declining with an estimated 3.3% of young adults using mephedrone in 2011-2012 compared to 1.6% in 2012-2013 (Home Office, 2013). Interestingly, the survey found that use of mephedrone in the 12 months prior to interview, was around 20 times higher (the largest difference across all types of drugs measured in the survey) among those who had visited a nightclub four or more times in the past month (4.4%) compared with those who had not visited a nightclub in the past month (0.2%) (Home Office, 2013:20).

In contrast, smaller scale localised surveys have tended to paint a picture of higher usage. For example Dargan *et al.*, (2010) conducted a study in Scotland with 1006 students from schools, colleges and universities in order to understand the use and associated adverse effects of mephedrone in school and college/university students before the UK legislation change. The study identified that just over one-fifth of the sample had used mephedrone. Of those that had used mephedrone, 23% stated they had done so once, whilst 4% stated they used mephedrone daily. The majority (49%) obtained their mephedrone through dealers and 11% sourced mephedrone through internet suppliers.

Measham et al., (2010) speculate that the availability of mephedrone is the primary factor for users choosing the drug. Thus, drug choice is based on the theory of displacement, suggesting that when other drugs become more available drug users will use the most easily accessible drug. However, McElrath and O'Neill., (2010) found that participants in their study enjoyed mephedrone that much, that even when high quality cocaine and ecstasy returned to Northern and Southern Ireland, their mephedrone use continued. Internet bought mephedrone is stated to have a very high rate of purity with over 99% (Corkery et al., 2012). The demand for mephedrone by consumers has coincided with the poor quality of dissimilar party drugs such as heroin, MDMA and cocaine (Psychonaught Web Mapping Research Group, 2009).

In 2009, Europol reported 48 seizures of mephedrone in the UK, which included 14.8 kilograms of mephedrone powder, 8 tablets and 4.95 kilograms of mephedrone labelled as 'Glucose' being exported from China. In January 2010, Europol intercepted a parcel of mephedrone being imported from China to the UK containing 5.1 kilograms of mephedrone (Europol, 2010).

Cutting and Mixing Mephedrone

The Psychonaught Web Mapping Research Group (2010) stated that mephedrone is usually used with other compounds. The compounds are used either in the same session or 'cut' with the drug. These compounds include: alcohol, other research chemicals (Methylone, MDV, Butylone), cocaine, MDMA, Ketamine, GBL, heroin (cut together and injected known as 'speedballing'), cannabis, kratom and pharmaceutical depressants (such as Benzodiazpines) both unusually taken when coming down from the high), Pharmaceutical stimulants (e.g. Adderrall), Viagra, BZP, TFMPP, or DMAA, Nitrous Oxide, Isobutyl nitrate (poppers), Metamfepramone and Phthalimidopropiophenonem.

Daly (2012) also reports that benzocaine and monosodium glutamate are also cut with mephedrone in order to make the snorting process less painful. Media reports in Wales have suggested that some users were cutting mephedrone with petrol

(Malone, 2013). The injection of mephedrone and petrol together is extremely harmful, with users reporting burns, wounds and cases of necrosis.

Side Effects of Mephedrone

Dargan et al (2010) reported that 56% of mephedrone users had experienced a negative side effect of the drug. Generally, the negative effects of the drug are mild and are short lived. Users have reported experiencing mild negative effects, such as jaw clenching, insomnia, nausea, paranoia and hallucinations. However a significant amount of mephedrone users end up in hospital and complain of irregular heartbeats, excessive sweating, tightening of the chest and headaches.

The injection of mephedrone is three times more likely to collapse veins than cocaine, whereas snorting mephedrone is twice as corrosive as cocaine on the membrane/septum (RIUW, 2012). The injection of mephedrone leads to rapid deterioration of injection sites which can lead to bruising and skin abscesses. Mephedrone can re-crystallise within the veins, and can cause serious damage and blockages. Mephedrone users are often unable to re-inject into the same injection site.

It is argued that the most harmful characteristic of mephedrone is its addictive properties, with 85% of users craving mephedrone after using the drug (Brunt et al., 2010). Europol (2010) state that the drug creates a high desire to redose, usually this coincides with the hangover/comedown period. Users are more likely to redose when they snort the drug because of how fast and hard the drug effects the user compared to when the drug is swallowed which has more prolonged but milder effects. Daly (2012) states that in extreme cases, users are injecting mephedrone 40 times a day. Tolerance to mephedrone develops quickly, thus the amount used increases dramatically to reach the desired effect. This is known as 'fiending'. There have been reports of users injecting 20 grams in 24 hours and purchasing £1000 of mephedrone per week. Users who had injected or snorted mephedrone were prone to being more aggressive and violent, compared to users who swallowed or bombed the drug (Daly, 2012).

Mephedrone, Aggression and Violence

Evidence on the links between mephedrone use and aggression and violence is generally scarce. This is not to suggest that there are no links, but rather, that there have been few credible studies to consider this issue. So, whilst there are numerous anecdotal accounts of mephedrone-induced aggression and violence (see Daly 2012; Chad, 2013) the empirical research base is sparse.

Van Hout and Bingham (2012) studied the patterns of use and perceived consequences of mephedrone based head shop products in Ireland. The study analysed 11 mephedrone users who all had a history of injecting and poly drug use. Mephedrone users stated that mephedrone heightened the sense of paranoia that in turn, led to elevated levels of violence and participation in criminal acts. Mephedrone users also reported acting violently when they were trying to secure further supplies of the drug for the next dose (Van Hout and Bingham, 2012).

Corkery *et al.,* (2012) reported violence towards mephedrone dealers. In one case a mephedrone dealer was stabbed to death and his supply of mephedrone was stolen.

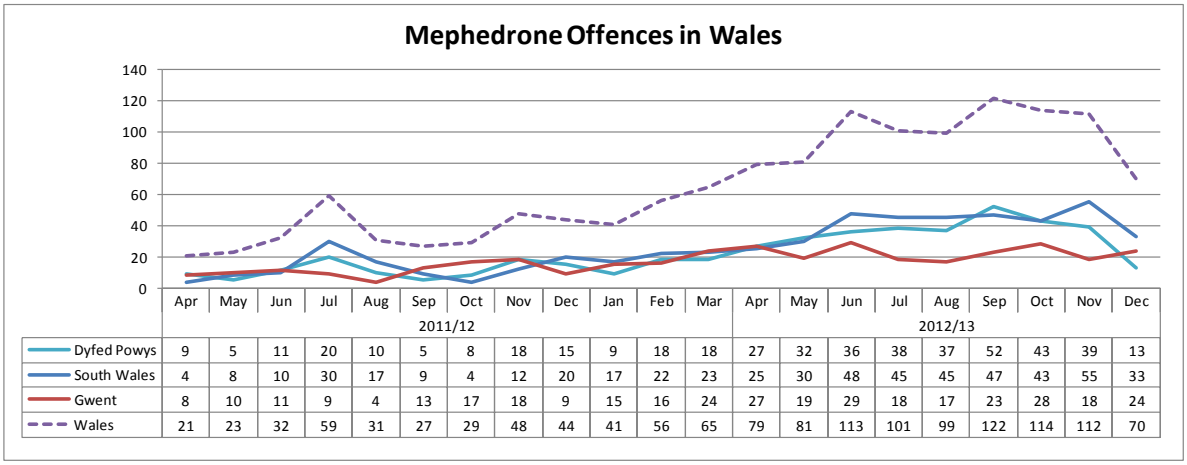
Lusthof et al (2011) reported an incident where a 36 year old man in the Netherlands injured himself in a rage of fury by smashing windows and then later died after using mephedrone. The toxicology report stated that the wounds inflicted led to substantial blood loss and the state of rage could have been triggered by the use of mephedrone. However, the toxicology report also found traces of other drugs including cocaine and MDMA. Nevertheless, mephedrone was deemed to be the main cause of the fatality.

Mephedrone in Wales: A National Picture

Drawing upon police data for Wales, there is evidence of a rise in the number of mephedrone offences between 2011 and 2012. Specifically, comparing the period April to December 2011 with the same period for 2012 the number of mephedrone offences apparently rose from 314 to 891 in the three Southern Wales Forces, an increase of 184% (see Figure 1 below). According to Wood (2013), the number of drugs offences involving mephedrone started increasing at the beginning of 2012 with a sharp increase in June and a peak in September. However, as Wood acknowledges, these peaks may reflect increased activity targeting mephedrone by the police as well as increased availability. During the last 3 months of 2012 mephedrone offences remained high, only falling slightly in December[4].

[4] Data for 2012-2013 were not available at the time of compiling this report.

Figure 1: Mephedrone Offences in Wales



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2011/12												2012/13								
Dyfed Powys	9	5	11	20	10	5	8	18	15	9	18	18	27	32	36	38	37	52	43	39	13
South Wales	4	8	10	30	17	9	4	12	20	17	22	23	25	30	48	45	45	47	43	55	33
Gwent	8	10	11	9	4	13	17	18	9	15	16	24	27	19	29	18	17	23	28	18	24
Wales	21	23	32	59	31	27	29	48	44	41	56	65	79	81	113	101	99	122	114	112	70

(Reproduced from Wood, 2013).

Anecdotal evidence from drug and health agencies across South Wales also indicates significant increases in referrals to services (both within criminal justice and community agencies) since 2011 (with periodic peaks and dips throughout).

User Profile: Wales

Finally, some information exists, from Police, drug and health agencies, regarding the *mephedrone user profile.* This data indicates that the majority of mephedrone users are in the age range 18-24 and predominantly male (RIUW, 2012)[5]. Richards (2012) states that young people are most vulnerable to mephedrone use because they are more exposed to drugs in pubs and nightclubs. Furthermore, youths are a particular high-risk group in that they are more likely than other age groups to try an unknown drug. Finally, there is evidence that young people are specifically targeted by mephedrone dealers and in some parts of South Wales school children have been offered tasters for less than £1.00 (RIUW, 2012).

Evidence from a range of agencies across Wales suggests that mephedrone has made service users who were normally placid, more aggressive. Drug support services have noted that users who binge on mephedrone for several days often had suicidal tendencies, paranoia and an absence of memory (Homeless and Vulnerable Adults Service, 2013). Finally, mephedrone users are reported to be more engaged in risky behaviour such as unprotected sex, injecting into necks and groins and sharing injecting equipment compared to other service users (Homeless and Vulnerable Adults Service, 2013).

[5] The gender data are based only on Welsh police figures for those *charged with* mephedrone-related offences and do not, therefore, represent the broader picture of male and female users.

Part Three: Methodology

This section details the methodology adopted to gather both quantitative and qualitative data on mephedrone use and its links to violence across South Wales. The research is predominantly qualitative in focus, the primary aim being to gather in-depth insights from users, and experienced experts who work with users, about any apparent links between mephedrone and violence and other harms.

The data sources utilised are summarised below and then explored in further detail. This section of the report ends with a consideration of the ethical issues that were dealt with as part of the research into this sensitive topic.

Data Sources: Overview

Quantitative:

(1) Questionnaire survey of 67 mephedrone users from across South Wales in order to explore patterns of use, impacts and cessation.

Qualitative:

(2) Semi-structured interviews with twelve mephedrone users to explore in depth the links to violence (to self and others) and other associated harms.

(3) Semi-structured interviews with twenty practitioner 'experts' who work closely with mephedrone users in order to gain further insights into the particular associations between mephedrone use and violence and other harms.

(4) Qualitative data elicited from the survey of 67 mephedrone users in South Wales.

Quantitative Data

Mephedrone User Survey

In order to capture a fairly wide range of views from users about their use of mephedrone and the harms associated with it two questionnaires were designed (one for young people aged below 18 and another for adults). The questionnaires (see Appendix A) differed only in terms of language use, covering identical issues and themes. Specifically, users were asked about onset, extent and patterns of use, methods of ingestion, the physical and emotional effects of mephedrone, how the drug was sourced, whether and how the use of mephedrone was associated with aggression and violence and a series of questions about cessation. The

questionnaire contained both closed and open questions and so allowed for the gathering of some important qualitative data to supplement the user interview data (discussed below).

The questionnaires were hand-delivered or e-mailed to fourteen different agencies across South Wales, including criminal justice organisations and charitable agencies that work with offenders, drug users or those with a broad range of needs. Agencies are not identified as some of the staff wished for both their own identities, and the identity of the agency, to remain anonymous.

Staff were asked if they could identify appropriate clients and ask them to complete the questionnaires (providing assistance where necessary). I was able to complete ten surveys with users after in-depth interviews or whilst users visited a needle exchange facility.

The data from these questionnaires were input into a statistical package (SPSS) and subject to quantitative analysis. Full results can be found in part four of the report that follows. The qualitative statements were extracted and analysed thematically. Findings from these data are included in part five of this report.

Qualitative Interview Data

Three forms of qualitative data are drawn upon in this report. Further details about each of these are considered below.

Mephedrone User Interviews

Semi-structured, in-depth interviews were conducted with twelve mephedrone users. Table 3.1 below provides an overview of the sample which includes a diverse mix of users in terms of age, gender, place of residence within South Wales and involvement in drug use generally and mephedrone use specifically. Further details of the sample can be found in table 5.1 in section five and a copy of the interview schedule can be found in Appendix B.

Table 3.1: An Overview of Mephedrone User Interview Sample

Pseudonym	Gender	Age	Regularity of Mephedrone use
Abby	Female	26	Every weekend
Charlie	Male	20	Every other day
Dave	Male	33	Daily
Steve	Male	34	Weekends
Mark	Male	26	Daily
Georgina	Female	31	Only twice
Morgan	Male	20	Daily
Smithy	Male	31	Daily
Clare	Female	23	Weekends
Ryan	Male	34	Weekends
Lou	Female	39	Weekends
Jack	Male	22	Daily

The men and women who took part in interviews were all in contact with one of the agencies detailed below in table 3.2. They were generally approached by a member of staff from the agency and asked if they would be interested in talking to a researcher, in confidence, about their experiences of using mephedrone.

Interviews lasted an average of 40 minutes, were all audio recorded (with the permission of the interviewees) and subsequently transcribed verbatim. The transcripts were entered into the qualitative software package NVivo 10 and subject to thematic analysis.

Practitioner 'Expert' Interviews

In-depth semi-structured interviews were also conducted with 20 practitioner 'experts' who work in a range of agencies that bring them into close contact with those whose lives have been impacted by drug use. Table 3.2 below provides an overview of the agencies where these experts worked[6] and illustrates that a range of agencies were represented including criminal justice (i.e. prison and probation), mental health and various independent charitable organisations. Of the latter, some were specifically established to help drug users, whilst others had a broader remit, for example to offer support to the homeless. All of the experts had a wealth of experience of dealing with the harms associated with drug use and direct experience

[6] Most of the experts interviewed were happy to be named but some were not and so, for the sake of consistency, none of the practitioner experts have been identified and the agencies to which they belonged have also been generalised.

of working with mephedrone users. A copy of the interview schedule can be found in Appendix C.

Aside from the detailed interviews, observation was also conducted at a needle exchange facility for one day and I attended a half-day training event for drug workers and other practitioners at the start of the research project.

Table 3.2: An Overview of the Agencies who Participated in Interviews.

Agency Type	Number of Interviews
Independent charitable organisations providing a range of services for drug users, their families and friends.	6
Charitable organisation for disadvantaged and homeless people.	3
Offender Management and Drugs Liaison.	1
Probation Service.	1
Prison Offender Intervention (drug) Service.	3
Criminal justice drug through and aftercare service.	2
Youth Offending Team.	2
Mental Health Day Service.	2
Total	**20**

Qualitative Survey Data

Finally, as indicated earlier, some qualitative data were gathered as part of the survey of 67 mephedrone users. These were simply extracted from the survey and subjected to thematic analysis. All respondents provided some level of qualitative comment.

Timescales

The data drawn upon in this report refers to a particular time period. Specifically, all in-depth interviews were conducted between May and September 2013 and all survey data were collected between May 2013 and February 2014. These time periods do not, necessarily, correspond to the periods during which the drug consumption or the associated harms occurred. For example, some of the 'users' had actually given up mephedrone at the time that we met for interview but reflected back (usually in months as opposed to years) to their former use. Others

had stopped and started numerous times and could discuss these various moments in their drug taking 'careers'.

Ethical Issues

There are several ethical issues involved in undertaking research on sensitive topics such as drug use and involvement in violence. In essence they include (i) ensuring that participants are fully informed about the project and their role within it (ii) avoiding harm to the participants (iii) ensuring that all data are stored securely and confidentially and (iv) that findings are disseminated in an anonymised format. Each of these are dealt with in more detail below.

It is important that subjects are given sufficient information about the project, the organisations involved in administering and funding the project, the aims of the research, and the use of the data to allow informed consent. In this respect, the research was informed by the British Society of Criminology and British Psychological Association Codes of Ethics. All participants approached to take part in the study were provided with detailed information about the purposes of the research, how the information that they provided would be stored and how the research would be disseminated. Most of the men and women who took part in interviews were initially approached by a member of staff who they already knew at the agency or institution where they were receiving assistance for drug-related problems. The information that they were provided with at this initial stage was repeated when we met for interview. The background to the research was explained as well as how it would be disseminated so that potential interviewees were fully informed before giving their consent to take part. It was also explained that they could stop the interview at any time and/or refuse to answer a particular question.

The purely voluntary nature of participation was carefully explained to all participants as well as the fact that that they could withdraw at any stage and should not feel obliged to answer all questions if they felt in any way uncomfortable or stressed at any time. I ensured that all participants only consented to take part having been fully informed of the aims of the research and how the information would be used. I explained who was funding the research and why and that I was an independent researcher who was not connected in any way with any of the agencies or the criminal justice system or the Welsh Government.

Assurances of anonymity and confidentiality were provided at the outset and explained carefully again when I met with each person. Specifically, all interviewees were assured that they would not be named in the report or any other publications that might arise from the research. Mephedrone users were asked to select a

pseudonym and these self-assigned names are used throughout the report. 'Expert' practitioners' identities are anonymised by only making reference to the kind of agency to which they were connected.

Avoiding harm to participants includes being cognisant of any emotional distress that might arise from taking part and taking appropriate remedial action. Interviews ran smoothly in most cases, with just one exception. During one of the interviews with a mephedrone user (that took place in a prison) the male interviewee began to perspire heavily and appear uncomfortable as he talked in detail about the affects of mephedrone. I handed him a glass of water and asked if he would like to have a break or stop the interview altogether. He explained that just thinking about it made him desperately want to consume it. This was not something that I had envisaged could happen. After a short break he indicated that he was happy to continue. However, he soon became uncomfortable again and so the interview was terminated. Nevertheless, important insights were already gleaned.

All data collected were stored in anonymised formats and held under secure conditions in accordance with the requirements of the Data Protection Act 1998. Quantitative findings from the user survey specifically excluded the recording of any user's names and, in any event, the data are aggregated and not attributable to particular individuals.

Interviews took place in designated safe areas such as rooms in drug centres or prisons.

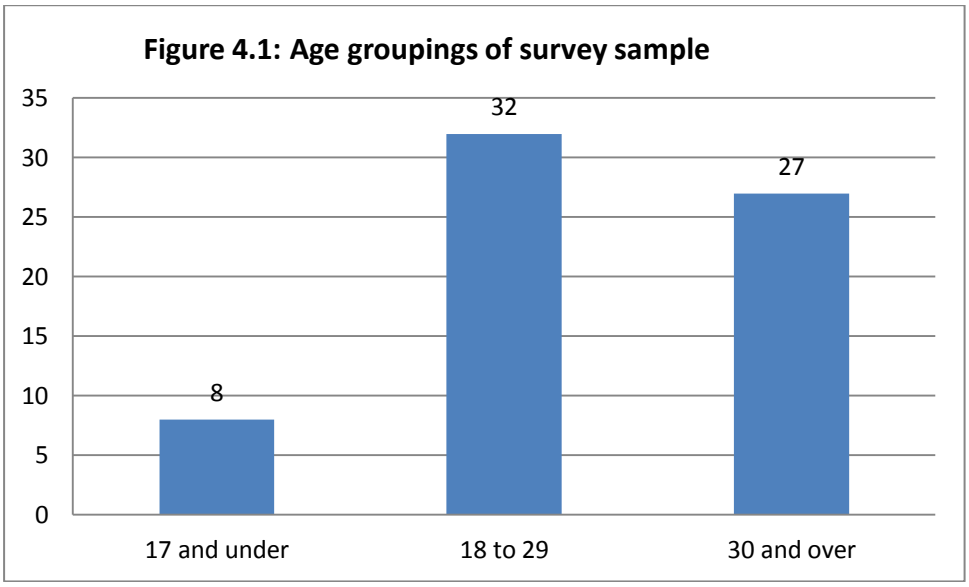
Part Four: Quantitative Survey Findings

Introduction

This part of the report presents and discusses the findings from the survey of 67 mephedrone users from across South Wales. As indicated in the methodology section earlier, the survey was designed in order to gain some broad yet detailed insights regarding the extent and patterns of mephedrone use, physical and emotional impacts, methods of ingestion, drug sourcing, whether and how the use of mephedrone was associated with aggression and violence and whether and how users had managed to abstain[7]. Here I begin by documenting aspects of mephedrone use in relation to the whole sample, before focusing in upon the 'violent subset' of users (i.e. those who reported acting violently whilst under the influence of mephedrone or during the withdrawal phase).

Overview of survey respondents

Almost three quarters (73%) of those who completed the survey were male, the remaining 27% being female. As illustrated in figure 4.1 below, almost half (48%) of the sample were aged between 18 and 29, a further forty per cent were aged over thirty years and twelve per cent were aged under 18. The youngest respondent was aged 15, the oldest, 55 years.

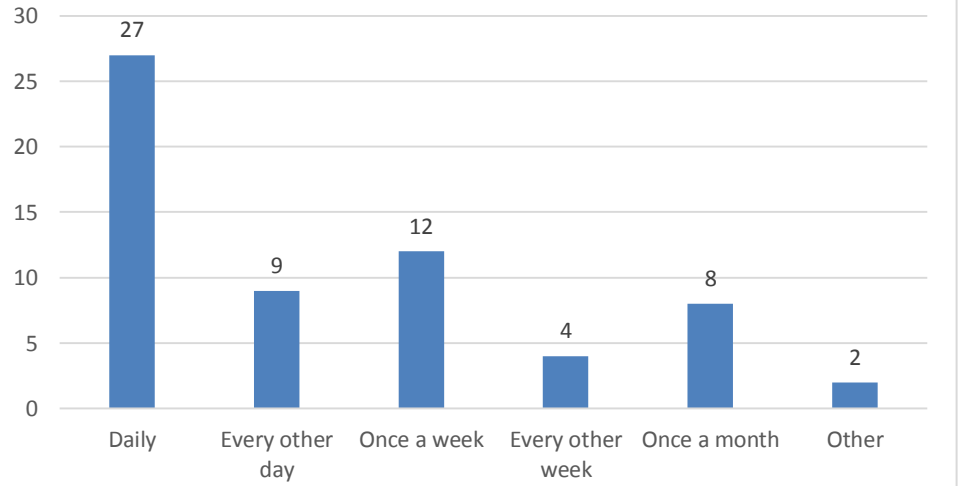


[7] Percentages have been rounded up to the next number where the figure is .5 or above at the first decimal place.

Frequency of Use and Mode of Administration

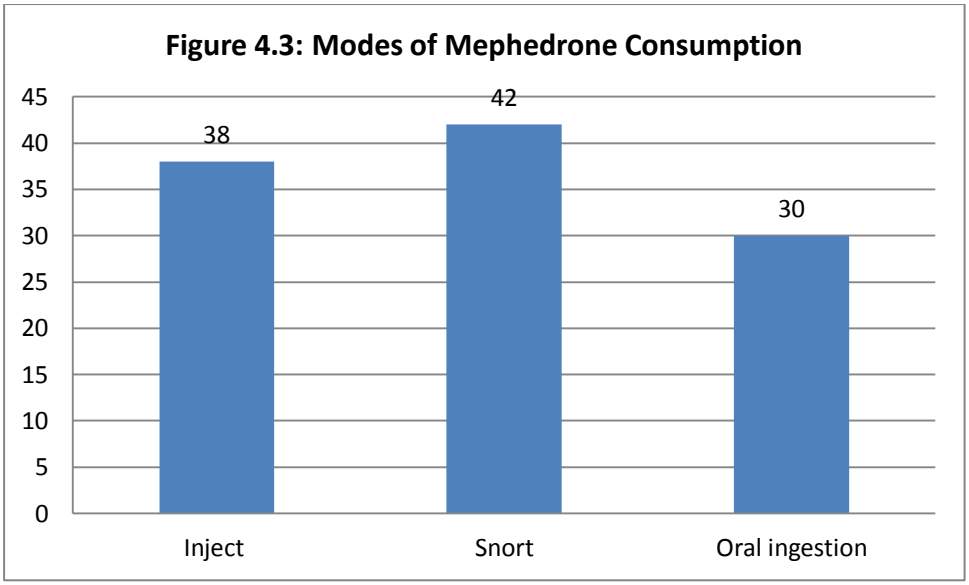
As illustrated in figure 4.2 below, the approaching half of users in this sample (46%) used mephedrone on a daily basis (N=27). A further 19% of the sample used mephedrone once a week (N=12) closely followed by those who used the drug every other day (15%, N=9) or once a month (13%, N=8). Finally a small number of users consumed the drug every other week (6%, N=4).[8]

Figure 4.2: Frequency of mephedrone use

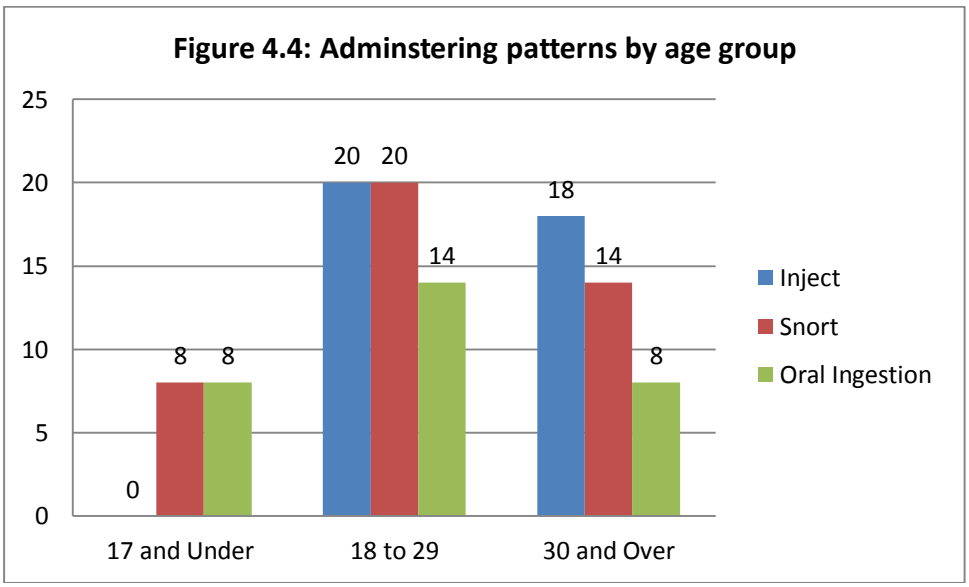


The most commonly reported means of consuming mephedrone was by snorting the product in powder form. Almost two thirds of the sample had snorted mephedrone (63%, N=42). This was closely followed by injecting (56%, N=38) and oral ingestion[9] (45%, N=30)[10]. Two of the respondents provided answers that did not fit the parameters provided (coded 'other' above). Specifically, one user indicated that he had only used mephedrone once; another stated that she had only ever used it 8 or 9 times.

[8] Five respondents failed to answer this question.
[9] Oral ingestion refers to either swallowing or 'bombing'. The latter involves wrapping the drug in some kind of material (such as a cigarette paper).
[10] Overall percentages do not add up to one hundred as many users adopted more than one mode of consumption.



Further analysis by age group revealed that young people (those aged 17 and under) had never used mephedrone intravenously and were equally likely to snort, or orally ingest, the drug. In contrast, those aged 18-29 and 30 plus were most likely to report having injected or snorted mephedrone.

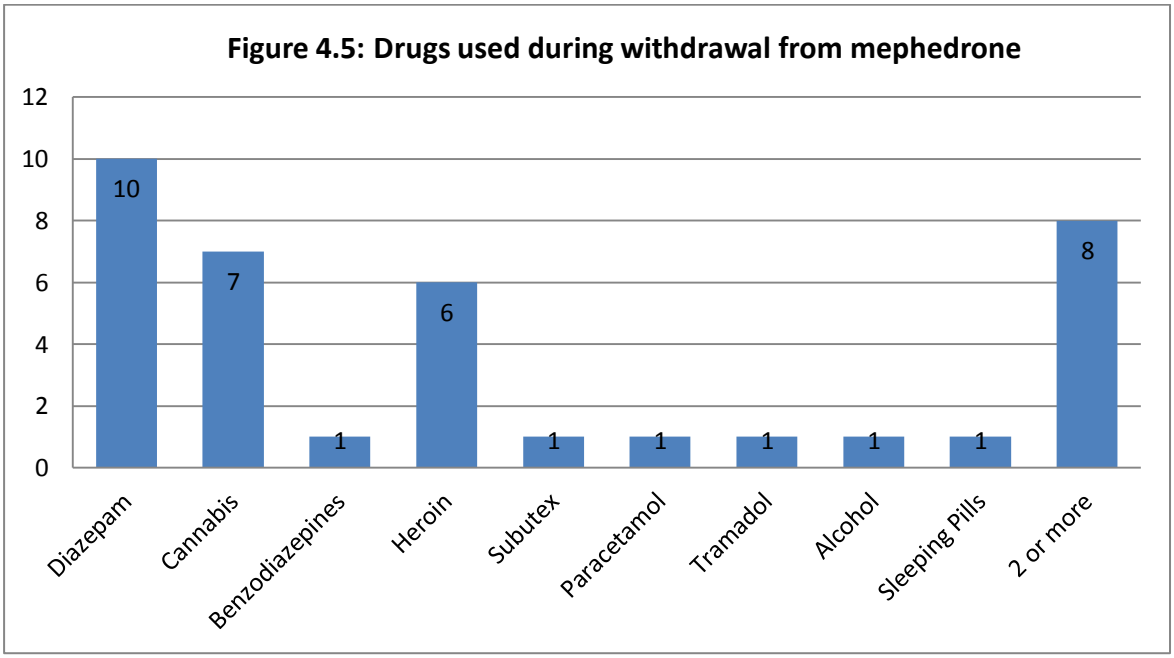


Mephedrone use combined with other drugs

Just over 80 per cent of the sample used mephedrone with some other drug. Mephedrone was most commonly used with drugs such as alcohol (N=29), cannabis (N=23) and heroin (N=19). Users also reported ingesting a range of drugs in order to ease the impacts of comedown. Just over half of the participants stated that they

had consumed a drug during the comedown (55%, N=37). Diazepam was the most represented drug with 27% (N=10) of the sample identifying this as their drug of choice to cushion the effects of withdrawal, followed by cannabis (19%, N=7) and heroin (16%, N=6). A small number of participants also reported using other drugs such as benzodiazepines, Subutex, Paracetamol, Tramadol, alcohol and sleeping pills.

Figure 4.5: Drugs used during withdrawal from mephedrone



One fifth of those who consumed drugs to ease the effects of withdrawal reported using a combination of two or more drugs. Most frequently, cannabis was combined with a second drug, as illustrated in table 4.1 below.

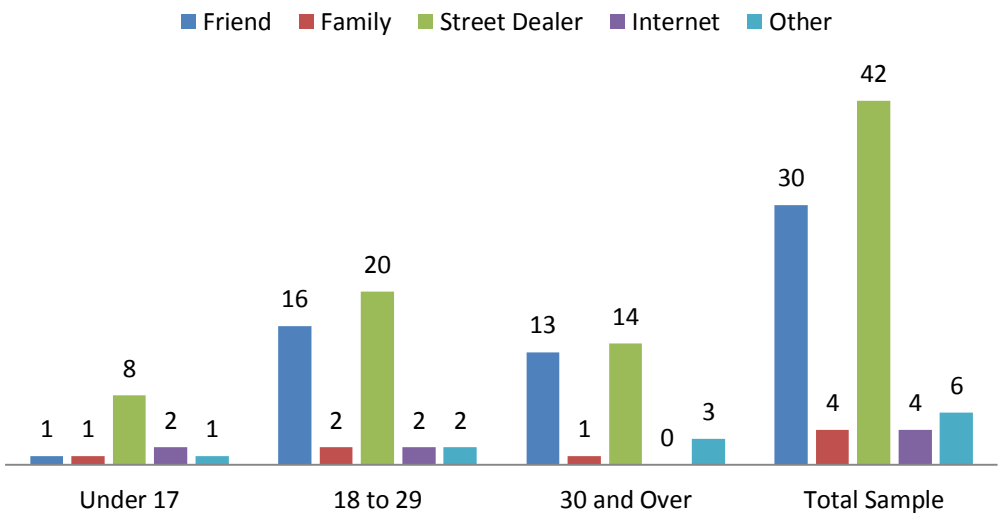
Table 4.1: Combined Drug Use to Ease the Effects of Mephedrone Withdrawal.

Drugs Used	Number of Participants
Cannabis and Alcohol	2
Cannabis and Diazepam	2
Cannabis and Heroin	1
Valium and Methadone	1
Benzodiazepines and Heroin	1
Cannabis, Benzodiazepines and Heroin	1

Sourcing Mephedrone

The majority of those sampled purchased mephedrone through street dealers (63%) followed by friends (45%). Just four participants indicated that they purchased mephedrone from internet-based sources. A handful of users purchased their mephedrone via other routes including social networking sites (such as Facebook) or did not purchase the drug at all but received 'a freebie' at a party or from their partner[11]. Purchasing routes did not vary significantly by age group.

Figure 4.6: Mephedrone Purchasing Patterns by Age

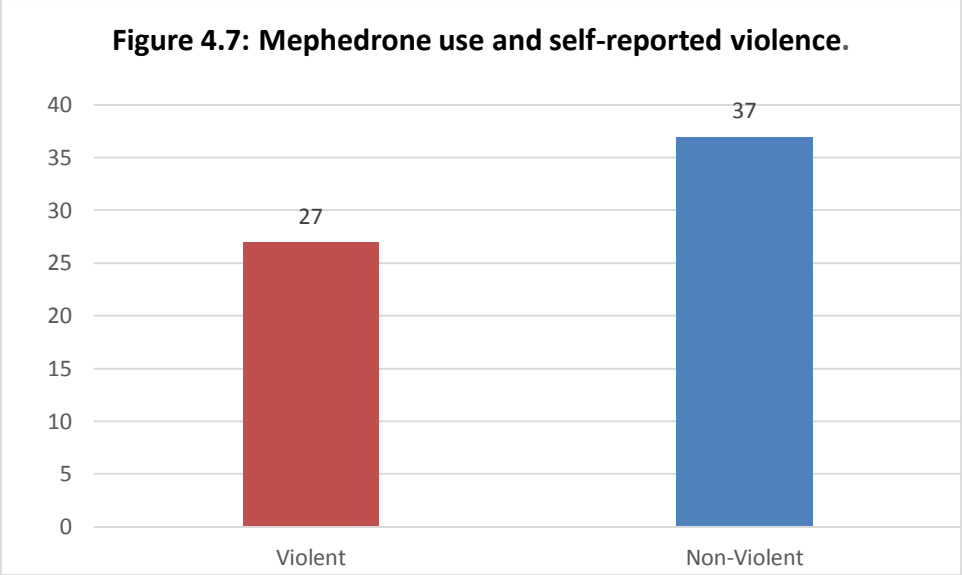


Mephedrone Use and Violence

A substantial proportion (42%, N=27) of those surveyed indicated that they had become violent when using mephedrone. The remainder of the sample, 58% (N=37) stated that they had not been violent when using mephedrone.

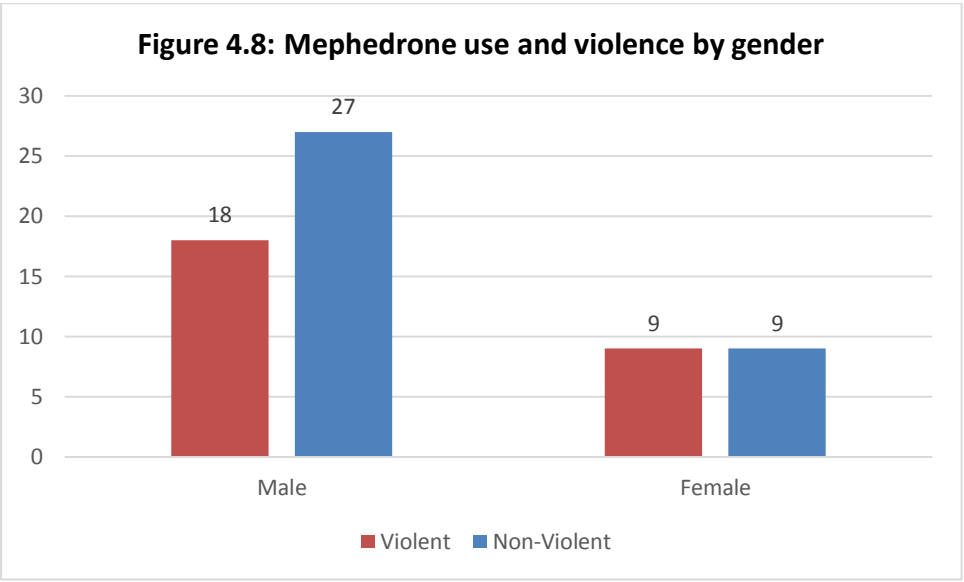
[11] A quarter of the sample purchased mephedrone from two or more sources, hence the total percentages exceed one hundred percent.

Figure 4.7: Mephedrone use and self-reported violence.



