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New Psychoactive Substance Use in Children and Young People: A Rapid Review of the Current Situation in Camden and Islington

Camden and Islington Public Health

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Summary

The pace at which new drugs appear on the market has snowballed over the last decade. Despite a decline in overall substance misuse, there has been an increase in the prevalence of new psychoactive substances (NPS), drugs manufactured to mimic the effects of traditional illicit drugs. The rapid emergence of so many new substances has meant that there is a limited amount of information available on the potential health and social harms that they pose. It has also meant that little has been done to measure and monitor population use of NPS.

National survey data gives us some insight into who is using these substances, suggesting that, as with traditional drug use, NPS use is higher amongst young people than it is in adults. A limited amount of information at a local however, makes it difficult to identify the scale and pattern of NPS use in Camden and Islington.

Using what prevalence data, research and local knowledge is available on NPS alongside the identified information gap, a number of recommendations have been made for local action. These recommendations are prioritised around prevention and early intervention, treatment and creating a safer environment:

1. Create a clear picture of local NPS usage
2. Up-skill the local workforce
3. Establish local NPS networks
4. Support the inclusion and delivery of NPS related information within drug education in schools, pupil referral units and community groups
5. Equip frontline staff working to prevent, identify and treat NPS use with the resources that they require to support discussions with parents, carers and young people
6. Raise awareness of local drug treatment and support services, and available health promotion information, ensuring that these resources are accessible to all
7. Implement measures to monitor and regulate the sale of uncontrolled NPS locally, and share information on locally available substances
8. Develop a localised pathway for product testing of uncontrolled NPS.

The most pressing of these actions is to create a clear picture of local NPS usage. This in turn will inform the implementation of new interventions to reduce the risks poses to young people by NPS use.

Effective partnership working is vital for the implementation of these recommendations and local NPS networks will, once formed, play a pivotal role in co-ordinating and monitoring the implementation of these recommendations.

Introduction

Over recent years there has been a rapid increase in the number of new drugs appearing on the market. Despite a decline in overall substance misuse, there has been an increase in the prevalence of new psychoactive substances (NPS).[1] The speed and volume at which these substances have emerged has made it hard for research to keep pace, meaning that little is known about the long and short term risks associated with each of them. It has also meant that little has been done to measure and monitor population use of NPS. Initial prevalence data suggests that the use of NPS appears lower than that of traditional illicit substances; however as with traditional illicit substances, a greater proportion of children and young people appear to be using these substances than adults.[2]

This report offers a quick look at what is known about the use of NPS in children and young people, particularly those in Camden and Islington, and offers an overview of some of the work currently taking place locally to prevent the use of NPS and minimise the harms posed by them. Following on from this, a number of recommendations have been made for further action at the local level in order to build upon existing offers in Camden and Islington.

Method

The evidence within this report was gathered both through consultation with local services, collation of locally and nationally available prevalence data and a rapid review of available research. Searches of medical and social science databases, national policy and guidance documents, grey literature and relevant websites were carried out using key terms in order to identify pertinent guidance and research.

Attention on NPS has grown over recent years and over the course of writing this report a number of new national guidance documents were published. Of the guidance available, both the Home Office (2014) new psychoactive substances in England - a review of the evidence report and the Public Health England (2015) new psychoactive substances: a toolkit for substance misuse commissioners report played a prominent role in shaping this report, though many other reports also contributed.[3,4]

A range of local services were contacted in order to capture local experiences, knowledge and views on NPS use amongst children and young people, as were those commissioning local substance misuse services. Services engaged included those directly involved with prevention of or early intervention around substance misuse, substance misuse treatment services, services involved in the regulation of product sales and those working with vulnerable young people (*for a full list of services contacted see appendix 1*).

Services were contacted either over email or telephone, and interviews were conducted both in person and over the telephone. Where this was not possible, feedback was gained over email. These consultations took place between October and December 2014 and therefore the information presented here is relevant to this time point.

What are NPS?

NPS is a collective term for substances which have been manufactured to mimic the effects of traditional illicit drugs (such as cocaine, cannabis and ecstasy).

More specifically, the Home Office's expert panel (2014) defined them as:

'Psychoactive drugs, newly available in the UK, which are not prohibited by the United Nations Drug Conventions but which may pose a public health threat comparable to that posed by substances listed in these conventions.'[5]

In order to consolidate research and understanding around all of the different NPS emerging, the Drug Scope (2014) business as usual report broke NPS down in to three sub-categories:

- Synthetic cannabinoids – traded under such names as Clockwork Orange, Black Mamba and Exodus Damnation. These bear no relation to the cannabis plant except in that the chemicals which are blended into the plant matter act on the brain in a similar way to cannabis.

- Stimulant-type drugs – e.g. BZP, mephedrone, MDPV, NRG-1, MDAI, ethylphenidate. The effects of these drugs replicate across the range, those effects encountered with amphetamine and MDMA.

- Hallucinogenic – e.g, 25i-NBOMe, bromo-dragonfly, benzo fury and the more ketamine-like methoxetamine.[6]

A wider selection of substances exist however, that do not fit under these headings and which are often bought over the internet. These substances can be grouped under the following subheadings: (i) benzodiazepines e.g. phenazepam and (ii) opioid medications e.g. oxycodone.

A number of substances classed as NPS internationally have over the last decade or so become controlled by legislation in the UK, including, mephedrone, BZP, NBOMe, benzo fury, ketamine and GBL/GBH.[6, 26] This means that the when looking at NPS in the UK, not all of the substances sitting under this heading are 'legal' or uncontrolled by law.

The initial scope of this report was on the use of uncontrolled NPS in children and young people (up to 25 years). Limited research exists around these uncontrolled substances however, and so some controlled NPS have also been included, making use of the more available research and prevalence data collected for NPS that have become illegal over recent years. Despite being legislated against, controlled NPS are still relatively unknown in comparison to more traditional illicit drugs and therefore their place in existing prevention, harm reduction and treatment interventions will also benefit from review.

In line with the recent NPS review in England published by the Home Office (2014), this report will concentrate on NPS that are currently legal or that have only become controlled

substances since 2008, the point at which the NPS phenomenon began to swell (*see appendix 2 for recent changes to drug legislation*).[3]

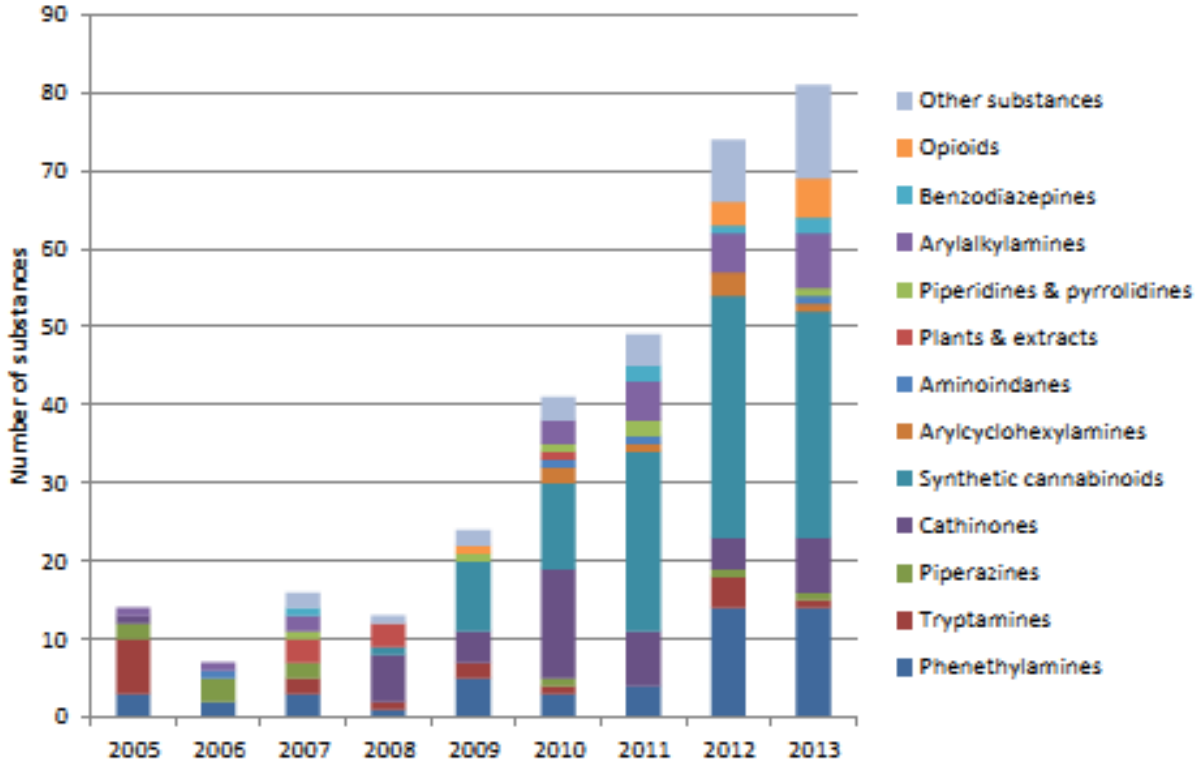
NPS are often referred to as legal highs, designer drugs and/or club drugs. The term legal highs primarily refers to uncontrolled NPS, although, due to ongoing updates to drug legislation, some illegal substances are still often mistakenly called legal highs. This makes the term difficult to define. The use of this term can also incorrectly infer that a substance is safe to use and is regulated, although it appears to be more commonly recognised than NPS.

A number of NPS also come under the heading of 'club drugs' (e.g. GHB), a collective term given to substances typically used in bars and nightclubs, at concerts and parties. This category does not solely consist of NPS however, but also more 'traditional' illicit substances such as cocaine, which has been controlled under legislation since the 1920s. For this reason this group are not looked at collectively within this report, however those that are classified as NPS will be.

The emergence of NPS

Innovation around drugs is not a new thing; however the pace at which new substances are emerging has changed, as has the type of substance being produced. The drug market today is fluid and less centred around plant based substances, with more synthetic NPS being produced. Eighty one NPS were officially announced for the first time through the EU early warning system in 2013 and the European Drug Report states that in 2013 they continued to receive reports of at least one new substance per week.[1] The number of substances now being monitored by the EU early warning system is now 350 and this system is under pressure from the volume and variety of NPS appearing on the market, suggesting the true figure to be greater still. Of the 81 new NPS in 2013, 29 of these were synthetic cannabinoids, 30 did not conform to the readily recognised chemical groups (including plants and medicines), 13 were new substituted phenethylamines and 7 were synthetic cathinones (*see figure 1*).[1]

Figure 1. Number and main groups of NPS notified to the EU Early Warning System, 2005-13



Source: Reproduced from the European Drug Report 2014 [1]

Prevalence of NPS use

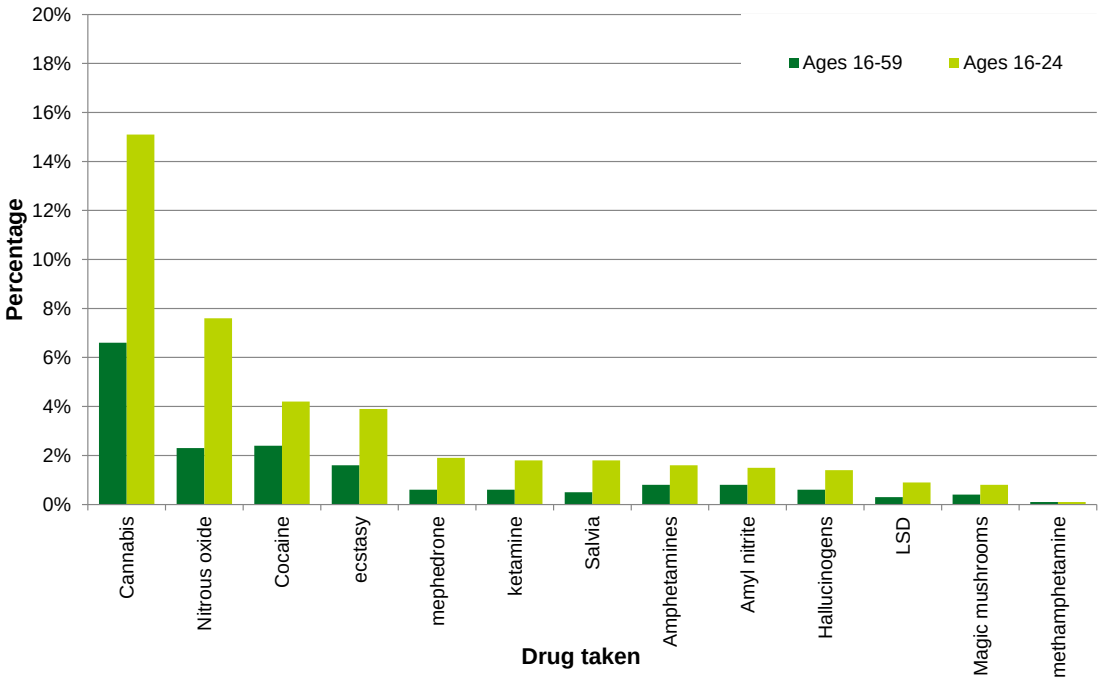
There are limitations regarding prevalence data of NPS usage. The recent rapid proliferation and diversity of NPS has made it difficult for surveys to keep up and accurately reflect the use of new drugs. This is seen in national data collected through for example, the crime survey for England and Wales (CSEW), which only measures a limited number of NPS, making it difficult to estimate overall NPS prevalence.

Similarly, this rapid proliferation has also meant that very few systems have been set up at the local level to monitor NPS usage, and hence it was only possible to present a limited amount of local data here. For this reason the majority of data presented is given at a national level. It is likely that London would be higher however, as overall drug taking is recognised to be higher across all ages in London, both overall and at an individual drug level.

NPS use in 16-24 year olds nationally

Generally the prevalence of NPS use is low and lower than that of illicit drugs. Similarly to traditional illicit drug use however, the use of NPS appears to be higher in young people (16-24 years) than it is in the overall 16-59 years age group.[2] This can be seen in figure 2, which includes the NPS nitrous oxide, salvia and amyl nitrate. NPS use has also been identified as higher in clubbers and men who have sex with men.

