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Club drugs can seriously harm the physical and mental health of those who use them... though only a small number of people need treatment for club drugs, the figure is creeping upwards

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# **CLUB DRUGS: EMERGING TRENDS AND RISKS**

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# Club drugs: emerging trends and risks

‘Club drugs’ is a collective term for a number of different substances typically used by young people in bars and nightclubs, at concerts and parties. These drugs can be harmful and heavy use can develop into a dependency.

Data collected since 2005-06 now tells us enough to form an idea of the scale and nature of the problems associated with the more established club drugs – ecstasy, ketamine, methamphetamine, GHB/GBL, and mephedrone.

What is becoming clear is that despite the widespread use of club drugs, they are currently causing a treatment problem for relatively few people. There is no evidence to suggest they are replacing the most damaging substances, heroin and crack, as drugs of dependency, but they can seriously harm the physical and mental health of the people who use them. Though only a small number of people need treatment for club drugs, the figure is creeping upwards. There is an inevitable time lag between first use and developing a dependency, so we do not yet know how many more may require treatment in the years to come.

But those club drug users who need help tend to respond well. Unlike typical heroin and crack users, they often have the good personal resources – jobs, relationships, accommodation – that mean they are more likely to make the most of that treatment...

## The report headlines

**1** While overall drug use has declined, the number of people needing treatment for club drugs has risen. Club drug users make up just 2% of over-18s and 10% of under-18s in treatment

**2** Club drugs aren't replacing more traditional drugs, such as heroin and crack, as different populations tend to use them. But club drugs can cause serious health problems and can lead to dependency

**3** As many as one million people may use club drugs. The delay between people using a club drug for the first time and developing a dependency means treatment figures could grow further

**4** Club drug users do well in treatment. Last year, 61% of over-18 and 74% of under-18 club drugs users who left treatment did so successfully. Club drug users typically have good personal resources

**5** With new substances emerging all the time, treatment services must remain vigilant and adaptable. For this to happen, continued investment is vital

# “Club drug users differ in many ways to the traditional drug treatment population”

## The extent of club-drug use

The British Crime Survey says the number of 16-59 year olds using drugs is falling: 3.3 million used in 2005, but this had fallen to 2.9 million in 2011. Cannabis, the most popular drug, dropped from 2.8 million in 2005 to 2.3 million in 2011. Over the same period, powder cocaine fell from 770,000 to 703,000. Other research shows the peak of 332,000 heroin and crack users in England in 2005-06 fell to 306,000 in 2009-10.

Despite this decline in overall use, around one million adults are estimated to have used club drugs in 2011-12. Ecstasy is used the most, but its popularity is waning: use is down from 502,000 in 2005-06 to 461,000 in 2011-12. Ketamine use has changed little over the last three years, hovering at around 200,000 adults. Just 0.1% of the adult population recently used either GHB/GBL or methamphetamine.

Last year, 6,486 people (4,479 over-18s, 2,007 under-18s) were treated for a club drug – up from the 2005-06 figure of 4,656 (3,122 over-18s, 1,534 under-18s). Most of this increase comes from more people receiving treatment for ketamine and mephedrone. However, club drug users make up just 2% of adults and 10% of young people in treatment.

## ALL OVER-18s IN TREATMENT FOR CLUB DRUGS 2005-12

2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
3,122	4,131	4,485	4,321	4,052	4,407	4,479

