NADA Discussion Paper:

New and emerging psychoactive substances

March 2014

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the non government drug and alcohol sector in NSW.

NADA’s goal is to advance and support non government drug and alcohol organisations in NSW to reduce the alcohol and drug related harm to individuals, families and the community.

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INTRODUCTION

The Network of Alcohol and other Drug Agencies (NADA) is the peak organisation for the non government drug and alcohol sector in NSW.

NADA represents over 100 organisational members that provide a broad range of services including drug and alcohol health promotion, early intervention, treatment, and after-care programs. These community based organisations operate throughout NSW. They comprise both large and small services that are diverse in their structure, philosophy and approach to drug and alcohol service delivery.

NADA’s goal is ‘to advance and support non government drug and alcohol organisations in NSW to reduce drug and alcohol related harm to individuals, families and the community’.

NADA provides a range of program and services that focus on sector representation and advocacy, workforce development, information management and data collection, governance and management support plus a range of capacity development initiatives.

NADA is governed by a Board of Directors primarily elected from the NADA membership. It holds accreditation with the Australian Council on Health Care Standards (ACHS) until 2014.

Further information about NADA, its programs and services is available on the NADA website at www.nada.org.au.

ACKNOWLEDGEMENTS

NADA would like to acknowledge the input of NADA members and stakeholders into the development of the paper. Much of the content is taken from a forum held in December 2013 with NADA members (including representatives from residential and day programs, Aboriginal controlled organisations, youth and health promotion services), and stakeholders (including representatives from academia, Local Health Districts, and the NSW Ministry of Health). As well as Stephen Bright, Curtin University, for providing a keynote presentation at the forum, and further contributing to the NADA Advocate with advice for the sector. In addition, Edwina Deakin, Principal of EJD Consulting & Associates, who facilitated the forum and contributed much of the content of the paper in writing up the outcomes of the consultation.

NADA is supported by funding from the Australian Government Department of Health.

PURPOSE

The purpose of the New and Emerging Psychoactive Substances Discussion Paper is primarily to describe some of the issues and experiences of the NSW non government drug and alcohol sector, as well as other stakeholders, and provide a discussion for future work to address issues impacting on the sector and NSW communities.
OVERVIEW OF THE PAPER

The discussion paper provides:

1. an overview and context of new and emerging psychoactive substances
2. key themes and issues
3. recommendations for discussion
4. useful resources
5. next steps.

1. OVERVIEW AND CONTEXT

What are new and emerging psychoactive substances?

New psychoactive substances (NPS) describe a range of synthetic drugs that have recently been the subject of considerable media and political attention. Other terms include emerging psychoactive substances, synthetic drugs, ‘legal highs’ or herbal highs.

NPS are constantly changing or evolving by the modification of existing molecules and chemical substances, often to avoid detection by drug testing or to get around legal prohibitions. Increased concern about NPS is a worldwide phenomenon.

NPS are subject to social trends as well as to marketing campaigns. New substances and new ‘brands’ are promoted on the web and through other social media networks. Local manufacturers, suppliers and outlets have also influenced local consumption patterns.

Some examples of NPS sold in Australia include various brands of synthetic cannabis (e.g., Kronic, Black Widow, Buddha, King Karma, and Iceblaze), party pills and powders (e.g., White Revolver), in addition to research chemicals (e.g., NBOMe, Methoxetamine).

Current Legal Status

Prior to the passing of legislation various types of NPS were widely advertised on the Internet and were also sold over the counter in speciality shops, such as tobacconist and herbal high stores.

In September 2013, following the death of a Sydney teenager who had consumed a type of NPS, the NSW Parliament passed amendments to the Drug Misuse and Trafficking Act 1985 that prohibited the manufacture, supply and advertising of ‘psychoactive substances’. The Drugs and Poisons Legislation Amendment (New Psychoactive and Other Substances) Act 2013 commenced on 7 October 2013, adding 45 new psychoactive substances to the Schedule of prohibited drugs and plants (including cathinones and 2C-X NBOMe substances). Penalties for possession under the legislation include up to two years imprisonment, more than $2200 in fines, or both.
Terminology in the Act:

"psychoactive substance" means any substance (other than a substance to which this Part does not apply) that, when consumed by a person, has the capacity to induce a psychoactive effect.