Figure 2. Prevalence of reported illicit drug use in the last year by individual drug taken, England and Wales, 2013/14



Source: Crime Survey for England and Wales 2013/14 [2]

Cannabis and alcohol remain the most prevalent substances used by children and young people, and the largest cause of this group seeking support for substance misuse.[7,2]

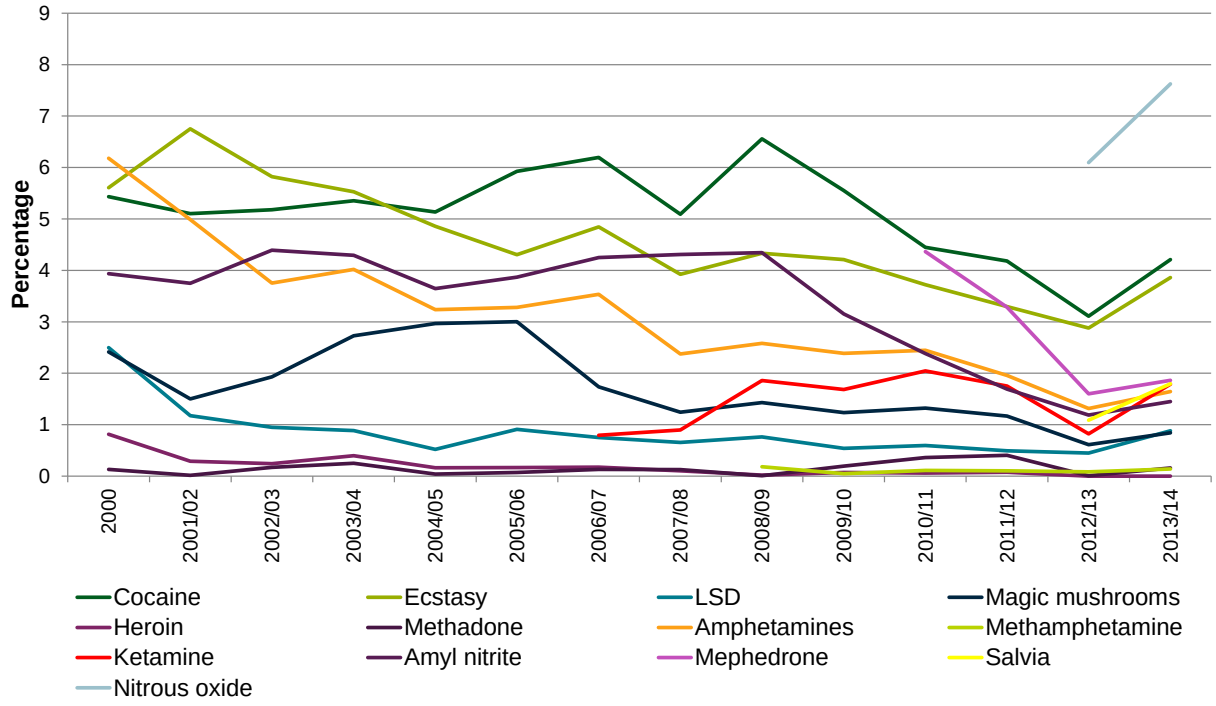
Survey data however, suggests that 10% of young people (15-24 years) have tried NPS in the UK, compared to 8% in Europe and 18.9% that have taken an illicit drug in England and Wales.[2,8] Using 2013 Office of National Statistics population estimates this would equate to approximately 3,400 young people in Camden and 3100 in Islington having tried NPS.[9]

According to the latest CSEW survey (2013/14) the prevalent drugs taken amongst 16 to 24 year olds are generally the more traditional illicit substances cannabis (15.1%), cocaine (4.2%) and ecstasy (3.9%), and nitrous oxide (7.6%) an uncontrolled NPS (*see figure 13 for more commonly used names for NPS*), and the second most used substance in this age group. In comparison, 1.8% of 16-24 year olds reported using salvia, a relatively well known uncontrolled NPS, and 1.9% mephedrone, a controlled NPS (*further comparisons can be seen in figure 2*).[2]

Due to the lack of long term data on these substances, it is hard to identify changes in their use; however an increase in nitrous oxide and salvia use can be seen in figure 3 over the last year. Anecdotal evidence from the local parks and safer streets teams in Camden and Islington have suggested a similar picture locally, having seen an increased number of discarded nitrous oxide canisters around parks and local music venues over the past year.

There has been an overall decline in the use of mephedrone since data started being collected on it in 2009/10.[2] Unlike the aforementioned substances however, mephedrone is a controlled NPS and its decline in use may be linked to the substance moving from an uncontrolled NPS to a controlled NPS in 2008 *(for a further breakdown of substance use in 16-19 year olds and 20-24 year olds see appendix 3).*

Figure 3. Trend in the proportion of 16 to 24 year olds reporting using drugs in the previous year, by drug taken (excluding cannabis), England and Wales, 2000 to 2013/14

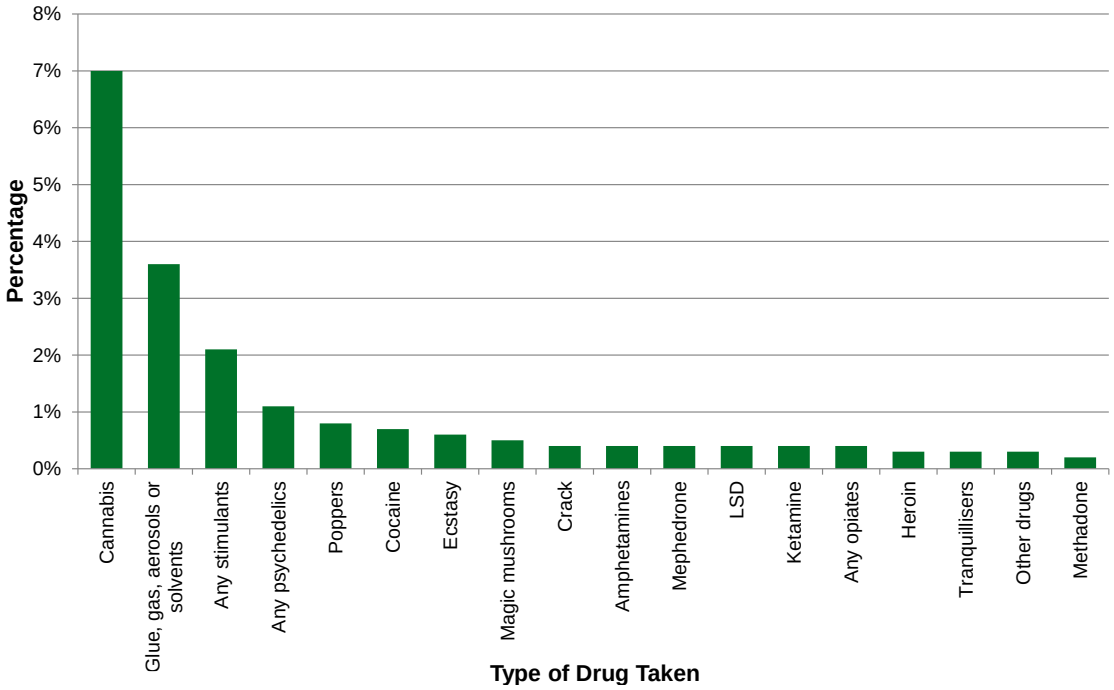


Source: Crime Survey for England and Wales 2013/14 [2]

NPS use in under 16 year olds nationally

As shown in figure 4, for young people aged 11-15 years, cannabis is the most prevalent drug taken, (7%), followed by glue, gas, aerosols/solvents (3.6%) which would include nitrous oxide.[10]

Figure 4. Percentage of pupils who have taken individual drugs in the last 12 months, aged 11-15 years, 2013, England



Source: HSCIC[10]

Local NPS use

Limited localised data is available around both illicit and uncontrolled drug use. The majority of data presented here is for Camden because this information is not yet available for Islington. A crude estimate of usage can be calculated by applying self-reported prevalence of illicit drug use and NPS use among 16-24 year olds data collected through the CSEW for 2012/13 to the local population (see figure 5).[2] It is possible that local rates may be higher than this however, as London has high rates of substance misuse than England.

Figure 5. Crude estimate of NPS use among 16 – 24 year olds in Camden and Islington

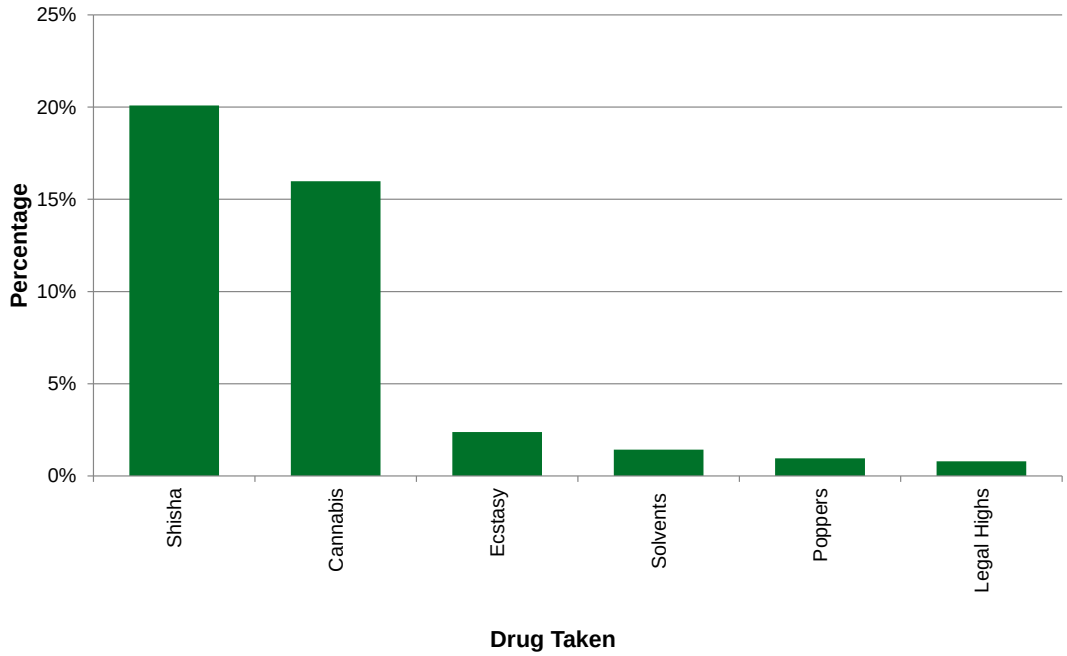
	England & Wales Prevalence	Camden estimate	Islington estimate
Cannabis	15.10%	4,870	4,370
Nitrous oxide	7.60%	2,460	2,210
Cocaine	4.20%	1360	1,220
Ecstasy	3.90%	1250	1,120
Mephedrone	1.90%	610	550
Salvia	1.80%	580	520
Ketamine	1.80%	580	520
Amphetamines	1.70%	550	490
Amyl Nitrite	1.50%	470	420
LSD	0.90%	280	260
Magic Mushrooms	0.80%	270	240
Methadone	0.20%	50	50
Methamphetamine	0.10%	40	40

Source: Crime Survey for England and Wales 2013/14, Office of National Statistics mid-year population estimates 2013 (substances classified as NPS under this reports definition include: Nitrous Oxide, Mephedrone, Salvia and Amyl Nitrate).[2,9]

The Camden joint strategic needs assessment (2012) highlighted 'legal highs' collectively as one of the most commonly misused substances across the borough's general population. As seen nationally, young people (16-24) in the borough have been found as having the highest prevalence of drug use amongst the population.[11]

The Young People in Camden Health Related Behaviour Survey sampled (n=1267) secondary pupils from Year 8 (aged 12 and 13 years) and Year 10 (aged 14 and 15 years) in Camden during 2013 and asked them about their experiences and attitudes towards drugs. There was a higher prevalence of drug use in Year 10 pupils than Year 8, with 20% of Year 10 pupils having taken cannabis in the last year compared with 4% in year 8. As can be seen in figure 6, 1% of Year 10 pupils had used the NPS collectively termed as poppers and 1% has used solvents. 1% (5 pupils) of those Year 10 pupils surveyed had taken 'legal highs' in the last 12 months (it is unknown however, whether children classified nitrous oxide as a solvent or legal high when completing this questionnaire), a somewhat lower proportion than the early 10% mentioned earlier as being seen national amongst the wider 15-24 year olds age group.

Figure 6. Percentage of year 10 pupils whom have taken different drugs during the last year, 14-15 years, Camden, 2013



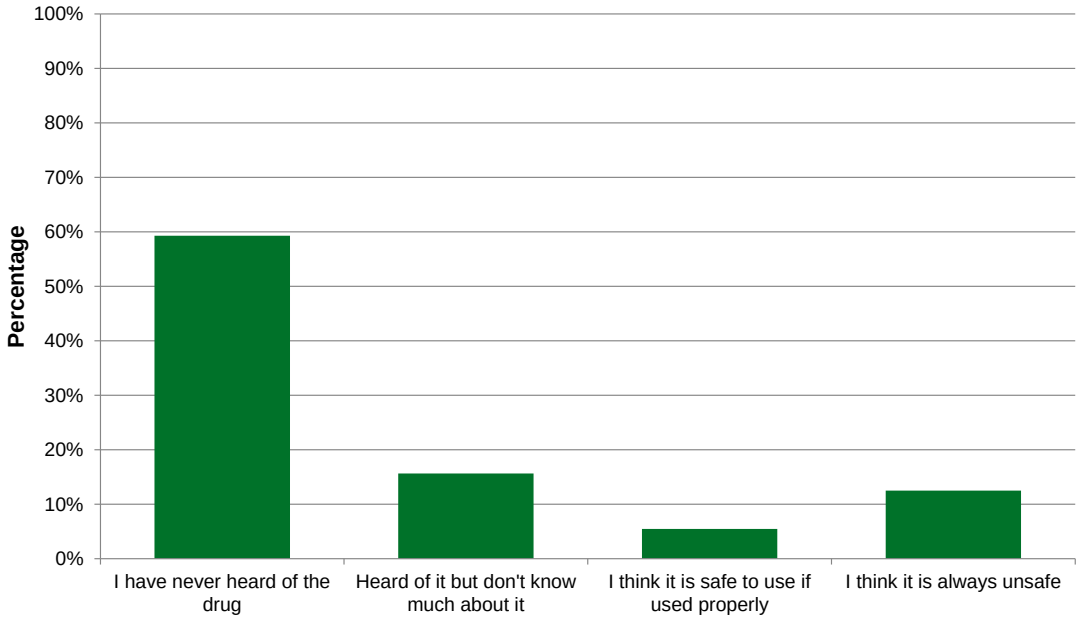
Note: Prevalence of other drugs such as steroids, amphetamines, magic mushrooms, tranquillisers, cocaine, LSD, mephedrone and heroin have not been shown due to small numbers. Source: Young People in Camden Health Related Behaviour Survey, 2013

Overall, 23% of those pupils surveyed had ever taken drugs (13% in Year 8 and 33% in Year 10). Figure 7 shows the survey findings around pupils understanding of NPS, and shows limited knowledge around what legal highs are and their safety. These knowledge levels showed little difference across the two age groups.