Focusing upon the violent sub-category it is evident that males were over-represented, which is not surprising and fits with general patterns of violent offending where males predominate (Brookman and Robinson, 2012). Specifically, over two-thirds of the violent sub-sample of mephedrone users were male (67%), the remaining 33% being female. Interestingly though, as illustrated in figure 4.8 below, half of the total female sample reported violence as a result of mephedrone use, compared to forty percent of the total male sample.

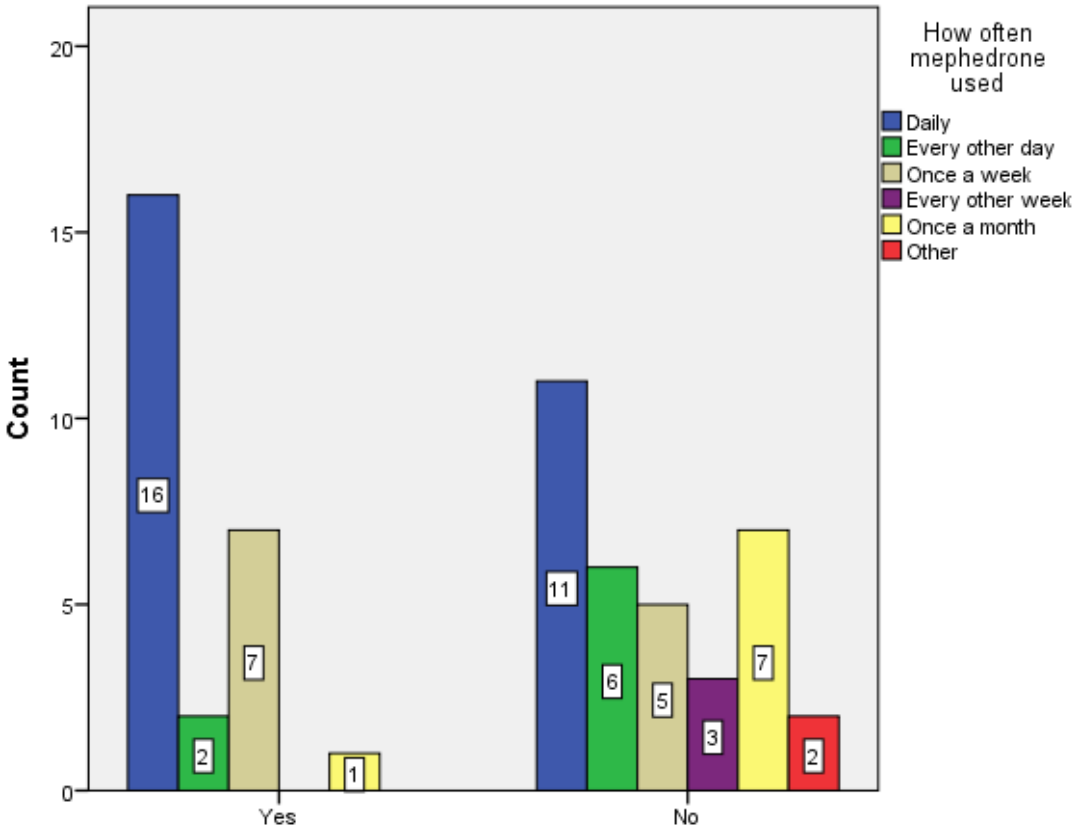
Figure 4.8: Mephedrone use and violence by gender



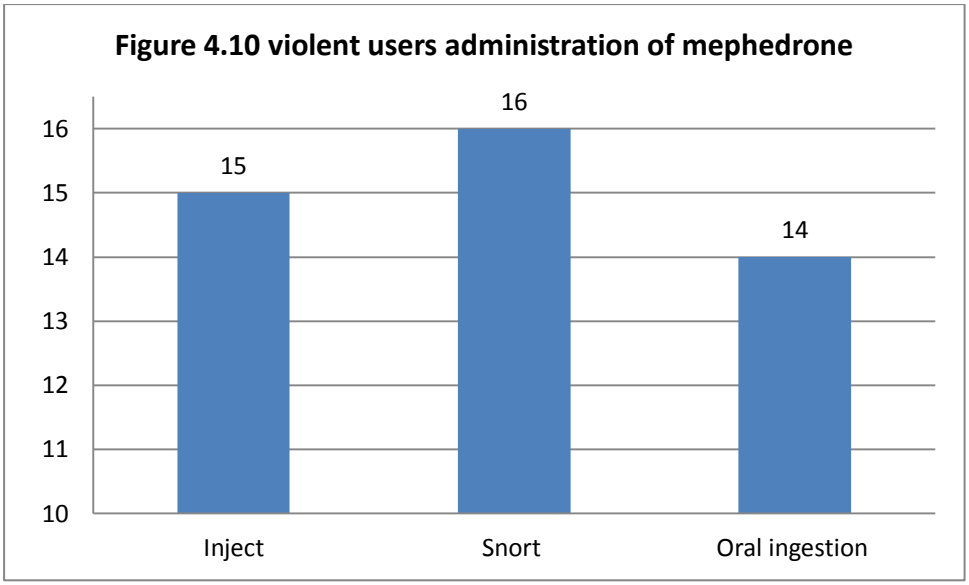
Violence was more likely to be reported when mephedrone was used on a daily basis. Specifically 27% of the violent sub-set (N=16) used mephedrone daily compared to 18% of the non-violent users. A significant amount of violence was also reported by those who consumed mephedrone once a week (12% of the violent sub-set, N=7). There were no self-reports of violence amongst those who used

mephedrone on a fortnightly basis and one user reported committing an act of violence who consumed the drug monthly. These findings suggest that there may be two distinct type of user involved in violence: (i) the heavy end user and (ii) the regular weekend recreational user. The links between violence and mephedrone use will be explored in much finer detail in the following chapter.

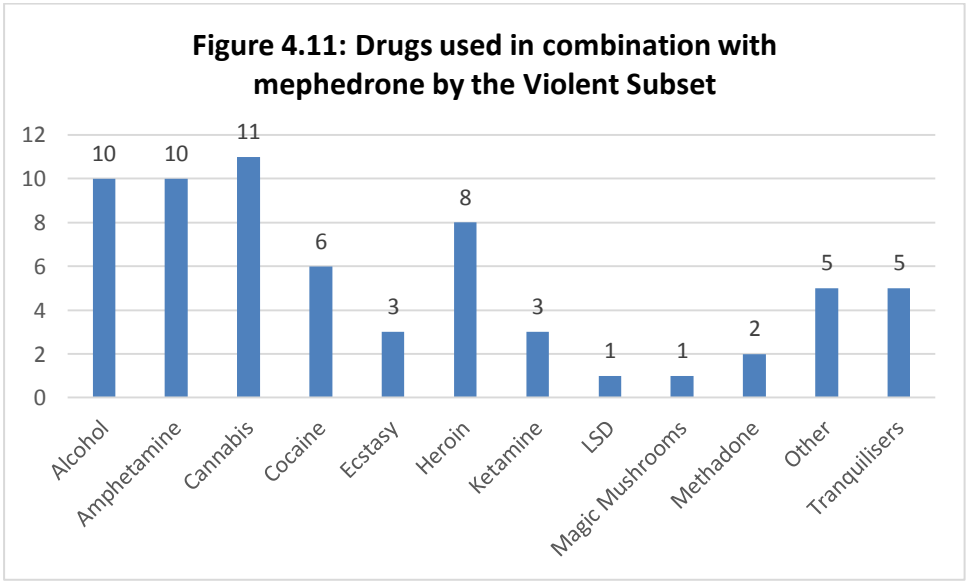
Figure 4.9: Frequency of mephedrone use by violent and non-violent users



Mode of administration did not appear to be associated with violence in that virtually equal numbers of violent users reported injecting, snorting or orally administering mephedrone, as illustrated in figure 4.10 below.



Finally, within the violent subset of participants, the most common drugs combined with mephedrone were cannabis (41%), alcohol (37%), amphetamine (37%) and heroin (30%).



Summary

In summary, almost three-quarters (72%) of this sample of 67 mephedrone users reported regular use of mephedrone – that is - using the drug daily (46%), every other day (15%) or weekly (19%). Users generally snorted, injected or orally ingested the drug though young people aged 17 or younger did not report any instances of intravenous use. Mephedrone was generally purchased from street dealers or friends and there was little evidence of internet-based purchases amongst

this sample. Over 80% of the sample combined mephedrone with other drugs, notably, alcohol, cannabis and heroin and over half of the sample also reported ingesting a range of drugs to try to alleviate the debilitating withdrawal impacts of mephedrone (most notably, diazepam, cannabis and heroin). Just over forty percent of the sample reported acting violently whilst under the influence of mephedrone. Interestingly, the violent sub-set reported combining amphetamine with mephedrone as often as alcohol and it is perhaps these combinations that are important in understanding why some users become violent when under the influence. Finally, the evidence presented here indicates that regular use of mephedrone (especially daily, but also weekly) is most associated with violence. These findings suggest that there may be two distinct type of user involved in violence: (i) the heavy end user and (ii) the regular weekend recreational user.

Part Five: Qualitative Research Findings (i)

The Voice of Mephedrone Users

Introduction

This section of the report documents, in the words of users themselves, their experiences of using mephedrone with particular emphasis upon any links between mephedrone use and violence and other harms. Details of the sample are set out in Table 5.1 below. The average age of the interviewees was 28. One third of the sample were female. Three quarters of those interviewed stated that using mephedrone had caused them to become involved in violent crime and Table 5.1 below provides a flavour of the violence enacted by these men and women as well as other details of the interviewees.

Table 5.1: Overview of Sample of Mephedrone Users who took part in Interviews.

Pseudonym	Gender	Age	Regularity of Mephedrone use	Stated links to Aggression	Stated links to Violence	Description of Violence	Stated harms to self
Abby	Female	26	Every weekend	No	No	-	No
Charlie	Male	20	Every other day	Yes	Yes	"I just went at him, battered him down."	No
Dave	Male	33	Daily	Yes	Yes	Violent assault on a dealer who had cut mephedrone with another substance (he was buying in bulk to sell on)	No
Steve	Male	34	Weekends	No	No	-	No
Mark	Male	26	Daily	Yes	Yes	I've burst through the door and I've started screaming and shouting about 'where's my f'ing money' and as soon as he's given me, "what are you on about?" I've grabbed him and threw him against the wall and lost the lot of it.	No but did accidentally overdose
Georgina	Female	31	Only twice	No	No	-	No
Morgan	Male	20	Daily	Yes	Yes	"I ran around (the town) with two knives in my hand." "threatened my friend with a metal bar"	No
Smithy	Male	31	Daily	Yes	Yes	"I've gone to do a deal and then someone's tried to sell it to me in singles and I've just attacked him for it." "Arson" "And he's mocked me a couple of times so I	No

						sunk my finger into his eye."	
Clare	Female	23	Weekends	Yes	Yes	"I have flipped out and smashed the house and stuff like that"	No
Ryan	Male	34	Weekends	Yes	Yes	"I tried cutting his head off...(with a) hedge shears" "I was going to cut his hands off with a meat cleaver" … I have been violent to her on the off-chance, just flipping out and that. She's been violent to me as well (Domestic Violence).	No
Lou	Female	39	Weekends	Yes	Yes	"Me and my partner used to fight"	Yes
Jack	Male	22	Daily	Yes	Yes	Beat up step dad. "Burglary" "I just went chasing this boy, and I don't even know why I went chasing. I didn't even know this boy, but when I caught him I just slapped him and walked away".	Yes Attempted suicide.

Before considering the various harms associated with mephedrone that emerged during interview, it is important to gain a sense of why users initially consumed mephedrone and what their initial experiences were.

Deciding to try mephedrone

The majority of those interviewed first tried the drug as friends were taking it and they were offered or even encouraged to try it:

> I didn't want to touch it at first and then a couple of the boys were doing it and he's like, "Oh try this, it's good like," because I've always been an heroin addict I have. He said, "try this, it's the way forward and that." So I tried it and I liked it (Ryan).

Clare had a similar introductory experience:

> I don't know, it was just the people I was with and that's what it is, the people you're with start doing it. I didn't start off with Meow it was just a thing, but then it was a total different buzz when it first came out (Clare).

Some of those who took it were initially against the idea but, in the absence of their drug of choice, decided to try it:

> I was dead against it when it first came out and then at one point I was at a house party and because they couldn't get any cocaine, only this stuff, I thought I'd try it. Because being wrecked and everything you don't really fully … you're just like, "Yeah, whatever." (Abby)

Not everyone who tried it had a pleasurable experience that they wanted to repeat:

> When I first took it was at a friend's house and I snorted it with a couple, two friends, and I didn't really think that much of it to be honest. It just burn my nose, it was crap (Georgina).

Nevertheless, even though it was not her type of drug, she did take it again with friends when handed some for free:

> It makes you feel nice, don't get me wrong, but it's really fast, it works, your brain goes overtime like this, you just can't shut up, you can't stop fidgeting ... and we just didn't shut up talking for about ten hours, it just went on for hours, it was just… it just went on, and that's what doesn't appeal to me. It didn't appeal to me at all (Georgina).

Georgina was, however, the exception within this sample and all other users

reported a highly enjoyable experience that they wanted to quickly repeat.

> Just makes you feel happy about everything, makes time fly. It is lovely stuff (Dave).

For many users then, their first experiences of using mephedrone were pleasurable and this led them to use the drug again. However, the reasons for sustained use were often far from those that prompted early use. For example, Clare's reasons for continuing to take mephedrone, that she described as "a dirty horrible drug" were to ease the psychological anguish of her life having spiralled out of control as a result of her addiction to mephedrone:

> So no job, no family, I couldn't get out with my friends and my phone, so it was a lot. It takes it from you, you forget about everything, so not having your family, you forget about that. That's one thing. That's why I do it I think (Clare).

The highly addictive nature of mephedrone

It emerged quickly and consistently during interviews that mephedrone was like no other drug that members of this sample had consumed (prior to or since). The 'buzz' was intense and needed 'feeding' regularly in order to maintain the uniquely pleasurable 'high'.

In order to better understand why the drug was so addictive, users were asked to reflect upon exactly how it made them feel (physically and emotionally) at the time of consumption. Several common themes emerged, including feelings of happiness, increased confidence, an enhanced ability to talk to people and a means to forgetting life's problems, as the following quotations from a range of users illustrate:

> You do have such a good time on it. You forget everything. Any of your problems and your worries. You're up so much. You love everyone. No enemies. It's just a good feeling (Charlie).

> Oh physically it just brings you up, and you feel a bit more bouncy and everything, you feel your heart rate increasing, you sometimes find it harder to breathe, you are a bit (exhales) like that from it (Morgan).

> I suppose it makes you feel nice, it makes you feel happy, it just makes you rush and it makes you like … like if you're doing it whilst you're in the house it'll make you like want to clean and potter about, you can't keep still. I

> would say it's a nice, happy drug. I wouldn't say it makes you aggressive, but some people have been aggressive (Abby).

Moreover, Abby explained that mephedrone made her (and her friends who also consumed it) more able to socialise easily:

> It makes you chat all the time so you can like not know somebody and within like an hour or two you'll know everything about them, then you'll be friends. It's easy to make friends from it. I'll say I meet most of my friends from it (Abby)

The links between confidence and the high of mephedrone were expressed by many of the users:

> Meow gave me more confidence, it made me feel more… Well it speeded up, it gave a stimulant effect, it speeded up everything. It's hard to explain, isn't it? Yes. I would become more chatty ... chatty, talkative. Confidence, it gave me confidence (Mark).

Other users consumed the drug to help to deal with significant emotional and social issues. For example, Mark (who was homeless and misusing heroin and alcohol) was at very low ebb in life and explained:

> Emotionally it give me a boost, it made me feel better. I was in a very dark place really and really quite down, you know, always negative, a bit disheartened, didn't want to be living anymore, didn't want to go on anymore, and drinking alcohol daily. As I said I was out getting money for more drugs and alcohol, and it made me feel better, it changed my mood (Mark).

However, any 'good' feelings or positive benefits associated with mephedrone use were short lived in two different senses. Firstly, short lived in that the positive effects of the drug wore off quickly and secondly, in the longer term, as tolerance levels increased, usage increased and the lives of those now addicted to mephedrone began to spiral downwards:

> Yeah, it just wiped everything. Somebody could knock on the door and say you're whole family have been wiped out, and but if you'd answered them and it would be like, okay. Nothing, you couldn't cry, you couldn't think of nothing else apart from the next line, nothing at all. I couldn't concentrate, I couldn't sit down to watch TV, I couldn't hold a conversation. I've forgotten how to socialise and I'm a socialising person (Lou).

Maintaining the 'Buzz'[12]

The excessive buzz or high associated with mephedrone use appears to be short lived. As a result, most users reported 'fiending' on the drug to try to maintain the peak. Furthermore, tolerance levels were reported to increase fairly quickly. Combined with the (relatively) cheap cost of mephedrone[13] and its widespread availability, users quickly found themselves involved in a cycle of increased frequency and volume of use:

> You keep topping up all the time and you start feeling... And like the first day is always the best buzz you're going to get and then the third day you're nowhere near, so you're taking a lot more (Clare).

Abbey reported a similar need to increase her intake:

> ..[L]ike M-Cat now, I've taken so much of it it'll take me a good couple of grams to even notice it I suppose (Abby).

Trying to reach the desired high again, often changed how users would administer mephedrone. Users sometimes resorted to riskier forms of drug administration such as injecting to get as close to their initial high as possible:

> ... because you get used to it and your buzz don't get its thing then, and then a lot of people have said they started injecting trying to find a better buzz (Clare).

Some users stated that they switched from heroin to mephedrone either to try to help with heroin withdrawal or because heroin was not available and they craved the process of injecting:

> I was trying to come off the heroin and it was sort of helping, instead of doing heroin do that. I think I was craving the injection, I know it sounds bad but I was craving that habit (Steve).

> The reason I took Meow was I was an intravenous drug user and it was something that I could inject, I could have a hit, so ... it was more about sticking a needle in my body and the hit, so it was about injecting something.

Most users stated that once they started using mephedrone it was very difficult to stop and many would binge on mephedrone for two to three days, usually over a weekend. Such intense periods of usage were costly, with users reporting spending up to a hundred pounds per evening:

[12] Interviewees tended to use the terms 'buzz' or 'high' to refer to the positive effects of mephedrone.
[13] Users stated that Mephedrone cost between £10 to £20 for a gram or a 'wrap'.

I couldn't stop. When I started doing it I couldn't stop doing it. I'd do sixty, seventy quid a night (Ryan).

In some cases the urge to re-administer and to avoid the come down was so great that users took the drug constantly. For example, Lou became a virtual prisoner in her own bedroom, moving only to take another 'hit':

Lou: Constantly, constantly, and it got to a point I was in one room, just my bedroom.

Fiona: And you never went out of there?

Lou: No, no. This is how I would do it, my table over there, my wardrobe over there, and my tray under there. I'd get the tray for more drugs with my legs over from the bed, get some more down and go like that [swing her legs back around onto the bed] ... and then lie back down.

In sum, mephedrone was reported as being more addictive than other drugs that had been consumed amongst this sample and, even after long periods of abstinence, cravings still prevailed:

I want it, I smell it. It's like smelling bacon, isn't it? If you can smell bacon you feel hungry... The one that I fiend over, the one I want, the one I still want is M-Cat...Still want it now, I can smell it on people...It smells… there's a very distinct smell to it ... I don't like getting close to people who I can smell it on (Smithy).

In fact two of the users interviewed experienced physiological symptoms (of craving) during interview whilst discussing and reflecting upon the drug. Both began sweating profusely, one over his whole body, the other, just the palms of his hands:

The palms of my hands are literally wet just from talking about it (Smithy).

Coming 'Down'

The pleasurable sensations associated with mephedrone use were inevitably followed with the negative effects of come down that all users reported were extreme:

Everything else just goes out the window - your morals, your life, your family, everything. All you're worried about is not coming down then because that's what it is I think because like the clucking, that's the worst bit of it (Clare).

Some users consumed excessive amounts of mephedrone and would forego sleep for many days. For example, Charlie reported staying awake for six days during one binge session and having to deal with the extreme effects of the come down:

> Six days and my head was really bad after... seeing people and talking to people, and realising there was no one there. Hallucinations. Bad as well. It's a horrible feeling. Really paranoid. Out the body experience, do you know what I mean? I was talking to people that weren't there. I'd look and realise there was no one there, do you know what I mean? (Charlie)

One consistently reported effect of coming down from mephedrone was an inability to sleep. Given that users had often already 'partied' for several days, the ability to sleep was important:

> It's physically damaging, it just makes you anxious, it makes you snappy then the next day because you haven't slept and you're coming down. When you want to go to sleep obviously you've still got it in your system so you can't go to sleep so obviously that makes …. Yeah, it's not good. I would recommend people taking something like a sleeping tablet otherwise yeah, it's not so good (Abby).

Users stated that they consumed other drugs to ease the impacts of withdrawal from mephedrone such as valium, cannabis, and sleeping tablets. Without these other drugs, the come down period would be more intense and lengthy and they could have little or no sleep for up to five days.

Aside from the debilitating impacts of sleep deprivation, many users stated that they felt very depressed during the come down phase and some felt suicidal:

> It gives you really bad depression, like you maybe have thoughts of suicide I suppose. Yeah I've had thoughts of it. I don't think I'd actually go through with it, but at the time you think of everything because it's making you depressed and then obviously you can't function properly, so you don't know how to cope with it because your brain's not functioning (Abby).

> If you're on a low you could quite easily slit your wrists, no problem (Lou).

Jack attempted suicide as a result of his inability to deal with the powerful effects of withdrawal:

> When you're coming down then it's like all the emotions just come hitting you straight in the head, like a council brick, and you think, 'woe,' you don't know whether to laugh, cry, scream, shout, kick, punch. It's just too much

> for me to take in, and I don't even know why I was taking it...I've actually sat there cried, I've laughed, I've tried killing myself off it (Jack).

Aside from a complex range of emotional and psychological effects of the come down from mephedrone, users reported a catalogue of physical effects including feeling very cold and nauseous, experiencing stomach cramps and being unable to eat. I return to the broader impacts of mephedrone on the health and wellbeing of the participants (beyond comedown) towards the end of this part of the report.

In summary, the comedown period was described as the most debilitating aspect of mephedrone use. Users reported that violence, aggression, emotional instability, paranoia, acquisitive crime, self-harm, physiological and social problems were all associated with the comedown period. Several users reported that they would seek out ways to avoid the come down, by re-dosing regularly and with this, inevitably, came soaring costs and a host of additional difficulties. For some users, the price of their addiction led to acquisitive or violent crime, to which I now turn.

Mephedrone Use and Acquisitive Crime

Just over half of the users interviewed (seven of the twelve) indicated that they had become involved in acquisitive crime at some point when using mephedrone in order to fund their habit. As regular income (from work or social benefits) became insufficient to fund their increased habit crime seemed the only option for many users. In some cases the spiralling costs and use of mephedrone led to unemployment, placing the user in an even more difficult financial situation, as Charlie explains:

Charlie First of all I started at the weekends because I had a job, but it rapidly started being day to day.

Fiona What's rapid, a week?

Charlie Within three weekends. It started going from Friday to Sunday, then it'd go Friday to Sunday, go to sleep Sunday, wake up Monday, straight back on it for three days.

Fiona By that stage presumably you weren't working then?

Charlie No. Lost my job and everything.

Some users stole from family members, many failed to keep up with their household bills and some resorted to theft of gas or electricity, as Lou's account illustrates:

> I stole all my mother's jewellery, eight thousand pounds worth, spent all my ESA money, my DLA, every penny I had. I didn't pay my bills, I wired my electric up (Lou).

Whilst many users began with relatively 'small' crimes such as stealing money from relatives and friends, in many cases this escalated to more serious offences including theft of vehicles, burglary and street robbery, as the following extracts from some of the interviewees indicate:

> I'd never done burglaries and that in my life, and when you're on it it's just like you start doing different crimes that you've never… I have never thought about entering somebody else's house at night to rob them, but when I'm on that you just don't care. You're in, bang, grab what you want to get and think, 'Oh yes, you're in the money on that,' and it's wrong because you're going through other peoples stuff and that (Jack).

> But, yeah, … he's in jail now for doing a street robbery for M-Cat. He tried to steal someone's phone so he could go sell it them again. But, yeah, that was after he was on bail for the offence he did with my friend who's on tag now. My other friend's in jail too (Smithy)

Much of the property crime was opportunistic in nature though users had already decided that they had to somehow steal to fund their increasingly expensive habit:

> It was the first thing I could think of. Saw an opportunity. I saw a vulnerable one (house) and so I thought I'd do it, which was a mistake. It's led to this [imprisonment] (Charlie).

Jack had already acquired 'skills' in vehicle theft and so resorted to stealing and weighing in cars to support his mephedrone habit:

> I know it's not something I want to be proud of and say, but I learnt how to rob cars off him because I was watching him. And then if I was short of a couple of quid one night and I think, 'oh shit, I need some drugs.' I just go out and do it, wait until the morning because I'd have enough money on me until the morning to get drugs, and then go and weigh the car in, take the number plates off and that, weigh the car in, scrap it, get the money off the car and then go and get more drugs. And I done that a couple of times (Jack).

Aside from this range of acquisitive crimes, nine of the twelve interviewees indicated that they had become involved in acts of violence as a result of their abuse of mephedrone, to which I now turn.

Mephedrone and Violence

The links between mephedrone use and violence appear to be complex and multi-faceted. Four somewhat distinct links were discerned during this research. There are users who only report violence as part of the comedown phase (and who are otherwise 'happy and chatty' when 'high' on mephedrone) but equally there are also users who clearly report acts of violence during the 'up' or 'buzz' phase (many of whom have little or no recollection of these incidents but were arrested by police or told about their violence the next day). Then there are some users whose violence is linked less to the actual physical or emotional impacts of the drug and more to the economic compulsion to secure funds to continue to purchase mephedrone. Finally there is violence associated with the murky context of buying, selling and dealing mephedrone. Each of these sub-categories are considered in further detail below.

(i) Violence when 'High'

Despite the apparent pleasurable buzz associated with mephedrone use (discussed earlier) many users spoke about their involvement in acts of violence during the high. Some Mephedrone users became involved in what seemed to be random acts of violence against members of the public. Joshua, for example, reported that he chased a man through a town, and then hit him in the face. He had no recollection of this event, and was only informed of his actions by the police after his arrest:

> I was going through [a town] going back last year before I was in jail. I was right off my teeth…and then I don't even know what happened. Something happened and I just went chasing this boy, and I don't even know why I went chasing. I didn't even know this boy, but when I caught him I just slapped him and walked away. And two police officers come up to me and said, "why did you hit him?" I said, "I didn't hit nobody," he said, "Look, we've just seen you hit somebody (Joshua).

Joshua had also assaulted a man who was talking to his girlfriend whilst under the influence of mephedrone and was clear that this behaviour was out of the ordinary for him as he was not usually a violent person:

> Just a boy talking to my girlfriend… I just went at him, battered him down ... punched him in the face, hit his head on the kerb. I was going to get done for GBH but he dropped the charges and the police took on the assault charge…Fractured his eye socket…hitting his head off the kerb (Joshua).

Several users reported becoming easily and instantly enraged in response to the most trivial of triggers:

> If somebody starts on you it's just like rage. You go on a road rage. It's just like that if somebody starts on you, or just walks past you and looks at you a funny way, you just want to turn round and just batter them and you just won't care about it (Jack).

Some users recounted extreme acts of attempted violence in response to trivial triggers, as the following account from Ryan illustrates:

> I tried cutting his head off…(with) hedge shears. I tried cutting his head off with that. My mate dragged me off him (Ryan)

Ryan had become enraged because an acquaintance had consumed his alcoholic drink.

Users within this sample frequently used the term 'paranoia' to explain their involvement in acts of violence. They essentially reported that the drug induced paranoia and that they would believe that people around them (friends, acquaintances or strangers) were talking about them, planning to harm them or ..... This sometimes led to confrontations that could end in violence. For example, Morgan threatened a group of 12-14 people with a large metal bar, because he believed that everyone in the room was trying to kill him:

> I just went paranoid, and I was just sat in the room, I just picked up the metal bar because I thought everybody was trying to kill me, and trying to beat me up and all that stuff... I just said f**k off, I am going to hit you with this f**king metal bar (Morgan).

Moreover, Morgan was certain that this (and other intense episodes of violence) were exclusively linked to the negative effects of mephedrone:

> Definitely isolate the whole of it down to Meow, that incident, one hundred percent (Morgan).

Charlie, who had also experienced what he referred to as paranoid-induced violence, explained that once the paranoia had taken hold it became very difficult to 'shake off':

> It's just once you've got something in your mind. It's the same with the paranoia thing, once you've got something in your mind, it sticks. You can't let it go out of your mind. You just go over and over and over and over it. It takes a lot for me to lose my cool. When I lose it, it's hard for to come back. I got arrested and charged for that…assault (Charlie).

Like Morgan, Charlie emphasises a direct link between mephedrone and violence:

Fiona: So is it your view that those two occasions, once in your cousin's garden and then the once when you were with your girlfriend, do you think that those acts of violence might have happened if you hadn't been on that drug?

Charlie: No.

Fiona: So you definitely make a link between the actual…

Charlie: Meow, yes.

Fiona: Okay and of all the actual substances you've ever taken, it's never made you…

Charlie: No, because even if I was aggressive, I can usually pull myself away, but not, I was like a madman, do you know what I mean?

Some interviewees also noted that sleep deprivation, alongside the drug's paranoia-inducing qualities, led to acts of violence, as Morgan's account illustrates:

> Bomb normally, I did sniff it as well, but bombing was the main one for me. That's what messed my head up really on it, made me really paranoid. After two or three days as well and sleep deprivation in with it, you start hearing things, start seeing things. I thought people were trying to kill me on it, so I ended running around [town] with two long bleeding knives and ended up being arrested for it. It is a seriously bad drug (Morgan).

Violence was not restricted to strangers, friends and acquaintances. Users also reported committing acts of violence against their partners and family members and recounted instances of other users who had also become involved in domestic violence[14]:

> My mum and my sister...Yeah but they were petrified of me because I just... it's not just having a fight... it wasn't really a fight, I just flipped out and then they were petrified of me when I'm storming round kicking things. It's ridiculous man... Yeah, I kicked my mum and I would never ever want to do that again (Clare).

> His father knew he was on drugs and he didn't like it, and he snapped, got a knife, stabbed his father, realised what he did. His mother was in the bathroom,

[14] Domestic violence is defined here in its broadest relational sense to include the abuse of any family members, not simply partners.

> so she wanted to come out and she tried to help him. He got a knife and stabbed her and then stabbed himself and he came out of the house then with this knife and all blood (Abby).

In some cases, relationships were extremely volatile with both male and female partners assaulting one another regularly:

> Yeah, me and my partner used to fight all the time. Oh I could stab him (when you were on the drug?) Yeah ... without a doubt (Lou).

> And another friend of mine…She was on it for months and months and months and she went really aggressive and her and her boyfriend ended up splitting up because they were fighting all the time, and obviously that had [mephedrone] to do with it (Marie).

A small amount of violence was reported during the drug administration stage. One user recounted his direct knowledge of a man who was thrown out of a window because he was unable to find a vein in his acquaintance's arm to inject mephedrone. His acquaintance became enraged:

> Another one of my mates, I won't use his name, but ... there was a man fell out of a window into town and that was all over… the guy was trying to jab him but can't get a decent vein and then because he can't get a decent vein it's going off in the needle and he jumped up and put him through the window essentially like, put him in intensive care (Smithy).

It was sometimes difficult to discern whether aggression and violence were exclusively associated with the high (and if so what stage of the high) or as the drug was in fact beginning to wear off. Perhaps the closest any of the interviewees came to explaining this is captured in the quote from Joshua below:

> It's not when you're at the high-high, it's not when you're low, it's when you're just alert. It's like when you go right up and you just want to dance and all that, but then as it's starting to wear off, you're like, is he talking about me? You see people, are they phoning or is he texting someone about me? That's when your mind starts working overtime. Like I said, once something's in your head, it's not going to change. Even if you know it's not, you'll still think and think and think.

If Joshua's experience is common, then it appears that there is a particular 'window' when some users are most likely to become violent when under the influence of the mephedrone, specifically, just as the peak or buzz begins to subside. Nevertheless, the research also found clear examples of violence associated with the more sustained comedown stage, to which I now turn.

(ii) *Violence associated with 'comedown'*

Several users stated that when they were high, they were placid and calm, however, on reaching the comedown period they became aggressive and violent. Clare was one of a number of interviewees who discussed violence related to physiological and emotional impacts of withdrawal:

> It's more about the coming down bit you do then, Like I say I've come down so then I…that's when I get aggressive…I'm really snappy with everyone, really nasty. I have flipped out and smashed the house and stuff like that then, but not when I'm on it (Clare).

Other users linked comedown-related violence more specifically to their urgent desire to gain more mephedrone. For example, one user reported that, during the comedown period, he envisaged killing someone just to gain cash to get high again.

> When you're coming down you're in so much of a mood you just feel like going out and killing somebody , and not thinking twice about it and then just getting the money off them, and just go out and get right off your nut again (Jack).

(iii) Economic Compulsion and Violence

It has been well established in the criminological literature that there is an association between the need to fund a drug habit and violent crime (see for example, Goldstein, 1985; Wright et al., 2006) and use of mephedrone appears to be no exception.

Many users started by stealing money or goods from family or friends but their crimes then escalated, as Jack and Charlie explain:

> It started off like petty things, like taking fivers out of my mum's purse and that just to get like a gram or something, and then I was actually addicted. Well I found myself addicted to it, and then I started into like doing robbing telly boxes, the meter boxes, and then I started going into burglaries and then it just escalated like robbing cars, selling cars for money. And you try and do anything to get money (Jack).

> Jack committed two burglaries in quick succession on one occasion:

> I was taking fifteen grams a day, and at the end of it then I'd just be sat there like three or four days down the line thinking, 'Right, what can I do?' And then I'd go out and do another burglary and think, 'Oh yes, got money, blah, blah, blah,' and then it was just a constant circle. And it had a big

impact on my mum because the police were going there telling her I'd been locked up for this, been locked up for that (Jack).

Charlie had also become involved in burglary to fund his habit:

Fiona: Was there a link between the burglary and taking Meow?

Charlie: Yes...No money and on Meow at the moment, do you know what I mean? Run out. Didn't want that buzz to go. (Charlie)

Purchasing, Dealing and Dealer-Related Violence

Drug dealing has been long associated with violence (Goldstein, 1995) and the dealing of mephedrone is no exception. Three somewhat distinct kinds of violence were identified amongst this sample in relation to the buying and selling of mephedrone: (a) debt-related violence; (b) Bad Deals and Violence amongst Dealers and (c) Reputation-enhancing violence. Each of these themes are explored in further detail below.

(a) Debt-related violence

Firstly, it was often reported that users would become in debt to drug dealers who would, at some point, use violence to retrieve the outstanding payments. In part this was due to the technique of allowing users to have drugs on a "pay later" understanding, as Morgan explains:

I would have most of it on lay, strap, on tick or whatever you call it; it was a have now pay later sort of thing … and that was 10 pound a gram, but they will lay it, but they will lay it at 15 pound (Morgan)

Morgan had been in debt on several occasions and was aware that the process of paying later (or not as the case may be) was widespread:

Well I have seen people who have had their houses smashed up, windows smashed in because they owe people money. I have seen people beaten up over it. Because you can have now, pay later. And it's a lot easier to get yourself in debt with, and because you think I will get money here and there, and then you don't, and then you will end up laying off two or three different people as well, because it's that easy to get. If you lay £20-30 from one person and they won't lay you anymore, you ring someone else up (Morgan).

Some respondents suggested that dealers paid others to carry out retaliatory attacks against those who owed them money, perhaps distancing themselves from the act in order to avoid criminal justice sanctions:

> And I've seen people having knee caps busted and shit like that because they owe the dealers, but it isn't the dealer that will go for them. The dealer will go and get other boys to go and do the dirty work, and then the dealer will just give them a couple of quid for doing it (Jack).

(b) Bad Deals and Violence amongst Dealers

In other cases violence was related to 'bad' or dishonest drug deals between dealers. For example, Dave, who was purchasing large quantities of the drug to sell on, committed a vicious assault against a dealer who tried "ripping him off". Only two of the three large boxes actually contained mephedrone, which Dave discovered when he arrived home with the drugs. His violent assault of the dealer led to further violence in the form of retaliatory attacks. The escalation in violence was excessive and Dave was only prepared to discuss the detail with the recording device turned off.

Similarly, Smithy attacked a dealer for 'inappropriate' dealing:

> I've been violent because I've gone to do a deal and then someone's tried to sell it to me in singles and I've just attacked him for it. I didn't even bother taking the gear after I'd attacked him, I just attacked him and then went off and scored it off someone else because I thought he was taking the piss. I didn't respond in a normal way I suppose (Smithy).

Smithy was one of two respondents interviewed who had become heavily involved in dealer-to-dealer violence. He also discussed an arson attack that he carried out. He burnt another dealer's car (because he owed him money). He had contemplated robbing him but reconsidered, given the violent nature of the other dealer:

> Arson... it was his car... I suppose you don't want to rob the person who would pour petrol through your letterbox when your family's in bed (Smithy).

(c) Reputation-enhancing violence

Finally, some participants reported using mephedrone specifically in order to feel aggressive and to facilitate violence as part of the process of drug dealing. For some dealers, the violent-inducing qualities of mephedrone were useful in helping them to portray a tough and menacing reputation, which is of course necessary in this line of work:

> I definitely felt aggressive and violent to other people and I've used M-Cat specifically to make me aggressive and violent to people because I used to deal… I'm quite a nice guy when I'm straight, quite reasonable. I'm not so much when I'm off my head and if someone owes me money, yeah, it's easier to get the money out of them if I'm not reasonable (Smithy).

