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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Friday 20 November 2020

Dear Home Secretary,

Re: Review of the classification and scheduling of GHB, GBL and closely related compounds

We are pleased to enclose the report of the Advisory Council on the Misuse of Drugs (ACMD) on GHB, GBL and closely related substances (GHBRS). This report is in response to your commission of January 2020, which sought the advice of the ACMD on classification under the Misuse of Drugs Act 1971 (MDA), and scheduling under the Misuse of Drugs Regulations 2001 (MDR), prompted by the suspected use of these substances in a number of criminal cases.

Classification and scheduling on their own are unlikely to be sufficient to significantly reduce the harms associated with GHBRS use. The ACMD has therefore broadened the scope of this report to include a number of comprehensive and interlinked recommendations which should be taken forward as a whole. Furthermore, it is important to consider these recommendations together in order to mitigate any unintended consequences.

In this report the following conclusions were reached:

- **There is a need to develop systems for future monitoring of the prevalence of GHBRS use and the harms they cause.** It is estimated that overall use of GHBRS in the UK, and in each devolved administration, is low – with more evidence of use in England than in the other devolved nations. There is consensus across the literature that there was a steep increase in GHBRS use in the UK, specifically in England, from 2005 to 2015. Since 2015 the evidence suggests a plateauing in use; albeit with a small and steady pattern of use and harm. However, prevalence estimates are challenging in the absence of general population data in the UK, and with no systematic data

collection. There is also a likely underestimate of harm due to the fast elimination of GHBRS from the body and subsequent difficulties identifying GHBRS in:

- post-mortem samples;
- emergency department (ED) admissions;
- sexual health and drug misuse services; and
- criminal investigations.

- **There is evidence of increasing mortality associated with GHBRS use since the ACMD last considered harms of GHB in 2003, and gamma-butyrolactone (GBL) and 1,4-butanediol (1,4-BD) in 2008.** Although the overall number of deaths is relatively low there was a steep rise in deaths between 2008 and 2015. There is more recent evidence that GHBRS have a higher risk of fatality when GHBRS mortality is compared with novel psychoactive substances (NPS) drugs. However, mortality figures are likely to be an underestimate due to the challenges in testing for and identifying GHBRS in post-mortem samples, due to both rapid elimination and endogenous GHB production post-mortem. Mandatory testing for GHBRS in cases of unexplained death would improve data on GHBRS mortality. Although there are several reasons why testing for GHBRS may not be possible or appropriate in all cases of unexplained death, a statement to the effect of why it has not been done, or the result of the test, would improve data on mortality associated with GHBRS.

- **GBL and 1,4-BD are pro-drugs for GHB and have a similarly steep dose-response curve as GHB, meaning their physical and psychoactive effects are very similar to GHB.** Although there was some evidence to suggest that GBL was slightly more potent than GHB, the harms associated with GHB, GBL and 1,4-BD were broadly comparable – meaning that it would be appropriate to classify all three under the same class of the MDA.

- **There is increasing evidence of physical, mental and social health harms related to GHBRS.** Of particular note are the new harms identified since the ACMD last considered GHBRS - severe harm from crimes facilitated by GHBRS and mental health harms associated with GHBRS use.

- **There is limited evidence of harms and prevalence of GHV and GVL misuse and therefore the control of these compounds under the MDA at this time is not recommended.** These compounds should be monitored by the ACMD and considered subsequently for control, should evidence emerge of associated harms or increased prevalence of use due to a shift towards these substances as a result of the recommended re-classification of GHB, GBL and 1,4-BD. GHV and GVL will not need to be scheduled under the Misuse of Drugs Regulations 2001.

- **There is a need to disrupt the unrestricted sale from suppliers of GBL and 1,4-BD on the open-web purporting to be 'cleaning materials' when clearly destined for the illicit market.** While a licensing regime would 'catch out' illegitimate suppliers, large-scale legitimate chemical suppliers would most likely be able to adapt to the imposition of a licensing regime for GBL

and 1,4-BD. There is limited prevalence of the utilisation of GBL and 1,4-BD among the UK chemical industry, and there is an existing framework (the controlled drug licensing regime) that can be used to control GBL and 1,4-BD. Additional controls could also mitigate the risk of diversion of GBL/1,4-BD from the chemical industry to the illicit market. Given the large volumes (multiple litres) that can often not be accounted for by the chemical industry, there is an argument that regulatory oversight could be beneficial in these settings.

- **GHBRS can cause profound unconsciousness and its steep dose-response curve puts the user at risk of overdose and death.** The harm from this is exacerbated by imprecise recreational dosing. The co-ingestion of alcohol, and other depressants such as benzodiazepines, is a significant additional risk factor for overdose and death.