In comparison, when looking at young people's understanding of all drugs (shown in figure 8), 9% of those pupils surveyed believed that ecstasy was safe to use if used properly and 14% thought that solvents as drugs (in which nitrous oxide may have been considered) were safe to use if used properly. Other NPS, including GHB/GBL and poppers, appear to be perceived as more dangerous than 'legal highs' or uncontrolled NPS. No explanation is given to explain this perceived difference, however it may be because they have been partially legislated against (*see health effects of NPS section for further information*), or because they are less aware of these substances.

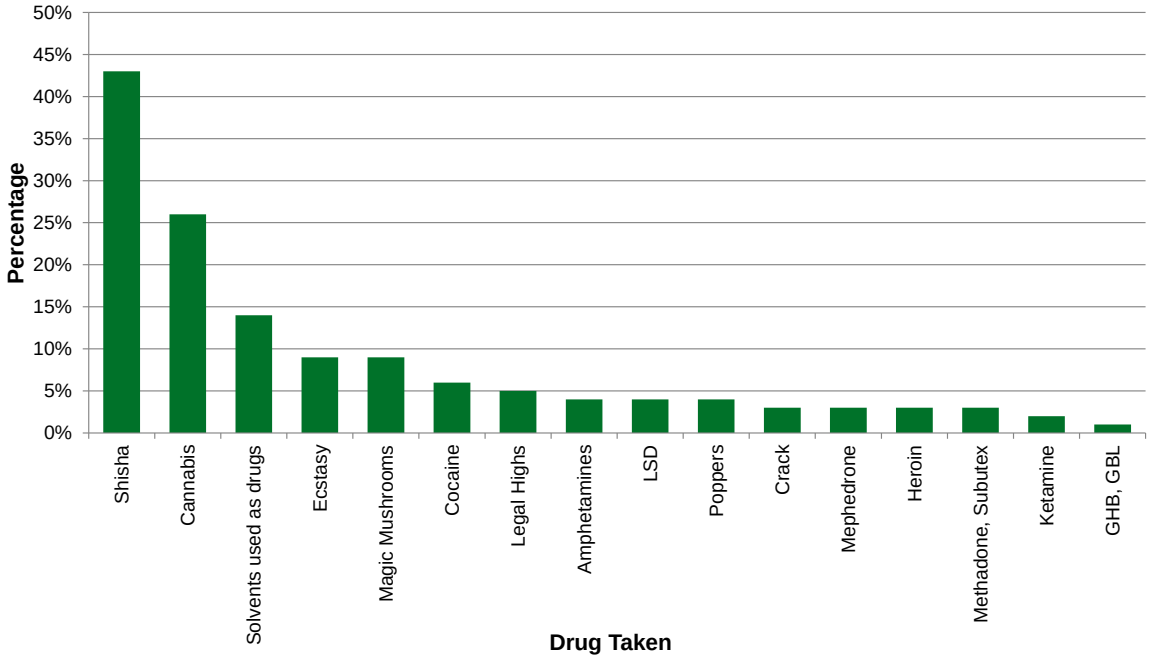
The Camden schools survey data suggests that use of NPS is not as high as that of more traditional illicit drugs, particularly cannabis, and Shisha. In Camden, NPS use appears to be very low, although the data around this is limited, and no data is held about young people in Islington.

Figure 7. Year 8 and 10 pupils understanding of legal highs, Camden, 2013



Note: There were 91 missing responses which have not been shown. Source: Young People in Camden Health Related Behaviour Survey, 2013

Figure 8. Percentage of year 8 and 10 pupils who believe a drug is safe if used properly, Camden, 2013



Source: Young People in Camden Health Related Behaviour Survey, 2013

NPS related harm

As with usage data, limited information exists around the prevalence of treatment for NPS related harm and problematic use.

While there are limitations to the analysis of A&E data and hospital episodes, the Advisory Council on the Misuse of Drugs reports an upward trend in admissions due to NPS drug toxicity for both hospital and pre hospital presentations. A rise in the rate of hospital admissions for overall substance misuse has been seen in those aged 15-24 years in Camden, as it has been in London and England; however NPS specific data is not available at the local level.[12]

The National Poisons Information Service (NPIS) provides rapidly available, specialist advice to frontline NHS healthcare professionals in order to facilitate optimal clinical management of patients. In 2013/14, NPIS monitored activity relating to 61 drugs of misuse, including NPS. This included 1600 telephone enquiries and over 58000 accesses of the TOXBASE online tool related to these substances, increases of 30% compared with 2012/13 (comparatively, club drug enquires rose by 10%). As shown in figure 9, the largest number of enquiries and TOXBASE accesses were concerning cocaine; however the largest increases from the previous year were for synthetic cannabinoids and legal highs, both categories of NPS, with legal highs being in the top three telephone enquiries.[13]

Figure 9. Top 10 drugs of misuse for NPIS telephone enquiries and TOXBASE accesses, England and Wales, 2013/14

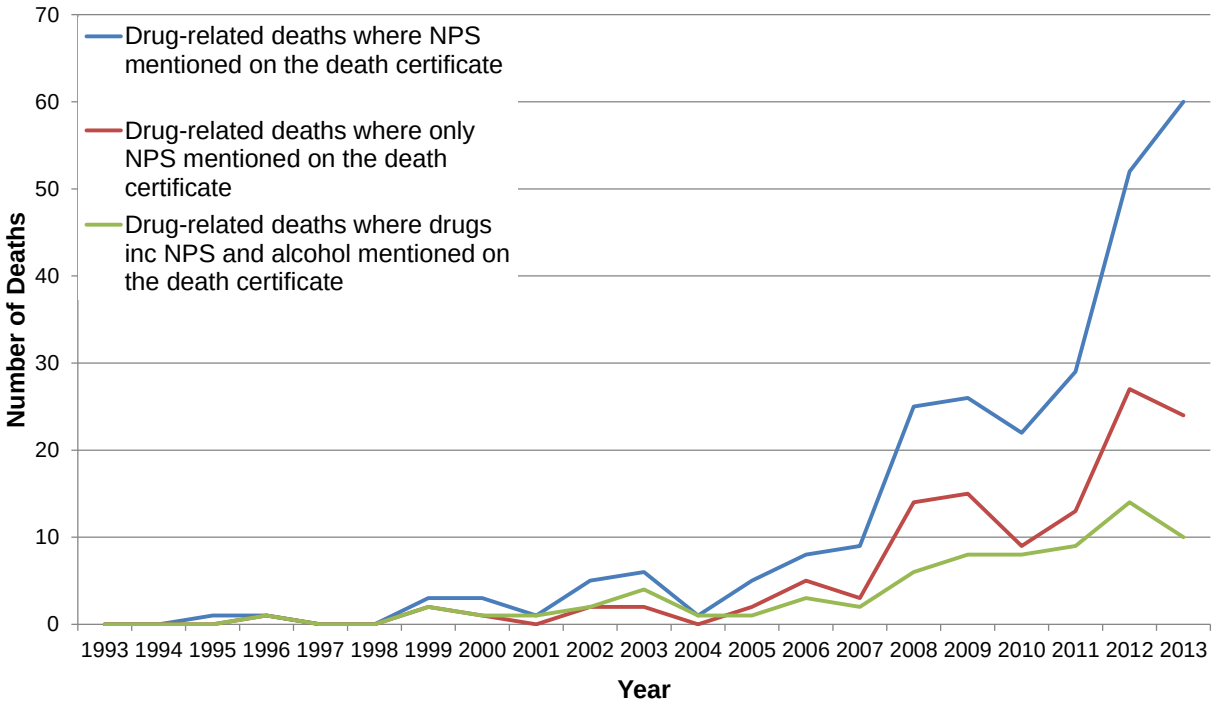
	Telephone enquiries			TOXBASE accesses		
Rank	Drug of misuse	Number of enquiries 2013/14	% change from 2012/13	Drug of misuse	Number of accesses 2013/14	% change from 2012/13
1	Cocaine	159	23	Cocaine	8,889	24
2	Synthetic Cannabinoids	131	1331	Mephedrone	7,061	-16
3	Legal Highs	111	63	MDMA	5,857	23
4	MDMA	104	19	Amphetamines	5,124	26
5	Cannabis	103	31	Heroin	4,862	26
6	Heroin	85	-1	Ketamine	3,576	20
7	Mphetamines	76	26	Cannabis	3,526	11
8	Methadone	68	22	Methadone	2,615	-9
9	Barbiturates	66	5	Legal Highs	2,381	66
10	Mephedrone	57	-15	Synthetic Cannabinoids	2,367	253

Source: NPIS 2014[13]

NPS related deaths

In the last 10 years there has been a rise in the number of drug-related deaths where NPS has been a recorded factor in England and Wales (*see figure 10*). The overall number remains small however, with 60 drug-related deaths recording NPS in England and Wales in 2013.[14]

Figure 10. Drug related deaths where NPS were mentioned on the death certificate, England and Wales, deaths registered between 1993-2013



Note: Approximately 60% of these deaths mentioned more than one substance on the death certificate, and it is not possible to tell which was primarily responsible for the death. Source: British Crime Survey 2013[14]

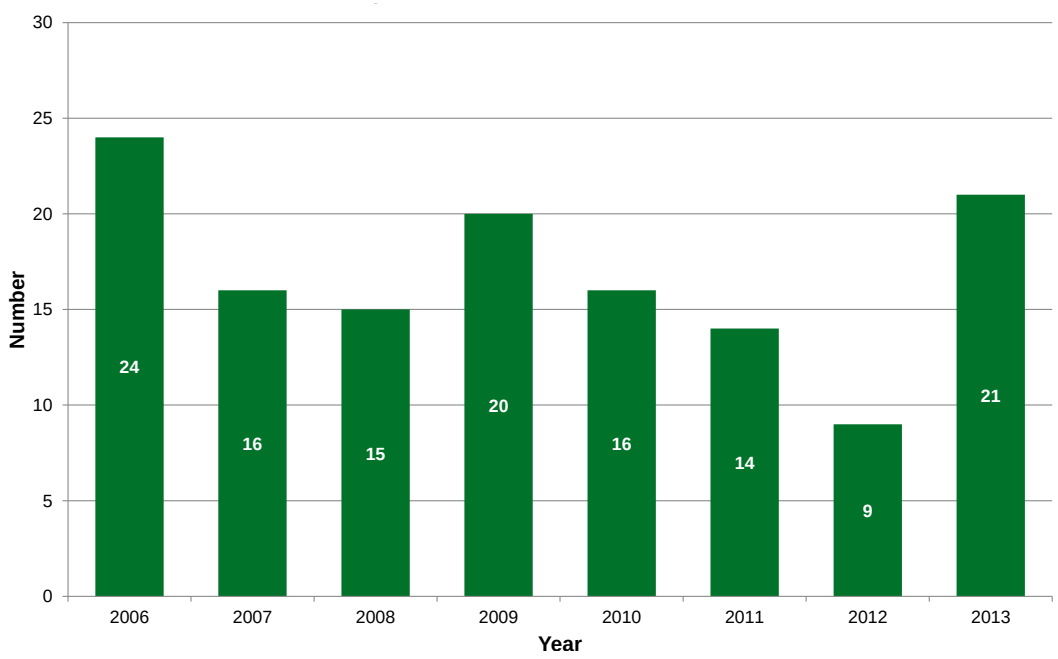
The increase in NPS related deaths in the last few years has been due to an increase in deaths related to cathinones and mephedrone, and other NPS which are not individually recorded.[14]

There are a small number of drug related deaths in Camden residents each year (*see figure 11*). The majority of these deaths have been in those over the age of 35, however in 2013, 3 deaths were in those aged between 16 and 24 years.[15]

There were 21 drug related deaths in Camden residents in 2013. Of these, 16 deaths were due to accidental poisoning by drugs with the majority due to multiple drug toxicity. Individual drugs mentioned included cocaine, morphine, heroin, methadone, tramadol, diazepam and the NPS GHB. Five deaths were due to intentional poisoning by drugs or where the intent was unknown.

These deaths do not include non-resident drug related deaths which occurred in Camden however which, given Camden's concentration of music and night life venues, may be higher.