Smithy was firmly of the view that his ability to carry out acts of violence and portray a violent persona were important assets that would strengthen his status as a dealer, and, in turn, help to ensure that he was not himself robbed or attacked (for his drugs or cash). Smithy also talked about his heightened sense of paranoia when dealing due to carrying and housing large amounts of the drug and large amounts of cash. His home had become an armoury where he hid various weapons for his own protection:

> The dealing. Yeah, because I was paranoid continuously on it and I had large amounts of it always around me, and I had large amounts of money always around me, the dealing side of it, every house I lived in looked like a little arsenal really. I'd stick things under table, it was just filled with weapons essentially. I still suffer with paranoia now and I keep a weapon under my bed (Smithy).

Mephedrone Use and Impacts upon Health and Wellbeing.

All of those interviewed reported some kind of adverse physical, emotional and social impacts directly related to their use of mephedrone. These impacts tended to be cumulative, as use of mephedrone became more sustained.

Physical Impacts

The majority of users cited some kind of negative physical side effects associated with their use of mephedrone. The specific effects varied according to how the drug tended to be ingested, as the following quotations reveal:

> Negative, it gives you like holes in your nose. I've got a massive hole in my nose...It's so strong it just makes everything corrode. It's powerful (Abby).

> I've got a hole in my nose, at the top. It's gone bigger, going into the other nose (Charlie).

> It's not a nice drug because I don't see why people are taking it because I know it's absolutely… it messed all my stomach up because I've got stomach ulcers now from it and it really hurt (Jack).

> When I first started taking it I took a bit too much, the next day I was just sat and the next day my mum did me a Sunday dinner, and I was trying to eat it and I had to mash everything up. I couldn't open my mouth, I had locked jaw. It really, really hurt. For two days I couldn't open my jaw, so I was drinking soup through a straw. It wasn't nice (Jack).

> For a bloke as well, it will just shrivel his penis up, it does make a man's willy go smaller (Morgan).

Some users reported that mephedrone caused severe skin rashes:

> Yeah, it flared my skin up really bad, and my friend's father rang social services about me then because I was getting really out of hand with it; I was doing about an ounce a week. So it was either hospital to let it settle my skin and everything, or sectioned (Morgan).

The majority of users stated that rapid weight loss and the blackening of skin around the eyes were common for physical outcomes for mephedrone users. Weight loss was associated with the lack of appetite during withdrawal periods:

> It changes you completely, even the way you look. It do make you look like a heroin addict I think, when you're on it. You're all drawn in, you've got black eyes. I lose weight, totally off it, straightaway, it drops off me when I'm on it, so. Say I've done a week the longest, and the weight you lose in that week because you're not eating (Clare).

Finally, two users reported accidentally almost overdosing on mephedrone. Mark believed that he had a lucky escape as his overdose was near fatal:

> ...so I put the needle in, pierced the skin into the vein, drew back and blood came into the syringe, and I remember pushing half of the solution into my, pushing it up into my, administering it intravenously, half, and I felt the rush and I was like,"phew, that is strong" and then I pushed the rest up, and I started, I had a very intense rush, and I would describe it as, on as that particular occasion, more intense than I've had from smoking crack cocaine. Then I remember hearing a buzzing, bzzzzzz, and going, seeing black. I think my eyes were still open but seeing black. And then I went unconscious. My cousin phoned an ambulance because I started having a fit and like a choking, and when I was on the floor unconscious he was on the phone to the paramedics (Mark).

Emotional and Psychological Impacts

Users reported a range of negative emotional and psychological impacts directly associated with mephedrone use including feelings of paranoia, depression and, in some cases, suicidal thoughts as well as un-nerving visual and auditory hallucinations and nightmares. The following quotations provide a flavour of these diverse impacts:

> And then after I come down, then I had two nights sleep not taking anything for like two days and then I woke up and I thought my reflection was going to kill me (Clare).

> Yeah, butterflies on the wall. My legs were walking up the side of me, and thinking somebody was up the side of me. I'll tell you the bad dreams, very, very bad, bad, bad, bad dreams (Lou)

> When I was taking it I thought I was hearing voices, and I went straight to my doctor and I said, "Look, I'm hearing voices," and he said, "Are you taking drugs?" And obviously I had say, "Yes," and he said, "Right…" and he got me help as well (Jack)

> Especially at night-time then as well, if you do a bomb and walk around at night-time, after two or three days of that you will start seeing things you wouldn't even believe. And staying up for two or three days, and taking heavy amounts, is like taking acid, it really does make you hallucinate (Morgan).

> I'd say you get depression, anxiety and you can get paranoid off it as well. You can feel like people are watching your house if you're out and everyone's watching because you get like a wet nose, so it makes you want to wipe your nose all the time. Yeah paranoia (Abby)

Depression was identified by most of the sample as one of the many adverse impacts of mephedrone consumption. It had led some users to almost give up on life and certainly they disengaged from usual routines and personal hygiene:

> You just don't care about nothing; your job could go out the window, your family. Well it did do me a bit, like I got thrown out and stuff like that, and then I really... like I got on then and then I come down and I was like I've got to sort my life out or this is what my life is going to be, stuck in the car like with nothing (Clare).

> You can't be arsed to bath. You can't be arsed to brush your teeth. You can't be arsed to put make-up on. You can't be arsed to walk to the shop unless you've got to (Lou).

Social Impacts

The impacts of mephedrone clearly went beyond the physical and emotional and also impacted upon the social lives of the users and, in many cases, those with whom they were intimately connected. Many users lost their jobs as they failed to attend work and soon became unable to pay household bills. Moreover, as their own lives spiralled downward, this inevitably had consequences for family and friends. Lou - who during interview referred several times to mephedrone as 'poison' and 'the devil' talked about the family impacts:

> I lost everybody. My children, my mother, my family, everybody (Lou).

> But in the end I was strapped and I was in debt all the time. I had no money, I had no food in the house, I had nothing. It was just like … it just ruined us, ruined our lives. And that was after a short term, so these people who are doing it now long term I don't know how they are coping (Ryan)

Prevalence of Use

Assessing prevalence of use was not a focus of this research. Nevertheless, many users spoke of the widespread use of mephedrone amongst their friends and associates and how it had taken a hold where they lived, as illustrated in the following quotations:

> I would say, including girls as well, I would say of all the people I know about 75-80% have taken it at least once (Morgan)

> My friends? I'd say at least 80% of my friends, if not more. All of them have tried it. Lots of people say they're not using it and are using it (Smithy)

They also explained that this was a drug taken by people of different ages (the youngest reported age being nine) and of varying socio-demographic status:

> I've seen women who are working, like 30 odd, working, kids and all, have had their kids taken off them, lost their jobs. I mean, they used to be respectable people and family people as well, which you'd never think. It's just everyone out there as well. You'd be surprised. Women like yourself, which you'd never suspect. I know teachers who used to take, I used to sell it to teachers … and I've sold to nurses from the hospital (Charlie).

Giving up Mephedrone

Interviewees were asked whether and how they had managed to cease using mephedrone and for their opinions on what might help users to give up. In addition, those who took part in the survey also provided some important insights into how they had managed to give up mephedrone and what might help users to give up. The findings from the survey respondents are detailed in Table 5.2 below.

Reasons for Giving Up

The findings from both sources indicate that there were two primary reasons that led users to give up mephedrone: (i) negative health impacts (physical and emotional) and (ii) negative family impacts. A smaller number of users mentioned the financial implications of continued use as a barrier to continuation as well as increased tolerance levels or boredom with the drug. In reality of course, it is often a combination of factors that leads one to reduce drug intake or cease altogether, as indicated by Lou below:

> One, I didn't have any money; two, I was losing all control of myself. My family, I could see the impact it was having on other people. I didn't like myself, the things I was doing to get the drug then (Lou).

Routes to Giving Up

There were various ways in which users managed to give up mephedrone. Many in the sample spoke about avoiding 'drug' friends i.e. those who used mephedrone or other drugs as a key positive step in giving up. These users would often stay at home and try to occupy themselves in new ways. Some users went so far as to move from one area to another in order to help them to break former ties with drug-taking friends and acquaintances. Some users talked about the importance of having the support of their family or a partner to help them to continue to abstain. Other users indicated that giving up mephedrone was not particularly difficult and that they simply applied will power to achieve this goal. These users tended to be at the light-use end of the scale of users and were likely less addicted to mephedrone. A small group of users felt that custodial sentences had assisted them in ceasing to consume mephedrone as their daily routines changed and they were separated from their drug-using peers. Two users replaced mephedrone with other drugs in order to specifically avoid the harms that they associated with mephedrone. Finally, a significant number of the sample had received support from drug agencies or other organisations that had aided the process of cessation.

What Helps Mephedrone Users to Abstain?

Finally, in terms of what kinds of help or support users felt would be beneficial to users of mephedrone who were hoping or trying to give up, various insights were provided. Notable amongst the recommendations were: (i) better education about the drug and its harms; (ii) support and counselling; (iii) bringing users together with ex-users who can provide 'real' experience-based advice.

Mark felt particularly passionate about the latter:

> You are going to need help from other recovering addicts ... people who are clean and sober who you can identify and relate to, who can gain your trust ... You need to have somebody with empathy, somebody who understands. Somebody who can build a rapport with you quite easily, somebody who can get your attention, give you a bit of hope, give you something to hold onto, "yes, I want a bit of what they've got" (Mark).

Summary

In summary, most of the users who took part in in-depth interviews revealed that they first decided to consume mephedrone in the context of a night out (or sometimes a night in) having fun with their peers where they were invited, or actively encouraged, to try it by a friend. Most users had an initially pleasurable experience prompting further use. The 'buzz' was described as being better than other drugs inducing happiness, chattiness and confidence. Mephedrone also helped some users to forget life's problems.

However, these pleasurable feelings were short lived and users had to deal with debilitating withdrawal impacts including stomach cramps, lock jaw, depression, paranoia, auditory and visual hallucinations and in some cases, psychosis and suicidal ideation. The desire to offset the effect of comedown and to return to the highly pleasurable effects of mephedrone invariably led to 'fiending' – i.e. increased frequency and volume of use. This in turn led to soaring costs and a host of additional difficulties. Over half of those interviewed had become involved in acquisitive crime (including shoplifting, burglary, vehicle theft and street robbery) and three-quarters of those interviewed had committed acts of violence connected in some way to their use of mephedrone. Four somewhat distinct violence-mephedrone links were discerned: (i) violence when 'high'; (ii) violence associated with comedown; (iii) economic compulsion and violence and (iv) violence associated with purchasing and dealing mephedrone. Importantly, regarding the first two categories, interviewees were very clear in their own minds that mephedrone had a

direct and significant influence on them becoming involved in acts of violence. This, they reasoned, must be the case as they were either not usually violent or, would not normally have been violent in relation to such trivial triggers.

Mephedrone also had a range of negative impacts upon the health and social well-being of users. Most users suffered significant physical and emotional side-effects and many were unable to pay bills, look after themselves properly and lost jobs, had children removed from their care and lost contact with family and friends.

Users consistently reported finding it extremely difficult to give up mephedrone. Nevertheless, some had succeeded and all of those interviewed, as well as those who took part in the survey, had important insights regarding what might help users to abstain permanently including: (i) better education about the drug and its harms; (ii) support and counselling; (iii) bringing ex-users together with users to provide 'real' experience-based advice.

In part six that follows a number of these themes are revisited as we hear from expert practitioners about their insights of the various impacts of mephedrone upon users.

Table 5.2: Giving up Mephedrone: Survey Participants' Insights.

Why users stopped	How users stopped	How we can help users to stop
Realising what it is doing to me and what I will lose.	Keeping myself occupied and staying in.	Talking, getting groups together.
Own health and for family- to have a closer bond. And to keep hold of girlfriend.	Jail, drug worker + probation + family support. Lots of support around me.	You can try as much as you like but as long as it is on the street you can't stop it.
Stopped using	Just stopped because I didn't want to use. I didn't like the person I turned in to.	
Bored - had enough. Couldn't get any higher.	Say goodbye to all drug use. Change way of thinking. Drug intervention programme and family help.	Has to come from within.
	Tried to reduce- DAYS helped me	
Family.	Help from drug service, tried to stop on my own- stopped for 2 weeks.	Detox in hospitals
Because it made my mum upset and I hated the comedowns.	Tried to keep myself in. I would lip my mam so she would ground me. I asked for professional help from a drug service.	Government give more money for drug support workers.
It was destroying my mind and body		Raise the Price. Education.
Tolerance rose to the point where the effects were miniscule.	Replaced mephedrone with other drugs.	Offer them support
Fed up	No Money	
Didn't agree with personality and due to health reasons.	Avoided certain groups of friends.	More aware of health factors & health.
Not Sure.		
Effects.	Stopped friend contact.	
Sick of it.	Take it or leave it.	Only I can stop it.
Made hole in leg.		More education.
		Go into schools and educate the young.

Little break.		
Because of depression.	Suddenly stopped. Some withdrawals but manageable	Education from peers.
DVT hospitalized few weeks. Almost died.	Wanted to stop and did stop. Found it quite easy.	
Losing too much weight and too expensive.	Find it quite easy to suddenly stop.	Education.
It was a one of drug and seeing what it does to people's skin.	I just stopped myself, no help needed as I didn't let myself get into that badly.	Every body's different, each person responds in all different ways to coming off it.
Yes, have stopped using.		Don't know.
Made me get sectioned.	Hospital.	They have to want to stop.
It's not a problem.		They can only help themselves.
It's not a problem.	Keep away from people who do it and dealer mobile phone numbers.	I don't know much about it! So could chat more about it or bring someone in.
Weighing up what was better, heroin or miaow and heroin won. So I stopped the miaow. If I carried on it would have killed me.	I just topped. Quickly became repulsed by it. Ended up in hospital with swollen legs. Started using more heroin to the miaow.	Leave a pair of miaow filled trainers so people can find out what they smell like. The drop-in is a great support just knowing it's there.
Financial cost. Doesn't work as well (tolerance). Losing Weight. Will power.	Will power.	Education people need to learn for themselves.
Because of the harm it did to me.	Went to prison. Saw this as a way of stopping	Education. Provide support.
		Education.
Had enough of being unable to spend time with non-users.	Motivation.	
	You can't they need to want to do it themselves when they're ready.	
Same time as I stopped cocaine, 3 months ago- new partner anti-drugs agreed to me using a few times a year at special events.	Just stopped using then for extra support contact Teds for support worker.	

I've cut down on it like I've cut down on everything.		
Ruined relationships with my family.	Moved away from area. Changed my friends.	Offer support and counselling.
I'm trying because its putting me down and making me lose my family.		It's really hard because its everywhere I go.
Because after doing it every day for weeks it makes you feel like shit when your doing it.	Moved away from the area.	
Too expensive. Stole to fund it. Dangerous.	Cut down and used amphetamine.	Use a treatment agency.
Losing sanity.	I just stopped.	Prescribed Benzo's.
		Prescribed diazepam.
Only did it for 5 days.	Stopped going out for a few weeks.	Showing more adverts, more meetings.
I moved to the refuge and got custody of my son after I stopped.	Went into a refuge. They helped a lot.	Dealing with the initial problem to start with counselling helped a lot.
Went a heroin and went to jail.	Went to jail.	Lock them up.
Felt the time for experimenting was over.	I was never addicted so I just stopped	It is seen as a 'safe' alternative to most drugs. More publicity on the long term effects without scaremongering.
		Counselling.
Got too much out of control, ended up on heroin.	No just stopped.	
	Didn't use much.	Don't know.
Because it is a cheap drug.	I just stopped with my own will power.	
Don't take it regularly. Take it or leave it.		
It's not the drug you would want to take regularly - lose weight.	Didn't have any and couldn't get any.	Find a substitute, address the facts etc. more info.
Playing head games.	Changed my mates.	More group chats.
		Lock them up.
Makes me nasty and rob a lot on it.	Change friends circle.	Help from drug agencies.
No worth doing now.	Taking other drugs.	Can't help anyone who is flat out of it

Now I am clean.	Woke up in hospital and family members helped me through.	Tell them my experience.
To sort my life out.	Just stayed away from it.	You can't.
	Just stopped.	Not using it now.

Part Six: Qualitative Research Findings (ii)

The Views of Practitioner 'Experts'

In this part of the report the findings from semi-structured interviews with a range of practitioner experts are discussed. As indicated in the methodology section of this report, the experts had direct experience of working with mephedrone users but also had extensive experience of working with users of other drugs and so were able to discern the particular impacts that mephedrone had upon the lives of the clients that they were assisting. Table 6.1 below provides an overview of the sample of experts interviewed for this project.

Agency Type	Coding used in findings	Number of Interviews
Charitable organisations providing a range of services for drug users & their families.	Independent Drugs Practitioner	6
Charitable organisation for disadvantaged and homeless people.	Independent Charity Practitioner	2
Charitable organisation for disadvantaged and homeless people	Health Practitioner	1
Offender Management and Drugs Liaison.	CJ Drugs Practitioner	1
Probation Service.	CJ Practitioner	1
Prison Offender Intervention (drug) Service.	CJ Drugs Practitioner	3
Criminal justice drug through and aftercare service.	CJ Drugs Practitioner	2
Youth Offending Team.	CJ Practitioner	2
Mental Health Day Service.	Mental Health Practitioner	2
Total		**20**

The findings are organised around five key themes: (i) The physical impacts of mephedrone; (ii) the emotional impacts of mephedrone (iii) family and social impacts; (iv) the links to acquisitive crime; and, finally, (v) links to aggression and violence.

The Physical Impacts of Mephedrone

Experts had witnessed a range of serious negative physical effects of mephedrone use upon their clients including rapid and extreme weight loss, damage to nasal passages and injection site damage:

> The top three would probably be the physical health side. Things like peoples noses coming away, very run down, poor circulation, so the kind of physical health… breakdown of, you know, nasal passages, poor circulation, extreme weight loss (Independent Drugs Practitioner).

> They get a lot of bruising, but not necessarily bruising at the site they're injecting, which I find strange. Abscesses they've had, lots of lumps and bumps, a burning sensation when they do inject. And some of them are having symptoms which they find inexplicable, and they've only had these symptoms since they've been injecting mephedrone (Independent Drugs Practitioner).

Some experts reported that heavy end mephedrone users had disregarded safe injecting practices when using mephedrone. Specifically, they had become aware of users sharing needles, injecting into the same site on multiple occasions and using unsafe injecting equipment. These risky behaviours had apparently led to an increase in blood borne viruses in certain parts of South Wales:

> We've had a lot of normally 20-year injecting drug users who have never shared works, never kind of kept going in the same site, would always take care with regards to injecting techniques, who went from 20-years safe practice into sharing with 20 people, using dirty pens, blood borne viruses has increased 50% in (region of south Wales) as a result…It's just bizarre on how someone can go 20 year injecting to now all of a sudden having six open wounds that need surgery on their arms, and big holes in their groin, legs going black, having fits, having bladder problems (Independent Drugs Practitioner).

The damage caused by intravenous use of mephedrone was emphasised by many of the practitioners:

> But people injecting twenty, 30 times a day, you know, it doesn't take a genius to work out that they're inflicting five, six, seven times as much damage on their veins as they would be if they were using heroin, say, for instance ... And it's much more corrosive, yes (Independent Drugs Practitioner).

> And people were nearly losing limbs because they were injecting it (Health Practitioner).

The Emotional Impacts of Mephedrone

The similar range of emotional impacts to those described by mephedrone users in the previous section, were also observed by practitioners who worked with users. These included depression, paranoia, psychosis, schizophrenia and, in some cases, these symptoms were so severe that clients had self-harmed and/or attempted suicide.

> Mental health, you know, paranoia, schizophrenia, certainly drug induced psychosis but on a much, I would say, more intense and much faster, much shorter period at least before that comes on, if you follow me (CJ Drugs Practitioner)

> This particular young girl jumped out of a window and broke both of her feet. That was a bit of wake-up call and … that wasn't an attempt at self-harm or suicide, it was just kind of her head had completely gone. She didn't really know what she was doing (Independent Drugs Practitioner).

> People come in, you know, who have been up for a few days and haven't eaten and haven't slept, and just talking to them you can see the place that they're at. Mentally, they're not in a great place, and some of them have mental health problems before they even start, and it seems to exacerbate it, the mephedrone does (Independent Charity Practitioner).

> Scratching their faces as well, they think there is something crawling on their faces so they'll be very irritable, edgy, paranoid and clearly delusionary and sort of, you know, hallucinating (CJ Drugs Practitioner).

The mental anguish and confusion caused my mephedrone had been observed first hand by many of the practitioners interviewed and manifest itself in various ways across users:

> Rocking back and forward in the chair, playing with everything, picking up things, picking up the chair, standing up, sitting down, getting quite hyperventilating, "They're all doing my head in, I'm going mad. I've been used as a mug, I'm not having this anymore." Kind of pacing the floor, pulling at his hair, picking at his skin, scratching everywhere. Not feeling very comfortable in his own body, working himself up into kind of frenzy then I suppose until he'd like start walking around the room pulling at his hair and bashing his head on the wall (Independent Charity Practitioner).

> He picked up a phone on the desk and he started continually pressing numbers, just random… you know, he must have pressed 50 or 60 numbers before I sort of managed to get through to him, "What are you doing?" "I'm

ringing my mum," and he's still pressing numbers, just pressing numbers as quickly as he could. I said to him, "Put the phone down," and it was like as if I wasn't there. "Put the phone down. Put the phone down. Put the phone down." And in the end I took the phone off him and put it down and he looked at me as if, "Where do you come from?" You know, he wasn't aware of my presence at all until I removed the phone from his grasp and it was only then, "Who did that?" (CJ Drugs Practitioner).

Drug workers spoke about self-harm and suicide more frequently than the users who took part in interviews. Clearly they had many extremely vulnerable people on their case loads:

Definitely self-harm. It seems that the higher they get, the lower they get. And heavy use over time, as well as the kind of environmental factors of family breakdown, losing jobs, those kinds of things. There is one particular gentleman that comes to my mind. He's only sixteen now, so this has been happening over the last couple of years. He tried to throw himself in front of a train and that was his kind of wake-up call (Independent Drugs Practitioner).

I was a bit worried about suicidal issues and he'd come in with cuts on his arms quite often, and he wasn't very open to talking about what had gone on with any sort of emotion. But there was still lots of self-harm issues that I could see, like fresh wounds on his arms and things like that (CJ Practitioner).

Yeah, self-harm has been not very, very common but there's definitely at least three or four cases in the last year that I've had personal interaction with who have committed self-harm, not having done so before (Independent Drugs Practitioner).

The withdrawal phase was reported by practitioners as a particularly vulnerable time for users and a period when they were most prone to self-harming:

When they're on the drug they're happy-go-lucky and they're flying high and whatever, but it's the come down after it is. It takes about three or four, five days to come down and that's when…Yeah, that's when the people try and kill themselves, trying to harm themselves (Independent Charity Practitioner)

When they're high they're so high, they say it's the best high that they've ever, ever had. So when they come down from that they consequently feel really, really low, really miserable and really fed up. So the number of people that have come in and told me that they're suicidal and they want to kill themselves and all the rest of it is… I can't… that was every day, I think,

> I had somebody coming in and telling me that they were suicidal (Health Practitioner)

Family and Social Impacts

Expert practitioners had observed the lives of some of their clients taking dramatic downward spirals as their use of mephedrone increased. Users accrued significant debt, became unemployed, gained criminal records and were sometimes imprisoned, had children removed from their care and experienced relationship and family break-up. Some of these social costs were likely to be difficult to overcome, even in the long-term:

> Total breakdown of kind of normal life then really, family life, perhaps losing jobs, debt (Independent Drugs Practitioner).

> Like one of those was a break up in relationship, another one was down to financial debts due to M-Cat, another one was that their children were about to be adopted, going through social services (Health Practitioner).

Practitioners were also aware of clients whose lives had fallen apart in various ways and who were determined to give up mephedrone but had, nevertheless, failed to abstain in the long-term:

> The fact that he now has a criminal record, he lost his job, family problems, his partner doesn't want him to see his children. You know, obviously he can see his children but supervised contact. All of these significant negative things was a bit of a wake-up call to him, yet he's still slipped back (Independent Drugs Practitioner).

> Some people will try and nip it in the bud, but unfortunately there are some then who hit rock bottom, who come in jobless, been kicked out of home, got no cash, on their arse completely (Independent Drugs Practitioner)

Mephedrone and Acquisitive Crime

Most of the practitioners interviewed had worked with clients who had become involved in some kind of acquisitive crime in order to fund their use of mephedrone. Offences include shoplifting, burglary and robbery.

> They spend a lot of money on M-Cat, and to fund that involves thieving for most of them (Independent Drugs Practitioner).

> It doesn't seem to be kind of planned, so it's usually the minute they kind of… they don't want to but then they start, and then it's just like they just feel as if they can't stop and they need more of it. And they're not sort of

thinking clearly what they're doing, so they're just getting money from anywhere really. Robberies are the main ones (CJ Practitioner).

Numerous practitioners indicated that whilst mephedrone was a relatively cheap drug, users nevertheless often spent significant amounts of money to fund their drug habit due to rapid increases in tolerance associated with mephedrone abuse:

> It's just when they're on Meow, because the quantity that they need is so vast than obviously when they're taking heroin, they can maintain maybe a £50 a day habit on heroin, whereas with Mephedrone you're taking of hundreds of pounds a day. And obviously if they're with a partner at the time they're also funding their drug habit as well (Independent Drugs Practitioner).

> When people start using it it's not acquisitive crime because it's so cheap and everybody's got it and everybody's like sharing with everybody else. The acquisitive crime will come later one when they're so hooked that they're doing it every half an hour and then they need a lot. At one point there was one guy that was on with us that was doing like seven, eight grams a day. Your body can't sustain that. But you've got to fund that as well because that's a daily thing (CJ Drugs Practitioner).

Several practitioners recounted direct knowledge of clients who had become prolific shoplifters or burglars in order to sustain their mephedrone habit:

> So she will just go to a supermarket, get a trolley, fill it up with meat or electrical goods and walk out. And she will do kind of three or four supermarkets a day just to keep herself in Meow and heroin, and whichever partner she's with. So she's now coming onto the prolific offender scheme, so when she kind of goes off the rails she goes off big time. She'll pay a taxi driver to take her wherever to do her 'shopping' (Independent Drugs Practitioner).

> And the other one will hook up with a male, go on a crime spree and she did five burglaries (Independent Drugs Practitioner).

A few practitioners were also aware of clients who were already involved in criminal activity but whose criminal actions had become more risky or dangerous as a result of their use of mephedrone abuse:

> How can I put it, a career criminal of very basic level intelligence was saying, "I felt like I could just walk in any shop and steal anything I wanted, and nobody could stop me or touch me. And really that nobody could really see me doing it, that I could just... I was invincible and that is all I wanted to do.

> And that is all I wanted to do was take more ... I felt so strong and I just wanted to keep on doing it because I've never felt like that before." Now when you, you know, when you couple that person's experience of that drug with the fact that they're already a prolific offender, that is quite a dangerous sort of scenario, combination really (CJ Practitioner).

Mephedrone, Aggression and Violence

Practitioners had both direct and indirect knowledge of their clients' use of aggression and violence in connection with mephedrone use, as the following excerpts illustrate:

> He started using mephedrone on weekends with his friends, kind of boys going down the pub drinking lots and then they started taking mephedrone. And this was happening over a period of probably up to about a year, where because of tolerance level they were having to take more and more and more. And it got to a point where, in his words, he kind of lost his head over something quite small, and was done for criminal damage and assault. Something he says is completely out of character (Independent Drugs Practitioner)

Practitioners recounted many examples of long-term clients who had never exhibited aggressive or violent behaviour until their involvement with mephedrone:

> Say if we had ten service users here now who weren't aggressive, I'd say eight of them would be aggressive on the come down of the M-Cat (Independent Charity Practitioner).

> Just very… people becoming very angry, very aggressive, they're on the edge as if they're about to start fighting, not taking up a boxer's stance sort of thing but when you're trying to talk to them they can be very aggressive in their demeanour, shouting, waving arms about, threatening. Yes, just becoming generally threatening, anxious and threatening aggression to people (CJ Practitioner)

> We had a young man and he came in, he signed in, he had a shower and you could see he'd taken something. The same as he was normally, he went on the computer, he read something on the computer on his Facebook, something set him off and he was chasing his brother around the dining hall. Then he did eventually get him and he tried to strangle him. We separated them and we took him outside, and he started fighting with a guy in the graveyard. We told him to leave, he told us to f**k off, this place is s**t.

> And two days later when he came back and he'd got no recollection of being in here (Independent Charity Practitioner).

Several members of staff stated that there was an association between the rise in domestic violence in the communities where they worked, and mephedrone use:

> No, domestic violence, and there's quite a lot of that going on at the moment. Family members attacking family members, long-term relationships breaking down. If you have a chat with social services they've seen an increase in child protection cases where parents are taking mephedrone, so it's having a knock-on effect on everything. Crime rates are changing, more social service involvement, more adult protection concerns, mental health increases. Domestic violence has more than doubled (Independent Drugs Practitioner).

Members of staff across several agencies stated that mephedrone users were particularly prone to being violent during the comedown phase of their drug use.

> Oh, they come in here and very aggressive. It's not so much when the drug is inside them, it's the come down after (Independent Charity Practitioner).

> Other sort of strains of violent behaviour have been verbally aggressive that stemmed from the extreme anxiety that people feel once they've been using for a while. The paranoia that grips people if they've been awake for seventy-two hours. And so people who have been verbally aggressive to partners and neighbours and things like that, because of perceived goings on that they've had, psychosis essentially (Independent Charity Drug Practitioner)

Some practitioners were aware of noticeable increases in various forms of violence associated with mephedrone addiction and, in particular, pointed to an increase in more 'brazen' forms of violence:

> Violent crime has increased ...There's more street robberies, there's more blasé burglaries where they're walking in and burgling people's houses when they're actually in the house. There's obviously more violence with regards to dealers expecting payback, especially from the pushers. And then people, who predominantly have been friends, are kind of on a comedown kind of losing the plot, paranoia's getting extremely high in the area. So there's a breakdown in mental health, therefore more likely to trigger violence between people who have predominantly been friends before. A more brazen violence and risky violence (Independent Charity Drug Practitioner).

Aside from their knowledge of violence committed by clients, many practitioners also had direct experience of violence and aggression during their dealings with mephedrone users:

> They can be very aggressive in their demeanour, shouting, waving arms about, threatening. Yes, just becoming generally threatening, anxious and threatening aggression to people (Independent Drugs Practitioner).

> If you ask a tricky question they're getting quite aggressive. Reporting kind of times when they've been violent, when normally violence has never kind of entered in their kind of criminal history in the past (Independent Charity Drug Practitioner).

In one case a practitioner was punched in the jaw by a mephedrone user who normally was placid and respectful. The user, who apparently had no recollection of the event, received a custodial sentence:

> Yes. It was absolutely [linked to mephedrone use] … had never posed any problems or threats to me whatsoever, and he couldn't think straight and up with his fist, hit me on the jaw. And then he was arrested, went to prison, but when he got to the court he said he had no recollection whatsoever of what he'd done and he said, "I can't believe…" It was about twelve or fifteen hours before he realised and he said, "I can't believe that I did that to somebody that I respect so much." He said, "I just feel so ashamed of myself." So no recollection at all. (Health Practitioner).

Practitioners were clear that the behaviours that they had to manage were distinct and beyond the normal challenges that confronted them in working with clients addicted to other illicit substances or clients with a range of social and emotional difficulties:

> He was going to knife us all, he was going to kill us all, and I think probably if he had a knife he might well have. He didn't, and he was really difficult to manage to even get him to leave the centre, and I think the police were called in the end and took him into custody. And that's not normal for us, we can normally always manage people. But we can't when they're completely taking enough mephedrone and we cannot manage them (Mental Health Practitioner).

> It was up in A and E ... managed to throw themselves against a plate glass window ... with enough force to break the window, and then he picked up shards of glass and was threatening and waving those around and wanting to attack everybody. He was physically restrained, it took six male police

> officers to restrain the individual and he had to be, what is the term, medically sedated (Independent Drugs Practitioner).

Whilst most of the practitioners were of the view that there was a clear link between mephedrone use and aggression and violence, some practitioners also recognised that the links were somewhat more complex. One criminal justice practitioner felt that mephedrone users who became aggressive or violent already had such tendencies, the drug simply unlocked them:

> And I think, like a lot of drugs, it unlocks… you know, takes away some of his inhibitions and unlocks some of the sort of underlying issues that you've got already. And the people that have been aggressive in the extreme under it have already been people with a bit of aggression in them. So I'm not sure that it's… it doesn't already facilitate what is already there, if you follow me? (CJ Drugs Practitioner).

Another very experienced drugs worker recounted the story of a man in his early thirties who had become extremely unstable and violent after his abuse of mephedrone. This was completely out of character:

> He's 34. Twenty years in substance use, well, more than 20 years in substance misuse, started at the age of 11. Within a three month period was starting to have major health problems, starting to fit, have blackouts, people would rob him when he was having a blackout in the street. And then snapped and became extremely violent. So during the kind of most vulnerable stages was presenting as a withdrawn person, sitting in a chair, shaking, having panic attacks, couldn't breathe. And then other a progression of a couple of weeks would start kind of slamming things on the table or pushing the chair back in an aggressive manner. And then reported on the Monday that he completely lost the plot, was in a house party and completely lost the plot, smashed the flat up, was randomly attacking people with like bottles and legs of chairs that he'd smashed up, and then presenting the day after completely … hard to describe his behaviour really, like a wild animal is the only way of describing him and that was on a comedown (Independent Drugs Practitioner).

When I pressed the drug worker on whether she was sure that it was mephedrone specifically that had led to this young man's violence, she explained:

> It was linked to the taking of that drug, but then because of obviously child protection issues, having the child removed, having supervision, contact of that child removed, subsequently had a negative impact where he went and just used more - thought bugger it, I'm going to go off and use whatever.

> So there were lots of other kind of underlying things, but heroin use had dropped. He wasn't using the heroin, was sporadically picking up his Subutex prescription, dropping in and out of treatment. Whereas he'd had a three year period testing negative, doing really well, no health problems, no mental health issues (Independent Drugs Practitioner).

Experts all agreed that the negative impacts of mephedrone were multi-layered, often affecting clients' physical and mental health, harming or destroying family relationships, leading to job loss and in some cases imprisonment. Most experts rated mephedrone as amongst the most damaging and debilitating drugs that they could recall, as exemplified by the following narrative from this experienced drug worker:

> But there's definitely been an escalation in everything crime-wise, violence-wise and in kind of how people are presenting, even down to their injecting techniques. It's just bizarre how someone can go 20 year injecting to now all of a sudden having six open wounds that need surgery on their arms, and big holes in their groin, legs going black, having fits, having bladder problems. And how people have kind of deteriorated, losing like three stone within a couple of months, and even their kind of decrease in mental health and just how quickly people are deteriorating. So, yeah, it's been one of the worst drugs that I've come across (Independent Drugs Practitioner).

Relatedly, drug-workers were often pleased and relieved when former heroin addicts, who had switched to mephedrone, returned to a more 'stable' position of using heroin:

> I was talking to drugs workers this week and ... you know, along the lines of, "isn't it nice to see him back on the heroin." (Independent Drugs Practitioner). "It's so nice for them to be back on the heroin because, you know, they were absolute nightmare on that Meow stuff, but now they're back on the heroin, you know, everything is okay again." And I heard that, honest to God, it's just if you had told me that three years ago that we'd be saying that about heroin, I would have looked at you daft. I've heard that on numerous occasions, people being thankful that somebody has managed to find their way back onto heroin (CJ Drugs Practitioner).

Finally, some of the expert practitioners had good local knowledge of drug-dealing and its links to violence. One of the particular problems highlighted with mephedrone in this regard was the practice of providing mephedrone free of charge but with 'interest' payments (known as 'laying'), as the following practitioner explains:

So they'll give a drug user an ounce of mephedrone and then expect payment within a week, and then obviously there's a lot of violence surrounding that as well, if they don't pay back. Each dealer's got their own methods of getting their money back. Some boys will just basically attack people with a plank of wood with nails in, and attack their legs, break their legs or damage their legs. A boy in (xxx) will just kidnap people, take them up the mountain and frighten them to death. One in (xxx) will just randomly go up, in their houses and rob. There's another boy from (xxx) who will just walk in your house and take everything that's in your house.

Q And you know this by speaking to the users who've owed them money, who've recounted these stories to you?

A Yeah. Sometimes they don't even accept money at the time, they just… there are two types of drug dealers. There are those that sell on demand and those that are pushers who will just know someone is … who's been using or is in withdrawal and will push an amount on expecting payment back knowing that they know the consequences of not doing that. So we've got a selection of pushers as we call them and then dealers. Dealers, those who basically supply on demand, and then those that are pushing on people larger and larger amounts knowing that they're then going to get payment back or there'll be consequences for that.

In summary, expert practitioners' views essentially mirrored those of the users that were interviewed in terms of the debilitating physical, emotional and social harms associated with the use of mephedrone. Practitioners generally found the behaviour of mephedrone users to be significantly more challenging than those of other drug-using clients. Many practitioners had been on the receiving-end of aggressive and violent behaviour by mephedrone-using clients, most of whom had not exhibited such tendencies in the past. Many had been verbally threatened and several had been physically assaulted. Practitioners also reported a range of acquisitive crimes committed by their clients specifically linked to their abuse of mephedrone and the necessity to fund their increased use of this highly addictive drug. In addition, given their more widespread knowledge and experience of working with many users of mephedrone and other drugs, they were able to discern that mephedrone appeared to have more damaging impacts than other drugs and, as identified above, many drug workers were 'relieved' when they learned that former heroin addicts (who had become involved with mephedrone) had returned to heroin. Overall, practitioners indicated that the behaviours that they had to manage were distinct and beyond the normal challenges that confronted them in working with clients addicted to other illicit substances.

