ADVISORY COUNCIL ON THE MISUSE OF DRUGS
Home Office, 2 Marsham Street, London SW1P 4DF

April 2007

Dear Home Secretary

In January 2006 your predecessor asked the Advisory Council on the Misuse of Drugs (ACMD) to look into the factors surrounding drug facilitated sexual assault. The Council has now done so and I am pleased to enclose its report.

The Council considers drug facilitated sexual assault, whether premeditated or opportunistic, to be a particularly disgusting offence. It makes a number of recommendations including:

1) A proposal for the ACMD to examine measures for restricting the availability of gamma butyrolactone (GBL) and 1, 4-butanediol.

2) A request that the Association of Chief Police Officers, in consultation with the Forensic Science Service, issue further advice to ensure appropriate body samples are collected from victims as soon as possible after an alleged attack.

3) A request that the Department of Health arranges for "early evidence kits", and appropriate advice on their use, to be made available in all Accident and Emergency Departments and Sexual Assault Referral Centres.

4) Further advice should be offered to young people about how to minimise the risks of drug facilitated sexual assault.

The Council will keep this matter under review and will make further reports as is appropriate.

Yours sincerely

Professor Sir Michael Rawlins FMedSci
Chairman

Advisory Council on the Misuse of Drugs

Photo illustration by Casey Templeton (USA)

DRUG FACILITATED SEXUAL ASSAULT

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1. Background

1.1 The Advisory Council on the Misuse of Drugs is established under the Misuse of Drugs Act. (1971) and its terms of reference and current membership are shown in Annexes 1 and 2 (respectively). In January 2006, the then Home Secretary requested the Council to report on drug facilitated sexual assault.

1.2 Two forms of serious sexual assault are now defined in law (1). *Rape* refers to penetration of the vagina, anus (since 1994) or mouth (since 2003) by an assailant's penis without consent. *Assault by penetration* is penetration of the vagina or anus by other body parts (such as fingers) or by objects.

1.3 The 2001 British Crime Survey included a self-completed questionnaire involving a representative sample of 22,463 women and men aged 16 to 59 years (2). The questionnaire was designed to ascertain the most reliable estimates of the incidence of domestic violence, sexual assault and stalking for England and Wales.

1.3.1 The results (2) showed that, amongst the age range of 16 to 59 years, 7.0% of women and 1.5% of men had been subjected to a serious sexual assault during their lives; and that 1.5% of women and 0.1% of men had been the subject of a serious sexual assault in the previous year. Extrapolated to the population of England and Wales these findings suggest that, during 2000, there were around 25,000 victims of rape (95% confidence intervals 11,000 to 39,000).

1.3.2 Of those respondents who had been subjected to serious sexual assault, 40% told no-one about their ordeal and in only 12% of instances did the police come to know about it (2).

1.4 The number of prosecutions for rape in 2004 was 2689 of which only 751 resulted in conviction (3).

2 Drug facilitated sexual assault: overview

2.1 Over the past ten years there have been increasing numbers of reports from Australia (4,5,6), the United States of America (7,8), the United Kingdom (9,10) as well as elsewhere in Europe expressing concern about the frequency with which drugs and/or alcohol have been used to induce people to engage in sexual activity without their consent.

2.2 The 2001 British Crime Survey (2) showed that of those who had ever been subjected to a serious sexual assault, 5% stated that they had undergone vaginal or anal penetration with a penis whilst drugged in some way; and 15% admitted to penetrative sexual activity whilst incapable of giving consent due to alcohol. A further 6% had been subjected to penetration of the mouth, or other assault by penetration,

whilst drugged; and 17% when incapable of giving consent due to alcohol.

2.3 A number of terms have been used to describe situations where drugs and/or alcohol have been used to induce people to engage in sexual activity without their consent (2). These terms include “date rape”, “date rape drugs” and “spiked drinks”.

