DRUG & ALCOHOL FINDINGS *Research analysis*

This entry is our analysis of a study added to the Effectiveness Bank. The original study was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. The summary conveys the findings and views expressed in the study. Below is a commentary from Drug and Alcohol Findings.

New psychoactive substances: new service provider challenges.

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Drugs: Education, Prevention and Policy: 2018, 25(4), p. 301–312.

How can the UK develop an effective treatment response to new psychoactive substances?

SUMMARY Over the past decade the UK drugs landscape has undergone a period of significant change. At the forefront was the introduction of a wide range of new or novel psychoactive substances (either newly manufactured to mimic the effects of traditional drugs or pre-existing drugs used in a novel way), with over 500 identified by the European Early Warning System up to 2016. The national response to new psychoactive substances has been focused on legislation (the Psychoactive Substances Act 2016) and its effectiveness, while relatively little consideration has been given to developing a treatment response.

Of the plethora of new psychoactive substances identified, only a smaller number have cemented themselves amongst the traditional menu of illicit drugs in the UK. These include nitrous oxide, mephedrone, ketamine, gamma butyrolactone (GBL), gamma hydroxybutyrate (GHB), and synthetic cannabinoids (synthetic forms of cannabis eg, 'spice'). The consumption of these drugs is often associated with particular sub-populations such as student, clubbing, lesbian, gay, bisexual, and transgender (LGBT), prison, and homeless.

The featured paper explores the emerging new psychoactive substance drug trends within two subpopulations – spice use among homeless people, and 'chemsex' (sexual activity while under the influence of drugs) among men who have sex with men. In particular, it asks whether specific service developments are necessary to respond to novel forms of drug use, and if so, what this should look like.

Key points
From summary and commentary

The national response to new psychoactive substances has been focused on legislation, while relatively little consideration has been given to developing effective treatments.

Research in Manchester (England) explored whether specific service developments are necessary to respond to novel forms of drug use, and if so, what this should look like.

The findings identified a need to shift the debate away from services adapting the interventions they currently offer, towards a focus on the distinct strategies that are required to successfully engage with sub-populations of people who use new psychoactive substances.

Research was undertaken in Manchester (England) between January and June 2016, and involved interviews with 38 people using synthetic cannabinoids (33 men and five women) and 15 men engaging in chemsex, as well as a further 31 interviews with staff and practitioners from a range of services in the area. The research location was significant, as Manchester has been at the forefront of media attention in recent years for the use of spice among homeless people (1 2 3 4 5 6), and recent research has suggested that Manchester (along with Brighton) has the fastest growing chemsex scene in the UK.

Outside of this study it has been argued (1 2) that the same harm reduction advice, motivational interviewing techniques and psychosocial interventions can be applied regardless of the substance involved. However, there is a competing discourse that new services and interventions are needed in response to emerging trends around the use of new or novel substances, and that without specialist training services will struggle to deliver successful treatment and intervention to these people.

Main findings

The study uncovered a shift away from injecting heroin and crack cocaine among homeless people to using spice, and a change in the ingestion route of drugs within the emergent chemsex scene among men who have sex with men from the conventional recreational use of substances (1 2) such as ecstasy and cocaine to 'slamming' (term used to describe intravenous injection) of crystal methamphetamine or mephedrone.

Throughout the research, many dependent drug users with considerable lifetime experience of heroin, crack cocaine and a variety of other illicit and prescription drugs consistently referred to synthetic cannabinoids as resulting in more acute withdrawals than other substances they had previously used. Indeed, former dependent heroin and crack cocaine users unanimously referred to spice as the most addictive substance that they had ever taken. Daily consumption was common, with many users reporting using spice to prevent unpleasant side effects that they attributed to withdrawal symptoms. These typically included problems with sleep, excessive sweats, loss of appetite, hallucinations and paranoia, severe stomach cramps, diarrhoea, and vomiting, as well as a variety of negative mental health effects.