Part 7: Conclusions and Recommendations

Conclusions

In conclusion, the research findings indicate that mephedrone is associated with involvement in acquisitive and violent crime as well as a wide range of physical, emotional and social harms for those users who become addicted to the drug and use it on a regular (notably daily or weekly) basis. Just over 40% of those who took part in the survey and over 75% of those interviewed, reported engaging in violent crime as a result of their abuse of mephedrone and over half of those interviewed reported having engaged in acquisitive crime (such as burglary, street robbery and shoplifting). Four somewhat distinct violence-mephedrone links were discerned: (i) violence when 'high'; (ii) violence associated with comedown; (iii) economic compulsion and violence and (iv) violence associated with purchasing and dealing mephedrone. Importantly, regarding the first two categories, interviewees were very clear in their own minds that mephedrone had a direct and significant influence on them becoming involved in acts of violence. This, they reasoned, must be the case as they were either not usually violent or, would not normally have been violent in relation to such trivial triggers. Many experts shared this view based on their long-term work with abusers of a range of drugs.

Mephedrone also had a range of negative impacts upon the health and social wellbeing of users. Most users suffered significant physical and emotional side-effects and many had contemplated suicide during the debilitating withdrawal periods.

Finally, users consistently reported finding it extremely difficult to give up mephedrone and this was also acknowledged by practitioners who had witnessed their clients relapse on many occasions. Users generally gave up either because of the negative health impacts (physical and emotional) or negative family impacts. Users generally had to break former ties with drug-taking friends and acquaintances and change their lifestyle in order to succeed in abstaining from mephedrone use. A significant number of the sample had received support from drug agencies or other organisations that had aided the process of cessation.

All of the users interviewed, as well as those who took part in the survey, had important insights regarding what might help users to abstain permanently including: (i) better education about the drug and its harms; (ii) support and counselling; (iii) bringing ex-users together with users to provide 'real' experience-based advice.

Finally, it is important to note that those users interviewed likely represent a particular sub-category of mephedrone user. These (relatively young) males and females were all, at the time of interview, receiving some kind of assistance either with their ongoing mephedrone abuse or other drug-related or social problems and perhaps represent users experiencing the most debilitating impacts. That said, included in this sample were users who had only dabbled in the drug as well as those who used daily, every other day and only at weekend. Data from the survey of 67 users across South Wales permits a somewhat broader glimpse into the lives of mephedrone users and did not conflict in any way with the findings reported from those who were interviewed in depth. Nevertheless, it is not possible to know how representative this group of users are of the broader group of users across South Wales or beyond. For example, college and university students or users in full-time employment[15] may have a rather different experience of mephedrone use.

Recommendations

Education: whilst there is a growing drug education literature emerging across Wales, much of the advisory and preventative materials that consider mephedrone tend to deal with it as part of a more general approach to tackling new psychoactive substances. Mephedrone appears to have distinctly debilitating impacts and so it would seem important to deal with this drug in isolation when educating people about its effects and harms. Education could come in various forms but ought to emphasise the physical, emotional and social impacts as well as the potential (as yet unknown) long-term damage of using mephedrone. Materials would need to be tailored to various audiences including potential users but also parents, teachers, practitioners, youth workers, health workers, staff at late night venues and so forth, all of whom may have knowledge of those using (or vulnerable to using) the drug. In addition, a diverse range of institutions could be targeted in different ways including schools, youth centres, colleges, universities, drug agencies, health centres and hospitals. Social media as well face-to-face presentations could be combined with information packs and signposting to relevant agencies for advice and support.

Education: Drawing upon the knowledge and experiences of ex-mephedrone users would be beneficial. Much like the Operation Trident anti gun and gang initiative in the Metropolitan Police Force that utilised ex-gang members to speak out about the harms, the 'real' voice of the ex-user will likely be more impactful than relying solely upon agency experts to deliver key preventative and harm

[15] In fact one user who also dealt mephedrone indicated that he had provided school teachers and nurses with the drug and suggested that the drug 'knew no boundaries'.

reduction messages. Using carefully developed DVDs and education packs, ex-users could accompany practitioners on educational campaigns in schools, colleges and universities, for example. Given the growing focus amongst young people upon physical appearance, one aspect of this campaign could perhaps focus upon the negative impacts of the drug upon appearance including its distinctively off-putting odour.

Treatment: Given the broad range of impacts that sustained use of mephedrone can have on the lives of users and their families, any 'treatment' would necessarily have to take this complexity into account. Networks of Support could be developed to ensure that users could access the relevant range of services to deal with the physical, emotional and social harms of mephedrone use.

Police Recording Measures: better recording of all mephedrone-related 'incidents' and crimes, with a particular emphasis upon more carefully identifying the kinds of acquisitive and violent crimes that users commit at national and local levels.

Data Synthesis: careful and regular synethsis of relevant data from police, probation, prison, health, social services, education and so forth in order to more accurately capture a national picture of the multiple physical, emotional and social harms associated with mephedrone use.

Further Research: Given that the current research only accessed local users (i.e. people resident in South Wales), further qualitative research specifically focusing upon college and university students in Wales may be useful. It is possible that their experiences or patterns of usage may differ.

Future Research: Future qualitative research could also try to untangle the multi-dimensional and complex associations between drug combinations and violence and further explore the four mephedrone-violence categories identified here. Also it is still somewhat unclear when, precisely, violence is most likely (i.e. during the up, just as the buzz wears off, during comedown, or all of these).

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Appendix A: Mephedrone User Survey (adult)

Mephedrone and Violence in South Wales Study

My name is Dr. Fiona Brookman and I am conducting a study of Mephedrone use in the South Wales area. I would be very grateful if you would complete this short questionnaire about your use and experiences of taking Mephedrone. It should take around 5 minutes to complete and all responses are completely confidential.

If you would prefer instead to speak to me in person or over the telephone then please let the representative at the agency you visited today know and provide contact details at the end of the questionnaire. If you are happy to complete this questionnaire and also speak to me that would be great. Thank you for your time and insights.

1. Please can you state your age _____

2. What gender are you? (Please tick the box below)

   a. Male ☐
   b. Female ☐

3. What age were you when you first used Mephedrone? _____

4. Roughly how many times have you ever used Mephedrone? _____

5. What made you decide to try it the first time? _____

6. How often do you usually use Mephedrone? (Please Tick)

   a. Daily ☐
   b. Every other day ☐
   c. Once a week ☐
   d. Every other week ☐
   e. Once a month ☐

7. How do you usually take it? (Please tick)
   a. Injecting ☐
   b. Snorting ☐
   c. Bombing ☐
   d. Swallowing ☐
   e. Other (Please state) _____

8. What other substances do you usually use whilst taking Mephedrone? (Please tick all that apply)

a. Heroin	☐	h. Tranquilizers/Benzodiazepine	☐
b. Cocaine	☐	i. Magic Mushrooms	☐
c. Alcohol	☐	j. Amphetamine	☐
d. Cannabis	☐	k. Methadone	☐
e. Ketamine	☐	l. None	☐
f. Ecstasy	☐	m. Other (please specify) _____	
g. LSD	☐		

9. Do you usually use any substances to help you to deal with the 'come down' from Mephedrone? If yes, please state which substances _____

10. How does taking Mephedrone make you feel (physically and emotionally)?

_____
_____
_____

11. What are the good things about taking Mephedrone?

_____
_____

12. What are the bad things about taking Mephedrone?

_____
_____

13. Has Mephedrone ever made you **feel** aggressive? (Please tick)

a. Yes ☐
b. No ☐

14. Has taking Mephedrone ever made you **act** in an aggressive or violent way? (Please tick)

a. Yes ☐
b. No ☐

15. If yes, please describe the occasion when you acted aggressively or violently (i.e. without giving identifying details who (or what) did you threaten, hurt or damage, what were the triggers, what was the outcome etc?)

_____
_____

_____

16. How do you usually purchase/get hold of Mephedrone? (Please tick)
    a. Friend ☐
    b. Family ☐
    c. Street dealer ☐
    d. Internet ☐
    e. Other ☐ If 'other' please elaborate _____

17. Have you ever tried to stop using Mephedrone?
    a. Yes ☐
    b. No ☐

If yes, please state **why** you tried to give up.

_____
_____

Please also state **how** you tried to stop (e.g. what did you do differently and/or where did you go for help)?

_____
_____

18. Would you currently like to stop using Mephedrone? (Please tick)

    a. Yes ☐
    b. No ☐

19. How do you think we can help people to stop using Mephedrone?

_____
_____

20. Would you be available to be interviewed by Fiona about your drug use either in person or over the telephone?

    c. Yes ☐
    d. No ☐

If yes please could you leave your telephone number or email address below or let the person at the agency you visited today know how I might contact you, or how you could contact me. For example, if you would prefer not to disclose your contact details then you could perhaps use the telephone at the agency to call me at some time in the near future.

Telephone: _____

Email: _____

Thank you again for taking the time to complete this questionnaire.

Appendix A: Mephedrone User Survey (young person)

Meow Meow and Violence in South Wales Study:

Young Persons Survey

Hello, my name is Fiona and I am a Criminologist from the University of South Wales in Pontypridd. I am doing some research to find out more about why young people take Meow Meow (also known as Mephedrone, M-Cat, Drone or white magic) and what some of the effects are upon behaviour. It has been suggested that Meow Meow can make some people become aggressive or violent and hurt themselves or other people. I am trying to find out if this really is the case.

If you have ever tried Meow Meow I would be very grateful if you could answer the questions below. Your views will help me to understand why young people decide to take this drug, the effects and how we might try to help young people to give it up if they wish to. It should take around 5 minutes to complete and all responses are completely confidential – that means no one will ever know that YOU gave these answers as I am not taking your name or any other identifying details. Thank you for your time and insights.

21. Please can you state your age _____

22. What gender are you? (Please tick the box below)

    a. Male ☐
    b. Female ☐

23. What age were you when you first tried Meow Meow? _____

24. Roughly how many times have you ever used Meow Meow? _____

25. What made you decide to try it the first time? _____

26. How often do (or did) you usually use Meow Meow? (Please Tick)

    a. Daily ☐
    b. Every other day ☐
    c. Once a week ☐
    d. Every other week ☐
    e. Once a month ☐

27. How do (or did) you usually take it? (Please tick)

    a. Injecting ☐
    b. Snorting ☐
    c. Bombing ☐
    d. Swallowing ☐

e. Other (Please state) _____

28. What other drugs do (or did) you usually use whilst taking Meow Meow? (Please tick all that apply)

a. Heroin	☐	h. Tranquilizers/Benzodiazepine	☐
b. Cocaine	☐	i. Magic Mushrooms	☐
c. Alcohol	☐	j. Amphetamine	☐
d. Cannabis	☐	k. Methadone	☐
e. Ketamine	☐	l. None	☐
f. Ecstasy	☐	m. Other (please specify) _____	
g. LSD	☐		

29. Do (or did) you usually use any drugs or substances to help you to deal with the 'come down' from Meow Meow? If yes, please state which substances _____

30. How does taking Meow Meow make you feel (think about how it makes your body and mind feel)?

_____
_____
_____

31. What are the good things about taking Meow Meow?

_____
_____

32. What are the bad things about taking Meow Meow?

_____
_____

33. Has Meow Meow ever made you **feel** aggressive? (Please tick)

a. Yes ☐
b. No ☐

34. Has taking Meow Meow ever made you **act** in an aggressive or violent way? (Please tick)

a. Yes ☐
b. No ☐

35. If yes, please describe the time when you acted aggressively or violently. Without giving names or places please tell me who (or what) did you threaten, hurt or damage? What started you off? What happened in the end?

_____
_____
_____

16. How do you usually get hold of Meow Meow? (Please tick)

    a. Friend ☐
    b. Family ☐
    c. Street dealer ☐
    d. Internet ☐
    e. Other ☐ If 'other' please elaborate _____

17. Have you ever tried to stop using Meow Meow?
    a. Yes ☐
    b. No ☐

If yes, please tell me **why** you tried to give up.

_____
_____

18. Please also tell me **how** you tried to stop (e.g. what did you do differently? Did you get any help to stop?

    _____
    _____
    _____

19. If you are still using Meow Meow, would you like to stop? (Please tick)

    e. Yes ☐
    f. No ☐

20. How do you think we can help young people to stop using Meow Meow?

_____
_____

Please add any other comments below. Also, if you would like further information about the study please feel free to e-mail me at: **Fiona.brookman@southwales.ac.uk**

Thank you again for taking the time to complete this questionnaire.

Appendix B: Mephedrone User Interview Schedule

Mephedrone Interview Schedule

Mephedrone Users

Preamble: Purpose of the study and assurances of anonymity and confidentiality.

1. Age.
2. Gender.
3. How did you come into contact with this agency?
4. How long have you been coming here?
5. Mephedrone use:
    - How long have you been taking mephedrone?
    - On average, how often do/did you use mephedrone?
    - How do/did you usually take it?
    - How do you usually get hold of it? (Internet, street dealer?)
6. Other Drug use:
    - Had you used any other drugs prior to trying mephedrone? If so, what and how often?
    - Do you use any other drugs now? If so, what and how often?
7. Can you tell me how it makes you feel when you take mephedrone?
    - Probe physical and emotional feelings (positive and negative).
8. Has taking mephedrone ever caused you to harm yourself?
    - If yes, ask to elaborate with example(s) and gain a sense of how often this happens.
9. Has taking mephedrone ever caused you to harm someone else?
    - If yes, get a sense of how often this happens.
    - If no, still probe whether has ever caused feelings of aggression or desire to harm that were suppressed.
10. Thinking back to a time when using mephedrone caused you to become aggressive/violent/commit a violent crime, can you talk me through what happened?
    - Probe nature and levels of violence, the specific context and what led up to the event?

- Probe actual causal mechanisms (e.g. impaired judgment, more courageous, revenge, economic-compulsive etc).

11. Do you think that you would have acted violently on this occasion if you had not taken mephedrone?
    - Probe whether other factors (including other substances) played a role.
    - Probe whether anything else different about that day that contributed.
12. Do you combine mephedrone use with other substances? If so, what, how often and why?
    - Probe how do you decide what drugs to take when and in what combinations?
13. What would you say are the 'bad' things about mephedrone?
14. Are there any good things about taking this drug?
15. Is you have managed to stop taking this drug (now or in the past) how did you manage to do so and why did you decide to abstain/stop?
16. What kind of reputational does mephedrone have amongst your friends/community?
    - Probe how this compares to other drugs.
    - Probe whether this affects drug use choice.
17. Are you, or have you, dealt drugs? If so, elaborate? (may be a sensitive issue in which case bypass).
18. Have you ever been arrested for an offence that you would link to mephedrone use?
    - If so, probe how many occasions and details of the offence(s) including CJ outcomes.
19. Is there anything else that you can tell me about using mephedrone and the links to violence (to self or others)?
20. Any other comments insights or questions?

Appendix C: 'Expert' Practitioner Interview Schedule

Mephedrone Interview Schedule

Practitioners (who work with users)

1. Agency and its remit.
2. Role within the agency.
3. Time in role and other relevant experience.
4. In what capacity do you work with mephedrone users?
5. Approximately what percentage of your clients are mephedrone users and/or dealers?
6. What is the age range and average age of your clients?
7. Approximately what percentage of your clients use other substances? (elaborate).
8. Mephedrone and other drugs:
    a. Do most of the mephedrone users that you work with combine it with the use of other drugs?
    b. Has mephedrone use replaced other drug use (such as heroin) amongst those with whom you have contact?
9. How many mephedrone users/dealers have you had direct contact with in the last 12 months?
10. Have you seen a rise or fall in the last 6 months, 12 months, other time scale?
11. Is there a link between mephedrone use and involvement in crime (of any kind)?
12. I'm particularly interested in the possible links between mephedrone use and violence. Do you have any direct experience within this agency of a client acting aggressively or violently as a direct result of mephedrone use? Please tell me about this event in detail:
    a. Probe the nature and levels of violence, the specific context, what led up to the event and outcome.
    b. Probe causal mechanisms: mephedrone → violence.
    c. Probe why they believe there to be a link between mephedrone use and violence.
    d. Probe possible role of other substances.

13. If you have no direct experience, do you have indirect knowledge from other staff at this agency or from clients who have reported incidents to you? Can you tell me about one such example (probe as above)?
14. Do you have any knowledge of violence associated with the dealing of this drug?
15. I'm also interested in any links between mephedrone use and intentional self-harm. Are you aware of any clients who have harmed themselves whilst under the influence of mephedrone? Please can you tell me about this?
16. If you had to summarize the three most significant harms associated with mephedrone use what would they be?
17. Reputation of the drug (amongst users, amongst you and your staff)?
18. How, specifically, are your agency working to tackle the problems associated with this drug?
19. Do you have any recommendations for ways to try to tackle the use of this drug and the problems associated with it?
20. Do you have any additional comments or insights?

Gwasanaeth Cenedlaethol
Rheoli Troseddwyr

National Offender
Management Service

National Assembly for Wales
Health and Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Evidence from National Offender Management Service – LH 02

Via email to
[redacted]

National Offender Management Service
3rd Floor Churchill House
Churchill Way
Cardiff CF10 2HH

Mike Hardy
Head of Offender Health Policy
Welsh Government
Mental Health & Vulnerable Groups Division
Department for Health and Social Services
Crown Building
Cathays Park
Cardiff CF10 3NQ

Telephone: [redacted]
Email : [redacted]

Sarah Payne
Director of NOMS Wales

Business manager - Louise Forman
Telephone: [redacted]

09.09.2014

Dear Mike,

The National Assembly for Wales' Health and Social Care Committee Inquiry into new psychoactive substances ("legal highs").

Thank you for the opportunity to respond to the above consultation. In May 2014 the Government published its command paper in response to the Home Affairs Select Committee's report on *Drugs: new psychoactive substances and prescription drugs*. The range of new substances, their unknown long term harms and the manner in which they are often sold, whether on the internet or in high street retail outlets, are all matters of concern for the National Offender Management Service (NOMS) both in the community and in prison.

Raising awareness of harm associated with new psychoactive substances

In Wales we work closely with our criminal justice and other partners to educate and reduce the risks of harm caused by offenders who take new psychoactive substances. All the constituent parts of NOMS in Wales seek to address offenders' substance misuse via cognitive behavioural programmes, advice and guidance, counselling and education, for example:

- In general we seek to raise offenders' awareness of the harm associated with these substances throughout the offender journey and in particular in those instances where substance misuse is indicated as a trigger to offending behaviour

- Offenders who are subject to a substance misuse Specified Activity Requirement (SAR) are invited to disclose what drugs they are using and the frequency of abuse as part of the assessment process

- Those offenders who are required as part of their sentence to undergo a drug rehabilitation requirement are also required to attend a drug awareness course whereby the risks of the new psychoactive substances are discussed and harm reduction techniques are shared with a view to reaching abstinence

- There are substance misuse accredited programmes delivered in custody and, where an offender's behaviour is giving cause for concern (usually order and control issues) and the trigger is believed to be related to abuse of new psychoactive substances advice is sought

- Individuals who disclose use of new and emerging drugs are worked with through motivational and cognitive behavioural techniques in order to educate them about the harms associated with the use of legal highs

- Staff across NOMS make service users aware of the free and confidential Dan 24/7 helpline with a view to enabling individuals to become more aware of social media awareness raising campaigns, such as those around the use of mephedrone, M-Cat and Meow-Meow.

- Through IOM Cymru we work with other criminal justice and voluntary sector partners with not only the offender but also with their family to reduce the risks of reoffending and risks of harm.

Local Services

NOMS in Wales are keen supporters of Drug Early Warning Systems (DEWS) which aim to link various national and international partners to share information about emerging new psychoactive substances. The Welsh Emerging Drugs and Identification of Novel Substances (WEDINOS) harm reduction project is widely discussed with our offenders through partnership agencies and leaflets are shared in our drug rehabilitation units.

We know that education is key to raising awareness. As the new Community Rehabilitation Company becomes more established we anticipate that it will develop innovative ways of educating offenders about the dangers of such substances and signpost them routinely to services which could help them abstain from drug abuse in the future.

Data collection

Staff awareness of new and emerging drugs is raised through notification from Tarian, the Southern Wales Regional Organised Crime Unit. This enables us to monitor and disclose offender usage. Risks are then discussed with offenders such as mood changing behaviours which may in turn impact upon their licence conditions to be of 'good behaviour' and the resultant potential consequence of recall to custody.

We also monitor the information available on the Welsh National Database for Substance Misuse (WNDSM) as this enables us to target and work with those offenders most in need of interventions.

Legislative approaches

We are aware of the process for making recommendations to the UK Government on the control of dangerous or otherwise harmful drugs through the Advisory Council on the Misuse of Drugs (ADMD). Membership of the Council includes representation from the London Community Rehabilitation Company, with which we have good links through our membership of the Integrated Offender Management (IOM) National Strategy Board.

The NOMS Security Group is fully aware that new psychoactive substances are of increasing concern to law enforcement in communities and safety and order in prisons, Of particular concern is "synthetic cannabinoids", as cannabis is the drug most misused by prisoners, and it remains a significant problem, despite levels of misuse being on a downward trend. It is likely that the increase in misuse of synthetic cannabinoids has been caused at least in part by the demand for cannabis, coupled with the presence of effective measures against cannabis, such as drug tests and drug dogs, alongside an absence of such measures to counter synthetic cannabinoids. There are also anecdotal concerns about the affect of these new substances on prisoners' health and mental well-being. Abuse tends to be more common in the Category C and open estate.

For Compact Based Drug Testing (CBDT), the contractor has recently developed a "dip and read" indicative test for synthetic cannabinoids which prisons (or their drug treatment commissioners) are able to buy and use as part of a CBDT programme. The problem with this test is that it covers only 3% of known synthetic cannabinoids and whilst these are some of the more common substances, it is far from a complete solution. At the moment we think it is very unlikely that a CBDT test could be developed to detect all synthetic cannabinoids.

In respect of Mandatory Drug Testing (MDT) no test is yet available but the MDT laboratory is working to develop one for prisons and their other customers. Given the range of substances and the need to keep up with the changing chemical compounds, any test is likely to be expensive. Our power to MDT prisoners is also constrained to testing them only for drugs controlled under the Misuse of Drugs Act 1971. Whilst we are seeking an amendment to primary legislation, via the Criminal Justice and Courts Bill, to change this for the time being we are legally prevented from MDT testing for non-controlled synthetic cannabinoids.

The National Offender Management Service is looking to include non controlled drugs, which would capture new psychoactive substances and medication, into "List B" under the Prisons Act 1952 by way of secondary legislation. That would make it a criminal offence to convey them into a prison.

Partnership approach

NOMS in Wales works closely with partners to share information on new and emerging drugs. At a strategic level we are a member of the Advisory Panel on Substance Misuse (APoSM) and of the Substance Misuse National Partnership Board (SMNPB). Through the SMNPB, we provide information on progress on our related work streams, advise the Minister for Health and Social Service, via Welsh Government officials, on progress, emerging issues and future priorities.

Through our membership of the SMNPB we also contribute to strategy review and refresh in the light of changes we see in patterns of substance misuse, agreeing priorities for subsequent delivery plans and increasing ownership of the strategy through encouraging wider involvement and engagement.

We provide senior leadership representation on Substance Misuse Area Planning Boards across Wales. This mechanism facilitates our contribution to the planning, commissioning, performance management and delivery of substance misuse services within a framework which strengthens partnership working.

We welcome any opportunity to work with you and others to better understand, detect and combat the use of and harm caused by these new drugs.

All good wishes/ cofion gorau,

Sarah

Sarah Payne
Cyrfarwyddwr/Director
Gwasanaeth Cenedlaethol Rheoli Troseddwyr yng Nghymru/
National Offender Management Service (NOMS) in Wales

National Assembly for Wales
Health and Social Care Committee
Inquiry into new psychoactive substances ("legal highs")
Evidence from The British Psychological Society - LH 03

The British Psychological Society

New psychoactive substances ("Legal Highs")

British Psychological Society response to the National Assembly for Wales's Health and Social Care Committee consultation

September 2014

About the Society

The British Psychological Society, incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. We are a registered charity with a total membership of just over 50,000.

Under its Royal Charter, the objective of the British Psychological Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge". We are committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research.

The British Psychological Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

Publication and Queries

We are content for our response, as well as our name and address, to be made public. We are also content for the Committee to contact us in the future in relation to this consultation response. Please direct all queries to:-

Joe Liardet, Policy Advice Administrator (Consultations)
The British Psychological Society, 48 Princess Road East, Leicester, LE1 7DR
Email: [redacted] Tel: [redacted]

This response was led for the British Psychological Society by:

Dr Pamela Roberts CPsychol, Division of Clinical Psychology and Division of Forensic Psychology

We hope you find our comments useful.

David J Murphy CPsychol
Chair, Professional Practice Board

Mary Clare O'Connell
Chair, Wales Branch

New psychoactive substances ("legal highs")

British Psychological Society response to the National Assembly for Wales's Health and Social Care Committee consultation

The Committee will consider the following areas as part of its inquiry:

How to raise awareness of the harms associated with the use of legal highs among the public and those working in the relevant public services.

Comments:

Wales currently benefits from the information provided through the Welsh Emerging Drugs and Identification of Novel Substances (WEDINOS). This is a website which provides quarterly, up to date information on new substances. The Society recommends working with this agency to provide additional information across a wider forum to include hospitals and schools as well as other public and voluntary sector agencies. These substances are often referred to as 'recreational drugs' and by this term there is an immediate implication of safety and less potent substances. In reality, many have not been tested and there is no information about the long term mental and physical health problems associated with their use. More recently, services have attempted to improve the spread of what knowledge there is via social media outlets and this is potentially an effective way of communicating to the largest using age group which appears to be between 20-34 years (WEDINOS, 2014). Because of the commonplace nature of acquiring these substances and the recreational label, many do not consider the possibility that they may at some point; require help in managing their use (NHS National Treatment Agency for Substance Misuse, 2012). We believe that it is important to consider these factors in any increase in awareness as they are seen as the 'legal' and less harmful option.

The Society believes there is a need for committed funding to develop projects which address partnership working; the development of treatment approaches and harms reduction techniques specifically for legal highs. Funding for educational projects across schools, universities, GP surgeries and prisons as well as for the dissemination of information once it becomes available would also be useful. We believe that consideration should be given to the use of social media outlets as part of this. Currently there are no identified drug services for users under the age of 16 and this may need to be addressed in the context of legal highs which are currently growing in popularity amongst this younger age group (Luxembourg Publications Office of the European Union, 2014).

The capacity of local services across Wales to raise awareness of – and deal with the impact of – the harms associated with the use of legal highs.

Comments:

Information from the NTA would suggest that the use of club drugs is rising and it is important that services are developed to meet the need for this (NHS National Treatment Agency for Substance Misuse, 2012). At a time when many statutory services are being dismantled in favour of voluntary sector agencies, it is important that street agencies have the correct information in order to keep service users safe. Hospitals are seeing a rise in presentations of both physical and mental health problems which appear to be directly related to the use of legal highs (Advisory Council on Misuse of Drugs, 2013) and information about these possible effects must be communicated to the relevant health services. Locally and nationally there are anecdotal reports of service users combining the use of Class A drugs such as heroin with legal highs (WEDINOS:

Philtre Bulletin, issue 3, 2014**)**. There is little understanding of the effects of using a combination of these drugs both in terms of physical or mental health and there needs to be an awareness of these issues across agencies.

The effectiveness of data collection and reporting on the use of legal highs in Wales and their effects.

Comments:

Information obtained through WEDINOS appears to be thorough and provides information relating to geographical patterns of use, demographics as well as the new and emerging chemical names of those drugs tested. This provides an anonymous means of reporting data across various sites in Wales. Promotion of this service would be useful in order to obtain as much data as possible. Because of the variations and changes in chemical make-up, little is known about what compounds are more or less dangerous and the short term versus long term changes associated with using them. The Society believes that there needs to be much more information about these both in terms of physical and mental health effects.

The possible legislative approaches to tackling the issue of legal highs, at both Welsh Government and UK Government level.

Comments:

Currently, 'legal highs' are being classified as illegal as they appear to give rise to other similar drugs with slightly altered chemical properties. As such, governments and agencies working with substance users are constantly trying to play 'catch up' with regard to the changed compounds. There are risks associated with a complete ban in that users will be driven away from the more visible sellers into an illegal market. Other countries have considered the development of a 'licensed seller' system and there is some evidence to suggest that numbers of people buying from these have not increased and admissions to A&E have decreased as a result.

How effectively a partnership approach to tackling the issue of legal highs in Wales is being coordinated, both within Wales and between the Welsh and UK Governments.

Comments:

The Society believes that this is something which needs to be developed more. There are legislative differences between services in England and Wales which have sometimes impeded partnership working. This is an area about which we still know very little and the importance of cross working must be emphasised.

International evidence on approaches taken to legal highs in other countries.

Comments:

There is disagreement between the UK and some European countries as to the way to manage the increasing use of legal highs. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) have considered the use of a European Early Warning System (Luxembourg

Publications Office of the European Union, 2014) which alerts agencies to the supply of legal highs which are considered most harmful and there has been a commitment to remove the most dangerous compounds from public use as quickly as possible (within 10 months). Consideration has also been paid to regulating the less harmful compounds, some of which are considered to have 'legitimate use'. However, this approach has been regarded as hindering the UK's decision to control the use of new and emerging legal psychoactive substances. In 2011, the UK developed a Forensic Early Warning System (DrugScope, 2014) which similarly identifies the any 'legal highs' coming on to the market. But there is, within UK, a commitment to ban rather than regulate substances. There is some evidence from New Zealand (APPG for Drug Policy Reform, 2013) who have adopted the regulation route, that the number of compounds now sold on the market have dropped from between three and four hundred to 100 and the number of outlets selling these compounds have also reduced through a system of 'self regulation' with many of the 'head shops' deciding against selling regulated products. The services in New Zealand further support this decision as, when faced with people entering the healthcare system following reactions to substances, there is now a clearer knowledge of what people have ingested. However, it is of note that New Zealand is again considering a complete ban on NPS. The Society believes that a detailed analysis of the different approaches to dealing with new psychoactive substances should be considered.

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End.

National Assembly for Wales
Health and Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Evidence from Turning Point – LH 04

Turning Point response to National Assembly for Wales' Health and Social Care Committee

Inquiry into New Psychoactive Substances

Overview

1.1 Turning Point is a leading health and social care organisation working in over 200 locations across England and Wales. We have been operating for 50 years, providing specialist and integrated services that meet the needs of individuals, families and communities. We are a social enterprise reinvesting its surplus to provide the best services in the right locations for those that need them most across mental health, learning disability, substance misuse, the criminal justice, primary care and employment.

1.2 Turning Point welcomes the opportunity to respond to the National Assembly of Wales' Health and Social Care Committee inquiry into New Psychoactive Substances (NPS) or 'legal highs'.

1.3 The information contained within this response has been gathered from Turning Point's experience of delivering over 50 substance misuse services across England and Wales. We have included information that is specific from our Wales services and also information from across England which we think is relevant to this inquiry.

1.4 The key points from our response are:

- Outreach from services is vital to raising awareness of NPS.
- Services need to be flexible to local needs and adapt to meet the needs of their local community.

1.5 Turning Point has responded to a number of the areas that the inquiry has highlighted for consideration, our response is set out beneath the heading for each area.

How to raise awareness of the harms associated with the use of legal highs among the public and those working in relevant public services.

2.1 It is vital that substance misuse services provide effective outreach, in various settings making use of community links and new technology to increase awareness of the impact of NPS use can have, whilst also informing people about the support that is available.

2.2 In response to the development of NPS, Turning Point has developed a new service model for engaging and supporting people who use NPS called Wreckreational. Outreach is a key feature of this model, as is partnership working.

2.3 There are a number of elements to effective outreach and partnership working. The Wreckreational model identifies the importance of outreach to other health and social care services where people using NPS may present. For example the provision of satellite services within GP surgeries for people

who may present to GPs with medical issues related to NPS use. As with use of other substances, it is vital that substance misuse services have strong links to sexual health services due to the impact some NPS can have on sexual inhibitions and potential for increased risk of contracting sexually transmitted infections.

2.4 It is important that services engage with other community services and members of the public that may encounter NPS use. Turning Point's service in Llanelli has provided training to members of staff in the Job Centre Plus and Work Programme providers amongst others. We are also engaging in the 'Behave or Be Banned' scheme to raise awareness of NPS amongst bar and pub staff and have distributed information within local shops, which has been well received.

Recommendation

2.5 We would recommend that all appropriate substance misuse services in Wales have service models for addressing the use of NPS in their communities. Outreach is an important part of this, but it is equally important that people using NPS are able to access a full range of support including psychosocial interventions to support them to recovery.

The capacity of local services across Wales to raise awareness of – and deal with the impact of – the harms associated with the use of legal highs

3.1 Nationally Turning Point has recorded an increase in the number of people accessing substance misuse services related to the use of NPS, however the total number remains low. The table (Table 1) below outlines the number of referrals Turning Point has received for Mephedrone and GBL in three previous years.

Drug	Primary	Secondary	Tertiary	Total
2011/12	90	43	31	164
2012/13	129	72	43	244
2013/14	177	147	85	409

Table 1 shows the number of referrals to Turning Point substance misuse services for Mephedrone and GBL for each of the past three years. When people are referred into treatment their three main problem substances are identified, the table identies the number of people at who identified Mephedrone or GBL at each level and the total number of people who identified these substances for each of the past three years.

3.2 The data from Table 1 indicates that there was a 49% increase in total number of Mephedrone and GBL referrals between 2011/12 and a 68% increase between 2012/13 and 2013/14. This indicates that whilst the numbers are relatively low compared to people being referred for traditional illicit drugs, we are seeing a significant increase in people accessing services for NPS use.

3.3 Our substance misuse service in Wales has identified that the number of people currently seeking support for NPS use is being managed within existing service capacity. However, it is important that services are flexible and able to provide innovative services to address the complex needs of the treatment population and engage with local communities to tackle local needs.

3.4 As highlighted above, the numbers of people being referred to substance misuse services is relatively low, however due to the relatively new emergence of these substances it is difficult to predict future impact on services.

Recommendation

3.5 Funding for substance misuse services should be maintained to ensure that effective support can be maintained for a complex treatment population, including ageing opiate users, an increasing impact of alcohol on elderly people and the impact of NPS and club drugs on young people.

The effectiveness of data collection and reporting on the use of legal highs in Wales and their effects

4.1 The current data collection systems in Wales limit the ability to capture effective data about NPS use and the impact they are having on the substance misuse treatment system. This limits the ability of both services and commissioners identifying local needs and putting in place services that are designed to meet those needs.

National Assembly for Wales
Health and Social Care Committee
Inquiry into new psychoactive substances ("legal highs")
Evidence from The Police Federation of England and Wales - LH 05

Influence. Represent. Negotiate

To: HSCCommittee@wales.gov.uk

National Assembly for Wales
Health and Social Care Committee
Inquiry into New Psychoactive Substances (NPS)

1. The Police Federation

1.1. The Police Federation of England & Wales ('The Federation') was formed in 1919 by an Act of Parliament and, in Wales, it represents 6,780 police officers, of all uniformed and CID ranks from Constable to Chief Inspector. The Federation's membership comes from each of Wales' four police forces.

1.2. The Federation was established to protect and promote the 'welfare & efficiency' of police officers and in its discharge of functions as laid down by statute.

1.3. The Police have a duty of care to the public. The sworn and attested duties are discharging their duty 'to protect life' and to 'enforce the law'. The Police Federation's principal representatives, are all serving police officers who are elected to their respective roles.

2. Evidence

2.1. The Police Federation will restrict this submission to the impact that NPS' are having upon the role that officers play in combating such emerging drug and associated crime. *We make a recommendation in this submission at paragraph 3.1.*

2.2. It is important to recognise that the criminal elements that make up NPS are simply to *generate profit through organised crime via the production and selling of drugs*. Such organised crime is not concerned with the wake it creates in regard to anti-social behaviour, the negative impact upon people's lives, their families or their health, or indeed - save for making criminal profit - the overall chain-reaction it generates through more serious crime such as to fund the further purchase of the drugs. The negative impact generated by NPS includes also violent and sexual crimes for those taking such drugs.

2.3 Policing in the front line to combat NPS is conducted exactly the same as it is in dealing with those drugs commonly known in classes A and B. Examples of Class A drugs being cocaine, heroin, LSD, and ecstasy and Class B drugs such as amphetamines, barbiturates, cannabis, mephedrone and synthetic cannabinoids which remain illegal.

2.4 To effect quality policing requires a combination of source-led intelligence. Such operations come from information gathered from the streets and elsewhere, but ultimately such a police resource that can effectively deal with the intelligence, arrest and associated processes, requires a physical presence of police officers. In Wales, since 2010 police numbers have reduced by circa 800 officers; effectively since that time, Wales' resilience to police the streets has reduced, we stand by these remarks irrespective of what political messages are given out on crime.

2.5 The collating of information of such drug usage is down to Wales' four individual police forces, each will have witnessed an increase in the prevalence of NPS and where necessary the recording of such use. This is apparent even with the known 'amnesty drop boxes' that are found outside night clubs etc. However, not all NPS usage is at public bars and clubs. The outcome of this is that this leaves communities vulnerable, especially so when the number of retailing outlets for these drugs (termed 'head shops') are actually not known.