2.3.1 In this report, the Council’s definition of *drug facilitated sexual assault* includes all forms of non-consensual penetrative sexual activity whether it involves the forcible or covert administration of an incapacitating or dysinhibiting substance by an assailant, for the purposes of serious sexual assault; as well as sexual activity by an assailant with a victim who is profoundly intoxicated by his or her own actions to the point of near or actual unconsciousness.

2.3.2 This definition does not distinguish between the use of controlled drugs, and other substances (including alcohol), that may induce people to engage in penetrative sexual activity without their consent; nor does it distinguish between forced, covert or self-administration.

2.4 The 2001 British Crime Survey clearly suggests that the prevalence of drug facilitated sexual assault is significant. The records of convictions for serious sexual assault, however, do not differentiate between those concerned with drug facilitated sexual assault and those involving other forms of force.

2.4.1 The low reporting rates, to the police, by victims of serious sexual assault are likely to be even lower than for those subjected to drug facilitated sexual assault. The reasons include (7):

- feelings of guilt or self-blame because of prior voluntary ingestion of alcohol and/or drugs;
- confusion and uncertainty, as a result of memory impairment due to the drug’s effects, about what happened;
- reluctance to make accusations without personal knowledge, or memory, of the circumstances leading to the assault.

3. Drug facilitated sexual assault: the drugs

3.1 Two groups of drugs – central nervous system depressants and central nervous system stimulants – have been implicated, in the literature, with drug facilitated sexual assault.

3.1.1 The intended effect of administering central nervous system depressants (sedatives and hypnotics), in drug facilitated sexual assault, is to alter a victim’s behaviour and cause anterograde amnesia (i.e. loss of memory for the events leading up to the assault). The behavioural change may range from acquiescence (as a result of drug-induced dysinhibition) to unconsciousness.

3.1.2 Emerging evidence also suggests that, paradoxically, at least some substances with central nervous system stimulant activity may also cause dysinhibition leading to inappropriate or more risky acquiescence in sexual activity (11).

3.2 The central nervous system depressant substances that have been most frequently associated with drug facilitated sexual assault in the international literature are alcohol, benzodiazepines, gamma-hydroxy butyrate (and related substances), and ketamine.

3.2.1 Alcohol, depending on the quantity consumed, will produce (12) effects ranging from dysinhibition (at low doses) to unconsciousness (at high doses). The potential of alcohol to be a causal agent in drug facilitated sexual assault is unquestionable irrespective as to whether it has been consumed knowingly, or unknowingly, by a victim.

3.2.2 Benzodiazepines, generally, are all central nervous system depressants. They are used, clinically, as hypnotics, sedatives, anxiolytics and anticonvulsants. They are also recognised to produce dysinhibition at doses that do not result in stupor (13). All are controlled under the Misuse of Drugs Act (1972) as class C substances.

The benzodiazepine most commonly claimed to be associated with drug facilitated sexual assault in the media is flunitrazepam (Rohypnol) which is licensed in many countries as a hypnotic. Although available on private prescription in the UK, it is not provided under the National Health Service. Flunitrazepam is tasteless, odourless and colourless and readily dissolves in liquid. After administration it is slowly metabolised, and it (or its metabolites) can be detected in the urine for at least 72 hours. It has been implicated in drug facilitated sexual assault in the US and Britain. The manufacturer of the licensed product (Roche Pharmaceuticals) undertook reformulation, in 1998, and added a blue dye which fizzes when it comes into contact with liquids. This dye is not, however, present in flunitrazepam from illicit sources. The UK law enforcement agencies report 31 seizures of illicit flunitrazepam between 2001 and 2006.

There is no reason to believe that flunitrazepam has unique properties as a weapon in drug facilitated sexual assault: all other benzodiazepines, as well as non-benzodiazepines with similar pharmacological properties (zaleplon, zopiclone, zolpidem), have dysinhibitory properties.