## ALL UNDER-18s IN TREATMENT FOR CLUB DRUGS 2005-12

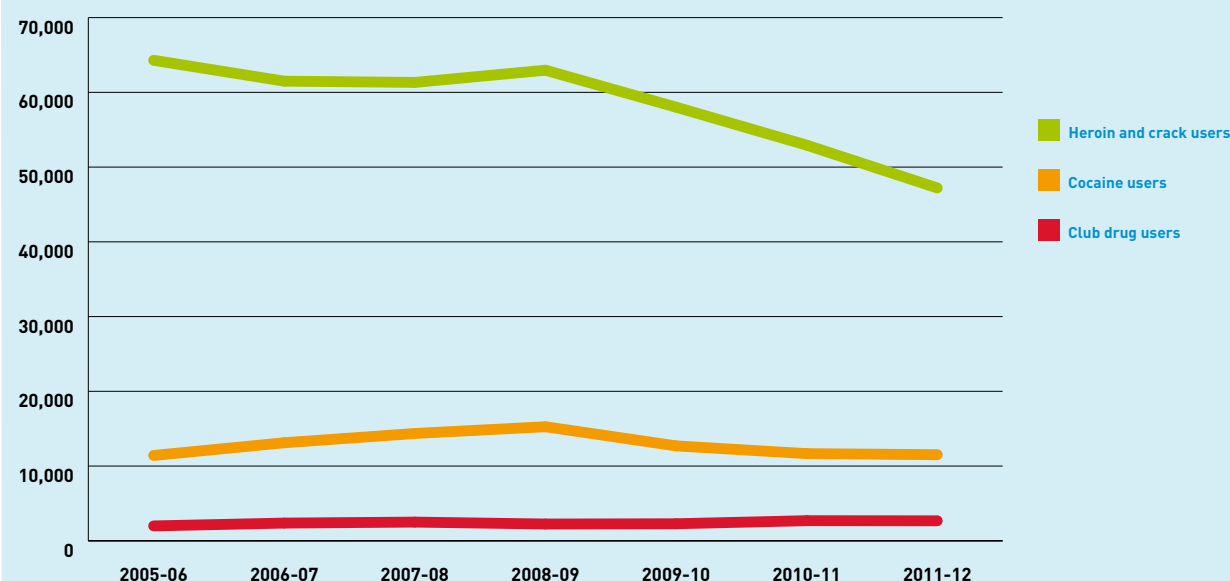
2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
1,534	2,168	2,390	1,831	1,556	1,975	2,007

Club drug users also differ in many ways to the traditional drug treatment population. Addiction psychiatrist Dr Adam Winstock says: ‘They respond well to treatment. But they tend to be a group whose level of functioning is quite high next to heroin and crack users. They’re not broke, they don’t have criminal records, and they have sought treatment voluntarily before getting arrested or something else bad has happened. I don’t think you can say it’s the drug; it’s the particular people who use this drug. Interestingly, they are people who wouldn’t necessarily run into problems if drugs like mephedrone and ketamine hadn’t been around.’

## Effects, settings, harm and dependency

Despite the rising popularity of club drugs among users, this has not translated into a dramatic increase for treatment. And

## 1. Over-18s new presentations for club drugs compared to other drugs, 2005-12



## “A small number of users get into significant difficulties”

while club drugs may not be as harmful to individuals and society as heroin and crack, they do present a real health risk to users.

Club drugs have a variety of effects. Ketamine, for example, distorts sight and sound perception, and produces feelings of detachment. Ecstasy users report increased energy, euphoria and empathy (see page 8 for more). Consultant psychiatrist Dr Owen Bowden-Jones, who runs a club drug clinic in London, says: ‘Many of these drugs have stimulant and hallucinogenic properties similar to ecstasy. The exceptions are GHB/GBL, which act more like alcohol and have a high risk of overdose.’

Consultant clinical psychologist Dr Luke Mitcheson, whose service treats club drug users, says: ‘Recreational drug use has diversified and the way people socialise has changed, so you see people using these drugs in pubs, at festivals, and at home.’ Dr Bowden-Jones adds: ‘The majority of the drugs we see are initially used in clubs or house parties and gradually spread to other settings.’