2.6 Police may arrest a suspect on producing, selling or using such NPS. However, to secure a charge and conviction it's chemical make-up has to be analysed and currently this is being conducted by Kings College London and latterly in Wales by Wedinos; this takes time and finance. Many of the branded products that are analysed contain more than one substance, in fact 77% of all branded psychoactive products contain at least two substances with 34% containing at least three substances. Around 19% of products sold do contain controlled drugs. Users do not know what they are taking – either for image/steroid enhancement, but also for psychoactive mind altering properties - producers do not know the exact chemical make-up of the NPS other than they are actually synthetically produced in cocktails (often from overseas) and for home-produced drugs this is extant also for hydroponic production across the UK.

2.7 Police can arrest any suspect under current police powers; we believe that those 'powers of arrest' are sufficient. However, the alteration of NPS compounds (i.e. their actual chemical make-up) can be rapid, as those engaged in 'organised crime' need to evade detection. Albeit The Misuse of Drugs Act 1971 has been amended to allow Temporary Class Drug Orders to be made - and that this goes some way to alleviate the issue, in reality it does not (with the exception of the possession offence) keep up-to-speed or in-step with the 'changing science' of NPS production. Such synthetic production has considerable momentum driven by criminal profit and 'social acceptance' across many age ranges.

2.8 It is not uncommon for 'head-shops' to obscure their identity of multiple outlets, or for 'online sales' not to comply with and to flout product safety. Indeed regularly, retail outlets cite that they are unaware of what the contents actually are within the products (often in pre-sealed packages) that they sell; despite what it 'says-on-the-tin'. So, to combat the increase of usage of NPS requires a multi-agency approach from not only the police, but trading standards, local authority, education and health boards.

2.9 The police of course provide training and awareness amongst its own officers and share this throughout police forces and indeed collaborate on intelligence; such collaboration is nothing new. However where a gap does exist is in the provision of training and awareness through community partnerships and this may prove of significant value, especially so as the authorities will be seen to be acting through various out-reach-groups and via diverse communities that are at risk right across Wales. This is an area, that other stakeholders may identify to you in detail.

3. Recommendation

3.1 We are concerned with application and enforcement of the law and so from a policing perspective, we believe that Trading Standards/Local Authorities need the continued resources to deal with the authorised opening of 'head-shops', but moreso, that the NAfW could examine examples from overseas 'licensing' in as much as in Eire, their *The Criminal Justice (Psychoactive Substances) Act 2010* became law that empowered the Garda to seek court orders to close head shops suspected of selling drug-like products, with the onus on the owners to prove they are not doing so. Let us stress we are not advocating the licensing or legalisation of drugs, but an enhancement to current powers that could be enacted quickly, with a Court Order - pending retrospective investigation of Chemical compounds therein - of such articles found. This power would need territorial enactment across both Wales and England jointly in legislative competence and effect.

We therefore recommend that jointly the Welsh and UK Government examine how best to progress legislation that allows a Court Order to be issued that allows the police and Welsh local authorities to close outlets suspected of selling illegal drug-like products, that would be categorised as NPS.

3.2 The result is that head-shops and any other shops would have the onus placed upon them to ensure that what they are selling is not 'illegal', such a power would extend to any other shops that sell products that are, or can be used for NPS. We accept that umbrella bodies such as retail consortiums etc., may also have a view upon this, but our sworn attested duties are both to enforce the law and to protect public life and property; we believe that such a power will go some way towards that service to the public.

3.3 We accept that such a legislative route will not fully curtail the selling of 'wraps' or 'poly bags' on the streets for personal consumption (or further illegal sale), or indeed online sales, however, not withstanding police resources, our current powers in this respect would be sufficient to stop, search and if necessary impound suspect goods and arrest a suspect. That current power extends also to S23 of the MDA that allows the police, with a warrant, to search premises when grounds exist that controlled substances are held.

4. Conclusion

4.1 What is abundantly clear, is that the current position on NPS is somewhat disjointed and albeit each 'stakeholder' is engaging, there is a lack of police powers and/or local authority powers to act decisively and to work with intelligence.

4.2 We cannot continue on such an *ad hoc* basis with no 'messages' being conveyed concisely to the public (or sellers) about the illegality of such drugs. Despite the valiant efforts with the Welsh Government's *DAN 24/7 Helpline* which has an important and integral part to play in education, help and support of the public, from our perspective, we are concerned with law enforcement, and we believe that our recommendations go some way further in ensuring safer communities and to help lower crime.

4.3 None of the information in this submission is classified as 'Restricted' and The Police Federation are happy that this submission is placed in the public domain. Additionally, we are happy to make available officers with considerable operational knowledge in this subject to give oral evidence to the Health & Social Care Committee or be called forward in respect of advice should a legislative route be progressed in due course.

Steve White
Chair etc

Andy Fittes
General Secretary etc

National Assembly for Wales

Health and Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Evidence from Trading Standards Wales – LH 06

Committee Clerk
Health & Social Care Committee,
National Assembly of Wales
Cardiff Bay
CF99 1NA

National Assembly for Wales' Health & Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Response on behalf of Welsh Heads of Trading Standards (WHoTS)

About WHOTS

Wales Heads of Trading Standards (WHOTS) is a Heads of Service Group under the umbrella of the Directors of Public Protection Wales (DPPW). DPPW represents Local Authority regulatory services that directly affect the health and well-being of communities in Wales.

The WHOTS vision is of 'A Wales where consumers are confident and protected and honest businesses can prosper in a fair, safe, market place', and its objectives are as follows:-

•WHOTS promotes inter-authority working and co-ordination to achieve continuous improvement

•WHOTS responds and contributes to the developing consumer agenda of the Government, Welsh Assembly Government and the Welsh Local Government Association

•WHOTS supports the personal and professional development of Trading Standards personnel

•WHOTS works in partnership to encourage fair and consistent enforcement and service provision

•WHOTS works together with others to promote the safety, the health and the economic well-being of communities.

WHOTS welcomes the opportunity to contribute to the inquiry into new psychoactive substances ("legal highs"). Its responses are set out below.

- **How to raise awareness of the harms associated with the use of legal highs among the public and those working in the relevant public services.**

1. It is the opinion of WHoTS that enforcers are not best placed to provide education/awareness regarding the use of new Psychoactive Substances (NPS)/'legal highs'. Health professionals and medical experts will need to be at the forefront of awareness/education as they will know the real risks.

2. As the use of NPS's is in some cases replacing illegal drugs use, it is thought that alongside public health and local health boards, the large network of organisations in place to help educate against or support drug users and warn of the dangers are best placed to raise awareness of the associated harms of NPS's.
3. Awareness could be raised through young adult charities, care workers universities, colleges, drop in centres, youth clubs, youth hostels, sexual health clinics, drama groups, substance misuse groups and general public spaces. It is also considered to fit well within the secondary school curriculum, specifically within the PHSE framework, which would also target the age group in which there is increasing use of these products.

4. As little evidential research has been completed for these products, they are often marketed as 'research chemicals not for human consumption', however users often have the misconception that the products must be safe as they are 'legal'.

5. Two medicinal products that have recently been found during sampling of such products are Lidocaine & Benzoates (the effects of which can be found online). A publicity campaign similar to those of tobacco warnings should be considered to highlight the real risks of these products. It is thought that any campaign should focus medical research findings and the uncertainty of unknown ingredients of the product and unknown effect of ingesting such products.

- **The capacity of local services across Wales to raise awareness of – and deal with the impact of – the harms associated with the use of legal highs.**

6. With ever reducing budgets across government agencies and in particular local authority Trading Standards Services, the capacity of services to deal with the impact of NPS's and raise awareness is depleting.

7. It is considered that dealing with the impact will require collaboration of partner agencies e.g. Police/local health boards and local authorities and ultimately be a matter for the Regional Area Planning Boards who have responsibility for substance misuse issues alongside their existing treatment and prevention campaigns.

8. There is uncertainty whether or not Trading Standards Services should be involved in the enforcement of such products as a safety concern, however if Trading Standards Services are to feature in any enforcement strategy to tackle NPS's funding will be essential as there is no capacity to deal with the matter in a comprehensive manner.

9. It is considered that a dedicated national resource is needed to tackle the problem with a view to developing a toolkit that be adopted by the relevant enforcement agencies and provide consistency of approach which is currently lacking.

- **The effectiveness of data collection and reporting on the use of legal highs in Wales and their effects.**

10. It is the opinion of WHoTS that data collection and reporting on the use of NPS's, in Wales, is currently poor and inconsistent.

11. The Welsh Emerging Drugs and Identification of Novel Substances Project (www.wedinos.org), does provide a potential platform for data collection, testing and sharing information on harm reduction, it needs better promotion and funding to reflect the scope of the problem.

12. Although some samples have been submitted to WEDINOS for testing for data collection and database development purposes, the analytical results produced cannot be used for evidential purposes.

13. There are many gaps in intelligence as health care professionals, youth and substance misuse workers see the effects on a regular basis but fail to report their concerns. Similarly the Police may deal with antisocial behaviour under the influence but fail to report the root cause, be it misuse of alcohol, drugs or legal highs.

14. Thought must be given to coordination of data collection/reporting and which agencies are best placed to collect, store and act upon the data collected.

15. Increasing data collection and reporting could assist in the identification of the problem areas and enable a collaborative approach of focussed awareness raising campaigns alongside enforcement activity to tackle the problem.

- **The possible legislative approaches to tackling the issue of legal highs, at both Welsh government and UK Government level.**

16. It is the opinion of WHoTS that the current legislative approaches are unclear and problematic.

17. The Police are unable to pursue an offence under the Misuse of Drugs Act 1971, due to the product not being a 'controlled drug' and where products have been found to contain a proportion of a controlled drug there are problems proving *mens rea (guilty intent).*

18. Trading Standards Services have had to resort to shoe horning circumstances into a variety of Consumer Protection legislation such as; paragraph 9, schedule 1 of the Consumer Protection from Unfair Trading Regulations 2008, or Consumer Protection Act 1987 and multitude of associated Product Safety legislation and associated labelling requirements.

19. There are problems with using both pieces of Trading Standards legislation depending on circumstances of sale, as a result of which current enforcement across

the region is inconsistent. Although CHIP & CLP labelling requirements can be applied there is no real effective way to prevent the sale of these products.

20. Ultimately, trying to shoe horn selling of NPS's into existing Police or Trading Standards legislation is not satisfactory, bespoke legislation is needed to address the problem.

21. Given the lack of legislative controls there is no current age restriction on the purchase of NSP's, as a result of which they are often marketed to vulnerable minors and school age children. If there is to be no outright ban on such substances, legislation to enforce age restrictions, proxy purchases and steep penalties would be essential to tackle the problem.

22. It is the opinion of WHoTS that as already demonstrated, a substance to substance ban is ineffective, as manufacturers remain one-step ahead, reformulating products to circumvent the ban.

23. Any bespoke legislation would need to include stringent requirements, draconian enforcement powers (including entry, test purchasing, seizure etc.) and penalties to make the prospect of manufacturing and selling NPS's unattractive and on a par with other Drugs.

24. It is considered that the Police, given their experience of dealing with drug related crime, would be best placed to enforce such legislation.

25. Establishing a licensing regime is an option to control the market along with the make-up and origin of the product. However, this in itself could prove problematic and effectively provide legitimacy to unscrupulous traders.

26. Any such scheme would need to be accompanied by bespoke legislation for enforcement in addition to licensing conditions which should include CRB checks on sellers and requirement for product technical files.

27. It is the opinion of WHoTS that greater more appropriate legislative control is needed to tackle these products, through classification of all such products as medicinal and requiring MHRA approval or preferably banning such products completely.

- **How effectively a partnership approach to tackling the issue of legal highs in Wales is being coordinated, both within Wales and between the Welsh and UK Governments.**

28. There currently appears to be no truly coordinated approach to tackling this issue of NPS's/'legal highs'.

29. There are several different partnership approaches involving Police and Trading Standards Services in Wales, however due to the lack of bespoke legislation each involve use of a wide mix of legal controls which fail to address the core issue of 'substance misuse', providing a sticking plaster approach.

30. Although these approaches have had some success in disrupting local supplies, the approach is wholly unsuitable and on a par with using a cancellation rights offence to deal with Serious organised crime/fraud. When legislation is introduced to ban a substance it is quickly circumvented by manufacturers, suppliers and their legal advisors.

- **International evidence on approaches taken to legal highs in other countries.**

31. New Zealand has adopted a licensing regime to provide a level of regulatory control on the market along with bespoke legislation (New Zealand's Psychoactive Substances Act).

32. Ireland have adopted a complete ban on the sale of all psychoactive or "brain altering" drugs, then introduces exceptions for some products such as alcohol and tobacco. In the opinion of WHoTS such an outright ban would be preferable as it would help to allay the message to the public that such products were not legal or safe, and also prevent circumvention by product reformulation.

For further information please contact:

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National Assembly for Wales

Health and Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Evidence from Drugstraining.com– LH 07

INQUIRY INTO NEW PSYCHOACTIVE SUBSTANCES ('legal highs')

Contributor: LIAM WATSON (MSc, BSc (hons), PGDip), Director of drugstraining.com

Previous relevant experience:

Member of the 'New Psychoactives' sub group of the APOSM before restructuring.

Previously worked in variety of roles in substance misuse field including development of substance misuse strategies for Public Health Department - Gwent NHS Trust.

Visiting Lecturer at the Department of Health and Social Care at the University of the West of England in Bristol.
Project Lead for nicotine addiction project at University of Wales College of Medicine. Produced the resource pack "Helping Patients Quit: Guidelines for GPs".

Presented on the theme of Online 'legal highs' at the Club Health Conference in Prague.

Current relevant experience:

Drugstraining.com is an independent training agency established in 1999 providing training on a range of current drugs issues across the U.K. Since the explosion of Mephedrone use in 2009 we have provided training for a range of professional groups on the issue of New Psychoactive Substances (aka 'legal highs'). We produce the bi-monthly 'Drugs Now' e-zine which updates 8000 professionals working in the drugs field on current developments. Most of our work is in England but in Wales organisations we have provided NPS training for include:

Youth Offending Services (Vale of Glamorgan, Cardiff, Bridgend, RCT, Wrexham, Carmarthenshire, Merthyr Tydfil),

Police Officers (South Wales Police, Dyfed Powys Police, North Wales Police),

DrugAid, Swansea Drugs Project, B@1 Young Persons Drugs Service, Kaleidoscope

University staff (Cardiff, Cardiff Met. University),

Social Services Children's Teams (RCT, Pembrokeshire)

Housing Associations (Seren Group, YMCA, Cartefi Cymru, Wrexham Foyer)

Youth Services (Wrexham, Cardiff, Neath Port Talbot, Blaenau Gwent)

Wales Ambulance Service

Through working with a wide range of organisations across the UK I have developed a comprehensive understanding of the key issues relating to information and service provision around New Psychoactive Substances ('legal highs')

Key points for consideration:

1. TERMINOLOGY

The terms ‘New Psychoactive Substances’ and ‘legal highs’ covers such a wide range of substances that they become vague and almost meaningless for many professionals and their clients. Greater effort needs to be made to specify the different categories of NPS. Currently they tend to fall into four main categories:

- **Synthetic Cannabinoids**: Spice, Black Mamba, Pandoras Box, AM2201, STS135.
- **Stimulant – type drugs**: Ethylphenidate, MDAI, MPA, Dimethocaine, Mephedrone
- **Hallucinogenics**: 25i – NBOMe, Bromo Dragonfly, AMT, MXE, 5-Meo-Dalt
- **Opiate type drugs**: AH 792, Kratom, Krokodil (desomorphine)

I am regularly told by professionals working with young people that ‘they are all using ‘legal highs’ but when I enquire about the *actual substance* they are not sure. There seems to be a sense amongst many professionals that ‘legal highs’ are all the same, whereas in reality they can range from fairly mild stimulants such as methiopropamine right thorough to very powerful opioids and long lasting benzodiazepines.

There is a real need for professionals to be educated about the diverse nature and *specific categories* of NPS otherwise they are clearly not in a position to educate, inform and assist their clients.

2. TARGETED EDUCATION FOR THE PUBLIC/USERS

2.1 Following on from the above point I believe that for education campaigns around NPS to have any real impact they need to focus on the specific categories of substances and give specific information for that group of NPS. While I appreciate that there is still a need for the generic ‘legal does not mean safe’ message to filter out to the general public, there is also a real need for more specific and sophisticated information about the different properties/effects of NPS. For example, any educational messages or materials that seemed to imply that ‘legal highs’ such as Nitrous Oxide and Bromo Dragonfly were similar would be seen as users as lacking any credibility. In reality the only thing that many ‘legal highs’ have in common is that they are not currently controlled under the Misuse of Drugs Act.

2.2 It is important that this information is presented in a format that is seen as credible and reliable. In my experience users of NPS come from very diverse backgrounds (see below) and any attempts to provide education and harm reduction advice will need to be appropriate to each population group. For example, I am aware from working with many universities that students are tending to get their ‘drug education’ about NPS from online ‘psychonaut’ drug forums (such as Bluelight and Erowid) and from watching videos of people experimenting with substances on video sharing websites such as Youtube. To reach this population group it would be appropriate to make use of similar types of digital/social media.

2.3 Research shows us that the best way to ensure that the targeted information is seen as credible, reliable and relevant is to involve the target group themselves in its development from the start. For example, any work targeting the use of NPS in the Gay clubbing community will need to involve people from that community in its development to ensure the appropriate needs are being met and that the information is in a format that would appear credible.

3. NPS USERS: DIVERSE POPULATION GROUPS WITH DIFFERENT NEEDS

3.1 YOUNG PEOPLE: For obvious reasons the media tend to focus on the use of ‘legal highs’ by teenagers. It may be that the death of a young person from taking a drug is seen as more tragic

and therefore more newsworthy. It may also be that, in terms of nuisance and anti-social behaviour, young people taking drugs is more visible and therefore attracts the attention of the police and other public services. There is a clear need to target young people who may be *thinking* of using NPS to clarify that these substances are certainly not safe, mild versions of illegal drugs as some believe. There are some key themes that need to be emphasised in the education of young people which are elaborated later in section 4.

3.2 ADULT PROFESSIONALS: For many adults (often in professional careers) the availability of 'legal' drugs which they can access online conveniently, anonymously and with no risk of prosecution has proved very tempting. The most recent Global Drug Survey found that in the U.K 25% of respondents had bought drugs online in the last year. For many the reason they were buying these drugs online was the same as for any other consumer product – cost, convenience, ease of access and good seller ratings. This ease of access to often powerful substances may be leading to many people developing a 'hidden' dependency on these substances - as has happened in Wales with Mephedrone. These adult professionals may not fit the stereotypical media image of a 'legal high' user, and they may not come to the attention of the police or social services, but there does appear to be a growing population group who are accessing NPS online. With such ease of access the regular, heavy use of some NPS may lead to both physical and mental health problems for users. There is also the real risk of serious drug addiction with some NPS such as the new synthetic opiates.

3.3 'PSYCHONAUTS': the psychonaut community is made up of people who have a profound belief that human beings can greatly benefit from experimenting with mind altering substances, particularly in terms of accessing 'hidden' areas of human consciousness. In relation to NPS many in the online psychonaut community are the first to experiment with newly developed compounds. The experience will then be shared (often in great detail) with their online community via the web forums. As they are often experimenting with virtually unknown new compounds the risk of overdose and 'bad trips' is very real. However, many in the community believe that by sharing their first hand, personal experiences others can benefit in terms of understanding dosage and reducing potential negative side effects. To develop accurate harm reduction information on specific new substances, professionals may need to use the information given and discussed on the online drug forums.

3.4 GAY COMMUNITY: a survey in the current edition of Gay Times shows that 75% of gay men between the ages of 17 – 75 have used illegal drugs recreationally. The figure is far higher than for the general population. There is growing concern regarding the use of stimulant NPS on the gay clubbing scene and in particular the use of stimulants such as Mephedrone as part of the so called 'chemsex' scene. The injecting of stimulants is a particular concern with regard to both the physical and mental health consequences for users. There is also a clear link between the use of these substances and decisions to have unprotected sex with strangers. It may be that a specific education and harm reduction campaign is required for those from the gay community around the dangers of NPS.

3.5 PRISONERS: through my recent work with RAPT (Rehabilitation of Addicted Prisoners Trust) in London and the north of England, I have been made aware of the huge problems being caused inside prisons by prisoners smoking 'Spice'. 'Spice' is the generic term used in our prisons for the new synthetic cannabinoids. One counsellor for RAPT told me that 80% of prisoners in his prison were smoking 'Spice' and that it was causing considerable problems in relation to both the health and behaviour of prisoners. As the powerful chemicals mimic THC but do not contain THC many prisoners are attracted by the fact that they can smoke the drug and not get sanctioned for failing the Mandatory Drugs Test. Additionally because the chemicals do not smell like cannabis prisoners can smoke the drug without being bothered by the prison officers. There may also be an issue with the use of other NPS being used in prison because they are not detectable with current drug testing procedures which only identify the main illegal drugs. There is undoubtedly a need for education, training and information for both prisoners and those working in the prison sector.

3.6 THOSE SUBJECT TO DRUG TESTING: whether it is in the workplace, in prison, as part of a Social Services parenting order or with the new roadside 'drugalyser' for 'drug driving', increasing numbers of people are now (or will be) subject to some form of drug testing procedure. As the current devices only test for the five main categories of illegal drugs many people seem attracted to NPS 'legal highs' as they know they can use them without fear of being detected. When the new 'drug driving' law comes in to action in March 2015 I anticipate a large number of cannabis users switching to NPS. The THC in cannabis can stay in the system for days or even weeks after the user has smoked cannabis. This is because the THC sticks to the fatty elements in the blood. With the 'zero tolerance' law for drug driving it means that regular cannabis users effectively face the risk of a driving ban each time they get behind the wheel.

4. KEY EDUCATIONAL/HARM REDUCTION THEMES

4.1 DOSAGE: with so many diverse chemicals appearing on the marketplace in such a short period of time it's not surprising that confusion over dosage has led to severe negative outcomes for some users. With the packaging stating 'Not for Human Consumption' and Head Shops being banned by law from giving dosage advice, users often have to guess what an average or 'safe' dose might be. With the synthetic cannabinoids many users made the mistake of thinking that they would need to use the same amount as they would with cannabis – not understanding that the chemical can be up to 40 times the potency of THC. Via experienced users on the online drug forums the 'common sense' understanding is now that users only need to use 'one pinch' or 'the size of a match head' to get the desired effects. It is particularly important that drug workers and any other professional working directly with users understand the importance of dosage information around NPS and are able to accurately inform their client group.

4.2 LEGAL ISSUES: information from testing laboratories indicate that many of the substances sold as 'legal highs' actually contain a Controlled Drug. Education around NPS needs to emphasise that those buying these products may actually be breaking the law.

4.3 VARIABLE CONTENT OF NPS: laboratory testing of NPS has consistently shown that the name on the packaging is not a reliable indicator of the actual content. Many 'research chemical' products have been found to contain a wide variety of chemicals. Brand names such as GoGaine and Sparkle are meaningless in terms of indicating what the *actual* content of the NPS might be.

4.4 NPS HAVE NO RESEARCH HISTORY: it's important to emphasise to those considering using NPS that many of the substances have not undergone any significant scientific or medical research. For the majority of the new chemicals very little is known about their potential toxicity or effects on long term health.

4.5 GENERAL SAFETY ADVICE: it is particularly important with the unknown nature of many NPS that those using them are given advice on staying safe. Tips such as 'Don't use alone', 'Start with a tiny amount', 'Don't redose for at least an hour' and 'Seek help immediately if you or a friend feel ill' are important messages given the often unpredictable nature of NPS.

5. IMPLICATIONS FOR SERVICE PROVISION

5.1 CHALLENGES FOR DRUG TREATMENT SERVICES: many of those working in adult drugs services are used to working with users of 'traditional' illegal drugs but NPS users present a series of new challenges. Firstly, how do we get those from such diverse backgrounds to access 'traditional' substance misuse services which are often seen by NPS users as being for those addicted to heroin, crack and alcohol? Secondly, there is currently no clear guidance on treatment

options for those using NPS as there are for ‘traditional’ illegal drugs. Thirdly, due to the lack of research into the effects of NPS substance misuse workers are unable to give accurate information and advice on issues such as toxicity and contraindications. Fourthly, the often random ‘pick n mix’ culture of poly drug use by those using NPS makes assessment and harm reduction advice even more difficult.

It may be that specific services along the lines of ‘Club Drug’ services in London (and using similar techniques to reach users) could be trialed in Wales. These services could be ‘stand alone’ services or run as an arm of an existing substance misuse service.

5.2 TRAINING FOR OTHER PROFESSIONALS: there is also a requirement for additional training for other professionals outside of drugs services. It appears that many users of NPS are being treated in either adolescent or adult mental health services rather than in drugs services. It is important that those working in the mental health field have a better understanding of the role that NPS might be playing in the mental health status of clients. Similarly, medical professionals in areas such as A & E, General Practice and the Ambulance Service, undoubtedly require an improved knowledge and understanding around the use of NPS.

There is also an expressed need from Police Officers to receive additional training on the new drug trends in Wales. They are often the first to come across someone who is intoxicated through the use of NPS and would benefit from having a clearer understanding of the nature and wide ranging effects of these new drugs.

If you would like to contact me to discuss any of the points raised then please email [redacted] or via telephone on [redacted].

Liam Watson

September 2014.

National Assembly for Wales
Health and Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Evidence from WLGA – LH 08

National Assembly for Wales

Health & Social Care Committee – New Psychoactive Substances

26th September 2014

WLGA • CLlLC

INTRODUCTION

1. The Welsh Local Government Association (WLGA) represents the 22 local authorities in Wales, and the three national park authorities and the three fire and rescue authorities are associate members.

2. It seeks to provide representation to local authorities within an emerging policy framework that satisfies the key priorities of our members and delivers a broad range of services that add value to Welsh Local Government and the communities they serve.

3. WLGA welcomes the opportunity to comment on the issue of New Psychoactive Substances (NPS) from a trading standards perspective.

The Wales and England position

4. The WLGA has been informed by the Wales Heads of Trading Standards, the National Trading Standards Board, and the Association of Chief Trading Standards Officers.

5. Local government trading standards services are currently discussing with the Home Office a review of the current legislative, enforcement, health and educational framework as it currently exists.

6. It is recognised that there are information gaps, enforcement gaps, legal complexities and uncertainties which must be addressed to enable the public to be properly protected.

7. The review is expected to make recommendations and comments to strengthen and assist coordinated responses to NPS situations. Local Government is therefore keen to help shape updated and consolidated enforcement guidance from the Home Office in due course.

8. Trading standards services in Wales recognise they have a role to play in educating reputable businesses, and enforcing legislation where there is detriment to consumers, or legitimate business.

9. At the end of this report, there are examples of current investigations which a number of local authority trading standards services are involved in – in conjunction with the police service.

Risk Focussed and Intelligence Led service

10. The Committee will also recognise the current financial context in which trading standards (and other regulatory services such as environmental health etc) operate.

11. These services have taken the biggest hit in terms of budgets, across the local government function – the latest analysis shows cuts equating to 30% for trading standards teams.

12. In order to attempt to maintain service delivery to the public and businesses alike, trading standards teams in Wales have adapted their operational and strategic methods to become risk focussed, and intelligence led.

13. The Integrated Operating Model (IOM) has been developed by the National Trading Standards Board (NTSB) for the benefit of the trading standards profession. It introduces a national intelligence framework to support not only the NTSB to deal with national and regional enforcement needs but also local authorities in their day to day work.

14. At the heart of the IOM is the effective use of intelligence. It aims to achieve a common understanding of the business processes that will help better coordinate enforcement efforts nationally, regionally and locally in England and Wales, focusing on agreed priorities and the issues causing significant consumer and business detriment.

15. Through a problem solving approach, trading standards will be able to effectively allocate resources to target the greatest problems. This will already be a familiar approach to trading standards, and is being used to help shape the development of local authority services.

16. The IOM is about the identification and assessment of threats, the management of prioritised threats through enforcement and other activity; and the review of the effectiveness of measures taken. It is designed to provide a structured approach to decision making and resource allocation.

17. Local government via its trading standards teams have therefore responded to incidents relating to NPS where intelligence has been received and the risk has been identified and assessed.

Capacity and market surveillance

18. What is less clear however is whether trading standards services are adequately resourced to proactively police the business landscape, whether on the high street, or on-line, where no intelligence of a threat has yet been received – ie market surveillance activity.

19. Enforcement falls behind the curve of preventing dangerous new products entering the market place, where resources only permit reactive activity – the outcome often being the newspaper headlines and the call for regulation following deaths or serious injuries.

20. Comparisons can be drawn to the "horsemeat scandal" and other similar market failures. A surveillance and proactive sampling regime is at least part of the answer to regulating market activity which prevents incidents occurring, and before they hit the headlines, hit public health, and hit public confidence.

21. However, trading standards in Wales is joined up with, and is a part of the ongoing review and improvement of the enforcement landscape relating to NPS across England and Wales.

Enforcement examples from trading standards in Wales

22. *"We are carrying out an investigation into a shop that has sold "NPS". The authority has worked closely with the police who agreed to analyse the substances seized and test purchased. The results have indicated the presence of Class A Controlled Drugs. Whilst the police are unable to proceed (due to the absence of any 'intent' to supply); Trading Standards has continued the investigation using its responsibilities under the Consumer Protection from Unfair Trading Regulations 2008 due to the prohibition on traders for falsely presenting a product as lawful when it is not. The investigation continues".*

23. *"Legal highs being sold from a retailer - awaiting more info on this but likely to be joint visit with police - and would look at wording/marketing of products, test purchase, before deciding on the most applicable legislation to consider enforcement action under."*

24. *"NOS laughing gas – we are considering the options of a combination of street trading / general product safety regulations and the police."*

25. *"We do have a retailer and samples were analysed but not found to contain any illegal substances. This was several months ago."*

26. *"We have a trader that I am currently dealing with, who provides virtual mailbox addresses and a mail forwarding service. His address is being used on legal high packs, although the actual business is not at his address. He just receives mail and packages and forwards them on."*

27. *"I have a current case with a problem trader and repeated visits to the store -seizing goods with the Police. In total 3 seizures have been made from the premises and goods have been taken on each occasion with the trader not making any attempts to ensure the products were compliant. We are looking at offences of Labelling requirements as per CHIP (*Chemicals (Hazard Information and Packaging for Supply)

Regulations) *and CLP (Chemicals Classification, Labelling and Packaging) requirements. We have asked the analyst to report on dangerous or toxic ingredients. Some products have undergone analysis and have highlighted medicinal products and should be labelled in accordance with MHRA – license number etc. however clearly not marked with this, we are looking at running CPR charges against those items for creating the impression the product can legally be sold when it cannot (Schedule 1).”*

28. *“I have been dealing with this issue over the last couple of years due to a local villain causing havoc from a shop. I adopted an approach of visiting a few times a week and encouraging the adoption of age restricted sales and only selling to over 18’s by using a refusal register to record sales etc. The police also kept raiding the shop and seizing all of the stock. This was submitted for analysis on the hope that there would be some controlled drugs found in the mixture. It seems to have quietened down in recent months but there was a meeting last Monday with the local plus a number of law enforcement representatives and health professionals.”*

For further information please contact:

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National Assembly for Wales

Health and Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Evidence from UKChemicalResearch – LH 09

www.ukchemicalreserch.org

[redacted]

Mission Statement

ukchemicalresearch (UKCR) was created in response to the growing need for information relating to Research Chemicals. We aim to provide individuals with a forum to document and discuss their experiences and views on research chemicals as well as highlighting dosage, safety and harm reduction information gathered from individuals' own findings for those who have made the choice to experiment with these substances.
Providing information on a range of ever changing substances and chemicals could be seen as breaking taboos, however the nature of the human is to explore and learn and by providing the individual with as much information as we can we are allowing people to make informed choices for themselves with the intention of reducing harm. The information on the forum is provided by the members for the members and guests - everyone is welcome to contribute. We encourage chat and debate surrounding well established, analogue and novel chemicals. Our primary aim is to support a safer, better informed community where experienced and inexperienced individuals can ask questions and potentially experiment under safer circumstances

Our Goals

To provide open and honest information about research chemicals
To encourage debate around chemicals and vendors

To promote non-judgemental information sharing leading to increased safety for members and individuals using research chemicals/NPS

To provide the most current and up to date information regarding use of research chemicals and new and emerging legal substances

To recognise humanist values, the drug user's decision to use drugs is accepted as fact. No moral judgement is made either to condemn or to support use of drugs.

Promote a general understanding and awareness of Research Chemicals and new emerging legal drugs to a wider audience by providing accurate and up-to-date information

Remaining independent of any company, vendor or individual with an interest in promotion of research chemicals

The forum was established four years ago in order to provide an environment where people could find and ask for information without being made to feel ridiculed in any way. Whilst some of the larger and longer established forums such as drugs forum and blue light provide excellent information and reference often people feel intimidated by some of the members.

In order to provide the best possible harm reduction information we believe it is vital to include sourcing of products, this has the benefit of making sure that the members have access to reputable vendors selling high quality products which minimises harm. The forum is completely independent of any vendor or advertising, this allows us to remain completely impartial and allows us to provide honest and accurate information to the members and guests.

We do however have open channels of communication with many of the major vendors of NPS this has proved to be invaluable. When the substance 5-IT was initially marketed our members began reporting negative side effects and we contacted all of the major vendors and asked them to withdraw the substance from sale, this was done immediately without question.

We currently have 4562 registered members making an average of 119 posts per day. Our average daily visitors are 1500, 200 members and 1300 guests.

Whilst we are a forum for the discussion of UK legal NPS our analytics show we have visitors from all over the world.

Over the last six months are visitors are detailed in the table below

COUNTRY	VISITORS
United Kingdom	70,028
USA	35,248
Germany	5,006
France	4,931
Australia	2,941
Ireland	1,220
Canada	2,768
Netherlands	2,177
Sweden	2,243
Belgium	854

England	60,054
Scotland	6,021
Wales	2,231
Northern Ireland	1,630

1. How to raise awareness of the harms associated with the use of legal highs among the public and those working in the relevant public services.

2. How effectively a partnership approach to tackling the issue of legal highs in Wales is being coordinated, both within Wales and between the Welsh and UK Governments

We believe that a source of information that relates directly to peoples honest and documented experiences using any NPS is an invaluable resource to highlight dangers and harms should they arise. It also allows people to discuss openly and honestly the effects and any potentially harmful effects of the particular substance.

Due to the community feeling and the relationships between members it provides a very open, honest and we believe unique resource where people can discuss and document the effects of any NPS.

The forum is moderated extensively and people who may be experiencing issues arising from use of NPS in any capacity are spoken to on a private and personal level to provide them with support in whichever capacity any issues are presented. This may include signposting to services in their area, advice and guidance and an open channel of communication at any time if they are in crisis or needing support.

There is also a real time chat resource that can be utilised in order to provide comfort, reassurance and support to anyone who may need advice and guidance.

Reports from the community allow us to monitor reactions between specific NPS and poly drug use.

Whilst specific information is not given regarding dosage of any particular substance a guideline can be provided to people who need that information. We specifically always advise people to use low doses and to incrementally increase a dose in order that they find their own personal tolerances. This is highlighted frequently with the underlying message that every person is an individual and indeed their response based on an individual substance may differ hugely from one individual to another and that to provide information would be unethical and dangerous for us to do so.

The information that is provided and discussed by the members is current and often members receive new NPS prior to them being more generally or widely available. This again provides a unique platform for safety and harm reduction.

This year we have set up links with John Ramsey of Tic Tac, Fiona Measham www.wearetheloop.co.uk and also Paul Bunt, Drug Strategy Manager all off of whom sit on the ACMD. We have also worked with Chris Russell from www.mylegalhigh.org a survey shortly due to be evaluated around NPS,

This has enabled a two way communication hereby we are able to alert the relevant parties to any NPS that could potentially have harmful or unexpected reactions. We also receive information on NPS in circulation that may be available to people or mis- sold under the guise of it being a different substance.

WEDINOS has been an invaluable resource allowing members to gain credible results on substances they have may obtained and be unsure of the actual product, similarly they are able to check if they have experienced an unexpected reaction to a substance. The effects of this are twofold, they can alert members to any potential issues and also advise on the source of the product so other members can avoid making purchases from a specific vendor.

We also undertake work in conjunction with Festival Welfare Services, a Swansea based service who provide welfare and crisis intervention at many music festivals, www.festivalwelfareservices.co.uk

This enables us to link in with current trends and to provide advice and information to people around harm reduction in situ.

Regulation of any NPS at this juncture in time is conceivably the best method for reducing harm amongst users of NPS. The banning of substances has only served to drive them into markets whereby they are unable to have any kind of quality control or comeback for users. Synthesis of the products has been shown to be of poor quality once the substances are no longer available through previous methods.

Banning also encourages bulk buying of the substances which in turn may encourage people to use the substances in a more reckless manner, using higher doses and more frequently which in turn has the unwanted of effect of increasing harm for people.

Banning substances has also effectively removed certain NPS which had been researched albeit on non-clinical level, but had proven that use when following guidelines provided by reports from users to have minimal health risks associated with them. It is clear that for every substance banned only a small chemical change needs to be effected to circumnavigate any current law surrounding that substance, this proves not only to be frustrating for the NPS community but effectively sends them back to the drawing board in researching the efficacy and safety of new products.

It also needs to be noted that there are many people who use NPS responsibly and safely in all manner of environments. Whilst there are risks and dangers associated with any of these substances they are still massively overshadowed by the legal and widely available drug alcohol. It would seem prudent to take into account the costs to public services between the two drugs and to take this into account when addressing any new kind of policies.

In conclusion it is clear to us that whilst on occasion we see problematic use as with any substance the age bracket with which we are dealing 25+ seem to have a much clearer understanding of the risks and harms associated with NPS. We are currently looking at a new website aimed at under 25's which will include topical and current harm reduction advice and guidelines for dosing. Dangers of self-diagnosis and medicating using analogues and advice for concerned parents and any professional bodies who may require training and information. We believe that we hold some of the most valuable information regarding NPS and are well placed within a safe environment to be able to monitor the effects of NPS.