Figure 11. Number of drug related deaths, Camden residents, 2006-2013



Source: PCMD 2014[15]

NPS treatment

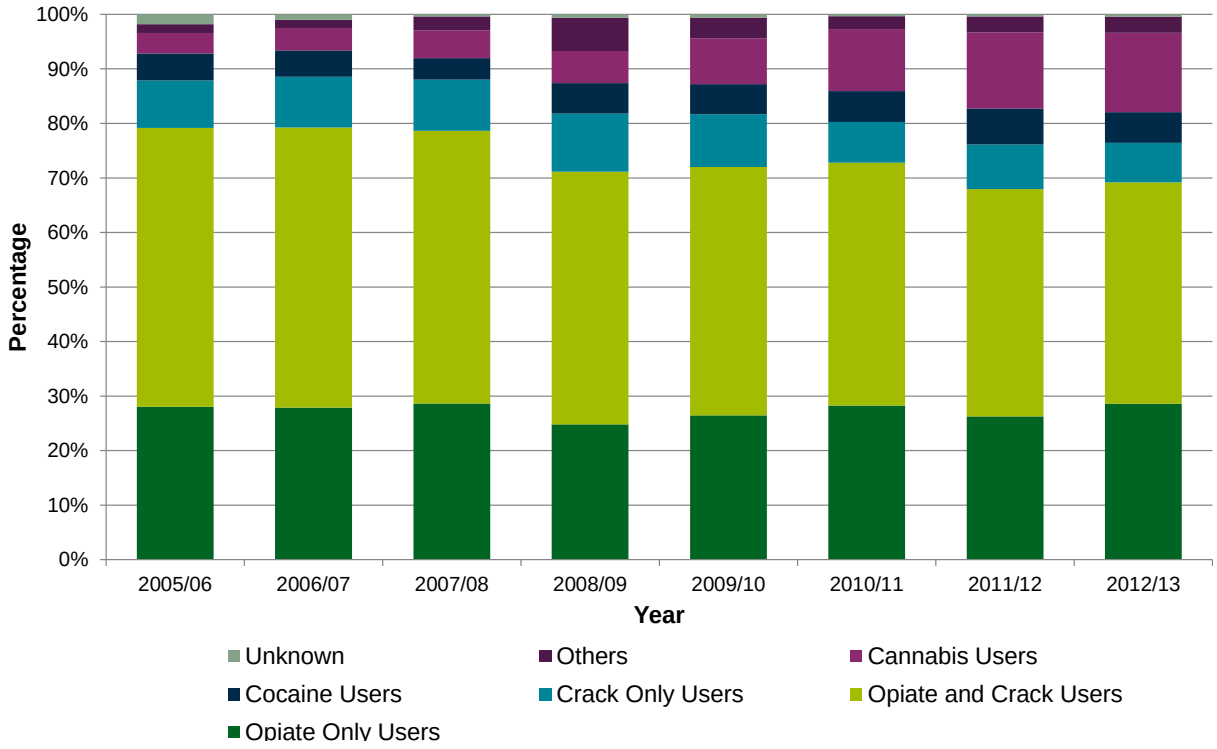
In terms of treatment for problematic use, there has been a rise in the number of new treatment entrants nationally who report the use of NPS mephedrone and GHB/GBL. Between 2010/11 and 2012/13 the prevalence of both under and over 18s in treatment who report using mephedrone rose (with 839 over 18s and 972 under 18s in 2010/11 and 1630 in over 18 and 1788 in under 18s in 2012/13), though mephedrone may not have been the primary drug used.[16,17] These treatment numbers are still low in comparison to those for traditional illicit drug use however.

National club drug treatment data identified a greater proportion of under 18s (10%) in treatment for club drugs than adults (2%), with the greatest proportion of the young people seen by specialists being between 15-17 years old (87%), however it is unclear what proportion of this is attributable to NPS use.[18]

Camden treatment data

Data from the national drug treatment monitoring system (NDTMS) shows that only a small number of adults in Camden (less than 60 in 2012/13) in treatment each year recorded primary drug use of something other than opiates, cocaine, crack or cannabis (figure 12*. See appendix 4 for an alternative presentation of this data*). Within this data NPS are classified in the "others" category, and therefore it is difficult to isolate numbers directly attributable to NPS.

Figure 12. Primary drug of adults in treatment, 2005/06 to 2012/13, Camden



Source: NDTMS 2014[19]

In November 2014, Camden adult treatment service identified 22 individuals engaged in psychosocial treatment within the open access community treatment services DAIS (Drugs Advice Intervention Service) and 184, who reported NPS use. These numbers do not include those accessing advice and information or brief intervention however, and therefore it is unclear at what level NPS users are seeking support. Those individuals seeking treatment are predominately male, white, and have links to the LGBT community. The most commonly used NPS amongst this group is recorded as mephedrone and the average age for first use of mephedrone in this population was mid-twenties. In comparison, the average age for methamphetamine use, another commonly used controlled substance reportedly used by this group was early thirties. Of this group, the majority listed an NPS as their main drug.

The GRIP clinic is a treatment service for residents of both Camden and Islington who are experiencing problems associated with their use of club drugs. In November 2014, 28 people were receiving treatment from the GRIP clinic, with a total of 41 people having received treatment from the service since its launch in spring 2014. As seen in the Camden DAIS and 184 service data, the majority of those in treatment were male (90%) and over the age of 25. Overall 7 were under 25 and of these, where the primary drugs used was NPS, this was mephedrone.

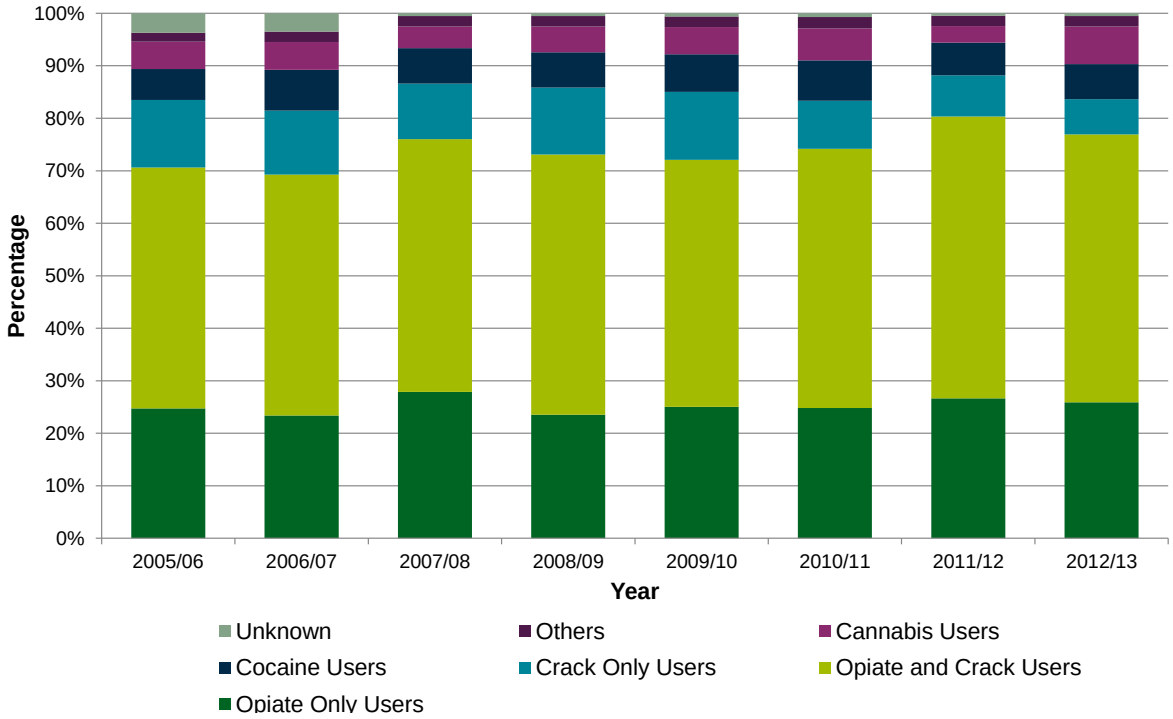
The GRIP, DAIS and 184 services are all adult services and therefore it is unsurprising that there are a low number of under 25s in treatment, however these services do offer treatment to individuals from the age 18 years. In Camden however, young people (16-24 years) have been identified as the group least likely to seek treatment for any substance misuse.[11]

No NPS related treatment data was available from children and young people's drug treatment services in Camden when this report was written.

Islington treatment data

Data from the NDTMS shows that only a small number of adults in Islington in treatment each year, as in Camden, recorded primary drug use of something other than opiates, cocaine, crack or cannabis (*figure 13. See appendix 5 for an alternative presentation of this data*).[19]

Figure 13. Primary drug of adults in treatment, 2005/06 to 2012/13, Islington



Source: NDTMS 2014[19]

The adult drug treatment service in Islington, ISIS, saw 37 people aged between 18-64 years using NPS or other recreations drugs (including amphetamine sulphate, amphetamine unspecified, GHB/GBH, ketamine, MDMA, mephedrone and methamphetamine) between November 2013 and November 2014. The majority (78%) of these individuals were aged between 24-44 years, male, and already known to ISIS (65%), having previously sort treatment. Very few people in treatment were under 25 years of age.

When the overall caseload for the service was reviewed back from November 2014 to its initiation in November 2006, only 5% of those on the caseload were recorded as using NPS or other recreational drugs, 65% of which were again already known to the service.

As in Camden, no NPS related treatment data was available from children and young people's drug treatment services in Islington when this report was written.

The profile of the NPS user

Little is known about the 'typical profile' of children and young people using NPS at present. Local data from Islington has highlighted that those young people taking drugs are more likely to use a number of difference substances at once, however this does not specifically look at NPS use. National surveys and research studies suggest that between 83% and 99% of all NPS users are also consumers of other illicit drugs and are using NPS either in place or in addition to them.[2,3] Though this gives little insight into the profile of those NPS users not using illicit drugs, it highlights that overall NPS users can be recognised as having a very similar demographic profile to illicit drug users.

Research around general substance misuse has highlighted frequent illicit drug use to be more common in vulnerable young people. Furthermore, this risk appears to increase if individuals belong to more than one vulnerable group.[20]

The NICE (2007) public health guidance defines vulnerable groups in the context of under 25 year olds as:

- those whose family members misuse substances
- those with behavioural, mental health or social problems
- those excluded from school and truants
- young offenders
- looked after children
- those who are homeless
- those involved in commercial sex work
- those from some black and minority ethnic groups.[21]

In Camden a similar users profile has been identified, with children and young people of substance misusing parents, those with mental health and/or disruptive behavioural disorders, looked after children, youth offenders and those excluded from or that truant from school having been identified as statistically more at risk of developing drug dependence.[11]

Further information on the profile of NPS and club drug users in Camden can be gained through local police data, though this information is for adults, and does not separate out the profile of young people using these substances.[22]

Based on suspect data from a limited sample of Police crime data where legal highs or club drugs were used, the profile of an average user in Camden is:

- Male
- White European
- Living in Camden Borough or perhaps outside of London altogether (this cannot be verified due to recording practices). Barnet Borough was also prevalent but to a lesser extent.
- Users are approximately 75% more likely to be under the age of 30. The median age is 25 and the mode age is 24.

Multiple users identified were also reported as having mental health problems, suggesting a somewhat similar profile to that of the earlier mentioned vulnerable young person. Crime data also highlighted a link with illicit drug use, finding that a high proportion of

uncontrolled NPS users were consuming these substances alongside illegal drugs and/or alcohol, again further supporting national findings.

Camden Safer Streets team have reported an anecdotal link between legal highs or uncontrolled NPS and street population, although no data is currently collected around this. Houseless young people in particular appear to be affected by uncontrolled NPS use, with the Safer Streets team seeing an increasing number of them ending up on the street as a result of their use of these substances. The homeless population are known to display high rates of overall substance misuse, making this anecdotal finding unsurprising, and anecdotal evidence suggests that the availability and low cost of these substances may be fuelling use of NPS.

Anecdotal evidence from a Community Warden highlighted that a group of street population youths (around 18 years old) have built up a rapport with shops in Camden Town selling legal highs. After becoming regular customers, it's reported that prices would drop from around £20 to £2. Low prices have obvious benefits for street population, but they also stated the appeal was that they were legal, highlighting that they were not doing anything wrong and could not be prevented from taking them.[22]

Health and Wider Societal Impacts of NPS Use

Health effects of NPS

"Just because a substance is termed "legal" this does not make it safe, nor may it be legal"

Advisory Council on the Misuse of Drugs, 2011[12]

NPS are, as they have been named, psychoactive substances that either stimulate or depress the central nervous system, or cause a state of dependency.[5]

The downstream health effects of NPS encompass physical, mental and sexual health. Their use is associated with increased mental disorders, increased risk of sexually transmitted infections, dependence, poisoning, death and reduced physical health, effects also common to tradition illicit substance misuse.

Understanding the impact of individual NPS beyond this can be problematic however, given the limited information on the pharmacology and toxicology of most NPS, the dynamic market and the variable contents of products. Some substances described as 'legal highs' for example, may in fact contain controlled substances. Previous studies on seized samples of NPS indicated that 19% of samples tested contained controlled substances.[23,24] A summary of the current knowledge around the health effects of NPS is summarised in figure 14.

The new nature of these products has meant that most of the existing evidence focuses on the short term impacts of NPS. The absence of long term health effects should not be mistaken for a lack of long term and chronic health impacts however, but rather due to a lack of research.