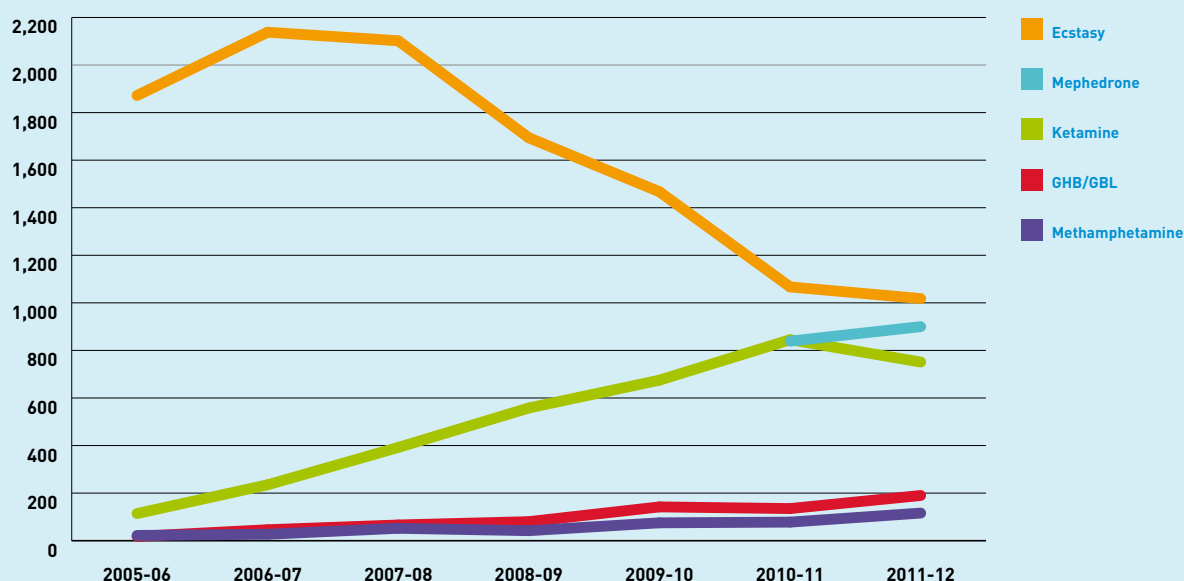
Dr Winstock has monitored these drugs for several years: ‘If you go clubbing, you take more drugs. But there are lots of people who don’t go clubbing and still take drugs.’

Users also tend to binge on these drugs. As a result, they are more likely to show up at A&E or their GP surgery reporting acute health effects such as heart irregularities or feeling paranoid. Evidence suggests a minority will use compulsively and develop a psychological dependence that requires treatment. ‘We don’t yet understand why some people develop problems and others don’t’, says Dr Bowden-Jones. Dr Mitcheson adds: ‘With most substances there are generally a proportion of users who experience problems, so increased use will be reflected in treatment stats.’

A small number of users get into significant difficulties. The problems they face depend on the drug. Dr Bowden-Jones says mephedrone and methamphetamine users can show signs of psychosis and mood disturbance, while GHB/GBL users report severe dependence and withdrawal. Dr Winstock says: ‘Ketamine is particularly nasty. It is moreish, cheap and has a horrendous comedown.’ Heavy use can turn into a dependency with physical effects such as bladder pain and damage.

Both have seen worrying trends among some of the people they treat: ‘Two years ago there were no reports of people injecting mephedrone,’ says Winstock, ‘now there are.’ NDTMS figures show that 8% of over-18 club drug users new to

### 2. Over-18s new presentations by club drug, 2005-12



## “Treatment services need to be alert to new trends and to adapt current treatment approaches accordingly”

treatment report injecting (most likely linked to concurrent heroin use among the small minority of club drug users who also use heroin or crack). It appears to be a growing issue among a minority of people who use only club drugs (up from 6% to 8% in the four years to 2011-12, bucking the overall decline in injecting). This rise in injecting is likely a result of high rates among methamphetamine (24% in 2011-12) and GHB users (9% in 2011-12). While injecting is currently a lesser problem among club drug users, it should remind treatment services that dependent club drug use can involve riskier drug-taking practices.