3.2.3 Gamma-hydroxy butyrate (GHB) is a central nervous system depressant with a mechanism of action that differs from those of either alcohol or the benzodiazepines (14). It produces sedation and anaesthesia but has a steep dose-response curve that is very variable between individuals. High blood concentrations may cause stupor and respiratory depression: low doses are associated with increased libido, euphoria, suggestibility, passivity and amnesia which are properties

rendering victims vulnerable to non-consensual sexual activity. GHB is rapidly absorbed with peak plasma concentration achieved between 30 and 45 minutes. It is rapidly metabolised, with a half-life of around 30 minutes, and is undetectable in urine after 12 hours. It may be possible to detect the compound for very much longer in hair.

GHB has been licensed in Europe as an anaesthetic agent and alcohol substitute for some years and is now authorised as a medicinal product in the UK (as sodium oxybutrate) for sleep fragmentation in narcolepsy; and it has been controlled under the Misuse of Drugs Act as a class C substance since 2003. GHB has been implicated in sexual assaults in the UK, other parts of Europe, and the US (9). The law enforcement agencies report 233 seizures of GHB between 2001 and 2006.

3.2.4 Gamma butyrolactone (GBL) and 1, 4-butanediol (1,4-B) are interconvertible forms of GHB that are rapidly metabolised to GHB after ingestion. They therefore produce effects that are identical to those of GHB. GBL is commonly used as a cleaning fluid and as an industrial solvent. It is also used as a precursor in the chemical synthesis of GHB. GBL is not currently controlled under the Misuse of Drugs Act.

1,4-B is also used as a cleaner and as an industrial solvent, but also in the manufacture of plastics. Like GBL it is not currently controlled under the Misuse of Drugs Act. Both GBL and 1,4-B appear in the urine as GHB. Law enforcement agencies are aware of substantial exports of GBL from the UK to the US where both are controlled substances.

3.2.5 Ketamine has been available since the 1960s as an anaesthetic agent and is a licensed medicinal product in the UK. It acts by blocking the action of glutamate and, at low doses, produces euphoria coupled with feelings of dissociation (15). It has been implicated as a weapon in drug facilitated sexual assault and has been controlled under the Misuse of Drugs Act, as a class C substance, since 1st January 2006.

3.3 The central nervous system stimulants most commonly associated with drug facilitated sexual assault are cocaine and MDMA (ecstasy).

3.3.1 Cocaine is a local anaesthetic and central nervous system stimulant that is administered as either the hydrochloride salt or the [free]-base. The salt is taken either intranasaly (snorted) or via other mucus membranes (such as by rubbing on the gums, vagina or anus) or is dissolved and then injected. The free base forms (including “crack”) are smokable and give a very fast and intense “high”. Methylamphetamine is a smokable derivative of amphetamine that is widely abused in the Far East and the USA but has limited use in the UK. When smoked a long lasting “high” is produced. It is thought that cocaine and methylamphetamine cause the release of dopamine in the frontal brain

leading to an increase in sexual drive, as well as loss of inhibitions, so encouraging risky sexual behaviour.

3.3.2 MDMA (ecstasy) is a stimulant that has a different profile of action to cocaine and methylamphatamine in that it probably releases serotonin as well as dopamine. It is very widely used as a dance drug because of its ability to energise as well as increase empathy and positive feelings towards others. There are anecdotal reports of its use being associated with increased sexual activity, though usually in a consensual manner.

4. Drug facilitated sexual assault: UK forensic experience

4.1 Two studies, carried out by the Forensic Science Service (16) and the Police Standards Unit (17), have recently been published. That of the Forensic Science Service (16) describes the toxicological findings in 1014 instances of alleged drug facilitated sexual assault for the period 2000 to 2002. Operation Matisse (17) was a 12 month study by the police, the Forensic Science Service and the Sexual Assault Referral Centres, in 6 areas of England. It investigated 120 police-referred victims who had reported a drug facilitated sexual assault within the previous 72 hours. Victims completed a questionnaire and provided samples of blood and urine (and, in some instances, hair) which were examined for the presence of alcohol and a wide range of licit and illicit drugs.

Forensic Science Service Study (16)

4.2 Alcohol, alone or with an illicit drug and/or medicinal drug, was present in 46% of cases. Illicit drugs were detected in 34%; cannabis (26%), cocaine (11%) and MDMA (5%) were the most common. GHB was detected in 2 cases.