"psychoactive effect", in relation to a person who is consuming or has consumed a psychoactive substance, means:

(a) stimulation or depression of the central nervous system of the person, resulting in hallucinations or a significant disturbance in, or significant change to, motor function, thinking, behaviour, perception, awareness or mood, or

(b) causing a state of dependence, including physical or psychological addiction.


Policy context

In NSW, the NSW Ministry of Health, Drug and Alcohol Program Council’s Quality in Treatment Sub Committee has established an Emerging Psychoactive Substances Advisory Group to conduct a mapping exercise and provide recommendations on: health policy and early intervention and treatment responses; information and education; data collection tools and strategies; and emerging evidence.

At a national level, the Intergovernmental Committee on Drugs (IGCD) is currently developing an NSP Framework.

2. KEY THEMES AND ISSUES

At the December 2013 forum, participants shared experiences, clinical observations and research findings related to NPS. The key findings are summarised below.

Terminology

- The terms ‘new’ or ‘emerging’ psychoactive substances were generally preferred over ‘synthetic drugs’ as it focused attention on the drug’s effects rather than its mode of production. The addition of the terms ‘new’ and ‘emerging’ was seen as useful as it communicated that this category of drugs was continuously evolving. The Forum was keen for a single term to be adopted to assist in education of the community as well as to help clinicians. Most appeared comfortable with NPS.

- One of the noted downsides of the use of NPS was that it covered a very wide spectrum of pharmacological substances, each with their own symptoms and potential treatment options. It was generally agreed that the sector needs to adopt not just a single term, but also agree on a set of sub-categories of NPS.
Legislative and Policy Issues

- The passing of the NSW legislation and the associated media coverage, while noted as having increased community awareness of the existence of NPS, has also had a number of other consequences. Some observations included:
  - The legislation has led the community to think NPS is primarily a law and crime issue, rather than a health issue where users may require help and support. This has the potential to delay people seeking assistance when they need it.
  - The banning of NPS has pushed discussion of usage ‘underground’. Anecdotal evidence suggested that some individuals were now ‘self-managing’ their issues and have been less likely to come forward for professional assistance.
  - Anecdotal evidence suggested that:
    - There has been a drop in Emergency Department presentations since the legislation, and
    - There have been more calls to help lines from people asking for advice anonymously, including questions about how long specific NPS stay in the system.
  - Some clinicians have observed increased curiosity about NPS amongst clients, with some indicating they were now keen to experiment with them where previously they may not have.
  - Some local supply networks appear to have become more ‘creative’ in their selling processes, adopting new delivery methods now that shopfronts are prohibited from selling NPS.
  - Some individuals appear less prepared to admit to usage than when they were legal.

- It should be recognised that drug manufacturers have limitless options to modify substances to get around bans on specific drugs or types of products.

- The use of NPS appears to pose challenges to court ordered drug testing. It was noted that:
  - Current drug tests would not detect most NPS.
  - It will be very difficult for drug tests to keep up to date with NPS as a lot of the overseas research and development for NPS is specifically focused on creating products undetectable in workplace and other testing regimes.
  - Drug testing is an expensive and often flawed option for managing the misuse of substances in particular individuals, including in social and occupational settings.

- Some services providers expressed that in the event of another NPS related death or high profile incident, that media and law makers should engage more with health services in formulating responses and key messages. The consequence of “over-reacting” may create more fear in the community when the most important message should be harm reduction.

Treatment Issues

- While most clinicians reported first-hand experience of working with clients who had consumed some form of NPS, in general these individuals were presenting in the context of poly-substance use, rather than as having NPS as the sole substance.

- Some clinicians had observed that NPS users were potentially younger than average clients of their service, though the data was not yet available to substantiate this.
Some clinicians indicated that aggressive or irrational behaviours had been evident amongst some NPS users. As a result of this one youth service reported not including group therapy in the treatment for these individuals due to potential ‘flare-ups’. It was noted, however, that increased levels of aggression was a sector-wide challenge and care needed to be taken to not solely link it to NPS usage.

A number of clinicians reported increased levels of agitation associated with synthetic cannabis usage. It was reported that this may in part be due to frustrations associated with:
- The withdrawal experience as it was observed to be more severe and more rapid compared to regular cannabis
- Some products having varying levels of active NPS ingredients
- Some individuals appeared not get the same ‘high’ from the same quantity of product.