Reflecting on recent trends, Dr Winstock says: ‘With new drugs such as mephedrone there is a honeymoon period, and now we are seeing people who are having problems. Its risk profile fits with other drugs such as GHB, GBL and ketamine, which have been around for a decade. Heavy users report deterioration in personal functioning, low moods, and lack of control.’

### Treating club drugs

Treatment typically involves psychosocial interventions, which address basic motivation and prevent relapse. Dr Winstock: ‘It’s important to offer to detox people for GHB and GBL, and

you perhaps need more skill in basic assessments and being aware of the sort of problems people might talk about. But I think the rest of the treatment is much the same.’ Dr Bowden-Jones: ‘Treating club drugs requires all the skills used for other drugs, but also benefits from links with other services, such as urology for ketamine users, sexual health for methamphetamine users and acute medical services as back up for GHB/GBL detox.’

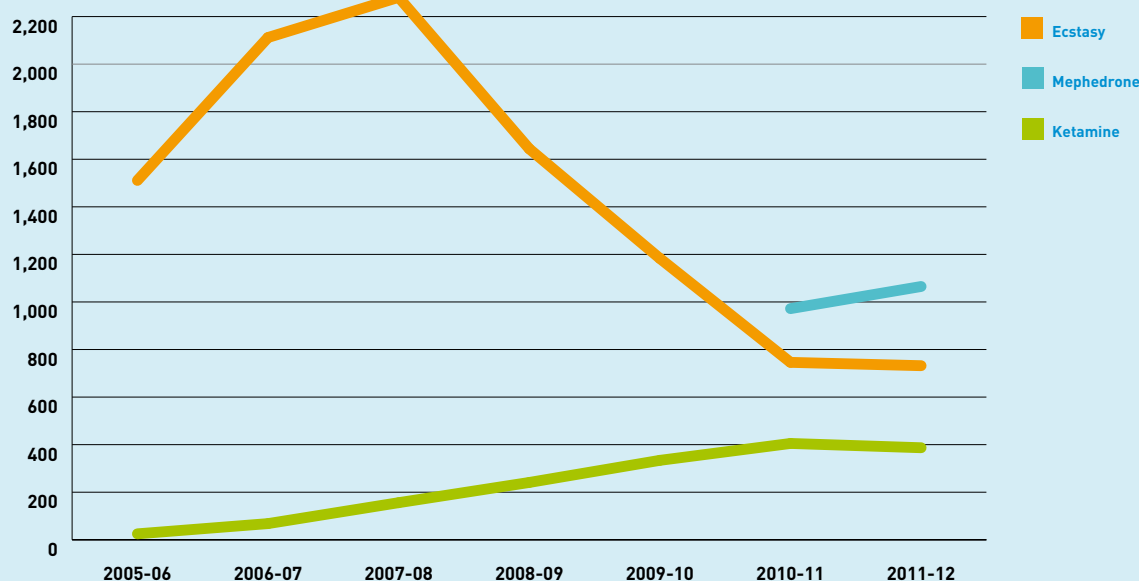
According to Dr Mitcheson, club drug users come into services either via walk-in clinics or a GP referral, often after ‘a serious incident, the concerns of friends or family or an individual’s own concerns about their health’.

All the experts say treatment services need to be alert to new trends and to adapt current treatment approaches accordingly. ‘Word of mouth among users raises the profile of the work we do,’ says Dr Mitcheson. ‘There is an argument for promoting services among specific populations where particular drug use is known to be high, such as gay men who use GBL.’

### The people who need treatment

Last year, 4,479 adults were treated for a club drug problem, 2,675 of whom started treatment in 2011-12. These new

### 3. Under-18s in treatment by club drug, 2005-12



## “This group is often easier to treat than heroin addicts and tends to do better in treatment”

entrants to treatment make up a fraction (4%) of the total intake of about 70,000 (including more than 47,000 for a heroin and/or crack problem).

Ecstasy remains the most commonly treated club drug for over-18s. However, numbers entering treatment for ecstasy have halved from 2,138 in 2006-07 to 1,018 last year (from 90% of new club drug presentations to 38%).

