ACMD

Advisory Council on the Misuse of Drugs

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Rt. Hon. Priti Patel MP
Home Secretary
2 Marsham Street
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Wednesday, 28 October 2020

Dear Home Secretary,

Re: ACMD Report – Synthetic Cannabinoid Receptor Agonists

In February 2019, the then-Home Secretary commissioned the Advisory Council on the Misuse of Drugs (ACMD) to conduct a longer-term review of cannabis-based products for medicinal use (CBPMs) and synthetic cannabinoids.

The synthetic cannabinoid component of this commission asked the ACMD to provide an updated harms assessment to the ACMD's previous reports on synthetic cannabinoids, and to make its recommendation on whether the current classification of synthetic cannabinoids under the Misuse of Drugs Act 1971 (MDA) and scheduling under the Misuse of Drugs Regulations 2001 (MDR) is appropriate.

The ACMD is pleased to enclose this report on Synthetic Cannabinoid Receptor Agonists (SCRA) which examines evidence of harm that has emerged since it last provided advice on SCRA in November 2014.

From the evidence presented the ACMD have drawn the following conclusions and recommendations:

Conclusions

1. A large number of SCRA compounds have been prevalent in Europe and in the UK in recent years. Evidence suggests that the main location of synthesis is China.

2. SCRA are typically provided as herbal smoking mixtures or sheets of paper sprayed with SCRA solution, which is then smoked by the user. Other methods of administration include vaporising (‘vaping’) SCRA liquid solutions or ingestion of pills or powders.

3. Over the past 5 years, the most prevalent SCRA compounds identified in the UK are all captured by the current third generation generic control and are therefore classified as Class B drugs under the Misuse of Drugs Act 1971.

4. There are examples of ‘fourth-generation’ SCRA that have been encountered in Europe, but these are currently not prevalent in the UK, although continued monitoring for their potential emergence remains important.

5. SCRA users are most commonly males and an important minority are under the age of 18 years. There is evidence that the overall prevalence of NPS use, including herbal smoking blends (predominantly SCRA), has declined in the UK since 2016, with consequent reductions in poisons centre referrals. Deaths related to SCRA may be underestimated as these compounds may not be routinely tested for in drug screens. Deaths in which SCRA have been identified analytically increased in frequency up to 2018 and occurred more frequently in winter. Limited data are available after 2018.

6. While overall population use of SCRA has declined in recent years use of SCRA is most prevalent in areas of high deprivation and is common in the homeless population and in custodial settings, driven by their 'mind-numbing' effects, low cost and difficulty in analytical detection.

7. Since the ACMD last reported on these compounds, further evidence has emerged of the physical, mental health and social harms of SCRA. Adverse effects can include loss of consciousness, sometimes associated with respiratory depression, rapid heart rate, nausea and vomiting, agitation, confusion, behavioural disturbance with aggression and violence, psychosis and seizures. Cardiac dysrhythmias, cardiac arrest, myocardial infarction, stroke and acute kidney failure have also been reported. Longer term effects associated with SCRA use include mood disorders, anxiety, depression and suicidal thoughts, and there is some emerging evidence of adverse impacts on memory and cognition.

8. There is also increasing evidence of pharmacological tolerance, dependence and withdrawal effects with SCRA use. SCRA are described by users as more addictive than other substances and users may need to smoke SCRA frequently to avoid withdrawal symptoms. Intensive support including medication and in-patient admission may be needed but drug treatment services may not be available or may not appear suitable to SCRA users.

9. Social harms associated with SCRA use include acquisitive crime and sex work to fund purchase of SCRA, violence, exploitation and victimisation. Those under the influence of SCRA may be victims of crime, including sexual assaults. Use in prison may be associated with debt, bullying, aggression, unpredictable behaviour and violence. Prisoners may be exposed to high doses of SCRA, either knowingly or after surreptitious administration ('spiking') for other inmates to be entertained by their effects.

10. The ACMD has previously provided advice relevant to populations that have a high prevalence of SCRA use. These reports are ‘Drug-related harms in homeless populations and how they can be reduced’ and ‘Custody-Community Transitions (CCT)’. In these reports, recommendations were made by the ACMD for the Government to offer more integrated and targeted services to the homeless with improvements to be made in outreach and peer mentoring programmes in order to engage and retain homeless people in proven treatments. Furthermore, it has been recommended that the services in contact with the homeless should receive better training to obtain skills in dealing with complexity and in retaining homeless drug users in treatment. Further recommendations have also been made to reduce the stigma held by services providers who are employed to support people that are homeless and engaged in substance use.

Recommendations

1. The ACMD has reviewed the available evidence of harms from SCRA use and recommends that the current classification of all SCRA controlled by the MDA, either under the synthetic cannabinoid generic definition or listed by individually by name remains appropriate. These substances should therefore continue to be controlled under Class B of the Misuse of Drugs Act 1971.