Some clinicians reported psychotic behaviours in NPS users (specifically associated with synthetic cannabis), though again it was noted that this could be the result of poly-drug use and/or mental health issues. When treating clients it was recommended to also consider mental health issues as this could be altering substance symptoms and impacts.

There was generally a lack of knowledge of the specific side-effects or pharmacology of different types of NPS. Adoption of some standardised categories of NPS was viewed as a positive step in terms of treatment.

There was currently little available data on NPS use in the community, with many services indicating they did not routinely collect data on it. Further, where services were recording use of NPS or ‘synthetic drugs’ (for example under “other”) these were not being consolidated or systematically analysed. As a result available data is not being consolidated in a useable format.

It was observed that some young people appear not to report or include some ‘herbal high’ products as drugs. As usage of NPS is not specifically asked in most assessment or intake tools, there was speculation that there could be under-reporting of usage, certainly prior to the legislation. Some standard interview questions on NPS were recommended.

Community Issues

- The impacts of NPS in the community are likely to have been exaggerated by the media given clinicians are not observing significant changes in usage patterns or behavioural impacts. Exaggerating the scale of the problem and the harm caused by NPS can distort community perceptions of the risks associated with taking NPS. This may potentially divert some individuals into experimenting with more harmful alternatives.

- There is currently no prominent reference point for young people and their families to find out about NPS. It was observed, for example, that the current information on the health website was “not youth-friendly” and was unlikely to be accessed by potential NPS users.
- It was noted that there is insufficient health promotional information readily available for distribution. Accessing alternative and reliable information sources was difficult due to different terminologies and product names. There was also a question over the accuracy of information on some websites.

- A serious risk in taking NPS is uncertainties about what the active ingredients are and what these are being mixed with. Harm reduction messages should alert potential users to this fact, and what to look for if things go wrong.

3. RECOMMENDATIONS FOR DISCUSSION

Identified options and actions that could assist clinicians, educators, researchers and policy makers have been suggested by the sector and are outlined below for discussion.

1) Policy

1.1 Advocate for the adoption of agreed terminology for NPS, including agreed terms for various sub-categories of NPS (suggestions described in 4.1).

1.2 Advocate for the establishment of an NPS Expert Advisory Group to oversee the development of new resources, information and training initiatives.

1.3 Prepare and disseminate plain English fact-sheets and basic data on NPS to better inform key decision makers and politicians about the actual problem and the need for improved health solutions.

1.4 Advocate for the government to commission a report on the impact of its legislation including:
   - Information on the number of individuals charged
   - Any NPS data available from public health sources, including data relating to emergency department presentations
   - Any unforeseen consequences arising from the legislation, such as significant upswings in other drug charges.

2) Information and Education

2.1 Redesign and re-launch the Health NPS information, or establish a new youth-focused central NPS information source containing accurate information about NPS and advice on how to reduce harm.

2.2 Develop education resources for the community with a strong public health message. This should provide reassurance to parents about what is known, and also ‘what is unknown’ given the fast developing nature of NPS.

Suggestion: Given the evolving nature of NPS, the focus of community education and information should be on:
• Addressing the myths and misconceptions associated with NPS, particularly misconceptions related to their ‘herbal’ or ‘natural’ base and benign impacts
• Building understanding of the complexity of NPS and the lack of long term studies into their impacts
• Improving the safety of those who use NPS with practical advice on ways to minimise harm when purchasing and consuming specific types of NPS.

2.3 Develop new e-resources and apps on different types of NPS, specifically for potential users with a focus on harm reduction.

Suggestion: The focus should be on keeping the individual safe, therefore it needs to include information such as:
- How will I know when I am not okay?
- What should I look for in myself or my friends?
- What should I do if in trouble?
- Where can I go for help?

Suggestion: A free mobile app would be an effective means of communicating this to the target audience. The app could be included in the promotions of specific events, such as music festivals or schoolies week.

2.4 Advocate for NPS information and harm reduction advice to be included in high school and other youth health education resources and training, along with education on traditional drugs.

2.5 Develop new web based resources and fact sheets on different types of NPS specifically for clinicians. The website should be regularly updated to ensure clinicians can rely on the information.

2.6 Provide further opportunities for clinicians to share experiences and discuss good practice when working with clients using specific types of NPS.

Suggestion: NADA, or NSW Ministry for Health, to host further forums or convene a conference on NPS. Joint events between NADA and the NSW Ministry for Health have the potential for greater reach, and cost effectiveness.