4.2.1 In those instances where alcohol was detected, back extrapolation suggested that, at the time of the alleged incident, 60% had levels in excess of 150 mg/100ml and 40% had levels above 200 mg/100ml. Levels above 150 mg/ml are associated with intense intoxication and memory impairment.

4.2.2 A range of benzodiazepines and other central nervous system depressants were identified in the samples examined. In 21 instances, their presence could not be explained by voluntary use. The drugs involved are shown in table 1.

Table 1: Unexplained drugs with central nervous system activity identified in blood or urine samples

Drug	Number attributed to deliberate "spiking"	
	Scott-Ham and Burton (n=1,014)	Operation Matisse (n=120)
Temazepam	6	1
Diazepam	3	1
Lorazepam	1	0
Lormetazepam	1	0
Nitrazepam	1	0
Flunitrazepam	1	0
Zopiclone	0	0
Diphenhydramine*	2	0
Mirtazapine	1	0
GHB	2	2
MDMA	3	1
Cocaine	0	2
Cocaine *plus* cannabis	0	2

* This is an antihistamine that will cause sedation and accentuate the actions of alcohol

4.2.3 There were a further 9 instances where the victim was allegedly offered, or forced to ingest, a drug. The substances involved included benzodiazepines or benzodiazepine-like substances (n=5) and cocaine (n=2).

Operation Matisse (17)

4.3 Although in 119 out of 120 cases alcohol had allegedly been taken before the offence, it could be detected in only 62 (52%) instances. There were marked time delays, between the incident and sample collection, where victims stated that alcohol had been consumed but none was detected.

4.3.1 In 41 of the 62 instances where alcohol was detected one or more controlled drugs were also present.

4.3.2 In those cases where alcohol levels could be back-extrapolated to the time of the alleged incident (n=31), all had levels in excess of 100mg/100ml and 22 had levels in excess of 200 mg/100ml.

4.4 In 9 instances, drugs which victims stated they had not used, were identified in body fluids (Table 1). In one case (not included in Table 1) the victim was forced to take cocaine.

4.4.1 In a further 11 instances, the covert administration of drugs could not be eliminated due to lack of clarity in circumstantial information. The drugs involved included cocaine (4 cases) and alcohol (3 cases), as

well as “Night Nurse”, dextropropoxyphene, codeine plus diphenhydramine and zopiclone (1 each).

4.5 Beer mats/coasters impregnated with materials designed to help in the detection of drugs that are used as weapons in drug facilitated sexual assault - so called "drug detectors" – are useful for raising awareness; but should not be relied on as they only test for a limited range of drugs and can give misleading results.

5. Conclusions

5.1 Drug facilitated sexual assault, including with alcohol, is a significant problem in Britain and the Council recognises two forms (17):

- *Proactive drug facilitated sexual assault* involves the covert or forcible administration of an incapacitating or dysinhibiting substance, by an assailant, for the purpose of sexual assault.

- *Opportunistic drug facilitated sexual assault* involves sexual activity, by an assailant, with a victim who is profoundly intoxicated by his or her own actions to the point of near or actual unconsciousness, and thus lacks the capacity to consent.

5.2 The incidence of drug facilitated sexual assault is unclear. Many victims fail to report the incident for reasons discussed above. Where victims do report the incident, the elapsed time may be too long for drugs to be reliably detected in blood or urine. This particularly applies to alcohol and GHB.

5.3 The evidence suggests that the most common weapon used in drug facilitated sexual assault, whether proactive or opportunistic, is probably alcohol.

5.4 Although no case of drug facilitated sexual assault using flunitrazepam was identified in either the Forensic Science Services study, or in Operation Matisse, other benzodiazepines appear to have been used as weapons.

5.5 Other controlled drugs – especially cocaine and GHB – appear to have been used as weapons in some instances of drug facilitated sexual assault.