As ecstasy numbers have fallen, ketamine and mephedrone cases have risen. Ketamine presentations rose year-on-year between 2005-06 and 2010-11, from 114 to 845, falling back to 751 this year. This year 900 over-18s started treatment for mephedrone, compared to 839 last year.

With only two years of treatment data, we cannot be sure what the long-term treatment demand for mephedrone will be. Presentations for GHB/GBL and methamphetamine are also gradually increasing, though overall numbers remain low.

The overall effect is a modest rise (under 700) in new over-18 club drug treatment presentations during the past seven years (1,991 or 2% of the 2005-06 intake, now 2,675 or 4%). This pattern echoes prevalence statistics that show mephedrone and ketamine have joined ecstasy as the club drugs of choice for many.

Most over-18 club drug users are relatively young, whereas the heroin and crack users in treatment are getting older. Last year 43% of all over-18s treated for club drugs were aged between 18-24 (56% of mephedrone, 49% of ketamine and 37% of ecstasy cases were 18-24). This group is typified by a minority of younger, poly-drug users whose prolonged binges on club drugs leads to a dependency.

In contrast, 70% of methamphetamine and over half of all GHB/GBL users in treatment were in their 30s or older. This group may be typified by older male users being treated for these and possibly other drugs – a by-product perhaps of the popularity of these drugs among LGBT clubbing communities. NDTMS does not record enough data to confirm this, but Dr Bowden-Jones says his clinic treats two broad groups: ‘LGBT people form a large part of the clinic, with the other made up of heterosexual clubbers and students.’

According to emerging clinical opinion and data, club drug users are often highly educated, have jobs and are socially

functional. They start using as a lifestyle choice, but go on to develop a dependency that requires treatment. Dr Winstock says they are not typical injecting drug users and their drug use neither defines them nor consumes their daily routine as it does with heroin and crack users.

Just over 2,000 under-18s had help for a club drug problem in 2011-12, one in ten of all the under-18s seen by services (they also saw 13,200 under-18s for primary cannabis use and 5,884 for alcohol).

Under-18 ecstasy presentations have fallen by 68%, from 2,281 in 2007-08 to 732 last year. Some of this has been offset by a rise in ketamine cases (25 in 2005-06 to 405 in 2010-11, but back to 387 in 2011-12).

Just over 1,000 under-18s were treated for mephedrone, up almost a hundred from the previous year. Typically in any one year, around ten under-18s are seen for either GHB/GBL or methamphetamine.

Most under-18 club drug users seen by specialist services are aged 15-17 (87%).

### Successful treatment

Last year 61% of all treatment exits involving over-18 club drug users were successful, compared to 28% in 2005-06.

Young people’s specialist services have also got better at dealing with club drug users. Last year, 74% of under-18 club drug users who left treatment successfully completed their programme, up from 48% in 2005-6.

The treatment system expanded to deal with the heroin epidemics of the 1980s and 1990s, and it is now more responsive to people addicted to other drugs, such as cocaine and cannabis. Just as the system has got better at dealing with these drugs, those with a club drug problem are now more likely to recover than ever before.

Club drugs users’ success rates suggests this group, like those treated for powder cocaine and cannabis, is often easier to treat than heroin addicts and tends to do better in treatment. A likely contributory factor is that they have fewer associated social problems and can draw on greater personal resources.

# “With new substances arriving on the market all the time, treatment services need to remain vigilant”

## Conclusion

Club drug users are a minority group in treatment, making up just 2% of over-18s and 10% of under-18s in contact with services. Once in treatment, club drug users do well. Last year, 61% of all over-18 and 74% of under-18 club drug users who left treatment did so successfully. This is to be expected given the typical personal resources this group can call upon.