- **GHBRS also have a particularly severe, life-threatening withdrawal syndrome.** Physical dependence on GHBRS develops quickly (over a few weeks to months depending on frequency of use), and withdrawal symptoms can develop within a few hours of cessation. In addition, effective clinical management is challenging due to the difficulties identifying the withdrawal syndrome, followed by resistance to treatment (benzodiazepines) and the high intensity of detoxification (treatment contacts and duration). This makes reducing the harms from GHB withdrawal challenging for clinicians, leaving individuals more exposed to harms from withdrawal. In addition, there is consensus within the literature that GHBRS withdrawal has high relapse rates after detoxification, meaning once an individual is addicted it is difficult for them to break the addiction cycle. The literature is also consistent in recommending that more research is needed to investigate effective clinical management of withdrawal, and effective relapse prevention.

- **There is increased evidence that GHBRS toxicity is significantly represented in hospitals and clinical care settings in London.** When this is considered alongside the estimated low prevalence of GHBRS use at a population level, it suggests that GHBRS harms are over-represented in hospitals, suggesting that harm from GHBRS may be higher than other drugs.

- **There is evidence that GHBRS use is associated with sleep disturbances, anxiety and mood disorders.** There is also new and emerging evidence of the occurrence of GHB-induced coma negatively impacting on an individual's ability to regulate emotions, and of GHBRS possibly causing negative effects on associative long-term memory processing and performance.

- **In addition to harms from overdose and withdrawal, there is also new evidence of mental health harms and harm from crimes facilitated by GHBRS, both of which are newly identified since the ACMD last reviewed GHBRS and are important to consider for treatment and service provision.**

- **There is strong new evidence of significant harm due to the criminal use of GHBRS, including murder, drug-facilitated sexual assault (DFSA) and robbery.** The harms resulting from these criminal acts are severe and include death in the most extreme instances. Survivors of DFSA may experience a complex wide-ranging combination of harms requiring support from several different services. Weaponisation of GHBRS is of particular concern because GHBRS are eliminated from the body rapidly, meaning it is very difficult to definitively pronounce in criminal cases. In addition, GHBRS cause amnesia, meaning victims of crime sometimes do not recall they have been the victim of crime, or can remember very little about it. Other evidence of social harms is sparse, but the evidence available suggests a reduction or loss of an individual's social and community networks, and a negative impact on personal relationships. There was a scarcity of information regarding the effects of GHBRS on employment, family life, education and housing.

- **GHBRS use is higher amongst the lesbian, gay, bisexual and trans-gender (LGBT) groups and particularly amongst men who have sex with men (MSM) within a sexualised context.** These users are vulnerable to additional harms, including sexually transmitted infections (STI), HIV and Hepatitis transmission. MSM using GHBRS in chemsex are at risk of sexual assault due to the effects of GHBRS (reduced consciousness or coma) rendering the individual unable or less able to give or rescind consent during sex. If sexual assault does occur, there is potential for significant harm from psychological distress. Additionally, there is significant evidence of stigma experienced by LGBT GHBRS users, which is a barrier to service access. The complex harms – both physical, mental and social – experienced by MSM require specialist sexual assault support, and it is reported that users believe that current services do not meet these needs.

- **There is a need for integrated and open access sexual health and substance misuse services in order to reduce harm from GHBRS.** Treatment services, including drug treatment, sexual health services and A&E, are currently under-prepared to treat people with harmful/dependent use of GHBRS due to the overlap between physical, mental and social harms from GHBRS drug use, along with the chemsex context of use and associated sexual health needs. LGBT and MSM individuals report experiencing stigma when attending treatment services for GHBRS, due to a lack of expertise or understanding of chemsex, which acts as a barrier to treatment access.

- **It is important to ensure that all services are equally accessible and not exclusive.** There is a concern stemming from reports by clinicians of emerging and increasing use of GHBRS as a recreational club drug, and in other groups who use them outside of a sexual context.

- **Whilst a significant proportion of GHBRS users experience a range of physical, mental and social health harms, few access professional support for fear of judgement or concern about chemsex expertise.** It is important not just to develop knowledge of the drug itself, but also the cultural context of use, and the ability and cultural competence of staff to create an

environment where a service user can be open and honest about associated behaviours such as sexual behaviour.

- **There is a lack of available training opportunities for staff who come into contact with GHBRS users.** Developing better service models (recommendation above) will only work if staff are appropriately skilled.

- **There is a need for improved management of GHBRS-related chronic harms (sexual trauma, stigma) and non-acute GHBRS-related presentations to support services, such as elective withdrawal.**

- **GHBRS have a unique risk profile to people who choose to use them (and to those who are given them covertly).** GHBRS users can reduce their risk by being provided with accurate and timely information regarding:
  - the safest way to manage doses;
  - interactions with other substances;
  - mental health harms from GHB-induced coma; and
  - vulnerability to crimes such as DFSA and robbery.