6. Recommendations

6.1 The Council considers drug facilitated sexual assault to be no less coercive as forcible sexual assault: both remove the capacity to consent. The Sexual Offences Act (2003) makes it an offence to administer any drug with intent to stupefy or overpower a person so as

to commit a sexual offence against them. Although this provision covers *proactive* drug facilitated sexual assault it fails to provide protection against *opportunistic* drug facilitated sexual assault. The Council is uncertain as to whether the law could be strengthened in this respect, but recommends that the Home Secretary seeks advice from the Government's law officers.

6.2 Apart from alcohol, those substances most frequently implicated in drug facilitated sexual assault are already adequately controlled under the Misuse of Drugs Act. Nevertheless, the Council is concerned at the continuing availability of gamma butyrolactone (GBL) and 1,4-butanediol (1,4-B) which are not controlled. It proposes to re-examine the use of these materials, and will provide the Home Secretary with further advice before the end of this year.

6.3 The Association of Chief Police Officers, in consultation with the Forensic Science Service, should issue further advice to ensure that appropriate samples of blood and urine are obtained from potential victims of drug facilitated sexual assault, at the earliest possible time, using the "early evidence kit" or other appropriate sampling techniques. In particular, this advice should emphasise that the collection of urine samples should not await the arrival of a forensic medical examiner. Advice on the collection of hair samples should also be included. All samples should be saved and tested for alcohol as well as drugs.

6.4 The Department of Health should ensure that "early evidence kits" are available in all Accident and Emergency Departments. The Department of Health should also consider developing, and disseminating, guidance to staff in Accident and Emergency Departments and Sexual Assault Referral Centres, to improve the management of victims of alleged drug facilitated sexual assault. Health ministers may wish to ask the National Institute for Health and Clinical Excellence (NICE) to develop such guidance.

6.5 Further efforts should be made to alert young people to the ways in which the risk of drug facilitated sexual assault can be minimised. Such advice should be particularly targeted through secondary schools as well as further and higher educational establishments and should include, as appropriate, the following messages:

- Plan your journey both to and from home.
- Avoid going to a club, pub or party alone.
- Make sure somebody knows where you are going and what time you will be back.
- Stay aware of what is happening around you and avoid situations in which you feel uncomfortable.
- Don't accept a drink from anyone you don't trust.
- Don't share or exchange drinks.
- Don't leave your drink unattended even when going to the toilet. Take it with you.

- Consider carefully whether to leave a party, club or pub with someone you've only just met.
- Be a friend by watching out for others, and be aware of any changes in their behaviour.

6.6 The public should be warned that so-called "drug detectors" (see paragraph 4.5), using beer mat tests, cannot be relied on to warn potential victims of the range of possible weapons used in drug facilitated sexual assault.

6.7 Further research in the area should be promoted. The Forensic Science Service should be encouraged to update the study by Scott-Ham and Burton (16). The British Crime Survey should be asked to repeat its 2001 study especially in respect of those parts of their questionnaire concerned with serious sexual assault. Convictions for drug facilitated sexual assault should also be recorded.

6.8 The Council will continue to keep this issue under review.

Annex 1

References

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Annex 2

Terms of Reference of the Advisory Council on the Misuse of Drugs

" It shall be the duty of the Advisory Council to keep under review the situation in the United Kingdom with respect to drugs which are being or appear to them likely to be misused and of which the misuse is having or appears to them capable of having harmful effects sufficient to constitute a social problem, and to give to any one or more of the Ministers, where either Council consider it expedient to do so or they are consulted by the Minister or Ministers in question, advice on measures (whether or not involving alteration of the law) which in the opinion of the Council ought to be taken for preventing the misuse of such drugs or dealing with social problems connected with their misuse, and in particular on measures which in the opinion of the Council, ought to be taken:

a) for restricting the availability of such drugs or supervising the arrangements for their supply;

b) for enabling persons affected by the misuse of such drugs to obtain proper advice, and for securing the provision of proper facilities and services for the treatment, rehabilitation and after-care of such persons;

c) for promoting co-operation between the various professional and community services which in the opinion of the Council have a part to play in dealing with social problems connected with the misuse of drugs;

d) for educating the public (and in particular the young) in the dangers of misusing such drugs and for giving publicity to those dangers; and

e) for promoting research into, or otherwise obtaining information about, any matter which in the opinion of the Council is of relevance for the purpose of preventing the misuse of such drugs or dealing with any social problem connected with their misuse".