In addition to the more recognisable NPS seen in figure 14, the EU drugs early warning systems recently identified two new substances known as MT-45, a synthetic opioid which mimics the effects of morphine, and 4,4'-DMAR, a chemical used as a 'legal high' stimulant. Information gather on 4,4'-DMAR in particular, has linked it to loss of lives including in the UK.[27]

Figure 14. The adverse health effects and legal status of recognisable NPS [25,26]

Drug	Adverse health effects	Status
GHB *Sedative; e.g. Gee, liquid ecstasy*	• Dependence and severe withdrawals • Confusion and loss of consciousness • Accidental overdose • Decreased sexual inhibitions • Delirium, paranoia, aggression, hallucinations	Illegal – Class A drug
Nitrous Oxide *Also known as Laughing Gas*	• Lack of oxygen, fainting, dizziness, unconsciousness • Numbness, tingling in limbs • Severe vitamin B deficiency and nerve damage	Legal, however it is illegal to sell to anyone under 18
Mephedrone *Stimulant; e.g. M-Cat, Meow Meow, Bubble*	• Heart problems • Agitation, psychosis • Increased sex drive, increased risk of sexually transmitted infections, including HIV • Aggressive behaviour when taken with alcohol	Illegal – Class B drug Banned in the UK in 2010
Salvia Divinorum *Hallucinogen; also known as Salvia or Sage*	• Psychosis, increased risk of psychosis relapse in vulnerable individuals, hallucinations • Headaches and irritability • Throat and lung irritation	Legal to possess Illegal to sell, supply or advertising it for human consumption
Synthetic Cannabinoids *Synthetic cannabis; e.g. Black Mamba, Exodus Damnation, Clockwork Orange*	• Rapid heart rate • Nausea and vomiting, convulsions • Confusion, anxiety, agitation, paranoia, psychosis, increased risk of psychosis relapse in vulnerable individuals, hallucinations • Smoking substances has been linked to collapse and hospitalisation	A large number of synthetic cannabinoids and any mixtures that contain these synthetic cannabinoids, including Black Mamba and Annihilation, are illegal, classified as Class B drugs
Piperazines *Stimulant; e.g. BZP, TFMPP, DBZP and mCPP, MeOPP.*	• High blood pressure, exacerbation of existing heart conditions • Serotonin syndrome • Agitation, vomiting, stomach pain, fits, irregular heart rhythms, diarrhoea, allergic reactions, and fever	Illegal – Class C drug

Drug	Adverse health effects	Status
Alpha-MethylTryptamine (aMT) *Hallucinogen; e.g. Methyl-ethylamine, Amt Freebase*	• Anxious, restless • Nausea, headache • Fast or irregular heartbeat • Hallucinations	Legal
Poppers *e.g. Rush, Liquid gold, TNT, Ram, Buzz, Tribal Juice*	• Reduced oxygen, loss of consciousness • Abnormal heart rhythm • Choking on vomit • Decreased sexual inhibitions • Nausea, headaches, disorientation	Poppers are not controlled under the Misuse of Drugs Act 1971, but amyl nitrite is regulated under the Medicines Act 1968. There have been cases where the Medicines Act was used to fine shops for selling poppers.
2-DPMP *Stimulant; e.g. Vanilla Sky, Purple Wave, Ivory Wave*	• Mood swings, anxiety, aggression and paranoia • Fits, hallucinations • Overheating and risk of kidney failure	Illegal – Class B drug
Benzofuran compounds *Stimulant; e.g. Benzo Fury, 6-APB, Bliss*	• Reported deaths • Anxiety, panic attacks, confused states, agitation or aggression, paranoid feelings and psychosis • Raised body temperature, increased blood pressure and heart rate, and insomnia • Research suggests a potential risk of heart damage associated with long-term use of 5- and 6 APB.	Illegal - class B drugs since 10th June 2014
Cathinones *Stimulant; e.g. Methylone, pyrovalerone, MDPV, Magic Crystals, M1, Butylone*	• Overstimulation of the heart and heart damage • Anxiety and paranoia • Fits • Reduced sexual inhibitions and increased risk of injury	Illegal – Class B drugs

Local anecdotal experience also offers some insight in to the effects of certain NPS, though its generalisability is limited. One local provider reported working with a young person who presented with challenging behaviour under the influence of a substance called 'G' (a substance that the individual reportedly made at home). Police in Camden report seeing an individual experiencing a psychotic episode during which the individual spat at and bit Officers. A number of reports from police officers refer to the user as behaving in an erratic and agitated manner after consuming legal highs in combination with cannabis and alcohol. Some users have also report increased libido to officers (particularly those using the stimulant MeOPP).[22]

Thames Valley Police (TVP) and Hampshire are currently investigating links between mephedrone use and child sexual exploitation (CSE). TVP reported finding an increase in sexual arousal and aggression amongst young users. Hampshire suspect suppliers are exploiting the young and vulnerable people taking the drug. At present however, there is no evidence of such a link in Camden from the data and sources reviewed as part of an analysis of police data.[22]

Data analysed by the Police in Camden highlighted the following substances as being used (through a variety of consumption methods including, snorting, smoking and ingesting) or sold in Camden (*Islington data was not available at the time of this report*):

- Bud Factory
- MDA
- Black Mamba
- Ching
- MeOPP
- Ethylphenidate
- Bath Salts
- Amnesia. [22]

Social impact of NPS

NPS use has been suggested to have both social and economic implications, imitating the effects of the illicit substances that they are mimicking. Until recently, those traditional illicit substances most linked to crime and social harm, such as heroin and crack cocaine, have largely avoided replication by legal substances. Opioid alternatives are now beginning to emerge however, e.g. MT-45, suggesting that the impact of NPS on antisocial behaviour, crime and young peoples' educational and employment attainment may grow. At present however, this is only speculative as research surrounding these new substances is limited.

The most available evidence surrounding the social harms of NPS is linked to mephedrone, though this may be because this is a more recognisable NPS for which data is now being recorded. This evidence is still limited however, and only highlights an initial link between mephedrone use and violence, most commonly identified when rather mephedrone is used alongside another substance.[28] Other research suggests however, that the risk of harm posed by mephedrone and GHB is greater for the user than it is to others.[29] Further data collection and trend analysis is needed both at a local and national level to help decipher the true social impact of these substances.

Reducing NPS Use and Harm

Nationally, the government are using a range of legislation to control both the supply and use of NPS. This has included the introduction of the temporary class drugs order (TCDO) in 2011, an amendment to the Misuse of Drugs Act 1971, that enables any NPS emerging as problematic to quickly be placed under temporary control for 12 months. This gives time for further research into the effects of a substance, in order to identify whether a substance should be more permanently regulated under the Misuse of Drugs Act. A number of substances put under a TCDO have since become permanently controlled, including for example, benzo fury, 2-DPMP (ivory wave) and NBOMe.[6]

Across Europe an early warning system was established in 1997 to facilitate the rapid risk assessment of NPS and which informs the regulation of harmful substances in the EU. The European Monitoring System for Drugs and Drug Addiction issued health alerts for eight NPS, including one uncontrolled NPS in 2012.[30] In addition, the Advisory Council on the Misuse of Drugs (ACMD) makes recommendations to the UK government in relation to the legislation on new potentially harmful drugs.

Legislation alone is not enough to reduce the risks attached to these substances, however, as demonstrated by the prevalence of use and harm still seen by more traditional controlled substances. Interventions at a local level therefore play an integral role in minimising the risks posed by NPS.

Local action should be multifaceted and can be broken down in the three key areas of opportunity, namely: prevention and early identification, treatment, and creating a safer environment. The scale of the response to NPS use should be proportional to the size of the problem; however service providers and commissioners need to consider the growth in NPS use over recent years as well as the emerging risks associated with these substances when defining the type and scale of interventions. At present the prevalence of NPS use amongst children and young people appears low across Camden and Islington, though this can only be inferred from a limited body of data. Furthermore, very few young people appear to be seeking treatment for problematic substance misuse. Police in Camden most commonly pick up 24-25 year olds using uncontrolled NPS, however this may be because of more prevalent instances of problematic use by this age.

National data suggests that 10% of 15-24 year olds have used NPS, whereas Camden data suggests that only 1% of 14-15 year olds were found to have tried a legal high. This, along with the treatment and police data, suggests that NPS use may be more prevalent in older young people, though requires further investigation.

Prevention and early identification of use

A key recommendation within the ACMD report on NPS (2011) and further national reports thereafter was to focus on reducing the demand for NPS.[12] Though usage numbers in young people locally are low in comparison to illicit drugs like cannabis, usage appears to be growing, and increases with age, highlighting a growing need for intervention in the teenage years.

Limited evidence exists around interventions specifically targeted at NPS, however lessons can be learnt from the available prevention and treatment research for more traditional illicit substances. This evidence suggests that resilience building, education and building awareness all have a role to play in the prevention of substance misuse.

Resilience

Resilience appears to play an important role in preventing people from both using drugs and developing a dependency on them. Evidence suggests that initiatives targeted at reducing associated risk factors such as truanting, unstable home environments and offending, as well as building resilience (through supporting the achievement of good social networks and stable home environments) are effective at preventing overall drug use and drug problems.[31] This includes programmes such as the National Troubled Families Programme, universal Health Visiting service and the Family Nurse Partnership programme, all of which are present in Camden and Islington.

The national Rise Above campaign, launched by Public Health England in December 2014, also aims to build resilience in young people by supporting them to make positive choices around their health related behaviours, though the impact of this is yet to be evaluated.[32]

Smaller scale resilience building programmes have also been found to have a positive impact on substance misuse in young people, such as Life Skills Training and Good Behaviour Game Training. These programmes could therefore be an effective addition to school or community based drug prevention initiative programmes.[32]

Drug education

Drug education in schools, pupil referral units and youth engagement programmes provide a prominent preventative opportunity.

School-based education programmes provide a valuable opportunity to raise young people's knowledge around risky behaviours and should be utilised to shape awareness of NPS. Generally the extent to which school-based interventions can actually lead to behaviour change appears limited, however peer-led drug prevention education programmes and interactive pupil-teacher school-based sessions have been identified as an effective method of reducing substance misuse.[31] Interactive sessions have also been found to have the greatest impact on those pupils that are most prone to substance use.[33]

Interactive drug education programmes would therefore be a valuable component within a local universal NPS prevention strategy across mainstream education, pupil referral units and youth engagement programmes. The effects of this type of intervention appear time limited however, being lost after 1-2 years.[33] This means that drug education programmes should not be limited to a single age point, but rather revisited at regular intervals. Given that 15% of children have taken any drug by the age of 12-13 years in Camden, rising to a third by the time they reach 14-15 years, there is a need to ensure that effective drug education sessions are taking place soon enough, ideally before the age of 12. This

recommendation is in line with the national curriculum which begins introducing drug education in key stage 2.

In addition to building upon existing provisions within education settings, some other areas of the country have chosen to commission external providers to come in and deliver one-off sessions to get young people engaged in the subject. One example of such a service is provided by the Solomon Theatre Company, which offers a performance and workshop package to schools that is targeted at children in year 8. This package aims to build young people's confidence and decision making skills in order to support them to make positive lifestyle choices around a number of risky heath behaviours, including NPS use.[34] Where this sort of service is procured as part of schools drug education programmes, settings should ensure that it is not the only intervention provided, and that by the time children get to year 8 drug education has already begun.

At present in Camden and Islington, NPS, particularly uncontrolled NPS, appear to make up a very small part of wider drug education discussions in school science and PSHE lessons (though this is difficult to quantify). Although the resilience element of drug education (e.g. developing social competencies around drug related situations) is highlighted as an effective prevention intervention which can be applied to all drugs, the new nature of NPS and the increased likelihood of their use by young people suggest that more specific information on the risks of these substances should be included. Anecdotal evidence suggests that a lack of up-to-date knowledge and resources makes discussions around NPS difficult for teachers and drug education leaders and can lead to avoidance of the topic.

School based health and wellbeing education in both boroughs is supported by a council based team, namely the Health and Wellbeing Team in Islington and the School Improvement Service in Camden. Although these services cannot define what health and wellbeing topics are covered within school lessons, they provide schools with guidance and support around a range of key topics, including drug education. As part of this role, Islington's Health and Wellbeing Team are currently undergoing a needs analysis of children and young people's experience and understanding around drugs. This will offer valuable insight and help to shape the content of future drug education guidance for schools. The Camden School Improvement Service are also beginning a similarly valuable programme which aims to look at what drug education is taking place in schools (including around NPS) and raise the profile of drug education in schools.

Drug education in pupil referral units across both boroughs is delivered by council-led children and young people's substance misuse support services, namely the Islington Young Peoples Drug and Alcohol service (IYPDAS) (and the broader Targeted Youth Support team) and FWD in Camden. These services touch on NPS to varying extents. The Islington IYPDAS and broader TYS team also provide some wider educational sessions as part of their youth engagement work (including detached youth work). Utilising children's substance misuse support services to deliver these education sessions offers a valuable opportunity for these services to build positive trusting relationships and breakdown barriers to seeking support from them around NPS use.

Nonetheless, as with school education programmes, the current impact of programmes in pupil referral units and community engagement programme may vary due to differing levels of knowledge around NPS across service providers. In addition, educational leaders also highlight having a lack of available resources to support the discussions that they have with young people, something which has also been reported by those leading education sessions in schools.

This highlights a need to ensure that those teaching children and young people about drugs understand the importance of educating young people about NPS and their associated risks, and feel comfortable and confident in making NPS a set part of their education sessions.

Resources

Education providers, treatment services and frontline services working with vulnerable young people all report a dearth of available health promotion resources to support discussions with young people, parents and carers around NPS use.

Nationally developed resources are beginning to emerge to support education programmes, including, for example, the Mentor ADEPIS free educational resources which include a 'legal high' lesson plan, and NPS teaching aids for 'drug boxes'. Services can also sign post young people to the online national resource 'talk to FRANK', which provides regularly updated information on the effects of emerging NPS and where to seek support, or an alternative charity or research led website (e.g. the Angelis foundation's whynotfindout.org or CRI's strangemolecules.org.uk) or app (e.g. Drugs Meter). Overall though, this information is still limited and does not contain information about locally available support services, leaving somewhat of a resource gap.

Having identified the need for them, the FWD team in Camden are currently designing their own leaflets and posters to support their work around NPS. In Islington no known local resources are available. There is therefore a need for further health promotion resources to be developed or identified for use in Islington. Where possible, resources devised for both Camden and Islington should be created as 'live documents', allowing them to be updated regularly with new NPS information as it emerges. Where services are concerned about the maintenance of this document, a more general leaflet should be considered that will not become quickly outdated, focussing on the more general risks around 'legal highs'. Furthermore, young people should be engaged in the development process to ensure that the language and messaging in these resources is meaningful to them. In turn, this could be added to local young people's websites such as the 'urlife' website in Camden.

Local commissioners and substance misuse support services should make use of the wider network of services involved in drug prevention and youth engagement work across the two boroughs when developing new resources, both to prevent duplication and maximise the reach of these resources. Fitzrovia Youth in Action in Camden for example, a local youth action charity which engages disadvantaged young people in projects that matter to them, run a peer-to-peer education programme. Young people are supported to lead education sessions on topics that matter to them, including drugs, alcohol and mental

health. This could provide a valuable opportunity to engage local young people in developing health promotion resources that are accessible for young people, as well as in the delivery of peer-to-peer drug education.

As well as engaging wider partners in the development of new resources, once developed these resources should be shared across partners, particularly those who hold regular discussions with young people and their parents or carers about NPS use, such as the youth offending service, MASH, social care and teachers delivering drug education programmes in schools.