This could stay a relatively small problem or it could become more significant. Only time will tell. It is also possible that some people with a club drug problem have not yet found their way into treatment, but services are increasingly alert to the issues these drugs can cause and need to be ready to provide help to anybody who needs it. We don't yet know the long-term consequences of club drugs, but the problems they currently cause are more related to the user's health, whereas heroin and crack use also has a wider societal impact on crime and worklessness. However, the nature of the substances and the population that uses them mean that club drugs are unlikely to replace heroin and crack as the drugs that generate the biggest demand for treatment.

But with new substances arriving on the drugs market all the time, treatment services need to remain vigilant to new trends and adapt their treatment approaches accordingly. Services in England have a good track record of this. Continued investment in services will be important if this success in adaptation is to be continued with newer substances. ■

In 2012, the NTA interviewed a group of expert practitioners who all treat club drugs or have other club drugs expertise:

- (1) Dr Owen Bowden-Jones (consultant psychiatrist at Central and North West London NHS Foundation Trust and clinical lead at the club drug clinic at Chelsea and Westminster Hospital)
- (2) Dr Adam R Winstock, addiction psychiatrist working for the South London and Maudsley NHS Foundation Trust and senior lecturer in addiction psychiatry (IoP). Adam is the managing director and founder of Global Drug Survey which has run online surveys about use of club drugs and other substances
- (3) Dr Luke Mitcheson is a consultant clinical psychologist working for the South London and Maudsley NHS Foundation Trust. He is currently a senior clinician and treatment service manager in Lambeth.

## 4. A user's story

*David (not his real name) was treated at the club drugs clinic at the Chelsea and Westminster hospital last year. His relationships with family and close friends have remained strong throughout, and he has held on to his job:*

### When did you first starting using newer types of drugs such as mephedrone?

In my teens in clubs. Es and some speed. It's been up and down since then but the last two years have been madness because of the ketamine and mephedrone. It spiralled out of control and ended as a total mess.

### When you realised you had a problem, what did you do?

My problems really started when my girlfriend left. She did drugs too but not like me and she just got fed up. After that it really got out of hand. There was nothing else going on and it seemed like fun. I ran out of money and got into debt but then I was caught using at work. That was when it all fell apart. The worse it got the more I used. Simple as that, until I started freaking out with depression, voices, pissing blood – you name it, it's happened to me in the last few months.

### How did you find your way into treatment?

A mate was getting help at the club drug clinic and told me about it. So I went with him and met the doctor. I felt like he'd seen lots of people like me before and there was no bullshit. I knew straight away that I needed the help and this was a chance I had to take.

### What has your treatment consisted of?

I meet with my key worker each week to go through the plan. She's brilliant and it's helped to go through things. I've seen an urologist to sort the bladder out. It still hurts but at least I don't need to go every ten minutes. I also see the doctor for my depression. The voices have gone since I stopped using but I still feel pretty miserable sometimes.

### What aspects of your life have improved?

Looking back, I can't believe what a state I was in. A real mess. I've not used for two months and feel so much better. Work have been very understanding and I've just gone back. It feels like normal service is resuming.