A further duty is placed on the Council by the Act to consider any matter relating to drug dependence or the misuse of drugs which may be referred to them by any one of the Ministers concerned, and in particular to consider and advise the Home Secretary on any communication which he refers to the Council which relates to the control of a dangerous or otherwise harmful drug and which is made to Her Majesty's Government by any organisation or authority established by treaty, convention or other agreement or arrangement to which Her Majesty's Government is a party.

Annex 3

Membership of the Advisory Council on the Misuse of Drugs

Professor Sir Michael Rawlins	Professor of Clinical Pharmacology, University of Newcastle upon Tyne and Chair of the National Institute for Health and Clinical Excellence
Dr Dima Abdulrahim	Senior Researcher, National Treatment Agency
Lord Victor Adebowale	Chief Executive, Turning Point
Mr Martin Barnes	Chief Executive, DrugScope
Dr Margaret Birtwistle	Specialist General Practitioner
Reverend Martin Blakebrough	Director, Kaleidoscope Drugs Project, Newport
Dr Cecilia Bottomley	Specialist Registrar in Obstetrics and Gynaecology, London
Ms Carmel Clancy	Principal Lecturer for Mental Health and Addictions, Middlesex University
Professor Ilana Crome	Professor of Addiction Psychiatry, Keele University Medical School, Harplands Hospital
Ms Robyn Doran	Registered Mental Health Nurse and Service Director Substance Misuse, Central and North-West London Mental Health Trust
Ms Dianne Draper	Health Policy Manager, Government Office for Yorkshire & Humberside
Mr Robert Eschle	Magistrate and District Councillor, Essex
Ms Vivienne Evans	Chief Executive, ADFAM
Professor C Robin Ganellin FRS	Emeritus Professor of Medicinal Chemistry, University College London
Dr Clare Gerada	General Practitioner, London and Primary Care Lead for Drug Misuse,

	Royal College of General Practitioners
Mr Patrick Hargreaves	Drugs and Alcohol Adviser, OFSTED School Inspector, Durham
Mr Paul Hayes	Chief Executive, National Treatment Agency
Mr Russell Hayton	Clinical Nurse Specialist and Clinical and Services Governance Manager, Plymouth Drug and Alcohol Action Team
Ms Caroline Healy	Children's Services Adviser
Dr Matthew Hickman	Senior Lecturer in Public Health and Epidemiology, Bristol University
Mr Alan Hunter	Legal Mentor to the Association of British Pharmaceutical Industry
Professor Leslie Iversen	Professor of Pharmacology, Oxford University
His Honour Judge Thomas Joseph	Resident Judge, Lewes Crown Council
Professor Michael Lewis	Head of Department and Professor of Oral Medicine, Cardiff University
Dr John Marsden	Senior Lecturer in Addictive Behaviour, Kings College, London
Mr Peter Martin	Independent Consultant in Substance Misuse
Mrs Samantha Mortimer	Head of Personal, Social and Health Education and Citizenship, St Paul's Catholic High School, Manchester
Professor David Nutt	Professor of Psychopharmacology, University of Bristol
Dr Richard Pates	Chair of Advisory Panel on Substance Misuse, Wales
Mr Trevor Pearce	Executive Director- Serious Organised Crime Agency

DCC Howard Roberts	Deputy Chief Constable, Nottinghamshire Police
Mrs Kay Roberts	Pharmacy Consultant, Glasgow
Dr Mary Rowlands	Consultant Psychiatrist in Substance Misuse, Exeter
Dr Polly Taylor	Freelance Consultant in Veterinary Anaesthesia, Cambridgeshire
Ms Monique Tomlinson	Freelance Consultant in Drug Misuse
Mr Arthur Wing	Assistant Chief Officer, Sussex Probation Area