2.7 Investigate developing NPS guidelines, or incorporate into existing guidelines. These should also be available for those working in aligned fields such as mental health, family and youth health, and generalist counselling.

Suggestion: In the meantime, clinicians should provide those evidence-based treatments that are recommended for the treatment of the traditional drug that the new drug is similar to.
2.8 Host other NPS forums and conferences to better educate non-clinicians including youth workers, school counsellors and family workers.

3) Services Responses and Treatment

3.1 Development of standardised intake tools to encourage clinicians to start prompting clients about the use of different types of NPS.

Suggested interim questions could include:
- Have you used anything that has been bought online, or from an adult store or tobacconist?
- Have you smoked synthetic cannabis, kronic or incense?
- How frequently are you using this substance?
- Is it being used in conjunction with other drugs?

3.2 Host additional NPS forums, conferences and training sessions to up-skill clinicians, with a specific focus on increasing knowledge, skills and capacity to work with clients who use NPS.

Suggestion: Include past users as presenters to provide first-hand insight into NPS and their effects, as well as what treatment options and education might be effective.

Suggestion: As it is expected that different regions see different usage patterns, there could be benefits from having regional workshops that incorporate local information sharing.

3.3 Utilise past NPS users in treatment programs and group work given the power of peer-to-peer education and the importance of encouraging conversations about usage.

3.4 Research and disseminate further information on the nature and treatment of withdrawal syndrome associated with NPS, as well as information on good practice in managing this with different substance types.

3.5 Establish mechanisms to enable clinicians to share information and advice in real time, particularly when new substances or presentations emerge.

3.6 Partner with the mental health sector to identify if mental health clinicians are seeing any impacts of NPS and identify opportunities for joint training or discussions of appropriate responses for clients with co-existing issues.
4) Data collection

4.1 Advocate for new standardised data fields to be included in National Minimum Data Sets and other standardised client information management and reporting systems, ensuring these are appropriately promoted across the sector.

Suggestion: Data fields need to provide some logical grouping of different categories of NPS. Fields could use chemical types so long as common names of NPS are also provided and regularly reported. This could include:
- Stimulant-like
- Cannabis-like
- Hallucinogen-like
- Other (please specify)……..

4.2 Amend NADA’s online data collection systems (NADAbase), including Client Outcomes Management System (COMS) to include appropriate NPS fields with sub-categories of types of substances, as above.

4.3 (As per 3.8) Partner with mental health bodies to implement data collection measures regarding NPS usage amongst mental health consumers.

5) Research

5.1 Prior to standardised NPS reporting implement a simple feedback system amongst NADA members to monitor NPS presentations and identify if there are any regional differences (see 4.1 above).

5.2 Investigate partnering with research organisations to initiate various NPS research projects. Topics might include:
   i) What NPS are currently being consumed in NSW? Under what names are they marketed?
   ii) What are the profiles and patterns of use of NPS users?
   iii) What are common NPS substances currently mixed with and what are the adverse or compounding risks of these?
   iv) What are the symptoms associated with NPS withdrawal (for example from synthetic cannabis)?
      What are the most effective interventions for these?
   v) What are the effects of specific NPS on mental and physical health? Where pre-existing health issues exist, does NPS compound the issues?
   vi) What are the early warning signs of NPS misuse for each category of NPS?
   vii) What are the most effective NPS treatment options (based on local and international experience)?

5.3 Disseminate all available NPS research as it becomes available, including the outcomes of current studies being undertaken (for example the current study by HNELHD).
Suggestion: Dissemination should include non-AOD sectors including mental health and youth sectors, and other related service provider networks.

5.4 Research what substances are currently captured in drug testing to ensure that providers know when they could be used and relied on.

4. USEFUL RESOURCES


Europe: The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Action on new drugs http://www.emcdda.europa.eu/activities/action-on-new-drugs

5. **NEXT STEPS**

NADA intends to explore the feasibility of implementing the recommendations that have come from sector and continue to promote best practices, and disseminate new research as it comes to hand. Where recommendations are outside of the scope of NADA, NADA will advocate on behalf of the sector, and investigate opportunities to partner with academia, Government, and broader sectors.

NADA welcomes comment on the *New and Emerging Psychoactive Substances Discussion Paper* to the contact details provided below.

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