Training and information sharing

Up to date knowledge and awareness of NPS, their risks and how to facilitate discussions on them is integral to effective drug education, as has already been mentioned. This need is not only confined to those providing preventative education, however, but is also important for those services that ask about wider substance misuse as part of service entry screening or that regularly work with vulnerable young people, such as social care, youth offending services, mental health services, A&E staff, GPs and school nurses. National Every Child Matters guidance highlighted that those professionals working with children and young people, including both those within healthcare services and schools, should be trained to identify, assess and respond to individuals with drug problems, and this should therefore include NPS.[35 - 39]

One-off training sessions have taken place for some frontline substance misuse support staff locally, as well as some teams that frequently come into contact with vulnerable young people (e.g. the youth offending team in Camden). Delivered by, for example, Foundation 66 in Islington and FWD in Camden, these training sessions have given staff a good foundation of knowledge around NPS. It did not, however, reach all of those staff that regularly come into contact with vulnerable young people or young people that are showing the physical or mental health effects of NPS use. This highlights a need for further roll out.

The impact of one-off training is limited however, given the fast pace at which NPS are emerging and use is changing. Information can quickly become outdated and risk being quickly forgotten when infrequently put into practice. In addition to initial introductory training, therefore, there is also a need for the development of a feedback mechanism, enabling frontline staff regularly coming in to contact with NPS and NPS users to share their learning around NPS with other professionals. This can take the form of a network that brings members together on a regular basis and which is led by local commissioners and substance misuse support service providers. Further membership may include representation from partners such the youth offending service, homeless pathways (including hostel and safer streets representatives), children's and adolescent mental health services (CAMHS), social care (including MASH and troubled families representation), local police, community safety and trading standards. Further frontline workforces, such as teachers and primary and secondary healthcare staff should also be invited to join the network; however time constraints and other work priorities may impact their attendance. A feedback mechanism should therefore be identified to share key

learning from the network with wider partners and those unable to attend the meetings. This will enable alignment of the messages given out across services on NPS and maintenance of up-to-date knowledge across the local workforce.

Other support mechanisms currently available to local workforces needing more information or guidance around NPS include national support services, such as the national NPIS helpline, and CRI online support groups. These services may also add value to local knowledge when interactions with local NPS users are infrequent and when unknown substances emerge. The Home Office is also currently developing a resource which aims to support staff working with young people to have conversations around NPS use, including their risks and how to stop use. This tool is likely to be of use to a range of services, particular those working with vulnerable young people, such as the youth offending service and pupil referral units.[32]

If a significant event or incidence occurs locally in relation to a young person's NPS use, it is important that any learning gained through a review of the incident is shared more widely than NPS networks and feedback mechanisms. In order to improve local services and minimise the risk of such an event happening again, this information should be shared amongst relevant local services, particularly those that had involvement with the affected individual at some level.

Data collection and early identification of use

A limited amount of data is collected locally around NPS. To get a clear picture of NPS use across the two boroughs a change needs to be made to the current data recording mechanisms across a range of services. More meaningful data collection will also help to raise the profile of the issue locally, enabling it to be considered alongside other more recognisable substances in key strategic documents, such as the Joint Strategic Needs Assessment, and committing local areas to action. Changes to data collection moreover, should not only be limited to children's services, but should be implemented across equivalent adult services.

NICE guidance on community based substance misuse interventions for young people highlights that all disadvantaged and vulnerable children are screened for substance misuse.[21] At present however, this does not appear to be the case. Those services regularly coming into contact with young people at risk of traditional illicit drug use are either not asking about NPS use or are recording and sharing a very limited amount of information. The NDTMS, a national data collection portal used largely by drug treatment providers, now collects data on mephedrone, GHB and 'other NPS' use, but with a limited amount of further meaningful information.[40] Other services coming into contact with vulnerable young people, such as youth offending services, homeless support services, CAMHS and social care, appear to be focussing on illicit substances.

The pressing need to strengthen the collection of NPS usage data locally is not only for population monitoring however. It will also ensure that frontline services are asking young people about NPS use, creating opportunities for staff to offer advice or an initial brief intervention and make any necessary referrals for additional support.

It is important that these discussions take place and are captured by services sitting outside of the council, including for example, the police, emergency health services (e.g. A&E departments and the ambulance service) and primary care. In order to make data collected across these services as meaningful as possible, a common approach should be taken to how this information is recorded.

To entrench the collection of this information across services, NPS need to be embedded into existing screening and service-entry tools, making NPS an integral part of any substance misuse discussion. Commissioners can further promote this by including NPS data collection within service specifications and performance monitoring frameworks for local providers.

The range of NPS available and the speed at which new substances are emerging throws up further challenges when trying to standardise methods of recording usage. For this reason consideration should be given to recording substances by their effects rather than by name, using categories such as those described earlier: Synthetic cannabinoids, stimulant-type drugs and hallucinogenic. New national NPS treatment guidelines called Project NEPTUNE which are due to be published by Public Health England in 2015, look to provider a further breakdown of NPS for treatment purposes and may therefore offer a useful framework for the classification of NPS in data recording.[4] Aligning categories to those used within treatment would not only be user friendly for treatment and emergency services, but would also allow those frontline staff that may hold only an overarching knowledge of NPS a method of recording an unknown or unrecognised substance by the effects that the user describes, still allowing the data to be recorded.

This approach would need to be piloted to identify its suitability in practice and a final recording method should in turn be agreed within local NPS networks. Ideally, the method of data collection chosen should still allow for some level of comparison between local and national prevalence data. Consideration will also be needed around how data will be recorded locally, particularly where services are recording prevalence data on national tools like NDTMS, and whether duplicate data recording is necessary as an intermediary solution.

The way in which data is recorded is not the only barrier to identifying the true picture of NPS use locally. How frontline staff ask children and young people about substance misuse may also affect the quality of information gathered.

Anecdotal evidence from local frontline services provides mixed feedback on young peoples' understanding of the term 'legal highs'. This suggests that further exploration is needed with young people to define the most appropriate terminology to use when discussing NPS. Frontline services suggest that young people are unlikely to be able to put a substance that they are taking under its 'type' heading, such as, synthetic cannabinoids, stimulant or hallucinogenic, unless descriptions of forms and effects are given. Sometimes, for example, young people will report taking a 'white powder' but may be unclear on whether the substance is controlled or uncontrolled, and so further discussion is needed to identify what it is likely to be. Asking the correct question not only allows young people to gain the most appropriate support around problematic substance

misuse and the recording of the NPS usage data, but it also helps to gather knowledge on any newly emerging substance that can be shared through a local NPS network.

It is important that within initial NPS related training, staff are given guidance on how best to ask the question about NPS use.

The use of appropriate language is not only relevant to interactive discussions. It is also pertinent to the school surveys completed by young people in Camden and Islington. As with the approach for interactions between service providers and young people, in order to gain meaningful information from these surveys young people should be consulted with to identify the most appropriate terminology for use on these surveys.

It will take time to implement new methods of data collection. In order to make rapid decisions around the future commissioning of NPS related services, more informative data on NPS use is needed quickly. Consideration should therefore be given to whether an initial piece of data collection work to needs to take place in the interim to give a more informed snap shot of NPS use locally. This could for example, be done by commissioning an organisation to complete a population wide survey with local residents to give a clearer picture of NPS use across all age brackets, as done in other local authorities by the Global Drugs Survey.[41] Alternatively, existing school surveys completed in both boroughs could provide this information for a given age range of children and young people, if they are implemented in a timely manner and if questions are phrased correctly.

A change to the way in which NPS data is collected may also support the identification of another grouping of misused substances, namely prescription drugs. As with NPS, the prevalence on prescription drug misuse appears to have grown rapidly over recent years, particularly misuse use of the drugs pregabalin and gabapentin. Though the use of these substances seems more prevalent in the prison and opiate using population than in children and young people, a population wide change to substance misuse screening may lead to a greater identification of their misuse. Services should therefore remain aware of this, and may need to consider how the wider recommendations of this report can also be broadened to apply to prescription drug misuse.[42,43]

Treatment

Available treatment

As seen earlier on in this report, only a limited amount of data is currently available on the number of young people seeking treatment from local substance misuse support services for problematic NPS use. Where it is available it comes primarily from adult treatment services. Only anecdotal information was available from children and young people's substance misuse support services at the time this report was written and this suggested that numbers are relatively low, particularly for uncontrolled NPS.

The children and young people's substance misuse support team in Islington, YPDAS, anecdotally report seeing very few, if any, young people using NPS. In Camden's equivalent service, FWD, just a handful of young were identified, however users largely appeared to be using NPS alongside the use of other substances for which they are seeking support. A greater proportion of young people were identified in adult treatment

services, although the actual numbers are still low and little is known about the types of NPS being used. The highest number of young people in treatment identified as using NPS was seen in the GRIP Club Drug Clinic. This raises a question around why young people are choosing to seek support from the club drug clinic rather than services for children and young people. More research is needed to better understand this, however it could for example, be attributed to young people no longer wanting to or not being permitted to access young people's services once over the age of 18 years (some young people's services only take those up to 21 years of age) or to the type of support that young people are looking for.

In the adult population, the establishment of a separate club drug clinic has been particularly successful in reaching service users in London that may not have previously sought support, as seen in the North West London Club Drug Clinic started by Dr Bowden-Jones.[6] It has been suggested that the success of this clinic can be attributed to users seeing it as something relevant to them, not considering themselves to be 'traditional illicit drug users' who access mainstream services. Similarly, this may explain the way that young people are accessing treatment locally.

Given the low prevalence of young people in treatment for problematic NPS use, there appears to be little need for further treatment services to support this. Consideration should be given however, to raising the profile of current treatment pathways for children and young people using NPS amongst the frontline workforce who report feeling unsure of what they should do once they have identified a young person using NPS. This may be done through training of frontline staff, local NPS networks and information sharing amongst partners, and should cover the thresholds at which young people should be sign posted to available services and when social care should be involved. Awareness of these services should also be raised amongst children, young people and their parents or carers to ensure that they know where they can get help if needed. Local providers should maintain oversight of the number of young NPS users accessing their services and where barriers to access are identified these should be addressed.

Treatment structure

Limited guidance exists around treatment for problematic NPS use. Treatment services for problematic use of more traditional substances are largely individualised, being tailored more to the needs of the individual than the drug itself. The style of treatment for problematic NPS use is unlikely to differ vastly from this, particularly given the array of different NPS available. Further support is expected for practitioners during 2015/16 through the publication of the national NEPTUNE project report findings and the UK Clinical Guidelines for Drug Dependence.[4]

In the interim, substance misuse support services should make use of existing substance misuse guidance, including NICE guidance on Community-Based Interventions to Reduce Substance Misuse Among Vulnerable and Disadvantaged Children and Young People (2007).[21] This includes, for example, incorporating approaches that consider a young person's whole family and wider environment, as well as working in partnership with other

services involved in a young person's care, e.g. educational welfare services, CAHMS, drug advisers or other specialists, in order to develop a mutually agreed care plan.

Acute treatment

Guidance around the acute treatment of NPS is similarly limited. The national NEPTUNE project report aims to change this, not only giving guidance on the ongoing treatment of chronic NPS use, but also the acute, providing for example, guidance for A&E departments.[4] In addition, local NPS networks should support emergency healthcare services to gain up-to-date information on the substances being seen on the ground locally. These services should also consider linking in with, or developing a separate clinical network to share learning around the care of acute NPS-related problems in the absence of treatment guidelines for each emerging substance. Clinicians working in community treatment services may also benefit from attending this.

Safer environment

At present, processes in place to legislate against individual substances nationally appear to be far out-paced by the emergence of new substances. Intervention at the local level is therefore needed to reduce the availability of those substances not yet controlled.

Uncontrolled NPS can be purchased freely online, although research suggests that most users do not purchase them in this manner. Research into how students (in school, college and university) in Scotland purchased mephedrone (prior to it becoming an illegal substance) found that only 10.7% of student users sourced their mephedrone online, compared to 30.8% of those over 24 years.[45] Possible explanations include younger users not having the credit or debit cards required for online purchasing and/or not having a safe place to get their purchases sent.[6] Young people may therefore be more likely to get NPS through "head shops" (high street shops that sell uncontrolled NPS), dealers or friends, who in turn may be purchasing their 'stock' in bulk online. Consequently, a two pronged approach is needed to tackle the supply of NPS, both through national regulation of online sales and local regulation of sale through head shops and dealers. The National Crime Agency has already closed down some of the websites selling these substances and local police forces currently monitor and legislate against the sale of controlled drugs through dealers.[6] There is an opportunity however, to build on this regulation of NPS supply at a local level via their sale in head shops.

Controlling the sale of NPS

Head shops selling uncontrolled NPS often do so under the guise of other products, selling them as research chemicals, plant food, bath salts and pond cleaner for example, and aim to circumvent the law by displaying warnings on product packaging stating that they are not for human consumption.