National Assembly for Wales
Health and Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Evidence from Royal College of Psychiatrists in Wales – LH 10

RCPsych in Wales

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National Assembly for Wales - Health and Social Care Committee Inquiry into new psychoactive substances ("legal highs")

The Royal College of Psychiatrists in Wales is pleased to respond to this inquiry. We represent a number of Psychiatrists in Wales, specialising in the assessment and treatment of people with complex medical and social needs arising out of addictions or addictive behaviour. We are increasingly treating more people who present with problems associated with legal highs.

Our response is coordinated by Dr Raman Sakhuja, Consultant Psychiatrist and Chair of the Faculty of Addictions. The response below follows the Committee's terms of reference. For further information on our views of Legal Highs, the Royal College of Psychiatrists' Central Addictions Faculty published a report into Legal Highs earlier this month One new drug a week: Why novel psychoactive substances and club drugs need a different response from UK treatment providers.

How to raise awareness of the harms associated with the use of legal highs among the public and those working in the relevant public services

1. The Faculty is aware that the use of NPS has grown over the recent years with more people being referred into specialist services with problems of NPS use and misuse. On average, one new NPS is made available for sale each week on the European and online market, with these being potentially available to users in the UK via online retailers (European Monitoring Centre for Drugs and Drug Addiction, 2012).

2. Statistics from the Global Drug Survey, 2014 paint an alarming picture, particularly in terms of the biggest users of research chemicals and legal highs. The United Kingdom trails only the US in the percentage of users of legal highs in the past 12 months. 22% of respondents from the UK said they had bought drugs on the internet.

3. Raising awareness of the use and misuse of these substances is a crucial first step in improving the management of this trend. The Faculty of Addictions believes that raising awareness of these needs to be achieved at various levels:

- There must be greater public education of harms associated with these drugs. One source of current information on these new trends is the internet, which is largely an unregulated source leading to debatable authenticity of information. It is important that the information is clinically sound, scientific and accurate. This remains a challenge for the future as the speed of introduction of drugs generally outweighs the speed of the scientific and health care community to validate that information. But wherever possible, public health campaigns facilitated by relevant Addiction experts can be a useful strategy.

- Since there is an increasing trend of using NPS, including a new cohort of users which are not part of 'traditional' cohort of heroin or stimulant users (Faculty report, 2014), raising awareness amongst existing and new service users of the harms associated with these drugs becomes important.

- People using these substances can present at various points of healthcare systems including Emergency departments, Primary Care, Secondary Care including Mental Health services, Voluntary substance misuse services and specialist and statutory NHS services in Wales. Raising awareness and educating these groups becomes logically crucial to enable improved management of a variety of presentations.

The capacity of local services across Wales to raise awareness of – and deal with the impact of – the harms associated with the use of legal highs

4. The current specialist prescribing services in Wales dealing with substance misuse are generally funded for the 'traditional' drugs- such as Opiates and alcohol related problems. Over the years, however, the trends of substance misuse have been changing and so are the challenges (Sakhuja, 2012) There is an increase in alcohol referrals, prescribed medication dependence, Over-the-counter medication dependence along with NPS (Fig 1). The Faculty believes that the current services do not have the capacity to deal with this increasing demand (Faculty report, 2014)

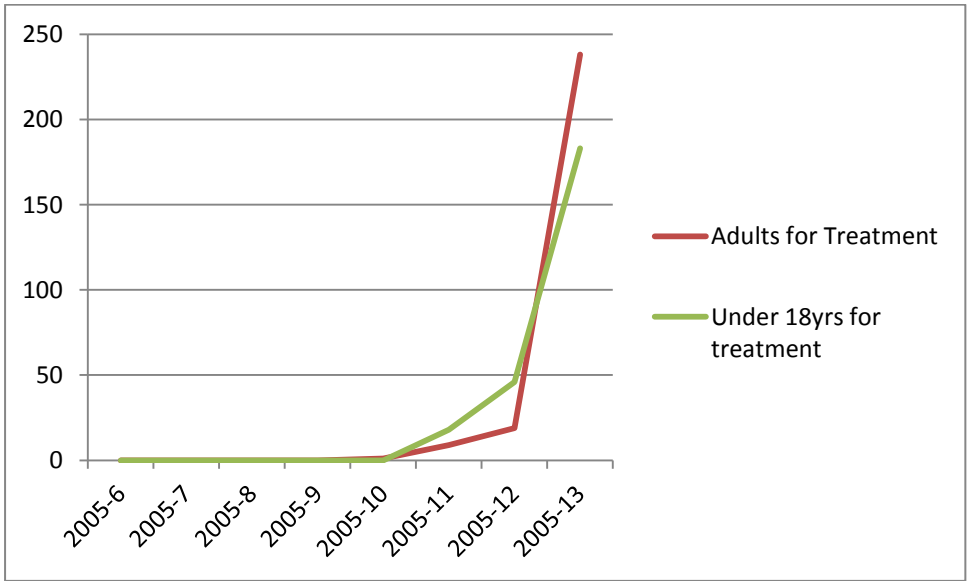

Fig 1: Mephadrone- referrals for treatment, reproduced from NHS Wales Informatics service & Welsh Government (2014)

5. There are difficulties in keeping up with the fast pace of the NPS market. Another problem we face is that most users of NPSs do not present at services (Faculty Report, 2014), though some of our established clients will admit to some use. Maintaining or even attaining first hand clinical experience is difficult. It raised the question as to what, if any, clinical services should be offered over and above what is available already. We do not and cannot know what is coming to current services with the drug groups on the Welsh National Database for Substance Misuse (WNDSM). If any specific services are set up they need to be part of research program given the unknowns.

6. WEDINOS (the Welsh Emerging Drugs and Identification of Novel Substances Project) is used to analyse substances brought in to Substance Misuse Services, although its main intention at the outset was to be used in relation to A&E presentations and matching substances taken with clinical presentation. We would like to see how successfully this has been done across Wales. We would also like to see WEDINOS carry more public health information and link into other credible information sources.

The effectiveness of data collection and reporting on the use of legal highs in Wales and their effects

7. The Faculty is aware that data collection for NPS within specialist services across Wales is variable. The Faculty, however, is not aware of how best this data collection gets transferred into meaningful data for clinical service development both at a national and at a local level. The Faculty recommends that current service provider databases should be analysed and a standardised way of reporting be developed. The Faculty of Addictions in Wales can help with the analysis and the clinical components of the database requirements. To be efficient, it may be useful to be able to trace the referral pathway or the patient journey, thus integration of databases becomes important as useful interventions ranging from raising awareness, harm minimisation strategies to specialist pharmacological and psychological support can be charted and put in place by this *integration* and *process mapping*.

The possible legislative approaches to tackling the issue of legal highs, at both Welsh Government and UK Government level.

How effectively a partnership approach to tackling the issue of legal highs in Wales is being coordinated, both within Wales and between the Welsh and UK Governments

8. With the changing trends, the Faculty of Addictions in Wales fully supports the RCPsych Addictions Faculty report *One new drug a week* recommendations which include:

    a. Making NPS and club drugs part of 'core business' of service delivery
    b. Raising awareness and educating the front line staff in primary care, secondary care, emergency departments and wider substance misuse

services of the harms associated with these drugs and clinical management of these harms.

c. Due to the varied nature of presentations at different parts of healthcare, it is crucial to improve the links of the non- specialist services and specialist services. This can be achieved by increasing the Liaison role of Addiction specialists within the various healthcare settings.
d. The rising trends necessitates the involvement of Addiction specialists and other stakeholders to carry out research in the effects, harms and management of clinical problems associated with NPS
e. The Novel drugs may require Novel treatments and with the rise in demand and lack of capacity necessitates resource allocation to specialist services to be able to meet the demand- both for research and for developing novel treatment strategies.

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National Assembly for Wales
Health and Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Evidence from Angelus Foundation – LH 11

National Assembly for Wales Inquiry into new psychoactive substances ("legal highs") - Angelus Submission

Introduction

1) The Angelus Foundation was founded in 2009 by Maryon Stewart, the health practitioner, author and broadcaster. Her 21 year-old daughter, Hester, a medical student and athlete, passed away after consuming a legal high (GBL) in April 2009. The Foundation has since attracted a group of experts, the Angelus Advisory Board, which brings together expertise from chemical, medical and behavioural sciences, as well as having considerable experience in both the areas of enforcement and misuse of new psychoactive substances (NPS).

2) Angelus is the only drugs charity dedicated to raise awareness about legal highs and club drugs. Much of our work is showed cased in our website for young people www.whynotfindout.org. There is also a website for families www.angelusfoundation.com.

Our Vision

3) All young people in the UK know the dangers of 'legal highs' and are able to make wise choices that keep them safe.

Introduction

4) Angelus's prime contribution to this Inquiry by the National Assembly for Wales is to offer evidence based on our Foundation's experience of how best to raise awareness of the threat of legal highs to young people**.** Below is a summary of Angelus's various programmes for education and prevention. Members are invited to assess the efficacy of these initiatives and their applicability in Wales. In addition, there is also a section (page 4) on a legal change we initiated with HM Opposition in 2013 aimed at ceasing the NPS trade in high street headshops.

5) All organisations who have tried to make constructive interventions on NPS will be aware of the difficulties deriving from a lack of reliable data around prevalence and behavioural change. However, that should not mean there should be no attempt affect change until such data is published. There is a wealth of anecdotal evidence from probation officers, police, prison staff, teachers and health professionals to indicate the immediate and longer-term harm from NPS is serious, growing and a strong response from agencies and NGOS is urgent. There is also a need to devote resources into research for example there is no data on where NPS are obtained i.e. proportion purchased online, from headshops, dealers or friends. This information would help inform how to target health messaging.

Education

Making PSHE Compulsory

6) The previous Westminster Government in 2010 had made clear its intention to make drugs education statutory through compulsory PSHE through national curriculum. The Coalition Government has rejected that policy and placed drugs education mainly in the science curriculum.

7) Angelus is not satisfied that is likely to allow the correcting messaging about the risks of drug harms particularly new legal drugs and has consequently been campaigning for compulsory PSHE. Placing drugs education within the constraints of an academic subject restricts its context to facts when there is considerable numbers of uncertain factors which lead to drug misuse. Moreover the issue at hand about NPS is that there are sparse numbers of facts which can be relied upon. There have not been any kind of comprehensive harms studies compiled. The purpose of drugs education should be to help build resilience of the individual into making better choices about their own well-being.

8) The Coalition has also given schools autonomy to determine the level of drugs education. Figures from Mentor UK show the majority (60%) are achieving one hour or less per year. Only 15% of schools reach the minimum standard recommended by Angelus of one hour, per term per school. There is also, in our view, insufficient direction from central Government on what should be taught and by what means. It is not clear whether the Labour Party maintains its previous level of enthusiasm for compulsory PSHE beyond its publicly stated commitments to Sex and Relationship Education.

Festivals

9) Festival audiences are particularly vulnerable to experimentation with NPS. The ambience can lend itself to novel experience for young groups and also older age groups who never or rarely tried drugs in their youth but are tempted to recapture their youth. The Association of Independent Festivals invited Angelus to partner them in raising awareness of the dangers of NPS in December 2013. It followed a succession of serious incidents the previous summer (including a death from 5-EAPB at Brownstock festival). We partnered AIF on a large-scale blackout of 25+ festival websites, including Glastonbury over May Bank Holiday which reached potentially a million young people through social and traditional media. Angelus has developed

comedy films setting out dangers of NPS and one specifically aimed at the effects of synthetic cannabis. We have also advised on safety information on websites, through e-flyers and leaflets, liaison with local media and promotion of an on-line challenge with Yourvine.com (see Prevention section).

Universities

10) There are over 1.8m undergraduates in the UK and often this is the first exposure they have to strong psychoactive substances whether legal or illegal. The rapid rise of Mephedrone (2008-10) was substantially fuelled by university students because of the drug's high purity and low cost. NPS/legal highs are still of considerable higher purity than competitor drugs such as ecstasy or cocaine. Angelus has been engaging with students at King's College London, Sussex University and Southampton University who showed a high interest in the subject but little knowledge of the risks. Our Fresher's survey from September 2014 showed 61% of their friends had tried NPS, 36% had been offered them and 19% had tried them.

Prevention

Harm Reduction through film

11) Angelus has delivered to over 1,500 school students (14 – 18 year olds) a lesson or assembly showing an Angelus film 'Not What it Says on the Tin' and measuring perception before and after, through surveys. Over three quarters of young people say they are shocked by the content and 95 per cent say it changes their minds about trying legal highs.

12) It is also clear from feedback from our school workshops that young people are angry with the sellers/suppliers who seek portray the substances as low risk but equally frustrated with the figures in authority who have not allowed them to be educated on this vital matter. We are awaiting the imminent publication of our schools programme data in an academic journal. We have made several other films for separate projects which can be viewed from our websites - some are drug specific, for example a ketamine film commissioned by ACMD chair Prof Les Iversen as well as films exposing harms of synthetic cannabis.
http://www.angelusfoundation.com/video/synthetic-cannabis-90sec-film/

Yourvine

13) 'The Real Deal', is an innovative online challenge designed to raise awareness among young people about the harms and consequences of legal highs. The player is put in the position of a supplier of NPS and quickly learns the haphazard nature of the industry where unpredictable and untested substances are marketed recklessly without any regard for the welfare of the consumer. Analytics produced by Yourvine show: 81% understood NPS were dangerous, 89% felt they had learnt something and 71% would definitely recommend it to a friend. Members can take the challenge on the following link after signing up to Yourvine. https://campaigns.yourvine.com

Parents

14) The Frank survey of 2012 showed 86% of parents had no knowledge of NPS/Legal highs or had simply not heard of them. Given the displacement from

illegal to legal drugs by a significant proportion of the youth population this a deeply concerning level of ignorance when many a majority (56%) of 11-15 year olds rely on their parents for information on drugs. Angelus has produced a highly successful parents booklet with Adfam and the Club Drug Clinic. Angelus has also recently produced some parents films featuring Eamonn Holmes, Cheri Lunghi and Dr Hillary Jones which will soon be launched. We are also soon to launch an online parents community.

Practioners' Views

15) Angelus co-hosted a conference aimed at practitioners on 26 June with VSA charity Re-Solve. The resulting report 'Legal Highs: An Action Plan for Change' was sent to all party leaders. Among its recommendations:

More research to fill knowledge gaps:

- The development of better data collection methods
- The creation of a robust, empirical, peer- reviewed research base
- Greater engagement with users to fill any knowledge gaps.

Resources targeted on education, with a focus on harm reduction:

- The creation of a central depository of resources and information on NPS
- Promotion of the message that 'legal' doesn't mean 'safe'
- Co-ordination from the central but delivery at a local level.

Clearly defined roles and responsibilities:

- National government to develop a clear legislative framework, act as a central point of co-ordination, and develop messages
- Local government to deliver treatment, support and enforcement
- Charities to continue their important work in spreading information

Legal Changes

16) In 2013, Angelus worked closely with HM Opposition in the formulation and accompanying submissions of an amendment to the Anti-Social Behaviour, Crime and Policing Bill (now 2014 Act). The purpose of the amendment was to stop the sale/supply of "synthetic, intoxicating psychoactive substances" with exemptions for alcohol, tobacco, medicines and certain foodstuffs. Its objective was to restrict the sale of products headshops would be permitted to sell, in the same way it is an offence to sell butane and glues to minors under the Intoxicating Substances Act 1985.

17) The legislation would work by a Court issuing a (civilian) Order against a particular shop listing the products identified by Trading Standards Officers, which appeared to be psychoactive, synthetic and intoxicating. Any breach of an Order issued to a supplier/retailer would be a criminal offence. If the court issuing the Order were satisfied, on the balance of probabilities, that the headshop in question were selling "psychoactive" and "intoxicating" substances then the onus would be on the owner to demonstrate he was not.

18) The Government is to shortly publish its own findings on how to tackle the easy access to these products through the Home Office review.

19) Angelus also supports a comprehensive review of the Misuse of Drugs Act 1971.

Angelus
September 2014

Contact:
Jeremy Sare
Director for Government Affairs and Communications
Angelus Foundation
[redacted]

54, Commercial Street, London E1 6LT
www.angelusfoundation.com
Twitter: @angelustweets

www.whynotfindout.org
Twitter: @whynotfindout

National Assembly for Wales
Health and Social Care Committee
Inquiry into new psychoactive substances ("legal highs")
Evidence from North Wales Police - LH 12

TICTAC®

Visual Drug Identification

A comprehensive database for the identification of drugs

Produced by TICTAC Communications at
St. George's University of London Medical School

TICTAC

TICTAC collects and analyses legal & illegal drugs to compile a database for the visual identification of solid dose drugs

What is TICTAC?

A comprehensive and trusted software & database system for:

1. The instant visual identification of solid dose drugs.
2. Information, reference and training material on drugs and drugs abuse.
3. Insight into new and emerging drugs

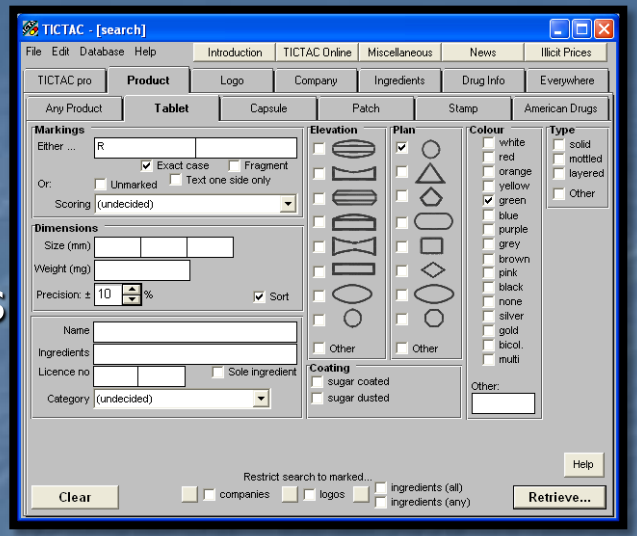
Which forces/labs use TICTAC ?

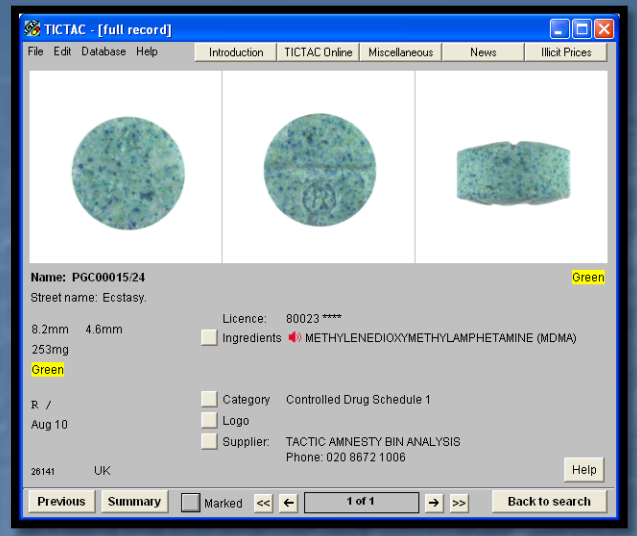
- Avon & Somerset *
- Bedfordshire*
- Cambridgeshire *
- Cheshire
- City Of London *
- Cleveland*
- Derbyshire
- Devon & Cornwall *
- Dorset *
- Essex
- Europol
- Garda
- Gloucester*
- Grampian
- Greater Manchester
- Gwent *
- Guernsey Police
- Hampshire *
- Hertfordshire
- Home Office
- Kent*
- Lancashire
- Leicestershire
- Lothian & Borders
- Norfolk *
- North Wales*
- Metropolitan Police
- Nottinghamshire*
- Royal Navy (Provost Marshal)
- SCDEA
- SOCA
- South Wales
- Strathclyde
- Suffolk *
- Surrey *
- Sussex *
- Staffordshire
- Tayside
- Thames Valley *
- West Mercia*
- West Yorkshire
- Environments Scientifics Group
- Forensic Science Service NI
- Guernsey Public Analysts
- Guernsey Customs & Immigration
- Key Forensic Services
- LGC Forensics
- Mass Spec Analytical
- Reading Scientifics

Three Versions that compliment each other

TICTAC Pro

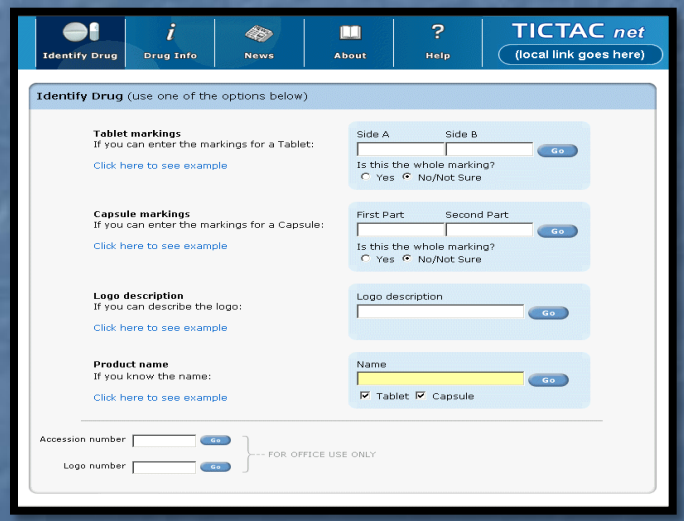
- Original version
- Will run on single computers or networks
- Requires training





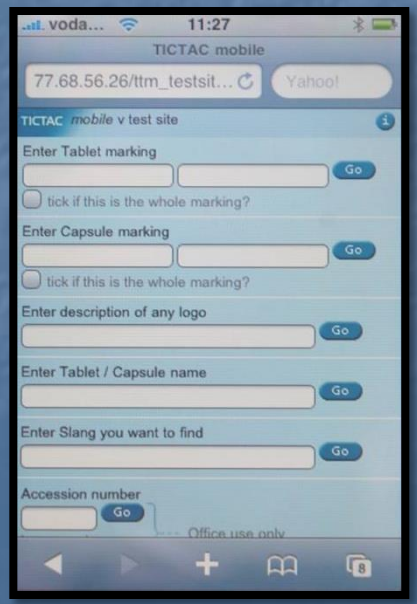
TICTAC Net

- Runs on Force Intranets
- Simplified interface
- Force-wide access
- Requires No training



TICTAC Mobile

- For mobile/Smart phones
- Similar to TICTAC net



Who uses TICTAC?

Law & Order

- UK Police (civil, military)
- Police overseas
- Home Office
- Prisons
- Customs
- Forensic laboratories

Industry

- Pharmaceutical Industry
  - New product development
  - Market intelligence
  - Rogue tablets
- Food Industry

Health

- Drug treatment & support organisations
- Medicines & Healthcare Products Regulatory Agency (MHRA)
- Healthcare Protection Agency (HPA)
- Community pharmacies
- Primary Care Trusts (PCT)
- Nursing/care homes
- Hospitals & pharmacies
  - Patient admissions
  - Mixed batches of tablets
  - Generic prescribing
  - Foreign visitors
  - Treatment of overdoses

Education

- University schools of forensic science
- University schools of pharmacy

What TICTAC provides

- Immediate visual identification of tablets & capsules
- Determine the legal status of drugs
- Establish what a drug is used for
- Drug test cross reactivity
- Education, Reference and News on drugs and drug abuse
- Index of drug slang

Benefits for the Police

- Instant results – saves Police time
- Avoid costly laboratory submission of non-controlled drugs
- Rapid confidential answers to drug ID enquiries
- Education & training
- Pace 2 compliancy in custody
- Supports specialist users

TICTAC SAVES MONEY & SAVES TIME

TICTAC users

Example of uses within forces

- Control Rooms
- Drug Liaison Officers
- Custody Suites
- Patrol & ACU Officers
- Drug Education / Expert Witness
- Drug Squads / Serious Crime
- Scientific Support
- Property Stores
- Chemist Inspection
- Community Policing
- Scene of Crime Officers
- Traffic (multi-agency vehicle searches)

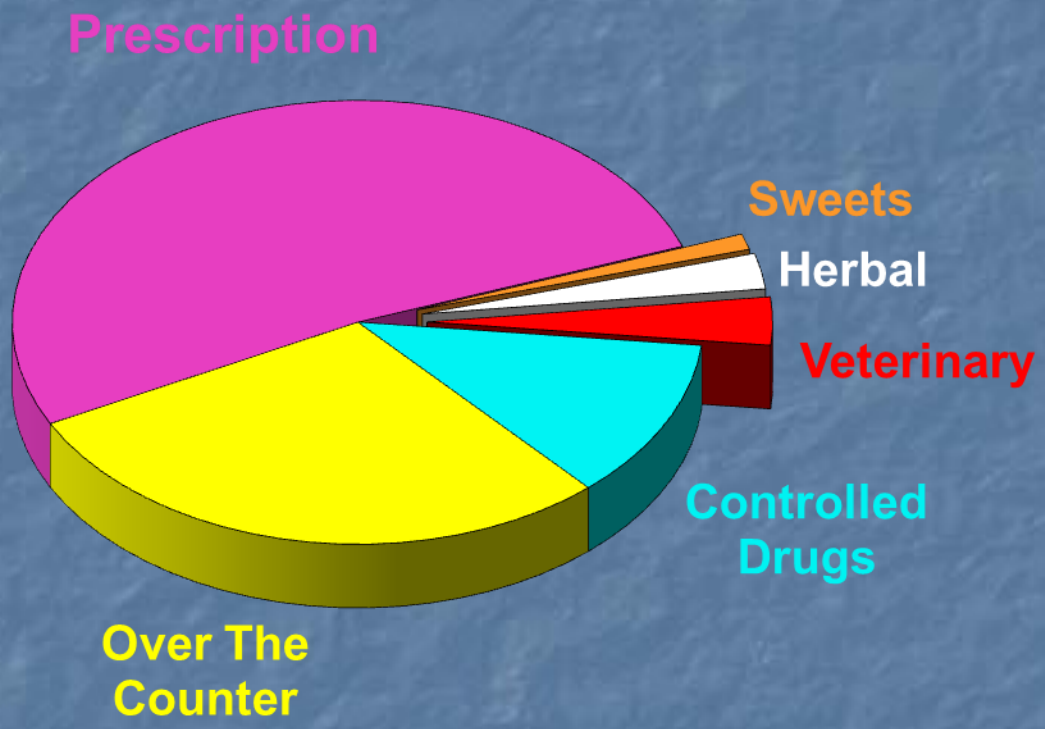
Products collected

- Prescription only products
- Over the counter products
- Licensed parallel imports
- Health and herbal
- Veterinary products
- Homeopathic medicines
- Illicit tablets & capsules
- Transdermal patches
- Stamps (mostly LSD)
- Confectionery
- Anything that resembles a tablet or capsule

TICTAC database

Products (tablets & capsules etc.)	**30,000**
Drugs (active ingredient)	**3,823**
Suppliers	**1,120**
Pictures	**77,000+**

Products by status



POM antiangina – prevent heart attacks

POM - diabetes

POM – epilepsy

POM antihypertensive - treat high blood pressure, prevent heart attacks

POM – antipsychotic – treat psychoses and other mental illnesses

MDMA MDMA Amphet. MDMA 2C-B Amphet. ----------Confectionary----------

Where does the data come from?

- TICTAC subscribers
- Pharmaceutical Industry
- Manufacturers
  - Confectionary
  - Health & Herbal
- Medicines & Healthcare products Regulatory Agency
  - Parallel imports
- Forensic Laboratories
- Police
- Customs
- Prisons
- Test purchases
- Amnesty bin analysis

Amnesty bin analysis

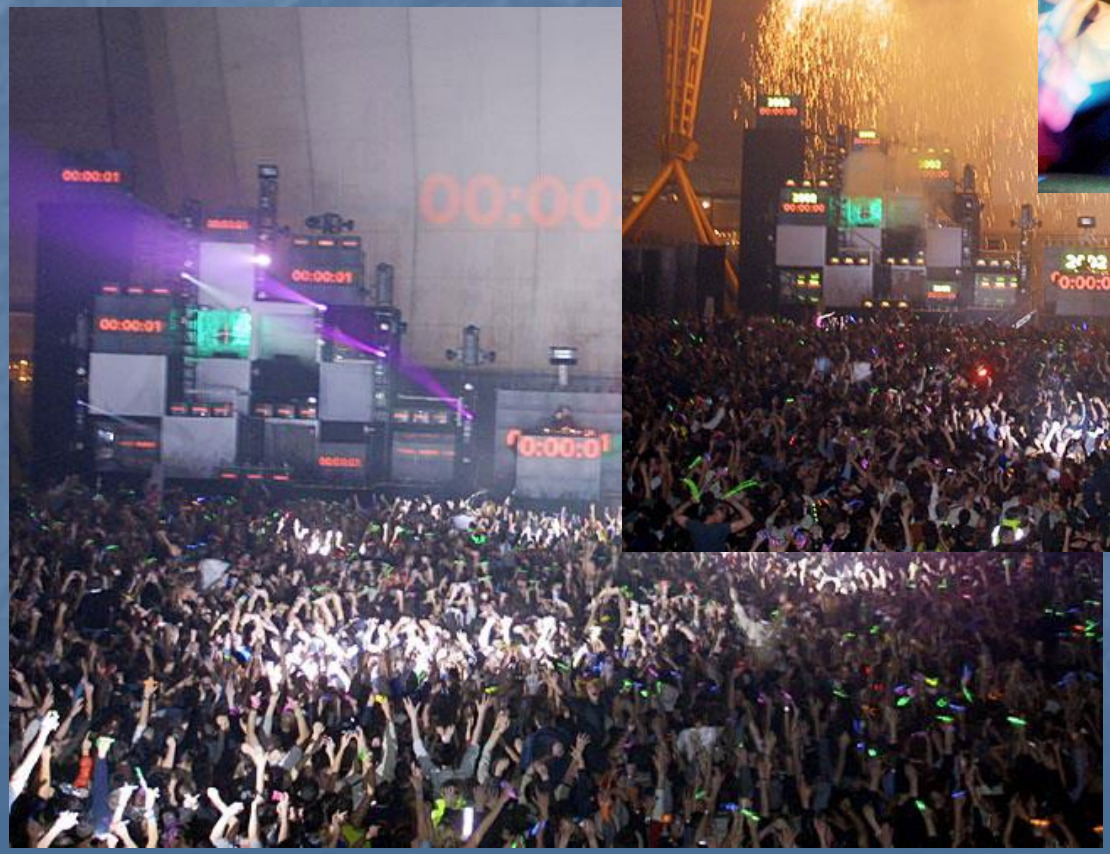
Innovative data collection methods for illicit drugs

- Drugs deposited in bin as the result of a search as condition of entry to club or music festival
- Bin emptied in the presence of a Police officer
- Contents documented and sealed in evidence bag
- Bag collected from Police station
- Transported to laboratory in evidence bag
- Analysed
- Results disseminated using TICTAC
- Home Office Licensed

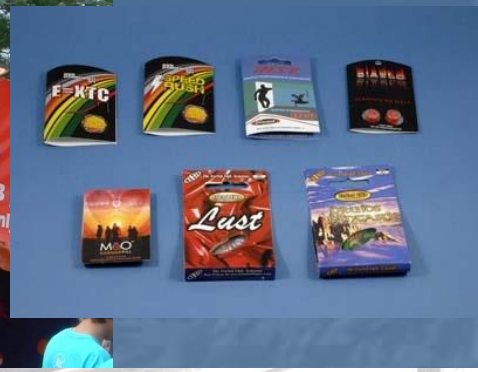
Amnesty bins

http://www.arengineering.co.uk/drugcabinets.html , cost £103 +VAT

Drugs & Clubs



Drugs and Festivals



Amnesty bin contents - clubs

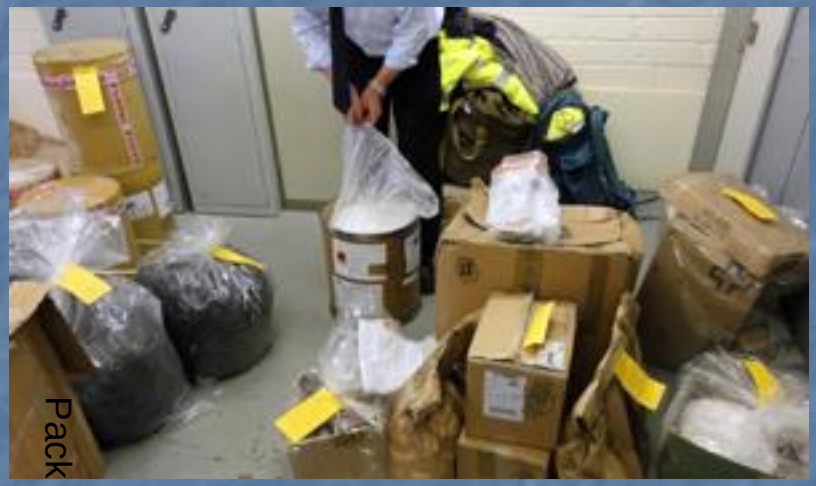
Small club

Large club

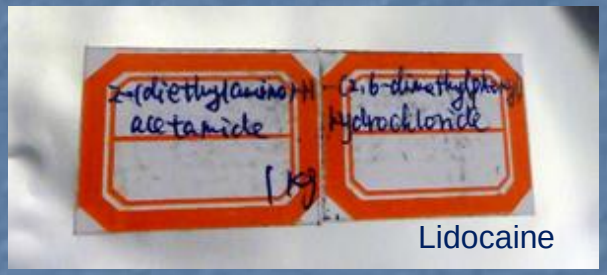
Cannabis

Amnesty bins - festivals

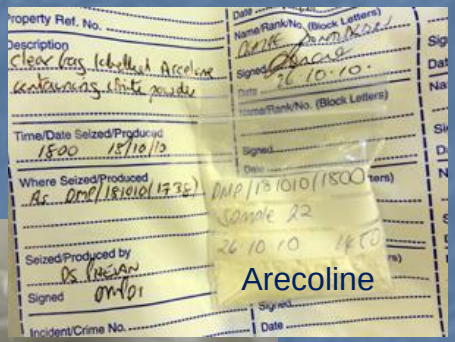
Impounded drugs



Pack Page 159

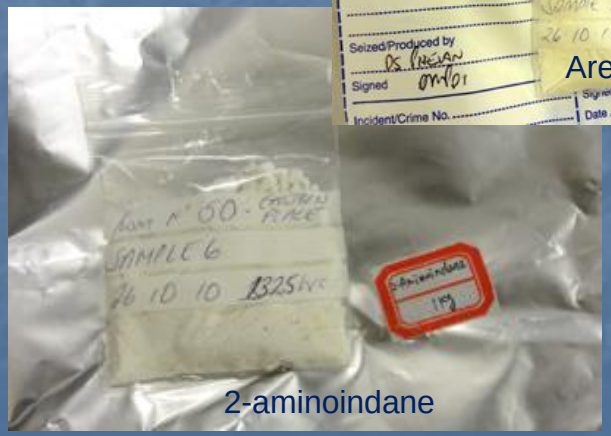


Lidocaine



Arecoline

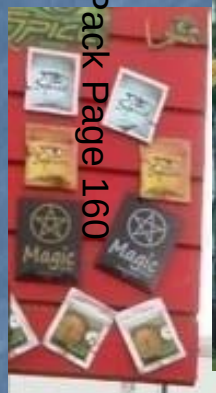
Seeds



2-aminoindane

Caffeine

Test purchasing



Test Purchases from websites

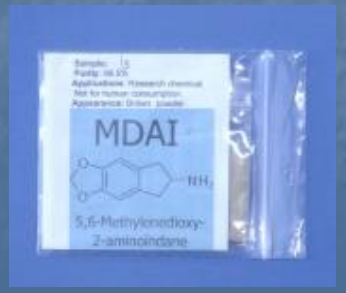
AmHiCo

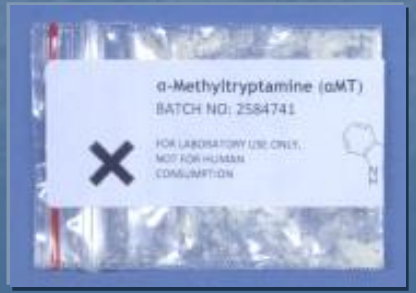
Red Eye Frog

Everyone Does It

Biorepublik

Salviadee





"Research chemicals" - not for human consumption

What we find: Piperazines

BZP + TFMPP

CPP

CCP

BZP + TFMPP + caffeine

CPP

BZP + caffeine

BZP

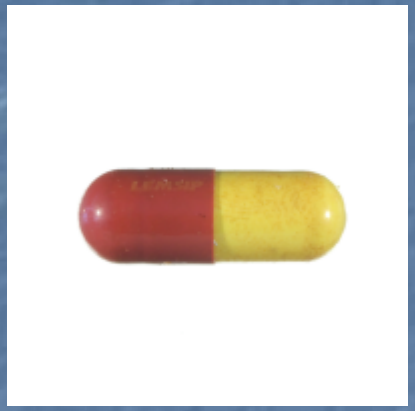
BZP + TFMPP

Ecstasy (MDMA)

No marking

Trade mark symbol

Armani



No mark

Omega

Diamond

A

Crystals

- Very little crystal meth
- Very little crack cocaine

Lots of crystal MDMA

Paraphernalia

Cannabis paraphernalia

Snorters

Drugs in ecstasy tablets marked with the Mitsubishi logo

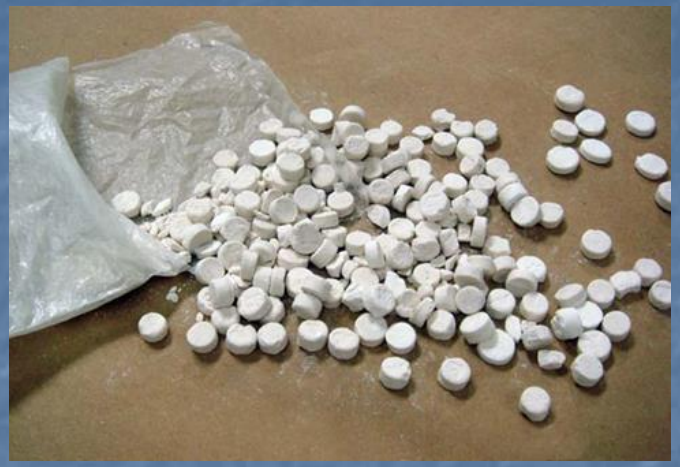
- Ephedrine, Ketamine, Paracetamol, Caffeine
- MDMA
- Ephedrine, Caffeine
- Diazepam, Ketamine
- Ephedrine
- Ketamine
- DL-amphetamine
- MDMA, Caffeine
- MDMA, MDEA
- Ephedrine, Ketamine
- PMA, PMMA

Fake Ecstasy tablets

Defaced Pro-plus, caffeine

No drug, plaster-of-Paris

Hand engraved logo, xanthanol niacinate ?