Practitioners and counsellors concerned about chemsex described harms commonly associated with drug use, as well as harms that would be specific to chemsex and/or transferable to the wider population of men who have sex with men:
• Chemsex can involve a heightened sexual focus, with more partners and less concern about taking protective measure against contracting sexually transmitted infections and blood-borne viruses.
• Overdoses and blackouts, common among people using GBL/GHB [see overview of effects and characteristics], raise concerns about users' ability to consent to sex.
• Lack of awareness that recreational drugs can have an effect on and compromise the effectiveness of antiretroviral treatments prescribed to treat HIV infection.

There is a group who describe their consumption of synthetic cannabinoids and chemsex drugs as 'dependent' or 'addictive', yet are not engaging with services. For some users this non-engagement stemmed from a lack of awareness and negative perceptions of the services on offer, while for others, the limitations of existing service delivery proved to be the primary barrier to engagement.

Compared with traditional populations of people who inject drugs, many men who engage in chemsex are in full time employment and require more flexible and extended opening times. In discussing the developing culture of intravenous drug use associated with chemsex there were suggestions for a needle exchange at the heart of the LGBT community to more directly reach people who would benefit from harm reduction.

Among homeless people using spice, the lack of a prescribed substitute medication was frequently cited as a reason for not engaging with services. In comparison, heroin was perceived to have a clear treatment pathway.

The authors' conclusions

The featured paper identified a need to shift the debate away from services adapting the interventions they currently offer, towards a focus on the distinct strategies that are required to successfully engage with the sub-populations of people who use new psychoactive substances. To this end, three approaches were recommended:
• Improved integration of services: Sub-populations impacted by new psychoactive substances are likely to have complex and overlapping needs, including substance use, mental health, and sexual health.
• Clearer referral pathways: People who use drugs and treatment providers were of the view that new drugs require new services and that existing support was only for substances such as alcohol, cannabis, cocaine and heroin. This, along with the lack of clear referral pathways through agencies, meant there were few referrals or self-referrals for people using new psychoactive substances into treatment services.
• More innovative engagement strategies: A large proportion of people entering treatment do so through self-referral. There is a need for different engagement strategies to ensure that people who use new psychoactive substances (some of whom are from already marginalised groups) know there are treatment and support options available, and they can actually access those services. This could include more targeted outreach, locating services within communities or contexts where drug use is prevalent, and new marketing strategies.

FINDINGS COMMENTARY With a focus on two populations known to use new psychoactive substances, the featured paper asked whether specific service developments are necessary to respond to novel forms of drug use, and if so, what this should look like. The challenges are not limited to there being new substances (with new effects and consequences), but the fact that sub-populations who are more likely to use, and more vulnerable to the harms of, new psychoactive substances are potentially already at a disadvantage when it comes to accessing treatment services. Therefore, while identifying effective components of treatment for new psychoactive substances is important, services must ensure that marginalised populations can engage with them in the first place.

Synthetic forms of cannabis

The paper "From niche to stigma" examined the changing face of the new psychoactive substance user between 2009 and 2016, focusing on people using spice. It covered the transition of (then) 'legal highs' from an "experimental and recreational" scene associated with a "niche middle class demographic", to

"those with degrees of stigma", especially homeless, prison, and socially vulnerable youth populations (including looked after children, those involved in or at risk of offending, and those excluded or at risk of exclusion from mainstream education).

In 2014, the DrugScope Street Drug Survey also observed a problem among these particular groups, recording a "rapid rise in the use of synthetic cannabinoids such as Black Mamba and Exodus Damnation by opiate users, the street homeless, socially excluded teenagers and by people in prison". A year later the prison inspectorate for England and Wales raised concerns about the rise in the use of psychoactive substances in prisons, in particular spice.

In May 2016 the Psychoactive Substances Act placed a 'blanket ban' on new psychoactive substances. While possession of a psychoactive substance as such wasn't criminalised, production, supply, offer to supply, possession with intent to supply, import or export were – with a maximum penalty of seven years' imprisonment.