Despite vendors taking advantage of the lack of direct legislation surrounding these substances (where they believe substances not to be banned under the misuse of drugs

act 1971), local policing, trading standards and community safety teams may be able to use other legislation to regulate the sale of uncontrolled NPS. In recent national guidelines the Home Office and Local Government Association have pulled together a list of a range of legislative regulations that either have been used or have the potential to be used to reduce the number and type of products available to purchase, including: [32,44]

- *The Intoxicating Substances (Supply) Act 1985.* This makes it illegal for vendors to sell an intoxicating substance to a person under 18 if they believe that it will be inhaled as an intoxicant. This legislation has been used by West Yorkshire police to effectively tackle the sale of NPS. Here local police arrested both the vendor on a market stall and the market stall holder after witnessing the purchase of synthetic cannabinoids by a 16 year old boy.
- *The Misuse of Drugs Act 1971.* Evidence suggests that substances being sold as legal often contain illegal substances, with 19% of samples test by FEWS in 2013/14 containing controlled substances (the same proportion was also found in samples collected in 2011).[42,43] This means that substances sold containing controlled NPS can potentially be seized and vendors prosecuted. It is likely that in order to achieve this however, a level of intent or vendor awareness may be needed.
- *General Product Safety Regulations 2005.* These aim to ensure the products on sale are safe and where appropriate, properly marked. This puts a duty of care on the vendor and can be used for example, to issue a notice to mark a product or warn consumers if a product is believed to be unsafe. These regulations were used in Great Yarmouth, where market traders were issued with warnings from trading standards around properly labelling products that might pose a risk to users. When traders were later found not to have complied with this request these products were seized and the traders were fined. There are limitations to the use of these regulations however, including the need to prove that a vendor is aware that the products may be used as NPS and to demonstrate that a product is unsafe (often requiring potentially expensive product testing).
- *Chemicals (Hazard Information and Packaging for Supply) Regulations 2009 (being replaced by Classification, Labelling and Packaging Regulations in June 2015).* These focus on preventing harm from chemicals through for example, informing customers of their associated risks. Similarly to General Product Safety Regulations (2005), there is potential to use these to regulate sale through the implementation of labelling requirements, where this is not already present.
- *The Enterprise Act 2002.* It may be possible to use this to apply for a court enforcement order to prevent breaches of consumer protection legislation by a vendor. Again, as with General Product Safety Regulations (2005), if for example, vendors suspect that products will be consumed, then they have a duty of care to their customers (collectively) to protect them from potential harm. It may therefore, be possible to take out an enforcement order that requires vendors to appropriately label products. Enforcement teams may face a challenge here when trying to prove that a product causes harm, potentially relying again on product testing.
- *The Local Government Act 1972 and 2000.* This act could be utilised to implement an injunction against an NPS vendor if it is believed that this will protect the wellbeing of the local community. It is likely to be more successful in court however, if it follows

other attempts at intervention. When an injunction is granted, it may for example, be used to enforce product labelling.

- *The Antisocial Behaviour, Crime and Policing Act 2014.* Where it can be shown that the sale of these products is resulting in for example, nuisance behaviours, this act may be used to implement community protection notices and public spaces protection orders. If not adhered to, this can lead to the seizure of products and/or their permanent confiscation, as well as a fine. Furthermore, if for example, a vendor is deemed to be having a persistent detrimental effect on the local community, a closure order may also be implemented.
- *Consumer Protection from Unfair Trading Regulations 2008*. These regulations legislate against the use of misleading or reckless acts or omissions which cause the average consumer to take a 'transactional decision' that they would not have otherwise done. This regulation can be somewhat limited by who is deemed to be the typical user of these products. In this case, it is likely to be NPS users, who are generally aware of what they are buying, and to whom therefore, labelling has little impact.

This is not an exhaustive list and local authorities should be encouraged to explore what regulations best suit their own situation (Home Office (2015) guidance for local authorities on taking action against 'head shops' selling new psychoactive substances, offers further useful guidance).

Further examples of interventions linked to these legislative regulations that could be implemented locally include:

- the use of mystery shoppers to identify the sale of NPS to under 18s
- working with vendors to education them about the possible harms of NPS, as well as the likelihood that they may contain controlled substances, meaning that they risk breeching the Misuse of Drugs Act, 1971 (this could potentially be implemented in Camden through the owner of the three main Camden Town markets)
- sample testing of NPS sold as uncontrolled substances to identify the presence of controlled substances or to enforce labelling requirements
- working with licencing teams to educate licenced venues where NPS may more commonly be used and traded, e.g. clubs and music venues, about their risks.

There are cost implications to the implementation of a number of these regulations and interventions, both financially and in terms of time, and therefore the scale of action should be driven by the patterns and scale of NPS use locally. As far as possible, information on the prevalence of head shops should be collected for each borough before defining the level of intervention locally. This will also support the evaluation of any interventions implemented.

Initial anecdotal evidence would suggest that there is a particularly high volume of head shops in Camden, with a number situated around the markets in Camden Town. Islington appears to have a small number of head shops, with anecdotal evidence from frontline services suggesting that NPS are instead being purchased from head shops in Camden or online. As stated however, this information is solely anecdotal and therefore local trading standards teams have a key role to play in quantifying the number of head shops in each borough to give further clarity.

Prior to further information on the prevalence of head shops, a trading standards or community safety led initiative to educate head shop owners about the risks associated with NPS would make a useful first line intervention locally. As earlier mentioned, this would include highlighting to the vendor both the health risks posed to the users of NPS and the legislative risks posed to them as a vendor of NPS. Once further information has been gathered around the prevalence of head shops locally, and considering the success of a vendor education programme, further intervention should be implemented.

In order to implement any of the safer environment interventions and regulations effectively it requires strong working partnerships between local police forces, trading standards and community safety teams. In addition, newly formed NPS networks are likely to act as a valuable portal for these teams to gather intelligence from other services on where young people report purchasing NPS. This information will give local enforcers reason to 'suspect' local shops of selling NPS, providing a potential catalyst for further action.

Product testing

A number of the legislative regulations that may be used to regulate the sale of NPS require enforcers to prove that a product is unsafe. A lack of evidence surrounding these new and varied substances means that product testing is often necessary. Product testing can act as more than just a tool to support legislating against the sale of NPS however. It can also offer a method of risk reduction for those individuals that continue to take these substances.

Experience from long established traditional illicit drugs highlights that even in the presence of drug prevention initiatives a proportion of the population will still continue to use these substances. Moreover, though the harms posed by NPS are not yet fully understood, their use has been associated with some serious health risks and linked to an increased number of substance misuse related deaths nationally (*see NPS related harm and health and wider societal impacts of NPS use sections*). In addition to reducing the supply and demand of NPS therefore, local areas should also consider what they can do to reduce the risks attached to those substances that are being sold and taken by young people.

The new nature of NPS means that the chemicals they contain may, in a number of cases, have never been used in drugs for human consumption before, meaning that lack any relevant testing (both on composition and safety). The chemical ingredients of NPS furthermore, are often changed and updated to circumvent new legislation, making the risks posed by them unpredictable to both users and those working with users. This makes harm minimisation for NPS particularly challenging and hugely important.

The EU Early Warning System tests the composition of new substances and provides information on the adverse health effects of NPS at a national level. This offers some insight into the likely effects of substances tested, however, the products tested do not always aligned to those used locally, nor is the information gathered disseminated to potential users and service providers at the local level.[20] There is therefore, room to build on the work of this system locally, both via the dissemination of national information

through local NPS networks and feedback mechanisms, and borough lead product testing of locally available uncontrolled NPS.

Product testing provides a valuable opportunity to increase frontline practitioner's knowledge of what substances are currently being sold locally, particularly amongst emergency healthcare services that may need to provide acute treatment for NPS use. It also gives areas the opportunity to share localised protection warnings with potential users around the dangers of certain products, targeting them towards those most at risk of their use, e.g. vulnerable young people and clubbers. It also inadvertently temporarily reduces the availability of uncontrolled NPS locally through the confiscation of stock for testing.

Local trading standard teams would play a key role in coordinating this type of intervention, confiscating stock for testing or coordinating test purchasing and sending samples away for testing.

This type of intervention would benefit from the development of strong links with local research institutions or universities in order to test products. One example is TICTAC Communications Limited, based St. George's, University of London, a laboratory dedicated to drug analysis and identification.

Prior to the implementation of localised product testing interventions however, further information is needed around the use of NPS locally. At present, current prevalence data is not enough to inform decisions on the implementation of such an intervention. Although there appears to be a low prevalence of NPS use and treatment for use locally, a lack of meaningful data collection methods means that current figures may well underestimate the scale of the problem.

Where product testing is initiated, localised procedures or guidance should be established to ensure that information gained from testing is effectively disseminated, potentially through NPS networks and wider NPS feedback mechanisms. Established procedures would also ensure that product testing is used appropriately, considering the potential implications of test findings alongside the cost of the intervention.

Recommendations

The Scale of NPS use amongst young people in Camden and Islington appears limited. A lack of data collection, however, makes it hard to draw clear conclusions. Similarly, the new nature of these substances means that there is also a limited amount of information available on both the potential health and social harms that they pose. Considering this, and using what data, research and guidance is available, the following recommendations have been made for local action:

1. **Create a clear picture of local NPS usage**

   Lead Services: local commissioners, drug treatment services (including children and young people's substance misuse support services) and the NPS network

   - A new method of measuring NPS use should be agreed across key substance misuse services and services that screen for substance misuse in order to gain a more insightful picture of NPS use locally. Where possible these measures should be aligned to national measures and once agreed this standardised measure should be used across local services (including adult services)
   - Consider using 'effects' headings to categorise NPS, in order to simplify the recording of unrecognised or previously unknown substances
   - Local commissioners to ensure that new data collection measures are written into service specifications for commissioned services where appropriate
   - Locally agreed measures of NPS should be included in existing screening tools that ask about substance misuse
   - Consultation with young people should inform how NPS use is asked about locally, both within surveys and during services consultations. Use this to inform how existing surveys of young people's health (e.g. Health Related Behaviours Questionnaire) can best gather accurate information on usage of and views on NPS
   - Consideration should be given to identifying and quickly implementing a snap shot measure of NPS use to build upon existing knowledge and inform commissioning decisions prior to overarching data collection changes.

2. **Up-skill the local workforce**

   Lead Services: drug treatment services (including children and young people's substance misuse support services), commissioners and the NPS network

   - Provide frontline health and social care staff and those in regular contact with vulnerable young people with baseline training around NPS, giving information on what they are, the risks associated with them, who is likely to use them and how problematic usage may be displayed
   - Training should also include guidance around how to raise the issue of NPS use with young people and what terminology to use
   - In addition to initial training around NPS, ongoing knowledge updates should be made available to staff through local NPS networks and feedback mechanisms
   - Learning from serious incidents or events related to NPS use should be share widely, through for example, borough-wide learning events.

3. **Establish local NPS networks**

   Lead Services: local commissioners and drug treatment providers (including children and young people's substance misuse support services)

   - Local NPS networks should be established in order to share learning between those frontline services seeing young people using NPS, that frequently see vulnerable young people or are involved in the regulation of NPS sale e.g. CAMHS, youth offending teams, drug treatment services, safer streets teams, trading standards, community safety, the local police and social care
   - Clinicians should also consider identifying existing clinical NPS networks or establishing a local clinical network to share experience and best practice around the treatment of problematic NPS use, particularly acute treatment
   - Establish a feedback mechanism to disseminate pertinent information shared within the NPS network to wider partners.

4. **Support the inclusion and delivery of NPS related information within drug education in schools, pupil referral units and community groups**

Lead Services: local healthy schools / health and wellbeing teams, local commissioners and children and young people's substance misuse support services

- Review current drug education provision within schools, pupil referral units and community groups, as well as the guidance given to them, to ensure that accurate NPS information is included
- Support schools to use an interactive approach to education programmes, including a peer-led element, and ensure that guidance to schools recommends that NPS within drug education in schools is repeated 1-2 yearly
- Ensure that those delivering information on NPS within drug education are equipped to do so, both through training, access to up-to-date local information, guidance and resources, and understand the importance of doing so.

5. **Equip frontline staff working to prevent, identify and treat NPS use with the resources that they require to support their discussions with parents, carers and young people**

   Lead Services: children and young people's substance misuse support services and local commissioners

   - Share up-to-date and locally available NPS resources amongst teams identifying substance misuse and offering frontline advice, e.g. social care teams, youth offending teams, CAMHS, drug treatment services, safer streets teams and the local police
   - Develop live NPS resources for Camden and Islington that can be updated regularly based on new learning about NPS and their use locally
   - Consult local young people when developing new resources to ensure that the language used within them is meaningful and accessible.

6. **Raise awareness of local drug treatment and support services, and available health promotion information, ensuring that these resources are accessible to all**
   Lead Services: children and young people's substance misuse support services and local commissioners
   - Raise the profile of local care pathways for support around NPS use, ensuring that frontline services know where and when to refer a young person, and at what threshold social care should be involved
   - Ensure that local health promotion information and information on local NPS support services are easily accessible to the general public
   - Monitor the use of NPS support services to identify whether barriers may be preventing young people from seeking support around NPS use.

7. **Implement measures to monitor and regulate the sale of uncontrolled NPS locally, and share information on locally available substance**
   Lead Services: trading standards teams, local police, community safety teams and local commissioners
   - As far as possible, quantify the number of head shops selling uncontrolled NPS locally
   - Implement a trading standards lead initiative to educate head shops about the risks associated with NPS, both for the user and them as the vendor
   - Share information on locally available NPS through local NPS networks
   - Informed by the volume of head shops and improved prevalence data on NPS usage, consider using further legislative controls to reduce the sale of these substances.

8. **Develop a localised pathway for product testing of uncontrolled NPS**
   Lead Services: trading standards teams, local police and local commissioners
   - Based on further prevalence data, consider implementing a trading standards lead test purchases programme, where products are confiscation from local head shops in order to analyse content
   - Consider the cost verses benefit of product testing to identify how and when test purchasing should be used locally
   - Make links with local research institutes to explore opportunities for the analysis of NPS samples
   - Share information gained through product analysis to frontline staff through local NPS networks and to young people at risk for using NPS to minimise potential harm.

Taking the recommendations forward

These recommendations target a range of different services across Camden and Islington. In order to take these actions forward in an effective and timely manner, clear responsibilities and modes of governance need to be established. In Camden, where a greater level of baseline information is available, these structures have started to become established. The community safety team will take the lead on the implementation of these

recommendations, though service leads and commissioners will need to be established to lead on up-skilling frontline staff and ensuring accurate and joined-up data collection. The community safety team and children and young people's substance misuse service have also agreed to take forward a programme of education targeted at head shops owners in Camden, and the healthy schools team have begun reviewing the support and guidance offered to schools around drug education. Services implementing these recommendations will in turn be accountable to the Camden Safeguarding Children Board. Building on the findings of this report, a three month project lead position has been established within the Camden trading standards team to pull together a Camden wider NPS strategy.

A governance structure for the implementation of the report recommendations has not yet been established for Islington, though the report will be circulated around local safeguarding boards to promote action locally. Moreover, local police in Islington plan to review what action is being taken locally to regulate the sale of NPS through head shops.

In addition to established points of accountability, local NPS networks should also, once formed, play a role in co-ordinating and monitoring the implementation of these recommendations. Local commissioners will also play a key role in monitoring any changes made to commissioned services, including to data collection methods.