170 tablets

Confectionary easily confused with ecstasy

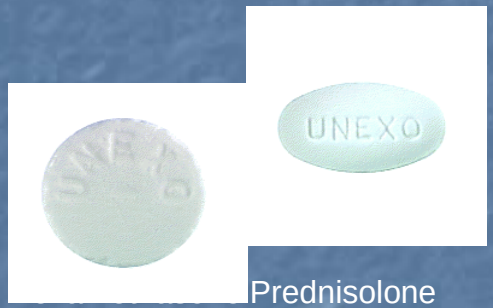
Pack Page 168

no sweeteners

Gourmet Candy Company

detect artificial sweeteners (e.g. aspartame, acesulfame) as confirmation that product is confectionary

Oral Anabolic Steroids

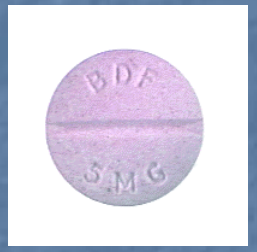


Prednisolone

Unexolabs (PVT) Ltd.
Pakistan

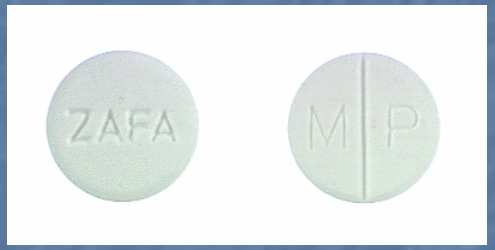
Methandrostenolone

Akrikhin Pharmaceuticals
Russia



Stanozolol

Unknown



Methandrostenolone

Unknown

Stanozolol

British Dragon
China

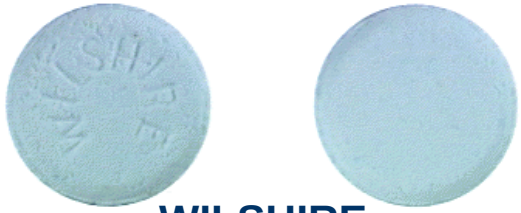
Methandrostenolone

British Dispensary (LP) Co Ltd
Thailand

Diazepam tablets of unknown origin

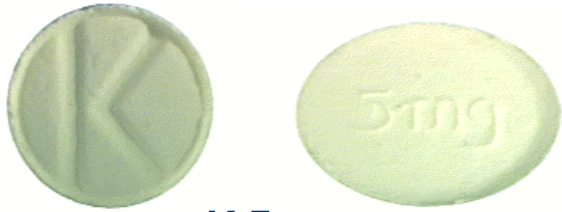
CX 10

MSJ

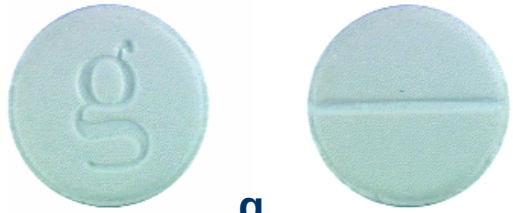


WILSHIRE

BJ / 5



K 5mg



g

MANO 10

W or M

TP / 10

Hallucinogenic (magic) mushrooms

Psilocybe semilanceata
Liberty Cap

http://www.canedintotnes.co.uk/mushrooms/libcap1.htm

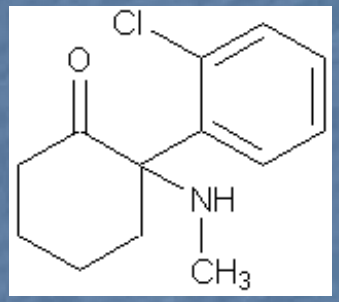
£10
13.5g

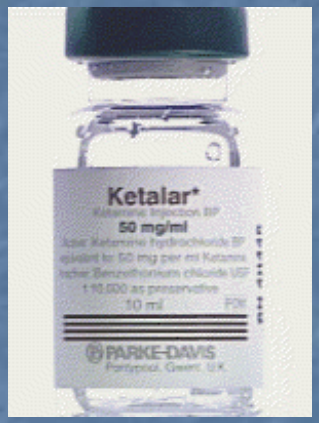
from Holland ?

Psilocybe cubensis
Colombia

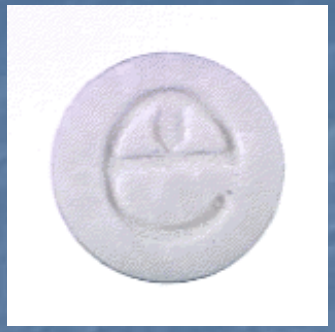
Ketamine

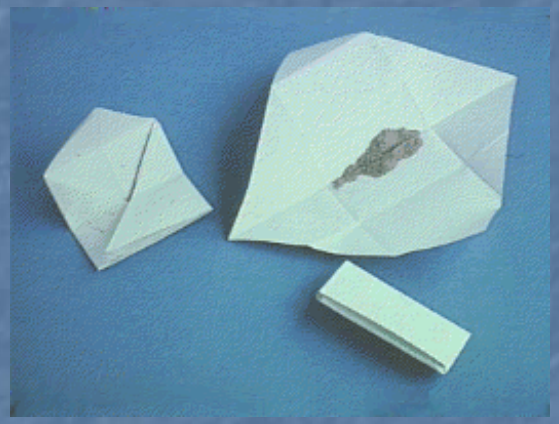
dissociative anaesthetic





Intravenous anaesthetic human & veterinary



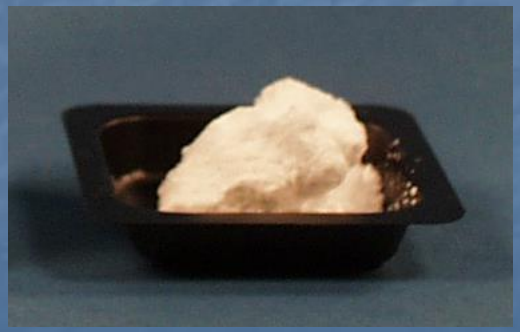


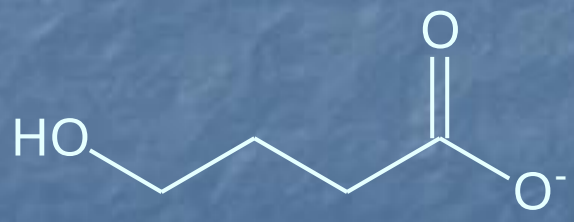
Solution evaporated & powder used in tablets or snorted

GHB gammahydroxybutyrate

GHB is a solid

- usually seen as a liquid also as powder in wraps or plastic bags or in capsules
- methods for GHB production easily available on Internet - produce preparations of unknown concentration





New Psychoactive substances ("LEGAL HIGHS")

National Assembly for Wales
Health and Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Evidence from DrugScope – LH 13

Minimising drug-related harms

Asra House
1 Long Lane
London
SE1 4PG

Tel [redacted]
Fax
E-mail [redacted]
www.drugscope.org.uk

8th October 2014

National Assembly for Wales' Health and Social Care Committee Inquiry into New Psychoactive Substances (NPS): note to accompany DrugScope NPS status report, *Business as Usual*.

With reference to the Committee's particular areas of interest:

Awareness of legal highs

Public awareness of NPS has been growing since 2009 when mephedrone first made an impact on the UK drug scene. There was widespread media coverage of its legal availability and many (ultimately unsubstantiated) report of mephedrone-related deaths.

Media interest has remained high, not least because the trade names of some of the NPS, in particular, synthetic cannabinoids such as Black Mamba, Clockwork Orange and Ecstasy Damnation are tailor-made for (especially tabloid) media coverage. And of course, the continuing legislative challenges presented by NPS, accompanied by calls from politicians, campaigners and the media for the government to act, all serve to keep the subject of NPS on the public radar.

In terms of awareness by specific groups; for example the 2013 English survey of drug use, smoking and drinking among those aged 11-15, listed only mephedrone among possible NPS in the table showing percentages of young people knowing about individual drugs. Knowledge was cited by 41% of the sample, almost the lowest drug awareness rating. By contrast, in a study of UK students (average age 19) published this year, of 446 student surveyed, 79% both said they knew about NPS and correctly defined them. DrugScope has heard anecdotally that in some of the more deprived areas of the north east of England, users simply refer to NPS as 'legals' without making much differentiation between the different drug types, while Professor Fiona

Measham from Durham University has referred to users in the north-west saying they use 'bubble' which has become a generic name for any white (usually stimulant) powder of unknown provenance. In some specific groups such members of those in the gay community who are active on the party scene, there will be high awareness of NPS, in particular mephedrone where agencies helping this group report high levels of injecting.

Use and impact

Without going into too much statistical detail in this note, it is fair to say that our knowledge of overall prevalence is patchy. The reasons are two-fold; either substances have been controlled too recently to appear on the crime statistics or they are not controlled hence they won't appear at all. The main exception would be mephedrone which was controlled under the Misuse of Drugs Act in 2010. Data from the Crime Survey for England and Wales (CSEW) indicate a fall in mephedrone use since control which could be for a number of reasons including the very fact of control and evidence of rising purity of MDMA (still the most favoured drug of the club scene) and increasing evidence of harms. There are also limitations of the CSEW as a household survey not picking up on some potential users groups including students living away from home.

Mephedrone is the NPS which has gained the most traction in the UK and across the widest groups of users from those groups of vulnerable young people, those on the club scene, established problem users and those in the gay community, the latter two groups becoming involved in injecting which is of a particular concern.

The other group of drugs widely available in the UK are the synthetic cannabinoids whose chemical composition is entirely unrelated to the cannabis plant, but get their name because they act on the same receptors in the brain as cannabis. However, many of the brands on sale are far stronger than 'natural' cannabis, but users, being unaware of this, have been using synthetic cannabinoids at the same dosage levels as they might cannabis resulting in acute symptoms and subsequent hospital admissions. In general, these compounds seem to be most popular among younger teenagers living in areas of economic and social deprivation.

Much has been made in reporting of how hundreds of new compounds have been identified in recent years. This has added to the general level of anxiety about NPS, but is rather misleading. It might be inferred that each new compound is totally distinct from the next in the way that, for example, cannabis is entirely different from cocaine. In fact most of these NPS can be categorised into known groups of drugs such as stimulants, hallucinogens or opiates. The second point is that while many new substances are certainly 'out there'. in the UK at least – and as mentioned above – so

far only mephedrone and the synthetic cannabinoids are widely known about and used.

Service capacity

Just to make some general points about this; so far adult services in England do not seem to be seeing significant numbers of new people coming forward with NPS-related problems. Some existing clients who are currently injecting drug users, have been using mephedrone, but the numbers appear relatively small. As far as young people services are concerned, the picture is similar, although when outreach workers go out into the community, they often identify a different group of users from those coming forward to services whose main problems still revolve around cannabis and alcohol. That said, Public Health England will be publishing an NPS toolkit for local commissioners to ensure that NPS are considered in service commissioning both in terms of treatment and prevention.

Governmental response

So far the UK government response has largely been through the Misuse of Drugs Act and – in the light of recent developments – temporary control orders which allow the immediate control of a substance to allow time for the government advisory group, the ACMD, to consider the evidence for permanent control. Earlier this year, the Home Office convened an expert panel to review legislative responses. At the time of writing this note, that review, while completed, has yet to be published. Other laws which have been invoked against the sellers of NPS include the Intoxicating Substances Supply Act 1985 and various local trading standards regulations. There are new Protection Notices and Orders coming into effect on October 20th under the Anti-Social Behaviour, Crime and Policing Act 2014. This will give the police powers to close premises that are having a 'detrimental effect' on localities or people within localities, which could possibly include NPS retail outlets such as 'head shops'.

In terms of legislative approach, the UK has been using a 'generic' approach to control substances and various compounds that are chemically similar. Other countries around the world have taken alternative approaches. For example the USA uses an 'analogue' approach which would control a substance and everything else that has a similar effect even if chemically different. Other countries such as Ireland, Romania, Poland and Portugal have imposed a 'blanket ban' on all sales of NPS from any outlet, although without the immediate imposition of a possession offence. There would still be the need to control each substance under respective drug control legislation. The most radical idea has come from New Zealand where a regulated, licensing regime has been voted into law, although this is a controversial move and has yet to be enacted. It is hard to say exactly how effective these measure have been; even where total ban on

high street sales have been imposed, there is some evidence of a return to street sales – and of course, trying to restrict internet sales is an even greater challenge.

Harry Shapiro

Director of Communications and Information

National Assembly for Wales

Health and Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Evidence from Abertawe Bro Morgannwg University Health Bored – LH 14

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

SUBMISSION TO THE HEALTH AND SOCIAL CARE ENQUIRY INTO NEW PSYCHOACTIVE SUBSTANCES ("LEGAL HIGHS")

Western Bay Area Planning Board response to the Welsh Government request for consultation and oral evidence for the Inquiry into new psychoactive substances ("legal highs"):

The Western Bay Area Planning Board welcomes the terms of reference for this consultation, which are apposite.

There is a marked lack of awareness amongst universal partners with regard to new and emerging psychoactive substances. There is a dearth of national or international research regarding the prevalence of use, effects and risks.

Tier 2 agencies are well placed to raise awareness of these substances and can also provide a pivotal link between substance users, the public and the police. It is unlikely that tier 3 services will have a greater proportion of the contact with users of legal highs, given that the majority of clients accessing tier 3 services will require a level of substitute prescribing for dependence or amelioration of withdrawal from dependence. However, it is likely that partners in wider adult mental health services will see clients with the associated features of substance use and mental ill health e.g. concurrent mental health issues and mephedrone use.

Locally, there has been an increase in requests at NSP outlets for paraphernalia for mephedrone use. Whilst national data suggests a reduction in alcohol consumption by children and young people, there is an anticipated exponential increase in young people using the new and emerging novel substances.

What is not feasible is the suggested role of agencies in submitting substance for testing. Agencies often do not have the capacity to gather substances from clients or to submit them for testing. Health service providers would not be encouraging staff to accept unknown substances from clients.

The police are an integral partner in tackling this issue. Whilst an increased presence in terms of 'stop and search' may assist in raising awareness of these substances, there may also be a risk of criminalising individuals, often young people.

Work with parents to be able to knowledgeably converse with and direct their children's choices with regard to alcohol has been neglected. If we are to remedy this, in addition to the new and emerging novel substances issue there needs to be national research as to the most effective way of engaging parents and young people in this debate. Additionally the information in the substance misuse component of the 'Healthy Schools' programme will require review and refresh, an exercise that we will be undertaking locally in line with our commissioning priorities.

There needs to be action and legislation to address the promotion of the use of psychoactive drugs. Web sites such as http://www.iceheadshop.co.uk/ make it woefully simple for people to purchase substances. Clearly this cannot be covered by a generic ban on advertising the sale of psychoactive substances and a more creative legislative solution is required. The response of making new and emerging substances illegal will lead to further and continued attempts to circumvent the prohibition. There should be an open debate regarding the decriminalisation of substance use to enable an ongoing dialogue regarding individual's substance use and methods of reducing harm.

One of the most concerning aspects of new and emerging psychoactive drugs are the lack of information with regard to the content of each substance and the 'time lag' in analysis. The potential effects are therefore often unknown or not fully realised by users.

There need to be strong national links to, and collaboration with the EMCDDA hosted EU early warning system, with clear routes of disseminating emerging information to local partnerships and substance users.

The WEDINOS system of reporting would appear to be unsustainable. The language used on the WEDINOS site is not user friendly and it demand for analysis of substance appears that the demand of substance analysis has overwhelmed the service.

National Assembly for Wales

Health and Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Evidence from Aneurin Bevan University Health Board – LH 15

Response to the Health and Social Care Committee inquiry into new psychoactive substances ("legal highs") - Aneurin Bevan University Health Board.

Dr Gillian Richardson , Director of Public Health, Julia Osmond, Principal in Public Health. 16.10.14

1. We welcome this opportunity to contribute to the National Assembly for Wales inquiry on New Psychoactive substances (NPS). The issue of whether it is legal or illegal to use a drug can result in confusion regarding its safety. The fact that a NPS is legal does not mean that it is safe. This is commonly mis-understood by the public. A more realistic term possibly would be 'not yet made illegal as new substance of unknown composition', ie) will probably be made illegal when chemical composition worked out and class of drug identified.

2. These drugs are often affordable and easily accessible. In many cases, these substances have been designed to mimic Class A drugs, often producing the same or similar effects as drugs such as cocaine or ecstasy, but are structurally different enough to be currently classified as illegal substances under the Misuse of Drugs Act 1971.

3. The European Monitoring Centre for Drugs and Drug Addiction define a New Psychoactive Substance as

> 'a new narcotic or psychotropic drug, in pure form or in preparation, that is not controlled by the United Nations drug conventions, but which may pose a public health threat comparable to that posed by substances listed in these conventions' (1)

4. With the major exception of mephedrone which was classified as a Class B drug in April 2010, many new psychoactive substances are legal to use and buy from the internet, in "head shops" (a store that sells drug-related paraphernalia(2) from street dealers and friends.

5. How to raise awareness of the harms associated with the use of NPS among the public and those working in the relevant public services.

This would be best achieved through a national social marketing campaign targeted at young people and young adults. Professional education of Educational Welfare Officers, Head Teachers and Teachers - through INSET day training - School Counsellors, School Nurses and Youth workers would also be beneficial.

Looked after children are particularly vulnerable and foster carers, care home workers and children and young people's Social workers would also benefit from training.

Additional training in the Health Sector for General Practitioners Practice Nurses and A and E staff is also essential. In ABUHB training supported by Police is to be offered at GP and Practice Nurse CPD events, and is to be offered to A and E departments.

6. A person buying NPS is unlikely to be sure of what he or she is buying. It is also the case that the seller is unlikely to know what he or she is selling. NPS vary considerably and are often designed to mimic more 'traditional drugs'. The chemical composition and potential affects are often unknown. This can be true of even the manufacturer as substances can be mutated into another drug along the supply chain by the adding of unknown cutting agents or other drugs.

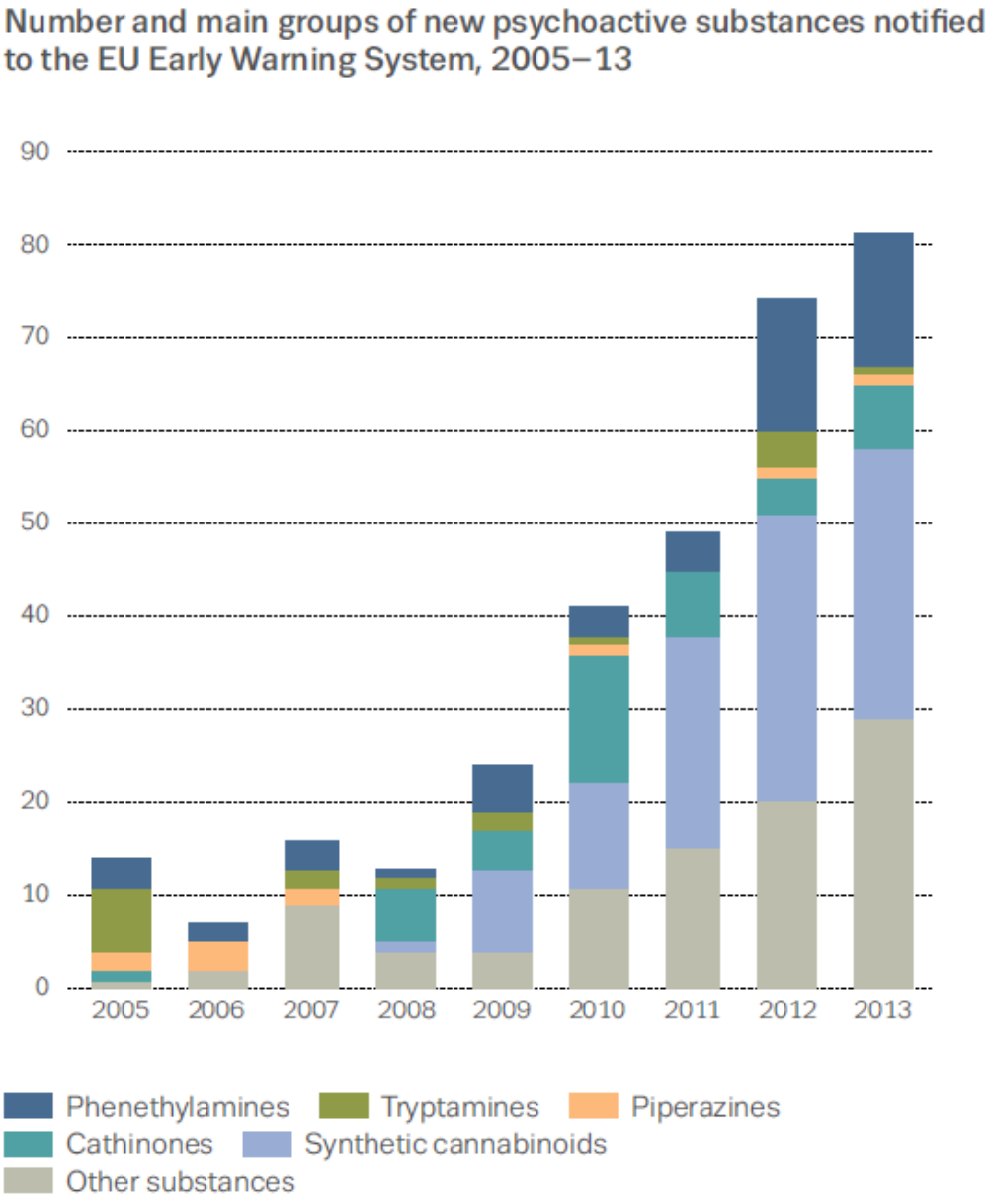
7. The capacity of local services across Wales to raise awareness of – and deal with the impact of – the harms associated with the use of legal highs.

The effectiveness of data collection and reporting on the use of legal highs in Wales and their effects.

8. (These aspects are interdependent as surveillance is 'information for action'. Lack of information on drug use patterns in the community hampers ability of services to plan and respond.)

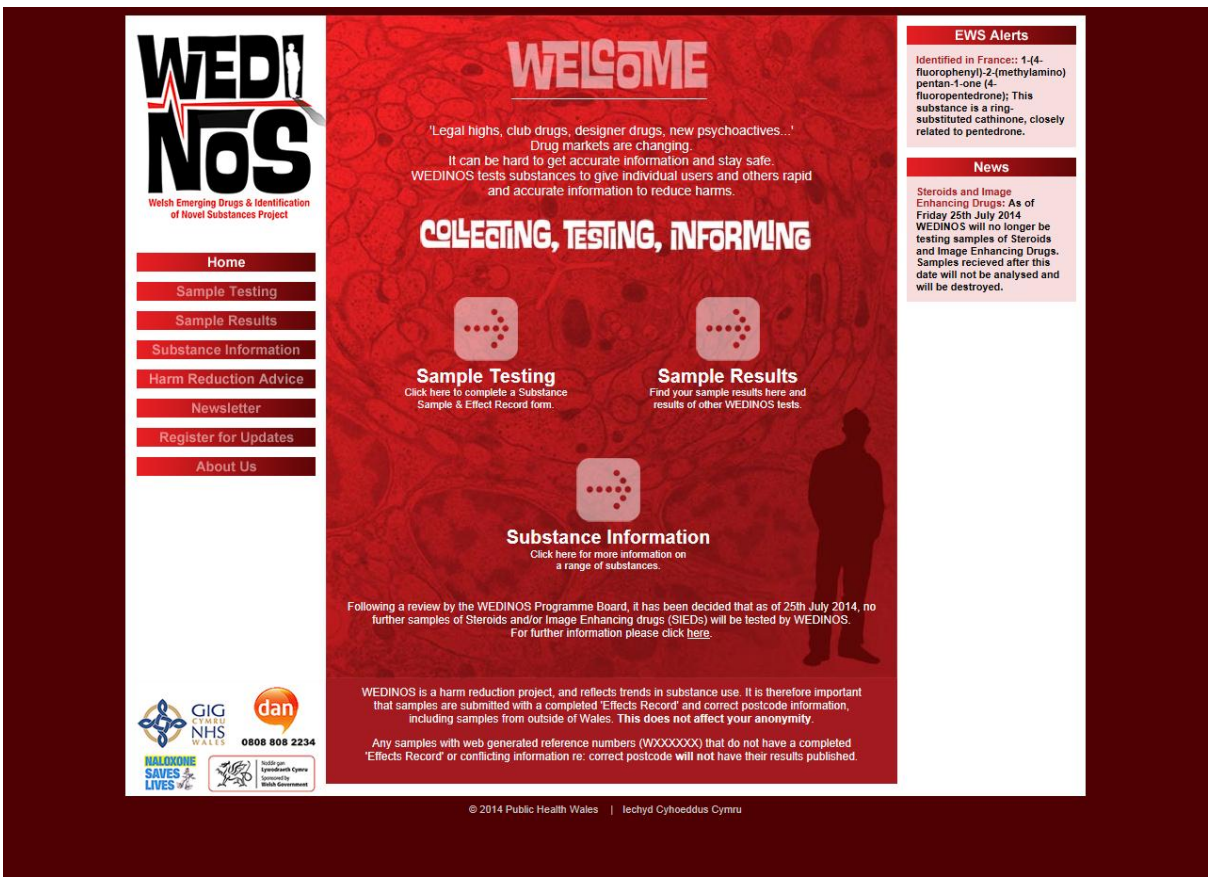
9. Services in Wales face a considerable challenge in dealing with impacts of NPS. There are numerous types of NPS being produced it is not possible to chemically analyse each substance in a timely fashion to provide enough information for them to be classified as illegal. Within each NPS drug category the number of substances are continually rising (3), as can be seen in Figure 1.

Figure 1:



10. A significant concern about NPS use is that if an unknown drug is taken resulting in adverse effects and there is a need for medical attention, health professionals are often unable to provide an appropriate intervention to counteract the effects of the unknown drug.

In an attempt to address this issue WEDINOS (Welsh Emerging Drugs and Identification of Novel Substances) has been designed to collect and test substances. Appropriate evidenced-based harm reduction information for individuals who misuse substances and interested professionals is disseminated via their website (http://www.wedinos.org/).



Samples are donated to WEDINOS anonymously. A code, known only to the donor is allocated, providing information about the substance being analysed free of charge, on the WEDINOS website.

9. The media have raised concern that this service supports sellers and manufacturers of NPS by providing them with analytical information about their 'product'.

Though it can be argued that the service has the potential to be abused, it has to recognised that it has a valuable role in contributing to our knowledge base, including how it is used and types of NPS available. This information is

necessary to inform primary prevention and secondary prevention (harm reduction) interventions wherever possible.

11. The WEDINOS facility is accessed more frequently in the ABUHB area than elsewhere in Wales. Between October 2013 and June 2014, some 237 samples were submitted. This compares with, Betsi Cadwaladr , 61 samples; Powys Teaching, 5; Cwm Taf, 39; Cardiff and the Vale, 69; Abertawe Bro Morgannwg, 69; and Hywel Dda, 18 during the same time period.

12. It is unclear why there is increased numbers of samples in the Gwent area. This could be due to high levels of professional involvement/awareness or greater prevalence of NPS use in the ABUHB area. We suspect the former.

13. The analysis of recent samples submitted to WEDINOS from the ABUHB area show at least 40 different substances were identified either in combination or in isolation.

14. In addition to this as well as taking NPS orally, there is increasing experimentation with alternative modes of administration such as intravenous use. This potentiates the effect of the drug and also increases the risk of the spread of blood borne viruses between users if needles are shared. In June 2014, there were two separate hepatitis C outbreaks confirmed in injecting mephedrone users in South Wales (4). Of the powders submitted for analysis to the WEDINOS project between October 2013 and June 2014, 4% would have been administered intravenously,indicating that 1 in 25 people injected NPS.

15. The full scale and impact of the use of NPS is not fully understood. There is no universal surveillance system in Emergency Departments in Wales which captures this information on a routine basis. There is also no standard ICD 10 coding definition which can be used to log diagnosis due to the number of different sorts of NPS. It is reasonable to suggest that numbers recorded of those affected is likely to represent just the 'tip of the iceberg'.

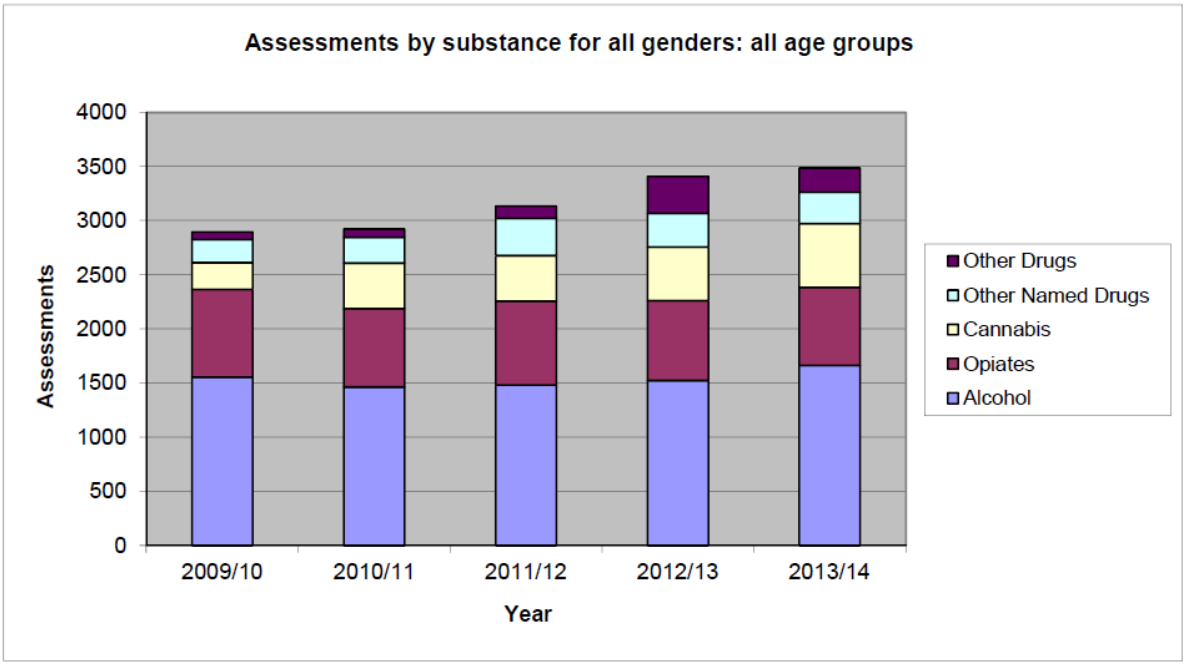
16. A look-back exercise to try to quantify impact of use of NPS in Torfaen area alone on A and E attendances in Gwent during 2013, showed 63 residents presented with mephedrone – like substance use. This equates to an average

of 5.25 presentations each month. Of these 63 people, 47 were under the age of 30, with 14 of them being between the ages of 15 and 20 years.

17. The number of people in Gwent presenting for assessment and or treatment, where the primary drug is classified as 'other substances' has risen gradually since 2009/2010 as illustrated in Figure 2. These might include substances not know at the assessment or which are not in the drug list so could include NPS. In many instances more than one substance will also be used.

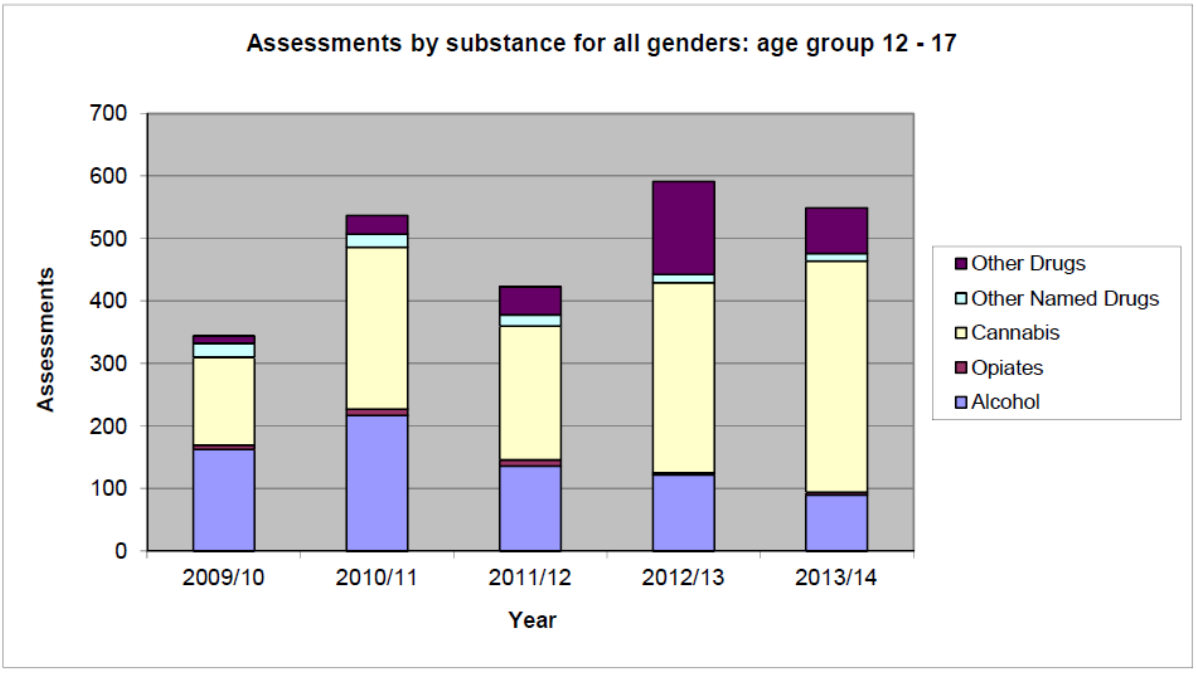
18. The Welsh National Database for Substance Misuse (WNDSM) was established in 2005. It contains guidance on the common data sets and data definitions regarding substance misuse for those seeking treatment by SM services (5).

Figure 2: Welsh National Database for Substance Misuse (WNDSM) Assessment Analysis All Ages.



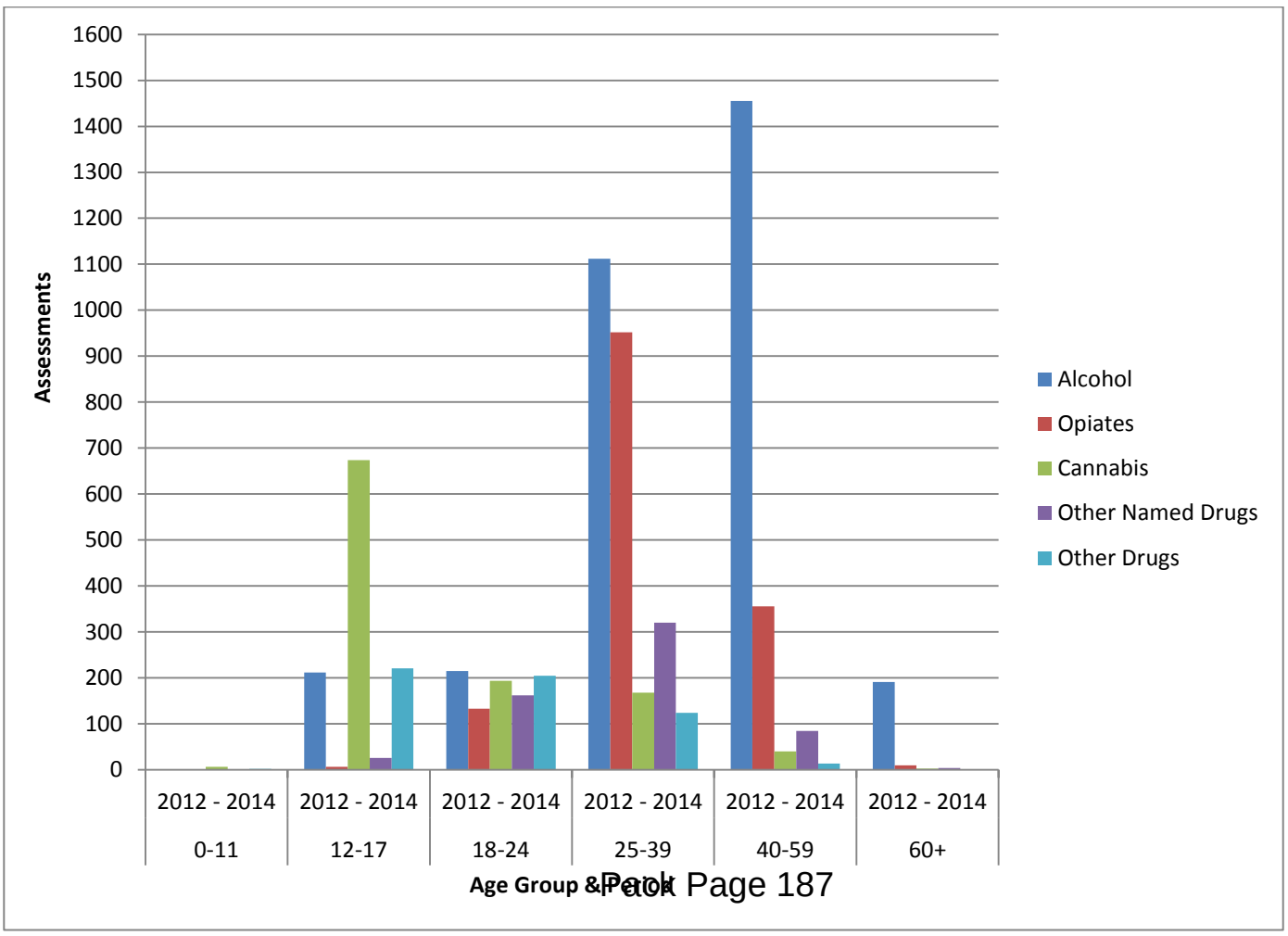
Primary assessment data for substance misuse services illustrates that the age groups where "other drugs" are the principal reason for assessment for drug service use are 12-24 years of age.