The ACMD has made the following recommendations:

Recommendation 1: Data collection and reporting

To improve current service level data collection and reporting in the following ways:

Part 1

- Ensure that sexual health services report relevant sections as required in GUMCAD V3, with financial support afforded to those services that require adaptation of electronic patient systems.

- For the PHE National Drug Treatment Monitoring System (NDTMS):
  a) service reporting of sexual orientation to remain above 95% field completion; and
  b) to make publicly available, on an annual basis, the sexual orientation for individuals in treatment for GHBRS, crystal methamphetamine, ketamine and mephedrone (note: all four relevant chemsex drugs are included to give an indication of chemsex needs and ensure that data for GHBRS does not need to be limited by PHE for the reasons of disclosure control).

- **Part 2**
  For the Crime Survey for England and Wales (CSEW) to collect data frequently from all individuals on:

  a) GHBRS use; and
  b) sexual orientation.

- **Part 3**
  For the UK Government to provide sufficient funding to enable provision and analysis of The Gay Men's Sex Survey (GMSS) for at least five years. As this has previously been funded as part of an EU grant this recommendation is in line with

the UK Government's commitment that research in the UK will not suffer as a result of EU-exit.

Lead organisations:
Part 1: PHE; the Home Office; and British Association for Sexual Health and HIV (BASHH).
Part 2: The Home Office; and the Office for National Statistics.
Part 3: UK Government department responsible for funding research.

Measure of impact:
Part 1 of recommendation:

- for 95% reporting from all services in NDTMS;
- at least 65% improvement in services reporting via GUMCAD V3; and
- evidence of financial support where services require it.

Part 2 of recommendation:

- CSEW survey: For subsequent CSEW survey reports to demonstrate that the question has been asked and data have been collected, and that there is improvement in the data completeness over time.

Part 3 of recommendation:

- GMSS: For confirmed funding of the GMSS survey for at least the next five years.

Recommendation 2: Testing

Testing for GHBRS should be routinely undertaken in all cases of unexplained sudden death. Where testing is not possible (for example, not enough sample, financial, or other reason) then a clear statement should be included in the toxicology report stating that GHBRS testing has not been carried out. Where a blood sample is positive for GHBRS, if possible, this should be confirmed in another sample type, for example, urine.

Lead organisations: Forensic services; sexual assault referral centres (SARCs); coroners in England, Wales and Northern Ireland; and procurators fiscal in Scotland.

Measure of impact: Non-systematic toxicology screening for GHBRS hinders the capacity to measure and understand trends in GHB use and harm. If these recommendations are implemented, those agencies and researchers monitoring GHBRS involvements in deaths, will be able to report GHBRS-related deaths as a proportion of those tested for GHBRS. In cases of unexplained sudden death, impact could be measured with testing (numerator) and autopsies (denominator).

Recommendation 3: Classification

The ACMD recommends that GHB, GBL and 1,4-BD be moved to Class B of the MDA.

Lead Department: The Home Office.

Measure of implementation: Legislative change to the MDA. This recommendation should be considered alongside recommendations 5 to 8, which will collectively provide a range of interventions to reduce the harms associated with these compounds.

Metrics for assessing the intended effect: Reduction in severe harm from crimes facilitated by GHBRS and mental health harms associated with GHBRS use

There may be unintended effects of the recommendation (see discussion in Annex E). These might be quantified and gaps in evidence could be explored further with research.

Recommendation 4: Scheduling

The ACMD recommends that:

i) GHB remains scheduled under Schedule 2 of the MDR (as amended).
ii) GBL and 1,4-BD are placed under Schedule 1 of the MDR (as amended), and that their legitimate industrial uses are made subject to a Home Office controlled drugs licensing regime.

Lead Department: The Home Office.

Measure of impact: Legislative change to the MDR (as amended).

Recommendation 5: Better integration of drug treatment and sexual health services

Commissioning (including at regional/local level as indicated by need) of open access, competent, culturally appropriate, substance use and sexual health services to address the inter-related harms and psychosocial aspects of health due to GHBRS use, including in the context of sexualised drug use. Integrated treatment models currently (as at 2020) exist in the UK and these should be examined to understand best practice.

In high demand areas, the closer integration of drug treatment and sexual health services, including co-location, should be further explored for effectiveness, underpinned by models of joint funding and commissioning. In areas of lower demand/capacity, commissioners and providers should ensure expert referral pathways between services.