The most pressing action from these recommendations is to create a clear picture of local NPS usage. This in turn will inform the implementation of new interventions to reduce the risks poses to young people by NPS use.

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Appendices

Appendix 1: Services interviewed within this review

Drug Treatment Services

GRIP Club Drug Clinic, Camden and Islington foundation trust, Camden and Islington

DAIS and 184, CRI adults' drug treatment service, Camden

FWD Substance Misuse Service- Children and Young People, Camden

DIP and ISIS, CRI adults' drug treatment service, Islington

Targeted Youth Support team (TYS) and Islington Young Peoples Drug and Alcohol Service (IYPDAS), Islington

Commissioning

Integrated Working and Commissioning Manager - Children and Young People, Camden

Strategic Commissioner - Substance Misuse, Camden

Senior Commissioning Manager, Substance Misuse, Islington

Young People Crime and Drugs Strategy and Commissioning Officer, Islington

Prevention

Healthy Schools Team, Camden

Safer Communities Partnership Team, Camden

Safer Streets Team, CRI, Camden

Children's Social Care, Camden *(including Multi Agency Safeguarding Hub (MASH) and the Children in Need team)*

Trading Standards, Camden

Youth Offending Service, Camden

School Improvement Service, Islington

Targeted and Specialist Children and Families Services, Islington *(including MASH)*

Trading Standards, Islington

Other

Fitzrovia Youth in Action, Camden *(voluntary organisation)*

Young Person's Pathway, Camden *(temporary accommodation)*

Family Mosaic, Islington *(temporary accommodation)*

Irish Centre Housing - Bethany House, Islington *(temporary accommodation)*

One Housing, Camden *(temporary accommodation)*

SHP- Barnsbury Road Service, Islington *(temporary accommodation)*

Appendix 2: Recent changes to drug legislation

Recent changes to drug legislation as laid out in the Drug Scope (2014) Business as usual? A status report on new psychoactive substances (NPS) and 'club drugs' in the UK *(Pg. 23)*

July 2003 - GHB classified as a Class C drug.

January 2004 - Reclassification of cannabis from a Class B to a Class C drug under the Criminal Justice Act 2003.

July 2005 - Raw magic mushrooms classified as a Class A drug. Previously, only prepared (such as dried or stewed) magic mushrooms were classified as Class A drugs.

January 2006 - Ketamine classified as a Class C drug.

January 2007 - Methamphetamine (commonly known as "Crystal Meth") reclassified from a Class B to a Class A drug.

January 2009 - Reclassification of cannabis from a Class C to a Class B drug.

December 2009 - GBL classified as a Class C drug.

December 2009 - Spice, a synthetic cannabinoid, classified as a Class B drug.

April 2010 - Mephedrone and other cathinone derivatives classified as Class B drugs.

July 2010 - Naphyrone, a stimulant drug closely related to the cathinone family, and often marketed as NRG-1, classified as a Class B drug.

April 2012 - Methoxetamine, a ketamine substitute, is given the first of a new kind of drug control, a Temporary Class Drug Order (TCDO), which bans its sale, but not possession, for up to 12 months while further classification is considered.

November 2012 - Methoxetamine, as well as a new group of synthetic cannabinoids including 'Black Mamba', are classified as Class B drugs.

June 2013 - NBOMe, a related drug to the hallucinogen 2CI, and 'Benzo Fury', a related drug to ecstasy, given TCDOs.

July 2013 - Classification of khat, a herbal stimulant, as a Class C drug announced.

September 2013 – Home Office announce that they will accept the advice of the ACMD, and classify lisdexamphetamine as a Class B drug, and zopiclone and zaleplon Class C. Lisdexamphetamine is used in treatment for ADHD, and is a pro-drug, which converts in the body to dexamphetamine, already a Class B drug. Zopiclone and zaleplon are part of the family of 'z-drugs', along with zolpidem, which is already a Class C drug, and are used as sedatives.

December 2013 – Home Office announce that they will accept the advice of the ACMD and make NBOMe a Class A drug, and Benzofuran Class B.

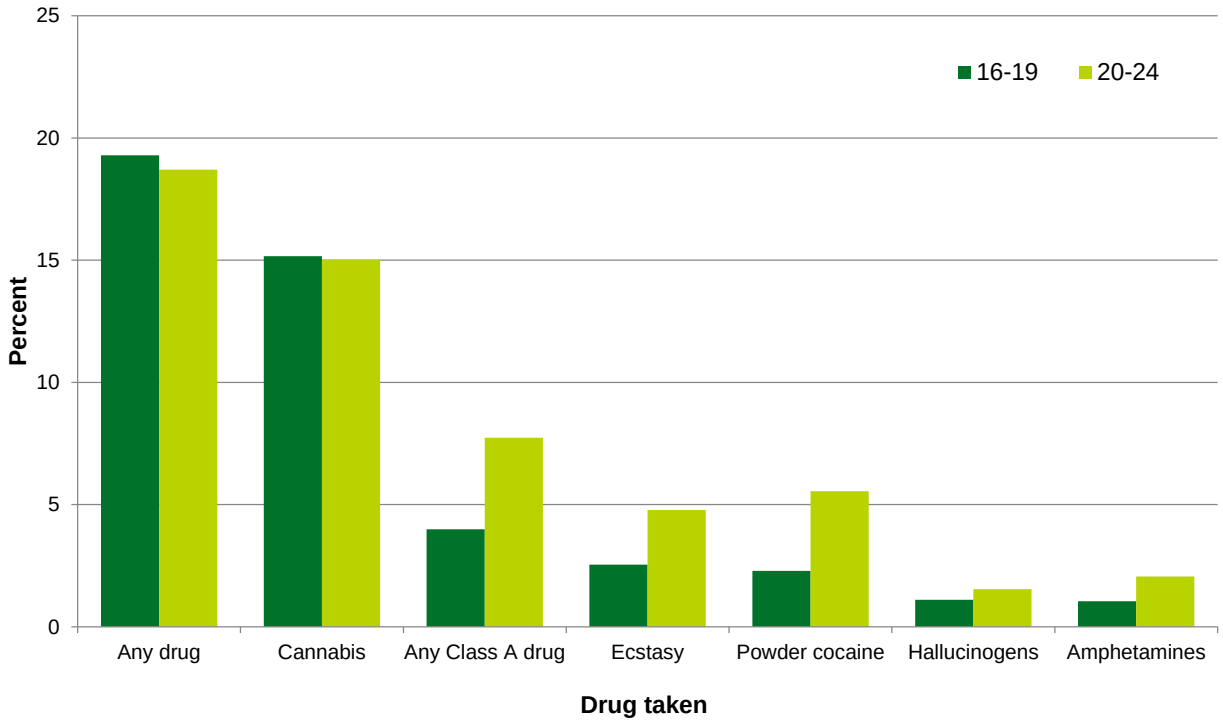
February 2014 – Home Office announce that they will accept the advice of the ACMD and reclassify ketamine as a Class B drug. It was previously Class C.

For the most up to date and complete list of substances controlled by law visit www.legislation.gov.uk/ukpga/1971/38/contents

Appendix 3: Breakdown of substance misuse data for 16-19 year olds and 20-24 year olds

When prevalence data for children and young people is further broken down by age, as can be seen below, it appears that a similar proportion of 16-19 and 20-24 year olds are using drugs. Though this tells us little about NPS use, the higher prevalence of individual drug use seen amongst 20-24 year olds suggests that at this age individuals are taking a greater number of substances simultaneously.

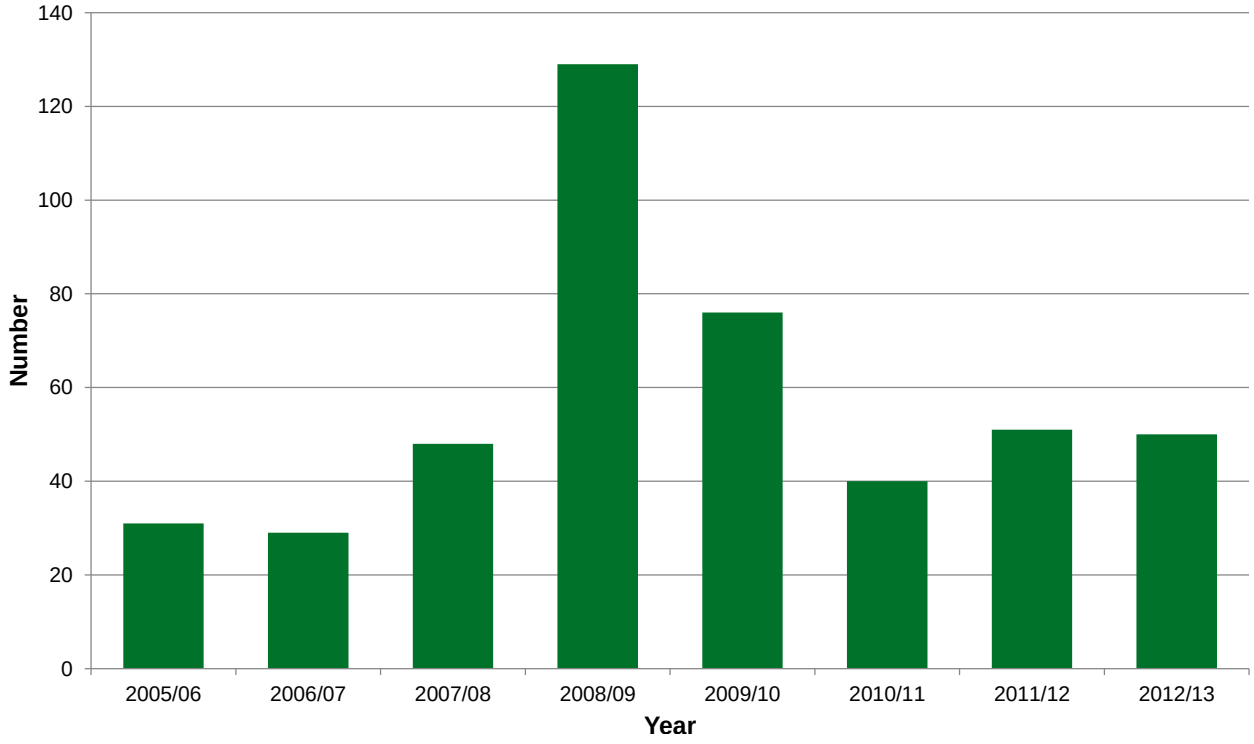
Proportion of young people using illicit drugs in the last year, 16-19 year olds and 20-24 year olds, England and Wales, 2013/14



Source: Crime Survey England and Wales 2013/14

Appendix 4: Camden drug treatment data, 2005/06 – 2012/13

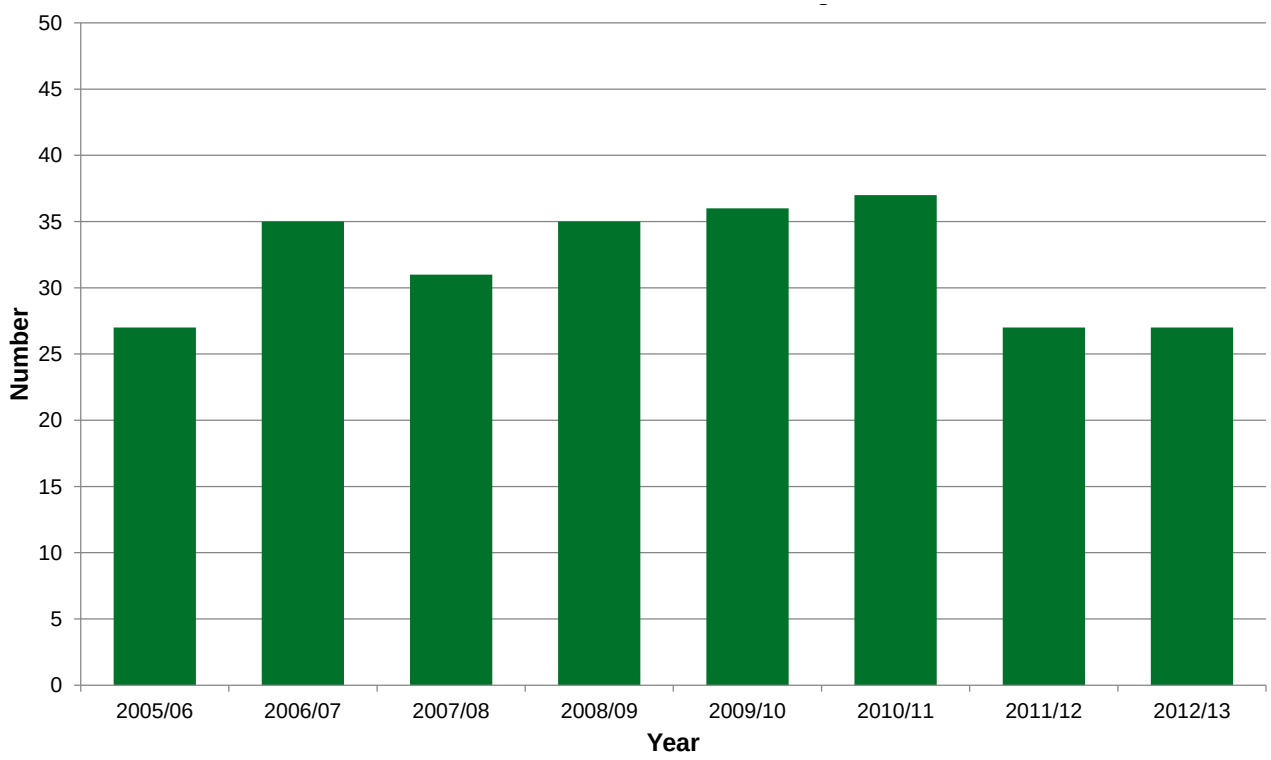
Number of adults in treatment where primary drug is not opiate, crack, cocaine or cannabis 2005/06 to 2013/13, Camden



Source: NDTMS 2014

Appendix 5: Islington drug treatment data, 2005/06 – 2012/13

Number of adults in treatment where primary drug is not opiate, crack, cocaine or cannabis 2005/06 to 2013/13, Islington



Source: NDTMS 2014