Figure 3 WNDSM Assessment Analysis, 12-17 years of age. Gwent



The age profile for NPS use in the Gwent area, is similar to that of the rest of south Wales, the main users of NPS being teenagers and young people.

Figure 4 WIDSM Assessment Analysis by Substance and Age Group From 2012 to 2014.



19. The possible legislative approaches to tackling the issue of legal highs, at both Welsh Government and UK Government level.

How effectively a partnership approach to tackling the issue of legal highs in Wales is being coordinated, both within Wales and between the Welsh and UK Governments.

20. Building health public policy

Reducing the harm associated with use of NPS should be regarded as a priority whether this is achieved through education or enforcement. A clear legislative framework needs to be developed by national government within which local agencies can operate. Collaborations between these agencies are of upmost importance. Action to identify and ban dangerous substances should be prompt and tools developed to enable this. Consistent messages regarding the risks and consequences of NPS which can be tailored to meet local need are necessary. The Director of Public Health Report for Gwent will this year include a section on NPS as an emerging threat.

If we are to ensure early identification of trends of NPS use and effective interventions the promotion of greater information sharing should be promoted locally. The development of better data collection methods to reduce gaps in knowledge is vital along with the need to engage with individuals who use NPS.

21.Creating supportive environments

Due to the legal status of NPS implementation of drug enforcement legislation to reduce supply and use is not an option. However, an alternative approach is the use of consumer protection legislation. An example of this is local authority departments such as trading standards taking action against suppliers such and 'head shops' and related businesses that sell NPS. This can result in NPS being seized and criminal investigations being pursued. There are also issues with this approach such as the need to be able to test a product on sale to establish if consumer protection law is being breached. This approach requires financial resources however.

For NPS which have already been classified as illegal, intervention is more straight forward, action can be taken to disrupt sales through known routes

such as internet sales, closing websites offering sales of banned substances. Substances sold as NPS often contain controlled drugs as well should this be found to be the case drug enforcement legislation can be implemented as being in possession of, or supplying controlled drugs is an offence.

Interventions should focus on environments where young people congregate. A number of third sector organisations have worked with the organisers of university events and social gatherings such as clubs, parties and music festivals to not only raise awareness of the potential effects of NPS and provide support if and when necessary.

22. Strengthening community action

Statutory services such as the Police and health services should work collaboratively with local communities to identify their needs and how restricting both the demand for and the supply of NPS can both be addressed. Raising awareness of NPS amongst the public is paramount, with education being delivered at a local/community level, allowing campaigns to be tailored to meet the needs of specific groups.

The idea that drug taking is an acceptable activity and an inevitable part of growing up needs to be challenged within certain communities. Tolerance of substance misuse should be challenged.

23. Development of personal skills

Prevention and education based interventions should focus on increasing individuals self efficacy and to promote/empower the choice not to take unknown, potentially harmful substances. It is important that we focus not only on substance misuse itself, but also on the root causes of the behaviour, helping people to develop necessary skills and values and building resilience in relation to risk taking behaviours.

Though use of NPS is not only the preserve of young people, use among this age group is very concerning. Resource should be targeted on resilience and skill development for this group through schools, youth services and non statutory services for young people. Ideally this would begin at primary school

with age appropriate messages being communicated. Information should be made available to parents to enable them to support their children. Programmes such as the charity Care for the Family's 'How to Drug proof your Kids' training days for parents should be promoted and expanded.

The key message should be that because a substance is labelled 'legal' it does not mean that it is guaranteed safe. The content of the package are not necessarily 'what it says on the tin'.

Although emphasis should be on prevention, a priority should be reducing harm for those who do use NPS. The WEDINOS system provides up to date information on the health effects of NPS, this should be used to enable harm reduction information to be publicised, increasing public awareness of the health risks and dangers of taking NPS.

24. Re-orientation of services

Substance Misuses services provide specialist treatment for people with problems relating to NPS and other substances. Data from the WEDINOS system should be used in conjunction with service utilisation data to inform future service planning.

However many recreational NPS users would not consider themselves 'substance misusers' and would certainly not approach traditional services that they may see as associated with users of 'hard drugs'. Drop in clinic facilities for teenagers/young people wishing to discuss health issues including NPS are needed.

There are a number of professionals and organisations with whom those who use NPS will come into contact (for example primary care, accident and emergency department, and housing staff). It is important that these professionals are equipped with knowledge about NPS and where support and treatment can be accessed.

The DAN 24/7 website is useful. Messages need 'post marketing surveillance' to ensure they remain relevant and hit the mark.

25. International evidence on approaches taken to combat legal highs in other countries.

The US has developed a system for temporarily banning new substances that are being classified. However classification is always one step behind production, and so a new approach is being piloted in New Zealand which has decriminalised NPS through the Psychoactive Substances Bill 2013. This enables regulation and licensing of a tightly controlled market for recreational drugs including safeguards, testing and regulation of new substances. Drug manufacturers must prove the product has 'low risk of harm' and pay research costs and fees to register. In effect *all NPS are therefore illegal until proven to be low risk.* This is at variance with EU and US approaches which are not proving effective, so international interest in effectiveness of New Zealand's approach is high. (7)

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(6) Gwent Police "Location of Mephedrone Dealing Based on Intelligence Submitted Between August and November 2012" in (2013) p109 Substance Misuse Interim Needs Assessment for Consultation Gwent Area Planning Board.

(7) New Zealand's regulation of new psychoactive substances; A response to the futility of trying to ban such substances as they appear

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National Assembly for Wales
Health and Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Evidence from Betsi Cadwaladr University Health Board – LH 16

Ein cyf / Our ref:
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E-bost / Email: [redacted]
Dyddiad / Date: 16/10/14

National Assembly for Wales
Health and Social Care Committee
Inquiry into New and Emerging Psychoactive Substances
Cardiff

Dear Sir/Madam

Please see response below in relation to the National Assembly for Wales Health and Social Care Committee Inquiry into New and Emerging Psychoactive Substances (NEPS). This response is collated on behalf of substance misuse clinicians working across tier 3 and tier 4 services in BCUHB and relates to the areas of the inquiry that interface with our service delivery currently.

As clinicians we experience patients in outpatients clinics who report to be using a variety of NEPS but these are often taken in conjunction with other opiates, cocaine or alcohol in dependant patients. We rarely see patients presenting with NEPs use in isolation but we accept that this may be because that group of users do not see tier 3 or 4 services as having a service to offer. Anecdotally we do get a picture of use in North Wales that does not appear to mirror the picture of use in some area in South Wales e.g. our tier 2 services are only seeing limited evidence of NEPs use and we aren't seeing an injecting profile in this group. The stimulant drug of choice in our patient population across North Wales continues to be crack cocaine and amphetamines.

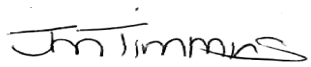
We feel there is more work that needs to be done in relation to awareness raising of the risks these new substances pose to individuals. However given their chemical makeup is often unknown and long term studies are problematic it is difficult to accurately predict harm and risk, therefore we consider general harm reduction messages are likely to be most credible.

We feel the use of current legislation may not be the best way to tackle the growing market in relation to these substances as it appears once legislation is changed to address one substance new substances are produced which may be more harmful or toxic and the flow appears difficult to stem. Whilst we don't have detailed information we are aware of some innovative approaches in New Zealand in relation to control and we would urge the committee to consider this in more detail.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

We have ensured frontline BCUHB substance misuse staff have been able to attend the local meeting in Glyndwr University to feedback their direct local experience to the committee.

Yours sincerely



Jill Timmins
Head of Programme
Substance Misuse Service

And

Dr Sue Ruben
FRCPsych
Consultant Psychiatrist
Substance Misuse Service

Copy to:
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National Assembly for Wales

Health and Social Care Committee

Inquiry into new psychoactive substances ("legal highs")

Evidence from Public Health Wales – LH 17

Submission to the National Assembly for Wales' Health and Social Care Committee Inquiry into New Psychoactive Substances

Author: Josie Smith, National Lead for Substance Misuse	
Date: 20 October 2014	**Version:** 1
Publication/ Distribution: • Public (Internet)	
Review Date: N/A	
Purpose and Summary of Document:	

This document is the Public Health Wales submission to the National Assembly for Wales' Health and Social Care Committee Inquiry into New Psychoactive Substances.

1 Introduction and summary

We welcome the opportunity to give evidence to the Assembly Committee Inquiry into New Psychoactive Substances.

Information from a number of sources in the UK, including Wales, suggests that new psychoactive substance (NPS) use is a growing public health issue. Users of NPS are at risk of a number of serious adverse effects on health. Principally these are the direct physical, psychological and behavioural effects from the drugs themselves. These harms reflect only the short term consequences of NPS use. It is not yet possible to predict the extent of future harm.

The approach being taken in Wales to harm reduction is the right one. It is multi disciplinary and focused on health. We wish to see it developed in three ways:

- **Development of clear pathways for care and engagement** – from early or initial contact with health and social services (for example ambulance, police, primary care, youth services and clinical practitioners) to specialist substance misuse services (from low threshold and outreach community work through to treatment).

- **Adaptation of specialist substance misuse services** - to meet the needs of current drug and poly-drug users including NPS users, particularly those using synthetic cannabinoid receptor agonists (SCRAs) and stimulants. Services are currently focussed mainly on more traditional drug use such as heroin but should provide support and treatment for **all** those experiencing problematic substance misuse.

- **Increase expertise** – there is a high level of knowledge and expertise in relation to NPS in some organisations in Wales. However we need to raise awareness in, and educate and train, professionals working with those who may use, or who consider using, NPS, as well as the wider population.

2 Raising awareness of the harms associated with the use of legal highs among the public and those working in the relevant public services

Use of the term 'legal highs' is unhelpful. It implies that these substances are legal and as such 'safe'. Very often the substances are not legal or safe. Therefore, we prefer to use the term new psychoactive substances (NPS)[1].

There is no single way to raise awareness for people who use NPS or who work with people using NPS. This is because there are different types of NPS users.

To communicate effectively we need to understand the attitudes, knowledge and behaviours of people using NPS. There are three definable groups:

Recreational and club/party goers

This group mainly comprises adolescents and young adults who often use NPS on a recreational basis at weekends, festivals etc. They may become problematic or poly-drug users.

They tend to binge use NPS, often using a range of substances, over a number of days. As such they are regularly at risk of acute toxicity and are vulnerable to other harms related to intoxication including risky sex and transmission of sexually transmitted infections.

As they may have developed no or limited tolerance to substances, they are more vulnerable to high strength / high dose substances, including synthetic cannabinoids.

Often NPS are sold as a single named or branded product, such as an Ecstasy (MDMA) tablet, but the actual tablet may contain an entirely different chemical/s e.g. Para-methoxyamphetamine (PMA). In 2012 a total of 17 deaths in the UK resulted specifically from PMA consumption which was purchased as Ecstasy.

[1] The term "new psychoactive substances" has been legally defined by the European Union as a new narcotic or psychotropic drug, in pure form or in preparation, that is not scheduled under the Single Convention on Narcotic Drugs of 1961 or the Convention on Psychotropic Substances of 1971, but which may pose a public health threat comparable to that posed by substances listed in those conventions. (Council of the European Union decision 2005/387/JHA)

Club/party goers will buy substances regularly, choosing substances for effect as well as perceived 'legal status'.

Based on this understanding, peer reports of adverse effects and word of mouth appear to be more effective in initiating behavioural change than clinical information. Peer communication can be supported by:

- The availability of information to ensure safer use of NPS in places where NPS are used (festivals, clubs etc)
- The sharing of information on NPS using social and traditional media
- Social marketing methods
- The promotion of services such as WEDINOS (see Appendix 1) which provide objective analysis and profiling of substances

"Psychonauts"

"Psychonauts' actively *experiment* with mind altering chemicals and are keen to try entirely new substances. They often take exact measurements and keep records of experiences.

They are highly active on the internet and social media and engage with online forum discussion regarding specific dose related experiences.

On this basis, the best ways to communicate with 'psychonauts' are to:

- Use the internet and social media e.g. WEDINOS minimises potential harm, particularly in respect of highly toxic substances, by identifying the self-reported effects from other users of entirely new substances.
- Engage them via online forums and discussion

Poly-drug users

Poly-drug users present the greatest public health challenge.

They are people with a history of taking drugs including controlled substances such as heroin, cocaine, amphetamine and cannabis. They and may add NPS to the repertoire of drugs they use.

There is clear evidence of increased blood borne virus (BBV) transmission in the UK and Wales as a consequence of NPS use. Increases have been recorded for HIV and Sexually Transmitted Infection (STI) transmission amongst 'Chem-sex' party goers where NPS and other drugs are taken over a prolonged weekend period. The parties are usually sex parties primarily between men who have sex with men.

The lack of knowledge of the content and strength of NPS may result in increased vulnerability to all users due to a lack of inhibition, unexpected effects and duration of effects.

The adoption of specific NPS alongside traditional controlled drugs has resulted in an increase in risk behaviour in relation to frequency of injecting from an average of three injections per day to upwards of 15-20 injections per day commonly reported.

Over the past few years, mephedrone and other NPS use including other cathinones and synthetic cannabinoids have become more established amongst poly-drug users. Whilst work to estimate prevalence is ongoing, self-reported use amongst injecting drug users alone has more than doubled.

NPS use amongst poly-drug users is not restricted to those injecting. The majority of NPS users do not inject. As such they are further removed from contact with the substance misuse services which provide sterile injecting equipment as well as harm reduction advice.

Taking the above into account, the most effective ways to raise awareness with, and to educate poly-drug users are to:

- Adapt specialist substance misuse services so they meet the needs of all substance users including young people and poly-drug users. This will additionally require increased expertise amongst staff.
- Target communications, proactive outreach and engagement via realigned substance misuse services

3 The capacity of local services across Wales to raise awareness of – and deal with the impact of – the harms associated with the use of legal highs.

The primary issue relates to the range of services offered locally, rather than their capacity.

Local services across Wales are well placed to raise awareness of the harms associated with the use of NPS using knowledge of local trends.

However, existing substance misuse services tend to address the use of more traditional drugs. As such, they may suffer from the perception by NPS, and more broadly, stimulant and cannabis/SCRA users, that they have nothing to offer. Therefore, NPS users may fail to engage with these services.

Adapting services, based upon evidence of the needs of the substance using population, would address this along with increasing levels of expertise amongst the staff. In addition, the development of a clear pathway to services would support engagement and reduce harms.

If they were adapted they could be engaging regularly with NPS users in the community. Local knowledge along with increased expertise among staff should facilitate awareness raising amongst risk populations.

Local services need to be supported by national information services such as DAN24/7 and WEDINOS. They can provide a unified and evidence based approach to ensure clear and relevant messages are tailored to the specific populations using NPS.

4 The effectiveness of data collection and reporting on the use of legal highs in Wales and their effects

There are a number of robust national data collection systems in place in Wales relating to the use of NPS, and a number of others in development:

- In response to the threat posed by NPS in Wales, Public Health Wales, with the support of the Welsh Government, developed the WEDINOS project in 2013. This enables data collection on the types of NPS being used in Wales, and on the harms experienced as reported by those using them. There are 71 contributing services across Wales including the four police forces in Wales, substance misuse services, housing and homelessness, youth services, education and emergency departments along with samples from NPS users.

  A quarterly report is produced and published online for all interested parties. In addition, the website www.wedinos.org provides information from the National Poisons Information Service (NPIS) on toxicity and harms.

  Whilst the system does not provide a prevalence estimate of all those using NPS, it does provide trend analysis of NPS in circulation and being used, by geographic area of residence. It also identifies the harms associated with the use of particular substances.

  In addition, Public Health Wales is undertaking a prevalence estimate of problematic drug use that will include opioids, cocaine

/ crack cocaine and amphetamines and amphetamine-like substances (including NPS cathinones) from 2011/12 and up to 2020/21. Previous prevalence estimates have focused on heroin and cocaine/crack use. This project is in development and going through ethical approval processes but should be in place for April 2015.

- The Welsh National Database for Substance Misuse (WNDSM) allows for the indication of specific NPS use on referral to treatment services. However, secondary and tertiary drugs used are not well recorded and, as such, the extent of NPS use may be under reported at present. NPS training for staff, as indicated above, may improve this.

- The Harm Reduction Database Wales – NSP module - provides high quality data on all those injecting drugs, including named NPS, who are in contact with needle and syringe programmes across Wales. Data from the last three years show a near fourfold increase in the number of people injecting mephedrone alongside other drugs (primarily heroin).

- The Crime Survey for England and Wales relies on self reporting use of substances including some NPS. It does not distinguish between certain substances e.g. cannabis and synthetic cannabinoids.

However, the majority of NPS users will not have contact with specialist treatment and related services. This represents a challenge in identifying the scale of NPS use and the nature of harms associated with their use.

Local needs assessments involving community field and outreach work, particularly amongst young people, should be undertaken regularly as part of the service adaptation to ensure that local knowledge regarding the scale and nature of NPS use is understood and fed into national data collection systems.

In terms of recording clinical health harms, hospital admissions data is not able at present to record the harms (e.g. acute poisoning) by specific named NPS. This is because the patient often does not know what they have consumed and because coding for individual NPS is not possible.

This challenge could be addressed if data was collected when people attend emergency and unscheduled care services. If people were asked two questions - "Have you consumed any drugs other than your own prescribed medication today" and "Have you consumed any alcohol today" - the system could 'flag' patient records for further analysis in relation to substance misuse (drugs and alcohol) and related harms and outcomes.

5 The possible legislative approaches to tackling the issue of legal highs, at both Welsh Government and UK Government level

The UK Government has powers for the legislation of NPS. There are a number of legislative approaches used within the UK at present. These include the use of Temporary Control Drug Orders (TCDOs), Trading Standards legislation and classification of NPS under the Misuse of Drugs Act (1971) and the Misuse of Drugs Regulations (2001). Legislation is informed by the Advisory Council on the Misuse of Drugs (ACMD) and other scientific bodies.

Public Health Wales has supported the work of the ACMD and the European Early Warning System (European Monitoring Centre for Drugs and Drug Addiction) with findings from WEDINOS evidencing the harms related to specific NPS.

There is a great deal of confusion in the population on the legal status of many drugs and the ongoing classification of new substances and existing prescription medication.

Within NPS user populations, the use of TCDOs and other legislation appears to have been less than effective. There is concern amongst those working in the field that, whilst some extremely toxic substances should be controlled, the existing control structures and processes may lead individuals to experiment with new uncontrolled substances of which very little is known. This thereby potentially increases the possible acute and chronic health harms.

A recent example involved the NPS stimulants 5 and 6-APB. Within five months of the implementation of a Temporary Class Drug Order (TCDO) being placed on the stimulants (phenethylamines) 5- and 6-APB, at least two new 'legal' derivatives had been notified. These drugs mimic the effects of ecstasy and amphetamines. 5 and 6-APB have since been controlled as Class B drugs following scientific evidence of hospital admissions and a small number of deaths.

Wedinos helps manage this issue by providing a system that identifies new substances and the actual and potential future harms associated with use.

We believe that a harm reduction and health-centred approach is likely to be more effective than one based on criminal justice. If Wales were to

adopt legislation prescribing health in all policies, this would be strengthened. We believe this should be achieved through the Wellbeing of Future Generations Bill with health included in its common aim.

6 How effectively a partnership approach to tackling the issue of legal highs in Wales is being coordinated, both within Wales and between the Welsh and UK Governments

There are strong and well-established multidisciplinary partnerships within Wales to address the harms associated with NPS. These include the Substance Misuse Area Planning Boards and associated harm reduction groups.

Through the suggested development of multi-disciplinary pathways, adaption of services and increased expertise, effective partnership working should be further strengthened.

At a national level, WEDINOS is an example of collaborative working with partners including criminal justice (police forces, probation and prison services), health (substance misuse, secondary care and ambulance/emergency departments), housing, education, youth services and local authorities. The partnership approach is essential to effective ongoing project management and development.

Wales and the Welsh Government is represented on all relevant UK-wide NPS boards and is an effective partner within the UK.

7 International evidence on approaches taken to legal highs in other countries

NPS represent a global challenge to those working in substance misuse, particularly in relation to reducing harms.

Across Europe the majority of countries have adopted legislative approaches to a greater or lesser extent alongside prevention, awareness raising and harm reduction interventions.

The most effective approaches, from a public health perspective, are those that adopt a less punitive and more pragmatic approach, supporting those who are using or considering use of NPS.

The emphasis needs to be on the provision of accurate, timely and credible information, proactive engagement through relevant media, psychosocial interventions and low threshold early engagement with specialist substance misuse services. Within Wales WEDINOS adopts

such an approach and as such is attracting international attention in the form of collaboration requests and a direct contribution to the European Monitoring Centre for Drugs and Drug addiction.

Appendix 1 – WEDINOS (Welsh Emerging Drugs and Identification of Novel Substances) – project outline

In response to the changes in drug use trends, Public Health Wales, in conjunction with Cardiff & Vale Toxicology Laboratory, Llandough, and Cardiff University Pharmacology developed the WEDINOS project (Welsh Emerging Drugs and Identification of Novel Substances). It is supported by the Welsh Government.

This national project provides a framework for the collection and testing of samples of new psychoactive substances and combinations of drugs, along with information regarding the symptoms users experienced, both expected and unexpected.

Collation of these findings, along with identification of the chemical structure of the samples, will facilitate dissemination of pragmatic evidence based harm reduction information for those using new psychoactive drugs or considering use. All relevant information will be available via the website: www.wedinos.org

A series of WEDINOS launch events were completed across Wales in September and October 2013 for all those using, or working with those using, New Psychoactive Substances. These include substance misuse service providers, the police, ambulance service, primary and secondary health care, youth and criminal justice leads, education and housing. Further events will be arranged focussing on developing mechanisms whereby other relevant health care providers, including pharmacy and emergency departments, may contribute to the WEDINOS project.

The WEDINOS project contributes to the wider UK and European Early Warning Systems in place to identify and monitor the changing trends in drug use.

National Assembly for Wales
Health and Social Care Committee
Inquiry into new psychoactive substances ("legal highs")
Evidence from HM Inspectorate of Prisons - LH 18

RESPONSE TO National Assembly for Wales - Health and Social Care Committee: Inquiry into new psychoactive substances

RESPONSE TO National Assembly for Wales - Health and Social Care Committee: Inquiry into new psychoactive substances

by Her Majesty's Chief Inspector of Prisons

Introduction

1. We welcome the opportunity to submit a response to the inquiry into new psychoactive substances (NPS).

2. Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent inspectorate whose duties are primarily set out in section 5A of the Prison Act 1952. HMI Prisons has a statutory duty to report on conditions for and treatment of those in prisons, young offender institutions (YOIs) and immigration detention facilities. HMI Prisons also inspects court custody, police custody and customs custody (jointly with HM Inspectorate of Constabulary), and secure training centres (with Ofsted).

3. HMI Prisons coordinates, and is a member of, the UK's National Preventive Mechanism (NPM) the body established in compliance with the UK government's obligations arising from its status as a party to the UN Optional Protocol to the Convention Against Torture (OPCAT). The NPM's primary focus is the prevention of torture and ill treatment in all places of detention. Article 19 (c) of the Protocol sets out the NPM's powers to submit proposals concerning existing or draft legislation.

4. All inspections are carried out against our *Expectations* - independent criteria based on relevant international human rights standards and norms.

5. In response to the serious threats that drugs and alcohol pose to health and safety in prisons, HMI Prisons has on its staff three specialist substance use inspectors. They have wide ranging backgrounds in substance use nursing, addiction rehabilitation and service management within prisons and the community. They also bring experience in substance use treatment programme design and evaluation, both in the UK and internationally. Inspectors' on-going involvement with substance misuse research in prisons adds to the specialist knowledge base. Working as part of the HMI Prisons healthcare team, they inspect clinical and psychosocial aspects of in-prison substance use treatment and associated education and awareness programmes. Substance use inspectors also work closely with security inspectors to determine the effectiveness of prisons' drug supply reduction initiatives including drug testing programmes.

6. As part of HMI Prisons' statutory duty to report on conditions for and treatment of those in prisons, YOIs and immigration detention facilities, we have monitored and reported on the rise of NPS use and availability in prisons in England and Wales. The following response is based on evidence from HMI Prisons' most recent inspections of Welsh prisons, as follows:

    - HMP Swansea: unannounced inspection, 29 September – 10 October 2014 (*report not yet published)*

    - HMYOI Parc Juvenile Unit: unannounced inspection, 28 April – 9 May 2014

- Arolygiad dirybudd Carchar EM / Sefydliad Troseddwyr Ifanc y Parc (9-19 Gorffennaf 2013) –/– HMP/YOI Parc: unannounced inspection, 9 – 19 July 2013

- Adroddiad ar arolygiad heb ei gyhoeddi ymlaen llaw o CEM Brynbuga a CEM/STI Prescoed (22 Ebrill – 3 Mai 2013) –/– HMP Usk and HMP/YOI Prescoed: unannounced inspection, 22 April – 3 May 2013

- Arolygiad lle rhoddwyd rhybudd o Garchar Ei Mawrhydi Caerdydd (18–22 Mawrth 2013) –/– HMP Cardiff: announced inspection, 18 – 22 March 2013

Summary

- Drugs get into prisons through five main routes.
- HMI Prisons inspections of Welsh prisons over the last two years have shown new psychoactive substances (NPS) to be less of a problem than in English prisons. This may change in the near future.
- Spice and Black Mamba have been an increasing problem in English prisons since autumn 2013.
- Areas of good practice are beginning to emerge, from which lessons can be learned.
- Current drug testing programmes in prisons are not equipped to deal with NPS.
- Under the current legislative framework, prisoners find NPS an attractive alternative to more traditional drugs for a number of reasons related to the lack of detectability and reduced risks of penalties.
- Inspection findings over the last year have pointed to increased safety concerns in prisons. The rise of NPS misuse is one such factor that may also partly be a result of the other factors that contribute to prisoners feeling less safe, given that people who feel under stress will often take drugs in an attempt to relieve that stress.

HMI Prisons response

7. In order to reflect the sole focus of HMIP on places of detention, this evidence focuses specifically on the inquiry's terms of reference that fit with the unique circumstances of prison environments. We have therefore left the remaining three areas more effectively to be evidenced by community-based service users and providers.

How to raise awareness of the harms associated with the use of legal highs among the public and those working in the relevant public services.

8. The wider awareness of drug problems in prisons at a strategic level, includes an understanding of how drugs get into prisons. In 2008, David Blakey produced a report entitled 'Disrupting the supply of illicit drugs into prisons.' That report cited five routes that are still widely used:

    - *With visitors* – normally passed to prisoners during a visit
    - *'Over the wall'* – people on the outside use various devices to throw drugs over prison walls for prisoners to retrieve from exercise yards and walkways. Small packets or even single coins holding a single tablet are commonly found especially in inner-city prisons. Coins are used to provide weight and velocity sufficient to ensure passage through nets that are sometimes erected to prevent throw overs.
    - *In post and parcels* – even confidential letters from legal representatives have been used to get drugs into prisons.

- *Brought in by prisoners* – drugs are often secreted in body cavities – a practice known as 'packing' or 'plugging'. As well as opportunistic attempts by individual prisoners, a new trend is emerging in this area. Intelligence from some areas of the UK points to organised gangs directing individuals released on licence to commit minor offences that ensure a short return custody. This enables drugs to be taken into local prisons regularly and in relatively large quantities.
- *Through corrupt staff* – Blakey said *"Most staff are not corrupt and have a clear integrity. They are let down by a minority of staff who are corrupt. That corruption will extend, in some cases, to receiving large amounts of money for carrying in phones or drugs."*

9. When we inspected HMP Cardiff in March 2013, whilst the diversion of prescribed medication was an issue, there was no evidence of NPS availability or use. Similarly, at HMP/YOI Parc four months later in July 2013 and at the inspection of the Parc Juvenile unit in May 2014, there was no evidence of an emerging NPS problem. Most recently, at our inspection of HMP Swansea in early October, (report not yet published), staff and prisoners told us there was little or no evidence that NPS were becoming and issue within the prison.

10. Nevertheless, prison staff and prisoners alike often say that drug trends within prisons follow those in the community. As NPS gain momentum in Welsh communities, it can be predicted with some confidence that Welsh prisons should expect a rise in the incidence of NPS misuse – as is certainly the case in England.

11. On 28 October 2014, the WalesOnLine website reported the Chief Inspector's warnings for the proposed new prison in North Wales. Stating legal highs had a "prison value" 10 times that of the "street value," he stressed the health dangers and warned: "[They] are a cause of debt and debt is a cause of violence. What we found is that on the whole in Welsh prisons, actually, they don't have the problem yet to the same extent as English prisons..."But I think it will [arrive] and therefore those Welsh prisons need to be ready for this to hit them and on the whole I think the system has been too slow to react."

International evidence on approaches taken to legal highs in other countries.

12. In the autumn of 2013 we reported the beginnings of the availability and use of NPS in prisons with our report on the Category D establishment, HMP Blantyre House (Kent, England), inspected 9 – 20 September 2013. We made the following comments:

> *The number of violent incidents had increased since the last inspection and there had been two recent serious assaults. Although the level was still low, more prisoners reported victimisation than at the last inspection and at similar establishments. This appeared, at least in part, to be due to the availability of 'Spice' – a synthetic cannabinoid – and associated debt and bullying. Current testing methods did not detect Spice, so the very low positive drug testing rate did not give an accurate picture of the availability of drugs in the prison. The prison's response to the issue was inadequate.*

13. In our report on the Category C establishment, HMP Ranby (Nottinghamshire, England), inspected 10 – 21 March 2014, we raised the following concern:

> *There were high levels of illicit drug and alcohol availability. More than half of the population said that it was easy to get illegal drugs and a quarter that it was easy to get alcohol. The number of finds was high. Most intelligence and finds related to undetectable diverted medication and new psychoactive substances (especially 'Mamba')... In the previous six months substance misuse and health services staff had responded to 25 acute medical situations which were thought to have resulted from prisoners taking such substances...The prison had taken some reactive measures but there was no coordinated action plan to reduce supply and demand.*

14. To address the above concern we made the following recommendation to HMP Ranby:

> *An action plan to address drug and alcohol supply reduction and demand should be implemented and should address the specific issue of new psychoactive substances and diverted medication.*

15. HM Chief Inspector reported on inspection findings across prisons in England and Wales in his Annual Report 2013-14, specifying:

> *NPS, specifically 'Spice' and 'Black Mamba', were cited as causes for concern at 14 (37%) of the adult male establishments inspected, particularly local and category D jails. Although many prisons had taken steps to promote awareness of this problem, we highlighted the need for some to give prisoners and staff accurate and up-to-date information on the acute health dangers associated with NPS.*

16. Drugs education and treatment programmes in prisons in England and Wales have experienced huge changes in recent years. The previous nationally-based and prison service-run CARAT (counselling, assessment, referral, advice and throughcare) service, has been replaced by locally commissioned, civilian-based services. Much time and effort has been, in our opinion rightly, devoted by these newer services to the development of integrated clinical and psychosocial opiate treatment programmes (e.g. heroin and its substitutes). Whilst this has been in response to previously assessed levels of need, the demographics of drug use are constantly changing. Services in England, where NPS is becoming a problem have had to devise awareness and education programmes quickly and with minimal resources.

17. Staff training, in some prisons where NPS is a problem, has been difficult to organise. Overall shortages in staff have reduced opportunities to take staff away from operational duties for training.

18. Nevertheless, as well as pointing out areas for improvement, the HMI Prisons inspection process is a useful way of identifying good practice. In recent months we have found good practice that has begun to address NPS in some prisons in England has included the following components: (due to this information being recent, reports are not yet published):

- Adaptations of drugs strategies and action plans that specifically address supply reduction, demand reduction and harm reduction relating to NPS.
- Up-to-date, accurate information on the appearance and effects of NPS – given to both staff and prisoners.
- Extra training given to discipline staff and primary healthcare staff that better equips them to recognise and deal with acute health situations caused by prisoners' use of NPS.
- Extra training given to drug workers to enable delivery of NPS-specific demand reduction and harm reduction initiatives.
- Exploration of initiatives to reduce the supply of NPS including:
- The training of drug dogs to recognise 'Spice' and other synthetic cannabinoid receptor agonists (SCRAs)
- The development of accurate tests to detect SCRAs

The possible legislative approaches to tackling the issue of legal highs, at both Welsh Government and UK Government level.

19. Powers to require prisoners to provide a sample for drug testing purposes were introduced as part of the Criminal Justice and Public Order Act 1994 (Appendix 1). The initial powers for testing prisoners for drugs were added under the aegis of Section 16A the Prison Act 1952, and came into force on 9 January 1995.

20. HMI Prisons has noted that while there has been a general decline in the positive rates resulting from the mandatory drug testing (MDT) of prisoners – both in random testing and that carried out under 'reasonable suspicion' – this trend does not mean that prisoners' illicit drug use has reduced. While MDT rates provide an indicator, they do not reliably measure drug availability in establishments – nor does testing necessarily deter prisoners' use of illicit drugs. In our survey, 31% said that illegal drugs were easy or very easy to obtain in their prison, and 7% told us they had developed a problem with illegal drugs and 7% with diverted medications since coming to prison. HMI Prisons considers that the main reason for this is that the current MDT does not detect new psychoactive substances (NPS) and most diverted prescribed medications.

21. It is important to consider that the wide range of drugs that fall into the 'NPS' (which includes stimulants like Mephedrone, to depressant hallucinogenics like Spice and other SCRAs) makes the development of tests a complex issue involving many drugs, the precise ingredients of which are constantly changing.

22. The current absence of a usable test for any NPS makes such drugs attractive to some prisoners who might otherwise be deterred by the risk of being caught through drugs testing programmes.

23. The previous two points notwithstanding, the types of drugs used in a prison environment tend not to include stimulants. The majority of prisoners will prefer to use drugs that depress levels of awareness of surroundings, reduce anxiety and produce a sedative effect. Such effects are brought on by depressant drugs. NPS that fall into this category are the SCRAs.

24. NPS, and specifically SCRAs are also attractive to prisoners for the following reasons:
    - These substances have little odour when mixed and smoked with tobacco.
    - The penalties for a prisoner caught with NPS will be limited to 'possession of an unauthorised article', rather than 'possession of a controlled drug'. The former will lead to a temporary loss of privileges whilst the later can be adjudicated by an Independent Adjudicator (a judge) and lead to the greater penalty of added days to the sentence.
    - This is because each sample, if found in the possession of a prisoner, would have to be forensically tested to determine whether or not it fell within current definitions of drugs controlled under the Misuse of Drugs Act (1971). Such analysis is expensive and unlikely to be given funding. Also, given the constantly changing nature of NPS at a molecular level, the manufacturers of NPS are often able to keep ahead of the drugs covered by statute.
    - We have spoken to many prisoners who say they enjoy the risks associated with taking new drugs, the effects of which are unpredictable.

25. In conclusion, the emergence of NPS in English prisons is likely to be mirrored in Welsh prisons in the near future. Lessons that can be learned include the need for a strategically co-ordinated, 'whole prison' approach to tackling the new threats posed by NPS.

26. A 'whole prison' approach to drugs is a strategy that recognises a simple principle: Drugs have the potential to affect virtually all areas of prison life. It therefore follows that an effective strategic response will address all relevant issues in all those same areas of prison life. The 'whole prison' approach will have at its core, strategies that tackle three areas:
    - Supply reduction: stopping drugs getting into the prison – security is everyone's business.
    - Demand reduction: treatment for drug users - but importantly not just that. This area also involves all areas that reduce demand. Some examples:
        - Where prisoners feel safer in custody they experience lower levels of stress and therefore will be likely to have reduced self-medication needs.

- Time out of cell and purposeful activity reduce boredom and stress, facilitating healthy sleep that prisoners otherwise may feel the need to induce with drugs.
- Good healthcare and effective pain management reduces demand for self-medication.

- Harm reduction: up-to-date, accurate and effective drugs awareness and education that equips staff and prisoners to deal with situations and make informed choices in their own behaviour. Good harm reduction supports demand reduction by recognising that some users of illicit recreational and diverted prescription drugs in prisons are not regular drug users in the community. Simply put, any prisoner who feels unsafe, unfulfilled and unhealthy may be more likely to want to take mind-altering substances.

Closing remarks

27. I hope that you find this information useful and should you require anything further, please do not hesitate to contact me. I look forward to attending the Committee hearing on 12 November 2014.

Paul Roberts
Specialist Substance Use Inspector
HM Inspectorate of Prisons

On behalf of
Nick Hardwick
HM Chief Inspector of Prisons

28 October 2014