Further research into effective service access should be conducted, particularly in areas of high prevalence, including A&E and primary care. It is noted that this recommendation applies to GHBRS but could also apply to chemsex drugs in general.

Lead organisations: The commissioners of Sexual Health Services (SHS) and Substance Misuse Services (SMS); BASHH – in the standards for STI management; PHE Health Improvement Division, The Local Government Association (LGA); The Association of Directors of Public Health.

Measure of impact
Delivery: PHE to conduct an annual audit/questionnaire of the SHS, SMS and local government to capture presence or co-commissioning, alongside treatment numbers.

Impact: Service user feedback annually undertaken by providers and commissioners jointly of service users. Feedback should be collected on:

- accessibility;
- acceptability;
- waiting times for appointment at integrated service; and
- out of area attendances.

A surrogate marker for improvement in acceptability of the SMS could be a decrease in the proportion of people over time who decline to give their sexual orientation when specifically asked by services. These data can be found in the PHE NDTMS data tables published annually.

Recommendation 6: Education

Develop a specialist education pathway for frontline staff in the health and social care system who come into contact with GHBRS users. These staff include those within the SHS, SMS, and emergency departments (overdose and withdrawal). The specialist education pathway should provide staff with relevant training on GHBRS-related harms in order to better equip them in managing complex cases and provide essential information on drug use, cultural competence and understanding. This should help to deliver a higher quality and non-judgemental service, working towards reducing harm and alleviating some of the stigma associated with the use of GHBRS. A skilled workforce should also enable improved engagement at the first point of contact with the SHS/SMS.

To review and update the chemsex e-Learning module of the Sexual Health and HIV training to ensure that the content reflects the importance of not just drug knowledge but also covers cultural competence and creating a safe environment for open discussion about risks and sexual behaviour.

In addition, for the inclusion of GHBRS within postgraduate programmes and speciality nurse training, Diploma of genitourinary (GU) Medicine, and speciality training curricula.

Lead organisations: BASHH; SAAS Advisory Board (NHS England and PHE); the Society of Apothecaries; NEPTUNE; Health Education England (HEE); the Academy of Royal Colleges; the Royal College of Psychiatrists; the Royal College of

Physicians (including the Faculty of Forensic and Legal Medicine); postgraduate programmes.

Measure of impact: Training requirements clearly stated in national standards (for example, BASHH standards for STI management, speciality training curricula and Faculty of Forensic and Legal Medicine national standards), service specifications and staff competencies monitored by commissioners and providers. Audit of relevant courses/standards for inclusion; metrics of current training courses; provider training records (staff continuing professional development (CPD) certification and e-learning completions).

Recommendation 7: Treatment interventions

Chronic harms (sexual trauma and stigma)
Services involved in the management of people who use GHBRS should provide comprehensive assessments and evidence-based psychological and social support to individuals within a key worker/client context. These should be tailored to the individual requirements of the service user according to their specific needs, for example, issues related to age, ethnicity, cultural context, diversity and social isolation. For those individuals with more complex needs all relevant services should have commissioned, clear and timely pathways to care.

Non-acute presentations to support services (for example, elective withdrawal)
The TOXBASE® clinical guidelines for GHBRS intoxication and withdrawal, which are used by emergency department staff, should be emphasised to be of value for non-acute services, such as elective detoxification presentations. Support services should access TOXBASE® guidelines directly or adapt the content to the local service need.

Lead organisations: PHE; the voluntary sector; NHS Sexual Health and Substance Misuse treatment providers; commissioners who have responsibility for funding services relevant to the sector.

Measure of impact: Number of individuals accessing sexual health and substance misuse treatment, for example, PHE to produce reports using GUMCAD V3 and NDTMS data and to monitor an individual's engagement with the service over time and any reduction in drug and sexual risky behaviour. Improved access to and retention in relevant service provision.

Recommendation 8: Information and support

To ensure the availability and promotion of information and support to those who are at highest risk of harms associated with GHBRS. This should utilise reliable and up-to-date sources of information that are already available on physical, mental and social harms, including sexual harms and consent in a chemsex setting. The information should, where necessary, be individualised and accessible (for example, in appropriate languages).
Current sources of available information include: FRANK, Antidote, Crew.

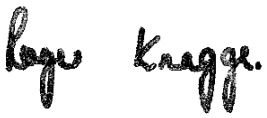
Lead organisations: The Department of Health and Social Care; PHE; SAAS; NHS England, Wales, Scotland and Northern Ireland; BASHH; third-sector treatment providers; relevant non-governmental organisations active in the field.

Measure of impact: Audit of advice (quality and access metrics repeated over time); research on reach and uptake of the information; organisations undertake feedback exercise with users.

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

Yours sincerely

Professor Owen Bowden-Jones
Chair of ACMD



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