2. The ACMD has reviewed potential uses of SCRA and recommends that the current scheduling of all SCRA in the Misuse of Drugs Regulations 2001, either under the synthetic cannabinoid generic definition or listed by individually by name remains appropriate. These substances should therefore, continue to be placed in Schedule 1 of the Misuse of Drugs Regulations 2001 on the grounds that they currently have no recognised medicinal use.

3. National user surveys should explicitly collect or continue to collect data on emerging substances of misuse. These should include the Crime Survey for England and Wales (CSEW), Scottish Crime and Justice Survey (SCJS), the Northern Ireland Health Survey series, and Smoking, Drinking and Drug use among young people in England (SDD) survey.

4. Guidance on a UK-wide minimum standard set of post-mortem toxicology tests is developed for apparent drug-related deaths, to include testing for novel psychoactive substances. This would include agreed reporting standards.

5. a) Toxicology analysis of samples from deaths thought to be drug-related, where there is no obvious toxicological cause, should include prevalent SCRA, including 'fourth-generation' SCRA reported in global drug markets. Where this testing is not possible because of inadequate resources, low sample volume, or another reason, toxicology reports should include a clear statement that a SCRA test has not been carried out. If SCRA testing has been carried out, a list of the compounds included in the test should be included in the toxicology report. Information on prevalent compounds should be available to coroners and forensic toxicologists, who should take this into account when deciding on the substances to be tested for. Forensic toxicologists should discuss important limitations of their analysis in their reports to the coroner.

   b) Local partnerships undertaking learning reviews of drug related deaths within their populations to be clear about the extent to which SCRA have or have not played a role in the death. Furthermore, to identify any local trends and patterns, and respond accordingly to reduce the future incidence of harm and deaths from SCRA.

6. The Forensic Early Warning System (FEWS) should provide support to improve analytical capabilities of toxicology laboratories nationally. Toxicology laboratories should have access to:

   (a) regularly updated information about SCRA that are currently prevalent in the UK, and reference materials (as provided by FEWS), and/or

   (b) a centralised screening service that can offer technical assistance when needed for the accurate identification of the SCRA present in relevant samples they process.

   Adequate resource should be made available to FEWS for these functions.

7. Surveillance should be commissioned to establish improved systematic monitoring of the prevalence of novel psychoactive substances, including SCRA, in relevant samples across the UK. These might include:

   a) drug seizures;
   b) waste water (including targeted studies); and
   c) biological samples from users.

   This surveillance should encompass those with non-fatal toxicity, including those attending emergency departments, mainstream drug services and special or vulnerable populations, such as the homeless and prisoners.

   Data should be consolidated and made available to those responsible for the investigation of drug-related deaths as well as authorities responsible for advising on clinical management and public health protection.

8. Assertive outreach teams should have the competencies and capacity to allow earlier identification and referral of those with problematic SCRA use. Community, residential and custodial treatment services should be specifically commissioned and appropriately funded to work with SCRA users. Treatment providers should survey existing clients to establish the burden of SCRA use for those already in treatment.

   Commissioners and treatment providers should work with other relevant organisations to ensure that SCRA-specific care pathways and structured tools are available. This should include assessment for signs of dependence and physical health harms, management of psychosis and withdrawal, and interventions to minimise the social impact of SCRA use. Examples of good practise should be shared between services and availability and use of these tools should be audited.

9. Training should be provided to all professional staff who may encounter SCRA users and delivery of this training should be subject to audit. Educational material should also be available that is tailored for SCRA users.

10. Research involving SCRA should be commissioned, including (but not limited to) the following areas:

    - pharmacology and toxicology of prevalent and emerging SCRA;

    - optimum management of acute SCRA intoxication, including evaluation of potential therapies;

    - development of accurate field tests for SCRA that can adapt to changes in the drug market;

    - longer-term health effects of SCRA use, including effects on memory and cognition and on reproductive and foetal health; and

    - development and validation of structured tools for rating intoxication and withdrawal states.

The ACMD has noted that the need for standardised testing and reporting in the analysis of drug-related deaths has now been identified in a number of ACMD reports. As discussed in this report, as well as in the ACMD's report on the misuse of fentanyl and fentanyl analogues (published in January 2020), the lack of a consistent testing mechanism across the UK undermines our capability to understand the prevalence and threat of specific substances.

As noted above, recommendations have been provided in this report on how to address this issue in the context of SCRA detections. However, the ACMD have agreed that further consideration should be given to this cross-substance issue and will consider providing advice on this issue in the coming months.

Additionally, a recommendation has been made in this report on the scheduling of SCRA under the MDR. Separately, the ACMD have also been assessing written submissions from researchers in response to an ACMD Call for Evidence regarding barriers to legitimate research with synthetic cannabinoids. The ACMD will issue recommendations to Government in due course to mitigate the issues identified.

We look forward to discussing the enclosed report with you in due course.

Yours sincerely,

Professor Owen Bowden-Jones
Chair of ACMD

Professor Simon Thomas
Chair of ACMD NPS Committee

CC: Kit Malthouse MP (Minister of State for Crime and Policing)