Just seven months after the Act came into effect, the Home Office labelled it a success, with a press release stating that nearly 500 people had been arrested, 332 shops around the UK had been stopped from selling the substances, and four people had been sent to prison. But did the Psychoactive Substances Act have the presumably desired effect of limiting access to psychoactive substances (and reducing deaths), or did it just push the drugs the way of dealers? Former chair of the Advisory Council on the Misuse of Drugs Professor Nutt had warned before the Act came into effect that the blanket ban would make it harder (not easier) to control drugs. And while Chief executive of DrugWise Harry Shapiro had said the new law would make new psychoactive substances harder to obtain, he also agreed that sale of the drugs would not cease, but merely be diverted to the illicit market: "The same people selling heroin and crack will simply add this to their repertoire."

Synthetic forms of cannabis contain chemicals that aim to copy the effects of 'THC' in cannabis. However, the effects of synthetic cannabis can be quite different (and often stronger): firstly, because synthetic production makes it easier to manipulate the amount of the THC-like chemical; and secondly, because of the absence of the moderating equivalent of 'CBD'. These differences, along with the unique challenges and risks synthetic forms of cannabis pose, are discussed in an Effectiveness Bank hot topic.

'Chemsex'

Men engaging in chemsex may see themselves outside the traditional clientele of drug and alcohol services, for example because of their use of new psychoactive substances (as opposed to the traditional menu of illicit drugs in the UK), or because they might be employed and have strong social networks.

Where presenting to doctors' surgeries, general practitioners may be able to identify men who would benefit from harm reduction advice or referral to treatment by discussing their sexual history, which could naturally lead to questions about drinking and drug use during sex. This ad hoc form of screening could also be achieved through sensitive enquiries after new diagnoses of blood-borne viruses, multiple episodes of sexually transmitted infections, recent overdose, or after patients have reported sexual assault.

Different drugs and ingestion routes carry different levels and types of risk. 'Slamming' is a particularly high-risk practice, which the featured study indicated may be increasing in prevalence. However, men not doing this aren't insulated from the risks of injecting drug use. Harm reduction services have an important role in advising how to minimise the *interconnected* risks of sex and drug use commonly associated with chemsex. Information resources designed by, with, and for men who have sex with men (1 2) can help address these harms, while acknowledging the complex reasons gay and bisexual men practice chemsex *and will continue* to do so. This includes "Chemsex First Aid", which "joins a harm reduction ecosystem of both institutional resources and the 'word-of-mouth amongst guys that engage in chemsex'", and is "part of queer men's 'long history of activism … of sharing information and stories, and of looking out for each other'".

Among men who have sex with men, reasons for engaging in chemsex may include wanting to reduce inhibitions, increase pleasure, facilitate sustained arousal, induce a feeling of instant rapport with sexual partners, as well as manage negative feelings such as a lack of confidence, self-esteem, internalised homophobia, and stigma about HIV status.

Public Health England has identified three distinct but overlapping areas in which men who have sex with men bear a disproportionate burden of ill-health: sexual health and HIV status; mental health; and the use of alcohol, drugs, and tobacco. For this population, chemsex may pose a public health problem (1 2), in particular facilitating the spread of sexually transmitted infections and blood-borne viruses.

Theories of substance use problems specific to this population build a more nuanced picture of the relationship between marginalised sexual identities and poor health outcomes and/or risk-

taking behaviours. Furthermore they can facilitate conversations about why men who have sex with men might struggle to access (or identify as a potential client of) services designed for the 'general' population:

1. The **minority stress** theory: Lesbian, bisexual, and gay people can experience additional stressors related to their 'sexual minority' status within society. Internalised homophobia, stigma, and experiences of discrimination and violence can result in chronic stress, associated with psychological distress and negative mental health outcomes including substance use problems (1 2). This can be compounded and qualitatively different among people with multiply socially-devalued characteristics.
2. The **cognitive escape** theory: The need to avoid sexual risk, and suppressing thoughts associated with this risk, can become a 'cognitive burden' and lead to people 'escaping' from the constraint of sexual safety norms and engaging in risky sexual behaviours. Alcohol and other drugs may lower inhibitions, and facilitate these and other risky practices (1 2).
3. The **expectancy** theory: Expectations that drinking or taking certain drugs will produce positive effects, for example lowering sexual inhibitions, enhancing sexual pleasure, and feeling closer or more open to other people.

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