## CLUB DRUGS: EFFECTS, HARMS, DEPENDENCE AND TREATMENT

Drug	Effects and patterns of use	Harms	Dependence and treatment
<b>Ecstasy</b> (also known by its chemical name, MDMA or methylenedioxymethamphetamine) is a synthetic derivative of amphetamine which has both stimulant and mild hallucinogenic properties.	Ecstasy users report increased feelings of euphoria and solidarity, heightened sensory awareness and ease of contact with others. As a stimulant type drug, binging rather than sustained regular use seems to be the normal pattern of use.	Short-term effects of use can include anxiety, panic attacks, confused episodes, paranoia and even psychosis. Anyone with a heart condition, blood pressure problems, epilepsy or asthma can have a very dangerous reaction to the drug. Evidence suggests long-term users can suffer memory problems and may develop depression and anxiety. There have been over 200 ecstasy-related deaths in the UK since 1996.	Heavy, frequent users can show signs of psychological dependency that may require treatment. Treatment involves psychosocial interventions that address motivation and relapse prevention.
<b>GHB</b> (gammahydroxybutrate) and <b>GBL</b> (gammabutyrolactone). Originally synthesised for use as an anaesthetic, these are used recreationally for their sedative and anaesthetic effects. GBL is converted to GHB shortly after entering the body.	Both are used recreationally to produce a feeling of euphoria, can reduce inhibitions and cause sleepiness.	Both can kill and are particularly dangerous when used with alcohol and other depressant or sedative substances. Severe intoxication can lead to loss of consciousness, breathing difficulties, cardiac depression, nausea, seizures, confusion and agitation.	Heavy, frequent users can become dependent. Treatment requires a medically supervised detoxification to manage physical withdrawal. Otherwise involves psychosocial interventions that address motivation and relapse prevention.
<b>Ketamine</b> is an anaesthetic, used recreationally.	Can cause hallucinations, with many users experiencing a distortion of reality and a floating feeling as if the mind and body have been separated. It can also reduce sensations in the body, making some people physically incapable of moving while under the influence.	High doses, especially when taken with other substances like alcohol, benzodiazepines or opiates, can dangerously affect breathing and the heart, and can lead to unconsciousness. Combined use with ecstasy or amphetamines can cause high blood pressure. With regular or large doses, ketamine can make existing mental health problems worse, and can cause feelings of confusion, panic attacks and depression. Heavy, frequent ketamine use can cause very serious bladder problems, with severe pain and difficulty passing urine, and left unchecked can even result in surgical removal of the bladder. Abdominal pain or 'K cramps' have been reported by many long-term users.	Heavy, frequent users can become dependent. Treatment involves psychosocial interventions that address motivation and relapse prevention and in more serious cases medical treatment of bladder damage.
<b>Methamphetamine</b> is a derivative of amphetamine. The pure crystalline form is sometimes known as 'Crystal Meth' or 'Ice' and may be smoked, achieving as rapid or even more rapid onset of effects than injection of the powder form.	As a stimulant-type drug, binging rather than sustained regular use seems to be the typical pattern of use. Effects range from feeling exhilarated and alert to feeling agitated, paranoid, confused and aggressive. Smoking the crystal form of methamphetamine, sometimes called crystal meth or ice, gives an intense 'high' similar to crack cocaine but much longer lasting - between four and 12 hours. It can also lead to reduced appetite, increased levels of activity and feelings of arousal, lowered inhibitions and increased heart rate and blood pressure, raising the risk of heart attack.	Long-term use can cause brain damage and psychoses. Can also lead to strokes and cause lung, kidney and gastrointestinal damage. As inhibitions are lowered and libido increased, methamphetamine use can lead to unsafe sex, transmission of sexually transmitted disease or unplanned pregnancy. Some local reports of high rates of methamphetamine injecting and very high risk sexual behaviours in LGBT patients.	Methamphetamine's mood elevating properties lends itself to abuse among users and periods of sustained regular use, particularly the smokable form of the drug, can lead to dependence. Treatment involves psychosocial interventions that address motivation and relapse prevention.
<b>Mephedrone</b> is part of the cathinone family of drugs, derived from the khat plant. It is a stimulant closely related to amphetamine, methamphetamine and ecstasy.	Effects range from euphoria, alertness and feelings of affection for others to feelings of anxiety and paranoia. It affects people's heart, circulation and nervous system, with risk of fits.	We have very little evidence about mephedrone and its long-term effects. Acute intoxication can cause agitation, seizures, headache and reduced appetite. Users have reported blue or cold fingers - this is probably because the drug affects the heart and the circulation. Others report severe nosebleeds after snorting the drug. Deaths involving mephedrone have been reported, overheating caused by combined use alongside other drugs, such as ecstasy, have been used along with mephedrone.	Emerging clinical reports suggest that mephedrone is similar to amphetamine in terms of abuse and dependence potential. Treatment involves psychosocial interventions that address motivation and relapse prevention.